SIERRA LEONE COUNTRY PROGRAMME EVALUATION

7TH GoSL / UNFPA COUNTRY PROGRAMME 2020 – 2023

FINAL EVALUATION REPORT

JULY 2022

Map of Sierra Leone

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The Evaluation Team hopes that the findings and recommendations presented in this report will positively contribute to building a sound foundation for the development of the 8th UNFPA Sierra Leone Country Programme, national development plans and the United Nations Sustainable Development Cooperation Framework (UNSDCF) in Sierra Leone.

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Abbreviations and Acronyms

A&Y	Adolescents and Youth
ASRH	Adolescent Sexual Reproductive Health
AWPs	Annual Work Plans
BCC	Behavioural Change Communication
CO	Country Office
COVID-19	Corona Virus Disease – 2019
CPD	Country Programme Document
CPE	Country Programme Evaluation
DHIS2	District Health Information Software 2
EQ	Evaluation Questions
ERG	Evaluation Reference Group
FGD	Focus Group Discussion
FP	Family Planning
GBV	Gender Based Violence
GDP	Gross Domestic Product
GE	Gender Equality
GEWE	Gender Equality and Women's Empowerment
GTG	Gender Thematic Group
HCI	Human Capital Index
HCT	Humanitarian Coordination Team
HDI	Human Development Index
HMIS	Health Management Information System
HIV	Human Immuno-Deficiency Virus
HRH	Human Resource for Health
ICPD	International Conference on Population and Development
ICT	Information and Communications Technology
IP	Implementing Partner
IRC	International Rescue Centre
KII	Key Informant Interviews
MTNDP	Medium-Term National Development Plan
MoPED	Ministry of Planning and Economic Development
MPDSR	Maternal and Perinatal Death Surveillance and Response
NGO	Non-governmental Organisation
NMSA	National Medical Supplies Agency
NPP	National Population Policy
ODA	Overseas Development Assistance
OECD/DAC	Organisation for Economic Cooperation and Development
PCA	Programme Coordination and Assistance
PD	Population Dynamics
PHC	National Population and Housing Census
PMT	Programme Management Team
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SIS	Strategic Information System

SLDHS	Sierra Leone Demographic and Health Survey
SLIHS	Sierra Leone Integrated Household Survey
SRH	Sexual and Reproductive health
SRHR	Sexual Reproductive Health and Rights
STI	Sexually Transmitted Infections
TFR	Total Fertility Rate
ToC	Theory of Change
ToR	Terms of Reference
TWG	Technical Working Group
UNAIDS	The Joint United Nations Programme on HIV and AIDS
UNSCDF	United Nations Sustainable Development Cooperation Framework
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Program
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Emergency Children Fund
UNSCDF	United Nations Sustainable Cooperation Development Framework
WB	World Bank
WCARO	West and Central Africa Regional Office
WHO	World Health Organisation
YTT	Youth Thematic Team

Sierra Leone Key Facts

Table 1- Sierra Leone Key Facts

Indicators	Facts (Data Value)	Source/ Year
Land	71,740 km (27,699 sq. miles)	**SLPHC, 2015**
Surface area	71,740 km^2 (27,699 sq mi)	SLPHC, 2015
People		
Population	7,092,113 Projected 7.8 million 110.5people per sq. km	PHC, 2015 World Bank 2020
Population aged below 15 years	40.9 %	SLPHC 2015
Population aged 15 – 24 years	19.%	SLPHC 2015
Population aged 65 years and above	3.5%	SLPHC 2015
Women of reproductive age (15 – 49)	48%	WHO, 2019
Urban population	41. %.	SLPHC, 2015
Rural population	59%	SLPHC, 2015
IDPs	5,300	WB, 2019
Population growth Rate	3.2 %	SLPHC 2015
Health		
Infant mortality rate (deaths per 1'000 live births)	75	SLDHS, 2019
Neonatal mortality rate (deaths per 1'000 live births)	31 %	SLDHS, 2019
Under-5 mortality (deaths by 1'000 live births)	122	SLDHS, 2019
Adolescent fertility rate (per 1'000 women	102	SLDHS, 2019
Contraceptive prevalence rate (% of women aged 15-49)	24.3 %	SLDHS, 2019
Unmet need for contraceptive use	20.8	SLDHS, 2019
Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods	53.1%	SLDHS, 2019
Maternal Mortality ratio (per 100'000 live births)	717	SLDHS, 2019
Life expectancy at birth	Female: 57 years Male: 55years	SWOP Report 2022
Total fertility rate (average number of children per woman)	4.5 %	SLDHS, 2019
Adults aged 15-49 HIV prevalence rate	Women 1.9% vs Men1.2%.	SLDHS, 2019
Proportion of births attended by skilled health personnel	86.9 %.	SLDHS, 2019
Total of Health Expenditure (% of GDP)	8.7 %.	World data Atlas, 2019
Proportion of girls and women aged 15-49 years who have undergone female genital mutilation/cutting	83.0%	SLDHS, 2019
Proportion of women aged 20-24 years who were married or in a union before age 15 and before age 18	a) Before age 15–8.6% b) Before age 18–29.6%	SLDHS, 2019
Government	A Constitutional government	

Type of government	Presidential	
Head of government	President	
Economy	3.87 billion US dollars	WB. 2020,
GDP	3.87 billion US dollars	WB, 2020
GDP annual growth rate	-2.70 %	WB, 2020
Per capita income	624.71 US dollar	WB, 2020
Unemployment rate	4.30%	SSL, 2019
Youth unemployment rate	**8.88%**	ILO, 2019
Multidimensional Poverty Index	**0.375**	SSL,2019
Social and Development Indicators		
Human Development Index rank	0.452 (182 out of 189 countries and territories)	WB, 2019
Literacy rate	43%	WB, 2018
Net enrolment in Primary school	**98.64 %**	WB, 2019
Net enrolment in secondary school	**41.77 %**	WB, 2018
Gender Inequality Index	**0.884**	HDR, 2019
Seats held by women in national parliament	12	WB, 2021
Gender based violence rate	61%	SLDHS 2019
Women experienced GBV (Percentage of ever-married women aged 15-49 who have ever experienced emotional, physical or sexual violence committed by their husband)	62%	SLDHS 2019
Prevalence of teenage marriage (proportion of women aged 15-19 years who were married or in a union)	**50%**	SLDHS, 2019

STRUCTURE OF THE COUNTRY PROGRAMME EVALUATION REPORT

This Country Programme Evaluation Report is structured according to the UNFPA Evaluation Handbook. Chapter One introduces the purpose and objectives of the Country Programme Evaluation, outlines its scope as well as the methodology and processes. Chapter Two, describes the programme implementation context, highlighting the development challenges, in addition to the national strategies, and the role of external assistance. Chapter Three describes the UN and UNFPA strategic response as well as the UNFPA response through the current 7CP and previous 6th CP.

Chapter Four presents the findings of the CPE guided by the evaluation questions under each evaluation criteria of relevance, effectiveness, sustainability, efficiency, coordination, Coverage and Connectedness. In addition, Chapter 4 also highlights the lessons learnt and the Unintended consequences. Chapter Five covers the conclusions to the report presented at both strategic and programmatic levels; and the Lessons learnt. Chapter 6 provides the CPE recommendations and are also presented at strategic and programmatic levels. Prior to the main chapters the report includes acknowledgements, acronyms and abbreviations, the list of tables and figures, a key facts table and an Executive Summary. Finally, the report provides the following annexes: Terms of reference, list of persons/ institutions visited and interviewed, documents reviewed, evaluation matrix, the CPE agenda and stakeholder's map.

EXECUTIVE SUMMARY

Purpose, Scope and intended audience: The Country Programme Evaluation (CPE) serves three **purposes**, namely; to (a) demonstrate accountability to stakeholders on performance in achieving development results and on invested resources, (b) support evidence-based decision-making, and (c) contribute key lessons learned to the existing knowledge based on how to accelerate the implementation of the Programme of Action of the 1994 International Conference on Population and Development (ICPD). The evaluation was commissioned by the UNFPA Sierra Leone Country Office (CO).

The **objectives** of this CPE were to; provide the UNFPA Sierra Leone CO, national stakeholders and rights-holders, the UNFPA West and Central Africa Regional Office (WCARO), UNFPA Headquarters as well as a wider audience with an independent assessment of the UNFPA Sierra Leone 7CP (2020-2023); and broaden the evidence base to inform the design of the next programme cycle.

Specifically, the objectives were, to: (i) Provide an independent assessment of the relevance, effectiveness, efficiency and sustainability of UNFPA support; (ii) Provide an assessment of the geographic and demographic coverage of UNFPA humanitarian assistance and the ability of UNFPA to connect immediate, life-saving support with long-term development objectives; (iii) Provide an assessment of the role played by the UNFPA Sierra Leone CO in the coordination mechanisms of the UNCT with a view to enhancing the United Nations collective contribution to national development and humanitarian results; and (iv) Draw key conclusions from past and current cooperation and provide a set of clear, forward-looking and actionable recommendations for the next programme cycle. The **geographic scope** covered the national level interventions with a specific focus on all the districts covered by the 7CP; the **thematic scope** covered the thematic areas of the 7CP: sexual and reproductive health (SRH); adolescents and youth (A&Y), gender equality and women's empowerment (GEWE), in addition to the cross-cutting issues, such as human rights and disability and transversal functions, such as coordination; monitoring and evaluation (M&E); innovation; resource mobilization; strategic partnerships; and the **temporal scope** covered interventions planned and/or implemented within the time period of the current CP: 2020-2023. The main **audience** and primary intended users of the evaluation were: (i) The UNFPA Sierra Leone CO; (ii) the Government of Sierra Leone; (iii) implementing partners of the UNFPA Sierra Leone CO; (iv) rights-holders involved in UNFPA interventions and the organisations that represent them (in particular women, adolescents and youth); (v) the United Nations Country Team (UNCT); (vi) WCARO; and (vii) development partners. The evaluation results are also of interest to a wider group of stakeholders, including: (i) UNFPA headquarters divisions, branches and offices; (ii) the UNFPA Executive Board; (iii) academia; and (iv) local civil society organisations and international NGOs.

The 7th UNFPA Sierra Leone Country Programme: The UNFPA 7CP was structured around three interlinked output areas and contributed to three outcome areas of the UNFPA Strategic Plan 2018 – 2021, contributing to strengthening policy, strategic and institutional frameworks, capacities and service provision in the thematic areas of SRHR aiming to strengthen the National health system to provide high-quality, integrated sexual and reproductive health and family planning services, including in humanitarian settings and ensure increased abilities of communities especially women and girls to demand sexual reproductive health, family planning and gender-based violence response services; The GEWE component aimed to improve capacities of government, human rights organizations, civil society organizations and communities to promote gender equality, prevent and respond to gender-based violence and other harmful practices, including in humanitarian setting; while the Adolescent and Youth component aimed to ensure that young people, in particular adolescent girls, have the skills and capabilities to make informed choices about their sexual and reproductive health and rights and well-being, including in humanitarian settings

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Methodology: The design of the CPE was guided by the UNFPA Evaluation Handbook on how to conduct a country programme evaluation[1], in addition to the formats of the design and evaluation reports. The CPE was a theory-based non-experimental design using a participatory approach, and guided by a set of nine questions that address the evaluation criteria as in the objectives above. The consultants determined the sample frame from the list of stakeholders, from a stakeholders' mapping by the CO and used a purposive sampling method to select participants for the CPE. The stakeholders' selection process was guided by the thematic areas of engagement with UNFPA. The sampling frame included IPs, partners from government and civil society organisations (CSOs), development and

[1] Evaluation Handbook: How to Design and Conduct a Country Programme Evaluation at UNFPA, 2019

strategic partners and direct and indirect beneficiaries. The CPE adopted mixed methods in data collection, namely; i) document review; ii) remote-based key informant interviews (KIIs) at group and individual levels with the selected stakeholders and CO staff (a total of 49 sessions); and iii) focus group discussions (FDGs) with stakeholders and beneficiaries (three sessions). In addition, triangulating the sources and methods of data collection, the evaluation used both qualitative and quantitative data in the analysis and generation of the evaluation report. The data were collected both virtually and in-person, depending on the stakeholder. Ethics and quality control requirements were adhered to by the consultants and assured by the Evaluation Manager. There were no major challenges encountered during the field phase, and the purpose and objectives of the CPE were fully met with invaluable support from the CO team.

Main Results and Conclusions:

Relevance: The UNFPA Sierra Leone 7CP (2020 – 2023) was developed in consultation with the Government of Sierra Leone, civil society organisations (CSOs) and development partners. It was strategically adapted to the national priorities and population needs, contributing to the Medium-Term National Development Plan (MTNDP) 2019 – 2023, and line ministry strategic foci, directly contributing to their respective objectives around SRH, A&Y and GEWE, thereby making it relevant to the national needs. The CP was aligned to the UNFPA's Strategic Plan (2018 – 2021) contributing to its results 1, 2 and 3, in addition to being aligned to the UNSCDF's Strategic Pillars. Further, the CP was designed to contribute to the SDG Goals 3, 4, 5, 10 and 17 and facilitated achievement of the goals of the ICPD Programme of Action. The 7CP's SRH priorities were also integrated into key Universal Health Coverage (UHC) Policies and Plans, including the National Health Sector Strategic Plan (2021 – 2025) and the National Health Sector M&E Strategy (2021 – 2025), with further plans of developing a framework to mainstream SRH within the UHC roadmap. Further, the 7CP was aligned to the National Youth policy (2020-2025) and strategy and the sectoral GEWE needs in the country including the need to eliminate harmful practices. UNFPA CO was responsive to emerging needs, particularly in response to the COVID-19 pandemic, where UNFPA adapted the 7CP interventions to the COVID-19 context ensuring community and enhanced COVID-19 infection prevention and control (IPC), and contributed to the UNCT COVID-19 socio-economic response plan. There is however an opportunity to strengthen strategic partnerships, particularly with the government, United Nations agencies and donors, during the alignment of the CP to the UNFPA SP (2022 – 2025) and to the development and humanitarian needs in the country to improve efficiency, effectiveness and sustainability.

Effectiveness: The 7CP contributed immensely to the result areas of the targeted thematic areas with the programme contributing to addressing the development and humanitarian needs in the areas of UNFPA's mandate in the county. Under the **SRH** component, UNFPA contributed to strengthening of the national health system to provide high-quality, integrated SRH and FP services, including in humanitarian settings; and increased communities' (especially women and girls) abilities to demand for quality integrated SRH, family planning and gender-based violence response services. UNFPA contributed to strengthening the national health capacities through supporting capacity and institutional system strengthening to enhance provision of SRH services, including FP, post-abortion care (within the context of EmONC), outreaches in the hard-to-reach areas, antenatal care (ANC), postnatal care (PNC), early detection of cervical cancer, prevention of HIV//STIs, and enhanced access to skilled birth attendance. Further, UNFPA contributed to addressing the unmet need of FP through supporting the Government in the procurement and distribution of RH commodities to the health facilities ensuring that no stock-outs were experienced, with nearly all (96 percent) of the health facilities experiencing no stock-outs of at least three contraceptive methods in three months prior to the reports. UNFPA also facilitated enhanced demand for SRH, FP and GBV response, especially among adolescent and young people and supporting communities on awareness raising and access to SRH, FP and GBV response services, in addition to strengthening integration approaches. There were however concerns on access to SRH services by adolescent girls as there were still social norms and practices that hindered their access to the services.

Through the 7CP, UNFPA technically and financially supported the **Adolescents and Youth** aspects, effectively contributing to increased knowledge, skills and capacities among the young people, particularly adolescent girls to make informed choices about their SRHR and well-being, including in humanitarian settings.

UNFPA enhanced participation of adolescents and youth in peacebuilding and in strengthening social cohesion, enhanced their empowerment and their involvement in decision-making. The results of the CPE indicated that the programme immensely contributed to enhancing the capacities of the adolescents and young people, particularly marginalised girls to express themselves and access rights effectively. The results under this component were achieved, utilizing different strategies where UNFPA contributed to strengthening the policy framework for the adolescent and young people, development of in and out of school CSE curriculum incorporating adolescent sexual and reproductive health (ASRH) and GBV, strengthening the skills of the marginalized and vulnerable girls, advocacy against harmful practices, including child marriage and female genital mutilation, and strengthening the capacities of

national institutions to develop strategies. However, there are still deeply-rooted social norms and economic factors that influence the existence of the harmful practices, some of which, like FGM, still remains too sensitive and emotive to address.

Under the **GEWE component**, the results show that UNFPA Sierra Leone is well positioned as a strategic partner on the mainstreaming of gender in the country. During the period, UNFPA played a key role in the development and formulation of policies and strategies further enhancing protection systems for the people affected by GBV and harmful practices. These included the development of GEWE policy, national policy on radical inclusion in schools and national male involvement strategy for the prevention of GBV. Further, the 7CP ensured financial and technical support to line ministries and CSOs focusing on institutional strengthening and enhancing community engagement in ensuring prevention of GBV and the elimination of harmful practices and promotion of women's empowerment. Advocacy activities were however affected by the COVID-19 pandemic slowing down the training of stakeholders. UNFPA and UNICEF are engaged in the development of GBV Information Management System (GBV IMS) for evidence-based programme and streamlining response. Further, UNFPA enhanced access to PSS, legal counselling and referral to immediate health services for the people in need through the rollout of free-toll hotline service available to the general population. There was however a need to enhance the capacity of the line ministries to ensure mainstreaming of gender.

Under **Efficiency**, the CO ensured efficient use of human, financial, administrative and technical resources to deliver the 7CP. The CO largely had adequate and skilled staff in the programme areas. UNFPA put in place mechanisms to ensure efficient use of resources, in addition to availability of guidelines to enable the facilitation of procurement and financial activities. The average rate of funds utilisation was at 86%. UNFPA nurtured different partnerships and technical assistance, which facilitated implementation of the programme to ensure efficiency, and the delivery of optimal results and geographic coverage. The strategic partnership with the government, the UN and Development Partners ensured a favourable implementation framework, leveraged synergies and funding opportunities for the CO. The partnership with the implementing partners, most of which were local NGOs, facilitated a wide geographical coverage, thus reaching marginalised and hard-to-reach populations. The monitoring and evaluation system was fairly robust, with clear processes and activities embedded in the programme management and delivery. The intervention logic however needs to be strengthened to ensure results-focused.

There is potential of ensuring **sustainability** of the 7CP results through the scaling up of engagements with stakeholders and strategic development partners in addition to building national capacities and influencing policy development and utilisation. The institutional capacity coupled with guidelines, SOPs, tools and infrastructure development will enhance quality service delivery. UNFPA invested in strengthening existing partnerships with local actors and in establishing linkages and providing capacity building to sustain their ability to offer services beyond the 7CP. On individual capacity building, trained healthcare workers, peer-to-peer networks and volunteers through the youth programmes and girls in safe spaces ensured knowledge and skills transfer to implement community and outreach activities. Inadequate resource and commitment of some national entities in the implementation of the policies, guidelines and financing them is low and require strengthening. Further contextual challenges, in addition to socio-cultural beliefs can affect the gains made during the 7CP.

The period saw the CO utilise its comparative advantage within the UNCT to facilitate functioning of **coordination** mechanisms among the United Nations agencies. UNFPA was particularly active in the PMT, GTG, YTT, DIG and OMT, ensuring commitment to collaborative activities and joint programmes with fellow UN agencies thus enhancing programme delivery processes. Participation in joint programme activities contributed to the achievement of the UNSCDF results through coordination, accountability and capacity building. Inadequate coordination mechanisms among the United Nations health agencies, in addition to inability of the MoHS to engage the development partners with clear strategies affected coordination and delivery as one principle.

The 7CP saw the CO contribute to addressing the needs of the vulnerable populations through partnerships, capacity building, integration, standardisation of response, coordination and leveraging resources, and service mapping across the country. Through IP (Government and non-governmental) the 7CP expanded its reach and responded to all the humanitarian situations arising during the period, particularly the COVID-19 pandemic support which enhanced coverage. On the other hand, the CO ensured **connectedness** through strengthening capacities of actors, development of strategies, guidelines and policies to guide implementation, coordination and promoting integration of programmes and national ownership in the implementation processes, in addition to supporting development of preparedness plans.

Main Recommendations

Strategic

1. Strengthen alignment of the CP to the new UNFPA SP (2022 – 2025) and to the country's development and humanitarian priorities, while maintaining strategic partnerships with government institutions and non-state actors to position its presence and leadership in ensuring its strategic relevance
2. Maintain its proactive role in facilitating UNCT coordination, explore further opportunities for collaboration and joint programming, and advocate for delivery as one modality
3. Strengthen intervention logic ensuring that the results areas are clearly linked to the key interventions supported through the CP, in addition to integrating learning and knowledge management
4. The CO should work closely with the Implementing partners to address the challenges that result in the delays in the disbursement of funds and reporting. Further, the CO should reassess its institutional capacity, guided by the strategic positioning in the country, identify gaps, especially on human resources and implement the findings to effectively deliver on its mandate
5. Continue enhancing the institutional capacity and system strengthening of the government and promotion of national ownership of the CP interventions and results
6. The CO should ensure that adequate resources are allocated for data and evidence-generation for national development, as well as strengthen its comparative advantage in the area of population dynamics within the UNCT

Programmatic Recommendations

7. The CO should strengthen integration of the SRH, FP, HIV, Cervical Cancer, and GBV programming, as well as improving monitoring and supervision for quality of care in service delivery
8. Advocate with the MoHS to strengthen MPDSR to contribute to the reduction of future preventable maternal deaths and to enhance the technical capacity in the management of obstetric fistula
9. The CO to advocate with the government to increase domestic financing of RH commodity procurement, and further strengthen the government and local stakeholders' technical capacity on the implementation and management of the RHCS supply chain strategy to ensure effectiveness and sustainability.
10. Nurture strategic partnerships with the Government and other stakeholders for the effective implementation of the CSE in schools.
11. Strengthen the consolidation of youth programming and coordination in the country while at the same time continuing to build the capacity of the youth on leadership skills and ability to influence policy and strategy
12. The CO should systematically advocate for changes in legal frameworks and social norms that are barriers to addressing GBV and harmful practices

CHAPTER ONE: INTRODUCTION

1.1 Purpose and Objectives of the CPE

The purposes of the CPE were to (a) demonstrate accountability to stakeholders on performance in achieving development results and on invested resources, (b) support evidence-based decision-making, and (c) contribute key lessons learned to the existing knowledge based on how to accelerate the implementation of the Programme of Action of the 1994 International Conference on Population and Development (ICPD).

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The **objectives** of this CPE were to; provide the UNFPA Sierra Leone CO, national stakeholders and rights-holders, the UNFPA West and Central Africa Regional Office (WCARO), UNFPA Headquarters as well as a wider audience with an independent assessment of the UNFPA Sierra Leone 7CP (2020-2023); and broaden the evidence base to inform the design of the next programme cycle.

Specifically, the objectives of this CPE were to:

i. Provide an independent assessment of the relevance, effectiveness, efficiency and sustainability of UNFPA support;
ii. Provide an assessment of the geographic and demographic coverage of UNFPA humanitarian assistance and the ability of UNFPA to connect immediate, life-saving support with long-term development objectives;
iii. Provide an assessment of the role played by the UNFPA Sierra Leone CO in the coordination mechanisms of the UNCT, with a view to enhancing the United Nations collective contribution to national development results. In addition, to provide an assessment of the role of the UNFPA Sierra Leone CO in the coordination mechanisms of the HCT, with a view to improving humanitarian response and ensuring contribution to longer-term recovery.
iv. Draw key conclusions from past and current cooperation and provide a set of clear, forward-looking and actionable recommendations for the next programme cycle.

1.2 Scope of the evaluation

- **Geographic Scope:** The evaluation covered the national level interventions with a sharp focus on districts where UNFPA interventions are implemented: Western Urban and Rural Districts, including, health facilities in Freetown, Regent, Jui. The coverage also included Kambia, Koinadugu, Pujehun, Bo, Bombali-Makeni and Tonkolili-Masanga.
- **Thematic Scope:** The evaluation covered the following thematic areas of the 7CP: sexual and reproductive health; adolescents and youth, gender equality and women's empowerment. In addition, the evaluation covered cross-cutting issues, such as human rights and disability and transversal functions, such as coordination; monitoring and evaluation (M&E); innovation; resource mobilization; strategic partnerships.
- **Temporal Scope:** The evaluation covered interventions planned and/or implemented within the time period of the current CP: 2020- July 2022

The main audience and primary intended users of the evaluation results were: (i) The UNFPA Sierra Leone CO; (ii) the Government of Sierra Leone; (iii) implementing partners of the UNFPA Sierra Leone CO; (iv) rights-holders involved in UNFPA interventions and the beneficiaries (in particular women, adolescents and youth); (v) the United Nations Country Team (UNCT); (vi) WCARO; and (vii) development Partners. The evaluation results are also of interest to a wider group of stakeholders, including: (i) UNFPA headquarters divisions, branches and offices; (ii) the UNFPA Executive Board; (iii) academia; and (iv) local civil society organisations and international NGOs.

1.3 Methodology and Process

As guided by the UNFPA Evaluation Handbook, the CPE assessed the contribution of the 7CP in Sierra Leone through looking into the respective strategic gaps in the national plans and the contribution to the country alignment to the international frameworks. In this respect, during the assessment of the CP along the evaluation questions, the Evaluation team analysed the extent to which the CP contributed in addressing the development challenges along the component areas, including the SRHR, adolescent and youth, GEWE and P and D. These entailed identifying the existing gaps and analysing how the CP filled the gaps and contributed to influencing the changes taking place in the respective thematic areas in the country. On the other hand, the CPE assessed the respective contribution of the CP to the UNFPA Strategic Plan (SP). Further, the CPE also looked into the CP's contribution to the UNSDCF, related SDGs and other international frameworks, including the ICPD programme of action. In order to ensure a clear understanding of the CP's influence to the changes in the country emanating from the implementation of the

interventions, the Evaluation team utilized a theory-based approach through assessing the CP's theory of change (ToC). In this case, the assessment was guided by questions establishing how the programme made contribution to the observed results, how it influenced the changes, in addition to assessing the reliability of the existing evidence. This entailed conceptualizing the programme across the results chain, building on its logic, along the existing risks and assumptions. Assessing the theory of change also entailed considering the other existing factors influencing the changes within the implementation context.

1.3.1 Evaluation questions

The CPE was informed by the UNFPA Evaluation Handbook "*How to design and conduct a CPE at UNFPA*" and assessed based on the four Organisation for Economic Cooperation and Development's, Development Assistance Committee (OECD/DAC) criteria, namely; Relevance, Effectiveness, Efficiency and Sustainability[2]. In addition, the CPE also assessed the extent to which UNFPA contributed to the coordination mechanism within the UNCT and the humanitarian coordination mechanisms of the humanitarian coordination team (HCT). Due to the country programme support to the humanitarian activities in the country, the evaluation also examined to what extent UNFPA was able to provide life-saving services to the affected population groups (coverage) and how well UNFPA support gave consideration to longer-term solutions during implementation of emergency interventions by examining the criteria of connectedness[3].
Under each evaluation criteria, there were 12 suggested evaluation questions (EQs) for assessment, as per the ToR. In compliance with the UNFPA Evaluation Handbook, the consultants, in consultation with the CO reviewed and reduced the evaluation questions to nine, ensuring that all the important details in the ToR were captured in the design. The Table below states the final list of evaluation questions that guided the CPE.

Table 2 List of the Final Evaluation Questions used in the CPE

Relevance (EQ1): To what extent is the country programme adapted to: (i) the needs of diverse populations, including the needs of vulnerable and marginalized groups (e.g. pregnant women, young people and women with disabilities, etc.); (ii) national development strategies and policies; (iii) the strategic direction and objectives of UNFPA; and (iv) priorities articulated in international frameworks and agreements, in particular the ICPD Programme of Action and the SDGs, (v) the New Way of Working? **Relevance (EQ2):** To what extent has the country office been able to respond to changes in national needs and priorities, including those of vulnerable or marginalized groups, and those imposed by the socio-economic impacts of COVID-19?
Effectiveness (EQ3): To what extent have the interventions supported by UNFPA delivered outputs and contributed to the achievement of the outcomes of the country programme? In particular: (i) increased access and use of integrated sexual and reproductive health services; (ii) empowerment of adolescents and youth to access sexual and reproductive health services and exercise their sexual and reproductive rights, (iii)advancement of gender equality and the empowerment fall women and girls; (iv) increased use of population data in the development of evidence-based national development plans, policies and programmes? **Effectiveness EQ4:** To what extent has UNFPA successfully integrated human rights, gender perspectives and disability inclusion in the design, implementation and monitoring of the country programme?
Efficiency (EQ5): To what extent has UNFPA made good use of its human, financial and administrative resources, and used a set of appropriate policies, procedures and tools to pursue the achievement of the outcomes defined in the county programme, ensuring quality assurance, risk mitigation and accountability of resources?
Sustainability (EQ6): To what extent has UNFPA been able to support its partners and the beneficiaries (women, adolescents and youth) in developing capacities and establishing mechanisms to ensure ownership and the durability of effects as well as established and maintained different types of partnerships across programme components during CP implementation?

[2] The OECD/DAC Criteria for International Development Evaluations https://www.oecd.org/dac/evaluation/49756382.pdf
[3] See The UNFPA Sierra Leone 7th Country Programme Evaluation Terms of Reference.

Coordination (EQ7): To what extent has UNFPA contributed to the functioning and consolidation of the coordination mechanisms of the UNCT and to the technical results groups, including the COVID-19 socio-economic response plan?
Coverage (EQ8): To what extent has the UNFPA humanitarian response reached those most in need and vulnerable in crisis situations both geographically and demographically (young people and women with disabilities; those of racial, LGBTQ populations, etc.)?
Connectedness (EQ9): To what extent has UNFPA contributed to developing the capacity of local and national stakeholders (state institutions/line ministries, youth and women organisations, health facilities, communities and civil society organisations) to better prepare, respond, build back better and recover from humanitarian crises?

Based on the finalised EQs, the team developed the evaluation matrix which guided the assessment and the causal assumptions on the extent to which the CP performed in the respective evaluation criteria. This is in Annex 2 of the report.

1.3.2 Methods for data collection and analysis

The evaluation primarily used qualitative methods for data collection, including document review, interviews, and focus group discussions. The qualitative data has been complemented with quantitative data to minimise biases. Quantitative data was compiled through desk review of programme documents including reports, websites and online databases, to obtain relevant data on key CP indicators as stated in the results framework that measure change at output and outcome levels. The financial data has also been accessed for analysis to determine the levels of performance by expenditure vis-à-vis the budget. The use of mixed methods in generating data for the evaluation was in line with the design, and enabled use of multiple sources of data to triangulate information before making conclusions on the gathered opinion.

The Evaluation Matrix (Annex **2**) adapted to the country programme implementation context provided the framework of the evaluation and was key for the data collection and analysis. The Evaluation Matrix details what was evaluated, taking into consideration the evaluation criteria, evaluation questions and related assumptions assessed, defining the indicators. It also shows how the evaluation was done, eliciting the sources of information and data collection methods required to answer the evaluation questions. After data collection, the Evaluation Matrix provided the foundation for drafting the findings for each evaluation question and for drawing conclusions and formulating recommendations that cut across different evaluation questions.

The evaluation methods used both quantitative and qualitative methods for data collection. The **data collection methods** were designed around the evaluation questions, related assumptions and indicators proposed in the Evaluation Matrix and taking into account the limitations arising during data collection. To ensure an effective and feasible way to collect the data and information required to fully answer the evaluation questions presented in the report, the following data collection techniques were used for this evaluation, including the rationale:

Document Review: This entailed, but not limited to review of programme-related documents and analysis of their content to elicit the CP design, implementation and management, and monitoring and evaluation. The consultants conducted the initial review of programme documents to inform the design report of the CPE and this continued during the evaluation, enriching the quality and content of the report. Over the course of the evaluation, the evaluation team identified and obtained other key documents with the support of the UNFPA Sierra Leone CO, in addition to related documents by other stakeholders to inform the evaluation process. Documentary evidence was a major part of this evaluation providing evidence complementing the information accessed from the primary sources. Further, the quantitative performance of the programme as defined by the CPD Results Framework were informed by documentary evidence in the various reports provided by the UNFPA Sierra Leone CO and relevant documents reviewed (Annex 3). The reviewed documents have been referenced as appropriate in the report, to provide evidence-based feedback on the programme performance.

Key Informant Interviews (KII): This entailed conducting interviews with individuals or groups as key informants from a range of stakeholders identified in the stakeholders' map. This technique was useful in getting feedback and inputs from the processes and results of the Country Programme for those who interacted with the programme both at field and policy levels based on the objectives of the CPE. The respondents included key stakeholders of the Country programme, including development and strategic partners[4]. Those reached included UNFPA Sierra Leone CO staff, officials from the government line ministries, representatives of UN agencies, and national and international NGOs

[4] The Strategic partners are those implementing similar programmes as UNFPA and were contacted for their relevance in the framework of implementation

as implementing partners, among others. Group interviews[5] were also conducted with key informants to collect key information on progress towards the intended outputs and outcomes of the Country Programme. The evaluation team prepared interview guides for KIIs with stakeholders (UNFPA staff, government counterparts, development partners other UN agencies, and national and international implementing partners) in the various thematic areas of programming.

Focus group discussion (FGD) - The FGDs gathered information among primary programme beneficiaries, including those benefiting from UNFPA capacity building interventions in the period of coverage. These included government staff like the health workers, among other ministry staff who directly benefited from the UNFPA CP support, midwifery trainees, adolescent and youth, and community level beneficiaries like volunteers, women and girls supported by UNFPA CP in the safe spaces. The discussion guides were designed thematically to gather information regarding the extent to which the programme achieved its intended results, in addition to establishing some of the emerging needs or unintended results. This technique was used based on its advantage of collecting data quickly and effectively from a large number of programme beneficiaries. It also has the ability to provide further insights into data obtained from other categories of respondents. In order to enrich the data on the performance of the programme, the evaluators used purposive sampling selecting participants in the FGDs, in addition to ensuring that specific performance issues are captured as guided by the evaluation questions. This would be to ensure balanced representation of respondents from all the different socio-economic backgrounds. While each FGD aimed to compose of at least 8-10 participants ensuring balance in terms of gender and focus area, the evaluation team is cognizant of the limitations posed by COVID-19 control-restrictions on large gatherings.

Site Visits: Based on the results of the documents reviewed and consultations with the UNFPA Sierra Leone CO, and situation, the evaluation team conducted site visits in Bo, Kenema, Koinadugu and Bombali districts (Makeni) for data collection in order to enrich the evidence base for this CPE.

Field organisation

Organisation of field data collection is dependent on proper planning between UNFPA and the evaluation team. The M&E Analyst facilitated access to and scheduling interview sessions with the targeted respondents. As most of the programme themes were integrated, most of the sessions were conducted by at least two of the evaluation team members to ensure capturing of the related issues of evaluation cross-cutting in the programme themes.

Data Validation and Analysis

The analysis and validation of the data was based on a synthesis and triangulation of information and data obtained through the different methods from various sources. Content analysis was employed to analyse documentary evidence as well as qualitative data (obtained through interviews and focus groups discussions) generating themes and concepts relevant to the different evaluation questions, related assumptions and indicators in the Evaluation Matrix. MS Excel has been used to analyse the financial data generating graphs and tables to present the findings. As the data collected for this evaluation was primarily of qualitative nature, it constituted the main technique used for data analysis. Data collected from multiple sources were triangulated to support and validate the evaluation findings. Additionally, the validation of data was sought through regular exchanges with the CO programme staff; technical officers at national and field levels and the Evaluation Manager. Further, following the submission of the first draft of the report, the evaluation team met with the CP staff and streamlined the preliminary findings.

In addition, descriptive statistics have been used to describe or summarise key characteristics of quantitative data obtained from secondary sources. The extent to which descriptive statistics have been conducted depended on the availability of quantitative data and the quality, reliability, timeliness and comparability of this data. The descriptive statistics, averages, have majorly been on the financial implementation rates, while at the same time report on the indicators in the results framework. As per the design, data analysis was a continuous process during the first three evaluation phases of design, field and reporting. While the documentary review during design provided a critical look at the programme and its implementation processes, during the field phase the consultants held consultations periodically on the key findings providing insights into the performance of the programme. Further, the validation of data was sought through regular exchanges with the UNFPA Staff and stakeholders.

1.3.3 Selection of the sample of stakeholders

The evaluators adopted a participatory approach in selecting the stakeholders to participate in the evaluation as respondents. Based on the initial stakeholders' map provided by the UNFPA Sierra Leone CO and a review of Atlas project and relevant programme documents provided by the CO in preparation for the design report, and the initial discussion with the UNFPA thematic component teams, the evaluators selected stakeholders to participate in the CPE. The stakeholders map identified stakeholders who were involved in the design, implementation and monitoring of the

[5] Groups interviews were conducted in situations where various contributions from members of an office or entity collected during an interview session, for example sessions with the CO thematic members included more than one person during the interviews.

7th Country Programme (2020-2023), and those partners who did not work directly with UNFPA, yet played a key role in a relevant thematic area of programming or specific outcome area of the Country Programme. The stakeholders map constituted the sampling frame for KIIs and FGDs. Further, in consultation with the UNFPA Sierra Leone CO staff, complementary document review was conducted to finalize the list of stakeholders for KIIs, and group interviews, where applicable.

The evaluation focused on major categories of stakeholders across the thematic areas of programming or outcomes areas of the 7CP. As per the scope of the CPE, the consultants identified respondents from all the geographical areas the programme covered. This also determined the selection of the respondents, especially based on geographical coverage in the country, at both national and sub-national levels. Specific interventions in various locations, like youth activities, safe spaces or safe GBV houses were selected in consultation with the team on the ground. Further, the consultants also ensured as much as possible inclusion of various beneficiary groups e.g. those from marginalised groups, including people living with disability, women, girls and boys. Analysis of UNFPA CP documents identified and clustered evaluation main stakeholders into the following groups:

- **UNFPA Sierra Leone CO staff:** Senior management of the UNFPA Sierra Leone CO; technical specialists and associates in the thematic areas of programming of the CP; and staff of operations and cross-cutting units, in the main office in Freetown.
- **Government counterparts:** Officials of relevant line ministries and institutions (Ministries: Health and Sanitation, Basic and Senior Secondary Education, Gender and Children's Affairs, Youth Affairs, Social Welfare, among others) and other government institutions in the supported districts, as appropriate.
- **Implementing partners:** Staff of non-governmental organisations in their respective areas of coverage
- **Direct beneficiaries:** These include the direct beneficiaries, be it through capacity building and development or service delivery support, including health workers, adolescents and youth, health facility staff, planning and economic development and the national statistics office trainees, education staff, midwives and trainees, among others.
- **Indirect beneficiaries**: Women of reproductive age, adolescents and youth in communities at programme implementation sites of UNFPA and its implementing partners, including clients of reproductive and maternal health, as well as family planning services; adolescents and youth participating in youth-led programmes and various activities and capacity building workshops at youth centres; religious leaders, among other indirect beneficiaries.
- **Donors:** Representatives of bilateral donor agencies funding interventions implemented by UNFPA and/or implementing projects in thematic areas of programming of UNFPA and geographic areas where UNFPA and its implementing partners operate.
- **United Nations agencies**: The United Nations Resident Coordinator's Office and representatives of relevant United Nations agencies, as agreed upon with the CO team; including members of system-wide development and humanitarian coordination mechanisms (GBV sub-cluster and SRH working group), where possible.

As stated earlier, purposive sampling technique was used to select key informants for KIIs and group interviews from the final stakeholders' map. Selection of stakeholders for KIIs and group interviews has been made premised on the following selection criteria:

- All types of main stakeholders for each output/outcome of the Country Programme - i.e., UNFPA Sierra Leone CO staff, Government counterparts, other implementing partners, direct and indirect beneficiaries, development partners and other United Nations agencies.
- For each output/outcome, stakeholders that are associated with on-going activities as well as with activities (AWPs) that have already been completed.
- Stakeholders operating and/or located in the various geographic areas of the country where UNFPA and its implementing partners provide support.
- Stakeholders involved in activities with both national execution modality and direct execution modality.

Table 3 Summary of Interviews and FGD Sessions Conducted by Respondent Group

Respondent Groups	KII and FGD Sessions conducted
Government	16
CSOs (IPs)	10
UNFPA	9
UN Agencies	8
Donor	3
Beneficiaries	3
Academia	1

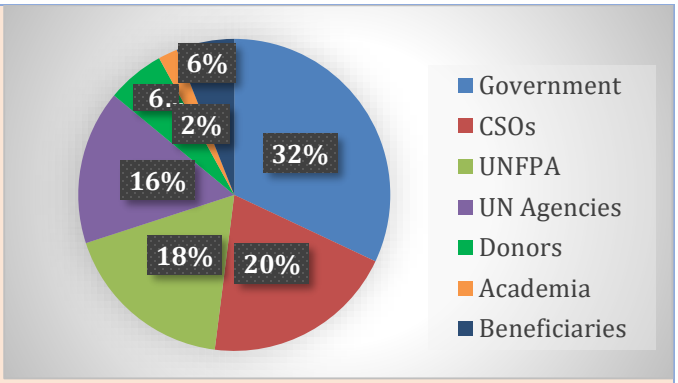

Figure 1 Distribution of CPE Respondent Groups

Ethical Guidelines

The evaluators took into account ethical considerations when collecting information, adhering to the United Nations Evaluation Group (UNEG) Code of Conduct and Ethical Guidelines for Evaluations[6]. The evaluation adopted a people-centred approach by emphasising respect for human rights, accountability, impartiality, gender-responsiveness and transparency. Prior to data collection, the evaluators got familiar with cultural and religious sensitivities existing in Sierra Leone, and clearly understood the harmful gender practices on women and girls, among others; to ensure no harm was done to the informants as they participated in the evaluation. Every interview and discussion session began with the evaluators seeking consent from the informants and providing them with assurance that all the discussions and information shared were treated confidentially. Privacy was upheld and anonymity ensured in analysing the responses. The informants and discussants were informed that their participation in this evaluation is voluntary and that they were free to stop the interview and discussions at any moment. The evaluators ensured that gender perspectives were taken into consideration when conducting particular on-site observations, where possible, and that gender equity was ensured in FGDs to gather views and opinions about different experiences of men and women and boys and girls.

