

COUNTRY CASE STUDY

MID-TERM EVALUATION OF THE UNFPA SUPPLIES PROGRAMME

(2013-2016)

SIERRA LEONE

EVALUATION OFFICE

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Mid-Term Evaluation of the UNFPA Supplies Programme (2013-2016)

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ABBREVIATIONS AND ACRONYMS

CHAI	Clinton Health Access Initiative
CHC	Community Health Centre
CIP	Sierra Leone Costed Implementation Plan
CMS	Central Medical Stores
CO	Country Office
CPR	Contraceptive Prevalence Rate
CSB	Commodity Security Branch
DDMS	Directorate of Drugs and Medical Supplies
DFID	UK Department for International Development
DHIS2	District Health Management Information Systems Version Two
DHMT	District Health Management Team
DIO	District Information Officer
DMO	District Medical Officer
DMS	District Medical Stores
DPPI	Directorate of Policy, Planning and Information
eLMIS	Electronic Logistics Management Information System
EVD	Ebola Virus Disease
FHC	Free Health Care
FHCI	Free Health Care Initiative
FINE SL	Family Initiative Network for Equality
GFF	Global Financing Facility
GoSL	Government of Sierra Leone
GPRHCS	Global Programme for Reproductive Health Security
H4+JPCS	H4+ Joint Programme Canada Sweden (Sida)
HFAC	Health for All Coalition
HMIS	Health Management Information System
IUD	Intra Uterine Device
JSI	John Snow Inc.
LMIS	Logistics Management Information System
MATCOPS	Matei Initiative Empowerment Programme for Sustainable Development
MCHP	Maternal and Child Health Posts
mCPR	Contraceptive Prevalence Rate, modern methods
MEST	Ministry of Education, Science and Technology
MoHS	Ministry of Health and Sanitation
MSSL	Marie Stopes Sierra Leone
NGO	Non-governmental organisation
NMSA	National Medical Supplies Agency
NPPU	National Pharmaceutical Procurement Unit
PEN	Male Peer Educators Network
PHU	Primary Health Unit
PPASL	Planned Parenthood Association of Sierra Leone
PSB	Procurement Services Branch
PSM	Procurement and supply management
RH	Reproductive Health
RH/FP	Reproductive Health/Family Planning
RHCS/FP	Reproductive Health Commodity Security/Family Planning
RHSC	Reproductive Health Supplies Coalition
RMNCH	Reproductive, Maternal, Newborn and Child Health
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SCM	Supply chain management

SDP	Service Delivery Point
SEED	Supply, Enabling Environment and Demand
SLDHS	Sierra Leone Demographic and Health Survey
SLFPCIP	Sierra Leone Family Planning Costed Implementation Plan
SLP	Saving Lives Programme
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
The Global Fund	Global Fund for Aids, Tuberculosis and Malaria
ToC	Theory of Change
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAN	Visibility Analytics Network
WHO	World Health Organisation
WICM	Women in Crisis Management

GLOSSARY OF MEDICAL TERMS

BEmONC	Basic emergency obstetric and newborn care (BEmONC) is defined as seven essential medical interventions, or 'signal functions', that treat the major causes of maternal and newborn morbidity and mortality and should be available as close to the community as possible. These signal functions include antibiotics to prevent puerperal infection; anticonvulsants for treatment of eclampsia and preeclampsia; uterotonic drugs (e.g., oxytoxics) administered for postpartum haemorrhage; manual removal of the placenta; assisted vaginal delivery; removal of retained products of conception; and neonatal resuscitation.
CEmONC	Comprehensive emergency obstetric and newborn care (CEmONC) includes all the signal functions of BEmONC plus blood transfusions, surgery (e.g., caesarean section), and advanced neonatal resuscitation. The skills, equipment and conditions for these functions should be made available at the referral level such as a district hospital.
EmONC	Emergency obstetric and neonatal care is a package of services provided to the mother-baby couple that includes urgent services to prevent maternal death (e.g. access to essential pharmaceuticals, including antibiotics, anticonvulsants, and uterotonics) and life saving measures for newborns (e.g. clean cord care and neonatal resuscitation).
Fistula	Fistula is a hole between the vagina and rectum or bladder that is caused by injury, leaving a woman incontinent of urine or faeces or both. It requires a surgical repair. Obstetric fistula is a childbirth injury caused by prolonged or obstructed labour.
Infant mortality	The death of a child between one and twelve completed months of life.
Magnesium Sulphate	Magnesium sulphate is used to prevent seizures in a woman with moderate to severe preeclampsia. It is also used to stop seizures (eclampsia) when they are occurring. When magnesium sulphate is used during labour and delivery, it is usually continued for at least 24 hours after delivery. Magnesium sulphate is given intravenously or by injection. It is stable at room temperature and does not need refrigeration.
Maternal death	The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental causes.
MDSR/ MNDSR	Maternal Death Surveillance and Response/ Maternal and Neonatal Death Surveillance and Response: A continuous action and surveillance cycle of identification, quantification, notification and review of maternal deaths followed by the interpretation of the aggregated information on the findings and the avoidability of the maternal deaths which is used for the recommended actions that will prevent future deaths. The primary goal of MDSR/ MNDSR is reducing future preventable maternal (and neonatal) deaths.
Misoprostol	A uterotonic medicine used to induce the uterus to contract and thus to control post-partum haemorrhage or initiate labour. Misoprostol is on the WHO Essential Medicines List and comes in tablet form. It has a

	long shelf life and is stable at room temperature (so does not need refrigeration).
Neonatal death	The death of an infant during the first month of life.
Oxytocin	A uterotonic medicine given to a woman to cause contraction of the uterus. It may be given to start or increase the speed of labour, and/or to stop bleeding following delivery. Oxytocin is given through injection or intravenously. It requires refrigeration and cannot (currently) be stored at room temperature.
Perinatal death	The perinatal period commences at 22 completed weeks (154 days) of gestation and ends seven completed days after birth. Perinatal mortality refers to the number of stillbirths and deaths in the first week of life (early neonatal mortality).
Stillbirth	Stillbirth is the death of foetus before birth. A macerated stillbirth is one where the foetus has died in utero some hours or days before the delivery. Fresh stillbirths are those where the foetus was alive going into labour but died in the course of the delivery. Both types of stillbirth are largely preventable. Numbering about 2.5 million annually across the world, stillbirths have only recently begun to be counted systematically and data is difficult to interpret as a result. A declining number of stillbirths is the direct result of better maternity care (both antenatal and during delivery).

1 INTRODUCTION

This note presents the results of the field country case study of Sierra Leone, undertaken for the mid-term evaluation of the UNFPA Supplies programme. It is one of four field country case studies carried out during the evaluation (the Lao People's Democratic Republic, Nigeria, Sierra Leone and Sudan). Another five of the 46 countries in which UNFPA Supplies operates were covered by desk-based country case studies (Haiti, Madagascar, Malawi, Nepal and Togo).

1.1 The mid-term evaluation of UNFPA Supplies

The purpose of the mid-term evaluation of UNFPA Supplies is to assess the progress made in implementing the programme since 2013. The objectives of the evaluation are to provide an independent and valid assessment of:

- The relevance and approach of UNFPA Supplies
- Results achieved across all output areas and movement toward national sustainability
- Gender equality, social inclusion and equity
- Coordination and synergy with partners
- The catalytic role of UNFPA Supplies.[1]

1.2 Objectives of the field country case studies

The country case studies aim to provide insights into the evaluation questions and a comprehensive, nuanced picture of programme actions and their results. They cover nine of the 46 programme countries of *UNFPA Supplies* and serve to illustrate programme results in a **wide range of contexts**. They do not form a statistically valid or representative sample of all programme countries.

Table 1: Field and Desk-Based Country Case Studies

Mid-Term Evaluation of UNFPA Supplies: Case Study Countries	
Field-Based Country Case Studies	**Desk-Based Country Case Studies**
Lao People's Democratic Republic	Haiti
Nigeria	Madagascar
Sierra Leone	Malawi
Sudan	Nepal
	Togo

The specific purpose of the field-based country case studies is to allow the evaluation to explore the evaluation questions in greater depth than would be possible in desk studies.

[1] Evaluation Office, UNFPA. *Mid-term Evaluation of the UNFPA Supplies Programme (2013-2020): Terms of Reference,* October, 2016. p. 9.

Box 1: Evaluation Questions

Evaluation Questions

1. To what extent has UNFPA Supplies **contributed to creating and strengthening an enabling environment for Reproductive Health Commodity Security/Family Planning (RHCS/FP)** at global, regional and national level?
2. To what extent has UNFPA Supplies contributed to **increasing demand for reproductive health and family planning (RH/FP) commodities and services,** including demand by poor and marginalized women and girls in keeping with their needs and choices (including in humanitarian situations)?
3. To what extent has UNFPA Supplies, through its global operations and advocacy interventions, **contributed to improving the efficiency of the procurement and supply of RH/FP commodities** for the 46 target countries?
4. To what extent has UNFPA Supplies contributed to **improved security of supply, availability and accessibility of RH/FP commodities and services** in programme countries, especially for poor and marginalized women and girls, **in keeping with their needs and choices**, including in humanitarian situations?
5. **To what extent has UNFPA Supplies contributed to improving systems and strengthening capacity for supply chain management for RH/FP commodities in programme countries?**
6. To what extent have the **governance structures'** (UNFPA Supplies Steering Committee) **management systems and internal coordination mechanisms** of UNFPA Supplies **contributed to overall programme performance**?
7. **To what extent has UNFPA Supplies played a catalytic role by leveraging increased investment by other actors and supplementing existing programmes in RH/FP at global, regional and national levels?** [2]

The country case studies are not individual programme evaluations at country level. They:

- Provide input for answering the evaluation questions and assumptions for verification
- Triangulate data collected from other sources and respondents with qualitative and quantitative information collected in country
- Identify lessons learned.

The evaluation also uses other methods, including an online survey of key stakeholders, interviews undertaken at global and regional level and a comprehensive global document and data review to ensure coverage of all UNFPA Supplies programme countries.

[2] Evaluation questions and related key causal assumptions are provided in the *Inception Report of the Mid-Term Evaluation of UNFPA Supplies*: UNFPA, September, 2017 available at: https://www.unfpa.org/sites/default/files/admin-resource/UNFPA_Supplies_Mid-Term_Evaluation_-_Draft_INCEPTION_REPORT_Volume_1_-_121017.pdf.

1.3 Approach and methodology

Each field country case study uses a theory-based evaluation approach which builds on the theory of change (ToC) and key causal assumptions developed for the UNFPA Supplies programme described in detail in the Inception Report of the mid-term evaluation.[3]
These assumptions (Annex 1), when tested using contribution analysis, allow each evaluation question to be addressed and, ultimately, provide the basis for assessing the contribution of UNFPA Supplies to outcomes in RH/FP in Sierra Leone.[4]

The main data collection methods used in each field country case study are:

- Identification and review of core documents at country level including: annual work plans; results frameworks and results reports; minutes of planning, review and steering committee meetings; programme review and evaluation documents; monitoring mission reports, national plans and programmes in family planning and Reproductive Health Commodity Security (RHCS); and reports and documents produced by other bilateral and multilateral agencies supporting RH/FP
- Review and profiling of quantitative data, including financial data on programme investments and data on availability and use of family planning commodities
- Key informant interviews with a wide range of stakeholders at national level (Annex 3)
- Site visits at district and local levels including: interviews and discussions with provincial and district health teams and group and individual interviews with staff of district hospitals, rural health centres and health posts, and static and mobile health clinics
- Interviews with staff of warehouses and medical stores facilities at national and district level and observation of conditions for storage, monitoring and distribution of RH/FP commodities at national, provincial, district and local levels
- Focus group discussions and group interviews with girls and young women accessing RH/FP services and using commodities supported by UNFPA Supplies
- Debriefings of key informants at national level in order to present preliminary findings and receive feedback on any gaps in the data used, and on factual errors or misinterpretation of the available data.

In each field country case study, the draft field country case study note was submitted to the UNFPA Supplies team in the Country Office for review and comments prior to submission to the Evaluation Office.

1.4 Carrying out the Sierra Leone field country case study

1.4.1 Data collection activities

The country case study mission was carried out by a team of three evaluators (the evaluation team leader and national consultant and the evaluation manager from the Evaluation Office of UNFPA) working in Sierra Leone from September 3 to 16, 2017.

Document reviews

[3] UNFPA, 2017. *Inception Report*: p. 31-40.
[4] For a full discussion of the analytical approach and methodology used in mid-term evaluation see the *Inception Report,* Chapters Three and Four.

The case study mission was preceded by a review of relevant documents provided by the Sierra Leone Country Office (CO). These were supplemented by documents gathered during the case study mission from key informants interviewed. For a list of documents referred to during the case study see Annex 4.

Key Informant interviews

The case study team carried out extensive interviews with key stakeholders for UNFPA Supplies in Sierra Leone. These included:

- The UNFPA Supplies team, including technical advisors and the UNFPA Country Representative, in the UNFPA CO
- Senior managers at the Ministry of Health and Sanitation (MoHS) in Freetown, including the RH/FP Programme, the Directorate of Drugs and Medical Supplies (DDMS), the Directorate of Policy Planning and Information (DPPI), and the Central Medical Stores (CMS)
- Senior staff of non-governmental implementing partners
- Staff of development partners supporting the health sector in general and RH/FP programming in particular (WHO, UNICEF, DFID, the World Bank)
- Staff of three of the 14 District Health Management Teams (DHMT) in Sierra Leone - Western Urban, Port Loko and Pujehun
- Staff of static and mobile clinics operated by Marie Stopes Sierra Leone (MSSL) and Planned Parenthood Association of Sierra Leone (PPASL) and staff of government-run facilities in four districts (Western Urban, Western Rural, Port Loko and Pujehon)
- Group interviews with women and girls attending mobile and static health facilities.

Site Visits

The case study included site visits and observations (along with key informant interviews and group discussions) at a range of facilities relevant to the operation and effectiveness of UNFPA Supplies. These included:

- A CMS warehouse in Freetown and District Medical Stores (DMS) warehouses in Freetown (Western Urban), Pujehun and Port Loko
- At total of five static clinics and service delivery points (Primary Health Units -PHCs) in four districts
- Mobile outreach clinics in three districts (Western Urban, Pujehun and Port Loko).

During visits to static and mobile clinics, the case study team interviewed service providers and clients and observed procedures followed in providing counselling and, in particular, choice of methods for family planning. They also observed and photographed facilities and processes for storing, stock control, and ordering of RH/FP commodities, including facilities for maintaining the cold-chain for oxytocin.

Figure 1: Districts of Sierra Leone visited by the evaluation team

Districts visited by the evaluation team: Western Area Urban; Western Area Rural; Port Loco; Pujehun

1.4.2 Limitations

While data collection activities during the case study were intensive and the evaluation team was able to access all the key informants they had identified in advance, the sample of key informants interviewed and facilities visited was, necessarily, limited. This is especially true in light of the very large network of health facilities in Sierra Leone. In 2016, UNFPA Supplies reported supplying modern contraceptive methods to 1,354 health facilities across the country.

In addition, as already noted, UNFPA Supplies is not the only source of support to activities in RH/FP funded through UNFPA – with 5.9 million USD provided to UNFPA from other sources compared to 12.9 million USD sourced through UNFPA Supplies. In addition, bilateral and multilateral development partners have also provided significant funding for RH/FP. For example, the current Saving Lives Programme (SLP) funded by DFID was initiated during the second half of 2016. Under this programme, DFID has committed to providing 150 million GB Pounds of support over five years, including 20 million GB Pounds for procuring commodities for the Free Health Care Initiative in 2017.[5] The SLP programme was the vehicle used by DFID to provide 700,000 USD to UNFPA Supplies to procure RH/FP commodities for Sierra Leone in 2017.

Given extensive support to the health sector in general and to RH/FP programming (and the supply chain) in particular from other sources of funding and other partners, care must be taken in identifying the contributions made to results in RH/FP by UNFPA Supplies. The case study findings presented in Chapter Four distinguish (wherever necessary) between contributions made directly by

[5] See Box 2, Section 2.1.
http://globalhealth.thelancet.com/2016/05/31/free-health-care-initiative-sierra-leone-six-years-six-lessons

the UNFPA Supplies programme and those that arise from working in combination with other sources of support, both financial and technical.

None of the limitations noted seriously undermine the validity of the findings reported in Chapter Four.

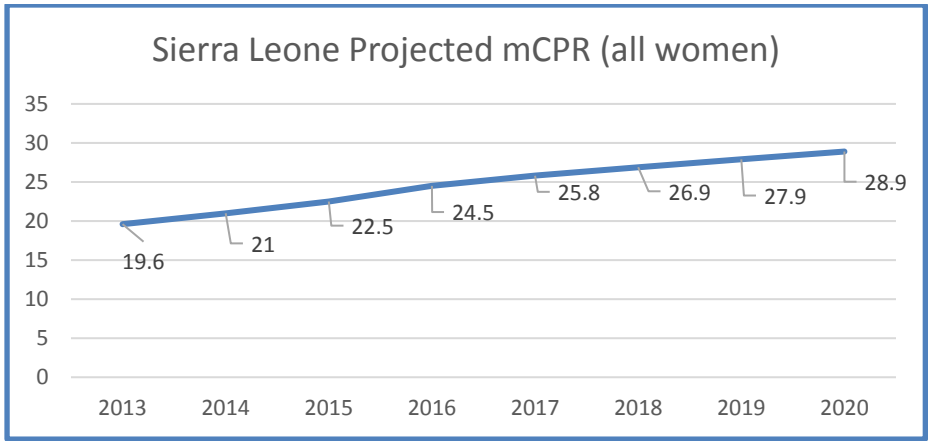
2 COUNTRY CONTEXT AND PROGRAMME RESPONSE

2.1 Demand, supply and unmet need for family planning in Sierra Leone

2.1.1 Trends in contraceptive prevalence and demand

Sierra Leone has an estimated total population of 7,092,113 with an estimated annual growth rate of 3.2 percent and a relatively youthful population, about 42 percent of the population are under age 15.[6] Family Planning 2020 estimates the current Contraceptive Prevalence Rate for the use of modern methods (mCPR) among all women in Sierra Leone stood at 24.5 percent at the end of 2016. The Track 20 model estimates that mCPR has improved moderately in the four years from 2013 to 2016 and is on a track to reach 28.9 percent by the end of 2020.

Figure 2: Past and projected mCPR for all women: Sierra Leone



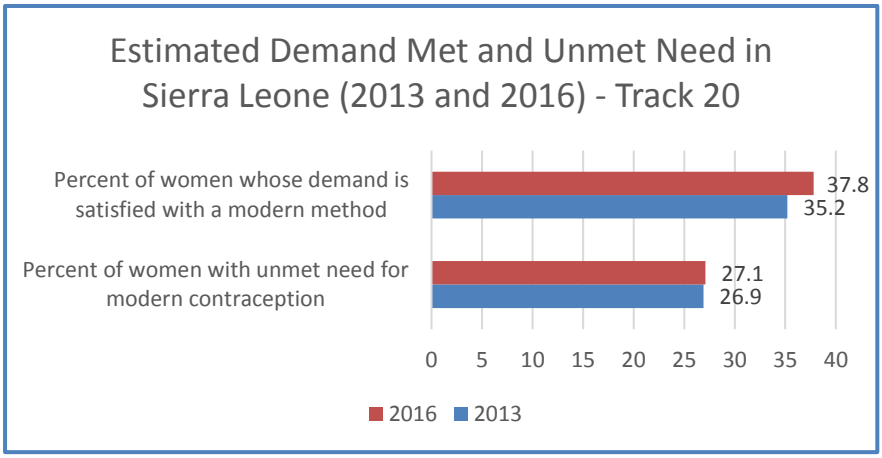
Source: FP 2020: Track 20[7]

This moderate pace of improvement in mCPR for all women, means that Sierra Leone would fail (but only by a single percentage point) to meet the commitment made to achieve its FP 2020 target of 30 percent.[8]

There has also been an increase in the percentage of women with an unmet need for family planning in Sierra Leone, from 26.9 percent in 2013 to 27.1 percent in 2016. However, there has been an improvement in the percent of women whose demand for modern methods has been met.

[6] UNFPA Country Office, Sierra Leone, *Country Level Narrative Report: UNFPA Supplies – 2016.* May, 2017. p.1.
[7] Accessible at: http://www.familyplanning2020.org/entities/96
[8] Government of Sierra Leone: *Family Planning Commitments.* July, 2012 and July 2017. Accessible at: http://www.familyplanning2020.org/entities/96

Figure 3: Estimated demand met and unmet need for family planning



The consequences of ongoing weaknesses in the supply of RH/FP services in Sierra Leone (including not meeting the level of existing demand for family planning) are serious. Drawing on data from the Sierra Leone Health and Demographic Survey (SLHDS)-2013 and other sources, the 2016 country level narrative report for UNFPA Supplies summarizes the RH/FP situation in Sierra Leone as follows:

> "Teenage pregnancy is estimated at 28 percent (SLDHS 2013), the birth rate for girls aged 15-19 is high at 125/1000 (World Bank, 2015) and 30 percent of adolescent girls are pregnant before their 19th birthday. Acceptance and access to Sexual and reproductive Health (SRH) services for adolescents is low, more than 86 percent of girls aged 15-19 have never used contraception and 30.7 percent of this age group have an unmet need for family planning (SLDHS, 2013). The country has one of the highest Maternal Mortality Ratios in the world at 1,360 per 100,000 live births (WHO Maternal Mortality Estimation Inter-Agency Group, 2015). In 2015 alone, an estimated 3,100 mothers died during child birth or from complications arising from pregnancy. A substantial portion of maternal mortality (46.8 percent) occurred among teenagers and 25 percent of maternal deaths are due to unsafe abortion among adolescents."[9]

Almost all key stakeholders interviewed in Sierra Leone (see Section 3.2) held a strong belief, that demand for family planning services and commodities has been on the increase in recent years, especially since the end of the Ebola Virus Disease (EVD) crisis in early 2016. In particular, they pointed to an increase in demand for longer lasting methods, especially implants, among teenage girls and young unmarried women. This perceived pattern of increased demand was consistent with observations made by the evaluation during visits to community outreach clinics. It was enthusiastically confirmed by young women accessing services.

2.1.2 Institutional arrangements

Delivery of RH/FP Services

The health sector in Sierra Leone has been designed around four levels of care: Tertiary (with three national referral hospitals located in Freetown), secondary, primary and community level. In 2016, the MoHS payroll verification exercise identified the number of facilities at each level.[10]

[9] *Country Level Narrative Report: UNFPA Supplies – 2016.* May, 2017. p.1.

[10] Government of Sierra Leone, Ministry of Health and Sanitation, *Human Resources for Health Country Profile 2016.* Freetown, p. 15.

Table 2: Health facilities in Sierra Leone

Level of Care	Facility Type	Number	Location	Population Served
Tertiary	Referral Hospital	3	Freetown	National
Secondary	Hospital (District and Regional Referral	21	District and Regional Centres	District and regional pop.
Primary	Community Health Centre (CHC)	229	Chiefdom	10,000 to 20,000
	Community Health Post (CHP)	386	Village Level	5,000 to 10,000
	Maternal Child Health Post	559	Village Level	Less than 5000
Community	Community Health Workers	(approx.) 15,000		

In 2016, the MoHS reported a total of 1,174 government-run PHUs and a cadre of 9,910 health workers in its employ.[11] Health service delivery in Sierra Leone is dominated by government-owned delivery, with about 90 percent of all facilities owned and operated by MoHS and 10 percent by faith-based organizations, non-governmental organizations (NGOs) and the private sector. A key feature of the health system in Sierra Leone is the existence of a cadre of unsalaried health workers (9,120 in 2016) roughly equal in size to the MoHS-employed workforce. "The geographic distribution of the unsalaried workforce is roughly equal to the MoHS workforce, with 25 percent concentrated in Freetown and the majority in facilities."[12] It is important to note that these unsalaried staff are not community health workers.

Approximately half of the health service delivery staff in government-operated health facilities visited by the evaluation team reported they were unsalaried staff. As key stakeholders pointed out, this poses a considerable risk to the provision of free services and commodities for RH/FP (in accordance with national policies and guidelines). Unsalaried staff may need to rely on fees or other sources of revenue to meet their basic needs.

Box 2: The Free Health Care Initiative

The Free Health Care Initiative: A Key Element in RH/FP Programming in Sierra Leone

The Free Health Care Initiative (FHCI) is a national programme in Sierra Leone aimed at providing free primary health care services, including RH/FP services, especially to underserved populations. It was implemented by the Government of Sierra Leone (GoSL) with support from development partners in 2011 and continues to this day. For a review of the FHCI see: The Free Health Care Initiative in Sierra Leone: six years on, six lessons. Accessible at:

http://globalhealth.thelancet.com/2016/05/31/free-health-care-initiative-sierra-leone-six-years-six-lessons

[11] *Human Resources for Health.* pp.14 and 17.
[12] *Human Resources for Health.* p.31.

Institutional structures for supply chain management

In response to a number of challenges to the health products supply chain in Sierra Leone, the government established the National Pharmaceuticals Procurement Unit (NPPU) in 2012.[13] The NPPU became operational in 2013. With support from UNFPA and from Crown Agents[14] (funded by DFID), the NPPU took over the responsibility for procurement and supply chain management of all health commodities in the country.[15] NPPU was thus responsible for managing the procurement and distribution of all the drugs and supplies covered by the FHCI, including the RH/FP commodities procured by UNFPA Supplies.

The NPPU was a key partner for UNFPA Supplies and played a central role in the management of the supply chain for FH/FP commodities until February 2016. At that time, reportedly with seven days of notice, the NPPU was disbanded on the orders of the President of Sierra Leone to be replaced, eventually, by a new National Medical Supplies Agency (NMSA) which would take over all of its functions. In the interim, responsibility for procurement and distribution of RH/FP commodities was assumed by the DDMS within the MoHS. As of September 2017, the legislation approving the establishment of the NMSA had been passed by Parliament and signed into law by the President of Sierra Leone. However, at the time of the evaluation, the board of directors had yet to be named and operational staffing of the agency was not yet under-way.

Key informant interviews (See Section 3.1) and documents reviewed indicate that the abrupt demise of the NPPU in early 2016 contributed to irregularities and disruptions in the supply of RH/FP commodities.[16] It also contributed to the fragmentation of the supply chain in Sierra Leone as described in detail in Section 3.5.

2.1.3 The Ebola Virus Disease crisis and its effects

Programming in RH/FP in Sierra Leone must contend with the effects of the EVD crisis on the health sector as a whole and, in particular, on the demand for and supply of services and commodities for RH/FP. In its annual report on the results of thematic trust funds (including UNFPA Supplies) for 2014, the UNFPA CO noted:

> "Unfortunately, the current Ebola crisis is threatening to reverse all the gains we have made in the past few years. The supply chain is overwhelmed with providing supplies to Ebola treatment/holding centres and all the efforts taken in the past to integrate the supply of contraceptives and RH commodities into the Free Health Care system currently do not matter as the main focus is on getting Ebola response items to the field."[17]

[13] *Human Resources for Health.* p.17.

[14] Crown Agents is an international development company headquartered in the United Kingdom and owned by a non-profit foundation. It partners with governments, aid agencies, NGOs and private companies in almost 100 countries: http://www.crownagents.com/about-us.

[15] UNFPA: *2014 Sierra Leone Annual Joint Reporting for Reproductive Health Thematic Trust Funds.* May, 2015. p. 7.

[16] UNFPA Country Office, *Country Level Narrative Report, UNFPA Supplies – 2016.* p.5.

[17] UNFPA Country Office, *2014 Sierra Leone Annual Joint Reporting for the Reproductive Health Thematic Trust Funds.* 2015. p.11

Annual reports by UNFPA Supplies (2014,15 and 16) as well as reports of its implementing partners, especially PPASL and MSSL, point to an interlocking set of negative effects for RH/FP services as a result of the EVD crisis:

- Overwhelming of the supply chain by the priority given to the movement of EVD response items during the crisis
- Closures of health facilities and restrictions on travel during the crisis
- Weakening of community confidence in the safety of accessing health facilities
- Drastic reductions in attendance at health facilities and in uptake of RH/FP services during the crisis (2014 and 2015)
- Especially negative impacts on adolescent girls who act as care-givers within the home and are the last to access services – including increases in gender-based violence, abuse and sexual exploitation
- Closures of schools and learning centres in 2014 and 2015 which prevented girls from accessing youth-friendly services
- The longer lasting effects of the EVD crisis on the availability of trained health services staff, including technical staff essential to operation of the supply chain (District Information Officers).

