COUNTRY PROGRAMME ACTION PLAN (CPAP)

2010 – 2013

BETWEEN

THE GOVERNMENT OF THE ISLAMIC REPUBLIC OF AFGHANISTAN

AND

THE UNITED NATIONS POPULATION FUND (UNFPA)

March 27, 2010

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LIST OF ABBREVIATIONS

AADA	Agency for Assistance and Development of Afghanistan
ACSF	Afghanistan Civil Society Foundation
AIHRC	Afghan Independent Human Rights Commission
ANDMA	Afghanistan National Disaster Management Authority
ANDS	Afghanistan National Development Strategy
APHC	Afghanistan Population and Housing Census
APRO	Asia and Pacific Regional Office
ARCS	Afghan Red Crescent Society
ASRH	Adolescent Sexual and Reproductive Health
AWN	Afghan Women's Network
AWP	Annual Work Plan
BCC	Behaviour Change Communication
BCP	Business Continuity Plan
BHC	Basic Health Centre
BPHS	Basic Package of Health Services
CBO	Community Based Organisation
CDC	Community Development Council
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CHC	Comprehensive Health Centre
CHW	Community Health Worker
CMW	Community Midwife
CO	Country Office
COAR	Country Office Annual Report
CP	Country Programme
CPAP	Country Programme Action Plan
CPCC	Country Programme Coordination Council
CPD	Country Programme Document
CPR	Contraceptive Prevalence Rate
CSO	Central Statistics Office
DHO	District Health Officers
DMoY	Deputy Ministry of Youth
DTP	Diphtheria, Tetanus and Polio
EC	European Commission
EDP	External Development Partners
EGP	Ethics and Gender in Policing
EMIS	Education Management Information System
EmOC	Emergency Obstetric Care
EPHS	Essential Package of Health Services
FAO	Food and Agriculture Organisation
FACE	Fund Authorization and Certificate of Expenditures
FHH	Family Health Houses
FP	Family Planning
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GEWE	Gender Equality and Women Empowerment
GIS	Geographic Information System
GSI	Gender Studies Institute
HCT	Humanitarian Country Team
HDI	Human Development Index
HHL	Household Listing
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
HQ	Headquarters
HRBA	Human Rights Based Approach
HRDP	Human Resources Development Plan
ICA	Information, Communication and Advocacy
ICAB	International Census Advisory Board
ICPD	International Conference on Population and Development
IDP	Internally Displaced Person
IDU	Injecting Drug Users

IEC	Information Education Communication
IFI	International Financial Institutions
ILO	International Labour Organisation
IMF	International Monetary Fund
IMR	Infant Mortality Rate
IP	Implementing Partners
IOM	International Organization for Migration
KAP	Knowledge, Attitudes and Practices
KPA	Kabul Police Academy
LMIS	Logistics Management Information System
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MERLIN	Medical Emergency Relief International
MHU	Mobile Health Unit
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MoF	Ministry of Finance
MoFA	Ministry of Foreign Affairs
MoEc	Ministry of Economy
MoEd	Ministry of Education
MoI	Ministry of Interior
MoJ	Ministry of Justice
MoPH	Ministry of Public Health
MoRRD	Ministry of Rehabilitation and Rural Development
MoWA	Ministry of Women Affairs
MoHRA	Ministry of Haj and Religious Affairs
MSH	Management Sciences for Health
MT Review	Mid-Term Review
NAPWA	National Action Plan for the Women of Afghanistan
(I)NGO	(International) Non Governmental Organisation
OBGYN	Obstetricians and Gynaecologists
PAS	Project Activity Sheet
PDS	Population and Development Strategies
PHD	Provincial Health Directorate
PRSP	Poverty Reduction Strategy Paper
PTT	Planning and Tracking Tool
RBM	Results-Based Management
RH	Reproductive Health
RHC	Reproductive Health Commodities
RHR	Reproductive Health & Rights
RHCS	Reproductive Health Commodity Security
RMS	Resource Mobilisation Strategy
RRF	Results and Resources Framework
SBAA	Standard Basic Assistance Agreement
SMI	Safe Motherhood Initiative
SPR	Standard Progress Report
SRA	Security Risk Assessment
SRH	Sexual and Reproductive Health
STAA	Standard Technical Assistance Agreement
STI	Sexually Transmitted Infection
TB	Tuberculosis
TFR	Total Fertility Rate
TRIPOD	Training, Research and Information facility on Population and Development
UN	United Nations
UNAMA	United Nations Assistance Mission in Afghanistan
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNESCO	United Nations Education, Sciences and Culture Organisation
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women

UNJP	United Nations Joint Programme
UNSCR	United Nations Security Council Resolution
UP	Uterine Prolapse
USAID	United States Agency for International Development
VAT	Value Added Tax
VCT	Voluntary Counselling and Testing
YAP	Youth Advisory Panel
WB	World Bank
WFP	World Food Programme
WHO	World Health Organisation

THE FRAMEWORK

The Government of the Islamic Republic of Afghanistan, hereinafter referred to as "the Government" and the United Nations Population Fund, hereinafter referred to as "UNFPA" are in mutual agreement on the content of this Country Programme Action Plan (CPAP), and on their respective roles and responsibilities in the implementation of the country programme; and

Furthering their cooperation on the *Programme of Action of the International Conference on Population and Development* (ICPD) of 1994, and their mutual agreement and cooperation for the fulfilment of the *UN Millennium Declaration* of 2000 and the *UN Global Summit* of 2005; in support of the *Afghanistan National Development Strategy 2008-2013* (ANDS) and the *United Nations Development Assistance Framework 2010-2013* (UNDAF), the Government and UNFPA are committed to;

Build upon the experience gained and progress made during the implementation of the second Programme of Cooperation (2006-2009) between the Government of Afghanistan and UNFPA;

Enter into a new period of cooperation, based on the third Country Programme Document 2010-2013 (CPD);

Declaring that these responsibilities will be fulfilled in a spirit of friendly cooperation;

The Government and UNFPA have agreed as follows:

PART I BASIS OF RELATIONSHIP

1. A draft Standard Basic Assistance Agreement (SBAA) is currently being discussed between the United Nations Development Programme (UNDP) and the Government of the Islamic Republic of Afghanistan. Once concluded and signed, the SBAA will be applied *mutatis mutandis* to UNFPA activities and personnel, through exchange of letters between UNFPA and the Government.

2. Until such time, the Standard Technical Assistance Agreement (STAA) between the Government of Afghanistan and the United Nations (UN), dated 10 May 1956, constitutes the legal basis for the relationship between the Government of Afghanistan and UNFPA.

PART II SITUATION ANALYSIS

General Overview

3. As the result of years of war and conflict, many Afghans lost their lives[1], while others were left orphaned or disabled. Almost one in three Afghans became a refugee, with many others displaced from their homes[2]. Destitution was wide-spread and continues to impede development. Rampant crime and endemic corruption combined with continued internal conflict pose serious challenges for reconstruction and development.

[1] Annual statistical book (CSO, 2009) estimated that 1.5 million people lost their lives between 1978 and 2001.
[2] UNHCR Global Appeal 2010-2011

4. By the end of 2002, well over 2 million Afghans had returned home from Pakistan and Iran. The repatriation continued throughout 2003 and 2004, with figures passing the half-million mark each year after which it started levelling off. In the areas of highest return, as many as one in three people is a returnee. This level of return has put a strain on receiving communities struggling to cope with already limited resources. At the same time, the return of internally displaced persons to their places of origin gathered pace.[3] As of 2010, there are still some 2.8 million registered refugees originating from Afghanistan, while another 230,000 Internally Displaced People (IDP) in Afghanistan remain[4].

5. Afghanistan is prone to natural disasters and extreme variations in weather conditions. Humanitarian emergencies impact highly on the most vulnerable, especially women, children and elderly people. Preparedness and recovery efforts tend to be hampered by political instability and insecurity, as well as cultural practices.

6. Sustained support from the international community has been imperative in the building and strengthening of governance systems. Since 2001 two presidential and provincial council elections have been held, while a second Parliamentary election is due in 2010. Significant progress has been made in the establishment and delivery of basic social services to large sections of society, especially in education and health.

7. However, continued insecurity threatens the establishment of sustainable governance and service delivery systems, at all administrative levels. It also increases transaction costs of development efforts, and limits access to the beneficiaries.

8. The Afghanistan Compact was agreed to by the Government of Afghanistan and its international development partners at the London International Conference on Afghanistan in January 2006. The UN Security Council unanimously endorsed the Afghanistan Compact and its annexes on 15 February 2006. The Compact details a set of outcomes, benchmarks, and timelines that encompass key Millennium Development Goals (MDG) and targets under the Paris Declaration on Aid Effectiveness. It called for the ANDS which was approved by the Cabinet in April 2008.

9. The overriding objective of the ANDS is to sustainably improve the lives of the Afghan people and create the foundation for a secure and stable country. The ANDS lays out strategic priorities and policies, programmes and projects related to its three pillars: (i) Security, (ii) Governance, Rule of Law and Human Rights and (iii) Economic and Social Development.

10. Notwithstanding the many detailed government strategies, policies and programmes that have been developed since 2002, they all were based on outdated and incomplete data sources. The country has never held a complete census nor is there a fully functional civil registration or cadastral system. The general lack of historic data, especially geographically defined socio-economic and demographic data, combined with weak institutional and technical capacity to produce and analyse socio-economic and demographic information, prevents the Government and other stakeholders to plan and implement evidence-based development efforts.

Population and poverty

11. Estimations concerning the population size of Afghanistan vary widely between 23 and 32 million[5]. Afghanistan faced a return of approximately 5 million refugees, whilst another 2.7 million are still registered and living in Iran and Pakistan[6]. This, combined with a total fertility rate (TFR) of 6.3 children per woman[7], makes that Afghanistan is experiencing rapid population growth, despite the very low life expectancy at birth (43.3 years for women and 43.4 for men)[8]. Large families are considered to be important to ensure

[3] The State of the World's Refugees 2006 - Chapter 6 Rethinking durable solutions: Box 6.2 Afghanistan - a complex transition

[4] UNHCR Global Appeal 2010-2011

[5] 23.8 million in 2005 (CSO and UNFPA, *Afghanistan Household Listing Project (HHL)*, 2003-2005); 23.8 million in 2005 (United Nations Department of Economic and Social Affairs, Population Division, 2009); 28.4 million in 2009 (US Census Bureau, 2009); 29.2 million in 2009 (Government of the United Kingdom, Department for International Development (DfID), 2009) and 31.9 million in 2009 (Population Reference Bureau, 2009).

[6] UNHCR Global Appeal 2010-2011

[7] NRVA, 2009

[8] MOWA, Women and men in Afghanistan. Baseline statistics on gender, 2008, p.35

security and social support. Although there are indications that preferences of family size are changing, e.g. increased Contraceptive Prevalence Rate (CPR) and unmet need for Family Planning.

12. Globally women tend to live longer than men by an average of 3-6 years; however, in Afghanistan the situation is different. 30 years of conflict and consequently a weak health care system, including limited access to health care facilities, have kept infant and maternal mortality ratio/rates high, causing low and virtually equal life expectancy at birth for women and men.

13. Notwithstanding the high infant mortality rate, half of the population is under 15 years of age, whereas the population aged 65 and over represents less than three percent of the total population. In comparison, the under 15 population only constitutes 26 percent of the total population in Iran and 39 percent in both Pakistan and Tajikistan.[9]

14. The population distribution in Afghanistan is mainly rural with a very low urbanization rate.[10] Many people live in highly dispersed small rural settlements. This obviously affects the ability to provide public services, implying high transition costs. Given the already high population pressure on the limited surface of arable land, ongoing population growth is now leading to a relatively more rapid increase of the urban population. It is likely that migration to urban areas will further increase, as educational levels are expected to improve. Especially young people from the more marginal and harsher rural areas, exposed to uncertain climatic conditions, will no doubt try to find better living conditions.

15. Youth is generally disenfranchised, lacks educational and employment opportunities, and rarely participates in decision-making at local and national levels. The situation of Afghan girls is of particular concern - under traditional pressures many enter early marriage and experience early motherhood. This contributes to Afghanistan's dire Maternal Mortality Ratio (MMR) and Infant Mortality Rate (IMR) as expanded on further below. Youth literacy rates are only 50% for boys and 18% for girls. Secondary school enrolment is respectively 23% and 7%. Less than 1% of the Afghan population enrols in higher education[11].

16. Afghan youth is at risk of un- and underemployment. Destitution of young males leads to increased risk of their induction into the narcotics industry, illegal armed groups and terrorist organisations, while girls are vulnerable to increased levels of violence including trafficking. This generation of youth, having experienced conflict and exile, generally lacks sufficient alternatives and initiatives to empower them.

