



**COUNTRY
PROGRAMME
ACTION PLAN
2015 - 2019**

**BETWEEN THE GOVERNMENT OF
THE ISLAMIC REPUBLIC OF AFGHANISTAN
AND THE UNITED NATIONS POPULATION FUND**



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LIST OF ACRONYMS

AHS	Afghanistan Health Survey
AMICS	Afghanistan Multiple Indicator Cluster Survey
AMS	Afghanistan Mortality Study
AFGA	Afghanistan Family Guidance Association
ANC	Antenatal Care
ARH	Adolescent Reproductive Health
BPHS	Basic Package of Health Services
CCA	Common Country Assessment
CEDAW	Convention on Elimination of all forms of Discrimination Against Women
CP	Country Programme
CP3	3rd Country Programme
CP4	4 th Country Programme
CPAP	Country Programme Action Plan
CSO	Central Statistics Organisation
D4D	Data for Development
EmOC	Emergency Obstetric Care
EPHS	Essential Package of Hospital Services
EPR	Emergency Preparedness Response
EU	European Union
FHH	Family Health House
FLE	Family Life Education
GBV	Gender Based Violence
GoIRA	Government of Islamic Republic of Afghanistan
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IANYD	Inter Agency Network on Youth and Development
ICPD	International Conference on Population and Development
IDP	Internally Displaced Person
IEC/BCC	Information, Education, Communication/Behaviour Change Communication
IMS	Information Management System
MDG	Millennium Development Goals
MHT	Mobile Health Team
MoF	Ministry of Finance
MoFA	Ministry of Foreign Affairs
MoE	Ministry of Education
MoEc	Ministry of Economy
MoHE	Ministry of Higher Education
MoHRA	Ministry of Hajj and Religious Affairs
MoI	Ministry of Interior
MoPH	Ministry of Public Health
MoU	Memorandum of Understanding
MST	Mobile Support Team
NGOs	Non-governmental organisations
NRVA	National Risk and Vulnerability Assessment
PD	Population and Development
POA	Programme of Action
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
RH/MH	Reproductive health/maternal health
RMNCH	Reproductive, maternal, newborn and child health
SBAA	Standard Basic Assistance Agreement

SDES	Socio-demographic economic survey
SGBV	Sexual and Gender-Based Violence
SIS	Strategic Information System
SRH	Sexual and Reproductive Health
STAA	Standard Technical Assistance Agreement
SWAp	Sector-Wide Approach
UN	United Nations
UNAIDS	United Nations Joint Action on AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
UNODC	United Nations Office on Drugs and Crime
UNPD	United Nations Population Department
UNWOMEN	United Nations Women
USAID	United States Agency for International Development
WHO	World Health Organisation

THE FRAMEWORK

The Government of Islamic Republic of Afghanistan, hereinafter referred to as “the Government” and the United Nations Population Fund, herein referred to as “UNFPA” are in mutual agreement to the content of the 4th Country Programme Action Plan (CPAP) and to their outlined responsibilities in the implementation of the Country Programme; and

Furthering their mutual agreement and cooperation for the fulfilment of the International Conference on Population and Development (ICPD) Programme of Action;

Building upon the experience gained and progress made during implementation of the 3rd GoIRA/ UNFPA Country Programme (CP3), and previous Programmes of Cooperation;

Entering into a new period of cooperation which is based on the approved 4th Country Programme Document (2015 – 2019), the United Nations Development Assistance Framework (2015-2019), and Afghanistan’s National Priority Plans;

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

Have agreed as follows:

PART I. BASIS OF RELATIONSHIP

The following documents form the basis for the relationship between the Government of Islamic Republic of Afghanistan and UNFPA.

The New Standard Technical Assistance Agreement (STAA) signed between the Government and the United Nations (UN), dated May 10, 1956, (the „Basic Agreement”) constitutes the legal basis for the relationship between the Government and UNFPA. The STAA applies *mutatis mutandis* to UNFPA activities and personnel in Afghanistan, until the draft Standard Basic Assistance Agreement (SBAA) currently being negotiated for conclusion and signing between UNFPA and the Government. This SBAA is complemented by Partnership Agreements that have been signed between UNFPA and concerned line ministries of Health, Women Affairs, Education, Youth and Interior and the Central Statistics Organization, that further strengthen the basis of the relationship between the Government and UNFPA.

This 4th CPAP, covering the period from 1 January 2015 to 31 December 2019, is to be interpreted and implemented in conformity with the SBAA and partnership frameworks.

PART II. SITUATION ANALYSIS

General overview

1. Afghanistan is a landlocked country located in South Asia region, bordered by Pakistan, China, Tajikistan, Turkmenistan, Uzbekistan, Turkmenistan and Iran. It has 34 provinces and is an Islamic state with 99 percent of the population Moslem. It follows parliamentary democracy with some form of decentralized governance at provincial levels, though most functions are retained at central level. It has had a long period of conflict and suffers from recurrent natural disasters.

2. Afghanistan has had a strong economic growth over the past decade, averaging 9 percent. However despite this growth, Afghanistan remains one of the poorest countries. In 2014 it ranked 169 out of 186 countries on the Human Development Index. About 36 per cent of the population live

below the poverty line. Sub-national poverty inequities vary from 9 percent in Helmand Province to 76 percent in Paktika¹ and vary between districts. About 62.6 percent of the population in the lowest wealth quintile live in the Central Highland region. While private investment plays an insignificant role in the economic growth² in Afghanistan, the new Government has prioritised private sector development.

3. The World Bank reported the gross national income per capita at \$700 in 2013. Dependence on external aid and economic distortions stemming from the security response to counter the antigovernment insurgency, the illicit opium trade, large cash based economy, large amount of unregulated financial activity and high levels of corruption create an unstable economic environment. Recognising the importance of stable and sustainable economic growth, government realises that there will be a lag between the time when Afghanistan can rely on its own economy to generate the needed revenue and jobs and its dependence on donor assistance. Government has noted that this will particularly affect the lives of the already marginalized segments of society: those living in remote areas, internally displaced settlements and border refugee camps.

4. The Afghan government has taken on a lead role in working to improve the security, governance, social and economic opportunities for its people. Progress in institution building has been slow and previous achievements were not always sustained. With the withdrawal of international forces, especially from key Southern and Eastern provinces, anti-government insurgency has increased as the Afghanistan National Police and governance structures try to maintain security and administrative control at the provincial and district levels. The quality of national and sub-national governance institutions, the continued political stalemate and corruption has challenged government's resilience. Public sector capacity, less than 30 percent non-security public expenditure and limited supervision of vast areas of the country due to insecurity also continue to challenge the provision of quality and sustainable social services. Significant progress has been made in health, such as maternal mortality reduction, due to increased access to services over the past decade but sustainable support for further progress is needed. Similarly, despite progress in education since 2001 with 16,000 schools and 10.5 million children reported attending school in 2013, a low adult literacy rate of 31 percent persists. The Ministry of Education estimates that about 3.5 million children are out of school.

Population and Development

5. With a life expectancy at birth of 61 years in 2012, an improvement from 45 years in 2000, the main issues of population concern in Afghanistan are: the high population growth rate; high maternal and child mortality, and rapid rural-urban migration. In 2012, Afghanistan had a population of 27 million, 72 per cent of whom lived in rural areas. The annual population growth ranged from 2.2 to 2.6 per cent. The crude birth rate was 37.8 per 1,000 population. The total fertility rate was 5.1 children per woman and average household size ranged between 7.3 to 7.5 people. While early marriage for girls aged below 18 years is consistently dropping with each successive birth cohort, early marriage contributes to this high population growth rate. About 53 per cent of all women aged 25 to 49 years are married by the age of 18, and 21 per cent married by the age of 15. The adolescent birth rate is 151 per 1,000 girls aged 15 – 19 years.

6. Afghanistan also faces rapid urbanization. Annually, 200,000 rural inhabitants migrate to the cities, creating one of the highest rates of urbanization in Asia. This has consequences on environment, housing, infrastructure and social services, all of which call for urban planning.

7. Unemployment and underemployment rates remain high at 8.2 percent and 16 percent respectively³. Young Afghans suffer most in terms of entry into the labour market as shown by a

¹ AusAID, WB, Provincial Briefs, June 2011.

² World Bank: Afghanistan in Transition, Looking beyond 2014, p. 4

³ NRVA 2011-2012. CSO, 2014.

higher unemployment rate of 10 percent amongst the 15-24 year age group⁴. Labour force participation differs vastly between males and females, 80 percent and 19 percent respectively, and reveals a vast gender disparity making it difficult for women to contribute to their households and the economy.

8. Unfortunately, most of these population level data rely on projections of first and last population and housing census that was conducted in 1979 and was incomplete. The second 2008 census was postponed, due to security and political constraints. As an alternative, the Socio-Demographic and Economic Survey (SDES) was undertaken in six provinces and will be completed in the next 28 provinces by 2018 for valid population and demographic data. A Demographic Health Survey is being planned with results in 18 to 24 months time. Regular National Risk and Vulnerability Assessments (NRVA), the Afghanistan Mortality Study (AMS) and the Multiple Indicator Cluster Survey (AMICS) have been conducted in Afghanistan. However, these data sources have used various methodologies and have provided widely conflicting data sometimes even on the same indicators.

9. Progress has been made in increasing availability of disaggregated population data to guide decision making at national and provincial level and in improving institutional and technical capacity for data generation and management. Programme experience, however, indicates that availability of data at various levels does not necessarily translate into data usage for decision making. Afghanistan needs to continually build capacities of national institutions to generate and use routine, reliable and valid information to aid in evidence-based planning.

10. Most sectors have not established systematic processes of data management and use. Collection, management and use of administrative data e.g. the Health Management Information System (HMIS) continues to improve. Civil registration and vital statistics is generally poor with a small percentage of births and deaths registered nationally. There is need to develop capacities of sectors and institutions to institutionalize data management and use, and to standardize surveys whose results can be used for evidence-based planning, monitoring and evaluation of government policies and programmes.

Adolescents and youth

11. As a result of the population dynamics, Afghanistan has a very young population with 63 per cent of the population below the age of 25 years and 46 per cent below the age of 15. Each year 400,000⁵, economically active population are added into the labour market due to a demographic transition driven by the world's second largest „youth bulge“ and a high childhood-dependency ratio. This „youth bulge“ presents significant challenges for the economy, social stability and service delivery over the next decade.

12. Investing in youth health, especially sexual and reproductive health (SRH); education including higher education and family life education; productive and employable skills development and employment needs of its youth are critical conditions affecting Afghanistan's ability to attain sustainable development with equity. These issues need to be urgently mainstreamed in national and sectoral development plans and budget frameworks for the country to address the “youth bulge” as an investment opportunity, and not a burden. Similarly, voice and participation or meaningful involvement of the youth should be urgently addressed in nation building.

13. Youth continue to carry a heavy burden of reproductive health in the country. Early marriage and adolescent pregnancy and associated sequelae remain high, against the backdrop of limited access to youth friendly reproductive health information and services and a lack of family life education within the educational curriculum. The strong influence of religion and culture on youth's health and education should be considered when designing and implementing relevant programmes.

⁴ ibid

⁵ This represents 5 percent of current estimated Afghan labour force

Reproductive Health and Rights

14. Afghanistan remains off-track on most of the Millennium Development Goals (MDGs). The Common Country Assessment analyzed the key dimensions of the Afghan transition that will be important determinants of its success, and the development challenges that need to be addressed from a medium- to longer-term perspective. These relate to equitable economic development with reduced dependence on the illicit economy; provision of quality, equitable and sustainable social services; securing social equity and investing in human capital especially for women, youth and vulnerable minorities; just and accessible rule of law for all; and inclusive and accountable governance.

15. Afghanistan has had significant improvements in some health indicators over the last decade. From 2002 to 2007, the number of functioning primary health care facilities increased from 496 to 1,169, and the proportion of facilities with female staff rose from 39 percent in 2004 to 76 percent in 2006⁶. There has been a reported ten-fold increase in number of midwives; from 467 in 2002 to 4,600 by 2014⁷. Primary health care coverage expanded to 68 percent in 2008, from only 9 percent in 2002. About 86 percent of the population lives within 2 hours of a health facility and skilled birth attendance and health facility deliveries have both risen to 40 percent. The contraceptive prevalence rate remains low at 22 percent with large and undocumented unmet need for family planning. There is limited data on up-to-date basic and comprehensive emergency obstetrics care coverage.

16. Despite some recorded improvements, many coverage indicators and health indicators have stagnated for the past five years and therefore limit achievement of MDGs by 2015. The total fertility rate in Afghanistan is 5.1; being highest in rural areas (5.2) compared to urban (4.7), amongst those with no education (5.3) in comparison to those with higher education (2.8), and amongst the poorer segment (5.3) compared to those in highest wealth quintile (4.8). Maternal deaths remain a leading cause of death (41 percent) for women in their childbearing years; with a woman having a 1-in-32 chance of maternal death during her lifetime.⁸ The maternal mortality ratio reported by government is 327 per 100,000 live births⁹ and it is higher for girls aged 15 – 19 years estimated at 531 per 100,000 live births. Significant disparities persist in maternal mortality within and between provinces.

17. The highest prevalence of contraception use is observed among married women aged 35 to 39 (29.6 percent), compared to only 7.1 percent of married women aged 15 to 19 years and 14.5 percent of married women aged 20 to 24 years (AMICS 2010-2011). Using existing data, 92 percent of the population are aware of family planning, but only 22 percent currently use family planning and 20 percent use modern methods. Contraceptive use is highest amongst those in the highest wealth quintile (33 percent), those with secondary education (33 percent) and those living in urban areas (33 percent). Conversely, those who are from the lowest wealth quintile, no education and from rural areas show lower use of family planning at 14 percent, 18 percent and 17 percent respectively. Family Planning use amongst married adolescents (15 – 19 years) is particularly low at 6 percent. Yet, by 18 years of age, more than 60 percent of the girls are already married. No information exists to fully explain the determinants of contraceptive use, especially related to birth spacing.