1.3.4 Limitations and mitigation measures

- The evaluation team heavily relied on information and documents shared by the UNFPA Sierra Leone CO to define the sampling frame from which key informants and locations were selected. In addition, the purposive sampling technique used to select key informants and locations is prone to selection bias due to its non-random nature. To prevent bias, the evaluation team conducted a thorough review of Atlas data and collected additional documents to establish a comprehensive stakeholders map. Moreover, snowball sampling was used in KIIs to ensure that stakeholders which may have been overlooked in the stakeholder mapping were also consulted. At the same time, the evaluation team minimized bias in selecting key informants and locations by defining clear selection criteria that were made transparent in this design report. Further, to avoid the possibility of bias from the presence of UNFPA staff, all KIIs, group discussions and FGDs were conducted by the evaluation team in private, without any UNFPA staff being present, and multiple sources of data were used to triangulate opinions or feedback provided by the informants.
- This CPE was based primarily on qualitative data collected from Government counterparts and implementing partners, with fewer indirect beneficiaries, especially youth, rather than most of them, who are also the intended beneficiaries of the services delivered through the UNFPA support. The evaluation assessed the achievement of the CP outputs and the likelihood of results on the outcome level as articulated in the Country Programme Results Framework. While the evaluation was able to provide some useful illustrations of changes at the beneficiary level and to study the causal mechanisms behind the changes observed, it was not possible to generalize the findings as the sample of beneficiaries included were not statistically representative of the entire population of UNFPA beneficiaries. To address these limitations, the evaluation triangulated primary qualitative data across multiple sources and cross-checked this information with secondary quantitative data, using existing data sets from other documentations including national surveys and/or from surveys, relevant publications and thematic evaluations that were carried out by development and humanitarian partners. In addition, the evaluation team cross-checked

[6] UNEG Ethical Guidelines provide for the ethical principles of evaluation as intentionality of evaluation, obligations of evaluators, obligations to participants, and evaluation process and product (Accessed from http://www.unevaluation.org/document/detail/102).

evaluation findings with the CO and component leads to analyse underlying reasons for successes or potential lack of it for lessons learned and to inform future programmes. Most importantly, the evaluation findings have reported on UNFPA programme stakeholders' feedback as trends and potentiality rather than changes in numerical values, which can be attributed solely to the programme interventions.

- Language barrier: Since the CPE was led by an international consultant who was not conversant with the local languages spoken by the local population, the language barrier during the field sessions were experienced to a little extent during sessions with FGD participants, and this was mitigated by having the national evaluators to facilitate the sessions in the local language.

1.4 Evaluation Process

The overall evaluation process involved five phases: (i) preparation; (ii) design; (iii) field; (iv) analysis and reporting; and (v) facilitation of use and dissemination phase, as summarised in the table below.

Table 4- Evaluation Process

Phase	Main Activity /Expected Deliverable
Preparatory (Done by the CO)	● Drafting and approval of the ToR ● Hiring of Consultants ● Establishment and orientation of the Evaluation Reference Group (ERG) ● Inform key stakeholders about the evaluation ● Compile Initial list of documentation\Stakeholder mapping and list of Atlas Projects.
Design (Done majorly by the Evaluation Team)	● Evaluation kick-off meeting between the Evaluation Manager and the evaluation team. ● Documentary review ● Stakeholder mapping ● Analysis and reconstructing the intervention logic (theory of change) of the programme ● Finalisation of the list of evaluation questions; and preparation of Evaluation Matrix; ● Developing data collection, sampling, and analysis strategy ● Specifying limitations and risks in conducting the evaluation and plan mitigation strategies to overcome these limitations and risks ● Development of the CPE work plan for the field phase. ● Drafting of the Design Report ● Presentation of the draft Design Report to the ERG and inclusion of its feedback ● Submission and approval of the Design Report
Field (Evaluation Team, with support from the CO)	● Meeting with the UNFPA Sierra Leone CO staff to launch the data collection. ● Meeting of evaluation team members with relevant programme officers at the UNFPA Sierra Leone CO. ● Data collection at national and sub-national levels. ● Debriefing meeting on preliminary findings, conclusions and recommendations to UNFPA CO, IPs and ERG
Reporting (Evaluation Team, with support from the CO)	● Comprehensive data analysis, integrating comments provided during the debriefing with UNFPA CO and ERG ● Development and submission of first draft of the CPE Report for review by the UNFPA CO and ERG ● Preparation of Second Draft CPE Report based on review comments of UNFPA CO and the ERG ● Submission of the Second Draft CPE Report for review ● Evaluation Quality Assurance ● Validation Workshop ● Production of Final CPE Report ● Approval of the CPE Report ● Development of an Evaluation Brief
Dissemination and Use (UNFPA)	Management response to the CPE recommendations Development of the dissemination strategy Dissemination of the CPE Findings and lessons learnt

CHAPTER 2: COUNTRY CONTEXT

2.1 Development Challenges and National Strategies

2.1.1 Political, Economic and Social Context

The 2015 census estimates the population of Sierra Leone at 7.1 million (49.2 per cent male and 50.8 per cent female) with a growth rate of 3.2 per cent per annum (2015). Sierra Leone's population is young, with around 40.9 percent below the age of 14; and 57.06 percent is between age 15-64 and 2.94 percent being above 64 years[7]. With an increase of 0.025 as referenced in the UN HDR 2022, Sierra Leone's Human Development Index (HDI) has shown a marginal improvement. With a 2021 HDI score of 0.477, Sierra Leone remains ranked 181 out of 195 nations and territories in the poor human development category. While the Gross National Income (GNI) per capita declined by 2.8%, both the life expectancy at birth and the average number of years spent in education grew by 5.4 and 0.9 years, respectively. The country's income poverty stands at 56.8 percent, rural 73.9 percent, compared to 34.8 percent for urban settlement. Multidimensional poverty measures 64.8 percent at national level; rural 86.3 percent, compared with 37.6 percent for the urban sector. Female multidimensional poverty at 65.9 percent compares well with male multidimensional poverty at 64.2 percent[8].

The weaknesses in the fundamentals of the national economy were exacerbated by the impact of the COVID-19 pandemic and the Ukraine crisis, both of which have worsened the less-than-ideal trends in per capita income, consumer price inflation, foreign direct investment and the debt-to-GDP ratio. The country's ability to maintain peace and move forward despite facing socio economic-challenges places it on a trajectory for the successful implementation of key development policies and public service delivery. It has successfully conducted five general elections that saw peaceful transfers of power from one political party to another, thus sustaining these democratic credentials in a region that continues to face political and security upheavals.

The United Nations in Sierra Leone has been a strategic medium through which international development practices are translated into national, sectoral and local development plans in the country. This has been enabled through enhanced development cooperation between the Government of Sierra Leone and the UN System. Successive national development plans have been strongly aligned to international development frameworks, such as SDGs, the CEDAW, the ICPD PoA, the Sendai framework etc. The core instrument through which the United Nations System articulates its collective role in achieving national development results, has been strongly aligned to the national development plans. UNFPA supported the Government of Sierra Leone to develop and implement the National Population Policy since 2019, within the country's Medium-Term Development Plan (MTNDP) 2019-2023. The country is also a party to the International Conference on Population and Development (ICPD), with national commitments renewed during the 25th anniversary of the ICPD in 2019.

2.1.2 Sexual and Reproductive Health

The Life time risk of dying of pregnancy in Sierra Leone is 1:17. UNFPA has been providing technical and financial support to the MoHS and non-governmental organisations (NGOs) such as Doctors with Africa (CUAMM), Aberdeen Women's Centre, Haikal, Planned Parenthood Sierra Leone Association Limited (PPSAL) and Capacare to implement interventions to prevent maternal deaths, manage childbirth complications and ensure accountability for every death that occurred, whilst implementing corrective measures to prevent recurrence through the Maternal and Perinatal Death Surveillance and Response Framework. This helped in the reduction of maternal deaths. UNFPA was very instrumental in supporting the Ministry of Health and Sanitation (MoHS) in strengthening Emergency Obstetric and Newborn Care (EmONC) and increasing the number of skilled attendants at births to save the lives of mothers and newborns.[9] There has been a steady decline in the total fertility rate (TFR) over time, from 5.1 children per woman in 2008 to 4.9 in 2013 and 4.2 in 2019. There has been a similar decline among women in rural areas (from 5.8 to 5.7 and 5.1, respectively) and urban areas (from 3.8 to 3.5 and 3.1) during the same period (Figure 5.1). In the last three SLDHS surveys (2008, 2013, and 2019), the age-specific fertility rate has been highest among women aged 20- 29 (Figure 5.2).

According to the 2013 Demographic and Health Survey, in Sierra Leone: 12.5% of women aged 20–24 years were married before the age of 15 years and 38.9% of 20-24-year-olds were married before the age of 18 years[10] whereas

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[7] https://countryeconomy.com/demography/population-structure/sierra-leone

[8] See Sierra Leone Multidimensional Poverty Index Report 2019, Ministry of Planning and Economic Development, Freetown.

[9] UNFPA Report on Maternal health, https://sierraleone.unfpa.org/en/topics/maternal-health-10

[10] National strategy for the reduction of adolescent pregnancy and child marriage 2018-2022, https://sierraleone.unfpa.org/sites/default/files/pubpdf/National%20Strategy%20for%20the%20reduction%20of%20Adolescent%20Pregnancy_final_Oct%202.pdf

the 2019 SLDHS found that the number has dropped from 38.9% in 2013 to **29.6% in 2019** which means there has been some progress in the strategy in the fight against child marriage.

However, there have been also major challenges around infrastructure. Some health facilities in Sierra Leone may require major infrastructure. The general service readiness index (a composite measure of the overall capacity of health facilities to provide the essential package of health services), is only 56 percent. Sierra Leone has an average of 12 inpatient bed densities per 10,000 population[11]. The country has, however, rolled out the electronic integrated diseases surveillance and response (e-IDSR) into the District Health Information Software (DHIS2) in all districts in 2016. The 2021 VNR report states that there has been major progress on training and employing 1000 midwives, 180 nurse anaesthetists, and 72 surgical assistants by 2025 under this commitment.
Several factors, mainly hinged on gender inequalities, increase the risks and vulnerabilities of adolescent girls and young women to infection with HIV in Sierra Leone. These include gender-based violence (GBV), harmful practices such as child marriage and Female Genital Mutilation, poverty, limited educational and economic opportunities, early childbearing, unequal access to information (including knowledge about sexual and reproductive health and the prevention of HIV and sexually transmitted infections (STIs)), and a lack of negotiating power and economic autonomy. Adolescent girls and young women belonging to especially marginalized groups, such as female sex workers, face elevated risks of violence, discrimination and stigma, compounding the risks of HIV. The HIV, sexual and reproductive health (SRH) services as well as GBV, mental health, and socioeconomic empowerment are failing to reach adolescent girls and young women especially those in sex work (Government of Sierra Leone; Gender Transformative Assessment, Policy Brief; 2020. From 2013 to 2019, Sierra Leone has made major improvements in maternal health indicators, particularly in the reduction of maternal mortality by almost 40 per cent. The country has also witnessed a substantial increase in the percentage of skilled birth attendants from 60 per cent in 2013 to 87 per cent in 2019.[12]

General health sector-related challenges
Government has incrementally increased its domestic resource to FHC initiatives (which targets pregnant women, lactating mothers and Under-fives) and is making efforts to sustain its contribution even at the face of the tremendous healthcare challenges in the country's healthcare system, notably chronic underfunding and a shortage of qualified workers coupled with an underlying high burden of both communicable and non-communicable diseases. Among these, the inadequate number of skilled health workforce coupled with mal-distribution of skilled health staff, and short of supplies and consumables remain a major bottleneck in quality service provision. The distribution of health workers has geographical variation which is skewed towards the urban areas leaving the urban setting with a higher density of health workers compared to rural areas. A physician density is estimated at 0.07 per 1,000 populations across the country[13]; the country require a minimum of 23 core health workers per 10,000 populations on average to achieve adequate coverage rates for the essential primary health care interventions. In Sierra Leone, the skilled health worker density is only 22.8 per 10,000 populations[14]. The country is making conscious effort to address these gaps by focusing on investing in Health human capital and enabling environment as part strengthening the health systems.

Family planning
In 2018, the Government of Sierra Leone set an ambitious target to increase the modern contraceptive prevalence rate (mCPR) from 20.9 in 2013 to 33.7% by 2022. By 2019, the country achieved 24% mCPR among all women which put the country behind the growth trajectory to be on track with the ambitions target. The unmet need for family planning among married women aged 15-49 decreased from 28% in 2008 to 25% in 2013, however it has stagnated since then. The unmet need for family planning among unmarried sexually active women is even higher at 34.2%. The highest unmet need for family planning is among adolescents aged 15-19. On the other hand, one out of every three women (35%) who began using a contraceptive method in the 5 years before the survey discontinued the method within 12 months. The most common reasons for discontinuation were side effects/health concerns (16%) and a desire to become pregnant (9%). The least common reason was method failure (1%).[15]

Contraceptive use is influenced by the level of educational attainment, rising from 17% among women with no education to 25% among those with a primary education, 30% among those with a secondary education. Women in

[11] Government of Sierra Leone, VNR, 2021.
[12] UNFPA SIERRA LEONE News Letter, January - June 2021-https://sierraleone.unfpa.org/sites/default/files/pub-pdf/newsletter_jan-june_2021_august_10.pdf
[13] https://knoema.com/WBHNPS2018DEC/health-nutrition-and-population-statistics?tsId=1691320
[14] https://www.afro.who.int/news/high-level-international-conference-health-workforce-ends-sierra-leone#:~:text=Sierra%20Leone's%20health%20sector%20is,health%20workers%20per%2010%2C000%20population).
[15] SLDHS 2019

the highest wealth quintile are more likely to use a method of contraception than those in the lowest quintile (26% versus 16%). Women in urban areas are more likely to use a contraceptive method than women in rural areas (26% and 19%, respectively). [16] Knowledge of contraceptive methods is nearly universal in Sierra Leone, with 98% of currently married women and 99% of men knowing at least one modern method[17]. Despite this knowledge, demand for modern contraceptives for currently married women stands at only 46%. This shows the significant role of social and gender norms in determining women's willingness to use modern contraceptives. For example, women in Sierra Leone who condemn wife beating or those who have the ability to refuse sex are more likely to use modern contraceptives[18].

2.1.3 Adolescents and Youth Reproductive Health

Sierra Leone is faced with one of the highest rates of child marriage in the world with 8.6 per cent of girls married, by age 15 and nearly 30 per cent of girls married by 18 years of age (among 20–24 year-olds). However, there has been progress with the SLDHS 2019 showing the rates dropped from 38.9% in 2013 to **29.6% in** 2019**.** An estimated 21 per cent of girls begin childbearing by the age of 18, and an estimated 83 per cent of females having undergone FGM[19]. According to SLDHS 2019 report, in Sierra Leone, women start sexual intercourse earlier than men. The median age at first sexual intercourse is 16.1 years among women and 18.3 years among men aged 20-49. By age 15, over a quarter (26%) of women had already started sexual intercourse, as compared with 7% of men. The report went further to state that, the percentage of women age 20-49 who have had sexual intercourse by age 18 increased from 67% in 2008 and 68% in 2013 to 74% in 2019. Among men, the percentage initiating sexual intercourse by age 18 increased from 39% in 2008 to 50% in 2013 before decreasing to 44% in 2019.[20] The 2019 SLDHS also states that rural woman, start sexual intercourse earlier than urban women; the median age at first sexual intercourse is 15.8 years among rural women and 16.3 years among urban women.

Early childbearing is a key driver of the adolescent birth rate, and it poses a real challenge to the country's development aspirations. According to the MICS 2017, 19.3 percent of women aged 15-19 have had a live birth. The figure is higher among the poorest quintile (28.3 percent) compared to the richest quintile (7.2 percent). The UNSDCF also posit that child marriage, teenage pregnancies and poverty are three prominent factors in adolescent girls' secondary school drop-out rates; and girls who are out of school are at greater risk of child marriage, early childbearing and exposure to sexual exploitation and physical violence. In 2013, the Government of Sierra Leone established a National Secretariat for the Reduction of Teenage Pregnancy and developed the National Strategy for the Reduction of Teenage Pregnancy (2013-2015). Taking cognisance of the linkages between adolescent pregnancy and child marriage, a subsequent National Strategy for the Reduction of Adolescent Pregnancy and Child Marriage (2018-2022) was developed to guide the prioritisation of evidence-based interventions in the country[21].

2.1.4 Gender Equality and Women's Empowerment

Gender equality in Sierra Leone was reported at 0.66667 % in 2020[22] The percentage of female population is 50.08 compared to 49.92 male population, but they occupy less than 20 percent of elected positions. Some of these challenges include lack of economic independence, high illiteracy and entrenched customs and traditions, political violence and reprisals, the absence of progressive laws that protect and promote participation for women, and the lack of confidence to vie for public positions[23]. Sierra Leone in the last decade has made efforts to promote gender equality and women's empowerment. Policies and programmes at institutional levels have improved public service delivery, while challenges to achieving desired results have always remained evident. The Ministry of Social Welfare, Gender and Children's Affairs was established to directly capture gender differential issues in public policy and programmes and to develop policy frameworks and programmes to address gender inequalities and women's empowerment at both national and community levels. A number of gender and women empowerment focused advocacy groups and civil society sprang up alongside. In 2019 the Ministry of Social Welfare, Gender and Children's Affairs was split into two

[16] SLDHS 2019
[17] Ibid
[18] P. Agbadi, T. T. Eunice, A. F and S. Owusu, "Complex samples logistic regression analysis of predictors of the current use of modern contraceptive among married or in-union women in Sierra Leone: Insight from the 2013 demographic and health survey," PLoS One, vol. 4, no. 15, 2020.
[19] Government of Sierra Leone UNSCDF, 2020-2023
[20] Government of Sierra Leone –DHS, Statistics Sierra Leone, SLDHS 2019.
[21] National Strategy for the Reduction of Adolescent Pregnancy and Child Marriage-https://sierraleone.unfpa.org/sites/default/files/pub-pdf/National%20Strategy%20for%20the%20reduction%20of%20Adolescent%20Pregnancy_final_Oct%202.pdf
[22] https://tradingeconomics.com/sierra-leone/gender-equality-wb-data.html
[23] https://www.usaid.gov/sierra-leone/gender-equality-and-womens-empowerment

distinct Ministries: 1) Ministry of Social Welfare and 2) Ministry of Gender and Children's Affairs. The Ministry of Gender and Children's Affairs is mandated to lead the development, implementation and monitoring of the policy and legal framework for issues relating to gender and Children.
Sierra Leone's successive post-war national development plans have captured gender issues as a policy pillar. The current plan, the Sierra Leone Medium-Term National Development Plan (MT-NDP, 2019-2023) has women, together with children and people with disabilities as its fifth pillar[24]. Accordingly, the UN Sustainable Development Cooperation Framework (UNSDCF, 2020-2023) Sierra Leone, has various actions on promoting gender and women empowerment across its four broad outcome areas: Outcome Area 1: Sustainable Agriculture, Food and Nutrition Security, and Climate Resilience; Outcome Area 2: Transformational Governance; Outcome Area 3: Access to Basic Services; and Outcome area 4: Protection and Empowerment of the most Vulnerable. These strategic areas also reflect efforts at mainstreaming gender in service delivery processes.

Violence against women and girls is endemic in Sierra Leone. Violence against women and girls within the household and in the larger society imposes significant economic cost to any country. Gender-based violence has far reaching implications by hindering the ability of women and girls to freely explore economic opportunities and stripping them of their fundamental human rights and freedoms. The formal justice institutions, such as the Family Support Unit-(FSU) based in the Sierra Leone Police, have displayed weak capacity to provide redress for VAWG survivors. This is largely due to limited resources, leading to impunity for sexual violence related crimes. VAWG cases are either resolved or under review by the police; few are charged to Court, and very few of those are successfully prosecuted. Community level mechanisms, such as traditional dispute resolution mechanisms, attempt to bridge the gap in justice service provision, but are not equipped with the required awareness on rights of women and girls and may even perpetuate further discrimination against women and girls. The percentage of women who have experienced physical violence since age 15 increased from 56% in 2013 to 61% in 2019. The percentage who experienced physical violence in the 12 months preceding the survey increased even more sharply over the same period, from 27% to 43%[25]. To address this issue, the President declared GBV a 'National Emergency' in 2019, which was followed by the Sexual Offences (Amendment) Act, 2019. Nonetheless, there are still gaps in the legal frameworks to prevent and respond to violence against women and girls. For example, Sierra Leone does not have explicit national laws against FGM.

In some communities where girls are susceptible to rape on their way to or back from school, girls have been reported to drop out of school as a result[26]. This has wider economic implications as these girls are deprived of an education and would be unable to attain the qualifications to gain formal employment and higher incomes. Within the workplace violence and sexual harassment hinders women from attaining their full potential and rising through the ranks of their careers. In comparison to individuals in the other education categories, women and men with a secondary education are more likely to have professional, technical, or managerial positions (52% and 57%, respectively). 38 percent of women and 51 percent of men are paid in cash, and an additional 7 percent of women and 21 percent of men are compensated in cash and in-kind for their labor. The percentage of currently married women who participate alone or jointly with their husband in choices concerning the use of their wages has decreased from 73% to 68%, according to the 2019 SLDHS estimates. In contrast to the number of women who earn more than their husbands (9%), which has stayed constant, the percentage of women who make roughly the same as their husbands (7% to 10%) has climbed.

2.1.5 Population Dynamics Context

The country's population was estimated at 7.09 million in 2015 as per the 2015 National Population and Housing Census (PHC 2015). It is currently estimated at 8.2 million as per the 2015 SLPHC projections (2017) projections with an annual population growth of 2.3 percent over the last decade. From 2004 to 2015 the population increased from 4,976,871 to 7,092,113, representing an inter censual percentage increase of 42.5 percent with an average annual growth rate of 3.2 percent from 2004 to 2015, compared to 1.8 percent from 1985 to 2004 and 2.3 percent from 1974 to 1985 (PHC 2015). About 40.9 percent of the population of Sierra Leone is under 14 years old, and 22 per cent of the population are adolescents and young adults between 15 and 24 years old. According to the World Bank, the age dependency ratio (% of working-age population) in Sierra Leone was reported at 76.28 % in 2020. However, Sierra Leone's economy has seen very little structural change. The country suffers from a crucial lack of access to

[24] See Sierra Leone's Medium-Term National Development Plan (2019-2023, p.136)
[25] SLDHS,2019.
[26] https://www.refworld.org/pdfid/523ac7a94.pdf

basic infrastructure, coupled with its relatively poor performance on governance measures of government effectiveness, regulatory quality, corruption, and the rule of law.

Sierra Leone has 16 different ethnic groups, each with a different language. The largest ethnic group is the Mende (31.9%), followed by the Temne (31.4%). The Temne are dominant in the Northern Sierra Leone and areas around the capital, while the Mende live mostly in the South-Eastern Sierra Leone and the Kono District. The third-largest ethnic group are the Limba (8.4%), who are native to the area and live in Northern Sierra Leone. The fourth group are the Fula (3.8%), who are descendants of Fulani migrant settlers from the 16th and 18th century who came from Guinea. Other major ethnic groups include the Mandingo (2.3%), who are descended from Guinea traders; the Kono (5.1%), who are also descended from Guinea migrants; and the Krio (1.3%) people; who are descendants of freed African American, West Indian and Liberated African Slaves and make up 1.3% of the population. Smaller ethnic groups include the kuranko, who arrived in the area around 1600; the Loko (2.3%), who are native to Sierra Leone; the Kissi, and the Sherbro[27]. Sierra Leone has a young population with 40.9% of its population under 14, and a rural population with 59% of people living outside of the cities. About 77% of the population are Muslims, while Christians make up 21.9% of the population. The remainder practice indigenous beliefs. Religious violence is rare in Sierra Leone. The execution of the National Population Policy and related programs has been hampered by the capacity (human and institutional) and financial challenges. Few policies and programs to address challenges of gender and reproductive health incorporate population considerations. To help with the integration of population issues into national policies and programs, however, efforts are being made to establish the National Population Commission and fully implement the National Population Policy, International Conference on Population and Development (ICPD), and Government commitments.

2.1.6 COVID-19 Context

Prior to the COVID-19 crisis, Sierra Leone was one of the fastest-growing economies in Africa. However, growth prospects have been severely undermined since the COVID-19 outbreak. The COVID-19 crisis, like the 2014-15 Ebola epidemic, is likely to damage adolescent girls' education prospects and their human capital potentials as the prevalence of child marriage and early childbearing as well as the risk of girls dropping out of school are all exacerbated during crises. Though Sierra Leone, as any other country in the world, faced extraordinary trying times since the COVID-19 pandemic, the country sustained the implementation of the SDGs within the national development plan. Since 2019 to date, these commitments and planned policy results have been followed up on in the context of the possible implications COVID-19 generates for future population management in the country.

It is reported that as a result of the eruption of the COVID-19, the number of households that had been able to consume required meals in a week dropped by 20 percent from April to the first week of July 2020; the number of those reporting reduced daily meals amounting to 30 percent.[28] The rural areas, where incomes are generally low, have been especially affected. The income-poor in the rural sector were reported by the 2018 Sierra Leone Integrated Household Survey (SLIHS, 2018) at 73.9 percent, compared to 34.8 percent for the urban poor.[29] Food insecurity had reached 63 percent in June 2020 from 53.3 percent in August 2019, according to an emergency food security monitoring system; with 10 percent reporting to be severely food insecure.[30] In real number terms, by July 2020, about 5.1 million people were food insecure, according to this survey; increasing by 41 percent from 3.9 million reported for this condition in January 2020.[31] UNFPA worked with development partners responding to the COVID-19 pandemic to update the Psychological First Aid Manual for the COVID-19 context. A new module was added to this version called 'Women and girls affected by coronavirus disease'. The manual was finalized and printed with technical and financial inputs from UNFPA and Irish Aid. Six hundred copies of the manual were printed and handed over to the Ministry of Social Welfare who led the roll-out of training of trainers and district level training in collaboration with UNICEF and NGOs.

2.2 The role of external assistance

The Net official development assistance and official aid received (current US$) in Sierra Leone was reported at US$ 836,799,988 USD in 2020[32]. The top donors in the period 2019 - 2020 was International Development Association at 176.1 million, followed by the IMF, United Kingdom and EU institutions, respectively at US$100.9 million, US$ 97.0

[27] UNFPA 6TH CPE, 2019
[28] See Report of the UN Socioeconomic Impact Assessment for COVID-19 (2020, page 26).
[29] See the 2018 SLIHS Report (2019, page lii).
[30] See Report of the UN Socioeconomic Impact Assessment for COVID-19
[31] See Report of the UN Socioeconomic Impact Assessment for COVID-19 (2020, page 27).
[32] https://tradingeconomics.com/sierra-leone/net-official-development-assistance-received-us-dollar-wb-data.html

million and US$92.2 million. This is presented in Figure 3. Between 2019-2020, the largest ODA contribution was to the social and infrastructure services which received 47% of the assistance followed by the humanitarian aid at 14%, with the rest receiving 39% combined. These distributions are presented in Figure 2 below.

Development assistance, which has been a substantial part of Sierra Leone's economy, constituted over 9 % of the country's Gross National Income (GNI) in 2013, and doubled during the height of the Ebola response.[33] An example officially overseen by the MoHS, the CHW programme is heavily dependent on donors and partners for technical, operational, and financial support. All programme costs are currently covered by donors. The CHW Policy 2016–2021.[34]

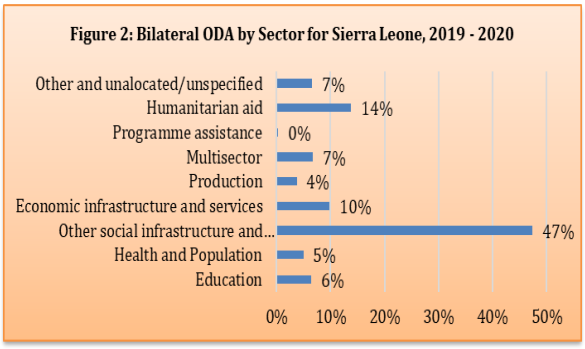


Figure 2 ***Bilateral ODA by Sector for SL, 2019 - 2020***

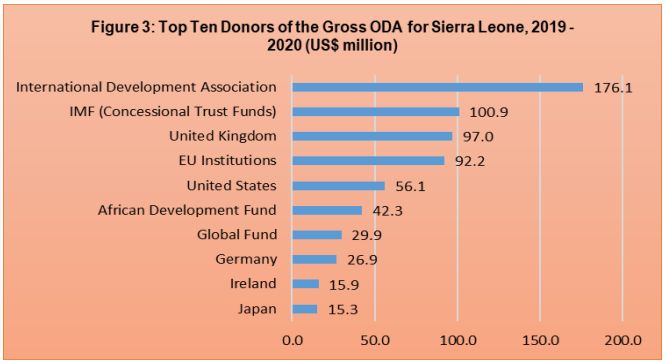


Figure 3 Top 10 Donors of the Gross ODA for SL, 2019 - 2020

[33] Organisation for Economic Co-operation and Development. Aid at a glance charts by recipient: Sierra Leone. 2016.from: http://www.oecd.org/dac/financing-sustainable-development/development-finance-data/aid-at-a-glance.htm .

[34] Ministry of Health and Sanitation. National community health worker policy 2016–2020. 2016b. from https://www.advancingpartners.org/sites/default/files/sites/default/files/resources/sl_national_chw_policy_2016-2020_508.pdf

CHAPTER 3: UNITED NATIONS / UNFPA RESPONSE AND PROGRAMME STRATEGIES

3.1 United Nations and UNFPA Strategic Response

UNFPA's global goal is to "*achieve universal access to sexual and reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the agenda of the Programme of Action of the International Conference on Population and Development (ICPD), to improve the lives of women, adolescents and youth, enabled by population dynamics, human rights and gender equality*". In pursuit of this goal, UNFPA works towards the achievement of three transformative and people-centred results, namely; (i) end preventable maternal deaths; (ii) end the unmet need for FP; and (iii) end GBV and all harmful practices, including female genital mutilation and child, early and forced marriage. [35]

The Strategic Plan (2018-2021) is the first of three consecutive plans through which UNFPA will contribute to the achievement of the Sustainable Development Goals (SDGs), in particular good health and well-being (Goal 3), the achievement of gender equality and the empowerment of women and girls (Goal 5), the reduction of inequality within and among countries (Goal 10), and peace, justice and strong institutions (Goal 16). In line with the vision of the 2030 Agenda for Sustainable Development, UNFPA seeks to ensure that no one will be left behind and that the furthest behind will be reached first. Informed by the International Conference on Population and Development (ICPD) – held in Cairo in 1994, the Strategic Plan focuses of four outcome areas of sexual and reproductive health, adolescents and youth, gender equality and the empowerment of women (GEWE), and population dynamics. The ICPD placed population and development issues within a human rights-based framework, and UNFPA is committed to integrating human rights into its work globally. The Strategic Plan also responds to other global frameworks underpinning the 2030 Agenda, including the Sendai Framework for Disaster Risk Reduction 2015 – 2030 of the Third United Nations World Conference on Disaster Risk Reduction, the 2015 Paris Agreement on climate change, and the 2015 Addis Ababa Action Agenda of the Third International Conference on Financing for Development.

Building on ongoing collaboration among United Nations organisations, UNFPA contributes to strengthening inter-agency policy and programming approaches that are cross-cutting and able to address complex, multidimensional issues. As a member of the UNCT, UNFPA works with the other United Nations agencies and other stakeholders' development to monitor and assess the progress achieved against the UNSDCF (2020-2023) outcomes. In humanitarian contexts, inter-agency accountabilities will be detailed through mechanisms such as the common humanitarian action plan, the consolidated appeal process, the inter-agency flash appeal and the transitional or early recovery appeal process.

[35] UNFPA strategy 2018-2021

Figure 4 - UNFPA Strategic Plan 2018-2021 incorporating the SDGs

3.2 UNFPA Response through the Country Programme

3.2.1 Brief Description of UNFPA Previous cycle strategy, goals and achievements

Since 1971, UNFPA has been working with the Government of Sierra Leone to enhance sexual and reproductive health and rights (SRHR), advance gender equality, realizing rights and choices for young people, and strengthen the generation and use of population data for development[36]

In 2015, UNFPA launched its Sixth Country Programme (2015-2019), in partnership with the Government of Sierra Leone. The overall goal of the programme was to contribute to "universal access to rights-based, gender-sensitive sexual and reproductive health information and services, including for adolescents and young people" as defined in the UNFPA Strategic Plan (2014-2017). Overall, the programme contributed to Government's development efforts especially in the areas of population and development; sexual and reproductive health and rights; reproductive health commodity security; gender equity, equality and empowerment of women, as well as promoting community advocacy and multi-sectoral partnerships for strengthening implementation of the ICPD Agenda in Sierra Leone.

In terms of synergies with other development frameworks, the Country programme was linked to the UN Development Assistance Framework for Sierra Leone (2015-2018); and the Government's Third Poverty Reduction Strategy Paper-Agenda for Prosperity (2013-2018). In particular, the programme was aligned primarily to three out of the eight key pillars of the Government's development agenda and related UNDAF Outcomes3. It also addressed related issues in the ICPD+10 Review Report; ICPD Beyond 2014, and the new Post-2015 Sustainable Development Goals. The 6th CPD was developed within the framework of the four (4) outcomes of the UNFPA Strategic Plan (2014-2017), namely:

- Increased availability and use of integrated sexual and reproductive health services (including FP, maternal health and HIV) that are gender responsive and meet human rights standards for quality of care and equity in access;
- Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health services;
- Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalised women, adolescents and youth; and
- Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality.

[36] See Terms of Reference for UNFPA Country Programme Evaluation.

3.2.2 The 7th UNFPA Sierra Leone Country Programme and an analysis of its theory of change

UNFPA Sierra Leone's current country programme was developed in consultation with the Government, civil society, bilateral and multilateral development partners, including United Nations organisations, the private sector and academia. It builds on, and consolidates, the gains from the previous programme to maximize impact.

The country programme is delivered through the following modes of engagement: (i) advocacy and policy dialogue, (ii) capacity development, (iii) knowledge management, (iv) partnerships and coordination, and (v) service delivery. The overall goal of the UNFPA Sierra Leone 7 CP (2020-2023) is universal access to sexual and reproductive health and reproductive rights and reduced maternal mortality through achievement of the three zeros: zero maternal deaths, zero unmet need for FP, and zero gender based violence and harmful cultural practices, as articulated in the UNFPA Strategic Plan 2018-2021. Designed to contribute to national needs and priorities, the programme articulates UNFPA's strategic priorities and programmatic interventions in Sierra Leone in three outcome areas, namely; i) sexual and reproductive health and reproductive rights; ii) adolescents and youth; and iii) gender equality and women's empowerment. The CP contributes to the following outcomes of the UNFPA Strategic Plan 2018-2021:

Table 5 - 7CP Results areas, indicators and key strategic interventions by Component

Result Area	Result Indicators and Targets by 2023[37]	Key CP Strategic Interventions
Strategic Outcome 1: Sexual and reproductive health and rights: Every woman, adolescent and youth everywhere, especially those furthest behind, have fully exercised their reproductive rights and have access to sexual and reproductive health services free of coercion, discrimination and violence.	● Proportion of births attended by skilled health personnel ***Baseline*:** 61.3% ***Target*:** 70% ● Unmet need for FP ***Baseline*:** 25%; ***Target**:* 19%	Output 1: 1. Establishing regional centres of excellence for maternal and newborn care, and supporting the scaling-up of quality improvement and assurance processes for maternal and newborn services; 2. Supporting the establishment of a network of comprehensive and basic emergency obstetric and newborn care (EmONC) facilities linked with a referral system; 3. Supporting the establishment of EmONC monitoring systems; 4. Strengthening maternal death surveillance and response at national and district levels; 5. Supporting interventions for obstetric fistula prevention and management; 6. Advocating for budgetary allocation and release of funds by government in support of contraceptive and reproductive health commodity procurement; 7. Galvanizing multi-stakeholder support and partnerships for the implementation of the family planning costed implementation plan (2018-2022) and the reproductive health commodity security strategy; 8. Supporting the provision of high-quality integrated rights-based family planning, adolescent and youth friendly sexual and reproductive health services including HIV; 9. Strengthening procurement and improvements in the national supply chain management system to assure delivery to the last mile and reduce stock-outs; 10. Providing sexual and reproductive health services in humanitarian settings; 11. Supporting the production and use of evidence-based data for decision making on sexual and reproductive health; and 12. Strengthening human resources for health capacity through the training, mentoring and preceptorship of midwives, nurse anaesthetists, surgical assistants and community health officers.
Output 1: National health system strengthened to provide high-quality, integrated sexual and reproductive health and FP services, including in humanitarian settings.	● Number of health facilities supported to provide emergency obstetric and Newborn care, as per international recommended minimum standards ***Baseline*:** 0; ***Target***: 6 ● Number of obstetric fistula cases repaired with support from UNFPA (surgery, catheterization/probe placement) ***Baseline*:** 0 ***Target***: 600 ● Number of health care providers graduated with support from UNFPA (cumulative) ***Baseline***: midwives: 0 surgical assistants 0, nurse anaesthetists 0. ***Target*:** midwives 422, surgical. assistants. 35, nurse anaesthetics 40. ● Percentage of service delivery points with no stock-out of at least three modern contraceptive methods during the last 3 months ***Baseline*:** 74% ***Target***: 90%	
Output 2: Communities especially women and girls have increased abilities to demand SRH, FP and gender-based violence response services.	● Number of community-based organizations supported for demand generation ***Baseline***: 0; ***Target:*** 100	1. Fostering socio-cultural and behaviour change strategies to create demand for family planning, sexual reproductive health services and gender-based violence response services, especially among young people; 2. Using technologies to create demand for family planning and sexual reproductive health services (SRH) among adolescents and young people; 3. Strengthening capacity of community-based organizations to create demand for SRH, family planning and gender-based violence response services;

[37] Source: The UNFPA 7CPD

		4. Mobilizing and empowering communities to raise awareness and demand for SRH, family planning and gender-based violence response services.
Strategic Outcome 2: Adolescent and Youth: Every adolescent and youth, in particular adolescent girls, is empowered to have access to sexual and reproductive health and rights, in all contexts	● Adolescents and youth (including marginalized) are engaged in the formulation of national sexual and reproductive health policies. ***Baseline*:** Yes; ***Target**:* Yes	1. Conducting advocacy for policies that address adolescent and youth health and well-being and child marriage; 2. Building capacity for implementation of comprehensive sexuality education and life skills for in- and out-of-school adolescents and young people; 3. Supporting the empowerment of young people, particularly adolescent girls to have skills and capabilities to make informed choices in relation to their sexual and reproductive health and rights and HIV prevention; 4. Strengthening systems and partnerships to generate and use evidence on adolescents and youth to contribute to harnessing the demographic dividend; and 5. Building capacity for implementation of the national youth service.
Output 1: Young people, in particular adolescent girls, have the skills and capabilities to make informed choices about their sexual and reproductive health and rights and well-being, including in humanitarian settings.	● Number of marginalized girls that are reached by life skills programmes that build their health, social and economic assets ***Baseline*:** 0; ***Target:*** 16,000 ● Number of schools in which the comprehensive sexuality education curriculum is implemented. ***Baseline*:** 0*;* ***Target*:** 300 ● A functional national demographic observatory for tracking progress on the demographic dividend in place ***Baseline*:** No; ***Target*:** Yes	
Strategic Outcome 3: **Gender equality and women's empowerment:** Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings	● Percentage of ever-married women age 15-49 who have experienced any form of emotional and/or physical and/or sexual violence in the 12 months preceding the survey, committed by their husbands/partners. ***Baseline*** (SLDHS 2013): 33.9%; ***Target*:** 28%	1. Supporting development of policy, legal and accountability frameworks for gender equality; 2. Building capacity of national institutions and civil society to prevent gender-based violence and eliminate harmful practices such as child marriage and female genital mutilation; 3. Supporting the provision of services and strengthening referral mechanisms to respond to victims and survivors of gender-based violence; 4. Engaging communities and networks, particularly men and boys to promote empowerment of women and to address gender-based violence, harmful practices and promote women's empowerment; 5. Producing and using disaggregated data on gender including gender-based violence and other harmful practices.
Output 1: Government, human rights organisations, civil society organisations and communities have improved capacities to promote gender equality, and to prevent and respond to gender-based violence and other harmful practices, including in humanitarian settings.	● Number of national strategies and frameworks to advance gender equality and reproductive rights developed with support from UNFPA ***Baseline*** (2018): 0; ***Target***: 5 ● Number of victims/survivors of gender-based violence provided with, comprehensive package of services. ***Baseline*:** 0; ***Target***: 2,515 ● Number of institutions with capacity to report on gender-based violence. ***Baseline*** (2018): 0; ***Target*:** 3 ● Number of communities reporting abandonment of harmful practices. ***Baseline*:** 0; ***Target***: 100	

Analysis of the CP's Theory of Change

In order to ensure a clear understanding of the CP's contribution to development outcomes in the country through the implementation of the interventions, the Evaluation team utilized a theory-based approach by assessing f the CP's theory of change (ToC). The assessment was guided by questions establishing how the programme has made contributions to the observed results and how it influenced the changes. This entailed conceptualizing the programme across the results chain, building on its logic, along the existing risks and assumptions. Assessing the theory of change also entailed considering the other exiting factors influencing the changes within the implementation context.

