UNFPA LESOTHO

COUNTRY PROGRAMME EVALUATION

7TH COUNTRY PROGRAMME 2019 – 2023

JANUARY 2023

MAP OF LESOTHO[1][2]

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[1] Source https://ontheworldmap.com/lesotho/

[2] The boundaries, names shown and the designations used on the map on this site do not imply official endorsement or acceptance by the United Nations Population Fund

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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 8th UNFPA Country Programme, national development plans and the United Nations Sustainable Development Cooperation Framework (UNSDCF) in Lesotho.

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ABBREVIATIONS AND ACRONYMS

A&Y	Adolescents and Youth
AAHA	Adaptation of the Action for Health of Adolescents
ANC	Ante-natal Care
ART	Antiretroviral Therapy
AWPs	Annual Work Plans
BoS	Bureau of Statistics
BTI	Bertelsmann Stiftung's Transformation Index
CERF	Central Emergency Response Fund
CO	Country Office
COVID-19	Corona Virus Disease – 2019
CGPU	Child and Gender Protection Unit
CP	Country Programme
CPD	Country Programme Document
CPE	Country Programme Evaluation
CSE	Comprehensive Sexuality Education
DHIS	District Health Information Software
eLMIS	electronic Logistics Management Information System
EQ	Evaluation Questions
EO	Evaluation Office
EASA	East and Southern Africa
EGPAF	The Elizabeth Glaser Pediatric AIDS Foundation
ERG	Evaluation Reference Group
ESARO	Eastern and Southern African Regional Office
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
GoL	Government of Lesotho
HCI	Human Capital Index
HCT	Humanitarian Coordination Team
HDI	Human Development Index
HDR	Human Development Report
HIV	Human Immuno-Deficiency Virus
HMIS	Health Management Information System
HRH	Human Resource for Health
ICPD	International Conference on Population and Development
ICT	Information and Communications Technology
IDP	Internally Displaced Persons
IEC	Independent Electoral Commission
IP	Implementing Partner
JUNTA	Joint UN Team on AIDS
KII	Key Informant Interviews
LBSE	Life skills-based Sexuality Education
LePHIA	Lesotho Population-Based HIV Impact Assessment
LMPS	Lesotho Mounted Police Service
M&E	Monitoring and Evaluation
MoGYSR	Ministry of Gender and Youth, Sports and Recreation

MICS	Multiple Indicator Cluster Survey
MoDP	Ministry of Development Planning
MoH	Ministry of Health
NAC	National AIDS Commission
NDSO	National Drug Service Organisation
NGO	Non-governmental Organization
ODA	Overseas Development Assistance
OECD/DAC	Organization for Economic Cooperation Development Assistance Committee
PCA	Programme Coordination and Assistance
PD	Population dynamics
PEP	Post-exposure Prophylaxis
PrEP	Pre-exposure Prophylaxis
RMCAHN	Reproductive, Maternal, Child and Adolescent Health and Nutrition
ROSSC	Regional Office Shared service Centre
SADC	Southern Africa Development Cooperation
SIS	Strategic Information System
SRH	Sexual and Reproductive health
SRHR	Sexual Reproductive Health and Rights
STI	Sexually Transmitted Infections
TB	Tuberculosis
TFR	Total Fertility Rate
ToC	Theory of Change
ToR	Terms of Reference
UBRAF	Unified Budget, Results and Accountability 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
UNRCO	United Nations Resident Coordination Office in Lesotho
UNSCDF	United Nations Sustainable Development Cooperation Framework
VMMC	voluntary medical male circumcision
VNR	Voluntary National Review
WB	World Bank
WHO	World Health Organization
YEE	Young and Emerging Evaluator

LESOTHO KEY FACTS

Indicators	Facts (Data Value)	Source/ Year
Land	30,355 Km^2	https://en.wikipedia.org
Geographical location	Lesotho is surrounded by South Africa	https://en.wikipedia.org
People		
Population	2 007 201 million	Lesotho Population & Household Census (LPHC) 2016
Population aged below 15 years	32%	UNFPA 2022
Population aged 10 – 24 years	29%	UNFPA 2022
Population aged below 30 years	30.8	LPHC 2016
Population aged 65 years and above	5%	UNFPA 2022
Women of reproductive age (15 – 49)	25.4%	LPHC 2016
Urban population	29%	World bank 2021
Rural population	71%	World bank 2021
Population growth Rate	0.8%	World Bank 2021
Health		
Infant mortality rate (deaths per 1,000 live births)	62/1,000	Lesotho Multiple Cluster Survey (MICS) 2018
Child mortality rate age 1 to 4 (deaths per 1'000 live births)	15/1,000	MICS 2018
Neonatal mortality rate (deaths per 1,000 live births)	36/1,000	MICS 2018
Under-5 mortality (deaths by 1,000 live births)	76/1,000	MICS 2018
Adolescent fertility rate (per 1,000 women	91/1,000	MICS 2018
Contraceptive prevalence rate (% of women aged 15-49)	64.6%	MICS 2018
Unmet need for contraceptive use	18%	MICS 2018
Maternal Mortality ratio (per 100,000 live births)	618/100,000 live births	LPHC 2016
Life expectancy at birth	55 years	World Bank 2021
Total fertility rate (average number of children per woman)	2.7	MICS 2018
Adults aged 15-49 HIV prevalence rate	22.6%	Lesotho Population-Based HIV Impact Assessment (LePHIA) 2020
Proportion of births attended by skilled health personnel	87%	MICS 2018
Total of Health Expenditure (% of GDP)	10.6%	UNICEF & World Bank Group. Lesotho Public Health Expenditure Review. 2017.
Government		
Type of government	Constitutional Monarchy	https://en.wikipedia.org
Head of government	Prime Minister	https://en.wikipedia.org
Economy		
GDP	USD2.52	World Bank 2021
GDP annual growth rate	USD1.0	World Bank 2021(estimate)
Per capita income	USD1 166.5	World Bank 2021(estimate)
Unemployment rate	24.6%	World Bank 2021(estimate)
Youth unemployment rate	37.4%	World bank 2021 (estimate)
Multidimensional Poverty Index	19.6%	UNDP 2021
Social and Development Indicators		
Human Development Index rank	168 (0.514)	UNDP HDR 2021/2022
Literacy rate	89%	LPHC 2016
Net enrolment in Primary school	93%	World bank 2017
Net enrolment in secondary school	41.35%	World Bank 2016

Indicators	Facts (Data Value)	Source/ Year
Gender Inequality Index	0.557	UNDP HDR 2021/2022
Seats held by women in national parliament	30 out of 120	IEC 2022
Women experienced GBV (Percentage of ever-married women aged 15-49 who have ever experienced emotional, physical or sexual violence committed by their husband)	17%	UNFPA 2018
Prevalence of child marriage (proportion of women aged 20-24 years who were married or in a union before age 18)	24%	UNFPA 2019

STRUCTURE OF THE COUNTRY PROGRAMME EVALUATION REPORT

The Evaluation Report is structured according to the UNFPA Evaluation Handbook. The first chapter covers the introduction and provides the purpose and objectives of the 7th Country Programme, Government of Lesotho/UNFPA the scope of the evaluation as well as the methodology and process. The second chapter presents the country context, specifically outlining the main development challenges and national strategies, followed by the role of external assistance. The third chapter covers the UN and UNFPA strategic response as well as the UNFPA response through the country programmes, including the current 7CP. The fourth chapter provides the findings of the evaluation covering all the evaluation questions with respect to relevance, coherence, effectiveness, efficiency, sustainability, coverage and connectedness. The conclusions to the reports are provided in the fifth chapter and these are given at strategic and programmatic levels. The sixth chapter provides the recommendations, at strategic and programmatic levels. Finally, the report provides the following and these are also given annexes: terms of reference, list of persons/ institutions visited and interviewed, documents reviewed, evaluation matrix, stakeholders map, and the CPE agenda.

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 Lesotho Country Office (CO). The **Objectives** of the CPE were to provide the UNFPA Lesotho CO, national stakeholders and rights-holders, the UNFPA Eastern and Southern Africa Regional Office (ESARO), UNFPA Headquarters as well as a wider audience with an independent assessment of the UNFPA Lesotho 7CP (2019-2023), and broaden the evidence base to inform the design of the next programme cycle. Specifically, the objectives of this CPE were to; (a) Provide an independent assessment of the relevance, effectiveness, efficiency and sustainability of UNFPA support; (b) 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; (c) Provide an assessment of the role played by the UNFPA Lesotho CO in the coordination mechanisms of the UNCT and HCT, 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 Lesotho CO in the coordination mechanisms of the HCT, with a view to improving humanitarian response and ensuring contribution to longer-term recovery (d) Draw key conclusions from past and current cooperation and provide a set of clear, forward-looking and actionable recommendations for the next programme cycle.

Scope: The Geographic Scope covered the national level interventions with a sharp focus on the following two districts where UNFPA implemented interventions: Mokhotlong and Quthing; the Thematic Scope covered all the thematic areas of the 7th CP: SRHR; HIV Prevention, adolescent and young people and gender equality and women's empowerment; in addition to the cross-cutting issues, such as human rights; gender equality, 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 under the current CP during the time period 2019 - 2022. The **main audience** and primary intended users of the evaluation are; the UNFPA Lesotho CO; the Government of Lesotho; implementing partners of the UNFPA Lesotho CO; rights-holders involved in UNFPA interventions and the organisations that represent them (in particular women, adolescents and youth); the United Nations Country Team (UNCT); Eastern and Southern African Regional Office (ESARO); and donors. The evaluation results will also be of interest to a wider group of stakeholders, including: (i) UNFPA headquarters divisions, branches and offices; (ii) the UNFPA Executive Board; (iii) academia; and (iv) local civil society organizations and international NGOs.

The 7th UNFPA Lesotho Country Programme: The UNFPA 7CP was structured around four interlinked output areas and contributed to two outcome areas of SRHR and GEWE of the UNFPA Strategic Plan 2018 – 2021, contributing to improving government institutional capacities to develop and implement gender-responsive policies, plans and programmes that prioritize the demographic dividend and access to integrated sexual and reproductive health and rights information and services by women, adolescents and youth, including the furthest left behind, and ensuring improved access to gender-responsive, high-quality, integrated SRH services, including in humanitarian settings by women, adolescents and young people. The GEWE component aimed at strengthening of policy, legal and accountability frameworks to advance gender equality and empower women and young people, especially adolescent girls, to exercise their reproductive rights and to be protected from violence and harmful practices, and to improve multisectoral capacity to prevent and address gender-based violence and harmful practices at national and district levels.

Methodology: The design of the CPE was guided by the UNFPA Evaluation Handbook on how to conduct a country programme evaluation[3], 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 are aligned along evaluation criteria as guided by the objectives. The consultants determined the sample frame from the list of stakeholders from a stakeholders' mapping provided by the CO and used a purposive sampling method to select participants for the CPE. The stakeholders' selection process was

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

guided by the thematic areas of engagement with UNFPA. The sampling frame included IPs, partners from government and civil society organisations (CSOs), development and strategic partners, in addition to direct and indirect beneficiaries. The CPE adopted mixed methods in data collection, namely, i) document review; ii) both remote-based and in-person key informant interviews (KIIs) at group and individual levels with the selected stakeholders and CO staff; and iii) focus group discussions (FDGs) with stakeholders and beneficiaries. A total of 36 males and 43 females, in addition to 3 LGBTIQ members participating. The evaluation used both qualitative and quantitative data and triangulated the various sources 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 support from the CO team.

Main Results and Conclusions:

Relevance: The results indicate that the Lesotho's 7CP was developed in a highly consultative manner with the leadership and participation of the Government of Lesotho, civil society organisations (CSOs) and development partners. It was strategically adapted to the national priorities and population needs, contributing to the NDSP II, and line ministry strategic priorities, directly contributing to their respective objectives around SRHR, A&Y and GEWE, thereby making it relevant to the national and population 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 UNDAF's outcome areas. Further, the CP was contributed to the SDGs 3, 4, 5, 10 and 17 and facilitated achievement of the goals of the ICPD Programme of Action. Through the 7CP, UNFPA exhibited strength in the areas of mandate in advancing access to SRHR by women, adolescent girls and youth, key populations, strategy and capacity strengthening development; strengthening advocacy on policy and legislative framework towards GBV prevention and response, and abandonment and elimination of harmful practices; and in improving existing capacities for evidence-based planning and development in the country. 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 in addition to reprogramming to integrate COVID-19 infection prevention and control (IPC), and contributed to the UNCT COVID-19 socio-economic response plan.

Effectiveness: There was immense contribution of the 7CP in the achievement of the national and international development and humanitarian priorities during the period of assessment across the components in the areas of UNFPA's mandate. Under the **Sexual and Reproductive Health and Rights (SRHR)** component, UNFPA greatly contributed to the enhancement of policies and strategies which are gender responsive to SRHR needs of adolescents and young people. The MoH utilised the support and disseminated the Minimum Standards in offering adolescents and youth friendly health services to all facilities. The CO was also instrumental in ensuring a chapter in the EHS on adolescent and youth health is well articulated with clear indicators which will later improve reporting and programming for adolescents and young people access to the SRHR services and information. UNFPA contributed to improving the capacity of the government in development and delivery of integrated gender-responsive SRHR services in the country, prioritising the marginalized women and girls and the hard-to-reach populations through strategically positioning itself to support upstream and downstream interventions. UNFPA technically and financially contributed to capacity strengthening of the MoH and IPs, in addition to development of strategies, plans and policies; advocacy on demand creation and supplies of RH commodities; and service delivery. UNFPA's support of the government in the review of the SRMNCAHN strategic plan, and promotion of policy contributed to increasing access to SRH services by the target population, including enhanced targeting of the adolescents, youth, men and key populations. There were enhanced advocacy mechanisms on SRH service through updating of EHS package, incorporating HIV and enhancing improved and standardized service delivery and reorganization to ensure effective delivery and targeting of services without leaving anyone behind, in addition to being used for budget allocation from the government. UNFPA further contributed to supporting the country is addressing the unmet need for family planning through enhancing demand creation, strengthening commodities supply chain, developing capacity of MoH and procuring of RH commodities for use in the country. The 7CP promoted evidence-based programming on FP; which includes targeting the heard-to-reach and underserved areas improving the last mile assurance and promotion of and uptake of long-term methods. The CO also contributed to strengthening delivery of integrated of friendly SRH/FP/GBV/HIV through capacity building of the service providers in health facilities, development of guidelines and production of information materials. Through strategic reporting,

surveillance and capacity development the CP contributed to capacity improvement in EmONC services. UNFPA supported the Midwifery Situational Analysis which highlighted a gap in the curriculum in schools of nursing; therefore, the CO supported the MoH in enhancing midwifery framework by upgrading the curriculum to meet international standards, review of midwifery and advocated for review of midwifery regulations, and association. Despite the achievements during the evaluation period, there were reported cases of stock-outs in health facilities in 2021 with only 50% of the facilities having the minimum required number of modern methods of contraception. Government commitment in the investment of FP commodities, monitoring and supervision is also low. The engagement of male partners to improve access to FP is still sub-optima with limited participation of male partners in FP programmes.

The 7CP contributed to addressing the scourge of early and unintended pregnancy (EUP) through supporting countrywide advocacy and consultations on EUP. The CO also supported the development of the Prevention and Management of Learner Pregnancy Policy which will not only provide guidance on how to deal with a pregnant girl but also how to prevent pregnancy of learners and the provision of a conducive school environment and support. Further, the 7CP advocated for and supported the review of Children Protection and Welfare Act utilizing the SADC Model of Law on Child marriage to ensure criminalizing marriage of children under the age of 18 years which leads to elimination of child marriage. Additionally, UNFPA, in collaboration with UNESCO, supported development of Retention Policy which, once completed, will also enhance completion of secondary education which is key in ensuring quality educational outcomes which have effect on EUP rate, HIV new infections and other related SRHR ill health among adolescents and young people. Further, the CO successfully supported the MoET in institutionalizing in-school CSE termed LBSE in Lesotho as a core compulsory and examinable subject. UNFPA also supported; a robust capacity building of MoET officials: officers, inspectorate, District Education manager, principals, teachers, schools boards and parents, development of tools; standardized training manuals for capacity, monitoring, supportive supervision and reporting to ensure quality implementation of the curriculum. it is worth noting that there are no teachers who have been trained or majored in CSE, the subject also addresses issues that are regarded taboo by the society, as a result the implementation of the subject is still challenged. Quality delivery of CSE will have direct impact in increased access of SRHR services and information which will have effect change on EUP, HIV and child marriage indicators.

Under the **GEWE component**, the CO was instrumental in advocating for and supporting review, finalization enhancement of policy, legal and institutional frameworks. The finalization of the Counter-Domestic Violence Bill 2021 was a key achievement in advancing gender equality. The review of the CPWA 2011 has been a relevant milestone in addressing the conflicting customary and civil laws on child marriage. UNFPA also contributed to strengthening of a multi-sectoral prevention, management and response system to Gender Based Violence including SGBV. Strengthening capacity of entities working on GEWE and coordination mechanisms harmonised GBV interventions including advocacy at all levels. UNFPA advocated for review of assessment tools to include the effects of disasters on SRHR status of women and girls. These tools are also promoted gender equality and targeting of marginalized and vulnerable women and girls, particularly during humanitarian situations. Within the UN as an entity addressing GBV and other harmful practices, UNFPA strategically facilitated mainstreaming of gender and PSEA interventions within the UNCT, HCT and government institutions. UNFPA supported different government Ministries to strengthen their Information Management Systems. The enhanced systems are envisioned to enhance appreciation of data quality and development of evidence based programming. Male and community level engagement, including religious, traditional and community level leaders, was found to be sub-optimal with the scale of targeting being low with results being scattered. The referral mechanisms were however identified to be weak with ineffective coordination among stakeholders.

UNFPA contributed to strengthening the country's statistics systems through supporting different ministries, including that of Police, working together with the BoS to develop tools to help in capturing data that support in the information of decisions-making. There are still data needs that could be an opportunity to support generation of large-population-based based surveys to inform programming in addition to enhanced advocacy for utilization of population data for decision-making. The design and implementation of the 7CP were done with a lot of consideration for integration of human rights and gender along programmatic and organizational levels.

Efficiency: The 7CP was largely efficient, particularly in the utilization of available resources in its delivery.

UNFPA utilized different strategic mechanisms including partnership with local NGOs and government line ministries, direct contribution into the national development strategies, to enhance coverage and partnerships. In the implementation to the 7CP, UNFPA adhered and complied with available internal controls in procurement and financial decisions. In addition, the CO had skilled staff providing technical support to the various IPs and the government. Partnerships within UNCT also enhanced the delivery as one principle which leveraged on cost-sharing, coordination and accountability and resources mobilization. The 7CP advocated and promoted integrated service delivery which enhanced access to services. The use of Annual Work Plans (AWP) for planning and budgeting purposes enabled effectiveness in guiding the financial and programmatic decisions by the CO. While the CO depended on the regional office for resource mobilization, this was not effective and therefore affected the level of resources with the CO entirely depending on the regional office, further affecting the extent of delivery of the 7CP with funding gaps reported. There was also inconsistency in the disbursement of funds to the IPs; with understaffing also cited for contributing to delays in disbursement and implementation, report reviews and feedback on reports and documentations shared. The operational support by Regional Office Shared service Centre (ROSSC) was reported to be inefficient. The monitoring and evaluation (M&E) system in place ensured capturing of performance of the CO is efficient and assistive in assessing the performance of the 7CP delivery. There was however inadequate financial support to M& for its various functions. There were also gaps in the programme's theory of change reducing results focus for the CO.

Sustainability: There were positive indications on ensuring sustainability of the results; the CO strengthened national ownership through directly supporting government line ministries as both strategic and implementing partner enhancing national ownership. The several high level consultations supported delivery of the national priorities addressing pertinent population needs. The contribution of UNFPA in development, review and implementation of policies, strategies and guidelines, enactment and implementation of laws in different CP components provides a strong base for sustainable programming. To ensure continuity, the 7CP strengthened the capacities of the national stakeholders in various areas instilling skills which are bound to stay beyond the programme period. The use of mentorship in the health facilities and integration of the CP aspects in data collection tools for national decision-making will continue to be used by the stakeholder beyond the CP. Inadequate resources affected the extent of achievement with some interventions not finalized due to inadequate finances. The government challenge with inadequate data, high staff turnover within the ministries and capacity to monitoring implementation of some of the interventions may also affect sustainability.

Coordination: UNFPA utilized its comparative advantage within the UNCT to facilitate functioning of coordination mechanisms among the UN agencies. UNFPA built collaborative partnerships and implemented joint programmes on the areas of strength with the UN agencies. UNFPA participated in joint activities, including contributing to the performance of the UN in the UNDAF. UNFPA also led thematic groups on M&E and technical working groups related to the thematic areas of comparative advantage, in addition to co-leading the PSEA Network and gender and GBV thematic areas. UNFPA also had strength in coordination and linkage of the MoH services to the different advocacy groups within the UNCT, further enhancing coordination, accountability and capacity building. There is weaknesses however in the UNCT-wide coordination mechanisms that need to be addressed. UNFPA also needs to strengthen coordination of the SRH with key partners.

Coverage: The 7CP contributed to the targeting and responding to the needs of both vulnerable populations in hard-to-reach areas and marginalized populations with services through advocacy, partnerships, capacity building, strategy development, policy dialogue, guidelines and SOPs to guide delivery of services to vulnerable populations including during disasters. UNFPA also supported evidence generation to identify vulnerabilities and inform response; and participated in partnerships and collaborations with various entities to support the country during disasters, in addition to further emphasising the targeting of the poorest population groups with services. During the period, UNFPA was successful in targeting and reaching the key populations and targeting districts with the worst indicators in the CP thematic areas and reaching them with services effectively. The CO further promoted strengthening institutionalization and national ownership of the CP results and these are likely to continue in the longer term, thereby strengthening **Connectedness**.

Main Recommendations

Strategic: The CO;

i. Should enhance strengthening of strategic partnerships, capacities and institutional frameworks, and advocacy, particularly for government institutions to facilitate implementation, monitoring and fulfilment of mandate while at the same time addressing the felt needs of the country

ii. Continue building and strengthening its comparative advantage; in addition to exploring more opportunities for joint programming and collaboration within the UNCT to ensure no one is left behind, and to enhance delivering as one. Further, enhance advocacy for more accountability among UN agencies

iii. Develop a clear resource mobilization strategy for the 8th CP to enable focused resource allocation according to the felt needs; and further assess the human resource structure and critically align the capacities to the expected deliverables and priorities of the respective components for maximum realization of results

iv. Needs to strengthen its financial management system, in addition to continued strengthening IPs' capacities, to facilitate programmatic delivery and accountability to enhance efficiency.

v. Should continue strengthening the relevant strategic partnerships with and capacity building of key government and non-government and private agencies to enhance national ownership and capacity of the stakeholders to deliver in their mandate and ensure sustainability

vi. Strengthen the programme's focus on M&E, in addition to both the theory of change and the intervention logic across and within the thematic areas in the RRF to ensure effectiveness and appropriateness of deliveries, and further ensure enhanced interactions among staff and other stakeholders

vii. Should build on its UN mandate on data and enhance its resource allocation for related large surveys to facilitate evidence generation and advocacy for data use in policy and development formulation.

Programmatic

viii. Advocate for quality of care and continue strengthening of integration of SRHR/FP/GBV and HIV, in addition to enhancing male engagement on HIV prevention and response; and continue to advocate for strengthened accountability by the government and adherence on monitoring and supervision systems for compliance

ix. Intensify the advocacy mechanisms for increased targeting of the key populations with SRHR/GBV and HIV services, in addition to enhancement of evidence-based response for the key populations

x. Prioritize multi-sectoral advocacy at the national levels to influence government to increase investment on RH commodities and increase funding for strengthening the FP supply chain both nationally and at district levels, in addition to continued condom promotion with a sustainable approach; and continue supplementing the efforts of the government while at the same time empowering the government to take over the responsibility

xi. Strengthen the operationalization of the CSE curriculum across the schools in the country and enhance the community level engagement to facilitate their ownership and support of the curriculum implementation. Strengthen the pre-service training of teachers to enhance capacity of delivery.

xii. There is need to increase advocacy, partnership and coordination for increased access to adolescent and youth-friendly services by the young people in the country

xiii. Increase resource allocation to HIV prevention programming expanding reach to the most at risk population, particularly, the adolescent and youth and strengthen advocacy for harmonization of HIV and AIDS response between NAC and MoH.

xiv. UNFPA should continue strengthening framework for policy and legal engagement, particularly strengthening implementation of the policies and strategies aimed at ensuring GEWE, in addition to eliminating harmful practices affecting women and girls in Lesotho through addressing the social norms promoting the practices

xv. The CO should continue increasing evidence-based GBV response mechanism through promotion of reporting structures and strengthening GBV referral pathways, particularly improving access to justice by the survivors. Further, strategically engage men and boys on ensuring prevention of GBV and empowerment of women and girls

CHAPTER ONE: INTRODUCTION

The United Nations Population Fund (UNFPA), Lesotho Country Office (CO) is currently implementing Seventh cycle of the UNFPA Country Programme (CP) of Cooperation support to the Government of Lesotho, which started in 2019 and slated to end in 2023. The CP is implemented covering three thematic areas, namely i) sexual and reproductive health and reproductive rights (SRHR); ii) adolescents and youth (A&Y); and iii) gender equality and women's empowerment (GEWE); with population dynamics (PD) being mainstreamed across the three components. The CO commissioned the Country Programme Evaluation (CPE) in compliance with the 2019 UNFPA Evaluation Policy[4]. The policy, along with the 2019 version of the *Handbook on How to Design and Conduct Country Programme Evaluations at UNFPA* guided the design, management and governance of the CPE process. in addition to the Norms and Standards, and Ethical Guidelines for Evaluators in the UN system and the Code of Conduct, established by the United Nations Evaluation Group (UNEG)[5]

1.1 Purpose and objectives of the CPE

The evaluation was commissioning in compliance with the 2019 UNFPA Evaluation Policy[6] in addition to the Norms and Standards, and Ethical Guidelines for Evaluators in the UN system and the Code of Conduct, established by the United Nations Evaluation Group (UNEG)[7]. The CPE serves three main purposes, in line with the 2019 UNFPA Evaluation Policy. The three primary purposes are; (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 Objectives of the CPE are to provide the UNFPA Lesotho CO, national stakeholders and rights-holders, the UNFPA ESARO, UNFPA Headquarters as well as a wider audience with an independent assessment of the UNFPA Lesotho 7th CP (2019-2023), and broaden the evidence base to inform the design of the next programme cycle.

Specifically, the objectives of this CPE are 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 Lesotho CO in the coordination mechanisms of the UNCT and HCT, 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 Lesotho 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.

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

[4] See The UNFPA Lesotho 7th Country Programme Evaluation Terms of Reference

[5] See ibid

[6] https://www.unfpa.org/admin-resource/unfpa-evaluation-policy-2019

[7] See The Evaluation Handbook: How to Design and Conduct a Country Programme Evaluation at UNFPA (2019)

1.2 Scope of the CPE

The evaluation covered all the interventions planned or implemented by UNFPA in Lesotho, guided by the following key aspects of scope:

- **Geographic Scope:** The evaluation coverd the national level interventions with a sharp focus on the following two districts where UNFPA implemented interventions: Mokhotlong and Quthing.
- **Thematic Scope:** The evaluation covered all the thematic areas of the 7th CP: SRHR; HIV Prevention, youth and young people and gender equality and women's empowerment. In addition, the evaluation covered cross-cutting issues, such as human rights; gender equality, 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 under the current CP (2019-2023) during the time period 2019 - 2022.

1.3 Scope of the CPE

The main audience and primary intended users of the evaluation are: (i) The UNFPA Lesotho CO; (ii) the GoM; (iii) IPs of the UNFPA Lesotho CO; (iv) rights-holders involved in UNFPA interventions and the organisations that represent them (in particular women, adolescents and youth); (v) the UNCT; (vi) Eastern and Southern Africa Regional Office (ESARO); and (vii) donors. The evaluation results will also be of interest to a wider group of stakeholders, including: (i) UNFPA headquarters divisions, branches and offices; (ii) the UNFPA Executive Board; (iii) academia; and (iv) local civil society organisations and international non-governmental organisation (NGOs). In addition, the evaluation results will be disseminated using a stakeholders' workshop and will be available on the UNFPA Lesotho website as well as on the corporate website for UNFPA evaluations

1.4 Methodology and Process

1.4.1 Methodology

1.4.1.1 Evaluation Criteria and Evaluation Questions

The evaluation was conducted through assessment of four Development Assistance Committee of the Organization for Economic Cooperation and Development (OECD/DAC) evaluation criteria of relevance, effectiveness, efficiency and sustainability[8], in addition to the strategic positioning of UNFPA within the UNCT and the role it has played in United Nations system-wide coordination mechanisms. The CPE also considered assessment of the humanitarian context-related criteria on the extent to which UNFPA provided coverage of the affected population groups and connectedness on how well the support gave consideration to longer-term solutions during disaster or emergency response[9]. The assessment of the CP performance along the evaluation criteria entailed utilizing evaluation questions (EQs) as stated in Table 2. The assessment and analysis of the EQs informed the development of the CPE Matrix (Annex 2), which guided the assumptions and indicators for ascertainment during the evaluation, defining sources of data collection methods, tools and data collection and analysis.

Table 1: List of the Final Evaluation Questions used in the CPE

Evaluation Questions under Each Criterion
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. young people and women, Key populations; (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? 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, or to shifts caused by crisis or major political changes?
Effectiveness

[8] The OECD/DAC Criteria for International Development Evaluations https://www.oecd.org/dac/evaluation/49756382.pdf

[9] Lesotho 7th Country Programme Evaluation Terms of Reference.

EQ2: 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? **EQ3**: 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
EQ4: 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, with the results effectively and efficiently measured and contributing to accountability?
EQ5: To what extent has UNFPA been able to support implementing partners and rights-holders (notably, women, adolescents and youth) in developing capacities and establishing mechanisms to ensure the durability of effects in particular related to SRHR, SGBV prevention and protection and data?
Coordination
EQ6: To what extent has UNFPA contributed to the functioning and consolidation of the coordination mechanisms of the UNCT and the HCT, including how the UNFPA country office provided leadership in SGBV and SRHR coordination and contributed to the collective response to the COVID-19 crisis?
Coverage
EQ7: To what extent have UNFPA humanitarian interventions during the drought and Covid-19 systematically i) reached all geographic areas in which affected populations (women, adolescents and youth) reside and ii) reached the most vulnerable and marginalized groups (young people and women ethnic), Sex workers, LGBTQI populations.
Connectedness
EQ8: 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? **EQ9**: To what extent have the interventions supported by UNFPA taken into account complementarity and integration of ongoing development plans, programmes including related thematic areas from various stakeholders?

1.4.1.2 Analysis of the CP Theory of Change

The CPE design was based on analysis of the theory of change of the programme which informed the design of the data collection tools, analysis and conclusions on the performance of the programme. From the design perspective, the 7CP's theory of change (ToC) was assessed and the evaluation felt that it needed to be strengthened further in terms of reassessing the logic that underpinned the programme design. The evaluators established gaps with the result areas not properly captured with inadequate linkages. The risk and assumptions were also not reflected, in addition to the linkage between the strategic interventions of the 7CP and the outputs and outcomes not clearly explained. This necessitated the reconstruction of programme logic and this entailed analysis of the causal links of the CP interventions and strategies across the results chain. Adjustments were made to focus the causal links across the results chain in addition to linking the result areas to reflect integration within the programme and the contribution that implementation of the interventions and achievement of the results at both output and outcome levels results into the strategic goal. In addition, guided by the evaluation questions, the evaluators took into consideration the contribution of the CP in addressing the country's development challenges along the component areas and entailed identifying the existing gaps and analysing how the CP filled the gaps and contributed to influencing the changes taking place the respective thematic areas in the country. The CPE also looked into the CP's contribution to the UNDAF, related SDGs and the other international frameworks, including the ICPD. In the analysis of the ToC, the process established the mechanisms of change, considering the risks, critical assumptions and the implementation context underlying the programme logic. The interpretation of the causation process guided the evaluators in understanding the programme's contribution to the observed results and gather evidence to validate the conclusions on the performance of the programme in the period of review. implementation. The reconstructed ToC is as in Annex 8.

The reconstructed ToR of the 7CP links the strategic interventions under each output area to the expected results across the chain, taking into consideration the integrated nature of the programme. The analysis of the theory of establishes the mechanisms for change, considering the risks that may hinder the achievement of the desired results and the assumptions that may facilitate achievement of the desired results, within the constraints of the context. The result areas in each of the CP components are further aimed at contributing

to the achievement of the strategic goal in line with the UNFPA Global Strategic Plan 2018 – 2021. 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 assessed the ToC of the CP guided by the evaluation questions establishing how the programme made contribution to the observed results, how it influenced the changes, in addition to assessing the reliability of the evidence existing. This entails conceptualizing the programme across the results chain, building on its logic, along the existing risks and assumptions. Assessing the ToC also entail considering the other existing factors influencing the changes within the implementation context.

This entailed analysis of how the CP outputs contributed to the overall achievement of the results of the CP, as well as those in higher level plans such as the UNFPA Strategic Plan and national plans. To illustrate the links from inputs, outputs and to the outcomes of the 1st CP, and since the CP did not have a Theory of Change (ToC), the evaluation team constructed one, as illustrated in Figure 1. The analysis of the ToC shows that the logical design of the CPE was fairly clear and the modes of engagement and interventions were delivered within the context of the identified strategies and assumptions, the CP would logically achieve its outputs and contribute to the outcomes. This is the logic assessed during the CPE.

1.4.2 Methods for data collection and analysis

The evaluation design, methodology and process were consistent with the UNFPA Evaluation Handbook "*How to design and conduct a CPE at UNFPA*" and its implementation was in accordance to the Norms and Standards, and Ethical Guidelines for Evaluators in the UN system and the Code of Conduct, established by the United Nations Evaluation Group (UNEG). The evaluation team used mixed methodologies in the design of the CPE for comprehensive data generation and triangulation to effectively meet the objectives of the assignment. The design of the CPE was non-experimental given the expected descriptive and non-normative nature of the objectives and the related EQs. This design was relevant due to the time and resource constraints and allowed the evaluation team to analyse the contributory relationship between the programme interventions and their effects on the UNFPA CP strategy.