18. Amongst women of reproductive age, the most used family planning methods in Afghanistan are: the injectable (7 percent); oral contraceptive pills (5 percent); male condoms (2 percent) and female sterilization (1 percent). Use of long term methods such as intra-uterine contraceptive devices and implants remain negligible in Afghanistan. The Health Management Information System (HMIS) shows stock out level of 79 percent of essential medicines in the last 6 months.

⁶ UNICEF(2008), *Afghanistan's community midwives. Context and challenge: Insufficient resources, poor maternal health outcomes, political instability.*

⁷ UNFPA (2014), *State of Afghanistan's Midwifery Report.*

⁸ UNICEF, *The State of the World's Children 2013, statistical table on women.*

⁹ UN estimates MMR 400 maternal deaths per 100,000 live births. WHO (2014). *GoIRA Afghanistan Mortality Study 2010 reported pregnancy related mortality ratio at 327. Both rates represent a significant decline in the past decade from a reported high of 1600 maternal deaths per 100,000 live births in 2003.*

19. Unfortunately, there is no current data on unmet need for family planning in Afghanistan, which makes it difficult to project potential demand in the country. Similarly, there is scanty information on family planning user profile, discontinuation rates and factors that influence use and non-use. Anecdotal reports indicate that socio-cultural factors, limited awareness on family planning, limited services delivery points to provide family planning services as well as method mix and skills of provider contribute to poor contraceptive use.

20. Afghanistan has a low prevalence of HIV in the general population of below 0.5 percent. However, Afghanistan faces a high risk of an HIV epidemic due to higher prevalence rates among key populations (UNGASS, 2010). These groups include people who inject drugs, female sex workers, men who have sex with men and prisoners. The HIV prevalence rate among people who inject drugs in five Afghan cities is 4.4 percent, but with wide variations among the cities (IBBS 2012). UNODC's 2009 *Afghanistan Drug Use Survey* found that there are around one million illicit drug users in Afghanistan (aged 15 to 64 years). This number equals around 3 percent of the population, a rate which is significantly higher than the world average.

21. At present, the capacity of national health system is not sufficient to meet these challenges. There is on average one qualified medical personnel (doctor, nurse or midwife) per 10,000 people in Afghanistan (WHO standard is for 23 medical personnel per 10,000 people). While increasing, the number and quality of midwifery workforce remain limited. The increase in deliveries by skilled birth attendants from 15 per cent in 2003 to 39 per cent in 2012, with a five-fold increase in rural areas is likely to stagnate, unless significant investment is made into midwifery improvement programme.

22. Afghanistan is prone to recurrent, sudden and slow-onset natural hazards; it is twelfth on the seismic risk index, twenty second on the drought risk index and twenty fourth on the flood risk index (CHAP 2014). Widespread level 1 and level 2 natural disasters occur every year, affecting on average a quarter of a million people. All year round, Afghanistan faces different forms of hazards; the most common hazards being insecurity, floods, mudslides and drought, and snow blocking access during winter season. Years of conflict have caused large population movements and civilians caught up in the conflict have often needed to abandon their homes and livelihoods. The conflict has led to about 600,000 people being internally displaced, vulnerable, and often unable to return to their places of origin. Conflicts in neighbouring countries, especially Pakistan, have also led to refugee influx.

23. The country has institutions and national strategies to prevent and manage risks associated with disasters and humanitarian situations. However, implementation of such strategies is hindered by limited resources. The integration of emergency preparedness response component into the Basic Package of Health Services/ Essential Package of Hospital Services (BPHS/EPHS) system is weak and inconsistent, lacks standardisation and depends on the donors' priorities. The damage/destruction of the infrastructure, equipment and medical stocks, the functioning of health system is disrupted due to loss of health staff, interruption of electric power and water supplies, disruption of supply chain as well as referral mechanism, and overburden of patients.

24. The BPHS serves as the foundation of the Afghan public health system. It was established by the Ministry of Public Health (MoPH) in 2003 to deliver high-impact primary health interventions. The BPHS now covers all rural districts, though coverage remains patchy, with only 31 percent of the population having access to the BPHS (AHS 2012) as sub-facilities are often far from remote communities.

25. The BPHS is almost completely financed by three donors - USAID, EU and the World Bank, and service delivery is largely through contracted non-government organisations (NGOs). Clearly, most delivery capacity remains outside the government as many health facilities are run by NGOs. This exposes the health care delivery system to be susceptible to sudden changes in funding and staffing which impacts long term sustainability. The private sector is the largest provider of health services (43

percent), especially in rural areas, but is unregulated. Quality of care in the public and private sector remains poor.

26. The EPHS is a complement to the BPHS which standardizes hospital services and promotes a referral system that integrates BPHS facilities with the hospital network. Since being established in 2005, limited attention has been paid to upgrading the quality of hospital services in the provinces because of high costs. Essential services such as fistula repairs have not been integrated across regional or provincial hospitals, limited only to Malalai Hospital in the capital Kabul.

Gender Equality and Gender Based Violence

27. Afghanistan ranked 147 out of 148 countries in the UNDP Gender Inequality Index in 2012. Gender inequality and discriminatory practices impact women and girls' survival and limit access to opportunities, resources, and socio-political participation. Out of 7.8 million children who were in school in 2011, only about a third (3 million) were girls. The female secondary school net attendance rate is 23.2% compared to 42% for male (NRVA, 2011/12). Afghanistan's literacy rate is 61.9% and 32.1% for male and female youth respectively.

28. In parliament, 28 percent of members of the National Parliament are women. Despite women's constitutionally guaranteed rights, indigenous cultural prohibitions, entrenched tribal traditions that discriminate against women and a localized understanding of the Sharia law continue to limit women's rights, including the right to life, property, justice, protection and economic participation. For instance, inheritance rights for daughters and wives are often abused by families and communities. Varied interpretation of formal law, religious sanctions and customary rules, further marginalizes Afghan women. A gender review of various laws, specifically focusing on the empowerment of women, is required.

29. Gender Based Violence (GBV) poses a major risk to the health rights of girls and young women, and also includes sexual violence against boys. Girls in early and forced marriages are particularly vulnerable to physical, mental and sexual violence. Studies on domestic violence in Afghanistan found that one in three girls in this group was a victim of sexual violence and 62.5 percent experienced physical violence. Approximately 87 per cent of women reported experiencing at least one form of physical, sexual or psychological violence or forced marriage in their lifetime. Government has positioned women's empowerment in its national development framework and passed the 2009 Law on the Elimination of Violence Against Women.

30. The MoPH estimates that 60 percent of Afghans suffer from stress disorders and mental health problems with women bearing the brunt of the problems (MoPH, 2012b). Suicide and self-immolation, in particular by young girls, has become a growing phenomenon in Afghanistan. While comprehensive data is missing, a related Afghanistan Independent Human Rights Commission study found that 184 cases of self-immolation were registered in 2007 while this number had dramatically increased in 2013. Reportedly, acts of violence, in particular GBV, were the main causes of female suicides and self-immolations. It is commonly assumed that violence against women and its consequences is heavily underreported due to a conservative culture which often does not permit women to talk about or report violence.

31. Management of GBV, especially during crisis, remains of concern, though GBV Sub-cluster coordination mechanism is gradually improving at national level and in selected regions/provinces. A framework for shared planning exists with WHO, UNDP and UNWOMEN, but coordination need to be strengthened while using each agency's comparative advantage and mandate on issues of GBV. Efforts at addressing GBV are curtailed by a weak services delivery mechanism, especially with regard to accessing health care, justice, psychosocial care and security which are limited to only 17 provinces, while health care for GBV is limited to only six provinces. Establishment of GBV Management Information System (IMS) remains at initial stage. Yet, GBV IMS would provide a basis for dialogue and advocacy at policy level for zero tolerance to end violence. Establishing a strong

government coordination mechanism, providing evidence and building alliances with Members of Parliament and gender activists“ groups is key in preventing and responding to GBV in Afghanistan.

PART III. PAST COOPERATION AND LESSONS LEARNED

32. The fourth CPAP builds on work and achievements attained under the 3rd CPAP. It was developed in a participatory, inclusive and consultative process jointly with government leadership and involving key sectors and civil society organizations.

33. The third UNFPA Country Programme, 2010-2013, which was extended to 2014, in line with the extension of the United Nations Development Assistance Framework (UNDAF), 2010-2013/4 contributed to overall national and regional reductions in maternal mortality, an increase in skilled birth attendance from 10 to 29 per cent, increased contraceptive prevalence rate, and increased number of health facilities with at least three modern contraceptive methods.

34. The third country programme evaluation revealed the country has succeeded in: (a) developing and revising numerous health and gender policies and strategies; (b) improving access to basic obstetric care by expanding services to underserved areas in the four selected provinces (through the establishment of 82 family health houses, with functioning community midwives supported by 13 mobile support teams; training more than 2,000 health care providers; and building capacity for prevention and repair of obstetric fistula (c) increasing the use of family planning and reproductive health services through refresher training, commodity provision and establishment of family protection centres, youth information centres and a youth health-line; (d) improving government capacity to collect, analyse and utilize population data and to undertake four provincial socio-demographic economic surveys (SDES); and (e) strengthening the capacity of parliamentarians and religious leaders to advocate for policies addressing population and elimination of gender-based GBV.

35. The evaluation recommended: (a) evaluating and integrating the model of family health houses and mobile support teams, working concurrently with community midwifery education in remote areas, into the health care system for sustainability; (b) focusing more on youth, particularly girls, through youth participation, programmatic coherence, greater government coordination and improved collaboration among development partners, including other United Nations organizations; (c) fostering strong ownership of and building capacity for SDES expansion to other provinces and the use of data for evidence-based planning; (d) undertaking multisectoral GBV prevention and response interventions focused on building capacity for health professionals, the police, the judiciary and coordination of development partners; and (e) involving religious and other influential leaders, local shura, and civil society in advocating for ICPD principles.

36. Internally, inadequate number of staff and low staff profiles at the UNFPA Country Office were identified as constraints to effective programme management and participation in high level policy dialogues. Regular orientation and spot checks of implementing partners on programme and financial performance were identified as best practices in ensuring compliance with UNFPA’s policy and procedures in programme and financial management.

PART IV. PROPOSED PROGRAMME

The proposed programme, 2015-2019, builds on three previous UNFPA country programme cycles and is aligned with national priorities as reflected in the Afghanistan National Development Strategy 2008-13 and national sectoral strategies. It is also aligned with the UNFPA Strategic Plan, 2014-2017, is grounded in human rights and gender equality principles, incorporates Islamic values, and contributes to UNDAF 2015-19 priorities. The programme will continue with downstream work to be implemented in selected provinces based on priority needs. The programme will leverage partnerships and resources in order to integrate successful interventions into public sector systems, with the aim of replicating in provinces and for the sake of scaling up and sustainability.

37. The Fourth Country Programme (CP4) intends to increase upstream policy interventions and maximize impact through synergies from ongoing collaboration with WHO and UNICEF in health and with UNDP and UNWOMEN in population development and gender equality. The programme will focus on vulnerable populations, based on (a) national development priorities and (b) recommendations from the third UNFPA country programme evaluation.

38. The CP4 will employ a human rights based approach by accelerating reduction of vulnerabilities and disparities, especially among people living in remote areas, working on issues of disabilities, youth and the most at risk population (female sex workers, displaced populations). It reaches out to the most disadvantaged groups using culturally-sensitive approaches. It seeks to develop capacities of duty bearers to create conducive socio-cultural, political and policy environments; and facilitates provision of services to those most in need; and mobilizes rights claimants to demand for and use these services.

39. The CP4 will seek to strengthen partnerships between government and civil society, including the involvement of media and community based organizations, expansion of South-South cooperation and ensuring local ownership by using participatory approaches to programme development, implementation, monitoring and evaluation at national and local levels, promotion and inclusion of target population groups in all stages of the development process, supporting the Government in the establishment of a clear accountability framework with sound results-based monitoring and evaluation and reporting mechanisms, and advocating for and providing technical assistance to the Government in establishing a Government-Civil Society Organization (CSO) feedback mechanism.

Detailed description of the programme and linkage with the UNFPA Strategic Plan

40. The CP4 aims to contribute to four outcomes of the UNFPA Strategic Plan 2014-2017:

- a. **SP Outcome 1:** *Increased availability and use of integrated sexual and reproductive health services, including family planning, maternal health and HIV that are gender-responsive and meet human rights standards for quality of care and equity in access.*
- b. **SP Outcome 2:** *Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health.*
- c. **SP Outcome 3:** *Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth.*
- d. **SP Outcome 4:** *Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality.*

REPRODUCTIVE HEALTH AND RIGHTS

Output 1. Increased national institutional capacity to deliver a coordinated supply of modern contraceptives and improved quality of family planning services in selected provinces.

41. The ***approach*** under this output will include:

- (a) establishing a conducive rights-based policy, political, religious, cultural and social environment for family planning/reproductive health commodity security (RHCS) in Afghanistan;
- (b) strengthening institutional and technical capacities at national and sub-national levels for management of family planning/RHCS in Afghanistan; and
- (c) increasing coverage and utilization of quality family planning/RHCS services to marginalised in selected provinces.

43. The *main strategies* are:

- (a) provision of technical support to develop rights-based policies and promote implementation of the national family planning programme through technical assistance, South-South exchanges and operations research;
- (b) strengthening national and subnational institutional capacities for the provision of quality family planning counselling and a wider choice of contraceptives, including for young women;
- (c) development of capacity for RHCS, including supply chain management and the logistics management information system;
- (d) support for the development and implementation of evidence-based demand generation initiatives for family planning; and
- (e) expansion of access to contraceptive services through public and private sector partnerships.