The theory of change underlying the **SRH** component of the UNFPA Sierra Leone's 7CP is generally based on a sound intervention logic with a clear flow across the results chain. The linkage of the outputs and the strategic outcome are evidenced in the assessment. The planned interventions under each output were also correspondingly clear, with the indicators generally sufficient for measuring progress. The theory of change underlying the **adolescent and youth** component as outlined in the CPD is based on a sound intervention logic. While the statements for the SP outcome and the output were well stated, the outcome indicator is not entirely clear as it is qualitative and not able to tell the extent to which the participation of the young people in policy formulation, therefore limiting the connection to the results. On the other hand, the linkage between the planned interventions and the outputs are clear and adequate to achieve the output. There is also an output indicator which is also qualitative requiring a *Yes* or *No* to show progress is also limiting to measure the milestones towards the final result. Further, the linkage between the SP outcome and the output is clear, however the stated indicator measuring the outcome is not so clear as it is a challenge identifying the level of engagement of the young people. The mainstreaming of data through the support partnerships to generate and use evidence on adolescents and youth to contribute to harnessing the demographic dividend was relevant.

On the other hand, the CPE team noted that the **GEWE component's** theory of change is based on sound intervention logic, with clear strategic linkage between the planned interventions and the outputs, and further the strategic interventions and outputs contributing to the outcome. Analysis of the SP statement and that of the output brings out clarity in the level of contribution, with the output directly contributing to the achievement of the SP outcome. The measurement of the output is to a larger extent sufficient to provide progress on the achievement of the CP in ensuring gender equality and women's empowerment. Further, the indicator measuring outcome is clear, though its achievement may not provide the perfect measurement of all the aspects of the SP outcome. The mainstreaming of evidence-based responses through producing and using disaggregated data on gender including gender-based violence and other harmful practices is relevant to the achievement of the 7CP component.

The overall analysis of the ToC of the programme entailed looking at its design and implementation framework. Considerations were made in the design, including designing questions to look at the contributions that 7CP interventions are leading to the desired changes at the outcome levels, the government development plans, the UNFPA global strategic plan and the UN framework. The framework of evaluation also entailed review of the context of implementation, particularly building on the assumptions and the risks and how they influenced the changes across the results chain. This was particularly achieved through ensuring that the interview questions assessed the causal links across the results chain, in addition to making considerations to the assumptions for the results to be realized as per the reconstructed theory of change of the CP (Annex 6). The evaluation also considered the interlinkages in the 7CP component result areas reflecting integration within the programme. further, the evaluators also considered the modes of engagement for the implementation context, including the strategies for each thematic area.

3.2.3 The Country Programme Financial Structure

During the programme design, the total proposed indicative assistance (in millions of USD) for the implementation of the seventh country programme of the UNFPA Country Office in Sierra Leone, over a period of four years (2020-2023) was $34.6 million. with$6.0 million expected from regular resources and $28.6 million through co-financing modalities and/or other resources. (United Nations Population Fund Country programme document for Sierra Leone, 2019).

Table 6 - Proposed Indicative Assistance (in million $)

Proposed indicative assistance (in millions of $):

Strategic plan outcome areas		Regular resources	Other resources	Total
Outcome 1	Sexual and reproductive health	3.7	16.1	19.8
Outcome 2	Adolescents and youth	0.9	10.4	11.3
Outcome 3	Gender equality and women's empowerment	0.7	2.1	2.8
Programme coordination and assistance		0.7	0.0	0.7
Total		6.0	28.6	34.6

As at the time of the CPE, budget data availed was for the period 2020 and 2021, and these combined showed that the CO mobilized a total budget of US$21,631,142.3 while the expenditure in the same period was at US$ 17,277,639.5. The budget expenditure across the programme during the CP, indicated that the overall utilization rate at the combined 2020 and 2021 was at 79.9% which is considerably good. While the SRH had the highest share of the resources at 83.1% (as shown in Figure 5), it had the lowest expenditure rate at 77.5%. On the other hand, the rest of the components were utilized at a rate more than 90%, with the exception of A&Y which had 82% as shown in Table 7. With an implementation context where resources are limited while the needs are exponential, especially under the SRH indicators of the country an expenditure rate of 77.5% is on the lower side and initiatives to increase expenditure should be considered. On the other hand, while A&Y component has comparatively lower budget allocation, the expenditure was still sub-optimal.

Table 7- Budget utilization rate by Programme Area

	Budget	Utilization	Utilization Rate
SRHR	17,974,299.3	13,938,631.9	77.5
A&Y	1,072,607.4	879,299.5	82.0
GEWE	2,021,338.0	1,921,264.8	95.0
PD	527,067.5	503,572.8	95.5
OEE	35,830.1	34,870.5	97.3
Total	21,631,142.3	17,277,639.5	79.9

Source : UNFPA Sierra Leone Financial records

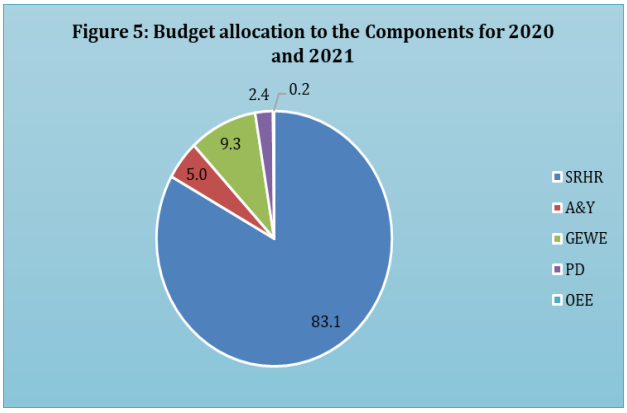


Figure 5 Budget allocation to the CP Components for 2020 -21

CHAPTER 4: FINDINGS

4. 1 Introduction

This chapter presents the findings of the UNFPA Sierra Leone's 7th Country Programme Evaluation, in compliance with the UNFPA Evaluation Handbook on how to conduct Evaluation. The results have been presented providing answers to the evaluation questions in relation to the evaluation criteria. The analysis has been guided by the evaluation matrix assessing the assumptions made at the design stage. The results have been triangulated using multiple data sources as elaborated in the methodology design and cited in the text.

4.2 Answer to Evaluation Questions on Relevance

Summary: The UNFPA Sierra Leone's 7CP addressed the country's development and humanitarian priorities espoused in the MTNDP 2019-2023, and sectoral strategies, guided by the line ministries. The CP's SRH component is also integrated into the UHC policies and plans, directly contributing to addressing the national needs of marginalized and vulnerable women and girls among the target populations. The CP is fully aligned to the UNFPA global Strategic Plan 2018 – 2021, the UNSCDF, ICPD Programme of Action and SDGs (particularly Goals 3, 5, 10 and 17). Evidence also revealed consultation upheld in the design and implementation of the programme, especially with the government and IPs, ensuring direct contribution to the national strategies, and ownership. The 7CP was responsive to changing national needs and environment especially during COVID-19, where UNFPA was instrumental as part of the UNCT to contribute to the response, in addition to reprogramming to adapt to the context of the pandemic, ensuring realization of results.
Through partnerships, UNFPA supported the development of various policies, guidelines and SOPs ensuring quality service delivery, in addition to strengthening advocacy mechanisms in the country targeting elimination of harmful practices. However, there was little evidence on how the design of the CP benefited from consultations of the most vulnerable and marginalized populations to effectively reflect on their needs. Further, the inadequate financial capacity of the government also limits the leveraging of resources for greater results.

EQ1: To what extent is the country programme adapted to: (i) the needs of diverse populations, including the needs of vulnerable and marginalized groups (e.g., pregnant women, young people and women with disabilities, etc.); (ii) national development strategies and policies; (iii) the strategic direction and objectives of UNFPA; and (iv) priorities articulated in international frameworks and agreements, in particular the ICPD Programme of Action and the SDGs, (v) the New Way of Working?

4.2.1 Alignment of the CP to the National Strategies and Policies

Analysis of the CPD, UNFPA's internal Strategic Information System (SIS) and interviews with partners, beneficiaries and the UNFPA staff reveal that there is evidence that the CP is adapted to the needs of the target populations and in line with the national priorities as described in the Medium-Term National Development Plan (MTNDP 2019 – 2023). UNFPA also implements the CP in collaboration and direct support to the various government line ministries, departments and agencies (MDAs) thereby contributing directly to their respective objectives and performance results. Interviews with the respective stakeholders also exemplified strong collaboration, consultation and participation of the government ministries in the design and implementation processes for the CP interventions. Strategically, review of the CP documents revealed that the components of the 7CP's SRHR are integrated into key universal health coverage (UHC) Policies and Plans, including the National Health Sector Strategic Plan (2021 – 2025) and the National Health Sector M&E Strategy (2021 – 2025), with further plans of developing a framework to mainstream SRHR within the UHC roadmap.
The government line ministries like Health and Sanitation, Gender and Children Affairs, Planning and Economic Development and Statistics Sierra Leone were implementing partners for the CP interventions, indicating direct contribution of the CP in addressing national strategies and needs, indicating the relevance of the CP. Further, all the respondents from the government confirmed that the work of UNFPA in Sierra Leone complemented the work of the government strategies and plans to provide services to the populations targeted. Review of the CPD also indicate that the CP directly contributes to the national priority of Cluster One of the MT-NDP–human capital development through improvement of healthcare; empowerment of women, children, adolescents and persons with disabilities; youth employment, sports and migration, roles that were confirmed through the interviews with the government and CO staff as highly evidenced during the period of evaluation.

Interviews with the CO and government staff confirmed UNFPA contributing in the identification of the needs of the population across the CP thematic areas thereby contributing to addressing their needs, while at the same time informing the government priorities and strategies. Furthermore, interviews and reviews of UNFPA Sierra Leone

annual reports indicate that UNFPA supported development of various policies, in addition to being an active partner in contributing to the development of policies, in addition to supporting the public engagement processes on and dissemination of the policies. For example, during the period, UNFPA supported the Ministry of Planning and Economic Development (MoPED) and the members of the Sierra Leone Parliamentary Action Group on Population and Development to sensitize the stakeholders at the district levels on the Population Policy, in addition to disseminating it. During the period of review, UNFPA supported the development of the Gender Equality and Women's Empowerment (GEWE) Policy, which also culminated into the development of the National Policy on Radical Inclusion in Schools (2021). All these are pointers of the relevance and alignment of the CP to the national strategies and policies (Interviews with CO and government staff and SIS reports).
At the time of the design of the CP, Sierra Leone had challenges in generating high quality data, analysis and use, especially at the decentralized levels. Further, the outcome areas of the programme had gaps in data needs and required response to ensure generation of evidence to inform evidence-based programme formulation and strengthened capacity in the 7CP. In order to ensure this, UNFPA mainstreamed population dynamics across the SRH, A&Y and GEWE components of the 7 CP. Interview sessions with the Statistics Sierra Leone also indicated that UNFPA contributed to strengthening the national statistical capacities, in addition to supporting the dissemination of the Population Policy and advocacy on the same. The mainstreaming however had limitations, especially in allocation of resources which was reported to be inadequate. The relevance of the CP is also explained under each of the components to bring out the performance of the programme in the period of coverage. These included, SRHR, GEWE, and Youth and Adolescents and are explained in the sections that follow.

4.2.1.1 Sexual and Reproductive Health and Rights

Sierra Leone still has maternal mortality ratio at 717/100000 live births and among the top three countries in the world (SDHS, 2019). On the other hand, while the coverage indicators like the level of access to skilled birth attendance and institutional deliveries were at 87 percent and 83 per cent respectively, the quality of emergency obstetric and neonatal care (EmONC) services in some of the public health facilities remains sub - standard. On the other hand, Sierra Leone still has cases of obstetric fistula estimated at 2300, which is also an indicator of a weak health system in the country, especially on access to quality EMONC services provided by skilled birth attendant.

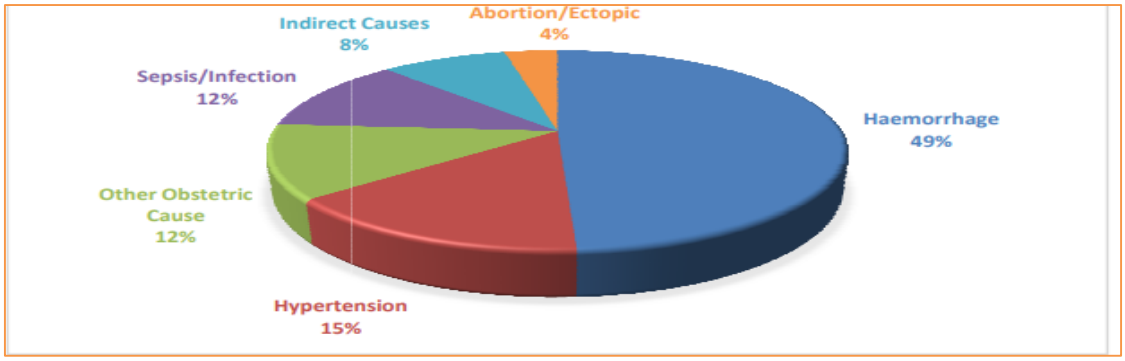


Figure 6 *- Maternal Death in Sierra Leone by Cause of Death 2016 – 2020* ***Source:*** *Ministry of Health and Sanitation (2022)*

Interviews and documents reviewed confirmed that UNFPA, through the 7CP, contributed to addressing the SRH needs in the country. In addressing poor maternal and newborn health outcomes, the CP supported EmONC services and training of midwives, surgical assistants and nurse anaesthetists for quality service delivered. UNFPA also supported the government in strengthening policy environment, identification, prevention, training, repairing of obstetric fistula through addressing the poor quality of EmONC in the areas of need training, reintegration and advocacy for the women and girls suffering from the condition. Strategically, some of the SRH components are integrated into key UHC Policies and Plans, including the National Health Sector Strategic Plan (2021-2025) and the National Health Sector M&E Strategy (2021-2025), in addition to the plan of developing a framework mainstreaming SRH within the UHC Roadmap.

The SLDHS 2019 report shows that the unmet need for FP among married women aged 15 – 49 was at 25 percent, with met needs at 21 percent and total demand at 46 percent. Results also showed that the unmet need for spacing births is highest among those aged 15-19 at 28 percent. On the other hand, the percentage of demand satisfied with

modern methods in urban and rural areas were 50 percent and 42 percent respectively. The report further estimated that 69 percent of women had no exposure to the FP messages. These unmet needs were addressed through the CP's integrated interventions, mainly under Output 1: Strengthened national health system to provide high-quality, integrated sexual and reproductive health and family planning services, including in humanitarian settings; and Output 2: Communities especially women and girls have increased abilities to demand SRH, family planning and gender-based violence response services.

Interviews with beneficiaries confirmed that the UNFPA activities and services they received addressed their needs to access quality SRH and healthcare services, as well as access to information. The SRH services were confirmed by the beneficiaries and the MoHS as mainly targeted at the hard-to-reach areas, mostly rural areas where the needs were dire. For example, the SLDHS indicated that the FP unmet needs were higher in Kambia, Tonkolili, Bonthe, Bo and Port Loko districts and these were part of the districts that UNFPA targeted with the 7CP. The interviews and document reviewed confirmed the CP met the needs of many vulnerable people, especially by increasing access to SRH services and provision of reproductive health commodities for vulnerable, disadvantaged, marginalized and prioritized the needs accordingly. The targeted population were consulted directly and indirectly as evidenced in the review of national assessments and consultations held with MoHS, MoYA, MoGCA, among other ministries, in addition to the approvals of the annual work plan (AWP) by the MoPED. The SRH services provided through UNFPA support were in alignment with the national needs, aimed at improving provision of maternal and neonatal health. UNFPA facilitated provision of these services in collaboration with the MoHS, and utilized the services of the government health workers, in addition to being provided in government health facilities. Further the CP IPs identified the participatory manner in which the CP interventions were designed confirmed the relevance of the activities supported. For example, discussions with the evaluation participants revealed that youth activities in relation to SRHR awareness and training were designed in a participatory approach ensuring responsiveness to their needs and concerns. Youth participation in the design of the advocacy activities ensured that the myths and misconceptions were identified and effectively addressed.

4.2.1.2 Adolescent and Youth

The CP output under the Adolescent and Youth component is aligned to the 2020 National Youth Policy which was developed based on three guiding principles of access, inclusivity and impact guided by rights based and gender responsiveness. Further, it is aligned to the National Strategy for the Reduction of Adolescent Pregnancy and Child Marriage (2018 – 2022) which seeks to have the interest of the adolescents, at the heart of planning and implementation, promote community ownership, ensure a multi-sectoral approach and ensure evidence-based strategies in place to reduce teenage pregnancies, end child marriage and other harmful cultural practices The CP is also aligned to the MTNDP (2019 – 2023) where Policy Cluster 6 focuses on enhancing youth empowerment and employment, in addition to revitalizing sporting activities for the youth. The design and implementation of the interventions of CP were informed by available evidence sourced from various studies and surveys, including those done by the IPs and evaluation report for the 6th CP.

Despite Sierra Leone significantly reducing the maternal mortality rate, teenage pregnancies continue to be an issue[38] with the SLDHS 2019 results showing that the 21 percent of women aged 15-19 have begun childbearing; 18% have had a live birth; and 4% are pregnant with their first child. The SLDHS also recognizes early initiation of sexual encounter with 19 percent of young women and seven percent of young men age 15-24 reported having had sexual intercourse before age 15, exposing them to the risk of becoming pregnant or contracting HIV/STIs. Further, the trends show that the proportion of teenagers who had begun childbearing increased from 4 percent at age 15 to 45 percent at age 19. Due to the contextual challenges of inadequate knowledge on and access to SRH services they are exposed to life-threatening consequences from the lack of access to family planning care and comprehensive sexuality education due to higher risks for complications in young mothers [39].

[38] https://www.unfpa.org/data/transparency-portal/unfpa-sierra-leone
[39] https://www.friendsofunfpa.org/freetown-sexual-and-reproductive-health-in-sierra-leone/

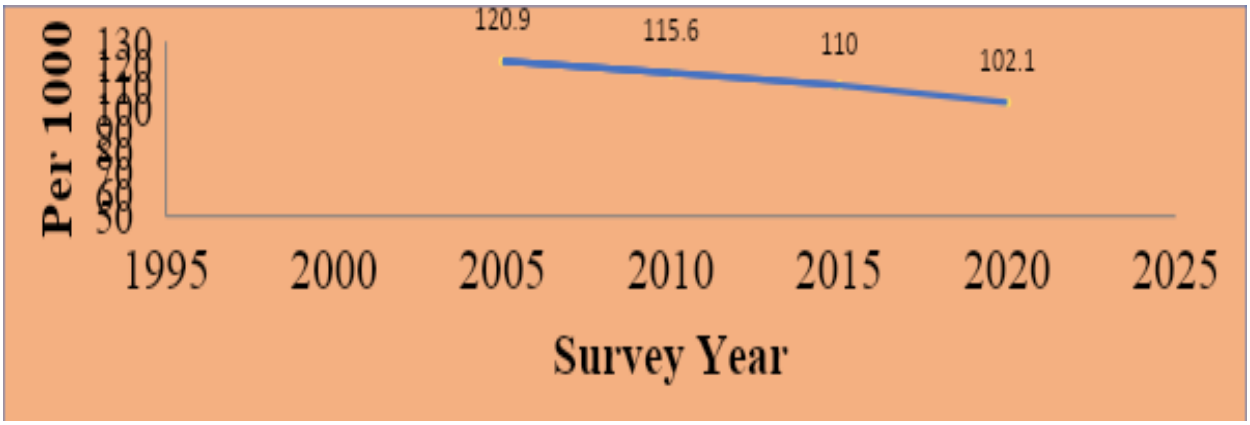


Figure 7 - Trends in Adolescent birth rate per 1000 live births **Source**: Ministry of Health and Sanitation (2022)

Interviews with IPs, CO, UNDP and MoYA staff and document reviews also revealed that the young people in the country face a high level of vulnerability to shocks, with the poverty level in the country being high at 64.8 percent and the youth are the majority of those in the poverty category. Historically, the young people are exposed to vulnerabilities, exacerbated by inadequate education background, they are often exposed to drugs and crime and engagement in menial economic activities, which also make them a target for exploitation by recruitment into criminal and political activities. Further, there is not a coordinated national programme for the young people (with IPs, CO, UNDP and MoYA staff). Recognizing the gaps that exist in the country, UNFPA provided both technical and financial support to the GoSL and the IPs to bridge them, in addition to the review and development of policies, capacity building, advocacy and service provision. The A&Y component was relevant to the needs of the adolescents and youth as confirmed by the youth and adolescents who participated in the evaluation, confirming that they were consulted by the CO IPs about their priorities. Those who were consulted during the district visits confirmed that they were consulted by the IPs about their priorities. These confirm the CP's relevance in contributing to the needs of the adolescents and youth in the country (Interviews and document reviews).

4.2.1.3 Gender Equality and Women's Empowerment

Despite making progress in expanding opportunities for women and girls through improving the policy and legal frameworks, and strengthening their access to services, including health and education opportunities for girls, realising gender equality and women's empowerment in Sierra Leone remains a challenge. There are several issues of inequalities contributed to harmful practices such as early marriage for girls, teenage pregnancies and Female Genital Mutilation (FGM). Further, the women and girls are at risk for sexual and gender-based violence (SGBV) in the form of domestic violence, sexual assault of adults and minors, marital rape, and school-related sexual abuse[40]. The SLDHS 2019 showed that 61 percent of the ever-married women had experienced physical, sexual, or emotional violence by their current or most recent husband/partner, increasing from 51 percent in 2013. 49 percent of women believed that a husband was justified in beating his wife compared to 31 percent of men. Further, many women and girls continue to face marginalization and discrimination, with unequal opportunities compared to men and boys, particularly in the areas of political participation, education access, employment and social justice (Interviews and document reviews).

The UNFPA-supported GEWE interventions under the 7 CP were relevant to bridge the gaps and respond to the needs of girls and women at risk. UNFPA, the government, through the line ministries, and non-governmental implementing partners engaged in identifying key interventions to address context-specific needs for the women and girls in the country. Some of the interventions implemented during the period through the support of the CP includes awareness creation on women empowerment, engagement on strategies to reduce harmful practices, supporting case management and referral mechanisms, policy development support, capacity development, legal support for GBV survivors, and psychosocial support, among others (Interviews and Document review).

Interviews with UNFPA and IP staff confirmed conducting need assessments and engagement of the targeted populations to identify their needs and to design interventions responding to the gaps. Further, the GEWE component was designed based on the existing situation at the time, in addition to the recommendations from the evaluation of the 6 CP, one of which was to focus on the reduction of the vulnerabilities and empowerment of women and girls

[40] https://www.usaid.gov/sierra-leone/gender-equality-and-womens-empowerment#:~:text=Women%20account%20for%2052%20percent,very%20low%20compared%20to%20men.

through community-based interventions (Interviews with CO and IP staff and CPD review). Interviews with the UNFPA CO, IPs and beneficiaries confirmed interventions implemented in areas with needs. For example, the programme supported interventions in selected districts like Tonkolili, Kambia, Pujehun and Koinadugu, among others where the GBV, teenage pregnancies and child marriages are comparatively high (SLDHS, 2019; MTNDP and Interviews with IPs and Line Ministry staff).

The GEWE component of the CP is aligned to the government strategies and policies, and directly contributed to the assessed needs in the country, in addition to working with the line ministries thereby contributing to the national policies and outcomes. The Output of the component focused on capacity development of the national agencies and CSOs to promote gender equality, prevention and response to GBV and other harmful practices. Through the 7 CP, UNFPA addressed the needs of various groups, with focus on girls, and adolescents. While the CP contributed to the strategies leading to the prevention of GBV and reduction of the harmful practices, there are still deep-rooted perceptions which are highly respected cultural and religious beliefs that hinder the realisation of the CP focus. Practices like GBV, though at a decline according to the SLDHS, are perceived to be normal. On the other hand, FGM is considered a very sensitive topic in the country and still requires a strategic approach to eliminate as per one of UNFPA SP's three Transformative results. The teenage pregnancies are also on the rise according to the SLDHS data. UNFPA, however, made strides in addressing some of these, especially on ensuring a multi-stakeholder engagement, led by the government, to respond to and address the issues (interviews with beneficiaries, IP, UNICEF, Government and CO staff and SIS review).

Although there is heightened child marriage campaign in communities, including the country's First Lady's Hands-off-our Girl's campaign, also, there are community engagements with traditional and religious leaders, the review of the Child Rights Act 2007; and the conduct of life skill sessions on ending child marriage in Sierra Leone. It is noted that there has been only limited progress in reducing child marriage and early childbearing.

4.2.2 Strategic Relevance

4.2.2.1 Alignment of the CP to UNFPA Strategic Plans[41] and UN in Sierra Leone

The design and development of the 7CP was informed by concerted consultations with the government, CSOs, bilateral and multilateral partners, including UN agencies in the country. The CP was designed and implemented in alignment with the UNFPA SP (2018 – 2021) contributing directly to the three outcome areas-SRH, A&Y and GEWE. Analysis of documents and interviews also confirmed that the CP focused on the SP goal (2018-2021) of achieving universal access to SRH and reproductive rights, focusing on women, adolescents and youth, mainstreaming population dynamics, human rights, and gender equality. The programme focused on addressing adolescents, youth and women's needs, all of which are critical to the achievement of the SP goal. Interviews conducted and document reviewed also showed commitment of the CP to the three transformative results of zero preventable maternal deaths; zero unmet need for family planning and zero gender-based violence and all harmful practices, including child marriage and FGM. These are in line with the UNFPA SP (2018 - 2021) ToC.

From interviews conducted and documents reviewed, UNFPA gave considerations to the principles of Leaving No One Behind and reaching the furthest first, human rights-based approaches and ensured gender responsiveness during the 7CP implementation. The alignment of the 7CP to the SP (2018-2021) is also evidenced by monitoring and reporting systems, with the CP results reported in the Strategic Information System (SIS), in line with the CP outputs. UNFPA Sierra Leone also implemented the CP in compliance with its business model, utilising all the five modes of engagement (partnership and coordination, knowledge management, advocacy and policy dialogue, capacity development and service delivery) in the delivery process of the CP. Interviews with the staff and documents reviewed also indicated that the modes of engagement were relevant to the context of implementation. South-South cooperation was however limited in the CP delivery.

The design of the CP, particularly the outcomes, was aligned with the strategic priorities of the United Nations Sustainable Cooperation Development Framework (UNSCDF 2020 – 2023) in Outcome area 3, which aims to ensure that the most vulnerable, benefit from increased and equitable access to and utilisation of quality education, health care, energy and WASH services, including during emergencies; and Outcome area 4, which aim to ensure that the

[41] At the time of the evaluation, the CO had plans to align the CP with the new UNFPA SP 2022 – 2025. This CPE is therefore based on the SP 2018 – 2021

most vulnerable, particularly women, youth, adolescents and children (especially girls), and persons with disabilities, are empowered and benefiting from increased social and economic opportunities.

4.2.2.2 Alignment of the CP to the ICPD, SDGs and New Way of Working and the Grand Bargain

Analysis of the CP documents and interviews with the CP stakeholders indicated that the UNFPA Sierra Leone implemented the CP in the spirit of the ICPD agenda and the objectives of the ICPD Programme of Action (ICPD PoA). The 7CP emphasizes access to comprehensive reproductive health services in the country through supporting family planning, increasing access to skilled birth attendance and empowerment of women and girls through advocacy for equality and eradication of all forms of discrimination, violence against women and girls and harmful practices like FGM, teenage pregnancies and early marriage. Interviews and documents reviewed also indicated that the UNFPA programme prioritises marginalised and vulnerable populations with services targeting locations with service gaps. The outputs under the CP components were delivered based on human-rights and people-centred approaches, ensuring that the dignities of the people targeted were upheld, by designing interventions that are socio-culturally sensitive, ensuring effectiveness. All these are in line with the ICPD PoA.

Principally, the development of the CP was in alignment with the Sustainable Development Goals (SDG)[42]. Interviews with CO staff, and stakeholders, and review of documents revealed that the CP contributed to the achievement of the SDGs, in particular Goal 3 (Good health and wellbeing), Goal 5 (Gender equality), Goal 10 (Reduced inequalities) and Goal 17 (Partnerships for the Goals). The Evaluation findings indicate that UNFPA 7CP facilitated access to health services by the vulnerable and marginalized populations through supporting SRH service delivery, enhancing skilled birth attendance, strengthening capacities of stakeholders, among others, thereby contributing to the achievement of Goal 3. Feedback from CP reports and interviews with CO, IPs, Government respondents and beneficiaries also indicated that UNFPA contributed to Goal 5 and 10 through enhancing gender equality and women's empowerment targeting vulnerable and marginalized women and girls, through skills development, providing psychosocial support and advocating for women and girls' rights, including elimination of harmful practices discriminating against them and affecting their well-being. Further, the CP also supported the development of GEWE policy, which also led to the development of the National Policy on Radical Inclusion in Schools targeting vulnerable girls and young mothers out of school, among others, thereby reducing inequality. The implementation and delivery of the CP is based on partnership building and collaboration with various stakeholders contributed to the achievement of Goal 17. These included communities, government agencies, NGOs, Civil society organizations (CSOs), UN agencies and donors. UNFPA also supported the reporting on SDGs through supporting Statistics Sierra Leone to integrate the reporting on the SDGs platform (Interviews with CO, RC and Statistics SL staff and SIS reviews). Review of the 2020 and 2021 annual SIS reports shared by the CO however did not indicate UNFPA-prioritized SDG indicators produced in the country. Though targets were indicated, there were no reports made on them.

Documents reviewed and interviews conducted with various stakeholders, including CO staff confirmed UNFPA Sierra Leone's CP alignment with the New Way of Working (NWoW). UNFPA collaboratively utilised its comparative advantage in the areas of SRH, GEWE, A&E and population dynamics to enhance achievement of collective results in the respective areas. UNFPA was confirmed to be an active member of the UNCT and leading key results areas within the UNCT (Interviews with RC, UNICEF, UNDP, WHO and CO staff). For example, UNFPA and UNDP supported efforts to bring out the situation of People living with Disabilities (PWDs) by ensuring that they are identified and supported, including ensuring they were included in the SDGs platform. UNFPA enhanced partnerships with local CSOs as IPs and strengthened their capacities to deliver services in the CP focus areas.

EQ2: To what extent has the country office been able to respond to changes in national needs and priorities, including those of vulnerable or marginalised groups, and those imposed by the socio-economic impacts of COVID-19?

During the period of CPE coverage, the country experienced changes in priorities due to COVID-19 and other emergencies experienced by the country. At the onset of the COVID-19 pandemic, a number of CP-related activities were affected with far-reaching effects. For example, healthcare facilities were closed, including labour wards (including the Princess Christian Maternity Hospital-PCMH), health workers got infected with the pandemic (Interviews with MOHS and CO staff). In order to respond to enhanced programme delivery, UNFPA supported the government in the establishment of triage centres for screening, and with a number of isolation centres in King Harman Maternity and Child Health Hospital and PCMH. UNFPA also intervened through an IP, Doctors with Africa CUAMM to train and support the health facilities with personal protective equipment (PPEs) and oxygen in the

[42]DP/FPA/CPD/SLE/7: UNFPA Country Programme Document 2020 - 2023

facilities. UNFPA also supported dissemination of key messages for women to deliver in the health facilities (Interviews and SIS reviews). These interventions ensured continuity of services and access to services by the affected populations.

During the period, UNFPA also adapted the CP interventions to the COVID-19 context, ensuring community-level COVID-19 infection prevention and control (IPC) mechanisms. UNFPA also supported the midwifery schools with internet modem and internet service subscription to deliver courses online since they were closed during the period. This ensured students continued with their learning (interviews with CO and midwifery schools' staff). Further, UNFPA ensured that the health facilities supported, performed routine screening and provided PPE for COVID-19 and IPC of COVID-19. In addition, UNFPA cancelled the routine training of midwives, in order to prioritise the emerging needs and to address them effectively amid the effects of COVID-19. The need for reprogramming of funds was also utilised. For example, UNFPA negotiated to use the funds to supply Mama and Baby packs in the health facilities supported (Interviews with CO staff). These activities confirmed UNFPA's responsiveness to the changes in the national needs and priorities.

UNFPA, as part of the UNCT, contributed to supporting the government under the COVID-19 Response Plan. UNFPA, together with WHO, developed non-clinical guidelines to COVID-19, contributed to the development of protocols to deliver GEWE, SRHR, psychosocial support (PSS) and capacity building services to cope with the pandemic. For example, UNFPA integrated SRH in the emergency response mechanisms, as well as supported nine COVID-19 essential health services to ensure continuity of services during the pandemic. UNFPA also supported RH commodities security (RHCS) through distribution and ensured prepositioning of the commodities in the facilities to allay disruptions (Interviews with supported-health facilities, IPs and CO staff and SIS review). As part of the UNCT, UNFPA was involved in setting up COVID treatment centres and oxygen plants, as part of the Global UN directive to the UN agencies, in conducting a social and economic analysis of COVID-19 to ensure support to the country with the findings informing the COVID-19 socio-economic response plan. This led to resource mobilisation efforts to meet the gaps in the plan (Interviews with RC, CO and UNICEF staff).

UNFPA also supported the country, as part of the UN task force for emergencies and supported environmental emergencies like flooding and displacement, in addition to national disasters. For example, UNFPA ensured that those displaced due to the mudslide in 2018, especially the marginalised communities in Freetown, were supported. UNFPA ensures that services remain available during emergencies (Interviews with CO staff and document reviews).

4.3 Answer to Evaluation Questions on Effectiveness

Summary of Findings: The CO, in partnership with both government and CSO IPs, utilized the five modes of engagement to extensively deliver the 7 CP, supporting the government both at national and district levels contributing to the development and humanitarian priorities. Under the 7CP SRH component, strengthened the national capacity in the delivery of the MNCAH through training, enhanced coordination, supporting policy and strategy development and further provided financial and/or technical support to address its mandate at national and sub-national levels, and also within communities. This has contributed to demand creation, enhanced RHCS supplies, increased access to quality-of-care services and information. The A&Y component immensely contributed to supporting the marginalised girls, strengthening their life skills to make decisions on health and social choices, and further supported the review and implementation of the national youth policy and strategy. The 7CP also led the development of the CSE curriculum, though the implementation had not yet commenced. The GEWE component contributed to strengthening legal and policy framework, in addition to supporting advocacy mechanisms addressing deeply-rooted traditional and harmful practices. The social norms are however still entrenched in the cultures of the populations, threatening the gains made and contributed to by the 7CP. The 7CP also supported strengthening of capacities on evidence generation, however in a limited extent given low resource allocation
The 7CP contributed effectively to planned results and reached almost all the intended populations in the targeted locations. There were mixed feedback on the achievements of the output targets where some were achieved, surpassed, while others not attained across the thematic areas. The interventions however had far-reaching effects from the COVID-19 pandemic and other contextual challenges, including low capacities and resources.

EQ3: To what extent have the interventions supported by UNFPA delivered outputs and contributed to the achievement of the outcomes of the country programme? In particular: (i) increased access and use of integrated sexual and reproductive health services; (ii) empowerment of adolescents and youth to access sexual and reproductive health services and exercise their sexual and reproductive rights, (iii)advancement of gender equality and the empowerment of all women and girls; (iv) increased use of population data in the development of evidence-based national development plans, policies and programmes?

4.3.1 Sexual Reproductive Health

4.3.1.1 Introduction of the Component

The SRH component of the 7CP was designed to contribute to two outputs aimed at strengthening the national health systems to provide high-quality, integrated sexual and reproductive health and family planning services, including in humanitarian settings; and ensure increased abilities of communities especially women and girls to demand SRH, family planning and gender-based violence response services. The component had two outcome indicators and five output indicators. These are stated in Table 4.1 showing the performance in the indicators by the time of the CPE. The evaluators reviewed the performance of the CP based on the achievements at the output level, looking into the indicators. Under output one, UNFPA supported both national and district level of governance by building capacity of healthcare workers at all levels, through training and strengthening coordination and support supervision, in addition to supporting equipment and infrastructure required for emergency obstetric care, post abortion care, obstetric fistula management; as well as Maternal and Perinatal Death Surveillance and Response (MPDSR). Further, UNFPA provided financial and technical support towards policy advocacy initiatives for increased government financial and human resources for maternal health and family planning; strengthening procurement and improvements in the national supply chain management system to assure delivery to the last mile and reduce stock-outs; supporting the production and use of evidence-based data for decision making on SRH; strengthening human resources for health capacity through the training, mentoring and preceptorship of midwives, nurse anaesthetists, surgical assistants and community health officers; and the midwifery support to strengthen the midwifery programme and provide equipment to health facilities for provision of comprehensive and basic emergency obstetric care.

Output two on the other hand focused on enhancing investment in fostering socio-cultural and behaviour change strategies to create demand for FP, SRH, and GBV services, especially among young people; using technologies to create demand for FP and SRH among adolescents and young people; enhance creation of demand for SRH, FP and GBV response services; and supporting communities on awareness raising and access to SRH, FP and GBV response services.

4.3.1.2 Achieved versus planned component results

Analysis of the CP reports, two out of the five SRHR indicators had their targets surpassed at the time of the CPE. The indicators achieved were on the health facilities supported to provide EmONC and the service delivery points with no stock-out of at least three modern contraceptive methods during three months prior to the survey, as captured in the SIS report. The three indicators not achieved at the time of assessment were also above fifty percent of achievement, with the lowest being the number of fistula cases treated at 52.2 percent compared to the target and the highest being at 85 percent on the number of community-based organizations supported to increase demand creation. Assessing the extent of achievement against the targets measured in the indicators, UNFPA and IPs excelled in performing despite the contextual challenges and effects of the COVID-19 pandemic. Particularly, the treatment of obstetric fistula was affected by the suspension of surgeries during the COVID-19 pandemic in addition to the challenges of inconsistent presence of a surgeon at the treatment facility as there were intermittent availability of the surgeons affecting the achievement of the targets. Interviews also reported that the results were achieved due to the flexibility and the quick adaptability of the programme to the COVID-19 context further enabling UNFPA to continue the implementation of the interventions and enabling services and support to be provided.

The results under the component show remarkable efforts that UNFPA put in place to ensure that RH indicators improved in the country. Notable was the focus of the CP through the SRHR component on the quality of care through capacity building of the healthcare providers on various aspects of SRHR in the country (Interviews and Annual reports). Particularly, UNFPA ensured improved quality of the FP services through strengthening the capacities of the healthcare workers based on WHO criteria specifying quality guidelines, in addition to enhancing mechanisms to ensure improved demand and supply during the period of focus (annual reports and interviews with, CO, MoPS and IP staff). UNFPA also supported improvement of skilled birth attendance, especially in the hard-to-reach and marginalized areas, further increasing coverage with the services for the women and girls of reproductive age through training of midwives and supporting preceptorship (Interviews with CO, IPs and MoPS staff, and review of the Annual reports).

Table 8 - SRH Component Performance Data

UNFPA strategic plan outcome: **Every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated sexual and reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence**

Output Indicators	Baseline (2019)	Targets (2023)	Progress as at July/ August 22	Performance Comments
Output 1: **National health system strengthened to provide high-quality, integrated sexual and reproductive health and family planning services, including in humanitarian settings.**				
Number of health facilities supported to provide emergency obstetric and newborn care, as per international recommended minimum standards	0	6	12	The CO supported the training of the health workers on various aspects of the SRH, renovations and equipment of selected health facilities improving the quality of services being delivered in the targeted health facilities supported. In addition, UNFPA also supported the MoHS to conduct a national assessment of EmONC services across all the 16 districts.
Number of obstetric fistula cases repaired with support from UNFPA (surgery, catheterization/probe placement)	0	600	313 (2021)	The target was not achieved mainly due to the suspension in most part of 2020 due to the effects of COVID-19 pandemic, and the erratic turnover of surgeons at the operating facility.
Number of health care providers graduated with support from UNFPA (cumulative)	Midwives: 0 Surgical assistants: 0 Nurse anaesthetists : 0	Midwives 422, Surgical. Assistants: 35 Nurse anaesthetics: 40	Midwives: **281** Surgical assistants: **26** Nurse anaesthetics: **30**	The target has not been achieved, but at the time of the evaluation, another cohort of trainees were in session. UNFPA also supported 11 midwifery tutors to pursue bachelors and master's degrees to enhance their skills and quality in teaching.
Percentage of service delivery points with no stock-out of at least three modern contraceptive methods during the last 3 months	74%	90%	96% (2021)	The source of the baseline indicated on the CPD for this particular indicator is the 2019 National Health Facility Assessment of RH Commodities and Services. While the same assessment has not been done since 2019, the data reported here is based on MoHS regular stock monitoring exercise, as reported in the SIS reports and therefore not a perfect comparison.
Output 2: **Communities especially women and girls have increased abilities to demand SRH, family planning and gender-based violence response services.**				
Number of community-based organizations supported for demand generation	0	100	1. (cumulative)	

- **UNFPA's contribution to Strengthening national health system to provide high-quality, integrated SRH and FP services**

Results from the review of a number of CP documents and interviews with various CP stakeholders indicated that UNFPA played a key role in contributing to the delivery of the SRH services in the country. Interviews with stakeholders indicated that UNFPA is recognized as the main stakeholder in SRH, especially in supporting health facilities in the country supporting both lifesaving interventions and provision of quality SRH services. UNFPA supported SRH services, including FP, post-abortion care, outreaches in the hard-to-reach areas, antenatal care (ANC), postnatal care (PNC), early detection of cervical cancer, prevention and management of Sexually Transmitted Infections (STIs), and enhanced access to skilled birth attendance. Further, UNFPA contributed in addressing the unmet needs of FP through supporting the government in the procurement and distribution of RH commodities and medications to the health facilities ensuring that no stock-outs were experienced, with nearly all (96 percent) of the health facilities experiencing no stock-outs in three months prior to the reports. The IP confirmed the role played by UNFPA through the 7CP in enhancing the reach of marginalized populations with services, in addition to increasing awareness among the populations on the SRH services available. Health facility staff interviewed during the evaluation reported that UNFPA was instrumental in ensuring that the SRH services and commodities were accessible and admissible to the beneficiaries. On the other hand, some healthcare workers expressed concerns, especially on the access to the SRH services by the teenage girls as there are still cultural or societal perspectives that hindered their access to the services, in addition to visiting the health facilities. The health workers however reported devising mechanisms to encourage them to visit the facilities including operating the clinics at different hours, especially late

in the evening so that the teenagers or youth could visit when the clinic hours for the ANC and PNC shall have elapsed. Others also stated promoting the use of separate doors as the normal access routes to the maternal and child health (MCH) clinics. The extent of achievement of results under this result area is elaborated in the sections that follow

UNFPA strengthened access to skilled birth attendance in Sierra Leone: During the period of evaluation, UNFPA contributed to the development of the government capacity in skilled birth attendance through supporting the training of midwives, supporting three midwifery schools (National School of Midwifery, School of Midwifery Bo, and School of Midwifery Makeni) with funding from UK's FCDO, through the Saving Lives Programme to deliver quality training of professional midwives to increase availability of skilled birth attendants in Makeni, Bo and Freetown, providing tuition fees, student allowance and capacity building of the tutors. Review of data indicate that at the time of the CPE, 281 midwives had graduated from the three midwifery schools and all were posted to various health facilities. UNFPA, particularly ensured, in collaboration with the MoHS, that the midwives were recruited from the rural, marginalized and health human resource-constrained areas, and this ensured that they went back to the areas after graduation to provide the midwifery services. The strategy of recruiting midwifery students from among the already employed nurses at various health institutions enables direct contribution to service delivery. It is also imperative to note that there was remarkable increase in the number of midwives recruited from the rural areas during the 7CP. Interviews with the MoHS, CO and IPs staff indicate that this support was effective in contributing to strengthening the capacity of the government in instituting the quality of the SRH services in the country, given that the levels of skilled birth attendance and institutional deliveries at 87 percent and 83 percent respectively, recruited among nurses that are already employed. The midwifery support was also confirmed by the MoHS and CO staff to produce quality midwives for improved service delivery. In order to enhance the quality of delivery of the midwifery training, UNFPA also supported the midwifery tutors to attain masters and bachelor's degrees in education. This was reported by the tutors to improve the delivery methods for the courses. Interviews with the MoHS also confirmed the role of UNFPA in contributing to the improvement of the midwifery training through supporting the development of the preceptorship policy and implementation guidelines which facilitated enhanced skills of the trainees through practical experiences in the facilities of placement. UNFPA also trained the preceptors and this facilitated effective transfer of practical clinical skills to the midwives enabling them to conduct actual deliveries.

