



SIXTH UNFPA COUNTRY PROGRAMME: SIERRA LEONE
[2015-2019]

FINAL EVALUATION REPORT

NOVEMBER, 2018

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ABBREVIATIONS AND ACRONYMS

AFP/A4P:	Agenda for Prosperity (GOSL)
ARR:	Annual Review Reports
AYG:	Adolescents, Youth and Gender
AWPs	Annual Work Plans
AYFHS	Adolescent and Youth Friendly Health Facilities
AYG Cluster	Adolescents, Youth and Gender Cluster
BEmONC	Basic Emergency Obstetric and New Born Care
CBOs:	Community-Based Organizations
CCA:	Common Country Assessment
CO:	Country Office
COAR:	Country Office Annual Report
CPAP:	Country Programme Action Plan
CPD:	Country Programme Document
CPE:	Country Programme Evaluation
CPR:	Contraceptive Prevalence
CBOs	Community Based Organizations
CCP	Center for Communication Programs
CEDAW	Convention on the Elimination of all forms of Discrimination against Women
CeMoNC	Comprehensive Emergency Maternal
CHC	Community Health Centre
CHOs	Community Health Officers
CHW	Community Health Workers
COAR	Country Office Annual Reports
CMS	Central Medical Stores
CP	Country Programme
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CPD	Commission on Population Development
CPE	Country Programme Evaluation
CPE ToR	Country Programme Evaluation Terms of Reference
CPR	Contraceptive Prevalence Rate

CSOs	Civil Society Organisations
DAC:	Development Assistance Committee (of OECD)
DCTM	District Contract Tracing Monitors
DFID:	Department for International Development (UK)
DD	Demographic Dividend
DFID	Department of Foreign and International Development
DHS	Demographic and Health Survey
EMONC	Emergency Obstetric and NewBorn Care
eMTCT	Ending Mother to Child transmission of HIV
EM	Evaluation Manager
EO	Evaluation Office
ERG	Evaluation Reference Group
ET	Evaluation Team
EU	European Union
EQA	Evaluation Quality Assessment
ERG	Evaluation Reference Group
EVD	Ebola Virus Disease
FACE	Fund Authorization and Certificate of Expenditures
FGDs	Focus Group Discussions
FGM	Female Genital Mutilation/Cut
FINE SL	Fambul Initiative Network
FP	Family Planning
FP/RH	Family Planning/Reproductive Health
FSU	Family Support Unit
GBV	Gender Based Violence
GDP	Gross Domestic Product
GIS	Geographic Information System
GoJ	Government of Japan
GoSL	Government of Sierra Leone
GPRHCS	Global Programme for Reproductive Health Commodity Security
HFAC	Health for All Coalition
HIV	Human Immunodeficiency Virus

ICPD	International Conference on Population and Development
IEC	Information Education and Communication
ICPD	International Conference on Population and Development
IPs	Implementing Partners
IEC/BCC	Information Education and Communication/Behavioural Change Communication
IPs	Implementation Partners
IRISH AID	Iris Agency for International Development
IUD	Intrauterine Device (contraceptive device)
JICA	Japanese International Cooperation Agency
LoE:	Length of Engagement
LMIS/CHANNEL	Logistics Management Information System
M&E	Monitoring and Evaluation
MDA	Ministries, Departments and Agencies
MDSR	Maternal Death Surveillance and Response
MEST	Ministry of Education, Science and Technology
MMR	Maternal Mortality Ratio
MICS	Multi-Indicator Cluster Survey
MoHS	Ministry of Health and Sanitation
MoPED	Ministry of Planning and Economic Development
MSWGCA	Ministry of Social Welfare, Gender and Children's Affairs
MOYA	Ministry of Youth Affairs
MSWGCA	Ministry of Social welfare, gender and Children's Affairs
MTR	Mid-Term Review
MYR	Mid-Year Review
NEX	National Execution
NGOs	Non-Governmental Organisations
NHSSP	National Health Sector Strategy Plan
NPPU	National Pharmaceutical Procurement Unit
ODA	Overseas Development Assistance
PCMH	Princess Christian Maternal Hospital
P&D	Population and Development
PHU	Peripheral Health Units

POA	Programme of Action
PRSP	Poverty Reduction Strategy Programme
RH	Reproductive Health
RRF	Results and Resources Framework
SDPs	Service Delivery Points
SGBV	Sexual and Gender Based Violence
SL CO CP	Sierra Leone Country Office Country Programme
SLDHS	Sierra Leone Demographic and Health Survey
SLIHS	Sierra Leone Integrated Household Survey
SLPAGPAD	Sierra Leone Parliamentary Action Group on Population and Development
SL-PHC	Sierra Leone Peripheral Health Centres
SPR	Standard Progress Report
SRH	Sexual and Reproductive Health
SRO	Sub-regional Office
SSL	Statistics Sierra Leone
STI	Sexually Transmitted Infections
TFR	Total fertility Rate
TRLs	Traditional and Religious Leaders
UKAID	United Kingdom Agency for International Development
UN	United Nations
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
USAID	United States of America Agency for International Development
WCARO	West and Central Africa Regional Office
WHO	World Health Organisation
WRH	Women's Reproductive Health

Table 1: Key facts on Sierra Leone

Land	
Geographical location	West Africa
Land area	71,740 sq.km
People	
Population (2017 estimate)	7,604,350
Urban Population	42.1%
Crude birth rate	36.3/1000
Crude death rate	10.4/1000
Sex ratio at birth	1.02 (males/females)
Population Growth rate	3.2 %
Total fertility rate	4.9
Adolescent birth rate	125/1000
Teenage pregnancy	28% (15-19), 38% (20-24)
Infant mortality	96/1000 livebirths
Child mortality	67/1000 livebirths
Under-5 mortality	156/1000
Contraceptive use rate	16.6%
Maternal Mortality ratio	1,360/100,000 livebirths
Unmet need for family planning	25
Life expectancy at birth	58.6 years
Skilled birth attendance	62
HIV prevalence rate	1.5
HIV prevalence rate among young people	1.4
Government	
Government	Republic, constitutional democracy
GDP per capita	\$ 1,600.00
GDP Growth rate	3.5%
Main industries	Mining
Social and Development Indicators	
Human Development Index Rank	0.420 (179out of 188 countries)
Unemployment	9.1 percent
Gini Index	34
Multidimensional poverty index	77.5 %
Population living below the national poverty line (%)	70.2%
Gender Indicators	
Gender inequality index	0.650 (151 out of 159 countries)
Seats held by women	12.4%
Women 15+ having experienced physical violence	45%
Sexual physical violence	29%
Child marriage	39 %
Female Genital mutilation women aged 45-49	98
Female Genital mutilation for girls aged 15-19	74

Millennium Development Goals: Progress by Goal	
1. Eradicate extreme poverty and hunger	None of the target met, but substantial progress made.
2. Achieve Universal Primary Education	Target was met on one indicator. Substantial progress was made generally
3. Promote Gender Equality and empower women	Target was met one indicator; substantial progress was made generally
4. Reduce Child Mortality	None of the targets as achieved, but substantial progress was made.
5. Improve Maternal Health	None of the targets was achieved, but substantial progress was made.
6. Combat HIV/AIDS, Malaria and other diseases	Target was met on one indicator, substantial progress was made generally
7. Ensure environmental sustainability	None of the targets was achieved but progress was made
8. Develop a global partnership for development	Inconclusive.

Structure of the country programme evaluation report

This report comprises an executive summary, six chapters and six annexes. Chapter 1 is the introductory chapter which provides the background to the evaluation, objectives, scope, methodology and limitations of the evaluations. Chapter two presents the development challenges faced by Government of Sierra Leone in the four thematic areas or three thematic clusters, as identified in the national strategic documents produced by the Government and provides the policy context of these challenges. The third chapter refers to the response of the UN system and then leads on to the specific response of the UNFPA Country Programme to the national challenges in the programme areas by Sierra Leone. The fourth chapter presents the findings of the evaluation for each of the three cluster areas, including the strategic positioning and added value of UNFPA CO in Sierra Leone, and the cross-cutting humanitarian, monitoring and evaluation, and communication system issues; Chapter five is the conclusions with recommendations arranged according to strategic and programmatic levels.

The annexures include the CPE terms of reference, completed evaluation matrix; list of individuals interviewed; documents consulted and interview guides.

MAP OF SIERRA LEONE



Source: Sierra Leone Google Map

EXECUTIVE SUMMARY

This report presents the findings, conclusions and recommendations of UNFPA SL 6th cycle (2015 – 2019) Country Programme Evaluation (CPE). The purpose of this evaluation is ‘assess the achievements of the programme, the factors which may have facilitated or constrained the achievements of intended results, and (ii) draw lessons learned from the programme design through implementation to inform development of the seventh country programme cycle (2020-2024). Lessons learnt in implementing the Country Programme are documented. Recommendations for the next country programme are proposed.

Context of the Country Programme

The 6th UNFPA Country Programme for the period 2013 to 2017 was designed to respond to Sierra Leone’s national needs and priorities as reflected in its national development plan, sectoral policies, strategies and international development agendas. UNFPA’s 6th Country Programme focused on four programmatic areas: sexual and reproductive health and rights, adolescents and youth, gender equality and women’s empowerment, and population and development. The goal of the 6th Country Programme was to contribute to “universal access to rights-based, gender-sensitive sexual and reproductive health information and services, including for adolescents and young people”. The Country Programme was implemented at central and district levels. Sixteen districts were selected for interventions.

Evaluation Approach

The CPE follows the structure provided in the UNFPA Handbook for Evaluation (UNFPA October 2013) using two separate components: first component employed four main criteria: relevance, effectiveness, efficiency, and sustainability. The second component assessed the positioning of the UNFPA SL CO in the country based on two criteria: UNCT coordination (its collaboration within the UNCT and other development agencies), and value added (comparative strengths in the country). Additional components assessed include the monitoring and evaluation system, and communication strategy.

Methodology: The evaluation was conducted by a two-person team (team leader and national expert) in two phases: development of a Design Report outside of SL CO, July 2018, and the data collection in Sierra Leone in August 2018. All interviews followed informed consent procedures as required by the UN ethics guidelines for evaluators. The collection of evaluation data was implemented using five main methods: 1) Desk review; 2) Semi-structured group and individual interviews with stakeholders; 3) Group and individual follow-up interviews with former and current staff of UNFPA SL CO; 4) Focus group discussions with stakeholders and client/beneficiaries and 5) Site visits to CP targeted areas in four districts and the Capital City. The primary data collection reached a total of 115 individuals in four districts and the Capital City (Freetown).

The analysis is based on the synthesis and triangulation of information obtained from the above-mentioned five evaluation activities. Limitations of the evaluation include its non-representative, qualitative nature due to small, non-random samples and low response rates for certain interview categories.

Main Findings

Relevance: All four program areas were found to be of high relevance to the needs of the country and are well aligned and relevant to Sierra Leone's needs, national and international priorities/mandates as reflected in the National Development Plan: Agenda for Prosperity, ICPD +15 Reviews, United Nations Development Assistance Framework 2015-2018 for Sierra Leone; ICPD PoA, Millennium Development Goals; UNFPA Strategic Plan 2014-2017, revised 2018-2021, Convention on the Elimination of all forms of Discrimination against Women (CEDAW); 1995 Beijing Declaration and Platform for Action and regional protocols; SDG Agenda and Agenda 2063. Virtually all activities are consistent with the needs of beneficiaries and implementing partners.

Effectiveness: Despite major constraints and challenges in the social and political context of Sierra Leone, including a difficult funding environment, there was significant progress in all four program areas. The 6th CP interventions resulted in strengthening the health system by training human resources for health (midwives, community health workers, surgical assistants and anaesthetists); renovating and building new health facilities, capacity-building; contributing towards increased demand for information on FP/RH, maternal and new-born health, fistulae management; improved logistics management information system for FP/RH commodity security at central and district levels etc.

Efficiency: Overall, the activities implemented toward the achievement of outputs for all program areas appeared to be reasonable for the amount of resources expended. UNFPA SL CO was generally efficient in mobilizing financial resources and efficient in disbursing annual programme budgets to support the implementation of Annual Work Plans (AWPs) through contracts with Implementing Partners as well as National Execution (NEX) modality. In spite of dwindling donors' interest globally, UNFPA CO was relatively efficient in raising financing for the country programme, increasing financing levels from non-core resources and accessing new donors. The CP has been implemented by a team of competent staff with support from a number of national and international consultants, and the Regional Office. However there are noticeable inefficiencies during the Cycle.

Sustainability: There is evidence of both short- and long-term sustainability of program results from program activities in all four program areas. Likelihood of sustainability is higher in thematic areas where UNFPA strategic interventions have gained traction, government endorsement and community acceptance such as in SRH, Youth Friendly Health Centres, community involvement in women's empowerment and equality. Where UNFPA strategic interventions are still mostly at the level of advocacy to break the cultural taboos such as FGM, child marriage and gender-based violence, the potential of sustainability is still weak. Sustainability of the interventions is further enhanced by policies, guidelines, procedures, health system strengthening, capacity building and community involvement in some culturally sensitive activities. Lack of government counterpart funding is a major risk to sustainability.

Humanitarian context: UNFPA SL CO is at the forefront of emergency response in the country, in partnership with other UNCT agencies. Its role during the Ebola crisis and flooding emergency in the country is well acknowledged by all IPs and stakeholders.

Coordination: In the area of strategic positioning, the UNFPA Country Office has made important contribution to improving inter-agency coordination in Sierra Leone and its contribution has helped

address issues arising from the UN Country team. UNFPA is a co-convenor of a number of Technical Working Groups within the UNCT.

Added Value: UNFPA has comparative advantage and technical expertise historically in population and development, sexual and reproductive health, adolescents and youth, and gender. Its added value is also found in its strategic positioning and coordination at UNCT in Sierra Leone.

M&E System: UNFPA M&E System is well aligned with a direct Output-Outcome relationship. Monitoring of inputs and activities is satisfactory but evaluation, an important part of the process is underutilized. While all the systems for M&E are in place, there is noticeable inconsistent operationalisation as some of the activities were never and are not carried out. Some output and outcome indicators are not well framed.

Communication Strategy: UNFPA communication strategy aims to give a human face to the challenges being faced by vulnerable and marginalised members of the population, to generate a call to action and global response to current and emerging crises. Its increased communication, advocacy and partnership with key stakeholders have resulted in political commitment by MoHS on government's support to FP and placement of billboards in all districts, declaration signed by Paramount Chiefs to support actions on ending teenage pregnancy, child marriage and gender-based violence, among others. There is a wide visibility of UNFPA SL CO contributing to a greater understanding of the challenges the CO faces in the country.

MAIN RECOMMENDATIONS

Strategic

1. There is need for the UNFPA CO to continue building partnerships with other UN Agencies under the umbrella of delivering as one so that resources can be pooled to support activities of the CP. These strategic partnerships have worked well and should continue in the next Country Programme.
2. UNFPA should continue to align the Country Programme to Sierra Leone's national policies and plans as well as international development agendas in order to respond to the country's national needs and priorities.
3. CP interventions should continue to be based on research and needs assessments, national strategies and plans and participatory consultations with stakeholders. It is also suggested that UNFPA CO coordinates with partner UN Agencies and discuss with IPs to include in future programming measures to improve degrees of programmes' sustainability.
4. UNFPA CO increase its fund raising efforts to access other non-core sources of funding to secure financial support for the thematic areas that were least funded in the past couple of years especially Population Dynamics and Development interventions. This will enable the Cluster to extend its activities to other areas of importance, not presently covered, especially ICPD PoA advocacy. Even though resource mobilisation was exceeded for the census, to build statistical capacity at decentralised district levels in response to UNFPA's vision in the new Strategic Plan (outcome 4), the SDGs 2030 and Agenda 2063, all of which advocate for "leaving no one behind" in population counts and interventions, resource mobilisation should be intensified.

5. UNFPA should always strive to improve its signature value in SRH, adolescents and young people, gender equality and women's empowerment, to enhance strategic and local positioning at the country and district levels and to improve coordination with other partner UN Agencies for joint advocacy of the government and in the implementation of joint programmes. More importantly its portfolio in Population and Development should be made more visible, active and relevant in national development and planning.

Programmatic Level

6. To Increase the effectiveness of the each programmatic area outputs, central and district level efforts should be more focused in both scope and geographical area.

In the area of Adolescents, Youth and Gender cluster, it is recommended that UNFPA continue its programme support for youth empowerment and engagement in community education on reproductive health while also advocating for identification of the youth/adolescents SRH needs. UNFPA to increase and enhance community mobilization and advocacy for maternal health , fistulae, family planning and GBV including to law reform and law enforcement for reducing FGM and child marriage.

In the areas of Population and Development, it is suggested that UNFPA increase programme support for the production of an improved quality of data related to PD and RH. UNFPA should also maintain and further support advocacy and coordination for the implementation of ICPD PoA and Sustainable Development Goals. Skills need to be improved to be able to measure progress in SDG and Agenda 2063.

7. UNFPA should continue supporting the SSL capacity to generate, analyse and utilize data to inform, monitor and evaluate policy and programme implementation. UNFPA should support the National Statistical System Strategy to provide for integrated statistical system for the production of improved quality of data related to population and other components of the CP. It should also support the advocacy and coordination for the implementation of ICPD PoA, SDG 2030 and Agenda 2063 in the country.
8. There is need to strengthen the national coordination unit in the Ministry of Planning and Economic Development to ensure continued effective and efficient implementation of next CP activities. In the 6th Country Programme, the role of this Unit is insignificant. The national coordination unit still requires strengthening for it to perform better than it did in the 6th CP. There is need therefore for a stakeholder's meeting to explore further how the CP coordination mechanism as indicated in the CPD can be strengthened so that it can effectively play its role in the next Country Programme.

Efficiency

9. Create conditions for sustainability of CP interventions by developing and integrating an exit strategy at both the coordination and implementation levels and develop a capacity building and technical assistance strategy for the entire programming cycle.

10. The CO should maintain its emergency response readiness to enable appropriate responsiveness to emerging humanitarian needs while also strengthening coordination and collaboration with other national relevant stakeholders.
11. UNFPA CO should continue and enhance its efforts to improve coordination with other UN agencies in the country for joint programming in advocacy, gender issues, adolescents and HIV.
12. UNFPA CO should strive to improve its headline value in population and development, sexual and reproductive health, adolescents and young people, gender equality and women's empowerment to enhance strategic positioning at the central and district levels and to improve coordination with other UN agencies for joint advocacy and implementation of programmes. Its portfolio in population and development should be made more visible, active and relevant to national development and planning.
13. Strengthen the UNFPA CO's monitoring and evaluation to ensure the availability of complete information. During the evaluation, gaps in information were noted, that is, some indicators were not specific to clearly follow which aspect is being measured in the numbers achieved. The definitions and measurement of the indicators were also not clear. There is need for the monitoring and evaluation system and unit to be strengthened and made more active in the next CP.
14. Strengthen the CO Communication Unit to make it more effective in advocacy and promoting the visibility of the activities of the CO.

Programme Design

15. UNFPA SL CO should review and define for itself what it will do and how it will do it in the next CP rather than take the definitions from the global strategy. This means that CP should reflect national context, and the definitions, activities, risks and assumptions require rethinking and adaptation.

CHAPTER 1 INTRODUCTION

1.1 Purpose and Objectives of the Country Programme Evaluation

The purpose of this evaluation undertaken within the context and provisions of UNFPA Evaluation Policy Framework is to assess the 6th CP of Sierra Leone. The broad objectives of the evaluation are (i) to assess the achievements of the programme, the factors which may have facilitated or constrained the achievements of intended results, and (ii) to draw lessons learned from design through implementation to inform development of the seventh country programme cycle (2020-2024).

1.2 Scope of the Evaluation

The CPE covered activities implemented from **January 2015 to 31 March 2018**. The evaluation covered all 16 districts¹. Government line ministries/agencies as well as all implementing partners involved in the CP implementation were covered taking into consideration the relevant programme components: (4 outcomes) and 8 outputs of the CPD 2015-2019 focusing on both development and humanitarian programs.

The evaluation covered the four technical areas of the Country Programme (sexual and reproductive health, gender equality and women empowerment, adolescents and youth reproductive health, population and development). In addition, it covered cross-cutting issues in the Country Programme such as human rights based approach, gender mainstreaming, adolescent and young people, data generation and use. It also focussed on the implementation process, achievements and challenges at both output and outcome levels of the 6th Country Programme 2015- 2018. This exercise would enhance accountability of UNFPA CO for the relevance and performance of its Country Programme, and broaden evidence-based design of the next programme cycle.

1.3 Methodology and process

The Evaluation utilised several data collection methods and undertook systematic triangulation to ensure robust analysis and understanding of the intervention logic underpinning the programme. The evaluation approach and its methods placed emphasis on participatory data collection to gain information on achievements, challenges and lessons learned in contributing to the different components of the 6th CP.

The evaluation team utilised four of the standard evaluation criteria drawn from the United Nations Evaluation Group/Organisation for Economic Cooperation and Development criteria of relevance, efficiency, effectiveness and sustainability. Additional criteria relevant to UNFPA CO with the view of addressing its strategic position within the United Nations Country Team, and its added value to the national development goals were used. Relevant also are the cross-cutting issues of monitoring and evaluation, and communication systems, human rights, gender mainstreaming within UNFPA's work. For each of the evaluation criteria, a set of evaluation questions was developed.

¹ Districts will be considered within their 2015 boundaries. Hence the two newly-created districts and the western area will be covered as part of the initial 16.

Evaluation criteria and evaluation questions

This evaluation was informed by the UNFPA Evaluation Handbook “*How to design and conduct a CPE at UNFPA*”² and will cover four out of the five criteria of the Development Assistance Committee of the Organization for Economic Cooperation and Development (OECD/DAC): Relevance, Effectiveness, Efficiency and Sustainability³. In addition, two other UN-specific evaluation criteria—coordination and added value will be considered in the evaluation to help assess the 6th CP’s alignment with the UN Development Assistance Framework with a view to assessing the UNFPA contribution to the UN country team (UNCT) coordination mechanisms. Evaluation questions will be framed around these key criteria.

The defined criteria are **relevance** (extent 6th Country Programme addressed national priorities and needs of population in relation to UNFPA mandate and comparative advantage; how UNFPA adapted to changing needs of the target populations in the planning and implementation of program interventions, particularly for the country’s vulnerability to disasters and emergencies); **effectiveness** (extent UNFPA-supported interventions, including in the humanitarian context, reached the different categories of beneficiaries and expected targets; extent the different outputs of the 6th program have been achieved through the interventions implemented; whether these interventions contributed or likely to contribute to the desired changes); **Efficiency** (extent the intervention mechanisms (including funds, human resources, expertise and timing) were converted to or impede the achievement of the programme outputs); **sustainability** (degree UNFPA has been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to ensure ownership and the durability of results). **Strategic Alignment** (extent the UNFPA Country Office contributed to the functioning and coordination of UNCT coordination mechanisms). **Added Value** (the main comparative advantages of UNFPA in Sierra Leone particularly in relation to other organizations operating in the country). Finally, **UNFPA’s engagement in fragile contexts** (the extent UNFPA, along with its partners, were able (or likely) to respond to crises during the period covered by the country programme).

