



UNFPA Bhutan
7th Country Programme Evaluation
2019-23

Evaluation Report
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Bhutan Map



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List of Abbreviations

AFHS	- Adolescent Friendly Health Services	MSTF	- Multi-Sectoral Task Force
AHP	- Adolescent Health Programme	MTP	- Medical Termination of Pregnancy
APRO	- Asia Pacific Regional Office	NCWC	- National Commission for Women and Children
ASRH	- Adolescent Sexual and Reproductive Health	NSB	- National Statistics Bureau
AWP	- Annual Work Plan	NSPAAH	- National Strategic Programme for Action for Adolescent Health
BSDS	-Bhutan Statistical Data Systems	OSCC	- One Stop Crisis Centre
CBSS	-Community Based Support System	POA	- Programme of Action
CCA	- Common Country Analysis	PSEAH	- Prevention of Sexual Exploitation, Abuse and Harassment
CO	- Country Office	PPD	- Policy and Planning Division
CP	- Country Programme	PPE	- Personal Protection Equipment
CPAP	- Country Programme Action Plan	PSA	- Population Situation Analysis
CPD	- Country Programme Document	PWD	- Persons With Disability
CPE	- Country Programme Evaluation	RENEW	- Respect Educate Nurture and Empower Women
CPR	- Contraceptive Prevalence Rate	RGOB	- Royal Government of Bhutan
CROB	- Commission for Religious Organizations of Bhutan	RR	-Reproductive Rights
CSE	- Comprehensive Sexuality Education	RRF	- Results and Resources Framework
CSO	- Civil Society Organization	RUB	- Royal University of Bhutan
DAC	- Development Assistant Committee	RMNCH	- Reproductive Maternal Newborn and Child Health
DCPD	- Department of Curriculum and Professional Development	SCED	- Scouts and Cultural Education Division
DHIS 2	- District Health Information System	SEN	- Special Education Needs
DYS	- Department of Youth and Sports	SDGs	- Sustainable Development Goals
EmONC	- Emergency Obstetric and Neonatal Care	SHND	- School Health and Nutrition Division
EQ	- Evaluation Question	SP	- Strategic Plan
EQAA	- Evaluation Quality Assurance and Assessment	SRHR	- Sexual and Reproductive Health and Rights
ERG	- Evaluation Reference Group	SSTC	- South- South and Triangular Cooperation
FONPH	- Faculty of Nursing and Public Health	SV	- Sexual Violence
GBV	- Gender-Based Violence	TOR	- Terms of Reference
GDP	- Gross Domestic Product	TOC	- Theory of Change
GEEW	- Gender Equality and Empowerment of Women	UHC	- Universal Health Coverage
GNHC	- Gross National Happiness Commission	UN	- United Nations
HRBA	- Human Rights-Based Approach	UNCT	- United Nations Country Team
HQ	- Headquarter	UNDP	- United Nations Development Programme
ICPD	- International Conference on Population and Development	UNEG	- United Nations Evaluation Group
IP	- Implementing Partner	UNFPA	- United Nations Population Fund
IPPF	- International Planned Parenthood Federation	UNICEF	- United Nations Children's Fund
IPV	- Intimate Partner Violence	UNSDPF	- UN Sustainable Development Partnership Framework
ITGSE	- International Technical Guide on Sex Education	UNRSCO	- UN Resident Coordinator's Office
KGUMSB	- KhesarGyalpo University of Medical Sciences of Bhutan	UN Women	- UN Entity for Gender Equality and Empowerment
LDC	- Least Developed Country	WHO	- World Health Organization
LGBTIQ	- Lesbian, Gay, Bisexual, Transvestite, Intersex, Queer	Y-PEER	- Youth Peer Education Network
LSE	- Life Skills Education		
M&E	- Monitoring and Evaluation		
MISP	-Minimum Initial Services Package		
MOE	- Ministry of Education		
MOH	- Ministry of Health		
MMR	- Maternal Mortality Ratio		
MPNDSR	- Maternal, Perinatal, Neonatal, Death Surveillance and Review		

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Box 1. Structure of the Bhutan Country Programme Evaluation (CPE) Report

This report comprises an executive summary, six chapters, and annexes and follows the structure recommended in the evaluation handbook by the UNFPA Independent Evaluation Office.

Chapter 1, the **Introduction**, provides the background to the evaluation, objectives and scope, the methodology used, and the evaluation process including the limitations encountered. The **second chapter** describes Bhutan country context, and the development challenges it faces in the UNFPA mandated areas, national strategies, national COVID-19 response and international assistance. The **third chapter** covers the UNFPA strategic response and UNFPA response through the country programme including overview of the to the national budget and UNFPA response to the pandemic. The **fourth chapter** presents the findings for each of the evaluation questions specified in the evaluation matrix (which is annexed); the **fifth chapter** discusses conclusions, and the **sixth chapter** concludes with strategic and programmatic level recommendations based on the conclusions. As listed in the table of contents, Annexures 1-5 contain the obligatory documents for CPE (terms of Reference, evaluation matrix, data collection tools, list of persons met and list of documents consulted and an additional one on progress of RRF indicators). Part 2 Annexes A-E provide additional reference documents compiled by CPE team. Due to the CPE page limit, useful details are not included in the main report and additional information which may be beneficial to the Country Office and other interested readers could be found in these annexes. The titles of these annexes are mentioned in the table of contents.

Table 1: Key facts table

Indicator	Status	Source
Geographical location	South Asia, between China (Tibet) and India	Statistical Yearbook of Bhutan 2021
Land area	38,394 sq. km	Statistical Yearbook of Bhutan 2021
Type of government	Democratic Constitutional Monarchy	The Constitution of the Kingdom of Bhutan
Population		
Total population, 2022	763,249	Population Projections Bhutan 2017-2047
Percent urban / rural population, 2022	40.9	Population Projections Bhutan 2017-2047
Life expectancy at birth (total), 2022	71.3	Population Projections Bhutan 2017-2047
Life expectancy at birth (female), 2022	72.8	Population Projections Bhutan 2017-2047
Life expectancy at birth (male), 2022	69.9	Population Projections Bhutan 2017-2047
Percentage of population aged below 15 years, 2022	23.5	Population Projections Bhutan 2017-2047
Percentage of population 10-24 years, 2022	26.1	Population Projections Bhutan 2017-2047
Percentage of population 15-64, 2022	69.3	Population Projections Bhutan 2017-2047
Percentage of population 65 and above, 2022	7.2	Population Projections Bhutan 2017-2047
Birth rate (births per 1,000 population), 2022	16.7	Population Projections Bhutan 2017-2047
Death rate (deaths per 1,000 population), 2022	6.7	Population Projections Bhutan 2017-2047
Total fertility rate, 2022	1.8	Population Projections Bhutan 2017-2047
Economic indicators		
Currency	Ngultrum (Nu)	Statistical Yearbook of Bhutan 2021
Percentage of population with income below poverty line, 2017	8.2	Poverty and Analysis Report 2017
Percentage of population living on less than USD 3.50 per day	12.2	The World Bank (Poverty and Equity brief)
GDP per capita, 2020	Nu 229,090.40 (USD 3,129.86)	National Accounts Statistics 2021

GDP growth rate, 2020	-10.08	National Accounts Statistics 2021
Unemployment rate, 2021	4.8	2021 Labour Force Survey Report
Youth unemployment rate, 2021	20.9	2021 Labour Force Survey Report
Reproductive health and family planning		
Maternal Mortality Ratio, deaths (per 100,000 live births), 2017	89	Population and Housing Census of Bhutan 2017
Under-5 mortality Rate, deaths (per 1000 live births), 2017	34	Population and Housing Census of Bhutan 2017
Neonatal Mortality Rate (per 1000 live births), 2017	21	Population and Housing Census of Bhutan 2017
Percent of births attended by skilled health personnel, 2021	98.9	Annual Health Bulletin 2022
Percent of pregnant women received Antenatal Care (at least one), 2012	97.9	National Health Survey 2012
Percent of pregnant women received Antenatal Care (4+), 2012	81.5	National Health Survey 2012
Percent of pregnant women received Antenatal Care (8+), 2012	26.1	National Health Survey 2012
Percent of births delivered by C-section, 2021	23.1	Annual Health Bulletin 2022
Contraceptive prevalence rate -total, 2010	65.6	Bhutan Multiple Indicator Survey 2010
Contraceptive prevalence rate -modern methods, 2010	65.4	Bhutan Multiple Indicator Survey 2010
Percent unmet need for family planning- Total, 2010	11.7	Bhutan Multiple Indicator Survey 2010
Percent unmet need for family planning- Spacing, 2010	4.7	Bhutan Multiple Indicator Survey 2010
Percent unmet need for family planning- Limitation, 2010	6.9	Bhutan Multiple Indicator Survey 2010
Percent demand satisfied modern methods, 2010	84.6	Bhutan Multiple Indicator Survey 2010
Health expenditure as percentage of GDP, 2019	3.6	Global Health Expenditure Database, WHO

Adolescents and young people		
Adolescent birth rate per 1,000 girls (15-19 years), 2017	18.9	Population Projections Bhutan 2017-2047
Percent teenage pregnancy and motherhood, 2010	2.5	Bhutan Multiple Indicator Survey 2010
Percent women 20-24 years married before the age of 18 years, 2010	25.8	Bhutan Multiple Indicator Survey 2010
Contraceptive prevalence rate among 15-24 years – total, 2010	52.4	Bhutan Multiple Indicator Survey 2010
Contraceptive prevalence among 15-24 years-modern methods, 2010	52.2	Bhutan Multiple Indicator Survey 2010
Percent of unmet need for family planning among 15-24 years, 2010	18.4	Bhutan Multiple Indicator Survey 2010
Percent of comprehensive knowledge of HIV, 15-24 years old, 2010	21.0	Bhutan Multiple Indicator Survey 2010
Social indicators		
Percent total net enrolment rate primary education, 2021	93.51	Annual education statistics 2021
Male	94.9	
Female	92.16	
Percent total net enrolment rate, secondary education, 2021	75.3	Annual education statistics 2021
Male	70.7	
Female	79.8	
Adult Literacy Rate (15+ years), 2017	66.6	Population and Housing Census of Bhutan 2017
Male	75.0	
Female	57.1	
Youth literacy rate (15-24 years), 2017	93.1	Population and Housing Census of Bhutan 2017
Male	93.3	
Female	92.9	
Human Development Index, 2019	0.654	Human Development Report 2020

Human Development Index (Rank), 2019	129	Human Development Report 2020
Gender equality and empowerment		
Gender Inequality Index, 2019	0.421	Human Development Report 2020
Gender Inequality (Rank), 2019	99	Human Development Report 2020
Global Gender Gap Index, 2020	0.639	Global Gender Gap Index 2021
Gender Parity in Tertiary Education (GPI), 2021	1.06	Annual Education Statistics 2021
Percent of seats held by women in national parliament, 2022	15	National Council of Bhutan, National Assembly of Bhutan
Sex ratio at birth (males per 100 females), 2019	104	2020 Vital Statistics Report Bhutan
Child sex ratio (males per 100 females), 2017	103.1	Bhutan Living Standards Survey 2017*
HIV Prevalence Rate (per 1000 population), 2022	0.8	Annual Health Bulletin 2022
Ever married women 15-49 years who have experienced partner violence, 2017	44.6	National Survey on Women's Health and Life Experiences 2017
Percentage of women accepting violence, 2017	53.4	National Survey on Women's Health and Life Experiences 2017
Prevalence of sexual violence among ever partnered women (15-64), 2017	4.5	National Survey on Women's Health and Life Experiences 2017
Proportion of ever pregnant women experience partnered physical violence, 2017	4.2	National Survey on Women's Health and Life Experiences 2017

Executive Summary

Background

In accordance with the UNFPA 2022 work plan and UNFPA evaluation policy, UNFPA Bhutan conducted an evaluation of its 7th Country Programme (CP) cycle of assistance to the Royal Government of Bhutan (RGOB) (2019-2023). An independent external team of evaluators conducted the evaluation as per UNFPA Guidance on Country Programme Evaluation (CPE), ethical norms and United Nations Evaluation Group norms and standards.

Key purposes of the evaluation include demonstrating accountability to stakeholders on performance in achieving development results and on invested resources and contributing key lessons learned to the existing knowledge based on how to accelerate the implementation of the Programme of Action of the International Conference on Population and Development (ICPD). The overall objective of the country programme evaluation is to provide UNFPA Bhutan CO and other stakeholders with an independent assessment of the UNFPA Bhutan 7th CP and to broaden the evidence-base to inform the design of the next programme cycle (CP 8) and to contribute to the UN Sustainable Development Partnership Framework (UNSDPF) 2018-2022 evaluation and the design of the new UNSDPF.

The targeted audience and primary users of the evaluation are the decision makers and programme managers in CO, UNFPA Asia Pacific Regional Office (APRO) and UNFPA Headquarter divisions, Executive Board, CP7 Government counterparts, other national partners, donors, development partners, UN Resident Coordinator's Office and relevant UN Agencies, civil society organizations and academia.

The scope of the evaluation covered all the activities planned and/or implemented during the period January 2019-July 2022 under the two outcome areas - Sexual and Reproductive Health and Rights (SRHR) and adolescents and young people. The evaluation covered cross-cutting issues such as Gender Equality and Women's Empowerment (GEEW) and strengthening data systems. It also assessed the progress towards the expected results under the Results and Resources Framework (RRF) and UNFPA response to the recent COVID-19 pandemic.

Methodology and Process

The CPE evaluated the programme outcome areas using OECD/DAC evaluation criteria of **Relevance, Coherence, Effectiveness, Efficiency and Sustainability**. UNFPA specific evaluation criterion of Coordination and Added value come under Coherence and assessed UNFPA's contribution to the existing coordination mechanisms and strategic positioning in the country. The evaluation team assessed how UNFPA has been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to achieve planned results, ensure ownership and the sustainability of effects. The evaluation matrix prepared by the team includes the nine Evaluation Questions (EQs) with assumptions, indicators, data sources and data collection methods. The stakeholder map and the data collection tools were organized according to the EQs. *Efforts were made to weave in the use of the six accelerators of business model of SP 2022-25.* In addition to the responses to the EQs, lessons learned, what worked, facilitating and hindering factors in achieving the results and unintended consequences were identified. A non-experimental design was used as the CP interventions are implemented nationwide and there is no control group. The evaluation used a theory-based approach. The Theory of Change (TOC) developed under the CP was reconstructed which formed the basis for developing the evaluation matrix and plays a central role in the identification of findings, as well as the articulation of conclusions and recommendations.

Data was collected at the national and subnational level using the stakeholder mapping. Data Collection, both primary and secondary, based on the type of evaluation questions and indicators selected for assumptions, was mostly done via face-to-face interviews and focus group discussions using semi-

structured interview questions, observations, and document reviews. In order to ensure adequate representation of the stakeholders given the nation-wide implementation of CP7, a sample of sites were selected for the interviews, focus group discussions and observations. Purposive sampling using specific criteria was used and two districts were selected (Chhukha and Dagana). Owing to the participatory nature of the evaluation, attempts were made to involve as many stakeholders as possible to get a wider and varied perspective on the design, interventions and implementation of the CP. A total of 155 (76 males and 73 females and 6 Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ) were interviewed.

Data analysis was mainly descriptive. Qualitative data was supplemented by analysis of quantitative data and content analysis to substantiate the findings, emerging trends and issues. A contributory analysis was done to assess the extent to which the CP contributed to expected results. Data quality was ensured by triangulation of data sources, data types and data collection. The retrospective and prospective analysis were done to respond to the EQs related to sustainability.

Main Findings and Conclusions

Overall, the UNFPA CP maintained the programme relevance by aligning with the population needs, 12th Five Year Plan priorities and related national priorities, UNFPA global priorities, UNSDPF and demonstrated its ability to be flexible to meet changes in the national priorities as in the case of the COVID-19 pandemic. The CP contributes to the three transformative goals through effective use of the six accelerators identified in UNFPA business model.

Vulnerable populations were consulted during the formulation of the CP. However, during the implementation of the programme, adolescent and youth and survivors of Gender Based Violence (GBV) were the main focus. The major reasons were related to UNFPA CO's change in mode of engagement and legal recognition of some of the vulnerable groups. However, the CO used opportunities during the pandemic to reach out to vulnerable populations but needs comprehensive understanding of the SRHR needs of these populations to enable providing services.

UNFPA has added value to the development of the 'One UN Plan' in Bhutan by leading the data thematic group, co-chairing the gender thematic group, and being an active member of the thematic group on social services for vulnerable and unreached populations. It has ensured that SRHR and GEEW issues are addressed in both development and humanitarian contexts. UNFPA's strengths in high-level advocacy, leadership in SRHR, contributions to Comprehensive Sexuality Education (CSE) in schools and the introduction of Life Skills Education (LSE) based CSE in monastic institutions, and its contributions to data systems are much appreciated by partners. Furthermore, its contributions under the Joint UN response during the pandemic are recognized by partners.

UNFPA has demonstrated its added value in the thematic areas of its comparative advantage, such as SRHR, LSE-CSE, GEEW and data systems. Its contributions to improving quality and rights-based approaches have strengthened the government programmes, in development and humanitarian contexts. UNFPA's contributions to Bhutan's statement at the ICPD @25 reflect its added value. Its collaboration with Civil Society Organizations (CSOs) has strengthened the collaboration between the government and CSOs, especially during the pandemic and also opened doors for improved collaboration with agencies working with vulnerable groups. However, it is felt that UNFPA could have done more on data, specifically in terms of quality, timeliness, and disaggregation.

UNFPA's technical leadership in SRHR was demonstrated through its assistance to the Ministry of Health (MOH) in creating evidence, supporting the development of policies and strategies, and strengthening health systems to provide rights-based and gender-sensitive quality services including for survivors of GBV. The policy and strategy support include the National Strategic Plan of Action for Adolescents, service delivery standards in family planning and midwifery (aligned to international standards), and the inclusion of the special needs of vulnerable groups such as LGBTIQ and People With Disability (PWD). UNFPA's continued high level support to the cervical cancer elimination programme has contributed significantly to the programme. The capacities of implementing partners and beneficiaries have been built. However, a

major concern is the continuation of the level of support by the RGOB for family planning services due to the below-replacement fertility level, which will require high-level, evidence-based advocacy. There are also concerns about the degree of RGOB support for Adolescent and Family Health Services (AFHS) and GBV due to the structural and policy changes in the country. Two major gaps observed are re lack of integration of SRH and HIV/STI services and support for monitoring routinely collected RMNCAH data. UNFPA's technical leadership in introducing sensitive topics such as CSE in schools and LSE based CSE in monastic schools has helped to institutionalize the topics. The support to youth networks such as Y-PEER has helped its growth and contribution in building capability of young people to exercise their RR and its support to Scouts has helped to strengthen the organization's capability in SRHR concerns and GBV prevention.

During the COVID-19 pandemic, UNFPA re-programmed its funds to support continuation of SRHR services through support for development of interim guidelines and capacity building for provision of services, especially for life saving services and services for GBV survivors. Efforts were made to reach vulnerable groups. Digital platforms were extensively used for provision of services and capacity building and has the potential to be continued as it contributes to the current thinking of RGOB.

UNFPA has employed two strategies for promoting and raising awareness of issues related to reproductive health, gender-based violence, sexual harassment, and the rights of women and adolescents. The first strategy involves utilizing high-level advocacy through UNFPA Goodwill Ambassador and influential decision-makers and legislators. The second strategy involves utilizing community mobilization through partnerships with civil society organizations, religious groups, and youth networks to address societal issues. While advocacy efforts targeting legislators and addressing SRHR and GBV is strategic, there is a need for more of such efforts.

Though there is no separate output on gender, gender and human rights have been effectively well integrated into CP outcomes. Besides support for gender equality policy development and its amendment, the advocacy and support for Prevention of Sexual Exploitation, Abuse and Harassment (PSEAH) is a significant contribution. Currently the MOH is providing a lead on this issue. Through its support for activities for survivors of GBV across various sectors, the CP has helped to establish a continuum of care approach, but needs strengthening.

Support for the Bhutan Statistical Data System (BSDS) is helping to build a strong data system in the country, but more investments are needed for optimal effectiveness. A major gap is the availability of recent and disaggregated data to monitor progress on national key result areas, SDGs, and ICPD indicators. The BSDS, once established, will enable integration of data systems from the village to national levels and may help to address this gap. Census-related publications have contributed to national policies and strategies, but the linkages are not always obvious. It is expected that legislation on statistics may help to overcome some of the issues.

UNFPA's investment in Bhutan has been effective despite limited resources, and has helped to leverage resources from other agencies. The UNFPA country office has efficiently carried out its engagement under the revised classification of the country and has used accelerators to enhance performance. However, it has not utilised its achievements in areas such as CSE, LSE-based CSE to host South- South and Triangular Cooperation (SSTC). Overall, the CP support appears to be sustainable due to the widespread ownership by stakeholders, but due to the recent policy and structural changes, there are concerns about the level of support for certain activities, particularly family planning.

Strategic and Programmatic Recommendations

High priority strategic recommendations include the following:

The next CP (CP 8) should focus on sustaining the gains in family planning while ensuring quality, expanding choices and including the needs of vulnerable populations and advocating for sustained national investments based on evidence. Key actions recommended include generating evidence by conducting a

study on the proximate determinants of fertility for advocacy for continued support for family planning and in-depth review of the current family planning programme.

UNFPA should assist Bhutan in achieving the last mile towards the SDG target related to maternal mortality ratio (has also implications for achieving the neonatal mortality target). Strategies for achieving this indicator will also support the development of human resources for health (particularly midwives), which is a concern expressed in the 12th Five Year Plan. Recommended actions include an in-depth review of maternal care services to respond to the changing landscape of maternal health, development of pre-conception care package and review of human resources for health, particularly midwives.

The support to the National Statistics Bureau in order to strengthen and expand the BSDS should be continued. Further, capacity building activities including data literacy for relevant officials should be strengthened to generate credible disaggregated data for planning to ensure that 'no one is left behind'. Key actions recommended include enactment of statistical legislation, use of innovation and technology, information on linkages between population and climate change, creation of a knowledge platform to share information on key population issues, support for developing a comprehensive strategy on population ageing and support for strengthening routinely collected reproductive, maternal, newborn, child and adolescent health indicators.

Advocacy and strategic partnerships should be further strengthened to deliver in UNFPA's core areas of support. One of the key actions recommended is the development of a national preparedness plan to respond to future pandemics/disasters and hosting of SSTC in CSE and LSE based CSE. The partnership with parliamentarians should be strengthened.

A medium priority strategic recommendation is the continued support on the prevention and management of GBV, not only as a life-threatening issue but also as a human rights issue, in both development and humanitarian contexts. This should include enhancing multi-sectoral and multi-partnership approaches to strengthen the continuum of care.

Programmatic recommendations

A medium priority recommendation is the support to selected SRH services as well as CSE in schools and LSE-based CSE in monastic institutions. The recommended actions cover continuation of support for CSE, LSE-based CSE, implementation research on adolescent friendly health services, assessments of digital health interventions, integration of SRH and HIV services, support for reproductive cancers including male cancers, studies on vulnerable populations, assessments to determine continuation of support to cervical cancer, Y-PEER, etc. and support for RH sub-accounts.

CP 8 design related

Ex-ante evaluation /evaluability assessment should be conducted after the drafting of the design of CP 8 to help assess the coherency and viability of the programme's underlying logic and overall design. Prior to the design of the CP 8, a situational and stakeholder analysis should be done. The TOC should be developed in collaboration with key stakeholders; Specific, Measurable, Achievable, Relevant and Time-bound (SMART) indicators should be developed; and a M&E plan should be developed.

Chapter 1: Introduction

1.1 Purpose and objectives of the evaluation

UNFPA Bhutan conducted an evaluation of its 7th Country Programme (CP) cycle of assistance to the Royal Government of Bhutan (RGOB) (2019-2023) as part of its 2022 work plan and in line with the UNFPA evaluation policy¹. The evaluation was an external and independent exercise conducted by an independent team of evaluators, in accordance with UNFPA Guidance on Country Programme Evaluations², ethical norms and United Nations Evaluation Group (UNEG) norms and standards. Managed by the CO in close collaboration with the Regional Monitoring and Evaluation (M&E) Adviser in the UNFPA Asia and the Pacific Regional Office (APRO) and with oversight from the Evaluation Office of UNFPA Headquarter (HQ), the purpose and overall objectives of the Country Programme Evaluation (CPE) are stated below. The evaluation consists of five phases detailed later in this chapter. The terms of reference is in Annex 1.

The CPE serves the following three main purposes, as outlined in the 2019 UNFPA Evaluation Policy: (i) demonstrate accountability to stakeholders on performance in achieving development results and on invested resources; (ii) support evidence-based decision-making; and (iii) contribute key lessons learned to the existing knowledge based on how to accelerate the implementation of the Programme of Action (POA) of the International Conference on Population and Development (ICPD).

The overall **objectives** of this CPE are:

- i. To provide the UNFPA Bhutan CO, national stakeholders and rights-holders, the UNFPA APRO, UNFPA HQs as well as a wider audience including rights-holders, with an independent assessment of the UNFPA Bhutan 7th CP (2019-23).
- ii. To broaden the evidence-base to inform the design of the next programme cycle.

The **specific objectives** of this CPE are:

- i. To provide an independent assessment of the relevance, coherence, effectiveness, efficiency and sustainability of UNFPA support and progress towards the expected outputs and outcomes set forth in the results framework of the CP.
- ii. To provide an assessment of the role played by the UNFPA Bhutan CO in the coordination mechanisms of the UN Country Teams (UNCT), development and national partners, with a view to enhancing the UN collective contribution to national development results as well as its ability to respond to national priority needs including those of vulnerable or marginalized groups, entailed by the crisis triggered by the COVID-19 pandemic and
- iii. To draw key lessons from past and current cooperation and provide a set of clear, forward-looking and actionable recommendations in light of Sustainable Development Goal (SDG) 2030 agenda for the next programme cycle, Common Country Analysis (CCA) and UN Sustainable Development Partnership Framework (UNSDPF).

The main audience and primary users of the evaluation are the decision makers and programme managers in CO, UNFPA APRO and UNFPA HQ divisions, Executive Board, CP7 Government counterparts, other national implementing partners (IPs), donors, development partners, relevant UN Agencies (UN Development Programme (UNDP), UN Resident Coordinators' Office (UNRCO), UN Children's Fund (UNICEF), UN Entity For Gender Equality and Empowerment (UN Women), World Health Organization (WHO), etc.), Civil Society Organizations (CSO) and academia. For transparency and accountability purposes, CPE report will be communicated to all stakeholders.

1.2 Scope of the evaluation

¹UNFPA. Evaluation Policy 2019

²UNFPA. Evaluation Handbook. How to design and conduct a country programme evaluation at UNFPA, 2019.

The scope of the evaluation covered all the activities planned and/or implemented during the period January 2019-July 2022 under the two outcome areas - Sexual and Reproductive Health and Rights (SRHR) and adolescents and young people with focus on universal and equitable access to high quality sexual and reproductive health information and services and health sector response to Gender Based Violence (GBV). The CPE covered cross-cutting issues such as mainstreaming of Gender Equality and Women's Empowerment (GEEW) and strengthening data systems and the use of data for policy and advocacy as well as for understanding the socio-cultural and economic contexts, especially with regard to young people. The coherence of UNFPA's CP activities with that of other UN agencies programme activities in the same thematic areas as well as contribution to strengthening partnerships with the Government were assessed. The CPE assessed the progress towards the expected results under the Results and Resources Framework (RRF) of the CP and UNSDPF RRF (2019-23). The use of resources funded from both UNFPA core resources as well as non-core resources were assessed. The evaluation covered the UNFPA response to the recent COVID-19 pandemic with focus on SRHR and GBV as well as its contribution to the joint UN response. Coordination, partnerships and resource mobilizations in developmental and humanitarian contexts were covered. The evaluation focused specially on partnerships with religious institutions, organizations representing persons with disabilities (PWD), volunteer/youth networks and Lesbian, Gay, Bisexual, Transgender, Intersex, Queer (LGBTIQ) communities. The CPE attempted to identify factors that enabled or hindered the progress as well as unintended outcomes. Regarding the geographic scope of the evaluation, the 7th CP is being implemented nationwide, with interventions at national and district levels; hence, the evaluation covered inputs at both levels.

1.3 Methodology and process

The methodology was developed adhering to the evaluation approach and guidance provided in the UNFPA Evaluation Handbook. The team has adhered to the principles articulated in various UNFPA and UNEG Guidance^{3,4,5,6,7}. Special attention was paid to follow the adaptations to the COVID-19 pandemic⁸ and integration of the principle of 'leaving no one behind and reaching the furthest behind first'⁹.

1.3.1 Evaluation criteria, evaluation questions and approaches

CPE evaluated the programme outcome areas using OECD/DAC evaluation criteria of **Relevance, Coherence, Effectiveness, Efficiency and Sustainability**¹⁰. UNFPA specific evaluation criterion Coordination and Added value come under Coherence and assess UNFPA's contribution to the existing coordination mechanisms and strategic positioning in the country with a focus on UNCT coordination and UNFPA's comparative advantage in the development agenda within the development community and national partners in responding to the national needs. The evaluation team assessed how UNFPA has been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to achieve planned results, ensure ownership and the sustainability of effects.

Table 2 provides the final list of Evaluation Questions (EQs) developed by the team and agreed by the CO, Evaluation Reference Group (ERG)¹¹ and Regional M&E officer.

³UNEG. Norms and Standards for Evaluation 2016

⁴UN. Ethical Guidelines for Evaluation 2008

⁵UNEG. Code of Conduct for Evaluation in the UN System 2008

⁶UNEG. Integrating human rights and gender equality in evaluation. Towards UNEG guidance 2011

⁷UNFPA. Guidance on disability inclusion in UNFPA evaluations: Integrating disability inclusion dimensions in UNFPA methodology and evaluation quality assurance and assessment 2020

⁸UNFPA. Adapting evaluations to the COVID-19 pandemic April 2020

⁹UNFPA. Guidance on integrating the principles of leaving no one behind and reaching the furthest behind in UNFPA evaluations 2022

¹⁰OECD (2021). Applying evaluation criteria thoughtfully, OECD publishing, Paris.

¹¹ERG is composed of relevant UNFPA Bhutan staff, representative of UN RCO, representative of Prime Minister's Office, representatives of the Royal Government of Bhutan from Gross National Happiness Commission (GNHC), Policy and Planning Division (PPD) from Ministry of Health (MOH) and Ministry of Education (MOE) and CSO- Respect Educate Nurture and Empower Women (RENEW) (Source. TOR Annex 1) .

Table 2: Evaluation Criteria and Evaluation Questions

Relevance	<p>EQ1: To what extent is the UNFPA country programme:</p> <p><i>i) adapted to the needs of the vulnerable including persons with disabilities (PWD) both during the design and implementation of all the UNFPA-supported interventions in development and humanitarian contexts in line with the priorities set by national and international policy and normative frameworks;</i></p> <p><i>ii) aligned to the national development strategies and policies;</i></p> <p><i>iii) is in line with the 2030 Agenda, UNFPA Strategic Plan 2018-21 and 2022-25 (particularly the transformative goals and business model) and UN partnership framework;</i></p> <p>iv) able to respond to changes in national needs and priorities caused by contextual changes (such as COVID19 & humanitarian situations) in the context of the outcome areas.</p>
Coherence	<p>EQ 2: To what extent has UNFPA contributed to the functioning and consolidation of the coordination mechanisms of the UNCT, and added value in the country context, including for the COVID-19 response and other humanitarian response and recovery efforts, as perceived by UNCT and national stakeholders (government and CSOs)?</p>
Effectiveness	<p>EQ 3: To what extent have the interventions supported by UNFPA delivered outputs have been achieved and the outputs contributed to the achievement of the outcomes of the CP, in both development as well as humanitarian setting/COVID-19 pandemic? And what are the facilitating and hindering factors in achievement of intended results and unintended results?</p> <p>EQ 4: To what extent has UNFPA support to the outcome areas strengthened the policy and legal frameworks and strategies to advance gender equality and reproductive rights both in development and humanitarian contexts?</p> <p>EQ 5: To what extent has UNFPA successfully integrated population and development issues as relevant into each of the outcome areas to provide evidence for advocacy and policy?</p>
Efficiency	<p>EQ. 6: To what extent has UNFPA made good use of its human, financial and administrative resources, and used a set of appropriate policies, procedures and tools to pursue the achievement of the outcomes defined in the country programme?</p> <p>EQ. 7: To what extent did UNFPA systems, processes and procedures (particularly in terms of finance, partnerships, logistics, procurement and human resources) foster or, on the contrary, impede the adaptation of the country programme to changes triggered by the COVID-19 crisis?</p>
Sustainability	<p>EQ 8: To what extent has UNFPA been able to support implementing partners and rights-holders (notably, women, adolescents and youth) in developing capacities and establishing mechanisms to ensure the durability of effects?</p> <p>EQ 9: To what extent have UNFPA COVID19 response and recovery efforts contributed to strengthening national capacities and systems in the field of SRHR, GBV prevention and data?</p>

The evaluation matrix prepared by the team covers the 9 EQs with assumptions, indicators, data sources and data collection methods (Annex2). The stakeholder map and the data collection tools were organized according to the EQs (Annex3). *Efforts were made to weave in the use of the six accelerators of business model of SP 2022-25.* In addition to the responses to the evaluation questions, the evaluation identified lessons learned, what worked and facilitating and hindering factors in achieving the results and what the unintended consequences were.

A non-experimental design was used as the CP interventions are implemented nationwide and there is no control group. The responses to the evaluation questions and sub-questions are descriptive and contribute to actionable findings regarding programme outcomes, lessons learned and performance improvement. The design ensured, as best as possible, that there was no selection bias or extraneous factors that could influence the outcome.

Evaluation approach Based on the objectives of the CPE, the evaluation used theory-based, participatory, mixed method and inclusive approaches to respond to the evaluation criteria and evaluation questions listed elsewhere in this section. Under the theory-based approach, the first activity undertaken by the team was to review the Theory of Change (TOC) developed under the CP that reflects the conceptual and programmatic approach taken by UNFPA over the period under evaluation including the most important implicit assumptions underlying the change pathway. The TOC was modified based on the information gathered from review of relevant CP documents and presentation on the CP by the country team and done with the concurrence of the country team (Annex Part 2-A). The reconstructed TOC formed the basis for developing the evaluation matrix and was tested during the field phase and plays a central role in the identification of findings, as well as the articulation of conclusions and recommendations. The CPE followed an inclusive, transparent and participatory approach, involving a broad range of partners and stakeholders at national and sub-national levels including vulnerable groups (includes PWD). The ERG's involvement in the evaluation provided another opportunity to bring in a wider perspective. Special attention was paid to determine whether there was adequate focus on advancing the rights of vulnerable populations, particularly women, adolescent girls, survivors of GBV and other individuals who are vulnerable including PWD. The CPE also tried to capture the information on whether the discriminatory and harmful practices such as GBV, early marriage, etc. have been challenged. The evaluation used primarily qualitative methods for data collection, including document review, interviews, focus group discussions and observations in health facilities during field visits. The plan was to complement qualitative data with quantitative data but the availability of recent reliable quantitative data and disaggregated data limited this approach.

1.3.2 Methods for data collection and analysis

The data sources, collection and analysis methods were designed around the assumptions and indicators proposed in the evaluation matrix, considering the most effective way of collecting information, in the limited time period.

Sample selection As the CP 7 implementation is nation-wide, to ensure adequate representation of the stakeholders, a sample of sites were selected for interviews, focus group discussions and observations. Data was collected at the national and subnational level using the stakeholder mapping. Due to the participatory nature of the evaluation, attempts were made to involve as many stakeholders as possible to get a wider and varied perspective on the design, interventions and implementation of the CP during the period under review. A purposive sampling was adopted for the sub-national level based on a set of criteria. The criteria included the number of interventions being implemented, types of beneficiaries, socio-economic characteristics such as poverty level and degree of urbanization or remoteness (see Annex Part 2-D). The travel time to different destinations was another factor that was considered. In addition, as the rainy season coincided with the field phase, the selection was also influenced by the ease of travel, road conditions, etc. Taking into consideration the above criteria, the team chose Chhukha (south) and Dagana (central) districts. Chhukha was selected because of the number and variety of interventions implemented. Phuentsholing, one of the Thromdes, on the border with India, is part of the district and implements several of the interventions. Dagana is situated in Central Bhutan, representing a medium level district with regard to population and few interventions were implemented including mobilization of community structures. It is remote and rural and has high poverty levels. Institutions in Thimphu were also selected as number of interventions took place in the central level institutions. Annex 4 provides the list of people interviewed, focus group discussions held and sites visited.

Data sources and collection Based on the selected evaluation questions and theory of change model, the sources of data were both primary and secondary. Primary data was collected at the national level and at the sub-national/district level (See Table 3 for the institutional affiliations of the people interviewed; the full list is in Annex 4). The methodologies of primary data collection were through semi-structured interviews, focus group discussions and direct observations during field site visits (where possible) (See Annex 3 for the tools used). Secondary data was collected through desk review of policies and strategies,

existing literature (evaluations, research, assessments etc. by UNFPA and other partners), annual reviews/progress reports, and other monitored data (Annex5).The data collected was mainly qualitative,supplemented by selected quantitative data that enabled triangulation of data and in-depth review of selected interventions.Since the COVID-19 situation did not pose any threats, most of the key informant interviews and focus group discussions were carried out in person. The team leader attended almost all the interviews in person with the national key informants and few virtually. All the questions and sub-questions (as relevant) were covered during the data collection. In addition to the application of the lens of vulnerability and disability, the team was able to hold focus group discussions with members of the organizations of PWD and LGBTIQ that added to the inclusive nature of the evaluation. A daily log was maintained by the team to record each day’s notes and grouped according to EQs (Annex Part 2-E).

Table 3:People interviewed by institutional affiliations

Stakeholder category	Female	Male	Other	Total
National level				
UNFPA (CO Bhutan, senior management and APRO, former staff)	7	3		10
Other UN agencies	5	3		8
National government (GNHC, MOH, MOE, NSB) and National Council for Women and Children (NCWC)	9	17		26
Academia	2	1		3
National NGO (RENEW, Disabled People’s Organization (DPO), Lhaksam (network of people living with HIV)	3	3		6
National referral hospital	6	2		8
District level				
District officials (Dzongda’s office, District Health Officer, District Education Officer District Statistical Officer (DSO), Health Information and Service Centre)	2	6		8
Hospital staff (District and Primary Health Centre)	4	8		11
Schools	5	1		6
Medical Store Divisional Depot	-	3		3
Monastic institutions	-	3		3
Youth centre	3	-		3
CBSS volunteer (RENEW)	-	1		1
Total	46	51		97
Percentage	47.4	52.6		100

Source: Evaluation team analysis (detailed list in Annex 4)

Focus group discussions were held with DSOs (7 males), women (7), Youth Peer Education Network (Y-PEER) (2 females and 6 males), Youth Centre participants (6 females and 1 male), students of nursing and public health (2 females and 2 males), school students (10 females and 9 males), Monks (7 males) and LGBTIQ (6) (See also Annex 4).

Data analysis Data analysis was based on the structure provided by the evaluation matrix. The evaluation questions determined the method of data analysis. The TOC was tested through analysis of response to the EQs to provide evidence of change along the results pathway and UNFPA’s contribution to the same. Triangulation of data helped further to confirm the validity of the reconstructed TOC. This is part of the evaluability assessment (ideally this process should be done prior to the CPE). The primary and secondary data gathered were evaluated to see whether the data is of sufficient quality to inform each evaluation question and in cases where the information was inadequate, further clarification was sought. Each of the EQs were answered using the content analysis of documents, interviews notes, focus group findings and observations in the field. Evidence gathered from descriptive analysis using information from document review was used to identify and understand the contexts in which the programme has evolved and to describe the types of interventions and other characteristics of the programme. Qualitative data was supplemented by analysis of quantitative data (where feasible) and content analysis to

substantiate the findings, emerging trends and issues. Quantitative data emerging from annual reports, studies, reports and financial data were used to triangulate the qualitative data and its utility was best when the data was of good quality and the data available was aligned with the period of the CP (timeliness of data). Similarly, qualitative data was used to interpret the quality of progress (for example- for commenting on the quality of training while reporting the numbers trained). The review of the efficiency of the programme by reviewing the staffing patterns, allocations and expenditures provided information on the management of the programme. Conclusions and recommendations are consistent with the findings, their interpretations in terms of progress towards achieving the outcomes or lack of it and lessons learned. This reflects the quality of the methodology and analysis methods. A contributory analysis was done to assess the extent to which the CP contributed to expected results. In the absence of recent quantitative data related to indicators, it was difficult to assess the contribution of the CP to achieving several of the outputs (for which it is responsible) and the contribution of UNFPA to achieve the outcomes. Analysis of GEEW and HRBA were done under the specific EQ (EQ 4) and in addition, throughout the analysis of all EQs. Similarly, the interactions with the vulnerable groups, described under the section on data collection, enabled the team to assess whether capacities of rights holders have been built.

Data quality and validation mechanisms The evaluation findings in Chapter 4 are based on evidence triangulated from various data sources. Data quality was ensured by triangulation of data sources, data types and data collection. Qualitative data, quantitative data and findings from existing reports were triangulated to reinforce the credibility and validity of findings and conclusions. The team members cross-validated findings among themselves, also validated preliminary findings with CO team, UNFPA senior management and APRO programme officer. The national consultants also sought clarifications on findings and interpretations with key stakeholders. Lack of data disaggregated by age, sex, vulnerability, disability, geography, etc. caused limitations. The triangulation of data sources and the evidence of the progress of the coverage of interventions were used to judge the progress of indicators, when quantitative information was not available. The draft findings, conclusions and recommendations have been shared with the CO team and key stakeholders. Another round of validation, specifically with the ERG members, was done as part of the evaluation requirement.

Retrospective and prospective analysis The retrospective and prospective analysis were done to respond to the EQs related to sustainability. Efforts were made to assess the extent to which the capacity of IPs have been built in the thematic areas where they are responsible – to deliver services and to advocate. The sustainability of results already achieved (policy, advocacy, training) were assessed by reviewing the implementation of some of the interventions over the past CPs, particularly CP 6 review, programme monitoring documents, high level advocacy materials/ decrees, responses obtained during interviews and observations in the field and analysis of funding to further substantiate the findings. Prospective analysis for sustainability of interventions was done through the review of implementation reports and interviews with key stakeholders and beneficiaries and evidence of policy discussions on the interventions. Where implementation of interventions has yielded results or has the potential to yield results, further review was undertaken through interviews of stakeholders. The responses received could be biased; however, the triangulation of information could validate the responses. Prospective views on sustaining interventions may be impacted by the current and significant changes in the policies of the Government.

Ethics and maintaining the quality of evaluations The evaluation was conducted in accordance with the UNFPA evaluation policy and various UNEG guidance as listed elsewhere in this section. Informed consent was obtained before all interviews were conducted. In school settings, where students were below 18 years, the consent was obtained from their teachers. Other ethical considerations were duly adhered to and at every interview, the purpose of the interview and confidentiality of information was assured.

1.4 Limitations and mitigation measures

Since the sample is purposive, it may be difficult to generalize the findings; however, due to the fact that there are no wider variations in the implementation, district level structures and financial allocations, it

may be acceptable to generalize the findings. Human resources in health could be a hindering factor. As pointed out in the earlier sections, availability of quantitative data was a major limitation and also availability of data disaggregated by age, sex and geography.

1.5 Evaluation process

The evaluation process consisted of five phases: (i) preparatory phase, (ii) design phase, (iii) field phase, (iv) reporting phase, and (v) dissemination and facilitation of use phase. The CO was responsible for the preparatory phase.

The design phase of the evaluation involved desk review of the secondary information of the programme and related documentation, analysis of the Annual Work Plans (AWPs) to enable the team to understand the CP and its stakeholders, analysis of the programme/intervention logic, reconstruction of the TOC, finalization of the evaluation questions, development of the evaluation matrix, revision of the stakeholder map provided by the CO, finalization of the templates for data collection, data analysis strategy and a plan for field phase.

Field phase: , Upon approval of the CPE Design, the team-initiated data collection at the central level and in the selected districts.

Reporting phase: Upon completion of preliminary analysis of data and the debriefing session, the first draft report was shared for review by CO staff, APRO and Evaluation Manager for feedback. Draft report was shared with national stakeholders. The final draft report was shared with the ERG members and also a presentation was done to the group. Based on the consolidated comments from the ERG, the team has made appropriate amendments and prepared the final report for submission to the evaluation manager.

Dissemination and facilitation of use phase: As part of dissemination and facilitation of use phase, the evaluation team has prepared a power point presentation of the evaluation results that summarizes the key findings, conclusions and recommendations of the evaluation.

Chapter 2: Country context

2.1 Introduction

The Kingdom of Bhutan is a small, mountainous and landlocked country in South Asia, bordered by India and China with an area of 38,394 square kilometres. Over 70 percent of the Kingdom is covered with forest. The administrative system consists of Central and Local Government. The Central Government comprises of Ministries, Departments and Autonomous bodies. The Local Government comprises of 20 Dzongkhag (district) Tshogdu, 205 Gewog (block) Tshogde and four Thromde (township) Tshogde.

The total resident population of Bhutan as per the 2017 Population and Housing Census was 763, 249 people and is expected to reach 883,866 with 57 percent living in urban areas by 2047¹². The life expectancy is 69.9 years and 72.8 years for female and male respectively¹³. Almost 50 percent of the population is young people below 24 years. With more than two-thirds of population in the working age-group, the potential to reap the demographic dividend is projected to continue till 2040. The Fertility rate has fallen below replacement level of 1.8¹⁴. Due to declining fertility rates and increasing life expectancy, the number of people in the age group of 65 years and above is expected to rise from 6 percent to 17.3 percent by 2050 and the old-age dependency ratio will increase from 11.2 percent to 26.2 percent in 2050. General literacy rate stands at 71.4 percent (female 63.9 percent, male 78.1 percent) with higher literacy rate among youth 15-24 years at 93.1 percent with no gender gap¹⁵. However, around 5 percent of the young population is illiterate and 8 percent have never attended school¹⁶. Bhutan is classified as a Least Developed Country (LDC). The income per capita has reached US\$3,000. Annual Gross Domestic Product (GDP) growth rate as of 2021 stood at negative 10.8 percent and overall unemployment rate was 5 percent with higher unemployment rate among youth at 22.6 percent (female 61.3 percent, male 38.7 percent)¹⁷. Poverty and inequality indicators remain high at disaggregated levels. Across districts, income poverty rates varied between 1 to 32 percent, and were considerably higher in rural areas (16.7 percent) than in urban areas (1.8 percent). The share of population living on less than \$3.20 per day fell from 14.7 percent in 2012 to 12.2 percent in 2017, marking a continuation of progress over previous years, however, the pace of poverty reduction has slowed down recently. As of 2017, less than 6 percent of Bhutanese were multidimensionally poor. Despite Bhutan's strong growth performance, and progress in social indicators, the continuing social, economic and gender gaps can impact longer-term sustainable development (see challenges section).

The RGoB is committed to achieving Universal Health Coverage (UHC), with the right to health care for all as mandated by the Constitution. The overarching goal of the 12th Five Year Plan in the health sector is to achieve UHC by providing access to quality health care services based on the principles of primary health care. Health expenditure as percentage of GDP is 3.6 percent¹⁸. Bhutan has made significant progress with regards to SRHR over the past two decades. Maternal Mortality Ratio [MMR] (maternal deaths per 100,000 live births) has declined from 255 in 2000 to 89 in 2017¹⁹. Similarly, infant and child mortality ratios have declined. However, the quality of care remain inadequate as evident from prevalence of maternal near miss ratio of 6.7 per 1000 live births and potential life-threatening conditions of 12.8 per 1000 live births²⁰. In addition, 55 percent of women of childbearing age suffer from anaemia²¹. The prevalence of HIV per 1000 population is 0.8 with infection concentrated most among the reproductive age group²². The issues of increasing prevalence of HIV/AIDS among females are a concern. Less than a quarter of young people have

¹² NSB. Population Projections Bhutan 2017-2047

¹³ NSB. Population Projections Bhutan 2017-2047

¹⁴ NSB. Population Projections Bhutan 2017-2047

¹⁵ NSB. Population and Housing Census of Bhutan 2017

¹⁶ NSB. Population and Housing Census of Bhutan 2017

¹⁷ 2021 Labour Force Survey

¹⁸ WHO. Global health expenditure data

¹⁹ GNHC. Population and Development Situation Analysis 2018

²⁰ MOH. Maternal Near-miss report 2021

²¹ MOH. Annual Health Bulletin, 2022

²² Country progress report-Bhutan; Global AIDS Monitoring 2020

comprehensive and correct knowledge of HIV prevention and transmission. The modern method Contraceptive Prevalence Rate (CPR) is 65.4 percent with unmet need 11.7 percent²³. The proportion whose demand is satisfied for modern methods of FP is 84.6 percent. The lowest prevalence of CPR is among adolescents (52.2 percent)²⁴ and modern contraceptive use among married adolescent girls was half of the national average²⁵. The unmet need for contraception is higher among adolescents (27.4 percent) than general population. Cervical cancer is the leading cause of death among Bhutanese women with the estimated incidence of 20.5 (per 100,000 women)²⁶.

The Constitution of the Kingdom of Bhutan 2008 provides an overarching framework and foundation within which gender equality is enshrined. Despite guarantees of formal equality, structural and cultural norms continue to obstruct the full realization of gender equality. Bhutan is ranked 131 out of 153 countries in the Global Gender Gap²⁷. The number of girls enrolled in tertiary education is lower than that of boys (19.1 percent as compared to 23.7 percent of boys)²⁸. The constitution guarantees and protects fundamental rights and freedom in consonance with international normative frameworks and ensures protection of children and women as well as those with disabilities. An estimated 2.1 percent of the population is living with disabilities²⁹. In recent years, the awareness about the rights of PWD among policy makers, health service providers and PWD themselves has improved, though not optimal. The 12th Five Year Plan incorporates human rights principles in all its priority areas. Based on the vulnerability assessment, 14 groups have been identified and the plan ensures access to health and education and other economic and social services³⁰.

Bhutan's progress in human development has also been significant with remarkable progress in achieving a number of commitments made to the ICPD POA. Bhutan is on track to achieve all the SDGs and is expected to graduate from the UN's Least Developed Countries (LDC) category in 2023 with the RGOB calling the latest 12th Five Year Plan (2018 – 2023) , "the last mile to LDC graduation" Bhutan has incorporated most of the sustainable development goal targets in its five-year development plan, which focuses on addressing the last-mile challenges that are preventing the country from graduating from the LDC category and is guided by the development philosophy of Gross National Happiness (GNH).

As shown in Annex Part 2-B on progress of UNFPA's focus SDG indicators, the indicators on track include MMR, deliveries by skilled birth attendants, proportion of women and girls 15 years who are victims of non-intimate partner violence and proportion of women 20-24 married before 18 years. The indicators with moderate progress include number of new HIV infections, proportion of women of reproductive age whose demand for family planning has been satisfied, adolescent birth rate and proportion of women and girls before the age of 15 and 18 years who are victims of intimate partner violence.

Bhutan is one of the least populated countries in the region where fertility has been low and mortality has declined steadily over the recent years. According to the Population Projections Bhutan 2017-2047 (Figure 1), the population in 2022 is projected at 763,249 and it is still expected to remain below one million (883,866 people) mark by the end of 2047. It accounts for 13.6 percent increase between 2022 and 2047. The annual growth rate is expected to fall to 0.3 percent in 2047 from the current 1.0 percent and indicates that Bhutan's population is unlikely to experience rapid growth unlike other developing countries. The slow growth of population can be attributed to steep decline of fertility rate, followed by fast declining birth rate and falling mortality rate due to improved health services. The crude death rate is expected to remain

²³ Bhutan Multiple Indicator Survey 2010

²⁴ Bhutan Multiple Indicator Survey 2010

²⁵ Bhutan Multiple Indicator Survey 2010

²⁶ UNFPA and Cancer Council. Cervical cancer elimination. Country review and roadmap for action 2021.

²⁷ RGOB. National gender equality policy 2020.

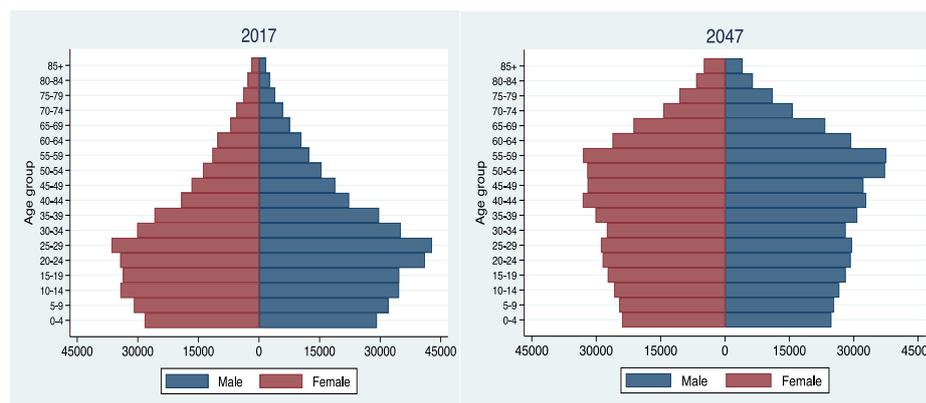
²⁸ RGOB. National gender policy 2020.

²⁹ Population and Housing Census 2017

³⁰ The vulnerable groups include people who beg; children in conflict with law; elderly in need of support; female workers working at Drayangs; persons practicing risky sexual behaviour: persons using drugs and alcohol; persons with disability; orphans; out of school children; people living with HIV/AIDS; single parents and their children; unemployed youth; victims of domestic violence and vulnerable urban dwellers (12th Five Year Plan).

at 8 per thousand. Due to the increase in life expectancy, the rising number of people in the age group 65 year and above is expected to increase from 6.6 percent in 2022 to 17.3 percent in 2050. This can further exert intense burden on the working-age population in terms of old age care. The old-age dependency ratio is expected to double from 9.5 in 2022 to 19.3 in 2047. The current share of urban population at 40.9 percent is expected to reach 56.8 percent by 2047³¹. The rapid increase in the proportion of population in the urban areas may further aggravate the current issues- rural lands leaving fallow thus increased reliance of its population on imported foods, feminization of agriculture and shortage of affordable urban housing and other amenities. Further, the proportion of poor people in urban areas is bound to increase which currently is virtually nonexistent (only 0.8 percent of urban population was estimated as poor in 2017).

Figure 1: Population pyramid of Bhutan showing changing age structure 2017-2047



2.2 Development challenges/opportunities and national strategies

2.2.1 Development challenges/opportunities

Despite improvements in socioeconomic development, the health and social challenges of adolescents and youth are increasing. Almost half the population is below 24 years with almost 30 percent between 10-24 years³². This poses a huge developmental challenge, in terms of providing gainful employment to the youth (one out of five youth (20.9 percent) unemployed in 2021). The unemployment rate among young females is higher (24.6 percent) compared to males (16.9 percent), one of the reasons being lack of adequate qualification³³. High youth unemployment and the inability to harness maximum benefit of demographic dividend underscore the need for creating more jobs that will encourage youth to work in the country. In the case of adolescents aged 10-19 years, it is reported that the prevalence of sexual activity is high with higher prevalence among males (23 percent) (females-10 percent). The high unmet need for contraception among adolescents which could be related to socio-cultural and accessibility issues as not all health facilities are adequately equipped to provide Adolescent Friendly Health Services (AFHS). The number of births per 1000 women aged 15-19 years is high at 18.9 percent with as many as 32 percent having their first pregnancy at the age of 18 or younger. The prevalence of early marriage is quite high at 30.8 percent³⁴. Two-thirds of the reported HIV/AIDS infections are among youth (15-24 years), and comprehensive knowledge on HIV/AIDS is as low as 23 percent. In the schools, more than half (55 percent) of the students are unaware of the risks of unprotected sex pointing to limited knowledge on sexuality and adolescent issues among the students due to low levels of Comprehensive Sexuality Education (CSE) in schools³⁵. Another contributory factor is the alarming negative perception of 74 percent of teachers on the impact of sexuality education as a factor promoting sexual activities. The high incidents of early marriages, teenage pregnancies, high unmet need for contraception, higher incidence of HIV/AIDS, and

³¹Population Projections of Bhutan 2017-2047

³²NSB. Population and Housing Census of Bhutan 2017

³³ 2021 Labour Force Survey Report Bhutan

³⁴2010 Bhutan Multiple Indicator Survey

³⁵Seventh Country Program Action Plan [CPAP]

limited knowledge on sexuality among students underscores the need for enhanced information and health services for adolescents.