***Participatory approach*:** The CPE implementation was based on an inclusive, transparent and participatory approach, involving a broad range of partners and stakeholders at national and sub-national levels. These stakeholders provided insights and information, as well as referrals to data sources that the evaluation required to assess the contribution of UNFPA and to answer the evaluation questions. Particular attention was paid to ensuring participation of women, adolescent girls and young people, especially those from vulnerable and marginalized communities during FGDs. Further, the Evaluation Reference Group (ERG) established by the UNFPA Lesotho CO for the CPE and comprises key stakeholders of the Country Programme contributed to the process. The ERG served as a quality assurance mechanism from a technical perspective by providing inputs on evaluation deliverables at different stages of the evaluation process. In addition, the engagement of the ERG helped facilitate knowledge-sharing and ensure the use of the evaluation results.

Guided by the selected evaluation questions and the objectives of the CPE, the consultants propose to use both primary and secondary sources of data. This entailed the use of mixed methods, generating quantitative and qualitative data derived from multiple sources. The primary data was collected through the use of key informant interviews, focus group discussions or unstructured interviews, and direct observation during field visit. These are explained below.

- **Key Informant Interviews:** This method entailed conducting interviews with individuals or groups as key informants from a range of stakeholders identified in the stakeholders' map. The respondents included key implementing partners, and strategic partners. Those reached include UNFPA CO staff, officials from the government line ministries, representatives of UN agencies, strategic partners, and national and international NGOs as implementing partners. The evaluators also conducted group interviews 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, donors, other UN agencies, and national and international implementing partners) in the various thematic areas of programming. In the selection of the participants, the consultants will ensure gender aspects are considered to capture as much as possible the gender issues. During interview sessions, the consultants also probe for gender issues to ensure gender perspectives were captured in the feedback and these have been documented in the report.

- **Focus group discussions (FGD):** The FGDs were designed to gather information among primary programme beneficiaries, including those benefiting from UNFPA capacity building interventions. Those reached were the Herd boys, beneficiaries of husband schools, Mokhotolong district health facility staff, teachers who benefited from the UNFPA CP support. 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 arising 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 provided further insights into data obtained from other categories of respondents. Purposive sampling was used for selecting participants in the FGDs. This ensure balanced representation of respondents from all the different socio-economic backgrounds. Each FGD will be aimed to compose of at least 5 -8 participants ensuring balance in terms of sex and focus area. During interview sessions, the consultants also probed for gender issues to ensure gender perspectives were captured in the feedback.

- **Desk review**: Secondary data were extensively reviewed through desk review of existing literature related to the UNFPA 7CP and other partners in the country, annual reviews/progress reports, administrative data, especially in the thematic areas of the programme like health sector data, other monitored data, including Gender areas as available. The consultants have conducted the initial review of programme documents to inform the design report of the CPE. This was a continuous process during the CPE, as it aimed at enriching the quality and content of the report. Over the course of the review, the team identified and obtained other key documents with the support of the UNFPA Lesotho CO, in addition to related documents by other stakeholders to inform the CPE process. Further, the quantitative performance of the programme as defined by the CPD Results Framework was informed by documentary evidence in the various reports provided by the UNFPA Lesotho CO. Documentary evidence was a major part of this CPE complementing the constraints in accessing primary data. These have been referenced as appropriate in the report, to provide evidence-based feedback on the programme performance. The list reviewed is in Annex 3.

- **Observations**: Based on the results of the document review and consultations with the UNFPA Lesotho CO, the consultants conducted site visits in the course of data collection in order to enrich the evidence base for this CPE. This was done through observing operations in real circumstances and/or to meet programme activities' participants to talk about UNFPA activities in the locality and results achieved to date.

Data Validation and Analysis: The analysis of the data has been based on a synthesis and triangulation of information and data obtained through the different methods from various sources. Besides a systematic triangulation of data sources and data collection methods and tools, validation of data will be sought through regular exchanges with the UNFPA programme staff. As the data collected for this evaluation was primarily of qualitative nature, it constituted the main technique used for data analysis. Content analysis was employed to analyse documentary evidence as well as qualitative data using themes and concepts relevant to the different evaluation questions, related assumptions and indicators in the Evaluation. Contribution analysis was assessed the extent to which the CP contributed to expected results. The team made use of the ToC focusing on the interventions contributing to the expected outputs and the said outcomes in turn. In addition, descriptive statistics was used to describe and summarize key characteristics of quantitative data obtained from secondary sources. The extent to which descriptive statistics was conducted was based on the availability of quantitative data and the quality, reliability, timeliness, comparability of this data. The financial data has been presented in the form of charts and graphs. 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 field phase the consultants held consultations periodically on the key findings providing insights into the performance of the programme. Further, the validation of data will be sought through regular exchanges with the UNFPA Staff and stakeholders.

1.4.3 Selection of the sample of stakeholders

The selection of the stakeholders to participate in the CPE was guided by the ToR, and the programmatic scope of the evaluation which is expected to cover the key programmatic areas of Sexual and Reproductive

Health and Rights; and Gender Equality and Women's Empowerment. Population dynamics and adolescent and youth were assessed as cross-cutting areas including the content of knowledge sharing and practices. In addition, the selection was guided by the period of the CP implementation and strategies such as partnership, resource mobilization and CP communication and advocacy interventions

The evaluators adopted a participatory approach in selecting the stakeholders, where UNFPA programme staff were involved in the selection of the evaluation as respondents, particularly the sampling framework without influencing the choice of the consultants. The stakeholders' map provided by the UNFPA Lesotho CO and a review of Atlas project and relevant programme documents provided by the CO in preparation for this design report guided the selection of the stakeholders to participate in the CPE. The stakeholders map constituted the sampling frame for KIIs, group discussions and FGDs. Further, in consultation with the UNFPA Lesotho CO staff, as well as complementary document review were 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. Further, the consultant also ensured as much as possible inclusion of various beneficiary groups e.g. those from marginalized groups, including the key populations, women. Analysis of UNFPA CP documents identified and clustered evaluation main stakeholders into the following groups:

- **UNFPA Lesotho CO staff:** Management of the UNFPA Lesotho CO; technical specialists and associates in the thematic areas of programming of the CP; and staff of operations and cross-cutting units in the CO.
- **Government counterparts:** Officials of relevant line ministries and institutions
- **Implementing partners:** Staff of non-governmental organizations in their respective areas of coverage
- **Direct beneficiaries:** These include the direct beneficiaries, be it through capacity building and development or service delivery support
- **Indirect beneficiaries**: Teachers, MoH field staff, husband schools' beneficiaries, adolescents and youth in the districts targeted by the CP, including key populations
- **United Nations agencies**: The United Nations Resident Coordinator and representatives of relevant United Nations agencies, as agreed upon with the CO team; including members of system-wide development and humanitarian coordination mechanisms, where possible and relevant.

The Evaluation team adopted a purposive sampling technique 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 Lesotho CO staff, Government counterparts, implementing partners, direct and indirect beneficiaries, donors 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 2: Summary of Interviews and FGD Sessions Conducted by Respondent Group

Component / Target Entity	Number of Participants	
	Male	Female
Government Agencies	6	16
Implementing Partner NGO/CSOs	8	6
UNFPA CO	3	6
UN Agencies	3	5
Beneficiaries	16	10
LGBTIQ+	3	

1.4.4 Limitations and mitigations measures

- ***The use of purposive sampling techniques to select respondents is*** not representative of all the interventions in the locations of CP implementation and therefore the findings cannot be generalized to the entire areas supported by the CO. The Evaluation team seeks to ensure that the selection of stakeholders as respondents cover all the CP interventions to mitigate any biases

- ***Short time allocated for field visits*** leading to limited number of site visits by the evaluation team. The team however split into teams or individuals to ensure that the sessions were conducted conclusively and comprehensively

- ***Language barrier for the Team Leader*** while he was expected to facilitate some of the sessions. While this was not common in most of the sessions as the respondents could speak the English language. In the circumstances that this presented itself, one of the three local team members would step in and translate or facilitate, and discuss the findings at a later time to ensure debrief of every situation.

- ***This CPE was based primarily on qualitative data collected*** from Government counterparts and implementing partners (direct beneficiaries) rather than indirect beneficiaries, who were also the intended beneficiaries of the services delivered through the UNFPA support. The CPE assessed the achievement of the CP outputs and the likelihood of results on the outcome level as articulated in the CP Results Framework. The evaluation team has highly triangulated primary qualitative data across multiple sources and cross-check this information with secondary quantitative data, using existing data sets from national surveys and/or from surveys and thematic evaluations that were carried out by development and humanitarian partners.

1.5 Evaluation Process

In compliance with the standard evaluation process outlined in the UNFPA Evaluation Handbook: How to design and conduct a CPE at UNFPA, evaluation process involved five phases: (i) preparation; (ii) design; (iii) field; (iv) analysis and reporting; and (v) facilitation of use and dissemination phase, as described in the section that follows below.

Table 3: Phases and Key Activities of Evaluation

Preparatory (done by the CO and ESARO)	▪ Drafting and approval of the ToR for CPE ▪ 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, and completion of annexes.
Design (Done majorly by the Evaluation Team)	▪ Evaluation kick-off meeting between the Evaluation Manager and the evaluation team. ▪ Development of an initial communication plan ▪ Desk review of background information and documentation on the context and CP ▪ Stakeholder mapping ▪ Detailed review of the ToC underlying the CP and Reconstructing the intervention logic of the programme ▪ Formulation of a final set of evaluation questions based on the preliminary evaluation questions provided in the ToR ▪ Development of Evaluation Matrix ▪ Developing and defining data collection, sampling, and analysis strategies ▪ 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

	▪ Submission and approval of the Design Report
Field (Evaluation Team, with support from the CO)	▪ Meeting with the UNFPA Lesotho CO staff to launch the data collection. ▪ Meeting of evaluation team members with relevant programme officers at the UNFPA Lesotho CO. ▪ Data collection at national and district levels. ▪ debriefing meeting with the CO and the ERG to present the emerging findings from the data collection.
Reporting (Evaluation Team, with support from the CO)	▪ Comprehensive data analysis, integrating comments provided during the debriefing with 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
Dissemination and Use (UNFPA)	▪ Finalization of the Communication plan ▪ Management response to the CPE recommendations ▪ Development of the dissemination strategy ▪ Dissemination of the CPE Findings and lessons learnt

CHAPTER TWO: COUNTRY CONTEXT

2.1 The Situation and Development Challenges

2.1.1 Geographical and Political Context

Lesotho is a small mountainous country situated in Southern Africa and is surrounded by South Africa[10]. The country covers a surface area of 30, 355km^2 and only 1.1percent of the land is forest area. It is divided into 10 administrative districts with the capital city housed in the Maseru district. The districts of Mokhotlong, Thaba Tseka, Qacha`s Nek and Quthing are located in the highland areas whereas, Maseru, Berea, Leribe, Butha Buthe, Mafeteng and Mohale`s Hoek are found in low land areas. However, the topography of the country is such that there are highland regions in areas designated as low lands especially at points of demarcation and these are referred to as foot hills. The districts of Maseru, Leribe, Berea, and Mafeteng constitute 62.2percent of Lesotho's population[11].

According to the BTI transformation index (2022), the Government of Lesotho controls the entire geographical territory of the country. Strong political lines are rooted in the politics of Lesotho's independence and political parties are differentiated by their strong allegiances and not their policies. Since

[10] Ministry of Health (MoH). National Tuberculosis Strategic Plan of Lesotho, 2018-2022

[11] Government of Lesotho. Report for a Joint Review of HIV/TB & Hepatitis programs 2017

2012, there has been political instability with the country being ruled by a series of coalition governments which made it difficult it to attract foreign investors. The national reforms program has brought many interest groups together including professional bodies, human rights organizations, business associations, faith-based organizations, media organizations, farmer's organizations, etc who have been working together to create an environment of greater cooperation between special interest groups. Unfortunately, unemployment, corruption, nepotism, pollution, insecurity, crime, indebtedness, and hunger continue to worsen irrespective of continuous democratic governments since 1993.

Lesotho is described as a lower-middle-income country whose population mainly relies on subsistence agriculture for livelihoods. Owing to poor agricultural productivity and with only 10percent of arable land, the country relies heavily on imports from South Africa. Road networks in highland and foothill areas remain poor and with extended droughts and soil erosion, the scope of farming continues to decline (BTI, 2022). In 2021, the World Bank reported that the Gross Domestic Product Growth (GDP) was estimated at USD2.52, the GDP per capita was USD1 166.5, the GDP growth rate was USD1.0, the personal remittances were 20.9percent in 2020, and the GDP growth was estimated at 0.6percent owing to the COVID-19 pandemic. During the first quarter of 2022, the economy of Lesotho expanded by 2.9 percent compared to a decline of 10 percent which was recorded during the same period in 2021[12]. The Human Development Index was 165 in 2018 and 2019 and it improved from 0.522 in 2018 to 0.527 in 2019 (BTI, 2022).

The biggest challenge to the economy of Lesotho is the increasing unemployment as more and more young people join the labour force which is predominantly dominated by the civil service. As there is high unemployment, the informal sector is large and does not require any licensing except for rents which are paid to local councils for allotted spaces to work from (BTI, 2022). World Bank estimates reported that in 2021 24,6 percent of Basotho were unemployed in 2021 and 37.4percent of youth were unemployed. In 2019, a total of 151 266 of Basotho were unemployed. Out of these, males were 80 320, whilst females were 70 946. The highest unemployed age group was 20-39 years for both males and females, whilst lower unemployment rates are in the 15-19 and 40-44 to 80 years and above[13].

The national poverty headcount rate was between 44.7percent and 49.7percent in 2017/2018 and was higher in rural areas as compared to urban areas[14]. In 2021 the multidimensional poverty index was 19.6percent[15]. Sadly, 2 in 5 Basotho children suffer from deprivation in three or more dimensions, with at least 55.6percent of them being affected by 3.5 of all possible deprivations. Majority of these children (19.4percent) live in rural areas as compared to urban areas and their poverty is attributable to the topography of the country, sociocultural issues, and lack of access to basic services[16].

Basotho are generally educated as the UN education index for the country was 0.532 in 2019 and in 2014 the literacy rate was 76.6percent. Primary education is solely funded by the government whilst parent will pay the costs of secondary education. UNICEF assisted the government with the primary school feeding program (BTI, 2022). The total net enrolment into primary education in 2022 was 98 percent, for lower secondary education it was 83 percent, and for upper secondary education it was 66 percent[17]. In 2018, 4 out of 5 children completed primary school, whilst 1 out of 3 children completed upper secondary school and the same number was found to be out of school. Twice as many boys of secondary school going age were out of school as compared to girls[18].Women are generally more advantaged in educational attainment as compared to men. Children with disabilities, herd boys, and orphans and vulnerable children (including child-headed households) remain disadvantaged when it comes to accessing education[19]. The school curriculum covers topics such as gender equality, sexual and reproductive health and rights, sexually transmitted infections including HIV, drugs, alcohol, substance use and abuse, human rights, and life skills. This has had positive results on fertility, infant, and maternal morbidity and mortality but has not translated to gender equality in society[20].

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[12] Bureau of Statistics (BoS). Quarterly National Accounts of Lesotho First Quarter 2022

[13] BoS. 2019 Labour Force Survey

[14] BoS. Lesotho Poverty Trends and Profile Report 2002/2003 to 2017/2018

[15] UNDP. Multidimensional Poverty Index 2021

[16] BoS & UNICEF Lesotho. Multidimensional Child Poverty Report Highlights 2021

[17] UNFPA. https://www.unfpa.org/data/LS

[18] BoS. Lesotho Multiple Indicator Cluster Survey (MICS) 2018

[19] Voluntary National Review (VNR) Report 2019

[20] MoH. Adolescent Health Strategy 2015-2020

2.1.2 Sexual and Reproductive Health and Rights (SRHR)

With majority of the population living below the poverty line, Lesotho continues to face major health challenges including HIV and a high maternal mortality rate. UNFPA supports Lesotho to reduce maternal mortality, prevent HIV (particularly amongst youth), decrease gender inequality, and development of quality data on population issues[21]. In 2017, the total health expenditure for Lesotho as of 2014 was 10.6percent per GDP. The private care expenditure was 24 percent and only 2.5percent per GDP. This was found to be less as compared to the sub-Sahara region, but higher than Lesotho's neighbouring countries[22].

The country is observing a dropping trend of maternal deaths from 1024 to 936 to 618 deaths per 100 000 live births observed since 2014, 2017 and 2019 respectively[23]. The maternal mortality ration is 544 per 1000 live births[24]. In 2018, pregnant women who had at least one ANC visit were 91percent, those who had at least four ANC visits were 77percent, women who had skilled attendance at birth were 87percent, 89percent of births were done institutionally, whilst 84percent of women and 82percent of babies had postnatal care for 2 days. Majority (9 out of 10) women delivered their babies at health facilities, whilst 87percent of pregnant women were attended to by skilled birth attendants during delivery.

The total fertility rate in 2018 was 2.7 and the peak age group for child bearing was 20-24 years. The adolescent birth rate was 91percent, child bearing amongst women aged 20-24 years before the age of 15 was 0.3percent, whilst child bearing before the age of 18 was 11.9percent. The use of modern contraceptives was by 64.6percent of married/in- union women in the 15-49 age group. The foothills were reported to experience the highest adolescent birth rates, highest total fertility rates, highest rate of early childbearing before age 18, and the lowest use of modern contraceptive methods. The unmet family planning need amongst women was 17% and the for age groups 10-14, 15-19 and 20-24 was 26.6percent, 33.7percent and 24.3percent, respectively[25]. Reportedly in 2022, the adolescent fertility rate was 91 per 1000 women, whilst 83percent of women aged 15-49 years were satisfied with the modern methods of contraception[26]. The rural areas of Lesotho are the most affected by teenage pregnancies as they are characterized by poor infrastructure and few health facilities that are hard to reach. Other United Nations agencies supporting Lesotho include but are not limited to the Joint United Nations Program on HIV/AIDS (UNAIDS), United Nations Children's Fund (UNICEF), and World Health Organization (WHO).

Lesotho reported a general decline in the under-five mortality rate in 15 years preceding the 2018 multiple indicator cluster (MICS) survey. The neonatal mortality rate was 36/1000 live births, the post-neonatal mortality rate was 26/1000 live births, the infant mortality rate was 62/1000 live births, the child mortality rate was 15/1000 live births, and the under-five mortality rate was 76/1000 live births for the 0-4-year period preceding the MICS survey. Notably, neonatal deaths contributed to 50percent of all under-five deaths during the 0-4 years before the survey and children from urban households had a higher probability of dying before reaching the age of 5 years as compared to those from rural households[27]. The most common causes of death amongst children include prematurity, birth asphyxia, pneumonia, and malnutrition[28].

Human Immunodeficiency Virus (HIV) and Tuberculosis (TB) continue to be the leading causes of morbidity and mortality amongst children, men, and women in Lesotho[29]. HIV prevalence amongst adults aged 15-59 years is 22.6 percent. The prevalence of TB in Lesotho is at 611 per 100 000 population[30], whilst the annual TB case incidence is at 788 per 100 000 with a death rate of 55 per 100 000[31]. Synergistic approaches to addressing the two epidemics remain slow as the country only attained treatment success of less than 80percent since 2008, falling below the national target of 85percent. The burden of TB in Lesotho is further worsened by drug-resistant TB[32]

[21] UNFPA. https://www.unfpa.org/data/transparency-portal/unfpa-lesotho

[22] UNICEF & World Bank Group. Lesotho Public Health Expenditure Review. 2017.

[23] MoH & UNAIDS. 2020. Epidemiological Fact Sheet. & UNFPA, 2018. Country Programme Document for Lesotho.

[24] UNFPA. https://www.unfpa.org/data/transparency-portal/unfpa-lesotho

[25] BoS. Lesotho Multiple Cluster Survey (MICS) 2018

[26] UNFPA. https://www.unfpa.org/data/LS

[27] BoS. Lesotho Multiple Cluster Survey (MICS) 2018

[28] UNICEF Lesotho Country Office Annual Report 2020

[29] Government of Lesotho (GoL). National AIDS Policy. 2019

[30] World Health Organization (WHO). Global Tuberculosis Report. 2020. https://www.who.int/teams/global-tuberculosis-programme/data

[31] MoH. Lesotho National HIV/AIDS Strategic Plan 2018/18 – 2022/23

[32] MoH. 2017 Final Report for a Joint Review of HIV,TB, & Hepatitis Programmes

and the TB-HIV co-infection which is estimated at 73 percent[33].

The scourge of TB and HIV was further worsened by labour migration which further exposed migrant workers to high risk behaviours, making them more vulnerable to infection[34]. The prevalence of HIV amongst adolescents and youth is very high and increasing, with females more infected than males. This is attributed to the fact that a significant proportion of adolescent girls and youth have sexual intercourse partners 10 years or older than them[35]. The introduction of Test and Treat, together with other initiatives such as voluntary medical male circumcision (VMMC), post exposure prophylaxis (PEP), and pre-exposure prophylaxis (PrEP) are hoped to curb the rise in new HIV infections amongst adolescents and society at large. These measures are available in Lesotho, however, there is insufficient knowledge about the availability of these services especially amongst adolescents who remain at high risk of contracting HIV[36].

2.1.3 Adolescent Health

Inequality in health, related to sociocultural practices, gender inequity, and socioeconomic challenges continue to pose a threat for effective adolescent health coverage in many countries (Bell et al., 2018). With the increasing economic gap, many children are faced with the risk of poor nutrition and other social disparities including Gender-based Violence (GBV) and Human Immunodeficiency Virus (HIV) infection. Adolescents are reported to begin sexual activity from as early as age 15, thereby increasing the risk of HIV transmission[37]. Before the age of 18, 67percent of girls and 49percent of boys debut sex, whilst 23percent of girls and 5percent of boys do so before 15 years of age[38]. A high incidence of HIV among adolescents and young people of 0.8 and adolescents and young girls at 1.5 was previously reported[39]. Infections have been reported to occur in every one out of four adolescent girls and young women due to discordancy, gender-based violence (sexual assault), and gender inequalities[40]. HIV prevalence was reportedly 19.9percent for girls and 5.1percent for boys[16]. Sadly, the antiretroviral therapy (ART) coverage amongst adolescents and young people remains low whilst viral load suppression amongst children is sub-standard[16]. Usually, the presentation of TB in older adolescents is similar to the presentation in adults[41]. Mortality risk remains highest amongst adolescents and those infected with HIV (Osman et al., 2021).

The report on child poverty in Lesotho estimated that HIV affects 74percent and 63percent of children aged 0-23 months and 24-59 months, respectively[42], whilst the LePHIA report (2016-2017) estimated that HIV prevalence amongst children was 2.1percent and significantly higher amongst girls (2.9percent) than boys (0.9percent). Out of 81.1percent of children previously diagnosed with HIV, 98.2percent of them were on ART, but viral load suppression was in only 73.9percent of them[43] between 2016 and 2017. Additionally, 13 000 children aged below 14 years are living with HIV in Lesotho, and this is five times higher than the average for sub-Saharan Africa[44]. The HIV treatment coverage for children 0-14 years was 71percent in 2019 and even though this was an upward trend, it was below the recommended coverage levels[45].

National Strategies Addressing SRHR and Adolescent Health

Lesotho's policy and legal context provides a conducive environment for adolescent development. There is National HIV and AIDS Policy (2019) and National HIV and AIDS Strategic Plan 2018/19-2022/23 whose vision is "Ending AIDS by 2030". The Policy and the strategy recognise the need to fully address challenges related to gender inequality in the traditional context and the need to eradicate sexual and gender-based violence. Sexual and gender-based violence is also addressed within the Gender and Development Policy 2015-2025 which is "premised towards confronting gender disparities between men and women. The Ministry of Health in conjunction with the Ministry of Gender and Youth, Sports and

[33] End TB Lesotho. http://www.endtb.org/lesotho

[34] Ministry of Social Development (MoSD). Pathways to Sustainable Livelihoods Project. 2022

[35] RNMCAH & N Strategy. 2017-2022

[36] MoH & UNAIDS 2020. Epidemiological Fact Sheet

[37] MoH. National Health Strategy for Adolescents and young people. 2015-2020

[38] Lesotho National HIV & AIDS strategic plan2018/19-2022/23

[39] MoH. Lesotho Population-Based HIV Impact Assessment (LePHIA)

[40] GoL. National AIDS Spending Assessment. 2015/2016-2017/2018

[41] MoH. National Guideline for Drug Susceptible Tuberculosis 2019

[42] Ministry of Development Planning (MoDP) & UNICEF. Child Poverty in Lesotho 2018

[43] MoH. Lesotho Population-Based HIV Impact Assessment (LePHIA)

[44] GoL. HIV & Social Protection Assessment Report 2019

[45] UNAIDS 2019. The Global HIV/AIDS epidemic. https://www.aids.gov/hiv-aids-basics/hiv-aids-101/globalstatistics/

Recreation (MGYSR) have developed Standard Operating Procedures for Prevention and Response to Gender Based Violence in Lesotho. These procedures "detail clear and minimum procedures for both prevention and response to GBV, including which organizations and/or community groups will be responsible for actions in the four main response sectors: health, psychosocial, legal/justice and security"[46]. In terms of Acts of Parliament, there is Sexual Offences Act, Vol. XL VIII (2003) which protects citizens against all forms of sexual and gender-based violence as well as Sexual Offences Special Provisions Act (1998). Sexual and Reproductive Health is provided for in the National Sexual, Reproductive, Maternal, New-born, Child and Adolescent Health and Nutrition Strategic Plan 2018-2022 (2018) within which is embedded the Sexual and Reproductive Health Policy[47].

2.1.4 Gender Equality and Women Empowerment

Lesotho is one of the most unequal countries in the world. In 2016, the government of Lesotho made a political declaration targeting social protection by eliminating gender inequality and all forms of violence against women and girls, people living with HIV, and key populations[48]. The same years, the Gender Inequality Index was 0.553, whilst the Gini index for inequality was 44.9percent in 2017. As such, majority of leadership positions are held by men, whilst women are found to be disproportionately represented in the factories and care work where they receive less income. Gender links (2017) reported that women held 27 out of 120 seats in Lesotho's parliament. This was a 2percent drop from 2015 where women occupied 30 out of 120 seat in the parliament.

Lesotho is a signatory to the SADC protocol on Gender and Development adopted by Heads of states in August 2008 and has enacted the sexual offenses act since 2003[49]. On average, 17percent of women aged 15-49 years have experienced emotional, physical, or sexual violence committed by their husband[50]. Amongst females aged 13-17, 4.1percent experience unwanted sexual touching, 2.9percent experience unwanted attempted sex; 1.2percent experience pressured or coerced sex; and 1.4percent experience physically forced sex; 2.2percent experience pressured, or physically forced sex in 2018. Common perpetrators of GBV are former intimate partners (42.6percent), neighbors, friends or strangers (all about 10percent each)[51]. Child marriage, another form of GBV, is estimated at 24percent[52]. In 2019, in urban areas, there were no girls married at the age of 15 years while in rural settings 2percent was married. At age 18, 13percent of urban girls and 20percent of rural girls were married[53]. Additionally, gender inequality, gender-based violence, and other forms of human rights violations significantly affect the relationship between HIV and TB epidemics in the country[54].

Suggestions to improve and strengthen gender equality include but are not limited to;

- Incorporation of gender issues in adolescent health and young people prioritised research agenda
- Educating parent and guardians on positive gender socialization, highlighting the equal value of both boys and girls
- Incorporate gender equality issues in the training/reorientation programmes of pre & and in- health services providers, NGOs, FBOs, CBOs programme implementers, Youth Peer Educators and other stakeholders
- Strengthen advocacy activities for promotion of girls and young women e.g. education, address social cultural practices that puts them into more vulnerability to health problems, E.g. early marriages,
- Strengthen advocacy activities targeting policy makers, community leaders including traditional leaders, and parents/guardians to formulate policies enact and enforce laws to eliminate GBV[55].

2.1.5 Population Dynamics in Lesotho

According to the World Bank (2021), the country has an estimated population of 2.159 million people. Life expectancy was reported to be 55 years in 2020, electricity is accessed by 47.4percent of the

[46] MoH. 2017. Standard Operating Procedures for Prevention of and Response to Gender Based Violence in Lesotho

[47] MoH & WHO. Adaptation of the Action for Health of Adolescents (AAHA). 2021

[48] Lesotho Social Protection report 2019

[49] MoH. 2017 Final Report for a Joint Review of HIV, TB, & Hepatitis Programs

[50] UNFPA. https://www.unfpa.org/data/LS

[51] MoSD, ICAP, & the Centers for Disease Control and Prevention. Violence Against Children and Youth Survey (VACS) 2018

[52] UNFPA. 2019. Sexual Reproductive Health and Rights https://reliefweb.int/sites/reliefweb.int/files/resources/MIC_Country_Policy_Brief_LESOTHO.pdf

[53] BoS. 2019. Lesotho Multiple Indicator Cluster Survey (MICS) 2018

[54] MoH. Lesotho National HIV/AIDS Strategic Plan 2018/18 – 2022/23

[55] MoH & WHO. Adaptation of the Action for Health of Adolescents (AAHA). 2021

population, and 48percent use safely managed sanitation services. The annual population growth rate was estimated at 0.8percent and the population density is 71.68/km^2 with the lowest being in the highlands. Majority (71percent) of the population live in rural areas as compared to 29percent who live in the urban areas. Thirty-two percent are aged 0-14 years, 29percent are aged 10-24 years, 63percent are aged 15-64 years, and 5percent are aged 65 years and older[56]. The country has generally had a very low influx of refugees as the Index for Displaced Persons (IDP) was 4.3 in 2021[57].

According to the 2016 population and housing census, males constituted 48.9percent of the total population whilst women were 51.1percent. Notably, the proportion of the population in the lowlands has been increasing. Majority (50.7 percent) of the youth were males. Most the youth were aged 16 years whilst the least were aged 35 years. Majority of the youth were found to reside in rural areas.

The BoS (2021) reported that there were a total of 16 171 inpatient admissions in 2020. Females represented the largest number of inpatient admissions. For the 0-4 age group, more males (19.7 percent) were admitted as compared to 13.3 percent of females. More females (11.3 percent) were admitted for the 15-19 up to 30-34 age groups whilst there was a decline for the 35 to39 age group. Conditions that were attributed to hospital admissions included incomplete abortion, diabetes mellitus, threatened abortion, diarrhoea and gastroenteritis, anaemia, pneumonia, primary hypertension, heart failure, head injuries, and non-specific signs and symptoms.

The National Strategic Development Plan phase II (2019) provides growth and development strategy and strategic direction on to all stakeholders on the framework and investment plan for Lesotho. Implementation of this strategy is also through guidance by the Sustainable Development Goals (SDGs). The country aspires to reduce poverty by enhancing food security and improving agricultural productivity. The population that was prone to food insecurity was estimated to be 640 000 people owing to droughts, land degradation, and lack of financial resources. Whilst there has been a significant reduction in malnutrition in Lesotho, high rates of stunting remain evident in children under five years of age, micro-nutrient deficiencies in children, adolescents, and adults, overweight in some populations segments, and the increasing diet related non-communicable diseases. In order to improve quality education, the country strives to improve enrolment for both boys and girls in both primary and secondary schools by addressing teenage pregnancy, child marriage, supporting menstrual health, and management of violence within schools.

2.1.6 COVID-19 Context

Just like many other countries, the COVID-19 pandemic has had devastating effect on Lesotho. In 2019, the GDP slightly reduced whilst debt to GDP increased to 46.5percent and the fiscal account balance declined from -USD59.9 million to –USD146.2 million. Prolonged lockdowns destroyed livelihoods of people who were already struggling to feed themselves. Food insecurity was projected to increase from 380 000 people to 582 000 people during the COVID-19 pandemic[58]. Majority of things that were available in society were reduced due to lockdown restrictions, and many families were left on their own without any social support from families or the general community. Whilst relief measures were introduced to help businesses and vulnerable members of society, the government struggled to provide adequate healthcare to the general population and democratic institutions such as courts had to suspend hearings due to the pandemic. Lesotho also struggled with the purchasing and supply of personal protective equipment. Consumers' ability to service their loans was affected by the pandemic. To mitigate this, the government then made delays on tax payments and asked banks and insurance companies to suspend loan repayment for three months. Social welfare of the old age pension was also extended not only to citizens aged 70 and above, but to older adults 60 years and above for three months during the COVID-19 induced lockdown. The government increased it public spending to cope with the COVID-19 restrictions, including establishing a WHO accredited laboratory to manage samples, and making special arrangements to enable the flow of goods and services between the boarders with South Africa.

2.2 The Role of External Assistance

Donors continue to play a critical role in the development of Lesotho through provision of development aid to finance government programs. The assistance received by Lesotho cuts across various sectors including education, health and population, social infrastructure and services, economic infrastructure and services, production, humanitarian

[56] UNFPA https://www.unfpa.org/data/world-population/LS

[57] The Global Economy. Lesotho refugees and Displaced Persons Index 2021

[58] UNICEF Lesotho Country Office Annual Report 2020

aid, program assistance, as well as other unspecified assistance. Table 2 below shows the overall development assistance that was provided to Lesotho since 2011 to 2020.

Table 4 : Overall Development Assistance for Lesotho (2011 – 2020)

Year	Amount	Year	Amount
2011	153.672	2016	67.708
2012	171.194	2017	84.516
2013	206.137	2018	96.333
2014	54.312	2019	64.179
2015	40.428	2020	86.976

Source: OECD data base (https://stats.oecd.org/Index.aspx?DataSetCode=crs1)

Between 2019 and 2020 the largest ODA assistance was made to health and population at 78.28 percent. This was followed by other unspecified assistance at 9 percent, education, social infrastructure and program assistance was made at 3 percent each, whilst the remaining sectors of humanitarian aid, multisector, production, and economic infrastructure were supported at 1 percent or less. The top most donors in the same period were the United States of America (USD 66.6 million), International Development Association (USD37.49 million), Global Fund (USD24.79 million), EU Institutions (USD13.7 million), IMF (Concessional Trust Funds) (USD8.12 million), Development fund (USD6.09 million), Japan (USD4.34 million), Central Emergency Response Fund (USD4.3 million), WFP (USD3.99 million), and IFAD (USD3.35 million)[59]. From 2018- 2021 in support of SRHR thematic areas UNICEF received USD1 257 365.00, UNFPA received USD1 080 626, WHO received USD1 149 804.00, and UNAIDS received USD550 000.00[60].