On the other hand, many senior staff in the health system, as well as workers and volunteers in government and NGO-run service delivery points strongly felt that the EVD crisis had one positive effect. In their view, the surge in teenage pregnancies which accompanied the crisis led to a significant shift in community norms regarding family planning, particularly for adolescent girls. They felt this has contributed to a sustained increase in demand for family planning services for girls and young women. Many service providers reported that, in the aftermath of Ebola, mothers started accompanying their unmarried teenage daughters to mobile and static clinics in order to seek contraceptive services. This was true for both Muslim and non-Muslim communities.

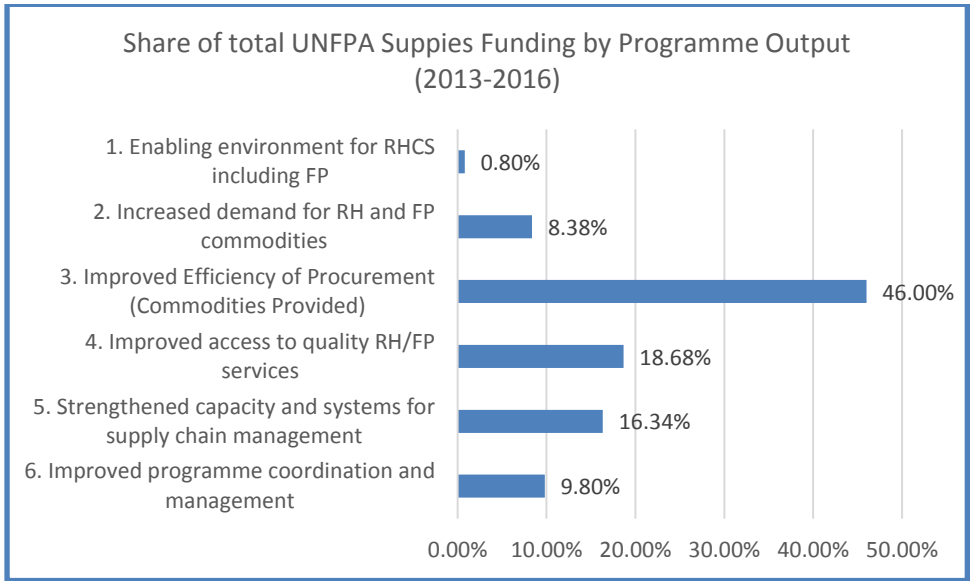
2.2 The UNFPA Supplies programme in Sierra Leone

2.2.1 UNFPA Supplies support to Sierra Leone 2013-2016

Value and distribution of allocations for UNFPA Supplies in Sierra Leone, 2013 to 2016
From 2013 to 2016, the total value of UNFPA Supplies support allocated to the programme in Sierra Leone was 12,950, 322 USD.[18] Figure 4 illustrates the allocation of those funds across the six programme outputs. Output three, improved efficiency of procurement refers to the value of commodities procured. It is the largest single category of funding, accounting for 46 percent of all the funds allocated to UNFPA Supplies in Sierra Leone from 2013 to 2016.

[18] All data on the allocation of resources to UNFPA Supplies is taken from UNFPA Country Office for Sierra Leone, *2013-2016 UNFPA Supplies Fund Allocations – Sierra Leone.*

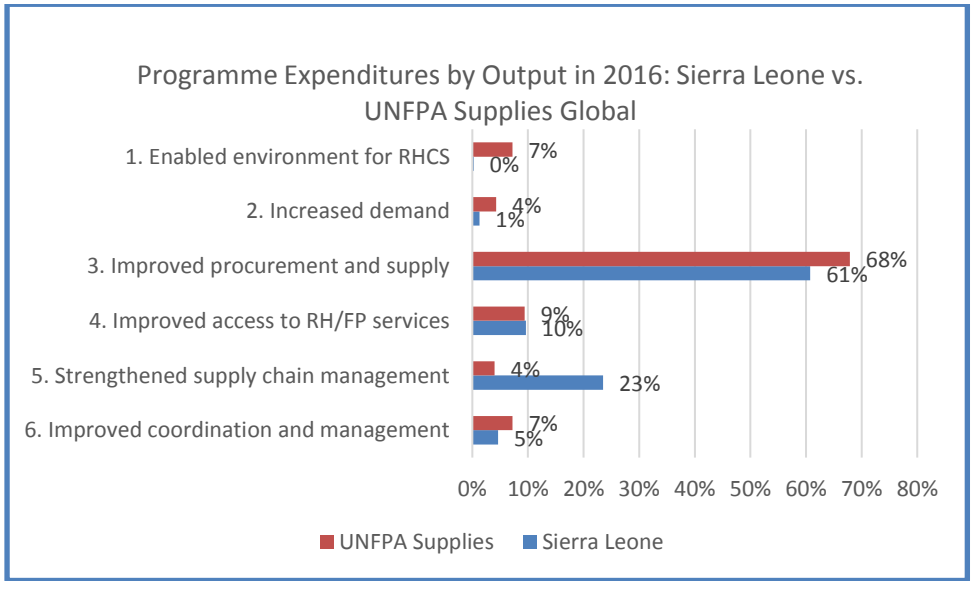
Figure 4: UNFPA Supplies fund allocations by programme output in Sierra Leone



Over the four-year period, the second largest allocation of funds was devoted to programme output four (improved access to quality RH/FP services) with output five (strengthened capacity for supply chain management) accounting for the third highest share of all funding. Direct support to demand creation was ranked fifth of the six programme outputs in terms of the funds allocated during the 2013 to 2016 period.

In 2016, the allocation of UNFPA Supplies funding in Sierra Leone by programme component followed a similar general pattern to overall programme expenditures. [19] However, UNFPA Supplies allocated 23 percent of available programme funds to strengthening supply chain management in Sierra Leone (output five) in comparison to an expenditure of just four percent globally. This may reflect the difficulties Sierra Leone has experienced in managing the supply chain for reproductive health commodities as detailed in Section 3.5.

Figure 5: Funds allocated by output in Sierra Leone and globally, 2016

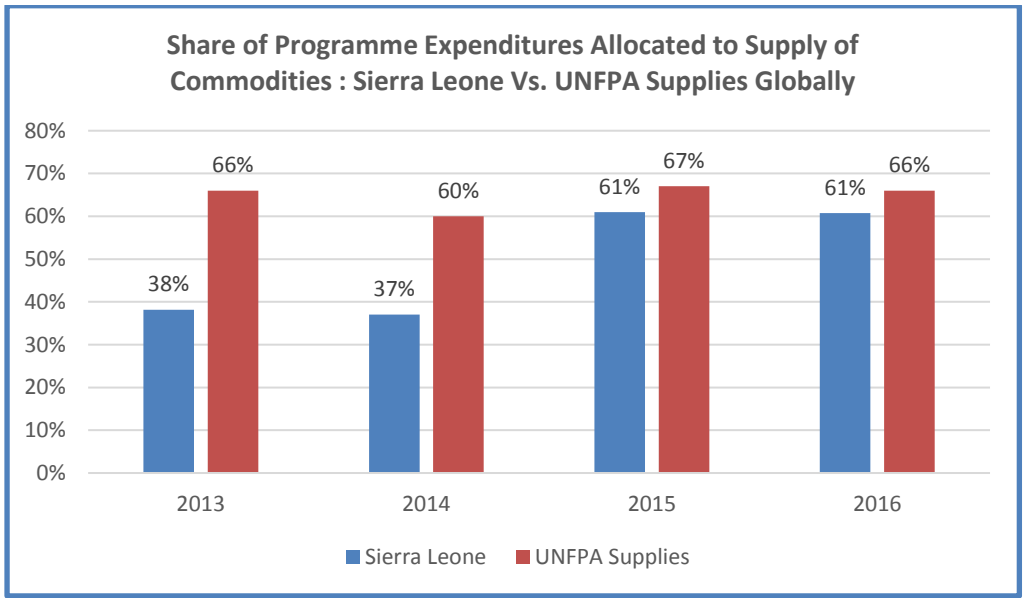


[19] Data for UNFPA Supplies Programme Globally see: UNFPA, *UNFPA Supplies, Annual Report 2016, pp.*86-92.

It is worth noting that by 2016, funding for direct demand creation activities had declined to 20,000 USD and was eliminated in planning for 2017. This reflects the decision taken at a global level during 2016 to eliminate direct support to demand creation as a programme output.

In 2013 the share of programme resources accounted for by commodities (programme output three) was much lower in Sierra Leone than for the overall programme (38 percent in Sierra Leone and 66 percent globally). However, the share of resources devoted to commodities was much more aligned with the global programme by 2016.

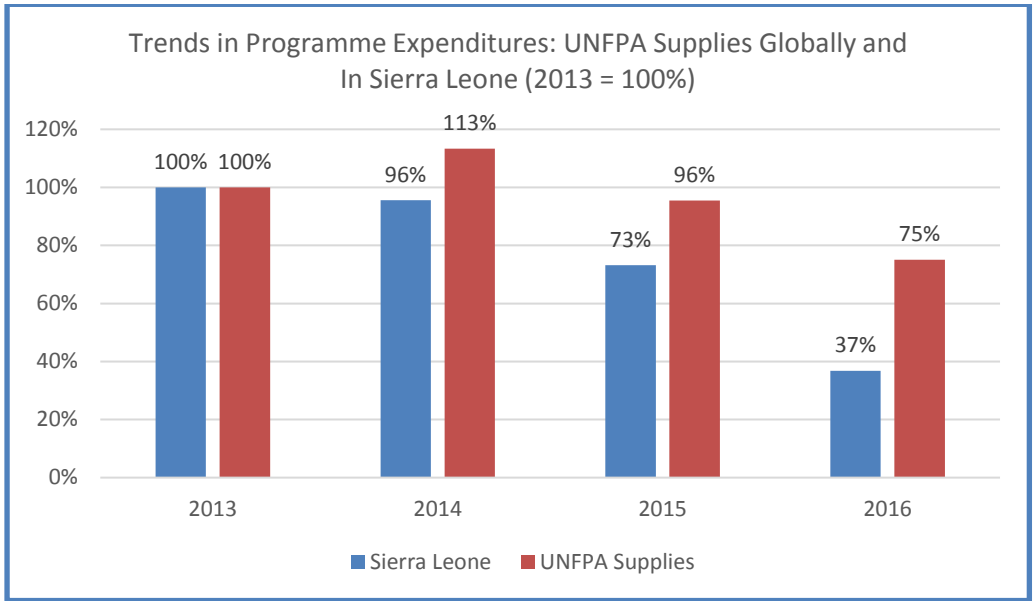
Figure 6: Expenditures dedicated to commodities: Sierra Leone vs. UNFPA Supplies



Procurement of commodities accounted for just 33.2 percent of programme funding allocations in Sierra Leone in 2013, but its share had risen to 60.8 percent in 2016. However, the procurement of RH/FP commodities also felt the effect of the reduction in programme funding during the period. It fell from a peak of 1,890,688 USD in 2015 to 947,848 USD in 2016.

Overall, the allocation of funds to UNFPA Supplies in Sierra Leone declined considerably from 2013 to 2016. This reflects a general decline in programme expenditures at a global level over the same period, but the decline in Sierra Leone was much more pronounced. After peaking in 2014, by 2016 expenditures in Sierra Leone stood at just 37 percent of their level in 2013. In comparison, 2016 global UNFPA Supplies expenditures stood at 75 percent of their 2013 value.

Figure 7: Allocation of funds to UNFPA Supplies in Sierra Leone, 2013-2016



2.2.2 Key implementing partners

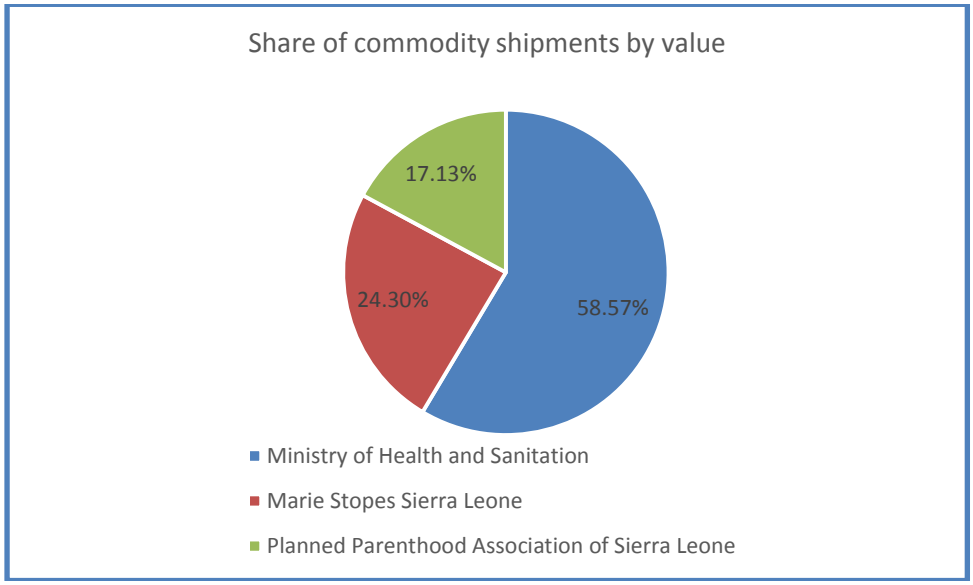
The key implementing partner for UNFPA Supplies in Sierra Leone is the MoHS and its different units involved in both service delivery and management of the supply chain for RH/FP commodities. These include:

- The RH/FP Programme responsible for policy development and service delivery in RH/FP
- The DDMS with its responsibility for the former roles of the NPPU, including the operation of the electronic Logistics Management Information System (eLMIS) and the further development of the UNFPA supported CHANNEL Software
- The CMSs
- The DPPI with responsibility for the operation of the overall Health Management Information System (HMIS).

In terms of commodity support, UNFPA Supplies accounts for an estimated 92 percent of all family planning supplies shipped to Sierra Leone.[20] However, not all of that support is provided to MoHS. As illustrated by Figure 8, MSSL and PPASL are also allocated a significant share of the family planning commodities procured by UNFPA Supplies. In 2016, these two national affiliates of international NGOs accounted for 41 percent of the total value of RH/FP commodities procured for Sierra Leone.

[20] Interview, senior staff of MoHS.

Figure 8: Share of UNFPA Supplies commodity shipments to partners in Sierra Leone in 2016



Source: UNFPA Country Office: 2016 Shipments Report

In addition to receiving direct commodity support from UNFPA Supplies, MSSL and PPASL have also received funding in support of their outreach clinics and for community mobilization and service delivery. MSSL and PPASL form part of a network of government and non-government implementing partners supported by UNFPA Supplies in the 2013 to 2016 period. The main implementing partners (other than MoHS) and their activities supported by UNFPA Supplies are described in Table 3.

Table 3: Other (non-MoHS) implementing partners of UNFPA Supplies[21]

Implementing Partners	Main Activities Supported by UNFPA Supplies
Fambul Initiative Network for Equality (FINE SL)	FINE SL conducts advocacy and sensitization activities among men and boys to promote women's reproductive rights and access to services in RH/FP. They operate Male Peer Educators Network (PEN) centres in three districts (Port Loko, Bombali and Bo) with support from UNFPA Supplies. FINE SL received support from UNFPA Supplies in 2014 and 2015.
Health for All Coalition (HFAC)	UNFPA Supplies supports the HFAC in its primary role to provide independent oversight by monitoring the supply chain for all Free Health Care commodities but with a specific focus on family planning. With support from UNFPA Supplies and UNICEF, HFAC maintains monitors in 149 communities across all 14 districts in Sierra Leone. HFAC publishes a quarterly report on the availability of RH/FP commodities at facilities across the country. They have been supported by UNFPA Supplies continuously since 2013.
MSSL	UNFPA Supplies is the main source of family planning commodities for MSSL. In addition, UNFPA Supplies has supported MSSL in providing integrated RH/FP services through its outreach clinics and to champion the use of long-term family planning methods among marginalized adolescent girls and young women. In 2016, UNFPA Supplies funding supported two MSSL outreach teams in Pujehun and Kambia districts.

[21] The information in table 3 is compiled from three sources: interviews with staff of the implementing partners; annual reports of UNFPA Supplies; and monitoring reports by the implementing partners.

Matei Initiative Empowerment Programme for Sustainable Development (MATCOPS)	MATCOPS works on demand generation for RH/FP services with a focus on in-school and out-of-school teenagers. For out-of-school advocacy they use peer educators to facilitate inter-generational community dialogue to address barriers to access to family planning services for teenage girls. MATCOPS operates mainly in Koinadugu district (8 of 13 chiefdoms). They were supported by UNFPA Supplies in 2013, 2014 and 2015.
Ministry of Education Science and Technology (MEST)	MEST has been supported by UNFPA Supplies to improve the incorporation of messages on comprehensive sexuality education and, specifically on RH/FP for adolescents and youth in both formal and non-formal settings. The programme assisted MEST to develop and implement an emergency programme to provide non-formal education to 14,500 teenage girls registered as pregnant during the EVD crisis. UNFPA Supplies also supported the operation of 282 non-formal learning centres for pregnant, school age girls.
Planned Parenthood Association of Sierra Leone (PPASL)	UNFPA is the main source of family planning commodities for PPASL but it also provides direct funding support to the provision of integrated maternal health and family planning services targeting adolescent girls and young women in marginalized communities. Support from UNFPA Supplies enabled PPASL to expand their mobile outreach operations to seven of the 14 districts of Sierra Leone. Programme support is ongoing.
Women in Crisis Management (WICM)	WICM engages with marginalized women and girls (aged 10-24 years) in order to empower them through asset building. They identify girls at risk of teenage pregnancy and early marriage and establish safe spaces in the community where they can gain knowledge on family planning, gender-based violence, reproductive health and the rights of women and girls. WICM has been supported throughout the 2013 to 2016 period. They work in six districts: Kono, Kailahun, Pujehun, Port Loko and Western District (Urban and Rural). WICM does not provide family planning services but does refer clients to service providers.

2.2.3 Geographic coverage of programme support

As indicated in Table 4, the UNFPA Supplies programme supported a number of interventions which covered every district of Sierra Leone (each activity supported in a specific district is shaded in green in the table). These included: procuring and shipping family planning and other life-saving commodities which were subsequently shipped to district medical stores in every district; funding and training district information officers in each district; providing support to Logistics Management Information System (LMIS) systems; and, supporting accountability through regular audits of stocks by HFAC. However, some activities supported by the programme were targeted to specific districts. The emergency programme of non-formal education for teenage mothers implemented by the MEST provides one example. Similarly, while MSSL and PPASL operate static and mobile clinics in most districts, they have used UNFPA Supplies support mainly in the districts indicated in Table 4. Finally, community engagement and demand generation efforts implemented by WICM, FINE SL, and MATCOPS have been concentrated in specific districts.

Table 4: Geographic distribution of UNFPA Supplies supported activities: 2013 to 2016

Programme Activity by District: 2013 to 2016							
Districts	**UNFPA Supplies Supported Activities**						
	Commoditi-es Procured and Shipped to District Medical Stores	**District Information Officers Trained and Supported**	**LMIS Supported (CHANNEL)**	**Oversight by Civil Society Org. (HFAC)**	**Education for Teenage Mothers (MEST)**	**Static and Mobile Clinic Services (MSSL and PPASL)**	**Community Engagement and Demand Generation (National NGOs)**
Bo							
Bombali							
Bonthe							
Falaba							
Kailahun							
Kambia							
Karene							
Kenema							
Koinadugu							
Kono							
Moyamba							
Port Loko							
Pujehun							
Tonkolili							
Western Area Rural							
Western Area Urban							

3 CASE STUDY FINDINGS

The documented evidence for the findings reported in this chapter can be found in detail in the Evaluation Matrix (Annex 1).

3.1 The enabling environment for RHCS and family planning

UNFPA Supplies and its partners, working closely with the MoHS, have put in place many of the most important policies, strategies and plans necessary to a strengthened enabling environment for RH/FP in Sierra Leone. As a result, UNFPA Supplies has been well aligned in its strategic direction and priorities with national policies and strategies. However, achieving a significantly improved enabling environment will require securing funds for and effectively implementing the Sierra Leone Family Planning Costed Implementation Plan (SLFP CIP). It will also require the establishment of an operationally effective NMSA.

For details of the evidence supporting findings in Section 4.1 see Annex 1: Assumptions 1.1, 1.2, and 1.3

3.1.1 UNFPA Supplies and the enabling environment

From 2013 to 2016, UNFPA Supplies has provided support to different ministries and agencies of the Government of Sierra Leone in order to strengthen, in particular, the policies, plans, strategies and guidelines which form a critical part of the enabling environment for RH/FP in general and for RHCS in particular. Some of the most important examples of the role of UNFPA in the joint development of national policies and commitments (with funding from UNFPA Supplies), include:

- Supporting the development of the national Health Sector Strategic Plan (2010 to 2015) and its revision in 2017 (2017 to 2021)
- Contributing to the development of the revised national Reproductive, Maternal, Newborn, Child and Adolescent Health Strategy (RMNCAH) 2017-2021
- Serving as the co-convenor, with MoHS for the preparation of commitments under the Family Planning 2020 meetings held in London in July 2017
- Advocating for and supporting the MoHS in revitalizing the Technical Working Group on Supply, which, in turn, supported the development of the Sierra Leone Costed Implementation Plan (CIP) for Family Planning (2018-2022)
- Advocating for resources and support to be provided by USAID for the development of the CIP on family planning
- Advocating for the revised RMNCAH Strategy and the SLFP CIP to be integral to Sierra Leone's investment case for the next round of funding under the Global Financing Facility (GFF).

Partly as a result of UNFPA Supplies, support to these policy and strategy development processes, the investments, activities and outputs of UNFPA Supplies align well with the policy environment for RH/FP in Sierra Leone, at least as reflected in strategies, policies and commitments. For example:

- The Reproductive, Maternal, Newborn and Child Health (RMNCH) Strategy (2011 to 2015) identifies nine separate objectives which are specified "with particular reference to reaching marginalized and vulnerable populations and reducing RMNCH inequalities".[22]
- The three main commitments by Sierra Leone made at the FP 2020 conference in London in August, 2017 are all directly relevant to the support provided by UNFPA Supplies:
    - To diversify the family planning resource base through sustainable financing
    - To improve access to family planning commodities through supply chain reforms and improved data visibility
    - To reduce the unmet need for family planning among adolescents and reduce adolescent birth rates.[23]
- The SLFP CIP (2017-2021) is structured around six thematic areas. The first three are directly relevant to the UNFPA Supplies Programme: demand creation, service delivery and contraceptive security.
- The CIP commits to a goal of achieving a modern CPR of 33.7 percent among all women in Sierra Leone by 2022. In order to achieve this goal, the CIP specifies the portion of the improvement to be achieved by investments in different aspects of family planning programming. Together, improved post-partum family planning and reductions in stock outs of family planning commodities account for 79 percent of the expected improvement.

[22] Government of Sierra Leone, MoHS. *Reproductive, Newborn and Child Health Strategy,* 2011-2015. p.16
[23] Accessible at: http://www.familyplaning 2020.org/entities/96

Other significant gains are expected from improvements in the operations of community health workers, mobile outreach clinics and youth-focused interventions.[24]

3.1.2 Highly contingent policy and institutional setting

While most of the needed strategies, policies and plans for an effective enabling environment for RH/FP in Sierra Leone are in place as of 2017, they are not sufficient. Achieving and sustaining a positive enabling environment for RH/FP in Sierra Leone is contingent on important institutional developments, none of which are guaranteed. These include:

1. Establishing a functioning NMSA with the necessary staff, a board of directors and the technical resources to take on its planned role as the sole agency for procuring and distributing medical supplies in Sierra Leone, including supplies for RH/FP services.
2. Addressing the long-term problem of imbalances in the human resources for health employed by the public sector. With approximately half of health services staff serving on a voluntary basis and an over-supply of PHUs - estimated at 50 percent by the World Bank - the current situation places undue strain on the supply chain for RH/FP commodities. It also represents an important risk of diversion of "free" services and commodities by unpaid health care workers.
3. Ensuring that the Government of Sierra Leone meets its commitments toward spending on procurement and distribution of HR/FP commodities. Without concrete evidence of national government financial commitment, it is highly unlikely that development partners will provide the resources necessary to fully implement the CIP for family planning. DFID has indicated that it will not fund procurement of drugs and supplies for the Free Health Care initiative after 2017 in the absence of substantial investments by the GoSL.

3.2 Increasing demand for reproductive health commodities and services

Longer term investments in demand creation by UNFPA Supplies (and other partners) have combined with positive changes in social norms following the EVD crisis facilitated to an apparent "virtuous circle" of rising demand for family planning services. This is especially true for longer term methods such as implants, particularly among teenage girls and younger women. However, this increase in demand also places increased stress on the supply chain for family planning commodities and on service delivery capacity.

For details of the evidence supporting findings in Section 4.2 see Annex 1: Assumptions 2.1, 2.2, 2.3.

3.2.1 A coalition of partners building a base for demand generation

Investing in demand creation and supporting networks

UNFPA Supplies in Sierra Leone has allocated eight percent of its total 2013 to 2016 budget to direct support of demand creation activities (a total investment of 1,085,620 USD).[25] In keeping with the decision by the UNFPA Supplies Steering Committee, the 2017 UNFPA Supplies allocation for Sierra Leone does not include funds for support to demand creation. However, the UNFPA CO has secured 147,000 USD from the DFID funded SLP to continue supporting demand creation activities.

From 2013 to 2016, UNFPA Supplies supported a coalition of NGO implementing partners who engaged in a diverse set of activities aimed at demand creation (see Table 3, above). MATCOPS, FINE

[24] MoSH, *Sierra Leone Family Planning Costed Implementation Plan 2018-2022 – Draft Brief.* June, 2017. p.2
[25] UNFPA Country Office, *2013-2016 UNFPA Fund Allocations – Sierra Leone.*

SL and WICM devoted substantial efforts to demand creation. Although they did not take part in the delivery of RH/FP services or commodities, they did refer their clients to family planning services as needed. MSSL and PPASL combined their direct service delivery activities with community mobilization and demand creation efforts – especially through community mobilizers engaging with communities a short time before the passage of mobile clinics. Finally, the non-formal MEST learning centres provided school aged pregnant girls with messaging regarding access to RH/FP services.

Service providers interviewed at NGO and government-run health facilities and outreach clinics pointed out that it is very difficult to separate the provision of services from demand creation. Especially for outreach activities and mobile clinics, community mobilization and demand creation activities are essential to the success of the clinics.

UNFPA Supplies was also instrumental in establishing the Sierra Leone Adolescent Girls Network which includes all NGO implementing partners of UNFPA who work with youth. UNFPA continues to host regular meetings of the network.

3.2.2 Addressing barriers and engaging communities

All of the NGO implementing partners of UNFPA Supplies indicated that addressing barriers to access RH/FP services represented an important institutional objective. For MSSL and PPASL, a key tool for meeting this objective has been provision of services through free mobile clinics. For both organizations, community mobilizers focus on addressing myths regarding contraception, especially those inhibiting girls and women from using longer lasting methods such as implants. MATCOPS focuses on inter-generational dialogue to address barriers to access while WICM engages with marginalized women and girls to help them develop the knowledge needed to overcome barriers to access. FINE SL works in the same communities as WICM but focuses on working with boys and men to promote access to RH/FP services for girls and women.

As noted in Table 3, the coalition of NGO partners supported by UNFPA Supplies does not cover all of the 14 districts of Sierra Leone with work on demand creation (or on service provision for that matter). However, they do target marginalized communities. Within those communities, they focus on reaching marginalized girls and women.

3.2.3 Changing norms and a possible “vicious circle” of increasing demand

The last Sierra Leone Demographic and Health Survey (SLDHS) was carried out in 2013 and there have been no systematic surveys of demand for RH/FP services and commodities, including Multiple Indicator Cluster Surveys, since that time. As a result, it is difficult to find quantitative data on the level of demand for family planning in Sierra Leone during the 2013 to 2016 period.