The ranking of Bhutan in the Global Gender Gap points to the fact that despite guarantees of formal equality, structural and cultural norms continue to obstruct the full realization of gender equality. The number of girls enrolled in tertiary education is lower compared to boys (19.1 percent as compared to 23.7 percent of boys). According to Bhutan Gender Policy Note 2013, poor academic performance due to domestic commitments and early pregnancy, impede girls' access to tertiary education. High adolescent pregnancies and increasing feminization of HIV/AIDS are concerns. Women in rural communities, in particular, are more vulnerable and have limited access to resources. More than two in five Bhutanese women have been physically, sexually, psychologically, or economically abused by a spouse at some point in their lives³⁶.

Bhutan's challenges in data availability, availability of disaggregated data and data harmonization are key concerns. Data on SRH situation and needs of adolescents and youth is scarce despite the fact adolescent pregnancies and access to care are major issues that could affect the full realization of the demographic dividend. Data for unintended births, safe abortion, sexually transmitted infections and financial protection, etc. as well as for autonomy in decision-making with respect to contraceptive use/ seeking own health care and sexual relations, are not available. In addition, data on people with diverse sexual orientation or gender identity / expression, or migrants are not available despite the fact these populations experience a significant burden of poor SRH and rights violations. Availability of disaggregated data is critical for planning policies and services as well as for monitoring national policy on being inclusive and has affected the development of coherent and effective policies and development planning. Disaggregated data is limited for TFR, CPR, maternal and neonatal mortality, maternal health indicators and HIV. Data source harmonization is an ongoing issue that needs to be solved. Bhutan still does not have national data policy or statistical act *per se*. The National Statistics Bureau as a central agency for statistics is guided by 'Executive Order 2006' for data collection and release of official statistics.

2.2.2 National strategies

Bhutan has made progress in enacting laws, policies, regulations and strategies related to SRH, young people and gender, such as the health policy, MCH policy, draft youth policy, gender equality policy, domestic violence prevention act, policy on persons with disability, adolescent health strategy, draft population policy, etc. However, findings indicate that many of these policy instruments are not well implemented, especially at the grassroots level. Some of the reasons include inadequate human and financial resources at national and subnational levels, geographical, social, cultural and financial barriers to health services and low level of awareness of service providers about policies and strategies. In addition, the rights-holders, specially vulnerable such as PWD, illiterate, rural women and young people, are not even aware of their rights.

2.2.3 COVID-19 pandemic and other natural calamities

Bhutan experienced four significant COVID-19 outbreaks since March 2020³⁷, the last one was in early part of 2022. The ongoing pandemic has brought serious challenges in ensuring that SRH, specially maternal health services, are not disrupted and that the number of cases of GBV does not increase. Comparative data for 2019, 2020 and 2021 did not show much disruption of services due to the RGOB's efforts to maintain services. More than 94.5 percent of eligible population above 12 years had been fully vaccinated and 96.1 percent of children 5-11 years had received the first dose of the vaccine as of March 2022. On the economic front, the RGOB initiated a comprehensive national response to address immediate socioeconomic challenges of the COVID-19 pandemic while initiating efforts to address large long-term priorities. 32 percent of the 12th Five Year Plan capital outlay was reallocated to stimulate economic activity. In addition, social relief grant for individuals directly affected by COVID, monetary measure to

³⁶ NCWC, UNDP. National survey on women's health and life experiences 2017. A study on violence against women and girls in Bhutan.

³⁷ The World Bank. Two years of Bhutan's Pandemic Response. April 2022

inject liquidity and economic contingency plan were implemented³⁸. The Druk Gyalpo's Relief *Kidup* provided support to the most vulnerable sections of the population affected by the pandemic and has provided income and interest payment support to affected individuals. Continuation of education was ensured by relocating students from some schools in high-risk zones to schools in low-risk zones and digitizing learning platforms. The government also provided shelter support to those affected directly or indirectly by the pandemic especially GBV survivors and affected youth.

Bhutan is vulnerable to several natural hazards particularly wild fire, flash floods and landslides. Glacial lake outburst is another threat that could trigger flashfloods downstream. Due to the impact of climate change, the frequency and intensity of floods (most recent in 2021) and other natural hazards have increased. Such hazards destroy agricultural lands, adversely affect women and girls and PWD. Bhutan is also located in one of the seismically active regions and had experienced moderately powerful earthquakes in 2009 and 2011. While considerable progress has been made in building community resilience, key barriers to effective disaster risk management include limitation on data, financial resources and national capacity.

2.3 The role of external assistance

Bhutan's reliance on support of development partners to finance public investments has witnessed a significant shift with more reliance on domestic resources. With a robust economic growth in the past decade, an annual GDP growth of 5 percent prior to the COVID-19 pandemic and its projected recovery in the fiscal year 2021/22 and its imminent graduation from LDC status, the country has seen a decline in the availability of concessional funding and the departure of most bilateral donors³⁹. As seen from Table 2, Bhutan's received grants amounting to Nu 16,425.75 Million (US D 221.07 Million)⁴⁰. Government of India's support is the highest with about 70 percent of the total support. It was reported in OECD-DAC site that 2 percent of bilateral ODA in 2018-19 was for health⁴¹.

Table 4: International assistance received

Sl. No:	Particulars	Nu In million		% change	% GDP
		2019-20	2018-19		
a)	Government of India	11,433.96	6,484.77	76.47%	6.04%
1	Program Grant	2,550.00	850	200.00%	1.35%
2	Project Grant	8,893.96	5,634.77	57.84%	4.69%
i	Cash	8,893.96	5,634.77	57.84%	4.69%
b)	Other donors	4,981.80	4,031.72	23.57%	2.63%
1	Program Grant	-	139.52	0.00%	0.00%
2	Project Grant	4,981.80	3,892.20	27.99%	2.63%
i.	Cash	3,943.60	3,700.01	6.58%	2.08%
ii	Kind	1,038.20	192.189	440.19%	0.55%
Total		16,425.75	10,376.96	58.29%	8.67%

Source: Annual Financial Statements of RGOB for the year ended 30 June 2020, Ministry of Finance, RGoB

³⁸ADB. Overcoming the COVID-10 pandemic in Bhutan. Lessons from coping with the pandemic in a tourism-dependent economy 2021

³⁹UNCT, Bhutan. Common Country Analysis (2018).

⁴⁰1 USD = Nu 74.3

⁴¹Source OECD-DAC: <http://www.oecd.org/dac/financing-sustainable-development-finance-data/aid-at-a-glance.htm>

Chapter 3: UNFPA strategic response and programme

3.1 UNFPA strategic response

The UNFPA CP in Bhutan 2019-23, spans across two Strategic Plans of UNFPA- mostly during the Strategic Plan of 2018-21 and in the current Strategic Plan of 2022-25. This provides an opportunity to analyze the CP from the perspective of both the strategic plans, the latter plan providing opportunities to identify future directions of the CP. The CP is aligned to the Strategic Plan (SP) of 2018-21.

The SP is aligned with the Sustainable Development Agenda for 2030 and other frameworks underpinning the agenda especially those related to climate change and disaster risk reduction and financing and development. The plan 2018-21 is the first of the three consecutive strategic plans during the 2030 Agenda time span and will contribute cumulatively to the achievement of the SDGs⁴². Continuing with the same goal as the previous SP of 2014-17, the goal of the SP 2018-21 was to “achieve universal access to sexual and reproductive health, realize reproductive rights (RR) and reduce maternal mortality to accelerate the progress on the agenda of the ICPD POA, to improve the lives of women, adolescents and youth, enabled by population dynamics, human rights and gender equality” (as illustrated in Figure 2- Bulls’ eye) and continues to be the focus in the current SP of 2022-25. The goal is applicable, both in development and humanitarian contexts and takes a life-course approach. The alignment of the SP to the SDGs, most directly to Goals 3, 5, 10,16 and 17, will be contributing to advancing the ICPD POA, achieving the SP goals and ultimately to eradication of poverty. While embracing the vision of 2030 Agenda, UNFPA has organized its work around three transformative and people-centred results in the period up to 2030. These include: (a) an end to preventable maternal deaths; (b) an end to the unmet need for family planning; and (c) an end to gender-based violence and all harmful practices, including female genital mutilation and child, early and forced marriage. The plan emphasizes the need for strengthened partnerships and innovation and also the need for a stronger collaboration and coordination with the UN system to ensure coherent, integrated and effective UN response to countries in achieving SDGs.

Figure 2: Alignment of the bull’s eye to SDGs



Source: UNFPA strategic plan 2018-21

⁴²UNFPA. UNFPA Strategic Plan, 2018-21

While reaffirming the strategic approaches presented through the Bull's eye, the SP also recognizes the need for a robust TOC, emphasis on demand side generation, supply side strengthening health systems for SRHR and programmatic and funding prioritization of interventions targeting young people especially adolescent girls. Hence, the outcomes and outputs lay emphasis on demand side and supply side aspect of services. The TOC is based on the foundation of number of principles such as protection and promotion of human rights, leaving no one behind and building resilience and improving accountability, transparency and efficiency.

UNFPA promotes GEEW (including adolescents) as a stand-alone and as a mainstreamed approach. Priorities to achieve the gender outcome of the SP include strengthening legal, policy and accountability frameworks to advance GEEW, strengthening civil society and community mobilization to eliminate discriminatory gender and socio-cultural norms, increased multi-sectoral capacity to prevent and address GBV using a continuum of approach in all contexts, strengthening response to eliminate harmful practices affecting women and girls, and strengthening capacities to develop gender responsive data, statistics, and advocacy and dialogues⁴³. UNFPA's strategy on adolescents and youth, "My Body, My Life, My World!", supports the implementation of Youth 2030, and is integral to UNFPA's efforts to achieve three transformative results by 2030⁴⁴. The achievement of the goals require the leadership and innovation of young people by young people, in development, in humanitarian action and in sustaining peace.

Aligned with the goal and outcomes of SP 2018-21, UNFPA's COVID-19 Global Response Plan focuses on continuity of SRH services and interventions, including protection of health work force, addressing GBV and harmful practices and ensuring supply of modern contraceptives and reproductive health commodities⁴⁵. The plan is fully aligned to and part of the UN Secretary-General's three-step plan to respond to the devastating socio-economic impacts of COVID-19 and complements the WHO COVID-19 Strategic Preparedness and Response Plan.

The SP includes an organizational business model to guide the implementation of the plan and the 2018-21 model included a country classification based on the need for country support (based on the degree of unfinished SRHR agenda and country's capacity to finance change). The classification determines the mode of delivery of UNFPA support⁴⁶. Bhutan is classified as a pink country and except for service delivery and individual capacity building, all other modes of engagement are followed.

The SP for 2022-25, the second of three consecutive SPs leading to 2030, builds on the momentum built on the ICPD@25 call to action and reaffirms the focus on the goal of universal access to SRH and RR and the three transformative goals⁴⁷. It has added focus on the centrality of data to ensure evidence-informed actions are taken across the three transformative results. The plan contributes directly to the 2030 Agenda, aligning with the principles of human rights, universal access and 'leaving no one behind'. The plan recognizes that the negative impact of the COVID-19 pandemic to women's and girls' access to SRHR and probably reversal of the progress towards achieving the three transformative goals. To accelerate the achievement of the transformative goals, the business model has changed. The countries are classified according to the achievement of transformative results (see the classification below in Table 4). The modes of engagement are as in the SP of 2018-21 and additionally identifies six accelerators for the achievement of the results⁴⁸. Bhutan has achieved 2 of the 3 indicators (*the data for need for FP satisfied is 2010 and presume the situation has improved*).

⁴³UNFPA. Gender Equality Strategy 2018-21

⁴⁴UNFPA. My Body, My Life, My World. 2019

⁴⁵UNFPA. COVID-19 Response plan 2021

⁴⁶UNFPA. UNFPA Strategic Plan, 2018-2021, Annex 4, Business Model. The five modes of delivery include service delivery, capacity development (individual, institutional and enabling environment (societal), partnerships and coordination (including South-South and Triangular Cooperation (SSTC), knowledge management and policy engagement

⁴⁷UNFPA. UNFPA Strategic Plan 2022-25

⁴⁸UNFPA. UNFPA strategic plan, 2022-2025, Annex 3: Business model, July 2021.

Table 5: Level of achievement of transformative indicators in Bhutan

Transformative results	Indicator	Threshold by 2030 ⁴⁹	Bhutan's achievement	Source of information
Ending the unmet need for FP	Need for family planning satisfied with modern methods	>75 %	84.9 %	Bhutan Multiple Cluster Indicator Survey 2010
Ending preventable maternal death	Maternal mortality ratio	<70 per 100,000 live births	89	Population and Housing Census of Bhutan 2017
Ending gender-based violence and harmful practices, including female genital mutilation and child, early and forced marriage	Gender inequality index ⁵⁰	< 0.3 (with 1.0 being unequal and 0.0 being equal)	0.421	Human Development Report 2020

3.2 UNFPA response through the country programme

3.2.1 The country programme

UNFPA has been working with the Royal Government of Bhutan since 1970 towards enhancing sexual and reproductive health and rights (SRHR), advancing gender equality, realizing rights and choices for young people, and strengthening the generation and use of population data for development. The seventh cycle of assistance, 2019-23, is aligned with the priorities of the Twelfth Five Year Plan of Bhutan (healthy caring society, GEEW, quality of education and skills). It is aligned with the UNFPA SP 2018-21, the Sustainable Development Agenda 2030 (with focus on SDGs 3,4 and 5) and ICPD POA. Under the paradigm of 'One UN' UNFPA contributes to the work plans under UNSDPF 2019-23 contributing to outcomes related to access of vulnerable groups to health, education and other social services, equal opportunities for women and vulnerable groups and timely and reliable data on those left behind for policy and decision making. The priorities for the CP have been identified through population situation analysis, CP 6 synthesis report⁵¹ and through a participatory, inclusive and consultative process that involved the relevant Government departments, civil society, bilateral and multilateral development partners including UN organizations, private sector, academia, religious institutions and youth groups. The CP reflects the comparative advantage of UNFPA as an effective advocate, convener and technical leader in supporting and advancing SRH and RR including that of adolescents and young people and prevention of GBV. The CP supports the government on the unfinished agenda of universal access to SRH (a key component to achieve RGOB's commitment to UHC) with a focus on adolescents and young people. The CP has an added focus on those left behind that includes survivors of GBV, vulnerable urban dwellers, unemployed youth and those practising risky sexual behaviour.

The **overall goal** of the UNFPA Bhutan 7th CP (2019-23) is **universal access to sexual and reproductive health and reproductive rights and reduced maternal mortality**, as articulated in the UNFPA SP 2018-2021. The CP contributes to the goal through the **outcomes** of the SP related to SRHR and adolescents and

⁴⁹UNFPA. UNFPA strategic plan, 2022-2025, Annex 3: Business model, July 2021. Accelerators: Human rights-based and gender transformative approaches, innovation and digitalization, partnerships, South-South and triangular cooperation and financing, data and evidence, 'leaving no-one behind and reaching the furthest behind first' and resilience and adaptation and complementarity among development, humanitarian action and peace-responsive efforts.

⁵⁰This indicator reflects inequality in achievement between women and men in three dimensions: reproductive health, empowerment and the labour market, which are essential for ending gender-based violence and harmful practices. According to the UNDP *Human Development Report, 2020*, the gender inequality index was 0.6 for low human development countries, 0.5 for medium human development countries, and 0.3 for high human development countries.

⁵¹UNFPA Bhutan. Synthesis report 6th Country Programme

youth (see Table 6). The CP has two thematic areas of programming with distinct **outputs** that are structured according to the two outcomes in the SP 2018-2021 to which they contribute. GEEW is an integral part of the programming areas and also support for data to provide evidence and to ensure that ‘no one is left behind’. The UNFPA Bhutan 7th CP focus is on SRH and RR with focus on adolescents and youth and those most left behind, vulnerable including PWD. The interventions will make direct contributions to the three transformative goals of UNFPA. Aligned with the UNFPA classification of Bhutan, the CO delivers its CP through the following modes of engagement: (i) advocacy and policy dialogue, (ii) capacity development, (iii) knowledge management, (iv) partnerships and coordination.

Table 6: CP 7 Outcomes and outputs

Thematic area: integrated sexual and reproductive health services	Thematic area: Adolescents and youth
Outcome 1: Every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated sexual and reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence.	Outcome 2: Every adolescent and youth, in particular adolescent girls, are empowered to realize their sexual and reproductive health and reproductive rights, and participate in sustainable development, humanitarian action and peace- building.
<i>Output 1: Increased national capacities to ensure universal and equitable access to high quality sexual and reproductive health information and services.</i>	<i>Output 2: Young people, in particular adolescents are empowered with knowledge, skills and capabilities to make informed choices about their sexual and reproductive health and rights, and well-being.</i>

The outputs and strategies are built on the 6th CP assessment findings and its recommendations⁵². The 7th CP continued advocacy and technical support to improve access to high quality SRH services and information. In support of the Government efforts to advance SRH and RR, the programme focused on building a knowledge base for facilitating policy dialogue and the establishment of broad partnerships and alliances to leverage resources and to advance the SRH and RR agenda as an integral part of the national sustainable development plan of Bhutan. The programme promoted policies and program interventions that aimed to build young people’s skills and capacities to make informed choices about their SRH and wellbeing, including in humanitarian context. The detailed list of CP interventions as mentioned in the TOR is given in Annex Part 2-C. There are no changes in interventions after the initiation of SP 2022-25 as there are no changes in corporate goals and outcomes. Most of the six accelerators listed in the business model are integrated into the current CP.

Thematic area: Integrated sexual and reproductive health services

Under the SRHR output, the 7th CP Document (CPD) and the draft Country Programme Action Plan (CPAP) identified three main strategies covering enabling environment, health system strengthening and addressing special needs of women and girls. Based on the review of the AWP, the team modified the TOC (see Annex Part 2-A). Some of the activities under the strategies were re-grouped and an additional strategy related to data was added. UNFPA is the lead agency for the UNSDPF outcome 1 related to data and evidence, the CP has invested in generating evidence on harmful practices, analysis of Population and Housing Census data on various population trends and has invested in capacity building to use data for action. The four strategies in the modified TOC are creation of an enabling environment for the delivery rights-based and gender response SRHR services with focus on adolescents and youth; Health system strengthening to deliver high quality integrated SRHR information and service including for adolescents and the young in development and humanitarian contexts; Addressing special needs of women and young girls in development and humanitarian contexts and ; Advocating and strengthening data collection, analysis and use for generating evidence. These are built on principles of GEEW and human rights and ‘leaving no one behind’.

⁵²No CPE was done, instead a review of the CP was done and a synthesis report was developed.

Thematic area: Adolescents and youth

The CP 6 assessment strongly recommended continuation, and strengthening and expansion of coverage of Life Skills Education (LSE). UNFPA adopted a gender-responsive and rights-based approach, and focused on advocacy and policy advisory services as primary modes of engagement. UNFPA partnered with Government, civil society organizations and youth groups to identify and address implementation gaps in existing laws, policies and strategies to improve access and use of SRH information and services by adolescents and youth. UNFPA promoted policies and programme interventions that aimed to build young people's skills and capacities to make informed choices about their SRH and well-being, including in humanitarian contexts. And focused on supporting the generation and use of disaggregated data and evidence on the linkages between population dynamics, intergenerational issues and the realization of the sustainable development goals, with a particular focus on guiding multi-sectoral policies and programmes on adolescents and youth. UNFPA interventions in particular promoted policies that provide adolescent boys and girls with the knowledge and skills to make informed choices about their sexual and reproductive health, including through access to comprehensive sexuality education.

Under the output related to adolescents and youth, the 7th CPD and draft CPAP, identified three strategies related to capability of young people to make informed choice, adolescents and young people are able to exercise their RR and positive changes in harmful social and gender norms and practices including reduction in early marriage. Based on the review of AWP, the evaluation team modified the TOC related to the output. Few modifications in the strategies have been made and an additional strategy related to data has been added as seen in Annex Part 2-A. The four strategies in the modified TOC are building capability /skills of young people to make informed choices about SRHR and well-being, Creation of enabling environment for adolescents and youth (A&Y) to exercise their RR; Building capacity of communities for enabling changes in social norms and harmful practices; and Supporting generation and use of disaggregated data and evidence for key population development issues and linkages with SDGs. These are built on principles of GEEW, human rights and leaving no one behind.

Though gender is not a separate output, UNFPA contributed to UNSDPF under the gender thematic working group to several national policies related to gender equality policies and reviews and violence against women, policies against sexual harassment, etc. From the review of the CP documents and reports, it is clear that gender is very well integrated into the strategies under SRHR and adolescents and youth.

The strategies under both outcomes also contribute to RGOB's commitment at ICPD @25 and 12th FYP concerns about the quality of SRH services.

Key Strategic Partners & Stakeholders

CP7 partnership plan promoted the aspirations and principles of the ICPD POA and SDGs through advocacy and upstream policy work, capacity building and knowledge management in partnership with the government and non-governmental organizations. Further, UNFPA partnered with key government agencies to facilitate the implementation of 12th FYP for the empowerment of adolescent girls and young people, maintain and advance legislative and policy environments on issues of sexual and reproductive health, youth, and gender equality and advocate the appropriate allocation of funds. UNFPA played a key role incorporating Adolescent Sexual and Reproductive Health (ASRH) issues in the draft National Youth Plan and National Strategic Plan of Action for Adolescent Health (NSPAAH)^{53, 54}. UNFPA has also partnered with Parliamentarians through CSOs on issues related to teenage pregnancy and GBV.

Government strategic partners includes: GNHC, MOH(RMNCAH program, PPD, Adolescent Health Program (AHP) , Jigme Dorji Wangchuk National Referral Hospital (Department of Forensic Medicine, Department of community health, Department of OBGYN), MOE (Department of Youths and Sports (DYS), School Health and Nutrition Division (SHND), Scouts and Cultural Education Division (SCED), Early Childhood Care and Development and Special Education Needs (SEN), Department of Curriculum and Professional Development (DCPD)), Royal University of Bhutan (RUB) (Paro college of education, Samtse College of

⁵³NYS. Draft National Youth Policy and action plan, 2021

⁵⁴MOH. National Strategic Plan of Action for Adolescent Health 2019-23

education, Institute of language and cultural studies), Khesar Gyalpo University of Medical Sciences of Bhutan (KGUMSB) (Faculty of Nursing and Public Health(FONPH), and National Statistics Bureau (NSB) and Commission for Religious Organizations of Bhutan (CROB).

Civil Society Organizations and organizations of vulnerable groups include: RENEW, Lhak-sam BNP+ (Bhutan network of people living with HIV and AIDs in Bhutan), Y-PEER network, Pride Bhutan, Queer voices of Bhutan and organization of persons with disability⁵⁵.

UNFPA response to COVID-19 pandemic and other natural calamities

In response to the COVID-19 pandemic UNFPA CO has revisited, redesigned and repurposed programmatic focus and modes of engagement and also reallocated resources to ensure continuation and timely access of SRH services, supplies such as personal protective equipment and information with focus on women of reproductive age and young people as well as GBV related services and protection of health workforce⁵⁶. As per UNFPA Guidance to adapting evaluation questions to COVID-19 pandemic, CPEs are expected to capture the response of COs to COVID-19 pandemic. UNFPA also contributed to the UN Bhutan Socio-Economic Response Plan and was responsible for reporting on few of the global Socio-Economic Response Plan Indicators.

UNFPA's main contribution during this CP was to build capacity for implementation of Minimum Initial Services Package (MISP) as part of emergency preparedness plan. The MISP for SRH includes a set of priority life-saving SRH services including gender based violence prevention activities.

3.2.2 The Country Programme Financial Structure

Table 7: Overview of the budget for the programmatic areas of CP7 2019-2023

Proposed indicative assistance (in million USD)				
Strategic plan outcome areas		Regular resources	Other resources	Total
Outcome 1	Sexual and reproductive health	1.0	0.2	1.2
Outcome 2	Adolescents and youth	1.3	0.2	1.5
Programme coordination and assistance		0.3	0.0	0.3
Total		2.6	0.4	3.0

Source: CPD July 2018

⁵⁵ (includes Ability Bhutan Society, Drak-tsho, Bhutan stroke foundation, Phensem (parent supporting group) and disabled people's organization of Bhutan)

⁵⁶ UNFPA APRO. COVID-19 Humanitarian Response plan July 2020-2021. Final Report 2021

Table 8: Overview of the budget as per thematic area of CP7 2019- Up to June 2022

Budgets and expenditures as per thematic area- Bhutan CO (in USD)												
Thematic area	2019			2020			2021			Up to June 2022		
	Budget	Exp.	Imp (%)	Budget	Exp.	Imp (%)	Budget	Exp.	Imp (%)	Budget	Exp.	Imp (%)
SRHR	317,777.1	316,827.1	99.70%	810,860.2	810,584.0	100.00%	414,658.9	409,783.6	98.80%	488,657.9	141,011.0	30%
Adolescents and youth	161,828.8	161,132.8	99.60%	98,190.0	98,188.5	100.00%	137,442.3	137,442.3	100.00%	197,641.9	61,727.0	21.1%
Operations * (PCA)	74,849.8	74,575.8	99.60%	55,000.0	53,590.3	97.40%	81,351.4	81,351.4	100.00%	99,684.6	75,832.1	76.1%
Total	554,455.6	552,535.7	99.70%	964,050.2	962,362.8	99.80%	633,452.6	628,577.4	99.20%	785,984.4	264,225.8	33.6%

PCA (Programme Coordination and Assistance) budget allocated to CO and CO utilizes to meet its operations and communications activities.36-40% for Advocacy and communications and rest for operations expenditure of Country Office

Table 9: Expenditure by thematic areas showing the source of funding

Expenditure for the period 2019-2022 - in USD (All Fund Sources)								
Thematic area	Expenditures 2019		Expenditures 2020		Expenditures 2021		Expenditures 2022	
	Core	Non-core	Core	Non-core	Core	Non-core	Core	Non-core
SRHR	317,777	0	558,812.6	252,047.6	394,049.9	20,609	391,018.5	97639.4
Adolescents and young people	161,829	0	98,190	0	137,442.3	0	197,641.9	0
PCA	74,829.8	0	5,500	0	59,473.37	21,878	99,684.6	0
Total	554,455.7	0	712,002.6	252,047.6	590,965.6	42,487	68,8345	97639.4

Source: UNFPA CO Bhutan

Chapter 4: Findings

The chapter provides the answers to the main evaluation questions. Key assumptions that were made in the evaluation matrix (Annex 2) at design stage are assessed *using findings from triangulated data sources*⁵⁷.

4.1 Answer to Evaluation Question 1 on Relevance

Relevance brings into focus the correspondence between the objectives and support strategies of the CP, on the one hand, and population needs (with a specific attention given to the needs of the most vulnerable and marginalized), government priorities, and UNFPA global policies and strategies on the other. In particular, it will look into the extent to which the objectives of the UNFPA CP correspond to population needs at country level and were aligned throughout the programme period with government priorities, with strategies of UNFPA and UNDAF/UNSDPF.

EQ1: To what extent is the UNFPA country programme:

- i) adapted to the needs of the vulnerable including PWD both during the design and implementation of all the UNFPA-supported interventions in development and humanitarian contexts in line with the priorities set by national and international policy and normative frameworks
- ii) aligned to the national development strategies and policies;
- iii) is in line with the 2030 Agenda, UNFPA Strategic Plan 2018-21 and 2022-25 (particularly the transformative goals and business model) and UN partnership framework;
- iv) been able to respond to changes in national needs and priorities caused by contextual changes (such as COVID19 & humanitarian situations) in the context of the outcome areas.

CP 7 has two outputs covered under 2 SP outcomes; due to the commonalities across the two outputs, the response to the question on relevance is discussed together.

Summary of findings

The CPD identified vulnerable including PWD from the groups identified by the RGOB through the national vulnerability assessment of 2016⁵⁸. During the CP development, all the vulnerable groups including PWD were consulted, but during implementation the focus has been mainly on adolescents and youth. Under the implementation of CSE framework, special attention was paid to the needs of the visually impaired. During the COVID-19 pandemic, UNFPA reached out to a wider network of vulnerable groups including PWD to create awareness about SRHR services, GBV prevention and services. More needs to be done in understanding the issues of the vulnerable and developing strategies for partnership within UNFPA's mandate.

The CP is well aligned with national policies and strategies and supports the 12th Five Year Plan to improve inclusiveness, quality of care and human resources development and national policies and strategies and contributes to national level key result areas. The CP support has also ensured RGOB's commitment to ICPD POA.

The CP outputs contribute to the SP 2022-25 outputs of adolescents and youth, quality of services, gender and social norms and accelerating policy and accountability and to the accelerators related to human rights and gender transformative approaches, leaving no one behind, partnerships

⁵⁷Findings are based on key informant interviews including CO programme staff, group and focused interviews, observations, document review and secondary data analyses and notes from the field phase (Annex Part 2- E). Only when quotes are used the source is mentioned, otherwise, the findings come from a combination of various sources as stated.

⁵⁸Vulnerable as per 7th CPD includes adolescents and youth, victims of GBV, vulnerable urban dwellers, unemployed youth, persons practising risky sexual behaviour, LGBTQI communities, persons with disabilities (Source. CPD 2019-23).

and data and evidence to a certain extent as well as innovation and digitization (during the pandemic). The CP contributes significantly to the outcome on services for vulnerable and unreached followed by to the outcome on data and gender.

The CP has responded significantly to the national response to COVID-19 by re-programming its budget.

Finding #1: *(Relevance specific to development and humanitarian setting) Needs of the vulnerable groups including PWD (as included under the CPD) were identified and taken into account in both design and implementation stages and the young people were meaningfully involved in implementation. The CP is aligned to the national development strategies and policies. The CP time frame cuts across the UNFPA strategic plans of 2018-21 and 2022-25 and is aligned to both the plans including the business plans. It is also aligned to the UN partnership framework. The CO has been able to adequately and appropriately respond to the new opportunities and threats that occurred in the national context.*

The sources of information for the findings are mainly from the stakeholder interviews and focus group discussions as listed in Annex Part 2 E and other sources are specified in the footnote.

During the CP 7 formulation, extensive consultations were held with government and civil society organizations as well as vulnerable populations including adolescents and youth and PWD (as identified in the CPD). The CP has been developed based on several assessments and analysis such as the Population Situation Analysis (PSA), analysis of situation of young people, access to services, thematic analysis of the Population and Housing Census of Bhutan, maternal health assessments, etc.

Overall, UNFPA CP 7 programmatic areas are well aligned to the government priorities especially with regard to inclusiveness, UNFPA strategic plan priorities, UNSDPF and 2030 Agenda and the needs of beneficiaries especially vulnerable including those with disability.

The vulnerable groups identified in the CPD include some of the vulnerable groups identified in the 12th Five Year Plan. Although during the CP formulation extensive consultations were held with the vulnerable groups identified in the CPD, during implementation, the adolescents and youth and survivors of GBV were mostly involved. The major reasons were related to changes in the mode of engagement of UNFPA Bhutan⁵⁹ that limited its funding and support. Legal recognition of some of the vulnerable groups also limited UNFPA's engagement with some of the groups⁶⁰. However, efforts have been made during the course of the CP to respond to the needs of the vulnerable groups such as PWD and LGBTIQ for family planning⁶¹ (Finding 5) and visually impaired when the CSE curriculum was developed (Finding 10). UNFPA support has ensured that the NSPAAH includes vulnerable groups in the list of priority groups⁶². During the COVID-19 pandemic, recognizing the increased vulnerability to GBV, UNFPA identified opportunities to reach out to vulnerable groups as described under the relevant findings related to effectiveness. In this context, UNFPA had organised a consultation with the vulnerable groups including PWD, in collaboration with its CSO partner RENEW, where SRHR issues faced by the groups were discussed. Follow up actions were also taken as described under effectiveness (Finding 11). Availability of disaggregated data on SRHR needs of PWD and other vulnerable populations is a serious gap that also makes it difficult to advocate for the needs of the vulnerable groups⁶³.

The CP is well aligned to the 12th Five Year Plan, especially with regard to inclusiveness of vulnerable including PWD, quality of services and human resources development. It is well aligned to national health policy, draft Youth Policy, Domestic Violence Prevention Act, National Policy for Persons with Disability, RH strategy, NSPAAH and cervical cancer elimination strategy. The CP contributes to achievement of

⁵⁹ Bhutan was classified as a pink country as per UNFPA's business model of 2018-22.

⁶⁰ Bhutan decriminalized same sex activity in February 2021.

⁶¹ MOH. Module 5 of training manual on family planning

⁶² MOH. National plan of action for adolescent health 2019-23

⁶³ UN Bhutan. CCA 2018 mentions non-availability of disaggregated data of vulnerable as a gap

several of the national level and programme level key indicators. UNFPA has played an active role in the development of some of the policies and strategies, support for improvements in quality of RH services including AFHS, expanding human resources through its support to strengthening midwifery in the current CP (continuing from the past CP) (described under effectiveness). Keeping up with its commitment to ICPD POA, UNFPA has been supporting the development of RH strategy since the first RH strategy. Such involvement has helped UNFPA to ensure that the ICPD POA principles including SRH and rights are incorporated into the national strategies and also implemented as evident from the RH strategy, NSPAAH, training materials, etc. The data sources for the above statements in this paragraph are Government documents, stakeholder interviews and focus group discussions with women and adolescents.

Though the current CP spans across two UNFPA strategic plans 2018-2021 and 2022-2025, the CP is well aligned as there is no change in the goal and outcomes and in the three transformative goals. The CP, though developed in 2018, aligns well to the business model of the SP 2022-25 and the modes of engagement (same as earlier SP). The CP outputs contribute mainly to the SP outputs (2022-25) of adolescents and youth and significantly to quality of care and services, gender and social norms and accelerating policy and accountability. Though not planned in the CP design phase, the contributions to humanitarian action have been significant during the pandemic. The contribution to the SP outputs of population and data is comparatively less. The CP already includes four of the six accelerators – human rights-based and gender transformative approaches, ‘leaving no one behind and reaching the furthest first’, data and evidence (to a certain extent) and partnerships (government, CSO, academia and youth)⁶⁴. Through the APRO supported study on inequities in the Asia Pacific Region⁶⁵, a quantitative analysis of SRHR inequities was done in Bhutan in the early part of the CP which enabled identification of inequities by services and geographical areas and plan for strategies to leave ‘no one behind’, but unfortunately due to the pandemic, there has been a setback. However, the pandemic provided opportunities for innovation and digitization as well as resilience and adaptation and complementarity among development and humanitarian action⁶⁶. The findings under effectiveness provide more details of how the accelerators are woven into the implementation of the various modes of service delivery. The main areas of Bhutan’s statement of commitment at ICPD@25 are already being implemented through the current CP and provides an opportunity to expand or implement other elements in the next CP⁶⁷. Some of the key areas of the commitment include ensuring safe motherhood, SRHR for all women and girls with special focus on socially and economically challenged women, cervical cancer elimination, strengthening and intensifying access to information and services related to ASRH and rights through CSE in schools and institutions, towards ending violence against women, improving gender equality, harnessing demographic dividend and raising adequate resources for meeting ICPD commitments and SDGs.

Majority of the CP activities are predominantly aligned with the UNSDPF outcome two on ‘vulnerable and unreached people have access and receive quality services’ and outcome 3 on ‘national stakeholders strengthened to provide equal opportunities for all, particularly women and vulnerable groups’ and to a lesser extent to outcome one on data (though UNFPA is the lead agency)⁶⁸. The CP outputs contribute to achieving the SDGs mainly SDGs 3 and 5 and through its engagement with the vulnerable including PWD promotes the principle of ‘leaving no one behind and reaching the furthest first’. A partnership strategy exists that reflects the collaborative contributions to SDG implementation in the context of Delivering-as-One⁶⁹.

⁶⁴UNFPA. UNFPA strategic plan, 2022-2025, Annex 3: Business model, July 2021. Accelerators: Human rights-based and gender transformative approaches, innovation and digitalization, partnerships, SSTC and financing, data and evidence, ‘leaving no-one behind and reaching the furthest behind first’ and resilience and adaptation and complementarity among development, humanitarian action and peace-responsive efforts. These accelerators enhance the performance in implementing a mode of engagement, scaling up or speeding up the progress towards the strategic plan results.

⁶⁵Burnet Institute. Who is being left behind. A quantitative analysis of sexual and reproductive health and rights in Asia and the Pacific, Bhutan Country Report, May 2020

⁶⁶UN Bhutan. UN Bhutan Covid-19 situation response, June 2021

⁶⁷RGOB. Bhutan’s Commitment at ICPD @25 Summit, Nairobi

⁶⁸UN Bhutan. UNSDPF 2019-2023

⁶⁹UNFPA Bhutan. Partnership plan 2019-23

The CP has responded to the national needs in responding to COVID-19 pandemic through direct support to MOH and RENEW by reallocating the CP budget to support the response to COVID-19 in continuation of life saving RMNCAH services and prevention of GBV with focus on vulnerable including those with disability and indirect support through the joint UN response to the pandemic. Details are provided under effectiveness section (Finding 8). UNFPA also raised additional resources to further support the pandemic response. UNFPA contributed to high-level advocacy on SRHR and prevention of GBV through its Goodwill Ambassador (Her Majesty the Queen Mother, Gyalyum Sangay Choden Wangchuck) and regular media engagement to advocate for continued use of SRHR services⁷⁰. There has been no major changes in national needs and no national calamities during the CP period.

4.2 Answers to evaluation question 2 on Coherence

Coherence assesses the extent to which country programme interventions are compatible (complementarity, harmonization, and coordination) in areas of UNFPA's mandates and with international norms and standards; and co-ordination and the extent to which the intervention is adding value while avoiding duplication of effort including during COVID19 pandemic. This section assesses the dimensions of contributions to good functioning of coordination and complementarity with UN Partners and value added within one UN plan. It also assesses the added value of UNFPA's partnerships with national stakeholders and academia. The responses are applicable to both the outcome areas and there are overlaps; hence both are discussed together.

EQ 2: To what extent has UNFPA contributed to the functioning and consolidation of the coordination mechanisms of the UNCT, and added value in the country context, including for the COVID-19 response and other humanitarian response and recovery efforts, as perceived by UNCT and national stakeholders (government and CSOs)?

Summary of findings

UNFPA added value to the UNCT through its active participation in the development of UNSDPF outcome areas and its contribution through the joint work plans to achieve the outcome results in three of the four outcome areas. UNFPA is not included in the list of agencies under outcome four on resilience to climate-induced and other disasters. UNFPA has provided time to all UNCT activities despite few staff and limited funding. The Agency is appreciated for its high level advocacy through the Queen Mother, leadership in RH, CSE, LSE based CSE in monastic institutions and data systems. Ageing population is a concern recognized in CCA and in the RH strategy and currently the CP is supporting a report on ageing to contribute to the national policy on ageing that is currently being developed.

UNFPA's contributions are recognized by IPs; however, much more needs to be done in generating evidence for advocacy and policy.

The sources of information for Findings 2 and 3 are mainly from the stakeholder interviews and focus group discussions as listed in Annex Part 2 E and other sources are specified in the footnote.

Finding # 2: UNFPA added value to the development of the One UN work plan, functioning and coordination mechanisms of the UNCT, ensuring synergy and maximizing and optimizing results and in development and humanitarian contexts and ensured that human rights-based approaches are followed. UNFPA has provided leadership and ensured that the issues related to SRHR and GEEW are addressed in joint UN response to humanitarian and COVID-19 preparedness and response plans.

UNFPA played an active role in the development of the current UNSDPF, lead of the outcome area 1 (access and utilization of data) and contribute significantly to outcome area 2 (access of vulnerable and unreached

⁷⁰UN Bhutan. UN Bhutan Covid-19 situation response, June 2021

to services) and outcome area 3 (equal opportunities to women and vulnerable groups). Such involvement has ensured that UNFPA focus areas are included in the One UN plan. Despite UNFPA’s contributions in mitigation activities in natural calamities and its leadership in population issues that has a direct bearing on climate change, the agency is not included in the list of agencies under outcome four on resilience to climate induced and other disasters. Preparedness is a component of resilience and UNFPA has an important role in disaster preparedness and response with regard to data, SRH, ASRH and gender. Under the UNSDPF outcome two, UNFPA supports few activities on disaster response and is a member of the interagency taskforce on disaster response⁷¹. UNFPA contributes to the joint annual work plans in the outcome areas where it is represented and also plays an important role in the joint planning, monitoring and evaluation group. It is a member of many of the working groups and had co-chaired the gender thematic group with UNICEF, contributing to the UNCT joint gender analysis. UNFPA is the lead agency for adolescent health in collaboration with WHO and for CSE, it partners with UNICEF. UNFPA has actively participated in joint proposal development on SDGs and data (UNFPA lead) and GBV and vulnerable groups (UNDP lead)⁷².

UNFPA’s leadership in SRHR as well as in CSE, introducing LSE /CSE education in monastic institutions and health sector response to GBV is well recognized among UN partners. UNRC and other UN agencies acknowledge UNFPA’s high level advocacy through its Goodwill Ambassador - the Queen Mother, on SRHR and GBV as well as ASRH. Another area UNFPA is recognised for is its contribution to improving data systems in the country (Findings 15, 16). UNFPA’s contribution to the joint UN response to COVID-19 and its support for maintaining SRH services, for prevention and management of GBV and establishment of shelter homes and its high level advocacy through the Goodwill Ambassador is noted by all partners and reflected in the UN response to COVID-19.

UNFPA collaborates with UNICEF and WHO in supporting Maternal, Perinatal and Neonatal Death Surveillance and Response (MPNDSR) activities by the MOH. Another collaborative effort is the support to national health survey by UNFPA, WHO and UNICEF to gather data on the current status of health of the populations, RMNCAH data, National Key Result Areas and SDG targets.

“It is just amazing how UNFPA has managed to infiltrate their interventions into the monastic institutes... none of the UN agencies have even thought of that although now UNICEF is following suit.... (from discussions with UN agencies).

Ageing population is a concern for RGOB with the projected increase in population aged 65 and above to 17.3 percent by 2050. Ageing population is included under vulnerable groups and is mentioned as a concern in the 12th Five Year. The CCA 2018 highlights the lack of comprehensive strategies or schemes for ageing population and the RH strategy of 2018 includes SRHR of elderly. Currently, the CO is providing leadership in policy advocacy through its support for developing a report on ageing population which will contribute to the National Policy for Senior Citizens in Bhutan. UNFPA is providing support to RGOB to develop the policy in collaboration with Royal Society for Senior Citizens. The leadership provides UNFPA an opportunity to coordinate and complement the contributions of potential partners supporting activities for ageing population.

Though UNFPA’s contributions to UNSDPF are noteworthy, due to the limited staff, it is also a major challenge for UNFPA to balance its involvement with the UNCT while trying to achieve its programme outputs. Another challenge noted from the discussions with UNCT members, is the lack of division of labour that has created confusion in responding to RGOB requests - agencies with easy access to funds responding to requests, sometimes without consultation with the agency under whose mandate the technical area falls.

Finding #3: Through its established relationships with MOH, MOE and NSB over several CPs and collaborations with RENEW and academia, UNFPA added value in thematic areas of its comparative advantage - SRHR, adolescent and youth SRHR, data and GEEW (despite the changes in mode of

⁷¹Stakeholder interviews and UNSDPF 2019-23

⁷²Interviews with current and former UNFPA CO staff and UNSDPF 2019-23

engagement). Its technical contributions to improving quality and rights-based approaches, have complemented the efforts of the government in development and humanitarian contexts. UNFPA's support for developing the country statement for ICPD@25 Summit at Nairobi and its support to Bhutan country team was appreciated. UNFPA's support for data access could be strengthened further.

UNFPA is recognised as the lead agency for SRHR, particularly in thematic areas such as family planning, reproductive health commodity security, safe motherhood, ASRH and health sector response to GBV. UNFPA is the only agency that provides support to family planning while it has carved a niche for itself in improving the quality of safe motherhood services especially Emergency Obstetric and Newborn Care (EmONC), ASRH and health sector response to GBV. UNFPA's inputs in complementing and supplementing the Government programmes, particularly in service delivery expansion, is appreciated and contributes to achieving programme outcomes. UNFPA's leadership and support to LSE over successive CPs, for in-school and out-of-school adolescents, through DYS under MOE, and its support for introduction of CSE in schools is recognized. UNFPA's strategic collaboration with CROB to institutionalize LSE-CSE education in monastic schools is another area of strength. UNFPA's long standing partnership with NSB and the various contributions to developing the statistical system, particularly the support for Bhutan Statistical Database Systems (BSDS), is well recognised by all the national and UN partners. However, it is felt that UNFPA support for access to various sources of data, particularly related to SDGs and National Key Result Areas could have been better (CO's plans to support the activity could not be implemented due to the limitations created by change in country status as per business model). UNFPA's support to the policy on ageing (Finding 2) is another evidence of its leadership in emerging issues.

Partnership with CSOs such as RENEW has opened up possibilities to strengthen the collaboration between the CSO and MOH in the area of health sector response to GBV and expanding the scope of collaboration with non-health sector agencies that monitor and support survivors of GBV. Other partnerships include organizations of vulnerable group and PWD as described under the section on effectiveness.

The collaboration with academia has been very specific– related to capacity building (teacher training institutions under RUB, FONPH under KGUMSB). Collaborations on research on root causes of selected social issues such as GBV, adolescent pregnancy, etc. had to be postponed due to the pandemic. Such collaborations would have contributed to evidence-based advocacy which is one of the modes of engagement of UNFPA. Findings of research also would have provided academic institutions an opportunity to impart such knowledge among their trainees to become agents of change.

4.3 Answers to evaluation questions 3,4 &5 on effectiveness

Effectiveness demonstrates the extent to which CP programme outputs have been achieved and the extent to which these changes have contributed to the achievement of the CP outcomes. It also highlights the extent to where the CP intended results were achieved, taking into account potential changes made to the initial results framework due to the COVID-19 crisis.

EQ 3: To what extent have the interventions supported by UNFPA delivered outputs have been achieved and the outputs contributed to the achievement of the outcomes of the CP, in both development as well as humanitarian setting/COVID-19 pandemic? And what are the facilitating and hindering factors in achievement of intended results and unintended results?

EQ 3 is related to the interventions supported by UNFPA delivered outputs on SRHR and adolescents and youth. The CP outputs contribute to the SP outcomes 2018-21 related to SRHR and adolescents and youth (as in the CPD) but also to the three outcome areas of SP 2022-25. Gender is mainstreamed in both outputs and population issues and data are part of the outputs and not a standalone output. Both the outputs overlap in some areas, but their mode of delivery and IPs are different, thus are discussed separately.

The sources of information for the findings in this section are mainly from the document review, stakeholder interviews and focus group discussions (Annex Part 2 E) and other sources as specified in the footnote.

Sexual and reproductive health

SP Outcome 1: Every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated sexual and reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence

CP output 1: Increased national capacities to ensure universal and equitable access to high quality sexual and reproductive health information and services

The key strategies and interventions listed below contribute towards achieving the transformative goals of zero unmet needs, zero preventable maternal mortality and zero GBV and other harmful practices.

Summary of findings

Progress of output indicators is noted despite the lockdowns during the pandemic due to consistent support of UNFPA to MOH for maintaining RMNCAH services. Recent data on outcome indicators is not available.

Aligned with the revised role as per the country classification, UNFPA has been providing support for gathering evidence for policy advocacy and supported the development of NSPAAH and training packages on family planning, midwifery and AFHS with focus on needs of vulnerable including PWD. The evidence also helped UNFPA to support the RGOB to develop the ICPD@25 commitment. Advocacy to parliamentarians on SRHR issues and GBV was done, but more needs to be done with this group.

The contributions to health system capacity building for SRH includes building the capacity of the health provider through training in family planning, EmONC, health sector response to GBV and AFHS and inclusion of family planning, GBV and AFHS in the final year curriculum of nursing and public health courses and capacity development of midwifery trainers in curriculum development (the latter two contribute to long-term impact). Joint training on AFHS with health sector and non-health sector players is expected to improve referral linkages between various ministries. Gaps noted are the lack of support for SRH/HIV integration, comprehensive pre-conception care package and strengthening RMNCAH indicators routinely collected through the District Health Information System (DHIS) -2 system.

UNFPA's support to cervical cancer screening and development of strategy for cervical cancer elimination has been a major contribution to the national flagship programme on cervical cancer screening. UNFPA has raised resources to further strengthen the newly introduced HPV-DNA testing. Capacity building including development of training materials for comprehensive health sector response to GBV is another significant contribution.

Through the support to developing the ICPD@25 commitments, UNFPA has ensured that its core mandate areas such as family planning, safe motherhood and GBV are covered under RGOB's commitments.

Besides support for infection prevention measures including provision of Personal Protection Equipment (PPE) (additional provision in high-risk areas), contribution to continuation of SRH services, prevention of GBV and management through digital health platforms has led to less disruption of RMNCAH services. The continuum of care approach in care of GBV linking health facilities with community workers was a notable contribution that also helped in creating awareness about the issue in the community. The additional efforts to reach out to vulnerable populations such as LGBTIQ and PWD to ensure access to information and services are significant.

Finding #4: Indicators related to SRHR output on increasing national capacities to ensure universal and equitable access to high quality SRH information and services have progressed/achieved despite the setback due to COVID pandemic.

Annex 6 shows progress of outcome and output indicators. Recent data on outcome indicators are not available as explained below. The MMR (89 per 100,000 live births) is based on the Census data of 2017. Based on WHO estimates of MMR (higher than 89), Bhutan is unlikely to achieve the goal of less than 70 maternal deaths by 2030⁷³. The data on percentage of women aged 15-49 years using modern methods of contraception (65.4%) and unmet need for contraception among 15-19 years (28%) is from 2010 and the new data is expected after the 2023 health survey. There is progress in output indicators with regard to proportion of district hospitals (total 25) offering AFHS (32% against a target of 60%)⁷⁴. Many of the AFHS services that were closed during the pandemic had not started functioning fully. The target for the indicator are likely to be achieved by the end of the CP. The proportion of district hospitals where at least 3 service providers have been trained in rights-based family planning have exceeded the target (60% against a target of 50%); however, there are concerns about the quality of training (See Finding 6). With regard to the indicator on implementation of updated clinical management protocols on GBV in selected districts, all three referral hospitals, 8 district hospitals and the PHCs in the same districts have implemented the guidelines, thus achieving the target⁷⁵. Due to the pandemic, there has been some setback in training more people.

Finding #5: The various assessments and studies contributed to creating an enabling environment for policy and advocacy for delivery of rights-based and gender responsive SRHR policies and services with focus on adolescents and youth including on vulnerable (includes PWD)

To identify gaps in existing policies, CP had supported reviews and assessments on reproductive health including, but not limited to, reproductive health strategy review, national EmONC assessment (done in 2018), maternal near-miss review, antenatal care assessment, and review of national family planning and midwifery standards. The National Family Planning (2018) and National Midwifery (2018) Standards were reviewed to develop training guides for both the standards for training of in-service care providers. The family planning standards, although is inclusive of the family planning needs of adolescents and youth, it doesn't cater to the special needs of other vulnerable groups; hence, the training guide developed during this CP had ensured to include the needs of PWD and LGBTIQ community. UNFPA is a member of the MPNDSR committee and recognising quality of maternal care as an issue, supported maternal near-miss review in all referral hospitals to dive deeper into quality of maternal care and national ANC assessment in selected 19 facilities across the country. Assessments done by other agencies have also been used to develop evidence based policies and strategies such as access to AFHS services at primary health care facilities(WHO)(findings contributed to the strategy on AFHS services under the NSPAAH). UNFPA supported the development of NSPAAH and also its costing. As indicated earlier, it is an inclusive strategy (with focus on vulnerable groups), emphasises coordination of services provided by various departments of MOH as well as MOE. The strategy takes into consideration GEEW issues⁷⁶.

Some of the evidence gathered through UNFPA supported assessments have no doubt contributed to the recent Policy to Accelerate Mother and Child Health Outcome- 1000 days plus (2020), particularly to strategies related to ANC, institutional delivery and EmONC. In addition, the parliamentarians were sensitized on SRHR and GBV situation in Bhutan; though it is too early to comment on its influence on policies and strategies, sensitization itself paves the way forward. UNFPA's support to development of national SRH strategy 2018-22 (also previous strategies) has contributed to building the RH programme across the life stages with focus on UNFPA core SRHR areas - family planning, maternal health, management of GBV and ASRH. The strategy also covers the SRH needs of ageing population, SRH needs during humanitarian crisis, in urban areas and among populations that are difficult to access. UNFPA's

⁷³WHO. Trends in maternal mortality 2000 to 2017: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva: World Health Organization; 2019

⁷⁴UNFPA monitoring reports and information from MOH programme officers

⁷⁵*Ibid*

⁷⁶MOH. National Strategic Plan of Action for Adolescent Health 2019-23.

contributions to providing evidence has been critical for its mode of engagement in policy and advocacy. The findings and studies also contributed to formulating Bhutan’s commitment at ICPD@25 in Nairobi. Some of the policies related to adolescents and youth are covered under Output 2.

Finding #6. UNFPA contributed to strengthening health system to deliver high quality integrated SRHR information and services, including for adolescents and youth in development and humanitarian contexts. Three areas of focus has been building capacity to deliver rights-based FP services including for vulnerable and PWD, in improving care and survival of pregnant mothers and during childbirth and in improving access to quality ASRH services. The capacity building included special focus on the needs of vulnerable including PWD.

A fully functional health system is a prerequisite for delivering good quality SRH services and for ensuring universal access to SRH services. Competent and motivated health workers are critical and also uninterrupted supply of RH commodities of good quality. The need to improve quality of services has been recognised from the various assessments listed under Finding 5. Aligned with the country classification and mode of engagement of UNFPA in Bhutan, the focus has been building the capacity of the MOH as well as hospitals and health facilities and training institutions and skills of RMNCAH workforce to deliver quality SRH services that are rights-based and inclusive. With limited resources UNFPA has managed to build capacity that has long lasting impact such as the development of standards and inclusion of rights-based approaches in the pre-service training as described in the subsequent paragraph.

UNFPA is the only agency that provides support to family planning services. Besides support for developing the family planning standards and support was also provided for development of training materials which includes a section on family planning needs of vulnerable populations including PWD. Plans to expand the choice of contraceptives by introducing implant could not be carried out due to the COVID pandemic; however, guidelines for delivery of services have been developed with UNFPA support. Healthcare providers, starting from the highest facility (national referral hospital) till the lowest facility (primary health centres- PHCs) have been trained on rights-based family planning and 60 % of hospitals in the country have at least three health care providers trained on rights- based family planning. The training is reported to be competency-based. However, there are concerns about the quality of training particularly with regard to skills in IUCD insertion as reported during stakeholder interviews (see quote)⁷⁷. UNFPA’s support under the past CPs had contributed to building the capacity of the logistics and supplies system and its advocacy

“In this PHC, we don’t provide IUCD services. it’s been 5 years since I graduated and during nursing school we were not taught to insert IUCD... after I joined service also I did not receive training on IUCD” (health care provider interview)

resulted in MOH procuring contraceptives with its own funds.