> "*The Midwifery support by UNFPA enabled enhanced access to EmONC services, particularly in the hard-to-reach areas where they are recruited from communities where the midwifes work… Initially referrals were done by the NGOs, but currently being managed and done by the MoHS-employed midwives trained by UNFPA… and it is also our policy to ensure that the midwives recruited have signed MoU to ensure that they work in their areas after graduating before being transferred"* – **MoHS Key Informant during the CPE**

In addition to supporting midwifery education, the 7CP also supported the midwifery association and regulations. Under the association, UNFPA supported the development of the national midwifery strategic plan incorporating the aspects of advocacy which were not structured before, improving the advocacy on the wellbeing of the midwives in the country. This has also led to the strengthening of the midwifery association, including informing the initiation of direct entry to midwifery through defining a clear career path (Interviews with MoHS, CO and Midwifery schools' staff). At the time of the evaluation, Interview with the MoHS and CO staff revealed that UNFPA supported the MoHS in developing the Midwifery curriculum and Policy, which was still under review, with the key aim of enhancing the quality of delivery in addition to inclusion of direct entry into the midwifery schools, unlike the current one where the applicants must have worked for more than two years to qualify. Further, interviews also revealed that the 7CP strengthened the midwifery regulations through supporting the midwifery board establish a database to ensure that midwives' work could be addressed effectively through certification and monitoring their skills application. This was also noted through stakeholders' interviews that it reinforced the standards in compliance with the international standards. While the midwifery support was instrumental in building the human resource skills-base in the health industry in the country, the modality of selecting nurses already employed to provide healthcare was reported to be a limitation as it had effects on the workforce, especially given that they would be trained continuously for 18 months meant their places of work would be constrained. It was however reported during the interviews that the new curriculum under development incorporates direct intake for fresh graduates from high school to study midwifery. This will bridge the gap in human resource.

UNFPA contributed to increased demand for access and supply of Family Planning: Interviews and document reviews revealed that UNFPA played a critical role in enhancing access to FP in the country using various approaches for increasing the demand for and enhancing access to the service, including; institutional and human resource capacity

building, community mobilization and sensitization, supply of FP commodities, evidence-generation, and strengthening of supply chain management. The CO contributed immensely to increased range and availability of quality-assured RH commodities, including expanding the range of FP methods through introduction and promotion of new and lesser used FP methods (Document review and interviews).

UNFPA was instrumental in averting stock-out of contraceptive commodities in the health facilities through supporting procurement and distribution of the nearly 95% of the national needs for contraceptives (Annual reports and Interviews with CO, MoHS and WHO staff). Further, the 7CP contributed to strengthening the supply chains through financial and technical support to the MoHS in the development of five-year integrated health supply chain management strategy, through highly consultative processes. This led to integrated and harmonized supply chains. UNFPA also provided technical assistance in the establishment of a functional national mechanism (involving key stakeholders) for regular needs assessment, multi-year forecasting, supply planning and funding gap analysis for contraceptive supplies through the support to the MoHS in the production of annual and quarterly reports (Interviews and document reviews).

Table 9 - Projected number of contraceptive users

Contraceptive Methods	Projected mCPR					Projected number of users				
	2021	2022	2023	2024	2025	2021	2022	2023	2024	2025
Target population (at risk of pregnancy)						2,110,586	2,164,435	2,217,939	2,270,780	2,322,650
mCPR (total/year), total no. of users	**31.6**	**33.7**	**35.8**	**37.9**	**40.0**	666,945	729,415	794,022	860,626	929,060
Sterilization (male and female)	0.26	0.28	0.30	0.32	0.33	5,581	6,104	6,645	7,202	7,775
IUDs	0.53	0.56	0.60	0.63	0.67	11,162	12,208	13,289	14,404	15,549
Implants	10.84	11.56	12.28	13.00	13.72	228,826	250,259	272,426	295,277	318,757
Injectables	13.35	14.24	15.13	16.02	16.90	281,847	308,246	335,549	363,695	392,615
Oral pills	5.82	6.20	6.59	6.98	7.36	122,785	134,286	146,180	158,442	171,040
Male condom	0.40	0.42	0.45	0.48	0.50	8,372	9,156	9,967	10,803	11,662
Other modern methods (inc. Emergency Contraceptive)	0.26	0.28	0.30	0.32	0.33	5,581	6,104	6,645	7,202	7,775

Source: MoHS (2021)

UNFPA supported the assessment of the use of RH commodities, generating evidence and informing decision-making through review of client and inventory records (Interview with NMSA and CO staff and document review). UNFPA supported the MoHS in the assessment of the down-stream supply chain management system in the last mile and identification of factors hindering the distribution and use of RH commodities in an attempt to provide assurance and visibility towards adequate safeguarding, management and use for intended purposes. This assessment involved all levels including the Central Medical Stores, District Medical Stores, Hospitals and Peripheral Health Units. UNFPA was also instrumental in convening key stakeholders to disseminate findings, development of remediation plan against risks identified and development and implementation of remediation plans and actions. With this support, MoHS was able to review the consumption patterns, document imminent shortages, and distribute the right type and quantity of commodities. This minimised risks (e.g. stock-out, wastage, excess stock) and improved accountability (Interviews with NMSA, CO and DHMT staff and document reviews).

There was also UNFPA's reported contribution in developing the capacities of the healthcare staff on the reporting tools, in addition to facilitating printing and distribution of the tools to the health facilities (MoHS and IPs). The MoHS also reported that UNFPA supported the renovation of the central warehouse improving its infrastructure enhancing safety of commodities and equipping it with CCTV and fire control system to enhance security at the facility. Interviews with the MoHS and RH stakeholders further revealed that UNFPA effectively contributed to improved use of the FP products in the country through enhanced product availability. UNFPA was recognized by the RH stakeholders for contributing to health systems strengthening through capacity enhancement mechanisms ensuring supply chain efficiency, enhanced warehouse and inventory management, trained trainers of trainers (ToT) across the country, training on the use of standard operating procedure (SOP) on management of health commodities and enhanced evidence generation on consumption patterns (Interviews with Marie Stopes, Planned Parenthood Association of Sierra Leone and MoHS staff).

"Initially it was not easy to know what was going on with the distribution and consumption from the national level to the PHCs… we did not know what the challenges were at all the levels. The consultant hired by UNFPA to conduct the assessment on the RH commodities supply chain enabled us to identify the issues, in addition to identifying preference of the strategy to be implemented at all levels, which has really changed currently. Right now, we are able to tell what is happening even at the PHC levels. The system is very holistic. We know everything going on at all levels and able to make the right decisions" ***– NMSA respondent****.*

UNFPA, through the IPs also enhanced demand generation through targeting communities and populations in hard-to-reach location, engagement of men and young people to enhance demand creation through sensitization, use of social media, promoting health seeking behaviours, among others. Through the Foreign, Commonwealth & Development Office (FCDO)-supported *Saving Lives Programme*, UNFPA used the social media to share key messages to target the young people to access the services. Through the safe spaces, UNFPA and IPs were also able to mentor the girls through sharing information and the willing ones were linked to health facilities to access the services. UNFPA also trained health service providers to provide services to the young people, including the adolescents, in addition to MoHS and IPs being supported to disseminate messages, creating demand for the RH commodities (Interviews with IPs, MoHS and CO staff). Young women, men and adolescents who had benefited from SRH awareness confirmed that they were able to access services because of UNFPA's sensitization activities. Further, in the course of promotion of health seeking behaviours in the hard-to-reach areas, integrate services, including FP. Promotion of adolescent services in the targeting health facilities was also a way of increasing demand. For example, in Makeni, the government hospital created a time in the evening to attend to the girls, while in Bo Government hospital, the girls use a different door and time to access the services (Interviews with HoHS, IP and CO staff).

In 2020, with support from Irish Aid, the Global Programme to End Child Marriage and core funds, UNFPA conducted a campaign to ensure that people were aware of the continuity of GBV, FP and maternal health services throughout the pandemic. Messaging on keeping safe during the coronavirus pandemic were included. The campaign was first rolled out in Freetown through radio, pre-recorded calls, SMS and social media platforms. [43]The telephone calls and SMS targeted all 645,000 active Africel subscribers in Freetown with messages on these thematic areas[44]. Further, UNFPA supported coordination mechanisms among stakeholders in Supply Chain where it supported the reproductive health commodity security (RHCS) technical working group (TWG). Interviews with MoHS, CO and IP staff indicated that this support contributed to the commodities annual quantification process using projections and based on previous years' results, in addition to the identified needs. Interviews indicated that UNFPA took the lead in organizing quarterly meetings of the TWG and ensuring that all stakeholders participated and the demands for the country met in terms of budget and commodities, in addition to leveraging of the resources.

It was however reported that there has not been much emphasis on the ToTs, especially in cascading the service at the PHU levels to facilitate adherence and monitoring. There was also reported absence of an integrated system as currently, the M-Supply is in all the districts and serves as the primary source of data while the PHUs still use paper data and this was reported to be time consuming compared to the time for service delivery. In addition, the health management information system (HMIS), and District Health Information Software 2 (DHIS2) currently sit at the MoHS, but M-Supply being the primary source of data, in addition to stock management. There is still need to improve on the data generation, especially on generating real-time information on the commodities and supply.

UNFPA also contributed to the provision **of high-quality and integrated EmONC services** through supporting a total of 12 health facilities to provide emergency obstetric and newborn care (EmONC), as per international recommended minimum standards, training health service providers on EmONC, in addition to supporting routine monitoring of EmONC services. UNFPA strengthened the capacity of health facilities through training of healthcare providers, support with the IEC materials to increase knowledge and enhance access to services, renovation expansion and equipment for quality service delivery. For example, the DHMT at Bo and Makeni government hospitals confirmed that the support by UNFPA through renovation and equipment of the health facilities to provide integrated SRH services including EmONC, information, education and communication (IEC) material and guidelines production and distribution, training of healthcare staff, including on EmONC mentorship, especially on FP methods and availability of RH commodities, including FP facilitated transfer of skills and capacity to deliver high quality EmONC services in the facilities. During the period, UNFPA also supported the MoHS to conduct a national

[43] UNFPAS Report 2017
[44] UNFPA Annual report 2021

assessment of EmONC services across all 16 districts which interviews with the CO and MoHS staff revealed was helpful in establishing service gaps and developing strategies for strengthening the service delivery systems in the districts.

- Further to the midwifery training support to the MoHS, UNFPA also supported the training of a total of 26 surgical assistant community health officers (SACHO) and 30 nurse anaesthetic assistants as part of the task shifting initiative for surgical services to community health assistants, where UNFPA partnered with the CapaCare and Government of Sierra Leone [School of Clinical Medicine in Makeni] and the Norwegian Agency for Development Cooperation (NORAD) to provide the training. The graduated SACHOs were reported to be instrumental, after being posted in the health facilities, in enhancing access to EmONC services, particularly in the rural and hard-to-reach communities which had high need to have access to basic surgical services (Interviews with CO, MoHS and CapaCare staff). The retention rate of the SACHOs in rural hospitals was also reported to be very high in the rural health facilities with the potential of increasing access to the EmONC services in the communities targeted (SIS review and interviews with MoHS and CO staff). Further, the presence of the SACHOs led to strengthening of theatres in the facilities they were posted, enabling pregnant women in the localities to access services from nearby facilities as opposed to before when they would walk long distances. For example, In Bonthe Island, pregnant women would travel by boats to the mainland to get EmONC services, while with the presence of the SACHOs, this has changed and people rely on them to provide the services, in addition to attracting more medical doctors to the island (CapaCare and MoHS interviews).

***Figure 8** - Facilities where the SACHOs were posted in 2021*

UNFPA also contributed to strengthening provision of quality of care and monitoring SRH services through supporting the construction of high dependency unit (HDU) in Makeni government hospital and the PCMH. Further, UNFPA enhanced the capacity in service delivery through supporting renovation of labour wards in the Bo government hospital and PCMH including supporting them with beds, in addition to construction of the theatre at the PCMH near the labour ward easing the wheeling to the theatre which enhanced access to quality service delivery. Additionally, UNFPA increased service delivery at the Makeni government hospital through renovating and decongesting the RH centre, and provision of equipment for FP and cervical cancer screening further leading to provision of integrated RH services including cancer screening, FP, and HIV counselling and testing. On the other hand, at the time of the CPE, the construction of the Cancer screening centre had not been done as there were delays in the identification of space for construction, but due to time and resource constraints, a place was renovated to allow for service delivery, and will be equipped with furniture, screening equipment and beds. During the period, UNFPA also supported Bo, Makeni and PCMH hospitals under the quality improvement projects where hospitals were engaged in identification of gaps and were strengthened through the support of the IP, CUAMM. The support included training of staff in different areas including supporting institutional capacity like electricity and stationery. This support was lauded by the MoHS and IPs as instrumental in increasing access to quality SRH services. On the other hand, it was reported that there have been experiences of dwindling stocks for contraceptives, in addition to inadequacy of funding.

UNFPA reduced the burden of obstetric fistula response and management: The 7 CP, through the support of Iceland Government, supported obstetric fistula case identification through screening, community sensitization to create demand for treatment, treatment (surgeries) and rehabilitation and social integration of the obstetric fistula survivors for socio-economic support. In partnership with the Aberdeen Women's Centre and Haikal Foundation, and in collaboration with the MoHS, UNFPA financially and technically supported the obstetric fistula response and

management coverall all the districts where identified cases were (Interviews with CO, IP and MoHS staff and SIS review). To enhance active identification of cases for surgery, UNFPA supported the Haikal Foundation which, while its focus is nationwide, targeted seven districts namely, Kailahun, Koinadugu, Bombali, Tonkolili, Pujehun, Moyamba and Bo which were identified to be those with low maternal health indicators, sensitized and screened women and facilitating their booking for surgeries by the Aberdeen Women's Centre.

UNFPA supported Haikal Foundation to conduct awareness and advocacy on obstetric fistula focusing on prevention, while at the same time sensitizing and referring those affected to Aberdeen Women's Centre for surgeries, where they stay for one to two weeks to two months after surgeries. The arrangement of sensitization and active identification of fistula cases was instrumental in enabling demand creation in identification of cases for treatment. UNFPA also supported capacity building of community action group members in community mobilisation for fistula. This contributed to reducing the burden of fistula which was reported by the stakeholders interviewed to have been an instrumental contribution by UNFPA in restoring the dignities of the affected women, in addition to strengthening family relationships. This was attributed to the financial support by UNFPA, and the collaborative approach in coordinating the activities with the MoHS, particularly working with the district health management teams (DHMT) composed of the CHP, MCHP and EmONC centres (Interviews with IPs, MoHS and CO staff, and review of CP reports). During the period of coverage, interviews and document reviews revealed that the coverage of the targets was not effectively achieved due to the effects of COVID-19 pandemic where the surgeries were suspended, in addition to inconsistent presence of surgeons at the facility. Further, identification of the fistula cases was also hampered by inadequate capacity by the health facility staff, in addition to the health records not containing indicators of fistula. The country also has inadequate capacity on Obstetric Fistula treatment due to lack of specialists as most of the times the specialists come from outside the country. There is also no known nationally-determined prevalence of fistula in the country, in addition to inadequate involvement and ownership of the government on the response.

On rehabilitation and social integration of the obstetric fistula survivors, UNFPA supported Haikal Foundation to support the patients after they are treated and are supported on psychosocial assistance and vocational skills training (VST) to equip and empower the survivor's socio-economically, and further facilitating community linkage and support for reintegration, including family reunion. Interviews with Haikal Foundation and CO staff indicated that the survivors stay in the centre for between one to three months while undertaking the VST to enhance their livelihood skills in soap making, tailoring, tie & dying, weaving, needlework, agriculture, and adult literacy/numeracy lessons) as part of rehabilitation and reintegration. Haikal Foundation reported that once the survivors completed the training sessions, they were certified, supported with start-up kits currently pegged at an amount of about US$ 77 and provided with seed money to start small business which helped them to socially re-integrate. Haikal Foundation ensured reintegration of the survivors through linkage of the survivors with their respective communities, including their families, where husbands had also abandoned their wives because of fistula. They are also taken through counselling to be able to accept the fistula survivors. UNFPA supported the accommodation and transport costs for the survivors (Interviews with IPs and CO staff). UNFPA also supported a total of 14 staff at the Haikal Foundation, including resident nurses to facilitate the activities at the centre.

> *Once the women have been identified to be having fistula, we bring them to our centre here where UNFPA supports us to train them on various VST (for between one – three months) as they wait for the Aberdeen Women's Centre to pick them for surgeries…. …After surgeries, they are advised to come back to the centre for reintegration where we reach out to the chiefs and family members to accept them back to their communities, since some of them even leave their families/ communities because of discrimination. UNFPA restores dignities of the women in addition to strengthening family bonds through the reintegration support* – **Haikal Foundation Informants**

UNFPA enhanced Maternal death surveillance and response: During the period of review, UNFPA supported the MoHS in conducting national maternal death surveillance and response (MDSR). This contribution was recognized by the government (MoHS) and WHO staff as an important achievement in Sierra Leone by UNFPA during the 7 CP period. The respective staff reported that this support enabled the stakeholders to understand the causes of death, where and how to prevent that from happening. In addition, production of MPDSR reports enabled capturing of the highest number of cases, and enabled investigation, reporting and review with mechanisms put in place to prevent future death.

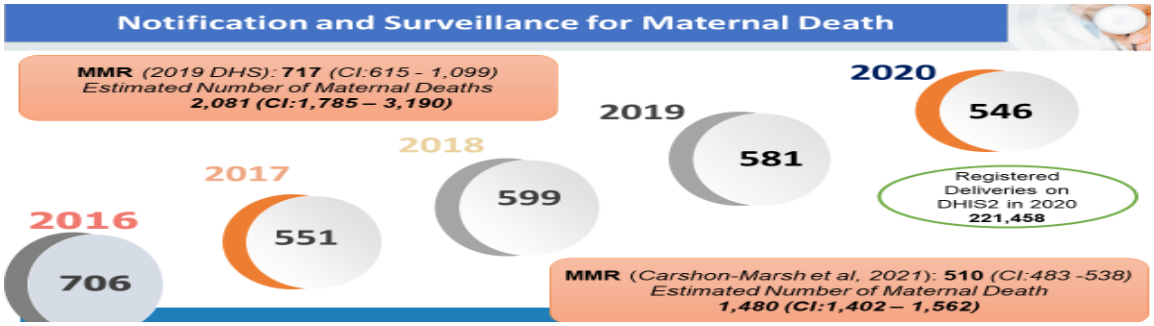
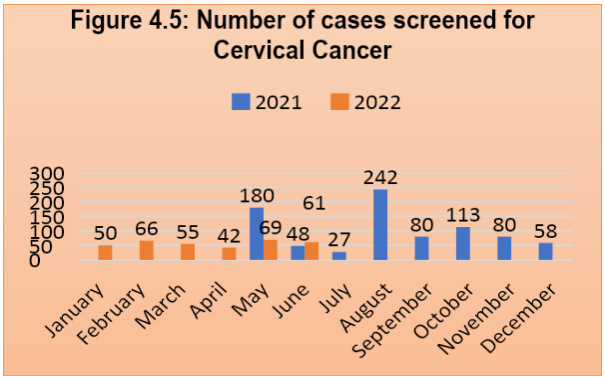


Figure 9 - Trends of Maternal Death and Surveillance **Source:** Ministry of Health and Sanitation (2022)

Interviews with CO and MoHS staff confirmed that UNFPA supported the MoHS in production of MDSR reports, MDSR Committee in each district including supporting training of two midwife investigators per district, in addition to data collection tools and national meetings. It was reported that UNFPA also supported the monthly meeting of the MDSR Committee meeting and the national MDSR steering committee conducted after every six months chaired by the Chief Medical Officer, to review the district data and establish implementation strategies of some of the mitigation measures (Interviews with MoHS, CO and WHO staff). Further, UNFPA also directly supported facilities to conduct the reviews of the maternal deaths so that the clinicians can come up with the response. While this support was instrumental in establishing the maternal deaths situation, especially causes and developing measure of prevention, the stakeholders reported that the functionality of the national steering committee needed to be improved as the response is currently weak, with reports being reported to be the same for the last three years of assessment, in addition to quality of investigation being poor (Interviews with UNFPA and WHO). In addition, the functioning district committees were also limited in the implementation of the action plans as the government was not adequately supportive to the implementation of the plans at the district levels. Initially, this was reported to be supported by the National Emergency Medical Services (NEMS), but due to inadequate funding as a result of the end of the Saving Lives programme in April 2022 affected them as this facilitated fuelling of the ambulances enabling referrals for EmONC services. With this situation, some of the components were deprioritized by the government (Review of programme reports and interviews with CO and WHO staff).

UNFPA was instrumental in the sensitization and case detection support on ***cervical cancer***. Interviews with the district health facility and CO staff indicated that UNFPA played a key role in the sensitization and ensuring early detection of cervical cancer. UNFPA supported the healthcare workers, and community health workers, through training them on screening. During the period of assessment, UNFPA made it possible in the country, for the first time, to set up nine (9) cervical cancer screening centres, which also acted as the referral points where clients could access the screening services. This was made possible by the South-to-South corporation project, between China and Sierra Leone, thereby strengthening the quality of EmONC services (Document review and Interviews with Chinese Embassy and CO staff). UNFPA also supported the facilities with all the consumables for screening and management of cancer (Document review and interviews with CO and MoHS staff). With the support, the MoHS staff reported that there is an increased understanding of what cervical cancer is and where the services can be accessed, with an increased number of women visiting the facilities for screening. The cervical cancer screening support has been lauded as successful as it helped in the early detection of cases, in addition to strengthening the referral pathway for cervical cancer screening (Interview with MoHS and IPs). The government has contributed to the success of the referral through supporting the CHWs with stipend (MoHS and CO staff).



- UNFPA contributed to strengthening mechanisms **for prevention of HIV services** through supporting the NAS in the development of the National Condom Promotion Strategy, procurement and distribution of condoms into the country, in addition to supporting "condomised" campaigns contributing to the improvement of the condom programming enhancing knowledge to facilitate consistent and correct use. UNFPA also supported the procurement of dispensers for distribution to the hotels and lodges targeting the key populations at risk of contracting HIV or spread (Document review and Interviews with CO and IP Staff). UNFPA also supported the

development of the prevention of mother-to-child-transmission Strategy, where it led in the Prong one of the strategies targeting HIV prevention. UNFPA is also part of The Global Fund's Country Coordination Mechanism (CCM) providing oversight on HIV prevention. UNFPA also contributed to increasing demand for the HIV services through supporting development of the CSE strategy targeting adolescents and young people, in addition to supporting the counselling and testing on HIV in different health facilities (Interviews with CO and IP staff). IPs however identified gaps in coordination and suggested inclusion of the HIV testing kits as part of the RH commodity distribution as they were facing constant challenges in accessing them. Towards contribution to HIV prevention, in 2021, UNFPA contributed to the development of PMTCT Strategy which was led by UNICEF, where UNFPA led in the 1st, and 2nd pillars which were on HIV prevention, prevention of unplanned pregnancy and finally being part of the Global Fund's Country Coordination Mechanism (CCM).

- Strengthening of **evidence generation, data management** and partnership in SRHR. UNFPA effectively mainstreamed population dynamics in the SRHR components during the period of evaluation enhancing evidence-based programme formulation and informed decision-making through capacity building, supporting data collection and strategy development. Firstly, interviews with MoHS and IPs indicated that UNFPA strengthened the capacity of the staff on DHIS2 tools, aligning the reporting to the DHMT tools, and currently the IPs's reports are captured in the government data system, which was never the case before UNFPA's support and contribution. This has also strengthened partnerships at the district level. For example, the IPs also reported that initially, the cervical cancer mobilization data were not captured but after training by UNFPA, they were captured. Interviews with PPASL reported that UNFPA facilitated their membership into the FP working group, enabling them to be part of the RH commodity supply planning, contributing to uptake of FP services.

- **UNFPA contributed to Increased Communities' abilities to demand SRH, FP and GBV response services.**

During the period of evaluation, interviews with the CO and IP staff indicated that UNFPA enhanced demand for SRH, FP and GBV response, especially among adolescent and young people and supporting communities on awareness raising and access to SRH, FP and GBV response services. These were achieved through various mechanisms including;

- Promoting integration of prevention of risk mechanisms in the SRH services delivery. For example, while the women would be sensitized for cervical cancer screening, they would also be counselled and tested for HIV when they went for the screening. Further, UNFPA supported procurement of condoms for dual protection from pregnancy and STI prevention; in addition to enhancing distribution through IPs, supporting dispensers in public places (Interviews MoHS and CO staff). UNFPA
- Supporting advocacy for integration of services into various service delivery strategies and policies in the country. For example, aspects of GBV are integrated into the National Health Sector Strategic Plan (2021 – 2025), in addition to the planned inclusion of SRH within the UHC roadmap. These will increase access to SRH and GBV services (SIS review and Interviews MoHS and CO staff)
- Supporting development of strategies promoting integration of services. For example, the National Condom Programming Strategies increased access to services by the lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) and key populations. For example, interviews with the National AIDS Secretariat and CO staff indicated that UNFPA was instrumental in reaching the key population with services through the strategy, building on the (UNAIDS) framework. The Comprehensive Sexuality Education (CSE) curriculum integrated STI prevention, and menstrual hygiene for in-school children and the out of school through the safe spaces. The obstetric fistula also integrated GBV response through restoring their dignity and eliminating stigma (Interview with CO and IPs staff).
- UNFPA also supported integrated multisectoral service delivery. For example, the one-stop centres and RH hubs are multisectoral in nature, including the police for justice system and Ministry of Gender and Children Affairs (MoGCA) for policy influence on service delivery, while the RH hubs provide mentors in safe spaces and are also linked with the health facilities for services. Further, safe spaces supported by UNFPA are created for girls to meet and discuss SRH issues, enhancing their demand and access to services (Interview with CO and IPs staff).
- Review of Annual reports and interviews with CO and IP staff also revealed that UNFPA deliberately supported mechanisms for increasing awareness on the services through supporting and training of the CHWs, peers' educators at the district and community levels, supporting dissemination of strategies and IEC materials, supporting youth action movements, and conducting on-site health talks.
- UNFPA also targeted the youth and women CBOs with training on SRH and GBV to demand for services. For example, in 2021, UNFPA supported training of 27 community-based youth organization and oriented on demand creation leading to the National Youth Summit. Further, 53 Community based organisations had their capacity built in the conduct of community sensitization and demand generation for cervical screening.

While there was reported effectiveness in integration of services, there were gaps in ensuring effective coordination between the involved ministries. For example, the collaboration between the MoGCA and MoHS was assessed to be weak, especially on the operation of the One-Stop centres and the RH hubs, as they were not working collaboratively. It was observed that it only happens when there are stock-outs and when reports are provided. Coordination was also reported to be a teething issue, hampering referrals (Interview with the MoGCA, MoHS, CO and IP staff).

COVID-19 response and CP Adaptation to the COVID-19 pandemic context

The onset of COVID-19 pandemic in 2020 led to emergency needs disrupting the normal operation of service delivery in the country. UNFPA devised innovative ways of ensuring resilience of the country's health systems enabling continuity of the services, especially the SRHR services. UNFPA supported the healthcare workers to conduct outreaches in the affected areas since community members were afraid of going to the health facilities for fear of being infected by the pandemic, supported sensitization activities on the infection, prevention and control (IPC) of COVID-19 reaching 444, 000 people through partnership with Africell Mobile Network Operator on messaging for community mobilization to foster continuity of SRH services during COVID-19 Pandemic, in addition to reaching 291 communities with messages on COVID-19 IPC (SIS 2020 report and Interviews with CO). UNFPA also distributed more than 20,000 dignity kits, including hygiene products. UNFPA 7CP was effectively adapted to the COVID-19 pandemic context of programming achieving most of the planned targets in the areas of implementation, except in the Obstetric fistula surgeries which had to be suspended until the 4th quarter of 2020 missing on targets.

4.3.2 Adolescent and Youth

4.3.2.1 Introduction of the Component

The design of the Adolescent and Youth component of the 7CP was to contribute to one output aimed at ensuring that young people, in particular adolescent girls, have the skills and capabilities to make informed choices about their sexual and reproductive health and rights and well-being, including in humanitarian settings, and measured through one outcome and three output indicators. The component has been assessed based on the interventions implemented and their contribution to the outcome at both strategic and national levels. The 7CP supported implementation interventions including providing financial and technical support on conducting advocacy for policies that address adolescent and youth health and well-being and child marriage; building capacity for implementation of CSE and life skills for in- and out-of-school adolescents and young people; supporting the empowerment of young people, particularly adolescent girls to have skills and capabilities to make informed choices in relation to their SRHR and HIV prevention; strengthening systems and partnerships to generate and use evidence on adolescents and youth to contribute to harnessing the demographic dividend; and building capacity for implementation of the national youth service.

4.3.2.2 Achieved versus planned component output

Assessment of the reports of 7CP indicate that two out of the planned three A&Y component output indicators are achieved. The indicators achieved were on the number of marginalized girls that were reached by the life skills programmes that built their health, social and economic asset which was surpassed; and while the CO managed to have in place a national demographic observatory for tracking progress on the demographic dividend in place. The functionality however was a limitation as the data to be fed onto the system was yet to be uploaded to inform if it is meeting its achievements. On the other hand, the indicator on the number of schools in which the CSE curriculum is implemented had not been achieved at the time of the CPE. However, feedback from interviews with CO and the Ministry of Basic and Senior Secondary Education (MBSSE) indicated that the curriculum had been revised to include comprehensive sexuality education, in addition to helping the MBSSE to develop teaching and learning materials and only awaiting validation and piloting. While the interventions had far-reaching effects from the COVID-19 pandemic, interviews with the IPs and assessment of the programme, documented indicated that UNFPA was able to devise mechanisms to ensure that the planned activities were implemented with targeted beneficiaries reached. This was attributed to the UNFPA's flexibility, technical capacity, strategic partnerships with both government and local CSOs whose presence on the ground is strong, relationship with the donors and promptly act on contextual changes, in addition to benefiting from the global presence (Interviews with IPs and MoYA).

Table 10 - Adolescent and Youth Component Performance Data

UNFPA strategic plan outcome: Every adolescent and youth, in particular adolescent girls, is empowered to have access to sexual and reproductive health and rights, in all contexts

Output Indicators	Baseline	Targets (2023)	Progress as at August 2022	Comments
Output 1: Young people, in particular adolescent girls, have the skills and capabilities to make informed choices about their sexual and reproductive health and rights and well-being, including in humanitarian settings.				
Number of marginalized girls that are reached by life skills programmes that build their health, social and economic assets	2400 (2016)	3,700[45]	4,834	The target was surpassed by 2021.
Number of schools in which the comprehensive sexuality education curriculum is implemented.	0 (2019)	300	0	UNFPA supported the Ministry of Basic and Senior Secondary Education (MBSSE) to revise the basic education curriculum to fully incorporate CSE. UNFPA also supported MBSSE to develop teaching and learning Materials which will be validated and piloted before the end of 2022.
A functional national demographic observatory for tracking progress on the demographic dividend in place	No (2019)	Yes	Yes	UNFPA supported Statistics Sierra Leone to establish a Functional Demographic Observatory system for Tracking Demographic Dividends. Data to update the tracker awaits the Mid-Term Census results.

Increased skills and capabilities of young people to make informed choices about their SRHR and well-being in the targeted locations.

The assessment of the contribution of the above output area under the A&Y component of the 7CP from interviews with various stakeholders and CO staff, and review of CP report indicated that the programme immensely contributed to enhancing the adolescents and young people, particularly marginalized girls to express themselves and access the rights. The results under this component were achieved, utilizing different strategies where UNFPA contributed to strengthening the policy framework for the adolescent and young people, development of in and out of school CSE curriculum incorporating adolescent sexual and reproductive health (ASRH) and GBV aspects, strengthening the skills of the marginalized and vulnerable girls, advocacy against harmful practices, including child marriage and female genital mutilation, and strengthening the capacities of national institutions to develop strategies.

Interviews with IPs, GoSL and CO staff, and beneficiaries, particularly marginalized girls revealed how UNFPA contributed to influencing the empowerment of the youth and adolescent through strengthening their life skills enhancing their capacity to make their life choices, including making choices of sexual debut and practices. For example; FGD sessions with girls in **safe spaces** in Koinadugu District stated that the UNFPA and UNICEF support has given them the life skills and were able to pinpoint the advantages if they are educated versus the liability of taking care of them if not educated because of dropping out of school to get married, showing a shift in mind-set from the traditional perceptions of early marriage. Further, the girls appreciated the end-child marriage (ECM) project supporting the safe spaces enabling them to learn and express themselves on issues, particularly sexuality, which were/ are considered a taboo topic in their communities. They reported gaining knowledge on SRH and GBV, particularly FP, STIs and harmful practices, things that they did not know before. The life skills training, the girls reported, enabled them to communicate better, respond and deal better to their problems, including supporting others in similar situations, including dealing with harmful traditional practices. UNFPA and UNICEF ensured standardization in the operation of the safe space through supporting the development of the standard operating procedures (SOPs) ensuring that the operations of the safe spaces meet the international standards (Interviews with MoGCA, CO and UNICEF staff). The UNFPA strategy of grouping the girls according to age-sets enabled them to learn age specific topics and enhance their knowledge levels on specific issues, particularly sexuality. Apart from the traditional and social norms, poverty was mentioned as the driving factor to the parents forcing their girls to get married at an early age so that they could get cows or money from the marriage. The ECM however did not address the economic factor while addressing the ending of child marriage.

[45] The CPD states that the target for the programme is 16,000, which the SIS reports indicate that the target for the two years 2020 and 2021 were 3200 and 500 respectively. This assessment has used the targets for two years to assess the performance in the indicator.

UNFPA further played a critical role towards **reducing teenage pregnancies, and supporting those already pregnant to empower them to go back to school**. UNFPA Sierra Leone contributed to strengthening the policy framework in the country. Further, UNFPA stood out to be the leading contributor to the National Secretariat for Reduction of Teenage Pregnancy and Child Marriage (Secretariat) through improvement of the policy and legal frameworks for the protection of the adolescent and young women. At the time of the CPE, UNFPA together with UNDP, UN Women, UNICEF had supported the Secretariat on the implementation and mid-term review of Communication Strategy for enhanced guided information and awareness creation on the risks and the availability of services, with a rights-based focus (Interviews with MoGCA, Secretariat, CO and IP staff). From interviews, the results indicate UNFPA's contribution in addressing early marriages and teenage pregnancies.

> "The ECM project has empowered girls in the target communities…. girls who had been forced to get married by their parent and exposed to the project ultimately go back to school or home and look for ways and means that would allow them to go back to school. Even communities where the ECM project was not covering had girls pushing to be enrolled because they had seen the befits of the programme" – **IP Informant during the CPE**

UNFPA's financial and technical support to the development of the National Policy on Radical Inclusion in Schools, provision of technical support to the amendment to the Child Rights Act (2007), development of the National Male Involvement Strategy for the prevention of sexual and gender-based violence in Sierra Leone, contributed immensely to the efforts toward reduction of teenage pregnancies and child marriage. For example, the Radical Inclusion Policy provided an enabling environment for the girls and young people to stay in school when pregnant and even while lactating. Interview with MBSSE and CO staff reported that UNFPA supported 200 girls distributed 11 community learning centres across Kambia, Koinadugu, Kambia and Pujehun districts to report back to school, including those lactating, pregnant or even those who dropped out of school due to pregnancies or early marriage. The interviews further confirmed that UNFPA provided them with uniforms, bags, schools, stipend for the teachers and supporting the centres where the girls were engaged in for three months to help them through their reintegration into school. The MBSSE informants also stated that the UNFPA's support on monitoring activities enabled them to collect experiences that they used to improve the programme. While the girls were supported for three months toward reintegration back to school, interviews indicated that some of them are not willing to go for fear of lacking financial support, and given that UNFPA support, the sustainability aspects were in doubt, necessitating the need for economic empowerment. As a package however to the support in the centres, UNFPA supported them on literacy, numeracy and SRH training empowering them.

> "Most of the girls are from poor background and do not have what to use to buy the school items even when they are supported by the policy… UNFPA's support to the girls to go back to school through supporting them with the basic items made a big difference and contributed to their motivation to go back to school. The stipend also motivates the teachers to support the girls" – **MBSSE Key Informant.**

UNFPA effectively facilitated the adolescent and young people on GBV and SRH information and services through advocacy and supporting the availability of the services. UNFPA utilized different platforms to facilitate these. The IPs and CO staff identified use of different structures to engage the adolescents and young people of the access to SRHR. These included used of transformative discussions, girl-led session and developing their skills, in addition to use of educative programmes further enhancing their life skills to end child marriage and other harmful practices, especially in communities where the social norms were rampant. The strategy of working with the community structures, especially with the chiefdoms in the four districts, mothers' clubs, schools' health club, out of school clubs, community board members and respective ministries contributed to enhancing behaviour change. Further, the presence of SRH hubs, one-stop centres, availability of referrals, hotline (116) for cases of rape presence of family support units and SL Police and other paralegal organizations facilitated the adolescent's access to services and support. According to the IPs and CO staff, the adolescent and young people increased their self-awareness on retrogressive cultural issues such as forced marriages and rape in the society that downplays their efforts to pursue their potential and careers (Document reviews and Interviews).

Through a Joint Programme with the UNDP and FAO, UNFPA is implementing the Youth-at-Risk project, with funding from the Peace Building Fund contributed to the engagement of the youth engaged in violent behaviours, while at the same time targeting men and younger youth and girls to reduce GBV behaviours. UNFPA utilized the positive masculinity approach to ensure that the young people, particularly men and boys, utilized alternative means to violence to address their issues. Through the efforts, UNFPA focused on engagement of men, supporting sensitization mechanisms, with results of self-reports from the young men turning away from the gangs that they

belonged to before the project, engaging in alternative livelihood activities enhancing their dignities (Interviews and document reviews).

Development of in and out of school CSE curriculum

During the 7CP implementation period, UNFPA succeeded in supporting the MBSSE and other stakeholders in the development and integration of the in and out of school Basic Education Curriculum Framework on comprehensive sexuality education (CSE), ensuring incorporation and delivery of gender-sensitive sexual and reproductive health components to the in and out of school children, in addition to the prevention of harmful practices. In addition, the CSE also aims to contribute to the prevention and treatment of HIV. In collaboration with the MBSSE, the 7 CP contributed to supporting the government in promoting delay in sexual debut and use of condoms, addressing the high rates of teenage pregnancies, in addition to ensuring that the girls are brought back to school (Interviews with CO, MBSSE and IPs staff). Advocacy by UNFPA and other stakeholders will ensure that the integration of CSE into primary and secondary school enables adolescents and young people to make life choices and will make a huge contribution in addressing GEWE and SRHR issues in the country. The next step will be to build the capacities of the government in addition to supporting the production of the training materials. At the time of the CPE, the CSE had not been launched, but it had been finalized awaiting official launch. UNFPA may need to work on modalities of accelerating implementation processes to meet the target during the remaining period of implementation. Properly implemented, and with a strong government ownership will lead to sustained benefits in the knowledge of in-school young people on SRH, sexuality, and gender relations, thereby contributing to improved GEWE, reducing teenage pregnancies, HIV acquisition, in addition to addressing of the harmful practices, especially when they are empowered.

