Evaluation of UNICEF Iran Adolescents Wellbeing Programme 2017-2021

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Acronyms

ART	Anti-retroviral therapy
AWB	Adolescent well-being
AWBC	Adolescent Well-being Centres
AWP	Adolescent Well-being Programme
BAFIA	Bureau for Aliens and Foreign Immigrants Affairs
CDC	The centre for Communicable Disease Control of MOHME
DCHQ	Drug Control Head Quarters
EQ	Evaluation questions
FGD	Focus group discussion
GDP	Gross Domestic Product
GOI	Government of Iran
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
HTS	HIV Testing Services
HRBA	Human rights-based approach
ICRS	Iranian Children's Rights Society
IrMIDHS	Iran's Multiple Indicator Demographic and Health Survey
KII	Key informant interviews
LGBTQ	Lesbian, gay, bisexual, transgender, queer
LNOB	Leaving no one behind
MCLSW	Ministry of Cooperatives, Labour, and Social Welfare
MEL	Monitoring, evaluation, and learning
MENA	Middle East/North Africa
MOE	Ministry of Education
MOHME	Ministry of Health and Medical Education
MOI	Ministry of Interior
MOSY	Ministry of Sports and Youth
MPO	Management and Planning Organization of Iran
NDP	National Development Plan
NSP	National Strategic Plan
OECD/DAC	Organization for Economic Cooperation and Development/Development Assistance Committee
PHC	Public health centre
PLHIV	People living with HIV
RA	Results area
RBM	Results-based management
SDG	Sustainable Development Goals
STI	Sexually transmitted infections
SWO	State Welfare Organization
TOR	Terms of reference
UN	United Nations
UNAIDS	UN Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDS	UN Development System
UNEG	UN Evaluation Group
UNICEF	UN Children's Fund
UNFPA	UN Fund for Population Activities
UNSDCF	United Nations Sustainable Development Cooperation Framework
VCT	Voluntary Counselling and Testing

Map of the Islamic Republic of Iran

The geographical distribution of the Adolescent Well-being Centres is marked below.

Executive summary

Introduction

This evaluation intended to cover the entire Adolescent Well-being Programme (AWP) with a focus on the work and achievements of the Adolescent Well-being Centres (AWBCs). However, the desk review found an absence of key documents such as the programme document and annual progress reports. The consultants received documentation only for a project under the AWP, "Empowering adolescents and youth in Iran to address their reproductive health needs" funded by the Government of the Netherlands. Data relating to AWBC performance in terms of achieving the primary objectives were not shared by MOHME. This made the evaluation focus change to the performance of this capacity development project, which was essential for the performance of the larger AWP. The provided capacity development is viewed as a critical enabler for the performance of implementers in adolescence wellbeing (AWB) and thus as indirect enabler of well-being among at-risk adolescents in Iran.

The findings were regarded as important for potential replication or further development of AWBC initiatives and adolescence well-being in general.

The focus and structures of the report adheres to GEROS Handbook and UNICEF Style Book.

A. The object of the evaluation

The Islamic Republic of Iran is the second largest economy in the Middle East and North Africa (MENA) region for med the **context of the programme.** Iran ranks second in the world in natural gas reserves and fourth in proven crude oil reserves. A major obstacle facing Iran's economy is the continuous isolation from the international community. This has hampered the growth of markets, limited the country's access to advanced technology and hampered foreign investment.

Iran's health system is generally cited in WHO and global health literature as one of the most robust health systems in the world, drawing its strength from its pioneering and well-established primary health care system, which emphasizes equity, community, and inter-sectoral collaboration[1]. Medical universities constitute a decentralized network of provincial health authorities overseen centrally by the MoHME.

Iran has a concentrated Human Immunodeficiency Virus (HIV) epidemic with a low prevalence of less than 0.1% in the general population, a prevalence among the 15 to 49 age group standing at 0.14 per cent and People Living with HIV (PLHIV) reported about 53,000 (38,000-140,000) by the end of 2021. This is the highest number of PLHIV in the MENA region[2].

The prevalence of behavioural risk factors among Iranian adolescents is relatively high. The pooled prevalence of drug abuse, alcohol consumption, tobacco smoking (cigarettes, hookah, and pipe) and premarital sex were 4%, 9%, 21%, and 20%, respectively. In all behaviours, the prevalence in boys is

[1] Islamic Republic of Iran – UNDAF 2017-2021.
[2] UNAIDS (https://www.unaids.org/en/regionscountries/countries/islamicrepublicofiran).

higher than in girls. Considering that both sale and consumption of alcohol is prohibited by the Iranian government, the prevalence of 9% is considered high and a high-risk for this age group.

The development of the Adolescent Well-being Programme (AWP) started in 2015 as an ALL-IN project in 2015 with a focus on reducing Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) among adolescents. Initial experiences with working with AWBCs combined with a formative review in 2016 resulted in a wider and more complex approach building a range of skills addressing the at-risk adolescents' risky behaviours (e.g., substance abuse, risky sexual behaviour, sexual exploitation, violence).

In 2016, five centres were established including two centres in Tehran and three centres in Shiraz, Kermanshah, and Ahvaz, respectively. One year later the AWBC initiative was expanded to Khorram-Abad and Karaj reaching seven centres nationwide. The sites were selected against the prevalence of HIV/AIDS[3].

In 2018, the Adolescent Well-being Programme (AWP) sought and got funding from the Netherlands for the full period of 2018-2021. However, support for the AWP ended by March 19th, 2020. To ensure continuity of services for at-risk adolescents, UNICEF and MoHME had agreed on an integration of AWBC initiatives into relevant MOHME services and in the national HIV prevention program.

The Adolescent Wellbeing Programme (AWP) interventions responded to the health prospects for the country's adolescents:

"Achieving the first place in the health and wellbeing of adolescents in the physical, mental, social and spiritual levels in the region until the year 2025/2026".

In the AWP this was, among others, done by establishing Adolescent Wellbeing Centres (AWBCs) with a mission of:

"….providing the prevention training for adolescents with high-risk behaviors and those exposed to high-risk behaviors, diagnosis of infected adolescents and referral of adolescents with HIV virus, and provision of preventive services and social harms prevention education to at-risk adolescents"[4].

The AWBCs provided a safe space for adolescents at-risk with no access for other adolescents, parents or others who could have interest in visiting the centres. With the gradual and informed changes, the AWP became complex addressing a range of at-risk adolescents[5].

Overall budget and yearly break-down of the multi-donor funding of AWP activities relates to a larger joint project with other UN agencies with extension till the end of 2023. A part of these funds was spent on the AWP and other parts were, and still are, spent on other projects related to adolescents. However, the summarised amounts availed and spent by the AWP are accounted for below.

Yearly budget and expenses

2017		2018		2019		2020		2021	
Available	Spent	Available	Spent	Available	Spent	Available	Spent	Available	Spent
376,800	265,717	419,000	296,880	482,292	244,334	237,957	182,228	100,000	55,729

[3] Moradi G, et al.: *Incidence, Mortality, and Burden of HIV/AIDS and Its Geographical Distribution in Iran during 2008-2016. Iran J Public Health,* 2019;48(1):pp.1-9.
[4] UNICEF Iran: *The Protocol for Adolescent Wellbeing Programme.*
[5] Details on the focus and the work of the AWBCs in annex 4.

B. Evaluation purpose, objectives and scope

This evaluation had a **dual purpose** of accountability and learning. It should "support (i) generation of knowledge on the successes and challenges of the Adolescents Well-Being Programme to inform future programming, and (ii) accountability for UNICEF and partners, as well as beneficiaries of the programme. The evaluation would consider the inclusiveness of services offered to the beneficiaries with the equity lens."

With regard to an "equity lens" the AWP had no programme document and progress reports and therefore no valid data on equity.

The objective of the evaluation was "to determine, as systematically and objectively as possible, the relevance, efficiency, sustainability and expansion as well as coherence of UNICEF's support of the above programme with emphasis on the AWBC"[6].

In the text of Terms of reference (ToR)[7] the **scope of the evaluation** was limited to UNICEF's support[8] to the adolescent wellbeing programme/model piloted in 6 provinces through 7 AWBCs since 2015. Programmatically, the evaluation intended to review the services offered via these centres, while they were operational. It was not possible after more than two years of AWBC closure and under the actual political tensity to track relevant numbers and categories of implementers and beneficiaries to document the relevance (and thus effect) and sustainability of the services offe red.

The thematic scope of the evaluation followed the scope of the programme activities supported by the Netherlands. It assessed delivery to the tree result areas listed in the project document[9]. The thematic scope was aligned with the AWP programme framework.

C. Evaluation framework and methods

The evaluation applied five of the six Standard Organization for Economic Cooperation and Development/Development Assistance Committee (OECD/DAC) **evaluation criteria**. In accordance with UN standards for evaluations (UNEG standards) evaluations should also consider equity, gender, and human rights. The availability of documents and data did not allow for a systematic, evidence-based analysis of these.

To respond to the ToR criteria the evaluation made use of two **approaches**: A utilization-focused approach which "aims to support effective action and informed decision-making based on meaningful evidence" and a summative approach to assess the accumulated achievements, which allowed for assessment of the comprehensiveness of the outreach, stakeholder adoption of initiatives followed by results-based decisions on the future focus.

The evaluation was based on, but not limited to, the **key questions** and sub-questions given in the TOR[10].

[6] TOR, annex 1.
[7] TOR, Annex 1
[8] With the view to capture and learn from the complementarity and establish the full coherence with other national activities the scope was widened to include the deliverables to capacity development of the two partner agencies, UNFPA and UNAIDS, but not the performance of the partner agencies.
[9] Project title: 'Empowering adolescents and youth in Iran to address their reproductive health needs'.
[10] TOR, annex 1.

The **methodology** comprised: (i) Desk studies of internal and external documents[11]; (II) Data collection based on semi-structured interviews and focus group discussions, and (III) Data consolidation, validation, and analysis.

For **data validation and analysis,** the data were consolidated as per the category of data sources: (i) desk review of documents, and interview findings from respectively (ii) involved UN agencies and (iii) implementing stakeholders which allowed for a validation using triangulation of findings from the three categories of data. Further, quantitative data were held against qualitative data where possible. The data analysis addressed two key aspects: (i) Programme and project adherence to key principles for programme design and management and (ii) analysis of type and level of achievements against the planned achievements.

Key constraints concerned the limited availability of important data adhering to UN standards.

The methodological approach observed all **ethical standards**[12]. This entails abidance by the four ethical principles: (i) Integrity; (ii) Accountability; (iii) Respect, and (iv) Beneficence. These were applied at all stages of the evaluation.

D. Evaluation findings

Relevance

This part was divided into two: One analysing the relevance of the portfolio, and another analysing the relevance of the programme design.

First analysis: The portfolio mirrors key UN principles and adheres to the NDP6 articles 74I, United Nations Development Assistance Framework (UNDAF) priorities outcome areas 3.1 and 4.1; Sustainable Development Goals (SDG) 3, 4, 5, 10 and 16. Further, the focus of the AWP responded to the target population needs as captured by national statistics and described in section 1.2.2.

Second analysis: The composition of result areas of the project "Empowering adolescents and youth in Iran to address their reproductive health needs" was highly relevant. The results areas (RA) deliver to the purpose of the project[13] and to the larger AWP while providing a range of capacity development across all three levels of interventions: (i) Direct AWBC intervention; (ii) National implementers & enablers, and (iii) Community level implementers (parents, police, religious leader etc.).

All levels of stakeholders were involved in design and amendment of practices and products as relevant.

Effectiveness

The project document had no results framework, and the reporting for 2019 and 2020 did not distinguish between output level and outcome level achievements.

With the relatively short project period of three years including hand-over to MOHME, it was not realistic to expect outcome level results for all result areas, least RA 2 supporting changes in systems and structures.

[11] List in annex 2.

[12] As given in: *UNICEF Procedure on Ethical Standards in Research, Evaluation, Data Collection and Analysis* (2021); UNEG 2020: *Ethical Guidelines for Evaluations and ERIC* a careful selection of evaluation participants was applied and anonymity in the evaluation response ensured.

[13] Project title: 'Empowering adolescents and youth in Iran to address their reproductive health needs'.

It was possible to extract some achievements from the reports that relate to project interventions. The project delivered to all three result areas (RA) with emphasis on RA 1 and 2.

The enhanced capacity resulted in a number of changes in practices and products. This included change in systems and structures, e.g., development and introduction of a monitoring systems supporting MOHME in monitoring the AWBCs; development of new ways to empower at risk adolescents, e.g., the TAHAMTAN life skills package which was introduced in all seven centres and in a range of information and training materials used for AWBC education of adolescents.

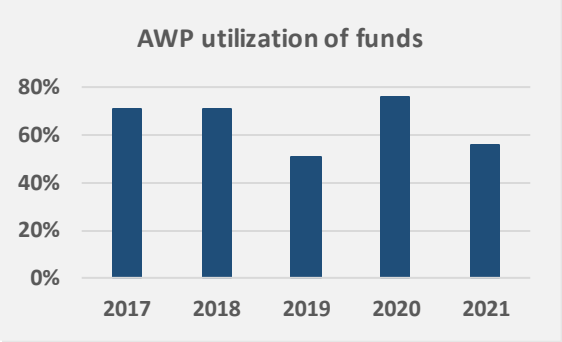
The project managed to adapt to the COVID-19 restrictions and continue the counselling of adolescents by changing from counselling in centres to online counselling. Some capacity development initiatives were cancelled including two study tours and workshops.

The use of adaptive management with involvement of all levels of stakeholders in relevant development and amendments of interventions made the roll-out and implementation be effective.

Efficiency

With no relevant progress reporting available, the analysis of efficiency[14] looked at the AWP ability to use and manage funds ensuring delivery of the project: 'Empowering adolescents and youth in Iran to address their reproductive health needs'.

As the figure below shows there was no over-expenditure and as established in section 4.2.2 and detailed in annexes[15] the results were delivered across all RAs, although mainly at output level.



The evaluation showed a high utilization of funds in 2020, the year of COVID-19 outbreak. However, counted in US dollars, the expenditures were the lowest compared to the previous years. The annual report 2020 mentions a range of changes in approach related to COVID-19 which may explain high utilization of funds despite an overall reduction in activities. Changes entailed a need for procurement of materials for remote counselling[16] and other changes in approach.

Coherence

At the national implementer/enabler level the AWP design and activities were coherent with national plans and policies and existing governmental services. The initiatives were expected to be fully adopted by Ministry of Health and Medical Education (MoHME), Ministry of Sports and Youth (MoSY), Ministry

[14] OECD definition of efficiency: The extent to which the intervention delivers, or is likely to deliver, results in an economic and timely way.
[15] List of capacity development activities and participants, annex 7. List of achievements, annex 9.
[16] List of capacity development activities and procurement, annex 7.

of Education (MoE) and Drug Control Head Quarters (DCHQ) and become an integrated part of MOHME services.

Evaluation findings indicated that despite the outreach and complexity of the programme, UNICEF stayed an effective and supportive coordinator both within the joint partnerships and to implementers in general ensuring coherence through a common and meaningful footstep.

Albeit coherent with national plans and policies the AWP support to STI affected adolescents and at-risk adolescents the area of intervention was new. Consequently, staff in MOHME, other ministries and government institutions had little experience with STI, abuse and adolescent well-being in general. The extensive capacity building involving all levels of stakeholders enabled the AWBCs and supporting systems under MOHME deliver on AWB.

Sustainability

Without systematic results reporting against targets only the *likely* sustainability could not be determined.

At the national implementer/enabler level the Law on Protection of Children and Adolescents was adopted and entered into force (2020) and can support a continuation of AWP activities.

At the direct intervention level, a formative evaluation of the integration process reported that 3,569 young people received services from Voluntary Counselling and Testing Centres (VCT)s implementing the integration model against 1,850 young people before the integration. The higher level of attendance after the integration should be viewed in the light of provision of a single service which will not have the empowerment effect of the wider AWB services.

At the local enabler level, the popular acceptance of the AWP activities became stronger and wider. The AWBCs experienced that an understanding of the need for an attitude change was gradually developing as a result of community and parental involvement in AWB protection and prevention measures.

However, evaluation findings indicate an inconsistency between "intended changes" and the amount of capacity building that was required to make the intended changes be introduced and become sustainable, and the time allocated for these changes.

Gender equality and inclusion

The evaluation found that none of the available materials had specific targets for gender equality and social inclusion, nor disaggregated data. Thus, the AWP at large did not apply the Leaving no one behind (LNOB) principle.

However, sporadic findings provide examples of gender equality and social inclusion. For example, the AWBCs responded to girls' needs[17] by tailoring the curricula to address girls needs and behaviour and by making two centres accommodate girls.

Finally, a wide range of at-risk adolescents was accepted in the AWBCs, including Lesbian, gay, bisexual, transgender, queer (LGBTQ) adolescents.

[17] UNAIDS Iran: *Feasibility Study on AWBC Services Sustainability*,2020, pp.54-55.

E. Key conclusions

The list of *key* conclusions is an extract from the full scope of conclusions.

Relevance: The wide inclusion in the programme design, programme amendments combined with the adaptive management approach was the combination that made the AWP initiatives relevant and implementable despite the sensitive nature of the these.

Effectiveness: Despite the complexity and sensitivity of the wider AWP *and* the project under evaluation, and the emergence of COVID-19, the programme proved effective in the full implementation of interventions.

Efficiency: The AWP managed to introduce substantial new capacity across the diversity of stakeholders, areas of capacity within a short timeframe without exceeding the availed funds.

Coherence: The difference between actual needs of the adolescents and officially acknowledged needs and/or interests at the overall national level constituted an unaddressed risk that the integration of a multisectoral approach will remain limited.

Sustainability: The insufficiently internalised skills in practising and manging a holistic approach to STI makes the integration frail and uncertain.

Gender: The absence of deliberate address of gender equality and social inclusion specifically for at-risk adolescents and the subsequent vacuum of key data of this is contrary to UN requirements, a potential forfeiture of opportunities for the AWP and the adolescents, and a loss of valuable information.

F. Key lessons learned

The lessons learned build on, but are not fully related to, conclusions made under section 4. A cross-cutting analysis of the findings resulted in overall lessons learned. The list of *key* lessons learned is an extract from the full scope of lessons learned.

Overall lessons learned

That systematic use of Results Based Management (RBM)/Human rights-based approach (HRBA) to planning, implementation, monitoring and reporting is a precondition for evidence-based learning for corporate development and knowledge sharing.

Programme related lessons learned

Relevance of focus and design

a) That an early and continued inclusion of key stakeholders in programme planning and amendments made the programme stay relevant to all involved stakeholders enhancing effectiveness and efficiency of the implementation.

Effectiveness

b) That systematic use of the adaptive management approach for inclusion of arising needs and/amendments of existing initiatives generated motivation for participation among all involved stakeholders. This motivation added to the effectiveness of the roll-out and implementation of complex initiatives.

Efficiency

c) The adaptive management approach is a cost-efficient and effective management tool when applied systematically, in conjunction with stakeholders and as a response to arising needs and lessons learned.

Coherence

d) That a high level of coherence in constellation of stakeholders and in types of deliverables implicitly supported a common footstep within and among different categories of stakeholders enables a relative fast and wide roll-out of the programme which added to the effectiveness.

Sustainability

e) The incoherence between the national priorities concerning AWP at large *in combination with* insufficiently internalised skills in practising and manging a holistic approach to STI makes the integration frail and uncertain.

Gender and inclusion

h) The absence of deliberate and systematic programming for gender and inclusion hindered considerations of a wider inclusion of at-risk adolescents which resulted in missed opportunities for contribution towards equal opportunities for empowerment among at-risk adolescents.

G. Key recommendations

The recommendations are based on findings with specific attentions to the changes proposed by the stakeholders and/or external documents. Key recommendations refer to evaluation findings that are relevant for AWP in Iran and the effective implementation of relevant United Nations Sustainable Development Cooperation Framework (UNSDCF) initiatives.

Key recommendations for overall actions

- Systematic adherence to UN standards for Results-based management (RBM) programming as described in the UNSDG Results-based Management Handbook.

Key recommendations for programming level

- Commence all programming with thorough preparations i.e. through a robust RBM/HRBA design as this enhances effectiveness and efficiency and increases the likelihood of sustainability.
- Make full and systematic use of RBM/HRBA (gender and disability mainstreaming and inclusion) in all programming, implementation, monitoring, reporting, learning and knowledge sharing.

Key recommendations relating to the AWBCs

- Continue supporting the AWB(C) concept.
- Build the capacity of communities and involve them in sharing the responsibility for a successful transition from at-risk adolescent exclusion from society to inclusion into society.

1. Background

1.1 The scale and complexity of the programm1.

1.1.1 The geographic locations

Geographically, the country of Iran is located in West Asia and borders the Caspian Sea, Persian Gulf, and Gulf of Oman. With an area of 1,648,000 square kilometres, Iran ranks seventeenth in size among the countries of the world. Iran is subdivided into thirty-one provinces, each governed from a local centre, usually the largest local city, which makes it the capital of the province.

In 2015 UNICEF and partners launched the ALL-IN initiative in Iran focusing on establishment of Adolescent Well-being Centres (AWBCs) which should address the needs of Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) affected and vulnerable adolescents providing them with knowledge and skills in protection and prevention measures addressing risky behaviours.

Selection of the cities was based on the results of a population-based study which showed the population-adjusted burden of HIV/AIDS was not equally distributed among different provinces of Iran. The frequency of HIV/AIDS was more concentrated in western regions of the country including the provinces of Kermanshah, Tehran, Fars, Hormozgan, and Lorestan[18].

Table 1.1: Adolescent Well-being Centres (AWBC) in Iran

No	Province	City	NGO Name	Target group sex
1	Tehran	Tehran	Ashiyane Mehr Janan Institution	Boys
2	Tehran	Tehran	Ofogh Health & Sustainable Development Institution	Girls
3	Khouzestan	Ahvaz	Kanoone Banovane Sabze Karoon	Boys
4	Kermanshah	Kermanshah	Afraye Sabz Population	Boys
5	Fars	Shiraz	Counselling Institute of Vahdate Khanevade	Boys
6	Alborz	Karaj	Shayesteh Golhaye Beheshti	Girls
7	Lorestan	Khoram-Abad	Salamat Afarine Delfan	Girls

1.1.2 Development of the Adolescent Well-being Programme

The Adolescent Well-being Programme (AWP) was implemented from 01.01.2017 – 19.03.2020 with the closure communicated in March 2021. The non-funded integration lasted until March 31st, 2022.