In addition, the CPE assessed cross-cutting elements of the 6th CP notably the **monitoring and evaluation system** (the extent to which the institutional monitoring and evaluation system of the programme has enabled the effective collection, circulation and reporting of data, favoring the monitoring of the achievement of the results, the decision-making and the accountability of the programme) as well as the **communication system** (the extent to which the institutional communication mechanism has enabled the dissemination of the program’s actions to the beneficiaries and other stakeholders and ensured the visibility of its interventions both internally and externally).

Evaluation Questions: Standard questions aimed at translating the abstract analytical perspectives of evaluation criteria into concrete language and conceptual components of the UNFPA Country Programme will be formulated. These questions must capture the main elements of the Government of Sierra Leone/UNFPA 6th Country Programme.

² <http://www.unfpa.org/public/home/about/Evaluation/Methodology>

³ UNFPA CPEs cover all OECD-DAC evaluation criteria to the exception of the impact. This evaluation will also not assess impact due to the lack of required data for in-depth analysis.

Inception phase

At the inception stage, the Evaluation Team met with UNFPA CO management and the Evaluation Reference Group to seek input, confirm and approve choice of methods and data collection tools and data analysis plan. The questions developed were based on the CPE ToR, Country Programme Document (CPD), CPAP Results and Resources Framework which articulated the indicators of the UNFPA Strategic Plan and CP interventions.

Field Phase

Data collection lasted for three weeks, starting from August 6 and ended in August 30, 2018. Field work involved data collection through stakeholder interviews using semi-structured interview schedules, focus group discussions, field visits and observation to provide primary data to supplement the extensive document review. The following methods for collecting data used are elaborated below:

Documents review: Extensive review of CP documents formed the basis of the CPE, informing evaluation design, including the evaluation matrix and data collection tools, and providing the most extensive data to triangulate the primary sources. The CO identified and provided the main documents for the evaluation team according to the guideline in the UNFPA Evaluation Handbook. The documents provided by the UNFPA CO are listed in **Annex 3**.

Semi-structured interviews: This method of data collection was done to provide deeper insights into the issues that were unearthed from the desk review. Information gathered from this method provided clarity on observed trends and gaps for each component area of analysis. Key informant interviews were held with national stakeholders using semi-structured interview guides. Interviewees included policy makers, programme heads in government, the UN agencies, and civil society organisations. Interviews were held at national level and in each of the nine districts. We also interviewed CO staff and management. Number of key informants interviewed was sixty-seven (67) including CO Management and Programme officers; In-depth interviews were held with seventeen (17) selected implementation partners at intervention sites.

Group interviews: These helped in gathering information on the opinions and views of program beneficiaries about the 6th CP. A total of 5 focus group interviews were conducted, each group being made up of a group size of 5 – 7 people. A total of 31 persons were engaged in these discussions.

Site visits and Observations: The evaluation team undertook site visits to 5 intervention sites in the districts to observe on-going activities and interview implementation partners and beneficiaries. The places visited include PCMH, Schools of Midwifery Makeni, Bo, Community Health Post, Pujehun and Community Health Centre at Jembe and NPPU, Freetown.

Validation

The use of a variety of methods was to ensure validity of information collected. The evaluation team also validated the data collected by internal team-based revisions and triangulation based on systematic cross-comparison of findings by data sources and by data collection methods. We compared findings from different data sources and data collection methods.

Methods for data analysis and validation

Data analysis was done based on the four thematic areas of the CP. Quantitative data were reviewed as secondary data from CP documents such as Strategic Programme Reports, Annual Reports, Quarterly Reports, Reports from IPs, among others.

The evaluation team used content analysis approach based on the extensive document review, interviews and focus group discussions and field visits. The second approach was Contribution analysis

used to assess the results chain logic in the CPD and the effectiveness of the UNFPA CP in achieving activities and outputs and their contribution to outcome results in the component areas. All the evaluation criteria were addressed and analysed for the component areas and also with respect to implementation modalities and efficiencies. The triangulated analysis allowed the drawing of conclusions and recommendations from different sources outcomes including both planned and unexpected outcomes. For each of the outcome areas of the Country Programme, the evaluation included the following levels of the results chain: activities, outputs and outcomes.

The formats of the UNFPA Evaluation report as specified in the UNFPA Handbook on Evaluation were used for tabulation and analysis to organise the findings within the main body of the report. The presentation of the findings is follows: (i) text of the evaluation question; (ii) short summary of the answer within a box and (iii) detailed answer to the evaluation question. Conclusions are arranged in two-cluster sequence: strategic, programmatic levels (UNFPA Evaluation Handbook, 2013).

Stakeholder Selection

Following the guidelines on comprehensive stakeholder selection from the UNFPA Evaluation Handbook, the Team worked with the evaluation manager and CO to identify a list of stakeholders after reviewing various programme documents and discussions with programme officers. They selected a number of people interviewed across the major stakeholder's categories of the 7th CP outputs and outcomes. These included national level stakeholders including UNFPA CO staff and implementing partners (national and district levels), strategic partners, and beneficiaries. Relevant stakeholders were involved at the different stages of the CPE including design, data collection, data analysis, and reporting especially at the recommendation formulation process, debriefing, and dissemination stages, as were appropriate.

Evaluation Process Overview

The UNFPA Handbook for Evaluation of CP provides the guidelines for the evaluation process. As much as possible, the ET adhered to the Evaluation Quality assessment grid, the Norms and Standards of the UN Evaluation Group and the Ethical Code of Conduct for UNEG/UNFPA evaluations. The overall process had five phases including the preliminary preparation phase prior to the consultant recruitment, as follows:

Phase 1: The recruitment and establishment of the evaluation reference group (ERG) and development of terms of reference; recruitment of consultants. The consultants then conducted the subsequent phases with technical, logistics and administrative support from the CO, especially the evaluation manager.

Phase 2: Evaluation design phase by consultants that terminated in a presentation to the ERG and CO and the final design report that outlined the evaluation process, the evaluation matrix and tools for data collection, stakeholder selection and mapping.

Phase 3: Field phase consisting of extensive documentation review and conducting the actual interviews as determined in the design report.

Phase 4: This Phase involved Synthesis of data, triangulation and analysis, development of the draft report, debriefing and presentation to the CO and ERG for critique and validation. The CO, RO and ERG provided important information, consolidated feedback for the consultants to undertake further revision and to develop a presentation first for the CO and ERG, and then further feedback, to stakeholders. This iterative process allows for repeated clarification and validation of the findings, conclusions, recommendations and lessons learned.

Phase 5: Final review and incorporation of comments from the UNFPA RO and UNFPA HQ. The evaluation manager and the CO then prepared a management response to the recommendations of the evaluation for the UNFPA WCARO and HQ.

1.4 Limitations

There are other important limitations in the methods. First, due to limited time and resources it was not feasible to collect representative samples. While there was some opportunity for a randomization process for the training follow-up interviews, all other samples were purposive and not truly representative of the target populations of stakeholders, trainees and client/beneficiaries. The evaluation is inherently qualitative in nature due to the small, non-random sample sizes. Second, due to the short time frame permitted to field the evaluation (less than three weeks in country), the response rates for certain interview categories was lower than desired and no client/beneficiary interviews could be conducted. There are possible biases in the selection of respondents due to the fact that locations were selected by the evaluation team on a purposive non-random basis. To avoid the possibility of bias from the presence of UNFPA staff, all interviews were conducted by the evaluation team in private without any UNFPA agency staff present.

Despite the above mentioned limitations and potential biases, the evaluation team was able to mitigate these constraints by triangulating a wide range of qualitative and secondary data. For example, the team was able collect beneficiary feedback using (focus) group discussions with key populations including fistulae patients, adolescent females in Safe Places, out of school youth, heads of Schools of Midwifery. Where feasible, the lack of current data were addressed by using other sources of quantitative data.

CHAPTER 2 COUNTRY CONTEXT

2.1 Development Challenges and National Strategies

2.1.1 Political, Economic and Social Context

Sierra Leone is a relatively small country with a land area of about 72,000 square kilometres and an estimated population of about 7.09 million from 4.98 million in 2004, showing a growth rate of 3.2% (2015 SL-PHC). The population is predominantly rural with about 59.2% primarily engaged in agriculture, and those in densely populated urban areas, including the capital city, primarily engaged in services and industry⁴. The country's population is largely youthful with those aged 0-35 years making up about 80%, and under 15 years constituting 40.9%. This presents challenges in the provision of education, healthcare and jobs, but also represents a great resource offering opportunities to establish a solid foundation for development and great potential for harnessing the demographic dividend.

Since the end of its protracted civil war in 2002, the country has made significant progress in peace consolidation, democratic governance, economic recovery and the fight against poverty. These gains have been triggered within the framework of poverty reduction strategies – the second PRSP (2007 – 2012), “Agenda for Change” and its successor programme, the “Agenda for Prosperity (2013 – 2018)”, which carves the roadmap for the attainment of middle-income status by 2035.

Economic growth for the past five years averaged around 7 per cent per annum and estimated to grow by at least 31 per cent in the last two years, mainly from intensive mining activities coupled with high prospects of oil discovery. Development efforts have, however, been constrained by the lack of skilled human resources in all sectors particularly health, poor infrastructure, inadequate budgetary resources, poor accountability systems and corruption. At least 70 per cent of the population mostly in the rural areas wallow in abject poverty and forced to live in extremely difficult situations, thereby limiting their access to basic social services for survival. The country has continued to be ranked at the bottom of the Human Development Index (183 out of 187 countries in 2013). The Ebola Virus Disease (EVD) outbreak has further worsened the human development situation.

Until the outbreak of Ebola in May 2014, Sierra Leone was seeking to attain middle-income status by 2035, but the country still carries its post-conflict attributes of high youth unemployment, corruption and weak governance. The country continues to face the daunting challenge of enhancing transparency in managing its natural resources and creating fiscal space for development. Problems of poor infrastructure and widespread rural impoverishment still persist in spite of remarkable strides and reforms.

The economy is driven by primary commodities, mainly agriculture and mineral production. The economy is presently undergoing a shift in the size of its major components as informed by movements in the sizes of their contributions to gross domestic product (GDP). The mining sector contribution to GDP is anticipated to reach 30% in 2017 due largely to the expansion in existing large scale iron ore operations. Agriculture including forestry and fisheries still accounts for the largest GDP share but that

⁴ Sierra Leone 2015 Population and Housing Census.

share is declining – reducing from 52% in 2011 to an estimated 42% in 2013. Despite this declining trend, the agriculture sector is still the largest employer, and accounts for over 70% of the current labour force. The mining sector, the current driver of growth in the economy, accounts for less than 3% of total labour force, due mainly to the capital-intensive and enclave nature of mining operations and reliance on highly skilled labour. The service sector, which is led by banking, retail, transport and tourism, has a 28% share of GDP in 2013, having slipped downwards from 35% in 2011. The manufacturing sector, mainly driven by cement and light scale consumer products is still relatively incipient and weak, and accounts for only 2% of GDP due to limitations in energy supply, weak infrastructure and poorly developed markets. Off shore oil and gas exploration is ongoing with additional block concessions contracted to renowned oil companies in October 2012. While the prospects of oil discoveries are imminent, commercial viability is expected to be achieved after 2017.

Sierra Leone has made substantial progress in its socio-economic indicators since the end of the war, moving 10 places upwards from the unenviable human development position it held a few years ago. Despite these improvements, there are significant challenges in socio-economic development characterized by its continued fragile status. Results from the 2011 Sierra Leone Integrated Household Survey (SLIHS) indicate a decrease in the poverty rates, from 66% in 2003 to 52.9% in 2011, with the decline being more in urban relative to rural areas. Underlying this poverty reduction was an annualized 1.6% per capita increase in real household expenditure from 2003 to 2011. Urban poverty declined from 46.9% in 2003 to 31.2% in 2011. District level poverty analysis showed that by 2011 most districts had converged to poverty levels between 50 and 60%, with the exceptions being Freetown at 20.7%; and 64% percent of households in the top two quintiles were found in the western urban areas.

2.1.2 Situation analysis of Sexual and Reproductive Health

The 6th CP was developed in 2014 when the country had the highest maternal mortality ratio (MMR) in the world, with 1,360 maternal deaths per 100,000 live births⁵, generally attributed to the poor access to quality reproductive health services, including family planning information and services, particularly in the remote and hard-to-reach rural communities. The fertility rate was estimated at 4.9 children born/woman⁶ and the CPR for modern contraceptives was about 16%; unmet need for family planning was estimated at 25% for currently married women ages 15 to 49 years, and even higher (30.7%) for the 15-19 age group. Maternal morbidity has also been of serious consideration, prominent among which is obstetric fistula, majority of cases found in remote and difficult-to-reach rural areas, with generally no established prevention programs.

Despite improvements in strengthening the health system, maternal mortality is still very high at 1,165 per 100,000 live births (DHS 2013) while another estimate indicated 1,360. (UN 2015) .Even though CEmONC facilities have been scaled-up with the refurbishment of 27 health facilities in five districts, there is still a vast group in providing adequate and quality services, with an unmet need for MNH services of about 76 per cent (SOWMY, 2014). The provision of emergency obstetric and new-born

⁵ WHO, (2015) Trends in maternal mortality: 1990 to 2015. Estimates by WHO, UNICEF, UNFPA, *World Bank Group and the United Nations Population Division*. Geneva: World Health Organization;

⁶ National Analytical Report- Sierra Leone 2015 Population and Housing Census.

care is further hindered by limited availability of essential and life-saving commodities, other medical supplies and equipment.

The high maternal mortality is further worsened by the long-term health complications among women, such as obstetric fistula, uterine prolapse, or infertility. It is estimated that for every woman who dies, 15-30 others are likely to face these morbidity problems. There are limited facilities to address these complications, with presently only two major centres that provide services for Obstetric fistula repairs 1. Managing Fistula and related maternal health problems have therefore been integrated in the national reproductive, maternal and child health policy.

Other causal factors that account for at least 36 per cent of maternal mortality include inadequate and reliable supply of safe blood, and inability to produce and retain sufficient medical personnel (doctors, midwives and nurses) to provide EmONC services. Caesarean sections increased from 0.9 per cent in 2008 to 2.1 per cent in 2012 due to the removal of user charges for pregnant women; but are still well below the standard rate of 5 -15 per cent. Unsafe abortion accounts for 13 per cent of all maternal deaths.

The proportion of women receiving ANC from a skilled provider increased from 87% in 2008 to 97% in 2013. Similarly there was a two-fold increase in the proportion of births that take place in a health facility, from 25% in the 2008 SLDS to 54 percent in the 2013 SLDHS. The proportion of births assisted by a skilled provider increased from 42 percent in 2008 to 60% in 2013

Trends in modern family planning practices have been positive and encouraging, as evident by an improvement in the contraceptive prevalence rate (CPR) from 3 per cent in 2002, to 7 per cent in (2008) and 16 per cent in (2013). This largely explains the decline in the Total Fertility Rate (TFR) from 6.3 children per woman in 1985, to 6.1 in 2004, 5.1 in 2008 to 4.9 in 2013 (DHS 2013). However, the increase in CPR (16 per cent) is still one of the lowest in the sub-region, with a considerably high unmet need for family planning at 28 per cent.

There remains a desire among 35 per cent of women to delay child-bearing by two or more years, with 26 per cent who do not want to have any more children (DHS 2013)⁷. Anecdotal evidence indicates a reduction in utilization of modern family planning methods, with the number of new acceptors dwindling and continuing users not turning up for refills. The decline in TFR is observed to be an urban phenomenon, as rural women are known to have on average 2 more births (5.7) than urban women (3.5), according to the SLDHS 2013.

The main impediments to contraceptive use among women in rural communities are that they have little or no education, encounter socio-cultural barriers such as spousal approval for family planning (14 per cent) and preferences for large family size (10.8 per cent). Other common reasons for not accepting family planning methods are religious prohibition (9.3 per cent) and fear of side-effects (10.8 per cent) as estimated by the DHS 2008.

Knowledge on family planning is also relatively high, with 69 per cent of all women and 82 per cent of men who have heard of any modern method of contraception. The three best-known methods amongst all women and men are pills, injectable and male condoms, and these are available in almost 80 per

⁷ Statistics Sierra Leone and ICF Macro (2013): Sierra Leone Demographic and Health Survey 2013. Calverton, Maryland, USA: Statistics Sierra Leone and ICF Macro.

cent of the Service Delivery Points (SDPs). Despite high unmet need of spacing and limiting pregnancy, it is estimated that implants account for 2.4 per cent CPR from zero in previous years; IUD use still very low at 0.1 per cent; less than 1 per cent uses female sterilization, and male sterilization is practically non-existent as a method (SLDHS 2013).

While there are integrated policies and strategies for family planning and midwifery, these are still inadequate to address the requirements. There is a dire need to develop appropriate policies and detailed strategic plans for the specific intervention areas. Despite the limited availability of human resources, the existing national policies serve to restrict the role of certain cadre of health care providers in the provision of family planning and post-abortion care services.

There have been improvements in Reproductive Health and Commodity Security, but the procurement and supply chain management systems remain challenging. In spite of efforts to support timely clearance, distribution, storage and reporting, stock-outs are still prevalent at Peripheral Health Units (PHUs). In 2012, only 41 per cent of Service Delivery Points (SDPs) reported 'no stock outs' with an increase to 53.2 per cent in 2013 (GPRHCS Annual Survey 2012 and 2013).

2.1.3 Adolescents and Youth Reproductive Health

Adolescents and youth constitute 55 per cent of the total population of Sierra Leone. They become sexually active as early as 12 years old. About 16 per cent of youth are married before the age of 15, and 50 per cent before the age of 18. High teenage pregnancy (34 per cent) and adolescent birth rates (146/1,000 live births) contribute to 40 per cent of maternal deaths. At least 25 per cent of maternal deaths are due to unsafe abortion among adolescents. (SLE CPD, 2015)

Sexual and Reproductive Health problems including STIs/HIV/AIDS are prevalent among adolescents and youth; hence, the need to intensify implementation of comprehensive condom programming. Addressing these challenges is largely constrained by inadequate facilities for providing comprehensive youth-friendly services. The large unmet need for these facilities impacts negatively on the health of young people, and compound by several barriers such as issues of stigma, discrimination and attitude of health personnel.

Since 2005, HIV prevalence has stabilized at 1.5 per cent with a prevalence of 1.2 per cent among young people aged 15-24 years, of which young females constitute about 57 per cent. Condom use among young people aged 15 to 24 has declined from 29.2 per cent to 21 per cent for males and from 12.2 per cent to 5.9 per cent for females. HIV prevalence is significantly higher among "Most-At-Risk" sub-populations, averaging around 6.7 per cent. Almost 75 per cent of this population constitute adolescents and youths and thus require serious attention. (SLE CPD, 2015)

2.1.4 Gender Equality and Empowerment Context

Sexual and Gender Based Violence (SGBV) and denial of women's rights are still highly prevalent at all levels in Sierra Leone. Harmful traditional practices primarily Female Genital Mutilation (FGM), child marriage, and high teenage pregnancies continued to inhibit women and girls empowerment. Despite the high prevalence of FGM (98% among women aged 45-49 years and 74% for girls aged 15-19

years (SLDHS 2013), no related legislation was in place. . Child marriage was an issue with 16 percent of women (aged 15-49) married before the age of 15 while 50 percent (aged 18-49) are married before 18 (MICS 2010)⁸.

There is no legislation in place on FGM/C with a high prevalence rate of 98 per cent among women aged 45-49 and 74 per cent for girls aged 15-19 (DHS2013). Also, SGBV is still prevalent with the records of the Family Support Unit (FSU) of the Sierra Leone Police in 2013 alone showing 7,684 reported cases of GBV, with 1,501 charged to court and 226 convictions. The FSUs are, however, ill-equipped and grossly underfunded to effectively handle the overwhelming reported cases of SGBV.

Despite strides in promoting gender equality and women's rights, SGBV, inequities and denial of women's rights at all levels in society are still highly prevalent. Most women continue to suffer marginalization and discrimination, particularly in the areas of education, employment, political participation, and poverty inheritance/ownership. Harmful traditional practices primarily female genital mutilation, child marriage, and high teenage pregnancies continue to inhibit women and girls empowerment.

In addition to international conventions and protocols on women's participation and empowerment, Government has also instituted a number of legislations, policies and strategies to address women's issues relating to decision-making and access to resources at all levels. There are, however, challenges with translating government commitments into concrete actions, mainly as a result of inadequate financial, technical and human resources in the relevant Ministries for implementing policies and programmes.

2.1.5 Population Dynamics Context

Sierra Leone's projected population, prior to this 6th CP was 6.1 million. Sierra Leone has a young population with 40.9% of its population under 15. A very young population presents a major challenge for the country as a result of high rates of dependents. Total fertility rate was 4.9 for the whole country, 5.7 in rural areas and 3.5 in urban areas. Infant mortality is 92 deaths per 1,000 livebirths. Child mortality is 70 deaths per 1,000 live births while the overall under-five mortality rate is 156 deaths per 1,000 live births. The neonatal mortality rate is 39 deaths per 1,000 live births while the post neonatal mortality rate is 54 deaths per 1,000 live births.

The inadequacy of reliable data continues to pose serious challenges for planning at both central and district levels. It also serves as a major deterrent to the monitoring of national development frameworks and programmes, including the MDGs and other global development initiatives. Several surveys and data collection activities sometimes generate conflicting data for the formation, implementation and monitoring of population and reproductive health policies and programmes. Thus, in addition to the need for data harmonization there are still challenges of serious data deficiencies in vital statistics (births, deaths, nuptiality and migration) for designing national population programmes.

⁸ UNICEF/SSL (2010): Multiple Indicator Survey 2010.

The lack of technical capacity (human and institutional) has impeded the formulation and implementation of the National Population Policy and related programmes. The integration of population issues in policies and plans to address reproductive health and gender concerns are limited.

2.2 The role of external assistance

Sierra Leone has a high dependency on donor assistance. Its Overseas Development Assistance [ODA] received as a percentage of the gross national income amounted to 22.6 percent in 2015. Its major development partners include United Kingdom, USA, IMF, EU institutions, World Bank, International Development Assistance, Germany, Japan, Global Fund and Islamic Development Bank., China and Ireland.