UNFPA's support to advocacy to **end child marriage**, particularly utilizing different mechanisms at the community levels, involving community structures yielded a number of benefits, including abandonment of the practice by communities. For example, in 2021, a total 67 communities in Kambia, Pujehun and Koinadugu declared the abandonment of Child Marriage practice and reported supporting the ECM project and its interventions (SIS 2021, confirmed by interviews with Restless Development and CO staff). UNFPA utilized the Male Advocacy Peer Educators (MAPEs) trained on advocacy topics on adolescent and youth, in Pujehun, Kambia and Koinadugu districts targeting communities, including chiefdoms, raising awareness campaigns on teenage pregnancy, child marriage and GBV. These were considered by the IPs, CO and MOYA to be very instrumental in community engagement and influencing the community perspectives of ECM. The amendment to the Child Rights Act (2007) drafted with explicit clause on prohibition of child marriage and harmful practices especially FGM, enabling the girls to make their own decisions if they become adults at age 18 years; is also likely to address the strengthen the legal framework for addressing harmful practices in the country. GBV cases against young people were also reported to be reducing since communities are getting sensitized and shifting their perceptions of the same.

UNFPA's technically and financially enhanced Youth Empowerment through support to the Ministry of Youth Affairs (MoYA) on the review of the National Youth Policy (2014) which was necessitated by the changing needs of the young populations and to ensure a more focused policy on young people's issues in the country. Interviews by the UN agencies, IPs, MoYA and CO staff indicated that the review of the policy through nationwide consultation and popularisation responded to the increasing cases of teenage pregnancies and youth violence. UNFPA was lauded by the IPs and MoYA for the enormous contribution leading to the empowerment of the youth in the country. For example, to address the unemployment rates of the youth leading to their engagement in violence, UNFPA supported the establishment of National Youth Service (NYS), recruiting unemployed graduates into a one-year internship programme in various institutions enabling them to acquire skills increasing their employability, with UNFPA providing stipend for the youth in the programme. The programme was reported by MoYA and CO staff to be very instrumental to the unemployed youth with some of them being absorbed in the institutions of engagement. Further, the engagement of the youth in economic activities increased with 149 youth being supported with income generating activities (IGAs) through car wash centres established, in addition to the youth being trained on basic numeracy, banking, book keeping and literacy increasing their skills. Additionally, 140 fishing boats and fish ponds were supported as youth initiatives. Interviews with youth stakeholders also revealed that the youth councils were strengthened to engage youth issues in the country since the policy prescribed the needs of the young people. Interviews with IPs indicate that the support have led to changes in behaviours among the youth, with the initially violent youth meaningfully engaged on IGAs and participating in sensitizing fellow youth against engaging in violent or criminal activities. For example, interviews with IPs indicated that police records showed that no involvement of the youth trained by the UNFPA-supported programme in violent activities reported in the last two years.

In line with the A&Y output, UNFPA contributed to increasing the participation of the young people in decision-making through strengthening their capacity on governance and sensitizing them to enhance accountability. UNFPA supported the youth at the district levels to participate and influence decisions affecting them, including policies (Interviews and document reviews). With UNFPA's support, the youth participated in decision-making through the establishment of 191 youth councils in 191 chiefdoms with representatives at the zones up to the national levels ensuring that the interests of their peers in the communities are taken care of, in addition to participating in monitoring programme activities. It is imperative to note that the councils have members elected by the members, and participate in the recruitment of members. Interviews with the MoYA and CO staff indicated that the youth platforms enabled them to get involved in national issues. For example, the youth reported participating and contributing to the review of the National Youth Policy (2014). The youth were also trained on teenage pregnancy, early marriage and GBV, and contributing to addressing the issues in their communities.

Towards harnessing the demographic dividend through investments in the youth, with the aim of adopting a coordinated, multi-sectoral and collaborative approach to implementing youth programming, UNFPA together with the other UN agencies, UNDP, UNICEF, FAO, IOM and the RCO organized and facilitated a National Youth Summit in November 2021. With UNFPA providing overall leadership and coordination, the Summit also provided a platform for the over 700 youth drawn from all the 16 districts to air the issues affecting them and engagement of the key stakeholders, the summit ended with a declaration, calling for young people to be actively involved in shaping and implementing fundamental changes across all aspects of their lives and societies. The other outcome of the Summit was the establishment of a Youth Empowerment Fund which will provide opportunities for youth to access capital to support them on initiating IGAs, access to training opportunities that will strengthen their skills (Interview with MoYA, CO, UNICEF and UNDP staff). Further, through the leadership of UNFPA, the Youth Thematic Team (YTT) drove the agenda of Youth2030 through organizing international youth days which also formed an advocacy platform to increase the involvement of youths in governance issues in the country.

While the A&Y component of the 7CP contributed immensely to address key issues bedevilling the adolescent and young people in the country, the component was less funded. For example, there were some chiefdoms that could not be covered because of inadequate funds. There were gaps in economic empowerment of the girls going back to school to ensure continuity of their being in school. In addition, the practices of child marriage and FGM had socio-economic benefits to the family, however the CP did not take this into consideration in the package of activities.

4.3.3 Gender Equality and Women's Empowerment

4.3.2.1 Introduction of the Component

The gender equality and women's empowerment (GEWE) component of the 7 CP aimed to contribute to one output targeting improved capacities of the government, human rights organisations, CSOs and communities to promote gender equality, prevent and respond to gender-based violence and other harmful practices, including in humanitarian settings. The 7 CP supported implementation interventions including supporting development of policy, legal and accountability frameworks for gender equality; developing capacity of national institutions and civil society to prevent gender-based violence and eliminate harmful practices such as child marriage and female genital mutilation; supporting the provision of services and strengthening referral mechanisms to respond to victims and survivors of gender-based violence; engaging communities and networks, particularly men and boys to promote empowerment of women, address gender-based violence and harmful practices, and promote women's empowerment; producing and using disaggregated data on gender including gender-based violence and other harmful practices.

4.3.2.2 Achieved versus planned component output

Review of the achievement of the 7CP under the GEWE component as per the 2020 and 2021 SIS reports indicate that one out of the planned four output indicators was achieved while the others are expected to be achieved by the end of the programming cycle. The indicator achieved was on the number of victims/survivors of GBV provided with a comprehensive package of services. The indicators that have not yet been achieved are on the number of institutions with capacity to report on gender-based violence, communities reporting abandonment of harmful practices and the national strategies and frameworks to advance gender equality and reproductive rights developed with support from UNFPA. While the targets of other three indicators were not achieved yet, the 7 CP contributed immensely in strengthening the capacity of the country on GEWE, particularly in the policy framework and supporting advocacy mechanisms addressing deeply-rooted tradition and harmful practices limiting girls and young people from exploring their potential and life choices. Further the advocacy-related activities held at the community level and those related to training were affected by COVID-19 which led to months of suspension of activities, in addition to adaptation of

the programming to the context of the pandemic, with the aim of IPC, limiting some of the activities' implementation. Interviews with the beneficiaries, especially those for advocacy at the community levels reported financial limitations to ensure coverage of the areas targeted. Strategically however, UNFPA partnered with both government and local CSOs, facilitating interventions and engaging various stakeholders ensuring effectiveness in the activity's delivery.

Table 11 - GEWE Component Performance Data

UNFPA strategic plan outcome: Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings				
Indicators	**Baseline**	**Targets (2023)**	**Progress as at 2021**	**Comments**
Output 1: Government, human rights organisations, civil society organisations and communities have improved capacities to promote gender equality, and to prevent and respond to gender-based violence and other harmful practices, including in humanitarian settings.				
Number of national strategies and frameworks to advance gender equality and reproductive rights developed with support from UNFPA	0	5	3 (2021)	The National Male Involvement Strategy for The Prevention of Sexual and Gender-Based Violence in Sierra Leone, the Policy on GEWE and the National Policy on Radical Inclusion in Schools were developed and launched during the period up to 2021.
Number of victims/survivors of gender-based violence provided with a comprehensive package of services.	0	2,515	4,490 (2021)	The 7 CP supported the Rainbo centres and government one-stop centres to provide a comprehensive package of services to GBV survivors. Further, the CP enhanced referral mechanisms for access to GBV services.
Number of institutions with capacity to report on gender-based violence	0	3	2 (2021)	
Number of communities reporting abandonment of harmful practices	0	100	67 (by 2021)	UNFPA utilised different mechanisms, including advocacy, training, policy development, engagement of duty bearers and rights holders, research and service provision to increase knowledge and influence attitudes and perceptions on harmful practices. The establishment of the male advocacy peer educators' network, and their orientation training sessions, contributed to this achievement. The indicator was however affected by the COVID-19 pandemic with related activities delayed or suspended.

Improved capacities of government, human rights organisations, CSO and communities have to promote gender equality, and to prevent and respond to GBV and other harmful practices.

In the period of coverage, the CPE established that UNFPA contributed to strengthening of the country's capacity in Gender equality and prevent and respond to GBV and other harmful practices through advancing advocacy mechanisms engaging various actors both at policy and community levels, men and media targeting strengthening legal and legislative framework, survivor protection, abandonment of child marriage, eliminate harmful practices and gender equality. UNFPA technically and financially supported capacities development of CSOs and government on child marriage and GBV prevention and response, including case management and referrals.

7 CP's contribution to strengthened GEWE policy and strategy development and reforms

UNFPA, through the 7 CP technically and financially contributed to supporting the country's policy and strategy development and reforms through supporting development and /or revision of existing laws or policies or strategies. For example, in 2020, UNFPA supported the development of the National Male Involvement Strategy for the Prevention of SGBV in Sierra Leone and the Policy on GEWE (SIS 2020). Further, the 2021 SIS reveals that the 7 CP supported the development and launch of the National SGBV Response Strategy. The GEWE policy aims at mainstreaming gender into all development and political processes in Sierra Leone to ensure protection for women, men, boys and girls for sustainable peace; and eliminating inequality and discrimination. The development and roll-out of the GEWE policy made it easier for all UN agencies to mobilise resources to support the MoGCA and other

ministries to respond on ensuring GEWE (Interviews with CO, MoGCA, UNICEF and UNDP staff). Further, the availability of this policy has ensured establishment of gender units in the ministries facilitating decision-making, in addition to ensuring mainstreaming of gender in the ministries. Interviews and reports also revealed that with the availability of the GEWE policy, the government is planning to have a gender responsive budget, with the World Bank supporting the government on how to support the fiscal policy. Creation of awareness on the policy and content has been ensured at the district councils with the development and gender officers factored in the budgets and plans of the ministries and councils. During the period, access to justice was enhanced through the creation the sexual offenses court as a separate court, which was identified to have played a key role in the reduction of SGBV cases since the court defines punishment – fines from LE 5Million to LE 50 million and not-more-than 2 years to the current 15 years and above jail term (interviews with CO and Parliamentary Action Group on PD). UNFPA provided support for the processes of the development of the National Male Involvement Strategy for the Prevention of SGBV in Sierra Leone, adopting a socially transformative approach that encourages the participation of men and boys as change agents and champions of women's and girls' rights, in their families, communities, schools and workplaces. launched by His Excellency, the President led to peer-to-peer engagement, particularly during the 16 Days of Activism. At the time of the CPE, the roll-out was being worked on (SIS and Interviews with CO, MoGCA and IPs staff).

Strengthening GBV Prevention and Response

UNFPA continued, during the 7 CP to support strengthening access to survivor-centred GBV response services. The CP made strides in ensuring that GBV services were available at the district headquarter level and made efforts to ensure that the survivors got the services. Through implementing partners, MoGCA and Rainbo Initiative, among others, UNFPA supported the provision of various services to the GBV survivors, including, psychosocial counselling (PSC), clinical services, establishment of GBV toll-free hotline (116) together with UNICEF, and legal services. Further, UNFPA also supported the MoGCA to conduct referrals, and report cases, in addition to support the Rainbo Initiative to make follow-ups on the cases, including boys reporting on issues of GBV to access and seek services. Towards ensuring that the survivors accessed justice, the government supported the establishment of a court to address the cases.

With Support from the Irish Aid and the Government of China, UNFPA supported MoGCA in the establishment of One-Stop Centres (OSC), providing a comprehensive service package of services including FP commodities to survivors of GBV, and have reached a total of 4,490 survivors by 2021 (SIS reports 2020 and 2021). UNFPA, together with UN Women and in collaboration with MoGCA, supported the establishment and operation of the OSCs which was hailed by the IPs, MoGCA and CO staff as instrumental in providing comprehensive multi sectoral services to GBV survivors. Managed and operated by the MoGCA, UNFPA supported the operations of the centres through providing stipends for the Centre Managers, office running costs and equipment of the centres and supporting them with drugs (Document reviews and Interviews with MoGCA, CO and IP staff). In places where the centres were absent, UNFPA supported other stakeholders and in coordination with the OSCs. The OSCs supported the GBV survivors to access multisectoral lifesaving services including psychosocial support (PSS), legal aid, medical support, dignity kits support, awareness raising, and GBV case management through follow-ups. The OSCs were also effective in contributing to the coordination of partners to ensure that the affected received the right support through the right referral pathways. The OSCs provided an entry point for comprehensive and integrated RH and GBV services including ensuring close follow-up by the service providers across the target locations in the country (Interviews with CO, MoGCA and CO staff, FGDs and Document reviews).

The OSCs also had far-reaching effects where it led to reduction in the cost of medical assessments to the survivors as the services were free, presence of the police to conduct investigation on legal issues leading to reduced costs accessing them Awareness sessions held at the OSCs were participatory led by the Centre Manager, contributing to the enhancement of their knowledge on issues of interest (FGDs and interviews with MoGCA and CO staff). The CP delivery promoted participation of women and girls, in addition to access to services for persons with disabilities (PWDs) in a safe environment. UNFPA also supported the IPs to continue providing GBV response and prevention services including information dissemination on COVID-19 in line with the guidelines on programme adaptation during COVID-19 (Interviews with MoGCA and UNFPA CO staff). While the OSCs provided a lot of support to the GBV survivors, including providing convenience in service access, there is a need to incorporate social treatment and social aspects like mental health. There is also a need to enhance follow-ups with the survivors, particularly with the Rainbo Centres. In addition, there is a need to target healthcare workers with capacity building on GBV response as they do not have technical expertise to offer PSS support to those admitted in the health facilities for treatment (Interviews with IPs and UN agencies). The judicial system however needs to be strengthened, especially in addressing the cultural barriers to GBV survivors accessing services. For example, in Sierra Leone taking someone to the police

is like telling someone that one is an enemy, thereby limiting the reported cases. Referral system also needs to be strengthened to ensure that the survivors have available services.

Mechanisms to end GBV and harmful practices

Male involvement: Interviews and document reviews indicate that UNFPA enhanced engagement of men and boys using a gender transformative approach to end GBV and harmful practices. Through identification, training and engagement of male advocacy peer educators (MAPEs) and boys out-of-school. The identification of the MAPEs entailed working with the community leaderships, ensuring that those recruited could act as role models for the community in ensuring positive behaviours. For example, in Kenema, the programme recruited five MAPEs per community, and worked in a total of nine communities, all recruited with the support of the community leaders. Trained on various topics spanning, child rights, teenage pregnancies, early marriage, GBV and SRHR and service availability, the MAPEs and boys out-of-school were effective as role models and in conducting outreach activities with men within the communities of operation. Strategically, the MAPES and the boys out-of-school targeted key stakeholders such as former and current chiefs, traditional and religious leaders, heads of households and youth groups in the target locations sensitizing them on the dangers of GBV, early child marriage, harmful traditional practices, in addition to discussing and agreeing on ways on which to end the practices in their respective communities. These were reported to have contributed to increasing their knowledge and targeting change of attitude on the harmful practices, in addition to enhancing referrals of cases of abuse through working with the police (Interviews and document review).

To enhance the engagement of the men, especially at family level, UNFPA supported the establishment of informal learning centres, ***Husband schools***, targeting positive behaviours from the men and youth at risk. In these facilities, husbands and potential fathers were identified with the help of the MAPEs and grouped into a maximum of 25 participants per session per community. The husbands undergo three-months training facilitated by the MAPEs and are informed on various topics spanning GBV, SRHR, positive parenting, drug abuse, STIs, HIV, patriarchal and masculinity awareness – targeting positive masculinity, especially in ending GBV and harmful practices. Utilizing the gender action and learning approach, the targets were mobilized and sensitized to take care of their families, including protecting their children from harmful practices. Further, to ensure that the wives or partners of the men trained were aware of the training aspects, the sessions were designed such that they joined their husbands in the training in the last month of training and then they are mentored together in *Papa-mama (Pamama*) sessions (Interviews with CO and IPs). Interviews with the IPs and beneficiaries revealed that the husband schools were effective in improving accountability among husbands due to the knowledge that they gained on taking care of their families, bringing up children and staying with their families.

> "Initially, men viewed accompanying their wives to the clinics for maternal child health (MCH) services as a taboo. Since they were trained in the Husband Schools, they help their wives to the hospitals… Since every family wants success, the men are now paying attention to ensure that their children, including girls, go to school as they have been sensitized on the needs to be responsible parents" **– IP Informants during CPE.**

UNFPA, through the IPs, contributed to enhancing the ***community level engagement*** of duty bearers and rights holders on the GBV prevention aspects, and further supported capacity strengthening to ensure that the GBV cases are reported. Further, interviews with the IPs and the CO staff indicated that the 7CP also engaged the communities to understand the laws that have been passed with the community members across the gender divide. There are however challenges experienced towards the realization of changes as men were not covered to receive services under the Universal Health Initiative (UHI). UNFPA however catered for the men to access health service at the health facilities, but this was not enough. When cases are referred, the referral costs are not catered for and therefore they are discouraged at going for the referred service. Since the police do not go to the scene of crime due to lack of fuel for their vehicles, the perpetrators run away discouraging the MAPEs (Interviews with IPs).

Advocacy for elimination of FGM

Appreciating the context of implementation and the sensitivity involved in the campaigns against harmful practice of female genital mutilation (FGM), UNFPA utilized an integrated approach to addressing the FGM interventions. Further, the intervention themes were cross-cutting in the SRHR and Adolescent and Youth component, where SRHR addressed advocacy issues on the sexual rights of the children, while the adolescent and youth component enhances sensitization among the harmful practices aimed at abandonment of the vice (Document review and interviews). The 7CP supported advocacy campaigns aimed at supporting mechanisms towards abandonment of the FGM as well as supporting the strengthening legislations towards zero tolerance to FGM integrating it into most of the activities in male engagement, safe spaces activities and girls in education (document review and interviews with IPs and staff).

The main challenges identified as the main drivers to the FGM practice in the country include absence of accurate information on the extent of FGM, political and cultural connotation on it and poor monitoring of the FGM (Document reviews and Interviews with IPs and CO staff). UNFPA contributed to enhancing engagement of the custodians of cultural beliefs, community level engagement, including the policy level engagement. Through the Forum for Harmful practices, the CP contributed to the engagement of local community groups, getting them to understand why it is important to take the children to go to school and not to go to school because of the effects of FGM. UNFPA was also in the process of engaging the Human Right Commission to support the programme to reach communities better. While the Constitution protects human dignity and equality, tradition beliefs play a major role in the spread of FGM. Interviews with IPs, CO and Government staff however indicated that eradication of the harmful practices, particularly the FGM is a challenge as it is considered a very sensitive aspect to discuss (quote). For example, during the period, UNFPA worked with UNICEF, and UN Women and other stakeholders and put together a strategy on how to end FGM, but this was not endorsed by the government (Interviews with CO, UNICEF and IP staff). Amendment of the Child Rights Act (2007) is however incorporating it and outlawing the practice for girls under the age of 18 years, that the girls should make their own decision to go for FGM when they become adults. This is considered a huge success as in 2007 it had been tried, but did not get through. It is hoped that, if properly implemented and monitored, it will reduce the prevalence of FGM, among other harmful practices. Interviews however confirmed that there were gradual changes, with some of the mothers stating that they will not expose their children to the experience they went through during the FGM ritual, and therefore given alternative to school to become the woman that they want to be in future.

Integrated SRH and GBV strengthened to enhance services access and delivery

During the period of evaluation, UNFPA succeeded in strengthening integration of programme interventions to enhance access to a myriad of services in the target locations. For example, through the support of the One-Stop Centres and RH hubs, which were multisectoral in nature with the support of the MoGCA and the Sierra Leone Police to ensure that services were delivered effectively. Interviews with IPs and review of the CP documentations revealed that the RH hubs provided girls being mentored from the safe spaces with RH commodities, in addition to the hubs being linked to health facilities which always facilitates referrals. Interviews also revealed that the girls in the safe spaces also had information sessions with health staff from the heath facilities, enabling them to know about their SRHR rights and those making choices to access the services. Interviews with the IPs and MoGCA also indicated that each of the One-Stop centres and safe spaces were also tagged to an existing health facility for referral purposes, especially for the convenience of the RH supplies enhancing access of the services. The One-Stop centres contribute to coordinating the partners involved in the provision of various services. While integration was largely a success during the 7CP, there were concerns of inadequate coordination and collaboration, particularly among the MoHS and MoGCA for the RH hubs and health facilities, and One-Stop centres respectively. This was identified to be a cause for stock-outs in some of the One-Stop centres. On the other hand, the referral pathway is also not as strong to effectively facilitate. Presence of the One-Stop centres in the district headquarters also limits access to the services.

To enhance consolidation of GBV data and ensure follow-up and access to response services by the stakeholders in the country, UNFPA and UNICEF supported piloting and the roll-out of GBV information management system (GBVIMS), with UNICEF leading the process. While it is at the planning stage, this is piloted in a development set-up to capture GBV data in alignment and coordinated ethical and effective way facilitating all the to organization in ensuring confidentiality and safety of the GBV survivors (Interviews with MoGCA, CO and UNICEF). In addition to providing technical and financial support, UNFPA is part of the steering committee to establish it.

4.3.4 Strengthening data generation capacity and advocacy for policy development

According to the design of the programme, population dynamics was mainstreamed in all the three components of the thematic areas. The design ensured that aspects of data generation were integrated in the delivery of the CP. This was deliberate to ensure that achievements and decisions in the thematic areas were informed by data and increase availability of evidence. UNFPA supported this delivery through partnering with Statistics Sierra Leone (SSL) and MoPED, while at the same time collaborating with other key institutions in the country aimed at strengthening advocacy and legislative capacity (document reviews and Interviews with MoPED, SSL and CO staff).

During the period of evaluation, UNFPA supported MoPED and the MoYA to harness the Demographic Dividend (DD) through supporting the scoping of the DD profile in the country using use of National Transfer Account approach[46] focusing on actualizing the African Union Roadmap on harnessing the DD by prioritising investment in

[46] The goal of the NTA project is to improve understanding of how population growth and changing population age structure influence economic growth, gender and generational equity, public finances, and other important features of the macro-economy – accessed from https://www.ntaccounts.org/web/nta/show/

youth to transform the country. UNFPA ensured this through hiring a consultant from the University of Sierra Leone's Institute of Population and Development (USL-IPD), for institutional readiness on the population dividend. This was done with the appreciation that the Sierra Leone population is more youth-led, necessitating the need to put young people first and invest in their health, education, employment and empowerment is critical in achieving the DD. To ensure that there is improved generation and access of data for informing decision, UNFPA supported SSL to establish a demographic dividend observatory tracking system through procuring six laptops, screen and router to set it up (Interviews with CO, SSL, USL-IPD and MoPED staff). At the time of the CPE, the DD observatory tracker had been set up, however it had not been updated since the data to update it was to be from the Mid-term census results which had not been launched. The functionality of the system therefore could not be established by the CPE.

> "The development of the DD tracker, we are able to tell how much we are spending on various sectors of the economy, and able to track the progress being made in the sectors, including the impact and the expenditure…. When we know how much is spent per sector, then it helps in knowing the allocation of resources". – **MoPED informant during the CPE**

During the period of the CPE, UNFPA contributed to the capacity building of the SSL through supporting it in a number of ways. To ensure that the generation of information was efficient and effective, UNFPA supported the office from paper-based to digital data collection, including hiring a consultant for a year to support on training, securing 200 tablets through South-to-South cooperation from Kenya for implementation of the Mid-term census, and procurement of GIS software from Addis Ababa to have GIS imagery for use for four years to enable them use it during the mid-term stage and main census (Interviews with SSL and CO staff). UNFPA also contributed to enhancing availability of data for decision-making through supporting SSL in conducting an in-depth analysis of SLDHS data to produce reports on various aspects including FGM, child marriage and teenage pregnancies, contributing to identifications of locations of high prevalence for policy influence in response and prevention (Document reviews and Interviews with CO and SSL staff).

UNFPA supported the availability of data for decision-making. For example, with financial and technical support of SSL, the launch of the SLDHS provide foundation of achievement by the government and other stakeholders in the country, with the survey report providing reliable source of data that can be relied upon, in addition to being used as baseline and availability of evidence of performance (Interviews with MoPED, MoHS, MoGCA, MoYA and CO staff). The availability of the DD tracker in place also provides an opportunity to enhance achievement of the ICPD PoA, especially on the government's commitment on the reduction of the MMR in the country. The 7CP also supported implementation of various surveys across the country enhancing evidence-based programming through tracking performance. For example, in 2021, UNFPA financially supported assessment of facilities across the country on EmONC to assess their functionality. Further, during the period, the 7CP supported the production of sub-sector reports from the SLDHS, including initiation of in-depth analysis of data on disability, elderly and FGM, in addition to digitizing the dashboard for the three transformative goals able to inform on the progress that the country is making on the achievement of the goals (Document review and Interview with SSL and CO staff).

UNFPA was also part of the SDG monitoring in the country, being part of the establishment of the SDG Platform through the UN. The SDG platform established is being managed by MoPED and SSL is to lead in capturing the data enhancing ownership by the government and production of reliable information on the progress the country is making on the SDG indicators. At the time of the CPE, UNFPA was contributing to the production of data on disability and elderly with the aim of integrating the details into the SDG platform. The challenge at the time was that the stakeholders were not clear on the data to be used in the platform, between SLDHS and mid-term census, as there exist a number of sources of data. While SSL is supposed to have the sole mandate of producing data, this is not the case as still there are other entities producing data. For example, the National Civil Registration Authority (NCRA) and SSL are not clear on who should host the data to inform the country's performance. UNFPA provided technical support to ensure that there is only one source of data and open source. There is also a conflict among NCRA, Internal security or MoHS to register deaths and births (Interviews with SSL and CO). further, there is a need to ensure a coordinated data system in the country that can serve purposes and inform the decision reliably. During the period, the country was financially supported by UNDPA, UNICEF and UNFPA to produce the voluntary national reviews report (VNR) providing an update on the progress in implementing the ICPD Commitments and the country's achievement on the SDG indicators (document review and Interviews with CO, UNRC and MoPED).

Enhanced advocacy on the use of population data

Through the 7CP, UNFPA largely contributed to strengthening the capacity of the country in utilization of generated data for advocacy, planning and development through partnerships, technical assistance, capacity building and

financial support. UNFPA, through the 7CP supported the MoPED to popularise the National Population Policy (NPP), developed during the 6th CP. The popularization entailed production of copies of the policy and sharing it with stakeholders at the regional and district headquarters. To ensure that there was a buy-in into the need for the NPP, UNFPA supported the MoPED to hold stakeholders' forum to engage, in addition to further production of briefs on the policy and reports to promote the importance of inclusion of population dynamics in development planning and management (Interviews with MoPED, CO, and Parliamentary advocacy group and document reviews).

During the 7CP, UNFPA partnered, through MoPED, with the Sierra Leone Parliamentary Action Group on Population and Development, and supported them to advocate and influence use of population dynamics to inform policy formulation. The partnership was instrumental during the roll-out of the NPP through enhancing sensitization of the parliamentarians, ministries and the stakeholders at national, regional and district levels to sensitize the people on the same. At the time of the CPE, however, the team had only gone to the northern part of the country, but yet to go to the other parts of the country due to limited funding. It is also imperative to note that the popularisation of the NPP contributed to informing the MTNDP process in addition to informing the SSL on statistical data generation (Interviews and document reviews). Composed of 17 Members of Parliament (MPs), the committee advocated and supported the passing of bills on GEWE Policy, establishment of the Sexual Offenses Court, in adding to leading the *Hands Off Our Girls* campaigns culminating into the amendment of the Child Rights Act (2007). This was made possible because it is part of the other committees that deal with women, children, population, education, and they join whenever there are bills or issues around population dynamics. The 7CP's contribution in the operation of the committee was through supporting travelling allowances and contributing to their internet access at the resource centre where they do research to enhance their advocacy. These achievements were noted and lauded by the Committee members, with the sole support of UNFPA, through MoPED (Interviews with CO and the Parliamentary Action Group members). While the Parliamentary committee seems instrumental in enhancing use of data for policy making, in addition to influencing passing of bills in Parliament, there were challenges that were identified to affect their operation, including being limited on budgetary allocations through MoPED, which was also reported to delay in most cases. The committee also faulted the arrangement where they have to depend on MoPED, and therefore they are not able to plan on their own as a government entity, in addition to inadequacy of commitment as it is seen to be a deliverable by another entity. There is an opportunity to enhance the advocacy on the use of population policy if UNFPA dealt with the committee directly. This also enhances efficiency in decision-making, and would have more benefits that depended on MoPED to drive their agenda. Further popularisation of the SLDHS report to ensure it reaches to the last man in the provinces did not work due to limitation of funds, but only managed to conduct it with MoPED.

UNFPA also enhanced advocacy on population issues in the country through supporting the commemoration of the annual World Population Days, with the development and launch of the State of the World Population report for the country advocating for the indicators that the country is making at the global level (Interview with CO and document review). While there were efforts made in conducting advocacy on production and utilization of data for evidence-based decision-making, there is still lot to be done, especially on coordination of stakeholders to consolidate the various data being generated in the country, enhance dissemination of data produced to the lower level of administration, there is also need to utilize research, in addition to enhancing utilization of data and policy documents and data generated, including advocacy and capacity building (Interviews with CO, MoPED and SSL).

4.3.5 CP Integration of Human Rights and Gender

EQ4: To what extent has UNFPA successfully integrated human rights, gender perspectives and disability inclusion in the design, implementation and monitoring of the country programme?

Analysis of the reports and interviews with various stakeholders of the CP, including CO staff indicate that the programme highly integrated human rights approaches to deliver the interventions. To start with, the design of the CP was grounded on human rights and gender equality principles with the interventions focused on addressing the needs of the most vulnerable and marginalized populations, in addition to addressing dignity and equality of vulnerable women and girls with the aim of empowering them and ensuring their access to services, upholding their dignity. The implementation of the 7CP also integrated human rights approaches in delivery, in addition to ensuring mainstreaming of gender in the delivery of the CP, in addition to ensuring non-discriminatory efforts to eliminate harmful practices were in place at all time. Further, UNFPA ensured integration of the gender mainstreaming and human rights approaches into the delivery of the programme through training, conducting advocacy sessions with rights holders and duty bearers, law enforcement agencies, encouraging inclusive policies (Interviews with IPs, CO and CO reports).

UNFPA embedded human rights perspectives in the delivery of the SRHR component. UNFPA's focus on integrated RH, GEWE needs and rights of the most vulnerable, including people with disabilities, marginalized women and girls, among others is also evidence of a human rights perspective. In addition, UNFPA programme focused on selection of districts with dire needs. For example, UNFPA supported assessments to identify areas with needs or inadequacy of access to services and ensured bridging of the gap through, with locations lacking service delivery being targeted through supporting health care workers to conduct mobile outreaches indicating the intention to reach those most in need and to ensure that they accessed the needed services. Nonetheless, the entire orientation of the UNFPA CP supports the realisation of rights to RH including for safe motherhood, cervical cancer screening, family planning, HIV prevention for adolescents, GBV prevention and response and for the empowerment of women (document review and interviews with CO and IPs).

Under the SRH component, UNFPA supported identification of cases of obstetric fistula and facilitating their surgeries after-which they are supported on reintegration processes, in addition to organizing for counselling sessions with the families and community leadership. This restores their dignity, as confirmed during the interviews.

The 7CP also supported implementation of strategies that addressed marginalization and discrimination based on social and harmful practices in the country, including the needs of people living with disabilities. UNFPA made deliberate efforts through partnerships with stakeholders to reach the hard-to-reach locations, in addition to supporting inclusion and participation of adolescents, young people, vulnerable women and girls in access to services, dialogues and education sessions aimed at changing discriminatory gender norms, especially in relation to abandonment of FGM, child marriages and participation in discourses on implementing their reproductive rights. There were also support to the MoGCA and IPs on gender issues, establishment of girls' safe spaces, and conducting early and child marriage awareness (Interviews with MoGCA, IPs and CO staff and CP reports review). During the COVID-19 period, UNFPA partnered with radio stations to disseminate integrated information on COVID-19 IPC, FGM and other harmful practices to reach wider audience (Interview with CO and IP staff and Document review).

The GEWE component of the 7CP is gender focused and, interviews confirmed UNFPA's commitment to ending gender inequality and human rights violations, which were identified to be key barriers that must be addressed to end GBV and harmful practices, including child marriage, sexual violence and other types of discrimination and vulnerability; embracing a rights-based approach to support the affected populations. Interviews conducted with CO and IPs staff confirmed that they upheld inclusion and empowerment in their quest to provide services to the targeted populations. For example, the component supported different advocacy and policy mechanisms that aim to ensure accountability on human rights of marginalized groups, gender equality, women's reproductive rights issues and GBV preventions and response in the country (Interviews with CO and IP staff and document review). UNFPA contributed to supporting of the vulnerable women and girls and GBV survivors with dignity kits restoring their dignity (Interviews with IPs and CO staff). These principles were found to be consistently applied in programme planning and implementation processes. This exhibited the rights-based approach.

Through the Radical Inclusion Policy, the programme supported the support of 200 girls who had dropped out of school due to either forced marriage or teenage pregnancy. By supporting the policy that allows their return to school while at the same time supporting them with materials to go back to school enables the girls to reclaim their dignity and proceed with education without discrimination. Further, UNFPA supported provision of services in OSC without paying, enabling the GBV survivors to access support, enhancing their dignity, in addition to enabling them to access justice through referrals and follow-ups. UNFPA, as part of the UNCT, was the chair of the disability group and supported inclusion of PWDs in targeting and decision-making processes, including access to services. (Interviews with IPs and CO staff and SIS reports).

Interviews and document reviews confirmed that implementation of the GEWE component integrates gender and human rights approach in its implementation. In addressing the empowerment of women of the country, UNFPA advocates for rights of the female populations and those discriminated against by provision of information, in addition to engaging community leaderships, like chiefdoms, especially where the cultures promoting harmful practices were prevalent. In addition, the component supports different advocacy mechanisms on the roadmap endorsement for policies and declarations that aim to ensure accountability on human rights of marginalized groups, gender equality, women's reproductive rights issues and GBV prevention and response in Sierra Leone. For example, UNFPA financially and technically supported the operations of the National Secretariat for the Reduction of Teenage Pregnancy and Child Marriage contributing to the empowerment of girls and enhance their continuity to enjoy their rights to access education, elevating the rights and dignity focus of the programme (Interviews with IPs and CO staff and document review).

During the period of evaluation, UNFPA immensely contributed to the mainstreaming of gender across programmes which the support to the development of the GEWE Policy which guided the mainstreaming of the gender across ministries. With the policy available, and in collaboration with MoGCA, UN Women, UNICEF and UNDP supported the mainstreaming processes, including training of ministries and supporting recruitment of staff to support the process (Document review and Interviews with UNDP, CO and MoGCA staff). Interviews also revealed that there were plans, in collaboration with the World Bank to ensure a gender-sensitive budget to further enhance the mainstreaming of gender due to the advocacy efforts in place.

The 7CP's support on data generation and availability contributed to production of reports with figures disaggregated by sex, age, disabilities and other inequality issues which are key in identifying gender and human-rights related needs for interventions. The implementation and uptake of the services were however influenced in a number of ways including societal issues, inadequate resources, access issues, among other limitations (Interviews with CO and SSL staff). Further, apart from interview confirmations of non-discriminatory service delivery, it was also not clear how the disables were specifically targeted with services because of the analysed data.

Review of programme reports however did not reveal sex and age disaggregated data among the beneficiaries of the programme. The reporting tools (SIS) also did not give provision for disaggregating the data into age, sex or diversity. Further, the reports did not also indicate that IPs received guidance on gender mainstreaming, across the programme apart from the engendered trainings conducted for healthcare workers and social campaigns. While interviews with IPs indicated that they provided sex disaggregated data, gender mainstreaming did not appear to be the underlying objective in the disaggregation.

4.4 Answer to Evaluation Question on Efficiency

EQ5: To what extent has UNFPA made good use of its human, financial and administrative resources, and used a set of appropriate policies, procedures and tools to pursue the achievement of the outcomes defined in the county programme, ensuring quality assurance, risk mitigation and accountability of resources?

Summary: The CO ensured efficiencies in the delivery of the 7CP through making good use of its human, financial, technical and administrative resources, in addition to strengthening internal controls, ensuring compliance. Further, the CO utilized effective strategic approaches, including provision of technical assistance, partnerships, communication strategies, integration of the CP interventions, having a fairly robust M&E system in place and employing comparative advantage to advance the results in its mandate. There is however room for improvement especially in terms of staff capacity in some other thematic areas, enhancing focus on results-based approaches, research and knowledge management, and integration, and the deliberate action in addressing the late disbursements of funds to the IPs.

4.4.1 Resource Management

Overall, the CO has made good use of its resources during the 7CP. There is evidence to show that UNFPA Sierra Leone made good use of its financial and human resources to achieve programme results during the 7CP. The office typology was such that the programme was managed from the Country Office headquarters in Freetown, with no field offices. The delivery of the programme was essentially working through partners and the government structures making the programme delivery mechanisms enabled follow-up in the field activities for UNFPA and enhancing supervision (Interviews with IPs and CO staff and SIS).

The staff skill sets during the 7CP were generally effective and appropriate for their roles, especially in the implementation context, facilitating delivery of programme and operational functions in an effective manner (Interviews with IPs and CO and line ministries staff). Respondents from different IPs and government reported that UNFPA staff have the right technical capacities to efficiently delivered in their various roles, providing technical assistance. Interviews with the IPs and the government line ministry indicated that the CO was very supportive and flexibility in decision-making.

UNFPA put in place mechanism to ensure compliance and quality assurance ensuring organizational efficiency. UNFPA utilized both national and direct execution (NEX and DEX) modalities to deliver the programme. To ensure compliance within the office, the CO ensured that the staff had a clear checklist on all the procedures, in addition to SOPs to customise processes in finance, procurement, logistics and HR and shared with staff for their reference, and were constantly reviewed and feedback provided, in addition to being actioned on. UNFPA CO innovatively incorporated learning mechanisms within the CP delivery processes where during the *Learning Afternoons*, different

topics were included to be shared with the staff, including operations, ensuring that the CO was appraised on the areas (Interviews with CO staff and document reviews). The CO also had weekly programme meetings to check on challenges on programmes and operations, including schedules for submission of various reports. Further, staff were specifically assigned to follow up on the deadlines and the action points, contained in the meeting minutes. These ensured the teams delivered in an efficient manner. The CO also ensured that regular audits were conducted and coordinated, in addition to spot checks done by the CO staff and recommendations documented including follow-ups with the results shared with them and a plan developed to strengthen the weak areas. (Interviews with CO staff and document reviews). Further, the CO coordinated with the UNDP and UNICEF to conduct micro-assessments to ensure the right IPs were selected and based on the risk-rating, determines cash transfer modalities where those with low risk are given funds to spend while those with high risks have direct payments to the suppliers made on their behalf to ensure reduced risks in handling cash. Further, the reimbursement modality is also employed where the IPs expenditures are authorized for payment or spending and funds reimbursed to them based on the approval. All these ensure efficiency and compliance with the UNFPA procedures. Interviews with IPs confirmed that UNFPA CO was very supportive in providing them with support, capacity building including training and provision of guidelines to ensure that they complied.

UNFPA had enhanced accountability through putting in place a system when the disbursement of funds was based on performance on a quarterly basis. Interviews with IPs and government line ministries also indicated that there was feedback provided on the reports submitted to the CO. There was however mixed feedback on the engagement on the content of the reports, especially on the challenges being faced by the IPs and Government. For example, the country lacks specialists to conduct obstetric fistula surgeries and this has been communicated to UNFPA by the IPs and the MoHS but this has not been adequately addressed (Interviews with MoHS and IP). UNFPA also ensured value for money from procurement procedures which were dependent on thresholds. The procurement processes were however affected by the limitation on the national suppliers where they could not supply everything with the required quality and quantity. This, they stated forced them to buy from Europe of elsewhere and this led to delays and expensive.

Interviews with the IPs and government found that the financial support provided by UNFPA was adequate for the implementation of service delivery activities. However, they reported that the insufficiency of the funds to cover the administrative and other human resource costs. The IPs, including government line ministries also reported challenges on the regularity of the fund disbursement, which they reported affected their effectiveness in planning. Rigidity in the allocation of the budget to the IPs was also reported. However, the IPs reported flexibility from the CO at the onset of the COVID-19 pandemic where they were allowed to reallocate funds, enabling them to make necessary adjustments. Further, the IPs reported that there were delays in the disbursement of funds which also affected planning of the activities.

While the staff were rated as having the right skills sets, there were gaps in some offices, including delays in recruitment. For example, the retirement of the Procurement Associate retired and had not been filled more than four months later. This they said increased their scope and thereby affecting their productivity. The interviews however did not specifically identify or receive any reports of compromised quality of deliverables. Funding levels were also identified to be affecting hiring of some of the positions. On staff capacity, there was a blend of both international and national staff providing effective support on areas of expertise, with the regional office also providing support on areas of weakness in the office (Interviews). Further, the CO made arrangements to cover the HR gaps. For example, the IT focal point is one, but when he is not in, an arrangement is made to have the WFP IT focal point to support, ensuring that there is no disruption in the operations. Capacity building the staff was also reported to be a concern, especially for the national staff where they stated difficulty in going out of the country for training.

4.4.2 Strategic Management Approaches

UNFPA employed different mode of engagements to ensure that programme achieved its intended goals. To ensure a wider reach and coverage of the programme areas, the CO partnered with both CSOs and government line ministries. Further, UNFPA also partnered with other UN agencies, donors and communities to deliver on its 7CP in an efficient manner (Interviews with line ministries, IPs, CO, and UN agencies' staff). UNFPA's partnership with government increased consultations and joint planning which enhanced national ownership of programme results. Further, this partnership ensured implementation of different policy documents, in addition to direct incorporation of the CP achievements into the government strategic plans or frameworks (Interviews and Document reviews). These partnerships played a key role in ensuring that programme contributed directly to UNFPA's interventions. This contributed to an equitable distribution of resources in delivering of the CP in an efficient manner (Interviews with IPs and CO staff and document review).