In 2016, five centres were established including two centres in Tehran and three centres in Shiraz, Kermanshah, and Ahvaz, respectively. One year later the AWBC initiative was expanded to Khorram-Abad and Karaj reaching seven centres nationwide.

The AWP started as an ALL-IN project in 2015 – a global project implemented in 25 countries (2015) with a focus on reducing HIV/AIDS among adolescents. However, initial experiences with working with AWBCs combined with a formative review in 2016 resulted in a wider and more complex approach building a range of skills[19] addressing the at-risk adolescents' risky behaviours (e.g., substance abuse,

[18] Moradi G, et al.: *Incidence, Mortality, and Burden of HIV/AIDS and Its Geographical Distribution in Iran during 2008-2016*. Iran J Public Health 2019;48(1):pp.1-9.

[19] Details in section 1.2.2 and annex 5 describing the operations of the AWBCs.

risky sexual behaviour, risky social behaviour, sexual exploitation, violence) from different angles[20]. This was different from the narrower ALL-IN angle focusing of injection related HIV/AIDs transmission and, therefore, generated a need for involvement of more categories of stakeholders, mostly at community level.

In 2018, the Adolescent Well-being Programme (AWP) sought and got funding from the Netherlands for the full period of 2018-2021. However, support for the AWP ended by March 19th, 2020. To ensure continuity of services for at-risk adolescents, UNICEF and Ministry of Health and Medical Education (MoHME) had agreed on an integration of AWBC initiatives into relevant MOHME services and in the national HIV prevention program. Hence, it was decided that by end of 2020 UNICEF would gradually withdraw from direct support of the interventions.

1.1.3 Overall budget and yearly break-down

The GEROS handbook requirement for an overall budget and yearly breakdown[21] cannot be met in this evaluation since the funding was an overall funding addressing all work with adolescents in Iran. Only UNICEF HIV thematic fund was related exclusively to the AWP.

The multi-donor funding of AWP activities relates to a larger joint project with other UN agencies with extension till the end of 2023. A part of these funds was spent on the AWP and other parts were, and still are, spent on other projects related to adolescents. It was therefore not possible to disaggregate the total fundings against specific donors. However, the summarised amounts availed and spent are accounted for below.

Table 1.2: Yearly budget and expenses

2017		2018		2019		2020		2021	
Available	Spent	Available	Spent	Available	Spent	Available	Spent	Available	Spent
376,800	265,717	419,000	296,880	482,292	244,334	237,957	182,228	100,000	55,729

The AWP never fully used the available funds but managed to have a quite high utilization in the year of the outbreak of COVID-19 due to a need for extensive changes in approach.

1.1.4 Adolescents Wellbeing Programme interventions

The Adolescent Wellbeing Programme (AWP) responded to the health prospects for the country's adolescents:

> "Achieving the first place in the health and wellbeing of adolescents in the physical, mental, social and spiritual levels in the region until the year 2025/2026"

In the AWP this was, among others, done by establishing Adolescent Wellbeing Centres (AWBCs) and providing the required capacity development[22] to support at-risk adolescents[23] covering recruitment to AWBCs, empowerment and sustainable graduation from the centres.

[20] Description in annex 4.
[21] GEROS handbook, p.34.
[22] As defined by OECD/DAC: Developing systems, structures, human resources, infrastructure/equipment and work environment.
[23] Details of types of risks described in annex 4.

Responding to the national health prospects the AWP mission of the AWBCs was:

> "….providing the prevention training for adolescents with high-risk behaviors and those exposed to high-risk behaviors, diagnosis of infected adolescents and referral of adolescents with HIV virus, and provision of preventive services and social harms prevention education to at-risk adolescents"[24].

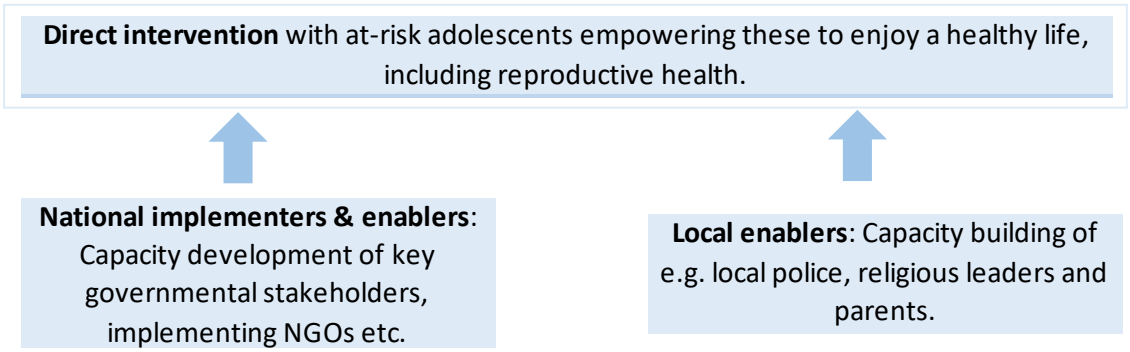
The AWBCs provided a safe space for adolescents at-risk with no access for other adolescents, parents or others who could have interest in visiting the centres.

The overall goals[25] of the AWBCs comprised:

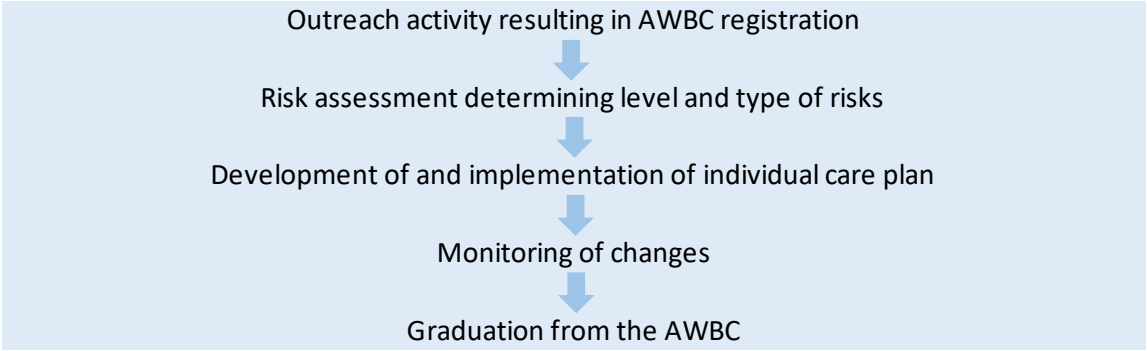
- Increasing their skills, knowledge, and awareness in the field of risky social behaviours to reduce new HIV infected cases.
- Empowering at risk adolescents in order to educate and increase their resilience against HIV-related risk factors.
- Emphasizing the prevention of drug and alcohol consumption, prevention and reduction of risky sexual behaviours, sexually transmitted diseases, and viral hepatitis in this group.

Acknowledging that the central government alone cannot provide the range of support required to move at-risk youth to a level of well-being a need arose for enabling local authorities, local leaders, and the parents of at-risk adolescents. With the gradual and informed changes, the AWP became complex addressing a range of at-risk adolescents[26].

To address the complexity of needs the AWP operated at three levels focusing on:



The direct interventions consisted of a line of interventions:



[24] UNICEF Iran: *The Protocol for Adolescent Wellbeing Programme.*
[25] AWBC protocols. The use of 'goal' equals 'objectives' in the UNSDG Results-based Management handbook (2011) (unsdg.un.org/resources/unsdg-results-based-management-handbook).
[26] Details on the focus and the work of the AWBCs in annex 4.

The individual care plan was multisectoral in design comprising three intertwined components:

Physical change in terms of stop the abuse (sexual, drugs, alcohol, tobacco, violence etc.)
Behavioural change through provision of new skills in terms of anger management, TAHAMTAM Positive Adolescent Life Skills Programme methods to prevent substance use, sexually transmitted infections (STI) and other risks.
Social change through behavioural change methods combined with engagement in environmental cleaning and other community activities helping the communities to look at the former at-risk adolescents with new eyes.

To develop or adjust systems to support the empowerment of at-risk adolescents the AWP applied for funds specifically for capacity development of the national implementers/enablers. The capacity development intended to provide[27]:

- Exchange of experience between Iran and other countries with successful integrated SRH/HIV prevention programs for adolescents and youth.
- Capacity building of MoHME, related institutions and AWBC implementers.
- Support partnership between all relevant organizations.
- Technical support to harmonization of services offered to adolescents……to provide most at-risk adolescents opportunities to build social and emotional competence through consultancies.
- Support to policy dialogue and advocacy.
- Ensure application of standards of HIV/AIDS in Adolescent Well-being Club

Since the project funded by the Government of the Netherlands, 'Empowering adolescents and youth in Iran to address their reproductive health needs,' was the only activity for which there was annual progress reports this evaluation focused on achievements deriving from this capacity development project. All project activities aimed at building systems, structures, knowledge and skills in reproductive health among all stakeholders. The findings from this project are viewed in the full AWP context given above.

With the application of adaptive management, the capacity development was adjusted to address actual needs, e.g. design and amendment of tools and protocols for the AWBCs[28] and inclusion of a wider range of stakeholders than initially intended, e.g. involvement of the adolescents in design and revision of approaches and products and of parents and local authorities The capacity development, thus, came to include community level enablers.

1.1.5 Programme delivery to national and international agendas

With the above focus and approach the AWP delivers to the Iran's Sixth National Development Plan, 2016-2021 (NDP6) on the following articles: 74, 78, 80 and 102(f)[29].

The UN Development Assistance Framework (UNDAF) 2017-2021 delivered to these NDP articles on two outcome areas: 3.1: Inclusive growth, poverty eradication and social welfare and 4.1. Drug abuse prevention and treatment-

[27] Details in project document: 'Empowering adolescents and youth in Iran to address their reproductive health needs', p.5.
[28] Overview over capacity development activities and participants in this is found in annex 7.
[29] Details found in annex 3.

This support was in line with global priorities, the Sustainable Development Goals (SDGs) as the support aimed at falling within the following Global Goals[30]:

SDG 3: Ensure healthy lives and promote well-being for all at all ages.
SDG 4: Quality education
SDG 5: Achieve gender equality and empower all women and girls.
SDG 10: Reduced inequality

1.2. The context of the Adolescents Wellbeing Programme in Iran

1.2.1. Iran profile

The Islamic Republic of Iran is the second largest economy in the MENA region, with an estimated Gross Domestic Product (GDP) in 2012 of 613,398 billion Rials[31]. Iran ranks second in the world in natural gas reserves and fourth in proven crude oil reserves. Although the economy was slowly emerging from a decade-long recession, Iran's economic outlook is exposed to significant risks such as the increased impact of climate change and the escalation of geopolitical tensions, including the impact of the Ukraine war[32]. According to official government figures the unemployment rate for the above 15 population was in average 9.7% with a distribution of male at 8.5% and female at 15.7%. The average unemployment rate for adolescents between the age of 15-24 years reached 24.2% with males reaching 22% and females 35.1%.[33]

11.5 percent in 2020, with unofficial estimates being higher[34]. A major obstacle facing Iran's economy is the continuous isolation from the international community. This has hampered the growth of markets, limited the country's access to advanced technology and hampered foreign investment.

Iran's health system is generally cited in WHO and global health literature as one of the most robust health systems in the world, drawing its strength from its pioneering and well-established primary health care system, which emphasizes equity, community, and inter-sectoral collaboration[35]. The primary health care system is the foundation of the country's good national health indicators. Medical universities constitute a decentralized network of provincial health authorities overseen centrally by the MoHME.

1.2.2. The status and needs of the target groups of the intervention

Iran is facing a demographic change with the largest youth population in its history. Almost 16 million people are between 11-24 years of age or around 18% of the population. This in combination with the mean age of marriage for women and men respectively rose from about 20% and 23.6% to 23 and respectively in 1986 to 23% and 27% respectively in 2016[36] increases the possibility of premarital sex among Iranian adolescents. The officially acknowledged and supported religious beliefs identify premarital sex as inappropriate. Hence, discussions and research on these issues are therefore difficult.

[30] See reference in programme document to Kingdom of the Netherlands, p.4.
[31] Islamic Republic of Iran – UNDAF 2017-2021.
[32] https://www.worldbank.org/en/country/iran/publication/economic-update-april-2022
[33] Statistical Centre, Iran: Winter 2023 analysis.
[34] https://www.macrotrends.net/countries/IRN/iran/unemployment-rate
[35] Islamic Republic of Iran – UNDAF 2017-2021.
[36] *The Journal of sex research, 2020, vol. 57, no. 6*: *Adolescents and young people's sexual reproductive health in Iran*. (www.tandfonline.com/doi/epdf/10.1080/00224499.2020.1768203?needAccess=true&role=button).

So is control of these risks. However, the prevalence of premarital sex gives rise to attraction and spread of HIV and at-risk behaviour related to HIV.

Iran has a concentrated HIV epidemic with a low prevalence of less than 0.1% in the general population, a prevalence among the 15 to 49 age group standing at 0.14 per cent and People Living with HIV (PLHIV) was reported about 53,000 (38,000-140,000) by the end of 2021. This is the highest number of PLHIV in the MENA region[37].

A highlight from recent reports[38] lists the following characteristics related to HIV/AIDS in Iran:

- Most people with HIV/AIDS are young.
- A sexual and age transition is occurring, with HIV/AIDS prevalence shifting from men to women, and from middle-aged people to youth and adolescents.
- Sexual transmission of HIV is becoming as important as injected (drug use) transmission.
- Findings in the last IrMIDHS[39] show that only 19.6 % of women aged 15-24 had adequate knowledge about prevention of HIV/AIDs.
- The profile of drug users has evolved to a younger population living in disadvantaged and suburban areas of the big cities, and
- Drug use is closely linked to the transmission of HIV.

The prevalence of behavioural risk factors among Iranian adolescents is relatively high[40]. The pooled prevalence of drug abuse, alcohol consumption, tobacco smoking (cigarettes, hookah, and pipe) and premarital sex were 4%, 9%, 21%, and 20%, respectively[41]. In all behaviours, the prevalence in boys is higher than in girls.

Considering that both sale and consumption of alcohol is prohibited by the Iranian government, the prevalence of 9% is considered high and a high-risk for this age group.

The prevalence of tobacco smoking (cigarettes, hookah, and pipe) among high school students was reported at 21%. These figures are higher than the average of Iran's neighbouring countries.

Other factors affecting adolescence well-being is sexual abuse which includes an array of activities such as sexual caress, child exposure to adult sexual activity, child participation in prostitution or pornography and sexual intercourse. Iran is a state party to the Optional Protocol to the CRC on Sale of Children, Child Prostitution and Child Pornography and has provided a report to the CRC on implementation of this protocol in 2021. Known abuse of children and adolescents is addressed by the legal authorities. The programme for rehabilitation and reintegration of victims of sexual abuse are not effective, though. The only exception from the CRC is the legality of marriage of individuals below age of 18.

[37] UNAIDS (https://www.unaids.org/en/regionscountries/countries/islamicrepublicofiran).

[38] World AIDS Day interview, late 2022 (https://www.salamatnews.com/news/347922); World AIDS day interview in the "transition", 2021 (https://www.farsnews.ir/news/).

[39] Iran's Multiple-Indicator Demographic and Health Survey (IrMIDHS).

[40] No comparison with global statistics was made as the disaggregation of data varies making a direct comparison be inaccurate.

[41] Bahadivand S, et al.: *Prevalence of High-Risk Behaviors among Iranian Adolescents: a Comprehensive Systematic Review and Meta-Analysis. Journal of Education and CommunityHealth*,2021;8(2):pp.135-142.

Adolescence violence has become a public health challenge. A study among a sample of school students in Isfahan, Iran, showed a prevalence of verbal and physical victimization of about 45.8% and 23.6%, respectively[42]. The prevalence of physical violence was significantly higher in middle school students than high school students as it was higher among boys than among girls. Risk factors include being a boy, carrying cold weapon (e.g., knife and dagger), being out of home or in school, being exposed to victimization, feeling unsafe at school, and experiencing violence in the family. This high rate of violence and related risk factors emphasize the need for comprehensive and inter-sectional prevention programmes to reduce and manage student violence and associated risk behaviours.
The above facts on at-risk behaviour among adolescents in Iran formed part of the background for and focus of the recommendations.

1.2.3 Relation between national context and the AWP

Although Iran is one of the pioneers in implementing applicable and appropriate policies in the MENA region, including harm reduction services to reduce HIV/AIDS incidences, people with substance abuse continue to be the majority of PLHIV in the country. However, there is a changing trend in attraction of HIV/AIDS from being spread through substance abuse, e.g., sharing of syringes, to becoming more sexually related, typically spreading among men for example in prisons, among young men wanting a sexual debut or young men engaging as male sex workers. Hence, the design of HIV/AIDS prevention, protection and rehabilitation must change accordingly.

In line with other nations, the programs in Iran aim at the UNAIDS 90-90-90 targets and to eliminate mother-to-child HIV transmission. However, in the context of Iran, data for 2018 show that 36%, 57% and 82% of the 90-90-90 goals have been achieved[43].

There are strong efforts in Iran aiming at strengthening the national health management system concerning HIV prevention and control.

Globally, an effort to plot the future course of the HIV response set interim targets for 2025 that need to be achieved to reach the SDG HIV targets by 2030. In line with the global effort priorities of the 5th National Strategic Plan (NSP) in the continuum of the 4th National Strategic Plan aim at reducing the prevalence rates among key populations and scales up HIV prevention, care, and treatment services for high-risk groups.[44] In support of this Iran's 5th NSP of HIV/AIDS for the period of 2020-2024 was approved.

To support the national initiatives and acknowledging the need for involving the next generation, UNICEF, and partners[45] initiated the AWP. Although the initial focus of this programme was prevention of HIV/AIDS, statistics on Adolescence well-being (AWB)[46] sustains the need for interventions supporting prevention, protection, and treatment with the aim to address the root causes for the spread on HIV and the risky behaviour.

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[42] Golshiri P, et al.: *Youth Violence and Related Risk Factors: A Cross-sectional Study in 2800 Adolescents*. Adv Biomed Res 2018;7:p.138 (https://www.advbiores.net/text.asp?2018/7/1/138/244706).
[43] UNAIDS data 2019 (https://www.unaids.org/en/resources/documents/2019/2019-UNAIDS-data).
[44] UNAIDS file (UNAIDS/PrEP/Papers/Threeday %20consultative%20meeting%20held%20to%20develop%20Iran%E2% 80%99s%205th%20National%20Strategic%20Plan%20of%20HIV_ AIDS%20UNDP%20in%20Iran.html).
[45] Both the All-In and the AWP were joint programmes involving UNICEF, UNFPA and UNAIDS. The programme was headed by UNICEF.
[46] Details in section 1.2.2.

Education and counselling activities combined with out-of-centre activities were established:

a. Improving mental health including impulse control, problem solving, anger management and empowerment,
b. Substance use including general information about drugs and substance abuse addictive substances and related beliefs, prevention of substance use, drug prevention education awareness of alcohol abuse and its complications, drug and alcohol harm reduction programs,
c. HIV prevention including ways virus is transmitted, risky behaviours in adolescents, groups at high-risk, ways to prevent HIV transmission, HIV testing and importance of diagnosis, importance of treatment and treatment adherence, .

- Effective communication between parents and adolescents
- STIs for girls/boys
- Peer-centered empowerment and adolescent resilience life skills training focusing on the TAHAMTAM Positive Adolescent Life Skills model in *seven* steps:
  First step: Individual and interpersonal communication skills.
  Second step: the skill of dealing with unpleasant feelings and managing emotions.
  Third step: Negotiation and Assertiveness Skills
  Fourth step: the skill of refusing risky behaviour (sexual relations and drug and alcohol abuse).
  Fifth step: The skill of managing stress and criticism.
  Sixth step: decision-making and problem-solving skills.
  Seventh step: Communication and social networking skills.

1.3 The logic of the results chain

No Theory of Change or Results Chain for the AWP was found in any of the availed documents. With no programme document for the AWP or annual results reporting it was not possible to post-construct a Theory of Change.

The AWP was based on the framework of the ALL-IN initiative. But with a substantial extension in activities and the gradually increasing complexity of activities of the AWBCs this framework does not reflect the scope of activities and mode of operations of the AWP. Consequently, a use of this framework for this evaluation was not relevant either.

1.4 Key stakeholders and their contributions

The multitude of initiatives required a range of experts and involvement of stakeholders at levels the contribution of each category of stakeholders was the following:

Table 1.3: Key stakeholders and their contribution

Key stakeholder	Contribution
Contributions at upstream level	
MOHME, DG of CDC (both current and Previous)	Implementing Partner taking a lead in, availing staff for and coordinating meetings, capacity development etc.
MOHME, Head of STIs/AIDS Office (both current and Previous)	Implementing Partner taking a lead in, availing staff for and coordinating meetings, capacity development etc.

MOHME, Staff of STIs/AIDS Office (both current and Previous)	Implementing Partner taking a lead in, availing staff for and coordinating meetings, capacity development etc.
UNICEF Country Office	Coordination and technical support
UNFPA Country Office and Representative	Joint partner providing expertise support to studies and development of key technical and methodological materials
UNAIDS Country Office and Representative	Joint partner providing expertise support to studies and development of key technical and methodological materials
The Embassy of the Kingdom of the Netherlands	Donors of adolescent well-being activities in Iran
The Embassy of Russia	
The Embassy of Switzerland	
Embassy with actual representation of the EU	
Contributions at downstream level	
Provincial government entities	Implementing Partner at the local level supporting AWBC initiatives
Medical Universities, CDC departments	Implementing Partner providing expertise in meetings and to executing staff
Health centres of the provinces	Primary supervising
Police, religious leaders, schools	Consulted on design and roll-out of activities
Directors and staffs of AWBCs	Provided a range of support activities for the adolescents. Availed time for intensive training in new knowledge and skills
Girls and Boys Adolescents	Ultimate beneficiaries availing time and trust that the AWBC support could help them have a better future

It should be noted that this evaluation is based mainly on data from the capacity development interventions funded by the Embassy of the Kingdom of Netherlands in Iran.