Over the last few years the net amount of overseas development assistance (ODA) received has drastically decreased. The total amount of ODA received by Sierra Leone in 2015 increased from US\$ 869.6 million but fell to US\$ 799.2m in 2016 (OECD-DAC, 2018).

The UN Country Team in Sierra Leone has a close cooperation with the Government of Sierra Leone. It developed the United Nations Development Assistance Framework (UNDAF) for support to the government of Sierra Leone. This assistance aims to support the government to improve the quality of life of Sierra Leoneans, ensure sustainable development. The support involves development planning and addressing humanitarian crises. The UNDAF is people-centred interventions to address the needs of the population with capacity development focused on human resources development. The framework addresses the needs and rights of children, women, pregnant women, adolescents and young people, and general population in vulnerable areas.

The UNDAF in Sierra Leone entails three strategic priority areas as well as cross-cutting themes, all of which are interdependent and will ensure a sustainable development process. The priorities of the UNDAF in SL are governance and human rights, shared growth, food security and livelihoods, maternal health and child health care, primary education with special emphasis on girls' education; HIV/AIDS, Tuberculosis, Malaria and related diseases.

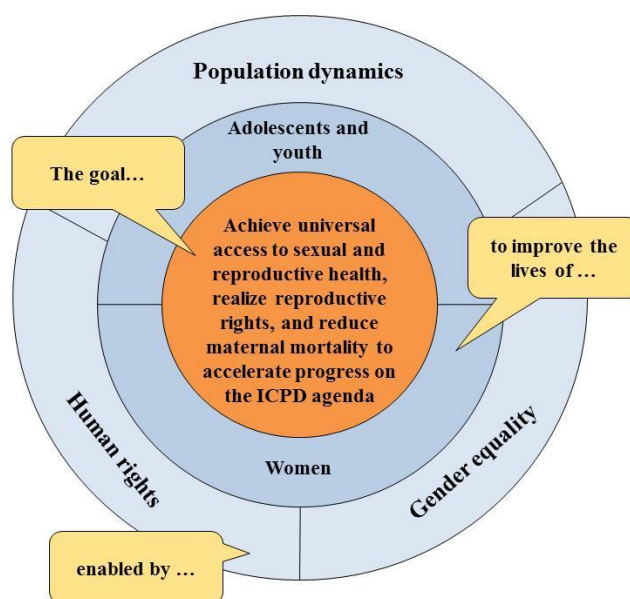
Apart from the UNCT, a number of bilateral development partners such as UKAID, Irish AID, Japanese International Cooperation Agency (JICA), are resident in the country. They do contribute to the development of the country.

CHAPTER 3 UNFPA STRATEGIC RESPONSE AND PROGRAMME

3.1 UNFPA Strategic response

Globally, UNFPA Strategic Plan identified and defined three broad programmatic areas: of sexual and reproductive health and rights, gender equality and women's empowerment, and population and development. In 2011, UNFPA adopted a set of 7 interrelated outcomes which in turn supports a single overarching goal to achieve universal access to sexual and reproductive health, promote reproductive rights, reduce maternal mortality and accelerate progress on the ICPD agenda and MDG5. The Strategic Plan placed SRH and reproductive rights squarely at the centre of the work of UNFPA. The new UNFPA Strategic Plan for the period of 2014-2017, colloquially known as the "bull's eye", reaffirms the strategic direction organised under five outcomes. The bull's eye, "the achievement of universal access to sexual and reproductive health, the organisation of reproductive rights and the reduction in maternal mortality" is the goal of UNFPA with women, adolescents and youth as the key beneficiaries of UNFPA work globally.

Figure 1: The bulls' eye



A revised Global Strategic Plan 2018-2021 which aligned with the 2030 Agenda for Sustainable Development and its 17 Sustainable Development Goals has been developed. Its goal similar to the SP 2014-2017, is to achieve universal access to sexual and reproductive health, realise reproductive rights, and reduce maternal mortality to accelerate progress on the agenda of the ICPD PoA to improve the lives of women, adolescents and youth, enabled by population dynamics, human rights and gender equality. UNFPA has designed its strategic plan to be the first of three consecutive strategic plans that will contribute cumulatively to the achievement of the SDGs [UNFPA 2018].

3.1.1 UNFPA Previous Country Programme

Table 2: Evolution of the CP Programme

Programmatic areas	5th Country Programme (2008-2012) and its extension (2013-2014)	6th Country Programme (2015-2019)
Sexual and Reproductive Health / HIV Prevention	<p>Outcome 1</p> <p>Improved access to skilled birth attendants and reproductive health information and services, with an emphasis on family planning, emergency obstetric care, and neonatal care and HIV prevention.</p>	<p>Outcome 1:</p> <p>Increased availability and use of integrated sexual and reproductive health services, including family planning, maternal health and HIV that are gender-responsive and meet human rights standards for quality of care and equity in access.</p>
	<p>Outcome 2</p> <p>Youth-friendly services and peer-education networks expanded to promote responsible sexual and reproductive health behavior for preventing sexually transmitted infections and HIV/AIDS</p>	<p>Outcome 2</p> <p>Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health.</p>
	<p>Outcome 3</p> <p>Improved availability and choice at all levels of the health system, of high quality reproductive health commodities including male and female condoms</p>	<p>Outcome 3</p> <p>Nil</p>
Gender Equality/ and Women Empowerment	<p>Outcome 1:</p> <p>Communities, human rights organizations and national leaders are mobilized to promote gender equity and reproductive rights, reduce gender-based violence and support survivors of gender-based violence</p>	<p>Outcome 3: Advanced gender equality, women's and girls' empowerment and reproductive rights, inclusive for the vulnerable and marginalized women, adolescents and youth.</p>

Programmatic areas	5th Country Programme (2008-2012) and its extension (2013-2014)	6th Country Programme (2015-2019)
	<p>Outcome 2:</p> <p>Enhanced capacities of key national and local institutions to formulate, coordinate and manage gender-responsive population and reproductive health policies and programs</p>	
Population and Development	<p>Output 1</p> <p>Expanded data base for gender-sensitive population and reproductive health data for use in governance, planning and programme monitoring at national and sub-national levels.</p>	<p>Outcome 4:</p> <p>Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality.</p>
	<p>Output 2</p> <p>Strengthened technical and institutional capacities within key ministries and civil society organisations to integrate population and gender concerns into development plans and programmes</p>	

3.2 UNFPA response through the Country Programme

The goal of the Sixth Country Programme (2015 – 2019) was to contribute to “universal access to rights-based, gender-sensitive sexual and reproductive health information and services, including for adolescents and young people” as defined in the UNFPA Strategic Plan (2014 – 2017). These efforts were guided by an understanding of population dynamics, human rights and gender equality, driven by country needs and tailored to the country context in order to empower and improve the lives of underserved populations, especially women, adolescents and youths.

The programme is linked to the following development frameworks- UNFPA Strategic Plan (2014 – 2017); UN Development Assistance Framework (UNDAF 2015 – 2018) for Sierra Leone; the Third Poverty Reduction Strategy Paper, -Agenda for Prosperity (2013 – 2018). Overall, it is aligned with four main pillars of the Government’s Agenda for Prosperity and related UNDAF outcomes. It also

addresses related issues in the ICPD + 10 Review Report; ICPD Beyond 2014, the new Post 2015 Sustainable Development Goals and African Union Agenda 2063.

In addressing the issues raised above, the 6th CPD was developed within the framework of the four (4) outcomes of the UNFPA Strategic Plan (2014-2017), namely: (i) Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access; (ii) Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health services; (iii) advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth; and (iv) strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality.

Based on the above outcomes, the 6th Country Programme interventions were based on eight outputs organized around three thematic clusters. **Outputs 1 - 3 (Women's Reproductive Health):** Increased national capacity to deliver integrated sexual and reproductive health services, including in humanitarian settings, and Increased national capacity to deliver comprehensive high-quality maternal health services, including Ending Mother to Child Transmission of HIV (etc.) services; **Outputs 4-7 (Adolescents, Youth and Gender):** Increased national capacity to strengthen enabling environments, increase demand for and supply of modern contraceptives and improve the quality of family planning services that are free of coercion, discrimination and violence; Increased national capacity to design and implement community and school-based comprehensive sexuality education programs that promote human rights and gender equality; Increased capacity of partners to design and implement comprehensive programs to reach marginalized adolescent girls, including those at risk of child marriage.; - Strengthened legislative frameworks and national protection systems for promoting reproductive rights, gender equality and addressing gender-based violence; **(Adolescents, Youth and Gender)** - Increased capacity of organizations and communities to prevent gender-based violence and harmful practices, including female genital mutilation/cutting, and provide delivery of multi-sectoral services for prevention, care and impact mitigation, including in humanitarian settings, and **Output 8 (Population and Development):** Strengthened national capacity of the statistical system to collect produce, analyze and disseminate high-quality disaggregated population data for evidence-informed planning and monitoring. To achieve the CP goal, the programme was also infused advocacy and communications strategy for improved UNFPA visibility and resource mobilization capacity.

The underlying strategy for program design and implementation is the UNFPA **"Cluster Approach"** adopted since the fifth country programme, including strategies outlined in the national Agenda for Prosperity- the roadmap for the country's attainment of a middle-income status by 2035. These efforts emphasised building strong partnerships with Government to facilitate improvements in the lives of women, youth and adolescents in Sierra Leone. The core strategy is how to integrate women's

reproductive health and the adolescent and young people's sexual and reproductive health into the country's development process.

Programme Outcomes and Strategies:

For each outcome, specific programme output(s) have been defined, including key strategies and interventions. These were implemented through an integrated approach and building on synergies across all outcomes and related outputs for greater impact and value for money.

For women's reproductive health Outcomes 1 - 3 and Outputs 1, 3 the strategies include (i) the development and review of integrated sexual and reproductive health national policies strategic plans, guidelines and action plans, including a humanitarian response plan at the national level (ii). Strengthening health systems for the provision of quality Emergency Obstetric and New-born Care. (iii) Institutionalizing the Maternal Death Surveillance and Response (MDSR) system. (iv) Human resources capacity development for health service delivery, (v) strengthening obstetric fistula prevention, treatment and social reintegration through awareness-raising; (vi) Integrating the management and prevention of sexually transmitted infections.

Adolescents, Youth and Gender Cluster addresses the needs of adolescents and young people by focussing on creating an enabling environment for the delivery of a comprehensive package of services for adolescents and young people in-school and out-of-school.

For its Outcomes and Outputs, the strategies include (i) promoting advocacy for creating an enabling environment in support of family planning and other reproductive and maternal health services; (ii) increasing knowledge of sexual and reproductive health issues using demand generation and behaviour change communication.; (iii) Building capacity for commodity security and logistics management systems., (iv) building human resources capacity to fulfil demand for family planning, as well as inclusion of family planning modules in curriculum of midwifery and MCH Aide education and (v) integrating family planning into other sexual and reproductive health services.

For Output 4, the strategies and activities for achieving this output include (i) providing technical assistance in collaboration with MEST to update national curricula, integrating sexual and reproductive health and gender; (ii) mobilizing communities on gender equality and SRH, including inter-generational dialogue; (iii) strengthening human resources in health and increasing availability and access to SRH, including HIV prevention information and services.

The strategies and interventions for achieving Output 5 are (i) *providing technical, operational and financial support to Government for implementing the National Teenage Pregnancy Strategy*; (ii) engaging civil society to advocate for the protection of the girl child from discrimination; (iii) undertaking programmes to improve adolescent girls' health, social and economic assets;(iv) developing an evidence base of key indicators of adolescent health and development.

Gender Equality and Women's Empowerment component of the AYG Cluster has one outcome with two outputs. This component addresses women's and girls' issues of inequality, discrimination and empowerment; promotion of policies that address mobilization of communities, national and traditional leaders, including men's engagement for advocacy on women and girls' SRHR, GBV prevention and support to victims and survivors. These issues are aligned to relevant pillars of both the Agenda for Prosperity and UNDAF Pillar 12.

The strategies for achieving output 6 include (i) advocating for gender and human rights-related policies and frameworks, including enforcement and implementation of existing laws;(ii) fostering the establishment of accountability mechanisms to domesticate and implement protocols and treaties relating to women's human rights;(iii) strengthening the coordination and management capacity of partners. The strategies for achieving Output 7 include: (i) mobilizing communities to address harmful traditional practices; (ii) building the capacity of institutions and civil society organizations to prevent gender-based violence. (iii) Providing support for survivors of sexual and gender-based violence.

The population and development component addresses the data needs of the country programme, including data use in governance, planning and monitoring and evaluation, and reporting at all levels. It mainly addresses the strengthening of capacities in national systems for generating accurate and reliable data as articulated in the results frameworks of both Government's Agenda for Prosperity and UNDAF

The strategies and interventions to achieve the Outcome 4 and Output 8 include (i) strengthening partnerships, policy dialogues and evidence-based advocacy; (ii) enhancing government capacity to generate, analyse and utilize age and sex disaggregated data.

Theory of Change Process

The intervention logic of UNFPA support and an approximation to the theory of change (ToC) as reconstructed from UNFPA planning documents and frameworks is presented. The documents used for reconstructing the ToC are Agenda for Prosperity, Strategic Plan 2014-2017 and UN Development Assistance Framework in Sierra Leone (2015-2018). The documents reveal the potential cause-effect linkages between outputs and outcomes. The logic is linked to the outcomes of the UNFPA Global Strategic Plan and UN Development Assistance Framework.

The intervention strategies of the 6th CP include capacity development including technical assistance and training; Service delivery, RH commodity security, behavior change communication, health systems strengthening, advocacy and policy, and dialogue/advice (e.g. national strategies, media campaigns etc.). These strategies are guided by the principles of human rights and gender equality.

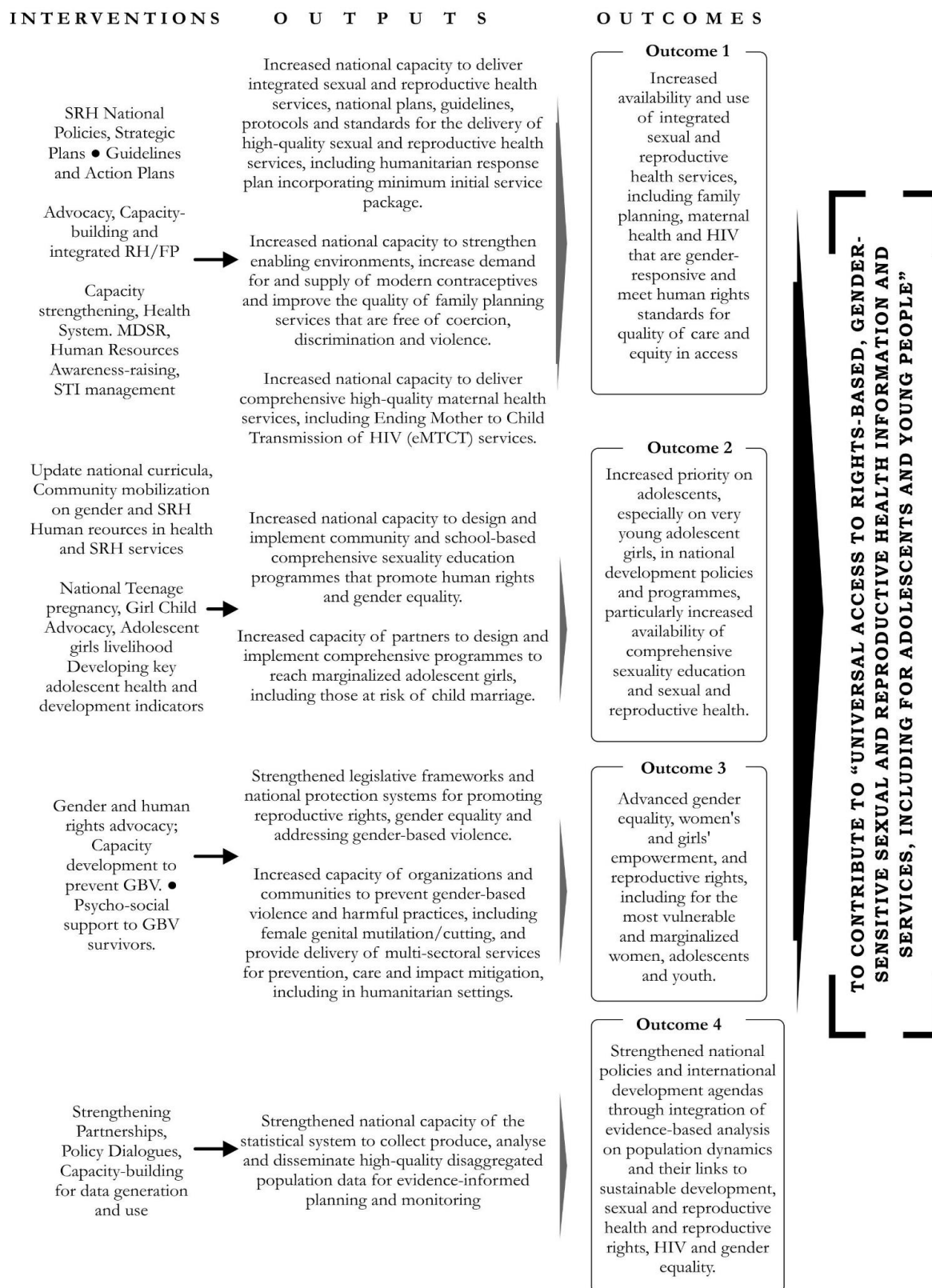
The elements of the intervention logic were inputs (human and financial resources, administrative arrangements, systems, implementing partners, agreements and contracts with IPs and consultants); intervention activities (different modes of engagement); outputs (the immediate or short-term improvements generated once the activities have been completed); outcomes (short and medium-term changes in conditions or effect; corresponding to tangible improvements compared to the baseline situation of target beneficiaries. They imply an improvement in the quality of life of beneficiaries and lastly impact (long-term changes on the population in terms of improvements in their conditions).

This theory simply states that when the inputs are implemented as intervention activities, under the stated assumptions, there would be a change in the quality of life of the beneficiaries of the CP, giving some assumptions or hypotheses.

The ToC was used as an analytical tool during the evaluation, representing the expected processes of change. Specifically, effectiveness and sustainability were assessed within the change pathways from

inputs (modes of engagement) to outcomes, with consideration of external factors that may affect the capacity of the program to achieve its objectives. Efficiency and management of UNFPA's inputs were also evaluated and considered in other key evaluation questions. Relevance, Partnership and Cooperation were evaluated as appropriate, within the context of the change pathways, again with consideration of external factors.

Figure 2: Reconstructed Intervention logic of the 6th Country Programme of Support to the Government for Sierra Leone (2015-2019).



3.2.3 The 6th Country Programme financial structure

Table 3: Indicative Assistance by core programme area (in millions of \$)

Strategic Plan Outcome Area	Regular resources	Other	Total
Integrated Sexual and Reproductive health services including family planning, maternal health and HIV	5.5	11	16.5
Young people's sexual and reproductive health and sexuality education	2.3	5.0	7.3
Gender equality and reproductive rights	1.3	5.5	6.8
Data availability and analysis	1.6	5.0	6.6
Programme coordination and assistance	1.0	-	1.0
Total	11.7	26.50	38.2

The total budget for the GoSL/UNFPA 6th Country Programme was about USD 38.2m. The amount of USD 11.7m was to be raised from UNFPA core resources while the balance of USD 26.50 m would be mobilised through co-financing modalities. The integrated sexual and reproductive health and rights programme area has the largest resource allocation of \$16.5m ; followed by young people's sexual and reproductive health (USD7.3m); gender equality programme (USD 6.8 m) and population and development (USD 6.6 m) and programme management and coordination and assistance (USD 1.0 m).

6th Country Programme Resources 2015-2018

Table 4 shows that more than USD75m were raised from non-core sources. These funds were sourced from the British DFID in the areas of maternal health, CemONC and others. This funded the Saving Lives Projects. Japan International Cooperation Agenda provided funds for both health infrastructure and training of health workers. Three community health centres were constructed, while additional fund from Government of Japan was used to construct five health facilities. The government of Ireland provided funding for a number of projects through its AID agency - Irish AID.

Table 4: Trends in the 6th CP Resources 2015-2018

Type	2015	2016	2017	2018	Total
Core	\$3,366,446.00	\$2,450,004.00	\$2,154,278.00	\$2,102,392.00	\$10,073,120.00
Others	\$18,966,160.00	\$15,207,045.00	\$25,798,347.00	\$15,387,413.00	\$75,358,965.00
Total	\$22,332,606.00	\$17,657,049.00	\$27,952,625.00	\$17,489,805.00	\$85,432,085.00

Assessment of the 6th CP resources by output from 2015-2018 reveals that Output 7 (Quality Maternal Health Care and Ending Mother-to-child transmission) has attracted more resources (\$46m, representing 57.4%) followed by output 1 (Integrated sexual and reproductive health care) with 14.12%, Output 4 (AY) with 8.5%. The Table 5 above shows the amount of resources available for each output showing clearly more investment in SRH.

CP Resources by CP Output Areas

Table 5: 6th CP Resources by CP Outputs

Output	2015	2016	2017	2018	Total	%
Output 1 ISRH	\$7,393,499.98	\$2,442,485.41	\$686,207.72	\$797,455.68	\$11,319,648.79	14.12
Output 2 ASRH	\$751,235.88	\$1,439,200.51	\$1,021,651.40	\$1,075,883.25	\$4,287,971.04	5.35
Output 3 FP	\$999,411.82	\$1,395,684.5	\$2,007,476.44	\$640,261.60	\$5,042,834.36	6.29
Output 4 P&D	\$3,749,440.30	\$1,869,244.13	\$857,885.26	\$221,514.26	\$6,698,083.95	8.35
Output 5 GBV	\$246,277.00	\$107,247.37	\$76,228.81	\$169,078.00	\$598,831.18	0.75
Output 6 RHR/G	\$226,501.00	\$283,407.55	\$315,077.77	\$303,913.00	\$1,128,899.32	1.41
Output 7 QMH/EMTCT	\$4,983,452.46	\$6,525,649.50	\$19,819,271.15	\$14,710,474.76	\$46,038,847.87	57.41
Output 8 P&D	\$1,397,846.78	\$992,372.48	\$1,090,519.41	\$365,145.00	\$3,845,883.67	4.80
Management- PCA	\$147,000.00	\$572,841.31	\$323,502.31	\$185,472.00	\$1,228,815.62	1.53
Total	\$19,894,665.22	\$15,628,132.76	\$26,197,820.27	\$18,469,197.55	\$80,189,815.8	100

NB: There is a variance of about \$5 million between resources and utilized funds. As at the finalisation of this report, no updated data was provided by the Finance Unit.