44. The *major activities* are to:

1. Mobilize institutional and social structures to advocate and support rights-based family planning/RHCS policies and programmes in Afghanistan using strategic information on family planning¹⁰. This includes to:

- (a) Provide institutional support/technical assistance to Reproductive Health (RH) Department of Ministry of Public Health (MoPH) for effective evidence-based advocacy of multi-sectoral family planning programmes;
- (b) Support/facilitate research on family planning/RHCS to provide evidence for advocacy, planning and policy development, monitoring and evaluation, including Comprehensive family planning/RHCS Needs Assessment, Family Planning Behaviour Survey, Quality studies on Family Planning in Afghanistan, etc.
- (c) Provide support to MoPH to develop/review/update policies, guidelines and strategic frameworks that promote and create supportive environment for family planning/RHCS, including policies on public-private-sector partnership for family planning; family planning/RHCS Strategic Action Plan, etc.
- (d) Mobilize and support programmes for mobilization of political, religious and cultural institutions; women and media networks to promote family planning amongst men, boys and women and girls in Afghanistan;
- (e) Develop a mass media and interpersonal communication programme for mobilization and demand generation on family planning; including development of information, education, communication/behaviour change communication (IEC/BCC) materials;
- (f) Establish/strengthen a coordinated family planning advocacy coalition/network for purposes of promoting family planning agenda in Afghanistan; and
- (g) Undertake advocacy to support family planning including advocacy for budget allocation and expenditure by government and development partners on family planning, and quality family planning commodities.

2. Strengthen capacities of national and sub-national institutions in the public and private sectors, and amongst Non-Governmental Organizations for a coordinated management of Family Planning programmes. This includes to:

- (a) Provide institutional support for technical assistance to RH Department in MoPH in family planning programme management;
- (b) Establish/strengthen RHCS coordination at national and provincial levels; and within health facilities;
- (c) Strengthen inter-sectoral collaboration and coordination with Ministry of Hajj and Religious Affairs (MOHRA), Ministry of Education (MOE), Ministry of Higher Education (MOHE) and information and communication for integration of family planning in their programmes;
- (d) Strengthen national institutional capacities for family planning/RHCS forecasting, planning, procurement, storage, distribution and reporting, including use of logistics management information

¹⁰ Strategic Information on Family Planning provided by the Family Planning Comprehensive Needs Assessment 2014, Family Planning Behavioural Study 2014-15 and the Demographic Health Survey 2015-16

system integrated within overall HMIS; and through strengthening capacity of health facility staff on family planning stock management, stock and bin cards use and in client information management;

- (e) Develop/strengthen capacity of educational institutions like medical and paramedical colleges and other relevant institutions to integrate training in family planning in their programmes;
- (f) Promote Best Practices documentation and sharing on family planning including south-south technical exchanges within and out of the country

3. *Increase coverage and quality in provision of Family Planning services in Afghanistan.* This will include to:

- (a) Provide technical support for competency based training for health service providers and community health workers in family planning counselling and service provision;
- (b) Partner with MoPH and BPHS/EPHS implementing partners to ensure procurement and distribution of quality contraceptive commodities in all service delivery points;
- (c) Expand family planning method mix in Afghanistan by introducing new scientifically proven family planning methods including long acting reversible methods to meet client choices;
- (d) Provide technical support to the private sector on integration of family planning services including integration of family planning data from private sector into public sector HMIS;
- (e) Promote the development and utilization of different services delivery modalities for increasing access to family planning: static clinic/facilities, mobile health teams and community based contraceptive distribution;
- (f) Develop and test innovative programmes in family planning e.g. quality improvement; demand side or provider side incentive schemes; integration of HIV prevention with family planning services, post-partum care, immunization and nutrition interventions/programmes and task shifting.

Output 2. Increased national institutional capacity to deliver comprehensive maternal health services to underserved populations.

45. The ***main strategies*** are:

- (a) expanding access to coordinated basic and comprehensive emergency obstetric care services by advocating for their integration into the health care system, promoting pooled funding of innovative models and training health care workers, including community midwives in emergency obstetrics care services;
- (b) strengthening specialist training for the treatment of obstetrics fistula through a Dignity Centre, and increase the number of provinces where such services are available;
- (c) providing support for in-service training of health care providers in integrated reproductive health services;
- (d) strengthening capacities for quality midwifery education delivery and regulation, and promote the professional midwifery association; and
- (e) conducting research to support evidence-based planning on maternal health.

46. The ***major activities*** are to:

1. *Strengthen the leadership and stewardship of national and sub-national institutions for reproductive health/maternal health programmes in Afghanistan.* This will include to:

- (a) Provide institutional support/technical assistance to RH Department of MoPH for effective coordination and management of reproductive health/maternal health (RH/MH) programmes, including quarterly Reproductive, Maternal, Newborn and Child Health (RMNCH) Coordination meetings;
- (b) Partner with MoPH and other RMNCH partners including professional associations to advocate for mainstreaming/integration of maternal health interventions in national and sectoral policies and plans; and budget allocations;
- (c) Provide support for development/review of policies, guidelines and strategic frameworks that promote maternal health in Afghanistan;
- (d) Strengthen systems for Maternal Death Surveillance and Review and health sector driven Civil Registration and Vital Statistics at national level and in targeted provinces;

- (e) Strengthen HMIS, monitoring, supervision and feedback mechanisms for RH/MH programmes and the use of such RH/MH data for planning at sectoral, sub-national and within health facilities;
 - (f) Conduct research, evaluation studies and best practice documentation in the area of RH/MH for purpose of evidence-based planning and scaling up for sustainability;
 - (g) Organize annual RH/MH priorities conference and
 - (h) Develop capacities of RH Department and key stakeholders in RH/MH programme leadership and management, including through south-south exchanges, short term training programmes, etc.
2. *Review and invest in programmes for expansion in coverage of Family Health Houses (FHH) through UNFPA execution in selected provinces; and advocacy for integration of FHH models into BPHS for replication across the country.* This will include to:
- (a) Partner with communities for the construction of new health units and mobilization of local support for FHH;
 - (b) Identify and provide “sponsorships” for training of community midwives to be deployed in the FHH, and ensuring continuous in-service updates, support supervision and monitoring;
 - (c) Procure and provide basic equipment and supplies for FHHs in target provinces;
 - (d) Establish training and support community health workers’ network for the purpose of community mobilization and health education;
 - (e) Provide RH/MH services within FHHs; with the support of Mobile Health/Support Teams (MHT/MST) and community health workers, especially targeting vulnerable groups including married adolescent girls.
 - (f) Document the FHH model and advocate with development partners and MoPH to integrate and replicate FHH model using BPHS network of facilities in order to reach other underserved areas;
 - (g) Mobilize and sensitize communities on RH/MH and availability of RH/MH services at the FHHs and/or MHT/MST outlets.
3. *Expand the programme for fistula prevention and repair services in 5 regions of Afghanistan.* This will include to:
- (a) Provide technical assistance to MoPH for coordination and management of fistula repair programme;
 - (b) Develop/review national obstetrics fistula strategy and action plan; and establishing a national fistula coordination framework;
 - (c) Mobilise and advocate with MoPH and regional leaderships for integration of fistula repair in regional hospitals;
 - (d) Procure and equip fistula repair units in targeted regional hospitals; and in Kabul.
 - (e) Support training of fistula repair teams (surgeons, anaesthetists, nurses) in basic and advanced fistula care;
 - (f) Provide support for operation during fistula surgical repair camps and for integration of fistula repair into routine services of the targeted regional hospitals;
 - (g) Work in partnership with MoPH to mobilise and leverage additional resources for fistula prevention and repair programmes;
 - (h) Support training of health workers in maternity care in life saving skills for purpose of fistula prevention;
 - (i) Initiate a programme for rehabilitation and social re-integration of fistula survivors.
 - (j) Develop and implement communication programme for promoting update of fistula repair services; re-integration of fistula survivors and addressing stigma associated with fistula.
4. *Strengthen midwifery improvement programme covering midwifery education and training; midwifery regulation and practice and midwifery association.* This will include to:
- (a) Invest in improved management and multi-sectoral coordination of midwifery programme;
 - (b) Review and develop curriculum and teaching aids and learning resources for midwifery schools and universities in line with International Congress on Midwifery competency based curriculum;
 - (c) Continue support for and expansion of community midwifery education; and bridging and Direct Entry Midwifery training programmes at bachelor degree level

- (d) Develop a faculty development programme based on international standards and support implementation of such programme
- (e) Conduct regular updates for in-service midwifery tutors/faculties on issues of policy, programmes and technical aspects of midwifery and maternal health, and in facilitation/training skills;
- (g) Strengthen midwifery schools and universities with midwifery skills laboratory and learning and teaching resources such as library books, computers and internet services;
- (h) Develop/review midwifery regulations, guidelines and handbooks to include new developments/practices; including task shifting.
- (i) Support supervision and accreditation for midwifery schools and universities;
- (j) Support advocacy and mobilization activities for midwives in Afghanistan such as annual midwifery congress/general meetings; commemoration of international day of the midwife, international conferences etc.
- (k) Develop skills of midwifery association and regulatory body in leadership and management, advocacy, networking and resources mobilization, etc. in order to advance midwifery and RH/MH agenda.
- (l) Promote technical exchanges including inter-country experience sharing and training programmes for promotion of sound midwifery practices in Afghanistan.

HUMANITARIAN ACTION

Output 3. Increased national capacity to provide sexual and reproductive health and GBV services in humanitarian settings.

47. The goal of this output is to reduce morbidity and mortality associated with RH and GBV during emergencies in Afghanistan, through strengthening the disaster risk reduction and management system and prompt interventions. The CPAP support under this output will prioritise building national institutional capacities for emergency preparedness and response in a timely, effective and visible manner. The interventions will combine upstream advocacy work for integration of SRH and GBV in emergencies into national policies, strategies, plans and budget allocation and expenditure; as well as down-stream in delivering UNFPA flagship interventions: Dignity Kits; RH Kits; Adolescent and Youth SRH and GBV in emergencies during humanitarian situations.

48. The *main strategies* will include:

- (a) Strengthening the health care system to ensure its capacity to implement the minimum initial service package;
- (b) Contributing to strengthened multisectoral coordination in humanitarian settings at national, regional and provincial levels; and
- (c) Developing contingency plans that meet the SRH service needs of displaced population and survivors of gender-based violence in crisis situations.

49. The *major activities* are:

1. Contribute to the strengthening of leadership and stewardship of national and sub-national institutions for emergency preparedness and response with focus on RH and GBV in emergencies.

This will include to:

- (a) Provide institutional support/technical assistance to Emergency Preparedness and Response Department of MoPH for effective management of emergency preparedness and response, including interventions on RH and GBV;
- (b) Partner with MoPH and other humanitarian agencies to advocate for mainstreaming/integration of RH and GBV in national, sectoral and sub-national (regional/provincial) disaster and emergency management policies and plans; and budget allocations;
- (c) Support a nation-wide mapping of areas (provinces, districts and villages)/vulnerable groups that are prone to disasters and conflicts in Afghanistan and use information for emergency preparedness planning and response;

- (d) Partner with Central Statistics Organization to advocate for and create baseline database for areas prone to humanitarian emergencies and use such population data for initial assessment and programme design, advocacy and resource mobilization during emergency;
- (e) Determine specific needs for RH and GBV in emergencies, and use this to develop contingency plans at central/sectoral levels and in disaster prone provinces for use during emergency situations and for internally displaced persons in addressing SRH needs of women and youth, including GBV prevention and response;
- (f) Procure and pre-position RH Kits and Dignity Kits at central and regional levels, with MoPH and NGO mechanism for faster response during humanitarian emergencies;
- (g) Develop and implement an institutionalised sustainable training programme for health workers at facility level and in the communities, especially from disaster and conflict prone areas on how to integrate RH and GBV emergency services into BPHS and EPHS; and in community level interventions; and
- (h) Provide support for the development and implementation of mechanisms for monitoring early warning systems and for results and risks monitoring; and evaluation/review of interventions for provision of RH and GBV services during emergencies.

2. *Strengthen multisectoral coordination of RH and GBV in humanitarian settings at national, regional and provincial levels.* This will include to:

- (a) Support the EPR Department of MoPH to develop guidelines for coordination of humanitarian response during emergencies;
- (b) Strengthen UNFPA and partners' capacities (through training, south-to-south exchange, etc.) to effectively advocate for SRH, GBV, data and youth issues to be addressed within the coordination framework for emergency preparedness and response at the national, sectoral and sub-national levels".
- (c) Provide support for effective coordination of the GBV Sub-cluster at national and regional levels including local multi-sectoral coordination during emergencies;
- (d) Train partners of GBV Sub-cluster mechanisms in GBV guiding principles, GBV programme management and inter-agency coordination; and develop location specific GBV sub-cluster coordination work plan and mechanism;
- (e) Strengthen effective communication, linkages and information sharing at all levels (national, regional and provincial level) during a humanitarian situation, including with affected communities;
- (f) Provide support for developing/strengthening mechanisms for risks and results monitoring for timely and effective response during emergencies;
- (g) Build strategic partnerships with government and NGOs at national and sub-national levels for purposes of implementation and coordination of timely and effective humanitarian response during crises situations.

3. *Ensure timely and effective provision of RH and GBV services in all emergencies and in the immediate post emergency/recovery period in Afghanistan.* This will include to:

- (a) Conduct needs assessment for GBV and RH in emergencies and facilitate integration of such assessments into overall humanitarian assessment in order to provide needed evidence for more effective planning and response;
- (b) Build capacities of MoPH and Humanitarian NGOs for effective implementation of the Minimum Initial Services Package and clinical management of rape during emergencies, including provision of commodities, training, and staffing where needed;
- (c) Work with partners and MoPH to mobilize/activate local committees/structures and infrastructure (security, local resources, recruitment of local staff/volunteers) for effective prevention and response to RH and GBV in emergency response;
- (d) Establish/strengthen mechanisms for timely and adequate distribution of Dignity Kits and provision of RH Kits during humanitarian emergencies,
- (e) Partner with NGOs and MoPH to increase access and provision of RH and GBV services for displaced population, including services for adolescents and youth through static clinics, mobile services and community based service delivery mechanisms.