Support was provided for updating the midwifery training guide to incorporate the changes in the updated midwifery standard and align with the International Confederation of Midwives’ curriculum. The revised standard includes some

of the new recommendations of WHO related to intrapartum care. The training package also includes the concerns of the people with disability. Using Low Dose High Frequency (LDHF) model of capacity building, the capacity of 53 EmONC focal points from all 10 bedded and above health facilities including reinforcement capacity building in the Eastern region, have been done. The team-based LDHF training has improved the skills of the trainees and has built the confidence of the trainees as evident from the post-training scores and the feedback⁷⁸. However, it is not clear whether supervised client practice was provided at the job sites (as a recommended component of the training). The changing landscape of causes of maternal

“The recent LDHF training I attended helped me manage post-partum haemorrhage and pre-eclampsia patients better....I felt more confident”. “The LDHF training not only trained us on skills such as post-partum haemorrhage, manual removal of placenta and Magnesium Sulphate loading dose... but also learnt that the LDHF model can be used in retaining skills such as neonatal resuscitation...” (interviews with participants of LDHF training)

⁷⁷Interviews in health facilities (Annex Part 2 E)

⁷⁸ Trainer’s reports of the LDHF training

deaths, increasingly skewed towards non-obstetric causes of death, requires more support in prevention and management of the transformative goal of zero preventable maternal deaths is to be achieved. The antenatal care assessment may have provided some evidence on non-obstetric causes as an important group of morbidities, but as no report is available it is not possible to confirm. Few independent research studies in maternal and child health areas and the annual MPNDSR reports had pointed towards quality of antenatal care as an important factor that needs to be looked into if the nation is to achieve targeted MMR of 70 by 2030. Another important contribution of the CP has been inclusion of Bhutan's country profile on midwifery in the State of the World's Midwifery 2021. The publication was released on line highlighting the critical role of midwives in primary health care and their contributions to achieving the progress towards several goals and targets of the 2030 Agenda.

Building the capability and capacity of the health systems to improve the access to and quality of AFHS is another area of capacity building that was supported under the CP. Two streams of support were provided - building capability of facilities at referral and primary health care level to meet the national standards for AFHS and improved access through strengthened collaboration between various institutions involved with health of adolescents and youth. The support provided included development of training materials, covering promotive and preventive services including mental health and curative services, training of 85 health care providers across 51 hospitals in the country in providing AFHS (maintaining confidentiality and privacy)⁷⁹ and improvement of health facilities to meet the national standards for AFHS. The trained providers (AFHS focal points) serve as referral points in hospitals, for adolescents availing health services. In addition, joint training within and outside health sectors for AFHS had been conducted for AFHS focal points, clinical counsellors, youth centre managers and Y-PEER coordinators to improve referral services and improved access in districts where AFHS clinics have been initiated. Eight district hospitals including the three referral hospitals have designated AFHS clinics⁸⁰. While the three referral hospitals have designated clinic rooms for AFHS and focal points, the situation is different in other district level hospitals and primary health care facilities due to lack of space and human resources. Impression gained during the visit to schools and health facilities is that the referral linkages between clinical counsellors in schools and AFHS services needs more strengthening. During the pandemic, majority of the facilities did not provide AFHS due to the focus of the facilities on mitigation activities. The services have been recently resumed in health facilities. During COVID, information related to ASRH issues and GBV were provided through peer networks and on-line advice was provided by the focal points (see Finding 8). UNFPA's contribution to AFHS is well recognised by key stakeholders as a critical intervention to make health care services adolescent and youth friendly, especially for sensitive and critical services such as SRHR and mental health.

A significant strategic input in terms of sustainability has been the review of the curriculum of general nursing and health assistant training to include rights-based family planning, AFHS and GBV. The curriculum had incorporated the competencies recommended by the International Confederation of Midwives as well the national standards and training materials for family planning and AFHS. The skill training in family planning mainly focuses on short acting methods. The skills lab is inadequate to provide skill training in long acting reversible contraceptive methods such as IUCD (the only long acting method currently available in the country). Management of GBV is included in the curriculum. The impression gained during discussions with the AFHS focal point in the faculty is that the topic was taught in the first year when non-clinical topics are taught, hence not adequate to develop clinical skills in AFHS. Another contribution of UNFPA to capacity development was through the UNFPA APRO Midwifery Faculty Development Course which was provided as a blended online course through the Moodle platform during the pandemic⁸¹.

⁷⁹MOH. AFHS training package

⁸⁰The country has 25 district level hospitals of which three are referral hospitals. The AFHS have been initiated in 8 district hospitals (of which 3 are referral hospitals)

⁸¹ UNFPA APRO's concept note on midwifery faculty development on line course and Interviews of midwifery faculty (Annex Part 2 E)

A gap in the health system support that was observed was lack of integration of HIV/STI into SRH services (a component of the national RH strategy)(based on literature review as well as observations during field visits).

UNFPA had provided support to monitor the availability of reproductive health commodities as part of the reproductive health monitoring tool of MOH. This input provides an opportunity to monitor the sustenance of its past inputs to reproductive health commodity security. The visit to the Medical Stores and Distribution Division in Phuentsholing, the main distributor of supplies including reproductive health commodities, across the nation, raised some concerns about storage management, particularly of RH commodities. Of particular concern was the storage of condoms. Since poor storage affects the effectiveness of the products, there are concerns about the quality of the products being distributed to health facilities.

Preconception package which is the provision of biomedical, behavioural and social health interventions to women and couples before conception occurs, is a core component of the RH strategy. Preconception package provides many health benefits across the life span such as prevention of non-communicable diseases, opportunity for safe pregnancy planning in women with medical conditions (high risk) and reduce the risk of unintended pregnancies and HIV and STIs. There were plans to introduce the package in five district hospitals but had to be postponed due to the pandemic. Recently UNICEF has developed a preconception package in collaboration with MOH and UNFPA could collaborate to further expand and strengthen its scope⁸².

A critical gap that was observed during stakeholder interviews is the lack of support for strengthening the RMNCAH indicator data collection through the DHIS 2, which could have provided more recent data (though the data has its limitations). The reason could be the lack of coordination by WHO (lead agency for DHIS 2) and MOH in the initial stages of development and implementation of DHIS 2.

Finding #7: The CP provided support to address the special needs of women and girls. The CP continued its support to cervical cancer screening initiated in the previous CPs through development of policies and strategies, playing a significant role in its recognition as a national flagship programme. UNFPA's contribution to strengthening management of victims of intimate partner violence and sexual violence in health care settings is significant (building on its support in the previous country programmes). Women and adolescents who are victims of GBV are considered vulnerable groups that adds to the attention paid to the victims. Another issue that was supported was the support for screening for infertility at primary health care facilities.

The previous CPs have provided support for cervical cancer screening and treatment of precancerous lesions through capacity building and support for monitoring the quality of services. Cervical cancer screening programme is one of the national Flagship programmes. Under the current CP, technical and financial support were provided for developing the National Strategic Plan for Cervical Cancer in Bhutan 2019-23 (towards elimination of cervical cancer) and a Roadmap for Elimination of Cervical Cancer by 2030. In addition, support was provided for developing guidelines for HPV-DNA testing and building capacity of health care providers for HPV-DNA screening, pre-cancerous treatment and referral. 23 laboratory technicians were trained in Thailand to support the screening. Development of indicators for monitoring the programme and quality were the other contributions. During 2019-20, the CP supported outreach cervical cancer screening camps in three districts, reaching to more than 12,000 women (90 percent of eligible population in those districts) followed by follow-up camps. With the case load of COVID-19 decreased, outreach cervical cancer screening camps in another three districts were held and reached out to more than 90 percent of eligible population. UNFPA's input in the past and the current CP inputs have contributed to the development of the Flagship programme for cervical cancer elimination and improved screening and early detection and management⁸³. Bhutan's commitment at ICPD @25 includes reducing morbidity and mortality due to cervical cancer.

⁸²MOH, UNICEF. Preconception care package guideline for health care provider 2019

⁸³UNFPA, Cancer Council. Cancer elimination- Country review and road map 2021

The support in the past CPs have focused on advocacy and policy support for prevention and management

“During lockdown, there were quite a number of adolescents and youths consulting me through phone mostly for stress and anxiety... sometimes it kept me busy even during odd hours as only AFHS focal providing services.... I even arranged for condoms and *i-pills* and have them dropped few times.”
(Discussions with AFHS focal during field visits)

of GBV which contributed to national policies and strategies and development of protocols for managing survivors of GBV, especially Intimate Partner Violence (IPV) and Sexual Violence (SV). UNFPA has further boosted its focus on GBV by including the victims of GBV in the ~~its~~ list of vulnerable populations listed in the CPD. Recognizing the critical role of the health sector

in responding to GBV, UNFPA supported the MOH in developing guidelines for provision of comprehensive management of victims of IPV and SV for referral and district hospitals and for primary health care facilities where there is no doctor. The guidelines also include information on documentation, reporting and referral as prescribed in the Act against violence. Support was also provided to build the capability of the designated health service providers for managing cases of GBV (forensic focal). The inclusion of GBV in the pre-service curriculum of nursing and public health will equip the trainees to identify and manage victims of GBV. In eight districts, capacity building was achieved. Monitoring of the implementation of the guidelines has not been assessed due to the pandemic. The impression gained during field visits was that the forensic focals were not providing the full package of primary care services as prescribed in the guidelines. The care of victims of GBV was a core service during the pandemic (described under Finding 8)⁸⁴.

The CP had initially supported the development guidance for screening for breast cancer which later became a National Flagship Programme. Screening tool for organ prolapse was also developed and is being used. Infertility is recognised as an important RH morbidity and the CP had supported the development of screening tools for infertility at the primary health care levels and also some support to the national referral hospital. However, the support did not progress much. The prevention and management of infertility is a core component of family planning services.

Finding 8: The CP supported the continuation of comprehensive, life-saving SRH services and services for survivors of GBV during COVID-19 pandemic, ensuring the coverage of services for the vulnerable including PWD.

The findings below refer to the support provided during the pandemic⁸⁵. The interventions described below was implemented in all the districts with special focus on five high risk areas. There were no major disasters during the CP period.

Besides the reallocation of programme funds to support continuation of RH services, supply of 4200 PPE, and sanitizers, supplies for infection prevention and training were provided for maternal and child health workers and front line workers as needed. 1000 PPEs were also supplied to Red Cross/ Taxi Association members who work as frontline responders to enable them to transport those who needed medical care especially pregnant women. Additional funding for PPE kits were also provided to MOH to provide for maternal and child health workers and frontline workers in high-risk districts. Details of reprogramming of funds is given in Finding 21 under efficiency.

UNFPA supported the MOH to distribute 240 set of dignity kits to women and girls through youth, Community Based Support Systems (CBSS) volunteers, scouts and volunteers in border district (Phuentsholing) to support their community engagement initiatives on COVID-19 pandemic, GBV prevention, etc.

Major contributions include the support for adapting the Regional UN Guidance on maintenance of RMNCAH services⁸⁶ during the pandemic with focus on family planning, antenatal care, institutional deliveries, EmONC and management of GBV. AFHS were provided through on-line consultation (exact

⁸⁴UN Bhutan. COVID-19 situation report June 2021 and various UNFPA sit reports 2020-21

⁸⁵*Ibid*

⁸⁶UNFPA, WHO, UNICEF. Maintaining essential RMNCAH services, May 2020.

number not known). 323 health service providers and managers, from all over the country were oriented on the interim guidelines through on-line platforms. All health facilities had developed microplans to provide essential services including ANC, deliveries, EmoNC, family planning, etc. as needed.

EmONC focal points from 20 district health facilities were trained to provide services through social media platform and enable women to seek advice on care. Oral contraceptives and condoms were distributed door-to-door by community volunteers and mobile services, as needed. Capacity building in AFHS, midwifery standards and family planning standards continued which was critical for providers from high-risk zones under the pandemic. The LDHF training continued using anatomic models for skills training. Through the above efforts, even when there were lock down (three major ones), the MOH has been able to continue majority of the RMNCAH services with minimal disruption⁸⁷. Regular awareness creation through radio, television and community groups on SRH issues and GBV and where to seek care (in person or through digital platforms) were done. 20 members of LGBTIQ community and 60 CBSS volunteers were sensitized to SRH issues and GBV to further spread awareness in their communities.

Reaching out to LGBTIQ communities is to ensure that the needs of the vulnerable groups are met during the pandemic as services were even more difficult to access during the pandemic. The CO developed and disseminated COVID-19 messages for PWDs, LGBTIQ and other vulnerable groups⁸⁸.

Another important contribution was orientation of the graduate students of Paro College of Education (246 students) and FONPH students (78) on SRHR issues including GBV and risk communication.

“It was initially difficult but soon providing services became smooth and standardized as we were clear on how to provide maternal and child health services through different modes as per training we received on interim guideline on RMNCH services....”

“I was busy with teleconsultation during lockdowns and here as we are in high risk area we had many and longer lockdowns.... I helped quite a number of GBV victims, mainly through tele-consultation and getting help for them from other relevant sectors such as health, police, shelter homes and sometimes even delivering them necessities through volunteers (*Desups*)” (Focus group discussion with health workers)

Adolescents and youth

SP Outcome 2: Every adolescent and youth, in particular adolescent girls, are empowered to realize their sexual and reproductive health and reproductive rights, and participate in sustainable development, humanitarian action and peace- building

Output 2: Young people, in particular adolescents are empowered with knowledge, skills and capabilities to make informed choices about their sexual and reproductive health and rights, and well-being.

The key strategies and interventions listed below contribute towards achieving UNFPA’s transformative goals of zero unmet needs, zero preventable maternal mortality and zero GBV and other harmful practices.

The sources of information for the findings in this section are mainly from the document review, stakeholder interviews and focus group discussions as listed in Annex Part 2 E and other sources are specified in the footnote.

Summary of findings

Due to lack of recent data, it is difficult to comment on the progress towards outcome indicators. Progress has been noted in the case of output indicators.

For building capability of adolescents and youth to make informed choices about SRHR, UNFPA has made significant contributions. These include its contributions towards National Strategic CSE

⁸⁷UNFPA APRO and Australian Aid. UNFPA Asia and the Pacific COVID-19 Humanitarian Response Plan July 2020 - June 2021.Final Report (1 July 2020 - 30 June 2021)

⁸⁸ CO COVID-19 Situation report 2020

framework, its inclusion in the curriculum of schools, introduction of LSE based CSE in monastic institutions and support to Y-PEER expansion and quality of network through DYS/MOE. Among the three, only Y-PEER network has been assessed, which showed positive results. The support for inclusion of CSE in the curriculum and introduction of LSE based CSE is well recognised in country and in the Region. The CP also supported the Scouts' network to strengthen their awareness about SRH and GBV.

For building an enabling environment for adolescents and youth to practice their SRHR rights, high level advocacy through UNFPA Goodwill Ambassador was the most significant intervention. The consultations with LGBTIQ community not only renewed UNFPA's past relationship with the community but also enabled connecting with other vulnerable groups including PWD. The existing relationship with the religious institutions was another enabling activity and through the collaboration with Nuns and Monks awareness creation about SRHR of young people and prevention of GBV was possible.

Capacities of communities for enabling changes in social norms and harmful practices were built through involvement of Multi-Sectoral Task Force (MSTF) and CBSS, collaboration with Nunneries and Monasteries and with Y-PEER and Scouts. Communities were educated about prevention of adolescent pregnancies and GBV and also enabled raising resources from local communities and expand community level partnerships.

During the pandemic, the high level advocacy on women's rights and bodily autonomy, unintended pregnancy, prevention of GBV, and interactive dialogue by UNFPA and others on SRHR and GBV issues had significant impact in creating awareness. Providing support to continue CSE training for teachers through on-line platforms and creation of digital training material for Y-PEER training and its use ensured continuity of the activities. The existing partnerships with youth networks as well as with communities were utilized to create awareness on SRHR issues and prevention of GBV and seeking care in case of emergencies. Support for shelter homes for victims of GBV was a significant contribution. An innovation introduced was the attempt to document successful documentation of experiences of young people during the pandemic.

Finding #9: Indicators related to empowering adolescents and youth with knowledge, skills and capabilities to make informed choices about SRH and well-being have progressed despite the set-back due to COVID pandemic

Annex 6 shows the progress of outcome and output indicators. Recent data on outcome indicators - percentage of women aged 20-24 years who were married before the age of 18 years and adolescent birth rate - is not available. At the time of the development of the CPD, the indicator related to CSE was proportion of institutions and schools implementing CSE; however, with the incorporation of CSE in the curriculum in early 2022 (see Finding 10), the target needs changing to 100 % as schools will be implementing the curriculum (see Annex 6 for details). An evaluation is being planned on the implementation of the integrated curriculum (see Finding 10). With regard to the indicator on implementing evidence-based programmes in districts with high teenage pregnancy, implementation has been initiated in three districts - Thimphu, Punakha and Mongar two more are planned (the target of five should be achieved by the end of the CP). UNFPA supported Census and demographic analysis would have contributed to the development of draft National Youth Policy, National Gender Equality Policy, National Housing Policy, National Policy of Persons with Disabilities and currently a policy paper on ageing (likely that the target of 6 planning documents would be achieved). In addition, the analysis of maternal deaths, SRH data, youth, gender, etc. have been used in several national, sub-national and sectoral planning documents (see also Findings 15,16).

Finding 10: The CP contributed to building the capability /skills of adolescents and youth to make informed choices about SRHR and well-being including vulnerable (includes PWD). Notable achievements are support

for incorporating CSE into school curriculum, incorporation of LSE based CSE in the curriculum of monastic institutions and collaboration with CROB. Another notable achievement is the support to building the Y-PEER network in Bhutan through successive CPs including the current CP and the contribution to the network being recognized nationally and in the Region.

The previous CPs had supported the MOE in introduction of LSE in schools and the introduction of CSE in schools (Pre-primary to 12th Standard) started in the last CP. With UNFPA support, mapping of the subjects and the integration of CSE in the identified subjects had started in 2018 and the subject was taught during non-curricular hours. With the integration of age-appropriate, rights-based, gender-sensitive CSE into school curricular frameworks and the development of instructional guides in late 2021, the subjects with integrated CSE have been aligned and integrated into the respective curricular frameworks and instructional guides of the revised curriculum. UNFPA supported MOE in developing the National Strategic CSE Framework, based on International Technical Guidance on Sexuality Education (ITGSE), by UNESCO, that outlines the strategies and activities that could be implemented at national, district (Dzongkhag), City corporation (Thromde) and school level and development of monitoring framework⁸⁹. Support is also being

“Integration of CSE into mainstream curriculum for me is the UNFPA CO’s biggest achievement towards empowering youth for ASRHR but lot of support will still be required for it to be a success... especially capacity development of teachers for successful implementation and for monitoring and evaluation once it is implemented” (discussion with programme focal at MOE)

provided to three schools based on a well-defined criterion to observe closely the implementation of the revised curriculum framework⁹⁰. The CSE curriculum had been made available for visually impaired and more inputs are being provided to enable the effective use of the materials including instructions for pictures. Such inputs contribute to UNFPA’s goal of ‘leaving no one

behind’ and in support of the 12th Five Year Plan focus. Support is also being provided to train teachers in the revised framework and instructional guides to ensure changes in attitude and improve facilitation skills through the teacher training institutions in the country with Paro College of Education taking the lead. UNFPA has assured that the training has focus on gender equality and empowerment and GBV and has focus on people with diverse sexual orientation, gender identify and sex characteristics. The training covers pre-service and in-service training of teachers. E-modules were developed on CSE to enable teacher trainees to access the materials through an interactive platform. School teachers are aware of the virtual briefing session on CSE framework; however, there is a concern about the school teachers not being aware of the changes in the curriculum as indicated during the field visit to a school. The contributions towards CSE are significant and Bhutan is one of the first countries in the South-Asia Region to incorporate all components of CSE as a curricular activity. The contribution is also recognised by other partners as mentioned under Finding 2. UNFPA’s contributions have paved the way for agencies such as International Planned Parenthood Federation (IPPF)/ RENEW to support the rest of the schools in the country.

Building on its ongoing collaboration with religious institutions as far back as 2011, beginning with the Bhutan Nuns Foundation and subsequent collaboration with monastic institutions since 2014 and in collaboration with CROB, UNFPA supported the introduction of LSE based CSE into the curriculum of monastic schools. LSE is integrated into the monastic



⁸⁹MOE. National strategic framework for comprehensive sexuality education
⁹⁰MOE, UNFPA. Concept note on CSE implementation in pilot schools

“We monks have same physical development and biological needs as any other adolescents of our age.... so, I feel that CSE must be taught to us.... we already have LSE which teaches things like stress management, time management, values, etc”-
(Focus group discussions with monks)

curriculum, incorporating CSE as relevant, from pre-primary to eighth grade of the monastic schools. Three schools are piloting the integrated curriculum⁹¹. Focus group discussions with monks underscored the importance of the inclusion of LSE based CSE (see the quote). The teachers also felt that it is

important to have the topics included in the curriculum of monastic education. The contribution is well recognized by all partners as was mentioned under Finding 2 and also in the Region and globally by UNFPAHQ. The CP supported the development of prevention of sexual harassment guideline in monastic institutions and its implementation through RENEW and in collaboration with CROB. Details are provided under Finding 14.

Through the previous CPs, support was provided to the DYS to establish Y-PEER in 2012 which has played a formative role in the lives of young people on sexual reproductive health and rights (SRHR)⁹². UNFPA Bhutan and APRO's contributions are acknowledged by the Y-PEER network. The Y-PEER Bhutan is recognized as the largest peer-led and decentralized network in the country and in the Asia Pacific Region as a best peer-led network in 2013. The Y-PEER network is across all the colleges under the RUB, FoNPH with a total of over 3000 members working in the broad areas of ASRH. The findings of the impact assessment of the network in 2022 reported on the effectiveness of the programme in developing capacity of young people at the sub-national level in social skills, building confidence and in achieving life skills⁹³. One of the hallmarks of this programme is the decentralized and participatory approach in programme design and planning. The peer educators were found to be very supportive and efficient, further endorsed during the focus group discussions with Y-PEER members. The evaluation team did raise issues related to the reach of the network to vulnerable groups; however, during the pandemic Y-PEER members did reach out as described under Finding 13. UNFPA provided assistance in updating and modifying the Y-PEER network capacity building materials to enable its use on-line and in-person training⁹⁴. The material refers to ICPD POA and highlights young people's SRH issues and rights and human rights and covers CSE, gender equality, GBV, and sexual harassment and other topics on which young people like to have more information. The manual also includes sections to facilitate reaching out to adolescents and youth not in colleges or schools and to vulnerable groups.

To further expand the capacity of young people to exercise their SRHR, support was provided to build the capacity of scout masters and advisors in collaboration with the SCED on SRHR and GBV at appropriate levels of scouts which enabled them to provide support during the pandemic as described under Finding 13. The sessions were found to be very useful as reported during the focus group discussions with teachers⁹⁵.

Finding 11. The CP contributed to creating enabling environment for adolescents and youth to exercise their reproductive rights (RR), including for vulnerable (includes PWD). High-level advocacy through UNFPA Goodwill Ambassador, inclusion of SRHR issues and CSE in the draft Youth Policy, advocating for involvement of young people and the vulnerable in the consultations and also consultations with LGBTIQ and PWDs on SRHR issues, are some of the key achievements.

UNFPA Goodwill Ambassador, the Queen Mother, has been advancing SRHR of women and girls and promoting choices for girls and women in Bhutan for the last two decades. Bhutan's commitment at ICPD @25 includes SRHR of young people as one of its focus areas. UNFPA played a significant advocacy role in the draft Youth Policy as evident from the inclusion of its core areas such as SRHR, CSE, gender equality, GBV and human rights in the policy with focus on vulnerable such as LGBTIQ and PWD⁹⁶. Inclusion of young people in reviewing the policy and providing feedback is believed to be the result of UNFPA's advocacy.

⁹¹UNFPA travel reports and Annex Part 2 E

⁹²DYS. Y-PEER Bhutan network's impact assessment, First impact assessment 2022.

⁹³*ibid*

⁹⁴Y-PEER Bhutan. Y-PEER e-course manual 2021

⁹⁵Annex Part 2 E

⁹⁶RGOB. Draft National Youth Policy

Support was also provided for review of the gender policy which is discussed under Finding 14. The support for Y-PEER network as described under Finding 10 has contributed to creating an enabling environment for young people to exercise their rights and the network's inclusion of vulnerable groups including PWD should enable these groups to exercise their rights.

Another enabling input to ensure inclusiveness and that 'no one is left behind' is the consultation with eight vulnerable groups including the LGBTIQ and PWD to understand their SRHR concerns through support

to RENEW(as also mentioned under Finding 1)⁹⁷. The consultation helped to gather information on SRH needs of the groups, policy and service barriers to accessing services, contribute to policies in national programmes to include SRH needs of vulnerable groups and to promote partnerships and explore modalities for meaningful engagement and peer-led SRH and GBV initiatives among the vulnerable groups. A follow up meeting with specialists in the national referral hospital was held to further explore the type of services that can be provided, following which few activities related to screening were carried out. The above consultation also led to a meeting by RENEW and IPPF to strengthen SRH services for LGBTIQ communities. In addition, the consultation opened doors for future partnerships with LGBTIQ, Red Purse Members (women engaged in high-risk sexual behaviour), Disabled People's Organization and women from low income groups. With UNFPA support, the parents of children with disability were connected with organisations for people with hearing impairment and also with an agency (Draktsho) to create awareness about mental health of children with disability, SRHR needs and GBV (26 participants). Sensitization of 58 women from low-income groups on SRHR issues and GBV prevention was done in collaboration with Department of Road, but no information on the knowledge level is available⁹⁸.

"UNFPA is the only UN agency that had reached out to us, although support had been very minimal...the support whatever minimal we received had benefited sex workers also because they don't come out on their own due to several reasons but they come with our groups of people to attend advocacies, meetings, consultations " (Focus group discussions with LGBTIQ community)

UNFPA has been able to create an enabling environment for advocacy on SRHR and GBV preventions through its sustained collaboration with religious institutions. The Agency has been engaged with religious leaders as far back as 2011, beginning with Bhutan Nuns' Foundation. Over the last decade, more than 1500 Nuns from 26 nunneries have been sensitized on SRHR and GBV prevention. The LSE education of male monks since 2014 has helped to demystify the perception of monks about discussing SRHR issues. 50 monks have been trained by UNFPA in counselling services across the 20 districts of Bhutan. SRHR and GBV messages have been incorporated into the interpretations of the mask dance at the local *tshechu* festivals ('day ten' festivals) in few districts; thus, further improving access to information⁹⁹.

Even prior to the pandemic, the CP supported an innovation through the creation of M-power App which is a digital platform for adolescents to access SRHR information; however, it is not very functional and requires revamping. Another App exclusively on condoms is under development, (as informed by young people who were interviewed) which will again enable young people to access information on correct and consistent use of condoms and access to condoms for prevention of pregnancy and sexually transmitted infections/HIV¹⁰⁰.

Finding 12. The CP contributed to building capacity of communities for enabling changes in social norms and harmful practices. Key achievements include mobilization of community level structures to educate communities about SRHR of young people and about prevention of harmful practices such as child marriages, GBV, etc.

⁹⁷ UNFPA, RENEW. Engagement of vulnerable group for peer led SRHR and GBV prevention initiative

⁹⁸RENEW. Report to UNFPA

⁹⁹Annex Part 2 E and UNFPA news August 2021

¹⁰⁰UNFPA work plan and annual report

Studies were planned for identifying root cause of child marriages, intimate partner violence, etc. However, due to the pandemic no progress was made.

The activities listed below are implemented with UNFPA support through its IPs RENEW¹⁰¹ and through DYS. Communities were mobilized to prevent harmful practices. Three channels were used to mobilize communities as described below: (i) collaboration between MSTF under the district authority and CBSS (created by RENEW) was developed (ii) collaboration with Nunneries and Monasteries for community

“I have been CBSS volunteer for 13 years now and I am a trained GBV victim care manager.... victims prefer to come to seek my support as reporting to law enforcer would make it into a legal case and they don't want a legal case but support and help”. “In my community our team conduct lot of advocacy on GBV, teenage pregnancy, early marriage... the Gup (local leader) in here is supportive of our advocacy activity that we managed to secure annual budget for our activities” (Focus group discussion with CBSS volunteers)

education on SRHR and prevention of GBV (both through RENEW); and (iii) collaboration with Scouts and Y-PEER who also reached out to young people in the community creating awareness about SRHR issues and prevention of GBV (through DYS). Y-PEER also reached out to vulnerable groups such as LGBTQI community as described under the section on Y-PEER under Finding 10.

The collaboration between MSTF and CBSS has strengthened the partnership between district government organization and CSOs to raise voice against GBV. The partnership helped to educate the communities, counsel survivors and report to district authorities and NCWC. To further strengthen the counselling services for adolescent and women survivors of GBV by CBSS case managers in 20 districts, 80 school counsellors were trained in mental health facilitation. The CP programme through incorporation of GBV under its outputs has promoted a multi-sectoral approach to prevention and management of GBV (education, youth and health) and partnerships with CSO (RENEW), and CBSS and monastic institutions. It has used the continuum of care approach that includes advocacy (at various levels), prevention, management (health sector) and data; however, the continuum of approach is not always evident. These partnerships build accountability to end GBV.

The involvement of village level authorities such as *GUPs* helped to raise resources for advocacy to prevent early marriage, GBV, etc. Through officials of the microfinance and non-formal education instructors, awareness and sensitization were carried out on early preventing early marriage and teenage pregnancy in three districts – Punakha, Mongar and Thimphu- with high level adolescent pregnancy¹⁰². 1483 community members (non-formal education learners, students, Monks, Nuns, *Gomchen*, house wives and department of road workers (women from low-income groups) were reached. A recent rapid assessment of the knowledge of the participants of the above training carried out by RENEW showed an increase in knowledge about teenage pregnancy and strategies for prevention of the same¹⁰³. The preliminary results show they have acquired knowledge about teenage pregnancy related issues, how to prevent the same, GBV prevention and contraception. Throughout the CP, efforts were made to mobilize boys and men against harmful practices by Y-PEER and Scouts (boys) and by local leaders and monks (men).

UNFPA supported the DYS to hold a national workshop on teenage pregnancy as it was reported that the number of teenage pregnancies were increasing but access to Medical Termination of Pregnancy (MTP) was limited due to medical and social barriers¹⁰⁴. A wider consultation was supported by UNFPA as described under Finding 14.

Finding 13. Support was provided for continuation of comprehensive LSE and CSE education, and activities and protection from GBV and other harmful practices, ensuring access of vulnerable (including PWD) during COVID-19 pandemic. Key achievements include high level advocacy through the release of UNFPA's State of the World's Population Report in 2021 and 2022, highlighting the issues of gender discrimination, intimate partner violence, unintended pregnancy, etc., support for shelter homes for victims of GBV,

¹⁰¹RENEW report 2021

¹⁰²UNFPA CO. The information on high teenage pregnancy is based on administrative data 2019

¹⁰³RENEW, UNFPA. Rapid assessment of the knowledge of participants of the training on teenage pregnancy and its prevention. 2022

¹⁰⁴UNFPA travel report on the consultation on teenage pregnancy and MTP 2021

extensive community mobilization, beyond the usual constituents such as involvement of national volunteers (DeSuung), for creating awareness about GBV prevention and creating awareness among LGBTI, Red Purse members, taxi associations, etc..

High level advocacy by UNFPA's Goodwill Ambassador about women's right to autonomy and self-determination through the release of the 2021 State of the World's Population Report on 'My body is my own- Claiming the Right to Autonomy and Self-determination' provided the opportunity to promote gender equality, awareness about GBV prevention, etc. To create awareness about bodily autonomy and the right to make choices without coercion or violence, UNFPA had organised a dialogue with young people on bodily autonomy and the right to make choices without coercion with students of Royal Thimphu College and organized essay competitions on the theme. Similarly, the launch of the 2022 State of World Population Report on 'Seeing the Unseen: The case for action in the neglected crisis of unintended pregnancy' by the Health Minister in presence of members of Parliament, officials from government and CSOs provided an opportunity to create awareness about the causes and consequences of unintended pregnancy especially among adolescent girls and to advocate for preventive action.

Continuation of CSE training of teachers continued through digital platforms created in Paro College of Education and activities have been planned to institutionalize virtual learning platform for CSE in additional four colleges of Samtse, Taktse, Gedu and CNR in Punakha under Royal University of Bhutan, by end of 2022. During interactions with students in schools visited by the team, it was reported that the students were continuously sensitized about prevention of pregnancy, safe sex and condom use and LSE components such as time management and dealing with stress before school closure and during lockdown, through virtual mode. The training materials for COVID-19 prevention included prevention of GBV with focus on men and boys for conveying the messages in their communities. LSE based CSE in monastic institutions also continued. As listed under Finding10, Y PEER had developed a e-learning module for training of its members.

As seen from the previous findings, UNFPA has invested in creating awareness about GBV and its prevention through its various partnerships with MOH, MOE (and DYS), CROB and RENEW. During the pandemic, UNFPA expanded its network for GBV prevention and care by incorporating GBV prevention and care information into the COVID prevention activities of all agencies it partnered with. Notably, a GBV prevention package was integrated into the accelerated *DeSuung* (Guardian of peace- national volunteer scheme). 2950 trainees (2350 male and 600 female trainees) from the 39th batch were trained. The training package has been integrated into the national *DeSuung* training programme. 30 tourist guides and 34 community volunteers comprising of local leaders, advocates, teachers, shelter home counsellors (see below), house wives and mental health counsellors were trained on GBV and SRHR issues.

Support was provided for six emergency shelter homes through RENEW (funded by DFAT equity fund) including standardization of procurement items, development of operational guidelines and training modules for shelter managers and volunteers. The homes serve as shelter home for survivors of GBV and was handed over to the district authorities (*Dzongdas*) who are the chair of the MSTF that is responsible for legal aspects of management of GBV. The above support helped survivors of GBV to avail shelter, psycho-social and medical services during lockdown. Support was also provided to manage cases of GBV through tele-counselling and few women and children were referred to emergency shelter homes. A multisectoral plan was developed for prevention of GBV which included door-door to advocacy and tele-counselling, dissemination of posters and animated films on GBV and SRHR issues through national television and social media platforms.

Another innovation was the documentation of the meaningful engagement of youth on SRHR issues and GBV prevention during the pandemic, called "Connecting youth and connecting stories" through an on-line competition for sharing young people's experiences on SRHR and GBV¹⁰⁵—The booklet was distributed to colleges, youth organizations and decision makers to enable youth involvement in future emergency

¹⁰⁵ UN Bhutan. UN Bhutan COVID-19 Sitrep June 2021

situations. The orientation programme for graduate students of Paro College of Education (246) and FONPH (78) on COVID-19 prevention incorporated SRHR issues and GBV.

Integration of gender and human rights

EQ 4: To what extent has UNFPA support to the outcome areas strengthened the policy and legal frameworks and strategies to advance gender equality and reproductive rights both in development and humanitarian contexts?

As stated in the beginning of the effectiveness section, there is no separate output on gender. Gender is well integrated into the two outputs as reflected in the modified TOC (Annex Part 2 A).

The sources of information for the findings in this section are mainly from the document review, stakeholder interviews and focus group discussions as listed in Annex Part 2 E and other sources are specified in the footnote.

Summary of findings

Gender and human rights are well integrated into CP as described under the preceding findings. A significant contribution has been the support in development of Prevention of Sexual Exploitation, Abuse and Harassment (PSEAH) policies in academic institutions which is being advocated as a national policy by higher level authorities and institutions. Other contributions include contribution to gender policies, inclusion of gender in youth policies and other strategies. Strengthening awareness about GBV, its prevention and care seeking has been described in the preceding sections and has contributed to establishing a continuum of care across multiple sectors and constituencies. The partnerships established through RENEW and youth networks contribute to building accountability to end GBV. During the COVID pandemic, as described under findings related to the outputs, several of the activities focused on gender equality. The COVID-19 interim guidelines for maintaining RMNCAH services has focus on gender.

Finding 14. Policy and programme support under both outcome areas have integrated GEEW and HRBA approaches, supported by evidence, to advance GEEW and RR especially for adolescent girls and young women who are vulnerable including PWD, both in the developmental and humanitarian contexts. Though there is no separate output on gender, it has been mainstreamed well into the CP outcomes. Besides incorporation of gender-responsive and rights-based approaches in delivery of SRH policies, strategies and services and integration of gender in CSE, LSE, Y-PEER and Scouts education and training, a significant contribution has been the support in development of gender equality policy and its revision and development of PSEAH Policy in educational institutions including monastic institutions.

The CP development was informed by gender analysis and Bhutan's commitment to international normative frameworks as part of CCA to which UNFPA was a major contributor as co-chair of the gender thematic group (Finding 2). In addition to the stakeholder consultation as part of CP development that included vulnerable groups including PWD, the CO had done consultations with key stakeholders such as the NCWC, RENEW, women particularly victims of GBV, etc. The CP also drew on lessons learned from its support to GEEW in the past CPs. The preceding sections on the two outcome areas have provided evidence of mainstreaming gender-responsive and rights-based approaches in its support to policies, strategies and services and training in the health sector as well as in the education sector, particularly under the national framework for CSE. The draft National Youth Policy that has a focus on gender equality and human rights. Building on its past support to building policy frameworks on GEEW and specifically legal framework related to GBV, support was provided to develop the National Gender Equality Policy 2020 and the National Action Plan for Gender Equality 2019-23 and its monitoring framework. UNFPA continued to play an active role in the revision of the Policy to include issues of LGBTIQ community, vulnerable women and women with disability. GEEW is a National Key Result Area; hence CP contributions to GEEW also contribute to national

results¹⁰⁶. As described under Findings 8 and 13, the focus on GEEW and rights continued during the pandemic. The interim guidelines for maintaining SRHR services has a section on gender considerations during the pandemic and delivery of services. No specific policies on GEEW and reproductive rights during humanitarian crisis are available; however, the National Gender Equality Policy specifically mentions mainstreaming gender in disaster responses¹⁰⁷.

As mentioned under Finding 12, UNFPA had facilitated a consultation on teenage pregnancy in collaboration with DYS. One of the objectives was to review the indications for MTP with a focus on teenage pregnancy and identify barriers (medical and social) that prevent even those who are covered by the legal provisions to access the services. The consultation also aimed at identifying strategies to overcome the barriers to access to MTP within the legal limits (this is one of the policy provisions under the social domain of the Penal Code of Bhutan 2004). Subsequently a wider consultation was organised by UNFPA with the national referral hospital (in collaboration with UNICEF, UNDP and WHO) to review the additional indications for MTP as listed in the ‘Standard Guideline for the Health Workers on the Management of Complications of Abortion’ and explore strategies for providing safe and accessible MTP services within the legal limits¹⁰⁸. The contributions to discuss issues related to MTP (a sensitive topic) is an indication of promoting rights of women and adolescents.

A major contribution, well recognised by policy makers and other stakeholders and UN partners is its contribution to creating awareness about sexual exploitation, abuse and harassment in institutions including in monastic institutions and the unwavering support towards creation of a policy to prevent the same to various academic institutions culminating in a PSEAH Policy of the Royal University of Bhutan. The Agency’s support and advocacy has promoted interest among higher levels of policy making such as the Minister of Health. The Minister of Health has advocated for a national level PSEAH policy and currently is being developed by the Pema Secretariat (chaired by Her Majesty Gyalsuen). Through its support to RENEW and in collaboration with CROB, support has been provided to develop a policy on PSEAH in monastic institutions (which is considered a bold move).

UNFPA’s contribution to health sector in responding to GBV particularly IPV and SV is described under Finding 7 and contributions to creating awareness and building capacity of community organizations, young people and other vulnerable groups to prevent and to take action in cases of GBV is also described under Finding 12 and during the pandemic under Findings 8 and 13. The CP did promote multi-sectoral approaches to prevention and services for survivors of GBV as was described in earlier sections

Integration of population and development

EQ 5: TO what extent has UNFPA successfully integrated population and development issues as relevant into each of the outcome areas to provide evidence for advocacy and policy?

As stated earlier in this section, there is no separate output on population and development and is integrated into the two outputs as also reflected in the modified TOC (Annex Part 2 A).

The sources of information for the findings in this section are mainly from the document review, stakeholder interviews and focus group discussions as listed in Annex Part 2 E and other sources are specified in the footnote.

Summary of findings

Most of the planned results were achieved in secondary data analysis, strengthening administrative and data literacy capacity. Notable achievements include strengthening the administrative data system through the on-going support to the BSDS (building the foundation for the national statistical database system), capacity building of district officials for data literacy for planning and decision making and

¹⁰⁶RGOB. 12th Five Year Plan 2018-23

¹⁰⁷NCWC. National gender equality policy 2020

¹⁰⁸UNFPA. UNFPA travel report on the consultation on teenage pregnancy and MTP 2021

improving NSB's capacity to undertake quality secondary analysis of Population and Housing Census data. Several of the publications from various analysis of data from Census and other demographic analysis have contributed to policies and strategies.

Lack of access to recent data for many of the National Key Result Areas, SDGs and ICPD indicators and also access to disaggregated information continue and are major gaps.

Finding 15. Building on its contributions over the past CPs to strengthening data systems, UNFPA contributed to strengthening capacity for evidence-based policy and advocacy to some extent, through capacity building of national and sub-national officials to analyse and interpret data. A significant contribution has been the support for BSDS. Some of the evidence generated through analysis of various thematic areas has been utilized for policy purposes including the development of the draft youth policy.

UNFPA had contributed to building the capacity of national and sub-national officials to analyse and interpret data for planning and monitoring SDGs through support to NSB. NSB conducted three regional workshops on data literacy for around 100 participants, who were mostly the sector heads from all 20 districts (programme, education, administration). The workshops covered interactive sessions on demography, health, unemployment, education, poverty, GDP and housing. Post-course tests showed that at least 92 percent of the participants found the workshop useful and relevant for planning process and decision-making. The participants recommended more of such workshops with additional participants from each sector and for longer duration and also training of higher officials¹⁰⁹. The data literacy workshops also helped in understanding and appreciating the role of the District Statistical Officers.

A significant support to NSB has been provided for building national statistical data base – BSDS and its roll out to 10 districts, building on the support for development of Gewog data under the last CP. It is significant that the RGOB recognised the potential of the support for strengthening Gewog system and plans to expand its scope to a national level statistical database¹¹⁰. NSB has also developed a user guide on the BSDS which is an indirect outcome of the support. The interface with the software of different sectors is underway. One of the concerns expressed by the district level statistical officers is the need to review the basic systems of different sectors and the role of the data coordinator at the Gewog level. The BSDS has the potential to improve data quality and replace some of the expensive surveys. UNFPA's support to BSDS was also recognized by other UN Partners.

The plans to support institutions and researchers to generate evidence on UNFPA priority areas and emerging issues at national and sub-national levels as well as analytical reports on root causes of child marriages, IPV, etc. could not be implemented, probably due to the pandemic. However, support to independent researchers/consultants has generated reports such as the young people's dynamics in Bhutan (contributed to draft Youth Policy), youth development index (specifically developed for the draft Youth Policy), low fertility and ageing (the latter two are not available in public domain). As mentioned under Finding 2, a report on ageing population based on the Census data is being supported which should contribute to the policy for senior citizens. As a part of the APRO publication on SRHR inequities in Asia and the Pacific, the Bhutan Report mapped inequities by geographic areas as well as by other social and economic parameters¹¹¹. There has been no support for active monitoring of HRBA and gender transformative programmatic approaches.

Finding 16. UNFPA support has contributed to a certain extent on sustained availability of data for monitoring SDGs and ICPD and disaggregated data with focus on UNFPA mandated areas.

¹⁰⁹Data literacy workshop feedback summary; key informant surveys at national and district level and FGDs with district statistical officers

¹¹⁰ Discussions with NSB officials

¹¹¹Burnet institute. Who is being left behind. A quantitative analysis of sexual and reproductive health and rights inequities in the Asia and the Pacific (Bhutan report), March 2020

Although some activities related to big data systems and capacity building to analyse data could not be carried out because of the financial constraints¹¹², most planned results were achieved especially Census-based publications, data literacy capacity and provision of technical assistance to analyse fertility and FP trends¹¹³. Utilizing the richness of the 2017 Population and Housing Census data, two in-depth and theme-specific analytical reports on rural-urban migration and urbanization, and harnessing Bhutan's demographic dividend were generated by NSB with support from UNFPA and disseminated. Support was also provided for national level and district level population projections. The support has strengthened the capacity of the implementing agency NSB as evident from the improved analysis, both in terms of quantity and quality as compared to that of the analysis of the 2005 Census. These publications have contributed towards evidence-based development and implementation of plans, programmes and policies for a myriad of stakeholders, particularly the RGoB, development partners, CSOs and research community of the country¹¹⁴. As also mentioned under Finding 9, it is difficult to pin point which policies and strategies have been influenced by the support for analysis and publications. Certainly, some policies/strategies could have used the data such as draft National Youth Policy, National Gender Equality Policy 2019, National Housing Policy 2020 and National Policy for Persons with Disabilities 2019 could have been influenced by these reports¹¹⁵. As listed under Finding 9 and Annex 6, data generated from Census have contributed to the development of national and sub-national and sectoral planning documents such as health, education, district plans, etc. The current support for developing a report on ageing and planned support for a study on total fertility rates should contribute to policy development. In addition to the support listed above, UNFPA strategically uses information from national surveys to identify areas of support to RGOB (for example, use of vulnerability assessment survey to identify vulnerable groups that can be supported under the CP).

A major gap observed in the 12th Five Year Plan, CCA, Voluntary National Review Report for the UN¹¹⁶ and under country context (Chapter 2) is related to the lack of access to recent data for National Key Result Areas, SDGs, ICPD indicators as well as for monitoring of progress of output indicators. Data for some critical indicators including contraceptive prevalence rate, unmet need for family planning, demand satisfied for modern methods and child marriage have not been collected since 2010¹¹⁷ and hopefully the 2023 health survey will provide some of the recent information. Where data is available, availability of disaggregated information is a gap. Availability of disaggregated data at sub-national levels would greatly help in local level planning and interventions as expressed by district officials. The comparison of data collected through various methodologies is a concern. The initiatives such as the BSDS and the capacity building described under Finding 15, will certainly contribute to sustained availability of data that is complete, of quality and timely and enable disaggregation of data¹¹⁸. In order to have a legal authority to implement statistical plans and programmes effectively, a legislation on statistics was proposed by the NSB but the RGOB decided not to pass the bill¹¹⁹.

UNFPA has provided support to the development of UNINFO and DEWA dashboard on SDG data. However, the major challenge is lack of data for regular updates¹²⁰.

4.3.a Facilitating and hindering factors in achieving the expected results

The factors listed below are identified based on the findings and literature review supplemented by personal knowledge about past CPs.

- UNFPA's high level advocacy as explained under the findings under coherence and effectiveness and the support to its core mandate areas such as family planning by Chief Abbot and Royal Family has

¹¹²Key stakeholder interviews at national level

¹¹³ Document review of the thematic reports; UNPFA Annual Reports

¹¹⁴References in policy documents and discussions with various stakeholders

¹¹⁵Discussions with CO staff, NSB and other stakeholders and reference documents

¹¹⁶GNHC. Bhutan's second voluntary national review report for the United Nations High-Level Political Forum 2021.

¹¹⁷ Document review of the survey reports; UNPFA Planning and Tracking tool

¹¹⁸ 12th FYP, Second voluntary national review report (footnote 112), Annex Part 2 E)

¹¹⁹Annex Part 2 E- key informant interview

¹²⁰ Key informant interviews at national level

certainly been a major facilitating factor. UNFPA's long partnership with RGOB since 1970, the country's commitment to ICPD POA since 1994 and its most recent commitment at ICPD@25 is another facilitating factor. The Agency's long standing partnership with MOH, MOE and NSB and its support to reproductive health policies, strategies and services and other national priority areas has resulted in significant achievements in reducing fertility and maternal mortality, its support to MOE starting with Population Education to CSE today and building the capacity of NSB have helped to establish the credibility of UNFPA as an important partner. Despite the decreased funding and mode of engagement, it has maintained its good standing with the RGOB.

- So far there were no major hindering factors, but the changes in the UNFPA classification of Bhutan and its mode of engagement could jeopardize some of the achievements so far. As elsewhere in the world, there were setbacks due to the pandemic, but the RGOB had efficiently managed the continuation of services. While Bhutan has achieved or on track to achieve the SDGs and ICPD indicators, the country still needs capacity building and technical assistance in quality and effective delivery of SRH services and realization of rights. The proposed changes in the Ministries and priority areas and expected mode of support by UN agencies and other developmental partners to RGOB may seriously affect the implementation of some of the interventions such as building capacity of teachers to deliver quality CSE, health sector response to GBV, etc. Lack of enough evidence for continuing /investing in some of the policies such as family planning, etc. could be a hindering factor.

4.3.b Unintended effects

- The focus on prevention of teenage pregnancy, led to consultations on MTP and advocacy to broaden the scope of the guidance.
- The wider consultations on prevention of GBV led to surfacing some of the hitherto hidden issues such as sexual exploitation, abuse and harassment that led to the development of PSEAH policies in academic and monastic institutions as well as at the national level.
- The pandemic opened up possibilities for wider use of digital health that could be very useful in knowledge sharing, monitoring, etc.; however, these interventions need to be evaluated as discussed under Chapter 6 on recommendations. The on-line faculty development course for midwifery tutors is another example where the digital platform provided opportunity for more trainers to be trained at the same time.
- The pandemic also widened the scope of partnership with non-governmental agencies and vulnerable groups' organizations.

4.4 Answers to evaluation questions on efficiency

Efficiency is the extent to which CP outputs and outcomes have been achieved with the appropriate amount of resources and captures how resources such as funds, expertise, time and administrative costs, etc., have been used by the CO and converted into the results along the results chain.

The efficiency questions listed below are applicable to both the outputs.

EQ. 6: To what extent has UNFPA made good use of its human, financial and administrative resources, and used a set of appropriate policies, procedures and tools to pursue the achievement of the outcomes defined in the county programme?

EQ. 7: To what extent did UNFPA systems, processes and procedures (particularly in terms of finance, partnerships, logistics, procurement and human resources) foster or, on the contrary, impede the adaptation of the country programme to changes triggered by the COVID-19 crisis?

The sources of information for the findings in this section are mainly from the document review, stakeholder interviews and focus group discussions as listed in Annex Part 2 E and other sources are specified in the footnote.

Summary of findings

CO has been able to manage the programme well and has achieved most of the planned results despite limited financial and human resources. Due to limited staffing, the programme staff are responsible for multiple tasks (beyond the core area of responsibility) and has efficiently carried its engagement under the revised classification of the country. The technical support provided by the CO directly through its advisors or through consultants is appreciated by RGOB. The CO has a robust system of resource management. The IPs have generally received the resources in a timely manner. A resource mobilization strategy exists and the CO has been able to raise resources for cervical cancer elimination.

CP programme strategies and work plans including integration of thematic areas and resources is satisfactory and as evident is gender responsive and uses HRBA. There is evidence of progress, despite the pandemic and is most likely to achieve the intended results.

The CO has a partnership strategy and has made use of its partnerships as was evident from the preceding sections. No South-South and triangular cooperation (SSTC) has been developed as yet, but there are potential opportunities with regard to CSE, LSE based CSE in monastic institutions and other areas.

UNFPA supported the government during the COVID-19 pandemic by reallocating its budget and securing funds from external sources on its own and through APRO (latter for shelter homes for survivors of violence). The CO has enhanced and introduced new digital health interventions. Following the principle of 'leaving no one behind', the CO also ensured that vulnerable populations were reached.

The delivery of services through digital health interventions has the potential to be continued specially to reach the remote and difficult to access areas and also contribute to the current thinking of the RGOB to enhance the use of digital technologies.

Finding 17. CP had sufficient financial and adequate human resources with relevant and adequate technical expertise to implement interventions to achieve planned results under both the outputs in develop and humanitarian contexts.

At the time of the CP evaluation, based on the realignment process that was completed in December 2021. The CO has a new position- Head of Office- which was filled in early 2022 (at a higher level than the previous post of Assistant Representative). For the rest of the staff, the recruitment has not started, but is expected to start soon. The undue delay in recruitment does affect the morale of the staff; however, the staff members are committed to carrying out the tasks assigned to them. The programme officers have additional responsibilities in addition to their core area of responsibility as described in the TOR. The post of adolescent and youth and gender is combined with distinct responsibilities for both the thematic areas. M&E is looked after by the SRHR programme officer. With regard to responsibilities with IPs, the core responsibility of programme officer is related to thematic activities; however, the programme officer does support the IP in other activities such as coordinating with other Ministries or Divisions on issues that require collaboration, as needed, thus improving the efficiency. The CO is reportedly in the process of recruiting a data person who will be responsible for population and development and humanitarian aspects. The post of the finance assistant is filled (the delay in recruitment had affected the timeliness of disbursements for a short while which was overcome by the programme officers handling the activity, adding to the burden of the existing staff). Overall, the staffing structure and the job descriptions largely meet the CP7 programme needs and is operated efficiently with optimal combination of skills of staffing. It is expected that the efficiency of the office will further improve with the above recruitments.

The overall budget allocation for CP7 was around USD 3 million with budget for SRHR at USD 1.2 million, Adolescents and youth at USD 1.5 million and the remaining USD 0.3 million for coordination and assistance. The budget for PD was subsumed under SRHR and the gender under Adolescents and youth. The budget allocation matches with the CP's focus on adolescents and young people. The budget utilization at the time of evaluation was nearly 100 percent indicating impressive utilization of the budget (see Chapter 3). The CO has efficiently delivered the programme adhering to the mode of engagement as per country classification under the business plan of UNFPA- focus on advocacy and policy dialogue, capacity development of institutions and coordination and partnership. The potential for hosting SSTC exists with

regard to CSE and LSE based CSE in monastic institutions. More needs to be done with regard to knowledge management and the reason could be the setback due to the pandemic; however, the attempt to document experiences of young people during the pandemic is in the right direction. The resource management system is robust. The IPs have received resources on time except for some delays before the finance assistant's recruitment and during the pandemic. In terms of accountability, CO has its own set of compliance mechanisms including annual reports and financial reports. In addition, the IPs are mandated to submit reports on all the UNFPA supported interventions. Further, there is a mechanism to monitor progress of activities towards output indicators through the indicator tracking tool.

A resource mobilization strategy 2019-23 is in place that covers international donors, private sector, co-financing with the RGOB and UN joint initiatives. As indicated under Finding 2, though UNFPA was part of UN joint proposals on data and GBV, but no funding was received. The CO had managed to raise an additional USD 50,000 from an individual donor and another US D 150, 000 in 2021 from a private sector pharmaceutical company (Chughai pharmaceuticals) for three years for cervical cancer elimination. Specific resources raised during the pandemic is described under Finding 21.

UNFPA's technical support, directly by programme staff, is appreciated by MOH and MOE and also the CO's ability to use internal and external expertise and the reports, strategies and training methodologies from such consultancies is appreciated by the Government counterparts. Few examples (not the full list) of technical contributions by internal experts on AFHS, thematic report on young people, near miss reports and other assessments and by external experts on cervical cancer strategy, LDHF training, etc.

Finding 18. CP 7 demonstrated accountability to achieve the outcome including selection of staff with right skills to achieve the planned results (both in development and humanitarian setting)

Accountability was demonstrated through periodic reporting to the government and donors (as needed)¹²¹. The CO has strictly adhered to reporting compliances as evident from the annual reports and financial reports. Inbuilt mechanisms such as indicator tracking tool has been created towards monitoring progress of activities towards output indicators. The CO regularly reports to the steering committee of CP as required. The rigorous process of realignment and selection of staff to ensure that the skill sets match the requirement of the CP is described under Finding 17¹²².

Finding 19. The CP programme strategies and work plans including integration of thematic areas and resources, as relevant has contributed to achieving the results, gender responsiveness and HRBA and results-based monitoring mechanisms to monitor progress towards results.

In general, the strategies and work plans are aligned to achieve the RRF indicators. The CP has developed indicators aligned to global indicators, as applicable to Bhutan. The indicators under Output 1 does not capture some of the excellent inputs provided under the CP. The CP has made efforts to integrate work plans across the thematic areas, integrating GEEW and HRBA with focus on needs of vulnerable groups including PWD¹²³. There was also evidence of joint participation of programme officers in consultations that are relevant to the outcome areas. It appears that the current monitoring mechanisms do not capture the aspects of integration of GEEW and HRBA.