However, interviews with key stakeholders and observations by the evaluation team at Service Delivery Points (SDPs) indicate a consistent and significant increase in the demand for modern methods of family planning, especially since the end of the EVD crisis. In particular, there is evidence of an increase in demand for longer term methods, especially implants, among teenage girls. Examples of evidence of increased demand include:

- Indications from the RH/FP programme of MoHS that demand creation efforts are resulting in a sustained increase in demand, especially for longer lasting methods
- Interviews with headquarters staff of NGO implementing partners and with District Health Management Teams in three districts which all cited increased demand as a source of stress for the supply chain for family planning commodities
- Dramatic evidence of increases in demand observed at outreach clinics with long waiting lines and staff reporting attendance three and four times higher than before the EVD crisis

- Statements by staff of static and mobile clinics that mothers are often seen accompanying their teenage daughters to seek modern methods of contraception. This is attributed to a significant change in social norms arising from community reaction to the very large number of teenage pregnancies reported during and after the EVD crisis.
- Exit interviews with teenage girls and younger women attending static and mobile clinics which indicated their preference and enthusiasm for longer lasting modern methods of contraception, especially Jadelle implants which are called “Captains Band” because of the striped impression they make on the upper arm.

Key stakeholders interviewed reported that demand for family planning services and commodities has increased since the EVD crisis. They credit at least part of this increase to a pro-family planning reaction to the highly publicized and notable surge in teenage pregnancy during the crisis. This has coincided with efforts by UNFPA Supplies to support access by expanding the number of PHUs which can provide longer lasting methods (by encouraging task shifting and supporting training in inserting implants and Intra Uterine Devices (IUDs)).

The noted increase in demand represents both an opportunity and a challenge. If the post-EVD increase in demand can be met with an adequate supply of quality services and modern methods of contraception, it can expand and solidify family planning coverage in Sierra Leone. Failure to meet the increase in demand could compromise trust between the community and health service providers and reduce the effectiveness of prior investments in demand creation.

Figure 9: Waiting for family planning consultation: PPASL outreach clinic in Lunsar (Port Loko District)

3.3 Improved efficiency of procurement – forecasting and quantification

At country level, improved procurement from global sources is most dependent on improved forecasting of demand at central, district and local levels (from the CMSs to the PHUs). UNFPA Supplies has contributed to efforts to improved quantification and demand forecasting but there are continuing challenges and bottlenecks. It is also questionable whether UNFPA Supplies is able to access the necessary funding to support the need for RH/FP commodities and services in Sierra Leone.

For details of the evidence supporting findings in Section 4.3 see Annex 1: Assumptions 3.1, and 3.3

3.3.1 Access to adequate funding to meet the need for RH/FP commodities

UNFPA Supplies is closely related to the ability of the programme to access the funding necessary to procure the RH/FP commodities required in focus countries.[26] Quantification and demand assessment efforts by MoHS (supported by UNFPA over the past four years) indicate a national requirement for RH/FP commodities that rose from 1.62 million USD in 2013 to 1.89 million USD in 2015. However, the approved allocation for RH/FP commodities for Sierra Leone was .95 million USD in 2016 and 1.07 million in 2017. To make up for this decrease in funding, UNFPA Supplies was able to access USD .70 million in funding from the DFID funded SLP for 2017. As a result, the total available for procuring RH/FP commodities in 2017 rose to USD 1.77 million.

Interviews with key stakeholders indicate that the reduction in funding available for procuring commodities in 2016 (along with the elimination of the NPPU and ongoing difficulties in the supply chain) contributed to stock outs of RH/FP commodities at facilities. At current levels of funding, it is unlikely that UNFPA Supplies alone will be able to fully meet Sierra Leone's need for RH/FP commodities in 2018 and beyond. The Sierra Leone CO has responded to this challenge by encouraging the development of the SLFP CIP and by seeking funding from other sources. The success of this strategy will depend on the GoSL meeting its budgetary commitments under FP 2020 and the country's ability to attract investments from other development partners.

3.3.2 Improving quantification through "informed push" systems

UNFPA supplies has worked with NPPU (from 2013 to 2016) and with DDMS (2016 and 2017) and other units of MoHS to support and improve the system for quantifying ongoing usage and forecasting the need for RH/FP commodities in Sierra Leone. This includes supporting data collection and compiling at all levels in the system but especially at Central and District Medical Stores and with DHMTs. One key element in this support has been recruiting, training and sustaining the salaries of the District Information Officers (DIOs) in each district.

In 2016 and 2017, UNFPA Supplies invested considerable efforts in improving the quality of data used to forecast the need for RH/FP commodities at national, district and PHU level. These efforts included:

- Funding and managing a survey of service delivery capacity in all service delivery points to ensure that commodities (such as IUDs) were not requested where facilities could not use them
- Hosting a workshop (June 2017) to reconcile data from the District Health Information System (DHIS2) and the UNFPA Supported CHANNEL Software to validate use of CHANNEL data for forecasting

[26] UNFPA, *Mid-Term Evaluation of the UNFPA Supplies Programme (2013-2016): Inception Report.* September, 2017. p.37.

- Providing ongoing support for the supervision of DIOs
- Continuing training of DIOs and data entry clerks
- Ensuring that MSSL and PPASL provide data on the usage of RH/FP commodities to the DDMS (through the CHANNEL system) for the development of forecasts of need for the ensuing programme year.

The result of these efforts has been a more accurate estimate of national, district and local needs which can inform the forecasting function. It also allows the DDMS in collaboration with the RH/FP programme of MoHS to develop a more accurate plan for the distribution of RH/FP commodities in both the "first" (from the Central Medical Stores to the 14 District Medical Stores) and the "last mile" (from the District Medical Stores to PHUs).

3.3.3 Needed improvements in Logistics Management Information Systems

There is a general agreement among stakeholders that UNFPA support has led to the development of a more accurate quantification of the RH/FP commodities needs in Sierra Leone. However, there is also agreement that the current "informed push system" has important limitations that need to be addressed. These improvements are necessary to avoid a situation whereby some PHUs have overstocks while others report persistent and long-lasting stock outs of RH/FP commodities. The deficiencies and needed improvements in quantification and forecasting include:

- Weaknesses in the capacity of managers in the PHUs and DHMTs to monitor and assess consumption and to use the information to forecast future requirements
- The lack of interoperability between the CHANNEL and DHIS2 computerized data management systems which undermines efforts to reconcile data on consumption of RH/FP commodities across the two systems
- The reported inability of District Medical Officers (DMOs) and the DHMTs to access and use CHANNEL data for managing the supply situation in individual PHUs.

These needed improvements in quantification are part of a much larger issue regarding supply chain management in Sierra Leone. That issue is the focus of Section 4.5.

3.4 Improving access for poor and marginalized women and girls

UNFPA Supplies and its partners have successfully targeted adolescent girls and young women, including the most vulnerable for access to family planning services. They have also generally applied a human-rights based approach to providing family planning services. By providing services to poor and marginalized women and girls and to adolescents and youth (including the disabled) and applying a human-rights based approach, implementing partners have enabled UNFPA Supplies to contribute to addressing issues of gender equality and social inclusion in Sierra Leone. However, these gains are placed at risk by continuing serious and repeated stock outs.

For details of the evidence supporting findings in Section 4.2 see Annex 1: Assumptions 4.1, and 4.2

3.4.1 Expanding service coverage for long term methods

In the period of recovery from the EVD crisis, UNFPA Supplies supported MoHS to develop and implement a plan to build capacity and expand service coverage to improve access to longer lasting methods of contraception, especially implants and IUDs. UNFPA Supplies directly supported training of service providers in insertion and removal of implants (160 in 2015 and 200 in 2016). This initiative involved shifting the task of insertion and removal of implants to Maternal and Child Health

Assistants. UNFPA Supplies also provided direct support to training of trainers on IUD insertion and removal in all districts. In 2015 and 2016, the programme supported development and printing of family planning service training manuals (including instructions on insertion and removal of implants and IUDs) for use across Sierra Leone.[27]

The net result of these efforts was an expansion of service coverage for longer lasting methods from 900 facilities in 2015 to 1335 facilities by early 2017. As noted, in section 4.3, longer lasting methods are particularly popular among teenage girls and young women. Therefore, expanding service coverage for these methods is an important element in reaching marginalized women and girls.

3.4.2 Targeting marginalized women and adolescent girls

The MoHS and the two large NGO providers of RH/FP services in Sierra Leone (MSSL and PPASL) follow a similar strategy to reach poor and marginalized women and girls with RH/FP services. This involves combining services from static clinics (for MSSL and PPASL) and PHUs with free mobile outreach clinics where agency staff are supported by Community Health Workers (for MoHS) or volunteer community mobilizers (MSSL and PPASL).

Under the FHCI launched in 2010, all services and commodities in RH/FP are provided free of charge to pregnant women and children in MoHS facilities. MSSL and PPASL do charge a fee for consultations at their static clinics but all RH/FP commodities are provided at no cost.

During mobile outreach clinics carried out by either MoHS or NGOs, all RH/FP services are provided free of charge. The evaluation team observed three mobile outreach clinics, one each in Freetown, Port Loko and Pujehon districts. All three were purposely located in locations with a high population of poor and marginalized women and girls. In Freetown, the clinic served a poor community with many families affected by the recent flooding. In Pujehun and Port Loko, both targeted communities were majority Muslim populations with many teenage girls in need of family planning services. Both MSSL and PPASL emphasized that mobile outreach clinics target poor and marginalized communities in urban and rural settings.

3.4.3 Efforts to reach disabled clients and adolescents

Reaching Disabled Clients

Mobile clinics and outreach service operated by MSSL and PPASL include significant efforts to provide RH/FP services to disabled clients. In the days prior to the clinics, community mobilizers identify disabled women and girls (as well as men) in need of RH/FP services and help to make arrangements for them to travel to the clinics. As observed by the evaluation team in three clinics, disabled clients are encouraged to arrive for treatment in the early morning before the build-up of waiting lines and are systematically given priority. This is done to spare them the burden of a long wait and to recognize that they may need extra care.

Reaching adolescents, especially unmarried women and teenage girls

There are three main pathways UNFPA Supplies has used to support efforts to reach adolescents and youth in Sierra Leone with RH/FP services and commodities:

- Supporting the operation of government-run PHUs providing services to adolescents
- Supporting the operation of MSSL and PPASL static and mobile clinics providing services to adolescent and youth

[27] UNFPA, *Joint Annual Thematic Trust Fund Report – 2015,* p.6 and *Country Level Narrative Report, UNFPA Supplies, 2016,* p.1.

- Supporting demand generation and mobilization efforts of other implementing partners (See Section 4.2).

Interviews with DHMT staff and observations at PHUs in three districts identified a number of positive aspects of attention to the needs of poor and marginalized women and girls in government-run facilities, notably:

- DHMTs report working with UNFPA supplies to make facilities friendly to meeting the needs of adolescents and youth by sensitizing and training PHU staff and establishing youth friendly corners which can be reached by all the young people in a district.
- Teenagers, particularly teenage girls are able to access well-sited youth friendly corners in some facilities as observed by the evaluation team.
- PHU staff conduct outreach visits to schools to encourage teenagers, especially teenage girls to seek and use family planning services.

Interviews and site visits to static and mobile clinics operated by MSSL and PPASL also provide evidence of considerable effort to reach adolescent girls and young women:

- By providing an integrated service with diagnosis and treatment for different diseases (malaria, typhus, cervical cancer, HIV), static clinics are able to provide family planning services to young women and girls while ensuring privacy.
- Static clinics for both MSSL and PPASL undertake community engagement efforts with volunteer community mobilizers identifying young women in need of family planning services and encouraging them to attend.
- Prior to conducting outreach activities, both MSSL and PPASL make a considerable effort to engage with young women and girls in the community. They also work with school guidance counsellors and parent/teachers' associations.

The result of these efforts has been an increase in demand for modern methods, especially among teenagers and young women, including those at risk of early pregnancy.

3.4.4 Applying a human-rights based approach and the impact of stock outs

The case study team was able to observe service providers in mobile and static clinics and PHUs operated by MoHS and by MSSL and PPASL in three districts. Discussions with staff, observations of counselling and service delivery, and exit interviews indicate that RH/FP services are almost always delivered using a rights-based approach to family planning. For example:

- Staff at PPASL and MSSL static clinics were observed adhering to a structured protocol for ensuring women and girls made an informed choice of whether or not to access family planning and which method they prefer to use.
- At static and outreach clinics patients were observed receiving consultation on methods available, products used, their different characteristics, advantages and disadvantages and possible side-effects.
- Clients seeking services at mobile clinics are registered, and given a follow up appointment, their addresses and contact numbers are taken down and, if they fail to attend the appointment, community service providers contact them directly so that follow up is ensured.

- Injectables are administered in a screened off area while implants are inserted in an ambulance attending the outreach clinic so that privacy is provided for these methods. Women opting for an IUD (few) are driven to the static clinic.
- Exit interviews with young women and girls in three of the outreach clinics indicate that they understood the method they had chosen and the alternatives. While a few had accepted a substitute for their first choice (in particular choosing an alternative injectable because of a stock out of *Depo Provera*) most were satisfied with the choice they made.

The annual Global Programme for Reproductive Health Security (GPRHCS)/UNFPA Supplies facilities surveys include an exit interview of clients in a sample of health facilities dispensing modern methods of contraception. Table 5 illustrates the results of surveys carried out in 2013, 2015 and 2016 (there was no GPRHCS facilities survey in Sierra Leone in 2014 due to the EVD crisis).

Table 5: GPRHCS/UNFPA Supplies Facilities Survey Exit Interview Responses

Client Responses to Exit Interview Questions (%)	2013	2015	2016
Provided with the method of their choice	99.2	94.2	94.1
Provider took clients preferences and wishes into consideration	90.2	97.1	97.3
Client taught how to use the method	97.7	94.2	98.2
Client told about common side effects of the method	93	91.3	87.7
Provider informed client about what can be done re: side effects	94.1	90.3	88.1
Provider informed client what to do in case of serious complications	89.8	86.4	88.1
Client given date to return to the SDP for check-up and/or supplies	98.8	96.1	95
Client indicated she was treated with courtesy and respect by staff	98	98.1	95.4
Client responded yes to "forced to accept" family planning method	9.4	18.4	25.1

For the most part, the exit interviews conducted during annual facilities surveys report a high level of satisfaction on the part of the women interviewed. Across nine of the ten questions concerned with different aspects of the quality of service, reported results are highly positive, in all three years of the surveys. However, there has been significant increase over time in the number of clients who responded yes to the question of whether or not they were “forced to accept” a given family planning method.[28] It is quite possible that this rise in clients reporting they were pressured to accept a given method arises directly from increasingly severe stock outs.

Negative impacts of stock outs

Staff at headquarters level and in NGO and government-run service delivery points frequently noted the negative impact of stock outs which undermine their efforts to adhere to a human rights-based approach to delivering family planning services. Stock outs of one or more modern methods place the client in a difficult position requiring them to either choose alternative methods they are not familiar with and risk different side effects or interrupt their contraceptive practice for an (undetermined) period of time and run the risk of an unwanted pregnancy.

The recurrence of stock outs and, at times, their prolonged duration, also triggers or reinforces mistrust between clients and health service providers based on the suspicion that commodities may have been diverted to private pharmacies. This is especially detrimental in a context in which the EVD crisis already impacted negatively on the relations between communities and health service providers and, if prolonged, could ultimately threaten the gains achieved through demand creation.

[28] UNFPA/MoHS, *Draft GPRHCS Facilities Survey Report, 2016.* p.56.

Another important negative impact of stock outs is the additional pressure it puts on already stretched health human resources. Indeed, in the absence of clients' preferred method(s), staff in health facilities have to spend a considerable amount of time explaining the efficacy and potential side-effects of alternative methods.

These observations indicate that effective management of the supply chain for RH/FP products in Sierra Leone is critically important to meaningful delivery of a human rights-based approach to family planning.

3.4.5 Gender equality, social inclusion and equity

The primary gender equality focus of UNFPA Supplies in Sierra Leone can be found in the programme's efforts to secure improved access to quality reproductive health and family planning services for marginalized women and girls, especially for those at risk of teenage pregnancy and early marriage. By supporting the work of WICM and FINE SL, UNFPA Supplies contributed to efforts to increase knowledge of RH/FP services and rights among girls and young women (and young men in the case of FINE SL). These partners also engaged with communities to address negative social norms restricting access to RH/FP services for girls and young women, including causes of gender-based violence.

Implementing partners have attempted to provide RH/FP services using a human-rights based approach - ensuring that girls and women are able to make an informed choice of the method which best suits their needs (if they choose to use any method). Further, by providing outreach services in poor and hard-to-reach districts, including services to the disabled, implementing partners have strengthened the social inclusion dimension of RH/FP programming in Sierra Leone.

3.5 Strengthening systems and capacity for supply chain management

UNFPA Supplies has, along with other programmes, contributed to selective efforts to strengthen supply chain management for RH/FP commodities in Sierra Leone. However, the persistent fragmentation of supply chains for these and other health commodities presents an ongoing and serious challenge to delivering RH/FP services. These challenges have been recognized by the GoSL and by its supporting partners, and a response has been incorporated into Sierra Leone's FP 2020 commitments.

For details of the evidence supporting findings in Section 4.5 see Annex 1: Assumptions 5.1, and 5.2.

3.5.1 Efforts to strengthen supply chain management

Identifying areas of supply chain management needing support

As the severity of the EVD crisis diminished in 2015, UNFPA and its partners identified areas of the supply chain for RH/FP commodities which required support. These included the need for:

- Continuing capacity development support to the NPPU (until it was disbanded in February 2016) which was provided by Crown Agents (UK) and the Clinton Health Access Initiative (CHAI) with support from DFID and US-AID
- Strengthening data collection and dissemination of information on consumption, demand and need for RH/FP commodities at national, district and health facility level (identified in 2015)
- Repairing the negative impact of the EVD crisis on the operation of the LMIS system for RH/FP products using CHANNEL which needed to be re-vitalized to be an effective basis for monitoring consumption and informing forecasting and distribution

- Revitalizing and re-constituting a Supply Chain Technical Working Group
- Addressing infrastructure problems, particularly the shortage of warehousing space, poor conditions in central and district medical stores and inadequate refrigeration facilities for oxytocin at all levels of the system.

UNFPA Supplies support to strengthening supply chain management
In 2015 and 2016, UNFPA Supplies undertook a series of actions in support of strengthening the supply chain. These consisted in:

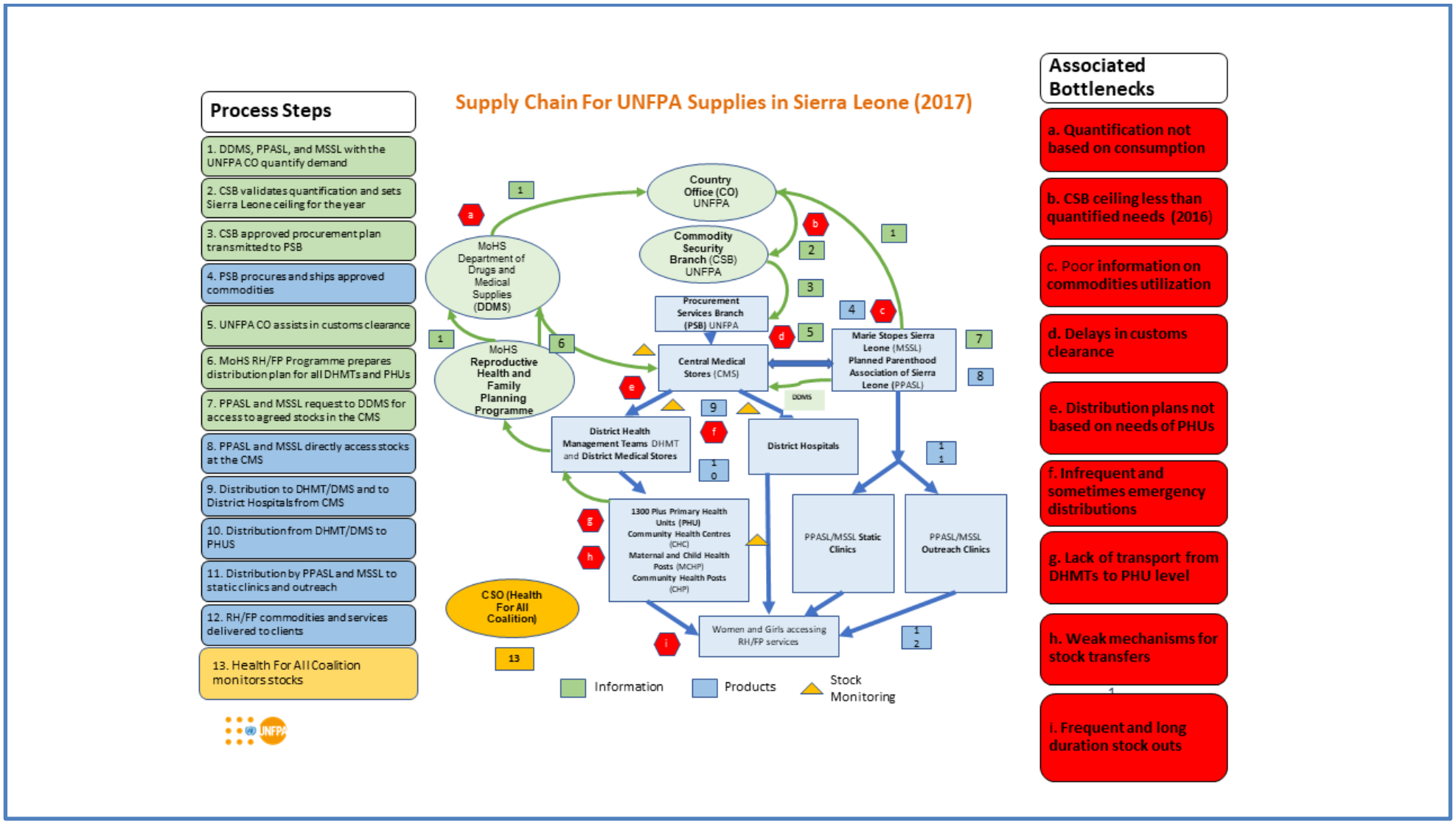
- Ensuring that RH/FP commodities procured by UNFPA Supplies were included (in 2015) in the approved list of Free Health Care (FHC) commodities (although not in DFID funded distributions to facilities)
- Supporting upgrades to shelving at the CMS and purchasing refrigerated storage facilities for oxytocin at CMS and selected Community Health Centres (CHCs)
- Providing training and funding the salaries of DIOs
- Funding an emergency distribution of RH/FP commodities from CMS to the districts and to facilities in September 2016
- Procuring computers and communications equipment for DIOs in every district to strengthen the operation of the CHANNEL LMIS system
- Assisting the DDMS and CMS with customs clearance of RH/FP commodities that have been shipped but are held in the port waiting for the necessary customs and duty waivers to be processed in, for example, the Ministry of Finance
- Supporting efforts to revitalise the operation of an effectively reconstituted Supply Chain Technical Working Group.

Interviews with UNFPA staff, MoHS staff and other development partners confirm that UNFPA support has been instrumental in maintaining a functioning supply chain for RH/FP commodities in Sierra Leone. However, they also agree that the supply chain is fragmented and dysfunctional in ways that contribute to persistent stock outs experienced where RH/FP services are delivered.

3.5.2 Continuing challenges of fragmented supply chains

The Supply Chain for UNFPA Supplies in Sierra Leone is illustrated in Figure 10. The processes and bottle necks identified in the graphic of the supply chain have been verified during discussion with key informants from the UNFPA CO, the DDMS, bilateral and multilateral development partners and staff of CMS and DMS facilities as well as DHMTs.

Figure 10: Process Diagram of the Supply Chain for RH/FP Commodities in Sierra Leone (2017)



In Figure 10, the process steps shaded in green and marked with green arrows on the chart represent flows of information. The steps in information flow include: forecasting demand in the coming year (process step 1); validation of quantification and establishing the programme ceiling (step 2); approval of a procurement plan by Commodity Security Branch (CSB) of UNFPA in New York (step 3); assistance in customs clearance (step 5); preparation of the distribution plan by the RH/FP programme at MoHS (step 6); and, the request from PPASL and MSSL to access allocated commodities at the central medical stores (step 7).

Process steps shaded in blue represent the actual shipment and delivery of RH/FP commodities. These include: procurement and shipment by Procurement Services Branch (PSB) of UNFPA in Copenhagen (step 4); first mile delivery (from the CMSs to the Districts – steps 8 and 9); and last mile distribution (From DMS to PHUs and onward to use by young women and girls – steps 10-12). The process marked in yellow illustrates the role of the HFAC acting as an external, civil society monitor of the availability of stocks at service delivery points across the country.

As indicated (red), there are important bottlenecks at each step of the supply chain cycle. The most important of these include:

a) Quantification and estimation of demand and need for the upcoming year which, though improved, is still not based on consumption data at the service delivery point and thus may over or under-estimate actual needs
b) A commodity procurement ceiling for UNFPA Supplies in Sierra Leone, established by the Commodity Security Branch in 2016, which was less than the quantified needs estimated in the previous year
c) Lack of reliable, systematically gathered information on commodities utilization by NGO implementing partners which makes it difficult to accurately forecast demand
d) Frequent and lengthy delays in customs clearance for shipments, necessitating intervention by the UNFPA CO to “walk” the needed paperwork among different GoSL agencies; delays which can incur demurrage costs
e) Plans for distribution from CMS to the district level which are not based on the actual needs of the PHUs due to limited capacity for monitoring and forecasting at the DHMT level so that some PHUs are allocated commodities they do not need and/or are not qualified to dispense (for example IUDs)
f) Infrequent, intermittent and occasionally emergency distributions from the CMS to the DHMT/DMS due to lack of funds for fuel, drivers and other transport costs
g) The absence of an adequate mechanism to identify overstocks and stock outs at the facility level and to facilitate inter-facility transfers. Without such a mechanism stock outs of some commodities persist in PHUs while others, located nearby, have stocks they cannot use.
h) The overall results are frequent and long duration stock outs which reduce choice, undermine a human-rights based approach to family planning and erode trust in service providers on the part of clients.

These identified bottlenecks in the supply chain for RH/FP commodities arise from (or are exacerbated by) a number of wider institutional factors operating in Sierra Leone. These include:

- A fragmented set of supply chains with separate systems for procuring and distributing RH/FP commodities (UNFPA/MoHS), FHCI drugs and supplies (DFID/UNICEF), and commodities for the National AIDS Control Programme (Global Fund/National AIDS Secretariat)

- The exclusion of RH/FP commodities from a procurement and distribution system for FHCI commodities which reaches the last mile but has been contracted to a private firm with strict specifications for both the volume and type of commodities to be transported
- Undue stress placed on the supply chain for RH/FP supplies by an over-extended system with too many service delivery points
- The absence of a central government authority with the capacity to procure and distribute RH/FP commodities pending the eventual establishment of an effective NMSA.

3.5.3 The problem of persistent stock outs

Data from the annual GPRHC/UNFPA Supplies facilities survey (2013, 2015 and 2016) show a worsening situation for stock outs of modern methods of contraception.

Table 6: Stock Outs of Modern Methods

Percent of facilities reporting a stock out of a modern contraceptive method on the day of the survey (2013-2016)			
Year	**2013**	**2015**	**2016**
Male Condoms	8.1	9.9	6.6
Female Condoms	11.6	23.8	36.8
Oral Contraceptives	9.3	7.9	14.2
Injectables	15.1	5	43.4
Emergency Contraceptives	26.9	42.6	49.1
IUDs	17.3	37.3	46.7
Implants	20	28.8	48.1

Source: GPRHCS/UNFPA Supplies Facilities Surveys: 2013, 2015, 2016

The data show that the overall situation for stock outs of modern methods of contraception was notably worse in 2016 than in 2013 for almost all commodities but most dramatically for implants, IUDs, emergency contraceptives and injectables. Further, the worsening situation cannot be entirely attributed to the EVD crisis of 2014/15 since the percent of SDPs reporting stock outs in 2016 was notably higher than in 2015, especially for injectables and implants.