UNFPA partnership with local institutions contributed to effective implementation of the 7CP interventions by providing local understanding of the contextual dynamics, including cultural structures and promoting local solutions to the various challenges. These organizations were strategic in extending UNFPA's interventions to marginalized communities, especially the hard-to reach locations, and vulnerable populations with limited access to facilities (interviews and document review). Because the targeted communities could easily identify with the local context, collaboration with the local organization also guaranteed programme approval and ownership from the communities. These in particular were important in the discussions over banning harmful practices including female genital mutilation (FGM), child marriage, teenage pregnancy, and service discrimination against women and girls (Interviews with IPs, CO, Line ministries and Document reviews). Programmes were implemented effectively thanks to the partners chosen, as shown by the high programme implementation rates. In addition to technical proficiency, UNFPA chose partners with broad geographic coverage, improving greater reach. For instance, Restless Development, which has extensive experience in BCC and youth activities, implemented the ECM project, making them effective in delivering the programme (Document reviews and IPs and CO interviews).
There were indications that the partners involved in the 7CP's implementation shared the costs of some of the functions. For instance, UNFPA only funded the students' tuition and other living expenses for students from the midwifery schools who were government employees, who received government-paid wages. For other IPs, UNFPA and other donors split the cost of employees, ensuring that the CP was delivered effectively (Interviews with CO and IPs). This partnership arrangement was very vital in resources utilization; UNFPA could have required massive financial capacity to implement the 7CP directly as a result of its staff remuneration and allowances (Interviews with IP and CO staff).

The 7CP was highly integrated with each of the components contributing to one another. For example, the FGM component did not have any budget allocation, but the Behavioural Change Communication interventions under SRH, Adolescent and Youth, and GEWE included aspects and sensitization done on the same. Further, the SRHR result are had components integrated, in addition to ensuring that the delivery was also integrated in the programme. for example, in Bo government hospital, the FP, cervical cancer screening, HIV counselling and testing, ANC and PNC were being done in one area courtesy of UNFPA support (Interviews with IPs and MoH staff). Further, the CO's adaptation of COVID-19 implementation context ensured that the messaging was incorporated into the programme activities, further to repurposing funds in order to achieve the critical milestones during the COVID-19 pandemic. These also ensured efficiency in delivery of the interventions (Interviews with CO staff).

During the period of evaluation, UNFPA also made available local and international technical assistance through consultants to support delivery of various results in the CP components. IPs, institutions and ministries viewed the support as effective and used the right approach to enhance their skills thereby contributing to their efficient delivery of the services in their areas of engagement. The CP enhanced utilization of South-to-South cooperation to support the delivery of programme interventions in addition to strengthening the capacities of national institutions and individuals, further achieving results, based on pre-identified priority areas of cooperation. For example, through South-South cooperation, the Government of the People's Republic of China supported the knowledge transfer in service delivery, and the rehabilitation of health facilities making service delivery efficient (Interviews with CO and document review).

UNFPA utilized communication as a strategy to raise its profile among stakeholders in and out of the country. With the existence of the UNFPA's communication unit, its visibility and profiling has improved among the stakeholders (Interviews with CO and UN agencies' staff). The Web and Media Analyst also represents UNFPA as in the UN Communications Group, and this has enabled positioning of UNFPA to profile its CP activities within UNCG. This has also facilitated delivery of common coordination mechanisms, ensuring leveraging of resources including conducting messaging activities together and in a coordinated manner, including communications on advocacy issues, social media groups, promotion of vaccination, among others (Interviews). Within the CO, the communication processes were reported to be effective, enabling sharing of information, especially for documentation of report. There is however inadequacy of staff. Further, the unit does not have a dedicated budget for the unit which also limits planning and guided decision-making as the staff currently depends on the thematic units to undertake the unit's work.

4.4.3 Monitoring and Evaluation

UNFPA put in place a mechanism to ensure that results were effectively and efficiently measured, enhancing accountability in programming. Overall, monitoring and evaluation is fairly robust, however with need for strengthening in some aspects. The M&E system in place enhanced streamlining and increased the efficiency of M&E functions. The UNFPA M&E system is hinged on the CP's results and resources framework (RRF), the UNSDCF and the UNFPA new SP (2022-2025) (Interviews with CO staff, and IPs staff and document review).

The 7CP utilized the planning mechanisms to develop the results and resources framework (RRF), which effectively facilitated alignment of the CP with the national priorities, the UNSCDF and UNFPA SP, with resources and targeted stakeholders clearly allocated and identified as confirmed by the document review and interviews with CO staff. There was also a confirmation of annual planning mechanisms, including setting targets and milestones based on the RRF for the CP, facilitating follow-up on progress and performance on the indicators (Interviews with CO and IP staff and Annual Planning 2020 – 2021). Interviews with IPs and, particularly, MoPED also indicated that UNFPA also held mid-year review sessions for the IPs, with the participation of all the relevant CO staff, facilitating experience sharing and enabling the teams to address arising challenges, in addition to planning. Compliance to the planning, monitoring and reporting structures was reported by the CO staff as generally high. Interviews confirmed that there is a mechanism in place by which COs undergo peer review by another CO coordinated by the regional office to ensure quality in reporting on progress on a Quarterly basis.

The CPE established through interviews with CO staff and SIS reviews that UNFPA used different mechanisms to capture performance and monitor progress of the CP, and ensure accountability to the various stakeholders involved in the country. The CO uses a UNFPA internal SIS for planning, monitoring and reporting, ensuring that the results are communicated and performance captured effectively, linking the CP outcomes, output and indicators. Further, the SIS also includes milestones that allow for tracking of progress towards CP output indicators and targets as well as the contribution to the SP objectives. The SIS allows for the capturing of reasons for over or under-achievement, which makes it good for reporting. The reporting is done on a quarterly basis, with a consolidated one at the end of each year, which the interviews with IPs and CO staff indicated was effective in following up on performance and assessment on the achievement of the 7CP.

The staff capacity in the unit was reported to be fairly adequate, though overstretched at times with the CO programme staff involved in making follow ups too. The unit is headed by a Quality Assurance Specialist responsible for the overall quality of the CP deliveries. This is currently supported by M&E Analyst who is responsible for the M&E components of the CP. The IPs, during interview sessions, reported an effective system of reporting as it allowed them to focus on the planned activities as contained in the AWPs, with specific indicators, guiding effective reporting on a quarterly basis, and based on the targets. Interviews with the CO staff also revealed that the reporting by the IPs was compliant with the UNFPA requirements, guided by the existing systems and tools provided by the CO. Interviews revealed an existing system of review of reports and eventual approvals of the IP reports where the CO ensures that there is effectiveness in capturing evidence-based, quality and standardized reports. In addition, the programme staff conduct field visits to the IPs for quality assurance and support on the implementation processes. While there was reported efficiency in the reporting processes, the IPs' capacity still needs strengthening as the interviews revealed some varied levels of quality and capacity gaps among them. The reports also tended to focus more on activity level achievements with generalized achievement rather than on the results from the actions, limiting accountability and understanding of the level of achievement of results from the financial support (Interviews and document review). While the IPs reported the ease of reporting, interviews with CO revealed that there were delays in submissions of reports by the IPs, reflected on the dashboard. On the other hand, donor reporting templates were varied and depended on each donor and not aligned to the UNFPA reporting formats, making the reports tedious to consolidate (Interviews).

All the IPs reported being trained on the operation of the Global Programming System (GPS) and understood its operation, with no IP reporting having challenges with using the system. Training on the use of the CP operations, including M&E tools was reported to be effective by the IPs. Further, it was confirmed that UNFPA rolled out through training of some IPs on an electronic system based on KoBo Toolbox for data collection on Behavorial Change Communication (BCC) activities and reporting by the IPs enabling real time data sharing on the performance of the CP, and with consolidation directly contributing to the SIS (Interviews with IPs and CO staff), the IPs trained were given tablets to capture the data, and this has improved the level of efficiency. On financial monitoring, UNFPA used the electronic Funding Authorisation and Certification of Expenditure (eFACE) system to disburse and report on fund utilisation on a quarterly basis. Interviews revealed that this was effective for monitoring the budget utilization by the IPs, and allowed for corrective measures, in case of deviations. Interviews further revealed that spot checks were periodically conducted as per IP expenditure level and risk ratings. IPs were assessed based on their level of compliance to UNFPA financial rules and regulations. In addition to ensuring compliance, this also contributes to minimizing the inherent risks on delivery of the CP (KI interviews and document review). The MoHS was also supported with the procurement of the QuickBooks accounting package and software licences paid for to ensure improvement in their financial accountability.

4.5 Answer to Evaluation Question on Sustainability

EQ6: To what extent has UNFPA been able to support its partners and the beneficiaries (women, adolescents and youth) in developing capacities and establishing mechanisms to ensure ownership and the durability of effects as well as established and maintained different types of partnerships across programme components during CP implementation?

From the analysis of the programme implementation and delivery strategies, the 7CP results are largely sustainable.

Summary: The CO immensely contributed to strengthening the capacities of the national and district level stakeholders through, in addition to promoting ownership of the programme results through working in consultation and collaboration with the national and local structures, including partnerships with local NGOs building trust into the community, and supporting development and implementation of the policies, strategies, guidelines, SOPs and tools development, renovation and infrastructure improvement. The budgetary allocations to the health sector by the government however remain low, particularly the RHCS is nearly financed by UNFPA entirely. Further, inadequate resource allocation, government commitment, deeply-rooted social norms, among others, affect sustainability.

The CO successfully incorporated mechanisms to ensure sustainability of the 7CP results. The prospects of sustainability of the 7CP results were achieved through building and supporting national partnerships, engagement of local partners, building national capacities and developing and influencing policies. These are categorised and discussed under capacity building and national ownership and policy framework.

4.5.1 Strengthened National Ownership and Policy Framework

Towards ensuring national ownership, the CO promoted technical support to the development of strategies, policies, guidelines, involvement of government in planning and planning stages, collaboration with government agencies, including at facility level and integration of programme interventions to ensure comprehensive access to services. UNFPA also promoted national ownership through working with the local NGOs to deliver services to the target groups. Interviews with the government entities indicated that UNFPA promoted joint planning with them, enhancing national ownership.

At the onset of the programme design, it is evidenced from the interviews with the government line ministries and agencies, and the CPD review that UNFPA upheld consultations with them, ensuring that the 7CP directly contributed to their objectives and targets enhancing ownership. There was also evidence of UNFPA consulting and planning with the government ministries identifying their needs and priorities for support by the CP. Further, evidence was also notable with government ministries, commissions and secretariats supporting UNFPA activities, manifesting ownership of the programme activities. For example, the MoPED was supported by UNFPA to lead the coordination of the 7CP IPs with the ministry leading the semi-annual programme review activities, ensuring that MoPED and the IPs, together with the CO staff reviewed the performance and shared experiences on the CP delivery (Interviews with MoPED, and CO staff and document review). UNFPA's partnership approach of working with nearly all local NGOs, training and guiding them on implementation processes including quality control processes is providing foundation for the IPs, and will be able to continue with the CP results even after the programme ends (Interviews with line ministries and document reviews).

The UNFPA CO in Sierra Leone established key partnerships with public entities at national level, particularly the line ministries and institutions. For example, the CO partnered with the MoHS to deliver the SRH, MoYA to deliver the A&Y component, MoGCA to deliver the GEWE components, and the MoPED and SSL to deliver the PD related activities with interviews with the ministries and agencies confirming that UNFPA coordinated the interviewing with them as ministries. On the other hand, UNFPA implements the 7CP through IPs, in collaboration with the line ministries, where the line ministries determine the standards and operations on the interventions implemented. These ensure that the ministries were part and parcel of the implementation processes of the 7CP interventions. Further, the IPs confirmed reporting using the government systems of reporting further contributing to the government delivery mechanism and the results being part of the national achievement for the government (Interviews with IPs, CO and line ministries). Ownership of the CP interventions by the IPs was also confirmed where they also stated that they contributed to the determination of the targets being set in the AWPs.

On policy and strategy development and influence, the 7CP contributed immensely to the development of strategies and strengthening the policy framework for the country in areas of SRH, A&Y, GEWE and population dynamics. Interviews with the key stakeholders in the line ministries and agencies, in addition to the CSO IPs confirmed that the strategies and policies technically and financially supported by UNFPA during the 7CP were useful and being used to guide implementation processes. For example, the need for Radical Inclusion Policy came as a result of implementation of the GEWE Policy developed the support of UNFPA and both the policies, particularly the Radical Inclusion policy was employed by the MBSSE to enable the girls dropping out of school because of teenage pregnancy or harmful practices like child marriage to go back to school and be supported (Interviews with MBSSE, CO, MoGCA and other IPs and document review). Further, the FP and RHCS issues are explicitly included in development strategies and plans: e.g., National Health and Sanitation Policy (2021), National Health Sector Strategic Plan (2021-2025), Sierra Leone Health Care Financing Strategy (2021-2025), Sierra Leone's Medium-Term National Development Plan (2019-2023). All the UNFPA supported policies and strategies were confirmed to be in use by the government and relevant institutions supporting or guiding the delivery of the services. Despite ownership by the government institutions, there is still need to support their enforcement, monitoring and institutionalization. There is also inadequacy of resource mobilization capacity to implement the policies as the ministries and agencies are mostly dependent on external support. Despite that, UNFPA is entering into a model where the CO is working with the government and other partners towards progressively increasing domestic financing for RH commodity procurement (Document reviews).

> "We use the guidelines and policies produced through the support of UNFPA and they are ones that guide the MoHS services that we deliver in the area of SRHR. They guide our work in the health facilities and have been very instrumental to us as a ministry especially in guiding quality of care" – **MoHS Staff respondent during CPE.**

Interviews with the UNFPA-supported midwifery schools' leaderships, MoHS and CO staff indicated that the MoHS was responsible for all the stages of recruitment of the midwives for training, staff to provide training and management of the schools. Further the graduated midwives were redeployed by the government, particularly in the hard-to-reach rural areas, where it was confirmed, they stayed to provide the services contributing to providing skilled birth attendance which further contributed to the reduction of the MMR, in the long-run. This assures continuity of the services, even when UNFPA's support ceases to be. It was also confirmed through interviews with the stakeholders that the MoHS participated in the selection of the midwives. It is imperative to note that the training facilities were government owned, illustrating the level of ownership and support of the UNFPA-supported activity. Ownership of the UNFPA-supported results was also exhibited in the MDSR committee at the district level where the government contributed funds for the committee to review the maternal death reports. UNFPA also ensured ownership of the programme interventions through use of government facilities to deliver the programmes with the service providers being employees of the government (Interviews with CO and MoHS staff).

From interviews and document reviews, there is evidence of institutionalization of results emanating from the 7CP support. For example, under the SRHR component, UNFPA's support to the review of the midwifery training curriculum and policy, guiding the delivery of the training, including the direct enrolment of the trainees from high school into the higher diploma level will be used by the government beyond the 7CP. The integration of the CSE into the MBSSE curriculum, including the issues of religious and cultural beliefs on harmful practices, is also institutionalized and will continue beyond the programme period to address the socio-cultural challenges. Further, Under the youth component, the establishment of the Youth Empowerment Fund is also an example of institutionalized result from the coordination and leadership of UNFPA.

At the community level, there were numerous instances of ownership of the UNFPA-related activities. Firstly, during the period 67 communities reported abandonment of harmful practices, showing that they had appreciated the harms and will not be practicing the same (SIS 2021 review and CO interview). It is not however clear on the mechanisms that UNFPA put in place to monitor the abandonment of the practices. Interviews with IPs also confirmed communities supporting the programme activities, in addition to the members participating in the activities, in addition to contributing to the delivery of the services. For example, in Koinadugu district, the parents allowed their children to attend sessions in the safe spaces supported by the 7CP, in addition to confirmation that there were other girls from other villages asking to be supported (Interviews with Girls and Volunteers at the safe spaces, and IPs). Since behaviour and social change takes time to realize result, it would be great monitoring the trends in the practise, especially in the areas where communities reported abandoning the harmful practices.

While UNFPA endeavours to address some of the existing gaps, especially on human resources, technical capacity and institutional development, more advocacy and support to the various entities to enhance implementation will be

key in ensuring sustainability and full realization of the benefits of the 7CP results. For example, the issue of harmful practices like FGM is still considered very sensitive and addressing it requires multi-stakeholder approach, including duty bearers and rights-holders as this was found to be limited (Review of SIS reports and Interviews with MoGCA, IPs and CO, UN agencies).

4.5.2 Capacity and Institutional Strengthening

During the period under evaluation, UNFPA financially and technically contributed to strengthening the capacities of the national stakeholders focusing on sustaining the results achieved during the 7CP. This was based on the assumption that that strengthening the capacities of the national stakeholders in the targeted areas of focus enhances their ability to continue with the ability to deliver the same results beyond the 7CP with the possibility of replicating the strategies and results in other set-ups. Through the 7CP, UNFPA contributed to strengthening the capacities of stakeholders in the country through skills development, technical assistance, consultancies, infrastructure improvements, South-South collaborations and on-the-job trainings (Interviews with IPs, CO, line ministries and CO reports)

The technical and financial support of the country, particularly the line ministries and national agencies, by UNFPA in the development of policies, strategies, guidelines, SOPs and tools enhanced the capacities and skills of the stakeholder's transferring knowledge and be able to continue implementing the supported results beyond the 7CP. There was evidence of the MoHS, MoGCA, MoYA and other agencies utilizing policy documents, strategies and tools developed through the support of UNFPA, confirming transfer of knowledge. Further, the availability of the documents and tools will ensure that the they are used beyond the life of the 7CP. For example, the availability of the GEWE Policy, Radical Inclusion Policy, MNCAH strategy, the reviewed Youth Policy, among others documents will continue to be used beyond the 7CP, confirming sustainability aspects of the programme (Interviews and document review). Further UNFPA supported training of the IPs and facility staff on the DHIS2 data tool, in addition to advocating for the integration of the SRHR indicators into the DHMIS and this will enable them to be captured beyond the life of the programme Interviews with IP and MoHS facility staff). IPs and the technical trainings supported by the 7CP will also continue to remains in the country regardless of UNFPA presence. A good example is the improvement in the delivery of EmONC services contributed to by the presence of the trained SACHOs, trained midwives and healthcare workers on various aspects. Training of healthcare workers on various quality assurance aspects on SRHR and GEWE ensure that there si knowledge management and skills transfer and these will remain with the beneficiaries and will able to transfer them in the delivery of similar areas. (Interviews with CO and IPs, MoHS, MoGCA, MoYA, and donor). More investments are needed in health services to ensure quality and universal health initiative as it is highly dependent on external support.

UNFPA endeavoured to strengthen institutionalization of service delivery through supporting and expanding health facilities and equipping them to be able to deliver the services. For example, through the South – South cooperation with the Chinese government, UNFPA contributed to building the capacities of the 9 heath facilities to deliver on the SRHR services, and with the training of staff on various aspects confirming transfer of skills, the results are likely to improve in the quality of services delivered (Interviews with CO, Chinese Embassy, MoHS and IPs staff and document reviews). During the 7CP, UNFPA supported improvement in skilled birth attendance through training of midwives using international WHO standards, with the midwifery schools tutor capacity also being strengthened on teaching methodology will enable continuity of the skills and they will use them beyond the life of the project and will contribute to improving the coverage with EmONC services in the country (Interviews with MoHS and CO staff and document reviews). At the community level, UNFPA contributed to establishing and strengthening community structures, where CHWs were trained to distribute pills and the condoms, and these were also recruited by the government, and given more roles beyond what UNFPA engaged them in. the CHWs also facilitated identification and referrals at the community level and given their engagement by the government, this will continue beyond the 7CP. Further, interviews confirmed that the youth actions groups and peer educators model initiated by UNFPA at the district and community levels had been replicated by other NGOs operating in the country (Interviews with IPs and Co staff).

Interviews with SSL, MoPED and CO staff confirmed that there were improved skills in data generation through UNFPA's support in data analysis, CAPI, GIS, report writing and training, skills that will continue to be within the institutions supported. This knowledge and skills gained are likely to enhance sustainability of the CP areas of focus. UNFPA also hired a consultant to support SSL on the design and use of CAPI and this facilitated on-job-training which encourage hands-on learning through practical experience (Document review and interviews with IP and CO staff). Integration of the SRH indicators into the DHIS and HMIS will enabled continued collection of data on the indictors beyond the programme (Interviews).

Interviews with the various IPs confirmed that the partnership with UNFPA enabled them to gain skills in addition to allowing them to participate in technical working groups which enable them to contribute to various aspects, in addition to influencing policies of the service being delivered. For example, UNFPA advocated and facilitate the joining of the Planned Parenthood Association of Sierra Leone and Marie Stopes into the Family Planning Technical Working Group where they would contribute to the processes for qualification and guiding implementation of the RHCS distribution strategies (Interviews and document review).

UNFPA nurtured partnerships with local CSOs and this contributes to the strengthening of their capacities. Through these partnerships, UNFPA has been able to provide sustainable support to the CSOs' staff, mainly in terms of capacity building and training that aimed at providing them with the necessary expertise and skills to be able to respond to people's needs in different areas and sectors including SRH, A&Y and GBV. For example, a key respondent from the Local NGO reported that UNFPA's support helped their staff to gain the necessary knowledge to be able to manage system of referrals, psychosocial support, and case managements in addition to application of tools and guidelines, enabling them delivering effectively in their responsibilities, especially in planning, reporting and technical aspects.

While these were effective mechanisms to ensure sustainability, inadequacy of financial resources limited the extent of results to influence change. On the other hand, context specific challenges like the deeply-rooted socio-cultural beliefs hinder some of the gains made through the CP and if not checked may take back the efforts made during the period, especially in addressing GBV and Gender challenges in the country (Interviews with IPs)

4.6 Answer to Evaluation Question on Coordination

EQ7: To what extent has UNFPA contributed to the functioning and consolidation of the coordination mechanisms of the UNCT and to the technical results groups, including the COVID-19 socio-economic response plan?

Summary of Findings: UNFPA is a highly valued member of the UNCT and actively contributed to the functioning and consolidation of the UNCT coordination mechanism. In addition, UNFPA had joint programming and promoted collaborative approaches in delivering the activities across the thematic areas, in addition to leading some of the thematic groups within the UNCT, and contributing to the joint reporting mechanisms under the result areas of the UNSCDF. There was however disharmony among the health sector agencies, where approaches were not harmonized, in addition to disjointed engagement with the MoHS.

Interviews with staff from the UN Agencies and the UN RC office indicate that UNFPA contribute positively to the UNCT and apply its comparative advantage for the effective and efficient running of the UN coordination mechanisms within the country, ensuring synergies within the UN mission in Sierra Leone and eliminating duplication among the agencies. The 7CP was delivered against the UNSCDF 2020 – 2023, supporting the priorities and the timelines of the NDP (2019 – 2023), and contributed to different coordination groups, in addition to being a member of different result groups and technical working groups contributing to the country's development and humanitarian agenda. UNFPA also implemented a joint programme, in addition to collaborating with various UN agencies contribution in different areas based on its comparative advantage. UNFPA was recognized as an influential player in the UNCT and participates regularly in the UNCT meetings and keeps other participants informed of any plans, achievements, and missions (Interviews with CO and UN agencies staff interviewed). All the UN agencies who participated in the CPE indicated the important role UNFPA played in the country's overall development agenda, contributing effectively to improving UNCT coordination mechanisms, particularly strengthening advocacy and technical support in several areas of responsibility (Interviews with CO and UN agencies and CO Reports).

UNFPA was recognized by the UN agencies' respondents in the key UNCT coordination mechanisms, namely as an active participant in the two UNCT coordination mechanisms through the programme management and operation management teams, attended respectively by the Country Representative and the Operations and Finance Manager or their respective designates. Specifically, UNFPA chairs the Programme Management Team (PMT) providing the technical guidance to the UNCT, ensuring that the interests of the various UN agencies are addressed, that they are not fragmented, in addition to ensuring strategic focus of the UNCT. UNFPA is also an active member of the UNCT Steering Committee where the Country Representative sits, and the Technical Coordination WG within the UNCT where the technical teams meet on various aspects. The decisions made by these teams are implemented by the agencies individually or collectively based on thematic strength, and directly contribute to the interests of the UN in the country, with the guidance of the UN RC (Interviews with CO and UN staff).

UNFPA Sierra Leone also participated in many results groups, including, health, peace building, emergency, M&E, Communication and Joint steering committees with Government, including Free Healthcare Initiative, Adolescent and Teenage pregnancy and ECM TWG. UNFPA leads Outcome 4 of the UNSCDF result group which focuses on protection and empowerment of vulnerable groups, contributes to the results of Outcome 3 on RMNCH aspects. (Interviews with UNRC, UNICEF and IOM staff). Further, UNFPA is part of the UN Joint team on HIV and AIDS where the CO lead the prevention pillar, particularly targeting the adolescent and the young people. In this role, UNFPA is technically and financially supporting the development of the Condom Programming strategy, facilitating a joint work plan to provide synergy on the delivery ensuring duplication is eliminated and efforts effectively coordinated (Interviews with UNICEF, CO and NAC staff). UNFPA also contributed to the reporting mechanism as team lead of the UNSCDF Outcome 4, part of Outcome 3 and M&E where they contributed to the work of the UNCT. UNFPA's technical and financial contributions on the production of the VNR reports, together with UNDP, and UNICEF, complementing the government financial resource (interview with MoPED and MoHS staff, and document reviews).

UNFPA collaborated with UNDP, UN Women and UNICEF in the development and operationalization of the GEWE Policy. UNFPA ensured that the MoHS integrated gender in the reporting system (HMIS), while UNDP ensured gender mainstreaming in the ministries and supported communication strategies and training of local councils on the same. On the other hand, UN Women hosted the coordination of the Policy Implementation Plan and supported technical staff from various ministries going on secondments with UNICEF supporting the policy implementation by the Ministry of Basic and Senior Secondary Education. Interviews with UNICEF, UNDP, UNFPA CO and MoGCA staff, it came out clearly that coordination among UN agencies in the operationalization of the GEWE policy was effective, with advocacy and sensitization efforts yielding results, with cases of violations reported effectively to the Family Support Units of the Sierra Leone Police, as people get sensitised. At the time of the evaluation process UNFPA and UNICEF were working on getting the GBVIMS, with UNICEF leading the piloting process. Sierra Leone is among two countries where the IMS is being piloted out of the humanitarian setting.

During the COVID-19 pandemic, UNFPA was part of the UNCT COVID-19 socio-economic response plan, and effectively participated in ensuring that the COVID-19 IPC mechanisms were in place. Interviews with the UNRC and other UN agencies indicated that UNFPA actively participated in sharing the responsibilities in the response plan and effectively utilized its strengths by ensuring services reached beneficiaries without discontinuity. UNFPA supported the government through the UNCT to ensure availability of treatment centres in a number of supported health facilities, further making sure facilities supported had screening and PPEs for COVID-19. Further, to ensure service delivery, UNFPA supported integration of SRH in the established nine COVID-19 emergency health service teams for the vulnerable and hard-to-reach populations. Further, UNFPA prepositioned and supported the medical stores in the distribution of the RH commodities to the targeted health facilities ensuring service delivery was not disrupted during emergencies, in addition to supporting dissemination of key messages encouraging women to deliver in health facilities (SIS 2020 and 2021 review and Interviews with WHO, UNICEF, UNRC and CO staff). There was also evidence of UNFPA reprogramming through the UN to ensure contribution to the COVID-19 socio-economic plan, in addition to being part of the joint plan to mobilize resources to cover the funding gaps on the plan (Document reviews and Interviews).

Interviews with WHO, CO and MoHS staff confirmed that UNFPA actively participated in different mechanisms for engagement with UN agencies as partners. For example, UNFPA was activity involved in the Health Sector coordination mechanisms co-chaired between MoHS and WHO, with all UN partners working in the health sector coming together to contribute to ensuring that essential health medicine, including the RH commodities, needs were fulfilled. The health sector coordination mechanisms were identified to be having coordination issues and the planning was done individually with MoHS and not as a team. There were also instances where it was reported that there were cases of overlap, especially on cross-training of healthcare workers on the same by different UN agencies (Interviews). There were also concerns of centralization of decision-making, where it was difficult to tell what was going on in the districts in terms of coordination. Further, UNFPA is a member of the health development partners' group having all the UN Health agencies, FCDO and World Bank where they meet every third Monday of the month to discuss health development progress and needs, and this was also reported to be very useful during the COVID-19 pandemic in which the comparative advantage of each agency was used. For example, UNFPA was recognized for ensuring that the RH commodities were prepositioned, with resources being mobilized for the same through the coordination with the donors. Further, UNFPA was a member of the National TWG on Family Planning, in addition to being a member of the National Supply Chain TWG where it is in the policy sub-committee and financially and technically supported the development of Nation Integrated supply chain strategy together with UNICEF and WFP (Interviews with CO and

UNICEF). It was however noted that the MoHS was not providing effective leadership in ensuring that the health development needs were strategical addressed. It was reported to be easily influenced by the agencies based on their own strategic focus and may not necessarily depend on the priorities identified in the MoHS strategy.

UNFPA also participated in mechanisms that ensured shared responsibilities among the UN agencies involved. UNFPA coordinates with UNICEF and UNDP to conduct micro-assessments audits for the respective IPs through the Harmonized Approach for Cash Transfers (HACT). In this arrangement, the coordination UN agencies assessed the IPs on capacity and financial management, using independent audit firms, DDO and Price Waterhouse Coopers (Interviews with CO staff).

UNFPA was also in a UN consortium with WHO and UNICEF, under the Saving Lives Programme, funded by FCDO, where the UN agencies were to provide technical support on provision of drugs and commodities. In this arrangement, UNFPA was responsible for providing FP commodities and safe motherhood, and MoHS human resource capacity provision through supporting midwifery schools. On the other hand, UNICEF bought vaccine drugs but transported through UNFPA, while WHO provided technical support on blood bank. While UNFPA was the lead by coordinating the planning and reporting mechanisms, feedback has it that the UN agencies could not coordinate effectively to ensure that one channel could be used for feedback on the performance of the programme (Interviews). This also confirms the disjointed manner in which the health-related UN agencies operate.

UNFPA actively provided leadership in coordinating the activities of the RMNCAH TWG, providing direction on the interventions, in addition to quality of care, in collaboration with UNICEF and WHO. Interviews with the UNICEF, WHO and CO staff revealed that the coordination mechanisms was enhanced through the agencies providing technical support based on their comparative advantage. For example, in the TWG, UNFPA provided progress and guidance on FP, cervical Cancer, Maternal Health while UNICEF led on child health, and WHO providing normative guidance across the sectors bringing on board the technical expertise in the areas. On the other hand, there was coordination targeting the adolescents by all the three agencies, ensuring that there was no overlap in targeting and reaching the beneficiaries. Interviews with UNICEF and WHO recognized the key leadership and technical role that UNFPA played in the TWG, particularly on using the FP platform to leverage on resource and opportunities leading to coverage. Further, UNFPA efforts of sharing experiences and evidence from implementation processes necessitated the rollout of the Human papillomavirus (HPV) TWG where UNFPA is financially supporting it, in addition to support on resource mobilization and helping direct them where the resources are. Under the RMNCAH TWG, UNFPA and WHO led in the review of the EmONC guidelines, and supported the EmONC assessment in all the government health facilities. UNFPA bore consultant and training costs, while WHO supported on data collection and transport costs (Interviews with UNICEF, WHO and MoHS). Further, in the FP policy guidelines development, WHO and UNFPA discussed, in addition to holding several consultative meetings and UNFPA supported on training and with supplies (MoHS, CO and WHO staff). UNFPA's active role in the RMNCAH TWG effectively contributed to the transfer of technical skills and knowledge during the development of various strategic documents in RMNCAH. Through these mechanisms, the UNCT operations have minimised overlaps in programme and at the same time increased coverage. While UNFPA had a good rating on strengthening coordination mechanisms among the UN peers interviewed, there were aspects that needed to be strengthened. For example, ensuring that the MoHS is supported to identify health priorities and effectively plan on response, including engaging the senior leaders of the agencies for support. There was however an issue on midwifery training delivery where the modules used were not uniform between UNFPA and UNICEF.

During the period of evaluation, there was registered contribution to the UNCT coordination mechanisms by UNFPA through implementing a joint programme or collaborating with a UN agency utilizing one another's area of strength. Under the Adolescent and GEWE components, UNFPA was a member of a joint programme, *The Youth-at-Risk Programme,* which was implemented jointly in Kenema with UNDP and FAO, funded by the Peace Building Fund (PBF). In this programme, there was clear division of labour, ensuring that the interventions complemented one another, capitalizing on the corporate strength of each organization. For example, FAO and UNDP led in the identification of beneficiaries in the community levels. In addition, FAO was responsible for the youth and women empowerment aspects supporting them on livelihood through economic empowerment through business enterprise management and farming; while UNDP focused on how strengthening financial security through promoting access to credit and savings culture among the members using the village savings and loaning association (VSLA) methodology and governance. On the other hand, UNFPA targeted empowering the youth-at-risk through the use of Male Advocates and Peer Educators (MAPEs) and husbands' schools approach targeting behaviour change and role models. It is imperative to note that the target communities and beneficiaries were the same with the contributions of the UN agencies being complementary. For example, FAO supported community projects like rice mills, UNDP promoted

the VSLA as an income source to ensure sustenance of the rice mill, while UNFPA targeted the MAPEs and Youth-at-risk who were supported by both UNDP and FAO interventions to provide alternative source of income to violent means of getting income (Interviews with FINE, UNDP, and CO staff and SIS review).

Further to the 7CP's contribution to the coordination mechanisms within the UNCT, Interviews indicated that UNFPA led in addition to being an active member of a number of coordination mechanisms. UNFPA Co-Chaired with the MoYA the Youth Task Team and was responsible for coordination of the UN organization that work on youth issues[47] in the country, where they successfully organized a Youth Summit in 2021 with participation and contribution of all the agencies. UNDP and UNFPA co-chair the UN Disability Inclusion group where they are supporting development of the Disability strategy and coordinating all the contributions of the UN agencies. There is however more to be done in targeting people with disability to ensure that they receive support specific to their needs, especially considering that disabilities are varied. UNFPA also co-chairs the Gender with UN Women. Further, UNFPA contributed to the emergency preparedness group where they supported COVID-19 response, working through the UN systems and led by OCHA. UNFPA also co-chairs with UNAIDS the Protection of the vulnerable group – Outcome 4 of the UNDAF (Document reviews and Interviews with UNRC and CO staff).

In commemoration of international days, the UN agencies conducted activities together, including sharing the same message using different communication mechanisms. Interviews indicated that the UN agencies shared roles and worked together on a plan for the activities, including pulling resources, in addition to organizing a panel discussion on issues in the country and providing solutions. The UN agencies also made a common statement on the days. Further, during COVID-19 pandemic, the agencies utilized the WHO social media platform to post and disseminate COVID-19 messages to dispel misinformation. The UN agencies also coordinated the development and implementation of the Communications Strategy for the Reduction of Adolescent Pregnancy and Child Marriage under the ECM project, geared towards supporting the National Secretariat for the Reduction of Teenage Pregnancy. At the time of the evaluation, UNFPA and UNICEF had reviewed a ToR to recruit a consultant to review the performance of the strategy, where UNFPA has allocated $20,000 for the same, while UNICEF is paying for the advertisement and will also contribute to the consultancy fee. Further, UNFPA and UNICEF came together to coordinate IEC/BCC messaging under the ECM project to coordinate the messaging (Interviews with UNICEF, Secretariat and CO staff).

4.7 Answer to Evaluation Question on Coverage

EQ8: To what extent has the UNFPA humanitarian response reached those most in need and vulnerable in crisis situations both geographically and demographically (young people and women with disabilities; those of racial, LGBTQ populations, etc.)?

Summary of Findings: UNFPA humanitarian response also effectively responded to situations of disasters and emerging humanitarian, including COVID-19. The CP also addressed the needs of the vulnerable populations, especially marginalized women, girls and youth in the hard-to-reach areas. UNFPA further facilitated inclusion of the PWDs into the SDG framework in the country, in addition to supporting their identification and inclusion for services together with the key populations, though at a lower extent.

The 7CP contributed to strengthening access to various services in the areas of strength, particularly targeting populations that have been affected by disasters and vulnerable populations, including women and girls. This was effected through supporting capacity strengthening of various stakeholders, including the government line ministries and non-state actors along CP components; thematic programme strategy development; provision of population data for needs identification and response; RH supplies and health facility support; and contributing to coordination of GBV and RH service provision in in the affected locations (Interviews with CO and UN staff and SIS). UNFPA particularly implemented programmes targeting young people, particularly adolescent women and girls discriminated against based on their socioeconomic situation (document reviews and interviews). In addition, UNFPA also supported coverage of the service and information access through the use of radio messaging and the Youth Champions conducting sensitization.

UNFPA generally contributed to the national response on humanitarian response, especially during crisis situations in close coordination with other stakeholders like UNOCHA. In partnership with the IPs UNFPA reached all the 16 districts with RH and GBV services during humanitarian crisis. In this partnership, UNFPA trained the MoHS and IPs on the various competencies of the MISP to deliver in the thematic areas of responsibility. UNFPA also supported

[47] These include UNFPA, UNDP, UNICEF, UN Women, FAO and UNICEF.

MoHS with supplies, including prepositioned dignity and emergency RH kits targeting affected population, in response to arising crisis. The development of strategies and policies had national coverage for the vulnerable and marginalized populations. UNFPA's focus on strengthening the capacities of both government and non-state actors in the country was reported to have contributed to improving the quality of response and coverage of services provided to the people affected by crisis (Interviews with MoHS, IPs and CO staff). The support of the government on policy development and operationalization, in addition to supporting service delivery processes enhanced wider coverage. It was however not easy to establish the extent of utilization of the enhanced capacity and policies in responding to emergency situation. Further, the humanitarian response in Siaerra Leone is done on a need-by-need basis, since humanitarian response as the context is generally developmental, limiting the assessment and extent of coverage. Environmental emergencies including flooding and displacement, and other calamities, and UN responds a taskforce on emergencies, with UNFPA ensuring that the services were avaialble (interviews with Line ministries, IPs and CO staff, and document reviews).

During the period, UNFPA participated in a number of coordination mechanisms to enhance service access by those affected by disasters. Like any other country during the period of the CPE coverage, Sierra Leone experienced devastating effects of the COVID-19 pandemic, in addition to a number of intermittent experiences of disasters. UNFPA contributed to the emergency preparedness and response group in coordination with the National Disaster Management Authority (NDMA) through the UN systems led by United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) and supporting COVID-19. Towards ensuring that there was capacity to deal with the pandemic, UNFPA contributed to the development of capacity on the actors ensuring response and coverage of vulnerable populations and those in the hard-to-reach areas. UNFPA trained partners on minimum initial service package (MISP) to position them and be prepared to effectively respond and ensure that services meet minimum standards (Interviews with IPs and CO staff and SIS review).
Since in Sierra Leone there is no cluster system to coordinate humanitarian activities, the COVID-19 response was coordinated by the newly created essential health services (EHS) pillar. As part of the UNCT, UNFPA was involved in conducting a social and economic analysis of COVID-19 to ensure the support of the country on it and deal with the after effects, with the findings informing the COVID-19 socio-economic response plan, in addition to leading resource mobilization efforts to meet the gaps in the plan. The data collected also enabled other stakeholders to respond in other areas of response based on the gaps established (Document review and Interviews with IPs and CO staff). This ensured that the vulnerable populations were identified and supported with services (Interviews with RC, UNICEF, WHO, and CO staff and SIS reviews). In the arrangement, UNFPA ensured that SRH services were integrated into the EHS pillar delivering the services to the people targeted effectively. On the other hand, the GBV services were provided through the Psychosocial / Protection Pillar which UNFPA is the UN Co-Lead with the MoGCA (Interviews and SIS review). Interviews and SIS review also revealed that the young people were included in the decision-making processes ensuring that they also received the services during the pandemic. The youth were trained on the action movement (Interviews and SIS review). UNFPA also supported the development of a draft National Disaster Psychosocial Support Services (PSS) Plan which aimed at supporting response on GBV aspects during the period.

Since access to SRH and GBV services were curtailed during the initial periods of the COVID-19 pandemic, UNFPA supported the delivery of services to the affected areas, especially the hard-to-reach areas, through supporting nine static sites and 14 integrated mobile outreaches. Through the integrated outreach services, UNFPA shifted focus to support locations with needs enhancing coverage of the affected populations and locations. Notable from the IPs was the flexibility by UNFPA enabling adaptation to changing situations, reprogramming and contextualizing response to suit the situation including putting a response plan (Interviews with IPs, CO and IP staff). Interviews with CO and IP staff and review of documents indicate that UNFPA was also able to mobilize resources to fund the gaps though were limited in scale. UNFPA also strengthened partnerships, in addition to developing and implementing an annual preparedness action plan, in addition to developing tools for response monitoring (SIS review and Interviews). Further, interviews and document reviews reveal that UNFPA supported prepositioning of RH commodities which were effective in ensuring no services were disrupted during the period. In addition, UNFPA ensured supply of the hospitals with PPEs to ensure continuity of services (Interviews).

UNFPA also collaborated with NAC to develop National Condom Programming Strategy through a process which brought together key stakeholders, and considering the needs of all the groups to ensure that they were covered during the implementation of the strategy. Key to note is that UNFPA ensures that the interests of key populations, including the Lesbians, Gays, Bisexual, Transgender, Intersex and Queer (LGBTIQ). At the same time, UNFPA supported distribution of condom dispensers in lodges and hotels, targeting prevention of HIV transmission among the

commercial sex workers (Interviews with NAC and CO staff). Further, under the UNAIDS framework, UNFPA ensured integration of the prevention of HIV, for example, where those who went for cervical cancer screening were counselled and tested for HIV, in addition to ensuring that the procurement of condoms provided dual protection (HIV and pregnancy) and supporting distribution in many ways, including through IPs and the central supply chain system (Interviews with IPs and CO staff). All these, especially the National Condom Programming Strategy will ensure coverage of all the vulnerable and key populations, including those at-risk. Facilitating of inclusion of the PWDs into the SDG reporting framework ensured national coverage. In addition, UNFPA facilitated coverage of people who are physically challenged, for example, with support from the Iceland strategy developing braille and platforms for the visually impaired and promoting of TV interpretation for the deaf will ensure coverage, in addition to having a nurse to provide health services to the same in the school for the blind (Interviews with CO staff).