Finding 20. UNFPA made good use of its partnerships (CSOs, UN partners) to pursue the achievement of the results

The CO has a partnership strategy including on the selection criteria for partners¹²⁴. The CO has four main IPs- MOH, MOE, NSB and RENEW. It had to discontinue partnerships with the organizations of some of the

¹²¹Interviews with GNHC, MOH, MOE, NSB, UNFPA senior staff

¹²²Interviews of UNFPA senior management

¹²³AWPs, annual reports, reports of field visits of programme staff

¹²⁴UNFPABhutan. Partnership plan 7th CP 2019-23

vulnerable groups such as the LGBTIQ community and Lhaksam, due to the reasons explained under Finding 1¹²⁵ and due to the institutional policy of limiting the number of IPs. However, the main IPs have used organizations with special skills/ reach to vulnerable communities to carry out the interventions planned (Finding 11).

CO partnered with other UN agencies on selected thematic areas such as SRHR and ASRH (as discussed under Finding 2 on Coherence and referred to in the Effectiveness sections).

As stated under Finding 17, under the CP, no SSTC has been developed but there are potential areas where the CO could host SSTC partnerships for programmes such as CSE, LSE CSE in monastic institutions, cervical cancer screening, etc. Bhutan has benefitted from some of the APRO partnerships such as with Burnet Institute in midwifery faculty development course.

Finding 21. UNFPA has flexibility to adapt the level and allocation of its resources to respond to Government priorities not identified at the time of the design phase and to respond to epidemics such as COVID-19 and other humanitarian situations through changes in delivery of interventions

The redesigning of programmes to respond to the COVID-19 pandemic and to continue the RMNCAH services as well as CSE, LSE and youth network activities is described under Findings 8 and 13, the CO has reallocated the budget to support to COVID-19 responses, specifically focusing on interventions that help to achieve the transformative goals of zero unmet needs for family planning, zero preventable maternal deaths and zero GBV and other harmful practices during the pandemic. The table below shows the allocations for responding to COVID-19 in 2020 and 2021.

Table 10: Reallocation of budget in response to COVID-19

Budget code	2020 (USD)	2021 (USD)
BTN07MOH	3,38,935.24	55109.5
BTN07REN	93,805.22	17000.00
	4,32,740.46	72,109.50

Source: UNFPA CO financial reports

The CO was able to secure an additional USD 100,000 in 2020 to procure PPE kits¹²⁶. The CO also secured USD 23,000 from DFAT for building shelter homes¹²⁷.

Finding 22. UNFPA has been able to sustain delivery of services, capacity building and learning efforts through innovative technologies such as digital platforms during the pandemic including for vulnerable including PWD

Digital health interventions have been effectively used by CO during the pandemic, as evident from the effectiveness section under Findings 8 and 13. During the pandemic, online consultation on RMNCH services was enhanced. Through the CO, midwifery faculty were oriented on safe delivery app and the app was used by all 20 district EmONC focal points¹²⁸. In addition, the CO supported online capacity development of course on midwifery faculty development for 80% of the midwifery tutors which resulted in institutionalization of competency-based midwifery training curriculum¹²⁹. The teleconsultation support by volunteers in districts helped in many cases of GBV while the community-based volunteers across districts and four major towns imparted training on IPV during lockdown. Various other initiatives such as the webinars, high-level advocacy (on national and local TV and radio), social-media platforms to seek advice and to share experiences were also initiated¹³⁰. Y-PEER training materials were developed for use on-line.

¹²⁵Annex Part 2 E

¹²⁶UNFPA Bhutan COVID-19 Situation report #6

¹²⁷UNFPA Bhutan Annual Report 2020

¹²⁸CO COVID-19 Situation report #3

¹²⁹ CO 2021 Annual Report

¹³⁰ CO COVID-19 Situation report #3

The support provided for strengthening digital health services is very valid in the context of the current structural changes being implemented by the RGOB where digital technologies are likely to play a significant role.

Use of accelerators¹³¹ to enhance performance of the CP

The six accelerators identified in the Business model of UNFPA Strategic Plan 2022-25 (see Chapter 3) enhance the performance in implementing a mode of engagement and scaling up or speeding up the progress towards the strategic plan results. As evident from the answers to effectiveness questions, particularly EQ 4, the CO has used rights-based and gender transformative approaches in its policy and strategy support, capacity building and development of training and IEC materials. Its support to various strategies for prevention and management of GBV, CSE, etc. is a significant effort towards gender transformation. The CO reaching out to vulnerable communities including PWD, especially during the pandemic to facilitate access to services in line with the principle of leaving no-one behind. UNFPA has effectively used its partnerships notable are the partnerships with monastic institutions, RENEW, Y-PEER, Scouts, academia, etc. to expand the access to information and services. The efficient and effective use of digital platforms was described under Finding 22. The CP could do better in raising resources and in SSTC and data for evidence and advocacy.

4.5 Answers to evaluation question on sustainability

The sustainability is related to the likelihood that benefits from the CP continue after UNFPA funding is terminated and the corresponding interventions are no longer supported by UNFPA. The criterion will assess the overall resilience of benefits to risks that could affect their continuation. The sustainability questions listed below are applicable to both the outputs.

EQ 8: To what extent has UNFPA been able to support implementing partners and rights-holders (notably, women, adolescents and youth) in developing capacities and establishing mechanisms to ensure the durability of effects?

EQ 9: To what extent have UNFPA COVID19 response and recovery efforts contributed to strengthening national capacities and systems in the field of SRHR, GBV prevention and data?

The sources of information for the findings in this section are mainly from the document review, stakeholder interviews and focus group discussions as listed in Annex Part 2 E and other sources are specified in the footnote.

Summary of findings

The ownership of the interventions supported by UNFPA by various Ministries is evident from the preceding sections and the findings listed below. The Flagship programme for cervical cancer elimination, capacity building in midwifery and institutionalization of quality of care and rights-based approaches to delivery of SRH services are examples. A service area that had proven to be sustainable is family planning services; however, there are serious concerns whether the same level of RGOB support will continue as explained elsewhere in this section. The integration of CSE into curriculum and inclusion of LSE based CSE in monastic institutions are other examples of interventions that are sustainable but need support for some more time. It appears that the support for Y-PEER has enabled its graduation as an independent network. The support for prevention of GBV and its management at various levels of health services and social services has helped to integrate the issue into public service delivery system. However, there are concerns whether the CSE and GBV would receive the same attention due to the impending changes in the RGOB policies and strategies.

¹³¹ UNFPA. UNFPA strategic plan, 2022-2025, Annex 3: Business model, July 2021

The support BSDS is sustainable as the GNH and other agencies recognize its value. Capacity building of statistical officers in use of data for planning is sustainable.

The varied support during COVID-19 pandemic to ensure continuation of RMNCAH services as well as support for continuation of CSE and other educational activities have contributed to strengthening the health system and educational system including introduction of digital platforms and innovations. Many of the lessons learned during the pandemic should be useful in dealing with future pandemics. The community mobilizations especially through MSTF and CBSS, youth networks, Nuns and Monks should be sustainable.

Finding 23. Capacities of implementing partners and beneficiaries have been developed as a result of programme interventions, enhancing durability of efforts both during development and humanitarian contexts

The evaluation team found a widespread ownership of UNFPA supported SRHR interventions, both among government and non-government IPs, increasing the chances of sustainability of the interventions. One of the reasons is support to MOH priority areas and sustained support over several CPs. A classic example is the support to cervical cancer screening under the national priority of cervical cancer elimination. The support for improving the quality of services through systematic assessments and introduction of tools to improve the quality of services is another sustainable support (examples are support for monitoring the availability of EmONC services and for near-miss death approach). Support to the family planning programme of MOH since UNFPA's partnership began in the seventies, has certainly led to rights-based approaches to family planning services (informed choice) and ownership of the programme; however, there are concerns about continuation of the extent of RGOB support in the context of having reached replacement fertility levels. The support for institutional capacity building of both in-service and pre-service health workforce, including faculty of midwifery, through curricular changes and introduction of competency-based training methodologies is another sustainable intervention.

Support to LSE and CSE culminating in the inclusion of CSE as a curricular activity should ensure the sustainability of the intervention; however, there are concerns about the quality of its implementation due to the recent structural and policy changes by the RGOB. With the high level advocacy through UNFPA's Goodwill Ambassador, the above risks may be minimized. The institutionalisation of LSE based CSE in monastic institutions appears to be sustainable as the key stakeholders consider it as a much-needed activity. The support for Y-PEER appears to have contributed to its sustainability. The health sector capacity building for GBV is an integral part of the RMNCAH services but for it to be sustainable, needs to be well integrated into the maternal health, FP and ASRH services and not as a stand-alone topic.

The creation of awareness, capacity building and mobilization of the communities through MSTF and CBSS against GBV, teenage pregnancies, etc have led to community ownership (as evident from the support from local resource) and adds to the potential of being sustained. The community based organizations including religious organizations and youth networks can create demand for health services for victims of GBV, demand changes in laws, etc.¹³² With the high level advocacy through UNFPA's Goodwill Ambassador, the above risks may be minimized.

The support to BSDS is sustainable as GNH commission has expressed in its expansion – scope and geographical coverage. Similarly, the capacity building initiatives for statistical officers in use of data for planning is sustainable, but needs continued support for ensuring optimal numbers with skills in use of data.

¹³²DYS. Y-PEER Bhutan network's impact assessment, First impact assessment 2022 and Part

During stakeholder interviews, in response to the query about capacities to continue activities after UNFPA support is withdrawn, many of the stakeholders felt the need for continued support for some of the new initiatives such as CSE, GBV, activities for vulnerable populations, etc.

Finding 24. UNFPA's support during COVID-19 has contributed to strengthening national capacities and systems in the field of SRHR, ASRH and GBV prevention and protection activities

The response and recovery efforts of UNFPA during the pandemic have led to strengthening of national capacities and systems for SRHR and GBV prevention as described below. The capacity building of health service providers during the pandemic (Finding 8), not only ensured minimal disruption of services, but also strengthened the system to provide services in areas of SRHR, ASRH and GBV response. The principles of infection prevention and risk communication training supported by UNFPA for both health workers and non-health frontline workers should have provided them with additional skills to respond to future pandemics. Similarly, the awareness about SRHR issues and GBV prevention were heightened during the pandemic with advocacies through different types of media channels which has the potential to be sustained. The YPEER and CBSS networks' capacities were strengthened to effectively partner with the Government during the pandemic which should be useful in future emergencies. Hopefully, the lessons learned will be documented and used in future emergencies.

4.6 Good practices and lessons learned

Advocacy

- High level advocacy is important to open dialogue on sensitive topics such as GBV, SRHR issues especially of vulnerable groups, etc.
- Using religious festivals as a platform to create awareness about SRHR issues and GBV (use of mask dance) increases the acceptance of the messages and reaches a wider audience.

Programme implementation

- Provision of evidence is critical for identifying needs and changes in policies/strategies as was seen in the case of the results of the monitoring of EmONC services, near-miss reports, adolescent SRHR issues, etc. as is evident from the preceding sections. Evidence also has helped to justify designation of focal points for specific service delivery (such as EmONC, AFHS, forensic) for strengthening referral systems and building accountability.
- Support for capacity building of pre-service institutions, especially in health, is effective and reduces the investments needed for in-service training. It also provides opportunities to instil interest in research for creation of evidence.
- Use of digital platforms widened the scope and reach of the programmes; however, as indicated earlier, the interventions need to be evaluated.
- Multi-sectoral involvement in ASRH services and GBV has established linkages between various constituencies including communities and religious organizations; however, the systems need to be further refined.
- Support for strengthening data systems at the Gewog level has opened opportunities for interfacing with wider systems and contributes to reducing the number and cost of surveys (very costly for a smaller country) and access data more efficiently. It also helps to provide a common population denominator for various indicators.

Management

- In the absence of a Resident Representative, creating the post of Head of Office increases the stature of the CO and greater involvement in policy dialogues.
- In a small country programme with limited staff and resources, the program staff's engagement in all the thematic areas has enhanced better coordination and facilitated integration of crosscutting issues such as gender and data in all the outcome areas.
- Though there are only four lead IPs, engagement of other relevant Implementing partners have been ensured by involving them as sub-IPs under each lead IPs.

Chapter 5. Conclusions

This Chapter provides conclusions on the performance of the CP based on the evidence-based and valid answers to the evaluation questions.

- 1. Overall, the UNFPA CP maintained the programme relevance by aligning with the population needs, 12th Five Year Plan priorities and related national priorities, UNFPA global priorities, UNSDPF and demonstrated its ability to be flexible to meet changes in the national priorities as in the case of the COVID-19 pandemic.** CP 7 contributes to UNFPA's three transformative goals through its 2 outputs with focus on the country's significant population- adolescents and young people. Of the six accelerators listed in the business model of the SP 2022-25, the CP implements human rights-based and gender transformative approaches, 'leaving no one behind, partnerships, data and evidence (latter to some extent). The pandemic provided opportunities for implementing the other accelerators- innovation and digitization, adaptation and complementarity among development and humanitarian action. (Origin: EQ 1 relevance Findings 1, EQ 3 effectiveness findings under effectiveness).
- 2. Vulnerable populations as defined by the CP were consulted during the formulation of the CP, but during the implementation of the programme adolescent and youth and survivors of GBV were the main focus.** The major reasons were related to UNFPA CO's change in mode of engagement and legal recognition of some of the vulnerable groups. Some efforts have been made during the course of the CP to provide attention to the needs of the vulnerable populations including people with disability. During the pandemic, opportunities opened up to provide information and services to the vulnerable including the PWD, but were not optimal. More needs to be done in reaching out to PWD to improve their access to SRHR and protection against GBV; however, this needs a comprehensive understanding of the needs. (Origin: EQ 1 relevance- Finding 1 and EQ 3 effectiveness – Findings 5, 8, 10, 11, 13)
- 3. UNFPA added value to the development of One UN plan, leading the data thematic group and co-chairing gender thematic group and being an active member of the thematic group on social services for vulnerable and unreached, while ensuring that SRHR and GEEW issues are addressed in the development and humanitarian contexts. UNFPA's strengths in high level advocacy, leadership in SRHR, contributions to CSE and introduction of LSE based CSE in monastic institutions and its contributions to data systems are much appreciated by the partners.** Its contributions under the Joint UN response during the pandemic is recognized by the partners. UNFPA's contributions to UNCT is noteworthy, but it is a challenge for the Agency to balance its core activities with UNCT collaboration due to the limited human resources. The division of labour among the UNCT is also not very clear that creates confusion in responding to RGOB requests. UNFPA is providing support to emerging issues such as ageing through a report on ageing and eventual support to a policy on senior citizens. (Origin: EQ 2 coherence- Finding 2)
- 4. The CP has demonstrated its added value in the thematic areas of its comparative advantage in SRHR, LSE and CSE, GEEW and data systems (despite changes in the mode of engagement). Its contributions to improving quality and rights-based approaches have strengthened the programme of the government in development and humanitarian contexts.** UNFPA's contribution to Bhutan's statement at ICPD@25 reflects its added value. Its collaboration with CSOs have strengthened the collaboration between the government and CSOs especially at the time of the pandemic and also opened doors for improved collaboration with agencies working with vulnerable groups. However, it is felt that UNFPA could have done more on data- quality, timeliness, disaggregation, etc. (Origin: EQ 2 coherence- Finding 3)
- 5. UNFPA has demonstrated its technical leadership in SRHR by assisting the MOH in creating evidence and supporting development of policies and strategies and strengthening health systems to provide rights-based and gender-sensitive quality services including services for survivors of GBV.** The policy/strategy support includes National Strategic Plan of Action for Adolescents (NSPAAH), service

delivery standards in family planning and midwifery (aligned to the standards of International Confederation of Midwifery) and inclusion of special needs of the vulnerable groups such as LGBTIQ and PWD. The capacities of implementing partners and beneficiaries have been built to enable sustainability of several of the interventions. However, a major concern is the continuation of the level of support by RGOB for family planning services due to the below-replacement fertility level, which will require high level evidence-based advocacy. There are also concerns about the degree of RGOB support for AFHS and GBV due to the structural and policy changes in the country. UNFPA's continued high level support to the cervical cancer elimination programme has contributed significantly to the programme; however, it may be time to assess the continuation of support. Despite all the significant contributions to SRHR, two major gaps observed are re lack of integration of SRH and HIV/STI services and support for monitoring routinely collected RMNCAH data. (Origin: EQ 3- Findings 5,6,7; EQ 8- Finding 23)

6. UNFPA's technical leadership in introducing sensitive topics such as CSE in schools and LSE based CSE in monastic schools has helped to institutionalise the topics. The support to youth networks such as Y-PEER has helped its growth and contribution in building capability of young people to exercise their RR and its support to Scouts has helped to strengthen the organization's capability in SRHR concerns and GBV prevention. Such support to youth networks improved their effective collaboration during the pandemic. There are concerns about the continuation of RGOB support to CSE at the current level (in the context of the changes in priorities and policies of the RGOB). Y-PEER is on its way to graduation as an independent network, with minimal support, these programmes should be able to be sustained. (Origin: EQ 3-Findings 10,11; EQ 8-Finding 23)

7. During the COVID-19 pandemic, UNFPA re-programmed its funds to support continuation of SRHR services through development of interim guidelines and capacity building for provision of services, especially for life saving services and services for GBV survivors. Digital platforms were extensively used for provision of services and capacity building. The interventions listed above made efforts to include vulnerable populations including PWD. Funds were also re-programmed to continue implementation of CSE framework in the school curriculum and continuation of capacity building of monastic schools to implement LSE based CSE. The CP effectively used the youth networks to create awareness about SRHR concerns and GBV prevention and merits documentation as a knowledge product. Digital health has been widely used to continue RMNCAH services, capacity building as well as risk communication during the time of the pandemic. Some of the activities has the potential to be continued to contribute to the current thinking of the RGOB to enhance the use of digital technologies. (Origin: EQ 3- Findings 8, 13, EQ 7- Finding 22, EQ 9-Finding 24)

8. UNFPA has effectively used two streams for advocacy and mobilization; (i) effective use of high-level advocacy on ASRH, GBV, sexual harassment and rights of women and adolescents through UNFPA Goodwill Ambassador (Her Majesty the Queen Mother) and decision makers and parliamentarians and (ii) effective community mobilization through its CSO partners, religious organizations and youth networks against social evils. The release of UNFPA's SOWP issues on bodily autonomy and unintended pregnancies and the discussion on the topics, led by high level officials, further highlighted the need to take action on the issues. Advocacy to parliamentarians on SRHR issues and GBV was strategic, but more of such meetings are needed. There is need to continue such multi-stakeholder involvement. (Origin: EQ 3- Findings 5, 11, 12; EQ 4- Finding 14)

9. Though there is no separate output on gender, gender and human rights have been effectively well integrated into CP outcomes. Besides support for gender equality policy development and its amendment, the advocacy and support for PSEAH is a significant contribution. The contributions to establishing a continuum of care approach for GBV prevention and care across multiple sectors and constituencies was significant; however, the interphase between different sectors is not always clear. (Origin EQ 4 – Finding 14, EQ 3- Finding 12)

10. Support for Bhutan Statistical Data System (BSDS) is contributing to building a robust data system in the country. In addition, the capacity building of district level officials for analysis of data for

planning also contributes to strengthening data system; however, more investments are needed for optimal effectiveness. A major gap is the availability of recent data as well as disaggregated data to monitor the progress of national key result areas, SDGs and ICPD indicators, CP RRF indicators. The gap may be remedied once the BSDS is well established as it will be enabling interphase of different data systems from village to national levels. Census related publications have contributed to national policies and strategies, though the linkages are not always obvious. It is expected that a legislation on statistics may help to overcome some of the issues. (Origin EQ 5 – Finding 15,16, EQ 3- Finding 12)

11. Resources invested by UNFPA have been effective, despite limited financial and human resources. It also helped to leverage resources from other agencies. The CO has efficiently carried out its country engagement under the revised classification of the country and has used the accelerators to enhance performance. A missing gap is SSTC in areas where the potential for hosting the cooperation exists such as CSE, LSE based CSE. (Origin: EQ 6,7- Findings 17, 18, 19,20,21)

12. Overall, UNFPA's investments appear to be sustainable as there is widespread ownership by stakeholders and the long term impact of some of the activities related to capacity building and advocacy. However as expressed in the preceding sections, due to the recent structural and policy changes, the extent of support by RGOB in important services, particularly family planning is a concern.

Chapter 6. Recommendations

The recommendations are made in the context of the impending graduation of Bhutan from a Least Developed Country status and also the structural changes the country is currently undergoing. The negative economic impact of COVID-19 pandemic that has implications for social sectors is also factored into the recommendations. As such, the graduation of the country from Least Developed Country category has implications for donor support especially in the social sector¹³³.

Recommendation 1 is related to the design of CP 8, to be carried out in the final year of CP 7 (2023). The recommendation is linked to all conclusions in general, particularly those related to 2, 5,6,8,9,10

Ex-ante evaluation /evaluability assessment should be conducted after the drafting of the design of CP 8 to help assess the coherency and viability of the programme’s underlying logic and overall design. Such as assessment would also aid in refining the key outcome areas, TOC, M&E framework and implementation road map(also a recommendation of the ERG).

Action plan:

- a) Conduct a situational and stakeholder analysis that takes into consideration the country status assigned as per the business model of the SP 2022-25, RGOB’s planned structural and policy changes, continuing challenges of data availability, vulnerability to natural hazards and gender equality and other challenges identified in the draft 13th Five Year Plan and CCA that is being developed and the need for human resources and human capital development in health and education to meet the needs of the country’s graduation from LDC status. Advocacy for increasing the resource envelope is needed.
- b) The TOC should be developed in collaboration with relevant stakeholders including CSOs to have a clear understanding of the context, objectives, expected results of interventions as well as to increase IP’s ownership. Integrated approaches especially integration of gender and HRBA should be reflected as guiding principles.
- c) Specific, Measurable, Achievable, Relevant and Time-bound (SMART) indicators should be developed. Measurements need to capture gender sensitivity and HRBA as well as behavioural changes (especially young people). To implement this recommendation, availability of timely and quality data is important or use of proxy indicators should be considered.
- d) The CP should have a M&E plan as part of the CP development (The ERG specifically recommended including an evaluation plan).

Priority- high

6.1 Strategic recommendations

Recommendation 2. Linked to Conclusions 5, 6 (latter specific to adolescent pregnancy), 10, 13

CP 8 should focus on sustaining the gains in family planning while ensuring quality, expanding choices and including the needs of vulnerable and advocating for sustained national investments based on evidence.

¹³³UN Bhutan. Common Country Analysis 2018

Action plan:

- a) Undertake a study on proximate determinants of fertility, to be done by top rated scholars in the field and use the findings of the same to advocate for continued support to family planning services. It will also be useful to undertake a literature review of the experiences of countries with low fertility.
- b) Assess the current status of FP programme (services (disaggregated by age, sex, geography), quality, competencies, training including availability of skills lab), barriers to use (social and gender norm-related) and implications for reaping the benefits of demographic dividend. The assessment should include the quality and efficiency of logistics and supply systems.

Both activities will require additional funding and technical assistance. The activities will contribute to achieving the transformative goal on zero unmet need for family planning.

Priority- High**Recommendation 3.** Linked to Conclusions 4, 5, 9, 10

CP 8 should focus on assisting the country to achieve the last mile to achieving the SDG target related to MMR that will also have implications for achieving SDG target for neonatal mortality. Strategies for achieving this indicator will also support development of human resources for health particularly midwives– a concern expressed in the 12th Five Year Plan.

Action plan:

- a) Conduct an in-depth review of the delivery of maternal care services including quality and coverage of antenatal care, intrapartum care and postnatal care to develop strategic approaches to maternal care to manage the changing landscape of maternal health (skewed towards morbidities from non-obstetric causes).
- b) Review and expand the current preconception care package, to identify and take early action to prevent morbidity and mortality during pregnancy (recommended intervention under the national RH strategy).
- c) In collaboration with Ministry of Labour and Human Resources, Royal Civil Service Commission and MOH, UNFPA should support the assessment of the production and distribution of current human resources for SRH, particularly midwives, critical for building resilience of the health system for survival and well-being of mothers and children. This action is critical for achieving universal health coverage and health related targets of SDGs.

The activities will need financial and technical support and will contribute to achieving the transformative goal of zero preventable maternal deaths.

Priority - High**Recommendation 4.** Linked to conclusions 10, 2,3

CP 8 should continue to provide support to National Statistical Bureau for strengthening and expanding the Bhutan Statistical Data Systems (BSDS), capacity building to generate credible disaggregated data so that no one is left behind and for use of data for planning.

Action plan

- a) UNFPA's support to BSDS is a major contribution to strengthening the data systems in the country and should be continued along with capacity building to generate credible disaggregated data

(including for vulnerable populations as appropriate). Such support will help UNFPA to monitor the progress of indicators in its core areas.

- b) Support to strengthen the *administrative-based data systems* which have the potential to fill critical data gaps should be considered. Activities should include development of standards and improvement of tools and business processes for data collection, validation, and reporting.
- c) Support should be considered towards optimizing the use of innovation and technology to produce real-time quality data, speeding up dissemination and communication of data to users. Efforts must be on harnessing the big data sources using ICT and promoting the use of Artificial Intelligence in official statistics. Partnership should be promoted under this support.
- d) UNFPA should advocate for the enactment of a legislation on statistics towards addressing the current issues on data inadequacy, unreliability and inconsistencies. In the event of non-enactment of the legislation, a statistical policy should be advocated that adopts the key provisions of the statistical bill (not enacted), including standards development, coordination and capacity development.
- e) Support should be provided for gathering information on the link between population dynamics and climate change. This is critical for Bhutan as the country is vulnerable. This requires high level technical assistance.
- f) Support should be continued towards bringing out thematic reports including on the link between population dynamics and climate change, small-area estimation to generate data at lower levels of geography (example. Gewog level), trends in ageing, knowledge products from the upcoming National Health Survey, etc (as indicated under conclusion 10, the generation of the thematic reports from the population housing census data has built the capacity of NSB). A knowledge platform should be created to enable sharing the information.
- g) Based on the current support for the report on ageing and its contribution to the National Policy for Senior Citizens in Bhutan, further support should be explored to develop a comprehensive strategy on ageing through partnerships as described under Recommendation 5.
- h) Continue to support the capacity development of district level officers in data analysis and its use or planning.
- i) Collaboration with MOH should be strengthened to support the monitoring of the routinely collected RMNCAH indicators – quality, completeness and frequency. Since WHO is the lead agency for DHIS 2 support, UNFPA should collaborate with WHO in ensuring the availability of RMNCAH data.

Priority - High

Recommendation 5. Linked to conclusions 3,5, 6, 8, 11

Advocacy and strategic partnerships should be strengthened to deliver in its core areas of support

- a) Building on its strength in high level advocacy, and partnerships with key relevant government, non-government partners and religious organizations, CP 8 should further strengthen its current engagements towards the development of a policy for population ageing and increase commitments for services to vulnerable populations including PWD through joint programming and partnerships.
- b) Considering the vulnerability of Bhutan to natural calamities and recently gained experience in supporting mitigation of the impact of COVID-19 pandemic, UNFPA should play a greater role in developing a UN preparedness plan for future pandemics and natural calamities, working closely with national disaster management agency.
- c) Termination of unintended pregnancy, especially teenage pregnancy, is a major but hidden issue that requires in-depth reviews and high level advocacy through religious institutions to expand the current indications for medical termination of pregnancy.

- d) SSTC should be promoted in areas such as CSE integration in school curriculum and LSE based CSE in monastic institutions. This requires more work in terms of evaluations and implementation research. SSTC could be an area of strength for RGOB as it is pushing for its graduation as a middle-income country.
- e) More engagement with Parliamentarians is needed – sharing the commitments at ICPD @25, research findings, etc to use the forum to advocate for SRHR and prevention and management of GBV.

Priority- high

Recommendation 6. Linked to conclusions 5, 6, 7,9

CP 8 should strengthen its focus on GBV as a life threatening and human rights’ issue during development and humanitarian contexts, focusing on prevention and management, and strengthening multi-sectoral and multi-partnership approaches to strengthen continuum of care.

- a) Building on its strength of high-level advocacy and its commitment to GEEW and HRBA and the current structural changes in the RGOB, CP 8 should focus on continuation of the support to GBV prevention and management, building in elements in sustainability of the programme.
- b) As planned under CP 7, support should be provided to undertake research on sociocultural reasons underlying GBV to provide evidence-based advocacy.
- c) Assessments of the current implementation of the GBV response in health sector, education sector and communities should be undertaken.

Priority- Medium

6.2 Programmatic recommendations

Recommendation 7. Linked to conclusions 5,6,

CP 8 should continue its support for selected SRH services and CSE and LSE based CSE in monastic institutions.

- a) Support for effective implementation of CSE in schools as a curricular activity, including effective training of teachers, should be continued and in-depth reviews/implementation research on the integration of CSE should be carried out to merit its consideration as a subject to for SSTC.
- b) Support to continue the expansion of LSE based CSE and its evaluation to merit its consideration as a subject for SSTC.
- c) Implementation research should be supported particularly on the referral linkages between the education and health sector, modalities of functioning of AFHS in referral hospitals, district hospitals and primary health centres to develop models for AFHS service delivery.
- d) In order to support the RGOB’s plans to expand digital interventions, support should be considered for assessing the quality and effectiveness of the various interventions instituted during the pandemic including the use of ICTG. The assessment should include the effectiveness of clinical training provided on-line, perspectives of providers and receivers of the services, capability of the providers to deliver digital health interventions and capability of receivers to use the digital systems and digital health ecosystems. Standards for digital health interventions should be developed including confidentiality and privacy clauses.
- e) Standards for quality assurance of various SRH services should be developed or modified.
- f) Studies on SRH needs of vulnerable populations, particularly PWD, identifying potential interventions should be supported. The latter requires high level technical assistance.

- g) Integration of SRH services and HIV/STI should be strengthened by incorporating the screening for HIV/STI in FP clinics, cervical cancer screening, AFHS and GBV services. Not only it is the right of individuals and couples to access integrated services, it also has implications for reducing secondary infertility, protecting the productive age group to harness the full benefit of the demographic dividend.
- h) Evaluations of support for elimination of cervical cancer, Y-PEER support, etc should be done to determine whether UNFPA should exit the collaboration and develop exit strategies.
- i) Support for continuing screening for reproductive cancers in females and expanding to men, in support of the national flagship programme on cancer screening should be provided.
- j) Support for generating incisive reports on the various interventions including experiences of responding to the pandemic particularly by youth, is critical for knowledge management. Young researchers from universities should be supported, supervised by the staff of the college or jointly with an expert from inside or outside the country.
- k) Support for RH sub-accounts should be provided to universities with skills in financing, with technical assistance from APRO / external consultants and in collaboration with WHO. Tracking expenditures for SRHR is a key intervention recommended under the SP (The MOH had done a National Health Accounts with support from WHO few years ago and UNFPA had supported costing of the NHASSSP.) Such inputs will strengthen national capacity.

Priority- Medium

Annex 1: Terms of Reference

**United Nations Population Fund (UNFPA) Bhutan 7th Country Programme
(2019-2023)**

Country Programme Evaluation

14th February 2022

1. Introduction

The United Nations Population Fund (UNFPA) is the lead United Nations agency for delivering a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled. The strategic goal of UNFPA is to "achieve universal access to sexual and reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the agenda of the Programme of Action of the International Conference on Population and Development (ICPD), to improve the lives of women, adolescents and youth, enabled by population dynamics, human rights and gender equality."¹³⁴ In pursuit of this goal, UNFPA works towards three transformative and people-centered results: (i) end preventable maternal deaths; (ii) end the unmet need for family planning; and (iii) end gender-based violence (GBV) and all harmful practices, including female genital mutilation and child, early and forced marriage. These transformative results will contribute to the achievement of the Sustainable Development Goals (SDGs), in particular good health and well-being (Goal 3), the achievement of gender equality and the empowerment of women and girls (Goal 5), the reduction of inequality within and among countries (Goal 10), and peace, justice and strong institutions (Goal 16). In line with the vision of the 2030 Agenda for Sustainable Development, UNFPA seeks to ensure that no one is left behind and that the furthest behind are reached first.

UNFPA has been operating in Bhutan since 1970s. The support that the UNFPA Bhutan Country Office (CO) provides to the Government of Bhutan under the framework of the 7th Country Programme (CP) 2019-2023 builds on national development needs and priorities articulated in:

- National 12th Five Year Plan, 2019-2023
- Common country analysis (Bhutan), 16 January 2018
- United Nations Sustainable Development Partnership Framework for Bhutan 2019-2023
- Seventh Country Programme Action Plan (CPAP) 2019 – 2023

The 2019 UNFPA Evaluation Policy requires CPs to be evaluated at least every two programme cycles, "unless the quality of the previous country programme evaluation was unsatisfactory and/or significant changes in the country contexts have occurred."¹³⁵ The country programme evaluation (CPE) will provide an independent assessment of the relevance and performance of the UNFPA 7th CP (2019-2023) in Bhutan, and offer an analysis of various facilitating and constraining factors influencing programme delivery and the achievement of intended results. The CPE will also draw conclusions and provide a set of actionable recommendations for the next programme cycle and will contribute to the greater accountability and transparency of the organization.

Therefore, UNFPA Bhutan Country Office plans to conduct an independent evaluation of the 7th Country Programme in line with the United Nations Evaluation Group (UNEG) Norms and Standards, code of conduct and ethical guidelines for evaluations, as well as UNEG guidance on gender and human rights responsive and disability inclusive evaluations, and in line with international best practice.

The evaluation will be implemented in line with the *Handbook on How to Design and Conduct a Country Programme Evaluation at UNFPA* (UNFPA Evaluation Handbook), which is available at <https://www.unfpa.org/EvaluationHandbook>. The Handbook provides practical guidance for managing and conducting CPEs to ensure the production of quality evaluations in line with the United Nations Evaluation Group (UNEG) norms and standards and international good practice for evaluation. It offers a step-by-step guidance to prepare methodologically robust evaluations and sets out the roles and responsibilities of key stakeholders at all stages of the evaluation process. The Handbook includes a number

¹³⁴ UNFPA Strategic Plan 2018-2021, p. 3. The document is available at: [https://www.unfpa.org/sites/default/files/resource-pdf/DP.FPA_.2017.9 - UNFPA strategic plan 2018-2021 - FINAL - 25July2017 - corrected 24Aug17.pdf](https://www.unfpa.org/sites/default/files/resource-pdf/DP.FPA_.2017.9_-_UNFPA_strategic_plan_2018-2021_-_FINAL_-_25July2017_-_corrected_24Aug17.pdf).

¹³⁵ UNFPA Evaluation Policy 2019, p. 20. The document is available at <https://www.unfpa.org/admin-resource/unfpa-evaluation-policy-2019>.

of tools, resources and templates that provide practical guidance on specific activities and tasks that the evaluators and the evaluation manager perform during the different evaluation phases.

The main audience and primary intended users of the evaluation are: (i) The UNFPA Bhutan CO; (ii) the Royal Government of Bhutan ; (iii) implementing partners of the UNFPA Bhutan CO; (iv) rights-holders involved in UNFPA interventions and the organizations that represent them (in particular women, adolescents and youth); (v) the United Nations Country Team (UNCT); (vi) Asia Pacific Regional Office (APRO) ; and (vii) other development partners. The evaluation results will also be of interest to a wider group of stakeholders, including: (i) UNFPA headquarters divisions, branches and offices; (ii) the UNFPA Executive Board; (iii) academia; and (iv) local civil society organizations and international NGOs. The evaluation results will be disseminated as appropriate, using traditional and digital channels of communication.

The evaluation will be managed by the evaluation manager within the UNFPA Bhutan CO, with guidance and support from the regional monitoring and evaluation (M&E) adviser at the APRO, and in consultation with the evaluation reference group (ERG) throughout the evaluation process. A team of independent external evaluators will conduct the evaluation and prepare an evaluation report in conformity with these terms of reference.

2. Country Context

The Kingdom of Bhutan is a small, mountainous, landlocked country in South Asia, located in the eastern Himalayas, bordered by India and China. It has an area of 38,394 square kilometers with east-west dimension (longest) stretching around 300 kilometers and 170 kilometers at its maximum north-south dimension. About 70 percent of the Kingdom is covered with forests. The administrative system in the country consists of Central and Local Government. The Central Government comprises Ministries, Departments and Autonomous bodies. The Local Government comprises of 20 Dzongkhag (districts) Tshogdu, 205 Gewog (block) Tshogde and the four Thromde (township) Tshogde.

The total population of Bhutan as per the 2017 Population and Housing Census was 760,000 people and is expected to reach a maximum of 1 million with over 55 per cent living in urban areas by 2050. Bhutan's population is young with more than half of them below the age of 23 years. Further, with more than two-third of population in the working age-group, the potentials to reap the demographic dividend is projected to continue till 2040. Due to declining fertility rates and increasing life expectancy, the number of people in the age group of 65 years and above is expected to rise from 6 percent to 17.3 percent by 2050 and the old-age dependency ratio will increase from 11.2% to 26.2% in 2050. Although fertility has fallen below replacement levels to 1.7, the unmet need for contraception continues to be high among adolescents at 27 per cent. General literacy rate stands at 71.4% (78.1%M: 63.9% F) with higher literacy rate among youth at 93.1 with no gender gap. However, around 15% of the young population are illiterate and slightly more than 7.5% have never attended school.

Bhutan is classified as a LDC and the income per capita has reached US\$3000. Annual GDP growth rate as of 2021 stands at negative 11 per cent and overall unemployment rate is 5 percent with higher unemployment rate among youth at 22.6 per cent (female 61.3%, Male 38.7%). Poverty and inequality indicators remains high at disaggregated levels. Across districts, income poverty rates vary between 1 to 32 per cent, and are considerably higher in rural areas (16.7 per cent) than in urban areas (1.8 per cent). The share of population living on less than \$3.20 per day fell from 14.7 percent in 2012 to 12.2 percent in 2017. While this marks a continuation of progress over previous years, the pace of poverty reduction has slowed down recently. As of 2017, less than 4 percent of Bhutanese live in multidimensional poverty. Despite Bhutan's strong growth performance, and progress in social indicators, greater attention still needs to be paid to many structural and other challenges to ensure longer-term sustainable development. Bhutan needs to continue and strengthen sustainable interventions to address social, economic and gender gaps and ensure increased coverage and quality of sexual reproductive health services.

The Royal Government of Bhutan (RGoB) is committed to achieving universal health coverage (UHC), with the right to health care for all as mandated by the Constitution. The overarching goal of the 12th Five Year

Plan of the Government of Bhutan in the health sector is to achieve UHC by providing access to quality health care services based on the principles of primary health care. National protocols and guidelines on improving quality care of SRH have been developed and widely adopted throughout the country. Bhutan has made significant progress in the SRHR over the past two decades. Maternal mortality has declined from 255/100,000 (maternal deaths per 100,000 live births) in the year 2000 to 89/100,000 in 2017. Despite the high coverage of skilled antenatal care and birth attendance, quality of care remains inadequate. Prevalence of maternal near miss ratio stands at 6.7 per 1000 live births and potential life-threatening conditions at 12.8 per 1000 live births. More than a quarter of women are classified as having any anaemia and less than a quarter of young people have comprehensive and correct knowledge of HIV prevention and transmission. Challenges around contraceptive use and child marriage remain for Bhutan; over a third of married women are not using an effective method of contraception and a quarter of young women entered a marital union before the age 18 years. Adolescent girls have the lowest demand satisfied with modern methods of contraception and prevalence of modern contraceptive use. Modern contraceptive use among married adolescent girls was half of the national average. Cervical cancer is the leading cause of death among Bhutanese women and

The Constitution of the Kingdom of Bhutan 2008 provides an overarching framework and foundation within which gender equality is enshrined. Despite guarantees of formal equality, structural and cultural norms continue to obstruct the full realization of gender equality. Bhutan is ranked 131 out of 153 countries in the Global Gender Gap. The number of girls enrolled in tertiary education continues to be low (19.1% as compared to 23.7% of boys). Poor academic performance due to domestic commitments and early pregnancy, according to the Bhutan Gender Policy Note 2013, impede girls' access to tertiary education. High adolescent pregnancies, with as many as 32% of females having their first pregnancy at the age of 18 or younger, and the growing issue of feminization of HIV/AIDS continue to exist. Women in rural communities, in particular, are more vulnerable and have limited access to resources. More than 2 in 5 Bhutanese women have been physically, sexually, psychologically, or economically abused by a spouse at some point in their lives.

Bhutan's progress in human development has also been significant, and has made remarkable progress in achieving a number of commitments made to the International Conference on Population and Development. Bhutan is on track to achieve all the SDGs and is expected to graduate from the UN's Least Developed Countries (LDC) category in 2023 with the RGOB calling the latest 12th Five Year Plan (2018 – 2023) , “the last mile to LDC graduation” Bhutan has incorporated most of the sustainable development goal targets in its five-year development plan, which focuses on addressing the last-mile challenges that are preventing the country from graduating from the least-developed country category and is guided by the development philosophy of Gross National Happiness (GNH).

Development challenges/opportunities

Bhutan is increasingly facing challenges for certain groups, especially adolescents and youth. Half of country's population is below the age of 24 years , and they face a range of social, health and development issues. The prevalence of sexual activity is high among adolescents aged 10–19 years, with 23 per cent among males and 10 per cent among females. Twenty-six per cent of women aged 20 to 24 years are already in union or married before they reach 18 years. The unmet need for contraception is higher among adolescents (27 per cent) than among the general population (12 per cent) and, as a result, the number of births per 1000 women aged 15-19 years is high at 28.4. The adolescent fertility rate is 77 per 1,000 women in rural areas and 30 per 1,000 women in urban areas, reflecting geographic disparities. One third of all HIV infections in the country are reported among 15–24 years old and comprehensive knowledge on HIV/AIDs is only 23% among 15-24 years old. More than 55% of students did not know about the pregnancy risk and the teachers' perception on impact of sexuality education on the student's behaviour is alarming with more than 74 % of teachers either perceiving CSE to be promoting sexual activities. The high incidents of early marriages, teenage pregnancies, high unmet need for contraception among 15-19 years old and higher incidence of STI and HIV underline the need for enhanced provision of high quality SRH and FP services, especially for young people. Therefore, improving access to youth-friendly sexual and reproductive health information and services is fundamental to ensure Bhutan's continuous progress on critical indicators such

as adolescent pregnancy, HIV/AIDS and maternal mortality and morbidities. The coverage for comprehensive sexuality education in schools is low, resulting in limited knowledge among students on sexuality and adolescent health – over 55 per cent of students are unaware of the risks of unprotected sex. There has been a marked increase in sexually transmitted infections in the country. The small numbers of health centres offering adolescent-friendly health services severely limits the access of such services to young people. Enhancing provision of high quality sexual and reproductive health information and services for adolescents and youth is key to ensuring continuous progress on the results areas envisaged under the Twelfth Five Year Plan of Bhutan.

Bhutan has made progress in enacting laws, policies, regulations and strategies related to SRH, young people and gender, such as the health policy, youth policy, gender equality policy, adolescent health strategy, draft population policy, and domestic violence prevention act. However, findings indicate that these instruments are fragmented or lack proper implementation, especially at grassroots level. Insufficient human resource capacities and inadequate resources at national and subnational levels hinder transforming national policies into functioning plans. Additionally, geographical, social, cultural and financial barriers impede access to services. Right holders, specifically vulnerable groups like people with disabilities disabled, illiterate, rural women and young people are not even aware of their rights. In addition, assessments and reviews conducted point out the low level of awareness of service providers regarding the policies and strategies.

There is a lack of data in several key areas such as on SRH, young people's development situation, migrants, vital statistics, etc. and a lack of harmonization of different sources of data. Data on unmarried people, particularly in relation to childbearing, maternal care are extremely limited, despite evidence that unmarried people (particularly adolescents) face considerable barriers to accessing SRH services. There are also no data for some key SRH areas, notably unintended births, decision-making autonomy with respect to contraceptive use, seeking own health care and sexual relations, safe abortion, STI care and financial protection. Limited disaggregated data for some of indicators included fertility rate, contraceptive knowledge, maternal and neonatal mortality, women with anaemia, maternal health care (ANC, SBA, facility-based births, Caesarean section and PNC), HIV and condom use. Addressing these data gaps is important to inform responsive policy and programs, and to track progress. There were no national-level data for people living with a disability, people with diverse sexual orientation or gender identity / expression, or migrants despite global evidence that these populations experience a significant burden of poor SRH and rights violations. Regular availability of disaggregated data has been affected by the country's limited capacity in data production and use of data for policy making and development planning.

In recent years, climate-related disasters have increased in number and magnitude. While considerable progress has been made in building community resilience, key barriers to effective disaster risk management include limitation on data, financial resources and national capacity.

3. UNFPA Country Programme

UNFPA has been working with the Royal Government of Bhutan since 1970 towards enhancing sexual and reproductive health and rights (SRHR), advancing gender equality, realizing rights and choices for young people, and strengthening the generation and use of population data for development. UNFPA is currently implementing the 7th CP in Bhutan.

The 7th CP (2019-2023) is aligned with the priorities of the National 12th Five Year plan, 2019-23, the United Nations Sustainable Development Partnership Framework for Bhutan (UNSDPF 2019-2023), the Sustainable Development Goals, particularly Goals 3, 4 and 5 and the International Conference on Population and Development. In 2019, the UNFPA Bhutan CO undertook the process of aligning the 7th CP to the UNFPA strategic plan 2018-19. It was developed in consultation with the Government, civil society, bilateral and multilateral development partners, including United Nations organizations, the private sector, academia, religious institutions and youth groups.

The UNFPA Bhutan CO delivers its CP through the following modes of engagement: (i) advocacy and policy dialogue, (ii) capacity development, (iii) knowledge management, (iv) partnerships and coordination. The **overall goal** of the UNFPA Bhutan 7th CP (2019-23) is **universal access to sexual and reproductive health and reproductive rights and reduced maternal mortality**, as articulated in the UNFPA Strategic Plan 2018-2021. The CP contributes to the UNFPA strategic Plan outcomes related to SRH and reproductive right

The CP contributes to the following **outcomes** of the UNFPA Strategic Plan 2018-2021:

- **Outcome 1.** *Every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated sexual and reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence.*
- **Outcome 2.** *Every adolescent and youth, in particular adolescent girls, is empowered to have access to sexual and reproductive health and reproductive rights, in all contexts.*

The UNFPA Bhutan 7th CP (2019-23) will advance the sexual and reproductive health and reproductive rights with focus on adolescents and young people and those most left behind and will make a direct contribution to the UNFPA transformative result on ending unmet need by focusing on access to contraception for adolescents and youth. It has two thematic areas of programming with distinct **outputs** that are structured according to the two outcomes in the Strategic Plan 2018-2021 to which they contribute.

Thematic area: Integrated Sexual and Reproductive Health Services

Outcome 1: Every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated sexual and reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence.

Output 1: Increased national capacities to ensure universal and equitable access to high quality sexual and reproductive health information and services.

UNFPA continued advocacy and technical support to improve access to high quality sexual and reproductive health services and information. In support of the Government efforts to advance sexual and reproductive health and rights, the programme focused on building a knowledge base for facilitating policy dialogue and the establishment of broad partnerships and alliances to leverage resources and to advance the sexual and reproductive health and rights agenda as an integral part of the national sustainable development plan of Bhutan. The programme promoted policies and program interventions that aimed to build young people skills and capacities to make informed choices about their sexual and reproductive health and wellbeing, including in humanitarian context.

Strategies:

- a) Provided technical support to the development and or update of rights based and gender sensitive SRH standards, curriculums and policy frameworks that improve the access and quality of services including during emergencies
- b) Supported evidence generation to facilitate the introduction and roll out of newer methods of contraceptives
- c) Advocated and provided technical assistance for strengthened health-sector response to gender-based violence within the context of a multi-sectoral response and civil society engagement
- d) Extended need based technical assistance to emerging reproductive health needs and priorities (RH cancer, ART, RH morbidities etc.) in the country
- e) Provided technical assistance to strengthen data collection, analysis and use in the areas constrained by data gaps with a focus on SRH

Thematic area: Adolescents and Young People

Outcome 2: Every adolescent and youth, in particular adolescent girls, are empowered to realize their sexual and reproductive health and reproductive rights, and participate in sustainable development, humanitarian action and peace- building.

Output 2: Young people, in particular adolescents are empowered with knowledge, skills and capabilities to make informed choices about their sexual and reproductive health and rights, and well-being

UNFPA adopted a gender-responsive and rights-based approach, and focused on advocacy and policy advisory services as primary modes of engagement. UNFPA partnered with Government, civil society organizations and youth groups to identify and address implementation gaps in existing laws, policies and strategies to improve access and use of sexual and reproductive health information and services by adolescents and youth. UNFPA promoted policies and programme interventions that aimed to build young people's skills and capacities to make informed choices about their sexual and reproductive health and well-being, including in humanitarian contexts. And focused on supporting the generation and use of disaggregated data and evidence on the linkages between population dynamics, intergenerational issues and the realization of the sustainable development goals, with a particular focus on guiding multi-sectoral policies and programmes on adolescents and youth.

UNFPA interventions in particular promoted policies that provide adolescent boys and girls with the knowledge and skills to make informed choices about their sexual and reproductive health, including through access to comprehensive sexuality education.

Strategies:

- a) Provided evidence-based advocacy and policy advice for the inclusion of sexual and reproductive health needs and rights of adolescents and young people in policies and programmes
- b) Supported evidence generation to identify and address barriers to promote and achieve adolescent sexual and reproductive health information and services and reproductive rights, with a particular focus on access to contraception, adolescent friendly health services and prevention of teenage pregnancy
- c) Provided technical support to strengthen the implementation of a gender-sensitive comprehensive sexuality education in and out of schools/institutions
- d) Technical assistance to develop and implement community-based strategies and youth led initiatives, to address child marriage and social norms and that constrain access to sexual and reproductive health information and services of adolescents and young people
- e) Engaged in advocacy and policy dialogue to strengthen the use of evidence on the linkages between demographic dividend, population dynamics and sustainable development, to guide public policies and programmes that seek to advance gender equality and address the gaps that limit the exercise of adolescent and young people's sexual and reproductive rights

Key Strategic Partners & Stakeholders:

CP7 partnership plan promoted the aspirations and principles of the ICPD Programme of Action and Sustainable Development Goals (SDGs) through advocacy and upstream policy work, capacity building and knowledge management in partnership with the government and non-governmental organizations. Further, UNFPA partnered with key government agencies and parliamentarians to facilitate the implementation of 12th FYP for the empowerment of adolescent girls and young people, maintain and advance legislative and policy environments on issues of sexual and reproductive health, youth, and gender equality and advocate the appropriate allocation of funds.

Government strategic partners includes: Gross National Happiness Commission, Ministry of Health (RMNCH program, Planning and policy division, Adolescent health program) , Ministry of Education (Department of Youths and sports, School health and nutrition division, School cultural and education division, ECCD and SEN, Department of curriculum and professional development) , Royal University of Bhutan (Paro college

of education, Samtse college of education, Institute of language and cultural studies), KhesarGyaelpo University of Medical sciences of Bhutan (Faculty of nursing and public health), and National Statistical Bureau

Civil Society Organizations and non-governmental organizations includes: Respect Educate Nurture and Empower Women, Commission for religious organization, Lhak-sam (BNP+) Bhutan network of people living with HIV and AIDs in Bhutan, YPEER network, Pride Bhutan, Queer voices of Bhutan, Disable people's organization of Bhutan, Ability Bhutan society.

The **theory of change** describes how and why the set of activities planned under the CP are expected to contribute to a sequence of results that culminates in the strategic goal of UNFPA is presented in Annex B. The theory of change will be an essential building block of the evaluation methodology.

4. Evaluation Purpose, Objectives and Scope

4.1. Purpose

The CPE will serve the following three main purposes, as outlined in the 2019 UNFPA Evaluation Policy: (i) demonstrate accountability to stakeholders on performance in achieving development results and on invested resources; (ii) support evidence-based decision-making; and (iii) contribute key lessons learned to the existing knowledge based on how to accelerate the implementation of the Programme of Action of the 1994 ICPD.

4.2. Objectives

The **objectives** of this CPE are:

- i. To provide the UNFPA Bhutan CO, national stakeholders and rights-holders, the UNFPA APRO , UNFPA Headquarters as well as a wider audience with an independent assessment of the UNFPA Bhutan 7th CP (2019-23).
- ii. To broaden the evidence-based to inform the design of the next programme cycle.

The **specific objectives** of this CPE are:

- i. To provide an independent assessment of the relevance, effectiveness, efficiency and sustainability of UNFPA support and progress towards the expected outputs and outcomes set forth in the results framework of the CP.
- ii. To provide an assessment of the role played by the UNFPA Bhutan CO in the coordination mechanisms of the UNCT, development and national partners, with a view to enhancing the United Nations collective contribution to national development results as well as its ability to respond to national priority needs including those of vulnerable or marginalized groups, entailed by the crisis triggered by the COVID-19 pandemic and
- iii. To draw key lessons from past and current cooperation and provide a set of clear, forward-looking and actionable recommendations in light of SDG 2030 agenda for the next programme cycle, CCA and UNSDPF.

4.3. Scope

The evaluation will cover the following two thematic areas of the 7CP: Sexual and Reproductive Health and adolescent and young people with focus on universal and equitable access to high quality sexual and reproductive health information and services, gender based violence prevention and in addition, the evaluation will cover cross-cutting issues, such as mainstreaming gender and addressing data gaps to ensure policies and programmes take into consideration the socio-cultural, economic context at local level particularly in relation to young people and transversal functions, such as partnership, resource mobilization and CP communication and advocacy interventions. The evaluation will cover all programmatic interventions planned and implemented during the period from January 2019 to July 2022.

The 7CP has been implemented nationwide so the evaluation will cover both national and district level. Partnership initiatives with CSOs, religious institutions, organizations representing persons with disabilities and volunteer/youth networks and LGBTIQ communities on SRHR and gender-based violence prevention knowledge sharing and practices will be included. Therefore, at least one community-based volunteer network, YPEER network, LGBTIQ network, youth centre and monastic institute will be selected for evaluation. Sites will be selected based on the discussion with Evaluation team members.

The evaluation will unfold in five phases, each of them including several steps are detailed in section 5.

5. Evaluation Criteria and Preliminary Evaluation Questions

5.1. Evaluation Criteria

In accordance with the methodology for CPEs outlined in the UNFPA Evaluation Handbook (see section 3.2, pp. 51-61), the evaluation will examine the following four OECD/DAC evaluation criteria: relevance, coherence, effectiveness, efficiency and sustainability.¹³⁶ Furthermore, the evaluation will adapt evaluation questions to the COVID 19 pandemic to assess the extent of UNFPA Bhutan CO has adapted its interventions, adaptive management capacity, ability to learn and innovate and optimized performance in the midst and aftermath of the COVID-19 pandemic.

Relevance	<p>The extent to which the objectives of the UNFPA country programme correspond to needs of the population at country level (in particular, those of vulnerable groups), and were aligned throughout the programme period with government priorities and with strategies of UNFPA.</p> <p>The extent to which the country office been able to respond to changes in national needs and priorities, including those of vulnerable or marginalized groups triggered by the COVID-19 pandemic</p>
Coherence	<p>The extent to which country programme interventions are compatible (complementarity, harmonization and coordination) in areas of UNFPA's mandates and with international norms and standards; and co-ordination and the extent to which the intervention is adding value while avoiding duplication of effort including during COVID19 pandemic.</p>
Effectiveness	<p>The extent to which country programme outputs have been achieved and the extent to which these outputs have contributed to the achievement of the country programme outcomes.</p> <p>The extent to where the UNFPA country programme intended results achieved, taking into account potential changes made to the initial results framework due to the COVID-19 crisis</p>
Efficiency	<p>The extent to which country programme outputs and outcomes have been achieved with the appropriate number of resources (funds, expertise, time, administrative costs, etc.).</p> <p>The extent to what mix of resources, procedures and implementation modalities were adapted by the country office in COVID-19 context</p>
Sustainability	<p>The continuation of benefits from a UNFPA-financed intervention after its termination, linked, in particular, to their continued resilience to risks.</p> <p>Does COVID-19 affect the likelihood that country programme achievements will be maintained after the end of UNFPA supported interventions?</p>

¹³⁶ The full set of OECD/DAC evaluation criteria, their adapted definitions and principles of use are available at: <https://www.oecd.org/dac/evaluation/revised-evaluation-criteria-dec-2019.pdf>.