17. The Afghan economy has maintained a significant rate of economic growth over the past few years, increasing per-capita Gross Domestic Product (GDP) from $190 in 2001 to $426 in 2009.[12] However, this growth has failed to significantly reduce food insecurity, extreme poverty and hunger in the country; 6.6 million Afghans do not meet their minimum food requirement, while 44 % of the population view themselves to varying degrees as food insecure[13].

18. Afghanistan's 2007 Human Development Index (HDI) stands at 0.345, which is slightly below that of 2004 (0.346). In terms of global rankings, this places Afghanistan 174 out of 178 countries[14].

19. Afghanistan's recent economic growth has been fuelled by large inflows of foreign assistance and earnings from opium production, both of which have increased domestic demand for goods and services. More diversified economic growth is required for sustainable development to occur.

20. At present, virtually no taxes are being raised by the Afghan Government; domestic revenue counts for 7.6% of the total GDP.[15] All government funding is highly dependent on international assistance. The government will need to increase its internal revenues substantially in order to lower this dependency.

[9] World Youth's Data sheet, 2006.
[10] NRVA, 2009
[11] UNDP: The state of Human Development and the Afghan Millennium Development Goals, 2006
[12] CSO: Annual Statistical Yearbook (2008-2009)
[13] UNDP: The state of Human Development and the Afghan Millennium Development Goals, 2006
[14] Ibid.
[15] CSO: Annual Statistical Yearbook (2008-2009)

Reproductive Health and Rights (RHR)

21. In traditional Afghan society, issues regarding the family, Reproductive Health (RH) and gender relationship are strongly governed by cultural norms and traditions, which do not favour free access to Sexual and Reproductive Health (SRH)-related information and services to men and women. Neither do they promote any free discussion within society, not even between married couples.

22. Since 2001, progress has been made in the effectiveness of the health care system, both in access and in utilization of services. For example, the use of modern contraceptives in Afghanistan has increased from 5 percent in 2003 to 16 percent in 2006[16]; trends in antenatal care utilisation in rural Afghanistan showed a several-fold increase from 5 percent in 2003 to 32 percent in 2006; the use of skilled birth attendants showed a threefold increase in rural Afghanistan, from 6 percent in 2003 to 19 percent in 2006[17].

23. IMR was 129 per 1,000 live births and under-5 mortality rate 191 per 1,000 live births in 2006, representing a 22% and 26% decline respectively since 2001[18]. Prenatal care coverage has stood at 32% and DTP3 coverage at 35% in 2006[19]. The number of operational primary health care facilities has increased from 498 in 2001 to 936 by 2007. It is important to note that the proportion of facilities with at least one skilled female health workers has increased from 25% in 2002 to 71% by 2006[20].

24. Nevertheless, overall health indicators are still way below international standards. For instance, approximately only 15 percent of women who had delivered in 2005-2006 have had their delivery in a health facility.[21] Afghanistan still has one of the highest MMR in the world, estimated at 1,600 per 100,000 live births and the above-mentioned under-five and infant mortality rates are still high.[22]

25. Although independent health facility assessments have shown that the quality of care in publicly financed facilities is improving, inadequate financing, lack of trained health staff, especially of female health staff, at all levels, continues to pose significant challenges.[23]

26. Health care services are mainly provided through Non-Government Organisations (NGO), selected by the Ministry of Public Health (MoPH) on the basis of a competitive selection process. Financing of these services is almost 100% dependent on international support. The three main donors are the European Commission (EC), the United States Agency for International Development (USAID) and the World Bank (WB). Although central government has set the standards for health care service delivery, inter alia the Basic Package of Health Services (BPHS) and the Essential Package of Health Services (EPHS), close monitoring and evaluation remains a challenge. Implementation of these services is mainly defined on a geographic basis where each donor supports service delivery in a cluster of provinces under own contract modalities. Hence, there are limited nation-wide initiatives and coordination and information sharing between clusters tends to be limited.

27. The direct causes of maternal death are due to haemorrhage, sepsis, pregnancy-induced hypertension, and obstructed labour. However, underlying causes of high MMR and IMR in Afghanistan include early marriage and child bearing, low Contraceptive Prevalence Rate (CPR) of only 16 percent, low percentage of skilled attendants at birth (19%) and limited access to information and health services, especially Emergency Obstetric Care services (EmOC). Inefficient referral systems and poor nutritional status of most rural pregnant women also serve as contributing factors. In addition, traditional cultural, religious and social barriers, combined with a highly dispersed population living in predominantly mountainous areas that tend to be highly inaccessible during large parts of the year, represent enormous challenges to further improve the utilisation of maternal health services.

28. The Afghan population is very young, with 50 percent of the population in the age group of 0-14, while 40 percent of the population is estimated to belong to the age group of adolescents and youth.[24] Based

[16] Johns Hopkins University, 2006

[17] Multiple Indicator Cluster Survey (MICS), 2003

[18] U5MR – 2006 Afghanistan Health survey showed this target already surpassed.

[19] Afghanistan Household Survey, 2006

[20] Ibid.

[21] Afghanistan Household Survey, 2007

[22] MMR study 2002 MoPH, UNICEF and CDC

[23] UNFPA monitoring reports 2006-2009

on a conservative estimation of the total population size of 27.5 million for 2009[25], at least 11 million people are expected to be adolescents and youth. The Adolescent Sexual and Reproductive Health (ASRH) status in Afghanistan is strongly affected by early marriage of girls, existing gender inequality, as well as limited access to appropriate adolescents' sexual and reproductive health services and information. Although the legal age of marriage is supposed to be 16 for girls and 18 for boys, 57 percent of all girls are married off before the age of 16[26]. On average, husbands are nearly 7 years older than their wives. While divorce and separation are practically invisible in the marital status distribution, the incidence of widowhood increases with age, especially for women. Afghanistan has around 135 thousand widowers, but considerably more than half a million widows. The two major causes of this large number of widows are high male mortality in the last three decades of conflict in Afghanistan and large age differences between spouses.[27]

29. Little is still known in Afghanistan about obstetric fistula, uterine prolapse (UP) or other complications due to child bearing. Since Afghanistan has the second highest MMR in the world and given the fact that obstetric labour is the main cause of maternal mortality and morbidity, the prevalence of complications like obstetric fistula is expected to be high.

30. The prevalence of HIV and AIDS among the 15-24 year old age group is expected to be so low as to be non-measurable.[28] However the population is exposed to the risk of HIV on a number of fronts such as unsafe blood supply, and very low prevalence of condom use and absence of public awareness on HIV and AIDS. Furthermore, the relatively high prevalence of Tuberculosis (TB) and sexually transmitted infections (STI)[29] may be indicative of a higher HIV prevalence than observed, also taking into account a low voluntary counselling and testing rate (VCT) in Afghanistan. The 'social drivers' of HIV in Afghanistan are similar to those of other countries, including violent conflict, easy access to drugs, gender inequity, mobile populations, lack of access to HIV and sex information, and policy barriers. Little is known about the HIV status of women in Afghanistan. HIV awareness and knowledge are low in Afghanistan, with more than a quarter of the population having never heard of AIDS and 40 percent having never heard of HIV. The HIV prevalence among Injecting Drug Users (IDU) in Kabul and Herat is estimated to be 3.0 percent and 3.1 percent respectively. Depending on their injecting behaviours and sexual practices, HIV-positive IDU may spread the infection to other populations (the majority of IDU are married, with 20 percent reported having ever had sex with a man or boy, and 70 percent have ever paid a woman for sex). Currently, the number of injecting drug users is rising in Afghanistan and sharing needles is common.

31. In Afghanistan, various agencies are involved in the acquisition and distribution of reproductive health commodities. Coordination among these agencies has so far been virtually non-existent. Among the NGO implementing the BPHS, the ones supported by United Stated Agency for International Development (USAID) receive their commodities from Management Sciences for Health (MSH), while the European Commission (EC) and World Bank (WB) supported NGO organise their own procurement and distribution. Some EC and WB-supported NGO have adopted a fully centralised procurement system and distribute the commodities to their sub-offices in the provinces from warehouses in Kabul. At the other end of the spectrum, others have adopted a fully decentralised system where they allocate a commodities budget to each health facility on a quarterly basis. A third group of EC and WB supported NGO operate halfway between these modalities.

32. MoPH has limited capacity to assess overall demand and supply of RH commodities, due to the high number of individual actors and lack of coordination among them. No Logistic Management Information System (LMIS) is in place. Although the Health Management Information System (HMIS) does provide reports on consumption of Reproductive Health Commodities (RHC) at the aggregate level, specific data on consumption and demand of each health facility or province or region is lacking. MoPH, with the support of UNFPA, has only one central warehouse which now has adequate storing conditions. Storage facilities are

[24] World Youth's Data sheet, 2006. According to the UNFPA definition, young people are considered to be between 10 to 25 years of age, whereas the Government of Afghanistan defines young people to be between 12 to 25 years of age, with adolescents making up the age group of 12 to 18 years of age (legal age of adulthood)

[25] Projection of the HHL data obtained by CSO and UNFPA in 2003-2005 by using a 2.8 estimated growth rate over 5 years

[26] The Situation of Women in Afghanistan", *UNIFEM Afghanistan Fact Sheet, 2008*, www.unifem.org

[27] NRVA, 2007

[28] CSO and UNIOCEF: *Best estimates of Social Indicators for children in Afghanistan*, 2006

[29] UNDP: The state of Human Development and the Afghan Millennium Development Goals, 2006

poor and lacking at both provincial and district level. The lack of an adequate distribution system has lead to frequent stock-out at the local level and under-utilisation at the central level.

33. Taking into account these challenges, the further increase of CPR and respond to increasing demand for modern contraceptives (the unmet need for contraception is 23%)[30] will require a stronger coordination between the various actors. This may also enhance the capacity to create awareness and involve male participation in Family Planning (FP).

Gender Equality

34. While the legislative environment for women has become more conducive for their rights to be recognised and for them to participate in decision-making processes, women are still confronted with many discriminatory social, economic, political and cultural barriers.

35. Of particular concern is the long history of violence against women and girls. This violence is widespread and deeply rooted in conservative interpretation of Islam and traditional values prevalent in Afghan society. Different country studies confirm that overall level of violence against women in Afghanistan is very high – up to 87 percent and an overwhelming majority of women experience at least one form of physical, sexual or psychological violence or forced marriage, and 62 percent experienced multiple forms of violence.[31]

36. Violence against women and children and harmful traditional practices manifest themselves in various forms, such as rape, "honour killings", early and forced marriage, sexual slavery (in particular when girls are given away in marriage to settle family debts or disputes), sexual abuse in detention, and female victims of violence criminalised by elements of the justice system. The Ministry of Women Affairs (MoWA) found that 82 percent of incidents of violence against women are committed by family members (both females and males), 9 percent by community members and 1.7 percent by state authorities.[32] There is a lack of capacity and resources to effectively implement, monitor and evaluate policies and programmes to eliminate and address cases of gender-based violence.

37. The United Nations Security Council Resolution (UNSCR) 1325 and 1820 are not specifically referred to in key documents that guide the reconstruction and peace building process in Afghanistan, such as ANDS. However, their provisions are echoed in for example the Berlin Declaration, which clarifies the commitments previously made by donors concerned with Afghanistan's reconstruction process[33]. Both documents pledge to assist the Afghan government with security and peace needs – including entrenching the rule of law, realizing women's rights and political participation and empowering civil society.

38. The National Action Plan for the Women of Afghanistan (NAPWA) was adopted by the Cabinet on 19 May 2008. Afghanistan ratified the Convention on the Elimination of Discrimination against Women (CEDAW) in March 2003, but did not ratify or sign the Optional Protocol of the CEDAW to date. Article 2(f) of CEDAW requires State Parties to "take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women". Despite the emerging legal framework to enshrine women's rights, some recent legal initiatives, such as the Shia Personal Status Law, undermine both the Constitution and international commitments made by Afghanistan.

[30] Herat Physicians for Human Rights, 2002
[31] Global Rights Report, Living with Violence: A National Report on Domestic Abuse in Afghanistan, 2008
[32] MOWA, Women and men in Afghanistan. Baseline statistics on gender, 2008, p.12
[33] Tokyo conference, 2002

PART III: PAST COOPERATION AND LESSONS LEARNT

Past Cooperation

39. UNFPA assistance to Afghanistan commenced in 1976 with a focus on family planning. As huge numbers of people fled Afghanistan, UNFPA besides continuing to provide support inside the country, started supporting refugees in Pakistan and Iran with RH services including EmOC services, FP and training.