2. Evaluation purpose, objectives and scope

2.1 Purpose and audience of the evaluation

This evaluation had a dual purpose of accountability and learning. It should "support (i) generation of knowledge on the successes and challenges of the Adolescents Well-Being Programme to inform future programming, and (ii) accountability for UNICEF and partners, as well as beneficiaries of the programme. The evaluation would consider the inclusiveness of services offered to the beneficiaries with the equity lens."[47]

With regard to an "equity lens" the AWP had no programme document and progress reports and therefore no valid data on equity.

2.2 Objective and scope of the evaluation

2.2.1 Objective of the evaluation

The objective of the evaluation was "to determine, as systematically and objectively as possible, the relevance, efficiency, sustainability and expansion as well as coherence of UNICEF's support of the above programme with emphasis on the AWBC"[48].

Since the desk study provided essential information about the effectiveness of the enabling activities it was decided to include this aspect.

The evaluation covered the design and the implementation of the programme during the period from 2017-2021. As the period indicates the programme was closed early 2021 which made it difficult to track the most relevant stakeholders in terms of both implementers and beneficiaries of the AWBCs.

2.2.2 Scope of evaluated programme initiatives

The scope of time under evaluation was the period of The Adolescent Well-being Programme (AWP) was implementation running from 01.01.2017 to 19.03.2021. The non-funded integration lasted until March 31st, 2022.

In the text of Terms of reference (ToR)[49] the scope of the evaluation was limited to UNICEF's support[50] to the adolescent wellbeing programme/model piloted in 6 provinces through 7 AWBCs since 2015.

Programmatically, the evaluation intended to review the services offered via these centres, while they were operational, mainly for their relevance and sustainability in addition to the coherence of the programming and efficiency of the implementation. It was not possible after more than two years of AWBC closure and under the actual political tensity to track relevant numbers and categories of implementers and beneficiaries to document the relevance (and thus effect) and sustainability of the services offered. Further, a focus on the AWBCs was not in line with the headline of the ToRs

[47] TOR, annex 1.
[48] TOR, annex 1.
[49] TOR, Annex 1
[50] With the view to capture and learn from the complementarity and establish the full coherence with other national activities the scope was widened to include the deliverables to capacity development of the two partner agencies, UNFPA and UNAIDS, but not their performance.

mentioning an "Evaluation of UNICEF Iran's Adolescents Wellbeing Programme," which had a far wider scope than supporting AWBCs[51].

In lieu of the missing AWP data the TOR suggested use of existing data sources 'Feasibility study on AWBCs (Adolescences Well-Being Centres) sustainability in Iran' conducted by UNAIDS and 'Sustainable financing options for AWBCs' conducted by UNFPA. Since these documents were based on concluding study findings and not performance per year these data were not directly relevant for evaluation of performance. As an alternative, these data were used to *exemplify* the positive and negative effect of intervention only.

To enable documentation of the relevance, effectiveness, efficiency, and sustainability of AWP interventions for which data were unavailable, the evaluation came to focus the capacity development activities supported by Government of the Netherlands entitled 'Empowering adolescents and youth in Iran to address their reproductive health needs'. A programme proposal/document and two annual reports for these activities were shared with the consultants. The findings from this capacity development were viewed as an enabler in the context of the AWP.

The thematic scope of the evaluation followed the scope of the programme activities supported by the Netherlands. It assessed delivery to the tree result areas listed in the project document[52].
The thematic scope was aligned with the programme framework.

The purpose of the AWP was:

> Eradicating the HIV epidemic, related stigma, and discrimination

The title of the evaluated project was:

> Empowering adolescents and youth in Iran to address their reproductive health needs.

Project results:

1. Adolescents and youth are empowered and enjoy a healthy life, including reproductive health. (Beneficiaries: 2400 adolescents per year).
2. The capacity of line ministries is strengthened, and inter-sectoral coordination is enhanced on programmes for adolescents and youth. (Beneficiaries: 500 experts from government).
3. Adolescent Well-being Centers[53] are strengthened to help end adolescents AIDS. (Beneficiaries: 800 adolescents per year)

Inputs:

1. UNICEF project management, implementation, and coordination of all interventions.
2. UNFPA and UNAIDS timely provision of studies and capacity building and other supporting materials.

The title of the evaluated project indicates a wider scope of risks than HIV/AIDS only.

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[51] The adolescent well-being programme is referring to:

1. Adolescent and youth well-being and empowerment programme - focusing on 'Learning to Earning': includes social well-being, vocational skills training, digital skills building, entrepreneurship, mentoring, volunteering, and apprenticeship (partner: MOSY.)
2. Adolescent girls psychosocial well-being and empowerment programme- focusing on social harm prevention among adolescent girls: includes MHPSS, drug use prevention, life and social skills training, and social participation (partner: IR. of Iran DCHQ).

[52] Project title: 'Empowering adolescents and youth in Iran to address their reproductive health needs'.

[53] AWBC activities can be divided into three categories: (i) Treatment (physical and/or mental); (ii) Knowledge creation about prevention and protection and (iii) Life skills development (e.g., social responsibility, anger management).

3. Evaluation framework and methods

3.1 Evaluation framework

3.1.1 Evaluation principles

The evaluation applied five of the six Standard Organization for Economic Cooperation and Development/Development Assistance Committee (OECD/DAC) Criteria. The ToR suggested that the evaluation of effectiveness and impact should be omitted. The desk review provided essential information about effectiveness, for which reason this was included.

In accordance with UN standards for evaluations (UNEG standards) evaluations should also consider equity, gender, and human rights. The availability of documents and data did not allow for a systematic, evidence-based analysis of these. An analysis of applied gender equality and social inclusion measures and the effect of these was conducted as feasible.

3.1.2 Evaluation approaches

To respond to the ToR criteria the evaluation made use of two *approaches*. To ensure "generation of knowledge" and "establishment of UNICEF and government accountability" the evaluation applied a utilization-focused approach which "aims to support effective action and informed decision-making based on meaningful evidence." In addition, the evaluation adopted a summative approach to assess the accumulated achievements, which allowed for assessment of the comprehensiveness of the outreach, stakeholder adoption of initiatives followed by results-based decisions on the future focus.

Overall, the evaluation adhered to United Nations Evaluation Group's (UNEG) norms and standards for evaluations[54]. One issue was not addressed:

- Reporting against gender-disaggregated indicators as the programme documentation was limited and data were not gender disaggregated – in this case the gender distribution of participants in capacity building activities.

3.1.3 Evaluation questions

The evaluation was based on, but not limited to, the key questions and sub-questions given in the TOR[55]. In TOR, the evaluation questions (EQ)s were not formulated as questions, but as points. Table 3.1 provides an overview over how the evaluation EQs responded to and covered the EQs in TOR:

Table 3.1.: Overview over change in evaluation questions.

EQ	OECD CRITIERIA	TOR FORMULATION	EVALUATOR FORMULATION
1.	Relevance	The extent to which the objectives of a development intervention are consistent with target populations' requirements, country needs, global priorities and partners' and donors' policies.	To what extent are the objectives of the AWP consistent with the UNDAF, target populations' requirements, country needs, global priorities, and partners' and donors' policies?

[54] United Nations Evaluation Group (UNEG): *Norms and Standards for Evaluations*, 2016, p.10
[55] TOR, annex 1.

EQ	OECD CRITIERIA	TOR FORMULATION	EVALUATOR FORMULATION
2.	Effectiveness	None in TOR With no results reporting available the evaluation assessed achievements at any level. The desk review indicated that e.g., monitoring was scarce for which reason an assessment of existence and relevance of systems was included.	To what extent were systems in place supporting achievements of the AWP objectives?
3.	Efficiency	The measure of how economically resources/inputs (funds, expertise, time, etc.) are converted to results	To what extent were economically resources/inputs (funds, expertise, time, etc.) converted to HRBA results?
5. (4)	Coherence	The compatibility of the intervention with other interventions in a country, sector, or institution	To what extent are the AWBC interventions[56] were compatible with other adolescent interventions in the country, relevant public sectors, or institutions?
4. (5)	Sustainability	The probability of continued long-term benefits. The resilience to risk of the net benefit flows over time	What is the probability of continued long-term benefits?
6.	MEL[57]	None in TOR	Were RBM/HRBA monitoring, evaluation and learning procedures in place and used?

In the data collection tools each question was broken down into items which provided a content and focus of the broader EQ. The items also served the purpose of a checklist for the evaluators. The template was shared with interviewees before the interview to provide an opportunity to prepare for the interview. The was supported by a guide to the template.

Each interviewee provided information only about the items with which he/she had experience[58]. The interviewees were given an opportunity to add items that were not included in the template. The break-down into items helped the evaluators react promptly if one or more items remained unanswered after several interviews which resulted in some additional interviews or follow-up on earlier interviews.

The EQs were developed to deliver to the two over-arching tasks (TOR)[59]:

a) Assess the programme and document the lessons learned for required management responses.
b) Support evidence generation to enhance/revise the design and implementation of programmes with similar components through other platforms.

The evaluators recognized the definition of the task:

a) Assessment was understood as assessment of the entire programme cycle and does therefore involve both planning, implementation and monitoring/reporting/data use and the results of the programme efforts.

[56] See annex 4.
[57] Monitoring, evaluation and learning
[58] All key questions and items are found in the evaluation matrix, annex 5.
[59] TOR, annex 1.

b) Provision of evidence-based data which should explain cause-effect enabling an establishment of "what works and how" and "what does not work, why and the potential negative effect" with the view to inform future implementers.

The limited recording of outcomes made the findings and conclusions presented in section 4 be supported by other documentation, e.g., 'The formative assessment of the ALL IN Centers', (2017) and the 'Feasibility study on AWB centers services sustainability in Iran', 2020.

3.2 Methods for data collection and analysis

3.2.1 The design of the evaluation

The design of the evaluation was retrospective. It applied Non-Probability Sampling Methods[60] making use of a mix of Convenience Sampling and Purposive Sampling[61]. The risk of influencing evaluator judgement was addressed by comparing the findings of the two evaluators, by holding individual evaluator findings against desk review findings and making use of a mix of qualitative and quantitative methods for validation.
The evaluation was participatory involving staff at UNICEF and the Steering Committee in the design and process, and a range of stakeholders in provision of data and experiences[62].

The methodology comprised:

- Desk studies of internal and external documents[63].
- Data collection based on semi-structured interviews and focus group discussions, and
- Data consolidation, validation, and analysis.

The methods considered that the programme support ended by March 19th., 2021, by being flexible in composition of methods. It was possible to let the situation and/or evaluation participants decide whether they preferred to participate in Focus group discussion (FGD), individual interviews or on-line talks or interviews – depending on the category of participants. The details of each method are explained below.

Since the programme support had ended more than one year before the evaluation commenced the likelihood of finding key stakeholders was uncertain. Hence the evaluation applied a Non-Probability Sampling Methods based on inclusion of those stakeholders that could be tracked and be available.

3.2.2 Desk review

The desk studies comprised three types of internal documents: Guidelines for all stages of the evaluation, documents related to operations in the AWBCs, most in Farsi, and the mentioned project documents with two annual progress reports.

The desk studies also included studies of external documents such as the UNDAF 2017-2021 which was extended to include 2022, Mid-term review (MTR) of the ALL-IN initiatives, MOHME work plans for

[60] Re: research-methodology.net/sampling-in-primary-data-collection/non-probability-sampling/
[61] Re.: www.healthknowledge.org.uk/public-health-textbook/research-methods/1a-epidemiology/methods-of-sampling-population
[62] List in section 3.2.5.
[63] List in annex 2.

2017 and 2018, UN CPD 2017-2022, United Nations Sustainable Development Cooperation Framework (UNSDCF) 2023-2027 and the 'Feasibility study on AWB centers services sustainability in Iran'[64].

The desk studies determined the final formulation of the evaluation questions and the items detailing each question.

3.2.3 Semi-structured interviews

The design of the interviews was based on semi-structured questions presented in a template introducing the questions in writing. The up-front presentation provided the interviewee with a clear picture of the content and focus of the interview and an opportunity to prepare for the interview. Having the questions at hand, the interviewee had the floor throughout the interview. The interviewee answered in the order and with the emphasis suiting him/her. In most cases the interviewee shared his/her experiences, while the items just guided the focus of the information. The information was subsequently computerised by the consultants.

Not all EQs were relevant for all interviewees. This applied for the items, too. Therefore, a template had been developed for each category of interviewees[65] extracting questions and items from the evaluation matrix.

Although having given prior consent to the participation in the interview, the interviewee could withdraw from the interview at any time and could ask the consultant to omit any information from the data pool.

The design of the semi-structured approach abided by all TOR-principles and priorities and made sure that all TOR questions were covered – whether programmatic, administrative, or corporate. The semi-structured interviews were used for key informant interviews (KII) with implementing partners such as the relevant ministries[66], districts, universities, heads of centres, focus group discussions (FGD) and involved UN agencies.

The national consultant conducted all data collection relating to national stakeholders while the international consultant conducted the interviews with UN agency partners and UNICEF staff at country level.

3.2.4 Focus group discussions

The FGDs were an option for beneficiaries of the AWBCs. If they preferred individual interviews, they could choose that option. However, all preferred the FGDs. To have acceptance of participation directly from the focus groups participants, all participants were between 18-25 years of age. Acknowledging that the AWP began in 2016, the age bracket of the evaluation participants was appropriate as they were all 10-19 at the time of receiving services from AWBCs.

[64] Full list of literature in annex 2
[65] Annex 7.
[66] This includes MOHME, MOSY and MOE.

In FGDs the participants discussed in disaggregated[67] groups of 2-5 peers guided by a template with the relevant EQs[68]. This prevented more influential beneficiaries or implementers from diverting or focusing a discussion to make it highlight their interests and not the interests of a wider group of beneficiaries. The anonymity of the method and the opportunity to have discussions with same-situation peers helped the adolescents to feel free to share also personal and sensitive experiences. The discussion was led by the national consultant.

The focus group members could choose to withdraw from the FGD at any time and could ask to have any information removed from the data pool.

It was projected to have two FGDs for each of the four selected centres and to include two centres for girls and boys, respectively. It was, however, only possible to meet four groups of adolescents.

3.2.5 Participants in the evaluation

A list of potential participants was developed to guide the tracking of people who had been key in the programme implementation. The initial listing and actual participation are shown below[69]:

Table 3.2: Number and distribution of interviewees

Category of respondents	Planned number	Actual number
Involved ministries	4	2
CDC departments, Medical Universities	6	5
Relevant district staff from districts with AWBC	4	4
Staff from 4-7 centres (KII)	16	12
Beneficiaries from 4 centre (FGD)	20	16[70]
UN agency AWP partners	7	2
UNICEF Iran	5	5
UNICEF RO	2	0
TOTAL	64	46

At the national enabler level, the participants were selected among national implementers at the upstream level, and among universities, centre management and staff and adolescents at the downstream level.

3.2.6 Data consolidation, validation, and analysis

The data were consolidated as per the category of data sources: (i) desk review of documents, and interview findings from respectively (ii) involved UN agencies and (iii) implementing stakeholders which allowed for a validation using triangulation of findings from the three categories of data.
Further, quantitative data were held against qualitative data where possible, e.g., the number of people trained in each subject and the achievements/changes recorded. Neither quantitative (e.g., number or gender of participants) nor qualitative data (changes in mode of operation or in lifestyle/life quality of adolescents) were systematically collected by the AWP of by the evaluated project. Thus,

[67] The disaggregation will concern gender, age and geography. The size of groups will be 2-5 same respondents of same category.
[68] See annex 7.
[69] Mitigation measures described in section 3.3.
[70] The 16 participants were distributed on boys/girls.

evaluation participant experiences could not always be held against the achievements provided in the project reporting.

The data analysis involved an analysis of same type of experiences from different data sources and thus for an analysis of potentially different experiences with same approach or intervention. This was further held against the category of data source.

Since the selection of respondents was not statistically representative, the findings cannot be generalised to a larger population. They did, though, provide strong evidence of the extent to which interventions had worked and of some positive and negative effects of the same interventions.
It was possible for the evaluated project[71] to hold project findings against planned achievements. With no similar, concurrent adolescent activities in Iran, the established achievements can be attributed to the AWP project. It was not possible, though, to verify the cause-effect of the supported capacity building on other AWP initiatives.

The data analysis addressed two key aspects: (i) Programme and project adherence to key principles for programme design and management[72] and (ii) analysis of type and level of achievements against the planned achievements.

3.3 Key limitations and mitigations

To reduce the number and severity of possible limitations of the evaluation process some time was spent during the planning phase to find modes of operations which were viewed to be most applicable during the political tensity at the time of the evaluation. The assessment covered all stages of the evaluation.

Table 3.3: Key limitations and mitigations

	POSSIBLE CONSTRAINTS AND LIMITATIONS	MITIGATION MEASURES
a.	There was no AWP programme document, no consolidated annual progress reporting for the AWP accounting for progress against planned achievements. Thus, no other programme documents, plans or reports to other donors were evaluated. Hence the full AWP programme progress was difficult to capture.	As a result, the evaluation builds primarily on the project description used for application of funds to the Embassy of the Kingdom of Netherlands and on the annual progress reports for 2019 and 2020 on the same. The findings from these were supported by interview findings.
b.	Availability of key stakeholders as some had changed position and AWBCs had been closed.	Availed time for tracking and inviting key data providers both before and while conducting the data collection which stretched over 2 months.
c.	Ability and willingness by stakeholders to participate in the evaluation.	Participants could determine time and venue for the participation, when accepting the invitation. No identifiable records of participants were kept.
d.	Need for extra efforts to develop a common understanding among the consultants when working at a distance.	More time was spent during the inception phase on creating a common understanding between UNICEF and the consultants and between the two consultants.

No need for further measures arose during the data collection and completion of the evaluation.

[71] Netherland supported "Empowering adolescents and youth in Iran to address their reproductive health needs ".
[72] Adherence to the OECD/DAC criteria for programming, to principles and standards of UNICEF's 'Results-Based Management Handbook',2017, and to UNDG's 'The Human Rights Based Approach to Development Programming', 2012.

3.4 Ethical considerations

The methodological approach observed all ethical standards[73]. This entails abidance by the four ethical principles: (i) Integrity; (ii) Accountability; (iii) Respect, and (iv) Beneficence.

The design of the evaluation abided by these principles (i) in the selection of categories of participants in the evaluation; (ii) by using a semi-structured interview approach which allowed the interviewee to explain individually relevant items; (iii) by introducing the EQs in advance. This enabled the participants to gain an overview over the content and focus of the discussion and, implicitly, a confidence in the process;(iv) through allowing for the possibility of adding information, which was outside the questions presented, but of importance to the participant.

For the FGDs the principles were applied by working with small groups of peers who could discuss among themselves and agree on which experiences to share. When accepting the invitation for an interview or FGD each participant was asked to give his/her consent to the participation and to the use of data using the Consent Form of UNICEF with the opportunity to withdraw at any time.

The data collection approach ensured anonymity as none of the answered templates had identification details but only indicated the sex and category of respondents. Thus, no names or other identification details were used during the data collection, recording or reporting.

Complementary to the ethical standards for data collection, the obligations of evaluators (independence, impartiality, credibility, conflicts of interest, accountability)[74] were followed.

- *Independence and impartiality* were ensured by separating the evaluation function from the line management responsible for planning and managing development assistance and by having an evaluation unit composed of key stakeholders.
- *Credibility* of evaluation was ensured through the complementary expertise of the two consultants and by having an open and transparent evaluation process. Further, by trying to capture both the positive and negative experience with the AWP and the derived effects.
- Potential *conflict of interests*[75] was mitigated by (i) avoiding politically related questions or involvement of participants with declared political interests, and (ii) by practising no payment/ remuneration of any kind for participation in the evaluation.
- Potential areas of conflicts were discussed in advance and mitigation measures were taken in advance with the option to stop the data collection session, if needed. This made the evaluation be implemented without unforeseen challenges.
- The principle of *Accountability*[76] involved all the above principles. It was, further addressed by (i) having thorough data collection/management and evaluation process protocols adhering to ethical standards, and by (ii) providing evidence for all judgements in the evaluations covering findings, conclusions, lessons learned and actionable recommendations.

[73] As given in UNICEF's 'Procedure Ethical Standards in Research, Evaluation, Data Collection and Analysis', 2021, UNEG's 'Ethical Guidelines for Evaluations', 2020, careful selection of evaluation participants and by providing anonymity in the evaluation response.
[74] OECD-DAC: *Principles for Evaluations*, 1991.
[75] www.un.org/en/ethics/assets/pdfs/Factsheet_Conflicts-of-interest.pdf
[76] UNEG: *Ethical guidelines for evaluations*, 2020. p.12

4. Findings

With the AWP having no programme documents and no progress reporting made available for UNICEF by MOHME, it was not possible to deliver an evidence-based evaluation of the full AWP. In addition, critical data from the MOHME managed monitoring of the AWBCs were not shared with UNICEF and were therefore not available for this evaluation. Such data would have included annual details about: Number of m/f empowered per centre; categories of risks against m/f and age groups that were empowered – per centre, and categories of risks with m/f and age details that graduated – and to what – per centre.

The desk review found that data existed for a part of the AWP, namely for the AWP project "Empowering adolescents and youth in Iran to address their reproductive health needs," funded by the Netherlands. This had both a project document and two annual reports, albeit with no reporting on results. However, being a capacity development project supporting the AWP at large[77] and the AWBCs more specifically this became the focus of the evaluation as this project is viewed as a strong enabler for the empowerment of at-risk adolescents.

All validated findings from the evaluation of this project are viewed in the context of the larger AWP, while also building on validated information about the AWP from the: *"Formative assessment of ALL IN Centers"*, UNICEF, Iran, 2017, and from: *Feasibility Study on AWB Centers Services Sustainability in Iran,* UNAIDS Iran, fall 2020. The early production of these documents made them lack data covering the entire project period until project termination, while the mentioned activities and modes of operations could provide examples of AWP activities and thus implicitly the relevance of the evaluated capacity development project.

All references to "evaluation findings" refer to triangulated and analysed findings[78] and thus to findings of validity.

The AWP was a joint programme between UNICEF, UNFPA and UNAIDS with UNICEF as the lead agency. This evaluation concerned UNICEF performance only. The contribution of the two partners is mentioned when contextually relevant.