In a similar pattern, the HFAC report for the last quarter of 2016 noted that stock outs of implants in the facilities it surveyed had reached a level of 56 percent in October. Stock outs of injectable contraceptives were found in 66 percent of the facilities surveyed. This survey took place just before the emergency distribution funded by UNFPA Supplies in November 2016.[29]

Interviews and site visits to CMS/DMS and to PHUs in September 2017 confirmed the problem of recurring and persistent stock outs. These were most notable for the injectable *Depo Provera* and the implant *Jadelle*. Some of these stock outs had persisted for six months or more.

3.5.4 Logistics Management Information Systems

UNFPA Supplies has consistently supported the operation of the LMIS system at PHU, DHMT and central level through its provision and support of the CHANNEL software. At the time of the case study the CHANNEL software system was functional at the district and central levels although it was not web-based and could not be electronically linked to data from DHIS2.

[29] Health for All Coalition – Sierra Leone: *Fourth Quarter Progress Report on Health for All Coalition Monitoring the Implementation of the Free Health Care System.* December, 2016. p. 5.

MoHS is faced with an important decision regarding electronic LMIS systems in Sierra Leone. In July 2017, the GoSL indicated that it had signed a contract with a private supplier to roll out the use of the proprietary "m-Supply" system as the LMIS of all medical supplies by January 2018.[30] However, the DPPI and other units of MoHS expressed a strong preference for upgrading and strengthening the use of CHANNEL rather than converting to mSupply. They pointed to some strengths of CHANNEL:

- It is already functioning at both district and central level
- DIOs and data entry clerks have been well trained in the use of CHANNEL
- It has been shown to be accurate enough to support forecasting RH/FP commodity demand
- UNFPA has a long history of providing support to CHANNEL in Sierra Leone at no cost
- CHANNEL is open-source software without the subscription costs, support costs and upgrade fees which may accompany use of mSupply
- The DPPI and DDMS now have the necessary in-house capacity to put CHANNEL on a web-based platform and to develop inter-operability between CHANNEL and DHIS2.

The evaluation team did not conduct a comparison of the two software systems but it seems clear that the MoHS and UNFPA are not yet fully aware of which electronic LMIS system will prevail in the near future in Sierra Leone. It is an urgent question which will need to be addressed by the NMSA when it becomes fully functional.

3.6 Improved coordination and management

Development partners have not yet been able to arrive at a common, coordinated approach to providing technical and financial support to RH/FP programming in Sierra Leone. In particular, they have not been able to provide coordinated support to strengthening the supply chain for medical supplies. This problem has been recognized by all key stakeholders and may be addressed in future in light of the commitments by the GoSL under FP 2020 and the Sierra Leone Family Planning Costed Implementation Plan (2018-2022).

For details of the evidence supporting findings in Section 4.6 see Annex 1: Assumptions 6.1 and 6.2.

3.6.1 Coordinating action in support of RH/FP in Sierra Leone

UNFPA has been a regular participant in the weekly meetings of the Operations Committee for coordinating medical supply procurement and distribution but interviews indicate that this committee deals only with operational problems, leaving aside more substantive technical and strategic questions. UNFPA Supplies has provided the CO with a platform for advocating for revitalization of the Reproductive Health Commodity Security Coordinating Committee and the Technical Working Group on Supply. Both these efforts were noted and appreciated by staff of the MoHS.

In contrast, many key informants indicated that one factor contributing to the fragmentation of supply chains has been the absence of a coordinated plan for providing technical and financial support to the supply chain for medical supplies in Sierra Leone with mutually agreed roles for development partners. It is possible that the newly completed SLFPCIP 2018-2022 will provide a framework for more coordinated national investments and external support to family planning. However, there is still a requirement for a coordinated and comprehensive approach to strengthen the supply chain for health care commodities in Sierra Leone.

[30] FP 2020, *Family Planning 2020 Commitment: Government of Sierra Leone.* Accessible at: HTTP://FAMILYPLANNING2020.ORG/ENTITY/96.

3.6.2 Capacities of the UNFPA country office

Interviews with key units of the MoHS (the RH/FP Programme, DDMS, DPPI) indicate that the UNFPA CO was able to provide an appropriate level of technical support to the UNFPA Supplies Programme. In particular, they noted that the country office provided strong technical support to the quantification process and to the operation of the CHANNEL LMIS software.

3.7 The catalytic role of UNFPA Supplies

Because it provides an estimated 90 percent of family planning commodities shipped to Sierra Leone each year, UNFPA Supplies is central to the operation of RH/FP programmes in the country. The decision to eliminate direct demand creation from supported activities in 2017 has been well managed by leveraging other sources of funds and assisting partners to secure continuing support. However, the lower level of funding provided to Sierra Leone under the programme since 2016, combined with uncertainty over funding from the national government and other key partners, raises the possibility of a very serious shortfall in the resources available for RH/FP commodities and programmes in Sierra Leone in 2018 and beyond. UNFPA has not been successful in securing increased investments by the GoSL in procuring RH/FP commodities despite the national commitment to such action under FP 2020.

For details of the evidence supporting findings in Section 4.7 see Annex 1: Assumption 7.1 and 7.2.

3.7.1 UNFPA Supplies as a core element in family planning programming

There is a general agreement among all key stakeholders interviewed in Sierra Leone that the UNFPA Supplies programme is essential to the operation of RH/FP services across the country. As already noted the programme is the exclusive source of RH/FP commodities for the MoHS facilities. It also provides the vast majority of the RH/FP commodities distributed by MMSL and PPASL. In a 2017 analysis of the supply situation for RH/FP commodities in Sierra Leone, John Snow Inc. reported that "UNFPA Supplies plays a vital role in funding and procuring family planning commodities in Sierra Leone, but faces funding constraints which limit expansion of its scope and scale of supply chain support activities."[31]

3.7.2 Leveraging international and national resources

UNFPA Supplies was able to draw on other sources of support to RH/FP outputs and outcomes from 2013 to 2016. The UNFPA CO accessed funding from other thematic trust funds in support of the same six programme outputs, as well as direct funding from bilateral partners and UNFPA core resources; these included the DFID SLP, the CIDA component of the H4+JPCS programme, and the RMNCH Trust Fund. In total, these sources provided a further 5,987,736 USD of support to activities aimed at producing the same outputs as UNFPA Supplies for programming by the Sierra Leone CO (2013 to 2016).

In 2017, in order to make up the shortfall in RH/FP commodity procurement resulting from the reduction in UNFPA Supplies commitments (from 1.89 million USD in 2015 to 1.07 million USD in 2016), DFID has provided a further .69 million USD to UNFPA for direct procurement of RH/FP commodities on behalf of MoHS.

3.7.3 Assisting partners to access other resources

As funding for demand generation and other non-commodity activities under the programme has declined over time (see Section 2.2), the UNFPA Supplies team in the CO has worked with NGO implementing partners to help them find and secure funding from other sources. Support from

[31] JSI Inc. *Analysis of Sierra Leone FH/FP Bottlenecks.* 2017. P.2

UNFPA has included providing funding under other UNFPA-led programmes (FINE SL and HFAC); helping in the preparation of concept papers and applications for funds (MATCOPS); and providing technical support and recommendations (WICM). UNFPA Supplies continues to provide direct funding support to the operational costs of the Adolescent Girls Network of Sierra Leone.

3.7.4 The challenge of sustainability

The health sector in Sierra Leone has been the recipient of very high levels of external support since well before the EVD crisis. As just one example, DFID has been the main partner supporting the GoSL in the delivery of the FHCI since 2011. In 2017 alone, DFID will provide 15 million GB pounds (19.9 million USD) for procuring and 5 million GB pounds (6.64 million USD) for distributing FHC commodities. In total, the DFID SLP commits to provide 150 million GB Pounds (199 million USD) to supporting life-saving health initiatives in Sierra Leone over five years. The World Bank is reported to be planning to support a revised Performance Based Financing programme for the health sector in Sierra Leon in 2018, with 50 million USD budgeted annually.

However, DFID and other multilateral and bilateral development partners indicate a strong reluctance to fund procurement of medical supplies and equipment after 2017 in the absence of a realized commitment for substantive funding from the GoSL. This raises an acute problem for the 2018 programming year since UNFPA Supplies needed to begin the procurement process for 2018 in the fourth quarter of 2017. There is, at this time, no concrete evidence that the GoSL will follow through on financing commitments to family planning programming made at the FP 2020 meetings in London in July 2017.

3.8 UNFPA Supplies in humanitarian crises

Partly by relying on its existing network of implementing partners, UNFPA Supplies was able to provide effective support to the response to the EVD crisis in 2014 and in recovery efforts in 2015-2016. UNFPA Supplies has also been able to provide timely support to its partners in responding to more recent, localized emergencies caused by flooding and mud-slides (2015 and 2017).

For details of the evidence supporting findings in Section 4.8 see Annex 1: Assumptions 4.4, and 4.5

3.8.1 Responding to the EVD Crisis

The major test of UNFPA Supplies' role in responding to humanitarian crises in Sierra Leone arose in 2014 from the outbreak of EVD.

> "In May 2014, Sierra Leone discovered its first laboratory confirmed case of Ebola Haemorrhagic fever in Koindu Chiefdom of Kailahun district. The situation progressively worsened and cases spread rapidly nationwide resulting in the declaration of a Public Health Emergency of International Concern by the World Health Organization and the GoSL. As of 13th January, 2015, a total of 7,389 cases had been laboratory confirmed and the number of deaths was 2,718, with a case fatality rate of 34.6 percent. The weak health system in Sierra Leone accelerated the spread of the outbreak."[32]

In 2014, UNFPA was designated by the GoSL, the UN Mission for Ebola Emergency Response and the National Ebola Response Centre to take a leading role in contact tracer training and the provision of incentives, transport and fuel to community contact tracers. A reported 400,000 USD was re-profiled

[32] UNFPA, *2014 Sierra Leone Annual Joint Reporting for the Reproductive Health Thematic Trust Funds.* 2015. p.11.

for support to contact tracing. A total of 5,211 contact tracers were trained along with 378 ward councillor supervisors and 347 technical supervisors.
UNFPA Supplies also supported the work of civil society community monitors to verify and report on whether contact tracers were tracking all persons who had been in contact with symptomatic EVD cases. The programme also provided funds to strengthen data entry and management for contact tracing information in all districts of Sierra Leone.

UNFPA Supplies was able to draw on MSSL and PPASL to provide RH/FP services during the EVD crisis and to try and fill gaps left by closures of government-run PHUs. By supporting these implementing partners before the crisis, the programme helped to build an institutional base and a presence within the affected communities. As a result, they were able to continue providing RH/FP services (at least in some locations) during the crisis.

3.8.2 UNFPA Supplies and the response to recent emergencies

In the period since the EVD crisis, UNFPA Supplies has been able to rapidly support the response to other more geographically concentrated humanitarian emergencies in Sierra Leone.

In 2015, UNFPA procured and distributed RH/FP humanitarian relief kits (dignity kits) for use by women and girls relocated because of intensive flooding near Freetown. According to MoHS, UNFPA was the first agency to respond to the 2015 flood emergency by providing commodities and services to camps for displaced persons established in Freetown. UNFPA Supplies also supported the work of midwives in providing services to pregnant girls and women and provided them with transport.

The evaluation team was able to observe some of the work supported by UNFPA Supplies in response to the August 2017 mud-slide and flooding emergency in Freetown. The programme provided a three-month contract to PPASL to provide RH/FP services to affected communities, especially by providing outreach services to relocated women and girls. The mobile clinic attended by the evaluation team was held in an area of Freetown where residents were affected by local flooding and some participants had been relocated from the area of the mud-slide. Pregnant girls and women who could not attend the mobile clinic were transported to the PPASL static clinic in Freetown for antenatal care and family planning services.

4 CONCLUSIONS

4.1 Strengths and Challenges

The conclusions presented here are based on findings reported in Chapter Three. The conclusions are intended to provide an overall summary of the contribution made by UNFPA Supplies in Sierra Leone from 2013 to 2016 and to point out some of the most important strategic choices facing the programme going forward.

The ToC for UNFPA Supplies[33] (Annex 2) illustrates how the different activities supported by the programme (from 2013 to the end of 2016) can be organized under three inter-locking and inter-related outputs necessary to achieve the programme goals:

1. Improved **supply and availability** of RH/FP commodities and services (including improved access for poor and marginalized women and girls)
2. An **enabling environment** for RHCS and family planning in Sierra Leone

[33] UNFPA, *Mid-Term Evaluation of UNFPA Supplies: Inception Report.* 2017, p.17.

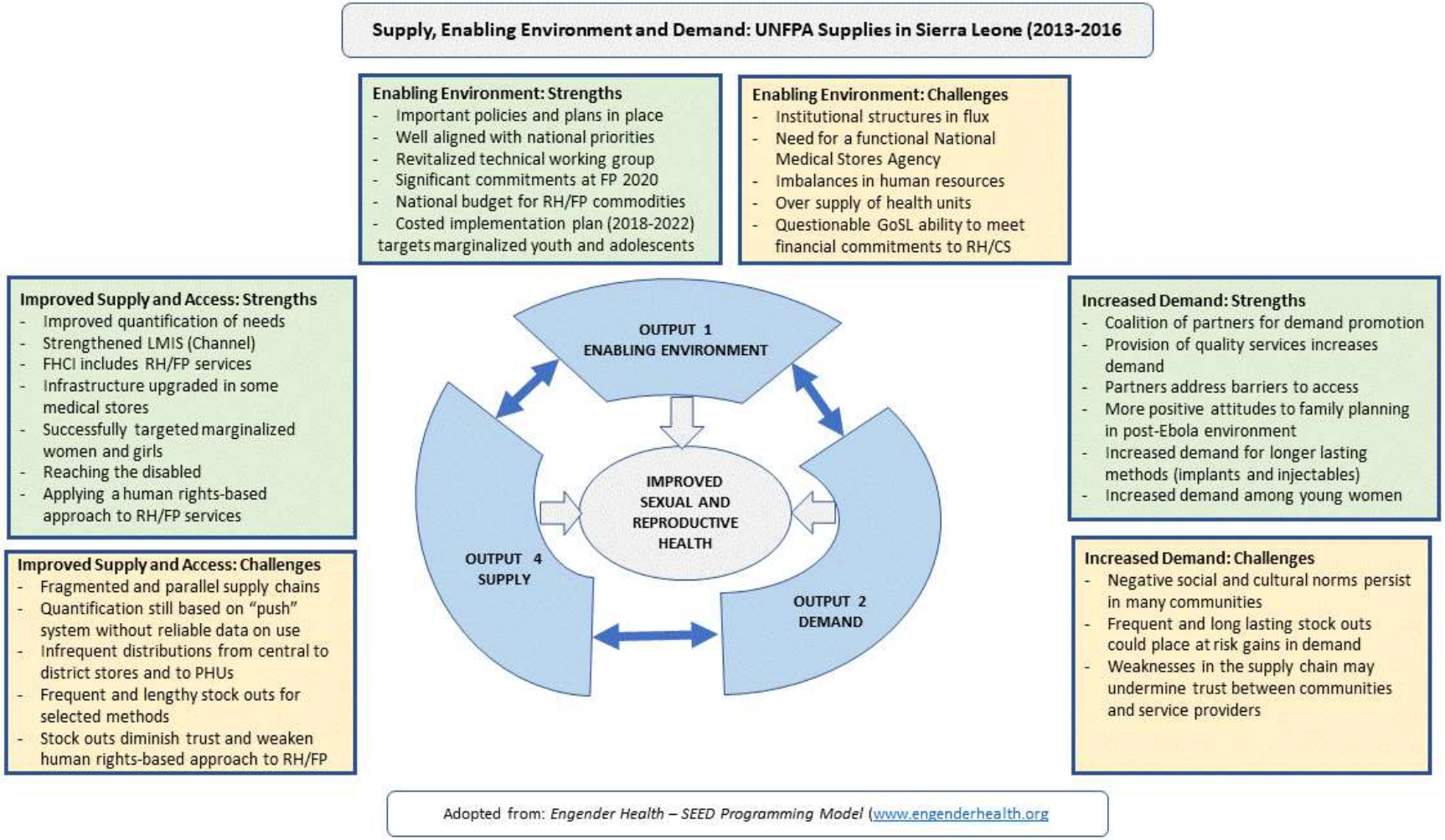
3. **Increased demand** for RH/FP commodities by poor and marginalized women and girls.

These three outputs constitute the main components of the Supply, Enabling Environment and Demand (SEED) model of effective RH/FP programming first advanced by Engender Health.[34] Of course, it is not necessary for the UNFPA Supplies programme to address all three components of the SEED model in any one country. Other sources of both funds and technical expertise, whether from national or external sources, may well address one or more of the three components. Indeed, from 2017 onwards, increased demand is not a designated output of the programme. However, because all three outputs were included in the design and operation of UNFPA Supplies in Sierra Leone during the evaluation period, it is useful to examine the overall effectiveness of the programme through the lens of the three component SEED model.

Figure 11 provides an overview of the strengths and challenges of the UNFPA Supplies Programme in Sierra Leone in relation to improved supply, a strengthened enabling environment and increased demand for RH/FP commodities and services.

[34] UNFPA, *Mid-Term Evaluation of UNFPA Supplies: Inception Report.* 2017, p.15. Original model accessible at:www.engenderhealth.org

Figure 11: Strengths and Challenges: UNFPA Supplies in Sierra Leone



The situation for RH/FP services and commodities in Sierra Leone at the end of 2016 and into 2017 indicates the continuing need for a strong UNFPA Supplies programme of support to the country.

As figure 11 illustrates, the recent strengthening of demand for RH/FP commodities and services presents an important opportunity to solidify gains and accelerate progress towards national commitments and goals formalized in 2017 under FP 2020. However, the current state of affairs in the supply chain for RH/FP commodities is characterized by fragmentation, important bottlenecks and an unclear institutional environment and there is an urgent need to strengthen the supply chain and overcome bottlenecks which contribute to frequent, serious and persistent stock outs of some methods. This need argues for a strategy which places the greatest priority on addressing the enabling environment and the supply situation. At present, direct support to demand creation represents a lower priority. The UNFPA Supplies programme policy (as of 2017) of not investing UNFPA Supplies resources in direct demand creation activities is currently appropriate in the context of Sierra Leone.

4.2 Contributing to reproductive health and family planning (2013-2016)

1. UNFPA Supplies has been an essential component of RHSC and has been vital to the operations of, in particular, family planning programming in Sierra Leone from 2013 to 2016.
2. There is a strong framework of policies, strategies and national commitments in place to support a strengthened enabling environment in RH/FP programmes and services in Sierra Leone. This has been developed by the GoSL with support from UNFPA Supplies and other partners.
3. UNFPA Supplies, working through a network of implementing partners, has made an important contribution to efforts to increase demand for RH/FP services in Sierra Leone. These efforts have produced, combined with changes in community norms, an increase in demand, especially among teenage girls and young women. This is especially true for longer lasting methods.
4. UNFPA Supplies has worked with MoHS and with NGO implementing partners to successfully target marginalized women and adolescent girls. The programme's partners have generally used a human rights-based approach to providing family planning services to both the abled and disabled. However, continued, serious stock outs of some modern methods present an ongoing challenge to the success of these efforts.
5. While UNFPA Supplies has made some important contributions to strengthening the supply chain for RH/FP commodities in Sierra Leone, it still faces serious challenges. The supply chain remains fragmented and contains serious bottlenecks which have led to worsening stock outs at central and district level warehouses and at Service Delivery Points.
6. There is not yet a commonly accepted plan among the GoSL and development partners concerning how development partners can provide coordinated and effective support to the supply chain and to supply chain management for medicines and other health products in Sierra Leone.
7. UNFPA Supplies has been able to leverage sources of support from outside the UNFPA Supplies thematic trust fund and has assisted implementing partners to do the same. However, it has not been successful in securing a national investment in procuring RH/FP commodities, despite commitments made by the Government of Sierra Leone under FP 2020.
8. UNFPA Supplies was able to build a strong network of implementing partners before the onset of the EVD crisis in 2014. UNFPA Supplies was able to build on the work of that

network and continue to support RH/FP services during the crisis. UNFPA Supplies was also agile in re-profiling budgeted resources and playing a key role in contact tracing during the crisis. In recent years, UNFPA Supplies has mobilized its network of implementing partner to provide a rapid response to more geographically focused humanitarian emergencies.

9. UNFPA Supplies has consistently provided support to implementing partners targeting poor and marginalized women and girls with quality family planning services and commodities using a rights-based approach. Its partners have also engaged in community mobilization to overcome barriers to access for marginalized women and girls and for the disabled. Overall, UNFPA Supplies has provided support which takes account of the need for gender equality, social inclusion and equity in the provision of reproductive health and family planning services.

4.3 Strategic choices

10. The combination of an apparent increase in demand for longer lasting methods and ongoing weaknesses in the supply chain for RH/FP commodities supports a strategy which focuses closely on the procurement and shipment of commodities (programme output number three) and on strengthening capacities and systems for supply chain management (programme output five).

11. UNFPA Supplies in Sierra Leone has been effective in providing support to outputs four (improved access to quality RH/FP services) and one (the enabling environment for RHCS and family planning). Continued support to these outputs can also make a contribution to meeting the goals in RH/FP set by the national government. However, the weak state of the supply chain, continued support to demand creation from other programmes, and the stress that current levels of demand place on the health system's ability to deliver RH/FP services and commodities all suggest that direct support to demand creation from UNFPA Supplies is not a priority in Sierra Leone.

12. Effective support to increasing the availability and use of RH/FP services in Sierra Leone in future will be dependent on a number of factors which can be addressed by UNFPA in partnership with other development partners and the GoSL. These include:
    a. The need to establish a fully functional and reasonably resourced NM SA.
    b. The need for the GoSL to follow through on commitments to provide national financial resources to family planning programming (and thereby help secure funding from external sources)
    c. The need for development partners and the GoSL to arrive at an agreed, coordinated plan for external support to strengthening supply chain management for medical and health related supplies, including RH/FP commodities.

5 ANNEXES

5.1 Annex 1: Evaluation Matrix

An enabling environment for Reproductive Health Commodity Security and Family Planning	
Evaluation Question 1:	To what extent has UNFPA Supplies contributed to **creating and strengthening an enabling environment for RHCS/FP** at global, regional and national level?
Sub-Questions:	a) To what extent has UNFPA Supplies been effective in **engaging with global and regional partners to secure commitments and mobilize resources** in support of country needs in RHCS/FP? b) To what extent has UNFPA Supplies been effective in **advocating with national partners** so that RHCS and family planning are **integrated into** and **prioritized in national budgets, programmes, and health policies and strategies** (including guidelines, protocols and tools)? c) To what extent has UNFPA Supplies been effective in s**trengthening and participating in coordination mechanisms** at all levels to ensure support and programming aligns with **global and national strategies to expand access to RH/FP commodities and services**, especially (but not exclusively) for poor and marginalized women and girls and other new users? d) To what extent has UNFPA Supplies been effective in a**dvocating for and supporting a total market approach** strategy for marketing of family planning commodities and services?

Question 1: Key Assumptions and Observations	Sources of Evidence
Assumption 1.1: UNFPA Supplies **advocacy efforts** at global, regional and national level **are coordinated and aligned with national and global strategies** to **expand access to RH/FP services and commodities.**	
Supporting the development of national plans, priorities and strategies	
• The GoSL's Reproductive, Newborn and Child Health Strategy for the period 2011 to 2015 specified nine over-arching objectives including a number specifically linked to the outputs of the UNFPA Supplies Programme. "The Reproductive, Newborn and Child Health objectives, as stated in the RNCH 2011-2015 policy are listed below with **particular reference to reaching marginalized and vulnerable populations and reducing RNCH inequalities.** The objectives are: 1. To ensure the provision of comprehensive, **adolescent friendly, sexual reproductive health services** 2. To reduce the level of **unwanted pregnancies** in all women of reproductive age 3. To **reduce the incidence of unsafe abortion** and ensure the provision of post-abortion care 4. To reduce **maternal and neonatal morbidity and mortality** 5. To **reduce child morbidity and mortality** 6. To improve the **nutritional status of women and children** 7. To reduce the **incidence and prevalence of STIs** [Sexual Transmitted Infections] including HIV and AIDS 8. To eliminate harmful practices such as **Female Genital Mutilation, premature marriage, and domestic and sexual violenc**e against women and children 9. To reduce the rate of **infectious and other non-infectious conditions of the reproductive health system**."	• GoSL, MoHS. *Reproductive, Newborn and Child Health Strategy 2011-2015.* 2014. p. 16
• The main strategy for achieving objective number two (reducing the number of unwanted pregnancies) in the 2011 to 2015 national RNCH strategy involves **improving family planning services**. • "Strategy 5: Ensure the **availability, access to and utilization of quality family planning services** using a wide range of **contraceptives methods** at both facility and community level including emergency contraception.	• GoSL, MoHS. *Reproductive, Newborn and Child Health Strategy 2011-2015.* 2014. p. 18

Question 1: Key Assumptions and Observations	Sources of Evidence
• UNFPA Supplies provided support to the national government in the preparation of their commitments under FP 2020 (July 2017 meeting in London). They also **served as co-convenor - with the MoHS - for this work in Sierra Leone** as well as the global co-coordinator.	• Interview: UNFPA CO staff, Freetown
• The three most recent **major commitments of Sierra Leone under FP 2020** are all consistent with the priorities and direction of the UNFPA Supplies programme in Sierra Leone: o Allocating **more domestic resources** to procuring family planning commodities o **Improving the supply chain** and distribution o Addressing the **needs of adolescents**.	
• UNFPA Supplies **provided technical support from** the Technical Advisor working closely with USAID on quantification and forecasting for the **CIP** – supported by USAID using MSH.	
Commitments of the GoSL at the Family Planning Summit in London, UK on July 11, 2017: • "The Government of Sierra Leone will diversify the **family planning resource base** through sustainable financing by 2020." [For details on commitments to diversify the resource base, see assumption 1.2] • "The Government of Sierra Leone is committed to improve access to family planning commodities through **supply chain reforms and improved data visibility** by 2020. Specifically, it commits to: o **Establish the National Medical Supply Agency** (NMSA) and pass an act integrating family planning commodities with the national supply chain structure, following passage of the necessary legislation o Address the **data visibility challenges** for its supply chains through the adoption of a new electronic Logistics Management and Information System (eLMIS) o Explore the interoperability of the national e-LMIS system, mSupply, within the wider **Global Visibility Analytics Network (VAN**) o Improve **quantification, supply planning, and reporting** from facilities through capacity building on LMIS and Logistics Management Systems o Instituting **a robust monitoring system** and follow-up with districts on data quality and commodity availability o Use the information derived to **make informed decisions and address stock imbalances**." • "The government commits to **reduce the unmet need for FP [Family Planning] to adolescents (aged 10-19 years)** from about 30% in 2013 to 20% in 2021 and reduce adolescent birth rates from 125.1/1000 (2013) to 74/1000 in 2021. Specifically, it commits to: o The finalization of the revised **Teenage Pregnancy Strategy** by August 2017 o The implementation of the **Comprehensive Sexuality Education** and policies related to its implementation will be in the revised National Education Policy o Scale-up and strengthen the existing CSE training (**Adolescent Sexual and Reproductive Health and Life Skills)** to Primary School teachers and expand this to Upper Primary School, Junior Secondary School, Senior Secondary School, technical and vocational institutions, teacher training colleges and out of school learning centres	• FP2020.ORG (July 2017)

Question 1: Key Assumptions and Observations	Sources of Evidence
○ The MoHS and MEST will reach **out of school adolescents through safe spaces and learning centres** in partnership with CSOs [civil society organisations] ○ Improve access to a full range of contraceptives, including long-acting reversible contraceptives, through the establishment of an additional **100 adolescent friendly clinics by 2020** ○ Working with CSOs on the engagement of youth through **community-based outreach services** for the provision of the contraceptive information, counselling, as well as contraceptive serviced directly to youth, aiming to provide ongoing training to healthcare workers in adolescent-friendly services according to the Adolescent and Young People Friendly Health Services Standards (2011) ○ Working with CSOs and the private sector to develop a *social marketing strategy*, to increase awareness of and access to contraceptive methods among youth ○ Improve the completeness and timeliness of the collection and collation of **gender and age disaggregated data** ○ Prioritize **Post-Partum Family Planning services to adolescents and young persons**." Accessible at: HTTP://WWW.FAMILYPLANNING2020.ORG/ENTITIES/96	
• UNFPA Supplies has had an important role in contributing to **strengthening the enabling environment for family planning** in Sierra Leone, for example: ○ They supported the **development of the Strategic Plan for the health sector (2010-2015)** ○ They are helping revise the strategic plan for 2015-2022 ○ They have provided technical assistance and support to the development of **the CIP for family planning** ○ They played a major role in re-establishing and re-invigorating the **Technical Working Group on Supply**	• Interview: RH/FP Programme, MoHS
• "The Government of Sierra Leone has committed to increasing the modern contraceptive prevalence rate (mCPR) to 33.7% amongst all women by 2022." • "**The Sierra Leone Family Planning Costed Implementation Plan (SLFPCIP)** analyses key issues and barriers to family planning and provides a technical strategy to guide investments over the next five years. The investments recommended in the CIP will help improve the ability of women, men and young people to fulfil their fertility intentions, leading to improved health and increased wealth at the individual, community and national levels. The **SLFPCIP is the guide for all family planning programming for the government across all sectors, development partners and implementing partners**."	• MoHS, GoSL, *Sierra Leone Family Planning Costed Implementation Plan – 2018-2022 – Draft Brief.* June 2017. p. 1-2.
• "The SLFPCIP is structured around **six main thematic areas**: **1. Demand creation** **2. Service Delivery** **3. Contraceptive Security** **4. Policy and enabling environment** **5. Financing** 6. **Stewardship, management and accountability."**	• MoHS, GoSL, *Sierra Leone Family Planning Costed Implementation Plan – 2018-2022. – Draft Brief.* June 2017. p. 2.