- (f) Establish community based interventions for mapping, referral and provision of psychosocial services to survivors of GBV in emergencies, especially those within displaced camps;
- (g) Provide support for the refurbishment and re-equipping of health facilities destroyed during emergency for purpose of provision of quality RH and GBV services;
- (h) Conduct mapping of and develop/strengthen surge capacity for RH and GBV for timely deployment during emergencies; and
- (i) Partner with government, UN agencies, etc. in resources (financial, human, materials) mobilization and leveraging for humanitarian emergency response.

ADOLESCENTS AND YOUTH

50. This outcome on adolescents and youth contributes to *UNFPA SP Outcome 2: Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health services*. It also contributes to *UNDAF Outcome 3: Social equity of women, youth and minorities and vulnerable populations is increased through government's improved and consistent application of principles of inclusion in implementing existing and creating new policies and legislation* as well as *UNDAF Outcome 2: All Afghans, especially the most marginalized and vulnerable, have equitable access to and utilization of quality health, nutrition, education, WASH, prevention and protection services that are appropriate and effectively address their rights and needs*. In order to make significant contributions to this outcome on adolescents and youth, the following output will be implemented.

Output 4. Increased national capacity to conduct evidence-based advocacy for incorporating the rights and needs of adolescents and youth in national laws, policies and programmes, in particular healthy family life education and youth-friendly services

51. This output will be achieved in partnership with the Deputy Ministry of Youth Affairs(DMoYA), MoPH, Ministry of Education (MoE), UN agencies within the framework of the Inter-Agency Network for Youth and Development (IANYD), selected NGOs and youth organisations. It should be noted that this output will be closely linked with Output 1 and 2 on sexual and reproductive health above, as well as Output 5 on gender and the two outputs (6 & 7) on population and development below, so that UNFPA support for youth development will be carried out in a comprehensive manner, and also in line with the new UNFPA Strategic Plan.

52. In partnership with relevant United Nations organizations, ***main strategies*** will include:

- (a) Developing and implementing advocacy strategies that involve youth and adolescent networks to incorporate their needs into national and sub-national level strategies, service delivery packages, and budgets, in partnership with DMoYA;
- (b) Supporting the MoE and the MoPH in designing and implementing community and school-based healthy family life education;
- (c) Strengthening capacities of selected national/subnational health facilities to provide rights-based, youth-friendly sexual and reproductive health information and services for married and unmarried girls and at-risk groups.

53. The ***major activities*** for this output are to:

1. *Prioritise the needs of adolescents and youth in the national development agenda, including national and sub-national policies, strategies, service delivery packages, and budgets, in partnership with the DMoYA*. This will include to:
 - (a) Follow-up on from the endorsement of the National Youth Policy in August 2014, the DMoYA to be supported to develop the national youth strategy and costed action plan (2015-2019), with action plans developed for selected provinces under the Provincial Youth Policy Implementation Oversight Committee;
 - (b) Support the development of policy implementation coordination mechanisms and monitoring and evaluation frameworks as outlined in the National Youth Policy;

- (c) Strengthen the evidence base on investing in youth for advocacy and policy development through research and secondary analysis of available youth data (eg SDES, MICS, and work with Central Statistics Office (CSO) to develop a YouthInfo knowledge sharing platform) to increase access and utilization of youth data in policy and programme development;
- (d) Conduct ongoing evidence based national advocacy on investing in the demographic bonus to increase national commitment to the implementation of the National Youth Policy, including the development of briefing papers, stakeholder and donor consultation meetings to mobilize commitment and resources to implement the National Youth Policy and other youth related sectoral plans (e.g. National Health Strategy for young people);
- (e) Support the DMoYA to mobilize and leverage resources for implementation of the National Youth Strategy and Action Plan; and
- (f) Provide leadership to the UN Afghanistan IANYD, and coordinate with other UN agencies to develop joint programmes to support implementation of specific elements of the youth strategy

2. *Support the Ministry of Education and the Ministry of Public Health to design and implement community and school-based healthy family life education (FLE) programmes. This will include to:*

- (a) Support for technical assistance to the MOE to review FLE components of the school curriculum and support the curriculum development department of the MoE to incorporate key components of FLE including rights, positive attitudes and values, communication and decision making, reproductive health including contraception, gender including child marriage and GBV;
- (b) Support coordination through the development of a Health Education Working Group within the Human Resources Development Board, through which the MoE will coordinate with education stakeholders including other ministries, donors and UN agencies to ensure strengthening of FLE topics in teacher training and supervision;
- (c) Support capacity building of key stakeholders including religious leaders on FLE and provide exposure to international evidence on FLE through national consultations, selected study tours and advocacy fora with international experts, including Islamic scholars;
- (d) Expand the evidence base for future strengthening of the FLE including i) baseline stakeholder analysis assessing attitudes to FLE in key decision makers; ii) a review of implementation of FLE at secondary school level, and iii) a review of curriculum of primary school with recommendations on inclusion of age appropriate FLE for primary level classes;
- (e) Increase access to information for out of school young people through a range of approaches including expansion of the Youth Health Line Services (increased callers and expansion of range of counselling services, education by midwives and peer education, etc.), to other provinces as stand-alone or integrated within existing facilities, in partnership with NGOs, MoPH and sports organisations;
- (f) Initiate programme for training of school teachers in the delivery of healthy family life education to their students/pupils.

3. *Strengthen capacities of selected national/sub-national health institutions for the management and coordination of adolescent and youth health programmes and in provision of rights-based, youth-friendly reproductive health information and services for adolescents and youth, including married and unmarried girls. This will include to:*

- (a) Support the MOPH to develop a National Health Strategy for Young People (10-24 years) and costed action plan (2015-2019) and coordinate its multi-sectoral implementation.
- (b) Establish and support an ARH working group under the MOPH to develop and implement the ARH components of the health strategy on young people;
- (c) Support the MoPH to finalise youth friendly service standards and guidelines and include ARH in the basic package of health services, HMIS and pre-service/in-service training of health providers;
- (d) Support the MOPH to conduct a Knowledge, Attitude and Practice survey on youth SRH to provide a baseline for the national health strategy implementation and inform programming and policy reviews;
- (e) Support the MOPH to mobilize and leverage resources for implementation of the National Health Strategy on Young People;

- (f) Support the MOPH to include ARH in the midwifery curriculum, revise job descriptions for midwives to include ARH and support midwifery role in outreach to married adolescents to reduce adolescent pregnancy and link pregnant adolescents with maternal health services;
- (g) Continue support to NGOs providing youth friendly urban clinics, as a referral point for clients from the Youth Health Line and support such NGOs to provide targeted outreach to young people at higher risk including young sex workers, young people using drugs, married adolescents, etc.

4. *Strengthen youth leadership and increase the capacity of youth organisations in joint advocacy and participation in policy dialogue and programming*. This will include to:

- (a) Map youth organizations, including structures and activities;
- (b) Undertake advocacy with and support government (DMoYA, MOPH) to institutionalise involvement of youth organisations in policy dialogue, with inclusion of marginalized groups particularly girls;
- (c) Strengthen representation from the youth network to government policy dialogue, including DMoYA committees and consultations, MoPH ARH working group and MOE stakeholder group;
- (d) Establish and support a network of youth organizations working on ARH/HIV, and those organizations working on broader issues with interests in ARH, including sports organizations;
- (e) Undertake capacity building on youth advocacy (for investing in youth and specifically on RH), peer education, and project management linked to a system of small grants for youth-led advocacy and peer education initiatives (in partnership with AFGA, Y-PEER);
- (f) Pro-actively support young women’s leadership development through several mechanisms including support for a Gender and RHR Civil Society Mentorship system – pairing promising young women leaders with established women from the NGO sector in a mentorship system.

GENDER EQUALITY AND GENDER BASED VIOLENCE

Output 5. Strengthened capacity of health sector and law-enforcement bodies for prevention, response and monitoring of GBV and child marriage in targeted provinces.

54. This component contributes to the UNDAF outcome designed to ensure that social equity of women, youth and minorities and vulnerable populations is increased. It should be noted that while this output entails a dedicated stand-alone output on GBV, gender and GBV are mainstreamed across other outputs on SRH, Humanitarian Response, Adolescent and Youth and Population and Development, in line with the new Strategic plan.

55. The *major activities* will include to:

1. *Support the development, adoption/adaptation and use of policies, protocols and monitoring tools on GBV, in line with international standards*: This will include to:
 - (a) Develop a handbook or Guidance Note for Health Service Providers to implement the existing Protocols on prevention and management of GBV;
 - (b) Conduct training and orientation on GBV management protocols for health service providers drawn from all relevant departments of a health facility;
 - (c) Advocate with MOPH to ensure that GBV management protocols are developed, adopted and its use institutionalised at all levels;
 - (d) Finalize draft Protocol for Police Response to GBV and institutionalise it within Ministry of Interior and support its implementation by developing a Guidance Note and conducting training workshops on its use for police personnel at all levels;
 - (e) Develop/update Standard Operating Procedures for non-health service providers who respond to GBV (psychosocial counsellors, social workers, legal officers, etc.)
 - (f) Establish monitoring systems (both for the health sector response and the police response) including supportive supervision to ensure effective implementation of protocols and ensure consistency in quality of care and response;
 - (g) Develop/update protocols for information sharing between relevant ministries and institutions within the multi-sectoral framework for GBV response: MoPH, MoI, MoJ, MoWA, MoHA, NGOs.

2. Develop capacities of health and police institutions by training health service providers, law enforcement bodies, and communities to prevent and respond to GBV, and care for survivors;

This will include to:

- (a) Continue support for capacity building of healthcare providers at multiple levels through regular in-service training on GBV management
- (b) Conduct sensitization workshops for health sector senior management and policymakers on GBV and health sector response
- (c) Conduct training of selected health service providers in GBV psychosocial counselling, referrals and documenting and recording GBV cases;
- (d) Advocate with relevant ministries and institutions for the integration of GBV into curriculae and pre-service and in-service training programmes for health care providers, including community health workers;
- (e) Assess ongoing training programme for police in 17 provinces and based on findings consolidate and expand the programme to other provinces (where GBV prevalence is high) on a phased manner;
- (f) In collaboration with UNDP ensure that GBV modules are integrated into training programme for the legal and justice fraternity, including judges, prosecutors and lawyers.

3. Integrate GBV response into reproductive health services of public institutions. This will include to:

- (a) Assess ongoing support for health-sector response to GBV in the 6 Family Protection Centres and based on the assessment, consolidate the programme in the 6 provinces and expand to 12 provinces in a phased manner with sustainability plan and exit strategy;
- (b) Refurbish, equip and ensure provision of adequate supplies for management of GBV and provision of quality GBV services in each health unit/Family Protection Centre;
- (c) Train health workers from target provinces on integration of GBV prevention and response into maternal health services such as family health houses, BPHS, EPHS and in community health outreach programmes, such as counselling, mobile health teams, community Shuras, etc.;
- (d) Support the establishment of a systematic two-way referral mechanism to and for Family Protection Centres through the focal points in each unit within same facility, and between referral units in different facilities: BPHS/EPHS health units, FHHs, Community Development Committees/Shuras; ERAW unit in Attorney General's Office; Provincial Directorate of Women Affairs; Forensic Response Unit of MoI; NGOs providing psycho-social and legal care and shelter services; etc. The formal referral system would entail defined roles and responsibilities of agencies (i.e. MOUs); defined pathways of care for victims of violence to promote coordination between medical departments and different service providers; a formal mechanism of directing the survivor to the relevant service points (i.e. through a referral form);
- (e) strengthen mechanism for inter-sectoral coordination(e.g. a multi-sectoral committee that meets regularly and obtain follow-up information about patients referred).

4. Systematically integrate sensitization on violence against women and girls in family life education and reproductive health education programmes (formal and non-formal). This will include to:

- (a) Develop a social and behaviour change communication (SBCC) strategy that strengthens the role of male advocates, cultural/traditional and religious leaders to raise awareness on GBV and child marriage, foster a culture of non-violence and advocate for policy and institutional change;
- (b) Support the Ministry of Haj and Religious Affairs to raise community awareness on progressive Islamic interpretations on non-acceptance of GBV and harmful practices, particularly child marriage, including support for the printing and distribution of the book entitled „Healthy Family – Fortunate Society,“ write up and distribution of sermons to be delivered after Friday prayers by Imams/religious leaders and support for talk shows and interviews on national TV and radio;
- (c) Conduct evidence-based advocacy and structured dialogues with key community decision-makers, including community shuras, (including women shuras), jirgas, Community Development Committee (CDC) cluster members, Local Health Committees, religious leaders, parliamentarians, doctors, teachers and community members including youth groups on prevention of early/child marriage, GBV, and the ERAW Law;

- (d) Support active engagement of men and boys as partners and agents for change in efforts to prevent violence against women and girls and harmful practices, including early marriage;
- (e) In collaboration with other UN agencies support strategic public awareness, education and mobilization campaigns, including the “16 Days of Activism”, commemoration of International Day campaigns on GBV and Day of the Girl Child.

5. *Strengthen the multisectoral, coordinated GBV response in humanitarian settings. As chair of the GBV Sub-Cluster (GBV is an Area of Responsibility) of the Protection Cluster, strengthen the coordination mechanism for GBV response and prevention in humanitarian settings through effective inter-agency, multi-sectoral GBV coordination with government, UN and NGO partners.*
This will include to:

- (a) Develop protocols for coordination and information sharing among actors in the area of GBV in disaster/humanitarian settings: GBV case management, referral mechanisms, provision of a wide range of services including healthcare, psychosocial counselling and assistance with legal aid;
- (b) Advocate for integration of gender dimensions and GBV in disaster management/humanitarian settings and raise public and political consciousness on priority gender concerns and GBV in humanitarian settings;
- (c) Strengthen UNFPA’s leadership in the inter-agency GBV Information Management System (GBVIMS) by supporting MOH to integrate it in the HMIS and ensure coordination of data collection from multiple sources;
- (d) Provide technical assistance to incorporate GBV in pre-crisis, crisis and post-crisis situations (e.g. emergency preparedness plans; consolidated appeals; humanitarian action plans; post-conflict needs assessments and transition frameworks; DDR plans; security sector reform initiatives etc.);
- (e) Identify focal points at provincial level for GBV response in humanitarian settings and build their capacity for coordination, referrals and partnership in responding to cases of GBV in a timely manner;
- (f) Monitor and assess GBV response in humanitarian settings to ensure that services are based on GBV survivor centered approach.