None of the provided AWP or project materials had gender disaggregated and social inclusion data. Therefore, the analysis of the achievements for each of the OECD/DAC criteria comprises no analysis of gender and/or social inclusion. A cross-cutting analysis is found at the end of this section.

4.1 Relevance

4.1.1 Relevance of the AWP focus

With the AWP purpose of 'Eradicating the HIV epidemic, related stigma and discrimination', the AWP was fully aligned to all relevant priorities, needs and goals (*see Table 4.1 below*).

[77] RAs in section 4.2.1.
[78] Details in section 3.2.6.

Table 4.1: AWP consistency with national, global and donor priorities

Needs and priorities	AWP goal adherence to needs, priorities and policies
Target population needs	People Living with HIV (PLHIV) was reported about 53,000 (38,000-140,000) by the end of 2021, which is the highest number of PLHIV in the MENA region
National priorities/country needs	NDP6, articles: 74I,78, 80, 102(F)[79]
UNDAF priorities	Outcome areas 3.1 and 4.1[80]
Partner goals[81]	(See footnote)
Donor policy	Overarching goal 2 and cross-cutting goal[82]
Global goals	SDG 3,4 5, 10 and 16[83]

Apart from adhering to national and international needs and priorities, the AWP addressed adolescence risks[84], which were generally unaddressed in Iran. Governmental services relating to HIV/AIDS and harm reduction centres were available. But none provided a systematic and multisectoral support as provided by the AWBCs.

4.1.2 Relevance of the project design

Being *innovative* in approach and reaching out to *hitherto unaddressed categories of risky behaviours* there was a recognised need for capacity development of all stakeholders of this intervention.

The composition of result areas of the project, 'Empowering adolescents and youth in Iran to address their reproductive health needs', was highly relevant comprising:

1. Adolescents and youth are empowered to enjoy a healthy life, including reproductive health. (Beneficiaries: 2400 adolescents per year)
2. The capacity of line ministries is strengthened, and inter-sectoral coordination is enhanced on programmes for adolescents and youth. (Beneficiaries: 500 experts from government)
   Adolescent Well-being Centers are strengthened to help end adolescents AIDS. (Beneficiaries: 80 adolescents per year).

The results areas (RA) deliver to the purpose of the project[85], while providing a range of capacity development across all three levels of interventions: (i) Direct AWBC intervention; (ii) National implementers & enablers, and (iii) Community level implementers (parents, police, religious leader etc.).

[79] Details in section 1.1.5
[80] Details in section 1.1.5
[81] UNPFA goal: "To reach marginalized people and communities, especially those who have been left behind by economic growth and development". UNAIDS goals: "Fewer than 500 000 people newly infected with HIV; Fewer than 500 000 people dying from AIDS-related causes; Elimination of HIV-related discrimination".
[82] Overarching goal 2: "Reducing poverty and social inequality". Cross-cutting goal: "Gender equality and the empowerment of women and girls". (/Users/birgi/Downloads/Investing+in+Global+Prospects.pdf).
[83] SDG 3: "Ensure healthy lives and promote well-being for all at all ages; SDG 4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all"; SDG 5: "Achieve gender equality and empower all women and girls; SDG 10: Reduce inequality within and among countries", and SDG 16: "Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels".
[84] See details in section 1.2.2
[85] Project title: 'Empowering adolescents and youth in Iran to address their reproductive health needs'.

The evaluation found no needs/gaps assessment[86] between (i) national statistics for at-risk adolescents, (ii) stakeholder definition of well-being as measure to curb risks and (iii) definition of gap to be filled to achieve adolescent well-being. This explains, in part, the gradual inclusion of new categories of stakeholders with time and also that some relevant categories of stakeholders were never included.

The 'Formative Assessment of the ALL IN Centers', 2017, and the 'Feasibility Study on AWB Centers Services Sustainability in Iran', 2020, both found the AWBCs services appropriate, satisfactory, and relevant for programme facilitators as well as adolescents. These findings were supported by findings from different categories of interviewees.

The structured and holistic way of empowering the at-risk adolescents[87] through (i) working with the peer recruitment of at-risk youth; (ii) development of a care-plan, which was adjusted on monthly basis, and (iii) the multisectoral approach[88] to empowerment using through provision of knowledge and skills relating to protection and prevention, in the use of creative activities such as gaming, theatre and music to help drop-outs discover own talent and the social activities such as cleaning of the local environment all helped in building a positive identity as replacement for the more negative 'at-risk' identity.

The inclusion of all levels of enablers,[89] and of the beneficiaries, in suggesting content and set-up of the AWBCs is commendable. Wide inclusion helps in establishing needs and gathering ideas of locally best ways to address the needs. An early inclusion of beneficiaries, implementers and enablers help generating a sense of ownership of the programme.
No evaluation findings indicated measures for inclusion of adolescents living with disabilities. Neither was a reason given why this may not be applicable.

At the national implementer/enabler level the evaluation found that some obvious enablers especially at downstream level were not included in the AWP design and implementation, e.g., a wider selection of ministries, national researchers, the local courts (magistrate level), local NGOs/CBOs working with human rights and social protection, national youth champions, informal community leaders etc.

Findings suggest that exclusion of key upstream decision-makers made the AWP have inadequate knowledge about the attitude, fears and needs of these decision-makers. Thus, the programme lost an opportunity to address specific needs, attitudes, and fears which evaluation findings show, in part, affected the commitment and ability to practise full ownership and responsibility. Services for at-risk adolescent are, therefore, still inadequate.

Evaluation findings indicate a need for more basic implementer/enabler capacity e.g., knowledge about HIV/AIDS and effective methods for engagement with adolescents. This suggests a discrepancy between the programme design and (i) skills of the service providers, (ii) the relevance of the services providers' educational level and experience and (iii) their responsibility in AWBCs and other activities supporting at-risk adolescents. UN Agency and implementer interviews emphasized that this applied especially to topics like Comprehensive Sexual Education and peer education. The effect of having less capable implementers than expected was not recorded.

[86] Neither for the AWP at large, nor for the Dutch funded capacity development project.
[87] Details in section 1.2.3 and annex 4.
[88] As above.
[89] See table 1.3.

The evaluation found that there was, and is, fear among some stakeholders that the AWBC initiative will promote approaches that discourage population growth acknowledging the sharply declining population growth rate of the country in the past decade. This fear was only addressed by a few stakeholders attempting late and minimal inclusion and/or clarifying talks. It was never addressed at programme level although known as a risk for programme implementation and achievements.

At the direct intervention level findings indicate that most of the adolescents in the AWBCs were school drop-outs. This had a bearing on their ability to engage in needs assessments and design of products as affectively as intended by the AWP. The adolescents were unfamiliar with being involved, being asked, and being heard and with what it entails in terms of reflection, prioritisation and decision-making to engage in decision-making. This partial involvement affected the adolescents' sense of ownership of the AWBCs and the relevance of design of capacity building materials and methods. The materials and teaching approach did not fully match the ability of groups with learning difficulties and/or low level of education and literacy skills.

The timing of the intervention was assessed as relevant, maybe late. This was supported by the statistics concerning risky behaviour[90].

Conclusions

i. The thematic response to documented adolescent risks in Iran was timely and relevant – albeit controversial for parts of the Iran population.
ii. Acknowledging that the AWP would have benefitted from a wider inclusion of enablers, the evaluation findings indicate that the wide and engaging inclusion of key stakeholders in the programme design, programme amendments development of training materials and guidelines combined with the adaptive management approach ensured relevant and timely address of stakeholder needs and interests. This was the combination that made the AWP initiatives be implementable despite the sensitive nature of the these.

4.2 Effectiveness

4.2.1 Management system

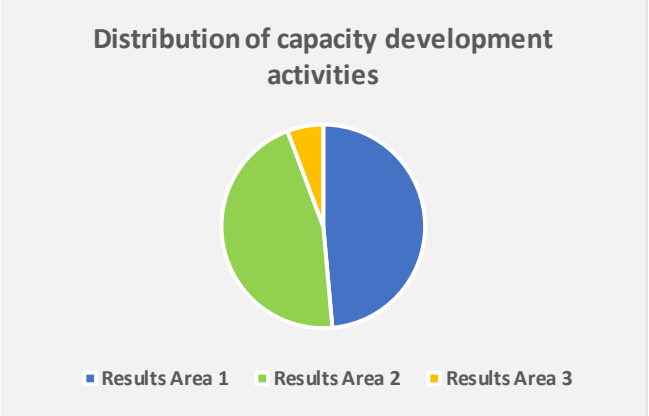
UNICEF and MoHME agreed on and practiced adaptive management. This enabled continued adaptation of programme activities as needs arose. Being innovative in approach, the adaptive management facilitated a learning-by-doing followed by immediate changes. Annual project reports[91] and interviews provided evidence of the effectiveness achieved from applying the adaptive management approach, which resulted in provision of ever relevant capacity building and centre services, e.g. change in the age of the main target groups from 10-24 years which was limited to 10-19 years with a focus on the 14-19 years old; establishment of AWBC activities for girls in two centres allowing girls to use the centres on turns with boys, and introduction of online counselling during COVID-19. The adaptive management was also used for more overall purposes such as asking implementers/ enablers to use the knowledge and common views of the group as a starting point and combine this with professional knowledge. This resulted in a bottom-up approach to addressing the risky sexual behaviours of adolescents.

[90] See section 1.2.3. and annex 4.
[91] Annual reports 2019 and 2020 for the project 'Empowering adolescents and youth in Iran to address their reproductive health needs'.

4.2.2 Project activities and achievements

This flexibility in programme scope and modes of operation resulted in need for improving, developing, or amending the existing capacity of all stakeholders. The capacity development interventions supported by UNICEF were distributed across the three RAs[92]:

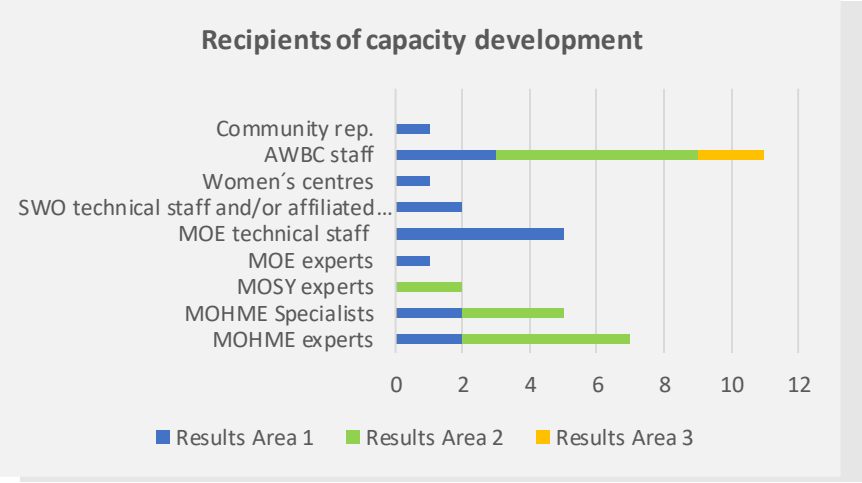
Fig. 4.1: Distribution of UNICEF capacity development activities[93]



RA 3, which concerns strengthening of the AWBC capacity to support at risk adolescents, received the least UNICEF support. However, the two partners in the joint programme, UNFPA and UNAIDS contributed strongly to this area through provision of studies and knowledge material and guidelines relevant for empowering at-risk adolescents[94]. This was to be supported by exchange visits most of which never materialised due to COVID-19 restrictions.

Not only were a wide scope of stakeholders involved in the programme design. They were also provided with the capacity that is required to implement necessary services for at-risk adolescents. The range of involvement shows below:

Fig 4.2: Recipients of capacity development



[92] Section 4.1.2

[93] Under the project: 'Empowering adolescents and youth in Iran to address their reproductive health needs'.

[94] Details of capacity development initiatives, annex 7.

Figure 4.2 above shows the *number* of capacity development[95] activities implemented under each RA in the period of 2019 and 2020. The evaluated project focused on building the capacity of a range of actual and future national implementers/enablers. Evaluation findings show that UNICEF made extensive use of consultants for specialised studies, training or other development activities involving stakeholders in the design, which made the programme change from a standard initiative into an initiative which was locally, culturally, and socially relevant.

Figure 4.2 shows that the capacity development includes all levels of national implementers/ enablers and not only implementing ministries, institutions and the NGOs running the AWBCs. It is noticeable that SWO, implementing NGOs, women's centres, youth and/or sports organizations and community representatives, all being enablers at community level, were provided with minimal capacity development. This category of stakeholders are the core enablers when intending to have prevention and protection measures close to the daily life of adolescents. They are also the category with the least capacity in supporting at-risk adolescents. In addition, supportive systems and structures at community level were not provided with relevant capacity development, e.g., the police, schools (only limited) and youth organizations.

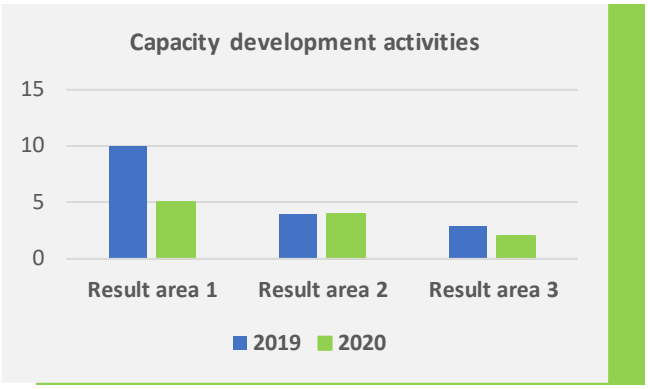
The aim of the capacity development project was to build the capacity of 500 experts[96]. The annual reports account for 665 experts[97]. But around half the capacity development activities have no reporting of the number of participants, nor of the gender of those involved in each activity. Hence, far more than the targeted number of experts were trained during the reported two-year period. The capacity development covered a range of subjects relating to support of at-risk adolescents, while also strengthening systems and structures, for example supporting MOHME in (i) developing a monitoring system capturing AWBC interventions, (ii) establishing coordinating structures for meetings with all ministries and institutions operating in the field of adolescence well-being or (iii) establishing and amending protocols for the running of the AWBCs[98]. In addition, UNICEF in partnership with UNFPA and UNAIDS conducted studies and developed a variety of information materials and guidelines on the effect of attracting STIs, prevention and protection measures and guidelines for engagement with at-risk adolescents[99].

Since the aim was a quite fast government integration of the AWP at-risk practices into MOHME services the focus on capacity development[100] was grossly relevant. The initially planned period of three project years plus a period of integration of activities into MOHME services was shortened to a little more than two years. With the multiplicity and complexity of intended changes in view the level and scope of implemented interventions were impressive. Fig 4.3 provides and overview over activities per RA[101].

The level and category of activities as indicated above derive from the annual reports for 2019 and 2020 and was supported by experiences of the two categories of evaluation participants, national implementers and involved UN agencies. The figure shows the general distribution of capacity development initiatives across the two years with annual reports. It also shows a major focus on RA1.

[95] OECD/DAC definition involving: Systems, structures, human resources, equipment/infrastructure and work environment.
[96] Details in annex 7.
[97] Details in annex 7.
[98] Details of activities, implementers and participants in annex 7.
[99] Details in annex 7.
[100] As defined by OECD/DAC comprising: Systems, structures, HR (number and adequacy of skills/expertise), infrastructure and work environment.
[101] Details of all capacity development in annex 7.

Fig. 4.3: Capacity development activities



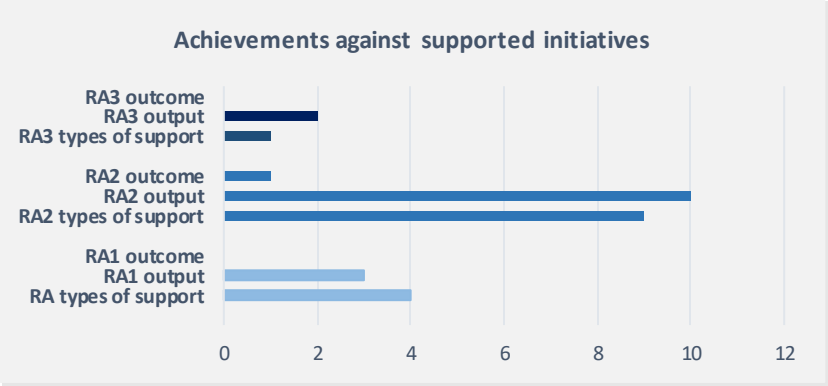
The capacity development under RA1, "Adolescents and youth are empowered enjoy a healthy life, including reproductive health", comprised knowledge about STI, activities helping the adolescents changing attitude, e.g., anger management, and methods on how best to engage with at-risk adolescents. Well-tested materials were developed, introduced, and amended during this period. It is now available for MOHME's and other ministry's work with at-risk youth.

The capacity developed under RA 2, "The capacity of line ministries is strengthened and inter-sectoral coordination is enhanced on programmes for adolescents and youth", concerned development of systems and structures, involved development of protocols for the AWBCs and for self-evaluation, support to MOHME's establishment of an M&E system and support to MoHME to hold the roundtable meetings with participation of Director Generals and senior experts from MOSY, IRCS, SWO, MFA, UNAIDS and UNFPA to identify coordination gaps. The reduced gaps and overlaps of efforts for at-risk adolescents was in place at project termination.

For RA 3, "Adolescent Well-being Clubs are strengthened to help end adolescents AIDS", the deliverables comprised materials and infrastructure and involved e.g., support of MoHME to procure seven portable clinics for AWBCs and, as a result of the COVID-19 pandemic, 124 telephone counselling headsets and 124 mobile holders that were procured for trained counsellors and social workers[102]. The scope and number of implemented activities delivering to the RAs bear evidence of effective use of resources.

The reporting for 2019 and 2020 did not distinguish between output level and outcome level achievements. It was possible, though, to extract some achievement/changes from the reports that relate to project interventions.

Fig. 4.4: Changes achieved against supported initiatives.



[102] Details of all capacity development in annex 8.

In the above figure the numbers indicate interventions for which the evaluation found documentation for achievements[103]. The number of inputs refer to the number or *overall initiatives* that were supported, e.g., development and introduction of the TAHAMTAN or development and introduction of the AWBC monitoring system, and not to the number of activities per initiative as in fig 4.3.

With the relatively short project period of three years including hand-over to MOHME, it was not realistic to expect outcome level results for all result areas, least RA2 supporting changes in systems and structures.

To assess the level of achievements/change in practices it was necessary to assess the (i) existence of the planned new practice/product, (ii) use of it and (iii) effect of the use of the new practise/product. The findings show that most inputs had output level results only.

RA1, the use of new practices/products empowering the at-risk adolescents, were only reported in part, while the full picture lies in MOHME.

For RA 2 and 3 the figures shows that some supported initiatives resulted in more than one change in practices and/or in more products.

Some examples of change in practices:

- Under RA1:
  The annual reports account for three achievements among these two changed practices under RA1 although these rightly belong under RA3[104] were:
  - Introduction of TAHAMTAN life skills package which was piloted in all 7 AWBCs training 110 adolescents in the first round of implementation, and
  - The piloting of the PAYAM' MAN programme at all seven sites with 12 to 24 at-risk adolescent boys and girls involved at each site.
- Under RA2:
  - Re-introduction of a comprehensive service package for at-risk adolescents, resulted in three outputs: (i) establishment of four support committees; (ii) piloting of the model in all seven AWBCs.
  - Support to MOHME development of a monitoring systems for the AWBCs had achievement at outcome level, as the system was launched and provided data on the performance of the centres and the change in lifestyle of the supported adolescents. The result is the use of the monitoring system, while the impact of the system in terms of changes in adolescents' lifestyle/life quality was not known, as data were not shared with UNICEF.
  - The project´s Covid-19 response to closure of AWBCs, the introduction of Remote Stepped Psychosocial Care and support (RESPCT) for adolescent, youth, and their parents which was based on telephone counselling. The approach reached 124 counsellors, social workers, and psychologists from seven AWBCs affiliated to MOHME, and 110 community counselling centres from 31 provinces providing 18 hours online trainings on Respect.
- Under RA3 achievements concerned:
  - Procurement supporting outreach activities.

[103] Details in annex 9.

[104] RA1: Adolescents and youth are empowered enjoy a healthy life, including reproductive health; RA3: Adolescent Well-being Centers are strengthened to help end adolescents AIDS.

The level of achievements was affected by the COVID-19 pandemic. In accordance with the restrictions introduced by the COVID-19 National Taskforce, many activities could not be carried out as planned. Study tours had to be cancelled and the AWBCs were closed. For the national implementers/enablers (MoHME, MOSY, AWBCs, Civil Society Organizations and Youth Houses) national seminars and face-to-face training capacity building events were either suspended or postponed. A package on selective drug use prevention for high-risk adolescents was developed to be used as a pilot programme in the high schools located in district 19 of Tehran city. But due to the COVID-19 pandemic the piloting was cancelled.

However, the pandemic also resulted in a positive development. In order to continue providing services to adolescent boys and girls at the direct intervention level during COVID-19, the methodology and format changed to online and virtual services. UNICEF used the challenges as an opportunity to harness innovative means – for example introducing and testing a remote psycho-social counselling programme for reaching vulnerable adolescents which proved effective. A challenge turned into an achievement. Single source findings indicated that more than 50% of at-risk adolescents in the AWBCs had changed/ improved their behaviour.

Evaluation findings suggest that the inclusion of and linkage with main stakeholders[105] were inadequately coordinated. This resulted in less effectiveness as staff and outreach personnel experienced problems with coordinating with other organizations, e.g., when needing legal permission to bring troubled adolescents to the centre or in getting legal permission for social workers to reach and take care of their adolescent clients. The need for a strong and wider understanding of the AWB purpose at all levels and among all categories of enablers and influencers was overlooked.

Overall, the use of adaptive management enhanced the effectiveness as changes in modes of operation were made as needs arose. This showed in e.g., permitting graduated adolescents a continued use of the AWBCs. The exact and actual number graduates per year was not found in the annual reports availed. But findings in the 'Feasibility Study on AWB Centers Services Sustainability in Iran' showed that more than 70% of the adolescents managed to graduate from the centres and some of them wished to continue attending the centres and using the services and trainings. This continued contact with the graduates enabled the centres to follow the current level of well-being of the graduated adolescents and thus act as a safety net.