40. In 2002 UNFPA established its Afghanistan Country Office (CO) in Kabul. Between late 2001 and early 2004, UNFPA provided RH assistance including rehabilitation of three maternity hospitals in Kabul, provision of logistical support for and delivery of maternity health care services. The major partners were MoPH and several NGO. UNFPA also worked with MOWA and other partners on gender issues. The work with the Central Statistics Office (CSO) focussed on strengthening its capacity towards collecting, processing and analysing data.

41. The First Country Programme (CP) of UNFPA commenced in May 2004 and was to have ended in 2007. However, to harmonise programme cycles of all UN agencies in Afghanistan it was decided to prepare a Second CP for 2006-2008. The Second CP was ultimately extended by another year to allow the UNDAF to be aligned with the ANDS adopted by Government in 2008. The UNDAF was developed in 2008 for confirmation in 2009. The Third CPD 2010-13 was developed in 2009 and subsequently approved by the Executive Board in September 2009.

42. The First CP (a) assisted Government to develop national reproductive health and HIV/AIDS strategies and reproductive health guidelines and implement programmes; (b) built capacity of MoPH, MoWA and CSO; and (c) provided support to the realisation of the first Household Listing (HHL) project covering the whole of Afghanistan in the preparation of the Afghanistan Population and Housing Census (APHC). The Second CP provided support to (a) develop the national RH and FP strategy, including provision of mobile health units in remote areas of Bamiyan, Daikundi, Badakhshan and Faryab provinces; (b) train midwives; (c) integrate obstetric fistula into national RH strategy and the establishment of fistula treatment facilities in Kabul; (d) build the capacity of service providers on RH/FP; (e) review the HIV and AIDS strategic plan; (f) develop a Reproductive Health Commodities Security (RHCS) action plan; (g) build a partnership with the Ministry of Haj and Religious Affairs (MoHRA) to train religious leaders on gender-based violence (GBV) and healthy families; (h) strengthen the capacity of CSO through infrastructural rehabilitation and development of the Census Data Processing Centre, construction of training facilities and warehouse and strengthening of Geographic Information System (GIS) and Cartography skills; and (i) prepare the census base maps and implement the pilot census for the first APHC, which was to be conducted in 2008 but was later on postponed till further notice.

43. Under the Second Country Programme, UNFPA was able to mobilise resources from a variety of donor organisations. The RHR programme component was supported by Iceland, Luxembourg and Spain, while Italy supported the Gender Equality programme component. The Population and Development Strategies (PDS) component received support from the EC, Estonia Japan, Italy and Norway.

Lessons Learnt

44. UNFPA needs to further strengthen its efforts in those areas where it has shown to have comparative strengths, such as in the (i) promotion of RHCS and FP; (ii) reduction of maternal mortality and morbidity; (iii) prevention of GBV and strengthen the support systems to GBV survivors; and (iv) generation and use of socio-economic and demographic information for development planning.

45. Nevertheless, while acknowledging the above, in a country like Afghanistan not all of the development goals may be achieved through a straight forward approach. Indirect interventions, such as the livelihood and life skills approach, are sometimes required and preferred as entry-points to address UNFPA's mandate.

46. Lessons learnt[34] during the implementation of the previous country programme point to the need to: (a) continue building institutional capacities at the national level while focusing on the sub-national level, including strengthening of national execution capabilities; (b) strengthen vertical linkages between different levels of Government; (c) promote inter-institutional and inter-sectoral cooperation; (d) strengthen the evidence-based advocacy capacity of the CO; (e) involve religious leaders and tribal elders to accelerate behaviour change; (f) promote participation of young people in RHR, Gender Equality and PDS; (g) increase the efficiency and effectiveness of the RH service delivery to underserved populations; (h) prioritise addressing the needs and rights of young people for education, life skills, empowerment and youth-friendly RH services; (i) use livelihood approaches to address economic and socio-cultural barriers faced by women, in particular young women, and by people who are socially excluded; (j) strengthen PDS by establishing strategic partnerships with non-traditional entities, focussing more on the utilisation of socio-economic and demographic information for policy development, planning, implementation, monitoring and evaluation of development programmes; (k) regularly carry out Security Risks Assessments (SRA) of programme operations; (l) regularly review and update UNFPA operational and programmatic contingency plans to better respond to changing security conditions and humanitarian crises, while ensuring continuity of critical programme activities; (m) ensure regular and high-quality reporting by the CO, especially towards government and donors; (n) actively participate in the Humanitarian Country Team (HCT) to ensure the integration of UNFPA's mandate in the preparedness and response to humanitarian emergencies; (o) actively pursue interagency cooperation; and (p) strengthen the Monitoring and Evaluation (M&E) system, including conducting a baseline study at the onset of the programme cycle.

47. High level political will and stronger involvement of the international development community is necessary to ensure successful implementation of the Third CP. Therefore, the UNFPA CO will need to develop an effective resource mobilisation strategy and an information, communication and advocacy strategy. This should lead to (a) improve the image of UNFPA in Afghanistan; (b) highlight the importance of the ICPD/MDG agenda for sustainable development; and (c) increased financial resources.

PART IV: PROPOSED PROGRAMME

Introduction

48. The design of the Third Country Programme (2010-2013) for UNFPA support takes place within a rapidly changing political, security and development aid environment in Afghanistan. The goals and targets of the Millennium Declaration of 2000, the Global Summit of 2005 and the national priorities identified in the ANDS provide the basis for the UNDAF 2010-2013. The UNFPA 2010-2013 CPD is aligned with the UNFPA Strategic Plan 2008-2011 and defines the Fund's contribution to the UNDAF. The proposed CPAP will contribute to the three major priority areas of UNDAF, which are:

- Governance, peace and stability (ANDS sectors 1 and 2; Afghanistan MDG 9 and 3);
- Sustainable livelihoods: agriculture, food security and income opportunities (ANDS sectors 3, 6 and 8; Afghanistan MDG 1, 3, 4, 8); and
- Basic social services: health, education, water and sanitation (ANDS sectors 4, 5 and 7; Afghanistan MDG 2, 3, 5, 6, 7).

49. In response to the UNDAF Outcomes, the UNFPA CPD identified five specific outcomes, of which the following two outcomes are for RH: (i) utilization of high-quality RH information and maternal health and FP services is increased in target provinces; and (ii) young women and men adopt healthy lifestyles; two outcomes for PDS: (iii) increased utilisation of socio-demographic data for evidence-based decision-making and policy and programme formulation and monitoring in support of the ANDS, at national and subnational levels; and (iv) the development, planning and allocation of available resources prioritizes the needs of

[34] The formal CP2 evaluation findings are expected to become available before July 2010 and will be addressed in the 2010 AWP Mid-Term review process

young people; and one Gender outcome: (v) by 2013, an environment conducive to empowering women and eliminating gender-based violence is created in target provinces.

50. The CPAP is based on the principle of realisation of human rights and aims to follow a participatory, gender and culturally sensitive approach, seeking to build the capacity of rights holders and duty bearers to improve the quality of life of the people of Afghanistan. The present CPAP expands on the CPD approved by the UNFPA Executive Board in September 2009. The two results statements under RH outcome one have been revised to rationalise the logical framework of the RH programme component. In addition, all CPD indicators have been reviewed and revised accordingly.

51. UNFPA will support the Government and other stakeholders in implementing the CPAP at the national level for capacity development and strengthening policies and national programmes, and at the provincial and district level for implementing and expanding new approaches to improve delivery of and access to services. At the national level support will be provided to collect, process and use data in support of policy and programme development. Similarly, advocacy efforts will be undertaken to promote implementation of policies and programmes on RHR, PDS, and Gender Equality. Advocacy will be evidence-based using information to support the arguments for these policies and programmes. At provincial and district level the programme will support design and may pilot for Government endorsement and wider replication, cost-effective improvements of coverage and quality of service delivery, especially concerning health care services.

52. The capacity for Afghanistan to meet its development objectives will highly depend on women and young people. Working with and for women and young people will therefore take a central place in the implementation of the CP, as this will impact on all MDG. Especially investments in SRH have proven to provide high levels of return.[35]

53. With regards to youth and gender, UNFPA will pursue strategies that cut across the three programme components, involving: (1) policy dialogue and evidence based advocacy for establishing an enabling environment, (2) gender-sensitive, life-skills-based ASRH education and youth friendly SRH services, (3) research on youth dynamics and (4) participation of women and young people in decision-making processes.

54. UNFPA will support the government of Afghanistan and strategic partners to (1) empower women and youth, girls and boys, with skills to achieve their dreams, think critically, negotiate risky situations, and express themselves freely; (2) provide access to youth and gender friendly health services, including sexual and reproductive health information, education and commodities; (3) connect women and young people to livelihood and employment programmes; (4) uphold the rights of women and young people, specifically girls, to grow up healthy and safe; (5) encourage women and young people to participate fully in design, planning, implementation, monitoring and evaluation of development programmes; and (6) recognise the rights of women and young people to a fair share of education, skills, and services, with a special focus on economically disadvantaged, socially marginalised, and vulnerable groups.

55. Although gender is considered to be a cross-cutting theme, it is also a substantive programme component. While gender-sensitive strategies will be applied under both the RHR and PDS programme components, the Gender Equality programme component will focus specifically on GBV and women empowerment.

56. UNFPA will concentrate its efforts both geographically and functionally by avoiding a thinly stretched programme. UNFPA will continue to provide assistance to Badakhshan, Bamiyan, and Faryab provinces, whereas it will upscale assistance to Daikundi, which in 2009 was identified by the UNCT as the province in which the entire UN system in Afghanistan aims at "Delivering as One". Additional provinces may be identified jointly with Government and respective donors taking into account the level of access to basic services; political will by provincial government; level of vulnerability; security conditions and accessibility; and cooperation opportunities – all in the context of the UNFPA mandate.

57. Support will be provided for institutional capacity building at the provincial level. While the programme will be firmly anchored in the community and will address both the demand as well as the supply side issues, aiming to strengthen community resilience, UNFPA will closely work together with the

[35] UN Millennium Project, *Investing in Development; Practical Plan to Achieve the Millennium Development Goals*, 2005

provincial and district authorities. Synergies and alliances will be built with Community Development Councils (CDC), civil society institutions and other development actors present. Specific strategies for the most vulnerable communities, such as the Kuchis and IDP will also be considered. Investment in consolidating and extending the service delivery system and community activation efforts across the three programme components will concentrate on un- and underserved populations.

Reproductive Health and Rights

58. The realisation of human rights (both political, civil, socio-economic and cultural) includes reproductive rights, such as the right of each individual and all couples to decide freely and responsibly the number of children, and the spacing and timing of births, and to have access to information and to quality RH services.

59. The RH programme component is designed to respond to the health sector priorities of Afghanistan as articulated in the ANDS, the National Health and Nutrition Sector Strategy, the National Reproductive Health Strategy and the Child and Adolescent Health Strategy. It also responds to the Human Resources Development Plan (HRDP) of MoPH, particularly with regard to the Safe Motherhood Initiative (SMI), e.g. training of skilled birth attendants.

60. The following strategies will be pursued: (a) involvement of stakeholders, especially women and young people, in programme and project design, planning, implementation and monitoring; (b) support rights holders to use systems and structures to hold duty bearers accountable for delivery of quality and equitable services; (c) build the capacity of duty bearers to fulfil, promote and protect reproductive rights; (d) use of gender and culturally sensitive behaviour change communication interventions to address RH and socio-cultural issues; (e) establishment of partnerships with key actors, such as UN agencies and other international development and donor agencies.

61. The two outcomes of this component are designed to effectively support and complement each other. The outcomes, to be achieved by 2013 are: (a) utilisation of high-quality reproductive health information and maternal health and family planning services is increased in selected provinces, as pursued through Output 1.1 and 1.2; and (b) young women and men adopt healthy lifestyles, as pursued through Output 2.1.

RHR Output 1.1: Increased institutional capacity of the MoPH to perform its stewardship role in relation to ensuring the availability of and demand for quality reproductive health services.