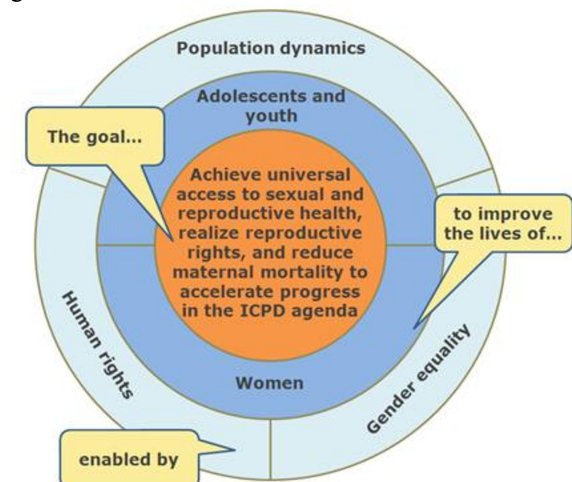
CHAPTER 3: UNITED NATIONS/UNFPA RESPONSE AND PROGRAMME STRATEGIES

[59] Workbook: OECD DAC Aid at a glance by recipient new (tableau.com)

[60] 2gether4SRHR program presentation. United Nations Lesotho Delivering as one. 2022

3.1 United Nations and UNFPA Strategic Response

The UNFPA Lesotho 7th Country Programme is guided by the UNFPA Strategic Plan (2018 - 2021), Sustainable Development Goals, and grounded on the implementation of the framework for the International Conference on Population and Development (ICPD). The 7th CP was developed in alignment with the corporate Strategic Plan 2018 – 21. UNFPA is the lead United Nations agency for delivering a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled. Its strategic goals are 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 order to achieve this goal, UNFPA works towards three transformative and people centred results: (i) end preventable maternal deaths; (ii) end the unmet need for family planning; and (iii) end gender-based violence and all harmful practices[61]. The global priorities are expressed in UNFPA's bull's eye as shown in Figure 4.

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 UNDAF (2019-2023) outcomes. In humanitarian contexts, inter-agency accountabilities are 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, of which UNFPA is also part.

3.2 UNFPA Response through the Country Programme

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

UNFPA has been a key member of the UN fraternity in Lesotho, spanning more than six cycles of country programmes. The sixth country programme contributed to the first digitized 2016 census in the region and strengthened the capacity of the Bureau of Statistics for data-collection and analysis. The final evaluation of the 6th country programme identified the following lessons learned: (i) mainstreaming youth as a cross-cutting component of sexual and reproductive health in the new country programme will yield greater programme results, due to the correlation

Figure 1: UNFPA bull's eye

between youth, HIV transmission, gender inequality and poor sexual reproductive health outcomes; (ii) promotion of behavioural change and condom demand generation interventions are equally as important as condom distribution; and (iii) disaggregated data on reproductive health and rights, and gender equality is crucial for effective policy advocacy efforts for investments in marginalized adolescents.

3.2.2 The 7th UNFPA Lesotho Country Programme

UNFPA in collaboration with the Government of Lesotho developed the 7th Country Programme to support the government towards enhancing sexual and reproductive health and rights (SRHR), advancing gender equality, realizing rights and choices for young people, and strengthening the generation and use of population data for development. The programme aims to increase access to high-quality, youth-friendly, integrated sexual and reproductive health services and rights to prevent maternal mortality, reduce new HIV infections and eliminate gender-based violence and harmful practices. It is implemented in collaboration

[61] UNFPA strategy 2018-2021

and partnership with the Government of Lesotho, civil society groups, United Nations organizations and external development partners. UNFPA builds on existing partnerships, support public-private partnerships and South-South cooperation, and forge new partnerships, including with international financial institutions[62]. The development and implementation of the programme aligns with SDG 3, 5, 16 and 17 as well as to the Strategic Plan 2019 - 2021, NSDP II and The Lesotho UNDAF 2019 -2023.

The UNFPA Lesotho was meant to deliver its 7th country Program 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 Lesotho 7th CP (2019-2023) is universal access to sexual and reproductive health and reproductive rights and reduced maternal mortality, as articulated in the UNFPA Strategic Plan 2018-2021. The proposed country programme contributes to national priorities as outlined in the National Strategic Development Plan II (2019-2023), the Sustainable Development Goals and the United Nations Development Assistance Framework (2019- 2023). It builds on the recommendations of the evaluation of the sixth country programme and is designed to address the three transformative results in the UNFPA Strategic Plan (2018-2022), ensuring that 'no one is left behind', especially people in remote areas and marginalized populations such as herd boys, young people with disabilities and adolescent girls. Therefore, the country programme contributes to the following outcomes of the UNFPA Strategic Plan 2018-2021, through the outputs described below:

Outcome 1: **Sexual and reproductive health and rights.**

Output 1: *Improved government institutional capacities to develop and implement gender-responsive policies, plans and programmes that harness the demographic dividend and improve access to integrated sexual and reproductive health and rights information and services by women, adolescents, and youth, including the furthest left behind.*

UNFPA intended to support the: (a) implementation and monitoring of the Reproductive, Maternal, Child and Adolescent Health and Nutrition Strategy as part of the roll out of integrated sexual and reproductive health services; (b) strengthening of the Health Management Information System and other national monitoring and evaluation systems by integrating age and gender disaggregated indicators; (c) updating of the condom strategy with a focus on improving access for young people; (d) finalization and implementation of the revised family planning guidelines; (e) rolling out of the Logistics Management Information System and capacity development to forecast and monitor essential supplies as well as to generate real-time data and traceability of commodities; (f) advocacy for laws, policies and appropriate budget allocations for integrated sexual and reproductive health and rights, HIV prevention and sexual gender-based violence, particularly targeting key populations and disadvantaged youth; (g) provision of adolescent and youth HIV/AIDS prevention services in formal and informal settings; (h) reinforcement of development frameworks to position the demographic dividend as the basis for accelerated economic growth and sustainable development; and (i) strengthening of response mechanisms for disaster management through the integration of gender-based violence services and the minimum initial service package into the national emergency plan.

Output 2: Women, adolescents and young people have improved access to gender responsive, high-quality, integrated sexual and reproductive health services, including in humanitarian settings.

The programme planned to support: (a) develop the national minimum package for integrated sexual reproductive health and gender-based violence services, including post-abortion care, and improve the capacity of health care workers to deliver these services to women, youth and marginalized groups, including young persons with disabilities and key populations; (b) support integrated sexual and reproductive health outreach services for key populations, adolescents and young people; (c) provide technical assistance to midwife training institutions to ensure compliance with international standards; (d) strengthen the pre-service training of nurses on adolescent friendly health services; (e) support training of health care providers to deliver a comprehensive, modern contraceptive method mix and collect reliable data for the logistics management information system, including last mile tracking,

[62] LESOTHO CPD (2).pdf

forecasting, quantification and monitoring of sexual and reproductive health commodities; (f) implement the minimum initial services package and strengthen community awareness of available services; (g) strengthen delivery of in-school comprehensive sexuality education and roll out of out-of-school comprehensive sexuality education programmes; and (h) engage in South-South cooperation to inform the establishment of 'husband schools' to address cultural and social barriers that impede access to sexual reproductive health and rights.

Outcome 3: Gender equality and women's empowerment

Output 3: Policy, legal and accountability frameworks are strengthened to advance gender equality and empower women and young people, especially adolescent girls, to exercise their reproductive rights and to be protected from violence and harmful practices.

UNFPA intended support the: (a) drafting and enactment of the Domestic Violence Act, the Gender Equality Law and the domestication of the Southern African Development Community Model Law on Child Marriage; (b) harmonization of laws, including those on the age of consent and the definition of a 'minor'; (c) dissemination of laws that protect and promote the rights of women and girls; (d) generation of data and analysis of gender-based violence indicators; and (d) costing and implementation of the Gender and Development Policy.

Output 4: Multisectoral capacity to prevent and address gender-based violence and harmful practices is improved at national and district levels.

In response to the high prevalence of gender-based violence, multisectoral efforts are needed to strengthen national capacity for comprehensive prevention and response interventions through: (a) technical assistance for provision of multi-sectoral services to survivors; (b) integration of gender-based violence within the health response, and in disaster policies, strategies and plans; (c) advocacy for enhanced data-collection and analysis to enable appropriate targeting; (d) strengthening gender-related statistical and research analysis (e) improving awareness and knowledge of men and boys, including herd boys, and strengthening the capacity of civil society and faith-based organizations, women and youth organizations, local leaders, parents and teachers to eliminate gender-based violence and child marriage; and (f) supporting adaptation and implementation of the essential services package for gender-based violence mitigation.

3.2.2 The Country programme financial structure

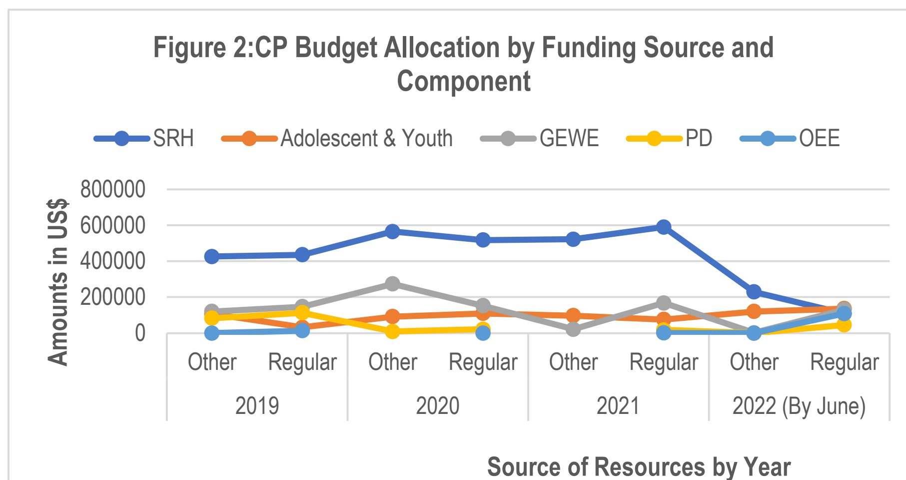
The total budget for the Lesotho/UNFPA 7th Country Programme at the design stage was estimated at about USD 7.6 million over the five-year period 2019-2023. The plan was to raise an amount of USD 3.6 million from UNFPA regular resources while the balance of USD 3.8 million is to be mobilized through co-financing modalities[63]. At the time of the CPE, the CO had mobilized a total of US$ **4,702,713.93,** with the SRH taking the bulk of the allocations at 64%, while the population dynamics component received the lowest at 2%, among the 7CP components.

Table 5: 7CP Budget allocation by Year and Component

CP Component	2019	2020	2021	2022 (By June)	Total	% Share
SRH	861,533.0	1,082,749.8	1,112,107.1	795,771.1	3,852,161.0	64
Youth	138,022.6	200,923.0	171,836.1	255,995.4	766,777.0	13
Gender	266,758.3	424,669.0	188,378.9	131,925.8	1,011,732.0	17
P&D	195,667.5	29,364.4	17,432.8	45,404.8	287,869.4	5
OEE	13,242.6	-	28.9	108,749.1	122,020.6	2
Grand Total	**1,475,224.0**	**1,737,706.1**	**1,489,783.8**	**1,337,846.1**	**6,040,560.0**	**100**

[63] LESOTHO CPD (2).pdf

Figure 3: CP Budget Allocation by Funding Source and Component



7CP Sources of funds: From the UNFPA CO financial data, the 7CP had almost equal sources of resources with the total resources mobilized from the regular sources and other sources are US$ 2,796230 (51%) and US$ 2,663,991.4 (49%). The distribution of the source across the programme components is as in Table 4 below.

Overall, the 7CP budget burn rate is 78.9%, with the highest being recorded in 2019 where the CO utilized 93.2 % of the budget allocated, while the lowest being in 2021. It is not clear what factors contributed to this given that in 2020, even with the COVID-19 effects, the CO still utilized more than three-quarters of the budget allocated for the year. Despite 78.9 being above three-quarters even at quarter 2, the CO may need to hasten the disbursement given the funding constraints by the CO (Interviews and document reviews).

Year	Budget	Expenditure	Burn rate
2019	1,475,224.0	1,375,305.1	93.2%
2020	1,737,706.1	1,399,934.2	80.6%
2021	1,489,783.8	971,467.9	65.2%
2022 (By June)	1,337,846.1	1,018,085.7	76.1%
Total	**6,040,560.0**	**4,764,792.9**	**78.9%**

4. 1 Introduction

This chapter presents the findings of the 7th Country Programme evaluation under each of the evaluation criteria, and providing answers to each of the ten evaluation questions. The findings are presented in compliance with the UNFPA Evaluation Handbook on how to conduct Evaluation. The analysis and presentations of the findings have been guided by the evaluation matrix in Annex 2 of the report, triangulating multiple data sources as elaborated in the methodology design. In addition, the constructed theory of change of the CP guided the analysis of the achievements across the programme thematic areas, especially under the criteria of Effectiveness. The presentation in the chapter follows the OECD-DAC criteria and the additional UNFPA strategic criteria of coordination, and the humanitarian-setting related criteria of Connectedness and Coverage.

4.2 Answer to Evaluation Questions on 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. young people and women, Key populations; (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? 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, or to shifts caused by crisis or major political changes?

Summary: The Lesotho UNFPA 7CP was adapted to the needs of the target populations, including addressing the needs of the vulnerable and marginalized populations, including strategically targeting the key populations. Further, the CP was aligned to the national and international development needs. The design of the CP incorporated the needs of the various populations, including evidence of consultation of government, IPs and the marginalized and vulnerable groups, enabling focus on their felt needs. UNFPA Lesotho also contributed to the government priorities in SRHR, A&Y, GEWE and data needs through supporting the work of the line ministries and agencies, ensuring direct contribution into their strategic direction and targets. Re was further evidence that design and implementation of the CP was fully aligned to the UNFPA global Strategic Plan 2018 – 2021, and UNDAF, in addition to contributing to the achievement of the ICPD Programme of Action, NEW Way of Working and the SDGs, especially goals 3, 5, 10 and 17. UNFPA CO was responsive to the changes in the national needs and priorities. The CPE revealed that UNFPA was instrumental in influencing the disaster management mechanisms contributing to the targeting of vulnerable populations during disasters, particularly ensuring identification of the vulnerable populations including women and girls. Further, UNFPA effectively adapted its programme implementation to COVID-19 supporting IPs and the line ministries on the same while at the same time ensuring continuity of SRHR services. The 7CP was however limited in resource allocation to the various components, in addition to inadequate government capacities and these limited the extent of targeting and achievements.

4.2.1 Alignment of the CP to the National Strategies and Policies

4.2.1.1 Sexual and Reproductive Health and Rights

Review of the CPD and interviews with the stakeholders confirm that UNFPA conducted consultative sessions in the decision to implement the SRH interventions, confirming its relevance. UNFPA also immensely contributed to addressing the felt needs identified through assessments and research. Lesotho still has high maternal mortality ratio of 1,024 deaths per 100,000 live births due to limited access to and inadequate quality of integrated sexual and reproductive health services and information. Inequalities in service access is also pronounced in the country. Further the skilled birth attendance is also a concern in the country, with nearly a-third of the rural women still delivering at home, with an overall 77 percent delivering in the hospitals. The healthcare providers, in addition to the health sectors have inadequate competencies and capacities to enable provision of specialised health services, particularly in managing obstetric complications as per standard protocols. Further, pre-and in-service training on safe delivery is inadequate (Interviews and review of documents).

Responding to the existing SRH gaps in the country, UNFPA used a number of strategies to strengthen SRH programme. To address the high maternal mortality ratio, UNFPA contributed to evidence-based response by supporting the MoH in documenting maternal death reports, profiling death cases and enabling identification of the causes of death to inform continued capacity development on competency for healthcare workers. UNFPA, together with other partners spearheaded the development of the Reproductive, Maternal, Child and Adolescent Health and Nutrition (RMCAHN) strategy, enabling refocusing of the maternal health, adolescent health and guiding implementation of interventions. In addition, UNFPA supported the development of EHS package for services, including those for the

adolescent and youth (Review of documents and interviews)

To respond to the inadequacy in competencies in the various aspects of RH, UNFPA capitalised on enhancing the capacities of the government and stakeholders in ensuring that they had the technical skills to deliver in RH. As MoH continued to institutionalize delivery of Emergency Obstetric and Neonatal Care (EmONC), UNFPA supported by building capacity of healthcare workers and strengthened health facilities to deliver EmNOC. This was achieved through conducting supportive mentorship and skills sharpening practical activities.

To strengthen the midwifery skills and ensure relevant skills are churned out of the training institutions, UNFPA supported the six country's nursing schools to review the nursing and midwifery training curriculum to ensure its alignment to the international. The reviewed curriculum was based on an assessment which revealed significant gaps in the curriculum which impeded positive outcomes of the Maternal Health. Although the review is not yet completed, the colleges are already utilizing the curriculum, and the upgrading of the curriculum content and skills is believed it to eventually produce competent healthcare workers for delivery and providing quality of care. With the regulation of midwifery services lacking in the country, UNFPA supported the regulation and association on midwifery building their capacity to monitor the midwifery service delivery.

To address the unmet need for family planning, UNFPA contributed to strengthening the Reproductive Health Commodities Security (RHCS). The support included procurement of around 90% of contraceptives issued in the country, strengthening of the Supply Chain for commodities; ensuring effective and timely facilitation of forecasting and quantification of commodities. In addition, the MoH was supported to develop guidelines on use of long-term methods and promotion of postpartum FP. UNFPA supported the MoH to conduct SDP, an exercise that generates data to determine availability or stock outs of modern methods of contraceptives. To scale up access to Family Planning, a self-injectable method (Depo Provera) was introduced which addressed different barriers in accessing contraceptives such as distance or fear of visiting the health facility among others. In addition, capacity building for community-based distributors was provided on FP, enabling the marginalized and vulnerable communities to access the services at their convenience (Interviews). UNFPA also supported the government on evidence generation to facilitate decision-making. there was however case of stock-outs in 2021 with 50% of the facilities lacking the long methods of FP. To address access issues within church owned health facilities not offering FP catchment areas, UNFPA supported the MoH with an outreach programme to provide a package of integrated services to the communities. To strengthen service delivery and quality of care, UNFPA chaired the SRH, Supply chain and RHCS technical working groups enabling coordination and technical support (Interviews and review of CP reports).

Inadequacy of resources, capacity of the government and IPs, frequent staff transfers, social norms and church-related doctrines affected effectiveness in the uptake of the RH services.

4.2.1.2 Adolescent and Youth

The development of the 7CP identified the key areas of gaps to strengthen during the implementation period. The 7CP contributed to strengthening access to Adolescent Sexual and Reproductive Health in line with the NDSP II key priority area II and Cross-cutting issues which seeks to increase access, coverage and effectiveness of quality health care service delivery for all, particularly through enhanced integrated programmes addressing the SRH needs of the adolescent and young people. The mid-term review for the National HIV and AIDS Strategic Plan highlighted the adolescent and young women as high risk groups and the need to have them in the key prevention pillars, in addition to ensuring that the key population issues were included in the related policies being developed. Further, the review identified the need to ensure integration of service delivery and care to facilitate ease of access to the beneficiaries. The 7CP contributed to addressing the causes of new HIV infections among the adolescents, youth and key populations through supporting assessment identifying the driving factors for incorporation into the policies and strategies, . (Interviews with CO and Document revises).

The 7CP also contributed to ensuring that the youth had an enabling environment where they could express themselves and make sexual and reproductive health choices through supporting development of policies and change in the strategies to reflect the needs of the young people. On the other hand, UNFPA contributed to supporting elimination of discriminate, and sometime stigmatizing and limiting access to the SRHR services through supporting prevention and treatment services to the adolescent and young people,

"The culture, in one way of the other, is discriminative. The adolescents and youth cannot conveniently ask for contraception, or condom as it will be considered a misbehaviour by the healthcare workers who are part of the society discriminating the young people" – **Respondent during CPE data collection**

in addition to training health staff on provision of adolescent and youth friendly services.

According to the LHDS 2014, the level of early or child marriage was high at 24%, with the rate for those in school being at 13%. UNFPA utilized rights approaches in aimed at eliminating early and child marriages through both downstream and upstream advocacy strategies. Recognizing the gaps and conflicts in the existing laws[64], particularly those recognizing the marriage age, UNFPA technically and financially supported the review of the Child Protection and Welfare Act 2011 to harmonize the laws on children ensuring that the rights of the children are protected and sensitized to make decisions when they are above 18 years (Interviews with the CO and document review). Further, UNFPA supported the review of laws that discriminated the adolescent and young people, hindering them from accessing school because they are pregnant (Interviews with MoGYSR and CO staff).

The development framework within Lesotho does not explicitly identify the needs of the youth with clear mechanism on how to address them. The 7CP enhanced and participated in mechanisms enabling the youth to participate equally without discrimination. Further the current National Youth Policy and its Implementation Plan 2017-2030, outlines the structure of engagement of the youth and adolescents but lacked a National Youth body that ensures coordinated, full and meaningful participation on young people on issues that affect them. UNFPA however, has supported individual adolescents and young people to participate in national and international forums which deliberated on different issues, including SRHR and climate change, CSE and peace building, among others. In addition, UNFPA built capacity of youth-led organisations managers on different aspects that enhance human rights. To address the absence of the National Youth Council, the MGYSR was supported to map youth-led organisations which should form the NYC which will ensure systematic targeting of the youth through their meaningful participation (Interviews and document reviews).

Improving the country's productivity and innovation capacity by strengthening human capital through investments in health, education and training. UNFPA provided both technical and financial support to the government of Lesotho and the IPs to bridge the existing gaps, in addition to 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' stakeholders 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 UNFPA youth IPs, Help Lesotho, MoGYSR and LPPA about their priorities, confirming the relevance of the in addressing the needs and priorities of the country (Document review and Interviews with IPs, CO and UN agency staff).

4.2.1.3 HIV Prevention

HIV continues to be one of the leading causes of morbidity and mortality among children, men, and women, with high prevalence at 22.6 per cent and it is further worsened by the high coinfection of HIV with TB at 73 percent. To enhance access, UNFPA supported integration of SRH/FP/GBV and HIV services to intensify access to HIV testing services. Healthcare providers have been trained to offer integrated SRHR services and skills and to be Key Population and Adolescent and youth Friendly to reduce stigma and discrimination as thus positively affected uptake of services. Although this is noted as a milestone, there is still room for improvement to ensure leaving no one behind. Further, HIV prevention is elevated as the regional priority Area for the East and Southern African Region, with UNFPA increasing targeting of the marginalized communities, inclusivity in the provision of services, and supporting to the government of Lesotho in prevention of HIV, ensuring alignment with the international standards (Interviews and document reviews).

With the prevalence of HIV being high in the country, UNFPA supported the review and updating of the EHS package which had not been done since 1976 to include HIV and advocated for programmes to be included in all the health facilities in the country, and

[64] While the Marriage Act, Sec 25 recognizes the legal age of marriage for both women and men is 21, there are certain exceptions where males at the age of 18 and females at the age of 16 may enter into marriage with the written consent of the Minister responsible if such marriage is considered desirable, as per the Marriage Act, Sec. 25, 27, with the consent of both parents of minors being required (www.genderindex.org).

this was useful in identifying the areas and people left behind, and facilitated the MoH to determine the budget that it required (Interviews with CO and MoH staff).

During the period, UNFPA also contributed to strengthening the HIV programming policy framework through supporting both NAC and MoH in development of strategies and guidelines to respond to existing challenges in the response framework. Building from the results of the UNFPA-supported condom analytic study, UNFPA supported the government of Lesotho to develop a condom strategy which included aspects of lubricants, in addition to rebranding the condoms to Plug 'N Play in response to ensuring that the condoms appeal to the target populations, including the young people and the most at risk populations, including female sex workers and the men having sex with men. Further, the condom strategy also included the lubricants, which were initially missing, with the government including them for purchases together with condoms (Interviews with MoH, NAC, LPPA and CO staff and SIS review). Identifying the stigma related to access to services by the young people and the at-risk populations, UNFPA supported the establishment of safe spaces for the female sex workers to access SRH services, including contraceptives, in addition to targeting the long-distance truck drivers with HIV prevention services Along the borders. This was done through the guidance of the National Comprehensive HIV Package for Key Populations which UNFPA supported the MOH to develop as it provides normative guidance with regards to differentiated service provision for the Key populations. UNFPA also supported the government in the development of a costed HIV Policy and strategies mainstreaming gender, youth and girls, Key Populations' interventions in the policies, which was previously lacking. Further, the CO also supported NAC in the mid-term review of the National HIV Strategic Plan highlighting the adolescent and young women as high risk groups as among the five key prevention pillars as espoused in the National Prevention 2020 which was too customised and adapted to the country's context through financial and technical support to NAC by UNFPA..

4.2.1.4 Gender Equality and Women Empowerment

The 7CP was responsive to national priorities and needs, as contained in the NSDP II Key Priority Areas (i.e., KPA IV on Strengthening National Governance and Accountability Systems), the expected outcomes include enhancing the protection and fulfilment of human rights through the adoption and domestication of the UN Convention on the Elimination of All Forms of Discrimination Against Women, the African Union Protocol on the Rights of Women, and the SADC Protocol on Gender and Development. One of the cross-cutting issues of NSDP II includes mainstreaming gender into national development programmes and projects because women, especially those in rural areas, are vulnerable to gender-based violence (GBV) and have an unequal voice in decision-making on family matters, including reproductive health, especially in rural areas. The planned activities and the implemented projects under the GEWE component of the 7CP were fully coherent with the expected outcomes of the strategic objectives of NDSP II. Example interventions under the gender equality and GBV component include advocating for male involvement in gender and reproductive health programmes, improving the capacity of law enforcement agencies (i.e., the Lesotho Mounted Police Service (LMPS) to deal effectively with GBV, and developing strategies to eliminate early, forced, and child marriages. For instance, to involve men in issues related to gender equality and to deconstruct masculinity, UNFPA, through the 7CP, piloted husband schools in the two districts of Mokhotlong and Quthing.

Interviews with IPs and government line ministries and agencies and document reviews revealed that the design of the 7CP and the implementation of interventions under the GEWE component were aligned and coherent with the priorities of the Lesotho Gender and Development Policy (2018 – 2030). The Policy identifies, among others, the absence of specific legislation on *Domestic Violence*, sub-optimal male involvement in the promotion of gender equity and equality, and gendered impacts of climate change as some of the emerging gender concerns in Lesotho. Interactions with staff from various government ministries, CSOs, and IPs revealed that the planned outputs of the CP were a result of a consultative process to ensure its alignment with the Lesotho Gender and Development Policy. Similarly, the implemented interventions were based on identified priorities of the Government of Lesotho. For instance, the drafting of the Domestic Violence bill was done through a series of stakeholder consultations led by the Ministry of Gender, Youth, Sports, and Recreation

(MoGYSR) with financial and technical support from UNFPA.

Moreover, the gender and GBV component was implemented in collaboration with line ministries, departments, and agencies (MDAs), which makes the component relevant to the government priorities. For example, UNFPA supported the Ministry of Education and Training (MoET) to develop of the policy on the *Prevention and Management of Learner Pregnancy*, which sought to reduce and manage the incidence of learner pregnancy and its adverse impact on the affected learners and, more broadly, on the basic education system in the country. Additionally, the Bureau of Statistics (BoS), DMA, and LMPS, through the support of UNFPA, are each working on improving the collection of data related to GBV gender-based violence in the country.

The extent to which UNFPA works with MoGYSR, a government ministry dedicated to addressing issues of gender inequality and empowerment of women and girls, is however unpredictable. Interviews with the IPs, ministry and UN staff indicated that the ministry is underfunded and needs resources to effectively coordinate and operationalize policies or to build its capacity to prevent and respond to GBV, thus UNFPA's support can be instrumental in this regard. But UNFPA's support is often constrained by political instability on the side of the government and UNFPA's narrow interest in GBV issues in some years. Coordination with the ministry of downstream activities, particularly with the IPs was also limited and hindered the ministry's role of consolidation of efforts and providing oversight for compliance.

The 6CP evaluation recommended that UNFPA CO should geographically concentrate its programme to maximise the impact. This recommendation was implemented through the selection of 2 target districts (Mokhotlong and Quthing) based on indicators relevant to the UNFPA mandate. These two districts had the highest rates of GBV, teen pregnancy, early marriage and school drop-out rate. Interactions with CO staff revealed it was not always possible to concentrate on only the two districts due to the need to respond and align some interventions with national priorities. It was also not clear how geographic sites (and beneficiaries) within each district were chosen and find out the level of involvement of beneficiaries in the programming process.

Evidence from document reviews and FGDs with some beneficiaries revealed that UNFPA, through the GEWE component, responded to the needs of diverse populations, especially women, adolescents, men and key populations. For instance, in the two targeted districts of Mokhotlong and Quthing, the programme (financially) supported the involvement of men (through husband schools) and community leaders to take the lead in challenging child marriage, teenage pregnancy and in promoting the use of SRHR services among women and girls, while reducing violence against women and children. Interaction with some of the men who participated in such reveals that the CP did not only raise awareness on gender inequality and women's empowerment and elimination of harmful practices, it also promoted the inclusion of CSOs, community leaders (such as chiefs, community council secretaries, priests, etc), and parents/guardians.

4.2.1.5 Population and Development

While the 7CP did not explicitly have an output on data generation capacity and policy development strengthening, the CO supported the country in highlighting the increased focus on data generation to inform policy development through supporting the BoS and Ministry of Development Planning to map the policies and ensuring commitment towards that. As part of ensuring alignment to the commitment with the Addis Ababa to harness demographic Dividend (DD) by Lesotho, UNFPA supported the country in conducting and validating the results of the DD. This will contribute in enhancing the aspects of DD for longer, particularly, FP and Youth empowerment and ensure amplification of advocacy on issues of youth empowerment, FP and SRH. In the course of conducting the DD, UNFPA contributed to strengthening the capacity of the country in using the National Transfer Account methodology that the consultant hired by UNFPA used to conduct the activity (Interviews with BoS, MoDP and CO staff and document review).

In response to the recommendation from the 6CP support and identifying the gaps in the current data for decision-making, the CO enhanced the capacity of the country in conducting population projection which interviews with BoS and MoPD confirmed enables decision-making, including informing development plans and strategies.

4.2.2 Strategic Relevance

4.2.2.1 Alignment of the CP to UNFPA Strategic Plan and UNDAF in Lesotho

While there is a new UNFPA Strategic Plan (2022 – 2025), at the time of the CPE, the CO had not aligned the 7CP to the new Strategic Plan (SP), but was operating under the old SP. The CPE therefore assessed the 7CP based on the alignment with the SP 2018 – 2021. The 7CP was developed in consultation with the Government, civil society organization, bilateral and multilateral development partners, including United Nations organizations. The CO designed and implemented the 7CP in line with the UNFPA SP (2018 – 2021) directly contributing to its goal of achieving universal access to SRH and reproductive rights, focusing on women, adolescents and youth, mainstreaming population dynamics, human rights, and gender equality through supporting interventions under each of the three outcome areas of SRH, GEWE and Adolescent and Youth. Interviews and document reviews confirmed that the 7CP's directly contributed to responding to the needs of the vulnerable and marginalized populations, including girls and women in the hard to reach locations. The 7CP's commitment to the realization of the SP's, and in line with its theory of change, 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 unintended pregnancies (Interviews and document reviews).

Further, the design and delivery of the 7CP were based on the principle of Leaving No One Behind and reaching the farthest first, human rights-based approaches and ensured gender responsiveness. The alignment of the 7CP to the SP (2018-2021) is also confirmed by the use of the Strategic Information System (SIS), in line with the CP outputs. The implementation of 7CP is also based on the SP's business model, utilising all the five modes of engagement (partnership and coordination, knowledge management, advocacy and policy dialogue, capacity development and service delivery. The extent to which the results and coverage were made were reportedly constrained by staff and CO financial capacity limiting the extent of coverage of the needs during the period (interviews and document interviews).

The design of the 7CP was aligned with the strategic priorities of the United Nations, as described in the United National Development Assistance Framework (UNDAF) 2019 – 2023, where UNFPA contributed to all the three pillars of delivery, namely; Pillar 1: Accountable Governance, Effective Institutions, Social Cohesion and Inclusion; Pillar 2: Sustainable Human Capital Development; and Pillar 3: Sustainable and Inclusive Economic Growth for Poverty Reduction. In addition, the 7CP contributed to the attainment of the outcome areas, where UNFPA led the reporting on Outcome 4 of the UNDAF (Interviews and document reviews).

4.2.2.2 Alignment of the CP to Priorities in the International Frameworks

ICPD: The results of CP documents and interviews with the CP stakeholders show that the UNFPA Lesotho programme was implemented in line with the achievement of the ICPD agenda and the objectives of the ICPD Programme of Action (ICPD PoA) in the country. During the period, UNFPA facilitated access to integrated 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 teenage pregnancies and early marriage. Interviews and documents reviewed also revealed that the 7CP prioritises marginalised and vulnerable populations with services, in addition to targeting locations with service gaps. For example, the CO emphasized targeting of key populations, especially the LGBTIQ+ community members and Sex Workers with services, including supplying them with condoms and lubricants, effectively addressing their RH needs, in addition to protecting them from sexually transmitted infections, including HIV. UNFPA also ensured the CP interventions were delivered, upholding the rights of the people being served, with them being allowed to make decisions based on their situations and experiences, ensuring people-centred mechanisms. further, the CO ensured that the interventions were designed and delivered in a socio-culturally sensitive manner, promoting effectiveness and sustainability.

SDG: Fundamentally, the CP contributed to SDG Goal 3: Good Health and Well-being, SDG Goal 4: Quality Education, SDG Goal 5: Gender Equality, SDG Goal 10: Reduced Inequalities and SDG Goal 17: Partnerships for the Goals.

New Way of Working and the Grand Bargain: Documents reviewed and interviews conducted with

various stakeholders, including CO staff confirmed the alignment of the 7CP 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 enhanced partnerships with local CSOs as IPs and strengthened their capacities to deliver services in the CP focus areas, in addition to strengthening their capacities in operation issues.