6. *Mobilize and sensitize social structures, including those of opinion leaders, religious leaders, customary law institutions, and men and boys on the need for prevention of child marriage and GBV, and for support to survivors of gender-based violence.* This will include to:

- (a) Work with other UN agencies to develop a joint initiative, advocate and build institutional capacity to design and implement comprehensive programmes to prevent child marriage and adolescent pregnancies with focus on vulnerable groups;
- (b) Conduct a situational analysis which reviews current strategic information (including SDES data) and identify research gaps e.g. qualitative research into the burden, trends and key determinants of child marriage in Afghanistan;
- (c) Jointly with other agencies, support the Government to develop a National Action Plan to Eliminate Child Marriage, with a costed work plan;
- (d) Focus on high burden provinces to implement a comprehensive model for child marriage interventions which includes legal and policy reform, a strong community component (working with parents, vulnerable girls, and institutions of marriage - religious and cultural) and capacity building of public sector institutional structures for prevention and response to child marriage.

It should be noted that activities to prevent child marriage will linked to Outcome 2 on ARH.

POPULATION DYNAMICS

56. This component contributes to the *UNDAF Outcome 5: Improved legitimate, transparent and inclusive governance at all levels that promotes progressive realization of human rights*. Resources will be mobilised to ensure national coverage of socio-demographic and economic surveys. The realisation of human rights (political, civil, socio-economic and cultural) includes the right to access information to enable people effectively and efficiently contribute to development processes at the community and individual level.

57. UNFPA will work alongside the government in realization of women's, youth's and girls' rights through strengthening the evidence based policy environment. UNFPA will also facilitate capacity development of the Government to fulfil its obligations to Afghan population.

58. The PDS programme component is designed to respond to opportunities and challenges facing the Afghan population with regard to socio-economic development. The component 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 plan, collect, process, analyse, and disseminate reliable and up-to-date data;
- (iii) the 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.

59. The **approach** will include:

- a) policy dialogue and evidence-based advocacy efforts to advance the ICPD and MDG/SDG Post 2015 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 levels 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, parliamentarians, UN and donor agencies, NGO, Religious Leaders and Community-Based Organisations, including youth organisations.

Output 6. Increased availability of national and local data, disaggregated by sex and age, used to formulate, implement and monitor policies and programmes.

60. The **main strategies** will include to:

- (a) Support the Central Statistics Office to plan and conduct national and provincial SDES in the remaining provinces and the Demographic Health Survey 2015-2016;
- (b) Strengthen national and subnational capacities to collect and analyse socio-demographic data;
- (c) Strengthen government capacity to collect and use data in humanitarian settings.

61. To achieve this output UNFPA and its partners will undertake the following **major activities**:

1. *Conduct Socio-Demographic and Economic surveys (SDES) in all provinces to fill the existing gap in data required for development, monitoring and evaluation of policies and programmes.*

This will include to:

- (a) Mobilise political support from policy makers, development actors, donors, legislative institutions and support public awareness campaigns to gain social support for SDES and other data generation processes;
- (b) Provide technical support services to CSO in the design, planning, implementation, monitoring and evaluation of census or SDES;
- (c) Provide support to CSO in publication and dissemination of population data at national and provincial levels.
- (d) Mobilise and leverage financial and technical resources for these surveys/studies,

2. *Provide support, enabling CSO to perform data analysis, data processing, data dissemination and population projection.* This will include to:

- (a) Collaborate with the United Nations Population Division (UNPD) to provide support to CSO to align population estimation and projection methodologies following international standard resulting in a unified figure of Afghanistan population;

(b) Provide support to provincial governments and Development Councils in terms of access, availability and effective use of socio-demographic and economic survey information and data in developing provincial development plans.

(c) Provide support to strengthening capacity of CSO in gender statistics.

(d) Support the capacity building of CSO provincial offices and concerned departments in processing, analysis of survey data, publication and dissemination of the data in user friendly formats through different means.

3. *To strengthen the theoretical, principles and practical foundation on statistics and demography.*

This will include to:

(a) Establish a Department of Demography and strengthen the Department of Statistics at Kabul University to introduce degree programmes in demography, population studies and applied statistics;

(b) Support development of training curriculum and learning resources for the degree programmes;

(c) Equip the faculty with academic materials and internet capability for academic exchange and research;

(d) Build capacities of faculty to undertake the training programme through south south collaboration, sponsorships, mentorships, study tours and twinning programmes with other established regional academic institutions, etc.

4. *Strengthen capacities for data/information management for purpose of evaluation and continuous learning.* This will include to:

(a) Undertake midterm review and final evaluation of CPAP;

(b) Provide support for conduct of Common Country Assessment to examine the effectiveness of implementation of UNDAF priority programme,

(c) Conduct population situation analysis;

(d) Provide support to streamline civil registration and vital statistics in the health sector as part of action on the UN Commission on Information and Accountability on Maternal and Newborn Health;

Output 7. Increased capacity of government counterparts, parliamentarians and academic institutions, in data utilization and advocacy for policy development, planning, and monitoring of programmes on youth, gender equality and reproductive health.

62. The *main strategies* will:

(a) Support the use of policy-oriented research on population and demographics, poverty, sexual and reproductive health and women's, youth and girls' empowerment;

(b) Build national and subnational capacities of statistical offices, relevant ministries, and academic and research institutions to analyse, use and disseminate disaggregated data;

(c) Partner with parliamentarians and religious leaders for evidence-based advocacy;

(d) Strengthen information management systems on health and GBV and subnational capacity to use data in emergency preparedness and response; and

(e) Support existing coordination mechanisms for data management and data availability.

63. To achieve this output UNFPA and its partners, the *major activities* will include to:

1. *Establish/strengthen a Forum on Population and Development for Afghanistan Parliament/lower house.* This will include to:

(a) Support the forum to formulate laws and policies that promotes population and development;

(b) Promote national and sub-national (provincial assemblies) dialogues on issues of population and development;

(c) Build capacity of members of parliament and secretariat staff of the Forum on Population and Development on issues of policy, policy making and legislative processes; population and development issues; GBV and sexual reproductive health and reproductive rights through training, study tours, south-to-south exchanges, etc.;

(d) Support the Forum to develop its 5-year Strategic Plan for addressing population and development issues;

(e) Enhance advocacy within the parliament members to streamline population issues in national policies and legislations.

2. *Support awareness campaign amongst members of parliament on issues of population and development.* This will include to:

(a) Sensitize members of parliament and relevant committees on Population and Development issues, rights of women and young people;

(b) Conduct policy analysis, policy dialogue and evidence based advocacy on emerging PDS issues, such as migration, urbanisation, GBV, maternal health, ageing and youth;

(c) Develop advocacy support materials for use by members of parliaments in their advocacy outreach programmes.

PART V. PARTNERSHIP STRATEGY

64. Successful implementation of the 4th GoIRA/UNFPA Country Programme will strongly depend on strategically identifying, nurturing and maintaining partnerships with government ministries, departments and agencies; with development partners and civil society organizations, including academia and media houses. The partnerships and alliances will be managed within the context of country ownership and leadership; alignment to Afghanistan national priorities, systems and processes; harmonization within the UN and the wider Development Partners' arrangements; and focus on results based management and mutual accountability; while developing national capacities and promoting active involvement of Civil Society Organizations (CSOs) and the private sector.

65. Within the public sector, UNFPA will partner and continuously engage with Ministry of Economy as the overall Government Coordinating Authority for this CPAP. It will work with Ministry of Foreign Affairs and Ministry of Finance within the framework of international relations and the Development Cooperation Dialogue for Aid Management. Respectively, it will liaise and coordinate with Ministry of Public Health for RH/MH interventions and with Ministry of Women Affairs as the coordinating entity for gender and GBV related interventions, while supported by Ministry of Interior and Ministry of Justice. Its work on adolescents and youth will be coordinated by Deputy Ministry of Youth Affairs. It will maintain close working relationships with Ministry of Education and Ministry of Higher Education. In terms of population and development, UNFPA will work closely with the Central Statistics Organization, the Population Bureau in the Ministry of Interior and both Lower House and Upper Chambers of the Parliament of Afghanistan. Kabul Medical University and provincial leaderships will be key partners in implementation of this 4th CPAP. UNFPA will actively participate in relevant public sector coordination and technical consultation fora and mechanisms. Its partnerships with these public sector institutions will be aimed at promoting, coordinating, monitoring and evaluating population programmes; and in policy development and implementation and institutional capacity building of these ministries, departments and agencies in relevant ICPD mandates for each institution. Each ministry, department and agency will be supported to develop its capacity, mobilize resources, undertake research, supervise and monitor its component in the 4th CPAP.

66. Partnerships will be strengthened with development partners for purposes of advocacy, resources mobilization and leveraging, capacity building, harmonization and technical exchanges. UNFPA will engage in all appropriate UN coordination fora as well as in development partners' coordination mechanisms on health; gender and GBV; on humanitarian action and youth including IANYD; the Data for Development and Humanitarian Programming and GBV in Humanitarian Sub-Cluster. Within UN coordination framework, UNFPA will seek not only coordination but also harmonization of a common voice and approach in engaging with government, development partners and civil society within the principle of Delivering as One. In addition, UNFPA will also use these partnerships for training; and for mobilization, leveraging and sharing of resources' and for joint programming; and mechanisms for interface between the development partners and national sector consultative and coordination frameworks using agreed upon division of labour. UNFPA will play a major role among

development partners in providing leadership for Reproductive Health, Gender Based Violence, adolescent and youth issues, RH in humanitarian context, Data and integration of population dynamics in national development plans.

67. UNFPA will partner with selected civil society organizations; including faith based organizations, NGOs, coalitions and networks/alliances, women support groups, media houses, and private-for-profit sector for purpose of advocacy, community mobilization and education for social and individual behaviour change; services delivery; capacity development; resources mobilization and leveraging; and knowledge management through testing innovations. The media will play a key role in the delivery of educational messages through various media channels. Religious leaders and parliamentarians will be treated as champions and will play key roles in promoting RH/MH, GBV and youth SRH, etc.

PART VI. PROGRAMME MANAGEMENT

Coordination

68. The Government of Afghanistan, represented by Ministry of Economy (MoEc), 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.

69. Coordination of the Country Programme will be done at two levels: at overall programme level and at thematic component level. At the overall programme level, the Ministry of Economy will be the Coordinating Authority and responsible for overall coordination of the Programme. At the thematic component level, the MoPH will coordinate the Reproductive Health component; the Ministry of Women Affairs and other relevant Ministries will be responsible for coordinating the Gender component; while the Central Statistics Organization will coordinate the Population and Development component. Adolescents and Youth will be coordinated by Deputy Ministry of Youth Affairs.

70. Responsibility for programme management will rest with the respective government coordinator for each thematic component and their assigned focal staff. For each component, a Government official will be designated to work with the designated UNFPA focal point. This official will have overall responsibility for coordinating the planning, managing and monitoring and reporting, including preparing Progress Report of the programme activities in that component. UNFPA will provide the necessary support to strengthen programme design, implementation, monitoring, evaluation and coordination.

71. A Country Programme Steering Committee will be established under the chairmanship of MoEc, with the participation of CSO, MoPH, MoI, MoWA, and DMoYA, four NGO representatives from each thematic area and UNFPA. Sector ministries and UNFPA will jointly identify one NGO Implementing Partner from each component to join the Country Programme Steering Committee. The Country Programme Steering Committee will meet once a year after Annual Review and Planning Meeting to approve the Work Plans and Progress Reports for each component. In so doing, the Country Programme Steering Committee will (a) endorse Progress Reports; (b) provide strategic guidance to programme implementation; and (c) approve on any changes and adjustments that may be required to the CPAP and CPD.

72. On a day to day basis, UNFPA will work with implementing partners and other relevant stakeholders in the design, planning, implementation, monitoring and evaluation of project documents and their respective Work Plans. 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 Work Plans will be prepared for signature by UNFPA and each of the implementing partners.

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

Implementation arrangements

74. The Programme will be implemented by national institutions, including government entities, Civil Society Organizations, Networks/coalitions and academic institutions. Some other interventions could be implemented through UNFPA, other UN agencies, and international partners. UNFPA execution will be limited to technical assistance, procurement of contraceptives and some equipment, studies and research and recruitment of international consultants. All implementing partners will implement the Programme within the context of the Afghanistan National Priorities, UNDAF and 4th CPD.

75. The criteria for selecting implementing partners will be based primarily on the principles of national ownership, national leadership, and building capacities of national institutions for effective and sustainable national execution. Added to this, selection will be based on the existence of sound management systems including financial management, institutional and technical capacities, proven past experience in implementing related activities, comparative advantage, complementarity and potential to contribute uniquely to the Country Programme outcomes and outputs. The programme implementation will utilize the existing structures within government institutions and other implementing partners in line with Harmonized Approach to Cash Transfer (HACT) and Country Programme Policies and Procedures.

76. In the areas of common interest among UN agencies, such as population, gender empowerment, gender-based violence, maternal health, youth, humanitarian interventions, and the like, joint programming and joint programmes or Integrated Work Plans will be considered and joint monitoring and annual reviews will be held to assess progress within the Monitoring and Evaluation Framework of UNDAF.

77. Implementing partners will be expected to carry out activities within the set guidelines and mechanisms to monitor and report on results of activities. Implementing partners will report to UNFPA and the designated government coordinating institutions according to an agreed format.

78. With UNFPA's prior agreement, implementing partners may subcontract some activities to the contractors. The contractors will report to the implementing partner with copies to UNFPA; however accountability will remain with the implementing partners to incorporate the information into their programme and financial reports.