5.2. Preliminary Evaluation Questions

The evaluation of the CP will provide answers to the evaluation questions (related to the above criteria), which determine the thematic scope of the CPE.

The evaluation questions presented below are indicative and preliminary. Based on these questions, the evaluators are expected to develop a final set of evaluation questions, in consultation with the evaluation manager at the UNFPA Bhutan CO and the ERG.

Relevance

1. To what extent is the country programme adapted to: (i) national development strategies and policies ; (ii) the strategic direction and objectives of UNFPA in particular to transformative goals and business model and (iii) priorities articulated in international frameworks and agreements, in particular the ICPD Programme of Action and the SDGs and (iv) aligned with the UN Partnership Framework?
2. To what extent has UNFPA ensured that the varied needs of vulnerable and marginalized populations, including adolescents and youth, those with disabilities and LGBTIQ communities, have been taken into account in both the planning and implementation of all UNFPA-supported interventions under the country programme?
3. To what extent were gender equality and empowerment of women, and disability inclusion mainstreamed into the design, implementation and monitoring of the Country Programme?
4. To what extent have UNFPA programmes ensured a flexible and adaptive approach to ensure access to a continuum of comprehensive life-saving sexual and reproductive health and GBV prevention and protection services as part of the COVID-19 response and recovery efforts?

Effectiveness

5. To what extent have the interventions supported by UNFPA delivered outputs and contributed to the achievement of the outcomes of the country programme? And what were the facilitating and hindering factors in achievement of intended results?
6. To what extent and in what ways has UNFPA been able to ensure continuity of sexual and reproductive health services and of interventions addressing GBV and harmful practices as part of the COVID-19 crisis response and recovery efforts?

Efficiency

7. To what extent has UNFPA made good use of its human, financial and administrative resources, and used a set of appropriate policies, procedures and tools to pursue the achievement of the outcomes defined in the county programme?
8. To what extent did UNFPA systems, processes and procedures (particularly in terms of finance, partnerships, logistics, procurement and human resources) foster or, on the contrary, impede the adaptation of the country programme to changes triggered by the COVID-19 crisis?

Sustainability

9. To what extent has UNFPA been able to support implementing partners and rights-holders (notably, women, adolescents and youth) in developing capacities and establishing mechanisms to ensure the durability of effects?
10. To what extent have UNFPA COVID19 response and recovery efforts contributed to strengthening national capacities and systems in the field of SRHR, GBV prevention and data?

Coherence

11. To what extent has UNFPA contributed to the functioning and consolidation of the coordination mechanisms of the UNCT, and added value in the country context, including for the COVID-19 response and recovery efforts, as perceived by UNCT and national stakeholders?

The final evaluation questions and the evaluation matrix will be presented in the design report.

6. Approach and Methodology

6.1. Evaluation Approach

Theory-based approach

The CPE will adopt a theory-based approach that relies on an explicit theory of change, which depicts how the interventions supported by the UNFPA Bhutan CO are expected to contribute to a series of results (outputs and outcomes) that contribute to the overall goal of UNFPA. The theory of change also identifies the causal links between the results, as well as critical assumptions and contextual factors that support or hinder the achievement of desired changes. A theory-based approach is fundamental for generating insights about what works, what does not and why. It focuses on the analysis of causal links between changes at different levels of the results chain that the theory of change describes, by exploring how the assumptions behind these causal links and contextual factors affect the achievement of intended results.

The theory of change will play a central role throughout the evaluation process, from the design and data collection to the analysis and identification of findings, as well as the articulation of conclusions and recommendations. The evaluation team will be required to verify the theory of change underpinning the UNFPA Bhutan 7th CP (2019-23) (see

C) and use this theory of change to determine whether changes at output and outcome levels occurred (or not) and whether assumptions about change hold true. The analysis of the theory of change will serve as the basis for the evaluators to assess how relevant, effective, efficient and sustainable the support provided by the UNFPA Bhutan CO was during the period of the 7th CP.

As part of the theory-based approach, the evaluators shall use a contribution analysis to explore whether evidence to support key assumptions exists, examine if evidence on observed results confirms the chain of expected results in the theory of change, and seek out evidence on the influence that other factors may have had in achieving desired results. This will enable the evaluation team to make a reasonable case about the difference that the UNFPA Bhutan 7th CP (2019-23) made.

Participatory approach

The CPE will be based on an inclusive, transparent and participatory approach, involving a broad range of partners and stakeholders at national and sub-national levels. The UNFPA Bhutan CO has developed an initial stakeholder map (see Annex C) to identify stakeholders who have been involved in the preparation and implementation of the CP, and those partners who do not work directly with UNFPA, yet play a key role in a relevant outcome or thematic area in the national context. These stakeholders include government representatives, civil society organizations, academia, youth networks, and other United Nations organizations and, most importantly, rights-holders (notably women, adolescents and youth). They can provide information and data that the evaluators should use to assess the contribution of UNFPA support to changes in each thematic area of the CP. Particular attention will be paid to ensuring

participation of women, adolescents and young people, especially those from vulnerable and marginalized groups (e.g. young people and women with disabilities, LGBTIQ community etc.).

The evaluation manager in the UNFPA Bhutan CO has established an ERG comprised of key stakeholders of the CP, including: GNHC, PPD from (MoH, MoE, NSB), RENEW, CROB, YPEER, at national level, including organizations representing persons with disabilities, the regional M&E adviser in UNFPA APRO. The ERG will provide inputs at different stages in the evaluation process.

Mixed-method approach

The evaluation will primarily use qualitative methods for data collection, including document review, interviews, group discussions and observations during field visits, where appropriate. The qualitative data will be complemented with quantitative data to minimize bias and strengthen the validity of findings. Quantitative data will be compiled through desk review of documents, websites and online databases to obtain relevant financial data and data on key indicators that measure change at output and outcome levels.

These complementary approaches described above will be used to ensure that the evaluation: (i) responds to the information needs of users and the intended use of the evaluation results; (ii) upholds human rights and principles throughout the evaluation process, including through participation and consultation of key stakeholders (rights holders and duty bearers); and (iii) provides credible information about the benefits for duty bearers and rights-holders (women, adolescents and youth) of UNFPA support through triangulation of collected data.

6.2. Methodology

The evaluation team shall develop the evaluation methodology in line with the evaluation approach and guidance provided in the UNFPA Evaluation Handbook. The Handbook will help the evaluators develop a methodology that meets good quality standards for evaluation at UNFPA and the professional evaluation standards of UNEG. It is expected that, once contracted by the UNFPA Bhutan CO, the evaluators acquire a solid knowledge of the Handbook and the proposed methodology of UNFPA.

The CPE will be conducted in accordance with the UNEG *Norms and Standards for Evaluation*,¹³⁷ *Ethical Guidelines for Evaluation*,¹³⁸ *Code of Conduct for Evaluation in the UN System*¹³⁹, and *Guidance on Integrating Human Rights and Gender Equality in Evaluations*.¹⁴⁰ When contracted by the UNFPA Bhutan CO, the evaluators will be requested to sign the UNEG *Code of Conduct*¹⁴¹ prior to starting their work.

The methodology that the evaluation team will develop builds the foundation for providing valid and evidence-based answers to the evaluation questions and for offering a robust and credible assessment of UNFPA support in Bhutan. The methodological design of the evaluation shall include in particular: (i) a theory of change; (ii) a strategy for collecting and analyzing data; (iii) specifically designed tools for data collection and analysis; (iv) an evaluation matrix; and (v) a detailed evaluation work plan and agenda for the field phase.

The evaluation team is strongly encouraged to refer to the Handbook throughout the whole evaluation process and use the provided tools and templates for the conduct of the evaluation.

The evaluation matrix

¹³⁷ Document available at: <http://www.unevaluation.org/document/detail/1914>.

¹³⁸ Document available at: <http://www.unevaluation.org/document/detail/102>.

¹³⁹ Document available at: <http://www.unevaluation.org/document/detail/100>.

¹⁴⁰ Document available at: <http://www.unevaluation.org/document/detail/980>.

¹⁴¹ UNEG Code of conduct: <http://www.unevaluation.org/document/detail/100>.

The evaluation matrix is centrepiece to the methodological design of the evaluation. The matrix contains the core elements of the evaluation. It outlines (i) *what will be evaluated*: evaluation questions for all evaluation criteria and key assumptions to be examined; and (ii) *how it will be evaluated*: data collection methods and tools and sources of information for each evaluation question and associated key assumptions. By linking each evaluation question (and associated assumptions) with the specific data sources and data collection methods required to answer the question, the evaluation matrix plays a crucial role before, during and after data collection.

In the design phase, the evaluators should use the evaluation matrix to develop a detailed agenda for data collection and analysis and to prepare the structure of interviews, group discussions and site visits. During the field phase, the evaluation matrix serves as a reference document to ensure that data is systematically collected (for each evaluation question) and is presented in an organized manner. At the end of the field phase, the matrix is useful to ensure that sufficient evidence has been collected to answer all evaluation questions or, on the contrary, to identify gaps that require additional data collection. In the reporting phase, the evaluators should use the data and information presented in the evaluation matrix to support their analysis (or findings) for each evaluation question.

As the evaluation matrix plays a crucial role at all stages of the evaluation process, it will require particular attention from both the evaluation team and the evaluation manager. The evaluation matrix will be drafted in the design phase and must be included in the design report. The evaluation matrix will also be included in the annexes of the final evaluation report, to enable users to access the supporting evidence for the answers to the evaluation questions.

Finalization of the evaluation questions and related assumptions

Based on the preliminary questions presented in the present terms of reference (section 5.2) and the theory of change underlying the CP (see Annex B), the evaluators are required to refine the evaluation questions. In their final form, the questions should reflect the evaluation criteria (section 5.1) and clearly define the key areas of inquiry of the CPE. The final evaluation questions will structure the evaluation matrix (see Annex D) and shall be presented in the design report.

The evaluation questions must be complemented by a set of critical assumptions that capture key aspects of how and why change is expected to occur, based on the theory of change of the CP. This will allow the evaluators to assess whether the preconditions for the achievement of outputs and the contribution of UNFPA to higher-level results, in particular at outcome level, are met. The data collection for each of the evaluation questions and related assumptions will be guided by clearly formulated quantitative and qualitative indicators, which need to be specified in the evaluation matrix.

Sampling strategy

The UNFPA Bhutan CO will provide an initial overview of the interventions supported by UNFPA, the locations where these interventions have taken place, and the stakeholders involved in these interventions. As part of this process, the UNFPA Bhutan CO has produced an initial stakeholder map to identify the range of stakeholders that are directly or indirectly involved in the implementation, or affected by the implementation of the CP (see Annex C).

Building on the initial stakeholder map and based on information gathered through document review and discussions with CO staff, the evaluators will develop the final stakeholder map. From this final stakeholder map, the evaluation team will select a sample of stakeholders at national and sub-national levels who will be consulted through interviews and/or group discussions during the data collection phase. These stakeholders must be selected through clearly defined criteria and the sampling approach outlined in the design report. In the design report, the evaluators should also make explicit what groups of stakeholders were not included and why. The evaluators should aim to select a sample of stakeholders that is as representative as possible, recognizing that it will not be possible to obtain a statistically representative sample.

The evaluation team shall also select a sample of sites that will be visited for data collection, and provide the rationale for the selection of the sites in the design report. The UNFPA Bhutan CO will provide the evaluators with necessary information to access the selected locations, including logistical requirements and security risks, if applicable. The sample of sites selected for visits should reflect the variety of interventions supported by UNFPA, both in terms of thematic focus and context.

The final sample of stakeholders and sites will be determined in consultation with the evaluation manager, based on the review of the design report.

Data collection

The evaluation will consider primary and secondary sources of information. For detailed guidance on the different data collection methods typically employed in CPEs.

Primary data will be collected at the national and district levels through semi-structured interviews with key informants at national and sub-national levels (government officials, representatives of implementing partners, civil society organizations, other United Nations organizations, and other stakeholders), as well as group discussions with service providers and rights-holders (notably women, adolescents and youth) and direct observation during visits to selected sites. Depending on the evolving COVID19 pandemic, if direct observation or face to face meetings are not allowed, the evaluation team will employ remote data collection methods that can include web-based or cell phone-based surveys and individual and/group interviews with key stakeholders, including beneficiaries. If it will be feasible for a local evaluation team member to undertake domestic travel for data collection, he/she will be virtually guided by the team leader.

Secondary data will be collected through document (policy, strategy and reports) review, primarily focusing on annual work plans, quarterly work plan progress reports, monitoring data and donor reports for projects of the CO, evaluations and research studies (incl. previous CPEs, mid-term reviews of the CP, evaluations by the UNFPA Evaluation Office, research by international NGOs and other United Nations organizations, etc.), housing census and population data, and records and data repositories of the CP and its implementing partners, such as health clinics/centres. Particular attention will be paid to compiling data on key performance indicators of the UNFPA Bhutan CO during the period of the 7th CP (2019-23).

The evaluation team will ensure that data collected is disaggregated by sex, age, location and other relevant dimensions, such as disability status, to the extent possible.

The evaluation team is expected to dedicate a total of four weeks for data collection in the field. The data collection tools that the evaluation team will develop, which may include protocols for semi-structured interviews and group discussions, survey questionnaire, checklists for direct observation at sites visited or a protocol for document review, shall be presented in the design report.

Data analysis

The evaluation matrix will be the major framework for analyzing data. The evaluators must enter the qualitative and quantitative data in the evaluation matrix for each evaluation question and each assumption. Once the evaluation matrix is completed, the evaluators should identify common themes and patterns that will help to answer the evaluation

Questions. The evaluators shall also identify aspects that should be further explored and for which complementary data should be collected, to fully answer all the evaluation questions and thus cover the whole scope of the evaluation.

The following methods of data analysis and synthesis are encouraged to be used:

- Descriptive analysis - to identify and understand the contexts in which the programme has evolved, and to describe the types of interventions and other characteristics of the programme.
- Content analysis - to analyze documents, interviews, group discussions and focus groups notes to identify emerging common trends, themes and patterns for each key evaluation question, at all levels of analyses. Content analysis can be used to highlight diverging views and opposing trends. The emerging issues and trends provide the basis for preliminary observations and evaluation findings.
- Comparative analysis - to examine evidence on specific themes or issues across different areas of programme implementation. It can be used to identify good practices, innovative approaches and lessons learned.
- Quantitative analysis - to interpret quantitative data, in particular data emerging from programme annual reports, studies and reports, and financial data.
- Contribution analysis - to assess the extent to which the country programme contributed to expected results. The team is encouraged to gather evidence to confirm the validity of the theory of change, and to identify any logical and information gaps that it contained; examine whether and what types of alternative explanations/reasons exist for noted changes; test assumptions, examine influencing factors, and identify alternative assumptions for each pathway of change.

Validation mechanisms

All findings of the evaluation need to be firmly grounded in evidence. The evaluation team will use a variety of mechanisms to ensure the validity of collected data and information . These mechanisms include (but are not limited to):

- Systematic triangulation of data sources and data collection methods
- Regular exchange with the evaluation manager at the CO;
- Internal evaluation team meetings to corroborate data and information for the analysis of assumptions, the formulation of emerging findings and the definition of preliminary conclusions; and
- The debriefing meeting with the CO and the ERG at the end of the field phase, when the evaluation team present the emerging findings of the evaluation.

Data validation is a continuous process throughout the different evaluation phases. The evaluators should check the validity of the collected data and information and verify the robustness of findings at each stage of the evaluation, so they can determine whether they should further pursue specific hypotheses (related to the evaluation questions) or disregard them when there are indications that these are weak (contradictory findings or lack of evidence, etc.).

A validation workshop with a wider group of stakeholders, not limited to Implementing Partners and the ERG, will be conducted to discuss evaluation findings, conclusions and recommendations before the final report is submitted. This opportunity will allow integrating comments from stakeholders into the final evaluation report. ERG members will review draft reports and participate in validation meetings.

The validation mechanisms will be presented in the design report.

7. Evaluation Process

The CPE process can be broken down into five different phases that include different stages and lead to different deliverables: preparatory phase; design phase; field phase; reporting phase; and phase of

dissemination and facilitation of use. The evaluation manager and the evaluation team leader must undertake quality assurance of each deliverable at each phase and step of the process, with a view to ensuring the production of a credible, useful and timely evaluation.

7.1. Preparatory Phase

The evaluation manager at the UNFPA Bhutan CO will lead the preparatory phase of the CPE, which includes:

- Establishment of the ERG.
- Compilation of background information and documentation on the country context and CP for desk review by the evaluation team in the design phase.
- Drafting the terms of reference (ToR) for the CPE with support from the regional M&E adviser in UNFPA (APRO) and in consultation with the ERG, and submission of the draft ToR (without annexes) to the UNFPA Evaluation Office for review and approval.
- Publication of the call for the evaluation consultancy.
- Completion of the annexes to the ToR with support of the CO staff.
- Pre-selection of consultants by the CO with support of APRO Regional M&E Adviser, pre-qualification of the consultants by the UNFPA Evaluation Office, and recruitment of the consultants by the CO to constitute the evaluation team.

7.2. Design Phase

- In the design phase, the evaluation manager will lay the foundation for communications around the CPE. All other activities will be carried out by the evaluation team, in close consultation with the evaluation manager and the ERG. This phase includes:
 - Evaluation kick-off meeting between the evaluation manager and the evaluation team.
 - Development of an initial communication plan by the evaluation manager, in consultation with the communication officer in the UNFPA Bhutan CO to support the dissemination and facilitation of use of the evaluation results. The initial communication plan will be updated during each phase of the evaluation, as appropriate, and finalized for implementation during the dissemination and facilitation of use phase.
 - Desk review of background information and documentation on the country context and CP, as well as other relevant documentation.
 - Review and refinement of the theory of change underlying the CP (see Annex B).
 - Formulation of a final set of evaluation questions based on the preliminary evaluation questions provided in the ToR.
 - Development of a final stakeholder map and a sampling strategy to select sites to be visited and stakeholders to be consulted in Bhutan through interviews and group discussions.
 - Development of a data collection and analysis strategy, as well as a concrete and feasible evaluation work plan and agenda for the field phase.
 - Development of data collection methods and tools, assessment of limitations to data collection and development of mitigation measures.
 - Development of the evaluation matrix (evaluation criteria, evaluation questions, related assumptions, indicators, data collection methods and sources of information).
- At the end of the design phase, the evaluation team will develop a design report that presents a robust, practical and feasible evaluation approach, detailed methodology and work plan. The evaluation team will develop the design report in consultation with the evaluation manager and the ERG and submit it to the regional M&E adviser in UNFPA APRO for review. The template for the design report is provided in Annex F.

7.3. Field Phase

The evaluation team will collect the data and information required to answer the evaluation questions in the field phase. Towards the end of the field phase, the evaluation team will conduct a preliminary analysis of the data to identify emerging findings that will be presented to the CO and the ERG. The field phase

should allow the evaluators sufficient time to collect valid and reliable data to cover the thematic scope of the CPE. A period of five weeks for data collection is planned for this evaluation. However, the evaluation manager will determine the optimal duration of data collection, in consultation with the evaluation team during the design phase.

The field phase includes:

- Meeting with the UNFPA Bhutan CO staff to launch the data collection.
- Meeting of the evaluation team with relevant programme officers at the UNFPA Bhutan CO.
- Data collection at national and sub-national levels.

At the end of the field phase, the evaluation team will hold a debriefing meeting with the CO and the ERG. The first meeting will be conducted with the UNFPA CO to validate and correct any misinterpretation of evidence. The second meeting with ERG and other relevant stakeholders to validate findings and discuss preliminary conclusions and recommendations. These meetings will serve as a mechanism for the validation of collected data and information and the exchange of views between the evaluators and important stakeholders. It will enable the evaluation team to refine the findings, which is necessary so they can then formulate their conclusions and develop credible and relevant recommendations.

7.4. Reporting Phase

In the reporting phase, the evaluation team will continue the analytical work (initiated during the field phase) and prepare a draft evaluation report, taking into account the comments and feedback provided by the CO and the ERG at the debriefing meeting at the end of the field phase.

Prior to the submission of the draft report to the evaluation manager, the evaluation team must perform an internal quality control against the criteria outlined in the Evaluation Quality Assessment (EQA) grid (see Annex G). The evaluation manager, other CO colleagues and the regional M&E adviser in UNFPA APRO will subsequently review the draft evaluation report, using the same criteria (defined in the EQAA grid). If the quality of the report is satisfactory (in form and substance), the draft report will be circulated to the ERG members for review. In the event that the quality of the draft report is unsatisfactory, the evaluation team will be required to revise the report and produce a second draft.

The evaluation manager will collect and consolidate the written comments and feedback provided by the members of the ERG. On the basis of the comments, the evaluation team should make appropriate amendments, prepare the **final evaluation report** and submit it to the evaluation manager. The final report should clearly account for the strength of evidence on which findings rest to support the reliability and validity of the evaluation. Conclusions and recommendations need to clearly build on the findings of the evaluation. Each conclusion shall make reference to the evaluation question(s) upon which it is based, while each recommendation shall indicate the conclusion(s) from which it logically stems.

The evaluation report is considered final once it is formally approved by the evaluation manager in the UNFPA Bhutan CO in consultation with regional M&E Adviser.

At the end of the reporting phase, the evaluation manager and the regional M&E adviser will jointly prepare an internal EQAA of the final evaluation report and the Regional M&E Advisor will submit the final report and the draft EQAA to EO to conduct the external quality assessment of the evaluation report. The Evaluation Office will subsequently conduct the final EQAA of the report, which will be made publicly available in the UNFPA evaluation database.

7.5. Dissemination and Facilitation of Use Phase

In the dissemination and facilitation of use phase, the evaluation team will develop a **PowerPoint presentation of the evaluation results** that summarizes the key findings, conclusions and recommendations of the evaluation in an easily understandable and user-friendly way.

The evaluation manager will finalize the **communication plan** together with the communication officer in the UNFPA Bhutan CO. Overall, the communication plan should include information on (i) target audiences of the evaluation; (ii) communication products that will be developed to cater to the target audiences' knowledge needs; (iii) dissemination channels and platforms; and (iv) timelines. At a minimum, the final evaluation report will be accompanied by a PowerPoint presentation of the evaluation results (prepared by the evaluation team) and an evaluation brief (prepared by the evaluation manager).

Based on the final communication plan, the evaluation manager will share the evaluation results with the CO staff (incl. senior management), implementing partners, APRO, the ERG and other target audiences, as identified in the communication plan. While circulating the final evaluation report to relevant units in the CO, the evaluation manager will also ensure that these units prepare their response to recommendations that concern them directly. The evaluation manager will subsequently consolidate all responses in a final **management response** document. In a last step, The UNFPA Bhutan CO will submit the management response to the UNFPA Policy and Strategy Division in HQ.

The evaluation manager, in collaboration with the communication officer in the UNFPA BhutanCO, will also develop an **evaluation brief**. This concise note will present the key results of the CPE, thereby making them more accessible to a larger audience (see sections 8 and 10 below).

The final evaluation report, along with the management response and the final EQAA will be included in the UNFPA evaluation database.¹⁴² The final evaluation report will also be circulated to the UNFPA Executive Board. Finally, the final evaluation report, the evaluation brief and the management response will be published on the UNFPA Bhutan CO website.

8. Expected Deliverables

The evaluation team is expected to produce the following deliverables:

- **Design report.** The design report should translate the requirements of the ToR into a practical and feasible evaluation approach, methodology and work plan. It should include (at a minimum): (i) the evaluation approach and methodology (incl. the theory of change and sampling strategy); (ii) the final stakeholder map; (iii) the evaluation matrix (incl. the final evaluation questions, indicators, data sources and data collection methods); (iv) data collection tools and techniques (incl. interview and group discussion protocols); and (v) a detailed evaluation work plan and agenda for the field phase. For guidance on the outline of the design report, see Annex F.
- **PowerPoint presentation of the design report.** The PowerPoint presentation will be delivered at an ERG meeting to present the contents of the design report and the agenda for the field phase. Based on the comments and feedback of the ERG, the evaluation manager and the regional M&E adviser, the evaluation team will develop the final version of the design report.
- **PowerPoint presentation for debriefing meeting with the CO and the ERG.** The presentation provides an overview of key emerging findings of the evaluation at the end of the field phase. It will serve as the basis for the exchange of views between the evaluation team, UNFPA Bhutan CO staff (incl. senior management) and the members of the ERG who will thus have the opportunity to provide complementary information and/or rectify the inaccurate interpretation of data and information collected.
- **Draft evaluation report.** The draft evaluation report will present findings, conclusions and recommendations, based on the evidence that data collection yielded. It will undergo review by the evaluation manager, the CO, the ERG and the regional M&E adviser. Based on the comments and feedback provided by these stakeholders, the evaluation team will develop a final evaluation report.

¹⁴² The UNFPA evaluation database can be accessed at the following link:
<https://web2.unfpa.org/public/about/oversight/evaluations/documentList.unfpa>.

- **Final evaluation report.** The final evaluation report (*maximum 70 pages, excluding annexes*) will present the findings and conclusions, as well as a set of practical and actionable recommendations to inform the next programme cycle. For guidance on the outline of the final evaluation report, see Annex H.
- **PowerPoint presentation of the evaluation results.** The presentation will provide a clear overview of the key findings, conclusions and recommendations to be used for the dissemination of the final evaluation report.

Based on these deliverables, the evaluation manager, in collaboration with the communication officer in the UNFPA Bhutan CO will develop an:

- **Evaluation brief.** The evaluation brief will consist of a short and concise document that provides an overview of the key evaluation results in an easily understandable and visually appealing manner, to promote their use among decision-makers and other stakeholders. The structure, content and layout of the evaluation brief should be similar to the briefs that the UNFPA Evaluation Office produces for centralized evaluations.

All the deliverables will be developed in English.

9. Quality Assurance and Assessment

The UNFPA Evaluation Quality Assurance and Assessment (EQAA) system aims to ensure the production of good quality evaluations at central and decentralized levels through two processes: quality assurance and quality assessment. Quality assurance occurs throughout the evaluation process, starting with the ToR of the evaluation and ending with the final evaluation report. Quality assessment takes place following the completion of the evaluation process and is limited to the final evaluation report to assess compliance with a certain number of criteria. The quality assessment will be conducted by the independent UNFPA Evaluation Office.

The EQAA of this CPE will be undertaken in accordance with the guidance and tools that the independent UNFPA Evaluation Office developed (see <https://www.unfpa.org/admin-resource/evaluation-quality-assurance-and-assessment-tools-and-guidance>). An essential component of the EQAA system is the EQA grid (see Handbook, pp. 268-276 and Annex F), which defines a set of criteria against which the draft and final evaluation reports are assessed to ensure clarity of reporting, methodological robustness, rigor of the analysis, credibility of findings, impartiality of conclusions and usefulness of recommendations.

The evaluation manager is primarily responsible for quality assurance of the deliverables of the evaluation in each phase of the evaluation process. However, the evaluation team leader also plays an important role in undertaking quality assurance. The evaluation team leader must ensure that all members of the evaluation team provide high-quality contributions (both form and substance) and, in particular, that the draft and final evaluation reports comply with the quality assessment criteria outlined in the EQA grid (Annex G)¹⁴³ before submission to the evaluation manager for review. The evaluation quality assessment checklist below outlines the main quality criteria that the draft and final version of the evaluation report must meet.

1. Structure and Clarity of the Report

Ensure the report is clear, user-friendly, comprehensive, logically structured and drafted in accordance with standards and practices of international organizations, including the editorial guidelines of the UNFPA Evaluation Office (see Annex I).

¹⁴³ The evaluators are invited to look at good quality CPE reports that can be found in the UNFPA evaluation database, which is available at: <https://web2.unfpa.org/public/about/oversight/evaluations/>. These reports must be read in conjunction with their EQAs (also available in the database) in order to gain a clear idea of the quality standards that UNFPA expects the evaluation team to meet.

<p>2. Executive Summary</p> <p>Provide an overview of the evaluation, written as a stand-alone section, including the following key elements of the evaluation: Purpose of the evaluation and target audiences; objectives of the evaluation and brief description of the country programme; methodology; main conclusions; and recommendations.</p>
<p>3. Design and Methodology</p> <p>Provide a clear explanation of the methods and tools used, including the rationale for the methodological approach and the appropriateness of the methods selected to capture the voices/perspectives of a range of stakeholders, including vulnerable and marginalized groups. Ensure constraints and limitations are made explicit (incl. limitations applying to interpretations and extrapolations in the analysis; robustness of data sources, etc.)</p>
<p>4. Reliability of Data</p> <p>Ensure sources of data are clearly stated for both primary and secondary data. Provide explanation on the credibility of primary (e.g. interviews and group discussions) and secondary (e.g. documents) data collected and make limitations explicit.</p>
<p>5. Analysis and Findings</p> <p>Ensure sound analysis and credible, evidence-based findings. Ensure interpretations are based on carefully described assumptions; contextual factors are identified; cause-and-effect links between an intervention and its end results (incl. unintended results) are explained.</p>
<p>6. Validity of Conclusions</p> <p>Ensure conclusions are based on credible findings and convey the evaluators' unbiased judgment of the intervention. Ensure conclusions are presented in order of priority; divided into strategic and programmatic conclusions (for guidance, see Handbook, p. 238); briefly summarized in a box that precedes a more detailed explanation; and for each conclusion its origin (on which evaluation question(s) the conclusion is based) is indicated.</p>
<p>7. Usefulness and Clarity of Recommendations</p> <p>Ensure recommendations flow logically from conclusions, are realistic and operationally feasible. Ensure recommendations are presented in order of priority; divided into strategic and programmatic recommendations (as done for conclusions); briefly summarized in a box that precedes a more detailed explanation of the main elements of the recommendation and how it could be implemented effectively. For each recommendation, indicate a priority level (high/moderate/low), a target (administrative unit(s) to which the recommendation is addressed), and its origin (which conclusion(s) the recommendation is based on).</p>
<p>8. United Nations System-wide Action Plan (SWAP) Evaluation Performance Indicator – Gender Equality</p> <p>Ensure the evaluation approach is aligned with the United Nations SWAP on Gender Equality and the Empowerment of Women¹⁴⁴ and UNEG guidance on integrating human rights and gender perspectives in evaluation.¹⁴⁵</p>

Using the grid in Annex G, the EQAA process for this CPE will be multi-layered and will involve: (i) the evaluation team leader (and each evaluation team member); (ii) the evaluation manager in the UNFPA Bhutan CO, (iii) the regional M&E adviser in UNFPA APRO and (iv) the UNFPA Evaluation Office, whose roles and responsibilities are described in section 11.

¹⁴⁴Guidance on the SWAP Evaluation Performance Indicator and its application to evaluation is available at: <http://www.unevaluation.org/document/detail/1452>.

¹⁴⁵ The UNEG Guidance on Integrating Human Rights and Gender Equality in Evaluations is available at <http://www.uneval.org/document/detail/980>.

10. Indicative Timeframe and Work Plan

The table below indicates all the activities that will be undertaken throughout the evaluation process, as well as their duration or specific dates for the submission of corresponding deliverables. It also indicates all relevant guidance (tools and templates) that can be found in the UNFPA Evaluation Handbook.

Nota Bene: Column “Deliverables”: In italics: The deliverables are the responsibility of the CO/evaluation manager; in bold: The deliverables are the responsibility of the evaluation team.

Evaluation Phases and Activities ¹⁴⁶	Deliverables	Dates/Duration	Handbook/CPE Management Kit
Preparatory Phase			
Preparation of letter for Government and other key stakeholders to inform them about the upcoming CPE	<i>Letter from the UNFPA Country Representative</i>	1 st wk Feb. 2022	
Establishment of the evaluation reference group (ERG)		2 nd -3 rd wk 2022	Template 14: Letter of Invitation to Participate in a Reference Group, p. 277
Compilation of background information and documentation on the country context and the CP for desk review by the evaluation team	<i>Creation of a Google Drive folder containing all relevant documents on country context and CP</i>	1 st wk-2 nd wk Feb. 2022	Tool 8: Checklist for the Documents to be Provided by the Evaluation Manager to the Evaluation Team, pp. 179-183 CPE Management Kit: Document Repository Checklist
Drafting the terms of reference (ToR) based on the ready-to-use ToR (R2U ToR) template (in consultation with the regional M&E adviser and with input from the ERG)	<i>Draft ToR</i>	1 st -2 nd Wk Feb 2022	CPE Management Kit: Evaluation Office Ready-to-Use ToR (R2U ToR) Template
Review and approval of the ToR by the UNFPA Evaluation Office	<i>Final ToR</i>	4 th Feb-1 st wk March 2022	

¹⁴⁶ The activities of the different evaluation phases noted in this table do not necessarily follow the presentation of activities in the UNFPA Evaluation Handbook because they are ordered chronologically and include some additional activities, based on best practices within UNFPA.

Publication of the call for the evaluation consultancy		<i>2nd -3rdWk March 2022</i>	CPE Management Kit: Call for Evaluation Consultancy Template
Completion of the annexes to the ToR (in consultation with the regional M&E adviser and with input from CO staff)	<i>Draft ToR annexes</i>	<i>2nd -3rdWk March 2022</i>	<p>Template 4: The Stakeholders Map, p. 255</p> <p>Tool 4: The Stakeholders Mapping Table, p. 166-167</p> <p>Template 3: List of Atlas Projects by Country Programme Output and Strategic Plan Outcome, pp. 253-254</p> <p>Tool 3: List of UNFPA Interventions by Country Programme Output and Strategic Plan Outcome, pp. 164-165</p> <p>Template 15: Work Plan, p. 278</p> <p>CPE Management Kit: Establishing the list of UNFPA interventions (Atlas projects)</p>
Pre-selection of consultants by the CO	<i>Consultant pre-selections scorecard</i>	<i>4thwk March . 2022</i>	CPE Management Kit: Consultant Pre-selection Scorecard
Pre-qualification of consultants by the UNFPA Evaluation Office		<i>2nd – 3rdWk April 2022</i>	
Recruitment of the evaluation team by the CO		<i>4thwk April - 1stwk May 2022</i>	

Design Phase

<p>Evaluation kick-off meeting between the evaluation manager, the evaluation team and the regional M&E adviser</p>		<p>2ndwk May 2022</p>	
<p>Development of an initial communication plan by the evaluation manager (in consultation with the communication officer in the CO)</p>	<p><i>Initial communication plan</i></p>	<p>2ndwk May 2022</p>	<p>Template 16: Communication Plan for Sharing Evaluation Results, p. 279</p> <p>CPE Management Kit: Guidance on Strategic Communication for a CPE</p>
<p>Desk review of background information and documentation on the country context and the CP (incl. bibliography and resources in the ToR)</p>		<p>2nd -3rd Week May 2022</p>	
<p>Drafting of the design report (incl. approach and methodology, theory of change, evaluation questions, duly completed evaluation matrix, final stakeholder map and sampling strategy, evaluation work plan and agenda for the field phase)</p>	<p>Draft design report</p>	<p>3rdwk May l- 1stwk June 2022</p>	<p>Template 8: The Design Report for CPE, pp. 259-261</p> <p>Tool 5: The Evaluation Questions Selection Matrix, pp. 168-169</p> <p>Tool 1: The Evaluation Matrix, pp. 138-160</p> <p>Template 5: The Evaluation Matrix, pp. 256</p> <p>Template 15: Work Plan, p. 278</p> <p>Tool 10: Guiding Principles to Develop Interview Guides, pp. 185-187</p>

			<p>Tool 11: Checklist for Sequencing Interviews, p. 188</p> <p>Template 7: Interview Logbook, p. 258</p> <p>Tool 9: Checklist of Issues to be Considered When Drafting the Agenda for Interviews, pp. 183-187</p> <p>Template 6: The CPE Agenda, p. 257</p> <p>Tool 6: The CPE Agenda, pp. 170-176</p> <p>CPE Management Kit: Compilation of Resources for Remote Data Collection (if applicable)</p>
Review of the draft design report by the evaluation manager and the regional M&E adviser	<i>Consolidated feedback provided by evaluation manager to evaluation team leader</i>	2 nd wk June 2022	
Presentation of the draft design report to the ERG for comments and feedback	PowerPoint presentation of the draft design report	3 rd wk June 2022	
Revision of the draft design report and circulation of the final version to the APRO M&E Adviser for approval	Final design report	4 th wk June 2022	

Update of the communication plan by the evaluation manager, in particular target audiences and timelines (based on the final stakeholder map and the evaluation work plan presented in the approved design report)	<i>Updated communication plan</i>	<i>1stwk July 2022</i>	Template 16: Communication Plan for Sharing Evaluation Results, p. 279 CPE Management Kit: Guidance on Strategic Communication for a CPE
Field Phase			
Inception meeting for data collection with CO staff	<i>Meeting between evaluation team/CO staff</i>	<i>2ndwk July 2022</i>	Tool 7: Field Phase Preparatory Tasks Checklist, pp. 177-183
Individual meetings with relevant CO programme officers	<i>Meeting of evaluators/CO programme officers</i>	<i>2ndwk July 2022</i>	
Data collection (incl. interviews with key informants, site visits for direct observation, group discussions, document review, etc.)	Entering data/information into the evaluation matrix	<i>3rdwk July to 2nd Aug 2022</i>	Tool 12: How to Conduct Interviews: Interview Logbook and Practical Tips, pp. 189-202 Tool 13: How to Conduct a Focus Group: Practical Tips, pp. 203-205 Template 9: Note of the Results of the Focus Group, p. 262 CPE Management Kit: Compilation of Resources for Remote Data Collection (if applicable)
Debriefing meeting with CO staff and the ERG to present emerging findings and preliminary conclusions after data collection	PowerPoint presentation for debriefing with the CO and the ERG	<i>2ndwk Aug. 2022</i>	

Update of the communication plan by the evaluation manager (as required)	<i>Updated communication plan</i>	2 nd wk Aug. 2022	<p>Template 16: Communication Plan for Sharing Evaluation Results, p. 279</p> <p>CPE Management Kit: Guidance on Strategic Communication for a CPE</p>
Reporting Phase			
Drafting of the evaluation report and circulation to the evaluation manager	Draft evaluation report	3 rd wk Aug to 1 st wk Sept. 2022	<p>Template 10: The Structure of the Final Report, pp. 253-264</p> <p>Template 11: Abstract of the Evaluation Report, p. 265</p> <p>Template 18: Basic Graphs and Tables in Excel, p. 288</p>
Review of the draft evaluation report by the evaluation manager, the ERG and the regional M&E adviser	<i>Consolidated feedback provided by evaluation manager to evaluation team leader</i>	2 nd -3 rd wk Sept. 2022	
Drafting of the final evaluation report (incl. annexes) and circulation to the evaluation manager	Final evaluation report (incl. annexes)	4 th wk Sept to 1 st wk Oct. 2022	
Joint development of the EQAA of the final evaluation report by the evaluation manager and the regional M&E adviser	<i>EQA of the draft evaluation report (by the evaluation manager and the regional M&E adviser)</i>	1 st -2 nd wk Oct. 2022	<p>Template 13: Evaluation Quality Assessment Grid and Explanatory Note, pp. 269-276</p> <p>Tool 14: Summary Checklist for Human Rights and Gender Equality in the Evaluation Process, pp. 206-207</p> <p>Tool 15: United Nations SWAP Individual Evaluation</p>

			Performance Indicator Scorecard, pp. 208-209
Circulation of the final evaluation report to the UNFPA Evaluation Office		2 nd wk Oct.. 2022	
Preparation of the independent EQAA of the final evaluation report by the UNFPA Evaluation Office	<i>Independent EQA of the final evaluation report (by the UNFPA Evaluation Office)</i>	3 rd -4 th wk Oct 2022	
Update of the communication plan by the evaluation manager (as required)	<i>Updated communication plan</i>	4 th wk Oct 2022	Template 16: Communication Plan for Sharing Evaluation Results, p. 279 CPE Management Kit: Guidance on Strategic Communication for a CPE
Dissemination and Facilitation of Use Phase			
Preparation of the management response by the CO and submission to the Policy and Strategy Division	<i>Management response</i>	1 st -2 nd Wk Nov. 2022	Template 12: Management Response, pp. 266-267
Finalization of the communication plan and preparation for its implementation by the evaluation manager, with support from the communication officer in the CO	<i>Final communication plan</i>	3 rd WkNov.. 2022	Template 16: Communication Plan for Sharing Evaluation Results, p. 279 CPE Management Kit: Guidance on Strategic Communication for a CPE
Development of the presentation on the evaluation results	PowerPoint presentation of the evaluation results	3 rd wk Nov. 2022	Example of PowerPoint presentation (for a centralized evaluation undertaken by the UNFPA Evaluation Office): https://www.unfpa.org/sites/default/files/admin-resource/FINAL_MTE_Supplies_PPT_Long_version.pdf

Development of the evaluation brief by the evaluation manager, with support from the communication officer in the CO	<i>Evaluation brief</i>	3 rd Wk Nov .. 2022	Example of evaluation brief (for a centralized evaluation undertaken by the UNFPA Evaluation Office): https://www.unfpa.org/sites/default/files/admin-resource/UNFPA_MTE_Supplies_Brief_FINAL.pdf
Announcement of CPE completion in M&E Net Community	<i>Blog post on the M&E Net Community</i>	4 th Wk Nov. 2022	CPE Management Kit: Guidance on How to Blog on The CPE Process
Publication of the final evaluation report, the independent EQA and the management response in the UNFPA evaluation database by the Evaluation Office		3 rd Wk Nov. 2022	
Publication of the final evaluation report, the evaluation brief and the management response on the CO website		1 st -3 rd wk Dec. 2022	
Dissemination of the evaluation report and the evaluation brief to stakeholders by the evaluation manager	<i>Including: Communication via email; stakeholders meeting; workshops with implementing partners, etc.</i>	3 rd -4 th Wkdec. 2022	CPE Management Kit: Guidance on Strategic Communication for a CPE

Once the evaluation team leader has been recruited, s/he will develop a detailed **evaluation work plan** (see Annex I) in close consultation with the evaluation manager.

11. Management of the Evaluation

The Head of the office in the UNFPA Bhutan CO will be responsible for the management of the evaluation and supervision of the evaluation team in line with the UNFPA Evaluation Handbook. The evaluation manager will oversee the entire process of the evaluation, from the preparation to the facilitation of the use and the dissemination of the evaluation results. S/he will also coordinate the exchanges between the evaluation team and the ERG. It is the responsibility of the evaluation manager to ensure the quality, independence and impartiality of the evaluation in line with the UNEG norms and standards and ethical guidelines for evaluation. The evaluation manager has the following key responsibilities:

- Establish the ERG.
- Compile background information and documentation on both the country context and the UNFPA CP and file them in a Google Drive to be shared with the evaluation team upon recruitment.
- Prepare the ToR (incl. annexes) for the evaluation, with support from the regional M&E adviser, and submit the ToR and annexes to the Evaluation Office for review and approval.
- Chair the ERG, convene meetings with the evaluation team and manage the interaction between the evaluation team and the ERG.

- Launch and lead the selection process for the team of evaluators in consultation with the regional M&E adviser.
- Identify potential candidates to conduct the evaluation, complete the [Consultant Pre-selection Scorecard](#) to assess their respective qualifications, and propose a final selection of evaluators with support from the regional M&E adviser, to be submitted to the UNFPA Evaluation Office for pre-qualification.
- Share the annexes of the ToR with the final selected evaluators and hold an evaluation kick-off meeting with the evaluation team and the regional M&E adviser.
- Provide evaluators with logistical support for data collection (site visits, interviews, group discussions, etc.).
- Prevent any attempts to compromise the independence of the evaluation team throughout the evaluation process.
- Perform the quality assurance of all the deliverables submitted by the evaluators throughout the evaluation process; notably the design report (focusing on the final evaluation questions, the theory of change, sample of stakeholders to be consulted and sites to be visited, the evaluation matrix, and the methods, tools and plans for data collection), as well as the draft and final evaluation report.
- Coordinate feedback and comments of the ERG on the evaluation deliverables and ensure that feedback and comments of the ERG are adequately addressed.
- Undertake quality assurance of the draft evaluation report in collaboration with the regional M&E adviser, according to the criteria specified in the EQA grid.
- Develop an initial communication plan (in coordination with the CO communication officer) and update it throughout the evaluation process, as required, to guide the dissemination and facilitation of use of the evaluation results.
- Prepare the EQAA of the final evaluation report in collaboration with the regional M&E adviser, using the EQAA grid and its explanatory note.
- Lead and participate in the preparation of the management response.
- Submit the final evaluation report, EQA and management response to the regional M&E adviser, the Evaluation Office and the Policy and Strategy Division at UNFPA headquarters.

At all stages of the evaluation process, the evaluation manager will require support from staff of the UNFPA Bhutan CO. Specifically, the responsibilities of the **country office staff** are:

- Contribute to the preparation of the ToR, the initial stakeholder map, the list of Atlas projects and the compilation of background information and documentation on the context and the CP, and provide input to the evaluation questions.
- Make time for meetings with/interviews by the evaluation team.
- Provide support to the evaluation manager in making logistical arrangements for site visits and setting up interviews and group discussions with stakeholders at national and sub-national levels.
- Provide input to the management response.
- Contribute to the dissemination of the evaluation results.

The progress of the evaluation will be followed closely by the **evaluation reference group (ERG)**, which is composed of relevant UNFPA staff from the Bhutan CO, APRO, representatives of the national Government of Bhutan, implementing partners, as well as other relevant key stakeholders, including organizations representing vulnerable and marginalized groups (e.g. persons with disabilities, etc.) (see Handbook, section 2.3, p.37). The ERG will serve as a body to ensure the relevance, quality and credibility of the evaluation. It will provide inputs on key milestones in the evaluation process, facilitate the evaluation team's access to sources of information and key informants and undertake quality assurance of the evaluation deliverables from a technical perspective. The ERG has the following key responsibilities:

- Support the evaluation manager in the development of the ToR, including the selection of preliminary evaluation questions.
- Provide feedback and comments on the design report.

- Act as the interface between the evaluators and key stakeholders of the evaluation, and facilitate access to key informants and documentation.
- Provide comments and substantive feedback from a technical perspective on the draft evaluation report.
- Participate in meetings with the evaluation team.
- Contribute to the dissemination of the evaluation results and learning and knowledge sharing, based on the final evaluation report, including follow-up on the management response.

The **regional M&E adviser** in UNFPA APRO will provide guidance and backstopping support to the evaluation manager at all stages of the evaluation process. The responsibilities of the regional M&E adviser are:

- Provide feedback and comments on the draft ToR (incl. annexes) in accordance with the UNFPA Evaluation Handbook, and submit the final draft version to the UNFPA Evaluation Office for review and approval.
- Support the evaluation manager in identifying potential candidates and assessing whether they have the appropriate level of qualifications and experience.
- Liaise with the UNFPA Evaluation Office on the completion and approval of the ToR and the selection pre-qualification of the selected evaluation team.
- Review the design report and provide comments to the evaluation manager, with a particular focus on the final evaluation questions, the theory of change, the sample of stakeholders to be consulted and sites to be visited, the evaluation matrix, and the methods, tools and plans for data collection.
- Review the draft evaluation report and provide comments to the evaluation manager.
- Support the evaluation manager in reviewing the final evaluation report.
- Prepare the draft EQAA of the final evaluation report in collaboration with the evaluation manager, using the EQAA grid and its explanatory note, and submit the draft EQAA and the final evaluation report to EO for an independent assessment.
- Ensure the CO complies with the request for a management response.
- Support the CO in the dissemination and use of the evaluation results.

The UNFPA **Evaluation Office** will play a crucial role in the EQAA of the evaluation. The responsibilities of the Evaluation Office are as follows:

- Review and approve the ToR (incl. annexes).
- Review and pre-qualification of the consultants.
- Commission the independent EQAA of the final evaluation report.
- Publish the final evaluation report, independent EQAA and management response in the UNFPA evaluation database.

12. Composition of the Evaluation Team

The evaluation team will comprise of four members: one international consultant – Team Leader, two national consultants – thematic experts and one national young and emerging evaluator.

The evaluation team leader will be recruited internationally (incl. in the region or sub-region), while the evaluation team members, the young and emerging evaluator will be recruited locally to ensure adequate knowledge of the country context. Finally, the evaluation team should have the requisite level of knowledge to conduct human rights- and gender-responsive and disability inclusive evaluations and all evaluators should be able to work in a multidisciplinary team and in a multicultural environment.

12.1. Roles and Responsibilities of the Evaluation Team

Evaluation team leader

The evaluation team leader will hold the overall responsibility for the design and implementation of the evaluation. S/he will be responsible for the production and timely submission of all expected deliverables in line with the ToR. S/he will lead and coordinate the work of the evaluation team and ensure the quality of all evaluation deliverables at all stages of the process. The evaluation team leader will provide methodological guidance to the evaluation team in developing the design report, in particular, but not limited to, defining the evaluation approach, methodology and work plan, as well as the agenda for the field phase. S/he will lead the drafting and presentation of the design report and the draft and final evaluation report, and play a leading role in meetings with the ERG and the CO. The team leader will also be responsible for communication with the evaluation manager. Beyond her/his responsibilities as team leader, the evaluation team leader will serve as technical gender expert. S/HE will cover the Gender component of the evaluation, focusing on gender quality and women's empowerment, with linkages to gender-based violence and domestic violence.

Evaluation team member: SRHR expert

The SRHR expert will provide expertise on Sexual and Reproductive Health including Family Planning, and Adolescents Sexual & Reproductive Health & Rights (ASRHR) components, including comprehensive sexuality/ life skills-based education of the evaluation for both development and humanitarian contexts. S/he will contribute to the methodological design of the evaluation and take part in the data collection and analysis work, with overall responsibility of contributions to the evaluation deliverables in her/his thematic area of expertise. S/he will provide substantive inputs throughout the evaluation process by contributing to the development of the evaluation methodology, evaluation work plan and agenda for the field phase, participating in meetings with the evaluation manager, UNFPA Bhutan CO staff and the ERG. S/he will undertake a document review and conduct interviews and group discussions with stakeholders, as agreed with the evaluation team leader.

Evaluation team member: Population and Development expert

The P&D and gender expert will provide expertise in the area of population dynamics and data for development on gender equality and adolescent/youth empowerment and linkages with other UNFPA programmes in the areas of sexual and reproductive health and rights and population. S/he will contribute to the methodological design of the evaluation and take part in the data collection and analysis work, with overall responsibility of contributions to the evaluation deliverables in her/his thematic area of expertise. S/he will provide substantive inputs throughout the evaluation process by contributing to the development of the evaluation methodology, evaluation work plan and agenda for the field phase, participating in meetings with the evaluation manager, UNFPA Bhutan CO staff and the ERG. S/he will undertake a document review and conduct interviews and group discussions with stakeholders, as agreed with the evaluation team leader.

Evaluation team member: Young and emerging evaluator

The young and emerging evaluator will contribute to all phases of the CPE. S/he will support the evaluation team leader and members in developing the evaluation methodology, reviewing and refining the theory of change, finalizing the evaluation questions, and developing the evaluation matrix, data collection methods and tools, as well as indicators. The young and emerging evaluator will also participate in data collection (site visits, interviews, group discussions and document review) and contribute to data analysis and the drafting of the evaluation report, as agreed with the evaluation team leader. In addition, s/he will provide administrative support throughout the evaluation process and participate in meetings with the evaluation manager, UNFPA Bhutan CO staff and the ERG.

The modalities for the participation of the evaluation team members in the evaluation process, their responsibilities during data collection and analysis, as well as the nature of their respective contributions

to the drafting of the design report and the draft and final evaluation report will be agreed with the evaluation team leader. These tasks will be performed under her/his supervision.

12.2. Qualifications and Experience of the Evaluation Team

Team leader – international consultant

The competencies, skills and experience of the evaluation team leader should include:

- Master's degree in public health, gender studies, social sciences, demography or population studies, development studies or a related field.
- 10 years of experience in conducting or managing evaluations in the field of international development.
- Extensive experience in leading complex evaluations commissioned by United Nations organizations and/or other international organizations and NGOs.
- Demonstrate knowledge on Gender/GBV component of the Evaluation, focusing on gender quality and women's empowerment, with linkages to gender-based violence and domestic violence both in development and humanitarian context
- In-depth knowledge of theory-based evaluation approaches and ability to apply both qualitative and quantitative data collection methods and to uphold high quality standards for evaluation as defined by UNFPA and UNEG.
- Ability to ensure ethics and integrity of the evaluation process, including confidentiality and the principle of do no harm.
- Ability to consistently integrate human rights and gender perspectives in all phases of the evaluation process.
- Excellent management and leadership skills to coordinate the work of the evaluation team, and strong ability to share technical evaluation skills and knowledge.
- Ability to supervise a young and emerging evaluator, create an enabling environment for her/his meaningful participation in the work of the evaluation team, and provide guidance and support required to develop her/his capacity.
- Experience working with a multidisciplinary team of experts.
- Excellent ability to analyze and synthesize large volumes of data and information from diverse sources.
- Excellent interpersonal and communication skills (written and spoken).
- Work experience in/good knowledge of the Asia Pacific region and the national development context of Bhutan.
- Fluent in written and spoken English

SRHR/ASRHR expert – national consultant

- The competencies, skills and experience of the SRHR expert should include:
- Master's degree in public health, medicine, social sciences or a related field.
- 5-7 years of experience in conducting evaluations, reviews, assessments, research studies or M&E work in the field of international development health, particularly in SRHR
- Substantive technical knowledge of SRHR/ASRHR, including HIV and other sexually transmitted infections, maternal health, and family planning, integrated sexual and reproductive health services, HIV and other sexually transmitted infections, maternal health, health sector response to GBV, comprehensive sexuality education, reproductive cancers and SRHR data.
- Ability to ensure ethics and integrity of the evaluation process, including confidentiality and the principle of do no harm.
- Ability to consistently integrate human rights and gender perspectives in all phases of the evaluation process.
- Solid knowledge of evaluation approaches and methodology and demonstrated ability to apply both qualitative and quantitative data collection methods.

- Excellent analytical and problem-solving skills.
- Experience working with a multidisciplinary team of experts.
- Excellent interpersonal and communication skills (written and spoken).
- Work experience in/good knowledge of the national development context of Bhutan
- Familiarity with UNFPA or other United Nations organizations' mandates and activities will be an advantage.
- Fluent in written and spoken English and Dzongkha (National Language).

Population and development– national consultant

The competencies, skills and experience of the PD and gender expert should include:

- Master's degree in demography, social sciences, political science, economics, statistics or related fields,
- Substantive knowledge of and professional experience (minimum 7 years) in population and development, including themes/issues relevant to: demographic trends (e.g. the demographic dividend), national statistical systems and utilization/analysis of census data, evidence-based policy advocacy, democratic governance, population dynamics, adolescents and youth policies and data, legal reform processes, evidence-based national and local development planning, monitoring and evaluation processes.
- Ability to ensure ethics and integrity of the evaluation process, including confidentiality and the principle of do no harm.
- Ability to consistently integrate human rights and gender perspectives in all phases of the evaluation process.
- Solid knowledge of evaluation approaches and methodology and demonstrated ability to apply both qualitative and quantitative data collection methods.
- Excellent analytical and problem-solving skills.
- Experience working with a multidisciplinary team of experts.
- Excellent interpersonal and communication skills (written and spoken).
- Work experience in/good knowledge of the national development context of Bhutan
- Familiarity with UNFPA or other United Nations organizations' mandates and activities will be an advantage.
- Fluent in written and spoken English and Dzongkha (National Language).