Question 1: Key Assumptions and Observations	Sources of Evidence
• The SLFPCIP identifies **the percentage share of seven different interventions** which will contribute to achieving its commitment to a modern CPR of 33.7% among all women by 2022: • "Post-partum family planning: 51.5% • Stock out reductions: 27.3% • Community health workers: 5.4% • Public sector mobile outreach: 4.4% • Youth focused interventions: 3.5% • Long-acting reversible contraceptives (LARCs) via PHUs: 3.4% • Private sector facilities: 3.3%"	
• The **Technical Working Group on Supply** is the platform where all those supporting the supply of family planning services and commodities meet. It includes MoSH, UNPFA, WHO, UNICEF, MSSL, PPASL with the RH/FP Programme in the lead • UNFPA provides financial and technical support to the TWG.	• Interview: RH/FP Programme, MoHS
• They (MSSL) participated in the FP 2020 summit in London in July 2017 which identified **serious gaps in the supply chain** for family planning in Sierra Leone: ○ **Method mix issues** ○ **A fragmented supply chain** ○ **Problems in financing** ○ **Access for adolescents** • Targets for Sierra Leone in the most recent round of FP 2020 were directly linked to the CIP which was supported by USAID.	• Interview: PPASL National Headquarters, Freetown
• UNFPA supported the development of the **original National Strategic Plan for Comprehensive Condom Programming** in Sierra Leone (2010 to 2014) under GPRHCS.	• Interview: National AIDS Secretariat
The evolving institutional architecture for RH/FP Commodity Security in Sierra Leone	
• UNFPA Supplies used to support the **National Pharmaceutical Procurement Unit (NPPU)** in the MoHS but this was disbanded in February 2016 on the order of the president with notice of just one week. This seems to be related to a meeting in the UK regarding its support to the FHC and DFID's assessment that NPPU did not have the capacity to procure and distribute FHC commodities • The interim institutional set up is led by Mr. Thomas in the **Department of Drugs and Medical Supplies (DDMS)** of MoHS. DDMS is in charge of the CMSs • DDM has agreed to have a proper **Technical Working Group on Supplies** (including the FCH and family planning supplies) • The interim arrangement is in place pending establishment of the **NMSA**. Legislation establishing the NMSA has been passed in Parliament but not yet fulfilled.	• Interview: UNFPA CO staff, Freetown
• The NMSA has at least received legislative approval and can now begin staffing but it is very much needed and quickly. **A great deal depends on it being established reasonably quickly and being effective.**	• Interview: RH/FP Programme, MoHS

Question 1: Key Assumptions and Observations	Sources of Evidence

• A **major setback for the institutional set up and enabling environment** for RHCS in SL was **the disbanding of the National Pharmaceutical Procurement Unit (NPPU) in February 2016** which meant that DDMS took over interim responsibility for all the functions around the Supply of RH/FP commodities
• This will all change with the advent of **the NMSA, a new autonomous unit which will be responsible for procuring and distributing all medical supplies**, including family planning products: mandate will involve ensuring procurement and distribution of safe, high quality drugs in a transparent manner.
• Current status of the NMSA
  ○ Legislation endorsed by cabinet and passed in Parliament (April)
  ○ Need to recruit a board of directors (nine members) in a transparent way and recommend them to Parliament
  ○ Chairman needs to be appointed by the board
• Then they can recruit staff for implementation of its mandate
	• Interview: DDMS, MoHS

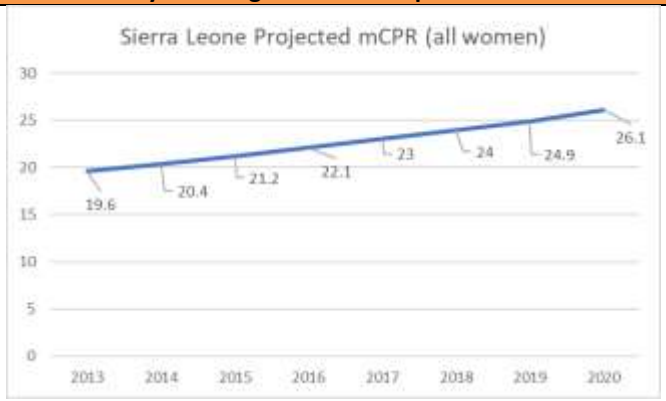
• The overall vision was to have partners build the **capacity for procurement and supply management** in the government with all these responsibilities being handed over to NPPU over time as it built that capacity – not just for RH/FP commodities but for all FHC Initiative commodities. But **that vision is difficult to maintain after NPPU was dissolved and until the NMSA becomes really functional**.	• Interview: UNICEF Country Office, Freetown
• The **NNPU did not deliver on its promise** because of a lack of capacity, poor management and issues of corruption so it definitely needed to be replaced • The NMSA legislation will allow the agency to **contract out any services they need to**. If the NMSA can mobilize the necessary resources and manage procurement it is acceptable to DFID if they contract out elements of the distribution process • It is **essential that the NMSA is up and running and that it should take responsibility for running and funding at least a part of the FHC commodity procurement and distribution**. In 2017 DFID will provide 20 million GB pounds for the FHC, 15 million for purchasing commodities and 5 million for distribution.	• Interview: DFID (UK) Office, Freetown
• **Procurement and Supply Management in Sierra Leone is entirely dependent on the transition from the, now defunct, NPPU to the still to be fully established, NMSA**. Plan A is to have a fully functional NMSA that all the development partners can support • Plan B would be to **contract private suppliers to replenish stocks based on contracts** • This would save huge costs of administration and could involve paying a private company for storage and distribution with performance targets and penalties – if Plan A (NMSA) does not work, it may mean a gradual shift to a private system.	• Interview: World Bank Office, Freetown
• They are concerned about the transition from NPPU to the NMSA but one good thing is that the **current staff of DDMS (with interim responsibility) is experienced** and once supplies are at the CMSs, MSSL is able to access them • There will need to be a **very large investment to set up a credible NMSA** with a functional system for distribution. Transport is very expensive.	• Interview: MSSL Head Office, Freetown
• They (**the partners) need to keep pushing hard for the establishment of the NMSA** and for direct funding of NMSA by the national government (MoHS) and the donor community instead of contracting out the supply chain.	• Interview: HFAC, National Headquarters, Freetown

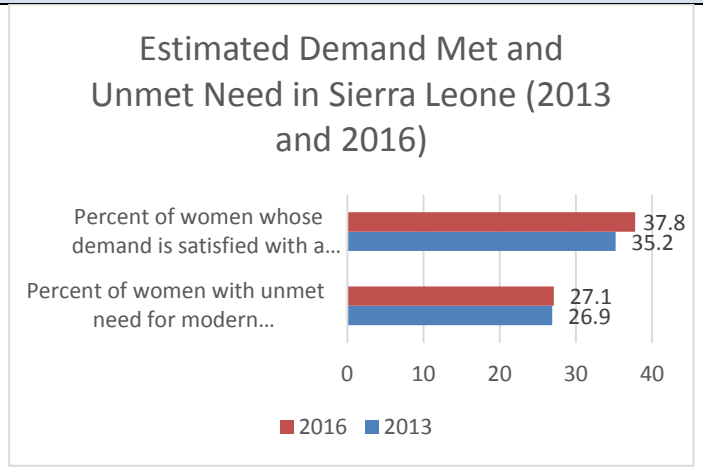
Question 1: Key Assumptions and Observations	Sources of Evidence
Assumption 1.2: Drawing on global, regional and national sources for financial support, **national health authorities have been able to achieve (and to varying degrees, sustain) increased budget allocations** and expenditures for RHCS/FP.	
GoSL Commitment Number One at the Family Planning Summit in London, UK on July 11, 2017 • "The Government of Sierra Leone will **diversify the family planning resource base through sustainable financing** by 2020. Specifically it commits to: o Announce in August 2017, the publication of its Reproductive Maternal Newborn and Adolescent (MNCAH) Strategy and the Costed Implementation Plan for Family Planning, using these as guides to identify resource gaps and leverage financing for family planning; o Review its goals for CPR and unmet need following a new Demographic Health Survey (DHS) in 2018; o **Diversity its resource base for family planning through a commitment to provide resources to the budget line for family planning and allocate a proportion of 1% of the health budget** for this; o Fast track the **finalization of an investment case for the Global Financing Facility prioritizing family planning** by December 2017 and pursue other bilateral sources of funding including – Sweden, Canada, Denmark, Norway and Australia". Accessible at: HTTP://WWW.FAMILYPLANNING2020.ORG/ENTITIES/96	• FP2020.ORG (July 2017)
• "The **total costs of the plan from 2018 to 2022** are 30.7 million USD. Between 2018 and 2022, the annual cost of the plan will average about 6.1 million USD. This amounts to a cost of about 4.7 million USD per year in activities costs, or 2.29 USD per woman of reproductive age per year, and **1.44 million USD per year in contraceptives and direct consumables**, **or 2.27 USD per FP user per year**."	• MoHS, GoSL, *Sierra Leone Family Planning Costed Implementation Plan – 2018-2022. – Draft Brief.* June 2017. p. 3.
• In 2017, the national government (for FP 2020) committed to spending 17 Billion Leones annually for procurement of drugs, of which 1 Billion was allocated to family planning commodities (133,333 USD at current exchange rate of 7,500 Leo = 1 USD). However, **the actual amount to be procured with national government funding for 2018 is still under discussion**.	• Interview: UNFPA CO staff, Freetown
The **CIP** (for the FP 2020 commitments) was started by the TWG Supply in November 2016 and **completed in August 2017** • From the very beginning UNFPA has been supportive of the CIP process. They provided support during the beginning of the CIP concept in FP 2020 meeting in Turkey in 2015 • The costed CIP has seven priorities, one of which is post-partum family planning and another improvement of the supply chain • They are working with UNFPA to identify support for the CIP: they need to get the Ministry of Finance, the development partners, the GFF and the private sector on board.	• Interview: RH/FP Programme, MoHS
• **Sierra Leone has one of the highest per-capita expenditures in the region but has the worst health outcome indicators** • Before Ebola: 55% of funds came from development partners and 25% was out of pocket • The **GoSL only spends about 6% of its total budget on health** • Their concern (the WB) is that while overall spending from all sources is quite high, it is **not very efficient**. There are too many, very small health units (twice the regional average per capita) and they need to decide which ones should be scrapped.	• Interview: World Bank Office, Freetown

Question 1: Key Assumptions and Observations	Sources of Evidence
• HFAC are advocating for a **specific budget for RH/FP** procurement and distribution • They also advocated strongly for a specific budget line to be included for distribution of RH/FP commodities in the budget of the DHMT.	• Interview: HFAC National Headquarters, Freetown
• There are **major issues in Human Resources for Health** – with Community Health Workers (15,000) being supported by external donors and no real strategy for funding them. There is also no plan to normalize the employment of health sector employees – 9,000 on the government payroll and 9,000 unpaid, so called volunteers • There needs to be a very broad discussion on the problem of too many health facilities.	• Interview: World Health Organization, Freetown
• The government is keen to introduce the **Social Health Insurance scheme** and development partners are willing to support it but it is very weak at the moment.	
Assumption 1.3: National **programmes, policies and strategies** (including guidelines, protocols and tools **prioritize improving access** to RH/FP services and commodities, including access **for poor and marginalized women and girls**.	
• See assumption 1.1 – National RMNCH Strategy 2011-2015	
• See assumption 1.1: Commitments under FP 2020 (2017) to address needs of adolescents	• Interview: RH/FP Programme, MoHS
• Their strategy for reaching poor and marginalized women and girls was **through static clinics providing family planning services and also collaborating with Community Health Workers on mobile outreach clinic**s which would be jointly carried out. • One thing they are considering is whether Community Health Workers could provide a low dose version of Depo called ***Sayana Press*** with its own injection device and a minimal training requirement. It would expand the methods used by community health nurses beyond pills and condoms • They also **have a pro-poor strategy** that stressed the fact that family planning services should be topmost in the free services and commodities to be provided under the FHC initiative.	
Assumption 1.4: National authorities are receptive to a **total market approach strategy for RH/FP services and commodities** which encourages **increased participation by NGOs, civil society and the private sector** and potentially can contribute to **improved marketing and increased demand**.	
• "Up to 2017, there was **very little conversation in Sierra Leone about the Total Market Approach** (TMA). It has only been during the development of the Costed Implementation Plan that UNFPA and the other partners began the discussion of the TMA." • "The problem in Sierra Leone is that the **private market for RH/FP products is not well structured** or well regulated. By the private market we mean for-profit clinics and pharmacies not the implementing partner NGOS of MSSL and PPASL. Until we have a better understanding of the private service providers and they are well regulated for quality and service it is hard to talk seriously about TMA".	• Interview: RH/FP Programme, MoHS

Increased demand for RH commodities by poor and marginalized women and girls	
Evaluation Question 2:	To what extent has UNFPA Supplies **contributed to increasing demand for RH/FP commodities and services,** including demand by poor and marginalized women and girls in keeping with their needs and choices (including in humanitarian situations)?

Sub - Questions:	a) Has UNFPA Supplies **advocated effectively for policies and programmes to strengthen demand and address barriers to access** (including but not limited to harmful socio-cultural norms) while taking account of the needs of marginalized women and girls? b) Has UNFPA Supplies been effective in **supporting engagement by community leaders, service providers, adolescents and women to build demand and address barriers to access**? c) To what extent have policies and programmes supported by UNFPA Supplies contributed to **improving knowledge and attitudes, reducing barriers and improving the capacity** of women and girls **to demand services and exercise choice** in accessing RH/FP commodities in a range of settings? d) **From 2017**, with UNFPA Supplies **no longer providing direct support to increasing demand**, what processes and mechanisms have been/will be used to **ensure that improvements in supply complement and are coordinated with demand generation actions of partners**?

Question 2: Observations	**Sources of Evidence**
Assumption 2.1: UNFPA Country Offices **advocate effectively for sustainable policies, programmes and investments addressing socio-cultural norms and other barriers** to improve **the knowledge and capacity of marginalized women and girls to demand access to RH/FP commodities**, including through community engagement and use of a total market approach.	
Overview of Family Planning Use and Acceptance in Sierra Leone (2013-2016)	
 Accessible at: http://www.track20.org/pages/countries_country_page.php?code=SL Based on FP 2020 estimates and projections, Sierra Leone is not on track to reach its FP 2020 goal of a modern mCPR for all women of 30.0 percent. The estimates do, however, project an increase in both demand and usage over time.	• FP2020 – Track 20. FP 2020 models projection using results of the most recent Sierra Leone Demographic and Health Survey (DHS) in 2013 as a baseline. Data for 2013 to 2016 are estimates, 2017 to 2020 are projections.

Question 2: Observations	Sources of Evidence
 Accessible at: http://www.track20.org/pages/countries_country_page.php?code=SL DHS data for 2013 and FP 2020 estimates for 2016 show that the **percent of women with unmet need for modern methods actually grew slightly from 2013 to 2016 when there was a modest 2.6 percent growth in the percentage of women whose demand for a modern method of contraception was being met**. There is a **persistent gap between the level of estimated demand for modern methods and the system's ability to provide them** in Sierra Leone.	• FP2020 – Track 20. FP 2020
• UNFPA Supplies reported **increasing demand for some modern methods during the 2013 to 2016 period** as evidenced by the annual quantification exercise and the volume of commodities shipped. In 2013 Procurement Services Branch reports that 35,000 units of subdermal implants were procured for and shipped to Sierra Leone. By 2015, this had risen to 68,500 unit before declining to 56,500 in 2016. This decline reportedly reflected an overall reduction in the ceiling available for Sierra Leone in the same year rather than a decline in demand.	• Procurement Services Branch, UNFPA Copenhagen
UNFPA Supplies Efforts to Improve National Strategies and Focus on Demand Creation	
• In 2015, UNFPA Supplies was approved for a ceiling of 338,000 USD of non-commodity funding (185,000 for demand creation) but in 2017 this dropped to 130,000 with no funds for demand creation) • You really **cannot stop work on demand creation given the low level of CPR which is just 23% given the FP 2020 goal of 33.7% in the next five years**. Overall demand is still around 50%.	• Interview: UNFPA CO staff, Freetown
• In a country like Sierra Leone**, a well-functioning supply system can also be seen as a means of increasing demand** and you cannot really separate demand creation from improvements in supply • Any **demand creation efforts supported by UNFPA** in Sierra Leone after 2017 are **funded through the SLP funded by DFID.**	

Question 2: Observations	Sources of Evidence
• In 2017 they accessed the DFID SLP programme for 147,000 USD to continue supporting demand creation activities outside the UNFPA Supplies programme.	
• Before 2013 and the current programme period, most efforts at demand creation were focused on short term methods but since then **UNFPA, and the MoHS, has concentrated on longer term but reversible methods**: Implants and IUDs • There has been an important shift toward providing information and **creating knowledge regarding longer lasting methods.**	• Interview: RH/FP Programme, MoHS
Assumption 2.2: UNFPA Supplies supports policies and programmes **including effective community** engagement to **directly address socio-cultural barriers to improving the knowledge and ability of marginalized women and girls to demand appropriate RH/FP commodities of their choice**.	
Addressing Barriers and Engaging Communities	
• It is critical that UNFPA continue to provide **assistance for community engagement** (even if it is from outside the UNFPA Supplies programme). For example, UNFPA support to community engagement for ending teenage pregnancy is essential • Helping to develop and implement the strategy for **ending teenage pregnancy** is one of the key roles of UNFPA given its specific focus on reproductive health. There is a draft multi-sectoral strategy for ending teenage pregnancy coordinated by the Teenage Pregnancy Secretariat • There has been a lot of **effective advocacy for family planning but it needs to be sustained**.	• Interview: UN Women Office, Freetown
• In addressing barriers: they have a specific strategy that **community-based mobilizers should work to help dispense with myths**, especially about different methods – this has helped them by increasing demand for implants in particular "captains band" preferred by girls and young women • They do not use social marketing or the franchise model in Sierra Leone but largely rely on word of mouth from satisfied clients. Women come with a notion of which method they want to use and then are open to good counselling.	• Interview: MSSL Head Office, Freetown
• Target group is **adolescent girls and women 10-24 years of age** • They engage community members in their outreach programmes (DHMT, police – especially the Family Support units of the police, matrons in the district hospital, chiefs.)	• Interview: WICM Head Office, Freetown
• MATOCPS focuses on **in and out of school teenagers**. In school they work with an SRH promoter and also develop peer educators for out of school work: Teenage Pregnancy/Early Marriage Core Trainers (TEPMAC) • For out-of-school work at community level they start by doing a study and checking what family planning methods teenage girls have access to and which they prefer. They engaged some of the girls as peer educators who receive training for three to six months from the Ministries of Health, Social Welfare, and Education • After receiving this they start a process of inter-generational community dialogue to address barriers to access to HR/FP for teenage girls. • In-school they start first with the educators and try to insert their key messages directly into the curriculum.	• Interview: MATCOPS, Freetown
• They work in the same communities as WICM and try to engage with **boys and men** to work on **barriers to access to women and girls for** SRH and Reproductive Rights • They have husband schools and promote the idea that men can take leadership roles in promoting demand and access. (MAPE = Male Advocate and Peer Educator).	• Interview: FINE SL

Question 2: Observations	Sources of Evidence
• PPASL **volunteers do mobilization work** for two days prior to the mobile clinic with community mobilizers going door to door in the neighbourhood. The clinic operates from about 9 am until after dark and no one will be turned away.	• Interview/Observation: PPASL Mobile Outreach Clinic, Freetown
• To reach in-school girls with demand creation activities MSSL staff visit schools and give health talks. They introduce the staff who will take part in the mobile clinics • In addition, **MSSL community mobilizers meet with principals before speaking to the girls about the risks of teenage pregnancy.** The principals participate by introducing MSSL staff to the classes before they speak about the need for family planning and the community has been very receptive to these messages.	• Interview: MSSL, Waterloo Clinic, Freetown
Effect of UNFPA Supplies Support, Other Programmes and Other Factors on Demand	
• The emphasis of UNFPA Supplies and the MoHS on longer lasting methods finally resulted in a **large and sustained increase in demand**, you can see this during outreach clinics when so many people come they have to keep serving clients well into the evening because so many people come. Mothers come with their 15-year-old daughters seeking family planning services; this is a fairly new thing • **Demand is now very high but they are unable to meet it.**	• Interview: RH/FP Programme, MoHS
• They see a major **increase in demand for long lasting methods**, especially implants. The increase in demand for RH/FP commodities and services is dramatically evident at their outreach clinics in both urban and rural settings.	• Interview: MSSL Head Office, Freetown

• They have two mobile team in each district. A mobile team has:
  ○ A project coordinator
  ○ A clinical nurse
  ○ A lab technician
  ○ Community mobilizers who work to create demand
• They feel there has been a sustained increase in demand but they are also very **concerned about creating demand which they will be unable to supply**.
	• Interview: PPASL, Head Office, Freetown

• In **the post EVD climate** people in general and parents in particular are much **more aware of the problem of teenage pregnancy** – this means the community members are much more willing to participate in efforts give teenagers access to family planning services, they want to resolve the problem.	• Interview: WICM Head Office, Freetown
• There is already high demand and with disruptions in distributions this leads to **important stock outs at PHUs** • You **need to do demand generation and service provision at one and the same time** • If we just work on demand but do not strengthen service provision, including supply chain management we just create disappointment.	• Interview: DHMT, Western Urban District
• Demand for different methods varies by community. Some PHUs use more implants, especially if there are more schoolgirls in that community since they tend to prefer implants • Demand for *Depo-Provera* seems to be going down and for implants it is rising	• Interview: DHMT, Pujehon District

Question 2: Observations	Sources of Evidence
• The DHMT needs to work a lot harder to meet the demand that has been built in the district. There has been **a consistent rise in demand since the EVD crisis**. For example, there have been very successful campaigns to sensitize teenagers. This becomes self-reinforcing because teenagers (in particular girls) who use family planning become enthusiastic promoters among their peers • Mobile clinics also have an important impact on demand but they need to happen more frequently, at least once a quarter. **The problem now is how to satisfy this building demand**.	
• **Married women prefer injectables** because there is no external mark and this avoids any violence from their husbands. In contrast, young women, especially **teenage girls, prefer longer lasting methods, especially implants** • **Outreach** in schools is increasing demand among younger women and teenage girls and NGOs, including MSSL are very active in doing outreach at the community level. The problem is we in the district are not meeting the demand that has been created for FP services and products.	• Interview: DHMT, Port Loko
• Married women like ***Depo Provera*** the best because it has very few side effects and they are able to understand its use and side effects. The next most popular method, especially among younger women and teenage girls are implants (*Jadelle*) because they last longer.	• Interview: Bandejuma Community Health Centre, MoHS
• This is a mining area (bauxite) and the population has increased on a regular basis. However, the allocation of RH/FP commodities to the health unit has not been adjusted to reflect the increasing population. This may be corrected when the new census is complete (data collection in 2017) • The district was originally predominantly Muslim but that is changing with considerable inward immigration because of the mining • They **work with Imams to encourage them to promote family planning among teenage girls** as a way to keep them in school and avoid teenage pregnancies. Some are receptive to this message but others are not • Overall there is **a pattern of rising demand** which the health unit is not able to meet due to regular and sometimes prolonged stock outs.	• Interview, Rogbery Junction Peripheral Health Unit, Maforki Chiefdom, MoHS
• Staff noticed a major increase in demand following the **EVD crisis linked to the increase in teenage pregnancy** during the crisis • Women (including Muslim women) now bring their teenage daughters for family planning services • Teenage girls prefer to get implants (Jadelle) and married women often prefer *Depo-Provera.*	• Interview: PPASL: Wesley Street Clinic, Freetown
• The evaluation team observed long lines of women and young girls, including teenaged girls, waiting in line for RH/FP services at the outreach clinic in Freetown	• Interview/Observation: PPASL Mobile Outreach Clinic, Freetown
• Implants are more and more popular because **MSSL, PPASL and others have been promoting them** very strongly. Women also like *Depo* because it is very simple and easy to use (easier than implants which need a careful procedure for insertion) and because they know it well • There has been **considerable coverage on television and radio** of the **increased in teenage pregnancy** during the EVD crisis and this has helped promote demand	• Interview: MSSL, Waterloo Clinic, Freetown

Question 2: Observations	Sources of Evidence
• Some of the young girls who became pregnant and left school have been returning to school and are helping with the messaging that family planning is needed.	
• In a group discussion with approximately 50 women in the line-up to register, 2/3 were existing clients and 1/3 new clients. This group included 12 young women who self-identified as teenagers and of that group eight were already mothers or were pregnant • **The most popular method** choice among those interviewed was the implant *Jadelle* followed by the injectable *Depo Provera*.	• Interview/Observation: MSSL Outreach Clinic; Futa Kpejeh, Pujehon District
• The outreach staff report a very significant increase in demand. These **mobile clinics** are seeing three or four times more clients than in previous years, despite the fact that this is a predominantly Muslim community • **Very long waiting lines** were observed and photographed both inside and outside the large community centre provided by the district council. These lines included a mix of age groups but with a strong representation by younger women and girls • Lunsar is a **Muslim community** but staff do report increasing levels of demand. The **community mobilizers work with Muslim community leaders and visit mosques as entry points**. There is real concern about teenage pregnancy and high levels of interest in the opportunity to access family planning services • Interviews with women in the waiting line indicated **highest levels of enthusiasm for implants and injectables**. As in other static and mobile clinics, demand for implants seemed to be highest among younger women and teenage girls (whether they already had a child or not).	• Interview/Observation: PPASL Outreach Clinic, Lunsar Community, Bo District
Assumption 2.3: UNFPA Supplies support to increasing demand **in partnership with governments and others for RH/FP commodities** complements and is coordinated with support from other sources at national and sub-national levels.	
• The UNFPA Supplies funds allowed PPASL to enhance their capacity to **increase the visibility of SRH/FP services in traditional areas and markets**.	• Interview: PPASL, Head Office, Freetown
• They concentrate on demand generation for RH/FP especially in Konandugu working closely with the DHMT • MATCOPS supports a lot of radio programming and in places with no radio reception do outreach, especially during campaigns like FP week.	• Interview: MATCOPS, Freetown
• UNFPA helped form and hosts regular meetings of the **Sierra Leone Adolescent Girls Network** • UNFPA initiated the idea in 2013 and it includes all the NGO implementing partners working with youth. As a network they engage with health care providers. If a girl moves from one community to another she is referred to another member of the network that might be working in that community • The members meet for review at the end of every year and have monthly meetings at UNFPA (WICM, FINE SL, MATCOPS).	• Interview, WICM, Head Office, Freetown

Improved efficiency for procurement and supply of RH commodities (global focus)	
Evaluation Question 3:	To what extent has UNFPA Supplies, through its global operations and advocacy interventions, contributed to **improving the efficiency of the procurement and supply** of RH/FP commodities for the 46 target countries?
Sub-Questions:	a) To what extent has UNFPA Supplies contributed to improving the **efficiency of global procurement of SRH/FP products** across all critical dimensions of performance (quality, mix, price, lead time, supplier performance, etc.)? b) Is there evidence that UNFPA Supplies has helped to **improve global forecasting, prequalification, pricing** and **long-term agreements** with a variety of suppliers? c) To what extent has UNFPA Supplies, in coordination with national authorities and partners, helped to **avoid global supply disruptions, overstocking, over-paying, and quality issues**? d) Is there **evidence** of **increased choice** (prequalified suppliers and products), competitive pricing, reduced lead times, and increasing volumes distributed to key populations, including populations experiencing humanitarian crises? e) To what extent has UNFPA Supplies helped to **improve the global supply chain** of these commodities, and to **shape the global market** for them (influencing price, quality, innovation, and availability), using its global reach and purchasing power?