62. In order to achieve this output UNFPA and its partners will aim to:

a) Strengthen the institutional capacity of the MOPH for provision of RH services in collaboration with other key stakeholders, including (i) provision of technical assistance to revise the national RH strategy and develop the corresponding action plans (FP, gender, maternal and new born health, ASRH, STI, HIV and AIDS); (ii) revision of available M&E tools, as well as of the supervision and quality assurance mechanisms related to reproductive health, such as maternal death audits; (iii) implementation of the selected and possibly adapted tools and mechanisms to the RH service delivery in selected provinces; (iv) identification of data and information requirements to feed back into the RH service delivery system; (v) provision of technical assistance in the development of decision support systems, such as GIS (see also PDS Output 1.1), combining population data on all settlements with geographical reference of the capacity of all health facilities, to support planning of nation-wide health campaigns, human resources needs, commodity planning and control of stocks, as well as identifying un- and underserved areas which need to be strengthened with the provision of additional health services, such as Community Midwives (CMW), Community Health Workers (CHW), Mobile Health Units (MHU) and Family Health Houses (FHH); (vi) the implementation and periodic revision of the human resource strategy for SMI, including midwifery education; and (vii) elaboration of strategies to enhance service delivery to special vulnerable population groups, including Kuchis and IDP;
b) Strengthen the institutional capacity for ensuring RHCS, including: (i) support to MoPH in establishing a RHCS coordination committee and development of a Comprehensive National RHCS Strategic Plan; (ii) strengthen the procurement, forecasting, LMIS capacity and distribution for RHCS, inter alia by promoting the use of SPECTRUM for forecasting and CHANNEL software for logistics management,

and thereby increasing the capacity to timely deliver RHC and avoid stock-outs; (iii) increase procurement efficiency, raise volumes of RHC and enhance stock management in collaboration with other partners, inter alia by promoting pooled procurement and sharing of warehouse facilities; (iv) promote Information, Education and Communication (IEC) and Behavioural Change Communication (BCC) among health service providers and target population to increase the CPR and decrease the unmet need for FP; (v) train service providers, including CMW, on family planning; and (vi) introduction of community based distribution for family planning commodities; and

c) Improve the availability of data and information on RHR for priority settings, e.g. related to FP, maternal mortality and morbidity, and EmOC.

RHR Output 1.2: Strengthened capacity of health facilities and service providers, with a focus on selected provinces, to provide antenatal and post-natal care, basic and comprehensive emergency obstetric care and fistula treatment

63. In order to achieve this output UNFPA and its partners will aim to:

a) Support government's human resource development efforts to improve access to skilled birth attendants, through (i) the training of CMW for deployment into un-served areas, initially in Badakhshan, Bamiyan, Daikundi and Faryab; (ii) standardising the residency training programme for Obstetricians and Gynaecologists (OBGYN); and (iii) promoting the integration of the CMW, combined with MHU, into BPHS financing;
b) Provide RH services, deploying MHU beyond catchment areas of the existing public health delivery system to link with CMW and FHH, initially in Badakhshan, Bamiyan, Daikundi and Faryab;
c) Provide support to MoPH to strengthen prevention of and treatment services for Obstetric Fistula, by (i) creating awareness among Community Health Shuras on the prevention of obstetric fistula and the location of treatment services; (ii) strengthening the technical capacity of skilled birth attendants for prevention of Obstetric Fistula and train surgeons for basic and more advanced treatment of Fistula; and (iii) supporting women for Fistula treatment identified by health facilities in selected provinces;
d) Provide continued, but reduced, support to two selected health facilities at the local level in Logar province in the interim to integration into the BPHS financing;
e) Enhance the capacity of Malalai and Khair Khana hospitals, as national RH referral hospitals, for the delivery of obstetric and gynaecological services, to the extent that external financing is made explicitly available for this purpose;
f) Establish partnerships with key stakeholders to ensure integration of RH services and GBV response in preparation of contingency plans for humanitarian emergencies at national, provincial, district and community level;
g) Build technical and managerial capacities of Provincial Health Directorates (PHD), focussing on RH Officers and District Health Officers (DHO) to (i) advocate and properly plan for RH services; and (ii) collect, analyse, utilise and disseminate reproductive health related information to support M&E as well as supervision and quality assurance, in collaboration with other development partners.

RHR Output 2.1: Increased availability of reproductive health information and life skills at community level focusing on girls and boys both in and out of school in the most underserved districts of targeted provinces

64. In order to achieve this output UNFPA and its partners will aim to:

a) Conduct policy dialogue, policy analysis and evidence based advocacy to position the adolescent and youth agenda within the national health policies and strategies; specifically to integrate ASRH into the BPHS;
b) Establish and strengthen existing partnerships to promote coordination and collaboration among ASRH partners (relevant ministries, NGO, RH professionals and other development partners), at the national level and selected provinces and districts to (i) facilitate knowledge sharing; (ii) review and develop common sets of standards regarding ASRH services; (iii) encourage community participation and youth empowerment in planning and decision-making processes; and (iv) network with key gatekeepers

(community elders, parents, teachers, religious leaders and health service providers) at the community level to promote ASRH;

c) Provide limited support to existing youth centres that have been established under the previous UNFPA country programmes, while promoting their rapid re-orientation to become more sustainable and focussed on enhancing youth friendly programmes and service delivery of government institutions and local NGO, especially in the field of ASRH;

d) Promote ASRH and population education through the provision of support to (i) the design of the curricula of teacher training schools, schools, vocational trainings and of the Madrasa of the Ministry of Education; (ii) comprehensive, gender-sensitive, life skills-based SRH education in schools and out-of-school settings at community level in selected provinces, ensuring the involvement of parents and guardians, aiming at postponement of age at marriage until at least the legal age of marriage (16 for girls and 18 for boys) and retaining girls in schools; (iii) the training of service providers (including CMW, teachers and health workers) and community gate keepers to understand and address adolescent development and youth-related health issues; and (iv) the training of youth to become peer educators and form peer groups.

Population and Development Strategies

65. The re`alisation of human rights (political, civil, socio-economic and cultural) includes the right to development, which implies the right to fully participate in decision-making processes and hence also implies the right to access information. This applies to the level of both communities and individuals.

66. The PDS programme component is designed to respond to the opportunities and challenges facing the Afghan population with regard to socio-economic development and focuses on: (i) the importance of availability and access to time-bound and geographically defined socio-economic and demographic data; (ii) the need to strengthen institutional capacities to collect, process and analyse these data to generate reliable information; (iii) use of socio-economic and demographic information to support evidence-based development, planning, implementation, monitoring and evaluation of strategies, policies, programmes and projects, with an emphasis on local level development planning and resource allocation processes.

67. The following strategies will be pursued: a) policy dialogue and evidence-based advocacy efforts to advance the ICPD and MDG agenda regarding population and development issues; b) inclusion of women and youth specific focus in programme and project design, planning, implementation and monitoring; c) capacity building of duty bearers at national and local level to use socio-economic and demographic information to enhance consensus building, development planning, resource allocation and service delivery processes; d) establishment of partnerships with key actors, such as government entities, academia, UN and donor agencies, NGO and Community-Based Organisations (CBO), including youth organisations.

68. The two outcomes of this component are designed to effectively support and complement each other. The outcomes, to be achieved by 2013 are: (a) increased utilization of socio-demographic data for evidence-based decision-making and policy and programme formulation and monitoring in support of the ANDS, at national and sub-national levels, as pursued through PDS Output 1.1; and (b) the development, planning and allocation of available resources prioritises the needs of young people, as pursued through Output 2.1.

PDS Output 1.1: Improved availability and use of national and local data, disaggregated by sex and age, to formulate, implement and monitor policies and programmes

69. In order to achieve this output UNFPA and its partners will aim to:

a) Conduct policy analysis, policy dialogue and evidence based advocacy to sensitise senior policy makers on the importance of the availability and accessibility of reliable socio-economic and demographic information;

b) Support CSO in the conduct of pre-census activities and the realisation of the APHC, this implies (i) mobilisation of political support; (ii) mobilisation of financial resources; (iii) activation of and support to International Census Advisory Board (ICAB); (iv) support public awareness campaigns to gain social support; (v) provision of technical advisory support services to CSO in the design, planning, implementation, monitoring and evaluation of all census-related operations, including GIS; and (vi)

support field operations and provide technical support to the processing and analysis of census data and publication and dissemination of the census data in user-friendly formats through different means;

c) Provide support, in conjunction with other development partners, to CSO and other relevant government institutions, in the build up of the national statistical system, implying among others, support to conduct socio-demographic surveys and to establish registry systems;
d) Carry out an assessment of different institutions and organisations, both of the national and local governments, as well as academia, NGO and other organisations with regards to the needs and capacity gaps that these institutions and organisations face in terms of access, availability and effective use of socio-economic and demographic information and data for design, planning, implementation, monitoring and evaluation of policies, strategies, programmes and projects;
e) Provide support to selected district administrations to use socio-economic and demographic data and information for evidence-based allocation of resources;
f) Generate critical mass capable of analysing socio-economic and demographic data and apply the information generated for planning, monitoring and evaluation purposes, by (i) promoting the establishment of a Training, Research and Information facility on Population and Development (TRIPOD); (ii) establishing partnerships with key government entities, such as the Ministry of Finance (MoF), Ministry of Economy (MoEc), MoPH , universities, CSO and other key partners to support TRIPOD; (iii) providing financial and technical support to the TRIPOD facility for training of professionals from different governmental and non-governmental institutions, as well as university students, on a variety of themes related to population and development; and (iv) following up of people trained by TRIPOD to promote the application of knowledge learnt in evidence-based planning and budgeting within relevant government institutions; and
g) Conduct programme support data collection activities at the local and national levels, by (i) undertaking surveys to establish baseline and end-line information for monitoring and evaluation of the CPAP; (ii) commissioning Implementing Partners (IP) to collect age and sex disaggregated data to map focus districts under the Country Programme; and (iii) providing technical support to the national and sub-national surveys on RHR, PDS, and gender-related issues.

PDS Output 2.1: Strengthened capacity of institutions and stakeholders, at national and community levels, to advocate, formulate, implement, monitor and evaluate policies and programmes related to young people and gender issues.

70. In order to achieve this output UNFPA and its partners will aim to:

a) Conduct policy analysis, policy dialogue and evidence based advocacy on emerging PDS issues, such as migration, urbanisation and youth;
b) Sensitise policy and decision makers on the importance to address the rights and concerns of women and young people;
c) Support relevant government institutions and other stakeholders to develop policies and programmes that address the rights and concerns of women and young people, including the provision and the development of tools for planning, monitoring and evaluation;
d) Advocate for the inclusion of population and development in the curricula of teachers' training and secondary schools (see also RHR Output 2.1);
e) Develop advocacy materials for policy makers, youth leaders, peer educators, religious leaders and the general public on participation of women and young people in the development process to reflect their interest and views in programmes at different levels; and
f) Promote the participation of women and young people in the design, planning and implementation, monitoring and evaluation of policies and programmes supported by UNFPA, by (i) establishing a Youth Advisory Panel (YAP) for UNFPA; (ii) supporting women and youth organisations and networks to advocate for gender-sensitive and youth-friendly policies and programmes; and (iii) facilitating women and youth participation in designing, planning, implementing, monitoring and evaluating UNFPA supported policies and programmes at national and sub-national level.

Gender Equality

71. The realisation of human rights (political, civil, socio-economic and cultural) includes the right to development for all men and women, which implies the right to fully participate in decision-making processes and amongst others implies the right to expression and the right to be free of violence.

72. Although gender is considered to be a crosscutting issue in this Country Programme, it is also considered to be a substantive programme component in and by itself, with a special focus on GBV and supporting women's access to services and resources, and participation in decision-making processes.

73. The following strategies will be pursued: (a) participation of women in programme and project design, planning, implementation and monitoring; (b) capacity building of duty bearers to fulfil, promote and protect reproductive rights and the right to live a life free of violence, through evidence-based advocacy, behaviour change communication interventions and the establishment of referral mechanism at the local level; (c) capacity building of rights holders, e.g. women, girls and GBV survivors, through awareness campaigns, behaviour change communication interventions and information provision on institutional support mechanisms and services, to claim and practise their rights; and (d) establishment of partnerships with key stakeholders, such as UN agencies, other international development partners, NGO and academia.

74. In the implementation of these strategies, UNFPA will focus on a limited group of districts within the selected provinces, identifying opportunities for women involvement in family and community life and for preventing, responding and monitoring GBV.

75. The outcome of the Gender Equality component is: by 2013, an environment conducive to empowering women and eliminating gender-based violence is created in target provinces. There are two outputs within this component.