Young and emerging evaluator – national consultant

The young and emerging evaluator must be under 35 years of age and her/his competencies, skills and experience should include:

- Bachelor's degree in public health, demography or population studies, social sciences, statistics, development studies or a related field.
- Excellent analytical and problem-solving skills.
- Demonstrated ability to work in a team.
- Strong organizational skills, communication skills and writing skills.
- Good command of information and communication technology and data visualization tools.
- Good knowledge of the mandate and activities of UNFPA or other United Nations organizations will be an advantage.
- Fluent in written and spoken English and Dzongkha (National Language).

Annex 2: Evaluation Matrix

(This is a dynamic document and a working tool for the evaluation team)

Evaluation Matrix
<p>Relevance (assumptions under this criterion are common to all programme areas (two outcome areas SRHR and Adolescents and youth (A&Y))</p> <p>Relevance brings into focus the correspondence between the objectives and support strategies of the CP, on the one hand, and population needs (with a specific attention given to the needs of the most vulnerable and people with disabilities), government priorities, UNDAF priorities and UNFPA global policies and strategies on the other. <i>It also includes an assessment of the responsiveness of the CP in light of changes and or additional requested from national counterparts, and shifts caused by external factors in an evolving country context (humanitarian, change in government priorities and directives specifically related to COVID-19 pandemic.</i></p>
<p><u>Evaluation question 1(EQ1): To what extent is the UNFPA country programme:</u></p> <ul style="list-style-type: none">v) <i>adapted to the needs of vulnerable* including persons with disabilities (PWD) both during the design and implementation of all the UNFPA-supported interventions in development and humanitarian contexts in line with the priorities set by national and international policy and normative frameworks</i>vi) <i>aligned to the national development strategies and policies;</i>vii) <i>is in line with the 2030 Agenda, UNFPA Strategic Plan 2018-21 and 2022-25 (particularly the transformative goals and business model) and UN partnership framework;</i>viii) <i>able to respond to changes in national needs and priorities caused by contextual changes (such as COVID19 & humanitarian situations) in the context of the outcome areas</i>

*Vulnerable as per 7th CPD includes adolescents and youth, victims of GBV, vulnerable urban dwellers, unemployed youth, persons practising risky sexual behaviour, LGBTQI communities, persons with disabilities

Assumptions to be assessed	Indicators	Sources of Information (not an exhaustive list)	Methods and tools for data collection
<p><i>(Relevance specific to Development and humanitarian context)</i></p> <p>1.adapted to the needs of vulnerable* including persons with disabilities (PWD) both during the design and implementation of all the UNFPA-supported interventions in line with the priorities set by national and international policy and normative frameworks</p>	<ul style="list-style-type: none"> - Programme and project design have been informed by vulnerability surveys and needs assessments and other studies/analysis of vulnerable populations including PWD in development context - The extent to which the CP design and interventions have taken into account the needs, challenges and inequalities and discrimination of the most vulnerable populations including PWD - Evidence of involvement of the vulnerable groups including PWD in implementation and monitoring - Emergency response plans (during humanitarian and pandemics) take into account the needs of the vulnerable including PWD 	<p>Secondary data</p> <ul style="list-style-type: none"> - CPD - CPAP - Annual WPs (AWPs) -Annual reports - Project documents - Theory of change (TOC) - Implementing partners' (IP's)reports -Vulnerability assessments, studies of vulnerable populations -M&E data if disaggregated information is available -Meta Data for CP9, M&E data base (SIS) -- CCA, UNSDPF 2019-23 - 12th FYP -National disaster management documents/ national preparedness and response plans for COVID <p>Primary data</p> <p>Semi-structured interviews and focus group discussions (see list in methodology)</p>	<p>Desk Review</p> <p><i>(Hybrid models of data collection methods and tools will apply throughout the CPE)</i></p> <p>Semi-structured key informant interview (on-line or in person)</p> <ul style="list-style-type: none"> -UNRC, RCO staff, -UNFPA (senior management Team (SMT) and programme officers (PO) -Government partners (GNHC, MOH:P PD, RMNCH, AHP, MOE: DYC, SEN) -RENEW and other Relevant CSOs and organizations <p>Focus group discussions</p> <p>Beneficiaries (PWD, vulnerable groups (as possible)</p>

Assumptions to be assessed	Indicators	Sources of Information (not an exhaustive list)	Methods and tools for data collection
<p><i>Alignment of CP7 to national priorities and strategies</i></p> <p>2. UNFPA support and its specific interventions in CP7 are aligned with national priorities and strategies on SRHR and adolescents and young people with focus on vulnerable including PWD and contributes to 12FYP agency specific and national key results areas</p>	<ul style="list-style-type: none"> - Extent to which the objectives and strategies of the each of the two programme components are consistent with the national sectoral plans and policies , at the national level and at the sub-national level - Extent to which the objectives and strategies of the 7th CP has been discussed with the national level partners. - Evidence of support to vulnerable including PWD in the CP - Evidence of Follow up of ICPD@25 commitments 	<p>Secondary data</p> <ul style="list-style-type: none"> - 12th FYP - National health policy - National youth policy - National gender equality policy - SRH related policies and strategies (RH strategy, National Strategic Plan of Action for Adolescent Health (NSPAAH), National Cervical Cancer Elimination Strategy) - National Framework for Comprehensive Sexuality Education (CSE) - Assessment of Adolescent Sexual and Reproductive Health (ASRH) services, Y-PEER assessment - AWP - Annual reports - RGOB statement at ICPD@25 in Nairobi <p>Primary data</p> <p>Semi-structured key informant interviews</p>	<p>Desk review/document analysis</p> <p>Semi-structured key informant interviews (on-line or in person)</p> <ul style="list-style-type: none"> - UNFPA SMT, PO - GNHC staff - MOH: Senior officials, PPD, HPD, MSD, RMNCH, AHP - MOE: DYS, SEN, DCPD, SHND - Academia RUB, FoNPH, Paro College of Education - RENEW

Assumptions to be assessed	Indicators	Sources of Information (not an exhaustive list)	Methods and tools for data collection
<p><i>Alignment to UNFPA SP and SDG, UNSDPF</i></p> <p>3. UNFPA support is aligned with the UNFPA Strategic Plan (SP) 2018-21 and 2022-25 (particularly the transformative goals and business model) SDG core principles (Leaving No one Behind (LNB) and reaching the furthest behind first and UN partnership framework</p>	<ul style="list-style-type: none"> - CP 7 priorities are in line with the UNFPA Strategic plan 2018-21 and 2022-25 and its transformative goals and Annexes (esp. business model and working together) - CP7 pays special attention to the six accelerators in the business plan * of SP 2022-25, especially those that were not included in the previous CP - UNFPA CP interventions promote LNB principle by focusing on vulnerable groups as identified in UNSDPF - Programme and project design are in line with the 2030 agenda contributing to the SDGs and with national SDGs - Extent to which the UNFPA support is aligned to outcomes in UNSDPF particularly data outcome and in disaggregating data (as the lead agency) - Partnership strategy 	<p>Secondary data</p> <ul style="list-style-type: none"> -CCA, UNSDPF -UNFPA strategic plan documents 2018-21 and 2022-25 (including business model, results framework) -CPD Results and Resources Framework -CPAP -AWPs -Annual reports - UNDAF evaluation reports --SDG related documents -Partnership strategy --Bhutan’s Secondary Voluntary National Review Report for the United Nations High-Level Political Forum 2021 <p>Primary data</p> <ul style="list-style-type: none"> Semi-structured key informant interviews 	<p>Desk review / document analysis</p> <p>Semi-structured key informant interviews (on-line or in person)</p> <ul style="list-style-type: none"> - UNRC office - Relevant staff of other UN Agencies (UNICEF, WHO, UNDP) - UNFPA SMT, PO - Government partners GNHC – for SDG) -Non-IP CSOs

- Human rights-based and gender transformative approaches, innovation and digitalization, partnerships, SSTC and financing, data and evidence, ‘leaving no-one behind and reaching the furthest behind first’ and resilience and adaptation and complementarity among development, humanitarian action and peace-responsive efforts.

Assumptions to be assessed	Indicators	Sources of Information (not an exhaustive list)	Methods and tools for data collection
<p><i>Response to changes in national needs and priorities</i></p> <p>4. CP has been adapted to respond to changes in national needs and priorities caused by major political and other contextual changes (such as COVID19 & natural calamities)</p>	<ul style="list-style-type: none"> - Extent to which the CO has been to realign budgetary allocations to meet support the response to COVID-19 pandemic - Extent to which the CO has been able to support the government in responding to COVID-19 pandemic in ensuring continuation of life-saving SRH services and GBV prevention and management - Extent to which the response plans of COVID-19 focused on vulnerable including PWD - ?? Focus on Ageing population (COVID) - Extent to which the CO has been able to respond to SRH needs during natural calamities such as floods, earth quake especially for the vulnerable including PWD 	<p>Secondary data</p> <ul style="list-style-type: none"> - National Preparedness and response plan for COVID-19 - Formal requests form RGOB - Revised MOU with RGOB - COVID-19 response plans (UN?) - UNFPA Bhutan situational reports - UNFPA Asia and the Pacific Regional Office (APRO) reports (DFAT report) - NDMA plan - ??UNFPA reports on response to floods/fire - UNINFO data - WHO report on health service gap analysis during COVID <p>Primary data</p> <p>Semi-structured key informant interviews</p>	<p>Desk review/document analysis</p> <p>Semi-structured key informant interviews (on-line or in person)</p> <ul style="list-style-type: none"> - UNFPA SMT, POs - UN RC - UN agencies - GNHC staff - MOH: PPD, RMNH, AHP - MOE: DYS, SCED - EMSD/DDA - DYS - RENEW - Y-PEER network
<p>Coherence (assumptions under this criterion, are common to all programme areas (SRHR & A&Y)</p> <p>Coherence assesses the extent to which country programme interventions are compatible (complementarity, harmonization and coordination) in areas of UNFPA's mandates and with international norms and standards; and co-ordination and the extent to which the intervention is adding value while avoiding duplication of effort including during COVID19 pandemic</p>			
<p><i>Evaluation question (EQ2): To what extent has UNFPA contributed to the functioning and consolidation of the coordination mechanisms of the UNCT, and added value in the country context, including for the COVID-19 response and other humanitarian response and recovery efforts, as perceived by UNCT and national stakeholders (government and Civil Society Organizations (CSOs)?</i></p>			

Assumptions to be assessed	Indicators	Sources of Information (not an exhaustive list)	Methods and tools for data collection
<p><i>Contribution to coordination</i></p> <p>5. UNFPA added value to the development of the one UN work plan, functioning and coordination mechanisms of the UNCT, ensuring synergy and maximizing and optimizing results and in development and humanitarian contexts and ensured that HBRA are followed</p>	<ul style="list-style-type: none"> -UNFPA CP7 priorities are reflected in the UNSDPF - Evidence of the leading role played by UNFPA in working groups or joint initiatives in areas under its mandate -Joint analysis and programming efforts with other UN agencies - Opportunities for joint programming identified and realized -UNFPA’s role in UNCT coordination/working groups related in topics related to its mandate and ensuring GEEW and HRBA -Evidence of consultative meetings with other UN agencies in areas of overlapping themes in design and implementation stages --UN RC’s valuation of UNFPA role in the coordination in development context -UN agencies’ valuation of UNFPA role in delivering UNSDPF 	<p>Secondary data</p> <ul style="list-style-type: none"> -CPD - CPAP -Annual report -CCA -UNSDPF -One UN AWP - UNSDPF M&E - Project documents -Report of UN joint working groups -Partnership strategy -UN youth policy? - <p>Primary data</p> <ul style="list-style-type: none"> -Semi-structured key informant interviews 	<p>Desk review/document analysis</p> <p>Semi-structured key informant interviews (on-line or in person)</p> <ul style="list-style-type: none"> - UNFPA SMT and PO - UN RC and staff - UNPME - UN outcome group lead and CO leads <p>-SMT of UN agencies</p>
<p>6.UNFPA provided leadership and ensured that the issues related to SRHR and GEEW have been addressed in joint UN response to humanitarian</p>	<ul style="list-style-type: none"> -- Evidence of UNFPA’s role joint programming during humanitarian crisis and during COVID-19 pandemic in ensuring SRHR services including for adolescents 	<p>Secondary data</p> <ul style="list-style-type: none"> - National Preparedness and response plan for COVID-19 - COVID-19 response plans (UN) - UNFPA COVID-19 situational assessment reports - UN Info 	<p>Desk review/document analysis</p> <p>Semi-structured key informant interviews (on-line or in person)</p> <ul style="list-style-type: none"> - UNFPA SMT and POs - -UNRC - UN women (UNDP)

<p>and COVID response and preparedness plan</p>	<p>UNFPA's role in humanitarian coordination structure including in GBV working group</p> <ul style="list-style-type: none"> -UN RC's valuation of UNFPA role in the coordination humanitarian programming and COVID-19 response - UN agencies' valuation of UNFPA's role in humanitarian and COVID response 	<p>Primary data</p> <p>Semi-structured key informant interviews</p>	<ul style="list-style-type: none"> - WHO - Other UNCT members
<p>7. UNFPA added value by partnering with government and academia, and CSOs working towards same objective (same end results) without duplicating efforts (and resources) in the development as well as humanitarian contexts <i>(external synergy)</i></p>	<ul style="list-style-type: none"> - Coherence with Government programmes in terms of the coordination efforts of the common outcome areas of the programme and design of interventions - Evidence of consultative meetings at the inception of programme interventions - Evidence of UNFPA's unique contribution to national priorities through CP interventions - Evidence of Follow up of ICPD@25 commitments - Implementing partners' valuation of UNFPA's added value in programme areas (Government and CSOs) - UN partner's valuation of UNFPA's leadership/added values - Programme priorities reflect comparative advantage of UNFPA as an advocate, convenor and technical leader in supporting and advancing SRHR including A&Y 	<p>Secondary data</p> <ul style="list-style-type: none"> - Government development strategies and policies in each of the programme components SRHR and A&Y - National Gender policy - Government strategies on prevention of GBV and management - RGOB statement at ICPD@25 in Nairobi - CSO partners' strategies and policies - AWP - Annual reports - Partnership strategy <p>Primary data</p> <ul style="list-style-type: none"> -Semi-structured key informant interviews 	<p>Desk review/document analysis</p> <p>Semi-structured key informant interviews (on-line or in person)</p> <ul style="list-style-type: none"> -UNFPA SMT, PO -MOH: PPD, RMNCH, AHP - MOE: DYS, DCPD -RUB, FONPH -Monastic institutions -RENEW - other CSO partners in each of the programme areas

Effectiveness: Effectiveness criterion assesses each output separately except for common areas of integration such as GEEW and HRBA and population and development issues)

Effectiveness is the extent to which CP outputs have been achieved, and the extent to which these outputs have contributed to the achievement of the CP outcomes and will require a comparison of the intended goals, outcomes and outputs with the actual achievement in terms of results

Evaluation question 3 (EQ 3): To what extent have the interventions supported by UNFPA delivered outputs have been achieved and contributed to the achievement of the outcomes of the CP including the degree of achievement of the outcomes in both development as well as humanitarian setting/COVID-19 pandemic ? And what are the facilitating and hindering factors in achievement of intended results and unintended results ?

Evaluation question 4 (EQ 4): EQ 4: To what extent has UNFPA support to the outcome areas strengthened the policy and legal frameworks and strategies to advance gender equality and reproductive rights both in development and humanitarian contexts?

Evaluation question 5 (EQ 5): TO what extent has UNFPA successfully integrated population and development issues as relevant into each of the outcome areas to provide evidence for advocacy and policy?

Sexual and reproductive health

SP Outcome 1: Every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated sexual and reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence

CP output 1: Increased national capacities to ensure universal and equitable access to high quality sexual and reproductive health information and services

Assumptions to be assessed	Indicators	Sources of Information (not an exhaustive list)	Methods and tools for data collection
<p><i>Output results due to interventions (EQ 3)</i></p> <p>8. a SRHR output on increasing national capacities to ensure universal and equitable access to high quality SRH services and information achieved taking</p>	<ul style="list-style-type: none"> - Proportion of district hospitals offering high quality integrated adolescent-friendly sexual and reproductive health information and services. - Proportion of district hospitals with at least 3 service providers trained on rights-based and gender-responsive standards of contraceptive information and services. 	<p>Secondary data</p> <ul style="list-style-type: none"> -CPD indicator tracking tool -UNFPA M&E reports -National surveys/assessments -Annual health bulletin (2020-2022) -Near-miss assessment report 	<p>Desk review/document analysis</p> <p>Semi-structured key informant interviews (on-line or in person)</p> <ul style="list-style-type: none"> -UNFPA SMT, POs, M&E -DHO -District hospital staff -FONPH -MOH: RMNCH, AHP

<p>into consideration the potential changes to the CP work plans (<i>results indicators</i>)</p>	<ul style="list-style-type: none"> - Updated protocol for clinical management of gender-based violence implemented in selected districts to strengthen the health sector response to violence 		
<p>.UNFPA’s technical assistance and programmatic inputs at national level have contributed to :</p> <p>8.b Creating an enabling environment for delivery of rights-based and gender responsive SRHR services with focus on A&Y through support for rights-based and gender responsive policies and frameworks with focus vulnerable including PWD</p> <p>(aligned with changed TOC)</p>	<ul style="list-style-type: none"> - Evidence of identification of Implementation gaps in existing policies in consultation with Government and CSOs and addressing the same - Evidence of supporting generation of evidence on SRH needs of adolescents and young people as well as VAW /GBV -Evidence of UNFPA support to national adolescent health strategy and costing of national plan of action completed and obtaining approval - Evidence of support to updating of national FP standards to meet the needs of the current context -- Provision of evidence and advocating to decision makers on SRHR issues including GBV 	<p>Secondary data</p> <ul style="list-style-type: none"> - CPD/CPAP - TOC - AWP’s - IP’s reports?? - Documentation of the gaps identified through consultations with government and CSOs - Strategies for addressing gaps?? - National adolescent health strategy including costing and evidence of approval - Updated FP standards - EmoNC NA report - Near-miss review reports - MDSR reports - Information generated on SRH needs of AY - Assessment report to access and availability of ASRH services - Y-PEER assessment - Assessment of adolescent health and nutrition (UNICEF) - NCWC’s GBV study report <p>Primary data</p> <p>Semi-structured interviews with key informants, focus group discussions</p>	<p>Desk review/document analysis</p> <p>Semi-structured key informant interviews (on-line or in person)</p> <ul style="list-style-type: none"> -UNFPA POs -MOH: PPD, RMNCH, AHP -MOE-:DYS -RUB - NSB -Community medicine dept, JDWNRH -WHO focal point for ASRH - UNICEF <p>Focus group</p> <p>Adolescents and young people</p>

Assumptions to be assessed	Indicators	Sources of Information (not an exhaustive list)	Methods and tools for data collection
<p>8.c Strengthening health system to deliver high quality integrated SRHR information and services. including for adolescents and young in development and humanitarian contexts</p> <p>(aligned with changed TOC)</p>	<ul style="list-style-type: none"> - Evidence of UNFPA’s contribution to improved capacity of health service providers (HSP) to deliver rights-based, quality on FP , maternal health services, STI/HIV prevention services, counselling and referral mechanisms -Evidence of UNFPA’s support for Introduction of FP and ICM competencies and adolescent health into pre-service curriculum - Evidence UNFPA contribution to health service providers skills in provision of age and gender-specific ASRH services according to AFHS standards -Evidence of UNFPA supporting RHCS information system as part of joint monitoring of services at facility level 	<p>Secondary data</p> <ul style="list-style-type: none"> - Annual work plans - TOC - Report of IPs - Assessments (EmONC NA, near-miss death reviews, MDSR) - Bhutan specific section in SWOM report - Pre-service curriculum of nurses and midwives - Standards for Adolescent Friendly Health Services (AFHS) standards - Reports of capacity building - -Midwifery training standards - -Cervical cancer screening standards, FP standards - Annual health bulletins <p>Primary data</p> <ul style="list-style-type: none"> -Semi-structured interviews with key informants -Observations in facilities -Focus group discussions with health service providers, women 	<p>Desk review and document analysis</p> <p>Semi-structured interviews with key informants</p> <ul style="list-style-type: none"> -UNFPA POs -MOH :Director PH, PPD, RMNH, adolescent health), -Department of medical services (supply) - FONPH -JDWNRH :OBGYN, CH -Referral hospitals :OBGYN District health officials Forensic focal, EmONC focal and AFHS focal in the health facilities <p>Observations in selected facilities</p> <p>FP, ASRH, respectful maternity care, quality ANC</p> <p>Focus group discussions</p> <ul style="list-style-type: none"> - Midwives and nurses -Beneficiaries (women and adolescents)

Assumptions to be assessed	Indicators	Sources of Information (not an exhaustive list)	Methods and tools for data collection
<p>8.d. addressing special needs of women and young girls in development and humanitarian context including GBV</p> <p>(aligned with changed TOC)</p>	<ul style="list-style-type: none"> -Evidence of UNFPA contribution to health system response to GBV through development and adoption of clinical management of GBV -Evidence on capacity building of health service providers in clinical management of victims of GBV -Support to national and local governments to monitor quality of services for GBV survivors -Evidence of technical assistance to emerging RH issues such as cancers of the reproductive organs and infertility -Evidence of technical assistance to develop and implement prevention of sexual exploitation, abuse and harassment 	<p>Secondary data</p> <ul style="list-style-type: none"> - AWP - TOC - Reports of IPs - Protocols on health sector response to GBV - Reports of capacity building - Tools for monitoring GBV services - Tools for screening for infertility - Cervical cancer strategy - Cervical cancer pamphlets - HPV prevalence study - Reports of consultants following up cervical cancer activities - Records of district hospitals that provide special services - PSEA policy draft <p>Primary data</p> <ul style="list-style-type: none"> -Semi-structured interviews with key informants -Focus group discussions 	<p>Desk review and document analysis</p> <p>Semi-structured interviews with key informants</p> <ul style="list-style-type: none"> -UNFPA POs -MOH: RMNCH --JDWNRH:OBGYN, Gyn-ONCO, OSCC -Referral hospitals :OBYM -FoNPH -RENEW -NCWC -Forensic focal, -Staff of EmONC and other health facilities - District and sub-district officials -District health officials <p>Focus group discussions</p> <ul style="list-style-type: none"> -Nurses and midwives of referral facilities -Health service providers of BHUs

Assumptions to be assessed	Indicators	Sources of Information (not an exhaustive list)	Methods and tools for data collection
<p>8.e continuation of comprehensive, life-saving SRH services including for adolescents and management of GBV during COVID-19 pandemic and in humanitarian situations, ensuring coverage of the needs of vulnerable including PWD</p>	<ul style="list-style-type: none"> - Evidence of support to continuation of RMNAH services and care of GBV victims and protection of frontline workers during COVID 19 pandemic - Evidence of contribution to guidelines for maintaining RMNH services including management of GBV victims - Evidence of capacity building of health service providers to deliver services and infection prevention and control - Use of digital applications for delivery of SRH services and information - Inclusion of delivery of Minimum Initial Service Package (MISP) in humanitarian contexts in national disaster response plans - Evidence of support to standardization of service to GBV survivors 	<p>Secondary data</p> <ul style="list-style-type: none"> - AWP's - Resource allocation (revision /addition) - UN joint response to COVID 19 - Guidelines for maintenance of RMNCH services - Guidelines for protection of front-line workers including use of PPE, infection prevention - IP's reports - HMIS data on RMNCH indicators - National COVID-19 response plans - Emergency disaster management plans - Report of capacity building in MISP - Operational manual for shelter homes <p>Primary data</p> <ul style="list-style-type: none"> - Semi-structured interviews with key informants 	<p>Desk review and document analysis</p> <p>Semi-structured interviews with key informants</p> <ul style="list-style-type: none"> -UNFPA POs -MOH:RMNCH, AHP, service delivery) -EMSD/DDA -DHO -Hospitals -RENEW -Gawaling happy home -Selected district shelter home

SP Outcome 2: Every adolescent and youth, in particular adolescent girls, are empowered to realize their sexual and reproductive health and reproductive rights, and participate in sustainable development, humanitarian action and peace- building
Output 2: Young people, in particular adolescents are empowered with knowledge, skills and capabilities to make informed choices about their sexual and reproductive health and rights, and well-being

Assumptions to be assessed	Indicators	Sources of Information (not an exhaustive list)	Methods and tools for data collection
<p>9.a. Output related to empowering adolescents and young people (A&Y) with knowledge, skills and capabilities to make informed choices achieved taking into consideration the potential changes to the CP work plans (<i>results indicators</i>)</p>	<ul style="list-style-type: none"> -Proportion of training institutions and schools implementing rights-based, gender-responsive comprehensive sexuality education -Number of communities with high levels of adolescent pregnancy, implementing evidence-based programmes to reduce early and unplanned pregnancies and empower adolescent -Number of national, subnational and sectoral development planning documents that used evidence and data from the UNFPA supported census and demographic analysis. 	<p>Secondary data</p> <ul style="list-style-type: none"> -CPD indicator tracking tool -UNFPA M&E reports -Annual reports (UNFPA) -MOE/ DYS annual reports - IP's reports -Data on geographical areas with early marriage - Report of implementation of community activities to reduce early marriage 	<p>Desk review and document analysis</p> <p>Semi-structured interviews with key informants</p> <ul style="list-style-type: none"> -GNHC -MOE: DYS (YCD), DCPD - District Officials -District Education Official -RUB: Paro College - NSB RENEW RENEW , CBSS CROB Scouts
<p>UNFPA's technical assistance and programmatic inputs at national level have contributed to:</p> <p>9.b. Building capability /skills of A&Y to make informed choices about SRHR and well-being including vulnerable (includes PWD)</p>	<ul style="list-style-type: none"> -Extent to which UNFPA provided support for updating of the Comprehensive Sexuality Education (CSE) implementation framework -Extent of UNFPA support to piloting in schools and training institutes (Paro) -Evidence of UNFPA contribution to rolling out age appropriate, rights-based, gender-responsive CSE in curriculum of schools - Extent to which UNFPA supported the introduction of CSE in curriculum of schools 	<p>Secondary data</p> <ul style="list-style-type: none"> - AWP - TOC - CSE implementation framework - Reports of implementation of CSE in curriculum - Monitoring report by - Reports of IPs - Reports of piloting CSE implementation framework - Reports of scaling up CSE framework 	<p>Desk review and document analysis</p> <p>Semi-structured interviews with key informants</p> <ul style="list-style-type: none"> --UNFPA SMT, POs -MOE: DYS, SEN, DCPD, SHND -PCE -CROB -Staff of selected nunneries and monastic institutions -MOH: AHP

(aligned with changed TOC)	<ul style="list-style-type: none"> -Evidence of support for development and monitoring the implementation of the CSE in curricular activities - Support for piloting standardized Life skills (LS) based CSE being piloted in three monastic schools - Introduction of CSE in schools for PWD - ?Evidence of Y- PEER clubs/networks functional in institutions - Support to development and implementation of sexual harassment guideline in monastic institutions. 	<ul style="list-style-type: none"> - Reports of advocacy and promotional activities in schools to support CSE - Curriculum incorporating CSE - Reports of Y-PEER networks <p>Primary data</p> <ul style="list-style-type: none"> - Semi-structured interviews with key informants - Focus group discussions 	<ul style="list-style-type: none"> -YPEER coordinator -Youth center managers <p>Focus group discussions</p> <ul style="list-style-type: none"> -Students of schools
<p>9.c Creation of enabling environment for A&Y to exercise their reproductive rights (RR), including for vulnerable (includes PWD)</p> <p>(aligned with changed TOC)</p>	<ul style="list-style-type: none"> - Reports of High-level advocacy for RR of A &Y and prevention of GBV in partnership with Government, CSOs, community-based organizations and civil society - Evidence for Policy support for realization of RR including that of PWD and vulnerable - Extent of UNFPA support for review and revision of gender policies to include vulnerable groups - Evidence of strengthening capacity of youth networks to promote information on SRHR/GBV and use of services with focus on vulnerable (includes PWD) -Evidence of providing information on barriers to access SRH services and information by vulnerable including PWD 	<p>Secondary data</p> <ul style="list-style-type: none"> - AWP - TOC - IP's reports - National youth policy - NSPAAH (National strategic plan of action for adolescent health) - Policies on prevention of sexual exploitation, abuse and sexual harassment in monastic institutions, Paro College and RUB - RENEW's policy on prevention of sexual exploitation, abuse and harassment - Assessment reports - Reports of Y-PEER activities - Reports of LGBTIQ networks - Information on barriers (including policy) <p>Primary data</p> <ul style="list-style-type: none"> - Semi-structured interviews - Focus group discussions 	<p>Desk review and document analysis</p> <p>Semi-structured interviews with key informants</p> <ul style="list-style-type: none"> - UNFPA POs -GNHC- -NCWC -MOH: AHP -MOE: DYS (YCD), SCED -District officials -DEO -DHO -RENEW <p>Focus group discussions</p> <ul style="list-style-type: none"> - A&Y -LGBTIQ -Y-PEER coordinators

<p>9.d. Building capacity of communities for enabling changes in social norms and harmful practices (aligned with changed TOC)</p>	<ul style="list-style-type: none"> - Evidence of support for generation of high-quality Identification of root causes for harmful practices including early marriage - Extent of support for development of evidence-based social behavioural change communication strategy and tools and its use - Extent of support to strengthen capacity of monks and nuns, community leaders and youth networks to mobilize communities to prevent harmful practices such as GBV, early marriage 	<p>Secondary data</p> <ul style="list-style-type: none"> - AWP's - TOC - IP's reports - National youth policy - NSPAAH - Assessment reports - Communication tools - Assessment reports - Reports of Y-PEER activities - Reports of LGBTQI networks - Reports of studies on early marriage - NCWC's GBV report <p>Primary data</p> <ul style="list-style-type: none"> - Semi-structured interviews - Focus group discussions 	<p>Desk review and document analysis</p> <p>Semi-structured interviews with key informants</p> <ul style="list-style-type: none"> -UNFPA POs MOH: AHP -MOE: DYS, SCED -CROB - RENEW -RENEW-CBSS - NSB -District officials -GUPs -Nuns and Monks <p>Focus group discussions</p> <ul style="list-style-type: none"> -Y-PEER network members/coordinators -Scout coordinators -LGBTQ
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Assumptions to be assessed	Indicators	Sources of Information (not an exhaustive list)	Methods and tools for data collection
<p>9.e. continuation of comprehensive LSE and CSE education, and activities and protection from GBV and other harmful practices, ensuring access of vulnerable (including PWD) during COVID-19 pandemic</p>	<ul style="list-style-type: none"> - Evidence of support to continuation of ASRH activities and care of GBV victims - Evidence of support to institutions to continue LSE and CSE education - Evidence of Support to Y-PEER networks and other networks on prevention of COVID and sensitizing about GBV and use of ASRH services - Use of digital applications for continuing information and education - Evidence of contribution to guidelines for maintaining ASRH services including management of GBV victims - Evidence for support to establish supportive networks 	<p>Secondary data</p> <ul style="list-style-type: none"> - AWP's - IP's reports - NSPAAH - Assessment reports - E-module on SRHR and GBV - Communication tools (M- power) - Assessment reports - Reports of Y-PEER activities - Reports of LGBTQI networks - HMIS reports of institutions providing AFHS <p>Primary data</p> <ul style="list-style-type: none"> - Semi-structured interviews - Focus group discussions 	<p>Desk review and document analysis</p> <p>Semi-structured interviews with key informants</p> <ul style="list-style-type: none"> -UNFPA POs MOH: AHP -MOE: DYS, SHND, SEN -RENEW -CBSS <p>Focus group discussions</p> <ul style="list-style-type: none"> - Coordinators of Y-PEER -LGBTQI networks
<p><i>Integration of gender and human rights (EQ 4)</i></p> <p>10. UNFPA support to outcome areas at policy and programme level have integrated GEEW and HRBA approaches, supported by evidence, to advance GEEW and reproductive rights especially for adolescent girls and young women who are vulnerable including PWD, both in the</p>	<ul style="list-style-type: none"> - Programme informed by gender analysis and Bhutan's commitment to international normative frameworks - Evidence of support to policy and legal framework related to GEEW - Evidence of support for using HRBAs of non-discrimination and equality, quality and accountability to interventions - Evidence of focus on gender while implementing CSE framework 	<p>Secondary data</p> <ul style="list-style-type: none"> - CPD, CPAP - AWP's - TOC - Annual reports - IP's reports - Gender analysis - CCA - UNSDPF - Human rights council Universal Periodic Review 	<p>Desk review and document analysis</p> <p>Semi-structured interviews with key informants</p> <ul style="list-style-type: none"> - UNFPA PO - UN women/UNDP - UNODC - MOH: RMNCH, AHP - MOE: DYS, DCPD - NCWC staff

<p>developmental and humanitarian contexts</p>	<ul style="list-style-type: none"> - Evidence of support to build capacity of health service providers to deliver rights-based SRH services - Evidence of strengthening multi-sectoral and multi-agency approaches to prevention and management of GBV using a continuum of approach that includes advocacy, health sector and data. - Evidence of application of minimum standards for prevention of and response to GBV and access to life saving EmONC - Evidence of support to build capacity of MSTF-CBSS members on women's empowerment - Evidence of promoting integrated approaches (gender, rights-based) through implementing partners and their sub-contractors - Partnership strategy focus on gender 	<p>-Bhutan's Secondary Voluntary National Review Report for the United Nations High-Level Political Forum 2021</p> <p>-CEDAW reports</p> <ul style="list-style-type: none"> - National gender equality policy - Policies on prevention of sexual exploitation, abuse and sexual harassment in monastic institutions, Paro College and RUB - RENEW's policy on prevention of sexual exploitation, abuse and harassment - Curriculum of nurses and midwives and other health providers - CSE framework - Review of implementation of CSE framework for inclusion of gender - Training reports - Data on GBV - Report of advocacy events - Report of support on - Gender policy review 	<ul style="list-style-type: none"> - RENEW - MSTF-CBSS members - Non-IP CSOs - Y-PEER networks
<p><i>Integration of population and development concerns (EQ5)</i></p> <p>11. UNFPA contributed to strengthening capacity for evidence -based policy and advocacy</p>	<ul style="list-style-type: none"> - Evidence of capacity building of national and sub-national officials to analyse and interpret data - Evidence of capacity building support to district officials to use data for planning and monitoring SDGs - -Evidence of support to building national statistical data base system - ?? Support to institutions and researchers to generate evidence on UNFPA priority areas 	<p>Secondary data</p> <ul style="list-style-type: none"> - AWP's - Annual report - Report of capacity building support - List of thematic papers (aging, young people's dynamics, TFR reversal) - ? implementation research 	<p>Desk review and document analysis</p> <p>Semi-structured interviews with key informants</p> <ul style="list-style-type: none"> -UNFPA POs - GNHC staff - Planning - NSB

	<p>and emerging issues at national and subnational level</p> <ul style="list-style-type: none"> - Number of analytical reports supported by UNFPA including on harmful practices - Support to institutions to provide evidence (i) on trends in implementation of human rights-based and gender transformative programming approaches , (ii) narrowing inequities in access to services by women and girls and vulnerable groups 	<p>Primary data</p> <p>Semi-structured interviews with key informants</p>	<ul style="list-style-type: none"> - RUB - KGUMSB - Other colleges (Sherubtse) - MOH: PPD - MOE: DYS - NCWC - District statistical office
<p>12. UNFPA support has contributed to sustained availability of data for monitoring SDGs and ICPD and disaggregated data with focus on UNFPA mandated areas</p>	<ul style="list-style-type: none"> - Evidence of support to analysis and reporting of big data systems such as Census, national vulnerability assessment, living standards survey, etc. to inform policies on SRHR, adolescents and young people, vulnerable including PWD and for GEEW - Proportion of UNFPA focus SDGs with disaggregated data (gender, vulnerable including PWD) - Evidence of capacity building to analyse data, specifically disaggregated (age, sex disaggregation for SDG reporting, ensuring ‘no one is left behind’ - Evidence of support for census based publications -population projection, age , distribution, fertility trends - Evidence of support to harness information on demographic dividend - Number of policies/strategies influenced by UNFPA supported analysis 	<p>Secondary data</p> <ul style="list-style-type: none"> - AWP - Annual report - Progress of RRF indicators - UNSDPF - Report of Joint UN support to census - Census reports including information on vulnerable including PWD - Census based publications - Report on demographic bonus - National vulnerability assessment - Living standards survey - Population projections - Youth development index - Population situational analysis <p>Primary data</p> <ul style="list-style-type: none"> - Semi-structured interviews with key informants 	<p>Desk review and document analysis</p> <p>Semi-structured interviews with key informants</p> <ul style="list-style-type: none"> -UNFPA POs - GNHC staff - Planning - NSB - KGUMSB - Other colleges (Sherubtse) - MOH (PPD) - NCWC - MoE (DYS)

	- Evidence of support to UNINFO and DEWA dashboard on SDG data		
<p>Efficiency: The <u>efficiency</u> criterion-the extent to which CP outputs and outcomes have been achieved with the appropriate amount of resources and captures how resources such as funds, expertise, time and administrative costs, etc., have been used by the CO and converted into the results along the results chain.</p>			
<p>Efficiency (Common to both outputs)</p> <p><i>Evaluation Question 6 (EQ. 6): To what extent has UNFPA made good use of its human, financial and administrative resources, and used a set of appropriate policies, procedures and tools to pursue the achievement of the outcomes defined in the county programme?</i></p> <p><i>Evaluation Question 7 (EQ. 7): To what extent did UNFPA systems, processes and procedures (particularly in terms of finance, partnerships, logistics, procurement and human resources) foster or, on the contrary, impede the adaptation of the country programme to changes triggered by the COVID-19 crisis?</i></p>			
Assumptions to be assessed	Indicators	Sources of Information (not an exhaustive list)	Methods and tools for data collection
<p><i>Efficiency in use of resources (EQ 7)</i></p> <p>13.CP7 has sufficient financial and adequate human resources with relevant and adequate technical expertise to implement interventions to achieve planned results under all outputs including in development and humanitarian contexts</p>	<ul style="list-style-type: none"> - Yearly budget allocated and spent (by each year) by core and non-core resources - Resource mobilization strategy in place including for response to humanitarian and COVID-19 pandemic -Evidence of resources mobilized -Financial reporting system in place and timely reporting conducted -Evidence of adequacy of UNFPA technical capacity in the outcome areas - Evidence of quality of technical assistance -Program operated with optimal combination of skills of staffing -Evidence of appreciation of UNFPA TA -- Vacancies filled in a prompt manner (no. and duration of vacancies before HR realignment) -Staffing structure (and matching job descriptions) to meet the CP7 programme needs 	<p>Secondary data</p> <ul style="list-style-type: none"> - Budget and expenditure analysis - Planning and tracking tool - Quarterly status reports - SiS annual reports - -Human resource plans - Annual reports - Monitoring reports - Project progress reports - IP's reports - Resource mobilization strategy 	<p>Document review</p> <p>Semi-structured interviews</p> <ul style="list-style-type: none"> - UNFPA SMT, PO, Financial unit staff - Relevant IPs - UN partners in joint programme - UNRCO

	<ul style="list-style-type: none"> -Programme is fully delivered (SIS annual results are fully achieved) -IPs receive resources on time 	<p>Primary data</p> <ul style="list-style-type: none"> - Semi-structured interviews key informants 	
14. CP 7 demonstrated accountability to achieve the outcome including selection of staff with right skills to achieve the planned results (both in development and humanitarian setting)	<ul style="list-style-type: none"> - Periodic reporting to the government partners, donors - Internal reporting compliances - Periodic reporting to Steering Committees of the CP or major projects - Evidence of matching skills to achieve the results - Evidence of built in mechanisms to monitor progress of activities towards output indicators 	<p>Secondary data</p> <ul style="list-style-type: none"> - CPD - Fiscal reports of implementing partners - M&E reports - Planning and tracking tool - Annual and SIS reports - IP reports - Reports of coordination meetings - micro-assessment reports <p>Primary data</p> <ul style="list-style-type: none"> - Semi-structured interviews with key informants 	<p>Desk review/document analysis</p> <p>Semi-structured interviews with key informants</p> <ul style="list-style-type: none"> - UNFPA SMT, M&E focal point - MOH: RMNCH, AHP - MOE: DYS - NSB - RENEW
15.UNFPA has designed its programme strategies and workplans including integration of thematic areas and resources, as relevant to achieve the results indicators, gender responsiveness and HRBA and results-based monitoring mechanisms to monitor progress towards results	<ul style="list-style-type: none"> - Integration across thematic areas - Evidence of greater effectiveness when programmes are implemented in an integrated manner - Strategies and work plans are aligned to/ contribute to results - Efficient monitoring systems to provide timely and quality data on progress towards results indicators (disaggregated, data on vulnerable) - Monitoring systems capture gender responsiveness and HRBA 	<p>Secondary data</p> <ul style="list-style-type: none"> -Annual work plans - Annual report -M&E framework -M &E data -Planning and tracking tool - Progress of results indicators -Annual plans <p>Primary data</p> <p>Semi-structured interviews with key informants</p>	<p>Desk review/document review</p> <p>Semi-structured interview with key informants</p> <ul style="list-style-type: none"> - UNFPA SMT, M&E, PO

<p>16.UNFPA made good use of its partnerships (CSOs, UN partners) to pursue the achievement of the results</p>	<ul style="list-style-type: none"> - Partnership strategy in place including selection criteria for partners - Evidence of transparent selection of implementing partners (expertise and experience) - Evidence of partnership with agencies that work with PWD and vulnerable groups - Consultations held with vulnerable including PWD and youth during ICPD consultation, CEDAW and other voluntary reporting mechanisms of the Government - Continuity in partnerships/ drop outs - Evidence of UN partnership in selected thematic areas such as SRHR, ASRH, ? data systems - Evidence of funding received from UN partners in selected thematic areas 	<p>Secondary data</p> <ul style="list-style-type: none"> - Partnership strategy - AWP - Partnership assessment - IP's reports - Annual reports and SIS reports - Progress reports - Reports of consultations <p>Primary data</p> <p>Semi-structured interviews with key informants</p>	<p>Desk review/Document analysis</p> <p>Semi-structured interview with key informants</p> <ul style="list-style-type: none"> -UNFPA SMT, POs -RENEW -Selected UN agencies
<p><i>Flexibility to adapt resources (EQ8)</i></p> <p>17.UNFPA has flexibility to adapt the level and allocation of its resources to respond to Government priorities not identified at the time of the design phase and to respond to epidemics such as COVID-19 and other humanitarian situations through changes in delivery of interventions</p>	<ul style="list-style-type: none"> - Evidence of re-organized CP budget for COVID-19 - Evidence of re-organizing programmes and procedures for logistics, procurement, etc. for responding to COVID-19 crisis 	<p>Secondary data</p> <ul style="list-style-type: none"> - Fiscal reports - M&E reports - Progress reports <p>Primary data</p> <p>-Semi-structured interviews with key informants</p>	<p>Desk review/document analysis</p> <p>Semi-structured interview with key informants</p> <ul style="list-style-type: none"> -UNFPA SMT, Finance -MOH PPD, RMNCH, AHP -MOE: DYS NSB GNHC UNCT

<p>18.UNFPA has been able to sustain delivery of services, capacity building and learning efforts through innovate technologies such as digital platforms during the pandemic including for vulnerable including PWD</p>	<ul style="list-style-type: none"> - Evidence of UNFPA contribution to - continuation of services through digital platforms - Evidence of contribution to capacity building to deliver services during the pandemic - Evidence of contribution to continue learning efforts A&Y through digital media - Continuation of provision of information on protection to vulnerable including PWD through digital media 	<p>Secondary data</p> <ul style="list-style-type: none"> - Work plan - Annual reports - Training materials adapted for digital use - IP's report - Y-PEER reports - Reports of Scouts <p>Primary data</p> <ul style="list-style-type: none"> - Semi-structured interviews with key stakeholders 	<p>Desk review and document analysis</p> <p>Semi-structured interviews with key stakeholders</p> <ul style="list-style-type: none"> - UNFPA SMT, PO, Communication team -MOH: PPD, RMNCH, AHP -MOE: DYS, SCED
<p>Sustainability:The <u>sustainability</u> is related to the likelihood that benefits from the CP continue after UNFPA funding is terminated and the corresponding interventions are closed. Therefore, the sustainability criterion - the continuation of benefits from a UNFPA - financed intervention after its termination, will assess the overall resilience of benefits to risks that could affect their continuation.</p>			
<p>Sustainability (common to both Outputs)</p> <p><i>Evaluation question 8 (EQ9): To what extent has UNFPA been able to support implementing partners and rights-holders (notably, women, adolescents and youth) in developing capacities and establishing mechanisms to ensure the durability of effects?</i></p> <p><i>Evaluation question 9 (EQ10): To what extent have UNFPA COVID19 response and recovery efforts contributed to strengthening national capacities and systems in the field of SRHR, GBV prevention and data?</i></p>			
<p>Assumptions to be assessed</p>	<p>Indicators</p>	<p>Sources of Information (not an exhaustive list)</p>	<p>Methods and tools for data collection</p>
<p><i>Sustaining effects (EQ 9)</i></p> <p>19.Capacities of implementing partners and beneficiaries have been developed as a result of programme interventions, enhancing durability of efforts</p>	<ul style="list-style-type: none"> - Sustained support for rights-based FP services in the context of fertility reduction - Evidence of capacities of MOH built in terms of ongoing efforts to improve quality of services including rights-based approaches - Evidence of capacities of MOE/DYS/RUB/monastic institutions for A&Y 	<p>Secondary data</p> <ul style="list-style-type: none"> - Annual report - IP's reports - Monitoring reports - Assessment reports - Strategies 	<p>Desk review and document review</p> <p>Semi-structured interviews of key informants and beneficiaries</p> <p>-UNFPA SMT, POs</p>

<p>both during development and humanitarian contexts</p>	<p>built to continue efforts in improving quality of CSE in schools and its expansion</p> <ul style="list-style-type: none"> - Evidence of likelihood of continuation of ASRH educational programmes after UNFPA support has been withdrawn - Evidence of capacities developed of rights-holders especially vulnerable including PWD 	<p>Primary data</p> <ul style="list-style-type: none"> - Semi-structured interview of key informants and beneficiaries 	<ul style="list-style-type: none"> -MOH: RMNCH, AHP -MOE: DYS -DOE -DHO -Students of selected schools and institutions including those with special needs
<p><i>Sustaining effects during COVID-19</i></p> <p>20. UNFPA’s support during COVID-19 has contributed to strengthening national capacities and systems in the field of SRHR, ASRH and GBV prevention and protection activities</p>	<ul style="list-style-type: none"> - Evidence of strengthened institutional capacity to ensure that the SRHR needs of the most vulnerable including PWD are addressed - Evidence of continued partnership between Government, CSOs and community organizations - Evidence of strengthened networks of young people and continued collaboration to reach out to A&Y, especially vulnerable including PWD - Evidence of strengthened community mobilization and participation - The national plans reflect the SRHR needs of women and adolescents and GBV prevention and protection - Evidence of continuation of digital platforms to reach information and services to those in remote areas and for training 	<p>Secondary data</p> <ul style="list-style-type: none"> - Annual reports - IP’s reports - Monitoring reports - Assessment reports - COVID-19 reports <p>Primary data</p> <p>Semi-structured interview of key informants and beneficiaries-</p>	<p>Desk review and document review</p> <p>Semi-structured interviews of key informants and beneficiaries</p> <ul style="list-style-type: none"> -UNFPA SMT, POs -MOH: RMNCH, AHP -MOE: DYS -NCWC -RENEW -Y--PEER

Annex 3: Template for data collection

List of tools

Section A. General

Section B. Specific

- UNFPA programme staff in each outcome area
- UNFPA senior management
- Implementing partners
 - a. Government
 - b. Institutions and CSOs
- UN partners
- District level officials
- Health facility visit

Section C. Guidelines for focus group discussions

Please note that there may be changes after discussions with UNFPA CO and national stakeholders.

Templates and tools for data collection

SECTION A. GENERAL

INTRODUCTORY REMARKS: TALKING POINTS (guidelines only)

- Explanation of the UNFPA 7th country programme (2019-23)
- The purpose of the country programme evaluation (accountability to results, take stock of actual performance and achievements, hindering and facilitating factors that and lessons learnt to design the next UNFPA country programme)
- CPE team: Three- person team with two thematic area experts in sexual and reproductive health and population and development and a team leader (international) and two young evaluators
- Confirming the role played by the interviewee in the country programme implementation
- Inform that the interview will cover both experiences and views on UNFPA's country programme and partnerships and suggestions for future UNFPA programme
- Inform and assure the confidentiality of the discussion in line with UN Evaluation Group norms and standards (Example: won't quote directly, will not share notes with UNFPA, encourage to speak off the record, the report will only highlight common responses among interviewees).
- Mention specific issues you want to learn from the person being interviewed or groups with whom discussions are taking place(refer to individual checklists).

GENERAL GUIDANCE and SEQUENCE FOR ALL INTERVIEWS

1. Begin the interview
 - Ask about experiences with UNFPA as partner or collaborator (responses to be sorted out after the interview in appropriate sections of the evaluation matrix).
 - Probe further to find out what worked well and what has not.
 - For long-term partners such as government or implementing partners, probe about continuity or lack of continuity in initiatives (sustainability)
 - If continuity is mentioned, ease of doing business-----
2. Any significant achievements or contributions of UNFPA-supported programmes that you would like to share (effectiveness)
 - Probe factors that contributed to the achievements (Lessons learned)
3. Ask specific questions as relevant from the specific checklist (SECTION B)
4. At the end of the interview:
 - What suggestions do you have for UNFPA to improve the effectiveness of the current programme (CP 7) and for future programme (CP 8)
 - Are there emerging issues or opportunities for significant development contributions UNFPA should be addressing?