79. The Programme will include both downstream and upstream interventions and implemented at the national level and in a number of provinces selected based on socio-demographic, gender and health indicators. At the national level, the focus will be on knowledge management, policies and advocacy and capacity development; while programmes at the provincial and lower levels will address specific population, reproductive health and gender needs, employing a results-based programming and management approach. A list of focus provinces and/or geographical areas is agreed upon by the government and UNFPA, as in Annex IV, and will be reviewed periodically.

80. Work Plans will be developed by implementing partners with UNFPA assistance within the framework of CPAP. In all cases, the Work Plans will be accompanied by a detailed Project Activity Sheet, identifying detailed budget requirements for each of the activities and/or sub-activities. There will only be one Work Plan per Implementing Partner, combining different projects/outputs implemented by the IP. The Work Plan will be signed for each Implementing Partner by the

Representative and Head of the Implementing Partner institution. Within the year, quarterly review meetings will be conducted for implementers by the component coordinators in collaboration with UNFPA to review the status of implementation, achievements and results. Regular field monitoring visits in the project sites will be conducted by all parties involved, including during quarterly and annual review meetings. Joint Annual Review and Planning Meeting will involve all partners and the Country Programme Steering Committee.

81. The implementing agent is allowed to use the funds in line with approved Work Plan. Any revision in Work Plan or budget will be based on a formal request in writing, clearly justifying such a revision. Only after formal approval has been received from the UNFPA Representative will the implementing partner be permitted to implement the activities against the revised Work Plan.

82. All cash transfers to an implementing partner are based on the Work Plans agreed between the implementing partner and UNFPA. Where cash transfers are made to an intermediary government department, e.g. MoF for execution by another one e.g., MoPH, the intermediary unit shall transfer such cash promptly to the implementing unit. Cash transfers for activities detailed in Work Plans can be made by UNFPA using the following modalities:

1. Cash transferred directly to the implementing partner:
 - a. Prior to the start of activities (direct cash transfer), or
 - b. After activities have been completed (reimbursement);
2. Direct payment to vendors or third parties for obligations incurred by the implementing partners on the basis of requests signed by the designated official of the Implementing Partner;
3. Direct payments to vendors or third parties for obligations incurred by UN agencies in support of activities agreed with implementing partners.

83. Direct cash transfers shall be requested and released for programme implementation periods not exceeding three months. Reimbursements of previously authorized expenditures shall be requested and released quarterly or after the completion of activities. UNFPA shall not be obligated to reimburse expenditure made by the implementing partner over and above the authorized amounts. Following the completion of any activity, any balance of funds shall be reprogrammed by mutual agreement between the Implementing Partner and UNFPA, or refunded.

84. 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 implementing partner, and of an assessment of the financial management capacity of the non-UN implementing partner conducted either by a qualified consultant such as public accounting firm selected by UNCT/UNFPA who may conduct such an assessment, in which the implementing partner shall participate. Alternatively, an assessment may be jointly done by the UN system under the HACT policy.

85. 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. 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

86. As part of this CPAP, a monitoring and evaluation framework will be developed in line with the UNDAF systems. Monitoring will be done through joint field visits and regular review mechanisms that will be aligned to some national sectoral mechanisms, such as Sector Working Groups or Management Information Systems. The Programme will use SDES, DHS and other household surveys and management information systems and service statistics to generate data for monitoring

and evaluation of programme performance. The Country Programme outcome indicators are linked to UNDAF indicators as well as performance monitoring indicators for the sectors in the country.

87. The UNFPA Country Office will invest in building its own capacity and that of its implementing partners, in results based management and in monitoring and evaluation. The focus will be placed on planning and budgeting, mobilising additional resources, financial management, procurement processes, record keeping, monitoring and evaluation, data collection and reporting processes, as well as in best practice documentations and in policy advocacy. This will be achieved through tailored training programmes and establishing clear operational and programme performance criteria.

88. Managing for results also implies managing risks within the context of Afghanistan. These risks have the potential to directly impact on results management and its processes: participation, efficiency, effectiveness and accountability, which 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. In order to identify and respond to these potential risks, the Country Office will conduct annual fraud and risk assessments, in compliance with UNFPA procedures, to further strengthen its internal control mechanisms.

89. In order to bring support services closer to where programme implementation and services delivery will take place, the Country Office will establish three Decentralised Offices in Balkh, Herat and Daikundi Provinces and deploy competent staff to manage the offices and to provide technical assistance; support planning, quality assurance, monitoring and support supervisory functions; promote sub-national level knowledge exchanges; and engage in policy advocacy and UNFPA representation in sector working groups or coordination fora at provincial and lower levels.

90. Because of the security situation and the fragile and humanitarian context in Afghanistan, which sometimes limit direct access by UNFPA personnel, the Country Office will use Programme Criticality in ensuring continued delivery of programmes and services in various security contexts, including when there is need to reduce UNFPA footprints for a given period. The Country Office will therefore implement programmes in partnership with strong and widely accepted national partners that have greater access and review its structure to ensure sufficient capacity for its national staff for business continuity over period of insecurity.

Human Resources

91. Afghanistan's fragile context and humanitarian challenges requires a UNFPA Country Office with strong and experienced Representative, Deputy-Representative, Assistant-Representative, International Operations Manager, and other programme and administrative staff within the framework of the approved country office typology. The Country Office structure, staff profile and number will be reviewed to ensure effective delivery of the 4th CPAP. National and international personnel will be recruited, using regular and extra-budgetary programme resources to strengthen programme implementation. UNFPA Country Office may also draw upon technical expertise from other UNFPA Country Offices, Asia Pacific Regional Office, UNFPA Headquarters, request support from other UN agencies or even recruit Junior Professional Officers, UN Volunteers, or seek for national and international experts and institutions. Furthermore, UNFPA will also support Country Office staff and selected personnel of implementing partners 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

92. UNFPA Country Office will develop and implement a Resources Mobilization Strategy to support implementation of the Country Programme. UNFPA Country Office 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, bilateral donor organisations, governments and the private sector will be pursued. Communities will be mobilised to make cash and/or in-kind contributions to support programme implementation, as part of increased ownership, participation and programme sustainability strategy.

Information, Communication and Advocacy

93. 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.

94. The information, communication and advocacy 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/SDGs agendas for sustainable development. Finally, the information, communication and advocacy strategy will be crucial to support the resource mobilization strategy mentioned earlier.

95. 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 monitoring and evaluation 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.

Risk Analysis and Management

96. 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.

97. The Country Office will conduct a regular review of the security risk assessment 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, ASSURANCE AND EVALUATION

Implementing partners

98. Implementing partners 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 MoF will establish an annual audit plan, giving priority to audits of Implementing Partner with large amounts of cash assistance provided by UNFPA, and those whose financial management capacity needs strengthening.

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

99. The Office of the Auditor General may undertake the audits of government implementing partners. If the Office of the Auditor General 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 agencies. Audits of non-government Implementing Partner 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.

100. The implementation of the 4th 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 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).

101. Situation monitoring relies on routine monitoring or data collection mechanisms, and on the national studies or surveys included in the CPAP monitoring and evaluation calendar. Where required, UNFPA will contribute to the design of these studies and surveys. CPAP Performance monitoring includes the following different types of monitoring and evaluation tools and activities:

- a) A baseline assessment of the 4th Country Programme will be conducted to provide the present status of the Country Programme 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. 2012 MICS, 2015 DHS and routine programme data;
- b) At the end of the Country Programme cycle, a CP4 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 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 planning and tracking tool contains outcome and output indicators, baselines and targets, implementing partners and indicative resources per output that will guide monitoring and evaluation processes;
- d) The CPAP Results and Resources Framework 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 Work Plans. All the activities of the Work Plans will be accompanied by at least one process indicator for enabling UNFPA and Implementing Partner to monitor progress. In addition, each Work Plan 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 implementing partners, 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, Implementing Partner and other international development agencies may be invited to participate in planned field visits. UNFPA will develop and implement a Country Office monitoring plan to ensure an effective and efficient monitoring process throughout the CP;

- h) 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 Afghanistan National Priorities, the MDG/SDG and ICPD objectives, and other international instruments to which Afghanistan is a party;
- i) CPAP Mid-Term Review and UNDAF Mid-Term Review will be undertaken in early 2018 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;
- j) The Country Office will contribute to other internal annual review processes of UNFPA, such as the development and submission of the Country Office reports such as Strategic Information System, Office Management Plan, etc.

102. The CPAP Results and Resources Framework, the CPAP Planning and Tracking Tool, and the Monitoring and Evaluation Calendar are attached as Annex I, II and III to this document.

PART VIII. COMMITMENTS OF UNFPA

103. UNFPA will commit an amount of US\$ 32 million in support of this CPAP covering the period 2015-2019, 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 total amount that will be sought from other sources will be approximately US\$ 50 million bringing a total contribution to US\$ 82 million. This support from regular and other resources shall be exclusive of funding received in response to emergency appeals.

104. UNFPA support for the development and implementation of activities within this Country Programme Action Plan will be in line with four key programme strategies viz., building and using a knowledge base for informed decision making; advocacy and policy dialogue for increased resources and conducive implementation environment; promoting, strengthening and coordinating partnerships for effective implementation; and developing capacities of counterpart institutions for improving performance. Specifically, the programme will support procurement of relevant supplies and equipment, provision of services, support supervision, data collection/analysis, advocacy, systems building, and policy formulation and implementation and management, improvement of facilities, monitoring and evaluation.

105. Support will be provided to national counterparts including civil society organizations, as agreed within the framework of the individual work plans. The release of funds will be in accordance with guidelines and financial procedures as provided by UNFPA. Specific details on the allocation and yearly phasing of UNFPA's assistance will be reviewed and further detailed through the preparation of the work plans.

106. In case of direct cash transfer or reimbursement, UNFPA shall notify the Implementing Partner of the amount approved by UNFPA and shall disburse funds to the Implementing Partner directly. In case of direct payment to vendors or third parties for obligations incurred by the Implementing Partners on the basis of requests signed by the designated official of the Implementing Partner; or to vendors or third parties for obligations incurred by UNFPA in support of activities agreed with Implementing Partners, UNFPA shall proceed with the payment within seven days.

107. UNFPA shall not have any direct liability under the contractual arrangements concluded between the Implementing Partner and a third party vendor.

108. Where more than one UN agency provides cash to the same Implementing Partner, programme monitoring, financial monitoring and auditing will be undertaken jointly or coordinated with those UN agencies.

109. During the review meetings, respective implementing partners will examine with the component coordinating institutions and UNFPA the rate of implementation for each programme component. Subject to the review meetings conclusions, if the rate of implementation in any programme component is substantially below the annual estimates, funds may be re-allocated by mutual consent between the Government and UNFPA to other programmatically equally worthwhile strategies that will yield results.

110. UNFPA maintains the right to request the return of any cash, equipment or supplies furnished by it, which are not used for the purpose specified in the Work Plans. UNFPA will keep the Government informed about the UNFPA Executive Board policies and any changes occurring during the programme period.

PART IX. COMMITMENTS OF THE GOVERNMENT

111. 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.

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

113. A Standard Fund Authorisation and Certificate of Expenditure (FACE) report, reflecting the activity lines of the Work Plan, will be used by Implementing Partner to request the release of funds, or to secure the agreement that UNFPA will reimburse or directly pay for planned expenditure. The Implementing Partner will use the FACE to report on the utilisation of cash received. The Implementing Partner 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 Implementing Plan. Cash transferred to Implementing Partner should be spent for the purpose of activities as agreed in the Work Plan only.

114. 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 Working Plan, and ensuring that expenditure 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.

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

116. To facilitate scheduled and special audits each Implementing Partner 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 Implementing Plan's internal control structure through which the cash transfers have passed.

117. The findings of each audit will be reported to the Implementing Partner and UNFPA. Each Implementing Partner 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.

118. 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.

119. 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 Work Plan. 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

120. This 4th GoIRA/UNFPA CPAP supersedes any previous signed Country Programme Document between the Government of Afghanistan and the United Nations Population Fund, and may be modified by mutual consent of both parties based on the recommendations of Annual Review Meetings. Nothing in this CPAP shall in any way be construed to waive the protection of UNFPA Afghanistan Country Office, accorded by the contents and substance of the United Nations Convention on Privileges and Immunities to which Government of the Islamic Republic of Afghanistan is signatory.

IN WITNESS THEREOF the undersigned, being duly authorized, have signed this Country Programme Action Plan on this day, February 8th 2015, in Kabul, Afghanistan.