Conclusions

(i) Despite the complexity and sensitivity of the wider AWP *and* the project under evaluation, and the emergence of COVID-19, the programme proved effective in the roll-out a wide scope of activities and involvement of an equally wide scope of stakeholders in innovative AWB activities whether the innovation concerned institutional or programmatic changes.
(ii) The evaluation found no negative effect of any of the reported interventions.

4.3 Efficiency

With no results framework or other definitions of planned results available, e.g.: "Number of boys/girls with x type of challenge have engaged in education", it was not possible to assess efficiency[106]. Further, there was no *consequent* mentioning in the annual reports of number and category people provided

[105] Including MOHME, MOE, MOSY, National Youth Organization, Municipality, Prisons' Organization and NGOs.
[106] OECD-DAC definition: The extent to which the intervention delivers, or is likely to deliver, results in an economic and timely way.

with a given capacity for which reason it was not possible to establish some level of efficiency by measuring outreach against expenditures – or actual outreach against planned outreach.
Below an overview over the *full* annual AWP funding and the programme ability to use funds for the period under evaluation.

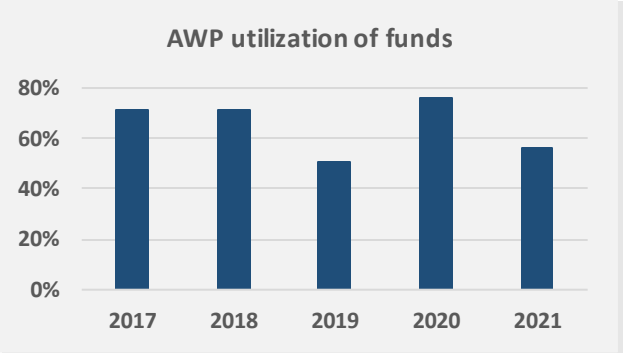
Table 4.2: Yearly budget and expenses

2017		2018		2019		2020		2021	
Available	Spent	Available	Spent	Available	Spent	Available	Spent	Available	Spent
376,800	265,717	419,000	296,880	482,292	244,334	237,957	182,228	100,000	55,729

The table shows that there was no over-expenditure as also established in section 4.2.2 and detailed in annexes[107]. The inability to use the availed funds by UNFPA can partly be explained by the cancellation of two study tours, several workshops and other relative costly activities which were cancelled due to COVID-19.

Despite this, the project had close to full delivery in development of products in terms of changes in practices and development of a range of support products (manuals, training materials, new knowledge etc.) without full use of the availed budget is remarkable. For some changes in practices the material or systems and structures were developed but were not piloted due to COVID-19.

Figure 4.5: Utilization of funds



The evaluation showed a high utilization of funds in 2020, the year of COVID-19 outbreak. However, counted in US dollars the expenditures were the lowest in 2020 compared to the previous years. The relatively high utilization can be ascribed to costs related to changes in approach with a need for procurement of materials for remote counselling[108] and other changes in approach.

The 2019 and 2020 progress reports provide details for some capacity building activities which tallies to capacity development of 665 experts. However, the reporting on numbers is incomplete. It is also noticed that the capacity development outreach went beyond experts and came to include all categories of stakeholders working with AWB. Details on gender or category of stakeholders provided with capacity development were not systematically recorded. But it can be concluded that the number of stakeholders that were involved in capacity development by far exceeded the targeted 500 persons.

[107] List of capacity development activities and participants, annex 8. List of achievements, annex 9.
[108] List of capacity development activities, annex 8.

The reporting for the period under evaluation focused solely on output level results for which reason the effect of changes in practices is not known. It is therefore not possible to provide evidence for outcome level results or results against use of funds.

In general, a period of three years would be too short for substantial development of a range of capacities including introduction of new practices/products and realisation of the full effect of these.

The Feasibility Study on AWBC Services Sustainability" (p.44) found that the average efficiency rate of the AWBCs was 68.66%. The efficiency rate was calculated and introduced by dividing the total number of adolescents educated in each center by the maximum educational capacity created in that center. Since the initiative was new and culturally sensitive, both regarding target groups and type of activities, a constant full adolescent attendance cannot be expected.

During the reported two years, the AWBCs worked intensively on developing, introducing, and improving the peer outreach system to reach those at-risk or high-risk and thus the adolescents in most need of the AWBC services. With the short duration of the programme, the 68.66% must be viewed as an acceptable efficiency, acknowledging the likelihood of stable use of centres with full development of the peer recruitment system. The study noticed that one AWBC had 100% attendance.

Conclusion

(i) The AWP managed to introduce substantial new capacity across the diversity of stakeholders, areas of capacity within a short timeframe without exceeding the availed funds.

4.4 Coherence

At the national implementer/enabler level the AWP design and activities were coherent[109] with national plans and policies[110] and other governmental STI-related services and were expected to be fully adopted by MoHME, MoSY, MoE and DCHQ and become an integrated part of MOHME services and the MOHME delivery to the national health prospect of ""Achieving the first place in the health and wellbeing of adolescents in the physical, mental, social and spiritual levels in the region until the year 2025/2"26". Initially MOHME requested to have 24 AWBCs. UNICEF agreed to develop examples and pilot these for up-scaling. The AWBCs were complementary to existing MOHME services. During the programme period the AWBCs referred high-risk adolescents to other governmental services such as Voluntary Counselling and Testing (VCT)s and harm reduction centres. Thus, the AWP was part of MoHME services from the design stage and until the phasing out when parts of the services were taken over by MOHME.

Evaluation findings indicated that despite the outreach and complexity of the programme, UNICEF stayed an effective and supportive coordinator both within the joint partnerships and to implementers in general ensuring coherence through a common and meaningful footstep without duplications at direct intervention level, national implementer/enabler level and at local enabler level. The latter was the weaker part.

[109] 'UN coherence' means that UN partners are working together to increase effectiveness (improved results), relevance (alignment with national priorities) and efficiency (reduced duplication and transactions costs) at country, regional and global levels (www.google.com/search?q=UNndefinition+of+coherence).
[110] See table 4.1.

The strong UNICEF coordination helped ensuring the high level of coherence between (i) stakeholder needs and programme design and response, and (ii) between programme intentions and interventions and the composition of joint partners possessing the required complementary expertise for optimum implementation of planned activities and (iii) that activities were shared among the joint partners (UNICEF, UNFPA and UNAIDS) in accordance with individual agency expertise.

This effect of the coherence and coordination showed in the effectiveness with which the AWP was rolled out despite its complex nature and the many categories of participants that were provided with capacity development. These included central level (relevant ministries) to decentralised level (local authorities, universities) and to communities (decision-makers, schools, parents, and at-risk adolescents). Thus, the AWP ensured coherence with the needs and interests of a range of stakeholders from national to local implementer/enabler level and across same levels introducing a multisectoral approach to empowerment of at-risk adolescents by addressing physical, mental, and social needs for empowerment to relevant service providers/enablers at all levels. The effect of coherence also showed at downstream level. Interviewees stated:

- UNICEF was always cooperative and shared knowledge. This helped in avoiding duplication and ensure complementarity.
- The JOINT work in general required frequent meetings and best use of each stakeholders' expertise.
- The gains from the JOINT initiative have resulted in discussions on how to cooperate more on adolescents.

The coherence was limited concerning ownership of the AWBCs which involved the Centre for Communicable Disease Control (CDC) without inclusion of other key actors e.g., Deputy for Health. This made the CDC have to raise the importance of AWBC services with the higher levels in government to convince them. Advise of higher levels by lower levels of government is contrary to governmental practices in Iran and globally and incoherent with ruling practices. With the in-built resistance towards being advised, the AWBC concept stood a lesser chance of being owned at the highest decision-making levels.

The AWP support to STI affected adolescents and adolescents involved in abuse (drug, alcohol, prostitution/early sex, violence) was in line with the national prospect of "Achieving the first place in the health and wellbeing of adolescents in the physical, mental, social, and spiritual levels in the region until the year 2025", but contrary to the officially acknowledged religious values. Consequently, staff in MOHME, other ministries and government institutions had little experience with STI, abuse and adolescent well-being in general. The official distancing to risky behaviour meant that governmental staff had no prior understanding of and education in working with at-risk adolescents or AWB. Despite massive capacity development at the direct intervention level, the AWBCs, with provision of tools and guidelines, the efforts at higher levels did to a large extend[111] rather concerned building of management systems and structures, e.g., high-level coordination of activities and MOHME monitoring system, and to a lesser extend a building of the understanding of AWB and national prospect of having well-functioning adolescents. The effect of this shows in the limited integration of the AWBC multisectoral concept into MOHME standard services during the phase-out.

The concept of a safe space and the mix of activities in terms of provision of knowledge and skills supporting behavioural change and social activities was very different from the services of the existing

[111] Overview over all capacity development activities, annex 8.

VCTs, the harm-reduction centres and similar services. Hence, only a minor integration took place although the AWP was fully coherent with the national prospect and complementary to existing services.

No integration took place at MOSY and DCHQ level.

Conclusion

(i) Despite the diverse and intensive involvement of stakeholders at all levels the programme managed to be and stay coherent delivering to priorities, services, and interventions of all stakeholders.
(ii) The difference between actual needs of the adolescents and nationally acknowledged needs and/or interests at the overall national level constituted an unaddressed risk that the integration of a multisectoral AWB approach will remain limited.

4.5 Likely sustainability

Without systematic results reporting against targets the sustainability could not be determined. The assessment of the *likely* sustainability was based on achievements against the RAs together with interviewees' prior development experiences with development in Iran – the latter for assessment of the likelihood of national support of AWP activities against the financial, cultural, and social context of Iran. Thus, the sustainability assessment derived from two categories of data sources only. The arrangements to ensure sustainability were multiple. The annual report, 2018, shows that:

> To mitigate this risk of jeopardizing the project, UNFPA organized many advocacy meetings with the ministry of health and the ministry of foreign affairs, and it was decided to even change some terms for the content to be more culturally appropriate.

At the national implementer/enabler level the Law on Protection of Children and Adolescents was adopted and entered into force (2020) and can support a continuation of AWP activities. At the direct intervention level, a formative evaluation of the integration process reported that 3,569 young people received services from VCTs implementing the integration model against 1,850 young people before the integration. This may partly be ascribed to the change in service opportunities as core youth VCT/HIV Testing Services (HTS)/Anti-Retroviral Therapy (ART) services were integrated into the National AIDS Programme's Voluntary Counselling and Testing Centres and Triangular Clinics in 2021. This means that essential VCT/HTS/ART services for youth are now available at Public Health Centres (PHC) level. At the local enabler level, the popular acceptance of the AWP activities became stronger and wider. The AWBCs experienced that an understanding of the need for an attitude change was gradually developing. This is a platform, maybe frail, on which to build sustainable measures. Such attitude change showed in:

- Parents coming to centres for assistance.
- Some called to ask for advice when hearing that the centres closed.
- Communities were not negative anymore – observant.
- Needs for prevention measures discussed locally.

Evidence of the attitude change could not be verified but tally well with late local level interest in being included in information about at-risk prevention and protection and participation in discussing the content and approach used in the AWBCs.

Contrary to the above, at the direct intervention level the concept was not fully adopted by MoHME. Prevention and empowerment components are not yet replicated in VCTs. Especially outreach activities and the safe space and the access to a range of activities which made at-risk adolescents attend AWBC activities. Without a continuation of this safe and multisectoral approach, AWP implementers found it uncertain whether at-risk adolescents will make use of the present and limited services at long term.

Evaluation findings indicate an inconsistency between "intended changes" and the amount of capacity building that was required to make the intended changes be introduced and become sustainable, and the time allocated for these changes. The project duration did not allow for (i) information generating a readiness to change; (ii) involvement generating an understanding, acceptance, and ownership of initiatives (iii) provision of knowledge; (iv) individual internalisation of the knowledge, and finally (v) transformation of knowledge into ability/skills into action in terms of introduction and modification of the new practices. The sufficiency of time spent for full materialisation of new practices/products determines the likelihood of sustainability of changes.

Acknowledging that most capacity development programmes/projects plan for a full programme duration of 10-15 years the estimate is that what has already been adopted by MOHME is unlikely to be adopted later unless additional and specific measures are taken to support a full adoption.

Conclusion

(i) The incoherence between national prospect and the officially acknowledged religious values with regard to in combination with insufficiently internalised skills in practising and manging a holistic approach to STI makes the integration be frail and uncertain.

4.6 Gender equality and inclusion

UN standards for evaluations require assessment of programme/project adherence to UN norms for human rights and gender equality. The SDGs set the frame for all UN agency strategies presupposing that all initiatives in a UN context involve gender equality and social inclusion measures while providing corresponding indicators. The goals listed below all deliver to the human child rights conventions of UN[112]. The following SDG goals were of relevance for the AWP:

Goal 3: Ensure healthy lives and promote well-being for all at all ages.
Goal 4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all.
Goal 5: Achieve gender equality and empower all women and girls.
Goal 10: Reduce inequality within and among countries.

This implies programming, monitoring, and reporting for each of these aspects. Without reporting on gender and inclusion the findings presented here were extracted through a cross-cutting analysis of the availed materials and rather provides examples of efforts addressing gender equality and social inclusion than evidence of systematic programmatic adherence to the international principles and goals for planning, budgeting, monitoring, and reporting.

The evaluation found that none of the available materials had specific targets for gender equality and social inclusion, nor disaggregated data. Nevertheless, the AWP aimed at "Eradicating the HIV

[112] United Nation: *Universal Declaration of Human Rights*, 2015, and United Nation: *Convention on the Rights of the Child*, 1989.

epidemic, related stigma and discrimination". This showed in the design of the centers (disaggregation of boys/girls), the contents/materials for the safe room, and all the services such as puberty health education, life and social skills education, and individual and group psychosocial counselling were designed/provided based on gender needs. ever, no records of how these needs were established, which were supported, how they were supported and why.

The programme inclusion of girls in two centres indicated a realised need for gender inclusion in the activities, which resulted in two centres accommodating girls separately from boys. The availed documents did not provide gender detailed information, for example, about experienced differences in girls'/boys' needs, potential difference in types of risks or potential differences in mode of operation and focus respectively of initiatives for at-risk girls and boys, respectively. The relevance and effect of a attempts to have empowerment of girls remains undocumented. The delayed response to girls' needs can partly be explained by the AWP start as an ALL-IN programme which was designed to prevent HIV/AIDS. In Iran, the majority of HIV/AIDS patients were men who were infected through injecting drug addiction. The change in the process of infection through sexual contact and the increase in the proportion of infected women occurred in recent years. Hence, the first target groups of the AWP were at-risk boys.

Interview findings provided examples of gender equality and social inclusion. For example, the AWBCs responded to girls' needs[113] by tailoring the curricula to address girls' needs and behaviour and by making two centres accommodate girls. The gender tailoring was well considered:

> For example, approaches to empower girls to overcome gender-based restrictions and disadvantages might include information about their rights and activities that promote their agency, autonomy, self-esteem, and ability to challenge inequitable gender norms, such as mentoring and sports. Boys, on the other hand, need approaches that enable them to recognize unearned male privileges and power while supporting them to challenge stereotypical norms about masculinities and femininities, and rewarding them when they do so. On the path of adaptation to the needs of high-risk adolescents, two separated STIs packages prepared for boys and girls. (Feasibility Study on AWB Centers Services Sustainability in Iran, 2020 (AWBC staff).

Likewise did the AWBCs gradually initiate a holistic approach addressing *both* the risky behaviour through information about prevention, protection and treatment *and* the cause-effect of this, e.g., by providing a safe space for the often socially ostracised adolescents who were reached through a peer outreach and recruitment approach. This in total is viewed as a response to the requirements for inclusion – or LNOB.

Finally, a wide range of at-risk adolescents was accepted in the AWBCs, including LGBTQ adolescents. But due to the limitations of the MOHME recording system these at-risk groups were not included in the official reports.

Conclusions

(i) The absence of deliberate address of gender equality and social inclusion specifically for at-risk adolescents and the subsequent vacuum of key data of this is contrary to UN requirements, a potential forfeiture of opportunities for the AWP and the adolescents, and a loss of valuable information.

[113] UNAIDS, Iran: *Feasibility Study on AWB Centers Services Sustainability*,2020, pp.54-55.

5. Lessons learned

The lessons learned build on, but are not fully related to, conclusions made under section 4.
A cross-cutting analysis of the findings resulted in overall lessons learned. The cross-cutting analysis also resulted in extraction of lessons learned which relate to programme performance.

5.1. Overall lessons learned

a) That evaluability of programme design and hence systematic use of RBM/HRBA to planning, implementation, monitoring and reporting is a precondition for evidence-based learning for corporate development and knowledge sharing. This would have formed the basis for the design of all capacity development activities.
b) That inclusion establishment of establishment of STI-related national fear and attitudes among non-key stakeholders and inclusion of these in designing and guiding AWB initiatives, is but one prerogative for sustainable development.
c) That a balance between "intended changes" and stakeholder ability to adopt changes is essential for sustainable change.

5.2 Programme related lessons learned

Relevance of focus and design

d) That controversy of a programme presupposes that needs and fears of the wider population is addressed
e) That effective and meaningful use of adaptive management made regular programme/project involvement of stakeholders be relevant.
f) That an early and continued inclusion of key stakeholders in programme planning and amendments made the programme stay relevant to all involved stakeholders enhancing effectiveness and efficiency of the implementation.
g) That programme formulation and design does not start with programme planning, but with programme preparations in terms of stakeholder scoping, assessments, knowledge provision etc.

Effectiveness

h) That systematic use of the adaptive management approach for inclusion of arising needs and/amendments of existing initiatives generated motivation for participation among all involved stakeholders. This motivation added to the effectiveness of the roll-out and implementation of complex initiatives.

Efficiency

i) The adaptive management approach is a cost-efficient and effective management tool when applied systematically, in conjunction with stakeholders and as a response to arising needs and lessons learned.

Coherence

j) That a high level of coherence in constellation of stakeholders and in types of deliverables implicitly supported a common footstep within and among different categories of stakeholders enables a relative fast and wide roll-out of the programme which added to the effectiveness.
k) That coherence between needs and interests of (i) various groups of stakeholders and (ii) between some upstream level stakeholders *and* beneficiaries at all levels is essential for sustainable development.

Sustainability

g) The incoherence between the national prospect national values with regarding AWP *in combination with* insufficiently internalised skills in practising and manging a holistic approach to STI makes the integration be frail and uncertain.

Gender and inclusion

i) The absence of deliberate and systematic programming for gender and inclusion hindered considerations of a wider inclusion of at-risk adolescents which resulted in missed opportunities for contribution towards equal opportunities for empowerment among at-risk adolescents.

6. Recommendations

The findings were disaggregated into (i) overall/institutional recommendations which affected an optimum AWP institutional delivery of the programme, (ii) programme related recommendations – issues upon which the programme could have reacted and shall react in case of continuation or replication and (iii) AWBC related recommendations.

6.1 Recommendations at overall/institutional level

The recommendations build on a mixture of evaluation findings with lessons learned *and* required UN corporate practices.

Table 6.1: Recommendation on overall/institutional changes.

	Recommendation	Proposed AActions
a.	Systematic adherence to UN standards for RBM programming as described in the UNSDG Results-based Management Handbook.	This starts with development a stakeholder needs and capacity assessment to know which aspects of a given problem are of most importance to address. These priorities are grouped and entered into the results framework format thematically organising needs and priorities. Details of how, why, when and who are given in the framework, while explanations on the same is given in a programme document. All planned activities are monitored, and progress is reported against the target set in the framework which will later the mid-year and annual reporting. Programmes benefit from semi-annual monitoring as it allows for timely learning and adjustments – also when reporting on annual basis only. All planning is gender and inclusion mainstreamed which involves gender and inclusion mainstreamed monitoring and reporting. All (semi-)annual achievements (positive and negative) are objects for systematic discussion and corporate learning resulting in evidence-based adjustment in the implementation. Further to establish a system for effective use of data: From data consolidation to data analysis, deciding what is important to share and with whom (agency colleagues, "joint" colleagues, wider UN sharing, ministries, governmental institutions, NGOs, donors etc.). Further who will do what: Collect data, consolidate data, ensure corporate learning from data, develop knowledge sharing products for each category of the mentioned stakeholders – and the frequency of the sharing, for reporting purposes etc.Since programme results are not achieved without having an adequate UN corporate and staff capacity, it is essential to include a specific results area for corporate and staff capacity building matching the risks and assumptions made in the results framework. With development of the corporate and staff capacity before and/or parallel to the project/programme implementation, this results area will have targets, indicators and annual progress reporting in line with the other results areas of the same project/programme. The planning, implementation, monitoring and reporting of this area will also consider gender and social inclusion and report on and learn from this. To reflect orporate performance, all result frameworks would benefit from having one objective/result that measures solely this, e.g., level of corporate/ institutional learning, knowledge sharing, –capacity - all of which helps in planning agency/programme capacity development.

6.2. Recommendations at programming level

The institutional changes will affect the programming practices and programme learning.
The recommendations here at based on a combination of evaluation findings and useful programming practices at large.

Table 6.2: Recommendations on strengthening of programming practices.