Question 3: Key Assumptions	Observations	Sources of Evidence

Assumption 3.1: UNFPA Supplies had **the necessary funding/resources made available** at the appropriate time in the 2013-2016 period to meet its mandate in procurement and supply of RH/FP commodities for focal countries.

Trends in Funding for UNFPA Supplies in Sierra Leone

Trends in Funds Allocated to Selected UNFPA Supplies Outputs in Sierra Leone

	2013	2014	2015	2016
Total UNFPA Supplies Funds (USD) Allocated to Sierra Leone	**4,239,433**	**4,049,968**	**3,100,668**	**1,560,253**
Allocated to commodities	1,618,302	1,500,000	1,890,668	947,848
Allocated to increased demand	490,620	390,000	185,000	20,000
Allocated to improving access	761,925	1,196,588	310,000	150,000
Allocated to strengthening supply chain management	547,184	635,279	567,000	366,405

- UNFPA CO, Freetown

Assumption 3.3: UNFPA Supplies actively participates in national commodity forecasting and planning processes and collaborates with national authorities to **provide appropriate commodities delivered on time to the 46 countries.** It also collaborates with national authorities and with other global and country-based partners, to ensure forecasting and supply functions are efficient and not duplicative.

Improvements/deficiencies in quantification of demand/need at country level in Sierra Leone

- In 2016 and 2017 they (UNFPA) have worked to **improve quantification** of commodities needed
- In 2016 they (UNFPA) were able to work with the DIO and DDMS to reconcile CHANNEL and DHIS2 data. The DIOs in all 13 districts are now able to use CHANNEL.

- Interview: UNFPA CO staff, Freetown

Improving the Push System

Question 3: Key Assumptions	Observations	Sources of Evidence
• In 2016, the advisor for RHCS did an estimated allocation of what is needed in each facility based on population, women of reproductive age, historical demand etc. • UNFPA Supplies funded and managed a survey of capacity of all facilities and some facilities did not have a trained provider in IUDs still might be receiving 400 IUDs in a distribution; this needed to be fixed • UNFPA then hosted a two-day workshop on LMIS (March 2017) and CHANNEL data. They also had PPSL and MSSL (for the first time) report their data on consumption of RH/FP products to the DDMS • In June 2017, UNFPA and DDMS participated in an exercise to check the accuracy of CHANNEL data by reconciling it with DHIS2 and found about 70 percent alignment between the two.		
• There is a major problem with quantification and forecasting that has to do with the **capacity of the managers in the PHUs** and in the DHMTs. They lack the ability to assess actual usage (consumption) and to use that data to develop a forecast of future requirements.		
• It is also necessary that **CHANNEL** become **inter-operable and able to communicate with the DHIS2 system** so that CHANNEL and DHIS2 data on consumption can be accurately reconciled.		

• The development of the NMSA should improve operation of the supply chain.
• They are **improving forecasting and CHANNEL data is now good enough to support forecasting**
• UNFPA Supplies has supported CHANNEL and helped with:
  ○ Training and follow up (with national workshops)
  ○ Supporting supervision for DIOs
  ○ Helping overcome challenges in getting the data from districts to the national level
  ○ Improved monitoring.
		• Interview: DDMS, MoHS

• On forecasting: They built up their estimated demand as follows:
  ○ Reaching 86,000 of the 240,000 active sex workers in Sierra Leone with needed condoms
  ○ Reaching Men having Sex with Men
  ○ Adding together needs of sex workers (20 per month x 86,000) plus needs of Men having Sex with Men and needs of sexually active heterosexual males **they arrive at figures in the tens of millions**
• **Indeed, their annual requirement is 100 million pieces. For just sex workers it is about 20 million**
• All distribution health facilities and other service points are through **their own separate supply chain** under the national AIDS control programme.
		• Interview: National AIDS Secretariat, Freetown.

• **MSSL do their forecasting each year** based on the number of functioning clinics and mobile teams and the expected number of clients • These requirements are shared with the MoHS (RH/FP Programme) and with the RHCS Committee where it is discussed in full • Mostly the UNFPA Supplies programme was able to allocate to them about **80 percent of what they need** (as a result of the RHCS committee deliberations).		• Interview: MSSL, Head Office, Freetown

Question 3: Key Assumptions	Observations	Sources of Evidence
• As of 2017, **all PPASL data** on usage goes into the CHANNEL system. UNFPA started this process so that all the data from both NGOS and government is provided to the RH/FP programme and is consolidated by them and is presented as a plan for which partner provides which commodities in the year to come (Quantification and Forecasting).		• Interview: PPASL, Head Office, Freetown
• UNFPA helped to set up a **National Quantification Committee** (with UNFPA participation) to quantify evidence of needs and this was used by UNICEF to procure pharmaceuticals for the FHC.		• Interview: MSH, Freetown

Improved access to quality RH/FP commodities and services	
Evaluation Question 4:	To what extent has UNFPA Supplies contributed to **improved security of supply, availability and accessibility of RH/FP commodities and services** in programme countries, especially for poor and marginalized women and girls, **in keeping with their needs and choices**, **including in humanitarian situations**?
Sub-Questions:	**a)** To what extent has UNFPA Supplies contributed to the **development of effective strategies and approaches** for making **high-quality RH/FP commodities and services available and accessible** for marginalized women and girls? b) To what extent has UNFPA Supplies been effective in supporting efforts to **strengthen the capacity of service providers for the delivery of quality RH/FP services and related commodities** and to integrate family planning into other services? c) Has UNFPA Supplies been effective in **brokering and managing partnerships that maximize the reach of efforts by all partners** to locate and provide a **secure and constant supply of high-quality RH/FP services and commodities** to poor and marginalized women and girls? d) To what extent has UNFPA Supplies worked effectively with national authorities, and other partners to provide a **timely, secure and constant supply** (and related services) of RH/FP **commodities to women and girls in areas affected by humanitarian crises**, using the Minimum Initial Services Package (MISP) kits and guidance as well as other necessary commodities and services where appropriate?

Question 4: Key Assumptions	Observations	Sources of Evidence
Assumption 4.1: UNFA Supplies works effectively to ensure procured commodities match demand and help **address gaps in national supply chains** (including gaps resulting from crises), to enhance the secure flow and constant availability of **affordable RH/FP commodities that are accessible to marginalized women and girls.**		
Expanding Service Coverage		
• Post EVD crisis, UNFPA Supplies helped to develop a **good plan for capacity building and increasing access to (and use of) long-lasting methods** in particular (implants and IUDs). The programme also worked with MoHS with a priority plan to increase the capacity of service providers to provide longer term methods.		• Interview: UNFPA CO staff, Freetown
• "UNFPA supported the **training of an additional 160 service providers in insertion and removal of implants in two districts** and conducted training of trainers on IUD insertion with participation from all districts in the country, followed by validation and printing of an IUD trainers' manual."		• UNFPA, *Joint Annual Thematic Trust Fund Report – 2015: Sierra Leone.* p 6.

Question 4: Key Assumptions	Observations	Sources of Evidence
• "UNFPA supported the **training of an additional 200 service providers in the insertion and removal of implants and IUDs**. Among that number, 132 are Maternal and Child Health Aids (MCHA) who were trained (task shifting) in order to increase FP uptake in rural communities. In addition, MoHS, with support from UNFPA Supplies, processed the printing of FP training manuals (1500 copies) and 2050 copies of IUD training curriculum (trainers' manuals and participants' handbooks) to strengthen FP service delivery."		• UNFPA, *Country Level Narrative Report: UNFPA Supplies – 2016.* p. 1.
• These efforts expanded coverage for the provision of **longer lasting methods** from 900 facilities in 2015 to 1335 in 2016		• Interview: UNFPA CO staff, Freetown
• "**UNFPA Supplies is one of the most efficient and important sources of support for RH/FP** in Sierra Leone. In addition to providing almost 90 percent of the commodities for FP in Sierra Leone, UNFPA Supplies has been essential in expanding service coverage, especially for longer lasting methods."		• Interview: RH/FP Programme, MoHS
General Strategies and Approaches to Targeting Poor and Marginalized Women and Girls		
• Their strategy for reaching poor and marginalized women and girls was through **static clinics** providing family planning services and also collaborating with Community Health Workers on **mobile outreach clinics** which would be jointly carried out • One thing they are considering is whether Community Health Workers could provide a low dose version of *Depo* called *Sayana Press*. It would expand the methods used by community health nurses beyond pills and condoms • They also have a **pro-poor strategy** that stressed the fact that family planning services should be topmost in the free services and commodities to be provided under the FHC initiative.		• Interview: RH/FP Programme, MoHS
• UNFPA Supplies very important support to their outreach. Supports three of ten **outreach teams** and provides commodities through all channels (static and outreach).		• Interview: MSSL, Head Office, Freetown
• **All outreach services are free** and they focus much of their community engagement work on promotional activities in slum areas working with community leaders – specifically targeting poor urban and rural areas. They also target disabled clients (confirmed in observation of outreach in Freetown).		

• There is normally a **fee for services for RH/FP services** but if a woman cannot pay they provide the service for free.
• **The process** for women who come for any care is always the same:
  ○ There is first a consultation process to see if they are aware of and are interested in family planning
  ○ If so, they go through the products and give the side effects of each one
  ○ They do a general examination and use the WHO template (a wheel) to take account of their condition and recommend a choice of method
  ○ For teenagers they tend to recommend a longer-term method like implants
• All pregnant women are **tested for HIV** and, if positive, are referred to the 34 Military Road Hospital for treatment with ARTs.
		• Interview: Waterloo Clinic, Freetown

Assumption 4.2: UNFPA Supplies and COs work effectively (with national authorities, and other partners) to **develop new approaches** to **address and resolve barriers preventing poor and marginalized women and girls** (including those in humanitarian crises) from accessing RH/FP commodities and services across the entire market (public, private, NGOs, etc.).		
Approaches to Providing RH/FP Services to the Disabled		

Question 4: Key Assumptions	Observations	Sources of Evidence
• The outreach clinic provides **services to the disabled** first thing in the morning before others arrive.		• Interview/Observation: PPASL Mobile Outreach Clinic, Freetown
• The mobile clinic made arrangements for **disabled clients to be treated in the morning before the build-up of waiting lines** because they need extra care. Disabled clients are given priority and are served first.		• Interviews/Observation: MSSL Mobile Outreach Clinic, Futa Kpejeh, Pujehon District
• **Disabled clients are given priority** and often come first thing in the morning so they do not have to wait in line.		• Interviews/Observation: PPASL Mobile Outreach Clinic, Lunsar Community
Approaches to Reaching Adolescents: Especially Unmarried Women and Teenage Girls		
• While family planning commodities are not distributed within **schools**, outside school premises, adolescents are allowed to access RH/FP services (often in youth friendly corners in CHCs). Services are provided through fixed and mobile (outreach) clinics.		• Interview/Observation: PPASL Mobile Outreach Clinic, Freetown
• In reality, young people do not have the access they need to the facilities providing RH/FP services. There are real **problems of confidentiality** which discourage them.		• Interview: World Health Organization, Freetown
• **MSSL outreach activities** include a great deal of community engagement • They also work with **school guidance counsellors** and with parent/teacher associations • **All services are free** and they focus much of their community engagement work on promotional activities in slum areas working with community leaders – specifically targeting poor urban and rural areas.		• Interview: MSSL, Head Office, Freetown
• In MSI's 37 countries of operations, **Sierra Leone is recognized as one where they reach the highest number of youth** • They are able to reach around 40 to 45 percent of communities in each district with outreach services every three months.		
• **Each static clinic has a youth volunteer** who will consult with and counsel adolescents who want to access services – the also have youth friendly services in the static clinics • For sustainability reasons they do charge for services but not for commodities in the static clinics.		
• **WICM** focuses on **empowering women and girls through asset building**; they map communities to identify girls at risk from early pregnancy. Community mobilizers have been trained by UNFPA and the Population Council • While WICM do not provide services themselves, they do referrals to the service providers in the communities where they work • WICM work **in six districts: Kono (Eastern), Hailung, Pujehon, Port Loko, and Western District (Urban and Rural)** • They cannot cover all chiefdoms in a given district – in Kono for example they cover three chiefdoms of 13 so they target the areas with the worst access for youth and adolescent girls.		• Interview: WICM, Head Office, Freetown
In-school • UNFPA Supplies provided **technical support and financing to the development and production of career counselling guidance notes and practical tools, printed the manuals and supported training of 50 guidance counsellors**		• Interview: MEST, Department of Non-

Question 4: Key Assumptions	Observations	Sources of Evidence
• UNFPA Supplies also supported the development of **integrated curriculum and readers** for the neo-literate and supported training of 60 literacy facilitators • In both cases these tools incorporated specific elements of SRH and of family planning. **Out of School** • UNFPA Supplies helped the MEST develop the concept note for an emergency programme to provide **non-formal education to 14,500 school age girls registered as pregnant during the EVD** crisis • UNFPA supported the **monitoring and development of curriculum in** math, language arts, social studies • UNFPA also supported the ongoing operation of **the learning centres (282 learning centres**). • Supported the training of teachers in how to interact with and support pregnant teenage girls • Between **10,000 and 11,000 girls have been reintegrated into the formal school system** • The others have been supported through non-formal education and a (non-UNFPA) revolving loan component to develop vocational skills. • UNFPA Supplies provided support from 2013 to 2016 and in the first quarter of 2017.		Formal Education, Freetown
• They made important progress in addressing youth during the response to the **EVD crisis**. While Pujehon was not heavily hit, they did see some rise in teenage pregnancies reported by a number of PHUs • They responded to the **rise in teenage pregnancy** by increasing the tempo of supervision and through community engagement. With support from UNFPA they worked to get the PHU facilities more user friendly for youth, especially teenage girls • UNFPA Supplies was helpful in this action to address teenage pregnancy by: o Helping with **sensitization and training of PHU staff** o Supporting the establishment of **youth corners** in the health facilities o Providing the **commodities**. • This initiative was very successful, the PHUs providing **family planning service to youth** are strategically positioned and every teenager in the district can reach these services in an easy walk and discreet manner.		• Interview: DHMT, Pujehon District
• The Health Centre provides a good service for **adolescent health care**. They have an adolescent friendly corner with a way that allows for privacy (observed by the team). Adolescents have a chance to talk to nurses and can come and go to and from the youth friendly corner unobserved. They also do outreach to schools to generate interest in family planning.		• Interview: Bandejuma Community Health Centre, MoSH
• The rate of **teenage pregnancy increased after the EVD** crisis perhaps because schools were closed during the crisis. Partly because of this, the PHU staff do outreach in the schools (every Friday) to try and get teenagers, in particular teenage girls interested in family planning services and products • Teenagers use **their youth friendly corners**, mostly younger girls come for family planning services but the boys do come for condoms • Teenagers do not want their parents to know they are sexually active so they need to find an excuse to come to the health post or to go to outreach clinics (teenagers can reach the youth friendly corner through a back entrance).		• Interview: Rogbery Junction Peripheral Health Unit, Maforki Chiefdom

<table>
<tr><th>Question 4: Key Assumptions</th><th>Observations</th><th>Sources of Evidence</th></tr>
<tr><td colspan="2">• They provide an integrated service (but charge a small fee) covering diagnosis and treatment of malaria, typhus, STIs, HIV, cervical cancer (supported by UNFPA and for which they do referrals to the cancer ward of government hospitals), FP services, ultrasound scans.
• While there is a fee (5,000 Leo, less than one USD) for family planning services, they are able to provide services for free to those who really cannot afford it
• They have their own lab and do blood work and urine testing as well as sperm counts
• The point is that all these services provided through the clinic mean that young women and girls can get family planning services and not be seen as just wanting those.</td><td rowspan="2">• Interview and Observations: PPASL Wesley Street Clinic, Freetown</td></tr>
<tr><td colspan="2">• Team observed counselling of one patient on use of Depo-Provera and administering the injection
• Staff were observed providing a full explanation of possible side-effects and of different methods.</td></tr>
<tr><td colspan="3">Applying a Human Rights Approach to Family Planning Services and the Impact of Stock Outs on Efforts to Reach Marginalized Women and Girls</td></tr>
<tr><td colspan="2"><table>
<tr><th colspan="4">GPRHCS/UNFPA Supplies Survey Findings on Exit Interviews: Primary Care Level Facilities (%)</th></tr>
<tr><td></td><td>2013</td><td>2015</td><td>2016</td></tr>
<tr><td>Provided with the method of their choice</td><td>99.2</td><td>94.2</td><td>94.1</td></tr>
<tr><td>Provider took clients preferences and wishes into consideration</td><td>90.2</td><td>97.1</td><td>97.3</td></tr>
<tr><td>Client taught how to use the method</td><td>97.7</td><td>94.2</td><td>98.2</td></tr>
<tr><td>Client told about common side effects of the method</td><td>93</td><td>91.3</td><td>87.7</td></tr>
<tr><td>Provider informed client about what can be done re: side effects</td><td>94.1</td><td>90.3</td><td>88.1</td></tr>
<tr><td>Provider informed client what to do in case of serious complications</td><td>89.8</td><td>86.4</td><td>88.1</td></tr>
<tr><td>Client given date to return to the SDP for check-up and/or supplies</td><td>98.8</td><td>96.1</td><td>95</td></tr>
<tr><td>Client indicated he/she was treated with courtesy and respect by staff</td><td>98</td><td>98.1</td><td>95.4</td></tr>
<tr><td>Client responded yes to "forced to accept" FP method</td><td>9.4</td><td>18.4</td><td>25.1</td></tr>
</table></td><td>• UNFPA/GPRHCS Facilities Surveys: 2013, 2015, 2016</td></tr>
<tr><td colspan="2">• Shortages and stock outs, particularly of implants (see question five) have a number of negative impacts:
  ○ Denies women choice
  ○ Takes considerable time for service providers and women to understand alternatives
  ○ Skews data on usage if that is used to predict demand for future procurement
• Undercuts a human rights-based approach to family planning.</td><td>• Interview: MSSL, Head Office, Freetown</td></tr>
<tr><td colspan="2">• They make it clear that family planning is not compulsory, but their advice to community leaders is to allow teenage girls to have access to family planning. Once a young girl has a baby, the community then views her as a mother and access to family planning and other maternal care is fine by them</td><td>• Interview: Rogbery Junction Peripheral</td></tr>
</table>

Question 4: Key Assumptions	Observations	Sources of Evidence
• **Stock outs do cause a big problem** of choice and when a teenage girl (or an adult woman) is not comfortable with an alternative that they have in stock then she runs the risk of an unwanted pregnancy.		Health Unit, Maforki Chiefdom
• Staff at the PPASL clinic adhered to a **structured protocol for ensuring women and girls made an informed choice** of whether or not to use family planning and which method they might wish to use.		• Interview and Observations: PPASL Wesley Street Clinic, Freetown
• Methods observed included both injectables and implants. Implants were done in the privacy of the ambulance and injectables in a private area in the main tent • **Full counselling on method choice**, different characteristics and side effects was being provided • On registration, patients' details including addresses and phone numbers are taken and follow up appointments are made so that any needed further action can be taken • Women and girls opting for IUDs are transported to the nearby PPASL static clinic for inserting the IUD.		• Interview/Observation: PPASL Mobile Outreach Clinic, Freetown
• MSSL nurse was observed counselling clients and **explaining in detail the methods available, the products used, their operation and advantages and disadvantages as well as what the client could expect to happen**.		• Interviews/Observations: MSSL Mobile Outreach Clinic, Futa Kpejeh, Pujehon District
• On registration, each client was given a **follow up appointment** to the nearest static clinic and their address and (where possible) a phone number was taken so that the clinic can follow up if the client misses the appointment. Staff report that approximately 80 percent of the clients do attend their scheduled follow up visit. The remaining twenty percent are followed up by community service providers • Observed clients being **advised of the characteristics, advantages, disadvantages and possible side effects of each method**. Implants were being inserted in an ambulance to provide for privacy and appropriate conditions • Exit interviews with several young women clients indicated they understood the choice they had made and were satisfied that it met their needs.		• Interviews/Observations: PPASL Mobile Outreach Clinic, Lunsar Community
• It is difficult when some commodities are out of stock because you then **need to inform the patient of the alternative**. The patients are comfortable with a given method and brand so if you have to ask them to switch it there is a big job to explain the differences, similarities, side effects, etc. It is essential that they make an informed choice.		• Interview: MSSL Waterloo Clinic, Freetown
Assumption 4.3: UNFPA Supplies works effectively with national authorities, and other partners, to enhance availability and ease of access to RH/FP services and commodities using a **total market approach** (engaging a full range of public, NGOs, and private sector providers including social insurers and social marketing outlets and kiosks/dispensers for condoms, etc.).		
See observations and evidence sources provided under assumption 1.4 above.		

Question 4: Key Assumptions	Observations	Sources of Evidence
Assumption 4.4: UNFPA Supplies procures, packages and delivers **emergency RH/FP kits** and individual products with the **appropriate range, quantity and quality reaching populations in a timely way at the start of and during humanitarian crises**, to enable those affected to meet their RH/FP requirements.		
• In 2015 UNFPA procured **RH Humanitarian relief kits in response to the flooding**: Kits number 6A, 6B, 11 and 12 • The EVD crisis disrupted all aspects of the UNFPA Supplies programme. Ever since MoHS, NGOs and partners have been **slowly rebuilding the Primary Health Care System**. During the EVD crisis there was no reliable data on service access and use. Last DHS was 2013 and there was no GPRHCS Facilities Survey in 2014.		• Interview: UNFPA CO staff, Freetown
Assumption 4.5: UNFPA Supplies has provided **effective support to RH/FP services** as one element in **a national response to humanitarian crises** (not only through the provision of commodities).		
• "In May 2014, Sierra Leone discovered its first laboratory confirmed case of **Ebola Haemorrhagic fever** in Koindu Chiefdom of Kailahun district. The situation progressively worsened and cases spread rapidly nationwide resulting in the declaration of a Public Health Emergency of International Concern by the World Health Organization and the GoSL. As of 13th January, 2015, a total of 7,389 cases had been laboratory confirmed and the number of deaths was 2,718, with a case fatality rate of 34.6 percent. The **weak health system in Sierra Leone, coupled with lack of effective prevention controls accelerated the spread of the outbreak**."		• UNFPA, *2014 Sierra Leone Annual Joint Reporting for the Reproductive Health Thematic Trust Funds.* 2015. p.11.
• "In the context of the outbreak of EVD [Ebola Virus Disease] UNFPA has been designated by the Government of Sierra Leone, UNMEER [The UN Mission for Ebola Emergency Response] and the NERC [National Ebola Response Centre, Freetown] to take a **leading role in contact tracer training and provision of incentives**. Alongside MoHS and WHO, UNPFA is the co-lead of the Surveillance Pillar and has provided support to all surveillance related efforts in the Ebola Response".		• UNFPA, *Narrative Report for funds received from GPRHCS for Support to Surveillance (Contact Tracing).* UNFPA Freetown, December 2014. p.1
Contact Tracing (EVD Response) • "In partnership with the Ministry of Health and Sanitation, UNFPA has **trained a total of 5,211 contact tracers, 378 ward councillor supervisors and 347 technical supervisors.** GPRCHS funds were reprogrammed to cover gaps in contact tracing activities, including incentives, visibility materials and costs associated with staff support to monitoring and evaluation."		• UNFPA, *Narrative Report for funds received from GPRHCS for Support to Surveillance (Contact Tracing).* UNFPA Freetown, December 2014. p.1
Independent Monitoring of Contact Tracing Activities • "To improve upon the quality and independently verify the performance of contact tracers, GPRHCS has supported **independent monitoring through the use of Civil Society Community Monitors**. To verify and report on whether contact tracers are tracking people who were in contact with symptomatic EVD cases, monitors verify the number of functional contact tracers in each district and establish and document the actions taken in the case of contacts who develop signs of EVD including removal from communities, home management and referral to holding/treatment centres."		• UNFPA, *Narrative Report for funds received from GPRHCS for Support to Surveillance (Contact Tracing).* UNFPA Freetown, December 2014. p.2

Question 4: Key Assumptions	Observations	Sources of Evidence
Support to DHMTs Data Entry Systems • "GPRHCS funds were used **to strengthen the data entry and management in all districts**. UNFPA supported the Surveillance Pillar partners and MoHS in conducting an assessment of ICT needs. Further to the consultation of national counterparts and needs, it was decided to proceed with the procurement of equipment to support the surveillance pillar data collection and management. For the purpose of improving the speed and accuracy of case investigation and contact tracing data, data entry clerks were deployed to all districts. Additionally, 13 desktop computers, printers and hard drives were provided [one set in each district]. This has enhanced the timeliness of data dissemination and let to more targeted response efforts."		• UNFPA, *Narrative Report for funds received from GPRHCS for Support to Surveillance (Contact Tracing).* UNFPA Freetown, December 2014. p.2
• During the EVD crisis, in 2014 and 2015, **UNFPA Supplies funding was used to support Community Health Workers in carrying out contact monitoring functions**. UNFPA was the lead UN agency for contact monitoring. Provided incentives, vehicles (motorbikes) and fuel.		• Interview: UNFPA CO staff, Freetown
• During the **2015 flood emergency near Freetown**, UNFPA was the very first UN Agency to be part of the response. The government established camps in the national stadium and in the east end of Freetown • **UNFPA Supplies provided dignity kits and supported the work of midwives** to provide services to pregnant and lactating mothers. They also provided transport for the midwives.		• Interview: RH/FP Programme, MoHS
• During the EVD crisis UNFPA, focused on **building confidence for maternal health services** and overcoming the myths and suspicions built up around the health facilities and health workers • However, they **failed regarding prevention of teenage pregnancy and on gender based violence** during the crisis but they did make progress on female genital mutilation.		• Interview: UN Women Offices, Freetown
• With support from UNFPA Supplies, **MSSL did a major outreach push during the EVD crisis**. MSSL worked with Ebola contact monitors supported by UNFPA Supplies, especially in Port Loko district • There was a gap in providing family planning services and commodities to Ebola survivors and they were able to provide services with funding from Japan and commodities provided through UNFPA • During the **2015 flood emergency they provided SRH services to displaced people located at the national stadium** with support from UNFPA Supplies for operational costs and commodities.		• Interview: MSSL Head Office, Freetown
• UNFPA Supplies support prior to the EVD crisis meant that had an institutional base and a presence in the community and were able to provide integrated services with the FP message embedded in it during the response to the crisis • UNFPA did play a key role in funding and supporting contact tracing during the EVD crisis • They also got funding from other sources for their work during the EVD crisis. CORDAID and IPPF provided funding for distribution of condoms • The EVD response could have been better in that they were perhaps not quite fast enough to get back on to the family planning programming in a really active way. This applies to the government, NGOs and all the development partners, not just to UNFPA.		• Interview: PPASL Head Office, Freetown
• During the **recent landslide/floods** UNFPA provided a three-month contract to PPASL to **provide RH/FP services** to the effected communities, especially by providing outreach services to women and girls who had been relocated.		