CHAPTER 4: ANALYSIS AND FINDINGS OF COUNTRY PROGRAMME

This Chapter covers the summative evaluation of the sixth UNFPA Country Programme of Support to the Government of Sierra Leone. It presents the analysis of the levels of achievements of results within each of the programme areas of the 6th CP (2015-2018).

4.1 Relevance

Evaluation Question: (a) To what extent has the 6th UNFPA/GoSL Country Programme addressed national priorities and needs of population in relation to UNFPA mandate and comparative advantage; (b) To what extent did the CP adapt to changing needs of the target populations in the planning and implementation of program interventions, particularly for the country's vulnerability to disasters and emergencies?

Summary: The 6th Country Programme in Sierra Leone showed a huge alignment with national and international priorities and needs of the people of Sierra Leone. It responded to the UNDAF outcomes addressing women's, adolescents and youth sexual and reproductive health, gender and population and development needs. The CP also demonstrated its agility in responding to emerging issues by committing resources and actions in times of humanitarian crises. The UNFPA SL CO demonstrated ability to provide leadership in emergencies by advancing and coordinating national responses to such issues.

The 6th UNFPA/Goals Country Programme comprised of the four programme components of sexual and reproductive health, adolescents and youth sexual health, gender equality and women empowerment, and population dynamics. These components are re-organised under three clusters: women's reproductive health, adolescents, youth and gender, and population and development.

The women's reproductive health cluster addresses the Government's health priority issues of reducing maternal mortality and morbidity, and strengthening family planning and new-born health as articulated in the Reproductive, New-born and Child Health Policy (2011-2015); Reproductive, Neonatal and Child Health Strategic Plan 2012 -2016; and Behaviour Change Communication Strategy (2011-2015). The CP is also aligned with the Sierra Leonean Agenda for Prosperity (2014-2018), a five-year development agenda for social and economic development of the country. This agenda has a number of Pillars, and the 6th CP is particularly aligned to Pillar 3 (accelerating human development), Pillar 6 (Social Protection) and Pillar 8 (Gender and Women's empowerment). Given the sexual and reproductive health needs in the country, high level of gender-based violence and gender inequality, the contribution of UNFPA becomes significant.

Internationally, the CP is aligned with the recommendations of the International Conference on Population and Development (ICPD) Programme of Action. The Country Programme is also aligned with the United Nations Development Assistance Framework (UNDAF) 2014-2018 in Sierra Leone and UNFPA Global Strategic Plans (2014-2017 and 2018-2021). The country is a signatory of the AU Maputo Plan of Action which advocates for integrated SRHR Plan.

UNFPA's Sexual and Reproductive Health and Rights programme in Sierra Leone also focused on realization of SRHR by ensuring universal access to quality sexual and reproductive services by women,

young people and men as well as reduction of maternal mortality. Support was provided to ensure functionality of Basic Emergency Obstetric and New born Care (BEmONC) at facility and district levels, especially in underserved areas, and among vulnerable populations. UNFPA's support in this area focuses on strengthening National SRHR policy advocacy, and district level capacity building for service delivery; maternal and new born health; fistula management (referrals, repairs, treatment and integration); health systems strengthening; FP/reproductive health commodity security and Strengthening Integration of SRHR and other services.

The gender equality and women's empowerment component is meant to address women's and girls' issues of inequality, discrimination and empowerment; promotion of policies that address mobilization of communities, national and traditional leaders, including men's engagement for advocacy on women and girls' SRHR, GBV prevention and support to victims and survivors are aligned to relevant pillars of both the Agenda for Prosperity and UNDAF. The 6th Country Programme is in tandem with the third MDG which aimed to promote equality and empower women; in line with the UN's CEDAW General Recommendation 19 on violence against women. The Country Programme promoted human rights particularly women's right and is consistent with the Constitution of Sierra Leone. It is also consistent with the fifth SDG which aims to achieve gender equality and empower all women and girls. The CP emphasises the adoption of gender and human right approaches as cross-cutting in all the components.

The population and development component was also aligned to national priorities and development strategies, ICPD PoA, SDG and AU Agenda 2063. In addition, it is in alignment with the 2014-2017 UNFPA Strategic Plan that highlights advocacy for population and development linkages, sexual and reproductive health rights, gender and adolescents and youths. The P&D component was anchored on the ICPD PoA principles which stipulate that human beings are at the centre of sustainable development. This component was designed to promote integration of population issues into development strategies, planning and programming to achieve social justice and eradicate poverty. Internationally, it was also responsive to the ideals and actions as outlined in the International Conference on Population and Development (ICPD) PoA and also by extension the Millennium Development Goals.

All stakeholders and beneficiaries assessed during the evaluation period indicated that the country programme was very much relevant to the Sexual and Reproductive Health, unwanted pregnancies and HIV related issues being discussed in the country. The programme proved to have been relevant as it was addressing the key issues affecting women and young people in Sierra Leone, facing serious health and psycho-social challenges. Many of the stakeholders interviewed, highlighted that the project responded to the needs of women and young people in particular on the male engagement for SRHR issues.

At the inception of the 6th Country Programme, there were some emerging issues and shifts in the global and national development framework. Internationally, the notable global changes were the shift from the Millennium Development Goals to Sustainable Development Goals and the adoption and championing of the Demographic Dividend (DD) concept by the African Union Summit in 2015 that provided a new direction and placed emphasis on the issue of the youthful population structure. These developments emphasised the need for data generation and utilisation underscoring the need for investment in population data issues.

4.2 Effectiveness

Evaluation Question 2: To what extent did UNFPA-supported interventions, including in the humanitarian context, reach the different categories of beneficiaries and expected targets? contributed to the desired changes; improving quality and affordability of SRH services? Etc.

Summary: The 6th CP was effective in reaching different beneficiaries and expected targets; improved the delivery of integrated sexual and reproductive health services, EmONC and fistula repair services in the country. The capacity building of the facility-based and community-based health care providers has contributed to improve the availability and accessibility of quality family planning services and maternal and new-born care. The CP has supported repair of many cases of fistula, though the fistula repair services were challenged with case finding/detection, the provision of surgical repair for the identified cases and lack of reliable information on the magnitude and geographical distribution of fistula cases. Country Programme support has effectively improved the logistics management information system for RH commodity security at the district health management level, utilization of facility-based family planning services. The current CP has made strides towards a better integration of health related activities with the aim to improve programme assistance efficiency.

According to the UNFPA Evaluation Handbook, effectiveness is the degree of achievement of outputs and the extent to which outputs have contributed to achievement of the CPAP outcomes. The evaluation used the CPAP monitoring framework which included indicators at the level of programme outcomes and outputs. To assess the levels of achievements, use was made of data from the monitoring system, interviews with CO Management and Programme staff, implementation partners and national stakeholders, reviewed Country Office Annual Reports and several documents and other secondary data.

Analysis of documents, annual reports from the implementation partners and CO Programme Officers showed the 6th Country Programme contributed to national priorities in SRHR through 4 outcomes of the Programme. The effect of this component was assessed based on the level of achievement of the targets set for the output and outcome indicators indicated in Table 4. The level of achievement of the components of the 6th CP in Sierra Leone is presented, starting with the outputs of the Women's RH , Adolescents,, Youth and Gender, and population and development Clusters in that order.

Women's Reproductive Health Cluster

Output 1: Increased national capacity to deliver integrated sexual and reproductive health services including humanitarian settings.

The 6th CP outlined the lead activity that was used in the implementation of the output.

- Development and review of integrated sexual and reproductive health national policies, strategic plan, guidelines and action plans, including a humanitarian response plan at national level

Document reviews and key informant interviews revealed that UNFPA has technically supported the process of developing the National Health Recovery Plan 2015. It also contributed to the development of Fact Pack to inform the NHSSP review and formulation process. The H4 consortium, of which UNFPA is a member, has worked with the MoHS in formulating the country commitments toward the Secretary

General's Global strategy on women, children and adolescents including commitments to expand midwifery, EmONC and family planning services especially to adolescent girls. UNFPA in partnership with MSWGCA and other stakeholders has implemented a high-level policy engagement on the implementation of the Sexual Offenses Act in the context of Ebola. IUD training manuals were developed with inclusion of aspects of national policy on infection prevention and control (IPC). GPRHCS surveys were conducted, which informed planning and monitoring of the FP/RHCs availability. UNFPA supported the development of the Technical Guidelines on Maternal Death Surveillance and Response (MDSR) and its roll-out at district level, and the development of Costed Strategic Plan. Assessment of 51 Emergency Obstetric and New-born Care (EmONC) health facilities informed resource mobilization for rehabilitation of facilities weakened by the EVD outbreak was done.

There was a review of curriculum in line with ICM Educational Standards and inclusion of SRH, FP, GBV, and FGM/C in the nursing curriculum. One of the Principals of Schools of Midwifery confirmed this. UNFPA supported the development of Nursing and Midwifery Standards of Education and the development of Nursing and Midwifery Accreditation Tools. Capacity Building of Nursing and Midwifery Tutors on Curriculum Development was implemented. A curriculum (trainer's and service providers' manual) on Short Term FP Methods was developed. Ministry of Health and Sanitation with support from development partners including UNFPA produced and launched the National RMNCAH Strategy 2017 – 2021. These training activities greatly empowered the teaching faculty of the Schools of Midwifery to deliver high quality midwifery education.

Output 2: Increased national capacity to strengthen enabling environments, increase demand for and supply of modern contraceptives and improve the quality of family planning services that are free of coercion, discrimination and violence.

The planned strategies used to deliver the output include:

- Increasing the knowledge on sexual and reproductive health issues
- Demand generation and behaviour change communication
- Capacity-building on reproductive commodity security and logistics management systems
- Human Resources capacity-building to fulfil demand for family planning
- Integration of family planning into other sexual and reproductive health services

With support from UNFPA, the MoHS launched the first ever national family planning campaign in Sierra Leone in 2015. There was an observed dramatic improvement in the utilization of FP services. Also, UNFPA supported government and NGO partners to intensify FP outreach services to respond to the growing demand in addition to the widely distributed FP messages using different media channels. It printed FP training manuals, curriculum, training participants' handbook, IEC Materials. Mass media campaigns were undertaken to promote FP, institutional delivery, identification, care and social integration of fistulae patients, HIV prevention, promotion of girls and women sexual and reproductive health rights and GBV prevention. Principally it supported PPA SL and Maries Stopes to deliver integrated maternal health and FP services targeting adolescent girls and women. *Restless Development*, another IP. Promoted sexual and reproductive education in schools in rural communities while *Women in Crisis Movement*

engaged communities, marginalised women and girls to conduct FP outreaches, community awareness creation on FP, maternal health and reproductive health, gender-based violence, fistulae issues and MCH.

In terms of capacity building on reproductive health commodity security, UNFP supported the training of 160 service providers in the insertion and removal of the implant contraceptives. MoHS added the IUD long term family planning method to the method mix in Sierra Leone through the development of the IUD curriculum, training of 20 trainers and 20 service providers from all districts. For strengthening of capacities in the delivery of FP services, FP training modules were procured to support training. A total of 380 service providers were trained in the provision of FP methods; 240 in LARC and 140 in STFP methods.

CP partners generated 386,091 new acceptors while 59,662 young persons were reached to increase the demand for Family Planning commodities and services. This resulted to 372,066 Couple Years Protection. Also, 1155 pregnant women, adolescents and young people were tested and counselled for HIV and 12,016 treated for other types Sexually Transmitted Infections (STI) cases. During outreach for integrated SRH services, 1921 pregnant women were reached with Ante Natal Care services, 888 women with postnatal services and 1758 pregnant women referred and followed up for institutional deliveries to avert possible maternal deaths. There were 11,361 brochures, 40,000 posters, jingles and TV educative series aired, 28 billboards developed and installed to create awareness on FP and SRH services. Logistic Management Information System software installed in all district to monitor 1200 health facilities and reported at least 80% of needed data on the distribution chain every month.

UNFPA and other partners provided technical and financial support to the development and costing of the national RMNCAH strategy 2016-2021. A total number of 440 service providers were trained in the provision of long-acting reversible methods (IUD & Implant) and 43 M&E officers and data entry clerks were trained in DHIS. There is a regular supply of FP commodities and essential maternal drugs were delivered to several health facilities across the country. UNFPA continued to account for more than 95 percent of public sector supply of the country's contraceptive needs. Technical support was also provided to MoHS/NPPU and Reproductive Health Commodity Security Committee to conduct quantification, forecasting and budgeting of contraceptives across the country. The Electronic Logistics Management Information System through the CHANNEL software was installed. Documents showed that UNFPA with stakeholders strengthened the monitoring functions, ensuring timely use of data for programmatic action to reduce the risk of stock out or irrational use of commodities.

UNFPA supported *Health for All Coalition*, a civil society organisation, to monitor Free Health Care initiative drugs, logistics and resources through regular monitoring visits and quarterly spot checks at health facilities. Another stock monitoring effort is the 'UNFPA Shipment Tracker' which helps to track all in-transit shipments of RH commodities in the country. UNFPA also provided technical assistance to develop a distribution plan which followed a needs-based rather than a supply-led approach. This included sufficient buffer stock planning to reduce risk of stock-out, deficit stock or even surplus stock at administrative and service delivery levels [UNFPA 2016). These efforts guaranteed accountability and transparency in the management of FP/RHC security. These activities led to increased availability of RH commodities.

Output 3: Increased national capacity to deliver comprehensive high-quality maternal health services, including Ending Mother to Child Transmission of HIV (eMTCT) services.

This output is achieved by the following strategies:

- Strengthening health systems for provision of quality emergency obstetric and new-born care, human resources for health including task-shifting, supply of commodities and strengthening logistics information systems
- Supporting obstetric fistula prevention, treatment and social integration
- Integrating the management and prevention of sexually transmitted infections and HIV into sexual and reproductive health outlets, with a special focus on young girls.

With the realization of the need to strengthen the health system in the country, UNFPA invested in 5 main strategies from 2015. These include (i) training of community health workers for improving health-seeking behaviour; (ii) nurse anaesthetist's investment for life-saving surgeries, (iii) task-shifting for scaling up access to C-section; (iv) Family Planning provision and services, (v) training, deployment and retention of midwives.

Human Resources for Health

With the realisation that women's access to quality midwifery in reducing maternal deaths, every woman needs to have best possible health care during pregnancy, childbirth and postpartum. According to the SLDHS (2013), lack of skilled attendants during labour and delivery is a major cause of maternal and infant deaths in Sierra Leone. Sierra Leone needed about 3,000 midwives. In this 6th CP, UNFPA supports the training of midwives, surgical assistants and nurse anaesthetists to provide EmONC to women and girls. Its investment in this area includes full scholarships, midwifery school uniforms, teaching equipment, infection prevention and control materials, and subsistence allowance. These midwives are being trained in Schools of Midwifery in Freetown and Makeni. A third School was recently established in Bo by joint efforts of Caritas and UNFPA and has admitted some students. There has been an increase in the number of midwives in the country. For the period 2015-2017, 359 midwives, 69 anaesthetists, 29 surgical assistants were trained while 452 fistulae surgeries were done and 214 fistulae patients reintegrated.

During this Cycle, UNFPA supported the training of 21 nurse anaesthetists to provide anaesthetic services at health facilities that provide comprehensive EmONC services. These nurses trained in anaesthesia can administer anaesthesia in the absence of medical doctors. Furthermore, 37 community health officers were trained by CapaCare to receive surgical training to diversify their skill sets and allow them to task-shift. Fourteen health service providers graduated from the scheme and have been posted to various facilities in the country. The training and throughput is helping to double the surgical capacity of service providers in district General Hospitals.

Interviews with the surgical health officers working in Makeni and Bo General Hospital echoed the value of the training as they are contributing to the surgical capacity of the hospitals. They narrated how they have been useful in the theatre, and showed us their Logbook where more than 100 surgeries including C-

section have been carried out by them. However, they complained that despite their skills and contribution to health care, there has not been any attempt to regularise their status and pay in the system. They reported that the fact that there is no enhancement in their salaries discourages their other colleagues from embarking on the training. The IP in charge of the Task Shifting opined this too.

Further midwifery education is supported by promoting clinical placements of students in various health facilities for on-the-job training. Seventy state enrolled community health nurses and midwives from four districts were given clinical mentoring by trained tutors for four weeks. Thirty midwives were trained to provide guidance to students during clinical placements. Midwives expressed happiness at the training they received and the opportunity to be contributing to the health care needs of the people.

Retention of Trained Health Workers

In order to retain the midwives who are trained under this programme, so that they will serve in public health facilities, UNFPA supported MoHS to develop a binding agreement for HRH basic training programs. The bonding agreement is made so that the midwives will remain in the public service for three years before moving to any other sector. This is planned to ensure equitable distribution of HRH post-training. The binding agreement was rolled out to the training programs of midwifery, surgical and nurse anaesthetist training.

Fistula Management

Over 11,000 individuals across 40 communities in 12 districts in a combined media campaign which included 36 road shows; screened 294 patients and identified 123 fistula cases. A total of 119 successful surgical repairs and 50 reintegration has been accomplished. A total of 509 fistulae patients were screened and more than 200 were referred for further confirmation and management. There are 212 successful obstetric fistulae repairs, and 84 obstetric fistulae survivors were provided with start-up capital (seed money) and supplies to embark on livelihood/income generating activities in their respective communities.

Capacity-Building

In-service training through a training of 14 Master Trainers (TOT) on HMS/HBB, who in turn after training, trained 23 midwives from 14 districts to become champions. Facility- and skills based trainings and clinical mentoring were done for a total of 70 state enrolled community health nurses (SECHNS) and midwives from PCMH, Bo, Kenema and Makeni for 4 weeks. In addition, 121 Service providers from 13 health facilities (BEmONC & CEmONC) were trained in competency based EmONC services.

UNFPA in collaboration with the Directorate of Nursing and Midwifery Services, MoHS and other stakeholders including WHO and CHAI held a workshop to develop the following documents including: Nursing and Midwifery Standards of Education, the National Nursing and Midwifery Accreditation Tools, Preceptorship Training Manual for student nurses and midwives; reviewed the State Enrolled Community Health Nurses training curriculum; developed Nurse Midwife Technician Training Curriculum and the Clinical Placement Policy for student Nurses and Midwives. The UNFPA CO rehabilitated/upgraded 18

EmONC facilities including infrastructure improvement, provision of equipment, solar electrification and HRH capacity building and staffing through a successful resources mobilization.

UNFPA in partnership with CapaCare continued supporting the task-shifting training (the Surgical Training Program) for non-physician clinicians. Currently 37 community Health Officers (CHOs) and/or Medical Officers (MOs) have benefitted from this training programme with 14 graduates providing comprehensive EmONC services at different facilities across the country. Also, UNFPA is currently leading the revision of the scheme of service and an Act governing the surgical CHOs services to ensure their proper regulation, retention and career development. This is very important as some of the graduates of the programme who are making important contribution in the health system complained of remaining at the same level since graduation. They would want upgrade to the next level so that they can be on higher pay. But this is not yet forthcoming and they then to be demotivated.

Maternal Death Surveillance and Response System

To strengthen the Maternal Death Surveillance and Response (MDSR) system, UNFPA provided support for improved capacity of 28 Midwives as Maternal Death Investigators who have investigated 88% of reported maternal deaths in various districts; 10 M & E officers to enter accurate data on MDSR and 359 Community Health Workers to enhance prompt death notification from the communities. UNFPA also supported the conduct of monthly District MDSR Review Meeting in all districts and selected hospitals to review the maternal death and undertake actions to avert similar deaths in future. UNFPA has supported printing and distribution of 2828 MDSR data collection tools for the entire country.

The CO supported the printing of the notification and investigation forms for maternal deaths; trained district MDSR committees in all 14 DHMTs and 19 hospitals (CEmONC) including the training of 67 M&E Officers, District Health Sisters and District Surveillance Officers. It also supported the procurement and distribution of filing cabinets, the provision of ICT equipment and the development in collaboration with WHO of an EpiData software for maternal death data entry. Furthermore, UNFPA supported the sensitization of Paramount Chiefs, Councillors, Media, Women and Professional Groups from all districts to ensure their active involvement in raising community awareness on safe motherhoods and their contribution to the MDSR committees.

In a continuous effort to build capacities for the delivery of comprehensive high-quality maternal health services UNFPA supported midwifery schools graduated 151 midwives in 2017. All have been deployed in health facilities, with 70 trained in preceptorship. Additionally, 6 surgical Assistants & Community Health Officers and 20 Anaesthetic Technicians were graduated and deployed. Forty facilitators, from 10 Districts, trained on harmonized Emmons Competency based training; 240 Health Service Provider with enhanced capacity in Competency based training on Emmons Package; 2,083 units of blood collected from 4 districts and 9,000 bags of reagents donated to the National Blood Services Program by CUAMM in addition to 446 Units of blood collected in 2 districts by the National Blood Unit/MoHS. A blood donation campaign started in December and covering the four (4) Regions of Freetown, Bo, Makeni and Kenema is expected to avail more blood units before the end of this year. There were 8965 deliveries and 2728 Caesarean Sections performed.

Construction and renovation of Emergency Obstetric and New-born Care Facilities.

The CO rehabilitated and equipped one district hospital and seven Community Health Centre (CHC) to provide quality Emergency Obstetric and New-born Care. Out of these eight facilities, Government of Japan (GoJ) funded five and JICA three. In addition, renovation and construction works are under progress in eight facilities which are funded by DFID including construction of two new 100-bed hospitals and maternity unit of one regional hospital and one additional CHC supported by GoJ.

UNFPA supported the infrastructure and equipment improvement of 12 health facilities (4 CEmONC and 8 BEmONC), improved lightning in 5 hospitals through provision of solar suitcases. Moreover, with support from MoHS/HRH/CNO, redeployed 100 HCPs in addition to the 86 new graduate midwives. Furthermore UNFPA support has helped line ministries (Health, Education and Social Welfare) and partners to identify girls who got pregnant during the closure of schools due to the EVD outbreak with a total of more than 18,000 girls identified as either pregnant or delivered during the EVD outbreak.

Adolescents, Youth and Gender Cluster

Output 4: Increased national capacity to design and implement community and school-based comprehensive sexuality education programmes that promote human rights and gender equality.

This output was addressed through the following strategies:

- Provision of technical assistance to update of national curricula integrating sexual and reproductive health and gender;
- Community mobilization on gender equality and SRH including inter-generational dialogue, and
- Provision of in-service training of health service providers and increased availability and access to SRH including HIV prevention information services.