	Recommendation	Proposed Actions
b.	Commence all programming with thorough preparations as this enhances effectiveness and efficiency and increase the likelihood of sustainability.	Overall: When naming a programme and formulating objectives think of the ultimate/long-term purpose and effect. The AWP was a non-sensitive name, while all programme descriptions focused on sexual behaviour. However, change in sexual behaviour was but one tool to achieving AWB. Which may not be the ultimate purpose, but a step to a higher-level development. This goal could be to have: 'Educated and healthy youth that can contribute to the development of Iran'. Programme preparations help in focusing on most needed interventions and select stakeholders being most potent for a given programme. Such preparations could include a wide scoping of potential stakeholders. When having a range of stakeholders, it is relevant to assess (i) stakeholder knowledge and skills concerning the programme subject matter, STI; who is fearing what; which existing systems support adolescent well-being and their readiness to engage; the capacity of each category of stakeholders. This includes knowledge and skills combined with supporting systems and structures – also formal and informal systems at community level. The scope of stakeholders that is assessed could, profitably, be wider than the scope subsequently selected for programme involvement. Additional categories of stakeholders could include champions at all levels of implementation, local leaders at large, families to adolescents at-risk, a wider selection of ministries at all levels and researchers in subjects relevant for adolescent well-being, PLWD, LGBTQ and stakeholders with a counterproductive attitude towards a given programme. Assessments help knowing the required duration of a given programme and the budget required for a full implementation. Capacity development programmes generally require a duration of 10-12 years broken down into programme period of 3 years concluding in a 1-2 year phasing out. Integration into national service can happen gradually over the programme period and not abruptly over a short period of time. For example, MOSY could have adopted some activities or could have established youth centers with some similar activities. Gradual integration will show the level of national ability to integrate and thus, implicitly the need for repeated or new types of support before a full integration takes place. The planning can start when creating a stakeholder understanding of the programme – the overall goal and the capacity required. Stakeholders with limited experience in analysis, prioritisation and expression of interests should be trained in this before the involvement in planning.
c.	Institute a corporate learning culture starting with learning how the adaptive management approach affected the implementation (activities, collaborations etc.) of the full AWP.	For effective future application of adaptive management, it may be relevant to conduct a small AWP joint programme learning assessing: Thematical disaggregated achievements of the programme indicating: implications (financially, human resource, change in order of activities or target group etc. with an account for result/effect of each of the changes/ achievements whether positive or negative.
d.	Think sustainability into all programming.	See point b. When designing a programme, rather than limiting it to the pilot stage, it is essential to define which activities will lead to which changes in stakeholder capacity to take over project/programme interventions. This

		should be indicated for each category of stakeholders. The planned change should describe what people will do differently or additionally and the effect of this on their life quality. An exit strategy should be designed to have time to realise if there are stakeholder capacity gaps. If so, there is still time to step in and repeat a training, adjust a new system to match the capacity of the stakeholder or similar. For capacity development programmes the gradual integration in recommended. Sustainability also depends on the realism of a given programme/project. This concerns the timeframe for each achievement, choice of direct and indirect stakeholders, choice of partners (their ability, relevance, and interests) – and UN agency capacity. Finally, sustainability is only realistic if people acquire the necessary skills/ability (not knowledge only) to internalise, use and take changes forward. Acquisition of skills is essential. This can be supported: ○ In peer learning groups established and supported by the agency ○ In workshop establishing needs for skills with more general learning combined with virtual individual or needs-related group mentoring ○ Individual mentoring/attachment by pairing of a learner and an experienced colleague for e.g., bi-weekly meetings providing guidance of specific challenges, e.g., with use of a new system – or a full attachment for e.g., 2 weeks acquiring guided hands-on experience with engagement with at-risk youth or with effective use of a new systems or new practices.
e.	Make full and systematic use of gender mainstreaming and inclusion in all programming, implementation, monitoring, reporting, learning and knowledge sharing.	With reference to the SDGs and the UNSDG RBM handbook: Any programme/project must have GESI aspects included in the design. Both gender equality and social inclusion of vulnerable groups should be considered during the preparation phase to ensure that their needs, interests, fears, and capacity are assessed and adequately incorporated into programme interventions. With regard to application of Leaving No One Behind (LNOB) not all types of risks and disabilities can be involved in all programmes. The selection should be explained in the programme document. To be successful and manageable inclusion has to be contextually relevant and meaningful. The inclusion should be accounted for at each stage of the programme cycle from programming – implementation – monitoring – learning – reporting – evaluation. It is recommended to develop procedures for partner accounts for inclusion across the programme cycle, e.g., a specific column indicating inclusion – or explaining if inclusion is not feasible in a given activity. Such templates will also help understand changes/progress when reporting, evaluating, or sharing knowledge. Finally, the templates will provide a corporate memory and be helpful for new colleagues.

Most of the recommendations concern thorough planning and introduction of practices and tools for this. Such investments in preparations and learning keeps a programme/project on track through all the OECD/DAC criteria for implementation.

6.3 Recommendations relating to the AWBC

Some findings emerged concerning the performance and relevance of the AWBCs. Since the evidence of the AWBC performance was minimal, desk review, interview findings and annual reports were used to make recommendations for the AWBCs.

Table 6.3: Recommendations for the AWBC

	Recommendation	Proposed Actions
f.	Focus on the individual physical, mental and social *capital* when building capacity rather than on constraints.	This concerns all levels of stakeholders. Further, at adolescence level a focus on the *future* instead of on the past makes adolescents feel relieved from the burden of an unacceptable behaviour when this is no longer the focus of discussions. When developing the strengths of an individual the weaknesses fade away. With a focus on individual capital against individual needs and priorities it is possible to develop a non-judgemental care plan. The AWBCs could play an active role in working with the education institutions on developing opportunities building on individual capital in schools while also enabling a smoother transition from being at-risk and socialising in a safe space (AWBC) to being able to manoeuvre in the open society where capital is appreciated.
g.	Continue supporting the AWBC concept.	As feasible, it is strongly recommended to continue the AWBC–concept - building on lessons learned (point c). This can be establishment of new centres, revival of old centres, support to integration of centre activities into national services, locally based part-initiatives – or a combination. Acknowledging that the ideal is not always available, and that risks exist. It is better to have something than nothing.
h.	Make use of community engagement in a successful transition from at-risk adolescent exclusion from society to inclusion into society.	Decide, with the local direct and indirect stakeholders (e.g., local leaders, security representatives, professional retirees), which behaviour to change to help the adolescents gain societal respect. Provide the required capacity building of local systems and structures, of knowledge and skills to facilitate the process. The communities could contribute *for example* by (i) establishing a community help desk manned by voluntary retired professionals e.g., doctors, nurses, social workers, and teachers which can be used by all youth facing temptations or having engaged for the first time in a risky behaviour etc.; (ii) letting the community employ graduated adolescents; (iii) establishing a community development committee engaging in developing a future for their youth, and/or (iv) by letting the community avail land for sports (e.g., football, basket, table tennis) which require few means. The latter would facilitate and integration of the at-risk adolescents with other adolescents since adolescents from both categories would like to participate in sports. Further, sports presuppose self-discipline in abiding by the rules of the game and to stay in the team of players. This, too, supports the re-integration. Apart from helping the adolescents to return as respected members of society such approach also enhances the local capacity to take responsibility for child and youth well-being.

6.4 The recommendations' alignment with UNSDCF 2023-2027

The above recommendations are made to support the UNSDCF 2023-2027 for Iran in the following areas[114]:

[114] United Nations' 'Sustainable Development Cooperation Framework' for the Islamic Republic of Iran, 2023-2027, pp.7-8.

- The **socio-economic resilience pillar** of the UNSDCF which is based on policies to support a full-employment economy and to help the country realize the "demographic dividend" by focusing on education and skills development….
- The **public health management pillar** which will work towards improved public health management systems promoting health for all through a health system that is resilient and that addresses a wide range of vulnerabilities in diverse settings and emergency….

…..This would include supporting service delivery and health information systems, capacity development of the health workforce, and enhancing the availability and affordability of medicines and health-care services.

- The **drug control**, where the Cooperation Framework would support improved access to evidence-based drug prevention, treatment, harm reduction, and drug-related ses.

… Drug use disorders are strongly associated with various vulnerabilities and adverse effects on individuals and their families. Addressing the multisectoral dimensions of this situation and supporting efforts of the Iranian Government to control the trafficking in drugs and to support drug users who undertake treatment and access harm reduction centres are among the development priorities for cooperation.

All interventions should be supported through a wider capacity development, among others by supporting establishment of strong results- based and evidence-based systems and structures.

The work of the AWP and the derived recommendations emphasising on building results- and evidence-based systems and structures, providing skills across all levels of actors and the graduation of youth into opportunities for full employment, all tally with the UNSDCF priorities and thus the priorities of the government of Iran.

Annex 1

Terms of reference

International Consultancy for Evaluation of UNICEF Iran's Adolescents Wellbeing Programme.

Contract type: Consultant
Duty Station: Teheran
Level: Consultancy
Location: Iran
Categories: Research, Planning, Monitoring and Evaluation

UNICEF works in some of the world's toughest places, to reach the world's most disadvantaged children. To save their lives. To defend their rights. To 57fulfill their potential.

Across 190 countries and territories, we work for every child, everywhere, every day, to build a better world for everyone.

And we never give up.

For every child, *Health*

International Consultancy for Evaluation of UNICEF Iran's Adolescents Wellbeing Programme

Background

Situation Analysis

Iran has the second largest population in MENA region after Egypt, with nearly 85 million people with an estimated total number of 14,380,000 adolescents aged 10-19.

Adolescents are particularly exposed to high-risk behaviours, and many of such behaviours can affect their future life include health and well-being. They can have detrimental effects on adolescents' development and health or can impede their future success and development.

In Iran, the prevalence of high-risk behaviours among adolescents has reportedly increased from 12.8% to 20%. For instance, the available data indicates that nearly one-third of those living with HIV are in the age range of 16-30. This implies that the transmission had been occurring at lower ages including the adolescence period. On a broader scale and based on reports by Iran Ministry of Health and Medical Education (MoHME), by early 2022, of total registered HIV cases, 32% are female and 68% are male with 15.5% transmitted through injecting drug users, 54.2% sexual contact, 2.1% mother to child and 28.2% unknown.

Of particular concern is the lack of knowledge/ ignorance about prevention and a rise in social harm, especially among adolescents. In addition, substance use and its reinforcing effects on high-risk behaviour, can not only result in unwanted pregnancies, abortion, and consequent infertility as well as sexually transmitted infections (STIs), according to the studies, anxiety, depression, dishonour, depriving adolescents of social activities are also among the consequences.

A considerable proportion of the affected population will not be identified until they seriously harm their own health and community as globally this age group has the lowest rate of HIV testing compared with other age groups which put them at a higher risk of HIV infection.

The coincidence of these behaviours can increase health problems among adolescents which calls for immediate and comprehensive preventive action.

Description of the intervention being evaluated

Iran is the only country in the MENA region that has been included in the global initiatives to enable the provision of targeted services for adolescents to help address risky behaviours. Based on recommendations, for the prevention of HIV/AIDS among adolescents in an inclusive programme, UNICEF jointly with UNAIDS and UNFPA has supported the MoHME since 2015 to develop and pilot an innovative Iranian model that combines awareness-raising, counselling, HIV testing, HIV prevention education, life skills training, drug use prevention, puberty health education, alternatives to risky behaviours, and health services in a safe and enabling environment for adolescents, especially for those most at risk, to enhance their knowledge and attitudes on HIV/AIDs preventative58 initiative also provided a safe and enabling environment for adolescents aged 10-19 to have access to individualized care plans based on their age group and level of risk. In addition, alternative activities provided room for adolescent empowerment through healthy social engagement and meaningful participation in prosocial activities.

Outreach activities are in place to ensure the inclusion of broader ranges of adolescents in need, and a comprehensive and multi-level assessment process permits for stratification of risk levels and informs the process of developing individualized care plans for adolescents. Although a range of services was provided under relevant initiatives for adolescents in general, the main target group of these centers is the most vulnerable adolescents aged 10-19 in terms of risky behaviours and social harm.

With a budget of about $ 700,000, UNICEF was able to set up and run a tailored adolescent wellbeing programme through specified centres in 6 provinces of Tehran, Alborz, Lorestan, Fars, Kermanshah, Khuzestan, to provide the aforementioned services for more than 10,000 adolescent boys and girls. While the modality of provision of the above support is under review by relevant national counterparts, UNICEF has remained prepared to scale up the programme towards better adaptation to the contextual needs and is exploring alternative options for service delivery.

Purpose

As foreseen in UNICEF's current country programme (2017-2022) evaluation plan, certain initiatives under the adolescent wellbeing programme are to be evaluated for necessary programme revisions and validation of the interventions for national scale-up.

The objective of the evaluation is to determine, as systematically and objectively as possible, the relevance, efficiency, sustainability, and expansion as well as coherence of UNICEF's support of the above programme.

This evaluation has a dual purpose of accountability and learning. It will support (i) generation of knowledge on the successes and challenges of the Adolescents Well-Being Programme to inform future programming, and (ii) accountability for UNICEF and partners, as well as beneficiaries of the programme. The evaluation would consider the inclusiveness of services offered to the beneficiaries with the equity lens

Scope

The scope of the evaluation is limited to UNICEF's support to the adolescent wellbeing programme/model piloted in 6 provinces through 7 centers since 2015. The evaluation intends to review the services offered via these centers, while they were operational, mainly for their relevance and sustainability in addition to the coherence of the programming and efficiency of the implementation. Some components of this model including outreach working, HIV prevention, mental health assessment and psychosocial care and support, empowerment including adolescent participation and engagement, and life skills training, as well as providing safe and enabling space are used in some new adolescent and youth programmes of MoHME and the Ministry of Sports & Youth.

Reference can be made to the "feasibility study on AWBCs (Adolescences Well-Being Clubs) sustainability in Iran" conducted by UNAIDS and "sustainable financing options for AWBCs" conducted by UNFPA, and the result of these two assessments will complement and feed into UNICEF evaluation to:

- Assess the programme and document the lessons learned for required management responses
- Support evidence generation to enhance the design and implementation of programmes with similar components through other platforms

Evaluation Criteria

The evaluation will attempt to answer the proposed following set of questions, organized around the OECD DAC evaluation criteria. Due to reasons elaborated as limitations under the methodology section, Effectiveness will not be considered as one of the key evaluation criteria but is intended to be investigated as much as possible with defined criteria and scales. It is also not expected that the Impact of the programme can be measured in a valid and reliable way given the information available and the major contribution of the external factors. Nonetheless, the unanticipated impact will be looked into and documented for future programming adjustment if required.

4. A set of sub-questions will be developed and framed in the evaluation matrices by the evaluator as a part of the deliverables of the inception report; however, the criteria will remain t Relevance: The extent to which the objectives of a development intervention are consistent with target populations' requirements, country needs, global priorities and partners' and donors' policies.

1- To what extent were the intervention's design and its intended results relevant to UNICEF's country programme health component and overall needs of the national health care objective including service providers and the beneficiaries?

2- How effectively the programme's theory of change facilitated the path toward the needs

II. Efficiency: The measure of how economically resources/inputs (funds, expertise, time, etc.) are converted to results.

3- Do the achieved results justify the resources invested?

4- Was work planning and reporting done sufficiently and appropriately?

5- How effective was the implementation process?

III. Sustainability: The probability of continued long-term benefits. The resilience to risk of the net benefit flows over time.

6- To what extent has the programme been incorporated into the national programmes and protocols?

7- To what extent the pilot initiatives are mature for replicability or scalability at the national level without UNICEF's support?

8- How has UNICEF's support been adapted to the contextual requirements

IV. Coherence: The compatibility of the intervention with other interventions in a country, sector, or institution

9- Did the intervention contribute to and/or complement the synergies and interlinkages with other interventions carried out by UNICEF and the government?

V. Child rights, gender, and disability

10- Did the programme design and/or implementation factor in the child rights, gender and disability-related considerations and inclusions criteria?

Methodology

The evaluation will use a mixed-method approach to collect the data questions. Both qualitative and quantitative data will be collected and will be triangulated to ensure the soundness of analysis.

Data and information collection methods will include but are not limited to:

(1) structured document review and content analysis of key documents (such as programme documents, progress reports, and etc.);

(2) primary and secondary analyses of data;

(3) semi-structured interviews and with informed individuals including, trained personnel, service providers, UNICEF, UNAIDS, and UNFPA Iran relevant staff, relevant officials/network from the ministry of health and medical education.

(4) focus group discussions with beneficiaries where possible and required, etc.

The analysis and the presentation of data and information will, to the extent possible, be gender-disaggregated and take into consideration the needs of vulnerable groups. Data collection is expected to take place at the individual, service provider, as well as ministerial and UNICEF levels. The inception report must include an explanation of how the data collection instruments relate to the evaluation questions, and how the data is going to be triangulated. Evaluation findings must be relevant, useful, and be presented concisely.

Limitations

A retrospective approach should be undertaken where the availability of some stakeholders, staff, and the target population, as well as data, becomes challenging. Hence, it is expected that a fair balance of qualitative and quantitative methods is deployed to allow conclusive analysis and interpretation.

List of stakeholders

In addition to UNICEF, the key stakeholders who may contribute to different phases of this evaluation are MoHME, UNAIDS, UNFPA, Management and technical staff of relevant universities, health deputies, district health centers and service delivery and centers as well as the beneficiaries of the programme. The internal nature of the evaluation may however imply various levels of involvement of each group/sub-group.

Key Arrangements

- Evaluation Terms of Reference and inception report are reviewed by and commented on by the Steering Committee.
- The Evaluator will report to UNICEF Planning, Monitoring, and Evaluation Officer (the Evaluation Manager).
- In direct coordination with the Evaluation Manager, relevant sections within UNICEF/Iran will facilitate access to all documents and information required, coordinate visits, organize meetings/interviews, provide backstopping, and liaise regularly on the progress of the evaluation with internal UNICEF management.

- The evaluation deliverables will be quality-assured by the Evaluation Manager and UNICEF regional evaluation advisor.
- The Evaluator shall use their own facilities and space to manage the work.
- The Evaluator is expected to undertake the evaluation in consultation with UNICEF, in full accordance with the terms of references outlined herewith and in full compliance with the UNEG's norms and standards for evaluation

Timeframe, key tasks, and deliverables, and payment schedule

The following timeframe describes the evaluation deliverable, key steps in the process, and the formal meetings from contract award to post-evaluation briefing:

Kick off (Week 1)

- Discuss timeline of activities, evaluation process, policies, guidelines, and tools at UNICEF
- Discuss expectations and timeline
- List respondents for inception interviews
- Document sharing

Deliverables and Payments: 0%

Inception (Week 2-4)

- Conduct inception interviews and desk review of the documents shared
- Draft Inception report and submission to UNICEF
- Quality review, ethical review, and endorsement of the Inception report

Deliverables and Payments: 20% (Upon endorsed inception report)

Fieldwork, Data Analysis and Preliminary Findings Presentation (Week 5-8)

- Primary data collection and review of secondary data
- Data analysis
- Draft preliminary findings presentation
- Quality Assurance of the Draft preliminary findings' presentation
- Present the preliminary findings to stakeholders

Deliverables and Payments: 30% (Upon presentation of preliminary findings)

Drafting report (Week 8-10)

- Draft the evaluation report and submission to UNICEF
- Quality assurance endorsement

Deliverables and Payments: 30% (Upon submission of draft final report endorsed for quality assurance)

Final report and other products (Week 11-13)

- Formal commenting process

- Respond to comments from stakeholders and adjust the report accordingly
- Quality assurance and endorsement of the final reports

Deliverables and Payments: 20% (Upon submission of the endorsed final report)

Notes:

- All deliverables must be in English.
- It is expected that the evaluation findings be presented to UNICEF in a PowerPoint presentation.
- The final report must include an executive summary
- The format and sections of the inception and final report must be based on applicable UN guidelines.

To qualify as an advocate for every child you will have… (International Applicants Only)

- Advanced university degree (PhD preferred) in public health, social science, or related fields. Familiarity with reproductive health, HIV/AIDS work, and literature as well as maternal and child health is desirable
- Completed training on evaluation, research, and analysis.
- Should have led at least five independent national/international evaluations.
- Previous experience evaluating UN Agencies programmes/projects is an advantage.
- Experience in health and/or social research and in applying qualitative and quantitative research methods.
- Working experience in the Middle East is an advantage.
- Prominent level analytical and report writing skills and experience writing clear and concise reports for a range of audiences.
- Excellent oral and written communication skills in English.
- Should not have any conflict of interest through paid involvement or any other aspect with the intervention under evaluation.
- Flexible to work with a local team member for the evaluation.
- Flexibility to adapt the Evaluation methodology based on the contextual needs and limitations

Application Submission

Interested applicants are requested to submit **i)** CV including 3 professional references **ii) a** Cover letter and **iii)** a financial proposal with a detailed cost breakdown based on the deliverables section of the terms of reference.

- Applicants should submit samples/hyperlinks of the national/international independent evaluation lead.
- International and domestic travel costs (ticket, accommodation, and transportation) will be reimbursed by UNICEF based on actual travel where required.
- Only shortlisted applicants will be contacted for the interview.

- Application deadline: 10 Sep 2022

Ethical Note

All the products, including data and analyses, developed in the course of this consultancy are the intellectual property of UNICEF and MOHME. The consultant may not share these products without the expressed permission and acknowledgment of UNICEF Iran and MOHME. All the products developed during this consultancy must comply with the UNEG (United Nations Evaluation Group) norms and standards and UNICEF-Adapted UNEG Evaluation Report Standards.

For every Child, you demonstrate'

UNICEF's values of Care, Respect, Integrity, Trust, and Accountability (CRITA).

To view our competency framework, please visit here.

UNICEF is committed to diversity and inclusion within its workforce, and encourages all candidates, irrespective of gender, nationality, religious and ethnic backgrounds, including persons living with disabilities, to apply to become a part of the organization.

UNICEF offers reasonable accommodation for consultants/individual contractors with disabilities. This may include, for example, accessible software, travel assistance for missions or personal attendants. We encourage you to disclose your disability during your application in case you need reasonable accommodation during the selection process and afterwards in your assignment.

UNICEF has a zero-tolerance policy on conduct that is incompatible with the aims and objectives of the United Nations and UNICEF, including sexual exploitation and abuse, sexual harassment, abuse of authority and discrimination. UNICEF also adheres to strict child safeguarding principles. All selected candidates will be expected to adhere to these standards and principles and will therefore undergo rigorous reference and background checks. Background checks will include the verification of academic credential(s) and employment history. Selected candidates may be required to provide additional information to conduct a background check.

Remarks:

Only shortlisted candidates will be contacted and advance to the next stage of the selection process.

Individuals engaged under a consultancy or individual contract will not be considered "staff members" under the Staff Regulations and Rules of the United Nations and UNICEF's policies and procedures and will not be entitled to benefits provided therein (such as leave entitlements and medical insurance coverage). Their conditions of service will be governed by their contract and the General Conditions of Contracts for the Services of Consultants and Individual Contractors. Consultants and individual contractors are responsible for determining their tax liabilities and for the payment of any taxes and/or duties, in accordance with local or other applicable laws.