Gender Output 1.1: Increased participation of women in decision-making that relates to healthy families and livelihoods, at household and community levels

76. In order to achieve this output UNFPA and its partners will aim to:

a) Conduct evidence based advocacy at provincial and district level to promote the implementation of projects aimed at increased participation of women in decision-making processes;
b) Promote women and girls' rights, including reproductive rights, by (i) engaging with MoHRA and the Supreme Court to orient religious leaders; (ii) arranging knowledge sharing fora among religious leaders and representatives of human rights institutions; and (iii) developing and implementing the advocacy strategy "healthy family, fortunate society" with the participation of religious leaders and CDC;
c) Promote women empowerment, by (i) promoting their participation in community decision making processes, e.g. Health Shuras and CDC; (ii) sensitising key gatekeepers at community level (religious leaders, teachers, members of CDC and health Shuras) on the importance of the role of women in building sustainable livelihoods; (iii) building the capacity of women and girls to identify opportunities to improve their livelihoods and manage small scale development projects, both technically and financially; and (iv) identifying partners that can build the capacity of selected communities to design and operate gender-sensitive financial schemes for community development projects; and
d) Design livelihood and life skills curricula aimed at women and girls, inter alia on family health and hygiene, reproductive health, entrepreneurship, peace and stability, environment, agriculture and natural disasters and promote utilisation of these curricula in literacy programmes and vocational schooling, initially for selected underserved communities.

Gender Output 2.1: Enhanced capacity of target communities to identify opportunities for women's involvement in family and community life, and to prevent, respond to and monitor gender-based violence

77. In order to achieve this output UNFPA and its partners will aim to:

a) Conduct advocacy and educational interventions to sensitise and train adolescents and young adults, religious leaders and community elders as change agents to advocate the benefits of women's empowerment to family and community;

b) Support the introduction of education on population and development, including issues pertaining to gender, reproductive health and reproductive rights, in the Madrasa curriculum of the Ministry of Education;
c) Support grass-root initiatives in the selected communities under the RHR programme component aimed at: (i) preventing gender-based violence; (ii) promoting an increase of age of marriage of girls; (iii) supporting female members of community health Shuras to identify and refer GBV and trauma cases; and (iv) providing basic skills training, including counselling, to community volunteers and health workers to effectively identify, respond to and refer GBV and trauma cases;
d) Finalise standard GBV treatment protocol with MoPH and other partners;
e) Train current and new police officers in the area of ethics and gender which will involve: (i) finalisation of the curriculum on "Ethics and Gender in Policing" (EGP) for Kabul Police Academy (KPA); (ii) design and implementation of Trainer of Trainers' course; (iii) review the curriculum on the basis of feedback received from the trainers; (iv) support implementation of the EGP for current and new police officers of KPA; (v) promote adoption of EGP to regional police academies; (vi) follow-up on police officers that passed the EGP after 12 months to assess the knowledge, attitude and practice change over time; and (vii) carry out research to analyse reporting of and response to GBV cases in selected police jurisdictions;
f) Train (i) selected BPHS implementers in psycho-social support and trauma counselling, with special focus on GBV survivors and women prisoners, and the capacity to refer special cases to CHC level and (ii) health service providers at CHC, Basic Health Centres (BHC) and provincial hospitals of selected provinces for the identification, treatment and follow-up on GBV cases;
g) Support to MoWA and its provincial departments in selected provinces in developing and implementing a Community Action Plan in line with NAPWA;
h) Promote the availability of fair justice mechanisms for women at community level, by means of (i) conducting evidence-based advocacy with community leaders to practice customary law without contradicting Constitutional rights and International Human Rights Conventions ratified by the Government of Afghanistan; (ii) creating a linkage between community leaders involved in customary law mechanisms and representatives of the formal justice system, with the aim to set up referral systems to monitor and respond to GBV at the district level; and (iii) conducting evidence-based advocacy with the Ministry of Justice (MoJ) based on documented lessons learnt and best practices;
i) Strengthen the capacity of Government and selected NGO to monitor and report on the CEDAW, in collaboration with other partners (UN agencies, other international development partners, etc.); and
j) Promote a consultative process with partner agencies and relevant government institutions, with the aim to develop and implement a national plan of action on UNSCR 1325 and 1820.

PART V: PARTNERSHIP STRATEGY

Introduction

78. Country leadership and ownership at all levels will remain a guiding principle for UNFPA. To this end, and in line with the Paris Declaration (2005), and the Accra Agenda of Action (2008), UNFPA will apply the principles of country ownership, alignment, harmonisation, managing for results and mutual accountability. For this purpose, and, taking into consideration the other provisions of this CPAP, UNFPA will seek to engage with a broad range of partners, under the overall coordination of the Ministry of Foreign Affairs. Partners and relevant stakeholders will be involved in all phases of project and programme design, planning, implementation, monitoring and evaluation.

79. To this end, UNFPA aims to build new and strengthen already existing partnership with government entities, bilateral and multilateral agencies, civil society organisations and networks, traditional and religious institutions, parliamentarians, professional organisations, academia and research institutions, and the media.

Government

80. The Ministry of Foreign Affairs (MoFA) will be one of the main partners of UNFPA in its role as principal coordinator of the Country Programme. Other Government institutions, like the Ministries of Finance, Economy and Public Health will also be partners in coordinating the Country Programme of the Government of Afghanistan and UNFPA.

81. Existing partnership with government entities will be strengthened, while also establishing new partnership with others, in order to ensure an efficient, effective and sustainable implementation of the Country Programme. These partnership with national government institutions and their respective provincial directorates, will also involve district administrations. The following national government institutions are considered to be the main partners in the implementation of the Country programme:

a) Under the RHR component: Ministry of Public Health; Ministry of Education; Ministry of Culture and Information; and the Afghanistan National Disaster Management Authority.
b) Under the PDS component: Central Statistics Office; Kabul University; Ministry of Finance; Ministry of Economy; Ministry of Higher Education; Ministry of Public Health; Independent Directorate of Local Governance; Ministry of Communication and Information Technology; Ministry of Culture and Information; Ministry of Rural Rehabilitation and Development; National Statistical Council; and Wolisy and Mishrano Jirga.
c) Under the Gender Equality component; Ministry of Women Affairs; Ministry of Interior; Ministry of Justice, Ministry of Public Health, Afghanistan Independent Human Rights Commission (AIHRC); Ministry of Religious Affairs and Haj; Ministry of Education; and Wolisy Jirga.

Interagency partnership

82. Exploratory discussions have taken place on joint programming on (i) safe motherhood with UNICEF and WHO; (ii) studies on maternal mortality and morbidity with WHO and UNICEF; (iii) literacy and education (LEARN)[36] with UNESCO, FAO, UNICEF, WFP, ILO, WHO, and UN Habitat; (iv) community development, IDP and returnees with IOM; (v) GBV with UNIFEM and UNDP; (vi) gender statistics with UNIFEM and UNICEF; (vii) humanitarian assistance through the HCT and co-leading the protection sub-cluster on GBV; (viii) support to the Daikundi province, which was selected as the priority province by UN Country Team (UNCT) to initiate "Delivery as One"; and (ix) cooperation with UNAMA for support in building political support and mobilising the necessary resources for the activities related to the first APHC, as well as other major population data collection tools, such as a national population registry system.

Other International Development Agencies

83. UNFPA will aim to strengthen partnership with multilateral, bilateral donors and other international development agencies in order to improve information and knowledge sharing on programme activities with a view to promote a more effective coordination with other development efforts and identification of synergies. It is hoped that these partnership will lead to an increased capacity of UNFPA and the Government of Afghanistan to mobilize the additional resources required, both financially and technically, for effective programme implementation.

Civil Society

84. For UNFPA and the government of Afghanistan partnering with civil society organization like NGO and CBO will be essential to ensure effective and efficient implementation of the Country Programme in a participatory and transparent manner. These partnership will include, but will not necessarily be limited to, the following: Community Development Councils (CDC); (I)NGO like Agency for Assistance and Development of Afghanistan (AADA), Medical Emergency Relief International (MERLIN), Afghanistan Civil Society Foundation (ACSF), Afghan Red Crescent Society (ARCS) and Gender Studies Institute

[36] LEARN: Literacy and Education in Afghanistan, Right Now

(GSI); academia, such as Kabul University and the American University; media; network of CBO, such as the Afghan Women's Network (AWN); and professional associations.

85. Besides the direct involvement of civil society in the programme implementation, efforts will be undertaken to ensure that civil society stakeholder will also be directly involved in the design, planning, monitoring and evaluation stages of the individual projects.

86. Another role that the civil society will play in the Country Programme of the Government of Afghanistan and UNFPA will be in field of policy analysis, policy dialogue and evidence-based advocacy.

South-South Cooperation

87. UNFPA will pursue South-to-South cooperation as an important strategy to build partnerships at the international level to facilitate information and knowledge sharing among government institutions and other stakeholders, such as professional associations, academia, such as Al Azhar University of Cairo, and NGO, such as with the Sisters in Islam of Malaysia.

88. Another objective of South-South Cooperation is to strengthen the technical capacity of Afghan partner agencies through participation training activities in abroad and by inviting professionals from abroad for short-term and longer-term technical cooperation, including training of Afghan nationals.

PART VI: PROGRAMME MANAGEMENT

Coordination

89. The Government of Afghanistan, represented by Ministry of Foreign Affairs (MoFA), and UNFPA will jointly be responsible for the effective realisation of the CPAP and the delivery of results specified under it. The Country Programme will be implemented using different execution modalities, in collaboration with state entities, civil society, private sector, UN agencies and other international development partners.

90. A Country Programme Coordination Council (CPCC) will be established under the chairmanship of MoFA, with the participation of MoF, MoPH and MoEc. MoFA and UNFPA will jointly identify two representatives of civil society and two representatives of key donors to UNFPA. The CPCC will meet twice a year to review progress of CPAP implementation. The Council has decision-making powers to ensure that the CPAP results are achieved over time. In so doing, the CPCC will (a) endorse Standard Progress Reports (SPR); (b) provide strategic guidance to programme implementation; and (c) approve on any changes and adjustments that may be required to the CPAP and CPD.

91. The CO reports to the UNFPA Asia and Pacific Regional Office (APRO). The APRO Director and representatives of UNFPA Executive Management may participate in the Country Programme coordination structure.

92. For complex projects that may be initiated under this Country Programme, the CPCC may decide to activate special coordination mechanisms and advisory boards.

93. On a day to day basis, UNFPA will work with IP and other relevant stakeholders in the design, planning, implementation, monitoring and evaluation of project documents and their respective Annual Work Plans (AWP). UNFPA will promote the development of longer-term project documents in order to clearly define relationship and strategies to be applied to achieve certain sub-outputs. On the basis of these project documents respective AWP will be prepared for signature by MoFA, UNFPA and IP.

94. UNFPA, in collaboration with IP, will report on an annual basis on the main activities completed and progress per component output; update the CPAP Planning and Tracking Tool whenever possible by compiling output data reported by IP in their Annual Reports; facilitate information sharing; and document lessons learned and best practices.

Implementation arrangements

95. The criteria for selecting IP and execution modalities will encompass the following considerations: (i) management systems including financial management; (ii) institutional and technical capacities; (iii) comparative advantage; and (iv) experience to contribute to the CPD outcomes and outputs. IP will sign a Letter of Understanding (LoU) with UNFPA which details rules and regulations pertaining to the partnership. The UNFPA Afghanistan Country Office will promote cost-effective and results-oriented approaches to programme management that aim at building national capacity.

96. Annual Work Plans (AWP) will be approved and signed by the head of the relevant government entity, UNFPA Representative and, where required, the head of the IP. AWP coding will be established for each and every one of the CP Outputs. Each overall AWP may consist of various sub-AWP, as each Output may be an aggregate of different projects. Hence, each sub-AWP will represent a different project, or will refer to a similar project either with a different IP or with different funding sources. At the level of each Output, the respective overall AWP will thus be constructed in the course of the year, as new projects/sub-AWP may be added. Each sub-AWP may be based on a multi-annual project document or may be a stand-alone work plan for the present year only. In virtually all cases, the AWP will be accompanied by a detailed Project Activity Sheet (PAS), identifying the detailed budget requirements for each of the activities and/or sub-activities. The broad activities as identified in the AWP will be realised in accordance with the specified timelines and budget groups. The implementing agent is allowed to use the funding as per specified per broad activity and budget group. The PAS is therefore only meant as a detailed guide for project implementation and can later be used to review whether the initial budgeting was realistic and in line with actual implementation. Once signed, budgetary revisions are still possible. The IP has to submit a formal request in writing, clearly argumenting for such a revision. Only after formal approval has been received from the UNFPA Representative is the IP be allowed to implement the activities against the revised AWP.

97. All cash transfers to an IP will be based on AWP as agreed between IP and UNFPA. Cash transfers for activities detailed in AWP will be made by UNFPA using the following modalities: (i) cash transferred directly to the IP (a) prior to the start of activities (direct cash transfer), or (b) after activities have been completed (reimbursement); (ii) direct payment to vendors or third parties for obligations incurred by the IP on the basis of requests signed by the designated official of the IP; (iii) direct payments to vendors or third parties for obligations incurred by UNFPA in support of activities agreed with IP. Where cash transfers are made to MoF, MoF shall transfer such cash promptly to the IP.