Document reviews and key informant interviews revealed that the capacity of 935 Health Care Providers was enhanced on Adolescent Health so that they can provide the SRH services in Adolescent and Young Peoples Friendly Health Facilities (AYFHS); the Ministry of Health and Sanitation upgraded and or established additional 39 Adolescent and Youth Friendly Health Centres across the country. In collaboration with the Ministries of Education, Science and Technology (MEST), Health and Sanitation (MoHS) and Social Welfare Gender and Children's Affairs (MSWGCA), 8918 Pregnant Adolescent Girls benefitted from SRH services provided to Pregnant Adolescent Girls in different communities

Additionally, 542 adolescents and young people trained on the Life Skills Manual. Also, 3,578 adolescent were reached with SRH/FP service/information and supported two staff from the National Youth Scheme were supported to participate in a conference on developing a youth roadmap for the restructuring of African Youth and Adolescent Network (AfriYAN). UNFPA supported MEST to print the existing IEC/BCC materials, guidelines, protocol on danger signs in pregnancy, childbirth and childhood illness which is used by facilitators and beneficiaries. IPs responsible for this theme indicated that what remains is the full operationalisation of the comprehensive sexuality education in school curriculum across the country. This process is on.

Output 5: Increased capacity of partners to design and implement comprehensive programmes to reach marginalized adolescent girls, including those at risk of child marriage.

The strategies for the achievement of this output include:

- Provision of technical, operational and financial support to the government in implementation of the national teenage pregnancy strategy
- Engaging civil society to advocate for the protection of the girl child from discrimination
- Undertaking programmes to improve adolescent girls' health, social and economic assets
- Developing an evidence base of key indicators of adolescent health and development

During this cycle the following results were achieved: 220 girls completed asset building courses; 170 girls undertook learning of life skills, SRH information, empowerment building, basic literacy and livelihood skills development for a period of one year; 50 girls received mentorship and leadership skills development at a week-long national girl's camp supported by UNFPA, the First Lady Office and other partners. The Ministry of Youth Affairs (MOYA) lobbied with the other ministries and the Parliamentary Committee on Youth to increase and make allocation to youth issues particularly adolescent health. Approximately 2,400 adolescents were reached with life skills in 80 Safe Spaces established in Pujehun, Bonthe, Tonkolili and Koinadugu Districts. Also 300 community stakeholders were reached with information on the adolescent girls programme and its importance on ending child marriage in six districts.

Documents and interviews with CO programme officers revealed that 120 vulnerable and marginalized girls attended the National Girls camp organized by the Office of the First Lady to provide support to adolescent girls to rethink their identity and develop their self-esteem in order to make informed decisions on their health, education and finances. In 2017, working with two IPs, Women in Crisis Movement and MATCOPS, 7,333 adolescent girls were reached with assets building programme (life skills, health, psychosocial and economic support) in 6 districts in the Safe Spaces by mentors, targeting both in-and- out of school girls to prevent child marriage, teenage pregnancy and other harmful practices. Through the outreach programmes, mentors of adolescent girls in the Safe Spaces reached out to 8,000 girls with key messages on child marriage; 185 out of school girls at risk of child marriage trained in livelihood skills and 340 mentors trained to support the girls in the Safe spaces.

Output 6: Strengthening legislative frameworks and national protection systems for promoting reproductive rights, gender equality and addressing gender-based violence.

This output was addressed through the following

- Advocacy for gender and human rights related policies and frameworks, and enforcement and implementation of existing laws
- Advocacy for the establishment of accountability mechanisms to domesticate and implement protocols and treaties relating to women's human rights
- Strengthen the coordination and management capacity of national partners.

As part of UNFPA's intervention in gender equality and women's empowerment component especially towards the prevention of gender-based violence, male advocates and peer educators were trained on GBV and SRHR referral pathways in Port Loko district, in partnership with Fambul Initiative Network (FINE

SL). Other accomplishments in this output include 2 MOUs signed at Community level (2 Chiefdoms in the Bombali District) to abandon under age FGM Practice and end child marriage and another 2 signed at District levels;

- Draft National Strategy for the Reduction of FGM developed
- Sexual Offenses Act Jingles in 4 local languages (Krio, Limbi, Mende and Temne)
- A draft National Strategy for the reduction of FGM was developed now awaiting the signature.

Output 7: Increased capacity of organizations and communities to prevent gender-based violence and harmful practices, including female genital mutilation/cutting, and provide delivery of multi-sectoral services for prevention care and impact mitigation, including in humanitarian settings.

The strategies to achieve the output include:

- Mobilizing communities to address harmful traditional practices with the following activities: (i) supporting community-based networks and advocacy groups, including traditional and religious leaders for sensitization on GBV and harmful practices (ii) develop and disseminate IEC and BCC materials on harmful traditional practices in target communities and (iii) support coordination and activities of CAGs and Peer Educations on GBV
- Building the capacity of institutions and civil society organisations to prevent gender-based violence, with the following activities (i) provide support for continued policy dialogue, advocacy and community education on legal rights, particularly sexual and reproductive rights, (ii) support trainings of stakeholders (IPs and GBV survivors) in diverse skills for addressing SGBV (iii) provide training for communities in the promotion of women's reproductive health and rights
- Providing support for survivors' sexual and gender-based violence, with the following activities (i) support SGBV services to victims including safe homes and access to justice for survivors, (ii) train communities/volunteers on basic psychosocial support, counselling and GBV referral, and (iii) provide post-rape and other sexual-violent kits in health facilities for timely clinical management and evidence preservation.

The following have been achieved.

- 1365 GBV victims/survivors accessed health and legal services for social justice through LAWYERS
- 120 GBV victims/survivors and vulnerable women and adolescent girls trained in livelihood skills for self-reliance, with 51 graduates for 2015 by women in Crisis Movement.
- 1,000 GBV victims/survivors supported for enhanced referral for social and health services by the Family support Unit of the Sierra Leone Police
- 726 GBV victims/survivors (pregnant and lactating adolescent girls) received SRH and legal aid services.
240 adolescents and vulnerable young women graduated and empowered in livelihood skill for self-reliance for economic sustainability and to prevent GBV.

One of the IPs, *Women in Crisis Movement*, through the women and adolescent girls' empowerment programme to prevent GBV and other harmful practices, made 162 referrals for SGBV psychosocial care, sexual penetration, physical assault, and sexual harassment and SRH services.

About 3,700 girls were reached through outreach programmes and IEC/BCC Materials were distributed with information for the prevention of child marriage, teenage pregnancy and harmful traditional practices. With support from UNFPA, the Ministry of Social Welfare, Gender and Children's Affairs (MSWGCA), promoted awareness and referrals for SRHR services in 6 districts (Kailahun, Pujehun, Kono, Bonthe, Tonkolili and Bombali). 51,025 women and adolescent girls were referred for ANC, PNC, STIs, GBV, Institutional Delivery, Malaria and Fistula services, and out of this 331 were referred for GBV services.

Six MOUs were signed through Community Mobilization programme to raise awareness to end child marriage and other harmful practices in 6 target districts (*Port Loko, Kambia, Pujehun, Bonthe, Tonkolili and Koniandugu*) with *Paramount Chiefs and other stakeholders including 120 local Chiefs in 120 communities*. The cumulative effects of these activities include self-reliance and economic empowerment, self-confidence, public education and awareness raising.

Beneficiaries of these interventions confirmed that they have gained good sense of awareness about their rights and how they should respond to gender based violence in their communities. Some cited numerous instances of increased personal confidence that has helped them deal with matters within the communities. Many beneficiaries interviewed believed that the interventions helped to shape their lives and also changed the mindset of communities. They believed that their source of information especially on early marriage and sexual reproductive health was as a result to the programme interventions in their communities. This has been very much helpful and now leading to a huge demand for services, and girls opting now for family planning services without being force to ask for family planning services. It is also evident that, girls speak out and now willing to pursue education which has led to the increase in school enrollment in schools.

Population and Development Cluster

The focus was on policy development, capacity building and data collection, at national level.

Output 8: Strengthening national capacity of the statistical system to collect produce, analyse and disseminate high-quality disaggregated population data for evidence-informed planning and monitoring.

This output was meant to be achieved through the following specific activities.

- Conducting secondary analysis of the 2013 demographic and health survey
- Enhancing capacity of government to generate, analyse and utilize age and sex disaggregated data, including the 2015 census and 2018 demographic and health survey for evidence-informed decision-making and programming

Analysis of programme documents and stakeholders interviews show that a number of results were achieved. The secondary analysis of 2013 demographic and health survey focused on maternal health indicators in the country. The 2015 Population and Housing Census is one of the flagship activities of the 6th Country Programme. UNFPA supported the following census activities: recruitment of field staff; applying data digitized for EA maps preparation and printing; cartographic fieldwork; trained 12 national staff in GIS and digitization; GIS Lab equipped and fully functional. The SL CO supported the recruitment,

training and deployment of 16,000 census field staff comprising enumerators, supervisors and field officers for the 2015 census exercise.

To enhance the capacity of the national statistics office, Statistics Sierra Leone, 150 computers, one server and other information technology equipment were installed. Fully-equipped and functional data processing centre and GIS laboratory established at Statistics Sierra Leone. The facilities enhanced and will continue to enhance national capacity for the production, utilization and dissemination of quality statistical and population data. The census data processing was completed. The final Population and Housing Census results released and launched by the then President in December 2016. It is hoped that the results will be used for development planning and management, promoting good governance, including the constituency boundary delimitation for the upcoming elections, as well as ensuring equity in resource distribution for the wellbeing of all population subgroups. However it must be noted that there are emerging controversies associated with the census result. UNFPA is currently assisting the national statistical agency to resolve the problem by hiring an expert data analyst to re-analyse some aspects of the census data.

National Population Policy: Draft population policy is being reviewed and updated with the 2015 census data. The policy document has been shared with government ministries for feedbacks, which will be incorporated in the final policy document. With UNFPA support, the Planning Directorate and Population Unit in the MoFED, now MoPED, coordinated the review of two sectorial plans/policies, i.e. Reproductive Maternal Neonatal Child Health Strategy and the Family Planning Costed Implementation Plan..

ICPD Advocacy: The Ministry of Planning and Economic Development (MoPED) and Sierra Leone Parliamentary Action Group on Population and Development (SLPAGPAD) are the main government bodies for the ICPD advocacy in Sierra Leone. In 2017, UNFPA supported a member of the SLPAGPAD to participate in 50 Session of the Commission on Population and Development (CPD) of the UN. These two bodies were able to bring together key MDAs to develop Sierra Leone's Position Paper, which underscored the importance of partnerships in the implementation of the ICPD Programme of Action (PoA).

Data for development: UNFPA supported the printing and distribution of 469 copies of high quality disaggregated census data. UNFPA worked with SSL to produce and disseminate 17 Thematic Reports and a 16- Chapter analytical report of the 2015 census. In collaboration with Statistics Sierra Leone, a Post Enumeration Survey was conducted to verify content and geographical coverage of the census and a report finalized for printing.

Without UNFPA's support, these activities, especially the conduct of the census, would not have been possible. UNFPA's support for capacity building contributed to improving the quality of management, analysis, reporting and dissemination of census results. Overall, UNFPA provided technical support in the 2015 census organisation. Census cartography, census quality control and evaluation. Communication, Operational control, data process and data base management, data analysis and dissemination.

Table 6: Summary of the 6th Country Programme Performance (2015–2019)

Output Indicators	Baseline 2014	2017 Results	2018 Targets	2019 Target	Variance	Comments
Women's Reproductive Health						
Outcome 1: Increased availability and use of integrated sexual and reproductive health services, including family planning, maternal health and HIV that are gender-responsive and meet human rights standards for quality of care and equity in access						
Output 1: Increased national capacity to deliver integrated sexual and reproductive health services including in humanitarian settings						
Number of national plans, guidelines, protocols and standards for the delivery of high quality sexual and reproductive health services, including humanitarian response plan incorporating minimum initial service package	3	7	Not part of planning	6	-1	Over achieved and not part of the planning
Number of costed integrated national sexual and reproductive health action plan	0	2	1 (3)	4	2	On Track and one more to be done this year to make total of three
Output 2: Increased national capacity to strengthen enabling environments, increase demand and supply of modern contraceptives and improve the quality of family planning services that are free of coercion, discrimination and violence						
Percentage of service delivery points offering a least 3 modern methods of contraception	96.5%	95.5%	97%	100%	4.5%	On track but dropped below previous achievements.
Number of couple-years-of-protection provided with UNFPA support	63,000	372,066	292,488	183,000	-109,488	Over achieved
Output 3: Increased national capacity to deliver comprehensive high quality maternal health services including ending Mother-to-child transmission of HIV services						
Proportion of tertiary level facilities providing comprehensive emergency obstetric and neonatal care	29%	60.4%	Not part of planning	100%		This indicator is very difficult to explain and measure; there was no clear consensus on what our tertiary facilities are. CO was advised during MTR to replace them.
Proportion of facilities with integrated services	57.6%	40%	Not part of planning	70%		This indicator is also very difficult to explain and measure; there were no explanation/ definition of what the integrated services are. CO was advised during MTR to replace them
Proportion of service delivery points covered by midwives	TBD	NA	Not part of planning	22%		This, also, is very difficult to measure; it requires field data collection or survey. CO was advised during MTR to replace them

Output Indicators	Baseline 2014	2017 Results	2018 Targets	2019 Target	Variance	Comments
Adolescents and Youth Sexual and Reproductive Health Rights						
Outcome Two: Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health						
Output 4 : Increased national capacity to design and implement community and school-based comprehensive sexuality education programmes that promote human rights and gender equality						
Number of national education guiding documents on comprehensive sexuality education	0	5	Not part of planning	2	-3	Over-achieved
Number of service delivery points providing youth-friendly sexual and reproductive health services	84	163	Not part of planning	134	-29	Over-achieved. Focus shifted to quality improvement.
Percent of youth aged 15-24 that reported condom use last time they had intercourse	5.9	NA	Not part of planning	15	NA	SLDHS 2018
Output 5: Increased capacity of partners to design and implement comprehensive programmes to reach marginalised adolescent girls, including those at risk of child marriage						
Number of ministries with budget allocation for adolescent sexual and reproductive health	2	3	Not part of planning	4	1	On track but not part of 2018 planning
Number of young girls at risk of child marriage reached with improved health, social and economic asset-building programmes	0	11,053	Not part of planning	100	10,953	This is the most achieved indicator which may be due low target set; but was also over achieved because new programmes like GATE, SLP1 that provided more funds.
Gender Equality and Women's Empowerment						
Outcome Three: Advanced gender equality, women's and girls' empowerment and reproductive rights, including for the most vulnerable and marginalised women, adolescents and youth.						
Output 6: Strengthened legislative frameworks and national protection systems for promoting reproductive rights, gender equality and addressing gender-based violence						
Number of policy frameworks developed, revised and implemented to promote gender equality and reproductive health	8	9	Not part of planning	12	3	On track but not part of 2018 planning
Number of 2014 concluding comments and recommendations from the CEDAW	0	3	Not part of planning	5	2	On track but not part of 2018 planning

Output Indicators	Baseline 2014	2017 Results	2018 Targets	2019 Target	Variance	Comments
implemented through UNFPA support						
Output 7: Increased capacity of organisations and communities to prevent gender-based violence and harmful practices, including female genital mutilation/cutting, and provide delivery of multi-sectoral services for prevention, care and impact mitigation, including in humanitarian settings						
Proportion of reported gender-based violence cases that receive health and other social services	20%	NA	NA	50%		This indicator has been found very difficult to compute due to incomplete data. The numerator was always compiled but the denominator was never provided, hence the indicator was dropped and replaced in 2018.
Number of communities that declare the abandonment of female genital mutilation and other harmful practices	0	8	Not part of planning	10	2	On track but not part of 2018 planning. This indicator was modified; meaning a new indicator all together.
Population and Development						
Outcome Four: Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality.						
Output 8: Strengthened national capacity of the statistical system to collect, produce, analyse and disseminate high quality disaggregated population data for evidence-informed planning and monitoring						
Number of national and sectoral plans that incorporate evidence-based disaggregated gender-sensitive data from 2014 census and the national demographic and health survey 2013.	0	8	Not part of planning	10	2	On track but not part of 2018 planning
Population Policy enacted and action plan implemented	Draft Policy and Action Plan	Policy finalised but not enacted	Not part of planning	Policy Finalised and enacted	NA	On track but not part of 2018 planning

Some of the indicators have been over-achieved and some very difficult to explain and measure. The mid-term review recommended review of the all indicators for the remaining years of the programme cycle. As a result new indicators were introduced for the 2018 planning and reporting and some existing indicators were not included in the planning.

4.3 Efficiency

Evaluation Question: To what extent did the intervention mechanisms (financing instruments, administrative regulatory framework, staff, timing and procedures) foster or hinder the achievement of the programme outputs?

Summary: Efficiency is influenced by the utilization rate of budgets and also in terms of the extent the Country Programme leveraged other resources. There were timing issues raised by implementing partners. There was a high level of activity completion and resource disbursement overall. Operational efficiency may have been due to internal system weaknesses such as UNFPA's bureaucracy, poor reporting, weak indicator design process and inability to meet some targets.

Efficiency in the use of resources and management of activities in the 6th CP is defined as whether the programme outputs were produced in the most cost-effective way to obtain expected results. The ET reviewed various aspects of the CP including staffing, resources mobilization and utilization. Monitoring component is deferred to the section on M&E.

There is a staffing set-up which guarantees the program planning and implementation is guided by the required level of technical expertise. At the time of this evaluation, the CO had an adequate number of qualified staff for each of the component areas: cluster leads of the 3 clusters are experts in the relevant fields, technical specialists and programme associates as well as qualified national professionals. The resident country programme staff included the CR and technical specialists. The CO programme staff included specialists with University degree qualifications in the relevant areas. There are about 39 CO staff, made up of 10 international staff and 29 national staff.

In programmatic terms, the CO is managed by the Country Representative. During the cycle of this CP, two CRs have overseen the Programme Cycle. The CO has made use of technical assistance and support of UNFPA WCARO in the identification of consultants to fill temporary technical support assignments, such as Technical Advisor on RH and International Consultants on specific assignments. During the evaluation, an International Programme Officer was on board to coordinate the evaluation processes. There were technical visits from WCARO, Dakar too. About 117 national and international consultants have been hired to assist in various aspects of the CP in the period 2015-2018. There were 8 IPs, 5 qualified Country Office officer and consultants for the WRH Cluster, 9 IPs, 10 officers and 32 consultants for AYG and 3 IPs, 3 CO Officers and 23 consultants for P&D cluster. During this 6th CP cycle, human resources have been adequately covered, although most CO programme officers complained of heavy workload, while some of the donors expressed the need for the CO to expand the remit of programme officers.

Table 7: Human Resource Allocation for the Implementation of the 7th CP in Sierra Leone

Programme Clusters	IPs	Qualified CO Officer	Consultants Used
Women's Reproductive Health	8	5	85
Adolescents, Youth and Gender	9	10	32
Population and Development	3	3	23

Financial Resources and Management

Programme Coordination had highest fund utilisation (90.7%), followed by WRH cluster (78%), AYG (78) and P&D (74.7%). Total programme expenditure amounted to \$79m with major part of the expenses covering the different aspects of SRH. Data from key informants and in-depth interviews and CO program documents indicate that partners develop work plans that are sent to UNFPA for approval. Once approved, UNFPA allocates resources to the submitted budget. UNFPA pays through different systems.

Table 8: 6th CP Component utilization 2015-2018

CP Component	Total resources [budget]	Total expense	Implementation rate
WRH	\$57,358,497.00	\$44,947,426.00	78.4
AYG	\$14,904,419.00	\$11,643,481.48	78.1
P&D	\$6,476,570.00	\$4,837,428.00	74.7
PROG COORDINATION	\$1,228,816.00	\$1,114,254.00	90.7
Overall	79,968,302.00	62,542,589.48	78.2

Table 9: 6th CP Component utilization by year 2015-2018

	2015		2016		2017		2018		Total	
		%		%		%		%		%
Women's Reproductive Health (WRH)										
Output 1-SRH policies, strategies etc advocacies	\$5,319.55	0.03	\$5,129.71	0.05	0		0		\$10,449.26	0.015
Output 2-RHC/FP services	\$2,643,286.64	13.34	\$4,036,463.30	36.43	\$1,669,374.07	7.82	\$538,788.01	3.18	\$8,887,912.02	12.852
Output 3- QMH/EMTCT	\$12,180,978.23	61.48	\$2,991,535.70	27.00	\$16,645,889.57	77.99	\$14,733,830.65	87.07	\$46,552,234.15	67.314
Adolescent & Youth										
Output 4- Sexuality Education	\$1,278,956.93	6.46	\$651,533.55	5.88	\$523,590.86	2.45	\$296,288.58	1.75	\$2,750,369.92	3.977
Output 5 - ASRH	\$646,957.15	3.27	\$1,102,424.64	9.95	\$928,707.02	4.35	\$728,340.84	4.30	\$3,406,429.65	4.926
Gender										
Output 6- Gender Legal Frameworks	\$240,303.07	1.21	\$101,807.88	0.92	\$71,676.27	0.34	\$108,096.23	0.64	\$521,883.45	0.755
Output 7- Prevent GBV and FGM	\$215,542.61	1.09	\$268,882.36	2.43	\$324,032.64	1.52	\$190,204.81	1.12	\$998,662.42	1.444
Population & Development										
Output 8- P&D	\$2,461,187.78	12.42	\$1,411,463.18	12.74	\$863,545.91	4.05	\$131,293.76	0.78	\$4,867,490.63	7.038
Management										
Management- PCA	\$139,362.51	0.70	\$509,999.22	4.60	\$317,307.71	1.49	\$194,635.42	1.15	\$1,161,304.86	1.679
Total	\$19,811,894.47		\$11,079,239.54		\$21,344,124.05		\$16,921,478.30		69,156,736.36	

Programme Management

In the 6th CP, each Implementing Partner prepares a Work Plan to facilitate programme implementation. The Work Plan (WP) is discussed by all relevant parties on the basis of agreed guidelines and submitted to UNFPA for approval on an annual basis. A standard Fund Authorization and Certificate of Expenditures (FACE) Form, reflecting the activity lines of the Work Plan, is used by Implementing Partners to request for advance of funds, or to secure the agreement that UNFPA will reimburse or directly pay for planned expenditures. The FACE is also used to report on the full utilization of all cash received and submitted to UNFPA within three (3) months after receipt of the funds.

UNFPA CO adopted the HACT model of payment. There are four types: 1) direct payment, 2) direct cash transfer and 3) reimbursement and 4) Agency. Depending on the risk level of the Implementing Partner, any of the HACT model of payment can be used the cash transfer process involves: (i) Direct Cash Transfer (DCT) directly provided to the Implementing Partner in the form of quarterly advances prior to the start of activities, and (ii) direct payment system where funds are paid directly to participants when IPs are conducting activities. If liquidation of funds is done well then, the implementing partners stand a better chance of being refunded. Currently, all activities are reflected in GPS which allows for transparency and accountability.