The selected candidate is solely responsible to ensure that the visa (applicable) and health insurance required to perform the duties of the contract are valid for the entire period of the contract. Selected candidates are subject to confirmation of fully vaccinated status against SARS-CoV-2 (Covid-19) with a World Health Organization (WHO)-endorsed vaccine, which must be met prior to taking up the assignment. It does not apply to consultants who will work remotely and are not expected to work on or visit UNICEF premises, programme delivery locations, or directly interact with communities UNICEF works with, nor to travel to perform functions for UNICEF for the duration of their consultancy contracts.

Advertised: 24 Aug 2022 Iran Daylight Time
Deadline: 10 Sep 2022 Iran Daylight Time

Annex 2

List of literature

Literature shared by UNICEF, Iran

Title and year	Publisher	Year
Revised evaluation policy of UNICEF	UNICEF	2018
UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis	UNICEF	2015
Ethical research Involving Children	UNICEF Office of Research et al	2013
UNICEF-Adapted UNEG Evaluation Reports Standards	UNICEF	2017
Evaluation Inception Report Checklist	UNICEF	2017
Research Ethics Review Feedback Template	UNICEF	-
Guidance Document for Informed Consent	UNICEF	2015
Informed Consent Form Example	UNICEF	-
Guidance Document for the Protection of Human Subjects' Identities	UNICEF	2015
Guidance Document of the Protection of Human Subjects' Safety	UNICEF	2015
Guidance Document for Protection of Research Data	UNICEF	2015
GEROS Handbook	UNICEF	2017
Final 2020 GEROS EQA Review checklist	UNICEF	2020
UNICEF Criteria for Ethical Review Checklist	UNICEF	
UNICEF Procedure on Ethical Standards in Research, Evaluation, Data Collection and Analysis	UNICEF	2021
HML Ethics Review Board - How to Request a Research Ethics Review	UNICEF	2021
Lessons learned (per centre)	UNICEF Iran	2018
AWBC Protocol	CDC Iran	2018
AWBC Protocol v.2	CDC Iran	2019
Formative Assessment on ALL IN Centers	UNICEF Iran	2017
MOH annual work plan 2017-2018	UNICEF Iran	2017
MOH annual work plan 2020-2021	UNICEF Iran	2020
UNICEF Transition Plan for Phasing-out the Adolescent Well-Being Clubs	UNICEF Iran	
Well-being clubs pre-proposal	UNICEF &CDC Iran	2016
AWB Adolescent Care Plan	UNICEF &CDC Iran	2017
AWBC NAC	UNICEF Iran	2018
Quarterly Assessment Form	CDC Iran	2017
Partnership proposal with the Embassy of the Kingdom of Netherlands in Iran	UNICEF Iran	2018
Project Financial and Substantive Progress Report on: Empowering Adolescents & Youth in I.R. of Iran. To Address Their Reproductive Health Needs 2019 Funded by the Kingdom of the Netherlands	UNICEF Iran	2020
Project Financial and Substantive Progress Report on: Empowering Adolescents & Youth in I.R. of Iran. To Address Their Reproductive Health Needs 2020 Funded by the Kingdom of the Netherlands	UNICEF Iran	2021
Adolescent Development and Participation (ADAP) Programme (UNICEF Transition Plan for Phasing-out the Adolescent Well-Being Clubs) In-house Document	UNICEF Iran	2017
UNSDCF 2023-2027	UN Iran	2023
Situation analysis and needs assessment of transmitted infections among adolescents of Adolescent Well-being Clubs in Iran and response to it	Center of Communicable Diseases Prevention	2020

Other literature

Title	Publisher	Year
Feasibility study on AWB centers services sustainability in Iran, 2020	UNAIDS	2020
How's Life? Measuring well-being	OECD	2011
Universal Periodic Review of the Situation of Human Rights in Iran	UNICEF Iran	2019
Country Office Annual report	UNICEF Iran	2019
Country Office Annual report	UNICEF Iran	2021

Country Office Annual report	UNICEF Iran	2020
Midterm review of the UNICEF Strategic Plan, 2018–2021: Lessons learned	UNICEF	2020
Report on the midterm review of the UNICEF Strategic Plan, 2018–2021 and annual report for 2019 of the Executive Director of UNICEF	UNICEF	2020
Evaluation of the UNICEF Strategic Plan, 2018–2021, Summary	UNICEF	2020
Country Programme Document	UNICEF Iran	2016
Extensions of Ongoing Programme 21/22	UNICEF Iran	2021
United Nations Development Assistance Framework (UNDAF) 2017-2021	UN Iran	2015
UNDAF 2017-2022 Internal Assessment	UN Iran	2021
UNICEF Strategic Plan 2017-2021	UN Economic and Social Council	2017
Integrated Results and Resources Framework of the UNICEF Strategic Plan, 2022–25	UN Economic and Social Council	2021
Iran sixth National Economic, Social and Cultural Development plan	Iran Parliament	2017
Report of visits to the Adolescent Well-Being Centres by Andrea Irvin	UNAIDS	2019
UNEG 2020 Ethical Guidelines for Evaluations	UNEG	2020

Annex 3

AWP adherence to national and international priorities

AWP delivery to national and international priorities

AWP delivered to the Iran's Sixth National Development Plan, 2016-2021 (NDP6) on the following articles:

Article 74I: The Ministry of Health and Medical Education is required to implement "Comprehensive and All-inclusive Health Services System", prioritizing health and prevention rather than treatment, based on primary health care and focused on the family doctor and referral system…
Article 78: In order to promote social justice and protect the vulnerable groups and extending relief, protection, and insurance coverage, and prevent and reduce social harms, the Government is required to plan and implement necessary programs…..
Article 80: The Government is required; in line with the relevant laws and approvals of the National Social Council and in order to prevent and reduce social harms; to design a Comprehensive Social Harm Control and Reduction Plan, concentrating on addiction, divorce, marginalization, child labour and moral degradation……
Article 102(F): Continuous and responsible education c69ounselling for teenagers and young adolescents focusing on family values before, during and at least five years after marriage, to be provided by all relevant organizations…….

The UN Development Assistance Framework (UNDAF) 2017-2021 delivered to these NDP articles on two outcome areas:

3.1: Inclusive growth, poverty eradication and social welfare
UNICEF will (in partnership with Ministry of Cooperatives, Labour, and Social Welfare (MCLSW), Management and Planning Organization of Iran (MPO), State Welfare Organization (SWO), Iranian Children's Rights Society (IRCS), MoHME, Bureau for Aliens and Foreign Immigrants Affairs (BAFIA), Judiciary, Ministry of Interior (MoI) and ministry of Education (MoE) assist to:

- (Conduct) regular monitoring of multidimensional child poverty, age-specific vulnerabilities, and welfare outcomes across the population.
- Support national capacities for effective evaluation of social programmes and policies.
- Promote social protection and sectoral policies that address multiple deprivations across the life cycle.
- Promote coordination across sectors and levels to ensure quality and equitable coverage of social services for children and adolescents.
- Support government's initiatives to ensure efficiency and effectiveness of social development programmes and policies.
- Support government's efforts to enhance the efficiency, equity, and adequacy of public investment in children and adolescents.
- Develop programmes which promote application of alternative measures for children in contact with the law, promote sustainable rehabilitation and reintegration of children in contact with the law into the society and promote inter-sectoral cooperation for effective response to the needs of children in contact with the law.
- Support Government of Iran (GOI) in developing and implementing policies and strategies to ensure equitable quality education for all children, with a particular focus on vulnerable and disadvantaged children.

- Assist in developing plans and strategies for a multisectoral life-skills and localized vocational training.

4.5 Drug abuse prevention and treatment

UNICEF, in partnership with MoE, BAFIA, MCLSW, MoH and IRCS, assisted to:

- Support partners in the design and implementation of effective programs for prevention of risky behaviours and substance abuse among adolescents and youth.
- Support developing evidence-based, effective, and comprehensive school-based prevention programmes with a particular focus on vulnerable and at-risk populations and localities.

This support is in line with global priorities, the Sustainable Development Goals (SDGs) as the support aimed at falling within the following Global Goals[115]:

SDG 3: Ensure healthy lives and promote well-being for all at all ages.
SDG 4: Quality education
SDG 5: Achieve gender equality and empower all women and girls.
SDG 10: Reduced inequality

[115] See reference in programme document to Kingdom of the Netherlands, p.4.

Annex 4

Focus and work of the AWBCs

Focus and work of the AWBCs

In the planning stage of the All-IN project in Iran in 2015, it was anticipated that various organizations, especially the Ministry of Education and the Ministry of Sports and Youth, would actively participate in this project. But in practice, all interventions were carried out by the MOH with the participation of UN agencies, especially UNICEF, UNAIDS and UNFPA. Of course, all the predicted interventions were more or less provided in seven AWBCs for adolescents, including: outreach working, HIV prevention, mental health assessment and psychosocial care and support, empowerment including adolescent participation and engagement, and life skills training for both girls and boys.

The goals of the AWBC were to be achieved through the following:

Specific objectives[116] of the program in the adolescent's wellbeing club:

1. Reduction of new cases of HIV infection; (at least 75% among Adolescents)
2. Reduction of death due to HIV among Adolescents by at least 65%
9. Increasing the percentage of HIV-positive Adolescents who are aware of their serological status.
4. Reducing the share of adolescents at risk of sexual relations
5. Reducing the share of drug-using Adolescents who report sexual relations and high-risk drug use;
6. An increase in the percentage of Adolescents diagnosed with HIV infection in the early stages of the disease (before stage 9: AIDS).

Program strategies in adolescents' wellbeing club:

1. Increasing access to at-risk adolescents deprived of counseling and health services through strengthening and implementing the needs assessment program.
2. Increasing involvement and constructive and positive connection between at risk adolescents with the adolescent's wellbeing club with the aim of education, information, and behavior change.
3. Providing a safe, supportive, and empowering environment for different groups of at-risk adolescents at risk with their own help.
4. Encouraging and persuading adolescents to participate and get involved with effective and quality counseling programs, diagnosis and prevention of HIV, sexually transmitted diseases, and addiction.
5. Providing different opportunities for at risk adolescents in order to build social and emotional competencies.
6. Providing quality training of special skills for at risk adolescents for peer assistance.
7. Strengthening and increasing communication and partnership with parallel and related organizations for the purpose of referral and cooperation.

Overview over level and types of risks addressed by the AWBCs:

[116] AWBC protocols. The use of "objectives" equals "outcomes" in the UNSDG Results-based Management handbook (2011) (unsdg.un.org/resources/unsdg-results-based-management-handbook).

Level and types of risks		
Level	**Indicator for AWBC attendance**	**Risk Factor**
1	**All of the adolescents (1019 years)**	1. Life traumatic events 2. Death of loved ones, friends, and family 3. Difficulty in communication with friends and peers
This group of adolescents is not the AWBs center's main audience and will only receive services from the center for some interventions, such as HIV prevention training and voluntary HIV testing.		
2	**Experience double problems** (Need to receive AWBs services)	1. Experience of any unprotected and risky sexual behaviour. History and experience of exposure to or engagement in sexual abuse 2. Experience with substance use Behavioural characteristics: ○ Absence and running away from school ○ Clashes with the police ○ Mental health problems ○ Conflict with the family ○ Unstable peer groups ○ Isolation and avoidance of community, school, family, and neighbourhood
In order to receive the main services of the AWBs, adolescents should have at least one of the first two cases, i.e., unprotected, and risky sexual behaviour or the second case, i.e., the experience of using drugs and alcohol, in which case it is necessary to define a care plan for them.		
3	**Severe vulnerability** (Requires comprehensive and coordinated interventions in the AWBCs)	1. Experience with unprotected sex 2. Experience with consuming drugs and alcohol 3. Experience with exposure to or engagement in sexual abuse Behavioural characteristics: ○ Leaving home / homeless ○ Disconnect from family ○ Unemployment and dropout ○ Mild psychiatric problems ○ Frequent escape from school ○ Experience being abused ○ Pregnant adolescent.
4	**"High-risk group"**	○ Severe substance use disorder that requires therapeutic interventions for the treatment of addiction. ○ Simultaneous chronic disorders such as substance use disorder and psychiatric disorders. ○ Proven criminal record and court order. ○ Multiple high-risk behaviours, including prostitution, sex in exchange for drugs, membership of drug-related groups, criminality and more.
These groups of adolescents (level 3 and 4) were not the AWBCs main audience and would only receive services from the centre for some interventions, such as HIV prevention training and voluntary HIV testing. These groups were referred to treatment in VCTs and/or risk-reduction centres.		

Because of the complexity of risks and of the overall negative community attitude towards this groups of adolescents the centres were designed to provide a safe space for high-risk adolescent groups (ages 10-19 years), in which they could come together in an environment free of stigma and discrimination and meet with peers while engaging in life-changing activities.

In the guidelines compiled by the CDC Department of the MOH for AWBCs, the standard of service for adolescents without gender discrimination is defined as follows:

- Finding adolescents who need the services of the AWBCs
- Admission, assessment, and care plan

- Orientation and initial notification of interventions
    - Providing a safe and empowering environment (safe room suitable for age and gender)
    - Training different skills (life skills and special skills
    - Individual and group counselling, and crisis intervention
    - Education and information
    - HIV prevention program:
        - Knowledge of HIV and its transmission
        - Abstinence; Delay in first sex
        - Reducing the number of sexual partners
        - Reducing the number of unprotected sex
        - Rapid HIV screening test
        - Increasing the use of condoms
            - Attitude towards condoms/intention and intent to use
            - Barriers to condom use
            - Self-efficacy in condom use
            - Condom use skills
        - Skill training, healthy behaviours
            - Self- Efficacy
            - Negotiation
            - Boldness
            - effective communication
            - Impulse control
    - Drug use prevention program
        - Public prevention of drug use
        - Selective prevention of drug use
    - Violence prevention program
    - Alternative programs
    - Referral
- Assessment
    - Reassess based on the goals of the care plan
    - Reviewing the care plan and adjusting the new version of the care plan if needed

Outreach activities (Finding adolescents who need the services of the AWBCs):

- Employing an experienced and expert mobile outreach team
- Identifying places and situations of access to teenagers at risk
- Identification of adolescents at risk
- Getting closer to at-risk teenagers
- Communicating with at-risk teenagers
- Training and delivery of educational products
- Teaching simple skills
- Counselling and brief intervention
- HIV risk level screening and drug use
- Persuading and motivating at-risk teenagers to go to the AWBC
- Inviting at-risk teenagers to the AWBC
- Support and facilitate the visit of at-risk teenagers to the AWBC

- Referral of needy teenagers to other services and centers
- Referral follow-up and requirement assessment

The CDC department of MOH had developed various educational materials for AWBC interventions (see annex 5), which were first presented to the staff and through the staff to the adolescents of AWBCs through the holding of educational workshops. The list of educational workshops is mentioned in the background section.

Annex 5

Evaluation Matrix

Considerations

The desk review of prior reports[117] gave occasion for two additional key questions Evaluation Questions (EQ).

The TOR suggested that evaluation of effectiveness and impact should be omitted. However, since the desk studies provided evidence of effectiveness, it is regarded as relevant to document e.g., the country office response to recommendations and new global practices and the effect of this. This made the evaluation team add a new EQ, which became EQ 2 to follow the OECD order of evaluation criteria.

The unavailability of project- and programme documents and progress reports for the same resulted in EQ 6 addressing solely the MEL practices with reference to the UN Development System (UNDS) reform (2018) principles[118] emphasising on systematic RBM/HRBA monitoring, reporting against the UNDAF/SDG indicators and effective use of these data for coherence and internal and external learning purposes.

Being cross-cutting, EQ 5 in TOR (child rights, gender, and disability) was changed from being a separate EQ to being a cross-cutting question that will be analysed for each of the selected OECD criteria and SDG criteria and indicators[119]. In the analysis this subject was made a separate subject again as the lack of systematic programming for and reporting on gender equality and social inclusion (GESI) findings across the evaluation findings provided some pieces to the GESI puzzle.

EQ 3 and 4 in TOR were interchanged since the level of coherence may affect the level of sustainability for which reason this part should be analysed before concluding on the level and areas of sustainability. Thus, the interchanging of the EQs provides a logic in the sequence of questions.

[117] E.g.: Formative Assessment of ALL IN Centers (2017); Feasibility study on AWB centers services sustainability in Iran (2020); Country Office Annual report (2019, 2020, 2021); Report on the midterm review of the (global) UNICEF Strategic Plan, 2018–2021 (2020); Evaluation of the UNICEF Strategic Plan, 2018–2021, Summary (2021); UNICEF Iran, Country Programme Document 2016-2020; UNICEF Iran: Extensions of Ongoing Programme 21/22 (2021). UNDAF 2017-2021 and UNDAF 2017-2022 Internal Assessment (2021).

[118] Details at: https://reform.un.org/content/un-development-system-reform-101

[119] Specifically, SDG indicators: 3.3, 3.5, 3.7, 4.1, 4.4, 4.7, 5.1, 5.2, 5.3 and 5.6.

Evaluation matrix[120]

	QUESTIONS	DATA SOURCE	CATEGORY OF PARTICIPANTS	DATA COLLECTION TOOLS/ SOURCES	Relevance	Effectiven.	Efficiency	Coherence	Sustainab.
EQ 1	**To what extent are the objectives of the AWP consistent with the UNDAF, target populations' requirements, country needs, global priorities, and partners' and donors' policies?**	UNICEF, UNFPA, UNAIDS, Government, universities and district level, centre staff	Implementers, programme staff	Prg. Reports National plans and strategies KII	**X**[121]	x		x	x
Indicator	**The extent to which programme outcomes inclusively addressed national and international priorities for the group of adolescents**								
EQ 2	**To what extent were systems in place supporting achievements of the AWP objectives?**	UNICEF, UNFPA, UNAIDS, Government, universities and district level, centre staff	Implementers, programme staff	KII	x	**X**	x		x
Indicator	**The extent to which the programme makes effective use of available capacity to address urgent and actual needs and priorities of the beneficiaries and/or engage in capacity development as means to enable adaptive planning and implementation**								
EQ 3	**To what extent were economically resources/inputs (funds, expertise, time, etc.) converted to HRBA results?**	UNICEF, desk review of annual plans, monitoring reports, university, district, centres each will report their own achievements.	Programme staff, implementing staff, adolescence	Plans and reports KII, FGD		x	**X**		
Indicator	**Percent programme progress towards achievements of results to date within the planned budget**								

[120] The items guiding each KQ are found in the data collection tools, annex

[121] The use of bold capital letter X indicates the OECD criteria to which the KQ makes the most contribution.

	QUESTIONS	DATA SOURCE	CATEGORY OF PARTICIPANTS	DATA COLLECTION TOOLS/ SOURCES	Relevance	Effectiveness	Efficiency	Coherence	Sustainablity
EQ 4	**To what extent are the AWBC interventions compatible with other interventions in the country, relevant sectors, or institutions?**	UNICEF, UNFPA, UNAIDS, Ministries, universities, relevant donors	Programme staff	UNDAF, KII		x	x	**X**	x
Indicator	**Degree and character of joint planning and implementation with national and international partners and other UN agencies**								
EQ 5	**What is the probability of continued long-term benefits?**	UNICEF, key implementers	Implementing staff	Annual Plans, reports, KII,		x		**x**	**X**
Indicator	**The extent to which each individual and/or a combination of activities has resulted in the planned behaviour change – and the effect of the behaviour change on the lives of the adolescents**								
EQ 6	**Were RBM/HRBA monitoring, evaluation, and learning (MEL) procedures in place and used?**	UNICEF, ministries, universities, districts, centres, donors	Monitoring officer, Head of programmes, donor programme staff	Results framework, existence of reports, KII		**X**	x		x
Indicator	**The number of HRBA progress reports, extent and type of other information sharing activities or material and number and type of evidence-based programme adaptations**								

Annex 6

Ethics approval letter
Invitation letter and
Informed consent document

Research Ethics Approval

24 January 2023

Birgitte Woel, PhD,
Freelance, Denmark
c/o UNICEF MENA Regional Office
P.O. Box 1551
11821 Amman, Jordan

RE: Ethics Review Board findings for: UNICEF Iran's Adolescents Wellbeing Programme (HML IRB Review #669IRAN22)

Dear Dr. Woel,

Protocols for the protection of human subjects in the above study were assessed through a research ethics review by HML Institutional Review Board (IRB) on 28 December 2022 – 24 January 2023. This study's human subjects' protection protocols, as stated in the materials submitted, received **ethics review approval.**

You and your project staff remain responsible for ensuring compliance with HML IRB's determinations. Those responsibilities include, but are not limited to:

- ensuring prompt reporting to HML IRB of proposed changes in this study's design, risks, consent, or other human protection protocols and providing copies of any revised materials;
- conducting the research activity in accordance with the terms of the IRB approval until any proposed changes have been reviewed and approved by the IRB, except when necessary to mitigate hazards to subjects;
- promptly reporting any unanticipated problems involving risks to subjects or others in the course of this study;
- notifying HML IRB when your study is completed.

HML IRB is authorized by the United States Department of Health and Human Services, Office of Human Research Protections (IRB #1211, IORG #850, FWA #1102).

Sincerely,

D. Michael Anderson, Ph.D., MPH
Chair & Human Subjects Protections Director, HML IRB

cc: Emmanuel Saka, Leonardo Menchini, Penelope Lantz, JD

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ADOLESCENT WELL-BEING PROJECT.

To ..

The national consultant, who will conduct the national data collection with key stakeholders, hereby invites you to share your experience with the Adolescent Well-Being Project. The project was implemented from 2017 till end of 2021.
The purpose of the evaluation is to learn from experience and thereby inform and enhance future UNICEF programming.
All information is confidential.

The interview will take around one hour and can be conducted at any venue suitable for you.
You will also choose the venue and best time for the interview.
If agreeing to the participation you will sign a Letter of Consent before the start of the interview.
It is attached to this invitation to enable a familiarisation before meeting for the interview.
Alternatively, you can give your consent verbally.

The interview is based on a set of issues rather than questions. The issues are assumed to fall under your work responsibility and experience with the project. However, you will only provide information about the issues with which you feel familiar, confident and/or comfortable.
Before starting the interview, the consultant will present a template with all the issues and go through these to ensure that all is well understood. After the introduction the floor is yours and you can provide the scope and details of your experience that you feel are relevant for this evaluation and the future programming.