98. Direct cash transfers shall be requested and released for programme implementation periods not exceeding three months. Reimbursements of previously authorised expenditures shall be requested and released quarterly or after the completion of activities. UNFPA shall not be obligated to reimburse expenditure made by the IP over and above the authorised amounts.

99. Following the completion of any activity, any balance of funds shall be reprogrammed by mutual agreement between the IP and UNFPA, or refunded.

100. Cash transfer modalities, the size of disbursements, and the scope and frequency of assurance activities may depend on the findings of a review of the public financial management capacity in the case of a Government IP, and of an assessment of the financial management capacity of the non-UN IP. A qualified consultant, such as a public accounting firm, selected by UNCT/UNFPA may conduct such an assessment, in which the IP shall participate.

101. Cash transfer modalities, the size of disbursements, and the scope and frequency of assurance activities may be revised in the course of programme implementation based on the findings of programme monitoring, expenditure monitoring and reporting and audits.

102. Audits will form an integral part of the programme to ensure standard financial and administrative management systems. The audit observations/findings will be applied in conjunction with other programme reports to improve quality of activities and management.

Managing for Results

103. UNFPA will implement the CP on the following eight key principles of Results-Based Management (RBM): (i) participation; (ii) relevance; (iii) efficiency; (iv) effectiveness; (v) sustainability; (vi) coherence; (vii) accountability; and (viii) impact.

104. The UNFPA CO will invest in further building its own capacity and that of its IP, to respond to these key principles. The focus will be placed on planning and budgeting, mobilising additional resources, financial management, procurement processes, record keeping, M&E data collection and reporting processes. This will be achieved through tailored training programmes and establishing clear operational and programme performance criteria.

105. Managing for results also implies managing risks within the context of Afghanistan. These risks have the potential to directly impact on the eight key principles of RBM mentioned above. For instance, participatory processes, efficiency, effectiveness and accountability of programme operations may be affected by political instability and insecurity, recurrent natural disasters, crime and corruption. In addition, high donor dependency due to the very narrow tax base, may affect sustainability.

106. In order to identify and respond to these potential risks, the CO will conduct annual fraud and risk assessments, in compliance with UNFPA procedures, to further strengthen its internal control mechanisms.

Human Resources

107. The UNFPA CO consists of a Representative, a Deputy-Representative, a national Assistant-Representative, an International Operations Manager, and other programme and administrative staff within the framework of the approved country office typology. National and international personnel may be recruited, using regular and extra-budgetary programme resources to strengthen programme implementation. UNFPA CO may also draw upon technical expertise from other UNFPA Country Offices, APRO, UNFPA Headquarters (HQ) or request support from other UN agencies.

108. Furthermore, UNFPA will also support CO staff and selected personnel of IP to participate in key national and international meetings to share programme experiences and acquire knowledge and skills aimed to improve planning and programming.

Resource Mobilisation

109. UNFPA will assist Government in mobilising additional resources and inputs to meet funding gaps identified that hamper implementation of the CPD. For this purpose, strategic alliances with International Financial Institutions (IFI), bilateral donor organisations, governments and the private sector will be pursued. To this end the UNFPA CO will formulate a Resource Mobilisation Strategy (RMS) identifying strategic opportunities where UNFPA's value added may be leveraged to secure additional resources for the implementation of the CPD.

Information, Communication and Advocacy (ICA)

110. In a country like Afghanistan, many of the areas that UNFPA intends to address are considered to be quite contentious; family planning, reproductive health care, adolescent sexual and reproductive health, gender-based violence and women empowerment are not the easiest topics to discuss openly. Similarly, in a political culture that has not been accustomed to evidence-based decision-making, the generation of reliable geographically defined socio-demographic data and information may constitute a challenge.

111. The ICA capacity of the CO will be increased by (i) contracting additional professionals; (ii) involving programme staff in ICA related activities; (iii) training CO programme staff in mapping and analysing interest groups; (iv) partnering with other development partners on ICA specific topics, e.g. RHCS; (v) using different communication and information channels; and (vi) fostering contacts with national and international media.

112. The right arguments need to be identified to support evidence-based advocacy and political dialogue to advance the country programme. Among others, research findings, periodical M&E reports, the country

population and situation analysis, findings of successful practices and lessons learnt from other countries will all provide the required information for such arguments to be made.

113. The ICA strategy will be important to better position UNFPA as a trusted international development partner. It will also aim to enhance the general understanding of and marshal political support for the ICPD and MDG agendas for sustainable development. Finally, the ICA strategy will be crucial to support the resource mobilisation strategy mentioned earlier.

Risk Analysis and Management

114. Given Afghanistan's volatile security environment and propensity to natural disasters, including pandemics, UNFPA will establish a Business Continuity Plan (BCP), detailing security, safety and emergency preparedness measures. The BCP will be developed with the aim to avoid loss of lives of staff, implementing agents and beneficiaries, as well as property. The BCP will therefore focus on providing the necessary measures to enable continuity of critical programme operations, while ensuring staff safety and security.

115. The CO will conduct a regular review of the SRA of the individual programme activities, adjusting programme operations in line with the renewed assessment of the security situation in the geographic areas where these activities are undertaken.

PART VII: MONITORING AND EVALUATION

Implementing partners

116. IP agree to cooperate with UNFPA for monitoring all activities supported by cash transfers and will facilitate access to relevant financial records and personnel responsible for the administration of cash provided by UNFPA. To that effect, implementing partners agree to the following:

a) Periodic on-site reviews and spot checks of their financial records by UNFPA or its representatives;
b) Programmatic monitoring of activities following UNFPA's standards and guidance for site visits and field monitoring;
c) Special or scheduled audits. UNFPA, in collaboration with other UN agencies and in consultation with the MoEc will establish an annual audit plan, giving priority to audits of IP with large amounts of cash assistance provided by UNFPA, and those whose financial management capacity needs strengthening.

117. To facilitate assurance activities, IP and the UNFPA may agree to use a programme monitoring and financial control tool allowing data sharing and analysis.

118. The Office of the Auditor General (OAG) may undertake the audits of government implementing partners. If the OAG chooses not to undertake the audits of any of these government implementing partners to the frequency and scope required by UNFPA, UNFPA will commission the audits to be undertaken by private sector audit services, in coordination with the other UN Ex.Com agencies.

119. Audits of non-government IP will always be commissioned by UNFPA, in coordination with other UN Ex.Com agencies, and are in accordance with the policies and procedures of UNFPA.

UNFPA

120. The implementation of the 3rd Country Programme will be monitored and evaluated as guided by the UNFPA procedures and guidelines and by the principles of Result-Based Management (RBM), Human Rights Based Approach (HRBA) to programming and will be aligned with the ANDS and UNDAF Results Matrix. A distinction will be made between situation monitoring (i.e. monitoring progress towards achieving national goals to which the UNFPA Country Programme contributes) and performance monitoring (i.e. the monitoring and evaluation of the activities of the UNFPA Country Programme).

121. Situation monitoring relies on routine monitoring or data collection mechanisms, and on the national studies or surveys included in the *CPAP M&E calendar*. Where required, UNFPA will contribute to the design of these studies and surveys.

122. CPAP Performance monitoring includes the following different types of M&E tools and activities:

a) A *baseline assessment* of the 3rd CP will be conducted to provide the present status of the CP Outcome and output indicators. The baseline assessment will be conducted at both national level and in selected provinces. In addition to the baseline data, the programme will also rely on data generated from other sources, e.g. 2010 MICS and routine programme data;
b) At the end of the Country Programme cycle, a *CP3 evaluation* will be conducted to assess the effectiveness, efficiency, impact, relevance, coherence and sustainability of the programme. Feedback on best practices and lessons learnt will serve as a guide for the formulation of the next CPD, as well as for advocacy and resource mobilisation;
c) *The CPAP Planning and Tracking Tool (PTT)* will be used to ascertain the progress of programme outputs and assess their contributions to programme outcomes. The targets established at the beginning of the programme will be reviewed and, if required, updated annually. The PTT contains outcome and output indicators, baselines and targets, implementing partners and indicative resources per output that will guide M&E processes;
d) *The CPAP Results and Resources Framework (RRF)* will be used to allocate financial resources per programme output and programme outcomes. The budget allocation will be reviewed annually and, if required, revised;
e) The CPAP will be implemented on the basis of the *Annual Work Plans*. All the activities of the AWP will be accompanied by at least one process indicator for enabling UNFPA and IP to monitor progress. In addition, each (sub-)AWP will specifically include monitoring and evaluation activities.
f) *Results based quarterly progress reports* and duly completed Fund Authorization and Certificate of Expenditures *(FACE) documents* will form the basis for quarterly disbursements of programme funds to IP, and will serve as one of the main monitoring tools for progress in project implementation. These quarterly progress reports will also include findings from field visits and other project reports;
g) *Field Monitoring Visits* will be regularly conducted by UNFPA. Stakeholders from the Government, civil society, IP and other international development agencies may be invited to participate in planned field visits. UNFPA will develop and implement a CO monitoring plan to ensure an effective and efficient monitoring process throughout the CP;
h) *Quarterly provincial programme review meetings* will be held in the selected programme provinces to review progress made vis-a-vis the individual AWP and will serve as a forum to collate data from all public and private service providers at provincial level;
i) UNFPA will continue supporting *data collection, research and monitoring functions* of the Government throughout the CP. This support aims to enable effective national monitoring of progress toward the targets of the ANDS, the MDG and ICPD objectives, and other international instruments to which Afghanistan is a party;
j) *CPAP Mid-Term Review and UNDAF Mid-Term Review* will be undertaken in early 2012 to assess achievements and shortcomings and to identify strategies for the remaining UNDAF period and to contribute to the planning and programming of the next Country Programme; and
k) The CO will contribute to other internal annual review processes of UNFPA, such as the development and submission of the *SPR* and the *Country Office Annual Report (COAR)*.

123. The CPAP Results and Resources Framework, the CPAP Planning and Tracking Tool, and the M&E Calendar are attached as Annex I, II and III to this document.

PART VIII: COMMITMENTS OF UNFPA

124. The Afghanistan 3rd Country Programme will require a total commitment of US $38.8 million that includes $20.8 million from regular resources and $18 million through other modalities, subject to the availability of funds. UNFPA will also seek additional funding from other sources, subject to donor interest in the proposed interventions of this CPAP. The additional support from regular and other resources shall be exclusive of funding received in response to emergency appeals.

125. The total amount of resources to be mobilised by the CO will not necessarily be limited to the above-mentioned $ 18 million, but will rather depend on the specific roles that the CO is asked to perform. For instance, if the CO were to be tasked to take the lead role in coordinating the financing for RHCS and direct procurement of RHC or the realisation of the APHC, the total amounts of funding to be mobilised from other sources would be several times the indicated amount.

126. If in the course of programme implementation, new opportunities or needs for additional support are identified, UNFPA will bring this to the attention of the CPCC for approval of concurrent CPAP revision. If these changes are substantial, implying new CP Outcomes or Outputs, UNFPA Executive Board approval will be required.

127. UNFPA support to the development and implementation of activities under the CP will comprise technical and financial assistance, supplies and equipment, and support for communication, information and advocacy.

128. In the case of direct cash transfer or reimbursement, UNFPA shall notify the IP of the amount approved by UNFPA and shall disburse funds to the IP within two weeks.

129. UNFPA maintains the right to request the return of any cash, equipment or supplies provided which were not used properly for the purposes specified in the AWP.

130. In the case of direct payment to vendors or third parties for obligations incurred by the IP on the basis of requests signed by the designated official of the IP; or to vendors or third parties for obligations incurred by UNFPA in support of activities agreed with IP, UNFPA shall proceed with the payment within two weeks.

131. UNFPA shall not have any direct liability under the contractual arrangements concluded between the IP and a third party vendor.

132. Where UNFPA and other UN agencies provide cash to the same IP, programme monitoring, financial monitoring and auditing will be undertaken jointly or coordinated with those UN agencies.

PART IX: COMMITMENTS OF THE GOVERNMENT

133. The Government will provide active support to the implementation of the Country Programme and, where possible, participating government entities will provide office premises and qualified human resources.

134. The Government will also support UNFPA in its efforts to raise the additional funds required for programme implementation.

135. The Government will organise an annual review meeting of the CPAP to assess progress, inviting relevant stakeholders, including donors, to facilitate information sharing and promote coordination.

136. A FACE report, reflecting the activity lines of the Annual Work Plan (AWP), will be used by IP to request the release of funds, or to secure the agreement that UNFPA will reimburse or directly pay for planned expenditure. The IP will use the FACE to report on the utilisation of cash received. The IP shall identify the designated official(s) authorized to provide the account details, request and certify the use of

cash. The FACE will be certified by the designated official(s) of the IP. Cash transferred to IP should be spent for the purpose of activities as agreed in the AWP only.