4.2.3 Responsiveness of the CO to Changes in the National Needs and Priorities, and changes in the implementation context

Interviews and documentation reviewed confirmed that UNFPA was responsive to the arising national priorities and needs through being part of disaster risk management team (DRMT) participating in rapid and vulnerability assessments, where it was instrumental in highlighting the capturing of varied needs and vulnerabilities of women and girls during disasters and contributing to training and supporting of the lead agency, Disaster Management Authority (DMA), on mainstreaming of gender and GBV in humanitarian response and targeting the affected populations with services. This entailed supporting the Disaster Management Authority to upgrade its data collection tools to incorporate family planning, STI, HIV, uncomplicated pregnancies, EmONC, cervical cancer, violence against women. On supporting the affected populations with services, UNFPA supported distribution of dignity kits to vulnerable women and girls. For example, during the 2019 drought, using the Central Emergency Response Fund (CERF), UNFPA supported DMA with dignity kits that they distributed to the identified vulnerable and crisis-affected households in Butha-Bothe, Leribe, Mafeteng, Mokhotlong and Quthing districts (Interviews with CO and DMA staff). UNFPA also supported the training of various national and district stakeholders on minimum initial service package (MISP). During the heavy rains in 2021/2022, UNFPA also participated in the UN disaster risk management (DRM) to conduct assessments to determine the needs, particularly the needs of the vulnerable and marginalized populations affected.

During the period of coverage saw the advent of COVID-19 pandemic which led to far-reaching effects in the normal operations within the country, in addition to leading to changes in priorities. During this period, the CO contributed to service delivery, especially in enhancing access to SRHR and GBV services including information on the same. UNFPA responsively responded by successfully repurposing the 7CP focus from development to be able to respond to emergency necessitated by the advent of COVID-19. Towards ensuring continuity of services during the period, UNFPA supported the MoH in the development of guiding document for continuation of essential SRH services and use by the health facilities for pregnant women and FP. For example, UNFPA facilitated strengthening of self-care mechanisms like FP and HIV self-testing. Further, the CO also adapted the CP interventions to the COVID-19 context, and reprogramming mechanisms to ensure community-level COVID-19 infection prevention and control (IPC) mechanisms. Additionally, UNFPA mobilized USD 500,000 from the Chinese Government for purchase of oxygen concentrators and PPE procurement and distribution, including dignity kits. UNFPA also supported the multi-months' dispensation of less skills FP methods and promoting telemedicine for counselling and assurance purposes during the period (Interviews with CO, MoH and IP staff and Document reviews). These interventions ensured continuity of services and access to services by the affected populations. All these show the programme's responsiveness to emerging national priorities and needs. The CO also supported the National Drug Supplies Organization (NDSO) to ensure continuity of supplies of medicine and other related commodities. Under the GEWE component, due to the rising cases of GBV during COVID-19 lockdown period, UNFPA supported the Lesotho Mounted Police Service (LMPS) and community structures to identify and capture the cases through supporting an assessment, which highlighted the need to establish a response unit within the police stations (Interviews and SIS report reviews). UNFPA also responded to the arising needs through training of community-based distributors of FP because of the Polihali construction site in Mapholening, in addition to enhancing advocacy targeting the risks young people, including vulnerable girls and women, were exposed to and promoting FP commodities for use by the young people. Interviews however indicated that UNFPA was constrained resource-wise and could not adequately meet some demands during the period. While it is clear UNFPA adapted the programme to the implementation context of COVID-19, there was no revision in the results and resources framework. While it is clear that the adaptation was to ensure that the 7CP plans were implemented within the constraints of

COVID-19, there were a lot of activities that UNFPA supported on COVID-19, that would have been areas of capturing for achievement during the period, but this did not happen.

4.3 Answer to Evaluation Questions on Effectiveness

EQ2: 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 and promoting reduction in gender-based violence and harmful practices; (iv) increased use of population data in the development of evidence-based national development plans, policies and programmes?

Summary: The 7CP, implemented in partnership with both government line ministries, NGOs, UN agencies and communities, immensely contributed to the achievement of key results in the components of implementation. The CO contributed to enhancing the capacity of the government line ministries in development and delivery of integrated gender-responsive SRHR services in the country, prioritising the marginalized women and girls and the hard-to-reach populations through strategically positioning itself to support upstream and downstream interventions. UNFPA technically and financially contributed to capacity strengthening of the MoH and IPs, in addition to development of strategies, plans and policies; advocacy on demand creation and supplies of RH commodities; and service delivery. Further, the CP was instrumental in addressing the country's unmet needs for family planning through enhancing demand creation, strengthening commodities supply chain, capacity enhancement and supporting procurement of RH commodities for use in the country, in addition to promoting evidence-based programming on FP. Government commitment in the investment of FP commodities and monitoring and supervision was however low. The CO also contributed to strengthening of integration of SRH/FP/GBV/HIV through capacity building of the service providers in health facilities, development of guidelines and production of information materials. Inadequate HIV integration, male engagement and targeting was also low.

The A&Y component immensely contributed to the institutionalizing in-school CSE termed LBSE in Lesotho as a core compulsory and examinable subject through a robust capacity building of MoET officials: officers, inspectorate, District Education manager, principals, teachers, schools boards and parents, development of tools; standardized training manuals for capacity, monitoring, supportive supervision and reporting to ensure quality implementation of the curriculum. In addition, the 7CP contributed to addressing EUP through supporting countrywide advocacy and consultations on EUP, in addition to strengthening the policy and legal framework to enhance protection of vulnerable girls. Inadequacy of trained teachers or majoring in CSE, and the societal barriers affect implementation.

The **GEWE component** contributed to strengthening policy, legal and institutional frameworks, enhancing gender equality and women's empowerment, in addition to strengthening of a multi-sectoral prevention, management and response system to Gender Based Violence including SGBV. In addition, the CO contributed to harmonisation of GBV interventions and advocacy at all levels through strengthening capacity of entities working on GEWE and coordination mechanisms. The CO also Male and community level engagement, including religious, traditional and community level leaders, was found to be sub-optimal with the scale of targeting being low with results being scattered. The referral mechanisms were however identified to be weak with ineffective coordination among stakeholders. The CO also contributed to strengthening the country's statistics systems through supporting different ministries, including that of Police, working together with the BoS to develop tools to help in capturing data that support in the information of decisions-making. There are still data needs that could be an opportunity to support generation of large-population-based based surveys to inform programming in addition to enhanced advocacy for utilization of population data for decision-making.

4.3.1 Sexual and Reproductive Health and Rights

Introduction

The SRH component of the UNFPA Lesotho's 7CP had two output areas, namely; improved government institutional capacities to develop and implement gender-responsive policies, plans and programmes that prioritize the demographic dividend and access to integrated sexual and reproductive health and rights information and services by women, adolescents and youth, including the furthest left behind; and women, adolescents and young people have improved access to gender-responsive, high-quality, integrated sexual and reproductive health services, including in humanitarian settings. Strategically, the results of output one of the 7CP were to be achieved through undertaking the following key interventions:

implementation and monitoring of the RMCAHN Strategy as part of the roll out of integrated SRH services; strengthening of the Health Management Information System (HMIS) and other national monitoring and evaluation (M&E) systems by integrating age and gender disaggregated indicators; updating of the condom strategy with a focus on improving access for young people; finalization and implementation of the revised family planning guidelines; rolling out of the Logistics Management Information System (LMIS) and capacity development to forecast and monitor essential supplies as well as to generate real-time data and traceability of commodities; advocacy for laws, policies and appropriate budget allocations for integrated SRH and rights, HIV prevention and sexual gender-based violence, particularly targeting key populations and disadvantaged youth; provision of adolescent and youth HIV/AIDS prevention services in formal and informal settings; reinforcement of development frameworks to position the demographic dividend as the basis for accelerated economic growth and sustainable development; and strengthening of response mechanisms for disaster management through the integration of gender-based violence services and the minimum initial service package into the national emergency plan. On the other hand, outcome two was to be achieved through development of the national minimum package for integrated SRH and GBV services, including post-abortion care, and improve the capacity of health care workers to deliver these services to women, youth and marginalized groups, including young persons with disabilities and key populations; support integrated SRH outreach services for key populations, adolescents and young people; provide technical assistance to midwife training institutions to ensure compliance with international standards; strengthen the pre-service training of nurses on adolescent-friendly health services; support training of health care providers to deliver a comprehensive, modern contraceptive method mix and collect reliable data for the LMIS, including last mile tracking, forecasting, quantification and monitoring of SRH commodities; implement the minimum initial services package (MISP) and strengthen community awareness of available services; strengthen delivery of in-school and roll out of out-of-school CSE programmes; and engage in South-South cooperation to inform the establishment of 'husband schools' to address cultural and social barriers that impede access to SRH and rights[65].

The performance of the programme was to be assessed through capturing data on four outcome and nine output indicators[66]. These are presented in Table 2 below indicating performance data on the indicators. Key to note that data on the outcome indicators had not been collected by the CO at the time of the CPE. The CPE therefore consolidated the performance of the CP at output level.

Achieved versus planned component results

There were mixed results from the CO's performance in the 7CP in the output indicators. Review of the 7CP annual SIS revealed that the CO attained four out of the targeted nine indicators, with two of then surpassing the targeted value by 2023. The CO surpassed the targets in the indicators on the gender-responsive policies, strategies and plans that integrate the SRHR of adolescents and youth, including disabled and most marginalized; and the indicator requiring identification of the most marginalized adolescents who successfully completed comprehensive sexuality education and life skills programmes in Mokhotlong and Quthing districts. Further, the other indicator achieved were about the midwifery schools implementing pre-service curricula in line with international standards as supported by UNFPA; and ensuring a functional electronic LMIS (eLMIS), Chanel, for forecasting, quantification, monitoring and tracing of health commodities to the last mile, operational in all ten districts (as stated in the section that follows). On the other hand, the CO did not achieve the rest of the indicators while the performance was satisfactory in most of them. For example, the indicator on health facilities with at least five modern methods of contraceptives was optimal almost throughout the period under CPE except in 2021 when it was achieved in half of the target health facilities. Further, integration of gender, ensuring gender-responsive SRH/FP and HIV services was an area of great achievement where the 7CP was recognized as a huge contribution to ensuring enhanced access to the integrated services. The results also show that there were some indicators that were not reported on in the SIS reports. These included gender-responsive, integrated SRHR, including SGBV, indicators incorporated in the Health Management Information System, and Percentage of women and men aged 15-24 years with comprehensive knowledge of HIV. It is not however clear the circumstances leading to this omission for the three years of reporting, in addition to no explanation being given in any of the reports.

[65] **DP/FPA/CPD/LSO/7**

[66] Ibid

Overall, looking the performance of the CP during the period of assessment, there were considerable achievements made by the CO, bearing in mind that the programme had dire effects of COVID-19 which affected implementation processes, and this necessitated the likes of UNFPA and its IPs to adapt to implementation context of COVID-19. The immense achievements were due to the technical assistance and flexibility by UNFPA in supporting the delivery of the programme, amid COVID-19. Capacity building, integration of services development of SRHR strategy, identification and delivery of specific services targeting of the key populations, young people and the hard-to-reach populations, enhanced advocacy targeting the marginalized populations including the PWDs and prevention of stigmatization of the adolescent and youth of services through enhanced partnership with the government, UN agencies and CSOs were great achievements during the period (Interviews and document reviews). There however reported delays by the government in approval of processes, inadequate resources by the government and the CO to finance some of the key activities, inadequate commitment by the government agencies on delivering the programme interventions were also cited as contributing to non-achievement of planned results.

Table 6: SRHR Component Performance Data

SRHR Outcome				**Comment**
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 **Outcome Indicators** ● Percentage of adolescents aged 15-19 who are mothers or pregnant with their first child. *Baseline: 19; Target: 14* ● Proportion of births attended by skilled health personnel. *Baseline: 77%; Target: 95%* ● Contraceptive prevalence rate. Baseline: 60; Target: 80 ● Percentage of women with unmet need for family planning. *Baseline: 18: Target: 11*				UNFPA was instrumental in contributing to addressing the outcome aspects through capacity building, advocacy, partnerships and supporting various engagements with key stakeholders to address the identified challenges and needs at the time of the programme design. At the time of the CPE, data on the outcome indicators had not been collected and these will be collected at the end of the CP.
Output Indicators	**Baseline**	**Targets 2023**	**Progress against Targets (2021)**	**Comments**
Output 1: Improved government institutional capacities to develop and implement gender-responsive policies, plans and programmes that prioritize the demographic dividend and access to integrated sexual and reproductive health and rights information and services by women, adolescents and youth, including the furthest left behind				
Number of gender-responsive policies, strategies and plans that integrate the SRHR of adolescents and youth, including disabled and most marginalised.	3	11	14	UNFPA supported the Government of Lesotho in developing gender-responsive policies, strategies and plans integrating SRHR of the A&Y, PWDs and marginalised during the period.
Number of gender-responsive, integrated SRHR, including SGBV, indicators incorporated in the Health Management Information System	0	10		Performance on the indicator is not captured in the SIS 2019 – 2021 reports. However, data such as inclusion of self-injection as types of FP were included in the HMIS.
Percentage of primary health facilities that have at least five modern methods of contraception.	97	100	50%	This indicator had mixed results with the achievement across the years fluctuating as 100%, 98% and 50% for 2019, 2020 and 2021 respectively.
Number of midwifery schools implementing pre-service curricula in line with international standards	0	6	6	

Number of national plans and strategies that mainstream interventions to harness the demographic dividend	0	8	1	As at the time of the CPE the Demographic Dividend had been used to inform the National Population Policy.
Output 2: Women, adolescents and young people have improved access to gender-responsive, high-quality, integrated sexual and reproductive health services, including in humanitarian settings				
Percentage of health facilities providing gender-responsive and adolescent and disability-friendly, integrated sexual and reproductive health and gender-based violence services in UNFPA priority districts.	0	100	69	Target not achieved
A functional electronic logistics management information system for forecasting, quantification, monitoring and tracing of health commodities to the last mile, operational in all ten districts.	0	Yes	Yes	This was piloted in the two UNFPA-priority districts of Mokhotolong and Quthing in 2019. The process of roll-out of system, however, did not take off as the developed system had challenges that threatened sustainability
Number of identified most marginalized adolescents who successfully completed comprehensive sexuality education and life skills programmes in UNFPA priority districts, disaggregated by sex.	*0 for girls and boys*	*Girls: 10,000; Boys: 7,000.*	204,761	This target is surpassed. However, the disaggregation was not done in the reporting as expected by the indicator
Percentage of women and men aged 15-24 years with comprehensive knowledge of HIV.	*38 for women and 31 for men*	Women: 55 Men: 50		Not reported on in the SIS reports. It however required a survey, which had not been done by the time of the CPE

Improved government institutional capacities to develop and implement gender-responsive policies, plans and programmes that prioritize the demographic dividend and access to integrated sexual and reproductive health and rights information and services by women, adolescents and youth, including the furthest left behind

Throughout the period of review, the SRHR stakeholders in the country, spanning the government line ministries and agencies, IPs, UN agencies and beneficiaries identified the immense role played by UNFPA in improving the capacity of the government in development and delivery of integrated gender-responsive SRHR services in the country, prioritising the marginalized women and girls and the hard-to-reach populations. UNFPA strategically positioned itself to support upstream and downstream interventions and ensured this through training, development of strategies, plans and policies; advocacy on demand creation and supplies of RH commodities; and technical and financial support to the government and IPs to deliver services.

At the upstream level, UNFPA contributed to strengthening institutional and policy systems in enhancing SRHR service delivery through development of the SRMNCAHN strategic plan, development of policies promoting access and contributing to the development of response plans enabling increased access to quality of SRH services, including the adolescents and youth and key populations. With the review of the SRMNCAHN to ensure comprehensive services, enabling guidance of the services being delivered, in addition to partner contribution to the country was guided. For example, interviews with the MoH, IPs WHO and CO staff also indicated that the development strategy and costing by WHO enabled partners to mobilize resources and select interventions that were contained in the strategy. Key to note that this strategy was drafted by the MoH but remained a draft for long, and this support was confirmed to contribute to empowering them and they were also guided and could steer the strategic direction of RH services delivered by the ministry. Further, the strategy raised the profile of RH concept in the country in addition to the inclusion of RH for men and the adolescents, areas that were never covered before (Interviews with CO, IPs and MoH staff). UNFPA also contributed to strengthening advocacy on RH services through supporting the MoH in updating of the EHS package, incorporating HIV, which had never been included in the package since 1975 despite HIV being

a strategic area of focus by the ESARO. There were confirmed implementation of the EHS by the MoH by ensuring that all programmes were included at each level of delivery point. With the implementation of this, it enabled reorganization of the health workers structure, including redeployment of staff to provide services in various facilities, ensuring there were no gaps in the delivery of the services, as it defined the services provided and the resources needed to deliver the services in the health facilities. The package also contributed to ensuring that no one was left behind in health service access as it defined the age groups and the services they needed. For example, the EHS package identified the age group from 6 years – the age before adolescent as they were never covered by the previous service packages. In addition, the MoH confirmed that this was adopted a national document to ask for budget allocation as it stated the extent of needs and the costs (Interviews with MoH, IPs and CO staff and document review).

Towards contributing to the reduction **of unmet needs for family planning in Lesotho**, document reviews and interviews with various stakeholders, including the MoH, IPs and UN agencies, revealed that UNFPA was instrumental during the 7CP in enhancing demand creation and strengthening the supply chain for the RH commodities. Particularly, UNFPA supported the MoH through capacity building, development of guidelines and policies streamlining the delivery of the service along human rights approach and introducing the self-injection Depo-Provera targeting individuals, particularly the adolescents and young people, which was very instrumental in enabling access to the FP services during COVID-19, limiting their exposure to the risk of contracting the pandemic. UNFPA also trained Community-based distributors on FP to facilitate distributions of commodities and targeting the hard-to-reach, marginalized and CHAL areas in the country. The policy documents put in place provided a framework and enhanced the quality and standardization of FP services. The period also saw UNFPA supporting the MoH in the introduction of the postpartum FP services in Butha Buther, Leribe, Mokhotolong and Quthing districts where long-term FP methods were promoted and accessed by the women and girls of reproductive ages.

UNFPA contributed to strengthening data management on FP service delivery through supporting the MoH in the review of registers, in addition to training health staff, including data clerks, on the same enhancing evidence on access and informing supply chain management decisions through quantification of commodities supplied. Considerable progress was achieved on the MoH's Last Mile assurance through capacity strengthening to utilize the registers and documentation used in tracking the movement from the NDSO to the health facilities, and monitoring of the FP commodities greatly leading to strengthened reporting on FP services, stock management, and related RH commodities security. This also ensured credibility of the government ensuring RH commodities security, further ensuring compliance through documentation, and eliminating pilferages in distribution. It is however worth noting that during the period, through UNFPA support, all the primary health facilities had at least more than five long-term methods of FP in the first two years of 2019 and 2020 (100% and 98% respectively). UNFPA and MoH needs to review and address the circumstances leading to the changes in 2021 where only 50% of the facilities had the same the services. Last mile assurance also enabled enhanced decision-making processes where joint verification was done with the health centre manager where identified challenges were remedied, real-time. While trainings were done on monitoring tools, there is still need to strengthen reporting, in addition to enhancing integration of the reporting into the HMIS (Interviews and SIS reports). There is room for improvement, particularly on capacity building on the new guidelines which were also yet to be stepped down, at the time of CPE, due to funding issues.

The 7CP immensely facilitated strengthening of the availability of FP commodities through supporting the government in procuring commodities, with interviews indicating that UNFPA contributed 80% of the commodities distributed in the country, with the government contributing the rest. UNFPA, however, contributed to ensuring efficiency in the procurement and distribution process for the commodities where it purchased them on behalf of the government, due to the government's long procurement processes, eliminating stock-outs of the commodities in the health facilities. During the period, UNFPA enhanced its advocacy mechanisms to ensure that the government increased its budget allocation for procurement of FP commodities, with the government willing to enter into a COMPACT agreement to transition gradually to procure the FP (Interviews and document review).

During the period, UNFPA planned to support in strengthening the country's supply chain to facilitated monitoring, quantification and forecasting of commodities to eliminate stock-outs and track utilization of FP commodities. UNFPA contributed to strengthening the capacity of the MoH through capacity building of healthcare workers as mentors on FP, in addition to facilitating regular monitoring of the

National supply plan and stock across all levels, which review of reports and interviews with MoH indicated had contributed to improved availability and accessibility of SRH commodities. Specifically, the engagement of SRHR mentors enhanced support to nurse-midwives on FP and the provision of integrated SRHR services. On the other hand, the review of the FP registers fed into the DHIS2 on the reporting and requesting module used by all health facilities to report and request for RH commodities. UNFPA supported the MoH in the development and piloting of an electronic logistics Management information system (eLMIS), Chanel. While the SIS captured that the indicator related to this had been achieved, the development and piloting of the eLMIS was only in the Quthing and Mokhotolong districts, with the rollout to the rest of the districts across the country not done since it presented challenges during implementation ranging from not being open source requiring licencing, and hosting not being done at the MoH compromising data security. On consultation with and advice from WHO, there was need to move to a more reliable system that could overcome the challenges that Chanel presented, and at the time of the CPE, World Bank was in the process of supporting the country in ensuring the system is developed (Interviews and SIS reviews)

Strengthened access to integrated gender-responsive RH services

The period of review saw the CO strengthening of integration of SRH/FP/GBV/HIV through capacity building of the service providers in health facilities and development of guidelines and production of information materials to strengthen integration of services, ensuring that services were conveniently accessed in one visit provided by one provider. Interviews with the beneficiaries in the supported health facilities indicated the integration of the SRH/FP/GBV /HIV services. Integration of services ensured access to comprehensive services from the facilities. For example, initially, the SRH/FP/GBV /HIV services were clouded by the SRH services, which also had shortfall with little focus on quality of services delivered as FP counselling, examination of client, and method selection based on evidence were lacking in the provision of the FP services (Interviews with CO, MoH and IPs).

With the support of the Swedish Government under the joint Together for SRH programme implemented together with UNICEF, UNAIDS and WHO, UNFPA effectively coordinated the integration mechanisms to ensure that the MoH facilities were able to deliver gender-responsive services and as stated in the guidelines. The amplification workshops for SRH indicators facilitated improvement on the indicators. Particularly, there was enhanced access to postpartum services, screening services for STI, provision of PreP, establishment of ART Corner, including nutrition and men's clinic increasing uptake of services (Interviews and document reviews). For example, in the district of Mokhotlong, family planning services are streamlined at general outpatient department, antiretroviral therapy clinic, men's clinic, female ward, gynaecology ward, and postnatal care clinic. To date 22 100 people were reached with SRHR, HIV, and SGBV information, 7,612 were reached with integrated maternal health services. Specifically, antenatal and postnatal coverage has been increased and improved through healthcare workers' capacity building to enhance service delivery (Interviews with CO, MoH, DHMT, Nurse-Midwives).

> *"Training of the community-based distributors enhanced access to FP services by people in the hard-to-reach areas, particularly, the CHAL areas. Initially, they were expected to travel to the health facilities and the attendance wasn't as reliable as some would even miss sessions…. Integration of SRH/FP/HIV/GBV services has enhanced health-seeking behaviours, as initially, the clients would be sent to different service points and that was tedious, in addition to harmonization of data tools at the health facilities. –* **Healthcare workers in Mokhotolong Distric Hospital**

UNFPA also supported the MoH in the review and production of the reporting tools to reflect integration and this facilitated responsibility among the stakeholders in addition to enhancing coordination. Feedback from the interviews indicate that the integration of services contributed to improvement in the targeting of the adolescents as data on teenage pregnancies became realistic, in addition to quality as the health seeking behaviours improved. Training on elimination of stigmatization of services also improved access to the services by the key populations. There were however challenges with partners still supporting individual activities, and therefore this implied that some of the integrated services were not covered during service delivery, and this therefore need to be reduced to eliminate duplication of efforts (Interviews).

Increased access to comprehensive maternal health services

UNFPA contributed to strengthening the capacity of healthcare workers and facilities to provide care and facilitating outreach facilities through equipment support, advocated for the production and supported the government in reporting on maternal death and supporting the government to deliver quality emergency obstetric neonatal care (EmONC) services, particularly to to underserved communities. Interviews with the MoH and IPs revealed that reporting on maternal deaths enhanced surveillance and contributed to identification of major causes of maternal deaths in addition to provision of solutions to the identified issues. UNFPA also ensured that all the health facilities had trained assessors who report maternal deaths locally and centrally. These enhanced evidence on the causes of maternal deaths informing strategies for prevention through advocacy and capacity building. For example, the reports indicated that despite the mothers completing ANC visits, they still died of bleeding because the heath workers could not identify, assist and manage the case at hand due to capacity issues. UNFPA supported MoH to produce 2011 – 2015 and 2016 – 2020 maternal death reports, with the 2021 yet to be produced at the time of the CPE. UNFPA promoted and utilized innovative methods in enhancing the capacities of the healthcare workers through abandoning conference training to practical training mechanisms. These enhanced the technical capacities of the healthcare workers improving the quality of service, hence quality of care strengthening EmONC. It is also through the evidence generation through assessment of death cases where the technical assessors realized that HIV positive women succumbed more often and were able to establish the relationship of that to particular drugs or combination; in addition to sensitizing for haemoglobin level to be taken consistently during ANC and enhanced monitoring during prolonged labour. This also led to the revision of the monitoring tools which proved effective in prevention of maternal deaths (Interviews and document reviews). Further, in order to improve skilled birth attendance UNFPA strengthened nurse-midwives on EmONC services and the management of pregnancy induced hypertension through training of healthcare workers on identification of cases and their management using calcium gluconate. These ensured the provision of quality midwifery services and enhanced access to skilled birth attendance, especially in hard-to-reach areas and among key and vulnerable populations, and ultimately contributed to a reduction in maternal mortality (Interviews with CO, IPs and MoH staff).

Strengthening to Midwifery Framework in Lesotho

During the period of evaluation, UNFPA contributed to strengthening the midwifery framework for the country. UNFPA made a huge contribution to strengthening midwifery preservice education. Particularly, this was partly informed by gaps established from the Quality of Care Assessment Report (2018) on the high mortality which identified of inadequacy of skills of healthcare workers, particularly the nurse-midwives graduate not equipped with EmONC. In addition, UNFPA's support to the MoH to conduct midwifery gap analysis, informed by the high maternal mortality rates in the country, facilitated identification of gaps in midwifery service delivery. All these efforts led to the engagement of MoH and the Midwifery schools in the country to review the midwifery curriculum, upgrading it to meet the international WHO standards, focusing on competency-based training.

At the time of the CPE, the curriculum was undergoing alignment with the Lesotho Qualification Framework (LQF) and was then to be submitted for accreditation from the Ministry of Higher Education. While the six schools of midwifery in the country have transitioned to competency-based curriculum though pilot-implementation of the new curriculum, interviews and document reviews indicated that there were challenges of resources as the curriculum promoted a lot of practical sessions, and this limited the extent to which the results of this could be realized in the country. Interviews however revealed that UNFPA plans to support the nursing schools to produce training modules from 2023, in addition to the Nursing Council supporting in the development of tools to ensure assessment of this curriculum. The stakeholders should also plan for a strong preceptorship programme targeting service delivery by the nurse-midwives.

Further to the establishment of the gaps in the midwifery training curriculum, the gap analysis also established that there were no regulations of the midwifery profession, and that it is not considered as a specialization in the county. The existing Nursing Council only embeds midwifery in the regulation which is a limitation on the extent of quality service delivery on skilled birth attendance. On service delivery, UNFPA was working with the Midwifery Association building its capacity to monitor the midwifery service delivery. While the work of the midwives is distinct, the MoH's Nursing directorate still believes that the midwifery service delivery can still be managed under the Nursing Council, which interviews revealed was an issue.

During the period of coverage, interviews revealed that UNFPA played a critical role in **contributing to coordination and advocacy mechanisms** among stakeholders in the delivery of SRHR services, in addition to chairing some of them. For example, UNFPA chaired the SRH, Supply Chain and reproductive health commodities security technical working groups, enhancing coordination among stakeholders, in addition to ensuring effective monitoring of implementation processes, in addition to ensuring capacity building of stakeholders and compliance to technical standards. Interviews with the MoH also stated that the contribution of UNFPA in co-chairing the technical working groups was instrumental in provision of services. For example, the Supply Chain technical working group enabled commodities annual quantification process, in addition to forecasting, based on identified needs. UNFPA also facilitated enabling environment through supporting Parliamentary SRH and HIV Committee to facilitate the SRH and HIV agenda in the country, including ensuring availability of laws and legislations on the same. For example, when the CO support the Parliamentary Committee to conduct spot check visits to selected health facilities to investigate the cause of high maternal mortality rates, they found out that there were shortages of staff, particularly those able to conduct deliveries, and they were able to advocate for more resources to the MoH to employ more staff and skills strengthening (Interviews with CO and MoH staff).

Strengthened Policy and Strategy development framework for the benefit of the adolescent and youth

During the period of coverage, UNFPA, through the 7CP, immensely contributed to the enhancement of policy and strategy development. Towards increasing access to health services by the adolescent and young people, UNFPA supported the MoH to develop minimum standards and review of the EHS allowing for the inclusion of adolescent and youth health services facilitating their access to the services. Further, UNFPA trained more than 1,500 healthcare workers to ensure its implementation, in addition to supporting enhanced high-level advocacy raising the importance and the need to allow the adolescent and youth to access the services without discrimination, with parents also being engaged on policies on child protection. Interviews with IPs, CO and teachers, indicated that UNFPA was effective in linking service providers to the agencies creating demand for the access to services by the adolescent and youth. The 7CP also supported studies on adolescents and situation analysis on the menstrual health contributing to informing policy decisions on adolescent health services, further contributing to the monitoring of the SADC. All these increased the access of the adolescent and the youth to health services (Interviews with CO and MoH staff).

UNFPA supported the development Prevention and Management of Learner Pregnancy Policy guiding on how to handle girls with pregnancies in school where they are protected and supported not to leave school because of pregnancy. On the other hand, UNFPA together with UNESCO collaborated to develop Retention policy with UNESCO which covers all cases of school dropouts to avoid expulsion and initiations, in addition to preventing them from dropping out of school. These brought out the contribution of the 7CP in the prevention and ending the unintended pregnancies (EUP) through strengthening the advocacy mechanisms and legal frameworks for the protection of the adolescent and young women. On early and child marriage, UNFPA supported the amendment of the Child Protection and Welfare Act 2011, criminalizing marriage of children under the age of 18 years (Interviews with IP, CO, UNESCO and MoGYSR staff and review of documents). UNFPA, in collaboration with WHO also supported MoH to adapt the Accelerated Action for the Health of Adolescents (AH-HA!) in Lesotho, for facilitating the development of adolescent health strategies and plans, providing accountability framework for adolescent health.

While the 7CP supported development and amendment of policies relating to the adolescent and young people's health and rights to education, there were reported improvements and challenges at the same time in the implementation of the policies and laws by the government. For example, the MoET is going to budget for the CSE in the next financial year, with provisions in place. Further, CSE is fully implemented in accordance with the Eastern and Southern Africa (ESA) Ministerial commitment on integration of CSE and SRH service for adolescents and young people. However, the CSE is not implemented in all schools; pregnant school-going girls get varied treatments including humiliation and expulsion from schools, despite the engagement on the yet-to-be disseminated Prevention and Management of Learner Pregnancy Policy. Although there has been a review of the Child Protection and Welfare Act

(CPWA) 2011, it is still at Bill level, leaving a gap in enforcement. There is also no progress in the harmonization of marriage-related laws to address and ensure protection of the interest of the children The A&Y response was also limited by challenges in the political instability with high turn-over of government officers hindering continuity of plans; lack of coordinated advocacy movement among the stakeholders to enhance accountability among the national leadership; and inadequacy of resources (Interviews and document reviews).

Enhanced access to adolescent and youth-friendly health services

During the period of coverage, the 7CP enhanced the adolescent and young people to access friendly health services through development of policies and strategies, capacity building of the healthcare workers, advocacy, implementation of a comprehensive community-wide prevention of early and unintended pregnancy programme and supporting linkage mechanisms for the services. Interviews and SIS report reviews revealed that the UNFPA, together with the youth and health stakeholders supported the MoH in the revision of the RHMNCAH strategy and the EHS to enhance the access of friendly services by the adolescent and youth, in addition to supporting the roll-out of the minimum standards in the delivery of the services.

Further, UNFPA supported training of healthcare workers on Adolescents and Youth Friendly Health Services (AYFHS) and the social accountability score card on minimum standards for delivery of AYFHS. Although an assessment has not been conducted on friendliness of health facilities, supportive supervision and social accountability interface reports indicated that healthcare workers and facilities have improved delivery of services to the adolescent and youth with an established shift on how the healthcare workers viewed access to the adolescent and youth health services. Further, reports and feedback show that the services are not discriminatory and stigmatizing to the adolescent and youth, and improved adolescents and youth's perceptions on access to SRH services from their local health facilities with impressive improvements recorded on the delivery of the services (Interviews with the MoH, MoGYSR, IP and CO staff and document reviews). The CO also supported programmes reaching adolescents and youth with SRHR information which enhanced access to services. Additionally, in a quest to reach the hard-to-reach populations, the CO implemented the herd boys programme, although implemented in a small magnitude of 100 boys per year, had remarkable improvement in the herd boys' health seeking behaviours. Interviews with IPs also indicated that the MoH and other partners service provided improved targeted outreach and static service to adolescent boys and girls targeted by the UNFPA-supported CSE/SBCC/HIV/SRHR interventions with the adolescent and youth.

While UNFPA has strived to enhance access to AYFHS by the adolescents and youth in the country, the attainment of AYFHS in all health facilities across the country is challenging to attain, in addition to persistence of barriers detrimental to access of AFHS including SRHR, particularly, contraception; sociocultural and religious norms; inadequate infrastructure for exclusive adolescent corners; mobility of trained health professions; and donor-oriented outreach programme. Further, interviews with MoH, IPs and CO staff indicated that UNFPA mobilised other partners and advocated for inclusion of FP in the outreach programmes provided by HIV testing services (HTS)-focused partners ensuring integrated services were provided to the adolescent and youth people. UNFPA also supported the review of the Nursing and Midwifery curriculum to include the AYFHS facilitating awareness and enabling skills to provide the services

UNFPA further supported engagement of young people on SRHR to raise awareness and discussions on key SRHR challenges for A&Y. In order to inform the Lesotho ICPD commitment there was a commitment derived from dialogues with youth proposing how to improve their SRHR/HIV/GBV status including for the key populations (Interviews with CO and MoH staff).