For the Government of
Islamic Republic of Afghanistan:

For the United Nations Population Fund



Signature



Signature

Mr. Hukum Khan Habibi
Name

Dr Annette Sachs Robertson
Name

Acting Minister of Economy
Title

Representative
Title

ANNEX I: CPAP RESULTS AND RESOURCE FRAMEWORK

OUTCOME 1: SEXUAL AND REPRODUCTIVE HEALTH							
UNDAF Outcome: All Afghans, especially the most marginalized and vulnerable, have equitable access to and use of quality health, nutrition, education, water, sanitation and hygiene (WASH), prevention and protection services that are appropriate and effectively address their rights and needs							
UNDAF Indicator: (a) Maternal Mortality Ratio; Baseline 460 per 100,000 (2010); Target – 325 per 100,000 (2020); (b) Contraceptive Prevalence Rate. Baseline: 135 (2012); Target: 40% (2020)							
UNFPA Strategic Plan Outcome	Country Programme Outputs	Output Indicators, Targets and Baselines	Implementing Partners	Indicative Resource by Output (per year in million US\$)			Total
				2015	2016	2017	
<p><u>SP Outcome #1: Sexual and Reproductive health</u></p> <p><u>Outcome indicators:</u></p> <ul style="list-style-type: none"> Percentage of skilled birth attendance. <u>Baseline: 40%</u> <u>Target: 60%</u> Prevalence of modern contraceptive use. <u>Baseline: 22%</u> <u>Target: 34%</u> 	<p><u>Output 1:</u> Increased national institutional capacity to deliver a coordinated supply of modern contraceptives and improved quality of family planning services in selected provinces</p>	<p><u>Output indicators:</u></p> <ul style="list-style-type: none"> Number of programme/policy guidance documents on family planning developed and disseminated. <u>Baseline: 3;</u> <u>Target: 6</u> Number of provinces using logistics management information system for forecasting and monitoring family planning commodities. <u>Baseline: 10;</u> <u>Target: 30</u> Number of health workers trained to provide family planning services that meet human rights standards and WHO criteria. <u>Baseline: 269;</u> <u>Target: 1,500</u> 	<p>MoPH, MoE, MoHE, MoHRA, PHDs, NGOs, Professional Societies Training Institutes</p>	REGULAR RESOURCES			5.0
				1.0	1.0	1.0	
	OTHER RESOURCES			3.0			
	0.5	0.5			0.5	0.8	0.7
	REGULAR RESOURCES			6.1			
	1.6	1.5			1.0	1.0	1.0
OTHER RESOURCES			4.4				
1.0	1.0	1.0		1.0	0.4		
<p><u>Output 2:</u> Increased national institutional capacity to deliver comprehensive maternal health services</p>	<p><u>Output indicators:</u></p> <ul style="list-style-type: none"> Number of family health houses established with functioning competent community midwives. <u>Baseline: 82;</u> <u>Target: 126</u> Number of women who received pelvic floor disorder repair surgeries (specifically obstetric fistula). <u>Baseline: 62 per year;</u> <u>Target: 150 per year</u> Number of midwives trained using policies and revised curriculum that meets International Confederation of Midwives WHO standards. <u>Baseline: 0;</u> <u>Target: 100</u> 	<p>MoPH, NGOs,</p>	REGULAR RESOURCES			3.0	
			0.7	0.8	0.5		0.5
			OTHER RESOURCES			2.6	
			0.5	0.6	0.5		0.5
<p><u>Output 3:</u> Increased national capacity to provide sexual and reproductive health services in humanitarian settings</p>	<p><u>Output indicators:</u></p> <ul style="list-style-type: none"> Number of competent personnel delivering the minimal initial service package. <u>Baseline: 150;</u> <u>Target: 390</u> National and provincial contingency plans developed to address sexual and reproductive health needs for women, youth and adolescents, including services for survivors of sexual violence in crises. <u>Baseline: 0;</u> <u>Target: 5</u> 	<p>MoPH, NGOs,</p>	REGULAR RESOURCES			3.0	
			0.7	0.8	0.5		0.5
			OTHER RESOURCES			2.6	
			0.5	0.6	0.5		0.5

OUTCOME 2: ADOLESCENTS AND YOUTH

UNDAF outcome: Social equity of women, youth and minorities and vulnerable populations is increased through government's improved and consistent application of principles of inclusion in implementing existing and creating new policies and legislation

UNDAF Indicators: (a) Percent of positive progress against relevant indicators reflected in government obligatory reports. **Baseline:** Potential to achieve MDG targets 4,5,6,7a,7b low; CEDAW Finding & recommendations; TMAF SOM government report on progress; **Target:** Achievement of MDG targets (2010); Government implements CEDAW recommendations; (b) Percent of national budget invested on promotion and protection of rights of target population in accordance with national and international commitments. **Baseline:** GRB approach into budget statement of 6 pilot ministries (MoPH, MoE, MoHE, MoLSAMD, MAIL and MRRD) for the years (2012-2013) to support fair distribution of resources from a gender equality perspective, resulted in GRB allocation increased from 27% in 2011 to 29% in 2013. **Target:** 30% annual budget expenditure principally or significantly on gender equality and women empowerment goals/objectives; GRB Strategy approved; 10 NPPs in HRD, Agriculture & Rural Development, Governance and Security Clusters enforced GRB by 2015

UNFPA Strategic Plan Outcome	Country Programme Outputs	Output Indicators, Targets and Baselines	Implementing partners	Indicative Resources per year (in million US\$)					
				2015	2016	2017	2018	2019	Total
SP Outcome #2: Adolescents and youth Outcome indicator: • Number of evidence-based policies and programmes, including service delivery packages that prioritize adolescents and youth. Baseline: 1; Target: 3	Output: Increased national capacity to conduct evidence-based advocacy for incorporating the rights and needs of adolescents and youth in national laws, policies and programmes, in particular healthy family life education and youth-friendly services	Output indicators: <ul style="list-style-type: none"> Existence of a functional multisectoral coordination mechanism on youth that advocates for increased investments in marginalized adolescents and youth, within development and health policies and programmes. Baseline: No; Target: Yes Healthy family life education programme, aligned with international standards, is integrated into high school curriculum. Baseline: No; Target: Yes Number of health service delivery points in urban centres which have integrated youth friendly services. Baseline: 0; Target: 8 	DMOYA, MoPH, MoE, MoHRA, PHDs, NGOs, Professional Societies	REGULAR RESOURCES					
				1.5	1.5	1.5	1.5	1.4	7.4
				OTHER RESOURCES					
				2.0	1.5	1.5	1.5	1.5	8.0

OUTCOME 3: GENDER EQUALITY AND WOMEN EMPOWERMENT

UNFPA Strategic Plan Outcome	Country Programme Outputs	Output Indicators, Targets and Baselines	Implementing partners	Indicative Resources per year (in million US\$)					
				2015	2016	2017	2018	2019	Total
SP Outcome #3: Gender Equality and GBV Outcome indicator: • Proportion of women who have experienced at least one form of violence (physical, sexual or psychological violence or forced marriage) in their lifetime. Baseline: 87.2% Target: 60%	Output: Strengthened capacities of health sector, and law-enforcement bodies for the prevention, response and monitoring of gender-based violence and child marriage in targeted provinces	Output indicators: <ul style="list-style-type: none"> Number of national policies, guidelines and protocols/procedures developed for the prevention of and response to gender-based violence and child marriage. Baseline: 1; Target: 3 Number of functional family protection centres and integrated into the basic package of health services. Baseline: 6; Target: 18 Number of health service providers and law enforcement personnel trained to respond to gender-based violence. Baseline: 280 health service providers, 1,200 law enforcement personnel; Target: 1,200 health services providers, 4,000 law enforcement personnel 	AIHRC, MOPH, MOHRA, MOWA, DMOYA, NGOS, UN Women UNDP; WHO	REGULAR RESOURCES					
				1.0	1.0	1.0	1.0	0.8	4.8
				OTHER RESOURCES					
				3.0	2.0	2.0	1.5	1.5	10.0

UNFPA Strategic Plan Outcome	Country Programme Outputs	Output Indicators, Targets and Baselines	Implementing partners	Indicative Resources per year (in million US\$)					
				2015	2016	2017	2018	2019	Total
OUTCOME 4: POPULATION DYNAMICS									
UNDAF outcome: Improved legitimate, transparent and inclusive governance at all levels that promotes progressive realization of human rights									
UNDAF Indicators: (a) Percent of population that have access to data on government budgets allocation. Baseline: OBI global score 59 (2012); Target: OBI global score to 30 (2019); (b) Percent of institutional capacity of Government to perform core governance. Baseline: Governance Cluster - NPP 3 challenges section and 9 Ministries reviewed in 2013; Target: 60% capacitated IARCSC to lead, coordinate and oversee whole-of-government public administration and civil service reforms									
<p>SP Outcome #4: Population dynamics</p> <p><u>Outcome indicators:</u></p> <ul style="list-style-type: none"> Number of provinces with SDES results analysed, published and disseminated. Baseline: 4 ; Target: 27 Number of evidence-based national policies, plans and programmes that address population dynamics. Baseline: 3; Target: 6 	<p>Output 1: Increased availability of national and local data, disaggregated by sex and age, to formulate, implement and monitor policies and programmes</p>	<p><u>Output indicators:</u></p> <ul style="list-style-type: none"> Number of provinces that have completed SDES data collection. Baseline: 4; Target: 34 Number of relevant government staff with competencies in data collection, generation, analysis and dissemination. Baseline: 80; Target: 400 Number of thematic sub-analysis reports on key population and development issues produced. Baseline: 0; Target: 32 	<p>CSO, Kabul University MOE MOHE MOEP, Parliament</p>	REGULAR RESOURCES					
				0.2	0.3	0.2	0.2	0.2	1.1
	OTHER RESOURCES								
	4.8	4.9		4.8	4.8	2.0	21.3		
	REGULAR RESOURCES								
	0.8	0.7		0.8	0.6	0.5	3.4		
OTHER RESOURCES									
	Output 2. Increased capacity of government counterparts, parliamentarians and academic institutions, in data utilization and advocacy for policy development, planning, and monitoring of programmes on youth, gender equality and reproductive health.	<p><u>Output indicators:</u></p> <ul style="list-style-type: none"> Number of national and sub-national development plans that used socio-demographic and economic survey data and information (including utilization of data for disaster preparedness). Baseline: 4; Target: 27 Existence of functional Department of Statistics, Demography and Population Studies at Kabul University. Baseline: No; Target: Yes Number of key stakeholders from government institutions, parliament, academia, civil society and local authorities trained on population and development issues. <u>Baseline:</u> 100; <u>Target:</u> 350 		0.2	0.1	0.2	0.2	0.0	0.7
Planning Coordination and Assistance (PCA)			UNFPA	0.24	0.24	0.24	0.24	0.24	1.2
Total regular resources				7.04	7.04	6.24	6.04	5.64	32.0
Total other resources¹¹				12.0	10.6	10.5	10.3	6.6	50.0
Grand total				19.04	17.64	16.74	16.34	12.24	82.0

¹¹ The total amount of resources to be mobilised by the CO will not necessarily be limited to the above-mentioned \$ 50 million, but will rather depend on the specific roles that the CO is asked to perform.

ANNEX II: PLANNING AND TRACKING TOOL 4th CPAP [2015 – 2019]

Result	Indicator	MoV	Responsible party	Baseline	2015	2016	2017	2018	2019	Target	Remarks
<u>SP Outcome #1: Sexual and Reproductive health</u>	• Percentage of skilled birth attendance.	DHS HMIS	RH Unit	40%	3%	8%	5%	2%	2%	60%	
	• Prevalence of modern contraceptive use.	DHS SDES	RH Unit	22%	2%	2%	3%	3%	2%	34%	Initially laying foundation and slow increase.
<u>Output 1: Increased national institutional capacity to deliver a coordinated supply of modern contraceptives and improved quality of family planning services in selected provinces</u>	Number of programme and/or policy guidance documents on family planning developed and disseminated.	Policy Document	RH Unit (FP Section)	3	2	1	0	0	0	6	RHCS Strategic Action Plan; Family Planning Advocacy & Communications Strategy
	Number of provinces using logistics management information system for forecasting and monitoring family planning commodities.	LMS Report	RH Unit (FP Section)	10	20	30	30	30	30	30	This is cumulative results
	Number of health workers trained to provide family planning services that meet human rights standards and WHO criteria.	Quarter Reports and SPR	RH Unit (FP Section)	269	500	500	231	0	0	1,500	
<u>Output 2: Increased national institutional capacity to deliver comprehensive maternal health services</u>	Number of family health houses established with functioning competent community midwives.	Quarter Reports and SPR	RH Unit (SNP)	82	10	22	12	0	0	126	There is a 2 year lead time to establish FHH. Those starting in 2015 will be ready in 2017.
	Number of women who received pelvic floor disorder repair surgeries per year (specifically obstetric fistula).	Quarter Reports and SPR	RH Unit (SNP)	62	150	150	150	150	150	150	Hospital Theatre Reports may be used to confirm
	Number of midwives trained using policies and revised curriculum that meets International Confederation of Midwives WHO standards.	Quarter Reports and SPR	RH Unit (Midwifery Program)	0	0	32	32	32	32	100	Each year, 32 enroll & complete course in 3 year. Those completing in 2016 enrolled in 2014
<u>Output 3: Increased national capacity to provide sexual and reproductive health services in humanitarian settings</u>	Number of competent personnel delivering the minimal initial service package.	Quarter Reports and SPR	HA Unit	150	100	100	40	0	0	390	
	National and provincial contingency plans developed to address sexual and reproductive health needs for women, youth and adolescents, including services for survivors of sexual violence	Quarter Reports and SPR	HA Unit	0	3	2	0	0	0	5	Copies of Plans also serve as MoV. Plans to be developed for each of the disaster prone provinces.