137. Cash received by the Government and national NGO shall be used in accordance with agreed policies and procedures consistent with international standards, in particular ensuring that cash is expended for activities as agreed in the AWP, and ensuring that reports on the full utilisation of all received cash are submitted to UNFPA within six months after receipt of the funds. Where any of the national regulations, policies and procedures is not consistent with international standards, the UNFPA regulations, policies and procedures will apply.

138. In the case of (I)NGO, cash received shall be used in accordance with international standards in particular ensuring that cash is expended for activities as agreed in the AWPs, and ensuring that reports on the full utilisation of all received cash are submitted to UNFPA within six months after receipt of the funds.

139. To facilitate scheduled and special audits each IP receiving cash from UNFPA will provide UNFPA or its representative with timely access to: (i) all financial records which establish the transactional record of the cash transfers provided by UNFPA; and (ii) all relevant documentation and personnel associated with the functioning of the IP's internal control structure through which the cash transfers have passed.

140. The findings of each audit will be reported to the IP and UNFPA. Each IP will, furthermore: (i) receive and review the audit report issued by the auditors; (ii) provide a timely statement of the acceptance or rejection of any audit recommendation to UNFPA that provided cash; (iii) undertake timely actions to address the accepted audit recommendations; and (iv) report on the actions taken to implement accepted recommendations to UNFPA on a quarterly basis.

141. Government confirms that UNFPA and UNFPA supported projects under UNFPA execution are exempted from Value Added Tax (VAT) and other applicable taxes and duties, including purchase and import of vehicles, equipment, materials, supplies and services.

142. In case of supply assistance, the Government will clear, store and distribute and ensure access by UNFPA officials to do periodic end user monitoring. Equipment, such as vehicles, may be provided under loan agreements. The recipient entity will be responsible to maintain equipment under loan in its assets registry, ensure proper insurance where required, provide proper maintenance and finance operations carried out with said equipment, unless part of the whole of these costs are included in the AWP. Normally, transferred equipment will remain with the recipient entity after completion of the project. However, UNFPA retains the right to request the return of the equipment provided under loan for project implementation if the recipient entity will no longer participate in project implementation.

PART X: OTHER PROVISIONS

143. This CPAP supersedes any previous signed country programme between the Government of the Islamic Republic of Afghanistan and UNFPA. It covers programme assistance from the period 1 January 2010 to 31 December 2013.

144. The CPAP may be modified by mutual consent of both the Government of the Islamic Republic of Afghanistan and UNFPA.

145. Nothing in this CPAP shall in any way be construed to waive the protection of UNFPA accorded by the contents and substance of the United Nations Convention on Privileges and Immunities to which the Government of Afghanistan is a signatory.

IN WITNESS THEREOF *the undersigned, being duly authorised, have signed this Country Programme Action Plan on this Saturday of March 27, 2010 in Kabul, Afghanistan.*

For the Government of the Islamic Republic of Afghanistan	For the United Nations Population Fund, Afghanistan
Mohammad Anwar Anwarzai, Director **United Nations and International Conferences Department** **Ministry of Foreign Affairs** **Afghanistan**	**Arie Hoekman, Representative** **United Nations Population Fund (UNFPA)** **Afghanistan**
Date	27 March 2010 **Date**

Annex I: CPAP Resource and Results Framework[37]

Programme component: Reproductive Health								
Expected Outcomes & indicators	Expected Outputs	Output indicators	Implementing partners	Indicative Resources per year (in million US$)				
				2010	2011	2012	2013	Total
Outcome 1: By 2013, utilization of high-quality reproductive health information and maternal health and family planning services is increased in selected underserved provinces **Outcome indicators:** • % of births attended by skilled birth attendants (disaggregated by province) • Modern contraceptive prevalence rate (disaggregated by province) • National RH strategy operationalised • % of health facilities providing at least three modern methods of contraception • Fistula prevalence rate in focus provinces	**Output 1.1:** Increased institutional capacity of the MoPH to perform its stewardship role in relation to ensuring the availability of and demand for quality reproductive health services.	• National RH strategy, including corresponding action plans, developed and costed • National RHCS Strategy and Plan of Action developed and costed • Donor RHCS coordination mechanism established and operational • % of provincial health directorates that apply the SPECTRUM and/or CHANNEL software • Evidence-based IEC materials on RHR developed and used for policy dialogue, advocacy and training	MoPH and NGO	REGULAR RESOURCES				
				0.25	0.30	0.50	0.55	1.60
				OTHER RESOURCES				
				0.50	0.75	1.00	1.00	3.25
	Output 1.2: Strengthened capacity of health facilities and service providers, with a focus on selected provinces, to provide antenatal and post-natal care, basic and comprehensive emergency obstetric care and fistula treatment	• % of people above 12 years of age who know three danger signs during pregnancy and know where to access health facilities, including MHU and CMW, for reproductive health services • # of FHH within the catchment area of MHU • % of households with a family health plan in catchment areas of MHU • # of district administrations in selected provinces that have an emergency preparedness plan available that integrates RH and GBV • # of women who received successful fistula repair	MoPH and NGO	REGULAR RESOURCES				
				3.25	2.70	2.10	1.90	9.95
				OTHER RESOURCES				
				1.00	1.00	1.00	1.00	4.00

[37] The total amount of resources to be mobilised by the CO will not necessarily be limited to the above-mentioned $ 18 million, but will rather depend on the specific roles that the CO is asked to perform. For instance, if the CO were to be tasked to take the lead role in coordinating the financing for RHCS and direct procurement of RHC or the realisation of the APHC, the total amounts of funding to be mobilised from other sources would be several times the indicated amount.

Outcome 2: By 2013, young women and men adopt healthy lifestyles. **Outcome indicators:** • Gender sensitive life skills based ASRH integrated into national curricula of primary schools, secondary schools, Madrasas and teacher training schools • % of women aged 16-24 who were married before age 16 and 18	**Output 2.1:** Increased availability of reproductive health information and life skills education at the community level, focusing on girls and boys both in and out of school, in the most underserved districts of the target provinces.	• % of young people who both correctly identify ways of preventing GBV, STI, including HIV, and who reject major misconceptions • % of teachers in catchment areas of MHU trained on and providing life skills training to students • % of communities with a trained peer educator promoting reproductive health knowledge • % of young people who can name at least three modern contraceptive methods	MOPH and NGO	REGULAR RESOURCES				
				0.30	0.35	0.40	0.40	1.45
				OTHER RESOURCES				
				0.00	0.25	0.25	0.25	0.75
Programme Component: Population and Development								
Expected Outcomes & indicators	Expected Outputs	Output indicators	Implementing partners	Indicative Resources per year (in million US$)				
				2010	2011	2012	2013	Total
Outcome 1: By 2013, increased utilization of socio-demographic data for evidence-based decision-making and policy and programme formulation and monitoring in support of the Afghanistan National Development Strategy, at national and sub-national levels **Outcome indicators:** • Census data collected and processed, results published, analysed and disseminated • # of central government institutions, their provincial directorates, and district administrations, that practice evidence-based planning • # of sectoral plans based on disaggregated data by sex and age	**Output 1.1:** Improved availability and use of national and local data, disaggregated by sex and age, to formulate, implement and monitor policies and programmes	• Training, Research and Information facility on Population and Development (TRIPOD) established and operational • # of selected national government institutions and district administrations with skilled staff and tools to collect and analyse data, and disseminate socio-economic and demographic information • Socio-economic, geographic and demographic information system for emergency preparedness and response in place	CSO, universities and MoPH	REGULAR RESOURCES				
				0.45	0.55	0.65	0.65	2.30
				OTHER RESOURCES				
				2.50	2.00	1.00	1.00	6.50

Outcome 2: By 2013, the development, planning and allocation of available resources prioritizes the needs of young people **Outcome indicator:** % of the national development budget allocated to gender and youth implemented at national and provincial level	**Output 2.1:** Strengthened capacity of institutions and stakeholders, at national and community levels, to advocate, formulate, implement, monitor and evaluate policies and programmes related to young people and gender issues	• Planning, monitoring and reporting tools available for integrating gender and youth in development planning • # of selected national government and district administrations with skilled staff to collect and analyse data, and disseminate information on gender and youth	CSO, MoPH, MoEd and NGO	REGULAR RESOURCES				
				0.15	0.15	0.20	0.20	0.70
				OTHER RESOURCES				
				0.20	0.40	0.50	0.40	1.50
Programme Component: Gender								
Expected Outcomes & indicators	Expected Outputs	Output indicators	Implementing partners	Indicative Resources per year (in million US$)				
				2010	2011	2012	2013	Total
Outcome 1: By 2013, an environment conducive to empowering women and eliminating gender-based violence is created in target provinces **Outcome indicators:** • # of communities with women-led community development fund • # of communities with a justice mechanism that arbitrates women's complaints without contradicting Constitutional rights and International Human Rights Conventions ratified by the Government of Afghanistan • Net enrolment rate of boys vs. girls	**Output 1.1:** Increased participation of women in decision-making that relates to healthy families and livelihoods, at household and community levels	• "Healthy family, fortunate society" strategy developed and operational • # of communities where women participate regularly in community health shuras and CDC • Gender-sensitive life skills and sustainable livelihoods training materials developed and used as supplementary teaching material in schooling in selected communities	MoHRA, MoEd and NGO	REGULAR RESOURCES				
				0.20	0.35	0.40	0.45	1.40
				OTHER RESOURCES				
				0.25	0.20	0.15	0.20	0.80
	Output 1.2: Enhanced capacity of target communities to identify opportunities for women's involvement in family and community life, and to prevent, respond to and monitor gender-based violence	• # of influential males who are against gender-based violence • "Ethics and Gender in Policing" curriculum developed and implementation strategy operational • Education material on population and development issues developed and integrated in primary, secondary and Madrasa education, and teacher training curricula • # of GBV survivors that received health or counselling services • GBV treatment protocol integrated into pre- and in-service training of health service providers	MoEd, MoWA, MoPH, MoHRA, KPA, MoJ and NGO	REGULAR RESOURCES				
				0.40	0.60	0.75	0.85	2.60
				OTHER RESOURCES				
				0.45	0.40	0.20	0.15	1.20
Planning Coordination and Assistance (PCA)			UNFPA	0.20	0.20	0.20	0.20	0.80
Total regular resources				5.20	5.20	5.20	5.20	20.80
Total other resources				4.90	5.00	4.10	4.00	18.00
Grand total				**10.10**	**10.20**	**9.30**	**9.20**	**38.80**

Annex II: CPAP Planning and Tracking Tool

Result	Indicator	MoV	Responsible party	2010			2011		2012		2013	
				Baseline	Target	Achievement	Target	Achiev.	Target	Achiev.	Target	Achiev.
REPRODUCTIVE HEALTH												
RH Outcome 1												
By 2013, utilization of high-quality reproductive health information and maternal health and family planning services is increased in selected underserved provinces	% of births attended by skilled birth attendants (disaggregated by province)	NRVA (2007)	MOPH	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
	Modern contraceptive prevalence rate (disaggregated by province)	NRVA (2007)	MOPH	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
	National RH strategy operationalised	MoPH reports	MoPH	No	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
	% of facilities in target provinces providing at least three modern methods of contraception	HMIS	MOPH and UNFPA	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
	Fistula prevalence rate in focus provinces	HMIS/Survey	MOPH and UNFPA	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
RH Output 1.1												
Increased institutional capacity of the MoPH to perform its stewardship role in relation to ensuring the availability of and demand for quality reproductive health services.	National RHCS Strategy and Plan of Action developed and costed	MoPH and UNFPA reports	MoPH	No	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
	National RH strategy, including corresponding action plans, developed and costed	MoPH and UNFPA reports	MoPH	No	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
	Donor RHCS coordination mechanism established and operational	Meeting minutes	UNFPA	No	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
	Evidence-based IEC materials on RHR developed and used for policy dialogue, advocacy and training	UNFPA reports	UNFPA	No	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
	% of provincial health directorates that apply the SPECTRUM and/or CHANNEL software	MoPH reports	MOPH and UNFPA	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD

RH Output 1.2												
Strengthened capacity of health facilities and service providers, with a focus on selected provinces, to provide antenatal and post-natal care, basic and comprehensive emergency obstetric care and fistula treatment	% of people above 12 years of age who know three danger signs during pregnancy and know where to access health facilities, including MHU and CMW, for reproductive health services	Survey	MoPH, NGO and UNFPA	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
	# of FHH within the catchment area of MHU	Mapping reports NGO	NGO and UNFPA	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
	% of households with a family health plan in catchment areas of MHU	MHU reports	NGO and UNFPA	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
	# of district administrations in selected provinces that have an emergency preparedness plan available that integrates RH and GBV	MoRRD reports	MoRRD and UNFPA	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
	# of women who received successful fistula repair	HMIS	MOPH and UNFPA	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
RH Outcome 2												
By 2013, young women and men adopt healthy lifestyles	Gender sensitive, life skills based ASRH, integrated in national curricula of primary schools, secondary schools, Madrasas and teacher training schools	MoEd and MoPH reports	MOPH and MOEd	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
	% of women aged 16-24 who were married before age 16 and 18	NRVA (2007)	CSO	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
RH Output 2.1												
Increased availability of reproductive health information and life-skills education at the community level, focusing on girls and boys both in and out	% of young people who both correctly identify ways of preventing GBV, STI, including HIV, and reject major misconceptions	Survey	MOPH and UNFPA	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
	% of young people who can name at least three	Survey	MOPH and UNFPA	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD

of school, in the most underserved districts of the target provinces	modern contraceptive methods											
	% of teachers in catchment areas of MHU trained on and providing life skills training to students	NGO reports	NGO and UNFPA	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
	% of communities with a trained peer educator promoting reproductive health knowledge	DMoY reports	DMoY and UNFPA	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
POPULATION AND DEVELOPMENT												
PDS Outcome 1												
By 2013, increased utilization of socio-demographic data for evidence-based decision-making and policy and programme formulation and monitoring in support of the Afghanistan National Development Strategy, at national and sub national levels	Census data collected and processed, results published, analysed and disseminated	Publications, Website and reports CSO	CSO	NO	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
	# of central government institutions, their provincial directorates, and district administrations, that practice evidence-based planning	Policy documents	selected government institutions	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
	# of sectoral plans based on disaggregated data by sex and age	Policy and Sectoral Plan documents	selected government institutions	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
PDS Output 1.1												
Improved availability and use of national and local data, disaggregated by sex and age, to formulate, implement and monitor policies and programmes	Training, Research and Information facility on Population and Development (TRIPOD) established and operationalised	TRIPOD reports	Government institutions and UNFPA	No	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
	# of selected national government institutions and district administrations with skilled staff and tools to collect and analyse data, and disseminate socio-economic and demographic information	(training) Reports of identified government institutions	Selected ministries and UNFPA	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
	Socio-economic, geographic and demographic information	UNFPA reports	UNFPA	NO	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD

	system for emergency preparedness and response in place											
PDS Outcome 2												
By 2013, the development, planning and allocation of available resources prioritizes the needs of young people	% of the national development budget allocated to gender and youth implemented at the national and provincial level	Annual Youth budget Annual Gender budget	Government institutions	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
PDS Output 2.1												
Strengthened capacity of institutions and stakeholders, at national and community levels, to advocate, formulate, implement, monitor and evaluate policies and programmes related to young people and gender issues	Planning, monitoring and reporting tools available for integrating gender and youth in development planning	Policy reports and observations	Government institutions and UNFPA	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
	# of selected national government and district administrations with skilled staff to collect and analyse data, and disseminate information on gender and youth	Training reports/survey	Government institutions and UNFPA	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
GENDER EQUALITY												
Gender Outcome 1												
By 2013, an environment conducive to empowering women and eliminating gender-based violence is created in target provinces	# of communities with women-led community development fund	CDC reports	MoWA	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
	# of communities with a justice mechanism that arbitrates women's complaints without contradicting Constitutional rights and International Human Rights Conventions ratified by the Government of Afghanistan	MoJ, MoWA and NGO reports	MoJ, MoWA and NGO	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
	Net enrolment rate of boys vs. girls (disaggregated by province)	MoEd reports	NGO and MoEd	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD

Gender Output 1.1												
Increased participation of women in decision-making that relates to healthy families and livelihoods, at household and community levels	# of communities where women participate regularly in community health shuras and CDC	CDC reports and MoRRD community level budget	UNFPA	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
	Gender-sensitive life skills and sustainable livelihoods training materials developed and used as supplementary teaching material in schooling in selected communities	MoEd reports	MoEd	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
	"Healthy family, fortunate society" strategy developed and operationalised	UNFPA reports	UNFPA	No	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
Gender Output 1.2												
Enhanced capacity of target communities to identify opportunities for women's involvement in family and community life, and to prevent, respond to and monitor gender-based violence	# of influential males who are against gender-based violence	MoHRA reports	MOHRA and UNFPA	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
	"Ethics and Gender in Policing" curriculum developed and implementation strategy operational	KPA and UNFPA reports	KPA and UNFPA	No	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
	Education material on population and development issues developed and integrated in primary, secondary and Madrasa education, and teacher training curricula	MoEd reports	MoEd and UNFPA	No	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
	# of GBV survivors that received health or counselling services	MoWA, CDC, NGO and MoPH reports	MoPH	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
	GBV treatment protocol integrated into pre- and in-service training of health service providers	training reports MoPH	MoPH	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD

Annex III: CPAP M&E Calendar

	2010	2011	2012	2013
	M&E activities			
Studies & Surveys	**Activity 1:** Baseline assessment **Focus:** CPAP baseline **Partners:** IP & Government **Time:** January - March **Activity 2:** National Mortality study **Focus:** Programme design **Partners:** UN agencies & Government **Time:** 2010 -2011			**Activity 1:** End-line assessment **Focus:** CPAP end-line **Partners:** UNFPA and all IP **Time:** September - December **Activity 2:** Baseline assessment **Focus:** CP4 baseline **Partners:** IP & Government **Time:** May - August
Monitoring systems	**Activity 1:** Establish M&E system, including a database **Focus:** Monitoring programme results **Partners:** all partners **Time:** January to July **Activity 2:** Interact and review DevInfo, EMIS and HMIS **Focus:** TA and monitoring programme results **Partners:** Government **Time:** ongoing	**Activity 1:** Utilize and update M&E system, including database **Focus:** Monitoring programme results **Partners:** all partners **Time:** ongoing **Activity 2:** Interact and review DevInfo, EMIS and HMIS **Focus:** TA and monitoring programme results **Partners:** Government **Time:** ongoing	**Activity 1:** Utilize and update M&E system, including database **Focus:** Monitoring programme results **Partners:** all partners **Time:** ongoing **Activity 2:** Interact and review DevInfo, EMIS and HMIS **Focus:** TA and monitoring programme results **Partners:** Government **Time:** ongoing	**Activity 1:** Utilize and update M&E system, including database **Focus:** Monitoring programme results **Partners:** all partners **Time:** ongoing **Activity 2:** Interact and review DevInfo, EMIS and HMIS **Focus:** TA and monitoring programme results **Partners:** Government **Time:** ongoing
Evaluations & Reviews	**Activity 1:** CP2 evaluation **Focus:** CP performance **Partners:** Government and IP **Time:** January - June **Activity 2:** Household listing evaluation **Focus:** Process **Partners:** CSO **Time:** March - April **Activity 3:** Census 2006-2008 (phase 2) review **Focus:** Lessons learnt and results obtained **Partners:** CSO and EDP **Time:** April - May **Activity 4:** CPAP and AWP review **Focus:** CP performance **Partners:** Government and IP **Time:** June and December	**Activity 1:** Sub-national programme evaluation **Focus:** 6 evaluation dimensions **Partners:** Government, IP **Time:** December 2010 - March **Activity 2:** CPAP MT Review **Focus:** CPAP strategy analysis **Partners:** all IP **Time:** September - December **Activity 3:** BPHS review **Focus:** periodical review **Partners:** MoPH and EDP **Time:** April-May **Activity 4:** GEWE UNCT evaluation **Focus:** Gender inclusion UNCT **Partners:** UNCT **Time:** June	**Activity 1:** Country Population Situation Analysis **Focus:** Positioning UNFPA mandate in PRSP of Afghanistan (ANDS) **Partners:** Government and IP **Time:** February - May **Activity 2:** CPAP and AWP MT Evaluation **Focus:** CP performance **Partners:** Government and IP **Time:** April - July **Activity 3:** Safe Motherhood Initiative evaluation **Focus:** JP collaboration and results **Partners:** MoPH, UNICEF, WHO and WB **Time:** June - December	**Activity 1:** CPAP and AWP review **Focus:** CP performance **Partners:** Government and IP **Time:** June and December **Activity 2:** CPAP evaluation 2010 -2013 **Focus:** Development of ToR **Partners:** Government and IP **Time:** September

	Activity 5: CEDAW review **Focus:** Reporting status CEDAW Afghanistan **Partners:** Government and IP **Time:** June – December	**Activity 5:** UNJP LEARN evaluation **Focus:** 6 dimension of evaluation **Partners:** UNCT **Time:** June and December **Activity 6:** CPAP MT Evaluation **Focus:** CPAP strategy analysis **Partners:** IP **Time:** September - December		
Support activities	**Activity 1:** Field visits to program sites **Focus:** All programme areas **Partners:** Implementing Partners **Time:** As required **Activity 2:** Technical support services **Focus:** Technical backstopping of programme activities **Partners:** APRO, HQ, consultants **Time:** When required **Activity 3:** Annual NEX audit **Focus:** Programme management **Partners:** IP **Time:** January - March	**Activity 1:** Field visits to program sites **Focus:** All programme areas **Partners:** Implementing Partners **Time:** As required **Activity 2:** Technical support services **Focus:** Technical backstopping of programme activities **Partners:** APRO, HQ, consultants **Time:** When required **Activity 3:** Annual NEX audit **Focus:** Programme management **Partners:** IP **Time:** January - March	**Activity 1:** Field visit to program sites **Focus:** All programme areas **Partners:** Implementing Partners **Time:** As required **Activity 2:** Technical support services **Focus:** Technical backstopping of programme activities **Partners:** APRO, HQ, consultants **Time:** When required **Activity 3:** Annual NEX audit **Focus:** Programme management **Partners:** IP **Time:** January - March	**Activity 1:** Field visits to program sites **Focus:** All programme areas **Partners:** Implementing Partners **Time:** As required **Activity 2:** Technical support services **Focus:** Technical backstopping of programme activities **Partners:** APRO, HQ, consultants **Time:** When required **Activity 3:** Annual NEX audit **Focus:** Programme management **Partners:** IP **Time:** January - March
Planning references				
M&E Capacity Building	**Activity 1:** M&E capacity building of key government institutions and IP **Focus:** RBM, HRBA and data management **Partners:** all IP **Time:** January - July	**Activity 1:** M&E capacity building of key government institutions and IP **Focus:** RBM, HRBA and data management **Partners:** IP **Time:** January - July	**Activity 1:** M&E capacity building of key government institutions and IP **Focus:** RBM, HRBA and data management **Partners:** IP **Time:** January - July	**Activity 1:** M&E capacity building of key government institutions and IP **Focus:** RBM, HRBA and data management **Partners:** IP **Time:** January - July
UNDAF Final Evaluation Milestone		**Activity 1:** Annual Joint UNDAF Inter-Agency Meeting **Focus:** Review UNDAF **Partners:** All UN Agencies **Time:** January	**Activity 1:** UNDAF MT Review **Focus:** UNDAF performance **Partners:** UN agencies **Time:** January	**Activity 1:** Annual Joint UNDAF Inter-Agency Meeting **Focus:** Review UNDAF **Partners:** All UN Agencies **Time:** January
Partner activities	TBD	TBD	TBD	TBD
Use of Information	**Activity 1:** Preparation of plans, reports and programme **Focus:** MDG, ANDS, CPAP, AWP, COAR & SPR **Partners:** Government and NGOs **Time:** As and when required **Activity 2:** Updating of CPAP PTT **Focus:** Results based management **Partners:** IP **Time:** March	**Activity 1:** Preparation of plans, reports and programme **Focus:** MDG, ANDS, AWP, COAR & SPR **Partners:** Government and NGOs **Time:** As and when required **Activity 2:** Updating of CPAP PTT **Focus:** Results based management **Partners:** IP **Time:** January	**Activity 1:** Preparation of plans, reports and programme **Focus:** ANDS, CPAP, AWP, COAR and SPR **Partners:** Government and NGOs **Time:** As and when required **Activity 2:** Updating of CPAP PTT **Focus:** Results based management **Partners:** IP **Time:** January	**Activity 1:** Preparation of plans, reports and programme **Focus:** MDG, ANDS, AWP, SPR and COAR **Partners:** Government and NGOs **Time:** As and when required **Activity 2:** Updating of CPAP PTT **Focus:** Results based management **Partners:** IP **Time:** January