Strengthened integration of the CSE into the In- and out-of-school curriculum

The UNFPA Lesotho CO immensely contributed to strengthening the implementation of the CSE curriculum for the In- and Out-of-school adolescent and youth. Building from the gains from the previous CP, where UNFPA supported the MoET in revising the life skills curriculum to make it Life Skills-Based /Sexuality Education (LBSE) ensuring content addresses knowledge, skills and attitudes for sexuality and healthy sexual behaviours, the CO continued to support the CSE institutionalization through building

capacity of the MoET officials, inspectorate, principals and teachers and engagement with parents to support LBSE implementation. In order to provide a standard framework for quality delivery of LBSE in the country, UNFPA in collaboration with UNESCO, supported MoET in the development of the standard teacher training manual, outlining the trainers and training content, with all partners supporting MoET utilizing it. UNFPA also supported the development of LBSE Observation Checklist, enhancing monitoring implementation and providing supportive supervision through assessing the confidence and competency of the teacher on the delivery of the subject and further informing focused capacity building (Interviews with UNESCO, MoET and CO staff and document review).

In the advent of COVID-19, UNFPA supported the MoET in development and implementation of a virtual LBSE monitoring tool which provided data on the scale of teaching and challenges schools had in the delivery of the subject. To ensure in-house capacity for the delivery of the LBSE in schools, UNFPA supported the training of 22 Master trainers (inspectorates) who were confirmed to be facilitating the training and providing supportive supervision to the teachers, which further enhanced the delivery of the programme (Interviews with MoET, UNESCO and CO staff and SIS review).

Interviews with various stakeholders, IPs, MoET and others, confirmed that the collaborative efforts that UNFPA put in place with the stakeholders in health and education, including communities yielded benefits in strengthening capacities for the secondary school teachers for quality delivery of LBSE, in addition to training the head teachers to enhance their support and oversight in the delivery of the subject in schools. Based on pre and post tests administered to A&Y, there is increased knowledge, skills and positive attitudes of the pupils to overcome social risks leading to harmful behaviours further, interviews confirmed that the boys and girls were able to make sound choices on. the in-school training also facilitated the teachers to learn and address the arising challenges with the implementation processes. With all these efforts in place including the support of teacher to access of SRHR, interviews confirmed that incidences of early and unintended pregnancies had reduced among the adolescent girls in school (Interviews with MoET, CO and IPs and reviews of CP documents).

Further, to ensure alignment of the in-school and teacher-training colleges within the country, UNFPA, in collaboration with the MoET and UNESCO supported Lesotho College of Education to review, based on an assessment results, its guidance and counselling course to improve content on CSE, targeting the student-teachers as young people and as future teachers. At the time of the CPE, the CSE Logical Framework and Course Document had been sent to the Senate for approval and then to the Council of Higher Learning, after which it will be offered at both Diploma and Degree levels. It is hoped that this will ensure institutionalization of CSE.

"*With UNFPA's support on the CSE in schools, there is remarkable changes realized during the period. Before this programme, we would have 7 – 10 pregnancies at one particular time in school. Currently, we have only two cases which could not be…. There is improved knowledge of the learners on sexuality. We even inform them on the services and with the collaboration made possible by UNFPA in the linkage to services like FP, HCT and importance of consistent and correct condom use, those who choose to go for them are encouraged to go without discrimination and marginalization. However, the sessions with the students have enlightened them to an extent that most of them choose abstinence…. Even the greater community members have joined us in mentoring and monitoring the girls, with absenteeism reduced since we work closely with the hostel owners who also ensure that the school learners attend school as per schedule*" – **FGD Sessions with Beneficiary Secondary School Teachers in Quthing District**

There was confirmed contribution of UNFPA in the support of the government in the adoption of the CSE package for the out-of-school technically and financially. The support included a Training Manual, Facilitator Guide, Youth Pamphlets, Music Videos and a Tune me mobile platform. The 7CP also supported the development of framework for CSE for young people out-of-school which outlines the minimum package for the subject. UNFPA further supported capacity development of CSOs providing CSE for young people out of school including the sub-recipients to Global Fund on quality delivery of LBSE. In addition, the CO capacity building of the health service practitioners reaching the adolescent and young people on CSE ensuring they understood and delivered AYFHS without marginalizing or prejudicing them (Interviews with teachers, MoET and CO staff). Further, teachers in the schools visited during the CPE confirmed that the sensitization that have been implemented beyond the schools, with the community members, including business communities, taxi drivers who were identified as the

key perpetrators of early and unintended pregnancies among the adolescent, the boarding hostels owners, among others and these were reported to be instrumental in checking on the behaviours of the adolescent and young people.

UNFPA also supported development and review of additional tools for CSE for young people out of school; the development of National Community Dialogue Guide, which is a standard tool to be used by all partners who conduct community dialogues on SRHR/GBV/HIV to address adolescents and young people challenges. The development was followed by capacity building of District AIDS Committee of Mokhotlong. In addition, UNFPA contributed to the review of the Risk, Reduction and Avoidance handbook and Comprehensive Sexuality Education Training Manual to include a unit on adolescents' nutrition.

With the 7CP's efforts to integrate CSE into the education curriculum in the country, there are still challenges existing that may need to be addressed to ensure effectiveness. Interviews with the IPs, beneficiaries and CO staff indicated that the capacities of the teachers still need to be enhanced for them to deliver CSE, delays on the implementation processes were also reported; inadequacy of adolescent and youth friendly services to meet the demand created leading to limited delivery; and challenges on commitment of the MoH on ensuring a strategic focus.

Strengthening prevention of new HIV infections

During the period of coverage by the evaluation, UNFPA contributed to enhancing the integration of SRH, HIV and GBV services for the adolescent, young people and key populations, enhancing their access through various strategies, including development of policies, strategies and conducting advocacy with the same. In alignment with the ESA regional transformative results area on HIV prevention, ensuring that no one is left behind and young people are incorporated in the programme, the CO supported the Government of Lesotho on prevention of new HIV infections through ensuring that GBV is crosscutting, targeting marginalized communities, and inclusivity of the programme through advocacy and policy strengthening. Interviews indicated that through UNFPA's leadership and advocacy, there was ensured mainstreaming of adolescent and youth interventions in the HIV policy. For example, interviews with the IPs and CO staff and document reviews revealed that the current policy has advocacy issues on gender targeting the young populations, which was very limited in the previous policies. UNFPA also supported the government of Lesotho on ensuring alignment of the HIV prevention strategies with the international standards (Interviews with MoH, NAC and CO staff and Beneficiaries and document review).

"The LGBTIQ+ community and the FSWs are today able to access the SRH, HIV and GBV services conveniently without discrimination. The training of the healthcare workers through UNFPA support enabled reduction of stigmatization and marginalization towards us. We even used to shy away from going to the health facilities as they workers would not understand us. Currently, the healthcare workers support us without any problem" – **FGD Sessions with Key Populations in Mafeteng' during CPE.**

UNFPA facilitated **key populations'** access to SRH, HIV and GBV services through technically and financially supporting the development of a strategy for comprehensive package for key populations covering pre-exposure prophylaxis (PrEP) and voluntary male medical circumcision (VMMC), enhancing access to the respective services by female sex workers (FSW), men having sex with men (MSM), transgender people, inmates, injecting drug users and long distance truck drivers and turn boys. In collaboration with LPPA, Matrix, MoH and IoM, UNFPA reached and support the key populations, including the Lesbians, Gay, Bisexual, Transgender, Intersex and Queer people (LGBTIQ+), identifying and supporting them to access services. In the use of human rights approaches, the 7CP ensured that the dignities of the key population beneficiaries were enhanced through enabling them access the services conveniently without discrimination. Interviews with the FSWs, LGBTIQ+ and IPs confirmed that UNFPA, through the 7CP support, was instrumental in enhancing the recognition of the key populations for services, including responding to their needs in service delivery. For example, the FSW had peer educators from among themselves, and were also responsible for condom distribution and supporting then to access health services through referrals, and they confirmed this to be very reliable for their access to the services particularly the establishment of the dropping centres (safe spaces) where they were able to pick the condoms and lubricants, in addition to having interpersonal communications take place. Of note is the recognition of the safe spaces, with The Elizabeth Glaser Pediatric AIDS Foundation (EGPAF)

occasionally facilitating nurses or medical staff to attend to the key population members.

Further, for the first time during the 7CP, through UNFPA support to the MoH, lubricants were procured and distributed to the key populations, in addition to ensuring additional to ensure they continuously accessed them, meeting their demand at any particular time. UNFPA also contributed to mapping of the hotspots to target the key populations with services, particularly at the border points where they provided linkages with health facilities for them to receive the services, with some makeshifts used as facilities to provide services to the key populations at risk of HIV. While UNFPA made efforts to reach and support the LGBTIQ+ community, there were still gaps in data collection tools as they are not disaggregated enough to capture members who are receiving services by type of community member.

UNFPA also utilized capacity building to ensure that the key populations, adolescent and the young people accessed services. The training of healthcare workers, supporting adolescent and youth friendly services, strategy and policy, and advocacy improved the environment for young people to access the services through integration of the SRH/HIV and GBV services meeting their needs. The training of healthcare workers on AYFHS included key aspects on key populations and clinical management of sexual abuse. (Interviews with IPs, MoH and CO staff). Interviews indicated that UNFPA's leadership and advocacy ensured mainstreaming of adolescent and youth interventions in the HIV policy. For example, interviews with the IPs and CO staff and document reviews revealed that the current policy has advocacy issues on gender targeting the young populations, which was very limited in the previous policies.

The 7CP's support of **condom programming**, which entailed strategy development, procurement, promoting and rebranding of condoms contributed immensely to addressing the SRHR needs of the target populations, in addition to contributing to the reduction of the exposure to the risks of contracting sexually transmitted diseases (STIs), including HIV, for adolescents and young people, herd boys more so to the key populations. Based on the results of the Condom analytic study conducted among the youth on acceptability of condoms in the country, suggestions were made to make condoms appealing to the young people and key populations, and UNFPA engaged the young people and key populations to determine the name and the design, leading to the realization of the name, *Plug n Play* brand of condom, which UNFPA supports the MoH to repackage and are scented and ribbed based on the feedback from the study. Document reviews and interviews with the MoH, IPs and CO staff and the key populations indicated that the condoms became more appealing and reliable for consistency in use and reliability in supply with the branding. With the 7CP support on the development of a condom strategy 2019 - 2022, ensured inclusion of the lubricants as part of the package for the usage of condoms by the key populations, with the Government of Lesotho procuring the same for the target groups, including young people, and distributed by the LPPA. The strategy also contributed to enhancing targeting and resource mobilization in the context of HIV programming in the country (Interviews with NAC and CO staff).

The 7CP support on the development of a condom strategy 2019 - 2022, ensured inclusion of the lubricants as part of the package for the usage of condoms by young people and the key populations, with the Government of Lesotho procuring the same for the target groups, including young people, and distributed by the LPPA. LPPA also played a key role in enhancing integration of services where it provided FP, GBV and HIV services at the same time to the youth and key populations. These actions further led to the customisation of the prevention roadmap where HIV preventions focus on targeting of the key populations, which also provided normative guidance on the prevention discourse in Lesotho. Interviews with NAC, MoH and CO staff further revealed that the condom strategy 2019 – 2022 was one of the key documents on which funding from the Global Fund for the country was based in addition to allowing the purchase of lubricants.

During the period of evaluation, UNFPA also supported the National AIDS Commission on coordination with the District AIDS Committees (DACs) enabling them to actively engage on HIV and AIDS activities in the districts, having been dormant previously. In this activity, interviews indicated that UNFPA managed to facilitate the revival of six out of the 10 DACs in the country, where they were assisted to hold community dialogues on prevention of HIV, with community leaders engaged and sensitized to advocate on HIV and AIDS issues in their localities. Further, the DACs were also capacity built to discuss the key issues on prevention of HIV. UNFPA also supported and coordinated with the UN agencies to

implementation of the World AIDS Days, which were also used as advocacy forums on prevention of new infections among the adolescent, youth and key populations (Interviews with CO, MoH, UN agencies and IPs).

In the spirit of leaving no one behind, UNFPA also ensured support to the male engagement through promoting their involvement in the access to SRH services in the health facilities. For example, in Mokhotlong, UNFPA supported the operation of a male clinic which responded to the needs of men, in addition to promoting their support to their spouses in accessing services. Interviews with the healthcare workers indicated that the support of the male clinics enhanced integration of the SRH/FP/HIV/GBV services and support by the male folk (Interviews with MoH, Beneficiaries and CO).

While there were efforts made during the period of coverage to increase integration of SRH, HIV and GBV services targeting the adolescent, youth, there are still gaps that exist to ensure these are effectively integrated. At the moment, there is inadequate coordination of HIV and AIDS functions between MoH and NAC, despite the requirement by SADC to ensure that MoH and NAC strengthen coordination. For example; NAC uses LePSHA to report while MoH uses DHIS2 and this is challenging in alignment of response. There is also a rising level of new infections among the young people, in addition to inadequate evidence-based response; inadequate male engagement on the HIV and AIDS discourse to ensure effective integration of GBV issues, in addition to inadequate capacity by NAC to effectively coordinate HIV and AIDS activities as per its mandate. There is also need to strengthen the health systems, eliminating stigma and discrimination and enhanced quality of care to the target populations.

Enhanced delivery of health services during COVID-19 period

UNFPA played a critical role in ensuring the delivery of essential health services during COVID-19 and supported the MoH in a number of ways, ensuring that the targeted populations were able to access the services. Under the Together for SRHR Programme, in collaboration with WHO, UNICEF and UNAIDS, UNFPA supported the IPC on COVID-19, in addition to supporting the MoH on vaccination through contributing to the procurement of the COVID-19 vaccines. To ensure coverage, UNFPA supported the MoH to strengthen the delivery of self-care interventions, like the HIV self-testing and the FP self-injections, contributing to the reduction of frequencies of visiting the health facilities, which could further expose the clients to the risk of contracting COVID-19. UNFPA as part of the UN health sector agencies collaborated to ensure joint development of essential health service (EHS) guidelines, and ensured that there was continuation of the EHS, in addition to supporting the MoH on supportive supervision and assessments (Interviews and SIS).

4.3.2 Gender Equality and Women's Empowerment

Introduction

The gender component addresses the UNFPA strategic outcome on gender equality and women's empowerment (GEWE) through two outputs, namely, policy, legal and accountability frameworks are strengthened to advance gender equality and empower women and young people, especially adolescent girls, to exercise their reproductive rights and to be protected from violence and harmful practices; and Multisectoral capacity to prevent and address gender-based violence and harmful practices is improved at national and district levels. The results of the first output were to be achieved through supporting the drafting and enactment of the Domestic Violence Act, the Gender Equality Law and the domestication of the Southern African Development Community Model Law on Child Marriage; harmonization of laws, including those on the age of consent and the definition of a 'minor'; dissemination of laws that protect and promote the rights of women and girls; generation of data and analysis of gender-based violence indicators; and costing and implementation of the Gender and Development Policy. The second output on the other hand was to be realized through providing technical assistance for provision of multisectoral services to survivors; integration of gender-based violence within the health response, and in disaster policies, strategies and plans; advocacy for enhanced data-collection and analysis to enable appropriate targeting; strengthening gender-related statistical and research analysis; improving awareness and knowledge of men and boys, including herd boys, and strengthening the capacity of civil society and faith-based organizations, women and youth organizations, local leaders, parents and teachers to eliminate gender-based violence and child marriage; and supporting adaptation and implementation of the

essential services package for gender-based violence mitigation[67].

The performance of the programme was to be assessed through capturing data on two outcome and four output indicators[68]. Table 4 below presents the performance of the 7CP in each of the indicators as at the time of the CPE. the CPE consolidated the findings from the SIS reports generated from 2019 to 2021. The performance in the outcome indicators was not captured at this time as capturing them would require conducting a demographic health survey, which was beyond the scope of the evaluation and is planned for after the end of the 7CP.

Achieved versus planned component results

Table 4 below indicate that the 7CP had achieved three out of the targeted output indicators, with one of them being surpassed, according to data from the 2019, 2020 and 2021 SIS reports. The indicators achieved were on the targeted policies developed, adaptation and implementation of the essential service package on GBV response, and parents/guardians and teachers with comprehensive knowledge and information to eliminate child marriage in UNFPA priority districts. The indicator not achieved is on the number of identified SGBV survivors aged 15-24 years in the UNFPA priority districts who received essential services. While the target of the unachieved indicator is not achieved, UNFPA made a lot of efforts in the strengthening of data collection mechanisms on GBV cases, and it is hoped that the results will improve as the advocacy efforts continue to be conducted in the next programme cycle. With the policies and service packages in place and adopted for implementation, it is hoped that more and more survivors will come on board to report their cases for enhanced access to services. It is also imperative to note that the period also saw the effects of COVID-19 in the advocacy measures and even service access by the affected communities.

Table 7: 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 against Targets**	**Comments**
Output 3: Policy, legal and accountability frameworks are strengthened to advance gender equality and empower women and young people, especially adolescent girls, to exercise their reproductive rights and to be protected from violence and harmful practices.				
Number of national policies, strategies and plans integrating gender-based violence prevention, protection and response interventions.	2	4	4	Target achieved, though the National University of Lesotho (NUL) Gender Policy was not completed due to long process for approval by the University's decision-making organs.
Output 4: Multisectoral capacity to prevent and address gender-based violence and harmful practices is improved at national and district levels.				
Essential services package for gender-based violence response adapted and implemented in UNFPA priority districts	No	Yes	Yes	
Number of identified sexual gender-based violence survivors aged 15-24 years in UNFPA priority districts who received essential services.	0	1,000	111	Target not achieved. This indicator was not reported on in 2021.
Number of parents/guardians and teachers with comprehensive knowledge and information to eliminate child marriage in UNFPA priority districts.	0	3,000	8,873	Target surpassed

[67] **DP/FPA/CPD/LSO/7**

[68] Ibid

Strengthened Policy, legal and accountability frameworks to advance gender equality and empower women and young people, especially adolescent girls, to exercise their reproductive rights and to be protected from violence and harmful practices.

Interviews and document reviews revealed that the 7CP was instrumental in contributing to the strengthening of the legal and policy frameworks in the country by supporting the finalisation of the Counter-Domestic Violence Bill 2021, harmonisation of Child Protection and Welfare Act 2011 on marriage with the South African Development Cooperation (SADC) model, advocacy and awareness raising on the laws that protect and promote the rights of women and girls and technical supporting IPs in the development of PSEA policies and advocacy.

> *"The domestic violence cases have been taken lightly in this country because of culture where men and boys are socialized to believe that women do not have a voice, and that they are supposed to be humble, respectful, submissive, and therefore most women would not report even if the relationship was life-threatening…. On the other hand, the police classify crimes according to the law, and GBV was not among them, therefore they would not be considered as crime, and therefore would be dropped. The support by UNFPA to enable us enact this law is the beginning of ensuring gender equality"* – **Key Informant on the enactment of the Counter-Domestic Violence law**

The finalization of the Counter-Domestic Violence Bill 2021 was a key achievement during the 7CP period as this had been drafted as early as 2013 without enactment. The contribution of UNFPA in supporting the MoGYSR financial and technically, enabled stakeholder engagement, advocacy with Parliament on enactment and sensitization, public consultations, and community sensitization. At the time of the CPE this had been enacted and signed by the King into law. Interviews revealed that this is a breakthrough in addressing the rampant cases of GBV, particularly between intimate partners. Given the context in Lesotho, interviews indicate that there will still be a lot of advocacy required into order to ensure that it is implemented for the realization of its benefits. However, interviews with IPs, MoGYSR and CO staff stated that the enactment has provided a legal framework that will be key in determining justice course for the survivors of domestic violence that has never been existent, with nearly all the cases going unheard. Particularly, the police classify cases according to the law and given that there was no mention of domestic or gender-based violence as a crime, the case went unheard, and with this law, the police have a framework and even the judicial system will be in a position to interpret it according to the law. It is hoped that with the existence of this law, there will contribute to the **reduction of perpetration of violence against women**. Further, UNFPA also supported the review and harmonization of the customary and civil laws, particularly on property rights for widows as the implementation in skewed towards men and disinherits the widows. At the time of the CPE, this was under review.

> *"UNFPA was very vocal about prevention of GBV, we had standard questionnaire for the household… UNFPA highlighted gender and GBV issues the DRMT had not captured on the assessment questionnaire, which included the vulnerabilities of the women and girls, in addition to their susceptibility to the Early and Unintended Pregnancy (EUP). We are currently aware of what to do, particularly in identifying the vulnerable households". –* ***KI Respondent from DRMT***

Advocacy and financial support by UNFPA to the Ministry of Social Development on harmonisation, through amendment, of the Children Protection and Welfare Act 2011 with that of the SADC Moral Law of Child Marriage. The Children's Protection and Welfare Act (2011) defines a 'minor' as a person under 18 years while the Marriage Act (1974) says the minimum legal age of marriage is 18 years for boys and 16 years for girls with parental consent, and the Laws of Lerotholi imputes that *Chobeliso*[69] (or forced marriage) is a crime for girls under the age of 16. Evidently, these laws are disharmonious in their definition of a minor and age of consent. The SADC Model Law requires member states to set the minimum age of marriage at 18, register all marriages and take effective action, including through legislation, to eradicate child marriage. It also, among others, encourages member states to delay marriage by providing economic incentives such as cash transfers or scholarships and bursaries to a girl child to encourage them to complete secondary education and remain single until they reach the minimum age of marriage. The advocacy efforts by UNFPA, World Vision and other stakeholders resulted in the Children

[69] *Chobeliso* is a type of forced marriage where a man (often assisted his friends) kidnap a (young) girl to coerce her and her family into marriage negotiations.

Protection and Welfare Amendment Bill 2021, awaiting tabling at the Parliament[70] by the Ministry of Social Development, at the time of the CPE. While UNFPA was part of the advocacy and the support to the Ministry of Social Development to draft the amendment, it was hit by financial limitations. World Vision International however was able to mobilize resources to continue with the amendment up to the time of delivery. UNFPA however was instrumental in the engagement of Parliamentarians highlighting the importance of the law. If this Bill is passed into law, it will criminalize child marriage in Lesotho and therefore will aim at **ending child marriage and harmful practices**.

Strengthening mainstreaming of Gender and GBV in the country

Interviews with UN agencies, MoGYSR and CO staff revealed that UNFPA immensely contributed to the support of different entities on gender mainstreaming, highlighting gender profile in the country. During the 7CP, UNFPA led the Gender thematic group where it led members in the country to enhance the Gender and GBV focus during interventions. Major contributions were the support to the DMA and disaster risk management team (DRMT) to specifically collect data identifying vulnerable women and girls for support during disasters. The UNFPA CO contributed to the integration of gender and GBV into the National Response Plan and the UN Response Plan. Interviews also indicate that the 7CP was instrumental in supporting the implementation of recommendation from the UNDP-led piloting of gender audit in the Ministry of Public services towards strengthening aspects of gender and GBV in the public service. With the advocacy on gender and GBV mainstreaming, interviews indicated that the Ministry of Finance through the support of UNDP and World Bank is planning to start gender-based budgeting. All these are due to the leadership, technical capacity and the comparative advantage UNFPA had in the area of Gender and GBV.

As the lead of the **PSEA network,** together with UNICEF within the UNCT and country, UNFPA provided technical support to the government and IPs to mainstream PSEA in their programming and in the service delivery. for example, during the period UNFPA supported the IPs and ministry of Public Service to be PSEA compliant through providing technical support, in addition to supporting development of PSEA guidelines both staff and external audience. UNFPA, together with UNDP supported the Ministry of Development Planning to have Gender and Guidelines. Due to the risk posed to the vulnerable women and girls in Pulihali Dam in Mapholaneng, UNFPA supported the Lesotho Highlands Development Authority and Lesotho Water Development Authority to develop PSEA Policy, in collaboration with World Vision International, that integrates gender and GBV, to ensure safeguards to the local populace. This has not been approved, though, but it is complete.

"Herd boys have been agents of change in the communities and have led advocacy and participated in sessions for human rights including those of adolescent girls and women"
– KI Respondent during CPE

Increased Male engagement in addressing GEWE

UNFPA also enhanced advocacy to end traditional practices that were harmful to the women and girls. UNFPA, working with the World Vision International and Gender Links enhanced mechanisms to reach church leaders and traditional leaders; and the community level to target the men respectively. During the period of evaluation, UNFPA and partner succeeded in reaching the traditional leaders with information aimed at addressing gender equality and women's empowerment. Further, the period saw the development of the Male engagement strategy with was instrumental in guiding the engagement of the hard-to-reach herd boys in the husband schools, training and sensitizing them to promote gender equity (interviews with IPs, UN agencies and CO staff). Interviews with the beneficiaries trained (husband schools) indicated that the initiative to reach out to the herd boys enabled attitudinal and social change towards empowerment of women and gender equality, in addition to enhancing their knowledge on key aspects of being responsible husbands and fathers. The targeting of the herd boys also led to the improvement of their respect to the women, and enhanced their participation in advocacy for protection of women and girls. (Interviews with CO and IPs). Feedback from the government authorities and stakeholders also indicated that the engagement of the Herd boys led to enhanced reporting with the herd boys not being reported among the perpetrators as it used to be before the programme. while UNFPA put in effort to ensure

[70] Parliament had been dissolved for parliamentary elections at the time of the CPE and this would await the new Parliament to review and pass it into law.

male engagement, including religious and traditional leaders and community members, interviews with the IPs and beneficiaries indicated that response was sub-optimal with the scale of targeting being low with results being scattered. Further, there is also need to strengthen male involvement in the HIV response through strengthening response.

Multisectoral capacity to prevent and address gender-based violence and harmful practices is improved at national and district levels.

GBV Case management and response

UNFPA contributed to strengthening the provision of multisectoral services to SGBV survivors through supporting a number of interventions, including

"Before the training, I could not allow my wife to talk back at me or question my decision. I believed that a woman is not supposed to question her husband. During the UNFPA-supported sessions, I learned how to talk to my wife and she can now even shout at me or suggest how we can spend our money after selling some sheep. Many people say "ke jele phehla" ***- Participant during FGDs with husbands***

financially and technically supporting capacity building of entities, supporting legislation, community outreaches advocacy, coordinating GBV interventions aimed at harmonizing actions and increasing evidence generation. Interviews with the IPs and Co staff confirmed that UNFPA had vast contributions in the enactment of the Counter-Domestic Violence Act 2021, which provides framework for addressing GBV cases. UNFPA also contributed to strengthening the capacities of the CGPU and LMPS on evidence generation through advocacy and capacity building. UNFPA supported the LMPS to conduct assessment on the prevalence of GBV among households, in addition to supporting and training them on data collection tools (Interviews and document review). This enhanced the reporting of GBV cases, in addition to determination of the prevalence of GBV in households, thereby informing decision-making. While a large part of the support to the LMPS was directed at enhancing the collection statistics on GBV, UNFPA also assisted police investigators and officers in the CGPU on how to respond to GBV incidents during emergencies. The CGPU were provided with a 24-hour hotline service to improve the reporting of GBV cases, especially during emergencies in addition to being trained strengthen the reporting and referral mechanism for GBV survivors (Interviews). The positive results of these interventions with the CGPU include more informed and sensitive police officers who are likely to offer psychosocial support to survivors and refer certain cases to health centres and courts. In addition, the intervention also led to the collection of comprehensive data on crimes, including SGBV cases, and since 2020, UNFPA has been receiving GBV data from the police every month. While the data has not been consolidated to be user-friendly, it has helped the police and other interested stakeholders understand the breadth of SGBV in the country (Interviews with CO, IP and LMPS). While the data has not been consolidated to be user-friendly, it has helped the police and other interested stakeholders understand the breadth of SGBV in the country. further, while this is the beginning given the enactment of the law, there is still a long way to go given the contextual challenges, particularly, socio-cultural perceptions that are deeply rooted in the society. Interview feedback with stakeholders also indicated that the existing approach to reporting, responses, and recovery to avoid re-victimisation of survivors had multiple uncoordinated entry points for GBV survivors, allocating a set of uncomprehensive services, and being unable to meet the complex needs of the GBV survivors.

During the period of 7CP, UNFPA supported the Police Training College (PTC) by training the police instructors on gender and GBV in order to highlight the importance of gender and GBV as a protection issues to the police fraternity. UNFPA also supported the PTC on the review and revision of the curriculum for new police recruits, ensuring that it was engendered the police training modules. While this was also aimed at sensitizing and raising the need to be sensitive on gender issues by the new recruits, the support on mainstreaming of gender into the modules of the training curriculum was also initiated but not completed due to resignation of the consultant as she was hired a government employee, and therefore was not available. Interviews indicated that the responsibilities were not clear on its completion, as it had taken longer than expected. While efforts have been made to ensure GBV reports are done, the community members mostly report to the traditional leader who then determine the referral pathway to follow, depending on the severity of the case. However, given the context of the gender and that the traditional leaders are the duty bearers, the extent to which they submit the reports is not certain. UNFPA also utilized the 16 days of Activism and International Women's days, together with other agencies, effectively advocated on how to report a case, where

to get the services, prevention of GBV and response, child marriages, and social services existing. Dissemination of laws also happened during these days (interviews and document reviews). UNFPA also supported the production and distribution of information, education and communication (IEC) materials on menstrual hygiene management and GBV, HIV and sexual reproductive health (Interviews with CO and Red Cross and document/SIS reviews).

Integration of Gender and GBV in service delivery

The level of gender-sensitivity in the programme, particularly the support in development of strategic, planning and guiding documents. For example, there was high integration of gender in the provision of SRH and HIV services. UNFPA contributed to strengthening the adaptation and implementation of the essential services package for GBV mitigation during the period of review, with EHS plan incorporating gender and GBV aspects (Interviews and document reviews). The reviewed RMCAHN strategy also integrated gender-sensitivity in the provision of services. Interviews with the MoGYSR, UN agencies and CO staff and document reviews confirmed the role that UNFPA played in ensuring that the services provided during the period were done with a gender lens. UNFPA also supported the Ministry of Health (MoH), in particular, the District Health Management Teams (DHMT), on the integration of SRHR/HIV/SGBV services. UNFPA, together with stakeholders, also supported the training of healthcare workers, including village health workers, on the provision of an assemblage of comprehensive services for survivors that reduce the effects and consequences of GBV and prevent further trauma, including re-victimisation. For example, in 2019, 30 health providers, inclusive of six doctors, were trained in the management of sexually abused individuals (Interviews with IPs, DHMT staff and observations)

UNFPA further capacity built the DHMT on collection of quality statistics with a GBV register being introduced at all SRHR service delivery points, though it has not been fully implemented but piloted in all 10 districts. Additionally, SRHR services are integrated into all the 18 hospitals and four filter clinics (Interviews with CO, IPs and DHMT staff and document reviews). The provision of training to healthcare workers contributed to improved the delivery of services to GBV survivors, particularly without stigmatization. Further, through advocacy and provision of comprehensive information on SRHR and GBV services, such as social support, the UNFPA support managed to raise awareness among healthcare staff, including community health workers, which has led to an increased level of safety and support for GBV survivors through the referral pathways (Interviews and document review).

UNFPA also initiated and provided support to the GBV **inter-agency coordination** technical working group, and this immensely contributed to the promotion of gender equity and the elimination of GBV in the country by ensuring that GBV issues are mainstreamed in all interventions, particularly among the UN agencies. The technical working group also enhanced harmonization of information and practices among stakeholders, in addition to sharing lessons and facilitating improved access to services by the survivors. (Interviews with CO and document reviews). Interviews also revealed that this contributed to improving the reporting of GBV cases by the agencies, thereby enhancing the availability of quality data. The technical working group also enabled the stakeholders to plan and identify areas of strength and need, providing opportunities for collaboration and resource mobilisation among agencies around issues related to gender and GBV. Despite the positive contributions of the team, the role played by UNFPA in leading the coordination of GBV advocacy and programming in the country is sub-optimal, with some stakeholders noting UNFPA's comparative advantage in GBV related matters but their voice/presence in the country could be improved, especially around coordination (Interviews with UN agencies and IPs).

Interviews also revealed that UNFPA supported the MoGYSR on the government obligations on international reporting. For example, the CO supported the ministry to report on Beijing @25, highlighting the progress that the country had made since the Beijing Conference. Further, UNFPA also supported the country on the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) reporting, Universal Periodic Review and Voluntary national reviews (VNR). Further, together with UNDP, UNFPA planned to support the country to have an institutionalized mechanism for reporting, but there were challenges of ownership and resource allocation from the ministries to support the activity (Interviews).

Strengthened the National Statistics Systems

During the period of coverage, UNFPA contributed to strengthening the country's statistics systems through supporting different ministries, including that of Police, working together with the BoS to develop tools to help in capturing data that support in the

information of decisions-making. for example, during the period, UNFPA supported the development of registers for the health facilities on GBV. The data however is not feeding into the health management information system (HMIS) and this may be limiting in terms of informing decision-making based on evidence generation. One of the challenges regarding data on GBV in the country was an uncoordinated system where GBV data was collected at different entry points, thus leading to conflicting findings. UNFPA supported the alignment of national GBV reporting tools with international guidelines. Further, UNFPA supported the LMPS and BoS to update the register to capture GBV data, with the data directly feeding into the BoS, with the data enabling determination of the prevalence of GBV in the country. the MoH was also supported to develop tools that would collect incidences of GBV at the Health Facility Level. The tools are being piloted in all 10 districts in the country, meaning some information on GBV cases is already collected (Interviews of MoH, BoS and CO staff and SIS reviews). Under the *Together for SRH* Programme UNFPA also contributed to strengthening the capacity of MoH staff, training the healthcare workers including data clerks to produce quality data, ability to use the district health information software (DHIS) tool which had been an issue and use it for analysis of district data, with current FP data at the district level informing decision-making on commodities distribution based on the utilization. It is imperative to note that UNFPA was instrumental in supporting the MOH on supervision and mentoring on the data registers (Interviews with CO and MoH staff). On the other hand, at the time of the CPE, planning for the Lesotho demographic health survey was ongoing, with the GBV and domestic violence modules planned for inclusion, which is a milestone made possible with UNFPA's advocacy.