SECTION B. SPECIFIC

UNFPA Staff in each of the outcome areas

Provide assurance about the confidentiality of the interview

Points for discussion - Common to all programme staff except specific section on effectiveness

Relevance of the UNFPA CP 7 in terms of :

- Adequacy of focus on vulnerable populations and persons with disability, while designing and implementing the programme- both in development context and humanitarian context? Give some examples
- Involvement of the vulnerable and persons with disability in the planning and implementation of the programme and give some examples
- Alignment with national policies and programmes related to sexual and reproductive health and rights (SRHR) and Adolescent Sexual and Reproductive Health (ASRH) and contribution to policies and strategies with focus on vulnerable and persons with disability during development and humanitarian contexts
- Contribution to UNFPA corporate goal and outcomes – specify contribution to all outcomes
- Integration with ONE UNSDPF outcomes to achieve SDGs
- Adaptation made to contextual changes especially during COVID-19

Coherence

Under the ONE UN plan

- UNFPA's contribution to achieving the UNSDPF outcomes
- Monitoring systems in place for tracking UNSDPF outcome indicators and ease of tracking UNFPA's contribution
- Role of UNFPA versus the role by other UN agencies in achieving the UNSDPF outcomes
- Comparative advantage of UNFPA versus other development partners in providing support to the Government in UNFPA focus areas, advancing SRHR and ASRH and rights of adolescents and young people as well as in population and development
- UNFPA's additional value through partnership with CSOs. Academia, etc.
- UNFPA's role in supporting joint UN plans for humanitarian programming especially during the COVID 19 pandemic

Effectiveness – results achieved through outputs and its contribution to outcomes

- Progress of RRF indicators and means of assessment
- Contribution to outcome indicators
- Effectiveness of the strategies and activities planned to achieve the outputs

FOR OUTPUT related to SRHR

- Contribution to creating an enabling environment for SRHR including for adolescents and young people through generation of evidence and updating policies
- Contribution to health system strengthening to deliver high quality integrated SRH services and information especially for adolescents and young people (emergency obstetric care, adolescent health services, FP services)
- Contribution to addressing the special needs of women and young girls such as prevention and protection against GBV, cervical cancer screening and management
- Contribution to availability of data/evidence for policy action and planning
- Effects of the COVID-19 pandemic on SRHR especially of adolescents and young people and health systems, UNFPA's contribution to ensure continuation of SRH services, utilization of services, provision of care to pregnant women, women in labour and post-natal women and babies, prevention and management of GBV, infection prevention, etc., contribution to national response and preparedness plans
- The extent to which the inputs to policy and programme was guided by /mainstreamed international normative frameworks to advance GEEW and reproductive rights

FOR OUTPUT related to adolescents and youth

- Contribution to strengthen the capabilities and skills of adolescents and youth to make informed choices through CSE/LSE in schools, monastic and other institutions
- Contribution to adolescents and Youth's capability to exercise reproductive rights through support to national policy and action plans and youth-led initiatives such as Y-Peer including vulnerable groups and persons with disability (PWD)
- Contribution to positive changes in harmful social norms and practices such as early marriage, prevention of GBV
- Contribution to generating data to guide policies on youth and demographic change
- Effects of the COVID-19 pandemic on adolescents and young people (disruption of education and vocation training and loss of jobs), UNFPA's contribution to ensure continuation of health services for adolescents, continuation of CSE and LSE through digital media, youth networks, education on prevention of GBV and referral support and contribution to national response and preparedness plans
- The extent to which the inputs to policy and programme were guided by /mainstreamed by international normative frameworks to advance GEEW and reproductive rights especially for adolescent girls and marginalized

For GEEW and HRBA related inputs

- Adequacy of analysis of gender issues prior to designing the CP interventions
- Contribution to CP interventions under SRHR and A&Y to advancing GEEW and reproductive rights
- Contribution of CP components to advancing principles of human rights
- Support for policy and legal frameworks related to GEEW
- Extent to which CP7 supported interventions have used HBRA of non-discrimination, equality, quality and accountability
- Building HW capacity to deliver rights-based services
- Promotion of multi-sectoral approaches to prevention and management of GBV
- Minimum standards for prevention and response to GBV and access to life saving EmONC
- Capacity building of MSTF and CBSS
- Promotion of integrated approaches (gender, rights-based) through implementing partners and their sub-contractors
- Focus of gender in partnership strategies

For population and development related inputs

- UNFPA's contribution to sustained availability of data for monitoring SDGs and UNFPA focus area
- UNFPA's contribution to strengthening capacity for evidence-based policy and advocacy
- Contribution to ensuring disaggregated data especially women, adolescents, vulnerable groups including those with disability
- Progress of the implementation of the activities
- The extent to which the programme implementation has covered vulnerable and persons with disability
- The extent to which the inputs to policy and programme was guided by /mainstreamed international normative frameworks to advance GEEW and reproductive rights especially for adolescent girls and marginalized
- Response during humanitarian crisis due to major floods /earthquakes
- Enabling and constraining factors for reaching results
- Unintended results, both positives and negatives

Pink country status – how well has the CP adhered to the mode of support (advocacy, knowledge management, policy advocacy, capacity building (institutional)) please provide examples

Efficiency

- Adequacy of resources allocated to match the inputs

- Adequacy of staff- in terms of numbers to meet the programme requirements and technical capability
- Efficient use of resources
- Efficiency of monitoring framework
- Inter-thematic consultations while developing programmes and also during assessments
- Timeliness of support to partners
- Financial management and procurement procedures in place and their efficiency
- Cost effectiveness of UN Joint programmes and opportunities for enhancing processes, results, transaction costs compared to results
- Partnership strategy, rationale for partnerships, criteria for selection of partners, UNFPA's role as a partner
- Resource mobilization strategy

Sustainability

- Capacity development of implementing partners to manage the project and implement interventions including capacity development of beneficiaries with focus on vulnerable and persons with disability
- Ownership of the interventions as evidenced - by plans to incorporate interventions in national strategies and policies and work plans as well as in district plans and strategies
- Allocation of financial resources for continuing some of the UNFPA supported activities

UNFPA's mode of engagement in Bhutan as per business model

- UNFPA's significant contribution to advocacy and policy, capacity building of institutions, and knowledge management

Lessons learned

- Lessons learned and experiences that can be applied for future support and can be shared with other countries

Recommendations for future support

- Suggestions for areas of focus in the next CP
- Suggestions for mode of engagement and adaptations needed to achieve results

UNFPA senior management

Points for discussion

Focus on strategic and policy issues to identify UNFPA's niche

Relevance

- Country programme development directions based on population situation analysis and other needs assessment
- Country programme planning adequate to ensure relevancy to meet country priorities
- The intended outputs of the CP were consistent with the needs of intended beneficiaries
- Adequacy of focus on vulnerable and persons with disability
- Contributes to SDGs and the principle of leaving no one behind and mainstreams gender and human rights

Coherence

- Clarity of roles and responsibilities of UNFPA under the ONE UN plan to contribute to UNDAF outcomes
- Areas where UNFPA has provided leadership in the UNCT
- Areas where UNFPA has the potential to provide leadership but left out
- Role of current partnerships in facilitating achievement of results

Effectiveness

- Main areas of achievement under each outcome
- Adequacy of the approaches/ strategies to achieve the output level results – Results indicators. Comment on the progress.
- Effectiveness of data integration compared to stand along strategy/output
- Effectiveness of gender mainstreaming and UNFPA's support to gender policies and frameworks
- Effectiveness of UNFPA's contributions to support the COVID response plans of MOH ensuring adequate focus on continuation of SRHR services and services for adolescents and young people

Pink country status – how well has the CP adhered to the mode of support (advocacy, knowledge management, policy advocacy, capacity building (institutional)) please provide examples

Efficiency

- Adequacy of human resources in terms of numbers and capacity in relation to classification of the country as pink – management, technical and fiscal
- Financial allocations, resource mobilization
- Flexibility in use of resources to respond to contextual changes/humanitarian/epidemic situations
- Partnership strategy including current selection of partners and effectiveness
- Programme monitoring at CO level
- Programme monitoring of UNFPA contributions through the on UN
- Potential for joint programming

Sustainability

- Ownership of interventions by Government at national and sub-national level and support for continuation of interventions
- Capacities built to sustain results in the priority areas and examples
- National budget and sub-national allocations sustained for SRHR, GEEW, Adolescents and young people
- Plans for /allocation of national budget

Lessons learned

- Key learning so far
- Lessons learned for future programming
- Potential South -South collaboration

Recommendations for future support

- Suggestions for areas of focus in the next CP
- Suggestions for mode of engagement and adaptations needed to achieve results

Implementing partners in each of the outcome areas, gender and population and development

Please start with section A and assure confidentiality of the discussions

Points for discussion

Please note that there may changes after discussions with UNFPA CO

a. Government – Senior Officials, programme staff in UNFPA focus areas (MOH, MOE, GNHC, NSB, NCWC)

- Areas of support by UNFPA including during humanitarian crisis and pandemic
- Strengths of the partnership

Relevance

- Alignment of UNFPA country programme with main government policies and outcome areas
- Attention of programming to vulnerable and persons with disability as in the national policies and programmes

- Contribution of UNFPA support to the National Key Areas indicators
- Programme supports national commitment to ICPD @25
- Flexibility of the programme to respond to national needs especially during humanitarian and pandemic crisis

Coherence

- Valuation of UNFPA support especially with regard to advocacy, policies, programme, technical assistance, capacity building and knowledge management
- Added value of UNFPA compared to other agencies under the ONE UN plan
- UNFPA monitoring frameworks' compatibility with national monitoring frameworks

Effectiveness

The following should be discussed with appropriate Government partners

FOR OUTPUT related to SRHR

- Results achieved at output levels and its contribution to national objectives
- Contribution to creating an enabling environment for SRHR including for adolescents and young people through creation of evidence and updating policies
- Contribution to health system strengthening to deliver high quality integrated SRH services and information especially for adolescents and young people (emergency obstetric care, adolescent health services, FP services)
- Contribution to addressing the special needs of women and young girls such as prevention and protection against GBV, cervical cancer screening and management ,SRHR including conception, fertility, STIs .
- Contribution to availability of data/evidence for policy action and planning
- Effects of the COVID-19 pandemic on SRHR especially of adolescents and young people and health systems, UNFPA's contribution to ensure continuation of SRH services, utilization of services, provision of care to pregnant women, women in labour and post-natal women and babies, prevention and management of GBV, infection prevention, etc., contribution to national response and preparedness plans

FOR OUTPUT related to adolescents and youth

- Contribution to strengthen the capabilities and skills of adolescents and youth to make informed choices through CSE/LSE in schools, monastic and other institutions
- Contribution to adolescents and Youth's capability to exercise reproductive rights through support to national policy and action plans and youth-led initiatives such as Y-Peer including vulnerable groups and persons with disability
- Contribution to positive changes in harmful social norms and practices such as early marriage, prevention of GBV
- Contribution to generating data to guide policies on youth and demographic change
- Effects of the COVID-19 pandemic on adolescents and young people (disruption of education and vocation training and loss of jobs), UNFPA's contribution to ensure continuation of services for adolescents, continuation of CSE and LSE through digital media, youth networks, education on prevention of GBV and referral support and contribution to national response and preparedness plans
- Contribution to prevention and response to sexual exploitation abuse and harassment in the institutions and work places.
- Programmes pay special attention to GEEW (explain GEEW) and rights-based approaches

For GEEW and HRBA related inputs

- Contribution to CP interventions under SRHR and A&Y to advancing GEEW and reproductive rights
- Contribution of CP components to advancing principles of human rights
- Support for policy and legal frameworks related to GEEW

- Extent to which CP7 supported interventions have used HBRA of non-discrimination, equality, quality and accountability
- UNFPA's specific contributions to prevention and management of GBV
- UNFPA's contributions to mobilizing communities against GBV, early marriage
- Capacity building of MSTF and CBSS
- Contribution of UNFPA to promoting gender and human rights-based approaches

For population and development related inputs

- UNFPA's contribution to sustained availability of data for monitoring SDGs and UNFPA focus area
 - UNFPA's contribution to strengthening capacity for evidence-based policy and advocacy
 - UNFPA contribution to strengthening national data system
 - Contribution to ensuring disaggregated data especially women, adolescents, vulnerable groups including those with disability
- Effectiveness of UNFPA contribution to advocacy, national policies, capacity building and knowledge management through documentation
 - Valuation of effectiveness of UNFPA technical assistance
 - What approaches worked /what did not work
 - Enabling and constraining factors to implement the programme
 - Evidence of unintended results
 - Support during humanitarian crisis such as severe floods, earthquake

Efficiency

- Efficiency and timeliness of support provided
- Cost effectiveness of UNFPA support compared to UN Joint support in the same thematic area
- Ease of doing business with UNFPA- Financial management and procurement procedures
- Quality of technical assistance (programmatic and financial)
- Adequacy of UNFPA staffing to provide adequate support
- Accountability of UNFPA
- Monitoring progress
- Role in intra-departmental and inter-departmental coordination
- Level of flexibility in changing programming to contribute to changing national needs
- Value of UNFPA as a partner

Sustainability

- Sustainability of CSE/LSE through integration into curriculum in schools and few monastic institutions .
- Sustainability of UNFPA's support for capacity building, advocacy, policy
- Additional support needed to sustain the investments

Lessons learned

- Lessons learned from partnership with UNFPA and its application beyond the current context

Recommendations for future support

- Focus areas for next country programme
- Adaptations / changes needed in processes

B. Institutions and Civil Society Organizations (CSOs)

*Please note there may be changes after discussions with CO and stakeholders at the national level.
Please start with section A and assure confidentiality of the discussions*

Points for discussion

- Areas of support by UNFPA including during humanitarian crisis and pandemic- specify which output the institution is contributing to
- Geographical coverage
- Strengths of the partnership

Relevance

- UNFPA programmes relevance in the context of national policies and 12FYP results
- UNFPA's focus on vulnerable including PWD

Coherence

- Added value of UNFPA partnership compared to other UN agencies and complementarity

Effectiveness of UNFPA programme

- Results achieved as per work plan and its contribution to UNFPA output (specify the achievements)
- Effectiveness of the strategies of the partnership to achieve UNFPA outputs
- Targeting vulnerable and persons with disability
- Capacity building of communities and community organizations (as relevant to the implementing partner)
- Changes in social norms and behaviours
- Support provided in humanitarian situations and COVID-19
- What worked /what has not worked
- Enabling and constraining factors

For GEEW and HRBA related inputs

- Contribution to CP interventions under SRHR and A&Y to advancing GEEW and reproductive rights
- Contribution of CP components to advancing principles of human rights
- Support for policy and legal frameworks related to GEEW
- Extent to which CP7 supported interventions have used HBRA of non-discrimination, equality, quality and accountability
- Building HW capacity to deliver rights-based services
- Promotion of multi-sectoral approaches to prevention and management of GBV
- Minimum standards for prevention and response to GBV and access to life saving EmONC
- Capacity building of MSTF and CBSS
- Promotion of integrated approaches (gender, rights-based) through implementing partners and their sub-contractors
- Focus of gender in partnership strategies
- Building institutional capacity to promote GEEW and HRBA
- Contribution to ensuring disaggregated data especially women, adolescents, vulnerable groups including those with disability

Efficiency

- Efficiency and timeliness of support provided
- Cost effectiveness of UNFPA support compared to UN Joint support in the same thematic area
- Ease of doing business with UNFPA- Financial management and procurement procedures
- Quality of technical assistance (programmatic and financial)
- Accountability of UNFPA
- Monitoring progress- systems in place to report to UNFPA
- Annual and midterm reviews- their value

- Valuation of UNFPA as a partner

Sustainability

- Sustainability of UNFPA's support for capacity building, advocacy, policy
- Additional support needed to sustain the investments

Lessons learned

- Lessons learned from partnership with UNFPA and its application beyond the current context

Recommendations for future support

- Focus areas for next country programme
- Adaptations / changes needed in processes

UN partners

Please start with section A and assure confidentiality of the discussions

Points for discussion

Relevance and Coherence

- Alignment of UNFPA programme to national policies and strategies
- Alignment of UNFPA with ONE UN plan outcomes
- Integration of UNFPA support into one UN plan
- Adequacy of UNFPA's focus on vulnerable and PWD
- UNFPA's leadership in ensuring GEEW and human rights are well integrated in its own work plans as well as ONE UN work plan
- UNFPA's comparative advantages and added value
- Contribution to joint monitoring

Effectiveness of UN programming (UNSDPF/joint programming)

- Common areas under UNSDPF outcome where UNFPA is contributing
- Effectiveness of UNFPA contribution in achieving UNSDPF outcome results (provide examples)
- What has worked and not worked
- Enabling and constraining factors
- UNFPA's contribution to one UN plan for COVID response and in maintaining services related to areas of its mandate
- UNFPA's response in other humanitarian crisis
- UNFPA's leadership in ensuring GEEW and human rights are well integrated in its own work plans as well as ONE UN work plan
- UNFPA's role in coordination in development and humanitarian settings
- Results of joint programming

Specific questions to UN staff responsible for gender

- Extent to which UNFPA has integrated GEEW and HRBA approaches (non-discrimination, equality, quality and accountability) in the CP interventions to advancing GEEW and reproductive rights
- Support for policy and legal frameworks related to GEEW
- UNFPA's role in prevention and management of GBV and other harmful practices (provide examples)
- Extent to which CP7 supported interventions have used HBRA of
- Focus of gender in partnership strategies
- Building institutional capacity to promote GEEW and HRBA

- Contribution to ensuring disaggregated data especially women, adolescents, vulnerable groups including those with disability

Efficiency

- Efficiency and timeliness of support provided
- Cost effectiveness of UNFPA support compared to UN Joint support in the same thematic area
- Ease of doing business with UNFPA- Financial management and procurement procedures
- Quality of technical assistance (programmatic and financial)
- Accountability of UNFPA
- Monitoring progress- systems in place to report to UNFPA to report to UNFPA
- Annual and midterm reviews- their value
- Valuation of UNFPA as a partner

Sustainability

- Sustainability of UNFPA's support for capacity building, advocacy, policy
- Additional support needed to sustain the investments

Lessons learned

- Lessons learned from collaboration with UNFPA and its application beyond the current context

Recommendations for future support

- Focus areas for next country programme
- Adaptations / changes needed in processes

District and sub-district officials

Please note there may be changes after discussions with CO and stakeholders at the national level.

Please start with section A and assure confidentiality of the discussions

Organization	Person/persons to be interviewed	
District organization	District-in-charge	
District statistical Unit	District Statistical Officer	
<i>Output: SRHR</i>		
District Health Officer		
District Hospital/Referral hospital	Medical Superintend	OBGYN, non-specialist docs Staff nurses/midwife, forensic focal JDWNRH- Head, Community Health One-stop crisis centre
PHC	In-charge	Staff
<i>Output: Adolescents and young people</i>		
District Education Office	District Education Officer	
Teacher training institute (Paro)	Principal	Teachers
School	Principal	Teachers
Monastic school	Principal	Teachers

Points for discussion

Ask as relevant

- Information about the district- population, number of health facilities by category, number of schools, number of monastic institutions, number of colleges involved with UNFPA programme
- Awareness about UNFPA's programme interventions in the district
- Specific support received in thematic areas of SRHR/ Adolescents and Young People/ GBV
- Institutions involved in the district with various UNFPA programmes
- Focus on vulnerable and persons with disability
- Key issues related to SRHR in the district
- Key issues related to adolescents and young people in the district

Relevance and coherence

- Relevance of UNFPA interventions in the district and rationale for the same
- Whether the interventions cater to the needs of the national plans in the district and contribute to 12FYP indicators
- Whether it reaches the vulnerable and pays attention to persons with disability
- Coherence with district plans (for health and education)
- Comparative advantage of UNFPA compared to other agencies
- Additional value of UNFPA

Effectiveness

SRHR

- Achievements so far under SRHR
 - introduction of services for GBV, adolescent friendly health services, EmoNC services, training of nurses and midwives), screening for cervical cancer, MDSR
 - Number of health facilities offering adolescent friendly health services, management of GBV cases, EmoNC services, MDSR reviews, screening for cervical cancer

A&Y

- Achievements so far under adolescents and young people
 - extent of implementation of CSE framework (including in teacher training institutes), preparation of school teachers to roll out CSE and feedback on extent of integration of CSE in curriculum in schools and promotional activities with parents, communities and adolescents) and Y-peer support
 - Achievements in introducing LS based CSE in monastic schools- adequacy of preparedness for teaching, impressions of effectiveness
 - Contributions of Y-PEER and scouts
 - Mobilization of communities to advocate against harmful practices – what type of activities have been carried out, tangible results
- Capacity building for data - numbers trained , evidence of use of data for district planning and monitoring, monitoring of SDGs and disaggregation by gender, age, vulnerable including PWD
- Support during COVID- support for continuation of services- supplies including PPE, capacity building, use of digital platforms
- What has worked and what has not worked
- Gender and HRBA approaches: UNFPA's role in promoting GEEW and HRBA in their interventions at district level

Efficiency (*UNFPA directly does not work at the district level*)

- Ease of working with UNFPA
- Timeliness of UNFPA support
- Improvements in monitoring systems

Sustainability of interventions

DHO, Medical Superintendent, District Education Officer

- Plan to continue
- Funding identified

Lessons learned

- Useful experiences that will be integrated into the services provided

Recommendations for future support

- Suggestions for future support
- What needs to be continued and what needs to be changes

Any other issues in the context of the current evaluation

Facility visit

Please note there may be changes after discussions with CO and stakeholders at the national level.

Please start with section A and assure confidentiality of the discussions

Points for discussion

General

- District
- Level of facility
- Infrastructure – maternity ward, labour room, operation theatre
- Staffing
- Population covered
- SRHR services included
 - FP (type of services provided)
 - Maternal care (type of services provided)- ANC, delivery, PNC
 - EmONC services- basic /comprehensive
 - Cervical cancer screening
 - Adolescent friendly health services- adolescent corners, focal points
 - MTP services
- SRHR and adolescent and young people's issues
- Referral arrangements

UNFPA supported activities and its relevance

- Type of activities supported by UNFPA in the facility
- Relevance of the support to meet the needs of the population
- Coherence with district plans
- New services initiated

Effectiveness/ Results

- Capacity building initiatives –topics of capacity building, type of staff trained
- New activities/ services initiated as a result of training
- Improvement in FP services (access to all methods as relevant to the facility, quality)
- Improvement in maternal care – especially increase in quality and number of ANC visits, deliveries by skilled birth attendants, postnatal care
- Increased access of adolescents and young people to SRHR services
- Access of GBV victims to services
- Service delivery during COVID
 - Mode of delivery of services during COVID (Changes in service delivery)
 - Capacity building
 - Availability of supplies including PPE
 - Use of digital platforms

Review of HMIS and facility level reports

- ANC, delivery, EmoNC, referral, PNC
- ASRH
- GBV
- MTP
- Flow of information to district and feedback

Observations (will expand further)

Labour room, operation theatre- Infection prevention including waste disposal, Emergency tray, Tray for PPH, neonatal resuscitation
availability of pre-packed delivery sets, sets for various procedures and number of sets

Availability of health educational material

Management of adolescent friendly services

Management of cases of GBV (ensuring privacy)

SECTION C **Guidelines for focus group discussions**

The interview guide identifies focus group discussions as a tool under selected questions under effectiveness and sustainability.

The following is a general guideline for conducting focus group discussions.

1. Selection of participants

- Similarity of participants (with regard to the issue and level of beneficiary)
- Size- 8-12 participants (may be even less if digital interview)
- Absence of hierarchical relations to enable each member to express their views without fear or repercussions
- Moderator- facilitated by a skilled moderator

2. Develop focus group discussion guide

- Develop the objective
- Questions should cover knowledge about a service, client rights, access to new services, the experience during the visit to a provider/facility

3. Sequencing

- Building rapport with the group
- Informing the group about the context and purpose of the discussions
- Opening question to gauge general understanding of a particular issue
- In-depth questions ensuring that all are given a chance to express, summarize opinions. Probe if the question is not understood. (interviewer should not express their views)
- Wrap up by asking the participants to reflect on the discussions and present a summary of the discussions

Suggested topics for focus group discussions

Please note that list below includes few suggested topics. The team will develop a detailed checklist to help the facilitators of focus group discussions

Women and adolescent girls

- Access to FP (including barriers, availability of methods, attitudes of providers)
- Access to maternal health (ANC care (explanations provided, examinations, danger signs); care during delivery- respectful providers, explanations provided and advice on discharge especially on FP and danger signs)
- Cervical cancer- explanations provided, follow-up, advice on vaccination (adolescent girls)
- GBV- attitude of providers, counselling, emergency contraception, treatment
- Support of community to victims of GBV
- Ease of access to facilities and providers during COVID, special precautions

Vulnerable groups including PWD

- Inclusiveness in UNFPA programmes (design of interventions, in implementation)
- Special actions taken by UNFPA to support the SRHR needs
- Support provided in cases of violence
- Special actions taken by UNFPA to overcome barriers due to disability

Students (regular and monastic schools)

- Inclusion of comprehensive sexuality education – benefits
- Ease with which the teachers deal with the subject
- Awareness about sexual harassment policies

Y-PEER and Scouts

UNFPA's role

- in promoting SRHR of adolescents and young people
- in promoting GEEW
- response during COVID in prevention of GBV and protecting SRHR
- UNFPA's role during COVID in protecting SRHR of adolescents and young people
- Role in prevention of sexual harassment in schools and colleges

Suggested topics for focus group discussions with organizations of vulnerable groups including that of persons with disabilities

- Awareness about UNFPA programmes and involvement (specify how the organizations or their members are involved)
- UNFPA's contributions to advancing GEEW and reproductive rights
- Suggestions for UNFPA support in future (within its mandate)
- Suggestions for involving the organizations of vulnerable groups for next

Annex 4: List of stakeholders interviewed and types of focus groups

Sl. No	Name	Title/Designation	M/F	Organization	CP7 affiliation
UNFPA					
1	PhuntsoWangyal	Head of Office	M	UNFPA CO	UNFPA
2	KarmaTshering	SRHR programme officer and M&E officer	F	UNFPA Co	UNFPA
3	Jigme Choden	ASRH and Gender Programme officer	F	UNFPA CO	UNFPA
4	Tara Monger	Finance Assistant	F	UNFPA CO	UNFPA
5	DechenChimme	Former ASRH and gender programme officer	F	UNFPA CO (now posted in the UNFPA office in Kiribati (on line)	UNFPA
6	YesheyDorji	Former Asst. Rep	M	UNFPA CO (now independent)	UNFPA
7	Andrea M Wojner	Country Director and UNFPA Representative to India	F	UNFPA	UNFPA
8	Sriram Haridass	UNFPA Deputy Representative to India and responsible for Bhutan	M	UNFPA	UNFPA
9	GalanneDeressa	Programme officer	F	UNFPA APRO	Programme support
10	OyuntsetsegChuluundorj	Regional M&E officer	F	UNFPA APRO	M&E
	<i>Total</i>		<i>10 (7 F, 3 M)</i>		
UN agencies					
11	Karla Robin Hershey	UNCT	F	UNRC Office	Head of UNSDGPF
12	Will Park	Representative	M	UNICEF	CP partnership
13	Indracarpe	Nutritionist & Health Focal	F	UNICEF	CP partnership
14	AsuzaKubato	The Resident Representative	F	UNDP	CP partnership

Sl. No	Name	Title/Designation	M/F	Organization	CP7 affiliation
15	Ngawang Dema	Health Focal	F	UNDP	CP partnership
16	Sonam Tshoki	Ass. Data manager and research	F	UNRC Office	CP partnership
17	Lobzang	RH programme officer	M	WHO	CP partnership
18	Pema Letho	NCD (former MOH RH focal point)	M	WHO	CP partnership
	<i>Total</i>		<i>8 (5 F, 3 M)</i>		
GNHC					
19	Dorji Pem	Ex UNFPA Focal	F	GNHC (Virtual)	CP partnership
	<i>Total</i>		<i>1 (1 F)</i>		
Ministry of Health					
20	DechenWangmo	Health Minister	F	MOH	MOH
21	Pemba Wangchuk	Secretary Health	M	MOH	MOH
22	TashiTshomo	RMNCH PO	F	MOH	SRHR
23	Chimmi Dem	RH	F	MOH	SRHR, Adolescents and youth (A&Y) outputs
24	YeshiPelden	AHP	F	MOH	A&Y output
25	Pema Yudon	AHP	F	MOH	A&Y output
26	RixinJamtsho	Director PH	M	MOH	SRHR and A&Y outputs
27	DolayTshering	HIV PO	M	MOH	SRHR output
28	Kunzang	Asst. PO EMS	M	MOH	Humanitarian
29	Kinley Dorji	HMIS	M	MOH	Both outputs of CP
	<i>Total</i>		<i>10 (5 F, 5 M)</i>		
Ministry of Education					
30	Sangay	Officiating Secretary	M	MOE	A&Y output

Sl. No	Name	Title/Designation	M/F	Organization	CP7 affiliation
31	SangayTshering	DCPD	M	MOE	A&Y output
32	Karma Wangchuk	SHND	M	MOE	A&Y output
33	Dochu	Chief PPD MOE	M	MOE	A&Y output
34	Pema Chogyal	SEN	M	MOE	A&Y output
35	Tenzin Thinley	DG, DYS	M	MOE	A&Y output
36	RinzinWangmo	DYS	F	MOE	A&Y output
37	AmrithBdr. Subha		M	MOE	A&Y output
38	Sonam Wangdi		M	MOE	A&Y output
39	Dorji (Scout & Culture)		M	MOE	A&Y output
	<i>Total</i>		<i>10 (1 F, 9 M)</i>		
NSB					
40	TashiDorjee (Social statics relation)	NSB	M		SRHR, A&Y outputs
41	TashiNamgay (survey & data)		M		SRHR, A&Y outputs
42	Birkha Gurung (planning & policy)		M		SRHR, A&Y outputs
	<i>Total</i>		<i>3 (M)</i>		
Academia					
43	Karma Choden	Asst. Professor	F	FNPH	SRHR
44	NidupGyeltshen	AFHS Focal	M	FNPH	SRHR
45	UgyenTshomo	Faculty/ UNFPA Focal	F	PCE & RUB (Virtual)	A&Y output
	<i>Total</i>		<i>3 (2 F, 1 M)</i>		
NGO					
46	TsheringDolker	ED	F	RENEW	SRHR, A&Y outputs

Sl. No	Name	Title/Designation	M/F	Organization	CP7 affiliation
47	Meenakshi	Programme Director	F	RENEW	SRHR, A&Y outputs
48	KenchoZangmo	Programme Officer	F	RENEW	SRHR, A&Y outputs
49	Sonam Jamtsho	ED	M	DPO	Potential SRHR partner
50	SingayNamgay	Programme officer	M	DPO	Potential SRHR partner
51	WangdaDorji	ED	M	Lhaksam	Potential SRHR partner
52	UgyenTshomo	officiating Director	F	NCWC	A&Y- gender
53	Pema Lhaden	Program officer	F	NCWC	A&Y - gender
	<i>Total</i>		<i>8 (5 F, 3 M)</i>		
National Referral Hospital					
54	Dr.ThinleyYangzom	Head of the Department	F	GJPMCH	SRHR
55	TandinZam	Nurse	F	GJPMCH	SRHR
56	Samten	Service Coordinator	F	GJPMCH	SRHR
57	Kinley Lemo	AFHS	F	GJPMCH	SRHR
58	Sonam Pelzom	Cervical Cancer Screening	F	GJPMCH	SRHR
59	Nim Dem	FP Unit	F	GJPMCH	SRHR
60	Dr. Sonam Gyamtsho	HOD, Ob/Gyn	M	JDWNRH	SRHR
61	Dr. Norbu	Forensic/OSCC Focal	M	JDWNRH	SRHR
	<i>Total</i>		<i>8(6F, 2 M)</i>		
Phuntsholing/Chukha					
62	Dr.ThinleyPelzang	Chief Medical Officer	M	Pling Hospital	SRHR
63	Diptika Pradhan	AFHS focal	F	Pling Hospital	SRHR
64	SONamLhendup	AFHS focal	M	Pling Hospital	SRHR

Sl. No	Name	Title/Designation	M/F	Organization	CP7 affiliation
65	Dorji Wangchuk	EmNOC	M	Pling Hospital	SRHR

Sl. No	Name	Title/Designation	M/F	Organization	CP7 affiliation
66	YoezerTshomo	Birthing Unit Head Nurse	F	Pling Hospital	SRHR
67	Phub Wangdi	Community Health Unit Incharge	M	Pling Hospital	SRHR
68	Karma Choden	HISC incharge	F	HISC, Pling	SRHR
69	Devi Bhagta Acharya	Chief procurement officer	M	MSDD	SRHR
70	DendupPenjor	Sr pharmacy tech	M	MSDD	SRHR
71	TashiNorbu	Pharmacist	M	MSDD	SRHR
72	Yangki Dem	Principal	F	Pling Higher Secondary School	A&Y
73	Pema Choden	Counsellor	F	Pling Higher Secondary School	A&Y
74	Karma Dendup	Dzongrab	M	Chukha Dzongkhag	Both outputs
75	Nimala	DSO	M	Chukha Dzongkhag	Both outputs
76	Kinley	Sr. DHO	M	Chukha Dzongkhag	SRHR
77	LhamaTshering	Deputy DEO	M	Chukha Dzongkhag	A&Y
78	Pema Deki	Ass. ADM	F	Youth Center	A&Y
79	Sonam Zangmo	Case Manager	F	NazhoenLamtoen as an integrated service at Youth Center	A&Y
80	Tandin T Eden	Youth Volunteer	F	Youth Center	A&Y
	<i>Total</i>		<i>19 (F 8, M 11)</i>		
Dagana					
81	Sonam Choki	CBSS volunteer (Branch Manager, RICBL)	M	RENEW	A&Y

Sl. No	Name	Title/Designation	M/F	Organization	CP7 affiliation
82	Yeshe Wangchuk	Lam	M	SangyeMigyurlingZ hirimShedra	A&Y
83	Sonam Wangchuk	Lopen	M	SangyeMigyurlingZ hirimShedra	A&Y
84	NimaGyeltshen	Lopen	M	SangyeMigyurlingZ hirimShedra	A&Y
85	Sonam Jamtsho	Officiating Dzongda	M	DaganaDzhongkha	Both outputs
86	UgyenPem	Chief DEO	F	DaganaDzhongkha	A&Y
87	Dorji Wangchuk	DHO	M	DaganaDzhongkha	SRHR
88	Tsheringla	Principal	M	Daga Central School	A&Y
89	Pema Yangzom	Health Coordinator	F	Daga Central School	A&Y
90	KunzangChoden	School Guidance Counselor	F	Daga Central School	A&Y
91	Tshering Dema	CBSS (Teacher)	F	Daga Central School	A&Y
92	Sandeep Sunwar	HA	M	Chapcha PHC	SRHR
93	JambayDuba	CMO	M	Dagapela Hospital	SRHR
94	Prem Kumar Neopany	AFHS	M	Dagapela Hospital	SRHR
95	Lhamo	EmNOC focal	F	Dagapela Hospital	SRHR
96	KadoWangdi	Community Health Unit In-charge	M	Dagapela Hospital	SRHR
97	Dan Lachi Monger	HA	F	Drujaygang PHC	SRHR
	<i>Total</i>		16(5 F, 11 M)		
	Grand total		97 (46 F, 51 M)		

Focus group

	Type	F	M	Other	Total
1	DSO		9		9
2	Women in ANC/PNC	7			7
3	Y-PEER	2	6		8
4	Professional students	2	2		4
6	Students	10	9		19
5	Students in monastic institutions		7		7
7	LGBTIQ			6	6

Annex 5: List of documents reviewed

National policies, strategies and assessments (socio-economic)	
1.	Planning Commission. Bhutan Vision 2020 Vol 1,2
2.	GNHC. 12 th FYP 2018-23 Vol.2
3.	GNHC. Vulnerability assessment 2016
4.	GNHC. National policy for persons with disability 2019
5.	GNHC. Draft Consultancy report for Bhutan's secondary voluntary national review report for the UN High-level Political Forum 2021
6.	<i>Sectoral national policies</i>
7.	MOH. National health policy 2011
8.	MOH. National reproductive health strategy 2018-23
9.	MoH. National strategic plan of action for adolescent health 2019-23
10.	MOH. Strategic plan for cervical cancer programme in Bhutan 2019-23
12.	MOH. Policy to accelerate mother and child outcome -1000 days ? 2020
13.	MOH. National HIV,AIDS and STI strategic plan 2017-23- On fast track to ending AIDS
14.	MOE. National strategic framework for comprehensive sexuality education 2021
15.	MOE, NYS: National youth policy 2011
16.	NCWC. National gender equality policy 2020
17.	NCWC. Domestic violence prevention act 2013
18.	NCEC. Domestic violence prevention- rules and regulations 2015
19.	RUB. Prevention of sexual exploitation, abuse and harassment 2022
20.	CROB. Guidelines on sexual harassment prevention 2021(in national language)
21.	RUB, PCE. Sexual harassment prevention policy 2021
22.	MOH. Bhutan's commitment at ICPD@25 delivered by Her Excellency Minister for Health 2019
23.	MO Home and Cultural Affairs. Disaster risk management strategy 2013

24.	MOH, EMSD. Health emergency and disaster contingency plan ? Year
25.	MOH. National preparedness and response plan for outbreak of Novel Coronal Virus 2020
Reproductive health	
26.	UNFPA. State of the World's Midwifery 2021. Bhutan Profile
27.	UNFPA. State of the world's midwifery policy brief- Bhutan.
28.	Burnet Institute. Who is being left behind. A quantitative analysis. A quantitative analysis of sexual and reproductive health and rights inequities in Asia and the Pacific. Bhutan Draft report 2020
29.	UNFPA. Draft report on comprehensive Cervical Cancer Screening Camp in three district; Bumthang, Monggar and Punakha, 2020
30.	UNFPA: Report of maternal near-miss review in three referral hospitals 2020
31.	Baussano I, Tshomo U, Tenet V, et al. Papillomavirus vaccine effectiveness in Thimphu, Bhutan in 2011-12 and 2018. A cross-sectional study. Ann. Intern. Med. doc 10.7326/M20-2849
32.	MOH. Country-wide EMONC assessment and review 2018
33.	UNFPA, Cancer Council. Cervical cancer elimination. Country review and road map for action. 2021
34.	Kinley W, Gurung MR. Understanding the factors associated with abortion women seeking abortion related health services in Phuentsholing General Hospital, Bhutan. Int. Arch. Nurs. Health Care 2016 ISSN 2469-5823, Vol 2, issue 5
35.	MOH. Operational guide for screening for cervical and breast cancers and pelvic organ prolapsed
36.	MOH. Monitoring and supervision checklist (RH)
37.	MOH, UNICEF. Pre-conception care package for health service provider, 2019
38.	MOH. Contraception for post-partum, post-abortion, adolescents and diverse groups and emergency contraceptive pill- Chapter 5
39.	UNPFA APRO. Concept note on midwifery faculty development
40.	Trainer's report on LDHF training
41.	UNFPA, RENEW. Engagement of vulnerable populations for peer-led SRHR and GBV prevention
ASRH	

42.	MOH. Assessment report on the access to and utilization of adolescent sexual and reproductive health services in Bhutan 2020
43.	MOH, UNFPA. Training manual for adolescent friendly health services, 2021
44.	MOH. Monitoring and supervisory checklist adolescent friendly health services
45.	MOE, DYS. Concept paper on national comprehensive sexuality education in schools 2022
46.	Yeshey S. Policy brief on young people's dynamics 2020
47.	MOE, DYS. Status of CSE integrated subjects. Workshop report 2021
48.	MOE, DYS. Y-PEER Bhutan networks impact assessment report 2022
49.	Y-PEER Bhutan. E-course
50.	UNICEF. Report of the assessment of the adolescent and nutrition services in Bhutan 2019
Population and Development	
51.	NSB, UNFPA. Population projections Bhutan 2017-2047
52.	NSB, UNFPA: Rural -urban migration and urbanization in Bhutan ? 2018
53.	GNHC. Population situation analysis 2018
54.	NSB,UNFPA. Harnessing Bhutan's demographic dividend- Policy and programmatic options 2019
Gender	
55.	RENEW. National Survey on Women's Health and Life Experiences 2017 in Bhutan
56.	RENEW: Prevention and responding to sexual exploitation, abuse and harassment policy 2022
547.	RENEW: Multi Sectoral Task Force and Community Based Support Systems 'Reaching out together'
58.	Tobgay t. Report on gender review for countries participating in the Global Fund Sustainability of HIV services for key populations in Asia (SKAP) program within the context of HIV: Bhutan ? 2020
COVID-19 pandemic	
59.	UNFPA APRO. Humanitarian response plan 2020-2021
60.	UNFPA APRO. Sexual and reproductive health services disruptions in selected Asia Pacific countries during 2020. Report submitted to DFAT
61.	UNFPA Bhutan. Situation report of COVID-19 pandemic various reports 2020

62.	UN Bhutan. Socio-economic response plan- interim update 2020
63.	UN Bhutan. COVID-19 Sit Report June 2020
64.	WB. Bhutan: Brief on two years of the pandemic response 2022
65.	ADB: Overcoming COVID-19 in Bhutan. Lessons learned from coping with the pandemic in a tourism dependent economy 2021
ODA support to Bhutan	
66.	OECD - DAC : h2p://www.oecd.org/dac/financing-sustainable-development/development-finance-data/aid-at-a-glance.htm
UNCT/UN	
67.	UN. Committee for development policy, 24 th plenary session. Monitoring of countries graduating and graduated from the list of LDC category. Virtual meeting 2022
68.	UN HRC, Working group on Universal Periodic Review. Compilation on Bhutan 2019
69.	UN commitment to GNHC
70.	UNCT Bhutan. Common country analysis 2018
71.	UNCT Bhutan. UN sustainable development partnership framework 2019-23
72.	UNGA. Working together to support implementation of the sustainable development agenda 2018-21. UNDP, UNFPA, UNICEF and UN Women Issued 2017 Annex to the common strategic plans 2018-21
UNFPA 7 th CP programme documents	
73.	7 th Country programme document
74.	7th CPAP
75.	(UNCT) Annual work plans 2019-22
76.	UNFPA Annual work plans 2019-21
77.	Annual reports 2019-21
78.	Compact commitments for development results
79.	7 th CP partnership plan 2019-23
80.	Resource mobilization plan 2019-23
81.	7 th CP planning and tracking tool 2019-23
82.	CPD meta data

83.	CP Expenditures 2019-21
84.	Work plans with implementing partners 2019-21
85.	Synthesis report CP 6
86.	UNSPDF M&E
87.	Travel reports
UNFPA global documents and UNEG documents	
88.	UNFPA strategic plan 2018-21 and annexures
89.	UNFPA strategic plan 2022-25 and annexures
90.	UNFPA. Guidance notes for applying human rights based approach to programming
91.	UNFPA. Corona virus disease (COVID-19) – UNFPA global response plan 2020
92..	UNFPA evaluation hand book 2019
93.	UNFPA. Guidance on disability inclusion in UNFPA evaluations 2020
94.	UNFPA. Adapting evaluation questions to the COVID-19 pandemic 2020
95.	UNFPA evaluation policy 2019
96.	UNFPA evaluation strategy 2022-25
97.	UNFPA. Strategy to enhance evaluation use through communications and knowledge management 2011-25
98.	UNFPA. Evaluation of UNFPA support to gender equality and women’s empowerment 2012-2020
99.	UNFPA. My Body, My Life, My World. 2019
100.	OECD. Applying evaluation criteria thoughtfully 2021
101.	UNEG. UN-SWAP Evaluation performance indicator- Technical note 2018
102.	UNEG. Integrating human rights and gender equality in evaluations 2014
103.	UNEG. Concept note on Theory of change 2016
104.	UNEG. Norms and standards for evaluation 2016
105.	UNEG. Ethical guidelines for evaluation 2008
106.	UNEG. Code of conduct for evaluation in the UN system 2008

Annex 6. Progress of indicators

Indicators	Baseline	Target	Current
Outcome 1. Every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated sexual and reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence.			
Maternal mortality/100,000 LB	89 (2017)	70	Not available
Percentage of women aged 15–49 years using modern methods	65.4 (2010)	70	Data not available
Unmet need for family planning for girls aged 15-19 years	27 (2010)	15	Data not available

Output 1. Increased national capacities to ensure universal, equitable access to high quality sexual and reproductive health information and services

Proportion of DHs offering AFHS	28%	60%	32% (8 of the 25 district hospitals including 3 referral hospitals) (many clinics closed during pandemic and yet to open)
Proportion of DH with at least 3 service providers trained in right-based family planning	0	50%	60%
Updated clinical management protocol on GBV implemented in selected districts:	0	Yes till PHC	All Referral hospitals and in 8 DHs including all PHCs in those districts

Indicators	Baseline	Target	Current
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Outcome 2. Every adolescent and youth, in particular adolescent girls, are empowered to realize their sexual and reproductive health and reproductive rights, and participate in sustainable development, humanitarian action and peace- building

Percentage of women aged 20 – 24 who were married before 18 years old	26%	20%	Data not available
Adolescent birth rate	28.4%	24%	Data not available (no update on the indicator since 2017)

Output 2 Young people, in particular adolescents are empowered with knowledge, skills and capabilities to make informed choices about their sexual and reproductive health and rights, and well-being

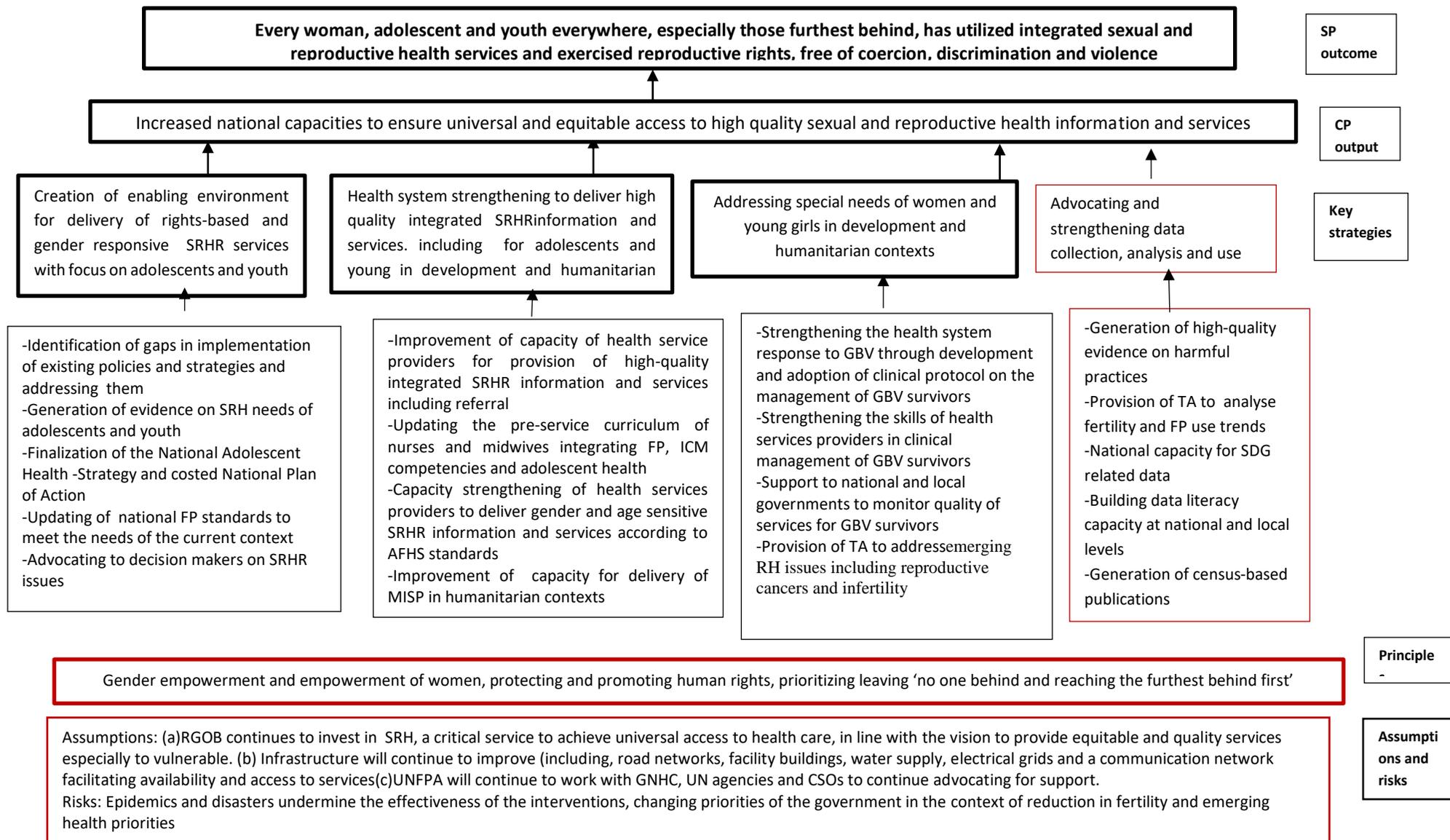
Proportion of training institutions and schools implementing rights-based, gender-responsive comprehensive sexuality education	25%	50%	Data not available*
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**NOTE: At the time of the development of the CPD, the indicator related to CSE was proportion of institutions and schools implementing CSE; however, with the incorporation of CSE in the curriculum in early 2022, the target needs changing to 100% as it is expected that all schools will be implementing the CSE as a curricular activity post pilot phase. An evaluation is being planned on the implementation of the integrated curriculum which will provide information on the exact coverage of implementation.*

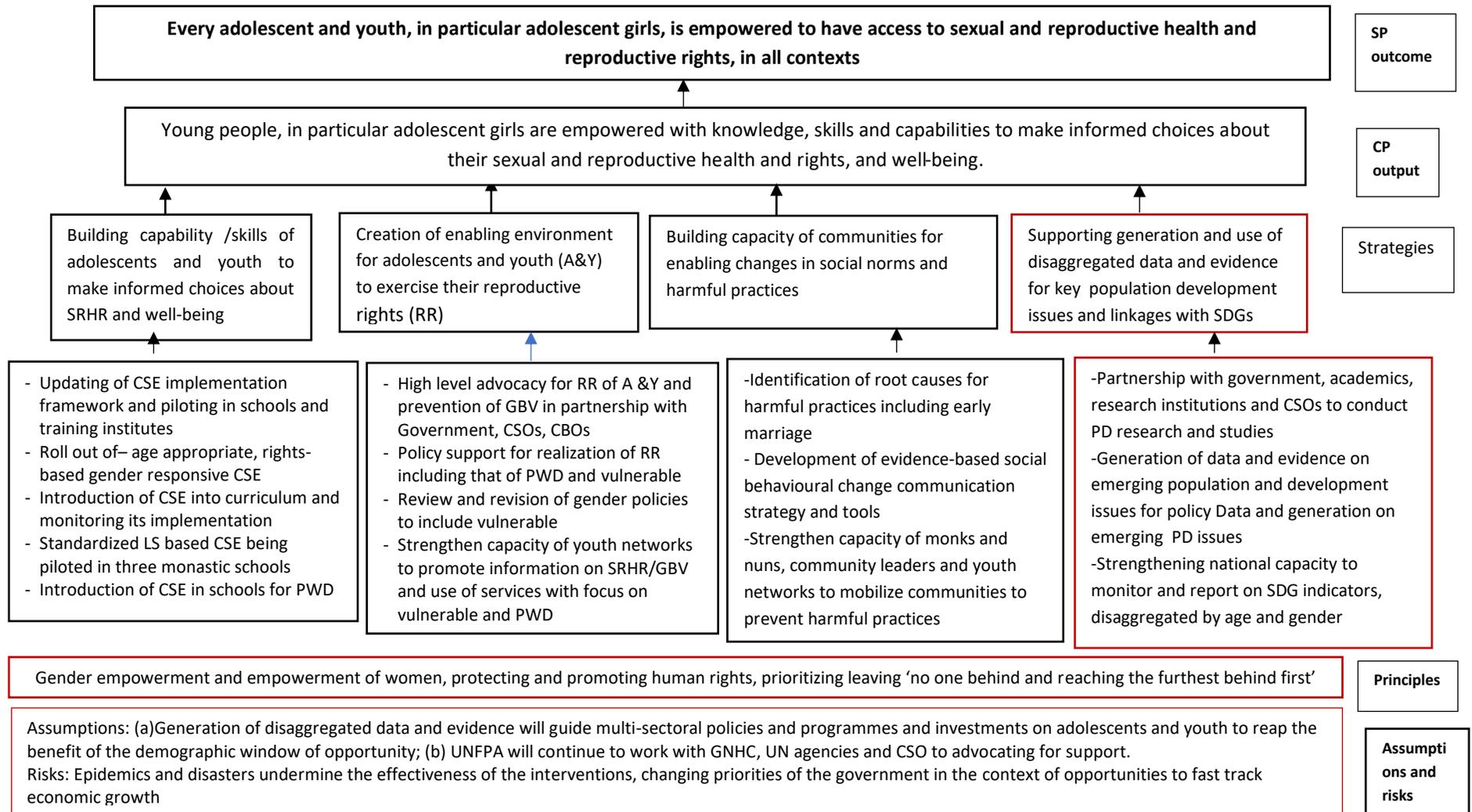
Number of communities with high levels of adolescent pregnancy, implementing evidence based programmes to reduce early and unplanned pregnancies and empower adolescents	0	5	3 (Mongar, Punakha, Thimphu) (2 initiated- Dagana and Chukkha)
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Number of national, sub-national and sectoral development planning documents that used evidence and data from UNFPA supported census and demographic analysis	0	6	Difficult to pinpoint which policies and strategies have used the data. Draft National Updated National Youth Policy, National Gender Equality Policy 2019, National Housing Policy 2020 and National Policy for persons with disabilities 2019 are likely to have used the data. Currently, census data is being used to develop a policy paper on ageing. In addition, the analysis of maternal deaths, SRH data, youth, gender, etc. have been used in several national, sub-national and sectoral planning documents. Likely to achieve the target
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Annex Part 2-A: Output 1: Sexual and Reproductive Health



OUTPUT 2: ADOLESCENTS AND YOUTH



Annex Part 2- B: Progress of UNFPA-focus SDG indicators

Status of selected SDG Indicators

 Decreasing
  Stagnating
  Moderately improving
  On track or maintaining SDG achievement
  Information unavailable

Sl. No.	SDG Indicator	Value	Status
1	3.1.1 Maternal mortality ratio, 2017	89	
2	3.1.2 Proportion of births attended by skilled health personnel, 2021	96.2	
3	3.3.1 Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations, 2022	0.8	
4	3.7.1 Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods, 2010	65.4	
5	3.7.2 Adolescent birth rate (aged 15-19 years) per 1,000 women in that age group, 2017	18.9	
6	3.8.1 Coverage of essential health services, 2021	87.7	
7	5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age, 2017	28.2	
8	5.2.2 Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence, 2017	1.8	
9	5.3.1 Proportion of women aged 20-24 years who were married or in a union before age 15 and before age 18, 2010	3.3 & 7.1	
10	5.3.2 Proportion of girls and women aged 15-49 years who have undergone female genital mutilation/cutting, by age	NA	
11	5.6.1 Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care	NA	
12	5.6.2 Number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education	NA	
13	10.3.1 Proportion of population reporting having personally felt discriminated against or harassed in the previous 12 months on the basis of a ground of discrimination prohibited under international human rights law	NA	
14	11.a.1 Proportion of population living in cities that implement urban and regional development plans integrating population projections and resource needs, by size of city	NA	
15	16.9.1 Proportion of children under 5 years of age whose births have been registered with a civil authority, by age, 2010	99.9	
16	17.18.1 Proportion of sustainable development indicators produced at the national level with full disaggregation when relevant to the target, in accordance with the Fundamental Principles of Official Statistics	NA	
17	17.19.2 Proportion of countries that: (a) have conducted at least one population and housing census in the last 10 years; and (b) have achieved 100 per cent birth registration and 80 per cent death registration	NA	

Annex Part 2-C: Results framework

Goal: Achieved universal access to sexual and reproductive health, realized reproductive rights, and reduced maternal mortality to accelerate progress on the ICPD agenda, to improve the lives of adolescents, youth and women, enabled by population dynamics, human rights, and gender equality	
UNFPA Thematic Areas of Programming	
Integrated Sexual and Reproductive Health Services	Adolescent and young people
UNFPA Strategic Plan Outcomes	
Every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated sexual and reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence.	Every adolescent and youth, in particular adolescent girls, are empowered to realize their sexual and reproductive health and reproductive rights, and participate in sustainable development, humanitarian action and peace- building.
Outcome indicators	
Maternal mortality ratio: <i>Baseline-89 Target -70</i> % of women 15-49 years using modern methods of contraception <i>Baseline-65.4% Target -70%</i> Unmet need for FP for girls aged 15-19 y <i>Baseline-27% Target -15%</i>	% of women aged 20-24 years who were married before 18 y <i>Baseline-26% Target -20%</i> Adolescent birth rate per 1,000 women 15-19 y <i>Baseline-28.4 Target -24</i>
UNFPA Bhutan 7th CP Outputs	
<i>Increased national capacities to ensure universal and equitable access to high quality sexual and reproductive health information and services</i>	<i>Young people, in particular adolescents are empowered with knowledge, skills and capabilities to make informed choices about their sexual and reproductive health and rights, and well-being</i>
Output indicators	
Proportion of district hospitals offering high quality integrated adolescent-friendly sexual and reproductive health information and services. <i>Baseline: 28% Target: 60%</i> Proportion of district hospitals with at least 3 service providers trained on rights-based and gender-responsive standards of contraceptive information and services. <i>Baseline: 0% Target: 50%</i> Updated protocol for clinical management of gender-based violence implemented in selected districts to strengthen the health sector response to violence <i>Baseline: No Target: Yestill OHC</i>	Proportion of training institutions and schools implementing rights-based, gender-responsive comprehensive sexuality education <i>Baseline: 25% Target: 50%</i> Number of communities with high levels of adolescent pregnancy, implementing evidence-based programmes to reduce early and unplanned pregnancies and empower adolescents <i>Baseline: 0 Target: 5</i> Number of national, subnational and sectoral development planning documents that used evidence and data from the UNFPA supported census and demographic analysis. <i>Baseline: 0 Target: 6</i>

Annex Part 2- D: Inventory of interventions and selected indicators for Chhukha and

Dagana

Activity description district-wise

Year	Activity Description	District/Institution
2019	Training of resident coordinators of colleges and newly recruited YIC manages (5 TTIs, 11 colleges, 6 YICs)	Monggar (Monggar YIC), Paro(Paro YIC), Punakha (Khuruthang YIC), Thimphu (Changji YIC), Trashigang (Trashigang YIC) Zhemgang (Zhemgang YIC)
2019	Capacity building on SOPs and revised essential service packages for health sector response to GBV in 2 regional hospitals (Gelephu and Mongar)	Gelephu RRH, Mongar RRH
2019	Competency based capacity building of health workers of BHU and sub-post on right based family planning services and on revised family planning forms and information collection, midwifery standard	All 20 districts
2019	Monitoring of SRH services in health centers	All 20 districts
2019	TA support to implement low dose high frequency capacity development for improvement of quality EmONC services in regional referral hospitals and includes ToT and roll out	Thimphu (JDWNRH), Punakha, Mongar, Chhukha (P/ling hospital), Samtse, Wangdue
2019	Monitoring of SRH services in health centers	All 20 districts
2020	Activity re-allocated for shelter support	Trashigang
2020	Engagement of MSTF/CBSS members for dissemination of risk communication materials on COVID19- GBV/SRH issues	All 20 districts
2020	SRHR in Munseling Institute of Khaling (visually impaired school) 1. Coordination meeting 2. Framework development	Trashigang (Khaling)
2020	Sensitization and coordination to expand YFISCs to youths through engagement of Youth Bhutan Network: 1. Training of AFHS focal persons on YFISC SoP	Chhukha (Phuentsholing YFISC), S/Jongkhar (S/Jongkhar YFISC), Sarpang (Gelephu YFISC), Thimphu (Harmony YFISC)

	2. Engagement of Young Bhutan Network YBN members as advocates of YFISC	
2020	Strengthen Y-PEER Network & partnership on SRHR: 1. National Y-PEER Meet to review annual action plan and share best practices including youths with disability (10,000) 2. Revise and implement Y-PEER monitoring tools (5,000) 3. Expansion of Y-PEER network in 3 Technical Training Institute in Thimphu and 1 College (Gelposhing) - (8,000)	Bumthang (TTI Chumey), Chhukha (GCBS, CST), Paro (PCE, NRC, JSWL), Punakha (CNR, TTI Khuruthang), JS/Jongkhar (JNEC), Samtse (SCE), Thimphu (RTC, FNPH, Appolo Bhutan, NIZC, Choki Traditional Arts School), Trashigang (Sherubtse College (Kanglung), TTI Rangjung), T/Yangtse (IZC), Trongsa (CLC)
2020	Life skills education to two more monastic institutions (Pema Gatshel and Mongar) --- Consultation meeting among stakeholders --- ToT for monks and nuns	Pema Gatshel and Mongar
2020	Inclusion of adolescent friendly health services and gender-based violence into Orientation program to newly graduate health assistants.	Thimphu (FNPH)
2020	Support to build competency of health workers from 23 basic health units' grade 1 on AFHS standards and adolescent job aids.	Wangdicholing Hospital, Paro, Trongsa, Damphu, Gasa, Haa, Gedu, Wangdue, Dagapela, Dangdung, JDWNRH, Punakha, Samdrup Jongkhar, Gidakom, P/gatsel, Lhuentse, Mongar RRH, Reserboo, Trashiyangtse, Yebelaptsa, Tgang,
2020	Preconception Package Pilot assessment in 5 health facilities and development of scale up plan of action and IEC materials	Thimphu (JDWNRH), Chhukha (P/ling hospital), Monggar (CRRH), Sarpang (Sarpang Hospital) Punakha (Punakha hospital)
2020	Implementation of Low Dose High Frequency methods to improve the quality of EmONC services in 10 district hospitals	Gasa, Gedu hospital, Pling hospital, mongar, Lhuentse, Trayangtse, Tgang hospital, Reserboo hospital, Pgatsel hospital, Punakha, Dagana, Tsirang, Zhemgang
2020	Annual EmONC Focals Review Meeting from 30 hospitals and 24 BHU Is and knowledge sharing of programme initiatives and implementation in the field	All 20 districts (All EmoNC focal from district hospitals)
2020	Implementation of National Guideline on management of victims of intimate partner violence and sexual violence in healthcare	Paro, Phuentsholing and Samtse hospitals

	facilities: Training of health care providers from Paro, Phuentsholing and Samtse hospitals	
2020	Development of SoP for health care facilities without medical doctors (Basic health unit grade 2) on management of GBV victims.	Thimphu (OSCC, JDWNRH)
2021	Sexual harassment prevention policy development and implementation in Royal University of Bhutan	Paro College of Education
2021	Young people skills and capabilities to make informed choice enhanced through implementation of CSE in schools, monastic institutions and in scouting program	CSE implemented in all schools with focus on Samcholing school in Trongsa, Tang central school in Bumthang and Khomshar Primary school in Zhemgang
2021	Young people skills and capabilities to make informed choice reach expanded to young people in monastic institution and in other religious institutes through implementation of LSE	Bumthang (KenchosumShdra, TamzhingLobdra, PadeslingShdra), Chukha (SangayMidyurling), Lhuentse (DrukOdhiyanga), Trashigang (Rangjung Foundation, Pemajejug, Ngajur Pea Ringlug, KhamsumNamdol, ThechogKuenzangChoden Nunnery), Wangdue (GangteyShedra), Zhemgang (BuliShedra)
2021	Sexual harassments prevention policy development and implementation in Royal University of Bhutan	Paro College of Education
2021	YP Skill/capacity informed choice: young people skills and capacities to make informed choice enhanced through implementation of CSE in Schools, Monastic Institutions and in Scouting Program.	CSE integrated in scout handbook of all sections of chechy, nachung, nazohen Rovers and community scout and rolled out in three schools of wangdiphodrang: Tencholing PS, Bjimethangkha PS, Samtengang PS.