Result	Indicator	MoV	Responsible party	Baseline	2015	2016	2017	2018	2019	Target	Remarks
	in crises										
<u>SP Outcome #2: Adolescents and youth</u>	Number of evidence-based policies and programmes, including service delivery packages that prioritize adolescents and youth.	Copies of Policies	Adolescent & Youth Unit	1	1	1	0	0	0	3	Adolescent & Youth Health Strategy; National Youth Policy Action Plan; Secondary School FLE Curriculum
<u>Output 4:</u> Increased national capacity to conduct evidence-based advocacy for incorporating the rights and needs of adolescents and youth in national laws, policies and programmes, in particular healthy family life education and youth-friendly services	Existence of a functional multisectoral coordination mechanism on youth that advocates for increased investments in marginalized adolescents and youth, within development and health policies and programmes.	TOR, Minutes of Meetings	Adolescent & Youth Unit	No	Yes	Yes	Yes	Yes	Yes	Yes	Coordination Structure as part of National Youth Policy. Within UN, IANYD is another Coordination body
	Number of provinces with healthy family life education programme, aligned with international standards, integrated into the high school curriculum.	Quarter Reports and SPR	Adolescents and Youth Unit	0	2	2	0	0	0	4	This will pilot the FLE curriculum after assessment and development of FLW curriculum for secondary schools
	Number of health service delivery points which have integrated youth friendly services into the basic package of health services.	HMIS MoPH Report	Adolescents and Youth Unit	0	3	3	2	0	0	8	The role out will be done in partnership with NGOs & BPHS implementers
<u>SP Outcome #3: Gender Equality and GBV</u>	Proportion of women who have experienced at least one form of violence (physical, sexual or psychological or forced marriage) in their lifetime.	DHS or GBV Survey	Gender Unit	87.2%	NA	NA	NA	NA	NA	60%	
<u>Output:</u> Strengthened capacities of health sector, and law-enforcement bodies for the prevention, response and monitoring of gender-based violence and child marriage in targeted provinces	Number of functional family protection centres established and integrated into the basic package of health services.	Quarter Reports and SPR HMIS	Gender Unit	6	2	4	4	2	0	18	FPC expansion will follow review and uses 2 approaches: UNFPA into new provinces where GBV police & legal programmes; and advocacy to integrate GBV into BPHS/EPHS
	Number of health service providers (HWs) and law enforcement (LE)	Quarter Reports	Gender Unit	280 HWs	200	200	200	200	200	1,200 HWs	

Result	Indicator	MoV	Responsible party	Baseline	2015	2016	2017	2018	2019	Target	Remarks
	personnel trained to respond to gender-based violence.	and SPR		1,200 LE	600	600	600	600	400	4,000 LE	
SP Outcome #4: Population dynamics	Number of provinces with SDES results analysed, published and disseminated.	Quarter Reports and SPR SDES Reports	PDS Unit	4	6	6	6	6	1	27	Expansion of SDES is dependent upon security and funding
	Number of evidence-based national policies, plans and programmes that address population dynamics.	Quarter Reports and SPR Copies of policies	PDS Unit (Policy Advocacy)	3	0	2	1	0	0	6	
Output 1: Increased availability of national and local data, disaggregated by sex and age, to formulate, implement and monitor policies and programmes	Number of provinces that have completed SDES data collection.	Quarter Reports and SPR	PDS Unit (Data Section)	4	6	6	6	6	4	34	
	Number of relevant government staff with competencies in data collection, generation, analysis and dissemination.	Quarter Reports and SPR Evaluation	PDS Unit (Data Section)	80	40	80	80	80	40	400	
	Number of thematic sub-analysis reports on key population and development issues produced.	Quarter Reports and Copies of Reports	PDS Unit (Data Section)	0	6	6	6	6	4	32	These reports will be generated from SDES data for each province
Output 2: Increased capacity of government counterparts, parliamentarians and academic institutions, in data utilization and advocacy for policy development, planning, and monitoring of programmes on youth, gender equality and reproductive health.	Number of national and sub-national development plans that used socio-demographic and economic survey data and information (including utilization of data for disaster preparedness).	Quarter Reports Evaluation Copies of Plans	PDS Unit (Policy Advocacy Section)	4	6	6	6	5	0	27	
	Existence of functional Department of Statistics, Demography and Population Studies at Kabul University.	Quarter Report University Report	PDS Unit (Policy Advocacy Section)	No	Yes	Yes	Yes	Yes	Yes	Yes	
	Number of key stakeholders from government institutions, parliament, academia, civil society and local authorities trained on population and development issues.	Quarter Reports	PDS Unit (Policy Advocacy Section)	100	100	100	50	0	0	350	

ANNEX III: MONITORING AND EVALUATION CALENDAR FOR 4th CPAP

ACTIVITY	2015	2016	2017	2018	2019
Monitoring Missions/ Field Monitoring Visits	<ul style="list-style-type: none"> Quarterly Joint Field Monitoring Visits with IPs Quarterly Joint Programme Implementation Monitoring Meetings with IPs/Government by Thematic Areas Bi-Yearly Joint Programme Implementation Monitoring Meetings with Government/IPs Quarterly WPMPR 	<ul style="list-style-type: none"> Quarterly Joint Field Monitoring Visits with IPs Quarterly Joint Programme Implementation Monitoring Meetings with IPs/Government by Thematic Areas Bi-Yearly Joint Programme Implementation Monitoring Meetings with Government/IPs Quarterly WPMPR 	<ul style="list-style-type: none"> Quarterly Joint Field Monitoring Visits with IPs Quarterly Joint Programme Implementation Monitoring Meetings with IPs/Government by Thematic Areas Bi-Yearly Joint Programme Implementation Monitoring Meetings with Government/IPs Quarterly WPMPR 	<ul style="list-style-type: none"> Quarterly Joint Field Monitoring Visits with IPs Quarterly Joint Programme Implementation Monitoring Meetings with IPs/Government by Thematic Areas Bi-Yearly Joint Programme Implementation Monitoring Meetings with Government/IPs Quarterly WPMPR 	<ul style="list-style-type: none"> Quarterly Joint Field Monitoring Visits with IPs Quarterly Joint Programme Implementation Monitoring Meetings with IPs/Government by Thematic Areas Bi-Yearly Joint Programme Implementation Monitoring Meetings with Government/IPs Quarterly WPMPR
Annual Reviews	<ul style="list-style-type: none"> SIS Annual Planning and Review Meeting with IPs/Government: 	<ul style="list-style-type: none"> SIS Annual Planning and Review Meeting with IPs/Government: 	<ul style="list-style-type: none"> SIS Annual and Review Meeting with IPs/Government: 	<ul style="list-style-type: none"> SIS Annual Planning and Review Meeting with IPs/Government: 	<ul style="list-style-type: none"> SIS Annual Planning and Review Meeting with IPs/Government:
Evaluations	<ul style="list-style-type: none"> FHH Review for Herat 	<ul style="list-style-type: none"> Evaluation of FHH in Daikundi Evaluation of FPCs 	<ul style="list-style-type: none"> MTR for CP4 	<ul style="list-style-type: none"> Thematic Evaluations 	<ul style="list-style-type: none"> Country Programme Evaluation
Studies/Surveys/Situation Analysis/Census	<ul style="list-style-type: none"> SDES DHS 	<ul style="list-style-type: none"> SDES DHS Monographs and analysis 	<ul style="list-style-type: none"> SDES DHS Monographs and Further Analysis 	<ul style="list-style-type: none"> SDES 	<ul style="list-style-type: none"> SDES
Baseline/Midline/Endline Surveys	<ul style="list-style-type: none"> CPAP Baseline Survey FP Behaviour Study Midwifery Needs Assessment Obstetrics Fistula Needs Assessment 	<ul style="list-style-type: none"> Survey on Child Marriage Facility Assessment for FPCs 			
Monitoring & Evaluation Capacity Building	<ul style="list-style-type: none"> RBM and M&E training with IPs Online RBM & M&E Training for Programme Staff Training Programme and Implementing Partner staff on Implementing Partner 	<ul style="list-style-type: none"> RBM and M&E training with IPs Online RBM & M&E Training for Programme Staff Training Programme and Implementing Partner staff on Implementing Partner management 	<ul style="list-style-type: none"> RBM and M&E training with IPs Online RBM & M&E Training for Programme Staff Training Programme and Implementing Partner staff on Implementing Partner 	<ul style="list-style-type: none"> RBM and M&E training with IPs Online RBM & M&E Training for Programme Staff Training Programme and Implementing Partner staff on Implementing Partner management 	<ul style="list-style-type: none"> RBM and M&E training with IPs Online RBM & M&E Training for Programme Staff Training Programme and Implementing Partner staff on Implementing Partner

	<p>management</p> <ul style="list-style-type: none"> • Training Programme and Implementing Partner Staff on FACE forms • Support to IPs and sectors, including MoPH HIS/HMIS 	<ul style="list-style-type: none"> • Training Programme and Implementing Partner Staff on FACE forms • Support to IPs and sectors, including MoPH HIS/HMIS 	<p>management</p> <ul style="list-style-type: none"> • Training Programme and Implementing Partner Staff on FACE forms • Support to IPs and sectors, including MoPH HIS/HMIS 	<ul style="list-style-type: none"> • Training Programme and Implementing Partner Staff on FACE forms • Support to IPs and sectors, including MoPH HIS/HMIS 	<p>management</p> <ul style="list-style-type: none"> • Training Programme and Implementing Partner Staff on FACE forms • Support to IPs and sectors, including MoPH HIS/HMIS
<p>Joint M&E with other UN agencies (e.g. UNDAF Reviews) and other partners</p>	<ul style="list-style-type: none"> • UNDAF M&E Working Group Meeting • UNDAF PMT meeting • UNCT Activity Database Update • RCO Results and Risks Monitoring • UNCT and NPP Alignment Database 	<ul style="list-style-type: none"> • UNDAF M&E Working Group Meeting • UNDAF PMT meeting • UNCT Activity Database Update • RCO Results and Risks Monitoring • UNCT and NPP Alignment Database 	<ul style="list-style-type: none"> • UNDAF M&E Working Group Meeting • UNDAF PMT meeting • UNCT Activity Database Update • RCO Results and Risks Monitoring • UNCT and NPP Alignment Database 	<ul style="list-style-type: none"> • UNDAF M&E Working Group Meeting • UNDAF PMT meeting • UNCT Activity Database Update • RCO Results and Risks Monitoring • UNCT and NPP Alignment Database 	<ul style="list-style-type: none"> • UNDAF M&E Working Group Meeting • UNDAF PMT meeting • UNCT Activity Database Update • RCO Results and Risks Monitoring • UNCT and NPP Alignment Database
<p>Other Agency/Organisation Studies relevant to PD/RH</p>	<ul style="list-style-type: none"> • UNICEF MICS • WHO Public Health Surveillance • National Vulnerability & Risk Assessment 	<ul style="list-style-type: none"> • UNICEF MICS • WHO Public Health Surveillance • National Vulnerability & Risk Assessment 	<ul style="list-style-type: none"> • UNICEF MICS • WHO Public Health Surveillance • National Vulnerability & Risk Assessment 	<ul style="list-style-type: none"> • UNICEF MICS • WHO Public Health Surveillance • National Vulnerability & Risk Assessment 	<ul style="list-style-type: none"> • WHO Public Health Surveillance • National Vulnerability & Risk Assessment

ANNEX IV: GEOGRAPHICAL FOCUS OF 4TH GOIRA/UNFPA CPAP

The 4th GoIRA/UNFPA Country Programme will support interventions both at national and in selected provinces. Government and UNFPA consulted on the choice of the provinces where the 4th Country Programme will be implemented. The following criteria were used to arrive at the proposed provinces for the next CP.

1. Poor indicators represented by: Total Fertility Rate, Skilled Birth Attendance, Women (15-49) who ever experienced physical violence, Net Enrolment Ratio for secondary education, percentage of deliveries in health facilities, Population Growth Rate, percentage of people living in poverty and Population size.
2. Presence and performance of past GoIRA/UNFPA programmes: continuity and consolidating earlier interventions
3. Provinces with adequate and functional structures; supportive environment and committed leadership for the programme
4. Presence of other UN Agencies – for purpose of coherence and delivering as one, as well as avoiding any duplication.
5. Regional distribution/representation
6. Unique issues most prevalent or not properly addressed in the given province– GBV, Child Marriage, Fistula, etc.
7. Available resource envelope
8. Areas prone to natural disasters: mainly earthquakes, landslides, floods, and avalanche. Drought and insecurity not considered in this case.






Based on the above criteria the list of agreed upon provinces for the 4th GoIRA/UNFPA Country Programme is shown in the table below. In some provinces there will be convergence of all the five main thematic interventions of UNFPA. In some there will be only three or two themes converging, while in others only one specific theme will be implemented, given uniqueness of the need to address that theme and available funding.

NB: (1) Depending on the prevailing context, the geographical coverage may be adjusted during the 4th Country Programme Cycle.

ANNEX IV: GEOGRAPHICAL FOCUS OF THE 4TH COUNTRY PROGRAMME

S/No	Region	S/No	Provincies	Theme Intervention					Remarks
				PDS	GBV	RH	ASRH	HA	
1	Central Afghanistan	1	Kabul						
		2	Panjshir						
		3	Kapisa					1H; 1M	High risk of Avalanche; Medium for Earthquake
		4	Parwan					1H; 1M	High risk of Avalanche; Medium for Earthquake
		5	Maidan Wardak						
		6	Logar					3M	Medium Risks for: earthquake, slides, avalanche
2	Central high Land	7	Bamyan					1H; 2M	High risk of Avalanche; Medium for Earthquake & Flood
		8	Daikundi						
3	North Eastern Region	9	Badakhshan					4H	High risks for all: floods, earthquake, slides, avalanche
		10	Takhar					2H; 2M	High for e/quake and L/slides; Medium for floods & Avalanche
		11	Kuduz					1H; 3M	High risks for floods; Medium for earthquake, slides, avalanche
		12	Baghlan					3H; 1M	High risks for earthquake, landslide, avalanche, medium for floods
4	Eastern Region	13	Kunar					3M	Medium risks for avalanche, earthquake and floods
		14	Nangarhar						Youth Health Line in Jalalabad
		15	Laghman					3M	Medium risks for avalanche, slides and floods
		16	Nooristan						
5	South eastern Region	17	Khost						
		18	Ghazni					2H	High risk of Avalanche and Floods
		19	Paktia						
		20	Paktika						
6	South Region	21	Zabul						
		22	Orozgan					2H	Risks of floods and avalanche
		23	Kandhahar						
		24	Hilmand					3M	Risks for E.quake, L/slide, Avalanche
		25	Nemroz						
7	North Region	26	Samangan					3H; 1M	High risk for flood, E/quake, L/slide; Medium for avalanche
		27	Balkh					1H; 3M	Youth Health Line in Mazar. High risk for flood, M for others
		28	Jawzjan					1H; 2M	High risk for flood, Medium for E/quake & avalanche
		29	Faryab					1H; 3M	High risk for flood, Medium for E/quake & avalanche
		30	Saripul						
8	Western Region	31	Hirat						
		32	Farakh					3M	Risks for E/quake, floods and Avalanche
		33	Ghor					1H	High risk for floods
		34	Badghis						

KEY TO COLOUR CODING

	PDS programme, especially SDES		Youth Health Line with 4 new sites
	GBV Response, esp. Legal & Police Sector. Health sector FPC in 18		Provinces most prone to natural hazards: E/quake, floods, L/slides, avalanche. Insecurity & drought not considered in choosing provinces of intervention.
	RH, esp. Sub-National Programme (FHH) and Fistula Repair Centres		