Regular follow-up was made with IPs for financial tracking and one evidence of qualified audit was reported to the evaluation team. But the issues around this were sorted out. Fund disbursements are made on the basis of standard quarterly reporting. There was perception among national stakeholders that UNFPA's processes are too complicated and burdensome in terms of monitoring activities. All the IPs expressed their difficulties with UNFPA's reporting and disbursement procedures because of the short quarterly period in which to implement and report. In some cases this delayed their implementation activities. The implication of this is that funding may not be received for several weeks and when received the IP will be required to deliver three months' worth of activities in only two months. Despite reported challenges in preparing reports by IPs, there was a high implementation rate across all programme areas. Key Informants and in-depth interviewees commended the UNFPA CO for having both internal and external audit systems and the use of the monitoring and evaluation tools that help to track progress, but noted that the process is cumbersome. No IPs reported cancellation or postponement of programs because all activities were done according to the Work Plans.

The 6th CP support to population and development focused on the national statistical agency. The focus was limited on the generation and utilisation of statistical and demographic data on population and development issues. The programme activities of the sexual and reproductive health have been more dispersed in terms of topics and geographical spread. The SRH component has included maternal, new-born care, emergency obstruct care, family planning procurement, commodity security, IEC/BCC, quality of care, STIs/HIV, fistulae, gender-based violence etc.

In geographical terms, the SRH programme has focused on 16 districts located in the 5 regions of the country. This has resulted in inefficiencies in terms of programme implementation with relatively small programme activities in the various health districts requiring much travel in order to provide services and to monitor programme implementation. It is not surprising that programme coordination has the highest utilization rate. The present spread of the SRH programme in terms of geographic distribution

will need to be reconsidered, in particular in the face of shrinking fund availability internationally. All programme components have made use of direct implementation mechanisms, which means that funds do not flow through the central government financial systems but the UNFPA SL CO

The timing and availability of resources is crucial to the success of the programme implementation. From observations on project documents, project implementation site visits, and spot checks conducted during the evaluation exercise, there has been efficient use of resources but there is need for a corresponding increase on human resource to also match and fully manage the projects in a more efficient manner. Some of the partners implementing the training and leadership programs, for their part, indicated that funds had been transferred on time and that the program management, including fund transfers, had been efficient. Whilst others see this as a problem, because there were delays in processing funds.

In terms of the quality of the communication, the partners felt that on some occasions the communication with UNFPA could have been improved to gain better understanding on implementation strategies. Some implementing partners and some of the beneficiaries felt that more inter-partner meetings at the inception stage would have enabled them to know each other better and to acquire a deeper understanding of the aspects of the project.

The 2016 'Unqualified Financial Audit Report' of UNFPA funds managed by the Ministry has built UNFPA's trust and confidence in the Ministry's financial management system. The Audit was conducted by an International Audit firm contracted by UNFPA. UNFPA's trust and confidence in the Ministry has been further enhanced by the timely submission of quarterly and annual programme reports. Importantly, government has demonstrated strong commitment to promoting Sexual Reproductive Health and Rights through the enactment and adoption of gender sensitive laws and policies. The framework for promoting gender equality was clearly articulated in Pillar 8 of the Agenda for Prosperity which the UN Agencies (including UNFPA) and development partners committed to implement.

4.4 Sustainability

Evaluation Question: To what degree has UNFPA been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to ensure ownership and the durability of results?

Summary: The extent to which the 6th CP has involved in close partnership with government partners can result in significant policy changes and institutional capacity development which are likely to have long lasting effects. Most of the 6th CP interventions are durable because the programme is aligned to and addresses national priorities and population needs in SL; investment in health system strengthening, capacity building, equipping public health facilities. However lack of exit strategy, donor dependence by direct and indirect implementation partners and weak physical infrastructures in the country may threaten the likelihood of sustainability. Sustainability is also challenged by more than the mere availability of financial resources or risks of staff turnover. Factors that enhanced likelihood of sustainability are political commitment and involvement of the community leaders and community members. Sustainability is still challenged by high staff turnover and limited financial resources among the IPs.

Sustainability assessment refers to the extent to which supported programme activities are likely to continue without UNFPA's support; or the willingness and capacity of implementing partners to maintain provision of these services without further programme technical and financial support from UNFPA. There are a number of key activities that give the impression that the programme components will be durable. The programme components are relevant to the national priorities and population needs in Sierra Leone, creating an environment of national ownership of the UNFPA 6th CP. The fact that UNFPA is in strategic collaboration with key government ministries means that UNFPA support is strategically positioned in the long term development policy direction of GoSL. Programme approach of participatory needs assessment, intensive consultations with stakeholders and joint programme planning with implementing partners helped develop a sense of ownership of programme interventions and goals.

Furthermore, this ownership and a direct implementation of UNFPA supported interventions has built IPs capacities and enhanced likelihood of sustainability, provided IPs are able to maintain acquired results technically, institutionally and raise needed financial resources. Stakeholders' interviews suggested that the CO should build capacity of the IPs in fund raising so that they would be able to source for funding elsewhere, and not be dependent on UNFPA alone. Commitment of UNFPA implementing partners in planning and implementing UNFPA-supported interventions, especially at the district levels, has effectively contributed to scaling up the capacity of those partners. However, as reported by many government's IPs, staff turnover and limited budgets are always a challenge for increased levels of sustainability.

Sustainability assessment results varied across the programme outputs, implementing partners and types of interventions. In thematic areas where UNFPA strategic interventions gained traction, government endorsement and some levels of community acceptance, such as in WRH and AYG. Sustainability potentialities have improved. In other thematic areas where UNFPA strategic interventions are still mostly at the level of advocacy to break the cultural taboos, such as in gender based violence and female genital mutilations, sustainability potentialities are still weak.

Women's Reproductive Health (Output 1-3): UNFPA programme support in capacity building in this cluster that targeted training of health workers at the local level, such as health care providers, midwives, nursing anaesthetists, surgical assistants and others, is likely to be sustainable as it focused capacity building on stakeholders who are more likely to be stable at the central and district levels and less subjected to staff turnover. The WRH government partners at both the central and district levels noted that the training of the community health officers and the in-service training of the other midwifery cadres can be sustained -should UNFPA support phase out. In fact it is commonly acknowledged by all key informants and beneficiaries that investment on human resources for health is a masterstroke for sustainability of the 6th CP interventions. However, according to interviewed stakeholders, activities such as advocacy, community sensitization, and fistula repair, and midwifery supervisory system and family planning supplies are unlikely to be sustained without UNFPA or other donors support.

Adolescents, and Youth and Gender Cluster (Outputs 4-7): It is possible that the management of the UNFPA-rehabilitated youth centres and disseminating educational messages on maternal health could continue, but the community mobilization and trainings would be discontinued if not supported. Despite poor infrastructure and limited facilities in the country, many of the youth centres have been in use at the time of the evaluation site visits, although the evaluation team did not witness any

adolescents accessing services at the centres. Most UNFPA-supported interventions and services in the field of gender equality, empowerment of women and GBV responses are unlikely to be maintained without UNFPA support. National stakeholders would continue implementation of some of the activities that are funded by other agencies (that is if there are) and donors such as advocacy, awareness raising and law enactment/reform related to FGM and Child marriage. But all the capacity building activities related to gender, maternal health, and research are unlikely to be sustained without UNFPA support.

Population and Development Cluster (Output 8). From the interviews, it was noted that the Statistics Sierra Leone may continue using the statistical system, supported by UNFPA CO for data collection and production, but would not be able to update these systems as needed without external support. The implementation of the current Statistical Strategy of the SSL would most likely be put on hold without support from UNFPA and other partners support. The lack of integrated statistical system, lack of requisite skills in integration of population issues in development will affect sustainability. IPs acknowledged that community sensitization activities will not be sustained due to limited access to funds without UNFPA's support for these interventions.

When emergencies occur, the costs are expensive. Interventions in humanitarian settings cannot be sustained without UNFPA continuous support. UNFPA programme' interventions in humanitarian contexts are dependent on UNFPA's ability to raise resources from donors/humanitarian funds. This limitation is due to the fact that no UNFPA core resources are committed to support assistance in humanitarian settings, and so when they happen, additional resources are sought. However UNFPA does well in supporting national systems for disaster management but does not have the sole responsibility to do so.

There are discernible threats to sustainability. The seeming lack of interest in knowledge production resulting in not including the national University in capacity building activities will have huge negative impact. The total absence of in-built hand-over mechanisms or long-term exit strategy does not guarantee sustainability.

Generally the possibility of sustainability of the 6th CP interventions depends on government policies, priorities and involvements, community ownership and involvement, the quality of capacity-building, fund availability, and international donor environment. Sustainability can be threatened by total absence of in-built exit strategy, absence of a long-term institutional capacity development and tracking strategy to ensure continuity in IPs and government ministries.

4.5 UNCT Coordination

Evaluation Question: To what extent has the UNFPA country office in SL contributed to the functioning and coordination of UNCT coordination mechanisms?

Summary: The 6th CP is well aligned with UNDAF in Sierra Leone and UNFPA SP 2014-2017, 2018-2021. Coordination with other UN agencies is cautiously satisfactory. UNFPA is a key player in the UN Joint Programmes and coordination mechanisms. UNFPA CO is an active participant in UNCT activities, especially in technical cooperation through coordinated programs the role of SLCO is well appreciated by other UN agencies. Some agencies would like to see more collaborative partnerships with UNFPA especially in fund-raising. Overall, there are high expectations of UNFPA, but there is a caution that UNFPA should not dabble into areas that it has no technical competence, e.g. in building construction. Constraints to Coordination include competition over Resources and Leadership. Limited access to funding resources has increased levels of inter-agency competition and negatively impacted 'coordination'. In the absence of a strong leadership or in case of conflict between leaderships or conflicting interests, coordination within the UN system for joint action is difficult.

The assumption for this criterion was that the UNFPA CO has actively contributed to UNCT working groups and joint initiatives, and ensured it did not duplicate efforts and created synergies with other UN agencies, where possible. UNFPA is involved in Delivering as One joint planning process accompanying the UNDAF which is signed by all the resident UN agencies in Sierra Leone. By working together with other UN agencies there are opportunities for UNFPA and its UN partners to provide a continuum of focus on development needs, such as the overlapping mandates of UNICEF (children up to age 18) and UNFPA (adolescents and adults). UNFPA works with UNICEF to address issues of violence against children including child marriage and with WHO to support Ministry of Health and Sanitation develop a protocol for strengthening health sectors response to SRH including maternal health challenges, and with UN Women on issues of women empowerment and gender equality.

UNFPA is a member of H6 consortium and a co-convenor of Technical Working Groups on Health, Gender, HIV, and chairs inter-agency working group on adolescents and youth. It is also the convenor of the working groups on Data for Development, SRH, Communication and Advocacy. UNFPA is a convenor of A4P Pillar 3. Currently the SL CO is actively involved in discussion towards the development of the next national development agenda for the country.

Sharing of information with UNCT happens on a regular basis through participation in the Technical Working Groups. Interviews with UN partners showed that while they appreciate such information sharing, they cautioned that UNFPA should not dabble into areas it has no competence. They questioned the competence of UNFPA in physical construction of health facilities like hospitals and clinics. Generally the Delivering as One initiative provides impetus for more collaboration and joint working but agencies are constrained by their individual systems, mandates and reporting mechanisms. However there is a question on the relevance of UNCT weekly meetings and RC positions when the different agencies and their leadership are not accountable to the Resident Coordinator.

4.6. Added Value

Evaluation Question: What are the main comparative advantages of UNFPA in Sierra Leone particularly in relation to other organizations operating in the country?

Summary: Interviewed stakeholders, specifically bilateral development partners and other UN Agencies, confirmed that UNFPA has its comparative advantages in such thematic areas of expertise as population and development, SRH, adolescents and young people, and gender equality, and its willingness and ability to address sensitive and complex issues in emergencies. There is an overall agreement among stakeholders on UNFPA historical comparative strengths and technical expertise in population census, SRH, adolescents and youths, and gender-based violence.

The UNFPA is acknowledged by other UN Agencies, implementing partners and national stakeholders as a reliable and responsive key lead agency for SRH, adolescent, young people, gender equality and GBV. By comparison, the P&D focus area, while well received by implementing partners, is perceived by some members of the UNCT as less visible. UNFPA is a member of the UN Communications Group in Sierra Leone. The Group is charged with responsibilities pertaining to international observances, UN Day, joint press releases, specific UN initiatives, showcasing the SDGs, training etc. It is also an active member of the UN Gender Technical Team, coordinated by UN Women. The agency is also a member of the UNCT Youths Technical group, where UNFPA advances the sexual and reproductive rights of adolescents and youth and ensure they are empowered to advance their well-being and rights in the spirit of One UN.

Generally, interviews with stakeholders revealed that UNFPA SL CO is scored well in its partnership efforts, such as contribution to joint programmes at country and district levels. The agency played a significant and valuable role in responding to humanitarian crises of Ebola outbreak and flood disasters in SL. Interviewees pointed out the role of UNFPA CO exemplified by its long time support for population censuses as well as demographic and health surveys over the years. A member of the UNCT said “*without UNFPA, who would have handled the 2015 census sexercise?*” This underscores the importance attached to the role of UNFPA in national development environment especially in census undertaking. Similarly its role in SRH especially as it concerns adolescents and young people is scored high among national stakeholders, IPs and UNCT members. Among government stakeholders, it was generally echoed in different interviews that the health care system in the country would have remained comatose, if not because of UNFPA.

Within the area of reproductive health as defined in 1994 ICPD PoA, the focus on planning and its related role in population and development placed UNFPA in the lead. This is the natural niche of the agency as indicated by key informant interviews with other UN agencies, development partners and government stakeholders in Sierra Leone. All respondents noted that the UNFPA plays a strategic role on key areas of concerns and priorities to the government of Sierra Leone. Key informants at the national level agreed that the activities of UNFPA are visible in the country and that the agency has the potential to take a more leadership role in population and related RH and gender programme components. The IPs and their beneficiaries, (though, most of the beneficiaries do not know of the agency), agreed that the funding provided by UNFPA has benefited them. These beneficiaries include fistula survivors, adolescent girls who are empowered at the Safe Places, heads of Schools of Midwifery in Freetown and Makeni, graduates of these schools who are now midwives, and those from

task shifting programme etc. One DHMT director noted “we appreciate the support of UNFPA in improving our health infrastructures, and their contribution to provision of quality services to clients of different groups”. Overall, the implementing partners and beneficiaries lauded the contribution of UNFPA and alluded to a close and cordial working relationship. The responses from beneficiaries such as fistulae and gender-based violence survivors, midwives, nurses, heads of Schools of Midwifery were positive about the contribution of UNFPA. Its support for improvement of infrastructure at health facilities was appreciated for its contribution to provision of quality SRH services in the country.

UNFPA SL CO was frequently commended for its joint programming approach, good coordination and leadership role in SRH. Respondents also acknowledged UNFPA’s capabilities related to GBV and the implementation of CEDAW. Stakeholders commented on how UNFPA SL CO has indeed provided added value to the overall development efforts in the country, with other partners. While respondents cited UNFPA as a stable source of regular and concrete support for population and development activities, and has always demonstrated a willingness to help, some respondents expressed concern that UNFPA P & D activities were less visible. They also commented on UNFPA lack of investment in strengthening local institutions to contribute to capacity-building instead of spending so much on external sourcing of capacities. Respondents noted that the need to provide data for the measurement of SDGs and AU Agenda 2063 indicators provide strong rationale for continued UNFPA SL CO support and contribution for population and development in the next CP.

4.7 UNFPA’s engagement in fragile context - Humanitarian Assistance

Evaluation Question: To what extent was (or is) UNFPA, along with its partners, able (or likely) to respond to crises during the period covered by the country programme?

Summary: Interviews with national stakeholders and members of UNCT in Sierra Leone showed that the SL CO played a significant role in series of emergencies in Sierra Leone, starting from the Ebola outbreak to flood and mudslides. In terms of the Ebola virus outbreak and mudslides, UNFPA responded to the emergency situations with the provision of reproductive health emergency kits, under the assumption that these items would be distributed to the worst affected areas by SL government.

Document reviews and many stakeholder interviews revealed the commendable role of UNFPA in all the humanitarian emergencies in Sierra Leone. This has been documented in many publications. UNFPA provided leadership and technical advice to the government of Sierra Leone at the outset and over the course of the outbreak. UNFPA, in collaboration with other UN agencies, worked closely with the government and other partner in planning the response, developing and reviewing response strategies as the outbreak evolved.

The CO recruited a field epidemiologist to develop a detailed contact tracing plan and lead the exercise. Based on this plan, UNFPA recruited and deployed 14 district contract tracing monitors (DCTMs). Six hundred supervisor and about 5,000 contract tracers were deployed at the height of the epidemic. UNFPA, in Collaboration with MoHS, trained the entire contact tracing team.

During the Ebola crisis, the agency supplied the MoHS with 50 motorcycles; 13 computers, printers and uninterruptable power supply devices; 149 GPS devices to assist surveillance; and provided laptops and modems for internet connection and transport to UNFPA DCTMs. In addition, the contact tracing team was provided with mobile phones connected to a closed user group for easy and accountable

communication. Payment of incentive to a large number of people across all district with non-existent banking service presented a challenge.

UNFPA contracted a civil society organization, Health for all Coalition (HFAC), to monitor the contract tracing exercise. HFAC monitored: (i) contact tracers visits to contacts assigned to the; (ii) number of times per day the contacts tracer visited assigned contacts, against the benchmark of four times; (iii) the time it took for a symptomatic to be transferred to a holding centre, against the benchmark of one hour; (iv) contact tracers visits to quarantined homes; and (v) tracing of missing persons.

UNFPA response to maternal health needs

The initial focus of government and partners on the EVD outbreak negatively impacted on the continuity of other health services including SRMNH. However, UNFPA SL continued to focus on critical interventions to prevent maternal deaths and to address SRMNH needs. The CO carried out the following activities. It initiated procurement of maternal health kits and IPC equipment and consumables, including maternity gowns, disposal aprons, masks, clogs and gynaecological gloves distributed to maternal health units; and sustained the supply of family planning (FP) commodities and essential RH drugs.

UNFPA provided technical assistance to MoHS to design a reproductive health impact mitigation strategy to prevent EVD- related maternal deaths. The strategy was presented to NERC, who and donors but implementation was delayed due to budgetary constraints. UNFPA secured funding for phase one activities, including identification of 51 frontlines facilities for upgrading to provide RMNH services; assessment of 51 facilities for rehabilitation; development of IPC protocols for MH services; deployment of local and international health workers; strengthening outreach services and upgrading facilities for adolescent girls and youth friendly centres; engagement with HFAC to monitor essential RH drugs at services delivery points; and support to the National AIDS Secretariat to provide counselling and distribute condoms to Ebola survivors at the treatment centres.

UNFPA response to sexual reproductive health and gender-based violence needs

UNFPA convened partners in the protection sector to evaluate the impact of Ebola on adolescent girls and explore immediate solutions. It provided technical, financial and operational support to MOSWGCA to coordinate case management of vulnerable groups during the outbreak. Similar support was provided to the MoHS Adolescent and School Health Unit to support health workers within their facilities, ensure availability of commodities and mentoring of health workers.

To protect women and girls from GBV during Ebola crisis, UNFPA supported the following activities included: (i) Training of 102 youth community volunteer in 51 communities to inform and empower adolescents and young people with specific focus on Adolescent girls. The volunteers' tasks included educating communities about EVD and SRH, prevention of GBV and Referrals of GBV cases to health facilities. (ii) Established a Safe Space in Kono for victims/survivors of SGBV. 140 SGBV survivors were aided financially to access medical care, transportation, maintenance fee and filing respective court maintenance documents.¹, 102 cases were followed up and referred to health facilities and the justice system by UNFPA implementing partners. (iii) Mobilized community-level male networks to raise awareness on prevention of SGBV and supposed referral in three EVD hotspot districts. (iv) Conducted a survey on pregnant girls in selected chiefdoms and identified 1,037 pregnant girls. UNFPA successfully advocated to the Government of Sierra Leone to help these girls to receive education on core school subjects outside of the formal school setting, as well as SRH information and services. UNFPA provided operational, financial and technical support to this initiative.

Support for social and community mobilization to control and stop the EVD outbreak

Community engagement was critical in addressing cultural practices and changing health behaviour that partly contributed to the infection. UNFPA supported social and community mobilization intervention by empowering community group and disseminating information. Two gender NGOs were engaged to train youth and women groups and conduct community mobilization. Surveillance committees were established in villages and town sections. (UNFPA 2016).

4.8 Monitoring and Evaluation system

Evaluation Question: To what extent did institutional monitoring and evaluation system of the programme enable the effective collection, circulation and reporting of data, favoring the monitoring of the achievement of the results, the decision-making and the accountability of the programme?

Summary: The 6th Country Programme has an M and E strategy being implemented over the CP cycle. Monitoring of data collection, analysis and management is weak as the M&E unit is not actively functional with no budgetary backup. The M&E is more of a clearing house than an active unit. There is no documented evidence of the use of monitoring and evaluation data in planning and programming. There is no evidence of the use of mid-term assessment in programming.

The Monitoring and Evaluation framework of the 6th UNFPA/GoSL is anchored on the principles of results-based management which linked the CP to the relevant M&E systems such as coordination and reporting programmes, review meetings, mid-year and annual review and planning meeting, data collection and management, field monitoring visits and evaluation. The M&E was guided by the UNFPA procedures and guidelines. The 6th CP designed a Monitoring and Evaluation System to provide the basis for CP Monitoring and Evaluation and to guide all programme M&E activities. It integrates the harmonised monitoring tools such as work plan, the CPAP tracking tools, the Standard Progress Report (SPR), Field Monitoring Visit Report, FACE form, COAR and others. It was aligned to the CPAP Results and Resources Framework. The CP Results and Resources Framework defined a set of indicators with corresponding baselines, targets and means of Verification. Programme progress and achievements are mainly reported through the following: Country Office Annual Reports (COAR), Standard Progress Report

In addition, the baseline and end-line data for a number of indicators were developed and targets set over the programme cycle. There were a number of indicators at outcome and output levels. At the output level, there are 24 indicators and 8 have no baseline indicators. All AYG and P&D indicators have baseline data. There was no indicator reference sheet to support the interpretation of indicators. Some indicators do provide precise and concise information on the degree of achievement but some fall short of these precisions. The program indicators are measured through data collection by the IPs' programme and M&E staff on the field reviewed by the CO program staff before sharing with the CO M&E Specialist for reporting.