UNFPA also technically supported the BoS in conducting inter-census. At the beginning of the process, UNFPA also supported the BoS to hold technical meetings, in addition to the development of the questionnaires in the thematic areas (GBV, general SRHR – MR, Fertility, FP; Migration) with youth aspects considered as cross-cutting, in addition to ensuring that the data is disaggregated to facilitate capturing of the data. It is worth noting that, for the first time the inter-census data has GBV module with UNFPA's advisory and participation in its development (Interviews and SIS review).

The 7CP also contributed to the generation of population data through collaboration, financial and technical support of the processes. In 2019, UNFPA supported the BoS in conducting population projection for the country until 2036. Interviews with the BoS, MoH, MoDP and CO staff indicated that the results of the population projection were useful as the MoH also utilized the results in 2020/2021 to conduct health facility catchment demarcation of areas in the whole country to assist in programming as the existing data was based in the 2016 census which was considered old. Interviews further indicate that the results were used to inform the EHS package including costs and locations; quantification and distribution of FP commodities[71]; GBV analysis determining basis for resource allocation, including registers and eliminating stock-outs; and costing and targeting in the development of the 2nd RHMCAH Strategy (2022 – 2025). Through the support in population projection, the BoS was able to provide the populations by villages and have a better estimate for the health facilities and the target, providing the data disaggregated by age (for example, under 1 year olds, under 5s, 6 – 24 Months for various services; and determine the service targets and by sex. This also led to improvement in the coverage for the EPI through setting targets and by locations (Interviews with BoS, MoH, IPs and CO staff and SIS review).

> *"The MoH has realized a lot of improvements in data quality and utilization for decision through the support of UNFPA. At the health facilities, the registers are up to do data and there no longer data gaps that used to be experienced before the mentorship and supervision support by UNFPA. Staff now appreciate the value of data in decision-making. Capacity has also improved at the facility levels. At the central level, most of the Programme Managers are able to track their programmes as they only need to log into the systems and track progress, in addition to determining which services lines have high demand, including planning for supervisory support in the weak areas. We could not do this without the technical and financial support of UNFPA"* – **MoH Respondent during the CPE.**

On the development, completion and validation of the demographic dividend, UNFPA supported the BoS training them on the methodology using the national transfer account aimed at harnessing the demographic

[71] The result of the MoH demarcation was particularly useful in determining where the RH commodities and other health services should be prioritised based on the needs. For example, the catchment areas of the Christian Health Association of Lesotho (CHAL)-supported health facilities where access to RH services is constrained due to prohibition.

dividend enabling Lesotho to meet the commitment in the Addis Ababa declaration for the member states to harness demographic dividend. The findings from the demographic dividend were instrumental leading to the capacity building of different stakeholders, and ensured alignment with the national population policy, providing the framework for its approval by the cabinet and implementation. The findings also provided potential and basis for the realization of longer term results like providing evidence for advocacy on FP, including funding by the government, SRH and empowerment of the young people (Interviews with MoDP, UNRCO, BoS, MoH and CO staff and document reviews). While the demographic dividend was completed and validated, there is still need for advocacy, particularly with the government and other stakeholders to ensure its ownership and utilization through harnessing the demographic dividend.

During the period of coverage, UNFPA was instrumental in supporting evidence-based programming through supporting evidence generations. For example; UNFPA supported the MoH's nursing directorate to conduct midwifery gap analysis; and interviews with MoH and CO revealed that this contributed to informing the review of the midwifery curriculum in addition to aligning the directorate's plans to its strategic priorities. The gap analysis also contributed to resource mobilization by the directorate, beyond UNFPA, with stakeholders brought in to support other existing gaps, which would not have been possible without the UNFPA support. Further, in 2021, UNFPA supported World Vision International to conduct assessment on the effects of COVID-19 pandemic in Mokhotlong, Maseru, Mohale's Hook, Mafeteng and Quthing Districts, and the results of this were that children were affected psychologically and GBV incidences and child marriages were high, and this led to provision of psychosocial support to the children and GBV survivors, reaching a total of 10,000 beneficiaries. World Vision International supported the identified vulnerable households with food packages as they were struggling and ended up getting into early marriage and GBV and sexual exploitation due to job losses occasioned by the pandemic.

UNFPA also enhanced advocacy on data through supporting the government in commemoration of the World Population Days every 11th July for the period of 7CP. During these periods, the CO produced media briefs along the 7CP thematic areas and highlighting what UNFPA is doing and the achievements made (Interviews). With the population projection and the demographic dividend in place, more advocacy mechanisms will be key in ensuring that they are utilized.

4.2.3 Integration of Gender and Human Rights in 7CP

EQ3: To what extent has UNFPA successfully integrated gender and human rights perspectives in the design, implementation and monitoring of the country programme?

The design and implementation of the 7CP were done with a lot of consideration for integration of human rights and gender along programmatic and organizational levels. However, the deeply-rooted traditions, inadequacy of resources, gaps in the documentation and utilization of sex-disaggregated data, in addition to age and disability-disaggregated data limited achievement of targeting and results.

The design and implementation of the 7CP were done with a lot of consideration for integration of gender along programmatic and organizational levels. Through the 7CP, UNFPA identified and continued to address the needs of boys, girls, women and men, in addition to monitoring their participation and access to services along gender lines. The 7CP facilitated participation and engagement of various segments of the society to enhance their equitable access to the services provided by the programme. Capacity strengthening activities targeting national partners and IPs covered GEWE and human rights issues. UNFPA Lesotho, on the other hand, ensured use of gender sensitive language in all its media materials and publications, in addition to reports (Interviews and reviews of CO documents).

Interview sessions with the CO and IP staff indicated that UNFPA Lesotho effectively made considerations on integration of gender into the 7CP interventions. For example, under the SRH, the CP promoted male engagement towards increasing access to FP services, in addition to training them on the mechanisms of contribution in the CP results. Further, the CP

supported integration of gender and GBV service delivery to the disaster-affected populations, supporting assessments processes to include the details to enable support a long gender lines. During the implementations of the CP, UNFPA also supported the development of gender responsive policies and strategies which were aimed at addressing specific gender issues in the country. UNFPA further ensured integration of the gender mainstreaming 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 was also instrumental in supporting of advocacy mechanisms aimed at increasing focus on ensuring gender mainstreaming in policies. The developed RMCAHN strategy endorsed by the government was gender-sensitive and facilitated integration of SRH services, considering age and sex. Within the UNCT, UNFPA was identified as a key proponent and leader on gender and GBV issues, where the CP supported mainstreaming. While UNFPA ensured the programme focused on gender mainstreaming, the reporting tools (SIS) were limited on capturing the gender aspects as they are not disaggregated, limiting the extent of evidenced response and access to services a long gender lines.

During the period, the CO ensured that the programme delivery embedded human rights approaches. Interviews with various 7CP stakeholders indicated that UNFPA ensured the programme design and delivery approach was focused on addressing the needs of the marginalised and most vulnerable populations, particularly women and girls, aimed at ensuring that they accessed services in an equitable manner. UNFPA ensured 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 elimination of child marriages and participation in discourses on implementing their reproductive rights. UNFPA also facilitated service delivery through supporting interventions in the hard-to-reach areas (Interviews and reviews of CO documents). Through supporting of rapid assessments and surveys facilitating identification of districts with low access to services, the CP was focused on enhancing human rights perspectives in delivery. for example, the CO supported implementation of programme interventions in Mokhotlong, Quthing, Mafeteng and Leribe based on the SRH access gaps that were existing at the time. Further, the structure of the delivery of the 7CP was based on promoting rights to access SRH services encompassing FP, adolescent and youth safe spaces, HIV prevention, GBV prevention and response, and targeting of the key populations with services. For example, UNFPA, through the IP, LPPA, facilitated procurement and distribution of condoms and lubricants for key populations, including sex workers, the LGBTIQ communities. In addition, the 7CP also facilitated access to services by people living with disabilities (Interviews with IPs, CO and MoH staff).

UNFPA supported development of strategies that integrated human rights into them, enhancing the dignities of the vulnerable populations. Interviews with IPs and CO staff confirmed that the GEWE component of the 7CP ensured UNFPA's commitment to elimination of 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. For example; during the period, the 7CP supported targeting of herd boys to sensitize them and promote gender equality, but in the end of it, they felt dignified in the way they were engaged in the programme, enhancing their participation and support in the 7CP delivery strategies. Interviews conducted with CO and IPs staff confirmed that during the 7CP, UNFPA contributed to supporting the vulnerable women and girls and GBV survivors, particularly during the humanitarian crisis, with dignity kits restoring their dignity. The Interviews further confirmed that the GEWE and SRH components were responsive to the needs of the marginalized population groups. For example, UNFPA promoted the inclusion of the LGBTIQ+ and PWDs in the service delivery, including advocating for their access to the services. There was however a confirmation from interviews with stakeholders that there was inadequate integration of PWDs in programming which may need to be enhanced.

During the period of evaluation, there was evidence that UNFPA supported integration of gender and human rights approaches in the implementation of the 7CP. UNFPA technical and financially supported advocacy mechanisms aimed at addressing the empowerment of women and girls in the country, upholding their rights and elimination of their discrimination (interviews and document reviews). UNFPA also engaged the county's leadership in a number of advocacy sessions supporting the need to e

sure the rights of girls are protected, especially in elimination of harmful practices like early and child marriage (Interviews with IPs and CO staff and document review). The completion of the Counter-Domestic Violence Act during the period was a milestone in ensuring that domestic violence had mechanisms of redress to facilitate discharge of the rights of the affected. While the results of the enactment had not been realized at the time of the CPE, its existence provides hope to the discriminated and enhances accountability within households to ensure that violence meted on partners a long gender lines will be addressed effectively. For example, cases of homicide would be addressed to enhance dignities of the people affected (Interviews with MoGYSR, IPs and CO staff).

UNFPA further enhanced the dignity of the marginalized and vulnerable populations through service delivery. during the period, UNFPA targeted the hard-to-reach areas with outreaches in Mokhotlong and Quthing districts. For example, UNFPA supported the targeting of the catchment areas for the Church-based health facilities where FP services were not being provided, enabling the populations in those areas to access the SRH services, expressing their rights in making health choices. Further, the 7CP targeted the key populations, particularly the sex workers at the major border points of the country, with information and health services, leading to reduction on their risk of infection from STIs (Interviews with CO and IP staff and document review).

While UNFPA enhanced integration of gender and human rights approaches in the delivery of the programme, the deeply-rooted traditions influenced the aspects of uptake and change in behaviours of the targeted populations. Inadequacy of resources, particularly targeting all the areas of need, inhibited the level of coverage (Interviews with CO and IP staff). There were also gaps in the documentation and utilization of sex-disaggregated data. Review of the reporting tools (SIS and GPS) revealed gaps in capturing sex, age and disability-disaggregated data which is a limitation on the targeting and ensuring that the needs were effectively addressed by the CP interventions (Interviews and document reviews).

4.4 Answer to Evaluation Question on Efficiency

EQ4: 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, with the results effectively and efficiently measured and contributing to accountability?

Summary: There was mixed feedback on the CO's efficiency in the delivery of the 7CP. The CO ensured compliance with the internal controls, in addition to utilizing strategic approaches, including provision of technical assistance, partnerships, integration of the CP interventions and administrative resource to enhance efficiency. The CO was however limited in resources, both financial and human capacity to adequately deliver the 7CP. While the M&E system in place enabled capturing of CP performance, there were inadequate focus on results, resource allocation and gaps in the theory of change of the programme. Inadequate capacity of the IPs also affected the CPs, efficiency.

4.4.1 CP Strategic Delivery Mechanisms

UNFPA utilized different strategic delivery mechanisms to ensure that the programme was efficient, enabling realization of the intended programme results with minimum costs and challenges. Interviews with IPs, UN agencies and CO staff and document reviews revealed that the use of partnership mechanisms was immensely beneficial to the programme meeting its results in an efficient manner. The partnership with IPs ensured that UNFPA expanded its reach to different areas in the country facilitating coverage and ensuring delivery of services concurrently enhancing time effectiveness unlike if UNFPA was to implement the same, and with the constrained staff size it would take a lot of time. The partnership strategy of UNFPA focused on engaging with local IPs (NGOs) with knowledge of local context enhancing access and facilitating decision-making and this ensured timely delivery of services. UNFPA engaged partners based on their technical expertise, capacity, and IP selection criteria and this improved programme delivery. Most of the IPs that worked with UNFPA were local and had pre-existing capacity, thereby making understanding local structures and solutions to problems much easier and they included Help Lesotho, Gender Links, Lesotho Planned Parenthood Association, and Care for Basotho (Interviews with CO, MoH, IPs). The local

NGOs also had different donors, and interviews with the IPs and CO staff indicated that the cost of staff were shared among donors and this reduced the staff costs borne by UNFPA, thereby facilitating efficiency. Given that the staff costs were shared, it meant that the respective staff also supported other donor-supported activities. There was however no feedback on delays in delivery of the 7CP interventions because the staff had to share the time. The IPs confirmed effective planning mechanisms to ensure that there were no delays. On the other hand, however, due to operational limitations, it was reported the IPs that UNFPA was not prompt in disbursing the financial resources leading to delays in the implementation of activities and this also affected the results and timely completion of the activities planned for in a particular period of time. Interviews with the MoH indicated that while majority of interventions are done through the ministry, most of the times there is no formal and adequate feedback on the achievements made by UNFPA.

UNFPA partnership with the government, particularly line ministries and related agencies facilitated efficiency in the delivery of the programme in the target areas. To begin with, the government holds the policy direction, and partnering with the entities ensured direct contribution of the 7CP into the policies of the government, and thereby directly facilitating uptake of services within the framework of the government. Working directly with the government ministries implied that the 7CP fed directly into the development and sectoral strategies of the government ensuring that the target populations are covered effectively by the support provided by the government. Partnering with the government in the delivery of the programme, interviews and document reviews revealed that implied the use of existing government structures, and this meant that the programme did not have to provide additional resources to reach the locations in the country. For example, the SRH services were provided through the government health facilities which were existent, in addition to utilizing the services of the e healthcare workers who were paid for by the government through the MoH. In addition, the arrangement made is easier for UNFPA to provide technical support to the ministries. Feedback however had it that the supervision by the MoH and addressing some of the challenges faced by the healthcare workers, particularly in ensuring effective delivery of some of the CP support was limited by the government, especially due to inadequate resources to ensure monitoring, inadequate capacities and there were also aspects of constant transfers of trained staff affecting continuity of the implementation of the strategies in some of the facilities or districts. Interviews also revealed that the instability in the government, with frequent changes in the ministry leadership led to some delays in decision-making with discussion, in most times having to start over and over again whenever a new leader comes on board. For example, since July 2019 up to the time of the evaluation, the Ministry of Health had had three ministers and five principle secretaries, and with most of them holding political patronage, contributed to hindering the continuity of the programme strategies. To deal with the situation of constant change in ministry leaderships, UNFPA prioritized working with the directors of the government ministries whose contract were not affected by political appointments.

UNFPA was also instrumental in implementing joint or collaborative programmes with other UN agencies, enhancing effectiveness and efficiency. The joint programmes in the Together for SRH Programme with WHO, UNICEF and UNAIDS facilitated effectiveness in delivery, particularly being implemented in the areas of complementarity, in addition to enhancing coordination limiting chances of duplication of efforts and overlaps. UNFPA was actively involved in the Joint United Nations Team on AIDS (JUNTA) as a lead in HIV prevention. The team ensures that all support that is provided to GOL related to HIV and AIDS issues is well coordinated and technically sound. Further, the collaboration between UNESCO and UNFPA on the implementation of CSE and support to the MoET was instrumental in ensuring efficiency in delivery of the programme. there were instances where the two agencies shared costs of activities which further facilitated enhanced coverage and effectiveness in coordination. This is also eliminated duplication of efforts, in addition to sharing of technical skills to deliver the results between the two agencies (Interviews and Document reviews). This coupled with the spirit of delivering as one (DaO) provided a framework that enhances coordination, consultation, joint planning and implementation among UN agencies. Joint Programmes also reduced duplication of efforts at national and sub-national levels. This needs to be further strengthened given that it enhances efficiency (Interviews with CO, Un agencies and IPs). Analysis of coverage and interviews also indicated that the *Together for SRH*

Programme had overlaps with the IOM's *SRH and HIV knows no border Programme* were sharing locations targeting the same groups, for example the sex workers.

The 7CP proved, to a larger extent, successful in the integration of the programme component services, ensuring that the access to the services had reduced logistics as they were received in one particular centre. Interviews confirmed that access to services improved due to the integration of FP, particularly the postpartum, which was never the case before, HIV/ ANC/ GBV services enhanced access reducing time wastage by the clients in accessing the services. For example, in the Mokhotlong hospital, FP commodities were provided at the general outpatients' department, ART clinic, men's' clinic, female ward, gynaecology ward, and at postnatal clinic. In the contrary, the integration of services is challenged by the limited staff and high staff turnover. Integrated service delivery resultantly led to increased demand of services and an increase in healthcare staff workload (Interviews and document reviews). Further, there was need to strengthen linkage between the CO components, in addition to enhancing communication among staff on what is going. A case in point is when staff report that they could attend meetings but would not be able to know what the other components are delivering. This an area that UNFPA needs to address internally.

While UNFPA mostly focused the 7CP interventions in the district of needs like Mokhotolong and Quthing, interviews with the IPs reported that full coverage of the districts had not been achieved. This was revealed to be partly due to funding and staffing constraints. Given that some models particularly for behavioural change requires reaching a critical mass for optimal diffusion to occur and social norm change, UNFPA should consider moving more towards consolidation and achieving universal coverage.

UNFPA was identified as an important linkage between the health service providers, particularly to the adolescent and youth, and the organizations and agencies involved in the advocacy mechanisms, enhancing access to the services by the target groups. It was however identified inadequacy of service providers for the adolescents and the youth, limiting their access, particularly compared to the demand created (Interviews and document reviews).

UNFPA immensely capitalized on capacity development for the IPs, including government line ministries enhancing transfer of skills in provision of quality of services, and based on high levels of standards. The technical assistance provided enhanced capacities of the line ministries and stakeholders in ensuring standardization of service delivery and access further enhancing effectiveness and efficiency (Interviews with CO and MoH staff)

Interviews with the IPs and CO staff identified the flexibility and responsiveness of UNFPA in decision-making enhancing delivery of services without delays. For example, during the COVID-19, UNFPA was able to adapt to the context of implementation, including allowing the IPs to realign the budgets to enhance integration of COVID-19 response activities. This facilitated effective coverage of the budgets and ensuring that the budget utilization rate being more than three quarters, which was a great achievement given the fact that there were challenges in delivery of the interventions.

Due to the limited resources to support advocacy mechanisms, UNFPA hired media influencers to work on various advocacy issues, particularly the LGBTIQ+, HIV among the adolescent and young people, gender and GBV and SRH service access by the target populations. While this was a new approach, the CO is shifting a lot this modality of delivery with the aim of investing in the people to contribute to the delivery of the services.

4.4.2 Operations Management

From the review of programme documents and interviews, UNFPA's put in place mechanisms to ensure operational efficiency facilitating effective delivery of the programme. Interviews with IPs and government stakeholders confirmed that the CO had skilled staff, in addition to clear financial and administration management in place and adhered to by the CO staff and the IPs facilitating efficiency in achieving the results of the 7CP. Interviews with various CO staff and document reviews confirm that the administrative procedures of UNFPA are well established and understood by the staff. UNFPA procurement procedures are well laid down and followed by the CO. The use of UNFPA procurement processes, especially for family planning and maternal health commodities, ensured timely delivery of the commodities in-country. In cases where there were stock outs, it was due to reasons outside UNFPA processes such as supply challenges. (Interviews with CO and IPs).

To inform disbursement of funds to the IPs, the CO put in place structures for compliance, in addition to monitoring accountability by the IPs. The use of Annual Work Plans (AWP) for planning and budgeting purposes enabled effectiveness in guiding the financial and programmatic decisions by the CO. Further, interviews revealed that the IPs were expected to report on a quarterly basis, and this determined the financial disbursements in the subsequent quarter. This ensured and facilitated accountability among the IPs, in addition to compliance. It is also imperative to note that the IPs also submitted both financial and narrative reports stating the progress and implementation rates, that also formed part of assessment of the delivery capacity of a particular IP. Further, IPs were supported in ensuring that they complied with the existing systems of UNFPA, in addition to quality of deliverables. (Interviews and Document reviews).

Results from the CPE indicated that the CO did not have a clear strategy for resource mobilization, and this affected the level of resources that were earmarked for the programme activities, which therefore affected the level of delivery by the CO in the 7CP. Interviews with the CO also indicated that the office wholly depended on resource mobilization support by the Regional Office, and this was cited to be limiting the extent to which the CO could even make commitments, particularly on areas of mandate and arising needs. Interviews with the IPs and government reported that UNFPA was not consistent in the disbursement of funds, while at the same time the funds were less, limiting the level of results that could be achieved. While there were funding gaps reported, the CO put in mechanisms to cover the deficits in most occasions, including collaboration, partnerships and cost-sharing of activities, enabling achievement of planned result within the financial limitations (Interviews with CO and IPs staff). Understaffing was also cited as a factor leading to delays. During the CPE, the respondents, particularly IPs, reported that there were delays and lateness in providing feedback of performance and in disbursement of funds affecting planning and commitments made with different stakeholders.

UNFPA staff were confirmed by the IPs, MDAs and UN agencies as having the right skill sets to deliver in their mandate effectively. The CO staff were all locals except the Country Representative and this enabled local understanding of the context which facilitated faster decision-making and ensuring that the strategies put in place to implement the interventions are contextually appropriate, enhancing efficiency. Interviews however established that the staff were overstretched in their roles, given that each component had only one staff, and given the mandate of UNFPA in the country, this was a little overbearing for the staff to meet the demands effectively, in addition to the quality of delivery. The programme staff reported undertaking operational as well as technical tasks, in addition to communicating with IPs, government, and other agencies. In fact, some IPs reported that while the UNFPA staff endeavoured to provide support in their areas of responsibility, there would be issues due to prioritization of tasks and demands. The staff however managed to deliver within those constraints. In addition, the staff's availability and passion to support the IPs, in addition to utilizing their skills effectively was recognized by the IPs and government stakeholders. UNFPA staffing, particularly for some functions were not covered during the period of coverage. For example, the Monitoring and Evaluation function was not covered until 2021 when the M&E Analyst hired for the Together for SRH programme took over the CO's mandate on M&E. In addition, the M&E Analyst also doubled up as the focal point for the PD components in the 7CP. While P&D component was not explicitly included in the 7th CP, it had a number of activities with the direct effect was heavy workload for the M&E staff, who also had to review progress of other components in addition to monitoring and reporting of the entire CP. The staff shortages pose a challenge of sustaining communication and coordination with IPs and government ministries (Interviews with CO and IPs staff and document reviews). The staff also cited inadequate coordination among the staff, where inadequacy of information was shared among the staff with some staff reporting learning about planned activities by UNFPA in stakeholder meetings or through stakeholders. The inconsistency in the staff and financial structure was also identified as insufficiently supporting the delivery of the programme. While Gender and GBV were a great concern in the county, the comparative resource allocation was limited and not commensurate with the needs. In addition, the staff position grading was also inconsistent with the scope of work. For example, all the staff were responsible for the 7CP components. However, their staff grades were not the same or commensurate to the level of responsibilities (Interviews).

During the period, the interviews revealed that the Lesotho CO had operational support from the Regional Office Shared service Centre (ROSSC), particularly on procurement and approvals. Interviews

indicated that the effectiveness of this systems was dependent on who the RO manager is to determine the process that it follows. While it was initiated with a view to increasing efficiency, interviews with the CO indicated that the staff were not consulted on its introduction, it was not helping and contributing to further delays which contributed to delays in the delivery of the programme. The other limitation of the ROSSC is that it does not solicit for requisition and the CO has to send the paperwork to South Africa, which is a tedious process, particularly the scanning and sending of the documents consume staff time, and given that they are only two in the operations unit, this was perceived to be adding no value to the processes. For example, in procurement, the CO does not source, in finance, the CO raises the paperwork and sends them to South Africa. While it took a short time to create a voucher, the ROSSC requires the Operations Unit to scan, upload then send to the Assistant Country Representative to approve then this is scanned and sent to the regional office which takes about three days to be completed while the staff indicated this would take them less than a day to do, beating the logic of the ROSSC if it is leading to delays, particularly affecting the office efficiency (Interviews with CO staff and document reviews).

Financial management within the organization was reported to be effective given existing internal controls facilitating the operational decisions, in addition to financial and operational decisions. Review of the financial records and analysis of financial data indicated that the overall budget expenditure rate was averagely 78 percent as shown in section 3.2 of the report. Interviews with the IPs indicated that the UNFPA systems in place were effective, particularly the FACE form for financial reporting and was clear in the expectations from the agency. The agency was however affected by the inefficient planning and decision-making processes which led to delays in disbursement processes. The CO and IPs staff stated that the transfer of funds was inefficient because the (quarterly) disbursements of the 7CP funds were late particularly the irregular sources, thereby delaying implementation of activities. Document reviews show that for many interventions, there were indeed no activities during the first quarter or funds would be disbursed in the last weeks of the quarter which also affects results.

Under the UNCT, UNFPA was part of the arrangement under the operational management team technical working group where there were common services shared among the agencies and this led to reduced costs. For example, UNFPA shared the services of common ICT, common human resources services, common premises, common finance and Harmonized Approach to Cash Transfers (HACT) which also ensured joint work plans are developed and implemented by the agencies. These enhanced efficiencies in the operational costs borne by the agency (Interviews with UN agencies and CO staff).

4.4.3 Monitoring and Evaluation

Review of the programme documents and interviews with the CO and IPs' staff revealed that UNFPA put in place mechanisms that ensured capturing of performance of the CO in assessing the performance of the delivery of the 7CP. From the review of the CPD and the SIS, the 7CP's monitoring and evaluation (M&E) aspects were anchored on the results and resources framework (RRF) at the design and implementation. Interviews with the CO staff and reviews of the SIS established that the CO had a number of mechanisms to capture performance and monitor progress of the CP, and ensure accountability to the various stakeholders of the 7CP. It was evident that the RRF had indicators in place to ensure that the performance of the programme could be captured during implementation, and reported on an annual basis. On the other hand, the M&E of the programme was also informed by the donor reporting requirements and the UNDAF.

The CP utilized planning, monitoring, programme reviews and reporting functions to guide and facilitate and inform the implementation and performance of the CP. At the design stage, the CO utilized planning functions which facilitated alignment of the CP to the national priorities, UNDAF and the SP, with the resources and the respective stakeholders targeted for the implementation of the related interventions. Interviews with the CO and IP staff also confirmed that UNFPA held planning sessions with the IPs which entailed development of the annual world plans (AWPs). The planning sessions, especially for determining the annual targets, were confirmed to be engaging and guided by the arising needs and the targets set in the RRF. The targeting was reported to the based on the available resources, the capacity and mandate of the respective IP. For example, the MoH would consider the needs on FP, then consider the contribution by the LPPA, and this will then inform the contributions by UNFPA, and that decided the targets included in the AWPs. The AWPs formed the

basis for the disbursement of funds to the IPs based on the planned activities. IPs reported that this process was engaging and enabled decisions on targeting guided by the RRF targets, in addition to agreeing on the interventions to be implemented on an annual basis, ensuring efficiency in resource allocation and decision-making (Interviews with the CO, IPs and review of Annual Planning Reports and SIS).

The CO reported using field monitoring and periodic reporting to facilitate assessment of the 7CP progress based on the planned activities in a particular period. Interviews with the CO and IPs staff and review of documents established that the CO used Global Programming System (GPS), AWPs and SIS to assess the effectiveness of the implementation of the 7CP strategies. There was confirmed training of the IPs on the UNFPA tools for monitoring and the IPs reported effectiveness in understanding of the tools and the systems provided by the CO. Feedback from the CO indicated that the field monitoring mechanisms enabled verification through review of site documents and records or registers, including engagement with the beneficiaries, capturing the changes that are occurring as a result of the programme support. Interviews with the IPs and CO staff also revealed that there were follow-up sessions conducted to ensure that the data fed into the system for reporting were authentic and followed the right procedures in capturing. In addition to the field monitoring visits by the M&E focal point, the programme component staff also had an active role in monitoring of CP component activities. Further, there were joint monitoring sessions conducted between UNFPA and the line ministries which were reported to be effective in ensuring quality assurance (Interviews with CO, and IPs staff).

The 7CP reporting was based on the Atlas system, taking into consideration all the interventions implemented and the achievements by indicators. In compliance with the UNFPA global reporting and monitoring structure, the CO uses the SIS to report. The SIS enables the linkage of the CP interventions, outputs and the outcome areas. Interviews and reviews also established that the SIS allows for the capturing narratives describing the achievements, including reasons for over or under-achievement, which makes it good for reporting, especially with a focus on results. All the IPs reported submitting quarterly reports on a quarterly basis using the Atlas system and reported that the tools were friendly to use, and at the same time not cumbersome, facilitating time efficiency. UNFPA CO on the other hand consolidated the report to present the status of achievement for the 7CP. The quarterly reports are then consolidated at the end of each calendar year, with the IPs and CO staff indicating was an effective way in following up on performance and assessment on the achievement of the 7CP.

The financial reporting was based on the utilization of the FACE forms, which the IPs utilized to report on the expenditures on a quarterly basis, and this was reported to be effective in monitoring of the utilization of the budget by the IPs, and interviews revealed that corrective measure were taken in case of deviations. The CO also conducted spot checks at least once a year with the IPs depending on expenditure levels and the risk involved, ensuring compliance and quality assurance. The CO also utilized audits to assess aspects of compliance and risk minimization from the utilization of funds for the 7CP (interviews and document reviews).

From reviews of the SIS reports, it is evidenced that the reporting was mainly focused on activity level reporting and did not go beyond the activities to describe the difference the achievements were making, particularly in relation to the results expected. To enhance accountability, and support evidence-based programming, particularly for the next programme cycle, UNFPA commissioned a CPE, which has been conducted in line with the UNFPA Evaluation Policy. There were confirmed evidence of utilization of M&E information for reporting to the donors, in addition to assessing IP performance; keeping track on performance based on the CP targets; and assessing partner capacities for effectiveness. While interviews revealed that there is little capturing of results in the reports, there were reviews done by the programme teams with the IPs and targets set based on experiences, and payments to IPs being based on performance.

While the CO conducted joint monitoring sessions with the government, there was inadequate investment on this aspect by the government in addition to the oversight role being pronounced in the interventions, an area that may need to be strengthened. On the other hand, reviews of the financial commitments by the CO on M&E was limited. For example, in 2020 there was not resources allocated for the OEE, which in 2021 it was only US$ 28.94, an indication that the CO's commitment on quality assurance is low. This is also confirmed by the fact that at the design stage, there was no CO level M&E focal point, until 2021 when the Together for SRH Programme M&E focal point took over the responsibility. Interviews with IPs and CO staff however indicated that the M&E focal point

has been up to the task and successfully supported the 7CP to the extent possible, including timely provision of data collection tools/ templates for reporting, in addition to support in capacity strengthening on reporting. The only limitation of the added responsibility on the population and development functions which might overstretch the responsibilities (Interviews with CO staff). There were also confirmed support from the regional office, particularly on training and support on compliance.

4.5 Answer to Evaluation Question on Sustainability

EQ5: To what extent has UNFPA been able to support implementing partners and rights-holders (notably, women, adolescents and youth) in developing capacities and establishing mechanisms to ensure the durability of effects in particular related to SRHR, SGBV prevention and protection and data?

Summary: The Lesotho CO was instrumental in enhancing the capacities of the different stakeholders and promoting national ownership during the implementation of the 7CP. The CP promoted national ownership through working with the line ministries and agencies in addition to promoting strategic consultations, collaborations and partnership in the delivery of the 7CP. The 7CP's support of the country in the development of policies, guidelines, laws tools and capacity building of various stakeholders confirmed transfer of skills enhanced sustainability. Inadequate resources affected the extent of achievement with some interventions not finalized due to inadequate finances. The government commitment inadequate data, high staff turnover within the ministries and capacity to monitoring implementation of some of the interventions may also affect sustainability.

4.5.1 Strengthening of National Ownership and Policy Framework

Review of the 7CPD revealed that UNFPA put in palace mechanisms promoting consultation and participation of the government ministries and agencies, in addition to communities and local institutions, enhancing national ownership of the programme results. At the design of the 7CP, UNFPA consulted the government line ministries and agencies to identify the needs and priorities for both the government and community level. Further, the 7CP directly contributed to the NDSP II priority areas, implying that the achievement of the 7CP goes directly into the achievement of the government, and this enhanced the ownership by the government, enhancing the potential of sustaining the results realized from the support.

During the period, UNFPA endeavoured to work with the local institutions including community structures like the chiefdoms where the chiefs were at the forefront of facilitating some of the 7CP-supported interventions, for example, UNFPA incorporated the chiefs and community leaders in the advocacy work particularly in addressing social norms like early and unintended pregnancies, GBV and other risky behaviours among the teenagers, where interviews with IPs, UN agencies and CO staff confirmed that the chiefs and community leaders led the advocacy mechanisms on the same in their respective communities, including facilitating dialogues sessions on the same in their localities. The chiefs were also part of the community committees formed to combat teenage pregnancies among the school-going children, particularly in Quthng District. To support their work, UNFPA, through Help Lesotho supported them with the development of a module engaging the chiefs and community leaders to enable them lead the dialogue session on harmful practices and arising issues like new infections of HIV among the youth. The chiefs and community leaders also participated in the decisions on where the interventions were to take place, working with the UNFPA IPs enhancing ownership of the community leadership. On the hand, they took part in the implementation process.

During the 7CP, UNFPA invested in strengthening existing partnerships IPs which were local, and this facilitated ease of identification of the local needs, with the 7CP contributing to their respective corporate objectives enhancing their ownership of the results. Interviews with the IPs and CO staff confirmed that the IPs participating in the implementation of the CP activities were existent before the 7CP and this implied that they would remain in operation to continue with the implementation of the related intervention and use the results of the 7CP to enhance services delivery. Even though the local IPs were able to go about their activities during the period of implementation, interviews with them revealed that they were weak in resource mobilization, which could threaten the sustainability of the results in case UNFPA 7CP ceases. The prospects of sustainability

among the IPs would also be affected, particularly on advocacy issues that seemed to have effects of social norms and these proved challenging for them to confront the government on their own, as they still needed the coordination mechanisms supported by the international organizations.