4.8 Answer to Evaluation Question on Connectedness

EQ9: To what extent has UNFPA contributed to developing the capacity of local and national stakeholders (state institutions/line ministries, youth and women organizations, health facilities, communities and civil society organizations) to better prepare, respond, build back better and recover from humanitarian crisis?

Summary of Findings: The CO contributed to strengthening the capacities of the actors, facilitating longer term results, in addition to supporting development of strategies, guidelines and policies to guide implementation; supporting youth participation in key decision-making platforms empowering them; supporting coordination and promoting integration of programmes and national ownership of interventions and results.

Even though the Sierra Leone context is almost purely developmental, the experience at the onset of COVID-19 provided the country with an opportunity to strengthen its humanitarian and crisis response mechanisms. UNFPA endeavoured, through the 7CP, to contribute to building mechanisms to facilitate longer term results in the programme implementation. UNFPA contributed to this through strengthening capacities of the actors, developing strategies, guidelines and policies to guide implementation, supporting the youth participate in key decision-making activities aimed at empowering them, coordination and promoting integration of programmes and national ownership of interventions and results (Document review and Interviews). Further, the CO made concrete strides in building capacities at local and national levels in Sierra Leone, primarily on SRH services, GBV response, adolescent and youth empowerment, data generation and management systems and policy development. At the same time, development capacity building efforts ensured to maximize effectiveness, and resilience ownership to manage and deliver SRH and GBV products and services to the target groups at the longer term.

Through comprehensive training packages, UNFPA improved individual skills, knowledge and capacities for both local and national stakeholders, including beneficiary men, women, and young people. Capacities of government and implementing partners and staff at the health facilities increased on diagnosis and, treatment and support on provision of related SRHR and GBV gaps and needs. In addition, UNFPA supported the capacity building of the stakeholders on the MISP, to be triggered in case of an emergency situation. Further capacity support was provided on prevention and infection control (Interviews and document reviews). The awareness sessions and mechanisms facilitated through the 7CP also added value to the knowledge base on the aspects of SRHR, Gender and GBV and Adolescents and Youth (Interviews). UNFPA also supported the creation of the Youth Empowerment Fund in Sierra Leone and this is envisaged to address some of the key challenges facing the youth in the context of implementation. Respondents however stated that there is a need to conduct more capacity strengthening for IPs, especially on resource mobilization and accountability aspects.

Towards contributing to addressing the issues of conflict in the country, especially among the youth, UNFPA supported a number of initiatives aimed at ensuring a lasting solution to the issues in the country. The youth component was majorly anchored on empowerment and improve their participation in decision-making, through use of interactive theatre, participating in training to influence others, using social media to engage other youth and the country at large (Interviews and document review). For example, as the co-chair of the Youth Task team, UNFPA facilitated promotion of the youth participation in addition to organizing the Youth Summit facilitated their involvement in activities empowering them through identification of the key challenges and solutions (Interviews). Under the joint programme with FAO and UNDP, UNFPA conducted training to the MAPES and strengthening of capacities of youth, reducing their involvement in risky behaviours, in addition to elimination of harmful behaviours. The integration of life skills support enabled the youth, particularly girls at risk on teenage pregnancy and child marriage, in addition to capacity building the line ministries on the same and promoting local governance which is also designed to contribute to development (Interviews).

During the 7CP, UNFPA facilitated rehabilitation activities for the various structures within the country. UNFPA implemented these in the government health facilities, including equipping them with the necessary equipment and expansion, enabling them to provide the needed health services (Interviews with CO). UNFPA also utilized government facilities and supporting them to deliver services using the same, enhancing their capabilities to deliver. Working the government in many aspects including being in coordination mechanisms, like working with the line ministries as co-chairs of the various TWGs enhances the government participation and support in decision-making on the interventions (Document reviews and interviews). UNFPA's support to the country in the development of policies, guidelines, SOPs and action plans will guide service delivery beyond the current CP.

While UNFPA endeavoured to ensure a lasting solution to the humanitarian context, the respondents identified limited funding on the capacity enhancement and given that the context is developmental, the donor funding goes to development activities. Further, given that UNFPA is a member of the UNCT supporting coordination among the UN agencies, the leadership by the MoHS, for the health sector services is still weak, in addition to the agencies not effectively coordinating support among themselves. While UNFPA had an elaborate mechanism for M&E, there was over-focus on the activity level reporting with limited capturing and orientation on results reporting, especially weaknesses in the theory of change to reflect the causal relationships across the logic model. There were weaknesses in the definition of some indicators in the RRF, which did not measure the extent to which the project results were being utilized. On the other hand, there was little to show on the use of disaggregated programme data, some of which were collected during interventions.

4.9 Lessons Learnt, Best Practices and Unintended Consequences

4.9.1 Lessons Learnt

2. The involvement of communities and local authorities in the design and implementation of the ECM project in the targeted Chiefdoms and use of local information to influence their perceptions enhanced ownership and led to contribution of the communities in the declaration of abandonment by the communities
3. Investments in changing social cultural norms and cultures that drive GBV are critical. They however require to be accompanied by a rapid response strategy in the event that it does not go as planned.
4. Integration of the 7CP components SRHR, GBV and A&Y ensured efficiency in the delivery of the services provide by the programme. further, integration enable coverage with programme interventions, thereby enhancing reach.
5. Strategic engagement with key government sectors at senior management level produces quick results.
6. The establishment Sierra Leone Parliamentary Advocacy Action Group on Population and Development facilitated passing of the various bills in the country through engagement of key population issues further enhancing advocacy for conducive environment for International Conference on Population, and Development Programme (ICPD) Programme of Action and the Sustainable Development Agenda 2030

4.9.3 Unintended Consequences

1. **GEWE Unintended Effects**: The UNFPA support to the development of the GEWE policy led to the development of the Radical Inclusion Policy, which was unforeseen as a consequence of the CP.
2. **A&Y Unintended effects**: The support of the CP in organization of the Youth Summit in 2021 yielded the establishment of the Youth Empowerment Fund and will go a long way in empowering the youth in the country, increasing their employability and meaningful engagement.

CHAPTER 5: CONCLUSIONS

5.1 Introduction

This section presents the conclusions drawn directly from the findings presented in Chapter Four, presented with both strategic and programmatic focus, especially based on the evaluation criteria. The strategic level (covering relevance, efficiency, sustainability, coverage, connectedness and coordination), and programmatic level covering the CP component areas.

5.2 Strategic Level

Conclusion 1: The 7CP is strategically aligned to the national and international development priorities, UNFPA SP, SDG and ICPD. The Country Office was responsive to the changing population need, leading to adaptation of the CP into COVID-19 context responding to different needs and challenges that this came with and strategically built partnerships within the SL Government, UNCT, donors and other stakeholders in the country. Inadequate allocation of resources to the programme components, particularly, PD and Youth interventions, limited the extent to which the CP achieved its results. Further, the CP results were influenced by the outbreak of COVID-19.

Associated Recommendation: 1 **Origin**: EQ 1, EQ 2, EQ 3, EQ 6

The 7CP was fully aligned to national and international development needs. The design was well adapted to the needs of the needs of the population, particularly of the most vulnerable and marginalized. The CP directly contributed to the government priorities as contained in the Medium-Term National Development Plan (MTNDP) 2019 – 2023, and the national sectoral ministry strategies. The CP was fully aligned to the UNFPA global Strategic Plan 2018 – 2021, and UNSDCF, the SDG and the ICPD. There is evidence of design and implementation of the programme in consultative manner with the participation of the government, local NGOs and beneficiaries, especially at the community level, advancing national ownership and capacity building. It was however not explicit in the CP design on how the most vulnerable were consulted during implementation. The 7CP was responsive to changing national needs and environment especially during the COVID-19 pandemic. The resource distribution among the programme components affected effectiveness in delivery of the results. There is however an opportunity to strengthen strategic partnership for ownership of the CP results and enhancement of the country's capacity to respond to the arising needs.

Conclusion 2: The CO has particular areas of strength where UNFPA's areas of responsibility were well recognized and acknowledged by other UN members as contributing to effective coordination mechanisms within the UNCT. There was high value addition by UNFPA in the delivery of joint programmes, supporting TWGs and resource mobilization to contribute to the functioning of the UNCT. There were however inadequate coordination and standardization in service delivery among the heath sector UN agencies.

Associated recommendation 2 **Origin**: EQ1, EQ2, EQ3

The CO was acknowledged as a key member of the UNCT, leading the PMT and actively participating in the functioning of the UNCT coordination mechanisms. The 7CP priority areas were also aligned to the UNSCDF result areas with the CO leading the Outcome area 4 of the RRF. The CO was further engaged actively in the various results groups within the UNCT, where it also chaired or co-chaired contributing to the results of the UNCT. UNFPA had joint programmes with FAO, and UNDP, in addition to collaborating with UN Women, UNICEF, IOM, WFP and WHO along its areas of comparative advantage, particularly A&Y, GBV, Gender and SRHR. Further, UNFPA immensely contributed to the implementation of the COVID-19 Socio-economic response plan ensuring continuity of service delivery amid COVID-19 challenges. There were however coordination gaps among the health sector UN agencies, in addition to disjointed engagement of the donors agencies by MoHS, where there is not specific strategy for engagement, with preference given to agencies on a case-by-case basis, limiting focus on national priorities.

Conclusion 3: The 7CP had a fairly strong and robust monitoring and evaluation (M&E) systems in place for programme monitoring, reviews, compliance and quality assurance. However, there were inherent weaknesses in the design, implementation and inadequate use of M&E learning and quality assurance.

Associated Recommendation 3 **Origin**: EQ 1, EQ 3, EQ4

The 7CP M&E system in place utilized by the various CO teams were effective and efficient in informing decision-making programmatically and operationally. Design issues, however affected effectiveness in the application of M&E

functions in quality assurance. Reporting was mostly activity-based with limited focus of the CP in achievement of the results across the results chain, in addition to inadequate accountability to the funding systems. There were inherent weaknesses in the design of the 7CP ToC across the results chain. The causal links, for example, between the output and corresponding indicators, and the outcome and corresponding indicator for the adolescent and youth component do not correspond well. Further, there were indicators reported on using wrong data sources, for example the data on 'FP stock-outs' was reported on using a different data source. Effectiveness in monitoring some activities was also not clear. For example, ensuring that communities declaring abandonment of harmful practices were monitored to ensure effectiveness was not clear.

Conclusion 4: UNFPA utilized strong partnership nurtured between the CO and NGOs and government ministries across the country, integration of the CP interventions, and with limited resources to achieve the planned results, in addition to leveraging resources and putting in place mechanisms to ensure efficient delivery of the 7CP. Delays in the disbursement of funds and limited times for spending per plans is also affecting the results of the CP. Further, there are units with staff inadequacies like Communications, Quality Assurance (M&E) and other Programme Units.
Associated Recommendation 4 **Origin**: EQ 3, EQ 5

UNFPA put in place strategic measures and processes to ensure efficient delivery of the 7CP. However, almost all the IPs and government partners reported late disbursement of funds to support the implementation of the CP interventions as contained in the AWPs. There were reported inadequacies in staffing in some of the programme units, including non-allocation of operational resources for effective implementation of their functions.

Conclusion 5: UNFPA enhanced mechanisms to strengthen sustainability through promotion of national ownership and capacity building of the different stakeholders. UNFPA upheld consultation with the government, supporting the development of strategies, policies and guidelines. UNFPA also strengthened the capacity and institutionalization of response, among others. However, this was highly limited by the capacity and high turnover of the government entities.
Associated Recommendation 5 **Origin** EQ 3, EQ6

During the period of evaluation, the CO enhanced mechanisms to promote national ownership through consultations, working with the government, utilizing government mechanisms to deliver the programme interventions. The CO also ensured that the CP deliverables were in line with the national priorities and needs. The CO also prioritized capacity and institutional strengthening ensuring that there is skills transfer. Inadequate capacity of the government and turnover of staff trained on various aspects of the programme can hamper continuity of results.

Conclusion 6: UNFPA utilized different strategies to enhance data generation and capacity of the country. The mainstreaming of the population dynamics into the programme limited the extent to which it could achieve results. Further, data as a foundation for evidence based programming was inadequately articulated in the results of the CPD. In addition, the investment in data in terms of human resources was sub-optimal.
Associated Recommendation 6 **Origin**: EQ 1, EQ3 and EQ 5

The integration of the PD component into the CP had good intentions, but limited by resource allocation. For example, the fact that the design of the CP did not consider generation of data like the Mid-term census could not be finalized because it had funding limitations. The investments in the component was also limited, with only one staff coordinating the activities of the component. Consequently, the workload was heavy on the staff who was expected to cross check the work of the IPs and ensure alignment and compliance.

5.3 Programmatic Level

5.3.1 Sexual and Reproductive Health

Conclusion 7: The 7CP made significant contributions in enhancing access to SRHR aspects through strengthening individual and institutional capacities, supporting development of strategy, policies and advocacy for access, in addition to enhancing delivery of services in the country. In addition, the CP ensured integration of the SRHR, cervical cancer, HIV and GBV service provision, contributing to some improved outcome indicators in the country. there is need for enhanced accountability in the delivery of support.
Associated Recommendation 7 **Origin**: EQ 3 and EQ 4

UNFPA was instrumental in increasing and strengthening access to quality and standardized integrated SRH, FP and GBV service delivery by the targeted populations through supporting strong EmONC service delivery through financially and technically supporting the delivery of the interventions. UNFPA also supported development of guidelines, policies, SOPs and training of healthcare staff on the various aspects of the programme, in addition to strengthening the skilled birth attendance in the country. In addition, FP and GBV services are integrated in the SRH service provision. Further, UNFPA strengthened national ownership through fostering partnerships with national line ministries and local organizations, in addition to strengthening their capacities to supervise and oversee delivery. There is a need to strengthen evidence-based programming and accountability through enhanced monitoring and supervision systems to ensure compliance and delivery.

Conclusion 8: The MPDSR support by the 7CP yielded substantive data on the causes of maternal deaths in the districts. However, utilization of the results was lacking among the committee members, especially at the district and national levels. Further, the Obstetric Fistula treatment (surgeries) were conducted by specialists from outside the country exposing the country to the risk of cases escalating due to inadequate or lack of manpower.

Associated Recommendation 8 **Origin**: EQ 3 and EQ 4

Feedback from interviews with the stakeholders indicated that the MPDSR was effectively implemented, especially in surveillance, establishing the causes of death among the women of reproductive age. The utilization of the report from the districts, in addition to the national coordination mechanisms to act on the report was identified to be a gap by the MoHS. On the other hand, UNFPA effectively supported the treatment and reintegration of survivors of obstetric fistula. However, the country depended on specialists from outside the country, putting a risk and cost to the efforts aimed at ensuring treatment of the identified cases.

Conclusion 9: UNFPA continued to play a critical role in supporting the government in strengthening the RHCS in the country using various approaches for increasing the demand for and enhancing access to the service, in addition to institutional and human resource capacity building, community mobilization and sensitization, supply of FP commodities, evidence-generation, and strengthening of supply chain management. There is however low government commitment in financing RHCS.

Associated Recommendation 9 **Origin**: EQ3, EQ4 and EQ6

UNFPA was instrumental in averting stock-out of contraceptive commodities in the health facilities through supporting procurement and distribution of the nearly 95% of the national needs for contraceptives, in addition to strengthening the supply chains through financially and technically supporting the MoHS in the development of five-year integrated health supply chain management strategy through highly consultative processes. The CP also made key contribution in the establishment of a functional national mechanism for regular need assessment, multi-year forecasting, supply planning and funding gap analysis for contraceptive supplies. There is however low financial commitment by the government in procuring the RHCS, threatening sustainability. However, the CO is shifting its engagement approach with the government, moving from donation to a subsidization or Partnership model, the CO is working with the government and other partners towards progressively increasing domestic financing for RH commodity procurement.

5.3.2 Adolescent and Youth

Conclusion 10: UNFPA immensely contributed to the integration of the SRHR aspects in the education curriculum for both in and out of school through the development of the CSE. This was not however implemented at the time of the evaluation and will require more investments in capacity strengthening for operationalization. It was also observed that the adolescent and youth friendly services were few, particularly non-existent beyond the district levels making it difficult to enhance their access to services.

Associated Recommendation 10 **Origin**: EQ 3 and EQ 4

The development and integration of the CSE into the in and out of school curricula was lauded as a great achievement during the 7CP. The roll-out will require training of the teachers, schools' inspectors, production of resources for training and implementation, among other stakeholders to ensure that the quality of delivery is according to standards, in addition to supporting the learners to build their life skills to express themselves from an informed point of view. Enhanced integration of the adolescent-friendly sexual and reproductive health will facilitate effectiveness and sustainability.

Conclusion 11: The results of the 7CP show great contribution to the empowerment of the youth through their enhanced participation in decision-making, including influencing and contributing to the development of policies and strategies, in addition to creating demand and access to service provision for young people, particularly adolescent girls and young women. Further enhancing active engagement of young people, creating and strengthening of youth networks or fora in advocacy and programming for impact.

Associated Recommendation 11 **Origin**: EQ1, EQ 3 and EQ 4

Results from the CPE show that the 7CP enhanced the engagement of the young people in decision-making, particularly in policy and strategy development, culminating into expanding their knowledge and access to services. There is a need to strengthen systems and structures to increase focus on young people's issues and reap the potentials that the youth have in contributing to the development of the country, with potential in harnessing the demographic dividend on the youth for an empowered society.

Conclusion 12: UNFPA is well placed to advance the national agenda for the young people, particularly related to their SRHR, and building from the potential presented by national data gathered through reaping from the demographic dividend.

Associated Recommendation 12 **Origin**: EQ1, EQ 3 and EQ 4

UNFPA made considerable efforts to increase the potential from the demographic dividend enhancing data gathering from different sources in the country facilitating prioritization of the needs of young people and the potential in addressing their needs. This will enhance planning through availability of data to inform decision-making and targeting, including programming for UNFPA in Sierra Leone. Strengthening the country's contribution to the SDGs in line with the new Strategic Plan 2022 – 2025 will be an opportunity too.

5.3.3 Gender Equality and Women Empowerment

Conclusion 13: UNFPA strengthened strategic partnership with the Government of Sierra Leone in addressing aspects of GEWE in addition to elimination of harmful practices, including teenage pregnancy, early child marriage and FGM. Despite the progress made, there is still a lot to be done, especially in strengthening legislative and advocacy frameworks to address the root causes behind inequalities, harmful practices and GBV in the country.

Associated Recommendation 13 **Origin**: EQ 1, EQ 3, EQ 6

UNFPA continued to strategically partner with the Government of Sierra Leone working with line ministries in the quest to reduce inequalities along age and gender lines, in addition to enhancing engagement of duty bearers and rights holders to address cultural and legal barriers to combat inequalities and harmful practices. Despite the efforts, the harmful practices continue to thrive among communities in the target districts. This calls for concerted efforts to strengthen action.

Conclusion 14: UNFPA significantly contributed to development and strengthening of the policies such as the GEWE policy, Male involvement Strategy for Prevention and Response to Gender Based Violence and Radical Inclusion Policy, among others. There is however low commitment and capacity in terms of operationalization, in addition to resource allocation for effective implementation and sustainability.

Associated Recommendation 14 **Origin**: EQ 1, EQ 3, EQ 6

There is need for a clear implementation framework for the policies and strategies developed, in addition to putting in place mechanisms for feedback and monitoring on the progress made. Resource allocation and capacity of the government are also constraining implementation of the policies and strategies.

CHAPTER 6: RECOMMENDATIONS

6.1 Introduction

This chapter presents the recommendations of the CPE along strategic and programmatic considerations based on the findings, conclusions and feedback from the CP stakeholders and documentations. The recommendations are classified into high and medium priority. High priority refers to implementation within a 1-2-year period whilst medium priority refers to implementation within 3-4-year period.

6.2 Strategic Level

Recommendation 1: UNFPA to continue strengthening of alignment of the CP to the new UNFPA SP (2022 – 2025) and to the country's development and humanitarian priorities, while maintaining strategic partnerships with government institutions and non-state actors to ensure its presence and leadership in enhancing its strategic relevance on the thematic areas of mandate.

Associated Conclusion: 1 **Origin**: EQ1, EQ2, EQ3, EQ6 **Priority**: High **Target**: CO and HQ

Operational Implications: The CO should enhance strategic alignment of the 8th CP through building on its comparative advantage to address felt needs in the country, in addition to incorporating and strengthening capacity development and strategic resource mobilization covering existing and new sources and ensuring adequate allocations to CP areas of felt needs along its mandate. These include, strengthening South-South Cooperation, partnerships, conducting SWOT and alignment with the New UNFPA SP for strategic relevance. Additionally, the CO should uphold flexibility and responsiveness to the arising needs in the country. This will enhance relevance, effectiveness, efficiency and sustainability

Recommendation 2: UNFPA should maintain its proactive role facilitating UNCT coordination, explore further opportunities for collaboration and joint programming, and advocate for delivery as one modality. Further, the health sector agencies should harmonize their approaches, in addition to approaching the MoHS as One to ensure shared prioritization of needs for the ministry and support by the UN agencies

Associated Conclusion: 2 **Origin**: EQ1, EQ2, EQ3 **Priority:** Medium **Target**: CO and RCO

Operational Implications: Enhanced coordination will ensure efficiencies in the delivery, M&E and support of the country in contributing to addressing the country's development and humanitarian needs. Joint programmes will require more resource mobilization, human and technical resources. The Health sector agencies to strengthen their coordination mechanisms, particularly in the approaches and engagement of the MoHS.

Recommendation 3: The 8th CP should have a strengthened interventions logic ensuring that the results areas are clearly linked in addition to ensuring alignment to the key interventions supported. The CO should also enhance learning and knowledge management mechanisms and promote advocacy for CO focus and use of results

Associated Conclusion 3 **Origin**: EQ 1, EQ 3, EQ4 **Priority**: High **Target**: CO and Regional Office

Operational Implications: Ensure logical linkage between the targeted results, interventions and indicators of measurement under each of the CP components. Promote mechanisms for learning and knowledge management to ensure evidence-based response, in addition to ensuring the results of the CP are clearly captured.

Recommendation 4: The CO should work closely with the Implementing partners to address the challenges that result in the delays in the disbursement of funds and reporting. Further, the CO should reassess its institutional capacity, guided by the strategic positioning in the country, identify gaps, especially on human resources and implement the findings to effectively deliver on the mandate

Associated Conclusion 4 **Origin**: EQ 3, EQ 5 **Priority**: High **Target**: CO

Operational Implications: The CO should enhance collaboration and CP planning with the IPs in the delivery of the programme; cconduct institutional capacity assessment for the CO to address existing gaps; and institutionalize capacity development and assistance for staff.

Recommendation 5: UNFPA should continue enhancing the institutional capacity and system strengthening of the government and promotion of national ownership of the CP interventions and results. Further, the CO should promote strategic engagement with CSOs and communities to enhance local capacity, participation and ownership for maximum and sustainable results

Associated Conclusion 5 **Origin** EQ 3, EQ6 **Priority**: High **Target**: CO and Regional Office
Operational Implications: This will require more allocation of resources for institutional capacity and systems strengthening. Collaboration with CSOs and communities will enhance capacity, in addition to ensuring ownership of the results for a lasting change.

Recommendation 6: With the high integration of the CP, UNFPA should ensure that adequate resources allocated for data and evidence-generation in all the programme components, in addition to enhancing its comparative advantage in the thematic area of population dynamics within the UNCT.

Associated **Conclusion** 6 **Origin**: EQ 1, EQ3 and EQ 5 **Priority**: High **Target**: CO, HQ and RO

Operational Implications: Enhancing evidence-based programming will require more Human and financial resources which will necessitate the need for resource mobilization. Enhanced partnership is also an opportunity for this area of focus while providing technical assistance.

6.3 Programmatic Level

6.3.1 Sexual and Reproductive Health

Recommendation 7: The CO should strengthen integration of the SRH, FP, HIV, Cervical Cancer, and GBV programming, as well as improving monitoring and supervision for quality of care in service delivery

Associated Conclusion 7 **Origin**: EQ 3 and EQ 4 **Priority**: High **Target**: CO, RO and HQ

Operational Implication: Increased financial and technical capacity will necessitate increased resource mobilization and human resource, in addition to innovative measures to ensure evidence-based programming and compliance. HQ and RO to support on technical capacity development and assistance.

Recommendation 8: Advocate with the MoHS to strengthen MPDSR to contribute to the reduction of future preventable maternal deaths and to enhance the technical capacity of the country in the management of obstetric fistula

Associated Conclusion 8 **Origin**: EQ 3 and EQ 4 **Priority**: High **Target**: CO

Operation Implications: Advocacy on implementation of the MPDSR recommendation will facilitate actions and will lead to addressing the causes of MMR. Further, training of local specialists will strengthen technical capacity ensuring uninterrupted treatment of obstetric fistula in the country.

Recommendation 9: The CO to advocate with the government to increase domestic financing of RH commodity procurement, and further strengthen the government and local stakeholders' technical capacity on the implementation and management of the RHCS supply chain strategy to ensure effectiveness and sustainability.

Associated Conclusion: 9 Origin: EQ3, EQ4 and EQ6 **Priority**: High **Target**: CO

Operation Implications: Institute modalities for ensuring that the shift in engagement approach through the Compact model is in place and frequently monitored and challenges addressed frequently. Further, enhance capacity strengthening of the government and local stakeholders, particularly in the implementation of the developed RHCS supply chain strategy to ensure enable them monitor, review and facilitate processes of evidence generation for decision-making.

6.3.2 Adolescent and Youth

Recommendation 10: UNFPA to enhance strategic partnership with the government and other stakeholders to facilitate capacity strengthening of MBSSE stakeholders to ensure effective implantation of the CSE in schools, in addition to availability of tools and materials for monitoring and learning respectively.

Associated Conclusion 10 **Origin**: EQ 3 and EQ 4 **Priority**: High **Target**: CO

Operation Implications: Operationalization of the CSE curriculum for in and out of school will increase access to SRHR information and empower them to effectively make sexual choices, in addition to enhancing their demand for services. Further, the operationalization will require fostering of partnership, and mobilization of resources to facilitate implementation.

Recommendation 11: UNFPA to Strengthen consolidation of youth programming and coordination in the country while at the same time continue to build the capacity of the youth on leadership skills and ability to influence policy and strategy, in addition to strengthening engagement networks and for a for young people in addition to creating and strengthening of youth networks or fora in advocacy and programming for impact.

Associated Conclusion 11 **Origin**: EQ1, EQ 3 and EQ 4 **Priority**: High **Target**: CO and RO

Operational Implications: The CO should advocate and use its comparative advantage for meaningful engagement and targeting of the youth through promoting implementation of the National Youth Policy and Strategy and action plan should also be in place to guide implementation. More resources will be required to engage stakeholders and resource persons for harmonized targeting and response to youth issues will be ensured.

Recommendation 12: Strengthen harnessing of the Demographic Dividend to advance the national agenda for the young people, particularly related to their SRHR.

Associated Conclusion 12 **Origin**: EQ1, EQ 3 and EQ 4 **Priority**: Medium**Target**: CO and RO

Operational Implications: Harnessing Demographic dividend will require data and multi-stakeholder approach to address the needs of the young people in the country.

6.3.3 Gender Equality and Women Empowerment

Recommendation 13: The CO should systematically advocate for changes in legal frameworks and social norms that are barriers to addressing GBV and harmful practices. This should also include meaningful engagement of rights holders, duty bearers and service providers, in addition to incorporation operation research

Associated Conclusion 13 **Origin**: EQ 1, EQ 3, EQ 6 **Priority**: Medium **Target**: CO

Operational Implications: To address the deeply rooted socio-cultural norms and strengthen the legislative frameworks, UNFPA should advocate and provide support for sustained mechanisms for behaviour and socio-cultural change involving leaders, community members and other actors to ensure coverage and effectiveness in response. The CO will need to increase investment in operation research to ensure evidence-based response targeting the root causes**.**

Recommendation 14: UNFPA should continue promoting multisectoral approach to strengthening national capacities on mainstreaming of GEWE issues in the relevant national strategies, policies and development plans

Associated Conclusion 14 **Origin**: EQ 1, EQ 3, EQ 6 **Priority**: High **Target**: CO

Operational Implications: The CO should continue advocating for the capacity building of the government counterparts to implement GEWE in the government policies and strategies, including strengthening the referral framework for the GBV survivors. There is also need to advocate for the government to allocate resources for implementation of GEWE related strategies and policies, incorporating enhanced accountability and evidence-based response

ANNEXES

Annex 1: Evaluation Matrix

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection	Updates based on findings
Relevance **EQ1:** To what extent is the country programme adapted to: (i) the needs of diverse populations, including the needs of vulnerable and marginalized groups (e.g. pregnant women, young people and women with disabilities, etc.); (ii) national development strategies and policies; (iii) the strategic direction and objectives of UNFPA; and (iv) priorities articulated in international frameworks and agreements, in particular the ICPD Programme of Action and the SDGs, (v) the New Way of Working?				
Assumption 1.1: UNFPA Country Programme were adapted to the needs of the populations, particularly of the most vulnerable and marginalized	• Evidence of an exhaustive and accurate identification of the needs prior to the programming of SRHR, Adolescent and Youth, and Gender Equality and women's empowerment by UNFPA and/Implementing partners • Evidence of systematic use of findings from needs assessments in programme planning and design and the selection of target groups for UNFPA-supported interventions in the four thematic areas of programming in line with identified needs (as detailed in the needs assessments) as well as priorities in the CPD and AWPs. • Extent to which the targeted populations, including vulnerable and marginalized groups, such as people with disabilities, were consulted in relation to programme design and activities throughout the programme	• CPD and AWPs • National policy/ strategy documents • Needs assessment studies • UNDAF • Country Office staff • IPs, key actors	• Document review • KIIs with UNFPA CO, IP and key actor's staff • FGDs with beneficiaries	• There is identification of needs through consultations with stakeholders. UNFPA works directly with the line ministries, and these directly contribute to the ministries' strategic plans and objectives. • There is direct contribution of the 7CP to the national Medium-Term National Development Plan (MTNDP) 2019 – 2023 adapted to the needs of the populations and in line with the national priorities.
Assumption 1.2: The UNFPA CP Interventions were aligned and contributed to the national	• The extent to which UNFPA-supported interventions have appropriately taken into account the priorities of the Government of Sierra Leone and key stakeholders.	• National policies and strategies • Implementing partners (State actors, implementing	• Document review • KIIs with UNFPA Staff, IPs and Government • FGDs with beneficiaries	• The UNFPA CP interventions are aligned and contributed to the national development strategies and policies, having coordinated implementation processes with the line ministries. UNFPA also directly support government initiatives, including secretariats

development strategies and policies	• Choice of beneficiaries for UNFPA-supported interventions are consistent with identified needs as well as national priorities in the AWPs, including women, youth and other vulnerable groups • Extent to which the objectives and strategies of the Country Programme and Annual Plan(s) have been discussed and agreed upon with a wide array of national stakeholders at national and provincial levels	NGOs) at the national and provincial levels • Program beneficiaries (PLW; young people, girls and boys) • AWPs • UNFPA CO Staff • Needs assessment studies • Implementing Partners		identified to address specific government directives and objectives. • The AWPs were developed based on consultations with the IPs and the government line ministries, ensuring alignment • There is however inadequacy of resources to facilitate response to the exponential needs, especially for the young people.
Assumption 1.3: The UNFPA-supported interventions are aligned with the UNFPA Strategic Plan 2018-2021 and international normative frameworks, policies and standards and the New Way of Working and the Grand Bargain	● Extent to which the interventions implemented are in line with the SDGs, ICPD and the UNFPA Strategic Plan 2018 - 2021 ● The expected results, targets and implementation strategies outlined in the CPD and the AWPs are in line with the priorities, results and targets of the United Nations Sustainable Development Framework (UNSDCF) for Sierra Leone. ● Extent to which the design and implementation and monitoring of UNFPA humanitarian assistance is aligned with the New Way of Working, the commitments of the Grand Bargain, and other international frameworks	● UNFPA SP 2018-2021 ● SDGs ● The Grand Bargain documents ● Government officials at national and state levels ● Needs assessments ● CPD ● AWPs	● Document review ● KII with UNFPA Country Office staff ● KIIs with other UN agencies ● KII with government officials ● KII with IPs and other development actors	● The CP was well aligned with the UNFPA SP 2018 - 2021, and designed according to the components of the SP. The Population dynamics and Adolescent and youth components were however mainstreamed limiting the pronouncement and resource allocation to the components in CP. ● The implementation of the CP also contributed to the achievement of the SGDs - Goals 3, 5, 10, and 17, in addition to 1, 4 and 16. ● UNFPA also works with local NGOs, contributing to addressing issues of localization and support their contribution to the local solutions.
Relevance **EQ2:** To what extent has the country office been able to respond to changes in national needs and priorities, including those of vulnerable or marginalized groups, and those imposed by the socio-economic impacts of COVID-19?				
Assumption 2.1: The CP is adapted to the national priorities and	● Evidence of capacity and flexibility in programming approaches to respond to emerging needs including for COVID-19 response	● UNFPA CO M&E Framework ● Strategic Information System	● Document review ● KIIs with CO, Government,	● UNFPA enhanced service access and delivery during the COVID-19 pandemic, in addition to reprogramming and adapting to the

effectively responded to the changes caused by external factors in an evolving country context, including in the context of COVID-19	• Evidence of changes in programme design or interventions reflecting context and influencing factors i.e. change in population needs and government priorities, COVID-19 response etc. • Evidence of financial capacity to respond to arising needs • Evidence of repeated needs assessments conducted by UNFPA and/or implementing partners, identifying the varied needs of diverse groups and lessons learned during programming period • Extent of CP interventions in the four thematic areas of programming were adapted to emerging needs, demands and priorities of the population, in particular the most vulnerable, disadvantaged, marginalized and excluded population groups	(SIS) annual reports. • Emergency Preparedness and Response Plans (EPRPs). • National policy/strategy docs. • Needs assessment studies (including HNOs). • KIs from Government, CSOs and UNFPA CO • Humanitarian Response Plans • Humanitarian programming documents • HCT members • Implementing partners	relevant UN agency and IPs staff • FGDs with beneficiaries and communities in targeted sites	implementation modalities of within the context.
Effectiveness **EQ3**: To what extent have the interventions supported by UNFPA delivered outputs and contributed to the achievement of the outcomes of the country programme? In particular: (i) increased access and use of integrated sexual and reproductive health services; (ii) empowerment of adolescents and youth to access sexual and reproductive health services and exercise their sexual and reproductive rights, (iii)advancement of gender equality and the empowerment of all women and girls; (iv) increased use of population data in the development of evidence-based national development plans, policies and programmes?				
Assumption 3.1: The planned UNFPA-supported intervention outputs under SRHR, A&Y, and GEWE have contributed to the achievement of the respective outcomes	• Degree of completion of outputs planned in the M&E Framework against indicators and targets • The evidence of changes taking place under each of the CP components due to the CO-supported interventions • Extent to which M&E of programme achievements indicate timely meeting of outputs. • Extent to which the response was adapted to emerging needs, demands	• The Global Programming System (GPS), AWP and annual reports (SIS) • Annual Review and Planning reports and related documents • IPs (government, NGOs) • UNFPA/ CO staff	• Documentary review • KII with Line Ministry staff and other IP and non-IP staff • Group Interviews with UNFPA staff • FGD with beneficiaries	• The CO achieved two out of the five targeted indicators, with the three of the non-achieved indicators being realized at more than 50% under the SRHR component. The effects of COVID-19 majorly contributed to the non-achievement of the targets, with some activities being suspended for a long time before resumption, like the treatment of the obstetric fistula. There was confirmed timeliness in the delivery of the interventions, in addition to contributing to the procurement of PPEs to ensure continuity of SRH services

	and national priorities during the period of implementation	• CP Results Framework • IP Progress reports • Beneficiary groups • Relevant MTR reports		during COVID-19. There is evidence of changes occurring due to the 7CP support under the SRHR, including strengthening of access to skilled birth attendance; increased demand for access and supply of Family Planning; enhanced provision of high-quality and integrated EmONC services; strengthening provision of quality of care and monitoring SRH services; treatment and reintegration of survivors of obstetric fistula, thought treatment is not sustainable; strengthened maternal death surveillance and reporting though the response part is weakly implemented; instrumental in the sensitization and case detection support on cervical cancer and prevention of HIV. • Two out of the planned three A&Y component output indicators were achieved. The CP immensely contributed to enhancing the adolescents and young people, particularly marginalized girls to express themselves and access their rights, in addition to contributing to their empowerment through strengthening their life skills enhancing their capacity to make their life choices, including making choices of sexual debut and practices. This further contributed to averting early child marriage and unintended pregnancies among the adolescent and young women. The CP also and supported those already pregnant to empower them to go back to school in addition to supporting development of the Radical inclusion policy, enabling their acceptance back to school. There were however girls not willing to go back to school due to fear of continuity as UNFPA was only providing back-to-school package and nothing after. • Only one out of the planned four output indicators under the GEWE was achieved. UNFPA however immensely contributed to

				strengthening of the country's capacity on enhancing gender equality, and prevention and response to GBV and other harmful practices through advancing advocacy mechanisms engaging various actors both at policy and community levels, promotion of involvement of men and media targeting strengthening legal and legislative framework, survivor protection, abandonment of child marriage, elimination of harmful practices and gender equality. In addition, UNFPA technically and financially supported building capacities of CSOs and government on child marriage and GBV prevention and response, including case management and referrals. Elimination of harmful practices, particularly the FGM is a challenge as it is considered a very sensitive aspect to discuss. Cultural and traditional beliefs are also still having a strong influence on GEWE and need more efforts to be addressed. ● UNFPA contributed to the harnessing of demographic dividend to harness the Demographic Dividend (DD) through supporting the scoping of the DD profile in the country. Further, the 7CP contributed to strengthening the capacity of the country's statistics in generation of evidence through capacity building of the SSL in mobile data collection, GIS training and support, among others. Mainstreaming of the PD component however limited the scope of the interventions during the 7CP.
Assumption 3.2: The UNFPA-supported intervention results effectively responded to achieve targeted	● The speed and timeliness of response (response capacity) ● Adequacy and quality of the response ● Evidence of facilitating factors ● Evidence of mitigate measures on the challenges during	● GPS AWPs ● APRs/SIS ● CO staff ● Government partners ● Implementing partners	● Document review ● KIIs with CO, Government and IPs staff	● UNFPA 7CP was effectively adapted to the COVID-19 pandemic context of programming achieving most of the planned targets in the areas of implementation, except in the Obstetric fistula surgeries which had to be suspended until the 4th quarter of 2020 missing on targets. UNFPA devised innovative ways of

results within the constraints of the context, including COVID-19	implementation of the UNFPA-supported interventions			ensuring resilience of the country health systems enabling continuity of the services, especially the SRHR services, including supporting healthcare workers to conduct outreaches in the affected areas, supported sensitization activities on the IPC of COVID-19 through partnership with Africell Telecommunications Company on messaging for community mobilization to foster continuity of SRH services during COVID-19 Pandemic, distribution of more than 20,000 dignity kits, including hygiene products.
Effectiveness **EQ4**: To what extent has UNFPA successfully integrated human rights, gender perspectives and disability inclusion in the design, implementation and monitoring of the country programme?				
Assumption 4.1: The CP design, implementation and monitoring integrated the cross-cutting issues of gender and human rights based approaches, including disability inclusion	• Extent to which a gender-responsive and human rights-based approach was integrated in situation assessment and analysis, planning and design, implementation and monitoring and evaluation of UNFPA-supported interventions in the four thematic areas of programming • Evidence of increased incorporation of a gender-responsive and human rights-based approach in Government policies, strategies and plans at federal and state levels during the period of the Country Programme • Evidence of inclusive and participatory mechanisms to systematically seek input from target populations in the design, implementation and monitoring of UNFPA-supported interventions in the four thematic areas of programming	• AWPs and SISs/APRs • CO staff • Government and key stakeholders • CP documents • Government and key partners • Key government policies, strategies and plans at national and county levels • IP progress reports • Beneficiaries	• Document review • KIIs with CO, Government, relevant UN and IP staff • FGDs with beneficiaries	• UNFPA employed rights-based approaches, ensuring services were accessed and provided to those in need, particularly the hard-to-reach areas and marginalized population ensuring they access services. • The CP also ensured mainstreaming of gender, in addition to supporting mechanisms to target those living with disabilities to get services. The d=support to the marginalized girls with dignity kits and services enhanced their service access and dignity. • During COVID-19, the 7th was adapted to the context to ensure continuity of the services by the target populations enhancing their rights and dignities. • Notably the support for the treatment and reintegration of the survivors of obstetric fistula and supporting of the return to school of the already pregnant and lactating enhanced their dignity and enabled than a second chance to go back to schools for empowerment.