The weakness in this approach is that the data provided are not verifiable by the CO M&E Officer and IP Focal persons. For instance, most of the AYFHS centres were empty at the time of our visits. One wonders where the data on the number of adolescents accessing FP/RH services came from. IPs claims of delivery in the intervention sites were not verifiable from the CO M&E Unit. The Unit

completed the data as provided by the IPs and CO programme officers, without authentication/verification.

The M&E calendar envisaged a bi-annual field monitoring visits. If this was adhered to, there would have been about 6 annual field monitoring visits to project sites. But by the time of this evaluation, and from desk reviews, only two field monitoring visits were undertaken in 2015 and 2016. This lack of field work was made up by spot-check, where the M&E specialist visited IPs offices in Freetown to do a spot check on their documents. This certainly is inadequate and does not verify the authenticity of data submitted by the IPs and the certainty of the activities that have taken place in the districts. The last monitoring visits to IPs' offices was done since May 2017 but was not complimented by any field/site visits. Visiting IPs offices in Freetown for spot-checks is not a substitute for accurate monitoring and evaluation. Further inquiry on the status of programme M&E shows that requests/proposals for field site visits have been submitted several times but the management declined support.

To track and review progress made in attaining planned activities, all the IPs continued to use the work plan monitoring tool which facilitated reporting on a quarterly basis with regard to progress towards achievement of annual targets as well as identifying facilitating and constraining factors. Similarly in order to document progress on the achievement of CP outputs and outcomes, all the IPs were made to prepare and submit Standard Progress Reports on quarterly and annual basis. Relevant CO programme officers reported that for the CO to take stock of programme performance and assess progress achieved in every year of the CP, two mid and annual review meetings were planned. The reports of these meetings served an important monitoring and evaluation function by providing a basis for responding to new opportunities and emerging issues, but *“these review meetings cannot take away the need for physical monitoring and evaluation visit by M&E Unit”*.

For each of the programme years of the 6th CP, COARs were prepared. These reports served an important function by providing the broad platform for taking stock of programme performance in relation to both internal and external threats. COARs highlight achievements, shortfalls in implementation in the implementation of CPAP and AWP for each year as well as the most important interventions undertaken to achieve results. While evaluation of major programme outcomes is mandatory and significance to the M&E process, evaluation of major CP outcomes had not been conducted by the time of this evaluation.

Data collection and management is another critical component of any M&E framework. In the 6th CP, IPs collect information on process indicators relevant to the activities they implemented. At the outcome level, government ministries were responsible for data collection. During the ET site visits, data capturing, analysis and reporting at the IPs level are good. Some of the IPs such as CapaCare, CUAMM, Aberdeen Women's Centre, Haikal Foundation, Jembe Community Outpost, PPA SL and Marie Stopes keep good record of their activities.

At the national level, there is weak coordination of the 6th CP by the coordinating Ministry of Planning and Economic Development [MOPED]. The CPD and CPAP indicated that the Programme Component Manager in the MOPED will work with other PCMs in MOHS, MOYA and MSWGCA, MEST to convene quarterly and annual meetings to review status of implementation, achievements, challenges and recommendations. No desk review confirmed that this ever happened. One of the Programme Coordination Managers opined that ***“meetings are convened by UNFPA and we have no control***

over the scheduling and the agenda". The Population Secretariat in the Ministry is very weak in terms of technical capacity, knowledge and management of UNFPA and government interfaces. The result of this is that the Unit cannot give correct update on the status of the 6th CP. In fact it was noted by some key informants that the Unit needs restructuring and reorganisation with clearly defined functions in order to make it active.

It is indicated that to assess the status of the implementation of the 6th CP, two evaluation exercises were planned. The present exercise was preceded in late 2017 by a mid-term assessment. The mid-term assessment was just completed in January 2018, but there is no record or interviews that confirmed the adoption and use of the MTR or presentation of findings to stakeholders. It is therefore not surprising that most of the issues raised in the mid-term assessment report are repeated in the CPE by stakeholders, key informant and in-depth interviewees.

Monitoring of Inputs and Activities

This is marginally addressed in the M&E document. UNFPA actively tracks the allocation of funding and shares the findings with IPs. The information is provided on quarterly basis. All commodities procured under the CP are documented in the action plans and reported too. But it does not track human resources, which is a major input in a CP.

The two joint field monitoring visits were conducted with the Population Secretariat of the Ministry of Planning and Economic Development (MoPED) to assess IPs activities in 2015 and 2016. The joint team also visited the operational fields to obtain first-hand information of the results achieved; ascertain which activities had been completed and verify assets and financial management capabilities. The visit provided on the spot assistance and advice to the IPs management in the areas of data, funds and asset management.

Table 10: The M&E System Assessment Grid for the 6th UNFPA/GoSL CPE

Feature of the M&E system	What to check	Quality / status ⁹	Answer
Type and nature of the M&E system			
Type	Is the system activity-based, results-based or both?	+	The system is result-based at CPAP levels, with the related monitoring matrix for outputs and outcomes which are reported quarterly. The CO also maintains a parallel activity-based monitoring through field visits for compliance purposes.
Nature	Is the system led by UNFPA, jointly managed with government counterparts, or led by them?	0	The UNFPA M&E system is designed jointly with the government and partners. The supervising ministry is the Ministry of Planning and Economic Development (MoPED) who leads the joint monitoring visits.
Information management system (IMS)			
Design and structure	Is there an IMS associated to the M&E system?	+	M&E is based on a dedicated Information Management System (IMS) called the SIS/myResults and managed by HQ. However, the CO also manages a parallel information management system to track quarterly and yearly programme results using an MS Excel system.
	Is the IMS design formalized in a written document e.g. an operational manual?	+	
Data collection	Does the system define who should collect what information?	+	The Results framework is clear, in most cases, who collects the data for the tracking of the output indicators and has means of verifications. Similarly, the programme indicators management system is clear on which partner provides for what indicators.
	Is the frequency of data collection well defined and appropriate?	+	
	Is the level of information depth/analysis appropriate vis-à-vis the CO and government info and management needs?	0	
Information flows	Does the system define who should report to whom?	+	For its activity-based reporting, the system defines clearly responsibilities. Field Monitoring Visits (FMV) reports are written by CO staff and are clearly defined. Annual Reviews are organized by the CO and the supervising ministry MoPED. The review meeting reports are written by the CO and reviewed by MoPED.
	Does the information get to the right persons in a timely manner and efficiently?	0	Information do get to the people but normally delayed because of bureaucratic processes.
	Are there appropriate templates to report the information?	+	There are appropriate templates/ formats for all report; some developed by HQ and others by the CO. For instance, there are HQ reporting templates for FMV, quarterly reports, mission reports and CO developed templates for Note-to-files, review meeting report and annual reporting and planning.
	Does the system provide feedback to local counterparts?	+	The FMV reports are shared with each IP individually and collectively during the mid-year review meetings as a way of providing feedbacks to partners.
Resources			
Financial resources	Is there a budget available at the UNFPA CO for monitoring purposes?	0	All monitoring & evaluations activities are budgeted for by project and funds, and are managed by their fund/project managers; there is no dedicated budget line for the CO M&E officer.
	Do relevant counterparts have budget allocations to implement the system?	+	The AWP do have budget allocations for M&E activities done by the IPs and their reports are shared with CO M&E during FMV.
Human resources	Is there a person in charge of the entire system within the CO?	+	There is an M&E focal point in the CO that coordinates the system and his function is overseen by the Assistant Representative.
	Are monitoring responsibilities clearly allocated to each staff?	0	Programme staff carries-out activity-based monitoring with tailored check list for the activity, while activity and work plan monitoring can be carried-out by the M&E focal person. However, the number of FMV by CO staff and M&E has dropped drastically over the last one year going to two because of management disapproval of FMV requests.
	Does the staff have the appropriate capacity to implement M&E tasks?	+	The CO staff do have the capacity but are not given free hand to operate.
	Does the system capitalize on local capacity to collect relevant information?	-	CO provides training in Results-Based Management and in UNFPA operation processes to partners during review meeting and sometimes dedicated time but this also has not taken place for quite a long time now.
	Does the system build local capacity to collect and use relevant information?	-	

⁹ Positive (+) ; positive with reservations (O) ; negative (-)

Feature of the M&E system	What to check	Quality / status ⁹	Answer
Indicators			
Feasibility of the objectives	Are the outputs and outcomes – associated with the indicators- attainable?	0	The output and Outcome are associated with their indicators even though some are not well defined. Some of these indicators are not attainable during this Country programme while others have been achieved far beyond their targets.
Quality of the indicators	Are indicators clearly formulated for the most part?	+	Most of the indicators are clearly formulated.
	Are indicators relevant for the most part?	+	Yes they are.
	Are indicators specific for the most part?	0	Yes, they are
	Are indicators operational for the most part?	-	The baseline and the end line are defined for most indicators but these targets were not annualised; hence annual targets are determined by the programme staff free choice. There are MoV and responsible institutions for the indicators but no indicator definition which makes it difficult to interpret them.
The role of evaluations in the system			
Integration into the system	Are evaluations well planned and selected so as to respond to the needs of the CO & UNFPA?	+	A mid-term review/evaluation was conducted in 2017 and currently the end line evaluation which is going on. Both were planned with formal ToRs developed and advertised and funds allocated.
	Are evaluations findings properly channelled into management and decision processes?	-	The Mid-term Review (MTR) was used to revise some output indicators; make them more sharper and set new targets.
	Are the results of evaluations used to update the CPAP results framework?	0	
Alignment	Are evaluations designed and its findings shared with relevant national stakeholders?	-	The MTR was never shared with CO staff nor with national stakeholders.
Monitoring of risks and assumptions¹⁰			
Assumptions	Has the CO correctly identified the main assumptions affecting the country programme?	+	Yes, CO every year identifies the risks and assesses their impacts. These are recorded in SIS/myRisk. The risks are regularly monitored and reported on by focal points and validated by CO Representative
	Is the CO able to obtain accurate and timely information on changes in those assumptions?	+	
Risks	Has the CO correctly identified the main risks affecting the country programme?	+	
	Is the CO able to obtain accurate and timely information on changes in those risks?	+	
Formalization	Is the monitoring of risks and assumptions formalized and recorded in written form?	+	The monitoring of risks and assumptions is formalised and reported on in the SIS/myResults every year and are supervised by RO and HQ.

Monitoring of Outputs and Outcomes

Outputs are the immediate results emanating from the implementation of CP activities. Their achievement sets the bases for confidence in the M&E system in ascertaining the achievement of outcomes. Following outputs, outcomes are the observed changes in the targeted population, however this occurs over a long time period. Generally in all CPs, monitoring of outputs and outcomes is based on the CPAP Results and Resources Framework including the M&E Plan and Calendar. The M&E calendar, provided to the evaluation team, showed data sources, means of data collection, its frequency, and who should collect and analyse what information. However the depth of the information required is not stated.

¹⁰ Assumptions are aspects needed for the satisfactory implementation of the programme, and risks key aspects that may put in danger its satisfactory implementation. Both stay outside the direct control of UNFPA.

RBM is not at its best in the implementation of the CP. In the first place for the current CP only detailed RBM local training was undertaken for both CO staff and IPs at the beginning of the programme in 2015. Additional RBM training for staff has been done in August 2018 and the training for IPs is planned for November of 2018. The monitoring strategy that included an overall framework which covered both activities undertaken. The plans were neither followed nor updated during the cycle. Since then, discussions on results-based monitoring are only held during mid-year and annual reviews without necessarily having any direct influence on the course of implementation. There is no systematic and/or institutionalised monitoring and evaluation done during the year in spite of the effort of the M&E officer to develop quarterly M&E plans. Again, a semblance of M&E is only done during the mid-year and annual review meeting with IPs with minimal or perhaps no participation of key stakeholders. It basically involves an assessment of progress implementation- constraints to implementation and recommendations to address critical bottlenecks, with no rigorous mechanisms in place to follow-up on recommendations. An IP, very conversant with the 6th CP concluded “*evaluation is an illusion here...we can say monitoring, but not evaluation.*” Most of the CO programme officers complained of heavy work load, hence they hardly have time to conduct planned trips to implementation sites. Most IPs confirmed to the ET that most of the monitoring visits were neither non-existent nor inconsistent. Programme officers had to obtain data through desk reviews of programme reports and FACE forms.

There are noticeable weaknesses in the outputs and outcome indicators. Some of the indicators are not clearly formulated since they do not aptly comply with SMART criteria. A few examples will suffice here. *The indicators of Output 1 namely (i) number of national plans, guidelines, protocols and standards for the delivery of high-quality sexual and reproductive health services, including humanitarian response plan incorporating minimum initial service package, and (ii) number of costed integrated national sexual and reproductive health action plan, are not directly related to the output and the outcome.* The emphasis is “*building national capacity to deliver integrated SRH services*”. One would think that the indicators should have focused on number of trained health personnel to provide SRH services; or number of health centres or SDPs equipped to provide SRH services etc. Also it is not clear how many costed integrated SRH action plans to be developed in one programme cycle. As a result of these ambiguities it is difficult to ascertain concrete results that have been achieved. Some of the results reported in SIS/myResults tool do not truly reflect progress made on the indicators defined.

Secondly the indicators of Output 8, number of national and sectoral plans that incorporate evidence-based disaggregated gender-sensitive data from 2014 census and the national demographic and health survey 2013.), and Population policy enacted and action plan implemented, do not comply with the SMART criteria in indicator formulation. There is no national plan or strategy document that will be produced that does not use data generated by the national statistical system. So there is no gain in using number of national documents produced to measure the strengthened capacity of the national statistical system. The documents may have been developed and provided by external consultants. That does not mean a strengthening of the national capacity. These weaknesses stem from the fact the CP failed to define the country-specific outputs from the global SP outputs, instead used them, *in situ or weakness* in supervisory capacity of the CO programme management. This observation of weak official supervisory capacity at CO has been noted in many other reports and assessments.

Monitoring of Risks and Assumptions

Assumptions are conditions which if held constant will mitigate a number of risks. These are informed by past programme experience. On the other hand, risks are conditions that threaten the achievement of programme implementation. The CP lists a number of assumptions. The M & E framework provides a mechanism for monitoring programme assumptions and risks.

Integration of Evaluation into the M&E system.

While the CO pays attention to the end-line evaluation exercise, documents and interviews did not show that adequate use is made of the outcome of the mid-term review of the CPAP. Sufficient attention had not been paid by the CO to the evaluation of its own internal systems. The result of this is that potential gains from complementarity between mid-term and end-line evaluation and internal evaluation systems are compromised.

A mid-term review was undertaken in October/November 2017 but the report was critical of the management of the CO and CP. There is no evidence that the report was accepted and adopted by the CO. The implications are far-reaching - clearly waste of resources and excessive micromanagement of the CP with minimal tangible results to show. The ET's interface with UNCT partners also raised these challenges as in the mid-term assessment of the CP.

M & E training of IPs

The UNFPA CO provided M&E technical capacity building for the IPs. It successfully conducted one M&E training in 2015 in Results Based Management (RBM) for both CO and IP staff. Another training was done for CO staff in August 2018. The strategy was to build capacity of CO staff and work with them to build the capacity of IPs. Other IP trainings were done during the midyear review meeting in reporting results and operation processes. Overall, while M&E is very key in every UNFPAA CP, its implementation in the current 6th UNFPA/GoSL Country Programme in Sierra Leone suffers from many weaknesses. The result of this is there is no verifiable evidence that the findings of pockets of monitoring ever guided the CP implementation.

4.9 Communication system

Evaluation Question: To what extent did the institutional communication mechanism enabled the dissemination of the program's actions to the beneficiaries and other stakeholders and ensured the visibility of its interventions both internally and externally?

Summary: The main objectives of the Communication strategy are closely tied to key UNFPA global and regional mandates, such as the ICPD beyond 2014 and SDG 2030. The UNFPA SL CO has developed a communication strategy as an important cross-cutting component. The CS has effectively addressed the need for web-based outreach which includes maintaining of the UNFPA website and development of social media. Given UNFPA's new business model as proposed by the SP 2014-2017, reinforced by new SP 2018-2021,, there may well be an increased focus on advocacy and policy dialogue in the next CP program cycle. Based on interviews and document, UNFPA SL CS activities are being implemented in a consistently professional manner.

The communication strategy of UNFPA CO in Sierra Leone 2015-2017, revised for 2018-21, is aligned with the 6th CP for the purpose of enhancing communication, advocacy and partnerships focussing on the three thematic clusters of the CP. The basic objective for a communications strategy for UNFPA Sierra Leon is to introduce a more organised approach to information sharing and targeting at all levels of the organisation. For SLCO, promoting the activities that encourage good health and well-being (SDG 3), promote gender equality (SDG 5) and reduce inequalities (SDG 10) is the pillar of the communication strategy. The sole aim of the communication strategy is to give human face to the challenges being faced by the different beneficiaries of the CP such as fistulae, pregnant women, adolescents and youths. Documents and interviews from key informants show there is a synergy between the communication unit and other programme clusters, ensuring increased coordination and effective communication.

A major aspect is to develop and strengthen the avenues where both internal and external communications can be accelerated, address the pressing needs of UNFPA CO priority goals. The strategic objectives of the SL CO communication strategy include raising the profile of UNFPA SLCO (through improved partnerships, social media, photography, blogging); improving internal communications (through monthly communication meetings, communications training, monthly communication updates), adopting a more results-oriented approach and supporting the United Nations System in Sierra Leone (through international observations, media relations).

These objectives are systematically addressed with events scheduled with local and national audiences: Government agencies, media/press, academia, civil society, donors, the UNCT and the general population. While highly relevant to the national stakeholders and donors, and the general public, the communication strategy does not focus directly on needs of specific beneficiaries or at risk populations. Thus the communication unit focuses on target groups whether they be fistula survivors, landslide survivors, girls who escaped early marriage, youth advocates etc. Communication for behavioural change / BCC and awareness raising campaigns are considered to be part of the UNFPA A SL CO programme component clusters.

The communication activities are balanced between general communications activities (for key public events, key UNFPA-priority national day promotional activities, information/advocacy materials, and website and social platforms) and communication work in support of the four main program

components. The communication strategy has effectively addressed the need for web-based outreach; this includes maintaining of the UNFPA website and development of social media. Based on interview findings with SL CO Communication Unit, the CO assesses communication activities through careful monitoring of process measures such as media-reporting following major public events, reporting on the numbers of visitors of UNFPA's online and social platforms.

UNFPA uses advocacy as a tool of communication to tackle problems in partnership with government, NGOs, civil society. The focus of its advocacy has been on mobilizing health workers for service provision to pregnant women, easy access to health facilities; advocating reduction of teenage pregnancy, child marriage, female genital mutilation and support to SSL for census sensitisation.

According to documents reviewed, programme reports and stakeholder interviews, UNFPA increased communication, and advocacy and partnership has resulted in political commitment by MoHS on government's support to FP and placement of billboards in all districts; provision of condoms to 2,895 EVD survivors, capacity-building of 412 health care service providers trained on providing SRH information and services to pregnant and lactating mothers attending alternative schooling at Community Learning Centres, and declaration signed by some paramount chiefs and other decision-makers to support action on ending teenage pregnancy and child marriage.

4.10 Challenges and Lessons Learnt¹¹

Despite the recorded achievements of the UNFPA/GoSL 6th CP interventions, some challenges are identified. These include

(i) **Delays in Releasing Funds to Implementing Partners:** Almost all implementing partners (IP's) complained of delays of releasing funds. They indicated that delays of receiving funds from UNFPA were the norm. All IP's want this area improved as one staff from an IP pointed out.

(ii) **Poor Quality Assurance of Outputs from Country Office:** The donors were concerned about the delayed reporting both financial and programme reports from the Country Office (CO). Further, even when submitted, most times these reports did not meet the reporting standards set by the donor making it difficult for donors to get the information they need for accountability. The ET's random assessment of reports of some commissioned studies including the Census monographs, lends credence to this observation. Some of the reports were badly written and poorly edited. These call into question whether there was a proper senior management oversight to provide quality assurance of reports, work plans, budgets, etc.

(iii) **Weak Coordination Mechanism:** According to the CPD the coordinating ministry for the CP is the Ministry of Planning and Economic Development (MoPED). But Interviews with national stakeholders showed that that coordination role is weak. Interviews showed that sometimes Ministry officials just learnt of UNFPA activities on television and other media. The MoPED indicated that it is not consulted when UNFPA is supporting major activities, yet it is the line ministry concerned with population policy and data. This makes it difficult for officers at the Ministry to defend and account for UNFPA activities to supervisors when they were not originally involved with the activities.

¹¹ This section drew heavily from the Mid-Term assessment report. The MTR was done between October-December and the report was submitted in February 2018. All the comments by respondents in that assessment were repeated in this CPE. Hence, the decision to report it as it is! The comments are still valid.

(iv) **Lack of Government Counterpart Funding:** The CPD indicates that the government will provide counterpart funding to all line ministries to complement donor funds for programme implementation. Most IPs and national stakeholders' interviews reported that the government had not fulfilled its pledges to complement the UNFPA resources.

(v) **Decreased Funding for some Programmes:** Although the 6th CP had so far attracted at \$40million, some stakeholders reported that UNFPA funding was decreasing for some programmes. As a result, several implementing partners have had their activities curtailed. Funding cuts by UNFPA CO to support the coordination role of MoFED have resulted in the weak partnership with government. The 6th CP funded Parliament Action Group which have been lobbied for increased resources for the ICPD agenda if it was optimally used. However, the group has not been optimally engaged because of lack of funds. (vi) **Human Resources:** There is simmering staff discontent in the CO, over issues of capacity building, work modalities, skill shifts, tasks versus pay, opportunities for regional and international workshops/seminar/conferences, and relationship with international staff, and others which affects their work. CO Staff, especially technical specialists and some national stakeholders including some UNCT partners commented on seeming discontent because of the leadership of the SL CO. One respondent said *"the environment is not conducive for work; it is hostile and discriminatory"*.

(vii) **Inadequate Monitoring and Evaluation System:** While monitoring and evaluation systems are in place, actual implementation is very weak. All IPs complained that communication with UNFPA is irregular and spontaneous. Some IPs reported that they do not get feedback from UNFPA on important issues. Similarly, when structures, procedures, procurement process, etc. change, IPs need to be updated and their staff oriented. UNFPA doesn't communicate early but calls impromptu meetings which inconvenience the IPs since they have other donors and activities to work with. Several IPs reveals that some programme staff are not in regular contact with them to help implement the programme. They claimed that programme staff only put in effort when monitoring teams are coming to visit the IPs, or when they expect evaluation or reviews from UNFPA. [MTR 2018].

Lessons Learnt

There have been lessons learnt from the three years of implementing the 6th Country Programme 2015-19. The recommendations of the mid-term assessment of the 6th CP remain valid as same issues were raised by different stakeholders: national partners, UNCT partners, and IPs and CO staff and donor agencies. These lessons, if adhered to, may inform the design of the seventh country programme.