UNFPA financially and technically supported the government in the development of policies, guidelines and strategies, at the request of the line ministries or agencies. With the polices and strategies endorsed by Parliament and Cabinet, there is potential of ownership by the country's leadership, hence likelihood of being taken up as a government document for implementation. Since the implementation of the policies, strategies and guidelines on the government, including oversight, these are likely to remain with the government even after the 7CP lapses. With the technical and financial support of the line ministries and agencies in the development, review and amendment of policies, laws and strategies to ensure that they facilitate effectiveness will ensure sustainability beyond the life of the 7CP. While some of the documents were not yet finalized at the time of the CPE, there were high levels of indications, from interviews with IPs and Government stakeholders that the documents had government's ownership and the line ministries and agencies took the lead in their development or reviews. Further, while there was support from the government on the policies, laws, guidelines and strategies, interviews indicated that the government had limitations especially on capacities to ensure that they were effectively implemented and oversight provided. Further, the government had inadequate resources to provide oversight on their implementation. With the development or review of laws in the context of a patriarchal society, more advocacy is still required to ensure that the laws and policies are effectively implemented. Further, policy like the Learner Policy is not completely being implemented in the country, especially in the church-supported schools. This will require time and advocacy, especially on laws touching on social perspectives in the country. There were also delays in the finalization of some of the policies, like the Gender Policy with the National University of Lesotho.

4.5.2 Capacity Building and Institutionalization of results

Prospects of sustainability of the 7CP support were enhanced by UNFPA investing heavily on capacity building and institutionalization of approaches, ensuring continuity of programme results even beyond its implementation period. Interviews with national stakeholders on CSE indicated that UNFPA strengthened the institutionalization of the curriculum through supporting development and implementation of data collections tools and training of School Principals, teachers and schools' curriculum inspectors further enhancing their capacities to implement the CSE-integrated curriculum. Interviews with MoET stakeholders, including teachers, confirmed using the tools developed and application of the skills to deliver the sessions. There was also confirmation that the tools were being used by other partners to monitor the delivery of CSE in schools and youth related activities. With the teachers confirming that teaching CSE enabled them to improve their delivery of the other class subjects implying that their skills improved and were able to apply them. The integration of the CSE curriculum and being made compulsory and examinable at both upper classes in primary and secondary school levels confirms institutionalization and assures sustainability of the concept.

There was evidence of skills transfer from the UNFPA's technical and financial investment on capacity strengthening. The support to MoH in development of data collection tools and reporting guidelines and training staff on them including the linkage of the tools to the national systems, DHIS2 tool, with confirmed improved capacity in data management at the facilities due to gained skills from UNFPA's support confirms skills transfer. While there confirmed capacity of the health staff on the data management at the facility levels, there were however concerns by respondents that the data clerks in the health facilities who contributed to the success of data management in the 10 districts are supported by partners, and is therefore a weak link to sustainability as they will go with the partner support as there is no budget by the government to absorb them and this may affect gains made on data quality. The training of the statisticians from the various ministries and government agencies of population projections and utilizing the skills to generate more data for decision-making by the trained ministries and agencies, for example, the MoH and BoS being able to coordinate demarcation of health facilities in the country utilizing the skills gained from the training support by UNFPA confirms transfer of skills and evidence of utilization that will continue to be used beyond the programme.

Interviews further confirmed that the demarcation results were effectively used during COVID-19 to plan where response should be provided.

Institutionalization was also exhibited in the establishment of systems that were utilized to provide services of facilitate action. The 7CP-supported review of strategies, service packages and training of healthcare of provision of adolescent and youth friendly services was institutionalized and interviews with the MoH and IPs confirmed that the services were part and parcel of the health facility services. During the period, UNFPA had an agreement with the Government of Lesotho to increase its budget allocation on procurement of FP commodities, in addition to plans to sign a compact agreement on this, and it is hoped that this will remain as part of the government commitment for implementation beyond the 7CP.

UNFPA's direct and collaborative support to the country on strengthening the policy, legal and institutional frameworks provide potential for institutionalization of support by the 7CP. The development of the Domestic Violence policy; Prevention and Management of Learner Pregnancy Policy, condom programming strategy; comprehensive package key populations strategy; the mainstreaming of gender and GBV in all the modules in the training manual for the National Police training curriculum; strengthened integration of SRH/FP/HIV and GBV training and development of guidelines on the same; among other policies, guidelines and strategies will be key to support interventions beyond the 7CP. Interviews and review of document revealed that UNFPA also supported the training of mentors at the health facility levels and these effectively supported on mentorship and supervision of other health facility staff to ensure quality service delivery and data management and it is hoped that these will continue to be even after the 7CP ends. The intended development of the midwifery curriculum with the National University of Lesotho will contribute to the quality of midwifery services through preservice training; enactment of the amendment of the Children's Protection and Welfare Act 2011 to reflect on the child marriage with contribute to addressing the cases of child marriage once it harmonizes the marriage age and enhance protection of the rights of the children, particularly, girls.

While UNFPA, through the 7CP supported mechanisms for ensuring lasting results beyond the life of the current programme, there were aspects that limited the extent to which the results could remain for long. UNFPA funded the RHCS support to the government due to inadequate government funding of the same and this limits sustainability. Further, there is low financial allocation to the health services and therefore most of the gaps are covered by donors, which also threatens sustainability as the gains made through the 7CP support may be affected. The capacity of the government to monitor and supervise implementation of the policies, strategies and guidelines developed were still low as they also dependent on the donor funds to conduct joint monitoring activities. Gender and GBV are still issues in the country, with the socio-cultural connotations being strong at the community level and may take some time before realization of results. Further, there are still gaps, especially in the government owning development processes. While there was a strong engagement with the MoH and MoGYSR including ownership of processes, this needs to be strengthened among the population related ministries.

4.6 Answer to Evaluation Question on Coordination

EQ6: To what extent has UNFPA contributed to the functioning and consolidation of the coordination mechanisms of the UNCT and the HCT, including how the UNFPA Country Office provided leadership in SGBV and SRHR coordination and contributed to the collective response to the COVID-19 crisis?

Summary: UNFPA's contribution to the UNCT and HCT coordination mechanisms is extensive and greatly appreciated by the UN agencies. The CO utilized its comparative advantage within the UNCT to facilitate functioning of coordination mechanisms among the UN agencies, in addition to building collaborative partnerships and implementation of joint programmes with respective UN agencies in SRHR, HIV and AIDS, DRM, A&Y and Gender and GBV. UNFPA also led thematic groups on M&E and technical working groups related to the thematic areas of comparative advantage, in addition to co-leading the PSEA Network and gender and GBV thematic areas. UNFPA also had strength in coordination and linkage of the MoH services to the different advocacy groups within the UNCT, further enhancing coordination, accountability and capacity building. There were, however, weaknesses in the UNCT-wide coordination mechanisms that needed to be addressed. UNFPA also needs to strengthen coordination of the SRH with key partners.

Interviews with UN agencies revealed that UNFPA played a major role in the coordination mechanisms within the UNCT and HCT. This entailed active participation on the inter-agency Programme Coherence Team (PCT), Operations Management Team, and other UNCT and HCT thematic groups, in addition to leading some of the groups, working with the other UN agencies in the country. Feedback from interviews also indicate that the CO collaborated with other UN agencies in the related thematic areas, in addition to implementing joint programmes with agencies in related interventions areas. UNFPA aslo participated in the UN agency meetings, led by the agency head and technical teams. These confirm the contribution UNFPA made in the coordination mechanisms within the country.

UNFPA contributed to the functioning of the UNCT through contributing and leading some of the thematic groups within the UNCT and HCT. During the period of evaluation, UNFPA provided leadership to the Gender and GBV thematic group. Interviews with the UN agencies and UNFPA staff revealed that UNFPA played a key role in ensuring gender mainstreaming by the UN agencies, where it was also confirmed that UNFPA was always consulted on the Gender and GBV issues, including taking lead roles. UNFPA also led the PSEA Network supporting the UN agencies, the government and IPs on the same to ensure mainstreaming of mechanisms preventing the same. For example, UNFPA provided technical support and leadership to the UNDP consultant hired to support the Ministry of Public Service on PSEA based on the recommendation of the pilot Gender Audit conducted in the Ministry of Public Service, with support from UNDP, to strengthen gender and GBV and mainstreaming of PSEA in the civil service. Further, UNFPA and WHO collaborate under the PSEA Network on prevention and response, ensuring that there they had a common plan and implementing it together (Interviews with UNRCO, CO and WHO). UNFPA also contributed to the outcome areas, through reporting, of the UNDAF, in addition to leading the Outcome 4 result area, a role that interviews indicated UNFPA played effectively.in the same strength, UNFPA chaired the M&E thematic group for more than two years where the CO facilitate effective consolidation of reporting mechanisms among the UN agencies in the country. Under the UNFPA leadership, in 2021 supported the joint collaboration in commemoration of 16 days of activism under the Gender theme group with all the UN agencies contributing to the occasion. In collaboration with UNDP in 2019, UNFPA supported the MoGYSR to develop an Implementation Plan for the Gender and Development Policy of 2018, which highlighted the centrality of women's empowerment and the prevention of GBV. In addition, the plan enabled clarity in roles and responsibilities, with the Gender stakeholders being able to select areas of focus without duplication of efforts and overlaps.

All these are indications that UNFPA contributed to facilitating coordination within the UNCT and HCT (Interviews with CO, UNICEF, UNAIDS and UNRCO).

Interviews with UN agency staff further confirmed the strength of UNFPA in its areas of comparative advantage. Under the adolescent and youth component, UNFPA effectively coordinated development of a joint plan on adolescent and young people and it is through this that the agencies ensure that there was no duplication of efforts, in addition to learning from one another on what each agency is doing. UNFPA also led the Adolescent Health services among the UN agencies in Lesotho, effectively facilitating the linkage between the health service providers to the adolescent and young people. On implementation of the CSE, UNESCO is the convenor, and targets those in school while UNFPA targeted those out of school. Further, UNFPA and UNESCO shared districts and supported each other financially. For example, when UNFPA did not have adequate funds to support CSE implementation in Butha Buthe district, UNESCO came in and took it up for support. Further, during training of journalists on Media

Engagement on ASRHR, UNFPA did not have adequate funds to finance the training, and UNESCO came on board and catered for the accommodation costs, while UNFPA footed the fieldwork costs and DSA for the 40 journalists attending the training (Interviews with CO, UNRCO and UNESCO staff). It is also through working together under the youth component that the related agencies consolidated efforts and engaged on areas of technical advantage. For example, UNFPA, UNESCO and UNAIDS collaborate to consolidate reports based on contribution from each of them for the UNDAF indicators. UNFPA and UNICEF collaborated and worked together in the coordination in provision of Adolescent-friendly health services, in addition to capacity building of the healthcare workers and service providers and development of key documents on adolescent health (Interviews with CO, UNICEF and UNAIDS staff). In coordination with WHO, policies, the adolescent minimum standards were developed, including supporting the adoption and operationalization of the SADC score card on adolescent health, and further ensuring that the EHS package for adolescent and youth indicators are integrated. When UNDP supported the development of Youth Development Act, UNFPA was instrumental in bringing the ASRHR components and job creation. Further, UNFPA also supported ILO during youth training in Leribe district bringing in SRHR aspects to the training. On HIV aspects, UNFPA and UNAIDS collaborated, with UNFPA supporting the CSE delivery, focusing on prevention of new infections among the adolescents and youth, while UNAIDS focused on financing the Faith-based organizations (FBO) targeting the faith sector strategies aimed at demystifying some of the faith-held beliefs on HIV, in addition to targeting the community level stakeholders (Interviews with UNAIDS, UNESCO and CO staff).

UNFPA contributed to the functioning of the coordination mechanisms among the UN agencies through participating in the implementation of joint programmes or initiatives. At the time of the CPE, UNFPA was leading and coordinating the implementation of the Together for SRH, together with UNICEF, WHO and UNAIDS, contributing to the strengthening of integration of GBV, HIV into SRHR services, leading to the development of the RMCAHN strategy, supported by the Swedish Government. Interviews with the related UN agencies indicated that UNFPA was effective, especially in taking the lead on SRH and ensuring that the integration took place effectively. Further, the contributions of the other UN agencies were also in a coordinated manner, with each providing support to the MoH based on an area of comparative advantage. For example, WHO ensured that the guidelines were compliant with the international standards; UNICEF supported on advocacy issues for children and the adolescent health; UNFPA on GBV mainstreaming, HIV prevention and SRHR aspects; while UNAIDS contributed to the integration of HIV into the strategic plan (Interviews with CO, WHO, UNICEF and UNAIDS staff). With the leadership role in the delivery of the programme, however, there were feedback that the CO could do better on holding follow-up meetings to plan and establish a combined programme progress as this was lacking from the coordination role of UNFPA.

"Under the Together for SRH, Under the coordination of UNFPA, all the implementing agencies (UNAODS, WHO and UNICEF) provide support supervision to the MoH and write the report together, in addition to identifying areas of support based on the areas of comparative advantage". – **Respondent from a UN agency during the CPE**

On the generation of the MDSR information, UNFPA, WHO and UNICEF were part of a technical committees coordinating the generation of the report. UNFPA provided financial support to MoH on the capturing and documentation of the MDSR results in collaboration and support by the UNICEF and WHO. Further, UNICEF contributed data on the neonatal death and still birth to beef up the details of the MDSR reports generated. Interviews revealed that these would initially be produced separately, but currently the data on neonatal and perinatal report are include in the MDSR reports generated and shared, an indication of ensured coherence in information and decision-making among the UN agencies. UNFPA and WHO also worked together on capacity building of healthcare workers and development of guidelines, particularly, contributing in their areas of strength. Additionally, UNFPA contributed to strengthening the health sector response, particularly working with the WHO and UNAIDS on adoption of essential health service package, provision of medical and legal services, capacity building, mainstreaming of GBV through development of GBV tools and manuals, among other contributions (interviews with CO, UNAIDS and WHO staff). The UN health agencies also collaborated under the H6 coordinating group, particularly under the leadership of WHO, with UNFPA identified as an active participant. While H6 group, under the leadership of WHO was effective and delivered effectively, it is currently weak having been affected by COVID-19. Inconsistent meeting sessions by the heads of agencies in the H6 group was also identified as an issue, despite efforts made last year in reviving it. It is even feared that the Together for SRH

programme is playing a key role in coordinating the H6 member agencies and there is fear that this will fizzle once the programme comes to an end (Interviews with CO, WHO, UNAIDS and UNICEF).

UNFPA was identified as an active participant in joint UN initiatives, particularly on related calls for proposals. For example, in the 2019 drought appeal for funds, UNFPA was part of the implementation of the CERF. Further, UNFPA was part of the UNDRM team where they supported the main partner DMA, ensuring that gender and GBV was mainstreamed in the response plans, in addition to using the platform to ensure effective response. In addition, during the El Nino in 2019, together with WHO and UNICEF, UNFPA supported the protection team on mainstreaming child protection and women protection mainstreaming, including conducting joint training on the same. UNFPA also participated in the joint programme on data where it strategically positioned itself to lead the UN agencies in supporting the country on the VNR report on SDGs. UNFPA was also recognized by the UN agencies for the role it played contributing to the Global UN Socio-Economic Response Plan to COVID-19 through supporting the Health First indicators covering the SRH aspects and supporting the government with the RH commodities and Medicine, including PPEs to the health facilities ensuring protection of the health staff. UNFPA also coordinated with the WHO how essential health services were to be delivered during COVID-19 and supported the MoH on the delivery of the services.

UNFPA was also a key member of the Lesotho Joint United Nations Team on AIDS (JUNTA) as a HIV Prevention Lead where all the UN agencies supported the country in a coordinated manner without duplication of efforts, in addition to funds being pooled accordingly with UNAIDS coordinating the efforts, particularly under the Unified Budget, Results and Accountability Framework (UBRAF), where resources and activities are coordinated effectively. Interviews with the CO, UNICEF and UNAIDS revealed that all the agencies contributed in their areas of strength with UNFPA supporting on condom programing targeting prevention of new HIV prevention among the young and key populations. Further, IOM focused SRHR among the mine workers and migrants and sex workers along the borders linking them to services across the borders; UNICEF supported on PMTCT and Child health; UNDP focused on human rights, livelihoods and entrepreneurship; WHO provided technical guidance and policy in the medical field in addition to ensuring quality control with situational analysis done in alignment with the policies and guidelines; and WFP focused on nutrition, food security and livelihoods. Additionally, UNFPA led the commemoration of the World AIDS days where the JUNTA members also coordinated activities jointly, including communicating the key messages (Interviews and document reviews). UNFPA further collaborated with UNAIDS, UNDP, WHO, UNESCO and UNFPA to support the NAC on strengthening HIV and AIDS response in the country, with UNICEF, WHO and UNFPA strengthening collaboration on maternal health, particularly on EmONC. UNFPA also participated in the activities of the Education-Plus Initiative (EPI) which is coordinated by the UNAIDS. While the EPI is an initiative bringing together different agencies together, there is a bit of mixed reaction on the clash of mandates, particularly with the leadership on UNAIDS, and why not UNESCO leading it (Interviews with UNAIDS, CO, and UNESCO staff)

While there were efforts noted to contribute to the functioning of the UNCT and HCT, particularly contributed by UNFPA, there were areas requiring improvement. For example, it needs to strengthen the coordination aspects within the Together for SRH Programme, including increasing the number of coordination meetings held on the same and adequate communication to the other focal points for the UN agencies. On the other hand, interviews indicated that coordination was not so effective in its fullest, particularly with gaps in coordination mechanisms. For example, the H6 group is no longer active; the M&E thematic group is lowly being coordinated by the UNRC office. There is need for enhanced coordination among the agency heads for the general coordination and enhanced delivery as one.

4.7 Answer to Evaluation Question on Coverage

EQ7: To what extent have UNFPA humanitarian interventions during the drought and COVID-19 systematically i) reached all geographic areas in which affected populations (women, adolescents and youth) reside and ii) reached the most vulnerable and marginalized groups (young people and women ethnic), Sex workers, LGBTIQ populations?

Summary: During the period of coverage, UNFPA was instrumental in ensuring targeting of the vulnerable, marginalized communities and most-at-risk populations with services and strategies and policies, through partnerships, particularly with the government and line ministries and NGO IPs facilitating coverage. UNFPA also supported and promoted evidence-based programming ensuring that the most vulnerable were identified to benefit from the programme interventions. UNFPA's identification and focus on districts with worse indicator in the areas of CP focus was also evident. Inadequate, however, funding and staff capacity limited the extent of coverage. vulnerable and marginalized groups.

"*UNFPA made it possible for us to focus on prevention of GBV and Teenage pregnancy through advocacy for their inclusion in the rapid assessment questionnaire since they were not captured in the tool. We turned a blind eye to the issues... We did not know about the issues of child marriages due to the vulnerabilities they are exposed to during disasters, and that the girls from poor households become more vulnerable due to susceptibility to sexual exploitation*". **– Respondent from DMA during CPE.**

The UNFPA programme coverage within the country is driven by the mission of leaving no one behind. In this spirit, UNFPA ensured that the programme targeted both vulnerable populations in hard-to-reach areas and marginalized populations with services and targeting them in advocacy and policy dialogue, and further emphasising the targeting of the poorest population groups with services. Interviews with the IPs, Government line ministries and agencies and CO staff indicated that UNFPA contributed to strengthening access to services by the marginalized and vulnerable populations affected by disasters in various locations during the period of coverage. UNFPA contributed to the development of strategies, guidelines and SOPs to guide delivery of services to vulnerable populations during disasters, capacity built and supported government agencies and IPs to deliver services and support the affected populations; supported evidence generation to identify vulnerabilities and inform response; and participated in partnerships and collaborations with various entities to support the country during disasters.

UNFPA's general contribution to meeting the needs of those affected by disaster was both at national and community level supporting interventions reaching the hard-to-reach locations. UNFPA was identified by the various respondents as a key contributor to the humanitarian response targeting the most vulnerable and marginalized populations. At national level, UNFPA was part of the DRMT, with the main partner being the DMA, where the CO used the platform and successfully advocated for the mainstreaming of gender in response plans, enhancing inclusion of vulnerable populations, including women and girls during disasters to ensure that they are included in the humanitarian response. Key to note is that UNFPA was instrumental in improving the national rapid assessment tools to include vulnerable women and girls, including GBV survivors and those susceptible, to ensure that their needs were identified to enable them access support services in their time of need (Interviews with DMA, Red Cross, World Vision International, UNRCO, CO and review of SIS reports).

Interviews with IPs and DMA indicated that UNFPA successfully supported identification and support of those affected by drought in Mokhotlong, Leribe, Quthing and Mafeteng districts during drought. While the evaluation could not establish the extent to which the needs were addressed, the contribution in identification of the vulnerable households, in itself and advocacy on targeting them, with feedback from respondents indicating that the identified vulnerable households were supported by various agencies, including NGOs based on needs and within the resource constraints confirms the contribution of the CO. For example, in 2019 when World Food Programme shifted to cash transfer modality targeting the vulnerable households, and while mainstreaming protection DMA advocated for dignity kits (menstrual kits) for the women and girls, ensuring that every household identified as a beneficiary received a basic package (Interviews with CO, IPs and MoGYSR staff).

There was great indication during the COVID-19 pandemic on the contribution that UNFPA made to

ensure that the vulnerable populations were supported reducing their level of vulnerabilities. As part of the global UN Socio-economic Response Plan to COVID-19, UNFPA contributed in the assessment in identifying the most affected in order to ensure they accessed the services at the height of COVID-19 pandemic. Interviews with the UNRCO, UN agencies and MoH staff confirmed that UNFPA ensured procurement of additional RH supplies, and PPEs, and positioned them in the health facilities, in addition to supporting development of guiding document for continuation of Essential services package for use by the facilities for pregnant women and FP, to ensure continuity of the services during the pandemic. UNFPA ensured continuity of supplies of medicine and other needed commodities through assisting the NDSO, further ensuring continued coverage for the affected populations. UNFPA and IOM also ensured that the key populations were covered in the Socio-economic response plan through providing disaggregated data on their access to services. To ensure coverage of the hard-to-reach areas, UNFPA confirmed contributing to the reducing the chances of adolescent girls getting pregnant by introduction of the self-injection FP methods with the young people trained on it, and collaborating with UNESCO to advocate for negotiations of condoms with sexual partners (Interviews and Document reviews). UNFPA supported the MoH to adopt the COVID-19 guidelines in relation to the SRH services, including covering the needs of the LGBTIQ+ and sex workers with supplies of condoms and lubricants for their access, in addition to promoting multi-months' dispensation of less skills methods and tele-medicine (calling healthcare provider for counselling and assurance) which were confirmed to enhance access to services by the affected populations. The support of UNFPA to the MoH in the demarcations enable the ministry to plan for the COVID-19 vaccination outreaches with the feedback that this was effective in coverage of the facilities and the populations. While is not clear about the data on attendance and uptake of the services, interviews results indicated that the attendance of men was low.

Under the GEWE component, UNFPA helped to set up a referral mechanism through the online hotline which helped stakeholders identify cases and refer them for services. Further, UNFPA supported the LMPS to set us a hotline for the remote reporting of cases of violations reporting through the Child Gender Protection Unit (CGPU), and the police trained, empowering them to respond to respond during emergencies, and was confirmed to be effective, with UNFPA further supporting the unit with 20,000 medical forms for reporting of sexual violence. UNFPA further supported the validation and dissemination of the National HIV policy which synergises HIV, SRHR and GBV also incorporating marginalized populations and the furthest left behind UNFPA was also part of the risk communication group on COVID-19 reaching the population with IPC information and services access. UNFPA also supported the World Vision International to identify and support the affected populations during COVID-19 (as described in Section 4.3.2). Interviews also confirmed that the PWDs were intentionally included for support along women and girls during the period, and the IPs worked with community leaders to intentionally invite women, girls, men and people with disabilities in addition to targeting them to benefit from the provision of the hygiene package through the social workers, ensuring that even those who could not walk were covered to benefit. Further, the programme made strides in reaching the marginalized communities/ groups through targeting the herd boys with GBV and SRH information and services (Interviews and SIS reports).

While UNFPA made efforts to ensure coverage of vulnerable and marginalized populations during disasters in the period of coverage, it was limited by funding and staff capacity, compared to the exponential needs and timely response. The CO however utilized different mechanisms, including partnerships with the government ministries, IPs like Red Cross and World Vision International with experiences in disaster response, in addition to collaboration within the UN, utilizing its comparative advantage which were effective in ensuring coverage, both geographically and demographically among those affected by the disasters.

4.8 Answer to Evaluation Question on Connectedness

EQ8: To what extent has UNFPA contributed to developing the capacity of local and national actors (government line ministries, youth and women's organizations, health facilities, communities, etc.) to better prepare for, respond to and recover from humanitarian crisis?

EQ9: To what extent have the interventions supported by UNFPA taken into account complementarity and integration of ongoing development plans, programmes including related thematic areas from various stakeholders?

Summary: The 7CP contributed to strengthening capacities of the national stakeholders, development of strategies, guidelines, policies and tools to guide implementation, and enhance advocacy. UNFPA also promoted national ownership through working with the government and IPs.

As illustrated in the previous sections of the report, UNFPA played a key role in strengthening the capacities of the national and local actors to better prepare and respond and recover from disasters. Interviews with IPs and Government staff indicated that UNFPA was instrumental in capacity building mechanisms on preparedness, enhancing long terms results beyond disasters. Under the GEWE component of the CP, the Lesotho CO supported the integration of gender in both the National Response Plan by DMA through the LVAC; and the UN Response Plan through the Humanitarian Country Team, ensuring mainstreaming of gender, identifying the vulnerabilities of those affected by disasters along age, gender and diversity (including PWDs and key populations), in addition to training the stakeholders on advocacy mechanisms on the same. DMA confirmed operationalizing this by advocating with WFP during cash transfer to cover the GBV survivors and those susceptible to exploitation due to the poverty situation.

UNFPA, together with UNDP also supported the production of the disability situational analysis report and was approved by Ministry of Social Development, producing it in braille formats for the visually impaired PWDs. It was not however clear how this report was utilized during the period of CPE. UNFPA also ensured incorporation of the marginalized populations and the furthest left behind coverage by the National HIV policy integrating HIV, SRHR and GBV (Interviews and SIS report). Interviews during the CPE confirmed that UNFPA contributed immensely to the introduction of GBV data collected by the police stations due to the training support it provided during the COVID-19 response to conduct assessment on its effects on GBV, and this continued to be implemented, with the current cases being collected at the police stations as these were never there before the support.

The 7CP had contributions from the government through the CO's strategic approach of partnered and implementing its interventions through the government structures in addition to channelling funding of activities directly through line ministries, ensuring that they were part of the results achievement. UNFPA directly contributed to the result of the line ministries in Lesotho, ensuring that they fed the results of the National Development Plan. The MoH staff, for example, supported the SRH activities contributed to by UNFPA during the 7CP. During COVID-19, the MoH supported outreach activities and implemented in the hard-to-reach areas enhancing on the results of the country and UNFPA SP. UNFPA also supported the MoH with training of healthcare workers training some of them as mentors providing supervision in the facilities and they continued to provide the services without UNFPA support. UNFPA also supported the development of guiding documents to be used during disasters. For example, the communication strategy put in place to advocate for the uptake of EHS and COVID-19 vaccination are still utilized to enhance service access, particularly in the SRH field. While during COVID-19 UNFPA supported introduction of self-injection to reduce congestion in the health facilities, particularly the hard-to-reach areas, this contributed to improving uptake of services, and continues to be used beyond the pandemic response period, enhancing inventory flow. This confirms uptake and utilization of the strategy and is likely to be used to beyond the programme.

With the support of the LMPS to conduct research on GBV at household levels during COVID-19, leading to the consideration of GBV as part of crime with data at the police stations currently disaggregated as such, ensuring that the cases are addressed. Interviews confirmed that this is still continuing at the CGPUs with UNFPA support with distribution of data tools.

During disasters, UNFPA ensured integration of SRH and GBV into programming with the government and IPs implementing humanitarian activities embracing this to ensure vulnerable households are targeted during response. The advocacy and awareness conducted by the CO enabled the success of this (Interviews with IPs and document reviews). Interviews also indicate that the due to the advocacy activities on mainstreaming of gender and GBV spearheaded by UNFPA during the 7CP, the PWDs,

PLWHA have lifelong support from the government of Lesotho through the social safety net. On the other hand, the government has taken seriously the issue of incest or rape to school-going girls and no longer treated as family affair as it used to be where the girls never got justice. The legal and referral frameworks are still not strong enough to ensure these are effectively addressed.

4.9 Lessons Learnt, Best Practices and Unintended Consequences

4.9.1 Lessons Learnt / Best Practice

- The act by UNFPA to design and deliver programmes specifically tailored to the needs of the key populations, like supporting procurement of condoms with lubricants for LGBTIQ+, and having informal repository sites for the FSW, enhanced their confidence and access to SRH and HIV services, including increasing their participation freely in activities targeting them
- UNFPA support to the community-based distributors, particularly targeting the hard-to-reach areas effectively facilitated the distribution of the FP commodities and made it convenient for the access by the clients particularly reducing the burden of access by the targeted populations in the locality
- UNFPA supporting integration of the SRH/GBV/ FP and HIV services made service delivery convenient in addition to facilitating capacity building of the healthcare workers on the same to ensure implementation of the strategies
- The partnership enhanced by UNFPA with the IP, MoET UNESCO and the communities, and development of registers and capacity strengthening enabled efficiency in the implementation of the CSE curriculum for the in and out of school
- The strategy by UNFPA to shift from conference training of healthcare workers to promoting implementation of mentorship programme enhanced transfer of practical skills strengthening sustainability
- Collaboration between MoE and MoH strengthened the mechanism for service delivery and enabling smooth access to ASRH services by the adolescent and young people
- The standardization of the CSE tools has enabled smooth operationalization of the curriculum without challenges
- UNFPA integration of evidence generation into the programme components enhanced evidence-based response, facilitating utilization of data.
- By UNFPA supporting the country in the development of the various policies and strategies aimed at enhancing GBV prevention and response generated interests in the country, it increases awareness and engagement among the duty beavers and policy holders to discuss the issues

4.9.2 Unintended Consequences

- The training of teachers on the CSE deliverer improved their practical skills in the delivery of other subjects and enabled more engagement with the pupils by the teachers, further improving the relationships between the teachers and their pupils.
- There was also improved performance of the pupils in class as the participation in the course provided them with practical experiences which enhanced their understanding further.

CHAPTER 5: CONCLUSIONS

5.1 Introduction

This chapter captures the conclusions of the CPE in compliance with the UNFPA CPE Handbook. It details both strategic and programmatic focus, and logically flow from the findings presented in Chapter Four. They are presented at strategic level (covering relevance, efficiency, sustainability, coverage, connectedness and coordination), and programmatic level covering the CP component area.

5.2 Strategic Level

Conclusion 1: The 7CP was well adapted and aligned to the intentional frameworks, national priorities and populations needs in the development and humanitarian context during the period of evaluation. UNFPA, particularly, adapted effectively to the COVID-19 implementation context, ensuring an integrated service delivery, including HIV, FP, SRH, Gender and GBV, evidence-based approaches in identification of the vulnerable populations for protection interventions and development of service packages for them.

Origin: EQ 1, EQ2, EQ5 and EQ7 *Evaluation Criteria*: Relevance, Sustainability, Effectiveness and Coverage *Associated Recommendation:* 1

The CP design and implementation was in alignment with the international development frameworks and directly contributed to the addressing strategic priorities of the government and the population in general. UNFPA capitalized on both upstream and downstream advocacy, in addition to strategic partnerships and consultations with the stakeholders providing effective targeting and reach of the affected populations. The programme was well adapted to the COVID-19 context, further enhancing integration of the programme to increase access to services, while at the same time limiting their exposure to the risk of contracting the pandemic. Further, during the period, UNFPA still aligned to its areas of mandate and effectively contributed to the response mechanism within the country. There is however room for more strategic partnership, particularly with the government structures to enhance response to the population needs.

Conclusion 2: The UNFPA CO demonstrated corporate strengths recognized by the UN agencies interviewed and this immensely contributed to the functioning of the coordination mechanisms within the UNCT through leading in various UNDAF result groups, implementation of joint programmes and collaborated with related agencies facilitating leveraging of resources and eliminating overlaps. There were however, challenges of coordination within the UNCT, with COVID-19 response weakening some of the mechanism. UNFPA also needed to ensure effective coordination among the members of the Together for SRH for maximum information sharing.

Origin: EQ 1 and EQ6 *Evaluation Criteria*: Relevance and Coordination *Associated Recommendation*: 2

UNFPA was instrumental in facilitating the coordination mechanism within the UNCT and HCT. UNFPA played a key role in the various results groups and effectively coordinated and utilized its areas of comparative advantage to contribute to the functioning of the UNCT and HCT coordination mechanisms. Particularly, UNFPA was instrumental in taking lead in gender and GBV mainstreaming and PSEA

supporting the various agencies in implementing the themes. UNFPA also had joint programmes SRH and HIV, and had collaborative efforts with the UN agencies further enhancing the principle of delivery as one. There were however weaknesses in the coordination mechanisms among the UN agencies that were hindering effective functioning of the UNCT. Further, UNFPA was reported to be weak in coordination particularly for the Together for SRH programme to ensure consistent sharing of information on progress and review. There was also reported overlaps with the IOM cross-border programmes.

Conclusion 3: UNFPA strived to ensure efficiency in the utilization of various resources, including human, financial and facilities through putting in place various mechanisms, like internal controls, strategic partnerships, especially with the government, effective planning mechanisms, integration among others. The CO was however constrained financially, especially given that the CO depended on the regional office for resource mobilization which did not work to effectively fundraise for the 7CP, in addition to the staff being overstretched due to high expectations and competing priorities while they were a staff each per component.

Origin: EQ1, EQ2, EQ 4 and EQ7

Evaluation Criteria: Relevance, Effectiveness, Efficiency and Coverage

Associated Recommendation: Strategic Recommendation 3 and 4

UNFPA Lesotho achieved a lot with the resources that they had, in addition to devising mechanisms and approaches that ensured that the results were effectively achieved within the resource constraints. UNFPA built strong strategic partnerships with the government and IPs ensuring national ownership and institutionalization of the results, and coverage. Further, joint programmes and collaborative efforts within the UNCT also contributed to the efficiency of the delivery in the programme interventions. Putting in place strong internal controls and adherence and compliance to the same, high integration of the programme, technical capacity of the staff enhancing technical assistance to the various stakeholders in their areas of responsibilities were instrumental in ensuring efficiency in the delivery of the 7CP. The CO however lacked a clear resource mobilization strategy leading to inadequate to technical capacity by the staff enabled effective support. Further the staff capacity in terms of size was reported to be constraining in comparison to the mandate and coverage. There were also reported lateness in disbursement mechanisms that affected programme delivery.