Question 4: Key Assumptions	Observations	Sources of Evidence
• "UNFPA transported 55 pregnant women from Pentagon, Kaningo, Regent, Kamayama and Dwarzak communities to the Planned Parenthood Association of Sierra Leone Sexual and Reproductive Health Clinic [Freetown] for routine antenatal checks and services."		• Office of the Resident Coordinator in Sierra Leone, *Sierra Leone Landslide and Floods, Situation Update Number Seven – 29 August, 2017.* p. 2.
• MoHS did **need to re-build demand after the EVD crisis**. Consumption was low, people were afraid to touch each other and did not want to give or receive injections. For a year or more people stopped coming for family planning services, many doses of injectables expired • UNFPA helped them with training on how to provide family planning services in how to work in RMNCH in an EVD environment.		• Interview: DHMT, Western Area, Urban District
• The DHMT began **contact tracing during the EVD crisis** very early in Pujehon Districts. Churches and mosques were closed and checkpoints interviewed people coming and going. This contact tracing effort was supported by UNFPA Supplies (funding CHW expenses) and was very effective.		• Interview: DHMT, Pujehon District
• They were able to stay open during the EVD crisis but the demand dropped way off at first. • People started **coming back to the health facilities in late 2014** • However, Pujehon district was very lucky and smart. They had a very strict quarantine and used medical staff at checkpoints. There was no recorded case of EVD in the district.		• Interview: Bandejuma Community Health Centre
• They were able to stay open during the EVD crisis. Only one PPASL static clinic was closed in the district hardest hit by Ebola (Kenema).		• Interview: PPASL, Wesley Street Clinic, Freetown
• The **mobile clinic was held in an area of Freetown where residents were affected by the local flooding** and some participants in the mobile clinic were women forced to relocate following the late August Mud-slide (2017) • Pregnant women and girls who had been relocated but could not attend the clinic were referred to the nearest PPASL static clinic in Freetown and UNFPA Supplies supported their transport and other costs.		• Interview: PPASL Mobile Outreach Clinic, Freetown
• Waterloo clinic was **able to stay open throughout the EVD crisis** because it had in place an infection protection standard before the crisis and, though some staff did not want to come many did attend • After the crisis staff had improved their use of personal protection equipment and continued to treat those recovering from Ebola who were shunned by many facilities at the time • MSSL **outreach services continued during the EVD** crisis although the static clinic in Kenema did have to close.		• Interview: MSSL Waterloo Clinic, Freetown

Strengthened systems and capacity for Supply Chain Management	
Evaluation Question 5:	To what extent has UNFPA Supplies contributed to **improving systems and strengthening capacity for supply chain management** for reproductive health and family planning commodities in programme countries?
Sub-Questions:	a) To what extent has UNFPA Supplies enhanced the ability of programme countries **to move commodities** from their point of arrival through various supply channels to the **last mile and service delivery points?** b) To what extent has UNFPA Supplies strengthened supply chains for RH/FP commodities in areas affected by **humanitarian crises?** c) To what extent has UNFPA Supplies contributed to strengthening the **capacity of supply chain managers and service providers** to forecast, order, receive, store, distribute and report on commodities? Has programme support addressed the capability, opportunity and motivation of supply chain managers and service providers? d) Has UNFPA Supplies been effective in **improving systems (both computerized and manual) and procedures** for supply chain management (including LMIS) and systems for inventory management, distribution, tracking and tracing of products), by working with **public, NGO and private sector actors**? Have countries reported positive results in tracking and managing these products? e) To what extent have UNFPA Supplies interventions incorporated a focus on **sustainability of supply** (to mitigate the potential risk of supply disruptions) through increased national ownership and support?

Question 5: Key Assumptions	Observations	Sources of Evidence
Assumption 5.1: UNFPA Supplies engages with national supply chain managers and development partners in countries to **discern key areas of supply chain management requiring support** (while seeking consensus among stakeholders regarding gaps and requirements to address them), and works to **supply targeted training, technology, and innovations to address the identified gaps**.		
Identifying elements of the supply chain that required support		
	• There was a clear need (identified in 2015) to strengthen the **data collection on consumption** and commodity requirements (quantification) at the PHU, DHMT and central level (DIOs).	• Interview: UNFPA CO, Freetown
	• There was also an important need to **improve infrastructure and conditions in the CMSs** and District Medical Stores (DMS) warehouses.	
	• The NPPU needed ongoing **capacity building support** (provided by Crown Agents and the Clinton Health Access Initiative (CHAI) with support from DFID and USAID (2015 and 2016) • The demise of NPPU in 2016 put a great deal of stress on the DDMS which was given interim leadership until the (still to be accomplished) establishment of the NMSA.	
	• There was also an urgent need in the post-EVD crisis period to support capacity development for service providers in RH/FP for **retraining, particularly for longer term methods**.	
	• The EVD crisis had a significant negative impact on the operation of the **LMIS** which, for RH/FP commodities, relied on CHANNEL as its operational software. The operation of CHANNEL needed to be re-vitalized and re-examined if it was to be an effective basis for monitoring consumption and stocks and thus informing forecasting.	

Question 5: Key Assumptions	Observations	Sources of Evidence
• After the EVD crisis it became clear that the absence of an effective **Technical Working Group for Supply** was hindering coordination of procurement, shipment and distribution of all medical supplies, especially for RH/FP commodities procured by UNFPA and FHC Initiative drugs and supplies funded by DFID and procured on their behalf by UNICEF.		• Interview: UNFPA CO, Freetown
Working to strengthen different dimensions of the supply chain		
• UNFPA Supplies was used to support the **NPPU** in the MoHS but this was disbanded in February 2016 on the order of the president with notice of just one week. The decision seems to be related to a meeting in the UK regarding its support to the FHC Initiative and DFID's assessment that NPPU did not have the capacity to procure and distribute FHC commodities.		• Interview: UNFPA CO, Freetown
• Post EVD crisis, UNFPA Supplies helped to develop a good plan for capacity building and increasing access to (and use of) **long-lasting, reversible methods** in particular (implants and IUDs) • They also worked with MoHS with a priority plan to increase the **capacity of service providers** to provide longer term methods.		
• The fact that the system was technically quite poor was one reason why there was a need for an effective Technical Working Group on Supply which UNFPA has worked with DDMS to set up.		
• Quarterly distribution of all health commodities (including RH/FP) was the norm until 2016. In that year there were only two distributions. This happened because **DFID funding for FHC commodities was channelled through UNICEF (which did the procurement) and RH/FP commodities were taken out of the distribution** (which was carried out by the contractor Crown Agents until 2016 first and subsequently by another contractor, AECOM) • In consequence, UNFPA Supplies funded an emergency distribution of RH commodities from the CMS in 2016 (November).		
• In 2015 UNFPA argued that all **RH/FP commodities should be included the list of FHC drugs and supplies**. They received significant support in this from the NPPU so they consolidated a single sheet into the requests form. The last distributions under this system were in the last quarter of 2015 and the first quarter of 2016. Each DHMT requested against the stock that was available and the distribution plan was adhered to • The decision to eliminate the NPPU in February 2016 came from a very high level. The president of Sierra Leone brought in Crown Agents with support from DFID (but no one will say so officially). The result was a **breakdown in the system for distributing family planning commodities in 2016** because the DFID contract with AECOM did not allow/require AECOM to transport family planning commodities.		
• "**UNFPA Supplies has done a lot to support and strengthen the supply chain in Sierra Leone**. The programme provided and continues to support the CHANNEL software for LMIS, it recruited, trained and continues to support the District Information Officers, and it has heled with infrastructure (shelving and warehouse improvements, cold chain equipment for oxytocin), as well as helping with customs clearance. There is still a great deal of strengthening that is needed from the Supplies programme. They need to: ○ Continue to provide RH/FP **commodities** ○ Provide **vehicles** ○ Upgrade the **medical stores** ○ Provide s**upport to distribution**, especially the last mile."		• Interview: RH/FP Programme, MoHS
• UNFPA Supplies support has helped the DDMS to:		• Interview: DDMS, MoSH

Question 5: Key Assumptions	Observations	Sources of Evidence
○ Build a **cold-chain for RH medicines** (oxytocin) including at the CHC level ○ Improve **shelving in the central warehouse** ○ Providing **salaries for District Information Officers** (16) ○ **Procured computers** for use by DIOs in administering CHANNEL ○ Supporting **the LMIS** through CHANNEL • Their **biggest problem has been distribution to the last mile** but they also have problems with, **customs clearance**: getting the customs waiver signed off by the Ministries of Finance, Health, External Affairs etc. UNFPA helps with this problem by walking the documents from one ministry to another and helping secure the necessary waivers		
• UNFPA Supplies mainly **supports the DPPI** in the area of LMIS where they work together with the RH/FP Directorate • The UNFPA Supplies supports the salaries of the DIOs who are supervised by the CMSs under the overall management of the DDMS.		• Interview: DPPI, MoHS
• The UNFPA Supplies programme is **the main source of family planning commodities for MSSL** but they can sometimes procure through Marie Stopes international.		• Interview: MSSL Head Office, Freetown
• With UNFPA Support, primary **role of the HFAC** is to provide independent oversite through monitoring the supply chain from procurement to delivery for all FHC commodities but with a focus on RH/FP • HFAC works with UNFPA Supplies to help **control leakages and ensure accountability**. There has been a significant reduction in leakages through the work of community monitors from the level of the CMS on down to the PHU level • HFAC head office receives the district distribution list from the RH/FP Programme at MoSH and sends it to community level monitors so they **can identify discrepancies at national, district and PHU level**. They also have quality checks internal measures to reduce the risk of leakages – including a series of spot checks.		• Interview: HFAC, Head Office, Freetown
Key challenges and weaknesses in the supply chain for RH/FP commodities (2017)		
Several major bottlenecks impede current supply chain performance. Review of existing reports, interviews with key informants, and a limited set of site visits identified several major constraints to current supply chain performance: • ***Limited funding for commodity procurement*** – products for the RH programme are not in full supply. For the most recent year, UNFPA allocated funds that were not sufficient to meet the national need for RH/FP commodities (~900,000 USD compared to prior years' funding of ~1.5 million USD), resulting in shortages across the system. There is currently (during 2016) no other significant source of commodity funding or procurement for FP commodities, including from the GoSL. These shortages directly constrain product availability and ultimately RH service delivery. Additionally, implementing partners have little information on the timing of shipments planned to support their service-provision activities. An earlier, complete sense of the commodity funding gap would better enable implementing partners to secure emergency funding through their own mechanisms. This		• JSI Inc. *Analysis of Sierra Leone FP/FH Supply Bottlenecks.* 2017. p.2.

Question 5: Key Assumptions	Observations	Sources of Evidence
requires that implementing partners actively secure understanding and documentation of commodity funding shortages and independently pursue internal emergency funding opportunities. • ***Delays in UNFPA-procured shipments*** – shipments of contraceptives have suffered delayed arrivals during the past year (2015 to 2016). These delays disrupt planning, lead to forecast inaccuracy, incur demurrage charges and have led to a current stock out of oral contraceptives at some facilities. • ***Limited central-level coordination between the RH programme and the CMS 'caretaker' environment*** – currently, there is little direct coordination between the RH programme, which develops the distribution plans for contraceptives, and the CMS, which is nominally responsible for distributing those commodities. Closer coordination is required to ensure that RH commodities can be included in free health care distribution, and avoid emergency shipments in the future. • ***'Push' calculation of distribution quantities*** – currently, quantities for resupply are calculated based on assumptions and are standardized across districts by facility type. This leads to the supply imbalances (simultaneous stock outs and overstocks) observed at service-delivery points in Sierra Leone. **UNFPA plays a vital role in funding and procuring family planning commodities in Sierra Leone, but faces funding constraints which limit expansion of its scope and scale of supply chain support activities.**		
• RH commodities are included in the list of approved FHC commodities but not in the **DFID contract with AECOM** as the distributing agent.		• Interview: UNFPA CO, Freetown
• The **problems of the supply chain** go well beyond just the overall level of stocks in the CMS, they include the fact that: o There is **no consistent and effective system for distribution** to the last mile (to the PHUs). o While some 90% of the PHUs have at least three methods in stock there are still **important stock outs** o The **LMIS needs to drive the distribution plan** prepared by the RH/FP Unit of MoHS (currently it does not do that, estimates are based on historical data updated by assumptions on population growth) o There is a weekly operational meeting on distribution at the DDMS (where the battle was fought over the FHC distribution excluding RH/FP commodities) but it remains highly operational o While DDMS has **tried to re-integrate family planning commodities into the distribution system for FHC** it has not been able to do so because of the DFID contract with AECOM.		
• There are **major problems in distribution, both in the first and last mile**. The first mile is defined as distribution from the CMSs to the District Medical Stores. The last mile is from the District Medical Stores to the PHU.		• Interview: RH/FP Programme, MoHS
• There was a change of emphasis on the part of **DFID** in the post-EVD period in the context of the FHC Initiative. They **de-emphasized family planning commodities**: were willing to include oxytocin and emergency contraceptives but left out pills, injectables and IUDs. The RH/FP programme fought that with the argument that family planning was very cost effective. At first,		

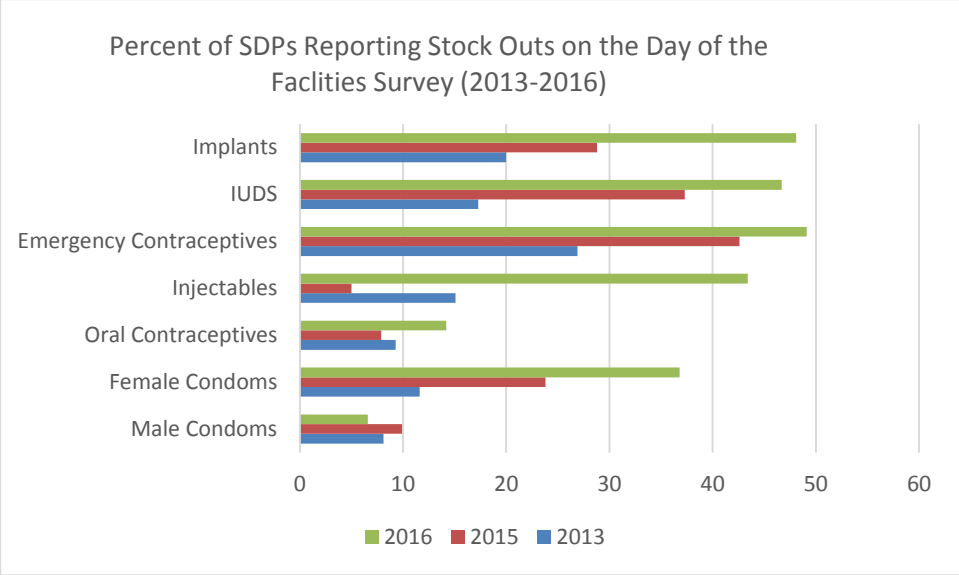
Question 5: Key Assumptions	Observations	Sources of Evidence
UNICEF argued that it could not carry family planning commodities because it was against policy – that their mandate did not allow them to be responsible for distributing FP commodities • Later, when the contract with AECOM was the problem, DFID conceded that the contract with AECOM did **not allow the firm to take responsibility for distribution of family planning commodities** • This makes no sense because DFID is a major supporter globally of family planning supplies and it provided 700,000 USD to procure family planning commodities in 2017 through UNFPA Supplies • This leaves the RH/FP programme in a really bad position because now they have to **beg for funds for distribution**. In November 2016 and in 2017 JSI (with UNFPA support) stepped in to do emergency distribution from the CMS to the districts but the last mile (from the District Medical Stores to the PHUs) is being left undone.		
• The **DFID procurement through UNICEF for the FHC drugs** was distributed originally through CAIPA (Crown Agents) up to the time that the NPPU was dissolved. Then AECOM started in December 2016 under its contract with DFID • Still have the issue that the **distribution of FHC commodities by AECOM under their contract with DFID does not allow them to distribute family planning commodities procured by UNFPA**.		• Interview: DPPI, MoHS
• From 2013 to 2016 UNFPA also provided condoms and supported the nine sub-contractors working for the NACP (to 2015 on the latter) but in 2017 **the Global Fund** took over provision of condoms and now 80 percent of funding for HIV • The Global Fund also supports the distribution of condoms. • The NAS/Global Fund don't have enough space to store the condoms that are procured – so these are shipped to the CMS warehouses but they (the **condoms) belong to NAS and are distributed by them under a separate distribution arrangement**. • The NAS condoms are shipped by the NAS to the District Medical Stores (the first mile). The DMHT is then responsible for getting them to the PHUs. He estimates they only cover about 50 percent of the PHUs • It is clear there is a need for an integrated and central distribution system supported by a common LMIS.		• Interview: National AIDS Secretariat Head Office, Freetown
• Right now, there are important **weaknesses in the procurement and supply management (PSM) function**: o Different partners insist on their own **supply chains**: ▪ The Global Fund has its own supply chains for malaria drugs (not included in FHC/DFID) and for condoms ▪ UNFPA works with the government system but it lacks funds for last mile distribution ▪ UNICEF is responsible for receiving and warehousing FHC drugs but the AECOM contract under DFID delivers directly to the PHUs, bypassing the DHMT o There is clearly **corruption and leakage** at the PHUs with FHC and UNFPA drugs appearing for sale in private pharmacies o **PHUs are poorly managed** and only about 50 percent are salaried, the others are non-salaried, so-called volunteers with a major incentive to sell commodities (including family planning commodities) as a means of sustaining themselves. Audits by pharmaceutical firms find supposedly free commodities in the private market o With many more **service delivery points** in the country than are needed (of the more than 1,300 in the country perhaps half are needed and really functional) the PSM function for medical supplies is vastly over-loaded o There is also need a stronger supply management **information system**		• Interview: World Bank Office, Freetown

Question 5: Key Assumptions	Observations	Sources of Evidence
○ The proposed national **Social Health Insurance Programme** is very weak and is not attracting donor support.		
• The **push system** is still the main method for allocating RH/FP commodities and, partly as a result, PHUs do not get the commodities they really need and can use.		• Interview: World Health Organization Offices, Freetown
• Because of the activities of PPASL and MSSL and the relative ease of distributing commodities in Freetown, you see much better availability and access there. However, in Freetown and elsewhere **free health care is not really free**, either because there are fees for service or because providers feel they have to charge for the commodities due to lack of salaries and the problem of the non-rational nature of the system of Human Resources for Health (with half of the service providers in the public sector not on salary).		
• There is a disjointed approach to supporting the **Health Information Systems (HIS)** with several different systems supported by different development partners.		
• The problem with the **PSM systems** is that they **largely operate in parallel** for example if we go commodity by commodity: ○ **Malaria**. Global Fund money is provided to UNICEF to distribute anti-malaria but not to procure them. Distribution is quarterly with funding varying according to a two-year programme cycle. Distribution is by private contractor ○ **Nutrition**. UNICEF has funding to do the distribution which is now vertical but pressure is on to integrate it into government systems ○ **Expanded Programme on Immunization (EPI)**. Has its own parallel supply chain and UNICEF sometimes procures vaccines for the EPI ○ **FHC Initiative**. FHC system for procurement and distribution has changed every year. In some years UNICEF along with the NPPU did the pick and pack function at the CMS and supported regular distributions but for the past 12 months it has been a different system (2016-2017). Under this system the funding for distribution of FHC commodities comes from the DFID funded Saving Lives Programme with distribution contracted by DFID to the private firm AECOM. ▪ UNICEF does the procurement ▪ UNICEF also helps with customs clearance when needed ▪ DFID financed and UNICEF procured FHC commodities are handed over to the contracted distributor for picking and packing for distribution ▪ Commodities are not sent to the districts for further distribution to the PHUs but rather are distributed directly to the PHUs by AECOM ▪ DHMTs may not know which commodities have been allocated to which PHUs and cannot check if they have been received ▪ RH/FP commodities at the CMS and DMS cannot normally be added to the trucks doing AECOM distribution because of contractual restrictions and liability concerns.		• Interview: UNICEF Country Office, Freetown
• There are important **issues relating to the procurement and distribution of FHC commodities** which limit its capacity to also take on RH/FP commodities:		• Interview: UNICEF Country Office, Freetown

Question 5: Key Assumptions	Observations	Sources of Evidence
○ The DFID/AECOM contract seems to **have underestimated the volume and weight of the FHC commodities** to be distributed ○ There is **no functioning system which could integrate RH/FP commodities into the FHC** distribution system with the current state of the (absence of) NPPU ○ You cannot burden the already **overburdened system for distributing FHC commodities** with any additional ones (RH/FP) ○ There is a **significant backlog of FHC commodities in the po**rt awaiting customs clearance and the list of FHC commodities has recently expanded to cover 222 different items ○ Problems in the Port used to be more difficult, now they are able to clear most commodities within three weeks. Currently they have 23 shipping containers of FHC commodities in the port.		
• On the **contract with AECOM** there has been some confusion about the UNFPA family planning commodities: Under the SLP of 150 million GB pounds over five years, UNFPA is accessing 700,000 to procure commodities for UNFPA Supplies in 2017. If they had asked for funds for distribution these could have been included but the contract with AECOM was set before they made that observation and it cannot be altered in retrospect. This is because AECOM is having trouble delivering the DFID procured FHC commodities that it is already contractually responsible for • It remains true that supply chains for medical supplies and for RH/FP commodities are fragmented.		• Interview: DFID (UK) Offices, Freetown
• The procurement process is very time consuming often due to **delays in customs clearance** • Sometimes there are delays because of problems at a global level with suppliers contracted by UNFPA • When shortages happen, they can sometimes get commodities from the DHMT or individual PHUs with overstocks.		• Interview: MSSL Head Office, Freetown
• The supply chain for the FHC commodities procured by DFID operates through **three partners**: ○ **UNICEF** ▪ Procures FHC Commodities ▪ Ships them to SL and offloads ▪ Turns them over to AECOM ○ **AECOM** ▪ Receives drugs ▪ Sorts them ▪ Picks and packs for distribution to the PHUs ▪ Ships them to the DHMT and the PHUs ▪ Does an audit of 35 percent of all facilities to confirm goods are in the right place ○ **CHAI (Clinton Health Access Initiative)** ▪ Supports the MoHS on quantification of FHC commodities There is an FHC operations meeting each week of all funding partners and MoHS and DFID		• Interview: DFID (UK) Offices, Freetown
• The supply chain operated more effectively from 2013 on (especially before the EVD crisis): ○ NPPU was functional		• Interview: HFAC Head Office, Freetown

Question 5: Key Assumptions	Observations	Sources of Evidence
- UNFPA office was strong - Systems for distribution were operating. • However, **in 2016, things deteriorated**: - NPPU was disbanded - Vehicles provided by UNFPA to CSM lacked fuel - The national procurement and distribution system was weakened and overall functionality of the system in 2016 was much worse. • Because of the situation with AECOM, it is much **more difficult to see what each PHU is receiving**. They do not get from AECOM the amounts to be distributed to each PHU • The view from HFAC is that government is not willing to be accountable for the AECOM/FHC distributions. The distribution system has been contracted out!		
• There is a **need for significant changes to the supply system** for example: **The DHMTs** need to be better informed of what is being send to the PHUs (AECOM does not inform them of contents of shipments of FHC commodities to PHUs) - There is a need for **better supportive supervision** where consumption differs by PHUs so that overstocks can be shifted to out of stock PHUs on a monthly basis - The DHMTs need to be able to **see if supplies and reported consumption match** - The **RH/FP unit of MoHS needs to be better informed** of what the DHMTs really need.		• Interview: DHMT, Western District, Urban (Freetown)
• When NPPU was responsible for distribution (until February 2016) the commodities were shipped to the DMS and picked and packed at the district level for distribution to the PHUS. In 2016 it was done by CAIPA (Crown Agents) and in 2017 by AECOM and always at central level with no coordination (or informing of) the DHMT • **Supply Chain Management has been a chronic problem** in their system • They need somehow to move, eventually to a pull system where distributions and shipments are actually based on real consumption data • One of the problems of distribution is that they **don't have at district level a specific budget for distribution**, including fuel for vehicles.		
• They would prefer to see AECOM integrate distribution at the district level and cooperate with the DHMT • While there are problems of distribution in the "last mile" which is defined in Sierra Leone as shipment from the District Medical Stores to the PHUs, there are some work-arounds they use when distributions are delayed or not forthcoming: • For example, at the monthly district meeting of heads of PHUs (in-charges) which takes place at the district offices, they can provide PHUs with some commodities to transport back to their units (usually they come on motorbikes).		• Interview: DHMT, Pujehon District
• **DHMT does the distribution matrix for the district**. This is the work of the Pharmacist and the District Logistics Officer. The resulting distribution plan is sent to DDMS/CMS at the start of the year and distribution is supposed to happen quarterly but: Often its four, five or six months before they get a **distribution – it is very irregular** and this is true for both pharmaceuticals under the FHC list and for FP commodities (which are distributed separately)		• Interview: DHMT, Port Loko District

Question 5: Key Assumptions	Observations	Sources of Evidence
○ AECOM does not provide them with the waybills of what FHC commodities are being shipped to the PHUs ○ They (the DHMT) have no say whatsoever in what is being shipped to the PHUs and to the district – at least for FHC commodities. • They experience **frequent stock-outs at the DMS** whether it is the FHC drugs or family planning commodities.		
The prevalence of stock outs and their effects		



- UNFPA, *Availability of Modern Contraceptives and Essential Life Saving Maternal and Reproductive Health Medicines at Service Points in Sierra Leone: 2016 GPRHC Survey Report.* 2016 *p.52*.
- UNFPA, *Report on 2013 Survey of Availability of Modern Contraceptives and Essential Maternal and Reproductive Health Medicines in Service Delivery Points in Sierra Leone.* 2013. p. 34
- UNFPA, *Report on the 2015 Survey of Availability of Modern Contraceptives and Essential Maternal and Reproductive Health Medicines in Service Delivery Points in Sierra Leone.* 2015. p. 41

Percent of SDPs reporting a stock out of a modern contraceptive method on the day of the survey (2013-2016)

Year	**2013**	**2015**	**2016**
Male Condoms	8.1	9.9	6.6
Female Condoms	11.6	23.8	36.8
Oral Contraceptives	9.3	7.9	14.2

- GPRHCS/UNFPA Supplies Facilities Surveys: 2013, 2015, and 2016.