(1) **Integration and cluster approaches:** These approaches promote easy access to SRH services by removing obstacles to health-seeking behaviour in the country. A client can assess all relevant services at a health facility in one visit.

(2) **Participatory Planning Process:** According to the CPD and interviews with IPs and national stakeholders, there was a consultative process involving various stakeholders engaged with the social and economic development in developing the 6th CP which was participatory and inclusive. It involved government, UNFPA Country Office, other United Nation Agencies, Development Partners, Implementing Partners, Non-Government Organizations (NGOs) and Community-Based Organisations (CBOs), including Traditional and Religious Leaders (TRLs).

The review also established that UNFPA brings together all implementation partners (IPs) during the annual work plan preparation process so that they share experience, successes, lessons, and constraints. The IP visited reported that they were always invited to workshops and agree on activities to do during the following year. Key lesson here is that this participatory planning process is important

in programme implementation which leads to ownership of the programme, strengthens and enhances IPs as they implement their activities.

(3) **Review Staff Work Load:** Following complaints of heavy work load by CO programme officers and reiterated by implementing partners, the issue of human resources assessment and re-alignment needs to be revisited. The lesson learnt is that there is need to make a human resource assessment and re-alignment so that programme staff concentrate on technical issues. The re-alignment may consider hiring programme associates to assist with the administrative issues while programme staff concentrate on technical issues.

(4) **Provide Timely Information:** The review found that there is poor sharing of information across the spectrum of the sixth country programme both within the country office and from the country office of implementing partners and donors. Almost all IPs visited wanted to improve the way it shares information with them for proper programme implementation. The major lesson learnt here is that providing accurate and prompt information is a good practice in the smooth implementation of the programme and helps in the delivery of decent quality outputs. It is important to improve information sharing within the country office and with the partners, donors and government.

(5) **Implementing Partners and Alternate Funding Sources:** One of the dilemmas faced by development aid is the sustainability of the interventions started after the project has closed. Usually such interventions end with the programme and there is no continuity after the donor funding has ended. Sustainability of intervention was one of the issues of the 6th CP. Several IPs reported that they had programmes started for the sixth country programme, but the funding was stopped for assorted reasons. The disruptions in programmes that were already started, lead to mistrust of the IPs and put increase burden on their staff as they must explain why the programmes were terminated. The lesson learnt is that implementing partners can think outside the box and look beyond donor funding to sustain interventions started by donors. This will be a great breakthrough for intervention that stall or are even reversed when donor funding ends. [MTR 2018].

CHAPTER 5: CONCLUSIONS

Strategic Level

UNFPA 6th Country Programme 2015-2019 interventions are relevant and adequately focused on areas that are of high priority to the GoSL and needs of the population as identified in GoSL development framework, Agenda for Prosperity, and participatory consultations with partners and stakeholders. The activities are well-aligned with the priorities of UNFPA Strategic Plan 2014-2017, revised 2018-2021 and with such international development agenda as ICPD PoA, MDG, CEDAW, SDG 2030, and Agenda 2063. It focussed on vulnerable, disadvantaged and marginalised population groups.

Origin: EQ 1

Associated Recommendation: # 1 and 2

UNFPA SL CO is well positioned within the UN system and government institutions at the national and district levels to effectively support programme implementation. UNFPA SL CO has clearly demonstrated that it has been an active and constructive partner contributing to the functioning and coordination of UNCT activities within the UNDAF framework. UNFPA SL CO is recognized for its work within the UNDAF Outputs and Outcomes. The SL CO is making important contribution in UNCT coordination in joint programming. UNFPA mandate, its comparative strengths, services and interventions in the thematic areas of reproductive health, population dynamics, youth, gender, GBV, FGM and HIV/AIDS are well recognized and acknowledged by relevant GoSL ministries, other UN agencies and local non-governmental organizations.

Origin: EQ 6

Associated Recommendation: # 1 and 2

The added value of UNFPA as a development agency in the country is very high and well appreciated by national stakeholders, IPs, beneficiaries and UNCT in Sierra Leone. UNFPA SL CO is acknowledged by national stakeholders as a reliable and responsive key lead agency for SRH, Youth, Gender and GBV. By comparison, the PD focus area, while well-received by implementing partners, is perceived by some members of the UNCT as less visible with relatively less impact.

Origin: EQ 6

Associated Recommendation: #5

From inception of the 6th CP in 2015, the SL CO has been responsive to changing national priorities especially in humanitarian areas. The CO played a leading role in EVD and mud sliding crises. It initiated procurement of maternal health kits, Infection Prevention Control equipment and consumables, sustained supply of FP/RH commodities and essential RH drugs, and maintained government focus on EVD on RH services, and also provided technical assistance. It, thus, responded to emergency situations in the areas of maternal health and sexual reproductive health.

Origin: EQ 6

Associated Recommendation: #2

Programmatic Level

Effectiveness

WRH Cluster

Sexual and reproductive health interventions were effective in delivering RH services and information in UNFPA-targeted districts. The CP supported health systems strengthening, capacity building through training of health care providers at various levels, infrastructural development (building of new and renovation of old health facilities), all these to increase access to quality health care for women, adolescents and young people and other vulnerable, marginalised groups. Logistical support in reproductive health commodities security at the central and district levels have led to increased access to FP/RH commodities, however, selective stock outs continue to persist. Integration of reproductive health, STI/HIV and FP services are well scored in the country. Additional evidence of effectiveness of the CP is in the identification and complete treatment of obstetric fistulae patients.

Origin: EQ 2

Associated Recommendation: #6, 7

AYG Cluster

Most of the results related to Adolescents, Youth and Gender cluster activities have been achieved. Community health centres and health posts in intervention districts were renovated to include separate and confidential space for the provision of services to adolescents and youths. Safe Spaces were established for asset building of vulnerable adolescent girls; support to the Salone Adolescent Girls Network; development of life skills manual, and community sensitization to protect adolescent girls' protection and empowerment. Health workers were trained to offer services in these centres. Advocacy and awareness raising on maternal health, gender, child marriage and FGM issues have reached men, women, school boys and girls, and youth at the central, district and chiefdom levels.

Origin: EQ 2

Associated Recommendation: #6, #7

Population and Development

The support for the development of the statistical systems contributed to the production and availability of census data, and DHS secondary data analysis on maternal health indicators, used for planning, monitoring and advocacy. Yet there is national limitation in the local capacities to write research report as most of the contributors to Census technical and analytical reports were international experts. Apart from generating data, no evidence exists for the data was and is being used in public and private sectors, neither is there any effort at integration of the population dynamics into the development sectoral policies and programme.

Origin: EQ 2**Associated Recommendation: #6, 7****Efficiency**

In terms of efficiency, there is relatively high utilization of funds across clusters and outputs. The CO has a good number of qualified staff together with national and international consultants in all the clusters who helped to manage and monitor programme implementation. There are reported delays in receiving funds from the CO, as well as IPs delays in submitting programme reports, among others. A number of inefficiencies are also identified. For example the sponsorship of Census Technical Advisor to US Census Bureau, instead of local staff either at the SSL or SL CO is not a good use of resources. Secondly the commission of the CPE so close to the Mid-Term assessment of the same programme is not a productive way of using resources.

Origin: EQ 3**Associated Recommendation: # 4****Sustainability**

The 6th CP interventions are durable to some extent. The programme design and implementation addressed the priorities that are relevant to national priorities; enabling systems strengthening, capacity building, working within the government structures to develop policies, guidelines, plans, procedures, these guarantee sustainability of the interventions. The integration of maternal health, FP/RH, and GBV services in health care systems also guarantees durability. Programme sustainability is deemed weak and challenged by dearth of local resources, inadequate institutional and human resource development in addition to prevailing cultural sensitivities in some of UNFPA thematic areas.

Origin: EQ 4**Associated Recommendation: # 9****Humanitarian Intervention**

The UNFPA SL CO was able to intervene effectively in humanitarian emergencies in Sierra Leone during this CP cycle. During the Ebola crisis, the SL CO led the contact tracing efforts as well as support for coordination of responses. During the flooding emergency, the CO was at the forefront of the identification and support to pregnant women and lactating mothers, support to the coordination of the response and provision of dignity kits. Emergency preparedness is an integral part of UNFPA SL CO programme of activities.

Origin: EQ 5**Associated Recommendation: #10****UNCT Coordination**

UNFPA CO has played a positive role within the UNCT system in line with the UNDAF in Sierra Leone. UNFPA CO has been active in UNCT Technical working groups which provide platforms for exchange

of information and sharing of ideas of good practices among UN agencies in the country. UNFPA has been instrumental in setting up of a number of joint coordination units within the UNCT. UNFPA adds value through its support to collection, analysis and use of population data through census and surveys for evidence-based policy-making. However partner agencies called for UNFPA's active collaboration in fund raising.

Origin: EQ 6

Associated Recommendation: #1, 2 & 11

Added Value

UNFPA is positioned as having technical mandate and value added in population and development, sexual and reproductive including adolescents and young people's issues. It is well-known among stakeholders that its comparative advantage in these areas over other UN agencies in the country is unparalleled.

Origin: EQ 7

Associated Recommendation: # 13

Monitoring and Evaluation System

Every UNFPA CP attaches great importance to monitoring and evaluation. The 6th CP has a clear M&E system that is linked to the CP Results and Resources Framework and is in alignment with UNFPA Global M&E Guidelines. While the M&E structure is clear, document and oral evidences show that its implementation is not adequate. M&E ought to be owned and directed by the national coordinating organ [MoPED] and IPs, for the purpose of accountability to the GoSL, rather there is a weak link in this coordination mechanism. Only two joint field monitoring visits have been undertaken: one in 2015 and another in 2016; no centrally coordinated budget for M&E officer. M&E calendar is not adhered to as most of the planned activities have not been implemented. The uncoordinated approach to M&E is one of the reasons why most IPs complain of lack of information as it constrains information flows between CO and IPs. National Coordination mechanism for the 6th CP is very weak.

The monitoring and evaluation system needs to be appropriate to capture information to inform decision making on an ongoing basis (i.e. monitoring) and in-depth understanding of overall strategy and effectiveness (i.e. evaluation)

Origin: EQ 8

Associated Recommendation: # 13

Communication Strategy

The SL CO's communication strategy has been effective in promoting the visibility of the CO's activities through traditional and social media. A great synergy was developed between the communication unit and programme clusters, and this ensured increased and effective communication of the activities of the CO. The public is regularly engaged through press briefings, radio and TV talks, jingles, Facebook, twitter and SL CO website. It has also helped in presenting human angle stories and experiences of different beneficiaries of the CP.

Origin: EQ 9

Associated Recommendation: #14

CHAPTER 6: MAIN RECOMMENDATIONS

Strategic

1. **There is need for the UNFPA CO to continue building partnerships with other UN Agencies under the umbrella of delivering as one so that resources can be pooled to support activities of the CP.** UNFPA CO has collaborated with other partners in implementing the CP activities. These strategic partnerships have worked well and should continue in the next Country Programme.

Priority: High

Audience/Action: SL CO, MoPED

Origin: EQ 1, Conclusion 1

Operational Implications:

- Continue to engage strategic partners in the next CP.
2. **UNFPA should continue to align the Country Programme to Sierra Leone's national policies and plans as well as international development agendas in order to respond to the country's national needs and priorities.**

Priority: High

Audience/Action: SL CO, MoPED, IPs

Origin: EQ 1; Conclusion 1

Operational Implications:

- Continue wide consultations and participation of government departments, civil society organisations and other relevant stakeholders for the next Country Programme to ensure that it is relevant and aligned to Sierra Leone's national policies and international development agendas. This will ensure that the national needs and priorities of the country are addressed with consensus of the various stakeholders, thereby enhancing the ownership of the CP.
3. **CP interventions should continue to be based on research and needs assessments, national strategies and plans and participatory consultations with stakeholders. It is also suggested that UNFPA coordinates with partner UN Agencies and discuss with IPs to include in future programming measures to improve degrees of programmes' sustainability.**

Priority: High

Audience/Action: SL CO

Origin: EQ 1, Conclusion 1

Operational Implications:

- Maintain strategic approach of evidence-based planning and joint consultations with partners
 - Plan programmes according to central sectoral strategies of the GoSL
 - Continue support for quality research, assessments and evaluations to provide the basis for targeted and focused programme interventions.
 - Conduct operational research on the different services especially the Youth Friendly Health Services.
4. UNFPA CO increase its fund raising efforts to access other non-core sources of funding to secure financial support for the thematic areas that were least funded in the past couple of years especially Population Dynamics and Development interventions. This will enable the Cluster to extend its activities to other areas of importance, not presently covered. Even though resource mobilisation was exceeded for the census, to build statistical capacity at decentralised district levels in response to UNFPA's vision in the new Strategic Plan (outcome 4), the SDGs 2030 and Agenda 2063, all of which advocate for 'leaving no one behind' in population counts and interventions, resource mobilisation should be intensified.

Priority: High

Audience/Action: SL CO, P&D cluster, IPs

Origin: EQ 3

Operational Implications:

- Intensify efforts to raise funding from non-core sources.
 - Train and devote specialised staff for fund raising, to support proposal writing and to follow up on maintaining relationships with existing donors.
 - Capacity for IPs on administrative and financial procedures to improve their conformity with UNFPA reporting and financial requirements
 - Capacity building for IPs on how to do raise funds from other sources, instead of complete reliance on UNFPA funding.
5. UNFPA should always strive to improve its signature value in SRH, adolescents and young people, gender equality and women's empowerment, population and development to enhance strategic and local positioning at the country and district levels and to improve coordination with other partner UN Agencies for joint advocacy of the government and in the implementation of joint programmes. More importantly its portfolio in Population and Development should be made more visible, active and relevant in national development and planning.

Priority: Medium

Audience/Action: SL CO, MoPED, UNCT

Origin: EQ 6

Operational Implications:

- Continue building capacities for service delivery, advocacy and community sensitization of local communities at district levels.

Programmatic Level

6. **To Increase the effectiveness of the each programmatic area outputs, central and district level efforts should be more focused in both scope and geographical area.**

A more integrated and focused approach is required – both in terms of the scope of the programme as well as the geographical focus. It is recommended that UNFPA fine-tune RH interventions for improved quality RH services and information to vulnerable groups. It is also recommended that UNFPA adopt more effective approaches to strengthen FP commodity delivery, monitoring and reporting and to ensure availability at the community level.

In the area of Adolescents, Youth and Gender cluster, it is recommended that UNFPA continue its programme support for youth empowerment and engagement in community education on reproductive health while also advocating for identification of the youth/adolescents SRH needs. UNFPA to increase and enhance community mobilization and advocacy for maternal health , fistulae, family planning and GBV including to law reform and law enforcement for reducing FGM and child marriage.

In the areas of Population and Development, there is need to ensure that that there is information available for evidence-based policy making as well as decision-making because of the ever changing data needs. In addition, there is need for data to monitor and evaluate the SDGs and Agenda 2063. UNFPA should support the National Statistical System Strategy which provides for integrated statistical system for the production of improved quality of data related to population and other components of the CP. It should also support the advocacy and coordination for the implementation of ICPD PoA, SDG 2030 and Agenda 2063

Priority: Very High

Audience/Action: SL CO, MoPED

Origin: EQ 2

Operational Implications:

- Follow through and implement targets that are not yet attained and sustain successful interventions
- Conduct regular review of the current SRH interventions through evidence-based approaches to improve the delivery of SRH services and information
- Conduct in-depth assessment of the Adolescents and Youth Friendly Health Centres
- Strengthen the referral and midwifery supervisory systems to improve the overall performance especially at community health facilities
- Enhance the recruitments and deployments and retention of midwives, surgical assistants and anaesthetists that can provide quality midwifery services
- Accredite the qualification of surgical assistants by revising the scheme of service and a legal framework governing the surgical CHOs services to ensure their proper regulation, retention and career development

- Strengthen the delivery of FP commodities at the district levels
 - Improve the reporting system on the distribution of the family planning commodities to enable estimating the unmet needs at community level
 - Continue to implement emergency preparedness and contingency guidelines
7. **UNFPA should continue supporting the SSL capacity to generate, analyse and utilize data to inform, monitor and evaluate policy and programme implementation.**

Priority: Very High

Audience/Action: SL CO, SSL, MoPED

Origin: EQ 2, CONCLUSION 2

Operational Implications:

- UNFPA to continue supporting the development, roll-out and implementation of National Statistical Strategy to strengthen the data production at national level and address gaps in district and chiefdom levels.
- Raise awareness of the importance of statistical and demographic data for planning and monitoring population developments
- Strengthen local capacities for quality research design, report writing, through technical assistance
- Finalise and operationalise the Population Policy and support the advocacy and coordination for the implementation of the Policy for all the aligned international development agenda.
- Coordinate with line ministries for the commitment and integration of population dynamics into sectoral development
- Provide technical support for the integration of population dynamics into national development
- Strengthen the capacities of Population Unit in the Ministry of Planning and Economic Development for coordination with and monitoring the district offices of SSL
- Support advocacy to promote the understanding of population dynamics through seminars, conferences and workshops
- Support IPs to be knowledge production unit in matters of research into population dynamics and development
- Coordinate with other UNCT and international development partners for orientations on ICPD, SDG 2030 and Agenda 2063.
- Encourage the use of these frameworks in policy formulation and plans

8. **There is need to strengthen the national coordination unit in the Ministry of Planning and Economic Development to ensure continued effective and efficient implementation of next CP activities.** In the 6th Country Programme, the role of this Unit is insignificant. The national coordination unit still requires strengthening for it to perform better than it did in the 6th CP. From the interviews there were concerns about the infrequent participation of high-level government officials in the meetings associated with the 6th CP. There is need therefore for a stakeholder's meeting to explore further how the CP coordination mechanism as indicated in

the CPD can be strengthened so that it can effectively play its role in the next Country Programme.

Priority: Very High

Audience/Action: SL CO, MoPED

Origin: EQ 2

Operational Implications:

- Reorganise the Population Secretariat to be a dynamic and active Unit with powers to monitor and evaluate all IPs activities.

Efficiency

9. Create conditions for sustainability of CP interventions by developing and integrating an exit strategy at both the coordination and implementation levels and develop a capacity building and technical assistance strategy for the entire programming cycle.

Priority: Very High

Audience/Action: SL CO, IPs

Origin: EQ 4

Operational Implications:

- Develop a negotiated exit strategy and have it integrated in the next CPAP.
- Discuss sustainability issues with IPs at the time of AWP to clarify executions and to gain IPs support to work towards improving the sustainability of CP interventions
- Develop capacity building and technical assistance strategy that distinguishes once-off capacity development efforts.
- Capacity building of IPs with clear goals on expected achievements in terms of capacity-building and sustainability.

10. The CO should maintain its emergency response readiness to enable appropriate responsiveness to emerging humanitarian needs while also strengthening coordination and collaboration with relevant stakeholders with national stakeholders.

Priority: High

Action: SL CO, GoSL, UNCT

Origin: EQ 5

Operational Implications:

- Maintain and increase efforts in leading and strengthening its coordination role in humanitarian situations
- Always be ready for its role in emergencies.

11. UNFPA CO should continue and enhance its efforts to improve coordination with other UN agencies in the country for joint programming in advocacy, gender issues, adolescents and HIV.

Priority: High

Action: SL CO, UNCT

Origin: EQ 6, CONCLUSION 6

Operational Implications:

- Continue to play active role in UNCT joint programmes
- Discuss with agencies with common thematic areas on common strategies for advocacy and programmes on such areas as FGM, GBV and child marriage.

12. UNFPA CO should strive to improve its headline value in population and development, sexual and reproductive health, adolescents and young people, gender equality and women's empowerment to enhance strategic positioning at the central and district levels and to improve coordination with other UN agencies for joint advocacy and implementation of programmes. Its portfolio in population and development should be made more visible, active and relevant to national development and planning.

Priority: High

Action: SL CO, UNCT, MoPED

Origin: EQ 7

Operational Implications:

- Continue building capacities for service delivery, advocacy and community sensitization
- Expand its value in building local capacity in its thematic areas.

13. **Strengthen the UNFPA CO's monitoring and evaluation to ensure the availability of complete information.** During the evaluation gaps in information were noted, that is, some indicators were not specific to clearly follow which aspect is being measured in the numbers achieved. The definitions and measurement of the indicators were also not clear. There is need for the monitoring and evaluation system and unit to be strengthened and made more active in the next CP.

Priority: Very High

Audience/Action: SL CO, MoPED

Origin: EQ 8

Operational Implications:

- CO programme staff and M&E Unit should carry out monitoring and evaluation visits to be able to witness activities in session and verify the plausibility of data often collected from the districts.
 - Implementation Partners should be regularly provided refresher training in the UNFPA financial and programme management operations
 - An integrated and coordinated M&E system is the way to go with a costed annual work plan for carrying out routine activities. It is strongly recommended that at least two monitoring visits be conducted per quarter per IP, the first being to verify the existence of purported project sites and targeted beneficiaries, and subsequently to confirm the use of funds for their intended purposes, and most importantly the progress of implementation and identify bottlenecks to implementation for remedial action.
 - Joint monitoring system is highly recommended with a lean team of members drawn from across the clusters, including (and mandatory) representation from the CP coordinating Government Ministry of Planning and Economic Development.
 - A dedicated annual budget allocation should be made with funds managed by the responsible Cluster. The M&E Officer is responsible for implementing planned activities and reporting directly to the Cluster Lead. Financial contributions to the M&E budget should be made from all programmes that have budgets for M&E. The modalities of access to funds from across programmes should be worked out with oversight of disbursements provided by the Fund Manager and/or M&E Officer.
 - Carry out comprehensive evaluation of the CO M&E system
 - Strengthen the SL CO M&E desk to manage data capture and to oversee the production of reports that inform programming
14. Strengthen the CO Communication Unit to make it more effective in advocacy and promoting the visibility of the activities of the CO.

Priority: Medium

Action: SL CO

Origin: EQ 9

Original Implications

- Communication Unit must be active in advocacy role on ICPD and SDG agenda
- Build partnerships that will be involved in advocacy activities.

Programme Design

15. UNFPA SL CO should review and define for itself what it will do and how it will do it in the next CP rather than take the definitions from the global strategy. This means that CP should reflect national context, and the definitions, activities, risks and assumptions require rethinking and adaptation.

Priority: High

Action: SL CO

Origin: EQ 2 and 3

Operational Implications:

- Reduce the number of intervention districts from 16 to 5 to represent the 5 regions of the country.
- Remove all bottlenecks due to unnecessary delays in work plan processes and quarterly disbursement of funds
- Continue to train IPs on administrative and financial issues to catch up with UNFP policies and procedures.
- The recommendations of the MTR and NEX Audit remain valid and must be attended to.

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