	• Presence of accountability mechanisms for populations affected by humanitarian crisis, such as complaints and feedback mechanisms to report sexual exploitation and abuse by UNFPA staff and/or implementing partners			
Efficiency **EQ5:** To what extent has UNFPA made good use of its human, financial and administrative resources, and used a set of appropriate policies, procedures and tools to pursue the achievement of the outcomes defined in the county programme, ensuring quality assurance, risk mitigation and accountability of resources?				
Assumption 5.1: Implementing partners received UNFPA financial and technical support as planned and in a timely manner, and UNFPA was able to mobilize appropriate resources in a timely manner to support the implementation of the Country Programme.	• Percentage of planned vs. actual resources • Evidence that implementing partners received the planned resources to the foreseen level in AWPs • Evidence that implementing partners received resources in a timely manner • Evidence of coordination and complementarity among the programme components of UNFPA • Evidence of progress towards the delivery of multi-year, predictable, core funding to implementing partners	• AWPs and APRs/SIS and IP, government reports • UNFPA CO financial reports • UNFPA CO staff • Government officials • Implementing partners • Resource mobilization strategy	• Document review • KIIs with CO, IP and Government staff • Group interviews	• The delivery of the 7CP was essentially delivered through partnership with both CSOs and the government of Sierra Leone. There is evidence that UNFPA had in place mechanisms to identify and engage implementing partners which was also based on the strength on programmatic focus and being the line ministry in the area of focus by UNFPA. • There was evidence of intervention planning and budgeting in consultation between the implementing partners and UNFPA through development AWPs which provided the basis for engagement on the CP interventions. UNFPA effectively supported coordination among the implementing partners, through supporting MoPED to hold semi-annual coordination meetings enabling experience sharing and identifying areas of needs and enhancing learning mechanisms. This also ensured complementarity among the IPs. The CO was also reported to be very supportive in providing IPs with support, including training and provision of guidelines to ensure that they complied with the operational and programmatic procedures. IPs and government reported that the financial support provided by UNFPA was adequate for the implementation of service delivery and technical activities targeted,

				amid exponential needs in the context, in addition to inadequate coverage of administration and staff costs. Disbursements were done to the IPs, however there were reported delays in disbursements, in addition to long approval time for the AWPs delaying the processes too.
Assumption 5.2: Programme strategic approaches, administrative, procurement and financial procedures as well as the mix of implementation modalities led to efficient achievement of programme outputs	• Evidence that UNFPA personnel (all types of contracts) have adequate expertise and experience to deliver development and humanitarian assistance • Evidence that CO staffing structure is appropriate for timely and effective implementation, including in humanitarian settings • The planned inputs and resources were received as set out in the AWPs and agreements with partners. • Evidence of strategic partnership for CP delivery, coverage and resource mobilization • The resources were received in a timely manner according to project timelines and plans • Budgeted funds were disbursed in a timely manner • Quality technical assistance to build capacity was available to the level planned • Evidence that technical assistance increased capacity among recipient stakeholders • Inefficiencies were corrected as soon as possible	• AWPs and SIS and IP, government • UNFPA CO financial reports • UNFPA CO, government and IP staff	• Document review • Interviews with CO, Government and IPs staff	• UNFPA employed effective and strategic approaches enhancing efficiency in the delivery of the 7CP. The CPE established that the staff was a mix of expats and nationals with diverse and appropriate skills-sets and capacities, with the regional office also providing support on the areas of weakness in the office, facilitating effective and efficient delivery of the CP. There were however reported staffing gaps in some CO dockets, including delays in recruitment, leading to overstretching of staff covering for the vacant roles. Learning activities were also embedded in the CP activities to ensure continuous improvement in skills and technical capacities of the staff. • The CO fostered strategic partnerships CSOs, government line ministries, donors, communities and within the UN to ensure efficiency in the delivery of the CP, enhancing coverage, resource availability and leveraging on use, and national ownership, in addition to employing contextual understanding. The CO also promoted integration of the CP components enhancing efficiency. • The CO also instituted internal controls and measures to ensure that the delivery of the programme was efficient with reduced inefficiencies reported. These were particularly in financial management, administration, procurement and staffing.

				Further, the CO also employed effective communication mechanisms to enhance the advocacy strategies ensuring effectiveness in design and delivery of key messages. The CO also enhanced the capacities of the IPs in addition to the line ministries through technical support, including technical assistant through hiring consultants to provide respective technical support. ● UNFPA also instituted audits and spot checks among the IPs, in addition to supporting them in the areas of weaknesses.
● **Assumption 5.3:** CO has robust M&E systems in place and are efficiently utilised	● Evidence of M&E system facilitating evidence generation on the programme interventions and effectiveness in documentation ● Evidence of utilization of M&E information in informing the programme strategies	● CP Resource and Results Framework ● Programme Reports (SIS and Annual Planning reports) ● UNFPA CO, Government and IP Staff	● Document review ● KII with CO, Government and IPs staff	● The M&E systems in place fairly supported evidence generation during the programme implementation of the CP. It supports the collection of information for reporting. The results from M&E information is utilized in informing the programme performance. There is need for strengthening the results-based focus, especially among the IPs, in addition to ensuring that the indicators are measurable.
Sustainability **EQ6**: To what extent has UNFPA been able to support its partners and the beneficiaries (women, adolescents and youth) in developing capacities and establishing mechanisms to ensure ownership and the durability of effects as well as established and maintained different types of partnerships across programme components during CP implementation?				
Assumption 6.1: The benefits of the Country Programme are sustainable and through UNFPA support, capacities of IPs and beneficiaries have been built for durable solutions to the implementation of	● Extent of ownership of each project by implementing partners ● Extent to which Government and implementing partners at national and sub-national levels have allocated adequate budget for continued implementation of interventions and safeguarding the gains that have been made in the four thematic areas of programming. ● Extent to which UNFPA has taken any mitigating steps to strengthen	● Beneficiary groups ● Government Ministries/Departments ● Implementing partners ● UNFPA CO staff ● AWPs ● Previous evaluations ● Projects and Interventions exit strategies	● Document review ● KI and Group Interviews ● FGD with beneficiaries	● UNFPA worked closely with the government line ministries and the support provided had contributions of the government. For example, in the Midwifery colleges, UNFPA only supported tuition and allowance for the learners, but the tutors were government employees, showing ownership by the government. Further, UNFPA put in place mechanism for contributing to government facilities, providing equipment and infrastructure which are managed by the government. The Policies and guidelines supported by the programme were used by the

the current programme and beyond.	areas with gaps hindering sustainability ● Evidence of the development of exit strategies in the four thematic areas of programming to hand over UNFPA-supported interventions to Government and/or implementing partners at national and sub-national levels ● Evidence for enhanced capacity of the Government and implementing partners at national and sub-national levels to implement interventions in the four thematic areas of programming without the technical support of UNFPA ● Extent to which programmes in the four thematic areas of programming were developed and implemented in a participatory multi-stakeholder process to promote ownership ● Evidence of partnerships with local institutions like academia, among others, to enhance implementation of the supported interventions.	● Government Ministries Policies and budget documents ● Training reports ● NGOs and Academia		government and they confirmed guided their everyday work, confirming national ownership ● UNFPA strengthened the capacities of the national entities, including local NGOs, which confirmed use of the skills trained in. there was confirmed skills transfer.
Coordination **EQ7:** To what extent has UNFPA contributed to the functioning and consolidation of the coordination mechanisms of the UNCT and to the technical results groups, including the COVID-19 socio-economic response plan				
Assumption 7.1: UNFPA effectively contributed to the functioning and consolidation of the coordination mechanisms of the UNCT and the technical results groups.	● Evidence of UNFPA actively contributing and taking initiative in UNCT meetings ● Evidence of UNFPA playing a leading role in thematic working groups of the UNCT relevant to the UNFPA mandate ● Extent to which UNFPA participates in the relevant technical working groups	● Joint initiatives. ● Monitoring / evaluation reports of joint initiatives. ● Staff of relevant United Nations agencies ● Coordination modalities with UN, federal and state stakeholders.	● Documentary review ● KIIs with UNFPA CO staff ● KII with relevant UN agencies staff	● UNFPA contribute positively to the UNCT and apply its comparative advantage for the effective and efficient running of the UN coordination mechanisms within the country, ensuring synergies within the UN mission in Sierra Leone and eliminating duplication among the agencies. UNFPA contributed to different coordination groups, in addition to being a member of different result groups and technical working groups contributing to the country's development

	• Extent to which UNFPA applied the Delivering as One (DAO) approach in its interventions • Evidence that synergies have been actively sought in the design, implementation and monitoring and evaluation of the UNFPA Country Programme and programmes and interventions of other UNCT members • Extent to which the comparative advantages and technical expertise of UNFPA in the four thematic areas of programming added value to the UNCT support for sustainable development • Evidence of UNFPA leading or actively contributing to the technical results groups	• UNCT meeting reports or minutes • Implementing partners		and humanitarian agenda. UNFPA also implemented a joint programme, in addition to collaborating with various UN agencies contribution in different areas based on its comparative advantage. UNFPA was recognized as an influential player in the UNCT and participates regularly in the UNCT meetings and keeps other participants informed of any plans, achievements, and missions. UNFPA was also confirmed to play an important role in the country's overall development agenda, contributing effectively to improving UNCT coordination mechanisms, particularly strengthening advocacy and technical support in several areas of responsibility
Assumption 7.2: UNFPA supported and contributed to the development and implementation of the COVID-19 socio-economic response plan	• Evidence of UNFPA actively contributing and taking initiative in the inter-cluster coordination group meetings • Evidence that synergies have been actively sought in the design, implementation and monitoring and evaluation of UNFPA support to the COVID-19 socio-economic response plan • Extent to which the comparative advantages and technical expertise of UNFPA in the thematic areas of programming added value to the COVID-19 response • Evidence of UNFPA CO contributing to the design and implementation of the COVID-19 socio-economic response plan	• Joint initiatives. • SIS • Monitoring / evaluation reports of joint initiatives. • Staff of relevant United Nations agencies • Coordination modalities with UN, federal and state stakeholders. • Implementing partners	• Documentary review • KIIs with UNFPA CO staff • KIIs with relevant UN agencies staff	• UNFPA was part of the UNCT COVID-19 socio-economic response plan, and effectively participated in ensuring that the COVID-19 IPC mechanisms were in place. UNFPA also actively participated in sharing the responsibilities in the response plan and effectively utilized its strengths in the area of responsibility by ensuring that services reached the people without discontinuity. UNFPA supported the government through the UNCT to ensure that there were treatment centres at the supported health facilities, in addition to ensuring that the facilities supported had screening and PPEs for COVID-19. Further, to ensure service delivery, UNFPA supported integration of SRHR in the established nine COVID-19 emergency health service teams for the vulnerable and hard-to-reach populations

Coverage **EQ8:** To what extent has the UNFPA humanitarian response reached those most in need and vulnerable in crisis situations both geographically and demographically (young people and women with disabilities; those of racial, LGBTQ populations, etc.)?				
Assumption 8.1: The CP SRHR and ASRH humanitarian interventions were targeted at and delivered in all geographical areas where affected population reside.	• Evidence of needs assessment conducted by UNFPA and/or implementing partners, identifying the varied needs of vulnerable populations in various geographical areas in the country prior to the programming of the SRH, A&Y, P&D and gender components of the CPD • Evidence of systematic use of findings from needs assessments in programme planning and design and the selection of target groups for UNFPA-supported interventions in the three thematic areas of programming in line with identified needs (as detailed in the needs assessments) as well as priorities in the CPD and AWPs. • Extent to which the planned interventions in the three thematic areas of programming, as described in the AWPs, were targeted at the most at-risk groups in a prioritized manner. • Extent to which the actual interventions implemented on the ground met the needs of the most at-risk groups. • Extent to which the most at-risk groups were consulted in relation to programme design and activities throughout the programme	• UNFPA CO M&E Framework • SIS / annual reports. • Needs assessment studies (incl. Humanitarian Needs Overviews) • Evaluations Reports and other UN agencies in the same thematic areas of focus. • Key Informants from Government, CSOs and UNFPA CO • Direct and indirect beneficiaries.	• Document review • KI interviews • FGDs with beneficiaries and communities in targeted sites • FGDs with direct and indirect beneficiaries and communities in targeted sites	• Through the 7CP, UNFPA ensured a national coverage, particularly contributing the national response on humanitarian response during disasters in close coordination with the national stakeholders, including UNOCHA. UNFPA also partnered with IPs ensuring that all the 16 districts were reached with RH and GBV services during humanitarian crisis, in addition to training MoHS and IPs on the various competencies of the MISP to deliver services effectively during humanitarian crisis. UNFPA also ensured prepositioning of dignity and emergency RH kits targeting affected population, in response to arising crisis. • There was evidence of assessment of the COVID-19 situation in the country with UNFPA being part of the planning and this informed the response mechanisms through the UNCT, supporting the MoHS and IPs to reach the vulnerable and marginalized population. • There was evidence of the programme targeting the most vulnerable population, particularly women and girls in the hard-to-reach areas, especially those with challenges of access to RH services. These include the areas with high early and unintended teenage pregnancies; supporting the MoGCA in the establishment of the One-Stop Centres to provide services to the GBV survivors; supporting the training of the SACHOs to enhance to EmONC services in the hard-to-reach areas, in addition to supporting cervical cancer screening across the country. • UNFPA also had a national coverage of the treatment and reintegration of the Obstetric
Assumption 8.2: The UNFPA humanitarian support	• Evidence of UNFPA responding to protection needs of the affected population in the country	• UNFPA CO M&E Framework • Strategic Information System	• Document review • KIIs with Government, IPs and CO staff	

systematically reaches demographic populations based on their vulnerability and marginalization (i.e. women, girls, and youth with disabilities; displaced women, adolescents and youth; the elderly; female-headed households; women and adolescents and youth at risk).	• Evidence of UNFPA response targets vulnerable and marginalized in Sierra Leone • Evidence of UNFPA programme supporting creation of humanitarian space to reach the vulnerable populations in Sierra Leone • Extent to which the planned UNFPA interventions in the three thematic areas of programming (including PD), as described in the AWPs, were targeted at the most vulnerable, disadvantaged, marginalized and excluded population groups in a prioritized manner. • Extent to which the actual interventions implemented on the ground met the needs of the most vulnerable, disadvantaged, marginalized and excluded population groups. • Extent to which the vulnerable and marginalized were consulted in relation to programme design and activities throughout the programme	(SIS) annual reports. • Needs assessment studies (incl. Humanitarian Needs Overviews) • Previous Evaluation Reports and other UN agencies in the same thematic areas of focus. • Key Informants from Government, CSOs and UNFPA CO • Direct and indirect beneficiaries.	• FGDs with beneficiaries and communities in targeted sites • FGDs with direct and indirect beneficiaries and communities in targeted sites	Fistula survivors. UNFPA also supported the at-risk groups through condom programming, particularly supporting installation of condom dispensers in lodges targeting key populations. Further, the 7CP also supported the facilitation of inclusion of the PWDs into the SDG reporting framework ensured national coverage, in addition to enabling focusing of the programmes to address the needs of the PWDs.
Connectedness **EQ9:** To what extent has UNFPA contributed to developing the capacity of local and national stakeholders (state institutions/line ministries, youth and women organizations, health facilities, communities and civil society organizations) to better prepare, respond, build back better and recover from humanitarian crisis?				
Assumption 9.1: UNFPA Sierra Leone strategic leadership on youth and women contributed to stronger capacities in the results and resources framework of the 7th Country Programme	• Evidence of the existence of an exit strategy with timelines, allocation of responsibility • Evidence of details of a handover process from UNFPA to the government departments and/or development agencies • Evidence of the existence of a transition strategy from humanitarian action to development, which specifies timelines, allocation	• UNFPA CO • Key Implementing Partners • Donors • Results and resources Framework • UNFPA Staff • Government staff • NGO/IP Staff • Programme reports	• KIIs with Donors, CO, Government, IPs staff • Document review • Interviews with staff • Group Interviews	• UNFPA contributed to ensuring longer term results through strengthening capacities of the actors, developing strategies, guidelines and policies to guide implementation, supporting the youth participate in key decision-making activities aimed at empowering them, coordination and promoting integration of programmes and national ownership of interventions and results

(2020-2023) contributes to bridging the development-humanitarian nexus by enhancing capacities at individual, community and systems level	of budget and roles and responsibilities • Extent to which the capacity of individuals, in particular women, adolescents and youth, has been increased to reduce vulnerability to and adapt to humanitarian crises, as well as transform livelihoods to successfully cope with humanitarian crisis • Extent to which the capacity of communities to prepare for, mitigate the impact of, and recover from humanitarian crisis has been enhanced • Extent to which the preparedness of the health and social protection systems at national and district levels and the capacity to deliver services in the mandate areas of UNFPA has been increased • Extent to which UNFPA humanitarian assistance was linked specifically to peacebuilding initiatives			• UNFPA also supported the training of IPs and MoHS on MISP which capacitated them to ensure effective response and to capacitate the stakeholders on response and delivery of services during emergencies. UNFPA also supported infrastructures in the government health facilities and are handed over and managed by the government. • In targeting the youth, UNFPA focused on addressing root causes of conflict among the youth and women in marginalized and affected locations. These efforts aimed at reducing their involvement in risky behaviours • There were confirmed increased capacity by the government, especially MoHS being able to implement interventions in an improved manner, especially using guidelines and policies supported by the 7CP. • UNFPA The context of implementation was however more developmental than humanitarian limiting the extent of response and assessment.

Annex 2: List of those Interviewed

Ministry / Organization	Designation	Thematic Area/ AoR
Government		
Ministry of Youth Affairs	Deputy Director of Youth	Adolescent and Youth
Ministry of Youth Affairs	Component Manager	Adolescent and Youth
School of Midwifery, Bo	Principal	SRHR (Midwifery)
School of Midwifery, Makeni	Principal	SRHR (Midwifery)
School of Midwifery, Makeni	Finance Officer	SRHR (Midwifery)
Bo Government Hospital	Hospital Matron	SRHR
Bo Government Hospital	Hospital FP Coordinator	SRHR
Makeni Government Hospital	Medical Superintendent	SRHR
Makeni Government Hospital	Maternity and Cervical	SRHR
Makeni Government Hospital	Hospital M&E	SRHR
National AIDS Commission	Director General	HIV
National AIDS Commission	Executive Secretary	HIV
Ministry of Gender and Children Affairs	Director of Gender	GEWE
Ministry of Gender and Children Affairs	National Coordinator for GBV Response	GEWE
National Secretariat for the Reduction of Teenage Pregnancy and Child Marriage	Director	GEWE
MBSSE	Director for Non-formal and Adult Education	GEWE
MBSSE	Finance Officer	GEWE
MoPED	Development Secretary	PD and Coordination
MoPED	Director Planning, Policy and Research	PD and Coordination
MoPED	Population Unit Head - Coordinator	PD and Coordination
Sierra Leone Parliamentary Action Group on Population and Development	Chairman	PD
Sierra Leone Parliamentary Action Group on Population and Development	Clerk	PD
MoHS	M&E Director – Directorate of RCH	SRHR
MoHS	Chief Pharmacist	SRHR
MoHS	Chief Nursing Officer	SRHR
MoHS (NMSA)	Supply Chain Director	SRHR

Statistics Sierra Leone	Director – Demography, health and Social Statistics Division	PD
Academia		
Institute of Population and Development Studies – University of Sierra Leone	Lecturer on Research	PD
Institute of Population and Development Studies – University of Sierra Leone	Lecturer	PD
Institute of Population and Development Studies – University of Sierra Leone	Head of the Institute	PD
CSO IPs		
FINE SL Kenema	Centre staff	A&Y and GEWE
FINE- SL Kenema	Administration and Financer	A&Y and GEWE
FINE -SL Kenema	Programme Officer	A&Y and GEWE
FINE - SL Kenema	Communications and Gender	A&Y and GEWE
UN RC Office	Head of Office	A&Y and GEWE
Haikal Foundation	Founder and Director	SRHR (Fistula)
Haikal Foundation	Programme Manager	SRHR (Fistula)
Rainbo Initiative - Makeni	Team Lead	GEWE
CapaCare	Finance Manager	SRHR
CapaCare	Finance Assistant	SRHR
CapaCare	National Programme	SRHR
CapaCare	Programme Coordinator	SRHR
CapaCare	Logistics Officer	SRHR
CapaCare	M&E Officer	SRHR
Restless Development - Koinadugu	ECM Programme Coordinator	GEWE
Restless Development - Koinadugu	Programme Field Officer	GEWE
Restless Development - Koinadugu	MEL Officer	GEWE
Planned Parenthood Association of Sierra Leone	Programmes Director	SRHR
Planned Parenthood Association of Sierra Leone	Logistics and Supplies Officer	SRHR
Planned Parenthood Association of Sierra Leone	West Regional Manager and Cervical Cancer Coordinator	SRHR
Planned Parenthood Association of Sierra Leone	Youth Officer – Communications and Advocacy	SRHR
Marie Stopes	Logistics Manager	
Marie Stopes	Clinical Director	
Marie Stopes	Finance Director	
Restless Development - Freetown	Programme Director	
Restless Development - Freetown	Head of Programmes and Partnerships	
Aberdeen Women's Centre	Country Director	SRHR (Fistula)

Aberdeen Women's Centre	Non-Clinical Director	SRHR (Fistula)
Doctors with Africa (CUAMM)	Country Manager	SRHR
Women in Crisis	Executive Director	GEWE
Women in Crisis	Programme Manager	GEWE
Women in Crisis	Monitoring and Evaluation Officer	GEWE
FINE –SL Freetown	Executive Director	GEWE
FINE – SL Freetown	Finance Manager	GEWE
UNFPA		
UNFPA	Programme Specialist - Population and Development	PD
UNFPA	Technical Specialist	SRHR
UNFPA	Family Planning Specialist	SRHR
UNFPA	Programme Coordination Analyst	SRHR
UNFPA	Technical Specialist – RH Commodities	SRHR
UNFPA	Project Coordination Specialist	SRHR
UNFPA	Programme Specialist - Gender	GEWE
UNFPA	Head of Programme	CP Level
UNFPA	Web and Media Analyst	Communication
UNFPA	Quality Assurance Specialist	Quality Assurance
UNFPA	M&E Analyst	Quality Assurance
UNFPA	Acting Operations Manager	Operations
UNFPA	Finance Associate	Operations
UN Agencies		
UN Resident Coordination Office	Head of Resident Coordinator Office	Coordination
UNDP	Gender Analyst	GEWE
WHO	Focal Point – RMNCAH and Quality of Care; Cluster – Basic Package Unit and Health System Strengthening - policy, leadership and coordination	SRHR
IOM	Head of Programme	A&Y
UNDP	Youth Technical Specialist	A&Y
UNICEF		SRHR
Donors		
Chinese Embassy		Donor
FCDO	Programme Manager - Health	Donor
FCDO	Team Leader for the Development Team	Donor
Ministry of Foreign Affairs – Directorate	Advisor Bilateral Cooperation – Department of Oversees Development Cooperation Focal Point to UNFPA Sierra Leone	Donor

Annex 3: List of Documents Consulted

1. UNFPA Evaluation Handbook on How to Design and Conduct a Country Programme Evaluation (2019)
2. UNFPA Sierra Leone Country Programme (2020 – 2023) Evaluation Terms of Reference (ToR)
3. Country Programme Document 2020 – 2023
4. UNFPA Strategic Plan 2018 – 2021
5. UNFPA Evaluation Policy, 2019
6. Human Development Index report 2019, UNDP
7. UNEG Ethical Guidelines - http://www.unevaluation.org/document/detail/102
8. The OECD/DAC Criteria for International Development Evaluations https://www.oecd.org/dac/evaluation/49756382.pdf
9. Country Partnership Framework for the Republic of Sierra Leone (FY21-FY26) World Bank (2020)
10. Government of Sierra Leone –DHS, Statistics Sierra Leone, SLDHS 2013.
11. Government of Sierra Leone –DHS, Statistics Sierra Leone, SLDHS 2019.
12. Government of Sierra Leone UNSCDF, 2020-2023
13. Government of Sierra Leone, VNR Report 2021.
14. Human Development Index report 2019, UNDP
15. Ministry of Health and Sanitation. National community health worker policy 2016–2020. 2016b. from https://www.advancingpartners.org/sites/default/files/sites/default/files/resources/sl_national_chw_policy_2016-2020_508.pdf
16. Ministry of Health and Sanitation. **National Needs Assessment and Forecasting of Contraceptive Supplies 2022 – 2025.** October 2021
17. National strategy for the reduction of adolescent pregnancy and child marriage 2018-2022, - https://sierraleone.unfpa.org/sites/default/files/pubpdf/National%20Strategy%20for%20the%20reduction%20of%20Adolescent%20Pregnancy_final_Oct%202.pdf
18. OECD/DAC Criteria for International Development Evaluations
19. Organisation for Economic Co-operation and Development. Aid at a glance chart by recipient: Sierra Leone. 2016. from: http://www.oecd.org/dac/financing-sustainable-development/development-finance-data/aid-at-a-glance.htm
20. Partnership for Global Health report, Strengthening Health Systems in Sierra Leone during COVID 19https://www.thet.org/case-studies/strengthening-health-systems-in-sierra-leone-during-covid-19/ 2020
21. Report of the UN Socioeconomic Impact Assessment for COVID-19 (2020, page 26, 27).
22. Sierra Leone Integrated Household Survey SLLIHS 2018
23. Sierra Leone Multidimensional Poverty Index Report 2019, Ministry of Planning and Economic Development, Freetown.
24. Sierra Leone's Medium-Term National Development Plan (2019-2023, p.136)
25. Statistics Sierra Leone (SSL), Population and Housing Census Report 2015.
26. Terms of Reference for UNFPA Country Programme Evaluation.
27. The Borgen Project, Decreasing Maternal Mortality in Sierra Leone - https://borgenproject.org/decreasing-maternal-in-sierra-leone/2020
28. UNEG Ethical Guidelines - http://www.unevaluation.org/document/detail/102

29. UNEG Ethical Guidelines provide for the ethical principles of evaluation as intentionality of evaluation, obligations of evaluators, obligations to participants, and evaluation process and product (Accessed from http://www.unevaluation.org/document/detail/102).
30. UNFPA 6TH CPE report, 2019
31. UNFPA Report on Maternal health, https://sierraleone.unfpa.org/en/topics/maternal-health-10
32. UNFPA Sierra Leone 7th Country Programme Evaluation Terms of Reference.
33. UNFPA Sierra Leone Country Programme (2020 – 2023) Evaluation Terms of Reference (ToR)
34. UNFPA SIERRA LEONE News Letter, January - June 2021- https://sierraleone.unfpa.org/sites/default/files/pub-pdf/newsletter_jan-june_2021_august_10.pdf
35. UNFPA Strategic Plan 2018 – 2021
36. UNFPA strategy 2018-2021

Annex 4: Data Collection Tools

Key Informant Interview Guide for UNFPA Staff and UN Agencies

Introduction:

a. Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current program cycle with the view of proposing recommendations for the next CP cycle.
b. Assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis.
c. Write names of all participants and their roles in the organization
d. **Probe: Focus on vulnerability, gender, disability and human rights as appropriate**

1. Rationale for the 7CP and Interventions undertaken

- How did you decide to undertake this work, what were the indications that it would be effective and would reach the target population?
- Who was consulted regarding the design? To what extent were they consulted?
- What other actors have been involved, how does this activity contribute to that of others?

2. Relevance

- How is the [SRH, A&Y, GEWE or PD] component of the 7th Country Programme (CP) aligned to the a) national needs and priorities in Sierra Leone such as articulated in the national and sectoral policies b) Partners and beneficiaries needs? c) UNFPA Strategic Priorities and strategic plan? d) International frameworks, policies and strategies on [SRH, A&Y, GEWE or PD] and human rights? **(Probe for the needs first)**
- What aspects of the national and sectoral policies do you consider are covered in the 7CP?
- Were the objectives and strategies of the Country Programme M&E Framework discussed and agreed with national partners? [Probe]
- How did you identify the needs prior to the programming of the [SRH, A&Y, GEWE or PD] components?
- Who was consulted regarding the design? What other actors have been involved, how does this activity contribute to that of others?
- In your view, does UNFPA have the right strategic partnerships? Mutual benefit, critical to achieving shared vision
- Were there any [SRHR, A&Y, GEWE or PD] needs or priorities of the implementing partners that the country program did not address adequately or at all? If yes, what were these needs and priorities

3. Effectiveness

- What are the indications that the approach is working or making progress toward goals established for the CP (e.g., anecdotes which provide illustrations of positive, negative or unintended effects, or quantitative and qualitative evidence)?
- Overall, what are the achievements of the 7CP in respect of the [SRH, A&Y, GEWE or PD] component area**? Probe** for evidence
- How have the outputs been utilized?
- What are the barriers/challenges to increasing demand and access to services, and how are they being addressed?
- What factors have facilitated effective implementation of the 7CP? Which ones hindered?
- What do you consider to be the best practices from the 7CP?
- To what extent did internal communication strategies on various CP components facilitate improved outcomes of the other components in terms of funding, personnel, administrative arrangements, time and other inputs contributed to, or hindered achievement of results.
- Were there any changes in national needs and global priorities during the implementation period? How did UNFPA CO respond to these changes?
- How did UNFPA ensure programme integration of gender and a human-rights approach, including people with disabilities, including in the COVID-19 context
- To what extent has UNFPA responded to [SRH, A&Y, GEWE or PD] emerging issues in the affected locations or calamities? What were the factors that facilitated UNFPA response to such emerging issues? What were the factors that hindered the UNFPA response to such SRH emerging issues?

Note: Remember to ask for documents if not already shared

4. Efficiency

- How many staff are in your unit? Qualified with appropriate skills?
- Do you think your staff strength and capacity are enough for the 7CP implementation and achievement of results?
- How timely did you receive resources for implementing this programme?
- How timely were resources for interventions disbursed to implementing partners? Were the resources sufficient for implementing partners to complete activities?
- Describe UNFPA CO administrative and financial procedures in the 7CP?
- Do you think UNFPA CO administration and financial procedures are appropriate for the 7CP implementation? [**Probe]**
- Were there any delays? If yes, why? And how did you solve the problem?
- Are there occasions when the budget was not enough or you overspent?
- How appropriate was the programme approach, partner and stakeholder engagement for CP implementation and achievement of results?
- Have the programme finances been audited?
- To what extent were the activities managed in a manner to ensure delivery of high-quality outputs and best value for money?
- Any additional funding from the Government and other partners?
- How robust and adequate is the M&E System in place to enable measurement of the CP performance during implementation? How are M&E results used to support the CP management?

5. Sustainability

- What mechanisms is UNFPA putting in place to ensure that the results of the CP are sustained beyond the programme cycle?
- How is partner capacity building integrated into the UNFPA mode of engagement with partners?
- How have national partners utilized capacity developed through UNFPA support?
- How are national partners involved in UNFPA programming?
- To what extent are the benefits likely to go beyond the programme completion?
- Are the strategies, plans, protocols and practices developed within the programme anchored on IPs institutional arrangements
- Do you believe that there is political will and national ownership behind the CP interventions, and is this changing? Have programmes been integrated in institutional government plans?
- How has UNFPA addressed changes in knowledge and perceptions of the target beneficiaries based on various aspects of the programme?

6. UNCT Coordination

- Is there any Inter-Agency Technical Working Group on this 7CP, involving other UN Country Team?
- What role has UNFPA played in the UNCT joint programs? Any specific contributions? Any lessons learned?
- What are the UNCT coordination structures and mechanisms in place?
- How active, relevant and effective is UNFPA in the UNCT?
- What is the role of UNFPA CO in the United Nations Country Team coordination structures and mechanisms in Sierra Leone? What partnerships exist? Any specific contributions to the achievement of results?
- What are the special strengths of UNFPA when compared to other UN agencies and development partners?
- How do implementing and national partners perceive UNFPA?
- Is UNFPA collaborating with other UN Agencies in implementation of interventions? Which UN Agencies and in which interventions? What are the roles of UNFPA and other UN Agencies? How has this contributed to the achievement of UNFPA results?
- How and to what extent are UNFPA priorities and mandate reflected in the UNDAF

7. Coverage

- How does UNFPA CP respond to humanitarian needs in Sierra Leone? In which locations? Who were the target groups?
- How does UNFPA programme identify those at risk or vulnerable?
- To what extent does UNFPA programme target the vulnerable and those in displacement in Sierra Leone?

- To what extent has UNFPA responded to SRH on the humanitarian and emerging needs in the affected locations or calamities?
- What were the factors that facilitated UNFPA response to such adolescent and youth humanitarian and emerging issues?
- What were the factors that hindered the UNFPA response to such humanitarian and emerging issues?
- To what extent does the UNFPA CP interventions address the needs of populations at risk and vulnerable?
- Budget allocation for humanitarian programme interventions

8. Connectedness

- To what extent has UNFPA built the capacities of local partners during the current CP? What are the indications that the capacity building efforts are working?
- How has UNFPA built partnerships with local organizations or institutions in the areas of SRHR in Sierra Leone?
- How adequate have the resources allocated to addressing emergency response been to ensure recovery and resilience
- How has UNFPA ensured that long-term plans are put in place to address the existing SRHR
- Have the facilities supported by UNFPA to respond to emergency been handed over to the local government or local communities?

Key Informant / Group Interviews: Government / IPs (adapted for **SRHR, A&Y, GEWE and PD)**

Introduction:

a. Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current programme cycle with the view of proposing recommendations for the next CP cycle.
b. Assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis.
c. Write the names of all the Participants and their roles in the organization
d. **Probe: Focus on vulnerability, gender, disability and human rights as appropriate**

1. Rationale of the Partnership and activities engaged in

- How did you decide to undertake this work, what were the indications that it would be effective and would reach the target populations (SRHR, A&Y, GEWE and PD needs)?
- Have you conducted a problem analysis, needs assessment? Who was consulted regarding the design?
- What other actors have been involved, how does this activity contribute to that of others?

2. Relevance

- To what extent is the [SRHR, A&Y, GEWE or PD] component of the 7th Country Programme (CP) aligned to the a) national needs and priorities in Sierra Leone such as those articulated in the national and sectoral policies; b) International frameworks, policies and strategies on gender equality and human rights
- What aspects of the national and sectoral policies do you consider are covered in the 7CP?
- How were the needs of vulnerable groups (i.e., youth, girls, women, young mothers, marginalized) addressed during the programming or planning process for your UNFPA project activities?
- What criteria did you use in the selection of target groups in the field of [SRHR, A&Y, GEWE or PD]? [**Probe** if the identified needs of these target groups included in the criteria]?
- Were there any [SRH, A&Y, GEWE or PD] needs or priorities of the implementing partners that the CP did not address adequately or at all? If yes, what were these needs and Priorities
- How does the CP intervention interface/merge with your institutional programmatic objectives and strategies?
- How were the needs of your institution identified prior to the programming of the [SRHR, A&Y, GEWE or PD]?
- Do you see the work of UNFPA and its implementing partners as supporting the right interventions to address SRHR/A&Y/GEWE/PD needs, harmful practices and discrimination against women and girls?

3. Effectiveness

- Looking at the implementation so far, to what extent have the planned 7CP outputs/targets been achieved? Were the intended beneficiaries reached? **Probe**
- What are the indications that the approach is working or making progress toward goals established to be achieved in 2023?

- How did UNFPA provide support for challenges in the implementation of interventions to address outputs and outcomes.
- To what extent did the support address the needs of the target groups i.e., women of reproductive age, survivors of GBV, adolescents and youth, boys and men?
- What factors have facilitated effective implementation of the 7CP? What factors hindered/affected successful implementation of the programme?
- What else should be done to make the programmes more effective?
- Has there been evidence of expected or unexpected results from work on SRHR/GEWE/GBV/A&Y/PD that has been supported by UNFPA?
- How timely was the disbursement of UNFPA funds to the IPs? Probe for any challenges
- How many times did you experience a humanitarian crisis or a political change during the 7CP? How did UNFPA support in each of the instances? Probe for the services or support provided
- To what extent has UNFPA responded to SRHR emerging issues in the affected locations or calamities? What were the factors that facilitated UNFPA response to such SRHR emerging issues? What were the factors that hindered the UNFPA response to such SRHR emerging issues?
- How did UNFPA ensure programme integration of gender and a human-rights approach, including people with disabilities, including in the COVID-19 context
- To what extent did UNFPA support use of disaggregated demographic and socio-economic data for evidence-based planning and development.

4. Sustainability

- What measures are in place for programme continuity in the absence of continued UNFPA support? [**Probe** e.g., re output/outcome areas integrated in institutional/government policies and plans/budget allocations]. In which areas do you need support to continue on your own?
- To what extent have your capacities been strengthened in the areas of support by UNFPA?
- How have you utilized capacity developed through UNFPA support?
- How is capacity building integrated into the UNFPA mode of engagement with its partners?
- Do you have other sources of technical and financial support? **[Probe]**
- What is the likelihood of sustained benefits (e.g., through capacity building, improved M&E and other systems, population data availability, etc. with or without continued UNFPA support)? **[Probe]**
- How has UNFPA ensured effective partnership in the country to facilitate strong sectoral networks in the country? **Probe** how they have participated
- Is your organization/agency a member of any national or local coordination mechanism (including bilateral dialogues) where UNFPA shares technical expertise either as a member or as a leader? [**Probe**: What are these coordination mechanisms?

5. Efficiency

- How appropriately and adequately are the available resources (funding and resources) used to carry out activities for the achievement of the outputs?
- How timely did you receive resources for implementing this programme? Were there delays? If yes, why and how did you solve the problem?
- To what extent were the activities managed in a manner to ensure delivery of high-quality outputs and best value for money?
- Any additional funding from the Government or other partners for the programmes funded by UNFPA?
- Do you think UNFPA CO administration and financial procedures are appropriate for the 7CP implementation?
- How about the programme approach, partner and stakeholder engagement, was it appropriate for implementation and achievement of results?
- How did UNFPA support capacity development for implementers of interventions?
- What implementation challenges were encountered?
- Were agreed outputs delivered?
- Was the programme approach, partner and stakeholder engagement appropriate for results delivery?
- Which partnerships were more strategic in bringing about results and value-for-money?
- Were institutions adequately equipped to deliver on results-based management/ M&E for the CP?

6. Coordination

- How is the UNFPA programme coordinated? What role does UNFPA play and what role do you play in coordination?
- Is there any Inter-Agency Technical Working Group on this 7CP, involving other UN Country Team?
- Can you say how well the activities are coordinated, overlapping and how is this handled?
- Is UNFPA playing an active coordination or leadership role around SRH, A&Y, GEWE and PD in the country?
- What are the special strengths of UNFPA when compared to other UN agencies and development partners?
- How do implementing and national partners perceive UNFPA?
- What partnerships exist? Any specific contributions to the achievement of results? Any challenges?
- What unique strategies/interventions in SRH, A&Y, PD or Gender of UNFPA add value to the work of other development partners, especially the UN system? Please give examples
- What strategic partnerships at the National level and /or local level has UNFPA supported that produced results and are worth replicating and institutionalizing?
- What specific technical contribution has UNFPA made to the country's development agenda

Key Informant Interview/ Focus group discussion Guide for CP Beneficiaries

Introduction:

a. Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current program cycle with the view of proposing recommendations for the next CP cycle.
b. Assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis.
c. Capture every participant's name
d. **Probe: Focus on vulnerability, gender, disability and human rights as appropriate**

I would like to know the type of support you received from (**UNFPA implementing partner**)

1. Relevance

- What are the national needs and priorities in Sierra Leone/in your community in terms of the development agenda with regards to the CP component (SRH, A&Y, GEWE and PD)?
- How important is the work supported by (UNFPA implementing partner) to these needs and priorities at the local, provincial and national levels?
- Does the (UNFPA implementing partner)'s work address the needs in (SRH, A&Y, GEWE and PD)?
- How has (UNFPA implementing partner) consulted you in the identification of your local needs in (SRH, A&Y, GEWE and PD)?
- How has (UNFPA implementing partner) integrated support for the marginalized, gender and other human rights?

2. Effectiveness

- To what extent has (UNFPA Implementing Partner) support reached the intended beneficiaries? **Probe** for vulnerable groups in the locality
- Are different beneficiaries appreciating the benefits of the UNFPA interventions? For example,
- What are the specific indicators of success in your programme?
- How are gender relations and human rights being influenced by the activities undertaken by the programme? Are there ways to sustain the positive changes?
- What do you think has worked best? What has not worked well
- What factors contributed to the effectiveness or otherwise?
- What else should be done to make the programmes more effective?

3. Sustainability

- What are the benefits of the programme interventions to you?
- To what extent are the benefits likely to go beyond the programme completion?
- What measures are in place at the end of the programme cycle for the various programmes to continue?

- Have programmes been integrated in institutional/government plans?
- How does the UNFPA CO/ (Implementing partner) ensure ownership and durability of its programmes?

Interview Guide for UNFPA Donors and Strategic Partners

Introduction:

a. Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current program cycle with the view of proposing recommendations for the next CP cycle.
b. Assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis.
c. Capture every participant's name

Probe: Focus on vulnerability, gender, disability and human rights as appropriate

1. Rationale for the Strategic Relationship

- What is the strategic involvement of [Donor/ partner] in Sierra Leone?
- What specific needs is your institution addressing in the country?
- Which specific areas did your institution support the Sierra Leone 7th CP (**Donor**)?

2. Relevance

- How is UNFPA CP contributing to addressing the same strategy that your institution is involved in the country
- How relevant is UNFPA programming in addressing the country's needs in the areas of (SRH, A&Y, GEWE and PD)? [**Probe** for specific approaches]
- What is UNFPA's comparative advantage in the country?

3. Effectiveness

- To what extent would you say UNFPA is addressing the national needs and priorities in Sierra Leone?
- What has been realized in the country because of UNFPA's CP from 2020 to present? [Results achieved compared to plans – **Probe** for capacities developed]
- What has worked well and what has not worked well?
- Are there gaps in UNFPA's approaches? How would they be improved?

4. Efficiency and Sustainability

- M&E systems in place, ensuring
    - Timely reporting
    - Use of data to inform decision-making
- Capacities in place
- Effectiveness of partnership approaches

5. Coordination

- How active, relevant and effective is UNFPA in the coordination mechanisms in the country?
- How does UNFPA contribute to the coordination within the country? Probe for specific responsibilities
- Where there are areas of potential overlap with other UN mandates, how is this resolved? e.g., re gender, disability, human-rights based programming, response in humanitarian situations as well as main focal areas of SRH, A&Y, PD
- What are UNFPA CO strengths, weaknesses/ limitations, and opportunities to improve its programming in the country?

Annex 5: Terms of Reference

CPE Terms of Reference

Annex 6: Reconstructed 7CP Theory of Change