If you feel that your participation is relevant for this evaluation and/or if you need additional information, kindly contact the undersigned.
For planning purposes, I kindly request that you provide your response latest by (to be decided)

Kind regards,

Dr. Hamidreza Farrokh
National consultant
Email:

Informed Consent document

Before your participation in the evaluation of the UNICEF Iran Adolescent Well-being Project UN procedures require that you provide an informed consent to your participation in this evaluation.
It can be a signing of this document or a verbal consent.
The purpose of the evaluation is to learn from experience and thereby inform and enhance future UNICEF programming.

All information is strictly confidential and will never be connected to you. The is no list of participants in this evaluation. The consultants will put the information from you together with information from other people we interview. Only the consultants will know who gave what information, but names will not be noted anywhere. All information will be stored safely under the care of the international consultant.

There is no compensation for participating in this interview. But as your experiences may improve future programming for adolescents in Iran you will play an important role in helping UNICEF know about ways to provide better services to the people of Iran.

Your participation in this study is voluntary. You can, therefore, decline to participate. If you choose to participate and you regret, you can withdraw at any time.
If you think that you want to be in the interview and you change your mind as the interview goes on, you can withdraw any time during the interview.
If you agree to participate, you can decide not to answer all questions and you can stop the interview at any time.
If you regret your participation at the end of or shortly after the interview you can ask the consultant to omit part or all information from the interview.

Your decision about whether to participate in this evaluation or to answer any specific questions will in no way affect any services or other benefits that you receive. If you do choose to participate, please answer the questions honestly and openly, so that we can understand your experience and find out what you really think and have experienced.
Before you say yes or no to participate in this evaluation, you can ask any question.
If you join the evaluation, you can ask questions at any time during the interview.

If you experience any risks or consequences (psychological risk, social risk, economic risk, legal risk, employment risk or any other risk) during or after this interview kindly contact UNICEF Iran (……..) for assistance.

Kindly sign below. A copy of the signed consent will be left with you.

I have read the Informed Consent document and confirm that I have understood my role in this evaluation, the use of my information, my right to withdraw at any time, the confidentiality of my participation, that my participation in no way will benefit or negatively affect me as a person and the opportunity to report possible consequences.

Name of respondent:

Date:

Signature:

Name of consultant:

Date:

Signature:

Annex 7

Templates for semi-structured interviews

6A. Government and other implementers – centres exempted

Item	What worked well	Positive impact	What did not work well	Negative impact	Proposed changes
EQ 1: To what extent are the objectives of the development intervention consistent with target populations' requirements, country needs, global priorities and partners' and donors' policies.					
a) Alignment with national polices					
b) National accountability/ transparency					
c) Participation in design					
d) Inclusion/non-discrimination					
e) Programme focus and approach					
f) Timing of the intervention					
EQ 2: To what extent were systems in place supporting achievements of the AWP objectives?					
a) Implementer capacity to deliver as agreed					
b) Design and use of RBM/HRBA results framework					
c) Applicability of monitoring and reporting tools					
d) Frequency of monitoring					
e) Data analysis and use					
f) Data use for reporting					
g) Data use for corporate learning					
h) Data use for knowledge sharing					

i) Relevance and effect of capacity building provided to implementers					
j) UNICEF's comparative advantage in this work					
EQ 5: What is the probability of continued long-term benefits? Are the initiatives resilient to risks? Are there a net benefit flows over time?					
a) Incorporation of programme initiatives into national programmes and protocols					
b) Replicability or scalability of programme initiatives at the national level without UNICEF's support					
c) The existence, relevance, and use of exit strategy					
d) Establishment and use of ownership					
Other items					
Any activity or mode of operation that has not been mentioned above – if any					

6B. Universities

Item	What worked well	Positive impact	What did not work well	Negative impact	Proposed changes
EQ 1: To what extent are the objectives of the development intervention consistent with target populations' requirements, country needs, global priorities and partners' and donors' policies.					
a) Budget for the intended achievements					
EQ 2: To what extent were systems in place supporting achievements of the AWP objectives?					
b) UNICEF delivery against plan					
c) Centre delivery against plans					
d) Utilization of centre capacity					
EQ 3: To what extent were economically resources/inputs (funds, expertise, time, etc.) converted to HRBA results?					
a) Level of achievements against plans					
b) UNICEF capacity to implement the programme					
EQ 4: To what extent are the AWBC interventions compatible with other interventions in the country, relevant sectors, or institutions?					
a) Programme contribution/attribution to the synergies and interlinkages with other interventions carried out by UNICEF					

Item	What worked well	Positive impact	What did not work well	Negative impact	Proposed changes
b) Programme contribution/attribution to the synergies and interlinkages with other interventions carried out by relevant country-wide organizations					
EQ 6: To what extent were RBM/HRBA monitoring, evaluation and learning procedures in place and used?					
a) Effective and correct use of data collection tools					
Other items					
Any activity or mode of operation that has not been mentioned above – if any					

6C. Centre head and staff

Item	What worked well	Positive impact	What did not work well	Negative impact	Proposed changes
EQ 1: To what extent are the objectives of the development intervention consistent with target populations' requirements, country needs, global priorities and partners' and donors' policies.					
a) Centre accountability/ transparency					
b) Participation in design					
c) Inclusion/non-discrimination					
d) Programme focus and approach					
e) Timing of the intervention					
EQ 2: To what extent were systems in place supporting achievements of the AWP objectives?					
a) Centre delivery against plans					
b) Utilization of centre capacity					
c) Perceived positive and negative/unintended effect among beneficiaries					
d) Centre delivery against plans					
e) Centre delivery against plans					
f) Utilization of centre capacity					

EQ 6: To what extent were RBM/HRBA monitoring, evaluation and learning procedures in place and used?					
a) Effective and correct use of data collection tools					
b) Effective use of data for reporting, staff learning and knowledge sharing					

6D. Beneficiaries (18-25 years) – The template will be used to guide the FGD discussion

Item	What worked well	Positive impact	What did not work well	Negative impact	Proposed changes
EQ 1: To what extent are the objectives of the development intervention consistent with target populations' requirements, country needs, global priorities and partners' and donors' policies.					
a) Participation in design					
b) Programme focus and approach					
c) Programme target group					
EQ 2: To what extent were systems in place supporting achievements of the AWP objectives?					
a) Centre capacity to deliver as agreed					
b) Activities and approaches with positive and negative/unintended effect among beneficiaries					
EQ 5: What is the probability of continued long-term benefits? Are the initiatives resilient to risks? Are there a net benefit flows over time?					
a) Establishment and use of ownership					
Other items					
Any activity or mode of operation that has not been mentioned above – if any					

6E. UNFPA and UNAIDS

Item	What worked well	Positive impact	What did not work well	Negative impact	Proposed changes
EQ 1: To what extent are the objectives of the development intervention consistent with target populations' requirements, country needs, global priorities and partners' and donors' policies.					
a) Alignment with national polices					
b) National accountability/ transparency					
c) Delivery to UNDAF					
d) Participation in design					
e) Inclusion/non-discrimination					
f) Programme focus and approach					
g) Programme target group					
h) Timing of the intervention					
EQ 2: To what extent were systems in place supporting achievements of the AWP objectives?					
a) Implementer capacity to deliver as agreed					
b) UNICEF's comparative advantage in this work					
c) Relevance and effect of capacity building provided to implementers					

Item	What worked well	Positive impact	What did not work well	Negative impact	Proposed changes
d) Use of project monitoring data for reporting and knowledge sharing					
EQ 4: **To what extent are the AWBC interventions compatible with other interventions in the country, relevant sectors, or institutions?**					
Programme contribution/ attribution to the synergies and interlinkages with other interventions carried out by other UN agencies					
UNICEF's comparative					
EQ 5: What is the probability of continued long-term benefits? Are the initiatives resilient to risks? Are there a net benefit flows over time?					
e) Incorporation of programme initiatives into national programmes and protocols					
f) Replicability or scalability of programme initiatives at the national level without UNICEF's support					
g) Establishment and use of ownership					
Other items					
Any activity or mode of operation that has not been mentioned above – if any					

6F. UNICEF – items will be selected specifically for each department e.g., programme, finance, and M&E

Item	What worked well	Positive impact	What did not work well	Negative impact	Proposed changes
EQ 1: To what extent are the objectives of the development intervention consistent with target populations' requirements, country needs, global priorities and partners' and donors' policies.					
a) Use of and support to national policies, strategies, and plans					
b) Delivery to UNDAF and UNICEF priorities					
c) National accountability/ transparency					
d) Participation in design/needs assessment					
e) Inclusion/non-discrimination					
f) Use of RBM/HRBA in programming					
g) Programme focus and approach					
h) Programme target group					
i) Timing of the intervention					
j) Budget for the intended achievements					
EQ 2: To what extent were systems in place supporting achievements of the AWP objectives?					
Design and use of ToC					

Item	What worked well	Positive impact	What did not work well	Negative impact	Proposed changes
a) Design and use of RBM/HRBA results framework					
b) Applicability of monitoring and reporting tools					
c) Frequency of monitoring					
d) Data analysis and use					
e) Data use for reporting					
f) Data use for corporate learning					
g) Data use for knowledge sharing					
h) UNICEF delivery against plan					
i) Centre delivery against plans					
j) Utilization of centre capacity					
k) Perceived positive and negative/unintended effect among beneficiaries					
l) UNICEF capacity to implement the programme					
m) Implementer capacity to deliver to the programme					
n) Relevance and effect of capacity building provided to implementers					
o) Relevance of UNICEF's choice partners					
p) Effectiveness of UNICEF's use of partners					

Annex 8

Overview over the capacity development provided

Capacity development provided

665 experts were accounted for as having been provided with capacity development.

A hyphen is used where the number of participants was not found in the annual reports.

RA 1		Lead agency	No	Target group
	2019			
1.	TAHAMTAN Positive Life Skills Programme Developed, Piloted, and Implemented; A National Consultant Recruited for Positive Life Skills Training Programme (TAHAMTAN) for At-risk Adolescent Boys and Girls	UNICEF	110	Adolescents in AWBCs
2.	Training Workshops on Positive Life Skills Programme (TAHAMTAN) conducted, and supervision provided	UNICEF	28	Technical staff from AWBCs and MOHME
3.	Training in PAYAM'MAN - A Life-Skills based HIV and Selective Drug Use Prevention among At-risk Adolescents	UNICEF	32	Technical staff from SWO and its affiliated NGOs from 8 provinces attended the workshop
4.	DCHQ and MOHME conducted Training of Trainers (TOT) and Pilot Study on'Life-Skills based Selective Drug Use Prevention Programme (PAYAM' MAN) among At-risk Adolescents' through MOHME	UNICEF	32	Counsellors and psychologists from seven Universities of Medical Sciences in 5 Provinces
5.	Adapting and Piloting of a School-based Life- Skills Training Programme (Unplugged) in 4 schools - training workshop and supervision	UNICEF	-	Teachers of four schools in high-risk area of Tehran
6.	Workshops on: 1)TOT for staff of AWBCs on how to conduct Focus Group Discussions (FGD) with AYP and their parents 2)Introduction on adolescent and youth reproductive health needs 3) Workshop on how to design a good training package for adolescents and youth with community-based activities. 4) Training in use of the package that was developed	UNFPA	- - - - -	Staff at AWBCs Staff of MOHME Staff of AWBCs Community representatives AWBC staff
	2020			
7.	The TAHAMTAN Life Skills Programme Packages were adapted, and two training workshops conducted for 18 school teachers and 10 experts from Ministry of Education (MOE) in Tehran City	UNICEF	18 10	School teachers Experts from MOE, Tehran
8.	3-day workshops on TAHMTAN programme for familiarization with the TAHAMTAN theorical and practical components.	UNICEF	28	Schoolteachers and technical staff from Narjes, Mirmiran, Kalhor, Anaari and Chamran schools MOE
9	One-day booster session was conducted to prepare them for piloting the TAHAMTAN (not piloted due to COVID-19).	UNICEF	28	Trained schoolteachers and technical staff
10	UNICEF supported the DCHQ and the MOE to organize three rounds of three-day training workshops on PAYAM' MAN	UNICEF/ UNODC	113	School Counsellors and Technical Staff of the MOE from 31 Provinces
11	Staff of 40 women centres in the country are now equipped with new knowledge on prevention and response to violence ("self-protection"), sexual health and counselling enabling them to provide better services to women at risk of HIV	UNFPA	-	Staff of 40 women centres

RA2		Lead agency	No	Target group
	2019			
1.	22 meetings of the SORENA team gathering MOHME experts, UNICEF ADAP officers, heads of 7 AWBCs, and adolescents, a comprehensive data collection system for AWBCs has been designed and plugged to the seven AWBCs	UNICEF	-	MOHME experts, UNICEF ADAP officers, heads of 7 AWBCs, and adolescents

2.	A 2-day training workshop on data collection system was organized to improve their capacity in working with this system	UNICEF	-	All technical staff of AWBCs, Universities of Medical Science, and MOHME
3.	To support cross-sectoral partnerships between organizations to increase coherence and synergy in adolescents related programmes across different organizations, UNICEF supported MOHME to hold the first roundtable	UNICEF	-	Director Generals and senior experts from MOSY, IRCS, SWO, MFA, UNAIDS, and UNFPA
4.	Trained in provision of relevant services in AWBCs	UNICEF	21 12 -	Technical staff of seven AWBCs Peers in clubs 7 teams of outreach
5.	Study visit to Kazakhstan was held which was informative in terms of finding gaps and strengths of available programmes in Iran.	UNICEF	14 - - -	MOHME experts Delegations from medical universities NGOs MFA
6.	Three days training of trainers (TOT) on 'Adolescent Drug and Sexual Risk Reduction Counselling' for 42 counsellors, psychologists, and mental health practitioners from 40 University of Medical Sciences (UMSs) MOHME Country Primary Health Care System (PHC) of 32 provinces.	UNICEF	42	Counsellors, psychologists, and mental health practitioners from 40 University of Medical Sciences (UMSs) MOHME Country Primary Health Care System (PHC) of 32 provinces.
	2020			
7.	Supported MOHME's Bureau of Psychosocial Health and Addiction to organize the second Training of Trainers (TOT) workshop	UNICEF	63	Heads of psychology groups from universities of medical sciences in Tehran
8.	About 28 technical meetings were organized to finalize the SAMAN system.	UNICEF	-	SORENA, MOHME, UNICEF, and AWBCs technical staff
9.	UNICEF supported Ministry of Sport and Youth (MOSY) to hold two consultative meetings aiming at enhancing cross-sectoral partnerships between organizations on adolescent and youth wellbeing and development	UNICEF	-	Two Director Generals, senior technical experts, and consultants from MOSY, and experts from MOHME
10.	Online training workshops, booster sessions, and supervision: 18 hours online trainings on ReSPCT.	UNICEF	224	124 counsellors, social workers, and psychologists from seven AWBCs affiliated to MOHME, and 110 community counseling centers from 31 provinces
11.	Review and revision the AWBC protocol and self-evaluation	UNICEF	-	Technical staff of AWBCs

RA3		Lead agency	No	Target group
	2019			
1.	In coordination with Drug Control Headquarters (DCHQ), UNICEF has recruited a national consultant to: 1) develop SOPs related to adolescent wellbeing programme for girls, 2) adapt MOHME's protocols for AWBCs, 3) provide on-site trainings, and 4) provide online supervisions and organize troubleshooting booster sessions for technical staff of Mashhad girl AWBC	UNICEF	-	
	2020			
1.	MOHME conducted: • A consultative workshop on protocol and self- evaluation; • One training workshop on advance outreach for AWBCs technical staff in Kermanshah.	UNICEF	?	Technical staff of AWBCs

Joint partner contribution per result area

Result 1: Establishment of human capacity to empower at-risk adolescents	
UN Agency	**Product delivery**
2019	
UNFPA	Conduct of a desk review to prepare for integration of SRH and HIV services for adolescents & youth.
UNAIDS	Production and dissemination of one animation on HIV.
UNAIDS	Production one short movie on STIs prevention.
UNAIDS	Organize a Concert on the occasion of World AIDS Day.
2020	
UNFPA	UNFPA Conduct of a desk review to prepare for integration of SRH and HIV services for adolescents & youth.
UNFPA	CDC with UNFPA technical assistance, developed 3 packages on Self Protection, Sexual Health, and Counselling for staff of centres providing services to young women at most risk of HIV to address HIV/STI prevention among women at risk.
Result 2: Establishment of support systems and structures	
2019	
UNFPA	Exchange of experience between Iran and other countries with successful integrated SRH/HIV prevention programs for adolescents & youth to build capacity for MOHME, MOW, MOSY and Ministry of Science to work with adolescents (consultants, study tours, i.e., to the Netherlands.
UNFPA	Revision of the developed protocols for Adolescent Well-being Centers to include SRH.
UNFPA	Technical support to partnership and coordination between organizations and ministries working on adolescents and youth.
UNAIDS	Assess and synthesize current knowledge on the HIV and STI situation of adolescents and youth in Iran.
UNAIDS	Conduct a legal environment assessment and development of legal framework for the Adolescent Well-being Centers.
2020	
UNAIDS	Develop training package and guideline on psychological crisis interventions for at risk adolescents – was not completed.
UNAIDS	Capacity building of AWBCs' service providers on ethical and legal issues related to Adolescent Wellbeing Centers' work and establishment of a referral system to address adolescents' legal issues through citizen rights clinics to get more support on all relevant legal issues as well as improving their social participation was developed, but workshop was not held.
UNAIDS	Development of STI Prevention, Care & Management Service Package and Related Guidelines for Adolescent KP. Developed.
UNAIDS	Feasibility Study on AWBs Services Sustainability, completed.
Result 3: Establishment/provision of materials/infrastructure	
2019	
UNFPA	Conduct of a financial sustainability analysis of Adolescent Well- being Centers, including costing of services.
2020	
UNFPA	Based on the request of CDC, UNFPA procured 894 HIV/Syphilis test kits (22,350 numbers of kits) in order to be used of most at risk young people. In addition, 27,777 gross condoms (3,999,888 numbers of condoms) were procured for CDC to be distributed among most at risk young people to prevent them from HIV and other STI infections.

Annex 9

Changes achieved through capacity development

Changes achieved or value added to the AWB area of work through capacity development

The training provided to a range of stakeholders is not recorded here but is viewed as a tool (or precondition) with which to achieve the changes. The full list of capacity development is found in annex 5.

RA1: Establishment of human capacity to empower at-risk adolescents

	2018		
1.	A Positive Life Skills Training Programme (TAHAMTAN) for At-risk Adolescent Boys and Girls Developed covering seven main categories of skills that adolescents need to achieve a healthier lifestyle.	This package has been piloted in all 7 Adolescent Wellbeing Centers 110 adolescents in the first round of implementation	-
2.	A Life-Skills based HIV and Selective Drug Use Prevention among At-risk Adolescents Developed and Piloted. It focuses mainly on life skills to avoid high risk situations regarding drug use	The PAYAM' MAN programme was piloted in the above mentioned seven sites and about 12 to 24 at-risk adolescent boys and girls were covered at each site	-
3.	A School-based Life- Skills Training Programme for Adolescent Students Adapted	-	--
	2019		
4.	7,000 books were published:_1,000 Payam'Man (PM) manuals for facilitators, 1,000 theoretical references, and 5,000 workbooks for adolescents and youth were published	Distributed among 21 psychologists of seven MOH medical universities, 110 MOE school counsellors and DCHQ drug prevention practitioners in 31 provinces	-

RA2: Establishment of support systems and structures

	2018		
1.	Strengthening the capacity of MOHME to collect, centralized and process information and data for improved adolescence related programming	-	-
2.	In support of partnerships: Roundtable on Adolescent Wellbeing and Development Conducted	Map of existing programmes on adolescent wellbeing and HIV prevention and identify coordination gaps	-
3.	An Adolescent Wellbeing Model Reinstated: Support of MOHME to reinstate a comprehensive service package including drug prevention, and social and life skills within a safe	4 advisory committees with representatives of high-risk adolescents, technical staff, and other beneficiaries like parents have been established This model has been piloted in seven AWBCs across 6 provinces	

	and adolescent friendly environment	A series of lessons learned by AWBCs is also ready for publication	
	2019		
4.	Strengthening the capacity of MOHME to collect and process data for improved adolescence related programming:	A data collection system for adolescent wellbeing programme piloted and troubleshooted in seven AWBCs	Monitoring of the adolescent wellbeing and development programme for at-risk adolescent boys and girls through seven AWBCs in six provinces.
5.	Support of partnerships between all relevant organizations in engaging, mobilizing, and empowering adolescents as leaders and actors of social change through National Youth Congresses, roundtables, and seminars	Adaptation and replication of adolescent and youth wellbeing and development model for Youth Houses and civil society organizations	-
6.	Procurement of HIV Rapid tests for AWBCs	These HIV rapid tests were distributed among seven AWBCs through provincial medical universities	-
7.	Remote Stepped Psychosocial Care and Support (ReSPCT) for adolescent, youth, and their parents introduced	124 counsellors, social workers, and psychologists from seven AWBCs affiliated to MOHME, and 110 community counselling centres from 31 provinces received 18 hours online trainings on ReSPCT 124 telephone counselling headsets, and 124 mobile holders were procured for trained counsellors and social workers. Also 750 board games for adolescents and 5,500 telephone charge cards were provided and given to vulnerable adolescents and youth to facilitate their telephone counselling process	-
8.	Risk Reduction Counselling for at-risk Adolescents: A national consultant was recruited to develop a 'Risk Reduction Counselling for at-risk Adolescents' service package for psychologists at Primary Health Care (PHC) level and to provide the three-day TOT workshop	-	-
9.	Developing new Scientific Resources on Adolescent Development	• Translation of the 'Handbook of Adolescent Development Research and its impact on Global Policy' into the Farsi; • Publishing AWBCs lessons learned and biographies; • Publishing 7,000 manuals, guides, and workbook on selective drug use prevention for adolescents; • Translation of Youth Participation Book	-

RA3: Establishment/provision of materials/infrastructure

	2018		
1.	Capacity building for staff of Centers in reducing risky behaviors (strengthening data collection, outreach activities, SRH protocols)	Procurement of seven portable clinics for AWBCs	-
		Four motorbikes procured for boys AWBCs	