Question 5: Key Assumptions	Observations			Sources of Evidence
Injectables	15.1	5	**43.4**	
Emergency Contraceptives	26.9	42.6	49.1	
IUDs	17.3	37.3	**46.7**	
Implants	20	28.8	**48.1**	
"The **predominant reason cited for stock outs of modern contraceptives** offered in line with national protocols were: (1) warehouse delays to re-supply the facility with contraceptives; (2) no trained staff to provide the contraceptive; (3) low client demand, and (4) lack of contraceptives in the market for the facility to procure.				• UNFPA, *GPRHCS Survey Report.* 2016 p.31
• Reported stock outs in SDPs surveyed in October 2016: o Male Condoms: 10 percent o Female Condoms: 35 percent o Oral contraceptives; 65 percent o Injectables: 66 percent o Emergency contraceptives: 82 percent o IUDs: 50 percent o Implants: 52 percent				
• At **MSSL**, the situation for most commodities is pretty good but they do experience shortages, in particular, of implants and male condoms.				• Interview: MSSL Head Office, Freetown
• In the first and second quarters of 2016, **PPASL** experienced serious stock outs.				• Interview: PPASL Head Office, Freetown
• MATCOPS does see disruptions in service and stock-outs which hinder their ability to **sustain demand side work**. The biggest problems seem to be shortages of *Depo* and of Implants.				• Interview: MATCOPS Head Office, Freetown
• The **push system** for allocating distributions to the District and from the District Medical Stores to the PHUs is not adequate. The District, because of lack of commodities in 2016 and 2017, has sometimes had to allocate the same amount to each PHU which will not be enough to satisfy demand (one box of *Jadelle* to each PHU for a three month period – 25 doses).				• Interview: DHMT, Western Region, Urban (Freetown)

Question 5: Key Assumptions	Observations	Sources of Evidence
• Team observed in the District Medical Stores that there were **only three cartons of *Jadelle* left** for distribution for the next three months. • For injectables (*Depo-Provera*) they **clearly cannot meet demand** in the view of the DMO • They have 31 PHUs which are qualified to provide IUDs so they provide only those with IUDs. • Severely overcrowded, minimal space • Poor shelving • Broken tiles on the floor • Very low levels of inventory for FP commodities especially injectables and implants • Obtained a copy of the monthly overall CHANNEL report for the district (July 2017). Shows very low levels and zero receipts of *Depo Provera* 36 doses available for 128 facilities • Cold chain **for oxytocin is improvised** as there are technical problems with the main refrigerator (provided by UNFPA).		• Observation: District Medical Stores, Western Region, Urban (Freetown)
• Interview and observations provided evidence of: o A **severe shortage of family planning products building up since the last distribution in July 2017** (two months before the visit) o A **total stock-out of *Depo Provera*** which was not included in the previous distribution o A **stock-out of misoprostol** for more than the preceding six months o A **limited supply of implants** (12 boxes x 14 treatments) but with no way to get them to the PHUs which are reporting stock outs. • There was **no distribution from CMS to the district in 2016** until JSI did an emergency distribution in November.		• Observation: District Medical Stores, Pujehon District
• They recently experienced **very serious stock outs of implants** at both the district and PHU levels • In 2016 they experienced very serious and lengthy stock outs, especially of implants and emergency contraceptives.		• Interview: **DHMT**, Port Loko District
• Implants are in good supply but they **do have stock outs of *Depo Provera*** • They can go to the PHUs which might have overstocks if they run out of some items • The stock control cards and the inventory forms seem to work ok but the problem is getting regular distributions on a monthly basis.		• Interview: Bandejuma Community Health Centre
• They do have **regular stock outs** and at this point in time they have a stock out of *Depo Provera* • When they have a stock out they can sometimes get the commodity from the District Hospital • This creates a big problem because some **women do not want to change their method so they go without and risk an unwanted pregnancy**. However, some women do accept an alternative method such as implants (when *Depo Provera* is not available).		• Interview: Rogbery Junction **Peripheral Health Unit**, Maforki Chiefdom
• No evidence of stock outs • **Clean storage of family planning commodities** • Functioning and clean **cold chain for oxytocin** • Careful reporting of stocks and usage of condoms, injectables, implants, and IUDs.		• Interviews/Observations: **PPASL**, Wesley Street Clinic, Freetown

Question 5: Key Assumptions	Observations	Sources of Evidence
• Commodities are distributed to them by MSSL from the central medical stores based on their monthly request and most of the time they do have a buffer stock • In 2015 they did suffer **a small stock out of implants** and sometimes of Microgynon pills but this was corrected by accessing funds from MSSL.		• Interviews/Observations: **MSSL**, Waterloo Clinic, Freetown
• **No evidence of stock outs** • Clean storage of family planning commodities • Functioning and clean cold chain for oxytocin • Careful reporting of stocks and usage of condoms, injectables, implants, and IUDs.		
Assumption 5.2: UNFPA Supplies (through COs) **collaborates effectively with country officials**, to enable **introduction and roll-out** (with requisite training) **of required new manual and automated supply chain management systems** and procedures **including LMIS**, inventory management, distribution to the last mile, track-and-trace mechanisms, etc.		
• UNFPA Supplies has consistently supported the operation of the LMIS system at PHU, DHMT and central level through its provision and support of the **CHANNEL software**. CHANNEL is functional at the district level and centrally. Some context and history of CHANNEL: o A significant negative effect of Ebola, including the death of one DIO funded by the UNFPA Supplies (2014) o An assessment mission in 2013 was done to see if CHANNEL could be improved or if MoHS would shift to M-Supply software (at this time MoHS still prefers CHANNEL) o In 2013 and 2014 they (UNFPA) addressed some of the issues in CHANNEL o In March 2016, UNFPA conducted a Data Review workshop with all the DHIOs and helped to revitalize CHANNEL by the 4th quarter o By the 4th quarter of 2016, the quality of CHANNEL data was good enough to allow for it to be used in forecasting (although this was not done) • UNFPA Supplies has helped recruit and has consistently paid the salaries of the DIOs.		• Interview: UNFPA CO, Freetown
• RH/FP would like to stick with CHANNEL and have it upgraded • The **Global Fund is providing funding to test M-Supply** in Sierra Leone but how will they sustain the funding tomorrow when the Global Fund no longer wants to pay subscription fees and support costs? CHANNEL is open sourced and ongoing support is provided by UNFPA. He is not sure why the Global Fund is pushing M-Supply so hard • **CHANNEL does need to be upgraded to be web-based and should be made inter-operable with DHIS2** which is already web-based.		• Interview: RH/FP Programme, MoHS
• Right now, the **consumption data from DHIS2 for RH/FP commodities and services does not match with the data from CHANNEL** (it has to be checked by hand)		• Interview: DPPI, MoHS

Question 5: Key Assumptions	Observations	Sources of Evidence
• The support to data entry clerks from UNFPA Supplies ended at the end of the first quarter in 2016 and DPPI have struggled to get other sources – had to fund ten months of back salaries. This was provided by the World Bank. WHO will fund them for the next 24 months. However, UNFPA Supplies does continue to fund the salaries of the DIOs • The biggest challenge it to either **absorb the CHANNEL data elements into DHIS2 or to develop CHANNEL so that it can readily connect to DHIS2** and make them interoperable so consumption data can be reconciled • There is an **ongoing concern that M-Supply which is proprietary software with subscription fees and maintenance costs may not be sustainable in comparison to CHANNEL**. DPPI is concerned that the Global Fund seems to be advocating so strongly for the use of the M-Supply software which is proprietary (with subscription fees) and will require ongoing support which MoSH perhaps would not be able to fund.		
• The DPPI now have the capacity to develop a **web-based platform for CHANNEL** and are pilot testing it. UNFPA and PPI also did a review of Channel in 2016 and identified ways to strengthen it.		
• UNFPA has contributed immensely to the adoption and use of **CHANNEL** which **is the preferred option of DDMS** (confirmed by them) • While a donor (the Global Fund) is supporting mSupply MSH can see no reason to leave CHANNEL. They (the Principal Technical Advisor of MSH) visited Guinea where CHANNEL is operating and it seemed to work well. Now is the time to push strongly for an updated CHANNEL 2.0		• Interview: MSH Offices, Freetown
• UNFPA has provided **important support, including technical support to CHANNEL** and the funding of the DIO. If CHANNEL can be put on-line and linked to the DHIS2 data on consumption it would very much help the DHMT • Also, you need to be able to search CHANNEL by an individual PHU.		• DHMT, Western Region, Urban (Freetown)
- It was useful that UNFPA Supplies paid for the DIO and helped with training as well as providing the CHANNEL software but: o They thought that CHANNEL would give them data on the state of stocks in each PHU and would provide a red flag when stock out situations are realized but they don't really serve the needs of the district o The DIO receives the RRIV form from each PHU and inputs the data into CHANNEL before sending the data to the DDMS in Freetown - DDMS have introduced an **Informed Push** system based on the RRIVs to identify what they need to procure at a national and district level - What they need from CHANNEL at the DHMT level is to be able to easily see what the situation is in each PHU, they have 109 PHUs and they bear the heat when there are stock outs and overstocks - **CHANNEL is a flat file with output in the form of excel files but it needs to be upgraded to allow for more and better queries.** The information is in there but it is very old fashioned in how it is accessed. It needs an upgrade and needs to be web based.		• Interview: DHMT, Port Loko District
Assumption 5.3: UNFPA Supplies has access to **high-quality supply chain management systems and to capability/expertise**, and the **ability to convey these and to share technologies** (for example CHANNEL software) with the 46 programme countries.		
• The **level of technical support and advocacy** provided by the RH/FP Team at **UNFPA** Supplies is **appropriate** (up to September 2017 at least). They have **provided good technical support** especially to the LMIS system and to the quantification process.		• Interview: RH/FP Programme, MoHS

Question 5: Key Assumptions	Observations	Sources of Evidence
• UNFPA has had the **necessary expertise in its CO** or from other sources to provide support to developments in the supply chain management (SCM) area, particularly in the area of LMIS and the CHANNEL software.		• Interview: DDMS, MoSH
Assumption 5.4: At the country level, UNFPA Supplies support **focuses on providing incremental value** (adding to the efforts of government and others without duplication), supporting **sustainability**.		
• As well as from UNFPA Supplies, the **DPPI gets support** from the Health Metrics Network (for the DHS, MICS, etc.) they get support for MHIS from WHO, USAID/DFID (through UNICEF) and the Global Fund which provides an HSS grant • They get DFID support under the saving lives programme • DDMS is receiving support through MSH to further integrate CHANNEL into the RMNCH Score-card system which will use data from both the DHIS2 and CHANNEL.		• Interview: DDMS, MoSH

Improved programme coordination and management	
Evaluation Question 6:	To what extent have **the governance structures** (UNFPA Supplies Steering Committee) **management systems and internal coordination mechanisms** of UNFPA Supplies **contributed to** overall **programme performance?**
Sub-Questions:	a) To what extent have the UNFPA Supplies Steering Committee and UNFPA programme managers (headquarters, regional and COs) been effective in **providing strategic direction and oversight** to UNFPA Supplies as well as **internal programme coordination** at the global, regional and national level? Are Steering Committee members satisfied with the current governance structure? b) Have systems for **work programming, budgeting, review and approval** been effective at the global, regional, and country level? Has UNFPA Supplies been **effectively integrated into UNFPA country programmes**? c) Has UNFPA Supplies been able to assemble and deploy the **required human resources with the appropriate mix of skills and capabilities** to effectively support programme implementation at global, regional and national levels? d) To what extent have the **systems for results-monitoring, reporting and accountability** for UNFPA Supplies been effective? Have they contributed to **learning and knowledge management** and to ongoing programme management?

Question 6: Key Assumptions	Observations	Sources of Evidence
Assumption 6.1: Systems for work planning, budgeting, approval and review of UNFPA Supplies at the country level incorporate **meaningful participation by national health authorities, implementing partners and other key stakeholders**.		
• HFAC are part of the Quarterly Reproductive Health Security Committee which meets quarterly. It includes; UN agencies (UNFPA, UNICEF,) Government implementing partners and the donors.		• Interview: HFAC Head Office, Freetown
• UNFPA advocacy has also focused on revitalizing the **RHCS Coordinating Committee** (supposed to meet quarterly and chaired by the Director RH/FP of MoHS).		• Interview, UNFPA CO, Freetown.
• They thrashed out the problem of the FHC distribution not being able to incorporate RH/FP commodities during the weekly operations committee (every Thursday). The problem is **the committee works well operationally but does not deal with more substantive or policy related issues**. For that they needed to re-establish the Technical Working Group Supply which has just been agreed to by the DDMS • The Operations Committee includes:		

Question 6: Key Assumptions	Observations	Sources of Evidence
○ UNFPA, JSI Inc., DDMS, MSH (SIAPS), WHO, JICA, DFID, US AID, UNICEF. It is separate from the technical working group.		
• UNFPA played a major role in re-establishing and re-invigorating the **Technical Working Group on Supply**. The Technical Working Group on Supply has been in existence since 2010 and was the platform where all those supporting the supply of FP services and commodities meet. It includes MoSH, UNPFA, WHO, UNICEF, MSSL, PPASL and all the partners working in Reproductive Health and Family Planning with RH/FP in the lead • UNFPA provides financial and technical support to the TWG. They provide a place to meet, transport, minutes and they follow up on decisions made. They also advocate and fight to get things done.		• Interview, RH/FP Programme, MoSH
• The World Bank participates, along with UNFPA which provides support to the committee, in the RHCS Committee and the Health Partners Coordinating Committee		• Interview, World Bank Offices, Freetown
• **The Operations Committee** meets on Thursdays with representation from UNICEF, UNFPA, DDMS, etc. but it focuses as the name implies directly on operational issues.		• Interview: UNICEF Country Office, Freetown
Assumption 6.2: UNFPA Supplies has been able to access **appropriate and needed human resources** at the global, regional and national level.		
• The level of **technical support and advocacy provided by the RH/FP Team at UNFPA** Supplies is appropriate (up to September 2017 at least). They have provided good technical support especially to the LMIS system and to the quantification process.		• Interview: RH/FP Programme, MoHS
• UNFPA has had the necessary expertise in its CO or from other sources to provide support to developments in the SCM area, particularly in the area of LMIS and the CHANNEL software.		• Interview: DDMS, MoSH
Assumption 6.3: The systems and processes for the **governance of UNFPA Supplies** (including the UNFPA Supplies Steering Committee) have been effective in balancing the viewpoints of donor partners, programme country health authorities, programme managers and other key stakeholders in providing **strategic direction and over-sight** which is **responsive to differing contexts and changing conditions**.		

8.7 - Cross Cutting Theme: The Catalytic Role of UNFPA Supplies

Evaluation Question 7:	To what extent has UNFPA Supplies **played a catalytic role** by leveraging increased investment by other actors and supplementing existing programmes in RH/FP at global, regional and national levels?
Sub-Questions	a) To what extent has UNFPA Supplies been able to leverage increased investments and commitments by other actors in support of RH/FP commodities and services at global, regional and country level? b) To what extent has UNFPA Supplies programming been **sufficiently flexible and responsive to changing country needs and priorities**, including during and after humanitarian crises? c) To what extent has UNFPA Supplies supported **effective action to mitigate environmental risks** in procurement and disposal of RH/FP commodities?

Question 7: Key Assumptions	Observations	Sources of Evidence
Assumption 7.1: The design of UNFPA Supplies as reflected in strategic documents and in systems and processes for programme planning, approval and review, takes account of the roles of other actors and sources of support to RH/FP and attempts to influence them in their programming and leverage their resources.		
• In 2017, through the **DFID funded SLP** UNFPA Supplies secured 700,000 USD to procure commodities and address shortfall in the programme		• Interview: UNFPA CO, Freetown

Question 7: Key Assumptions	Observations	Sources of Evidence
• They were also able to **access the DFID SLP programme** to help with training service providers, especially in providing long term methods (implants and IUDs).		
• UNFPA Supplies is one of the most efficient and important sources of support for RH/FP in Sierra Leone • Almost **90 percent of commodities for FP are provided by UNFPA Supplies** so it is catalytic to all of the activities of the RH/FP Programme.		• Interview: RH/FP Programme, MoHS
• As well as from UNFPA Supplies, the **DDMS gets support** from the Health Metrics Network (for the DHS, MICS, etc.) they also get support for MHIS from WHO, USAID/DFID (through UNICEF) and the Global Fund which provides a Health Systems Strengthening grant • They get DFID support under the SLP • DDMS is receiving support through MSH to further integrate CHANNEL into the RMNCH Score-card system which will use data from both the DHIS2 and CHANNEL.		• Interview: DPPI, MoHS
• **DFID has been the government's key partner** on the FHC Initiative since its beginnings. Last year they procured almost 100 percent of the FHC commodities • DFID provides 15 million GB pounds (in 2017) for procurement 5 million GB pounds for distribution of FHC drugs and commodities • They have told the GoSL that this will be the last year they procure the FHC commodities • **The SLP** came on board in the second half of 2016. The contribution agreement was signed in 2016. It is for 150 million GB pounds over 5 years. UNFPA received 700,000 for the UNFPA Supplies programme under SLP for 2017 • When DFID agreed to provide 20 million GB pounds for FHC commodities procurement and distribution in 2017, they made it clear that this is a **one-year commitment**. The national government needs to make this a priority • The SLP programme runs from August 2017 until March 2021. It provides 65 million GB pounds in the first two years and just under 30 million GB pounds in the last three years. It is being administered through: Three UN agencies (UNICEF, WHO, UNFPA); CHAI (the Clinton Health Access Initiative) AECOM and a consortium of NGOs • The **World Bank** is to restart its **Performance Based Budgeting Programme** with 50 million USD worth of funding in 2018.		• Interview: DFID (UK), Freetown

• **PPASL have a number of sources of funding** but UNFPA is by far the most important and is the core of their funding for RH/FP
  ○ UNFPA: main support in RH/FP
  ○ Netherlands, Save the Children and CORDAID: support for combatting teenage pregnancy
  ○ Global Fund and KFW: HIV/AIDS programming
• Up to end of 2016, UNFPA Supplies provided 70-80 percent of funding.
		• Interview: PPASL, Head Office, Freetown

• **WICM** also works with the Global Fund and UNAIDS but have worked with UNFPA since 2001 • WICM is a UNFPA baby, they got funding from the UNFPA Supplies in 2013,2014,2015 and 2016 (funding from the UNFPA Supplies Trust Fund ZZT05) • They get a small grant from UNAIDS (2017) and from the Global Fund • UNFPA helped them apply for grants and programme funding by providing technical support and recommendations.		• Interview: WICM, Head Office, Freetown

<table>
<tr><th>Question 7: Key Assumptions</th><th>Observations</th><th>Sources of Evidence</th></tr>
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MATCOPS received funding from UNFPA Supplies in 2013, 2014 and 2015 but not in 2016
2013 =51,807 USD, 2014 = 50,00 USD, 2015 = 20,000 USD
In 2016 they began to receive support from UNFPA under its End-Child Marriage programme which will run until 2019. There was a six-month gap in funding
The End Child Marriage programme involves the establishment of safe centres (End Child Marriage Centres) with the existing recreation centres in schools and communities
The End Child Marriage programme also has a family planning component which allows them to carry on their work on demand creation
UNFPA has worked with them to help them mobilize resources by helping them call meetings with potential donors. The RH/FP focal person at the UNFPA CO also helps them apply for funds from different sources.

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Interview: MATCOPS Head Office, Freetown

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UNFPA was the main supporter of FINE SL; they have no other donor supporting the Peer Educator Network
Their funding from UNFPA ended in 2016. They received funding in 2014 and 15 from a combination of other UNFPA programmes and UNFPA Supplies

<table>
<tr><td>Year</td><td>Total UNFPA (Leo)</td><td>UNFPA Supplies (Leo)</td></tr>
<tr><td>2014</td><td>400,000,020</td><td>396,020,800</td></tr>
<tr><td>2015</td><td>699,201,00</td><td>209,510</td></tr>
</table>

In 2016 there was a shift to a new programme called HOPE (Health, Opportunities for Protection and Employment) with funding from IRISH AID and UNFPA (not Supplies) with 308, 202,000 Leos of funding
They also receive support from UNFPA in 2016 for a project focused directly on child marriage. This comes under behavioural change.

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Interview: Fambul Initiative Network for Equality (FINE-SL) Head Office, Freetown

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UNFPA Supplies provided support to the national government in the preparation of their commitments under FP 2020 (July 2017 meeting in London. They also served as co-convenor - with the MoHS - for this work in Sierra Leone as well as the global co-coordinator.

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Interview: UNFPA CO staff, Freetown

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UNFPA Supplies has had an important role in contributing to strengthening the enabling environment for family planning in Sierra Leone, for example:

They supported the development of the Strategic Plan for the health sector (2010-2015)
They are helping revise the strategic plan for 2015-2022
They have provided technical assistance and support to the development of the CIP for family planning

They played a major role in re-establishing and re-invigorating the Technical Working Group on Supply

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Interview: RH/FP Programme, MoHS

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It is critical that UNFPA continue to provide assistance for community engagement (even if it is from outside the UNFPA Supplies programme). For example, UNFPA support to community engagement for ending teenage pregnancy is essential

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Interview: UN Women Office, Freetown

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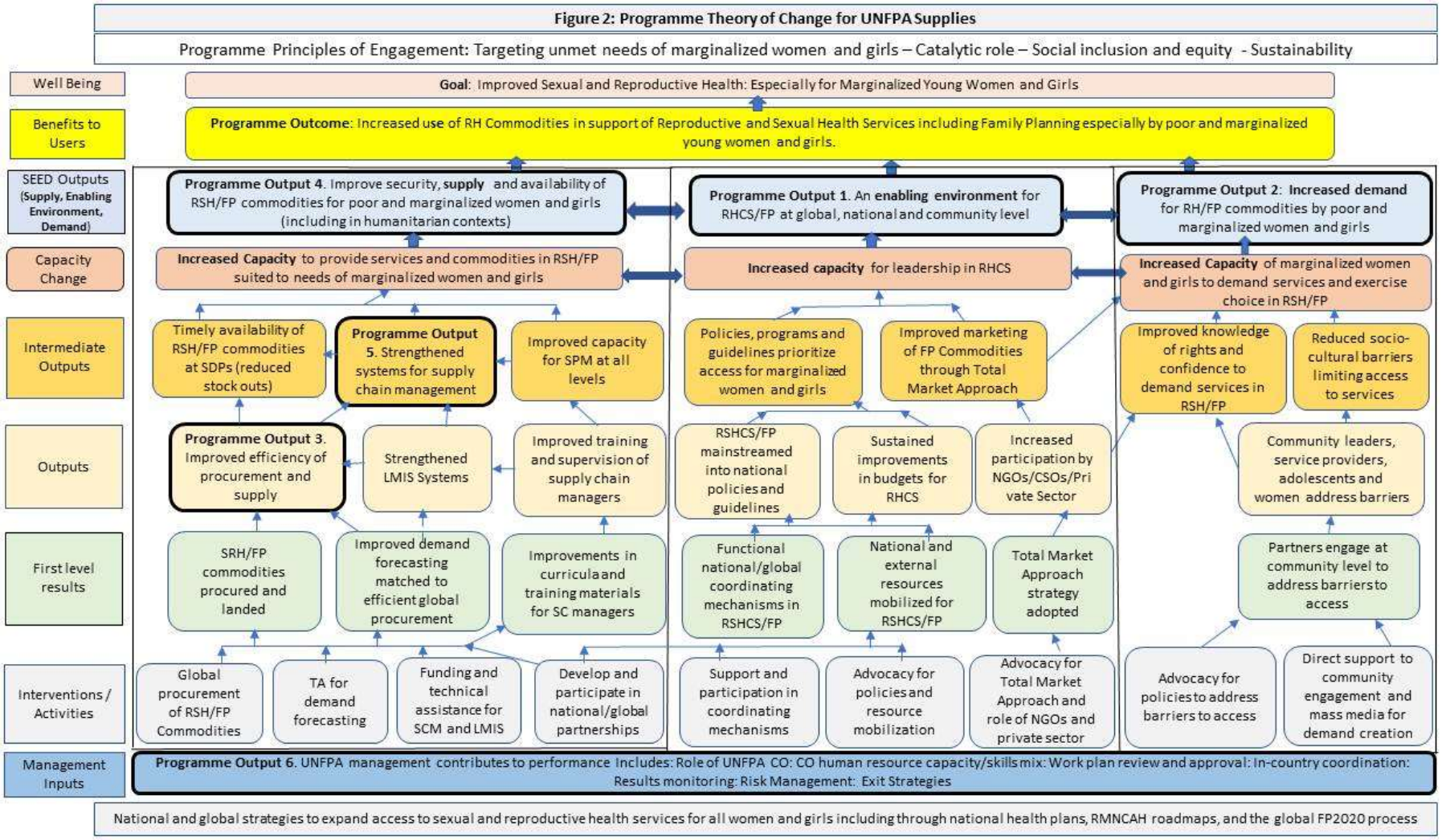
Question 7: Key Assumptions	Observations	Sources of Evidence
• Helping to develop and implement the strategy for **ending teenage pregnancy** is one of the key roles of UNFPA given its specific focus on reproductive health. There is a draft multi-sectoral strategy for ending teenage pregnancy coordinated by the Teenage Pregnancy Secretariat • There has been a lot of effective advocacy for family planning but it needs to be sustained.		
• Post EVD crisis, UNFPA Supplies helped to develop a **good plan for capacity building and increasing access to (and use of) long-lasting methods** in particular (implants and IUDs). The programme also worked with MoHS with a priority plan to increase the capacity of service providers to provide longer term methods.		• Interview: UNFPA CO staff, Freetown

5.2 Annex 2: Comprehensive theory of change for the UNFPA Supplies Programme



5.3 Annex 3: Persons Interviewed

Organization	Person Interviewed	Position
UNFPA CO	Dickson, Kim Eva	Representative
	Foday, Safiatu Agnes	Programme Analyst RH/FP
	Oyeyipo, Dr. Abiodun (Chris)	Technical Advisor, Family Planning
	Ul Hassan, Sayed Nauman	Advisor for RHCS
MoHS, Freetown	Conteh, Dr. Sulaiman G.	Manager, RH/FP
	Kamara, Mr. Wogba	Monitoring and Evaluation Specialist
	Thomas, Mr. Dennis	Interim NPPU Operations Director
	Turay, Mr. Bassie	Director, Directorate of Drugs and Medical Supplies
	Williams, Edward P.	Central Information Officer
DHMT, Freetown (Western Urban)	Bailor, Samual S.	District Pharmacist
	Kanu, Mariama Y.	Public Health Sister
	Nunie, Aminata	Senior Public Health Sister
	Samba, Dr. Thomas T.	District Medical Officer
DHMT, Pujehun District	Bome, Dr. David	District Medical Officer
	Sesay, Timothy	District Information Officer
	Williams, Jude	District Pharmacist
DHMT, Port Loko District	Bengue, Katumu	Maternal and Child Health Aid
	Kabia, Abdul	District Pharmacist
	Kallon Hawa	District Health Sister
	Kargbo Abu Bockarie	Laboratory Assistant
	Kamara Ishmael	District Information Officer
	Sesay, Dr. Tom	District Medical Officer
Bandajuma Community Health Centre	Kamara Massah	Maternal Child Health Aid
	Massaquoi, Josephine	Midwife Maternity
	Sawanneh, Mohamed	Community Health Officer In Charge
	Sellu Onita Y.	Midwife
Rogbere Junction Peripheral Health Unit,	Bequia, Salamatu	State Enrolled Community Health Nurse
	Kamara, Isha	Maternal and Child Health Aid
Ministry of Education, Science and Technology, Freetown	Musa, Mrs. Olive	Director of Non-Formal Education
National AIDS Secretariat, Freetown	Koroma, Abu Bakarr	IEC-BCC Coordinator
MSSL	Benya, Edward J.	Senior Programme Manager, Sierra Leone
PPASL	Conteh, Idrissa	Youth Officer
	Gobba, Mrs. Gladys	Regional Manager for West and Northern Regions
	Massaquoi, Dr. Victor	Director
	Williams, David E.	Executive Director
	Ansumana, Daniel	Coordinator, Kailahun

Organization	Person Interviewed	Position
Women in Crisis Management	Konteh, Juliana	Executive Director
	Malikie	Assistant Finance Officer
	Sellu, L. Mohamed	Monitoring and Evaluation Officer
	Saidu Jonathan	Head of Programmes
	Sidique, Jabbie	Data Entry Officer, Head Office
	Tucker, Benedict	Programme Officer, M&E
	Vandi, King David	Programme Officer
MATCOPS	Labia, Joseph D.	Programme Manager
	Sesay, Mustapha N'Dai	Head of Finance
	William, Mamusu	Executive Director
FINE SL	George-Buanie, Rev. Songaye D.	Executive Director
HFAC, Freetown	Kamara, Al Hassan	Programme Manager
PPASL, Wesley Street Clinic, Freetown	Bannerman, Victoria	Clinic Assistant
	Conteh, Fatmata	Midwife
	Gabba, Steven	Laboratory Technician
	Moseray Huliamatu	Theatre Nurse
	Ogwarie Sylvia	Clinic Coordinator
	Saccoh, Hannah	Service Delivery Manager
	Tway, James	Finance Assistant
PPASL Mobile Clinic, Freetown	Macaulay, Edith Roy	Mobile Clinic Nurse
	Musa, Joseph (Bob)	Project Supervisor
MSSL Waterloo Clinic, Freetown	Kamara, Alhaji A.	Finance Administrative Assistant
	Olmangu, Adama Kumba Manger	Waterloo Rural Reproductive Health Progamme Manager
	Sherrif, Massah Maccela	Centre Nurse
	Vandi, Morris	Senior Laboratory Technician
MSSL Outreach Clinic, Futa Kpejeh	Kamara Sheku	Driver and Registrar
	Mattia, Elizabeth	Senior Nurse
	Zombo, Mustapha	Community Mobilizer
PPASL Outreach Clinic, Lunsar Community	Bangura, Fatmata	Outreach Nurse
	Fofanah Samuel	Laboratory Technician
	Kamara, Matilda	Clinical Nurse
	Musa, Joseph (Bob)	Project Supervisor
	Neale, Thomas	Nurse
DFID, UK	Bandari, Dr. Amit	Senior Health Advisor
United Nations Children's Fund	Jenkins, Dr, Alison	Chief, Child Survival and Development
UN Women	Massaquoi, Baindu P.	Programme Specialist
World Health Organization	Forma, Dr. Fatu	Team Lead, Reproductive and Maternal Health
The World Bank, Freetown	Wang, Shiyong	Senior Health Specialist
MSH (USAID SIAPS Project)	Sesay, Murtada Mohammed	Country Progamme Director

5.4 Annex 4: References

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