Selected indicators for Chhukha and Dagana

Indicator	Status		Source
	Chhukha	Dagana	
Population			
Total population, 2022	69,820	25,732	Dzongkhag Population Projections2017-2027
Male	36,016	13,410	
Female	33,804	12,322	
Population 10-24 years, 2022	19,089	6,692	Dzongkhag Population Projections2017-2027
Male	9,364	3,156	
Female	9,725	3,536	
Sex ratio, 2022	106	108	Dzongkhag Population Projections2017-2027
Drinking Water and Sanitation			
Improved source of drinking water, 2017	99.5	100	Bhutan Living Standards Survey 2017
Improved sanitation facilities, 2017	91.4	91.1	Bhutan Living Standards Survey 2017
Birth registration			
Birth registration under age 5 (%)	100.0	99.8	Bhutan Multiple Indicator Survey 2010
Education attainment			
Completed Primary School (%), 2017	83.8	94.4	Bhutan Living Standards Survey 2017
Male	83.0	82.5	
Female	84.6	94.4	
Completed Secondary School (%), 2017	98.2	70.0	Bhutan Living Standards Survey 2017
Male	96.8	108.4	
Female	99.3	42.4	
Literacy			
literate (%), 2017	66.3	65.8	Bhutan Living Standards Survey 2017
Male	74.5	73.7	
Female	58.6	58.1	
Average age at Marriage			
Mean age at first marriage age, 2017	22	21	Bhutan Living Standards Survey 2017
Male	24	22	
Female	21	19	

Percentage of women age 15-24 years who had sex before age 15, 2010	2.6	5.1	Bhutan Multiple Indicator Survey 2010
Fertility & teenage pregnancy			
Gave live births by women 15-19 years (%), 2010	6.5	20.9	Bhutan Multiple Indicator Survey 2010
Total fertility rate per women, 2017	1.6	3.0	Population and Housing Census of Bhutan 2017
Adolescent birth rate (per 1,000 women 15-19 years)	29	124	Bhutan Multiple Indicator Survey 2010
ANC and Family planning			
Delivery by skilled health provider (%), 2010	69.5	59.8	Bhutan Multiple Indicator Survey 2010
Unmet need for family planning aged 15-49, 2010	9.6	7.4	Bhutan Multiple Indicator Survey 2010
ANC visits 4+	84.2	70.7	Bhutan Multiple Indicator Survey 2010
Contraceptive prevalence rate women age 15-49 years, 2010			Bhutan Multiple Indicator Survey 2010
All Methods (%)	65.8	77.0	
Modern Method (%)	65.0	76.7	
HIV/AIDS and STI			
HIV tested and received results aged 15-49 (%), 2010	7.6	7.5	Bhutan Multiple Indicator Survey 2010
Number of health Facilities	19	10	
Hospital	5	3	
PHC/Sub-post	14	7	
Others			
Poverty rate, 2017 (%)	3.4	33.3	

Annex Part 2- E: Notes from interviews, field visits and focus group discussions

Section A- notes grouped under Evaluation Questions

EQ 1- Relevance

- The target population for the vulnerable group for UNFPA is youth and adolescents with a focus on unmet family planning needs and other SRH needs. It is in line with the 12th FYP.
- UNFPA had consultation meetings with vulnerable groups during the planning phase of the CP7. However, did not have much engagement later on. There were several reasons for the same – legal status of some of the vulnerable groups (LGBTQI, sex workers), the COVID pandemic and lack of expertise to deal with the SRHR issues. Lack of expertise to deal with SRHR issues of People With Disability (PWD) was also pointed out as a reason. However, UNFPA is one of the first UN agencies to focus on LGBTQ groups and the engagement began with LSE training for the group in the previous CP. UNFPA supported Health Information and Services Centre (HISC) in Phuntsholing to cater to the sex worker and address issues faced by them under CP 6 , but the support did not continue from CP6 to CP7. Consultations with LGBTQ, PWD, sex workers and other vulnerable groups were conducted late 2021. The linkages with sex workers has been only informal, however, upon legal acknowledgment by the government, the formal linkages could be possibly formed in the future. Consultations were carried out to include the LGBTQ+ community in the gender Policy that focuses on economic and social aspects but doesn't include the SOGIESC. There is a need to be more inclusive and diverse to include people living with disabilities which will require better TA expertise. Special efforts were made to accommodate the needs of the visually handicapped during the integration of CSE into the curriculum. There were issues in transcribing pictorial messages into braille. The budgetary support was limited. DPO collaborated with UNFPA to provide training using the approach of disability equality training for the disabled to advocate for themselves. PWD's major challenges is that they are excluded from decision-making forum
- The CP is aligned with the national policies and strategies -12th FYP, RH strategy, national policies related to youth, gender equality, policy on disability, etc. The work UNFPA does is aligned to the SDGs, they work with the government to support the government on priority issues. UNFPA's contributions are well recognized by MOH, MOE, NSB, and RENEW.
- The CP is well aligned to UNFPA's Strategic Plan and also the UNSDPF. The CP contributes to the principle of leaving no one behind. UNFPA's outputs focus on the three transformative goals
- The CP responded to the COVID-19 pandemic by realigning its funds and work plan.

EQ 2 - Coherence

- UNFPA is the lead agency for outcome 1, Data. UNFPA contributes predominantly to outcome 2 of UNSDPF focusing on vulnerable and unreachable access to services and outcome 3 on equal opportunities to women and vulnerable. UNFPA contributed to the development of UNSDPF and was co-chair of gender thematic working group. Contributed to joint annual work plans. Supported gender analysis. UNFPA chair human rights and disability, and co-chair for the gender working group with UNICEF. ?? Chairing the UNSDF group of evaluation of sustainable development.
- For EmONC, UNFPA, WHO, and UNICEF work together. Also support MOH on MPNDSR and upcoming national health survey that will contribute to ICPD and national level indicators. It is

easier for UNFPA to work with UNICEF but not with WHO. Co-ordination with WHO is not optimal. More collaboration is needed for strengthening BEmONC and CEmONC services.

- In 2018 WHO, UNFPA, and UNICEF were engaged in the National Youth Town Meeting engaging 600 youths.
- UNICEF & UNDP are the lead agencies looking at GBV, UNFPA should be also more involved in terms of GBV against young and adolescents and vulnerable groups. Violence against women and children study was done through the financial support of UNDP and the technical support is given by UNFPA.
- The division of labour between various UN agencies is not clear and there are overlaps- For example Shelter homes for GBV victims were supported by UNICEF on its own with no coordination with UNFPA who was the first agency to support the homes. Similarly support for ICTG for monitoring pregnant mothers was supported by UNDP (Japanese agency donated the equipment) with no discussion with UNFPA (UNFPA has been supporting MOH on maternal health for many years). While other agencies are welcome to support RGOB efforts, coordination with the lead agency is important. Other UN agencies take up gender components whenever funds are available to them.
- The pressure for a small org like UNFPA to demonstrate at par with other UN agencies should be lessened. The number of internal meetings held should be lessened to enable national officers to focus on advocacy. UNFPA country office also have limited staff to carry out the work because most of the time they are engaged in meetings with IPs or writing reports.
- UNFPA is the lead agency for family planning services, ASRH, maternal health, cervical cancers, etc.
- UNFPA's contribution to Bhutan Statistical Data Systems is recognized by other UN agencies.
- UNFPA's role in integration of CSE into school curriculum and work with monastic institutions on integrating LSE based CSE in the school curriculum is well recognized by UN Partners and also its high -level advocacy through UNFPA Goodwill Ambassador, Her Majesty, the Queen Mother. UNFPA is the only UN agency who has managed to work with monastic bodies which none of UN agencies here has succeeded although UNICEF is following suit.
- UNFPA's support for analysis of Census showed that the proportion of the population 65+ is increasing and needs attention with regard to health services and social support. Recently UNFPA started working with the Royal Society for Senior Citizens to develop a policy.
- All UN agencies to take up AGENDA in their own areas of focus and do consolidated implementations for larger impact. Need better collaboration among donors and also among implementing agencies for consolidated implementation as donor-driven activities are often duplicated.
- UNFPA's support for strengthening competencies of midwifery is good but UNFPA and UNICEF should collaborate for enhancing the quality of care and also in clinical program management (UNICEF).
- It was pointed by UN partners that it would be better if UNFPA got more involved in GBV than they already are. Also, should focus on mental health and health of the elderly
- Jointly advocate and push forward the MICS (UNICEF suggested) – as new data is needed to plan the 13th FYP (latest data is from the year 2010).
- UNDP would like to collaborate on safety network and social security of women laid off from Drayangs and other similar vulnerable groups who need support
- UNFPA has created a forum for RENEW to expand with other partners like the IPPF. UNFPA's collaboration with RENEW on GBV provided opportunities for the CSO to collaborate with MOH and similarly the collaboration helped RENEW to open doors for UNFPA to work with Monastic Institutions.

- UNFPA support had been relevant and addressed the needs or priorities of implementing partners.
- UNFPA supports is enough to meet the priority of MOE. However, DYS is of the view that there is duplication of efforts among donors including UN agencies
- UNFPA should continue the support for monastic institutions as they have done so well in that field.
- The GNHC ex UNFPA focal said initially when UNFPA was planning CP 7 they were focused on SRHR and ASHR.... There is good alignment with national priorities during the planning phase... However, because of COVID there was little shift from the initial plan but they have done well and they are scaling up... UNFPA is the lead UN agency for Data and if you look at the plan and their intervention, there is little deviation. UNFPA's support despite their limited budget was much appreciated.
- Partnership with academic institutions to do research into root causes of GBV and teenage pregnancies did not materialize due to the pandemic. This would have provided opportunity to further add to provide evidence for advocacy.

EQ3 – Effectiveness: SRHR and adolescents and youth

SRH output

- UNFPA had supported EmONC needs assessment, near-miss reviews, ANC assessment, etc. which provided evidence for various policies including national MCH Policy. UNFPA contributed to the development of NSPAAH.
- UNFPA lead agency for FP and supported development of standards, training package and its revision to include FP services for adolescents, PWD and other vulnerable groups. Supported rights-based FP training. Feedback obtained during field visits pointed to lack of hands-on training in IUCD insertion. It was also pointed out that the IUCD insertion rates are low. Assessment of few midwives found that some of the nurses could not do the procedure of inserting IUD at BHU levels and training to 13 nurses on the insertion of IUD were provided so women from remote areas can avail services at the BHU level. Implants were planned to be introduced and the guidelines were ready but could not initiate due to the availability of the implant supplies and also got postponed due to COVID-19. FP services must be continued despite increasing or reducing TFR.
- Updating of midwifery standards were supported in last CP and training materials were supported in CP 7 and also training. LDHF training in EmONC was done effectively as gathered from the feedback from providers who were trained. There are concerns about follow up supervised client practice. For LDHF mode of training, provided training for the trainers. These trainers go back to their office and give training in their office. For example, in the 1st month they teach them about cervical tears and the next month they teach them how to stop bleeding after birth and so on. LDHF was rolled out till HW in hospitals, but every HW conducting delivery needs basic life-saving skills of maternal and newborn. There is need for capacity development of midwives and NICU nurses if quality of maternal and newborn care is to improve.
- Supported the development of the training manual for AFHS and its training. Training included AFHS focal points from health facilities as well as health focal points from schools, Y-PEER, youth centres, etc. were trained to strengthen referral facilities. To make facilities adolescent friendly for AFHS, few facilities especially in referral hospitals have AFHS corners- AFHS focal (male and female each) in 51 hospitals/facilities have been trained. Need an assessment to see if AFHS standards are implemented in all 51 hospitals those are supposed to be having AFHS. Access may be an issue for AFHS for those in communities but there is a referral mechanism both in health facilities and schools. AFHS focal are nominated by CMOs or Department heads and then receive training for AFHS. AFHS focal in district hospitals and health facilities are responsible for other health activities

compared to designated staff in referral facilities. There is lack of awareness and advocacy on AFHS. Support was provided for sensitization of hospital staff, AFHS for focal so they can TOT for fellow colleagues. 81 focal were trained for 51 hospitals. There are concerns about lack of coordination between the health services for adolescents in various locations- hospital, school, youth centre.

- The AFHS centre at national referral hospital provides AFHS/CST/ORC- cater to school, religious and communities. The department of psychology comes to AFHS centre to provide service on Tuesday and Thursday. AFHS services available from 10 - 5 pm. Youth can seek services on adolescent preferred services during off hours over the phone. Clients have issues such as depression, anxiety and substance abuse. Mostly calls for unsafe sex, I pills and GBV (then refer to forensic)
- Inclusion of FP, GBV, AFHS in the curriculum of final year nursing and DPH ensures long term effectiveness. However, there were concerns about the inclusion of AFHS training in Year 1 when basic subjects were taught. It was felt it was more appropriate at the time of clinical training.
- UNFPA APRO Midwifery Faculty Development Course, developed in collaboration with Burnet Institute in 2019 was converted to an on-line course through Moodle platform and certificates were provided to students who successfully completed the course. Feedback from midwifery faculty of FoNPH showed that the course was extremely useful, relevant and the platform was easily accessible.
- UNFPA should support capacity building of health workers in international standards, but plans for exit from support should be considered.
- Recognizing the changing patterns of morbidity and mortality during pregnancy and childbirth- skewed towards non-obstetric causes, preconception package is being implemented on trial in a few hospitals including JDWNRH (this effort is supported by UNICEF. UNFPA collaborates but should have taken the lead as this is a component of the RH strategy and UNFPA provides leadership in maternal health.
- There is checklist on basic infertility screening starting from PCH level. UNFPA supported setting up infertility clinic at JDWNRH but don't know how much service uptake is there- doesn't seem to be a priority at JDWNRH. More needs to be done.
- Concerns about current fertility rate being low was expressed by several officers but the team emphasized the importance of looking at other determinants of fertility.
- UNFPA had supported screening for cervical cancer, assisted with development of strategies, and supported capacity building for use of HPV-DNA screening techniques and supported camps in three districts. Support to cervical cancer must continue especially for advocacy and timely access to services in terms of early detection. Also supported guidelines for screening for breast cancer and pelvic organ prolapse.
- In a major way, supported the development of training materials and training of health service providers in health sector response to GBV. The training covered intimate partner violence and sexual violence. Two types of manuals were produced- one a comprehensive one for facilities with doctors and another one for facilities without doctors (focus on identification, counselling and referral). The guidelines cover provision of i pills, first support system, and forensic services. Referral to other support system maintaining privacy and confidentiality. It appeared from discussions with forensic focal points (for GBV) that the full protocol is not being followed. No assessments have been done due to the pandemic.
- Advocacy to parliamentarians on SRH and GBV issues was done.
- The data on SRH indicators are not recent or not available.
- HIV/STI not integrated with SRH services.

- Storage of supplies at the medical store and supply division in Phuentsholing was a concern. While oxytocin, injectable contraceptives and oral contraceptives were stored as per specifications; condoms packages were damaged with the contents falling out and the packages were not stored on shelves. Maintenance of temperature and ventilation was another concern.
- UNFPA had supported the development of Bhutan's commitment at ICPS @25. UNFPA printed out the commitment and distributed to all the health facilities in the country.
- The possibility of creating a Technical Advisory Group for RMNCAH was explored with the Minister of Health.
- MOH had supported for training in MISP but not much support during CP 7. MOH found the MISP training useful. Data collection during disaster or humanitarian crisis were carried out through partnership by sharing the template through other agencies capable of assessing.
- UNFPA supports the printing of key messages for mother and child care at hospitals which got postponed due to COVID.
- The HIV program from the MOH used to work with UNFPA but they pulled away five years ago. HIV program sees an opportunity to work with UNFPA for PMCT & LGBTIQ.
- UNFPA should invest in technology assistants for MCH as we are becoming more technology-driven.
- Should support the hospital for comprehensive screening process for all the people like HIV, STIs, High blood pressure, Diabetes, what the WHO calls a pandemic.
- During COVID, UNFPA supported MOH in developing the interim guidelines for continuation of SRH services based on the Regional documents jointly developed by UNFPA, WHO and UNICEF. Supported virtual review of maternal deaths, virtual training on capacity development continued. Essential services were continued. some challenges were there related to coordination of services. Interactive platforms were developed to support pregnant mothers with advice and services. FP supplies were provided at home as needed. PPE kits, sanitizers and other supplies were provided. OSCC provided continued services & guidance to victims through telecommunication and delivered i-pills. GBV was refereed for social support to CSO

Adolescents and youth output

- Data on RRF indicators related to outcome is not available. There are definitional issues related to number of schools implementing CSE as the curricular integration happened later in the course of the CP implementation.
- CSE integration in the curriculum is successful and also it has removed the challenge of sustainability once it is in the curriculum. CSE is integrated into the curriculum in all schools, especially in 6 subjects of HPE, Value Education, English, Social Science, science etc. But the challenges remain such as training of teachers on the CSE framework and guides on integration. The CO had planned to provide the training to teachers of Bhutan but due to the government reforms, many such plans may not be implemented. CSE implementation has a big potential for south-south collaboration. MoE has developed instructional guidelines on CSE. There is national strategy for CSE. Currently it is piloted in 3 schools. After which it will be rolled out in all the schools. CSE has been taught in 3 colleges of CLCS, PCE and Samtse teacher training colleges. The UNFPA-supported CSE curriculums have not included the SOGIESC component. SOGIESC is seen as an LGBTQ+ subject only and sensitive, hence, awareness creation is not present among curriculum developers. UNFPA's contribution to introduction of CSE in school curriculum has paved the way for other agencies such as IPPF to support its implementation nation-wide.
- UNFPA supported the introduction of LSE based CSE in three monastic institutions and has been successful. In collaboration with CROB, more monks and nuns are being trained. The support

should be continued in the next CP. The chief abbot of Bhutan has endorsed the importance of CSE for the monastic institution by which we were able to provide training to the religious leaders, figures, monks and nun.

- Y-PEER network is a success story for UNFPA. SRHR is supported through Y-PEER. DAISAN members in schools when they reach colleges usually join Y-PEER. Initially they also wanted to form a different group which could have been duplication. There are 19 networks of YPEER. YPEER from PCE has helped the UNFPA project programmer from the college to reach out to the unreached on advocacy and sensitization of FP, SRHR, and ASRH. Even the students like to share, confide and seek help from people of their same age groups. Need support for young girls' circle. YPEER was first formed with support of UNFPA - they advocate for SRHR, Menstrual Hygiene, safe sex, contraception and GBV to college students and communities. Peers feel more comfortable to talk about these issues with them.
- Needs more capacity development for Scout master and leaders to roll our scout handbooks which have recently integrated SRH and GBV components. Scout has been supported for the last 2 years by UNFPA for sensitization of SRHR and GBV as a component in scout, the scoutmaster (teacher) and advisor are trained in health book planning. Scout member after finishing college can then join the scout group of a community-based system for which the UNFPA, RENEW, and NCWC gives training. Scout initiated safety from harm to create awareness on SRHR and GBV
- UNFPA held a consultation with vulnerable groups such as PWD, LGBTIQ, PLWHIV, sex workers and other vulnerable groups in 2021 to create awareness about SRHR issues and GBV and where to access care. The consultation was followed by specialist consultations at JDWNRH and screening for LGBQTIQ were done, but not much progress has been made.
- UNFPA support to DYS can also be in the form of M and E training and capacity building, so impacts can be measured and identified. Monitoring and evaluation needs to be strengthened for sustainability of any interventions and also quality of interventions .
- The high-level advocacy through UNFPA Goodwill Ambassador has helped to highlight sensitive but critical issues such as ASRH, GBV, teenage pregnancy, etc.
- The evidences from other parts of the world were used to advocate on prevention of teenage pregnancy due to lack of data or research on SRH issues- need to generate data for evidence. Through RENEW, UNFPA has been working with local leaders like *gup* for advocacy and prevention of teenage pregnancy, early marriages, marital rape and GBV. UNFPA has supported RENEW for CSE; sensitization in communities and monk institutions. Collaboration with MSTF and CBSS were established through RENEW which helped to create awareness and advocate for prevention of teenage pregnancy, early marriage, GBV, etc.
- In collaboration with RENEW, Special campaigns on prevention of teenage pregnancy were done in high adolescent pregnancy districts such as Thimphu, Punakha and Mongar. Awareness was created among Microfinance coordinators and non-formal education trainers.
- In collaboration with DYS, a consultation on barriers to accessing medical termination of pregnancy was held was followed by another consultancy at JDWNRH with WHO and UNICEF to review the current SOP on medical termination of pregnancy and to develop strategies for overcoming barriers to accessing the services especially by adolescents.
- SRHR and GBV messages have been incorporated into the interpretations of the mask dance at the local *tshechu* festivals ('day ten' festivals) in few districts; thus, further improving access to information.
- UNFPA's support to GBV goes beyond the health sector response. There is a 'We chat' group for MSTF/CBSS through which the group shares information or learning and support the victims of

GBV in the communities. UNFPA has been supporting multi-sectoral involvement in GBV – health, community mobilization and involved in engagement of judiciary and police through its involvement with NCWC and RENEW. There is not much support from UNFPA on counseling, legal and shelter services, and limited support on reintegration. UNFPA can consider the support on these areas. Some of the key findings related to its support for MSTF-CBSS collaboration through RENEW are given below. The MSTF (Dzongda, DHO and DEO), the principal and counselor from Daga central school with CBSS focal and members, do mapping about their villages to see which Dzongkha have what issues based on data provided by police (is used for mapping not for reports) to see the intervention the communities needed. They have a high suicide rate at Dagapela (10 in August 2022) so they went to that community to talk about suicide awareness (The parents are welcoming of the idea of looking at signs of suicide). Or for the community of Nerwala where most of the people are pandits so they do not touch alcohol so they would give advocacy on menstrual hygiene. The people of Drujagang have a lot of alcohol issues with high domestic violence (DV) and GBV sensitization was done. The fund is received from the Dzongkhag or the RENEW. And before COVID funds were raised by the MST/CBSS through campaigns and farm festivals (stall). When a GBV/DV/suicide/ mental health cases such as stress of DV and emotional abuse or trauma case comes, we do the basic assessment and a referral to the relevant agency. Efforts were also made to connect victims to 24hrs RENEW counselors. Shelter homes were established temporarily. Support was provided to victims through telephonic consultations for counseling and other social issues such as reaching supplies at home by working closely with the task force and helped them get supplies and were given a room in the guest house. The GBV counselors were given training on mental health so they could be certified to provide counseling on these through support of UNFPA through their IP RENEW. The CBSS conducts awareness campaigns on FP in communities where social evils are not major concerns. There is need for a dedicated CBSS coordinator for GBV as the current coordinator is busy with many other tasks. There is a need to build capacity for the CBSS volunteers to deal with sensitive cases and build professionalism. There are some incidents where volunteers did not even maintain confidentiality.

- People avail of GBV service more because they don't want to report a case to the police for fear of being charged... they say they need help and not punishment as often their perpetrators are their source of income.
- The UNFPA's support of the Red Dot Campaign is seen as a success, a measure that was timely in the pandemic. RED DOT Bhutan campaign supported by UNFPA with AshiUphelma as the royal patronage during the COVID pandemic was started it. For example, for menstrual hygiene - schools have one stall in the toilet built in the girl's restroom without the toilet pots, the school staff and faculties used it as a storage room but it was meant as a changing room for girls at school. They made advocacy for this and brought the changes. The sub partner is UNICEF promoting WASH.
- UNFPA had supported the development of M-Power App for adolescents to access SRH information, but it is not functional due to technical glitches. A similar app on condoms is being developed and will enable young people to access information on condoms and where to get supplies.
- During the pandemic, support was provided to continue the implementation of CSE framework in schools through continued support for teachers' training through Paro College of Education through digital media. Support also was provided to continue LSE based CSE in monastic schools through digital media. GBV became a concern during the COVID pandemic so UNFPA wrote a proposal to the regional office and got support for shelter homes. During the 1st Lock down UNFPA helped RENEW in full force to reach out at grass root level for services that they provide. Also supported 6 centers (Trashigang, Bumthang, Zhemgang, Samtse, Sarpang, and SamdrupJongkhar) of RENEW with amenities during COVID.

EQ 4 – Effectiveness GEEW

- UNFPA collaborated with NCWC and provided support to the development of gender equality policy and its action plan 2019-23 and its monitoring framework. Also supported the revisions to include vulnerable groups. Also supported the development of the legal frameworks related to GBV.
- NCWC develops a guide and action plan for GBV, and RENEW implements this through the support of UNFPA. These activities are guided by the Domestic Violence Prevention Act. NCWC as a lead agency have come up with a framework for GBV at workplace but lack proper implementation by agencies. This may be an area where UNFPA support could be used.
- The CSE and LSE support has a major component on gender.
- UNFPA has supported a range of community-based activities to prevent GBV and its management; there is a fear that GBV may not be a national priority under the current structural changes in the Government. The agency has utilized religious institutions such as monasteries and nunneries to mobilize the community against GBV.
- UNFPA's contributions to PSEAH policy is well recognized. From the support to institutions under RUB to develop the policy, it has become a policy of RGOB. The Minister of Health wants to further develop the policy as a national PSEAH policy. With support of RENEW, UNFPA has developed a PSEAH policy for monastic institutions which is considered a bold move.
- RUB has developed a policy on GBV prevention - sexual harassment. 2 rounds of advocacy. Capacity development on case manager. Each institute should have a team of case managers.
- Every UNFPA funded workshop or meeting has a mandate to integrate PSEA in the agenda.
- It was pointed out that gender inequality affects the use of FP. For example, family planning client cards are retained in the health centres and the reason was that the clients did not want their husbands to know that they are using contraceptives. There have been cases of husbands who do not approve their wives using family planning confronting health providers. (this information was provided during an interview and needs further validation as such actions are not common in Bhutan).
- UNFPA works with GNHC as the custodian of gender equality policy with sub IP as NCWC.

EQ 5- Effectiveness PD

- UNFPA is the lead agency for data under UNSDPF. UNFPA need to look at data systems in a country, coordination between UN agencies, and coordinate the data survey that is coming up.
- UNFPA's budget on data which was 1 million USD was later reduced to 600,000. So much could not be done beyond its support for development of statistical data systems and capacity building of district level officers.
- UNFPA is a major supporter of NSB. Bhutan Statistical Database System, previously called Gewog Database, is being upgraded with an aim to serve as the country's main statistical database. As of now, the interface development for Agriculture, Livestock and Gewog Administration is completed. The system developer is currently working on integration of EMIS (Education system) through APIs. After that, the integration of the Forestry system (FIRMS) and ePIS will be initiated. Bhutan Statistics Quality Assurance Framework (BSQAF) was developed. Chukha Dzongkhag is included for the current FY for roll-out.
- The current practice of entering data by GAO in the statistical database has to be reviewed. The concerned sector should be given the responsibility.

- The capacity building of the district level statistical officers (DSOs) in use of data for planning was much appreciated and recommended more of such training. The participants included DPO, DHO, DEO, DSO and GAO. Pre-test and post-test were also conducted to evaluate the effectiveness of the training which showed a positive outcome. Also recommended training for senior officials in the use of data. DSOs collect secondary data from different sectors including education and health. They help in calculating indicators such as NER, Literacy rate. Data literacy training conducted by NSB with UNFPA support was beneficial for the officials from other sectors in understanding statistics. They realized the importance of statistics. The DSO is perceived to be working directly under NSB and not an integral part of dzongkhag administration which was expressed as a concern.
- UNFPA supported the development of Youth Development Index which is similar to situational analysis of adolescents, this was not accepted by the GNHC ?.
- As a Pink country, UNFPA has to provide evidence which is based on the availability of data.
- The support to NSB in coming up with thematic reports based on the 2017 PHCB data such as the population projections report, rural-urban migration report, population dividends report. With DYS, UNFPA supported in coming up with the Youth Development Index report". It was reported that the thematic reports by NSB were better in quality compared to the earlier reports and is considered a positive outcome of UNFPA support in the past. "Thematic reports based on 2017 PHCB were produced by NSB include Population Projections, Rural-urban Migration and Urbanization in Bhutan, Harnessing Demographic Dividend in Bhutan"
- MoH is planning to conduct a National Health Survey which will be much more comprehensive. The Government is aiming to reduce multiple surveys. UNFPA managed to push for ICPD indicators in the upcoming Health Surveys.
- UNFPA may be credited for pushing SRH indicators to be put in NKRA and that was done with an aim to bring visibility on population and development.
- Issues identified with MOH data systems : Currently MOH uses DHI-2, HMIS and MCH tracking system (Bhutan Vaccine system was created during COVID). It also has a cancer tracking system and HIV tracking system integrated into DHIS 2. MCH system is rolled out in 16 districts and since it is not 100% coverage, they do not generate information for the nation. For the particular district, data is generated for internal use. For MMR calculation, the MOH has an issue with denominator (number of live births)
- MoH will conduct NHS in 2023 which has components from Step survey, MICS and nutrition survey
- Data is recognized as important but not much done because of the lack of understanding of the importance of data and sometimes the data is not analyzed and used because of work load. There is a push for a Data legislation statistical bill but the government decided not to pass a new bill.
- Emerging issues of population in Bhutan that needs joint action by relevant UN agencies are everyone mostly young people leaving for abroad, urban migration, mental health issues of those children left behind by parents leaving for abroad, and aging population who will soon be left with no support
- Definitions of indicators varies at dzongkhag level. For example, improved sanitation is defined differently. The other issues are non-availability of required data, poor quality, not able to interpret and use. The same data request from Gewog is often made where by annoying the concerned focal. This mainly due to lack of common database in the dzongkhag.
- DHOs have access to DHIS-2. They can review the data of all facilities in the Dzongkhag and then ask the facility in-charge to rectify if required. Data entry/uploading become an issue for facilities without the Internet. They are provided with mobile hotspots. The Data collected in DHIS2 is shared by DHO to DSO and both the offices work together.

- The role of data needs to be strengthened... Health, education, and all other sectors are submitting data to their respective agencies by their own sector heads. DSO needs to be overall data focal and all data submitted should route through DSO.
- Need for disaggregated data at Gewog and Chiwog level for planning and focus interventions. District level data is viewed as not so important.
- It is important for the neutral body to conduct surveys. Concerned agencies conducting surveys are biased as they tend to present data in their favour.
- Currently, data available are at district and national level. For informed decisions, data should be collected at gewogs and community levels.
- 3 issues related to data are 1. Availability 2. if available, lacks quality and can't be interpreted. 3. Available quality data is not put to use.

EQ 6, 7 Efficiency

- The implementing partners and others felt that with limited human resources and budget, UNFPA is efficient in its support. TA provided is appreciated. It was felt that if UNFPA decides to have a separate focal point for gender, that person should have multiple skills – expertise in climate, humanitarian, youth, etc., gender and poverty as women headed households are poorer and more needs to be done (this needs to be validated).
- UNFPA is easy to do business with and has been efficient in timely release of budget.
- It has a resource mobilisation and partnership strategy and raised resources for cervical cancer screening. It has supported the MOH in continuation of SRH services and prevention and management of GBV services. UNFPA's support is much appreciated at all levels of governance.

EQ 8, 9 – Sustainability

- UNFPA's support to family planning, maternal health, AFHS, cervical cancer, health sector response to GBV, are considered sustainable as they are well integrated into the programmes. However, there is a concern about the level of support for family planning in the context of reduced fertility. There are also concerns about continuation of GBV in the context of the current changes in policies and structure of the government.
- While CSE is a curricular activity, it ensures sustainability. However, it is in its earlier stages and may not receive the kind of support expected.
- Implementing partners are hopeful that the activities will continue.

Section B- Notes from field visits

The notes from the following field visits have been incorporated into EQ 3.

Phuentsholing

- Phuentsholing (P'ling) hospital is one of the 5 hospitals directly under MoH. It does not have Psychiatrist nor an OSCC
- The District Hospital of P'ling had to give away their AFHS room for medical specialists. The AFHS focal at P'ling used to go to the youth center every Wednesday from 1 pm to 4 pm before COVID. (average of 10 youths seek service). There are 2 nurses as AFHS focal at Pling hospital. Serve as a referral hospital for the whole catchment area and the nearby area. Focus on nutritional health assessment. The facility gets referrals from Youth centers for physical and substance abuse. No

separate clinic for AFHS clinic in the hospital – it was there before but now no space for the clinic but AFHS is integrated into the system and the focal work actively. Separate rooms for AFHS also create stigma which may be a barrier in using the services. AFHS focal attended two international online courses on AFHS funded by UNFPA and WHO- topics on sexual and reproductive health. The AFHS focal facilitate the clients coming to hospital. The AFHS at P'ling youth center was integrated with school health services due to a survey at P'ling High School where they have asked for that service for the students and youth of P'ling. Capacity building for AFHS was done at Bumthang for BHU focal.

- EmONC Focal appointed at P'ling hospital since 2015 but never had EMNOC training.
- The MCH at P'ling hospital receives about FP- 10 per day and for IUCD they go to hospital (ER) and put it there on the same day. The PNC mother interviewed at the MCH unit said that no advice received on the danger signs and no advice on FP.
- The higher secondary school in the district: P'ling high school has LSE in Biology subjects, school orientation covers SRHR/ASRH, they also have a group for 'girls talk, talk now and prevent it' for classes 4- 8 as a group and 9 - 12 as a group. The teachers of Pling did not receive any information about the CSE integration curriculum. The counselor of P'ling got LSE training. They have separate room for counselor where she counsels the students. The counsellor takes class on reproductive issues every week. The school does not keep any contraceptives fearing the students and parents accusing teachers of promoting and encouraging sexual behavior for young students. The school celebrates menstrual hygiene days- Red Dot Day. Fewer female students are dropping out of school at Pling because of more advocacy, and awareness, and as the school has better support like free pads and new underwear available. If student fall sick- health coordinator is informed – make them rest and call their parents- if parents can come they send them to hospital with students, if not teachers take them to hospital- The AFHS focal in the district hospital is contacted and if not available, follow through normal OPD routes. P'ling has 550 teachers who are active Scouts leaders they are given a bulk course which is 3 hours long
- The Youth Center at P'ling has integrated services; employment (MOLHR), AFHS, Counselor (From Thromde School), and drop-in centers BNCA and case manager from NazhoenLamtoen. Youth centre- P'ling is the newest of the 4 Integrated services of Youth centre. Before COVID, the integrated services were given on Wednesday and those needing services are referred to the health facility or if children are in immediate need of services, they are provided immediately. But right now , no services as these were not provided during the pandemic.
- Young girls' group have been formed at the P'ling center where the group of girls aged 9 - 18 years talks about their personal issues that they would feel discussing with their peers such as rape, abuse, teenage pregnancy, menstrual hygiene, and safe sex. They coordinate meetings and inform on their group chat when they will be having their talk. On average they would have 15 - 30 young girls.
- HISC centre in P'ling offers 4 tests- HIV, Hep B, Hep C, Syphilis- tested lot for Hep B but not found anyone positive till date. All kinds of people drop in to test but mostly truckers and housewives (they come because they say that their husbands go around and they are at risk and they themselves are at risk) to test. The centre focuses on high risk areas such as discotheques, Karaoke bars, and high-risk population (truckers, housewives). If HIV is detected, they conduct contact tracing. They get 6 to 7 positive cases in a year
- Medical Supplies Division, Phuentsholing: Contraceptive supplies (indenting happens at the national level as in each health facility submits their indent to the MOH and after compilation, the items are procured centrally. Once products received, experts invited to do quality assessment which includes physical inspection by a technical person... for example, DRA checks all the drugs

and medicine products and samples are tested at NDTL (national drug testing laboratory- the testing is not done unless there is an issue with a batch of product). It appears there were excess supplies of condoms- packages were open and not stored properly. The same situation was with PPE kits that were lying outside on the verandah. Some packages were not in good condition. The storage of supplies was a concern.

- CBSS: There are 13 CBSS members at the P'ling town. The CBSS focal at the P'ling has received the case management training. They were also trained to be focal for GBV but the training was related to attending death and not related to GBV. The CBSS focal received about 29-30 cases of GBV in a year, mostly DV and extramarital affairs. Tshogpa and other village head is focal point for CBSS in villages and CBSS volunteers work closely with the heads.
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Chukkha Dzongkhag

The Deputy DEO mentioned that the CSE had been in education and curriculum for a very long time now... when the deputy DEO was a teacher in one of the remote schools in Phobjikha, they had Her Majesty's visit for her level advocacy on SRHR... now he see sexuality subjects being discussed more comfortably and the schools also observe Red Dot Day. In higher secondary school they concentrate on having a geyser or hot water in toilets for menstrual hygiene. The 42 schools at Chukkha did not receive any CSE training from MOE. Health in-charge in schools are trained in health issue. Scout leaders' courses have a module on SRHR.... The Principals' meeting had the SRHR topic as an agenda and include even in parents' meetings. The students were not taught FP but they were taught to have a family size which the family can sustain.

SangyeMigyurlingZhimdra

- 4 lopens from SangyeMigyurlingZhimdrashedra were trained in CSE at Bumthang last year. They will integrate into the curriculum in 2023. But when they get open during class times they share it with the students with relatable examples from religion. The monastic students from SangyeMigyurling are saying that the ASRH/SRHR are needed, they would be ready to get this teaching because the current situation demands they are aware of safe sex and preventing STIs. They need to be informed to understand healthy information on mental health and receive full support.

Dagana

- Secondary School: About CSE, Principal received brief information virtually by MOE before the beginning of the academic year, but not sure whether the CSE framework was shared and also whether there were instructions on integration. The counselor said she has heard about CSE being implemented in 20 schools for now. She teaches while teaching guidance and career education to all classes once a week and also talks about LSE (CSE component integrated into it and focus on negotiation skills, menstruation, puberty, teenage pregnancy, etc.). The counselor said some counselors are of the view that with CSE being integrated, the counselor will lose their job but they believe that if CSE is taught by teachers as an integrated into subjects, counselors like them can focus more on one-on-one sessions which can help the students more. With time, teachers are gaining confidence in teaching on ASRH issues. The schools do advocacy for celebrating red dot day... They don't have sanitary pad boxes but the health coordinator keeps the pads and gives them during an emergency. The health coordinator said that most SRHR issues for young girls and boys consult them for irregular menstruation, UTI among girls and genital sores. The school does not have a referral network or system. The school helped a girl who was sexually abused -

relocated her and we even arranged for her to stay during the holidays as her home is not safe. We relocated her under the through SEN although she is not a candidate for SEN. Menstrual hygiene is a key issue of adolescents in schools, with weather posing a challenge in drying the undergarments. A washing machine could be a big support.

- There is a program called, 'home group' where one teacher meets with 10-15 students to listen to the students' problems – any problem. They meet every Friday and it is the same group and same teacher whoever we are comfortable with- they talk about what good things and bad things happened to them in that week, exams results and weekly scores, but once they shared a problem where a teacher was not teaching them well and then home group teacher shared it to that teacher which created some trouble for the students, so they now don't share complaints about teachers.
- The students had not heard about CSE, one student heard about GBV through the DAISON advocacy program. The students did learn about stress management, time management, job interviews, friends circle, mindfulness, sexuality, sexual desire and how to deal with it, menstrual hygiene, and dealing with bullies are taught in guidance career counseling. The other teachers teach them about good touch, and bad touch, and IEC materials are pasted on the walls of our schools. One girl student said the school did celebrate the Red Dot Day where the male teachers and students were asked to give pads to the female teachers and students and in return, they would be tied a red ribbon on the arm but she said in her classroom the female students were not willing to take the pads from the male students. The male students were forcing them to take it. It happened to the students who were embarrassed and shy about it. 'Some of our friends are shy and some are not but I think it is important to teach young kids about it. We will be more confident to deal with such issues when we come across it later....'.
- HR at the Dzongkha is NCWC focal and one of our teachers is RENEW focal for the Dzongkhag,
- MSTF's mandate is HIV initially but later on included STIs, NCDs, Suicide (MOH).

Hospitals and health facilities

- In Dagana district, there are AFHS focal in 3 hospitals (Dagana, Dagapela, Lhamoizingkha) The AFHS focal in Dagapela does sensitization activities for other staff in the hospital. Among the adolescents, irregular menstruation is the common morbidity.
- The HA at Drujagang BHU 2 does not know how to insert IUDs so they do not provide that service. She also didn't receive training for AFHS or EmONC. The HA got training through her friend who got training on revised FP last year. The HA got training for low-dose high-frequency training in June 2022. It helped her with risk assessment and referral for preeclampsia (helps with knowing the definition of it). Deliver 3 - 4 babies in a year at the BHU at Drujaygang.
 - Dagapela hospital has no forensic focal and managed by a clinician. Hospital does 7-15 deliveries per month at Dagapela. STI cases in the community but usually do come to hospital. No training received on FP rights-based. Hospital received 4 GBV/IPV cases in the week prior to the visit of the team. This year, 3 AFHS focal from this hospital (2 nurse and 1 nutritionist) were trained. EmONC focal received LDHF training in 2021- helped in especially managing PPH and Eclampsia and can manage cervical tear. Though management of other obstetric emergencies taught, have not had a chance to practice as the hospital did not have any such emergency. Hospital requires basic counseling training as currently those cases are referred to Tsirang hospital. Also require refresher training on AFHS.
- The Dzongkhag has high adolescent fertility and high number of GBV cases.
- CBSS: 2021 4 CBSS members from Dagana were given training on case management and in September 2022 they would be giving training to 4 CBSS members again. There are 26 CBSS volunteers in Dagana of which 8 are at Lhamozhingkha and rest are located in sporadic locations

in dzongkhags... and she has been a volunteer for 6 years. For severe DV cases, CBSS coordinator facilitates in getting legal help and providing temporary shelter at the district guest house,

Section C: Focus Group Discussion

1. Students of FNPH (12/08/2022)

The discussion was kicked started by inquiry on the awareness level of students on family planning. Students were asked if they were involved as part of their training in recommending different family planning methods to service seekers. Some were asked to demonstrate the process of instructing patients on the use of oral contraceptives, and they were also asked on their familiarity on the use of IUD.

Being an institute where YPEER network has strong presence, the discussion was pivoted to the challenges of working as peer educator. The students were under the NESTED program, and those who graduated from private nursing colleges also shared their views; according to them, the administration in the private nursing college were supportive of the activities of YPEER, whereby funding was given when the networks couldn't secure them under DYS. Further, the students who are not a member feel that the work by YPEER members is helping to shape the perception of the students and faculties alike on SRHR. Even though FNPH is a nursing college, many first and second years are not well informed on SRHR and the need to address them may not be very different from other non-nursing institutes in the country. The first years in particular are not well aware about contraceptives, and they could be at risk of unplanned pregnancy and contracting STIs.

The YPEER members pointed out the ineffectiveness of the condom vending machines, and their initiatives to address the issue relating to condom inaccessibility through a condom delivery app were shared by the students. The app according to the students could be used to connect the consumers and vendors to enable easy access. A non-member also shared that YPEER networks in their institutes are doing a commendable job, and the network's presence and intervention is needed for "all times to come".

2. YPEER (13/08/2022)

According to the members present, YPEER act as a referral agent for peers who seek services such as on SRHR and counselling. There are 19 networks of Y PEER spread all across the country in the tertiary and training institutes in the country. The emergence of cases of sexual harassments in colleges is a concern to them, and YPEER members also face challenges in conducting advocacy and activities in the colleges. However, braving most hurdles, the networks have been working to carry out works on SRHR through a peer based approach. As one of their mandates lies in the young key population, some college networks claim to have been inclusive of the LGBTQIA+ community in their training. In the recent training of trainers in Thimphu, an LGBTQIA+ person was invited as a guest speaker, and some trainees also openly came out as LGBTQIA+ members during the training.

Some YPEER members find it hard to communicate about their SRHR needs to their family, and even the colleges they are part of don't render full support to their cause. This is largely owing to the fact that areas of focus by YPEER are sensitive in nature and it challenges them in implementing their activities in their respective campuses. The funding support in the recent time has seen reduction, and the COVID pandemic also contributed to the growing challenge. YPEER carries out extensive media literacy on SRHR and mental health components. It has also been informed that the source of funding for YPEER is largely through the

government agencies and no private agencies could be roped in for the funding support. The funding has been facilitated by the Department of Youth and Sports to reach the networks in the institutions to carry out their activities.

YPEER mainly gets funding from UNFPA and Robert Carr funding internationally. The YPEER members were present during the reviewing of national Youth Policy. During the lockdown, YPEER faced challenges in adopting the virtual medium in conducting activities. However, with time, some of the sensitization and training were carried out virtually. Some of the prominent members were also involved in developing e-courses for YPEER which were used both nationally and internationally for teaching about YPEER and SRHR.

3. Phuentsholing HSS (17/08/2022)

The comprehensive sexuality education (CSE) in schools was supposed to be integrated in the curriculum beginning this year. During the lockdown last year, the school teachers, especially counsellors, took initiatives to teach about certain components of CSE such as good and bad touch, and teenage pregnancy. However, the students didn't recognize the term CSE as opposed to Life Skill Education (LSE) which was familiarized to students with a component on child abuse. The students also recalled lessons where a teacher shared their own experience of undergoing abuse in their younger years to help relate with the issue.

The DIASON club member recounted learning about human trafficking as part of their club activity, however, in school topics of CSE has not advanced beyond the basics of the existing curriculum. The Phuentsholing H.S.S. has observed the menstrual Hygiene day boisterously with focus on involving male students and teachers in donating to the school's reserve of Sanitary pads which are freely accessible to students in need; The day was also marked with a Skit aimed at reducing stigma surrounding menstruation.

While inquiring with students of different grades with their allocated topics of CSE in the new curriculum, class VII students didn't recall learning about relationships; class VIII didn't recall learning about Health and Well-being but learned about intimate relationships among teenagers. None in the FGD has learned about body image but all have expressed familiarization to menstruation owing to programs and classroom learning.

With no prior guidelines to teach CSE before, teachers have taken the independence of imparting lessons based on their own level of knowledge on CSE. A teacher has acquainted the students with the extension of LGBTQIA+ but didn't get into the details. "A teacher taught us that bisexuality in human is when a person possess sexual organs of both male and female sexes," a student recalled. Evidently, CSE in school curriculum are still at an infancy level with integration of CSE by MOE and other relevant agencies indicating gaps in implementation.

Consequently, most students have recognized the CSE topics from their exposure to social media such as YouTube. A student has also come out as a survivor of violence and abuse in the discussion, and another has shared experience of cyber criminals who reached out to them and solicited their video and images of sexually explicit nature. A student has also shared about knowing an underage relative who was coerced in marriage and underwent sexual abuse.

The focus group discussion has pointed to the sparse existence of CSE in schools despite the new curriculum. It also shed light on the existing danger and risk that children are facing, and with less knowledge on CSE, their right to safety would be a challenge to achieve.

4. Integrated Youth Center in Phuentsholing (18/08/2022)

The youth Center under the Department of Youth and Sports offers a variety of services to young people including adolescents. Located in the heart of Phuentsholing town, the members who avail the services find it accessible and ideally located. Most of the members involved in the FGD discovered the center through friends and family members, and facilities such as games, library, free internet and photocopy services continued to attract them.

The members have also become aware of the services such as counselling and AFHS in the Center but no one has availed the services till date. When asked if they understand what counselling is for, many have indicated awareness but lacking willingness to avail it. Some students who have grown up availing services of Youth Center have used their knowledge on SRHR to educate and help others in problems. A senior member claims to have encountered a friend in distress seeking abortion. Using her knowledge on the legal aspect of abortion, she counselled her friend and helped inform the mother of the girl.

The friendly environment has attracted many young members who claim to find a 'safe space' in the Center. In schools and hospitals, there is little to no privacy while availing the services such as counselling and AFHS. A member who left Phuentsholing to another district for school also visits the center during her breaks. She said that the counselling room in the center, unlike in her school, is located inside the library, and availing counselling would draw minimal unwanted attention.

5. SangayMinjurling (18/08/2022)

The monks have not been acquainted with the term LSE, and hence lack awareness on the integration of LSE in their curriculum. However, after introducing them to the concept, one of them found the LSE as a prospective learning area to improve the lives of those residing in the monastery. He pointed out that subjects of LSE are usually accessible to them through social media; however, the risk of misinformation looms large over them. Moreover, as monks, the language barrier in accessing LSE through social media is also a challenge with some even lacking the means to access the internet.

"The LSE may equip young monks and nuns to survive in the modern world since one can't always be protected and hidden behind the closed doors of monasteries," a participant remarked. Another monk added that Lessons on time management, awareness on physical changes with age, and sense of community could benefit as they are also youths like anyone their age.

This was a shared consensus among the majority that discussing about sexual and reproductive health is a concern for all, and measures to address them would be embraced by their institutions.

There was also concern that lessons if not age appropriate would entice younger monks instead of deterring them from engaging in sexual activities. There were also concerns expressed about the SRHR component of LSE facing disapproval from the society and leading to reduced faith of people in the religious institution.

6. Pride Bhutan and Queer Voices of Bhutan (20/08/2022)

The LGBTQIA+ community under the banners of two different organizations, Pride Bhutan and Queer Voices of Bhutan has mentioned RENEW as the sole Implementing Partner that both organizations worked with for UNFPA programs. The program in Punakha last year saw both the groups in two separate but successive workshops, which focused on sensitizing the community on topics of SRHR, GBV and reproductive cancers. However, some of the members found the workshop, like many others they have attended before, hetero-normative in nature and not designed for the LGBTQIA+ community. “Many of the SRHR workshops don’t cater to the needs of LGBTQIA+, and their materials and resources are not inclusive of our needs – this workshop did not meet our expectations because they had what we knew already,” a member pointed out.

Although minimal, UNFPA is the only one that consistently supported the community among all the UN agencies. The scout associations of Bhutan provided platform for Queer community to advocate and reach to a wider audience. The both groups expressed appreciation for their involvement in consultation for National Youth policy and National Gender policy.

One of the main concerns raised in the FGD was on the system of involving LGBTQIA+ community in the UN programs which was not through formal network and linkages, but through their informal access to the prestigious offices. A member remarked, “We expect more from UN agencies as it is their mandate to reach the vulnerable population. Their interventions should be more responsive to our needs. Just now, we are reached and involved in programs out of good will.”

Further, the members agree that agencies even outside of the UN lack awareness of the community and their needs while dealing with issues such as GBV or SRHR. The fear of being stigmatized among the community also contributes to the GBV going unreported and unaddressed. The members opined that policies, guidelines and standards such as for sexual harassments need to be more gender neutral and inclusive. Another concern by the members regarding the UNFPA IPs working on LGBTQIA+ issues is their lack of adequate knowledge on the community, and they also don’t involve the community in their programs.

7. The Dzongkhag Statistical Officers. (23/08/2022)

According to the DSOs present, all sectors in dzongkhag should have improved coordination while feeding data into the system. In the beginning, attempts to set up various systems for data such as Druk info and child info existed but they eventually disappeared. Another agency had a gewog level database which too disappeared out of the picture. At districts, there doesn't exist a proper data dissemination platform and all the data collected are available only at the national level.

Along with the work that needs to be done in improving data collection and dissemination, data literacy is what the country needs currently. There is a lack of data literacy even in the highest offices of the country including the parliament and executives of agencies. Hence, the future activities with support from UNFPA should be at improving data literacy. Data literacy also should be focused on the relevant agencies like the Ministry of Health, so they could be educated on the types of data used for the intended purposes; all the while, NSB should spearhead the process to avoid contradictions. NSB as opposed to other agencies uses international standards methods of data collection.

The whole system of the country is currently dependent on secondary data such as ones collected by the Ministry of Health and the Ministry of Education from the field. However, both MOE and MOH use their own systems which are outdated. Often, data collected from the districts are directly sent to the ministries without involving the DSO or NSB for the validation. This further challenges at ensuring reliability and authenticity in data production. If quality data is a priority, there should be collaboration and coordination between relevant agencies for data collection and validation. Furthermore, it is recommended that DSO should be well involved in the upcoming Health Surveys by the MOH.

Additionally, data collection should be from the chiwog level; the gewog and dzongkhag level data are not adequate to determine the right intervention as Gewogs have varying poverty, literacy and other indicators. Overall, the data collected would be precise and more apt in informing the infrastructural development of the country.

The funds and time allocated for data are a challenge in ensuring quality data. The DSO are currently working like messengers who can only feed the data into the system but can't extract them. One key potential area of UNFPA support should be improving the administration data which has the potential to replace survey data. UNFPA could also initiate research on the good practice of countries with strong data systems and help to integrate it into Bhutan's system. Moreover, the system of feeding should be made simpler so that even individuals other than data experts can use it.

A system which enables access to the database to everyone online should be built which can help remind individuals to feed their data timely. Such a system if in place could make data manipulation harder, giving ways for check and balance for data systems.

8. Daga High School (25/08/2022)

The students of the school remember menstrual hygiene day as the highlight of this year's program on SRHR. The event included male teacher's donating sanitary pads to the school and as a show of support, the teachers of opposite genders exchanged sanitary pads and ribbons of acknowledgement to each other. However, CSE in school curriculum has not been implemented and with students not able to recognize most topics of CSE from their lessons. It was also evident from the discussion with teachers that CSE implementation has not formally taken place with instruction from the Education Ministry lacking clarity. Nevertheless, the presence of CSE is felt by students in lessons taught in science on reproductive system and menstruation. The school's career and guidance counsellors also dedicate their time in teaching about topics of safe relationship to students along with their regular lessons on career guidance. Some senior year students also recollect counsellor teaching them on the sexual desires being a natural phenomenon, and asexuality to indicate abnormality.

Most of the students have learned about good touch and bad touch; their sources vary with some having learned from watching TV, and others receiving formal lessons on the subject. Two junior year students

said they learned about the good and bad touch in their previous school where the instructor taught those using PowerPoint presentations and drawing activities of human body parts. Topics such as on types of violence, bullying, bystanders and mindfulness are also taught which students relate with CSE.

The students don't find their science teachers hesitating while teaching on subjects of reproductive system, and having a franker approach on the teachers' part makes learning CSE comfortable for the students. Being a boarding school, there is a system of "Home Groups" where a group of students are adopted by a single teacher; the students in the group meet their designated teacher every Friday and this is an opportunity for them to interact, and share any grievances with the teachers. Some use home groups to inform their teacher about issues related to menstruation and SRH.