Conclusion 4: The 7CP was successful on institutionalization of the interventions and strategically focused the support through the national structures promoting ownership, in addition to capacity building of the various national institutions, including line ministries, agencies and IPs contributing to transfer of skills that facilitated both ownership and strengthened capacity to provide the services. The instability in the line ministries' leadership, inadequate capacities and support by the government to facilitate implementation of some of the support results hindered the extent of sustainability.

Origin: EQ 5, EQ8 and EQ 9 *Evaluation Criteria*: Sustainability and Connectedness

Associated Recommendation: Strategic Recommendation 5

UNFPA immensely contributed to strengthening national and community ownership of the programme through targeting and working with the government, local IP and community structures. In addition, there were efforts made in strengthening capacities within the ministries and stakeholder groups, in addition to institutionalization of support particularly in development of policies, plans, guidelines and strategies. There were however gaps hindering prospects of sustainability, like inadequacy in commitment by the government and capacity in making follow-ups on implementation of policies. High turnover in key government offices, in addition to frequent transfers of health staff also threatened continuity and institutionalization of 7CP results. Further, inadequate resource mobilization capacities by the IPs and government have propensity to affect continued implementation of the gains made by the 7CP. The emergence of COVID-19, in addition to refocusing funds for response also limits focus on sustainability.

Conclusion 5: The integration of monitoring and evaluation functions into the 7CP was sub-optimal. Inadequate allocation of resources for the function was evident limiting the extent of focus on its achievement. The overarching theory of change is insufficiently robust in determining the results.

Origin: EQ2, EQ3, EQ4 and EQ5 *Evaluation Criteria*: Effectiveness, Efficiency, and Sustainability

Associated Recommendation: Strategic Recommendation 6

While the 7CP's M&E obligations were largely implemented during the period, it was not given a consideration at the beginning of the programme, and this contributed to a number of gaps in the quality delivery of the programme, and inadequate accountability as the programme staff were the implementers and the same people reporting on performance. The resources allocated to the OEE functions were also very limited, with some years being allocated nothing. The review of the reports also showed mostly activity level of reporting and this also limited the programme's focus on results. The feedback from the IPs and CO staff indicated that the M&E focal point was instrumental in ensuring alignment of the programme and compliance to the data and donor needs, in addition to providing capacity support to the programme in the area of planning and monitoring.

Conclusion 6: UNFPA was successful in the integration of evidence generation into the three components of the 7CP through development of data collection tools, particularly strengthening the country's statistical systems to capture gender and GBV, SRH and adolescent and youth information, in addition to population projections. There was however inadequate financial allocation to this docket limiting the capacity and level of support, in addition to suboptimal utilization of data for policy formulation and programming.

Origin: EQ 1, EQ2 and EQ5 *Evaluation Criteria*: Relevance, Effectiveness and Sustainability
Associated Recommendation: Strategic Recommendation 7
The 7CP saw the CO implement evidence generation as part of the CP component and this directly feed into the functions of the components. For example, the support to the DMA on data tools, profiling vulnerability of women and girls during disasters; BoS including GBV, FP, Maternal Health, adolescent and disability aspects into the national data management systems, and population projections were instrumental. The support on the Demographic dividend brought to the fore the potential that the country has in making investments in the young people. There was however inadequate resource allocation for leveraging large-scale surveys, supporting advocacy for data use in policy formulation and programme development and institutionalization were inadequate.

5.3 Programmatic Level
Sexual and Reproductive Health

SHR Conclusion 1: There was great achievements made through strengthening integration strategies for SRH/ FP/GBV and HIV services during the 7CP. There was also enhanced capacity strengthening through supporting development of strategy, policies, guidelines, response plans and advocacy for institutional capacity development and enhanced delivery of and access to services in the country. There was however inadequate advocacy for improved quality of care, and male engagement in the HIV prevention and response during the period.

Origin: EQ2 and EQ5 *Evaluation Criteria*: Effectiveness and Sustainability

Associated Recommendation: SRH Recommendation 1

Improved access to integrated SRH, FP and GBV service delivery by the targeted populations through financial and technical and technical support of the government in building capacities, development of policies, strategies, response plans and strengthening evidence was realised during the period. In addition, access to postpartum services were enhanced and became integral part of the SRH service provision according to EHS package. Further, UNFPA strengthened government structures to provide mentorships in facilities, enhancement of skills of staff. Advocacy for quality of care was however inadequately done during the period. Male engagement on HIV prevention and response in the programme was low. There is a need to strengthen evidence-based programming and accountability through enhanced monitoring and supervision systems to ensure compliance and delivery.

SHR Conclusion 2: The CO made considerable strides in enhancing access to SRH, FP, GBV and HIV services for the key populations in addition to advocacy and capacity building the health services providers eliminating stigmatization of service delivery to the segment of the population. There is still room for improvement in enhancing the partnerships and collaborations to strengthen targeting of the key

populations, in addition to promoting advocacy and evidence-based response among them.

Origin: EQ2 and EQ3 *Evaluation Criteria*: *Associated Recommendation*: SRH Recommendation 2

Targeting of the key populations was one of the greatest milestones of the 7CP. UNFPA utilized a human rights approach to ensured that the key populations were targeted, in addition to supporting development of a comprehensive strategy for a service package for them. Further, UNFPA contributed to strengthening advocacy for service delivery to the target populations in addition to targeting reduction of stigmatization of service access by the key populations. While there were reduced stigma in targeting the key populations by the service providers, there were still cases of stigmatization, in addition to inadequacy of service access by a number of members as interviews indicated that they were still yet to come out, warranting more advocacy for enhanced targeting

SHR Conclusion 3: There was remarkable contribution of UNFPA in addressing the unmet needs for FP in the country through procurement and distribution of RH commodities, capacity building, supporting forecasting, quantification and tracking of last mile and reporting, strengthening access to long-term and mixed FP methods, and enhanced access to SRH services, in addition to postpartum services. There were however reported FP commodity stock-outs experienced across the health facilities. Further, the LMIS was not user friendly and presented challenges of sustainability. The government is still allocating inadequate allocation for FP in the country.

Origin: EQ2 &EQ5 *Evaluation Criteria*: Effectiveness and Sustainability

Associated Recommendation: SRH Recommendation 3

UNFPA strengthened demand creation, ensuring commodities security and access to and tracking data on FP services in the country, and this contributed to an increased uptake of the services, in addition to use of data for decision-making. However, stock-outs were still experienced, due to weak systems, particularly for stock re-distribution to other districts of need, commodity quantification and forecasting, and inadequate logistic management information system for FP commodities. At the time of the CPE, UNFPA was procuring nearly 90 percent of the FP commodity used by the country with government allocation being very little, in addition to LMIS which failed to meet its functions and had to be rejected during the period.

Adolescent and Youth

A&Y Conclusion 1: UNFPA was successful in the institutionalization and roll-out of the CSE into the In- and Out-of-School curriculum through supporting the MoET in revising the life skills curriculum to LBSE. Interviews however indicated that there were inadequate number of teachers trained on the same, learning materials and support to the primary school level delivery of the curriculum, with much focus at secondary school level. There were also strides made in targeting the parents and the community at large with the advocacy mechanisms to enhance the well-being and support for the young people to access SRH services. The community level targeting was however reported to be suboptimal as there were still cases of resistance from the community on the implementation of the curriculum

Origin: EQ2, EQ4 and EQ5 *Evaluation Criteria*: Effectiveness, Efficiency and Sustainability

Associated Recommendation: A&Y Recommendation 1

UNFPA's collaboration and support to the MoET to integrate LBSE curriculum was instrumental in enabling the young people to lead a healthy lifestyle and enhancing the response to the early and unintended pregnancies among the adolescents and youth, particularly in the target districts with high incidences. The 7CP ensured strengthened capacity of the MoET to deliver the curriculum in addition to enabling them monitor and ensure quality assurance. Inadequate learning materials, trained teachers and targeting of the primary level of education were reported to be affecting its effectiveness.

A&Y Conclusion 2: UNFPA's contribution to strengthened capacities of healthcare workers, policies, strategies, and programmes in relevant sectors to prioritize adolescents and youth to address the broader determinants of their SRH, development, and well-being was great. Reduced stigmatization towards and support for adolescent and youth-friendly service provision were also notable. There is still need for strengthening integration of adolescent and youth friendly services as these were said to be limited,

compared to the demand that was being created by the IPs and other stakeholders

Origin: EQ2 *Evaluation Criteria*: Effectiveness *Associated Recommendation*: A&Y Recommendation 2

UNFPA contribution in strengthening of establishment and provision adolescent and youth-friendly services by the MoH through development of policies, strategies, capacity strengthening of the healthcare workers and advocacy mechanisms was instrumental in facilitating the access to ASRH services by the target populations. The IPs and other stakeholders were also key in enhancing demand creating for the services. Interviews however identified weaknesses in the provision of the ASRH services within the health facilities, in addition to other structural bottlenecks occasioned by the socio-cultural norms.

HIV Prevention

HIV Conclusion: UNFPA's contribution and focus on HIV prevention targeting the marginalized and at-risk populations, including the key populations was evidenced. Development of strategies, guidelines and capacity building of NAC and DAC enhanced effectiveness in the HIV prevention. Resource allocation to the component was however limited, in addition to disjointed coordination between NAC and MoH limited the extent of targeting and consolidation of results.

Origin: EQ2 and EQ3 *Evaluation Criteria*: Effectiveness and cross-cutting

Associated Recommendation: HIV Recommendation

UNFPA contributed to strengthened the strategic and policy frameworks in the HIV prevention mechanisms in the country. The development of policies, strategies and conducting advocacy with the government and stakeholders to enhance access to HIV prevention services by the affected populations was immense during the period. Further, UNFPA ensured mainstreaming of GBV, targeting of the marginalized communities, inclusivity in the provision of services, and supporting the government of Lesotho in prevention of HIV, ensuring alignment with the international standards. Challenges of coordination, with use of different reporting mechanisms between NAC and the MoH limited results NAC used LePHIA and MoH uses DHIS 2 to report to report on HIV programming capturing different parameters limiting consolidation of results.

Gender Equality and Women Empowerment

GEWE Conclusion 1: The 7CP enhanced strengthening of the policy, legislative and institutional systems in combating gender inequality and GBV in the country. The CO further successed in strengthening evidence-based response for the GBV through strengthening capacity and data systems in the LMPS, enabling capturing of the data, in addition to classification of GBV as a crime. Inadequate allocation of resources to the GEWE component in the 7CP however led to inconsistency in support and consolidation of results for an effective response. In addition, there was low commitment and capacity of the government to implement the framework

Origin: EQ2 and EQ3 *Evaluation Criteria*: Effectiveness and cross-cutting

Associated Recommendation: GEWE Recommendation 1

UNFPA strengthened the country's legal and policy framework to protect women and girls from violence and harmful practices, in addition to advocacy with duty bearers, particularly upstream and it also developed a policy to manage teen pregnancy and child marriages. Additionally, it enhanced the capacity of police to deal GBV cases not as common offense but as a separate crime. Many of these frameworks have not been implemented due to the laxity of government when dealing with social problems and their implementation may further be delayed due to the resources the government needs to fully implement them.

GEWE Conclusion 2: UNFPA was consistent in the advocacy for identification and targeting of the vulnerable and marginalized women and girls in the country. There was also improved reporting of cases due to the capacity building and advocacy efforts by the GBV stakeholders, led by UNFPA. Further, there was also contribution to the strengthening of access to services by the GBV survivors, though these were limited. There were also reported weak referral systems, particularly access to the legal services by the survivors as evidence was weak. Engagement of duty bearers was also reported to be inadequate for effectiveness and sustainability.

Origin: EQ2 and EQ3 *Evaluation Criteria*: Effectiveness and Cross-cutting

Associated Recommendation: GEWE Recommendation 2

UNFPA contributed to the gender and GBV service delivery mechanisms as well as response mechanisms through awareness raising and advancing advocacy on child marriages and unequal power relation between men and women by engaging various actors such as legislators, policymakers, community leaders, and perpetrators such as men and boys. However, more community leaders, including men and decision-makers in government, must be involved and targeted in advocacy programmes to set the tone and publicly demonstrate their conviction and commitment to gender equality in their public stances. Men's involvement in prevention and response to GBV was not sufficiently integrated into the CP support.

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

Strategic Recommendation 1: UNFPA should continue to strengthen strategic partnerships, capacities and institutional frameworks, particularly government institutions to facilitate implementation, monitoring and fulfilment of mandate while at the same time addressing the felt needs of the country, in addition to advocacy for enhanced replication of successful 7CP initiatives for enhanced results, targeting hard-to-reach and marginalized communities in the country.

Associated Conclusion 1 **Origin**: EQ 1, EQ2, EQ 5 and EQ7 **Priority**: High **Target**: CO

Operational Implications: For enhanced delivery of services and response to the existing gaps, the CO should strengthen capacity building for the government institutions, strengthen and explore new partnership and resource mobilization opportunities and invest on evidence generation to inform programme formulation in the 8th CP.

Strategic Recommendation 2: UNFPA should continue building and strengthening its comparative advantage, in addition to exploring more opportunities for joint programming and collaboration within the UNCT to ensure no one is left behind, and to enhance delivering as one. Further, advocate for more accountability among UN agencies though enhanced coordination among the UN agencies

Associated Conclusion 2 **Origin**: EQ 1 and EQ6 **Priority**: High **Target**: CO and UNRCO

Operational Implications: Strengthen partnerships with the UN agencies for leveraging of resource to support collaboration and joint programmes. In addition, UNFPA should continue and strengthen utilization of its comparative advantage to participially enhance evidence-based programming while mainstreaming gender and strengthening advocacy for human rights approaches among the UN agencies. Advocate for more coordination and collaboration in the areas of responsibility to eliminate overlaps and maximize results.

Strategic Recommendation 3: The CO should have a clear resource mobilization strategy for the 8th CP to enable focused resource allocation according to the felt needs. The CO should also reassess its human resource structure and critically align the capacities to the expected deliverables and priorities of the respective components for maximum realization of results.

Associated Conclusion 3 **Origin**: EQ1, EQ2, EQ 4 and EQ7 **Priority**: High **Target**: CO

Operational Implications: Resource mobilization strategy will demand wider partnership mechanisms with donors, UN agencies and NGOs, among others. The decision on human resources would also require reassessment of strategic positioning in the country to ensure that right capacity exists

Strategic Recommendation 4: The CO needs to strengthen it financial management system to facilitate

programmatic delivery and accountability by reducing time taken between requisition and disbursement of funds to the IPs. The CO should also ensure early planning in the year in alignment to the available resources to facilitate implementation of programmes as approved in the AWPs

Associated Conclusion: 3 **Origin**: EQ1, EQ2, EQ 4 and EQ7 **Priority**: High **Target**: CO

Operational Implications: There will be need to enhance capacity building mechanisms to the IPs on financial management systems, reporting and accountability mechanisms. Programme reviews should also be enhanced to ensure quick turnaround on the AWP development processes. The human resources, particularly in the finance unit of the CO will also need to be enhanced to ensure efficiency in delivery.

Strategic Recommendation 5: Continue to strengthen the relevant strategic partnerships with and capacity building of key government and non-government and private agencies to enhance national ownership and capacity of the stakeholders to deliver in their mandate and ensure sustainability. The CO should therefore focus on strengthening institutionalization of support to the government to overcome the high turnover of staff.

Associated Conclusion 4 **Origin**: EQ 5, EQ8 and EQ 9 **Priority**: High **Target**: CO

Operational Implications: Elevate partnership and capacity building as the main modes of engagement. Enhanced resource allocation will be required for capacity building and assessments to ensure evidence-based support.

Strategic Recommendation 6: Strengthen the programme's focus on M&E, in addition to both the theory of change and the logic across and within the thematic areas in the RRF to ensure effectiveness and appropriateness of deliveries.

Associated Conclusion 5 **Origin**: EQ2, EQ3, EQ4 and EQ5 **Priority**: High **Target**: CO and RO

Operational Implications: There will be need for financial allocation for M&E functions and to strengthen the capacity of the CO on the results-based focus, in addition to enhancing the potential for greater interactions among staff and other stakeholders on results, given the high integration in the current CP.

Strategic Recommendation 7: The CO should build on its UN mandate on data and enhance its resource allocation for related large surveys to facilitate evidence generation for policy and development formulation. In addition, the CO should strengthen advocacy mechanisms for utilization of the generated data for enhanced decision-making, with a particular focus on harnessing the demographic dividend.

Associated Conclusion 6 **Origin**: EQ 1, EQ2 and EQ5 **Priority**: High **Target**: CO, HQ and RO

Operational Implications: There will be increased comparative advantage and resource allocation to the surveys. Technical capacity of the staff and the targeted government institutions will also need to be strengthened. More partnerships and South-South cooperation warranted for efficiency and effectiveness

6.3 Programmatic Level

6.3.1 Sexual and Reproductive Health

SRH Recommendation 1: Advocate for quality of care and continue strengthening of integration of SRHR/FP/GBV and HIV, in addition to enhancing male engagement on HIV prevention and response in the continuum of services. Strengthen accountability by the government through enhanced monitoring and supervision systems for compliance.

Associated Conclusion: SRH Conclusion 1 **Origin**: EQ 2 and EQ 5 **Priority**: High **Target**: CO

Operational Implications: Enhancement of quality of care will come with more capacity building of the government, in addition to enhanced partnerships

SRH Recommendation 2: Continue the advocacy mechanisms for increased targeting of the key populations with SRHR/GBV and HIV services, in addition to enhancement of evidence-based response for the key populations

Associated Conclusion: SRH 2 **Origin**: EQ1, EQ2, EQ 4 and EQ7 **Priority**: High **Target**: CO

Operational Implications: No particular implication, but there is potential for increased partnerships in evidence generation and access to services by the key populations

SRH Recommendation 3: The CO should prioritize multi-sectoral advocacy at the national levels to influence government to increase investment on RH commodities and increase funding for strengthening the FP supply chain both nationally and district levels,

in addition to continued condom promotion with a sustainable approach. UNFPA should support the government in development of the Contraceptive Implementation Plan and continue supplementing the efforts of the government while at the same time empowering the government to take over the responsibility

Associated Conclusion: SRH Conclusion 3 **Origin**: EQ 1 and EQ 5 **Priority**: High
Target: CO
Operational Implications: Ensure adequacy in capacity for high-level advocacy and strategic engagement of the government to increase resources on FP commodities. UNFPA should continue supplementing through allocation of resources to the component in order to meet the demand created.

6.3.2 Adolescent and Youth

A&Y Recommendation 1: Continue supporting the MOET in the operationalization of the CSE curriculum across the schools in the country and strengthening the community level engagement to enhance their ownership and support of the curriculum implementation. Strengthen the pre-service training of teachers to enhance capacity of delivery.

Associated Conclusion: A&Y Conclusion 1 **Origin**: EQ2, EQ4 and EQ5 **Priority**: High **Target**: CO

Operational Implications: Increased engagement of the community with require more strategic advocacy mechanisms. 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, and therefore will require more advocacy and partnerships to deliver it. Mobilization of resources to facilitate implementation will also be key.

A&Y Recommendation 2: There is need to increase advocacy, partnership and coordination for increased access to adolescent and youth-friendly services by the young people in the country

Associated Conclusion A&Y Conclusion 2 **Origin**: EQ 2 **Priority**: High **Target**: CO

Operational Implications: There is potential for enhancing provision of ASRH services for the young people, through increased engagement of the government and potential partners and addressing the social norms

6.3.3 HIV Prevention

HIV Recommendation: The CO should increase resource allocation to HIV prevention programming expanding reach to the most at risk population, particularly, the adolescent and youth and strengthen advocacy for harmonization of HIV and AIDS response between NAC and MoH.

Associated Conclusion: HIV Recommendation

Origin: EQ2 and EQ3 **Priority**: High **Target**: CO and ESARO

Operational Implications: Increase in resource will require mobilization of more resource for allocation to the HIV prevention programming given that the component has been minimally resources during the current CP. The regional office could also support the CO on partnerships for technical support on the delivery in the area of HIV prevention given its regional strategic focus. Evidence-based HIV programming should also be enhanced in the 8th CP and this also requires resources.

6.3.4 Gender Equality and Women Empowerment

GEWE Recommendation 1: UNFPA should continue strengthening framework for policy and legal engagement, particularly strengthening implementation of the policies and strategies aimed at ensuring GEWE, in addition to eliminating harmful practices affecting women and girls in Lesotho through addressing the social norms promoting the practices.

Associated Conclusion: GEWE Conclusion 1 **Origin**: EQ 2 and EQ 3 **Priority**: High
Target: CO and RO

Operational Implication: Increase resource allocation for the GEWE component, particularly on advocacy mechanisms and capacity building of the policyholders to support implementation. There will also be increased partnerships to enhance advocacy

GEWE Recommendation 2: The CO should continue increasing evidence-based GBV response mechanism through promotion of reporting structures and strengthening GBV referral pathways, particularly improving access to justice by the survivors. Further, strategically engage men and boys on ensuring prevention of GBV and empowerment of women and girls

Associated Conclusion: GEWE Conclusion 2 **Origin**: EQ 1 and EQ **Priority**: High
Target: CO

Operational Implications: This will require capacity building of the service providers in addition to development of GBV service provision guidelines. It will also require increased engagement of duty bearers and advocacy at the community level

ANNEXES

Annex 1: Terms of Reference

Terms of Reference_CPE.docx

Annex 2: List of Reviewed Respondents

Ministry/Organization	Designation	Sex	Place	Thematic Area/AoR
		Government		
Ministry of Education and Training				
NCDC	LBSE Subject Specialist	Female	Maseru	A&Y, SRHR
	Subject Specialist for Physical & Health	Female	Maseru	A&Y, SRHR
District Office	District Education Manager	Female	Mokhotlong	A&Y, SRHR
	LBSE Coordinator	Male	Mokhotlong	A&Y, SRHR
Ministry of Gender, Youth, Sports & Recreation				
Gender Department Statistics	Director in the Gender Department	Female	Maseru	GEWE and A&Y
Ministry of Development of Planning				
Policy Development Directorate	Director-Policy Development	Female	Maseru	PD and Coordination
	Chief Economic Planning	Male		PD and Coordination
Bureau of Statistics	Senior Statistician	Male	Maseru	PD
	Head of Population Division	Female	Maseru	PD
	Lead: Vital Statistics Section	Female	Maseru	PD
Ministry of Health				
MOH Headquarters	Chief Statistician-Health MIS Unit	Female	Maseru	SRHR, HIV, A&Y
	Adolescent Health Programme Manger	Female	Maseru	SRHR, HIV, A&Y
	SRHR Manager	Female	Maseru	SRHR, HIV, A&Y
	FP Manager	Female	Maseru	SRHR, HIV, A&Y
DHMT Mokhotlong	SRHR Mentor	Female	Mokhotlong	SRHR, HIV, A&Y

	Public Health Nurse	Female	Mokhotlong	SRHR, HIV, A&Y
Nursing Directorate	Director Nursing and Midwifery Services	Female	Maseru	HIV, SRHR, A&Y
DMA	Disaster Manager	Male	Maseru	Humanitarian
LMPS	Deputy Director	Male	Maseru	
NAC	Programme Manager	Female	Maseru	HIV
	CSO Coordinator	Male	Maseru	
National University of Lesotho	Gender Steering Committee	Female	Maseru	SRHR, GEWE
	NGO IPs			
Gender Links	Country Manager	Female	Maseru	GEWE
LPPA	Director Programmes	Male	Maseru	HIV, SRHR, A&Y
	Finance Director	Female	Maseru	HIV, SRHR, A&Y
	Supplies Officer	Male	Maseru	HIV, SRHR, A&Y
	Accountant	Male	Maseru	HIV, SRHR, A&Y
	M&E Officer	Male	Maseru	HIV, SRHR, A&Y
	UNFPA Programme Coordinator	Male	Maseru	HIV, SRHR, A&Y
World Vision International	Advocacy and Justice for Children Manager	Female	Maseru	HIV, A&Y and Humanitarian
Help Lesotho	Country Director	Female	Leribe	GEWE, SRHR, HIV, A&Y
	Programme Manager	Male	Leribe	GEWE, SRHR, HIV, A&Y
	Help Lesotho- Ha Koali Umbrella Committee	Males & Females	Quthing	A&Y, SRHR, GEWE
Care for Basotho	Executive Director	Female	Maseru	GEWE, HIV, SRHR
People's Matrix	Executive Director	1	Maseru	SRHR, HIV, A&Y, GEWE
Red Cross	Head of Programmes	Male	Maseru	Humanitarian
UN Agencies				
UNESCO	Program Officer-Education wellbeing for SRHR	Male	Maseru	SRHR, Adolescent & Youth
UNAIDS	Community Support Advisor	Male	Maseru	HIV
IOM	PO-Protection, Migration Management	Female	Maseru	SRHR,HIV
	PO - SRH Knows NO borders- Netherlands and HIV Knows no border Project	Male	Maseru	SRHR,HIV
UNICEF	Health Officer	Male	Maseru	HIV, A&Y

WHO	SRHR Programme Officer	Female	Maseru	
	Focal person for MNCAH	Female	Maseru	SRHR,HIV
UNRCO	Data management and monitoring of the core team	Male	Maseru	PD
		UNFPA		
UNFPA	PO- SRH	Female	Maseru	SRHR, HIV, A&Y
	PO-GBV	Female	Maseru	GEWE
	PO-A&Y	Male	Maseru	A&Y, SRHR, HIV
	PO – Finance and Admin	Female	Maseru	Operations
	PO – Former RH Commodities Security	Male	Maseru	SRHR/FP
	PO-Communication	Female	Maseru	Operations
	PO – Population Dynamics & M&E	Female	Maseru	PD and M&E
	Assistant Representative	Female	Maseru	All
	Country Representative	Male	Maseru	All
	Beneficiaries			
Mokhotlong Hospital (Beneficiaries)	MCH registered Nurse	Female	Mokhotlong	SRHR, HIV, A&Y
	Nurse form Adolescent Health Corner	Female	Mokhotlong	SRHR, HIV, A&Y
	Nurse from ART department	Male	Mokhotlong	SRHR, HIV, A&Y
	Nurse from Maternity	Female	Mokhotlong	SRHR, HIV,A&Y
Key Populations	Beneficiaries – Sex workers	3 Females & 1 Male	Mafeteng	HIV, SRHR ,A&Y
	Beneficiaries – LGBTIQ Members	2	Mafeteng	HIV, SRHR
	Peer Educators	1 Males & 1 Female	Mafeteng	HIV, SRHR
	Nurse	1 Female	Mafeteng	HIV, SRHR
	Beneficiaries – Husband Schools	3 Males	Mokhotlong	GEWE
	Beneficiaries – Husband Schools	4 Males	Mapholening	GEWE
Maseribane High School (Beneficiaries)	LBSE Teachers	4 Males & 1 Female	Quthing	A&Y, SRHR
				A&Y, SRHR
Sepabala High School (Beneficiaries)	Principal	Male	Quthing	A&Y, SRHR
	LBSE teachers	1 Male 1 Female	Quthing	A&Y, SRHR

Annex 3: List of Documents and Reference material reviewed

1. UNFPA Evaluation Handbook on How to Design and Conduct a Country Programme Evaluation (2019)
2. UNFPA Lesotho Country Programme (2019 – 2023) Evaluation Terms of Reference (ToR)
3. Country Programme Document 2019 – 2023
4. UNFPA Strategic Plan 2018 - 2021
5. UNFPA annual report 2021
6. UNFPA annual report 2019
7. UNFPA annual report 2020
8. 2019 Annual Planning Report
9. 2020 Annual Planning Report
10. 2021 Annual Planning Report
11. Human Development Index report 2019, UNDP
12. UNFPA Lesotho CP Financial Records 2019 – 2021
13. UNEG Ethical Guidelines - http://www.unevaluation.org/document/detail/102
14. UNFPA EVALUATION POLICY, 2019
15. The OECD/DAC Criteria for International Development Evaluations https://www.oecd.org/dac/evaluation/49756382.pdf
16. https://stats.oecd.org/Index.aspx?DataSetCode=crs1
17. Ministry of Health (MoH). National Tuberculosis Strategic Plan of Lesotho, 2018-2022
18. Government of Lesotho. Report for a Joint Review of HIV/TB & Hepatitis programs 2017
19. Bureau of Statistics (BoS). Quarterly National Accounts of Lesotho First Quarter 2022
20. BoS. Labour Force Survey 2019
21. BoS. Lesotho Poverty Trends and Profile Report 2002/2003 to 2017/2018
22. UNDP. Multidimensional Poverty Index: Unmasking disparities by ethnicity, caste, and gender. 2021
23. BoS & UNICEF Lesotho. Multidimensional Child Poverty Report Highlights 2021
24. UNFPA. https://www.unfpa.org/data/LS
25. BoS. Lesotho Multiple Indicator Cluster Survey (MICS): Generating Evidence to Deliver for Children 2018
26. Kingdom of Lesotho. Voluntary National Review (VNR) on the Implementation of the Agenda 2030 Report. 2019
27. MoH. Adolescent Health Strategy 2015-2020

28. UNFPA. https://www.unfpa.org/data/transparency-portal/unfpa-lesotho
29. UNICEF & World Bank Group. Lesotho Public Health Expenditure Review. 2017.
30. MoH & UNAIDS. 2020. Epidemiological Fact Sheet. & UNFPA, 2018. Country Programme Document for Lesotho.
31. UNICEF Lesotho Country Office Annual Report. Update on the context and situation of children. 2020
32. Government of Lesotho (GoL). National AIDS Policy. 2019
33. MoH. Lesotho Population-Based HIV Impact Assessment (LePHIA) 2016-2017. Final Report. 2019
34. World Health Organization (WHO). Global Tuberculosis Report. 2020. https://www.who.int/teams/global-tuberculosis-programme/data
35. MoH. Lesotho National HIV/AIDS Strategic Plan 2018/18 – 2022/23
36. End TB Lesotho. http://www.endtb.org/lesotho
37. Ministry of Social Development (MoSD). Pathways to Sustainable Livelihoods Project. 2022
38. Reproductive, Maternal, Newborn, Child, and Adolescent (RNMCAH) & Neonatal Strategy. 2017-2022
39. MoH & UNAIDS 2020. Epidemiological Fact Sheet
40. MoH. National Health Strategy for Adolescents and young people. 2015-2020
41. Lesotho National HIV & AIDS strategic plan2018/19-2022/23
42. GoL. National AIDS Spending Assessment. 2015/2016-2017/2018
43. MoH. National Guideline for Drug Susceptible Tuberculosis 2019
44. Ministry of Development Planning (MoDP) & UNICEF. Child Poverty in Lesotho 2018
45. GoL. HIV & Social Protection Assessment Report 2019
46. UNAIDS 2019. The Global HIV/AIDS epidemic. https://www.aids.gov/hiv-aids-basics/hiv-aids-101/globalstatistics/
47. MoH. 2017. Standard Operating Procedures for Prevention of and Response to Gender Based Violence in Lesotho
48. MoH & WHO. Adaptation of the Action for Health of Adolescents (AAHA). 2021
49. MoSD, ICAP, & the Centers for Disease Control and Prevention. Violence Against Children and Youth Survey (VACS) 2018
50. UNFPA. 2019. Sexual Reproductive Health and Rights https://reliefweb.int/sites/reliefweb.int/files/resources/MIC_Country_Policy_Brief_LESOTHO.pdf
51. https://www.unfpa.org/strategic-plan-2022
52. The Global Economy. Lesotho refugees and Displaced Persons Index 2021
53. UNICEF Lesotho Country Office Annual Report 2020

Annex 4: List of Atlas Projects

Year [2021]								
	Fund type	***IA Group***	***Implementing agency***	**Activity description**	**Geographic location**	**Atlas budget**	**Expense**	**Implementation rate**
GENDER EQUALITY AND WOMEN'S EMPOWERMENT								
Strategic Plan Outcome:: Gender equality and women's empowerment								
Country Programme Output: 4: Multisector capacity to prevent and address gender-based violence and harmful practices is improved at national and district levels.								
Annual work plan (code and name): Prevention and response to Gender based violence								
	FPA 90	***NGO***	***Gender Links PN7036***	Management of GBV Data	Mokhotlong and Quthing	19 272	18 883	98,0%
				Documentations of I stories	Mokhotlong and Quthing	16 132	15 281	94,7%
				Management of GBV Data	Mokhotlong and Quthing	3 023	2 895	95,8%
Annual work plan (code and name):Elimination of Harmful Cultural practices and Child Marriage								
…	CHA44	NGO	WORLD Vision	PSEA	Mokhotlong and Quthing	350	323	92,4%
	FPA90	NGO	WORLD Vision	Support Costs	Mokhotlong and Quthing	15 302	13 770	90,0%
	FPA90	NGO	WORLD Vision	Advocacy on child marriage	Mokhotlong and Quthing	1 152	830	72,1%
			WORLD Vision					
Annual work plan (code and name): UNFPA Implemented Work Plan In Lesotho								
	FPA90	UNFPA	UNFPA	EUP Policy and Advocacy	Nationally	28 680	39 864	139,0%
	FPA90		UNFPA	Advocacy on PSEA	Nationally	6 593	6 400	97,1%
ADOLESCENTS AND YOUTH								
Annual work plan (code and name): Integrated Adolescent Sexual Reproductive Health Services								
	CHA44	NGO	Help Lesotho	Prevention of EUP& ASRHR	Quthing	31 327	31 321	100,0%
	CHA44		Help Lesotho	Supports Costs	Quthing	2 358	2 060	87,4%
	FPA90		Help Lesotho	EUP Program	Quthing		-15	
	FPA90		Help Lesotho	Herd Boys Program in TT	Thaba Tseka	15 000	14 956	99,7%
	FPA90		Help Lesotho	Support Costs	National	1 050	934	89,0%
	Fund type	***IA Group***	***Implementing agency***	**Activity description**	**Geographic location**	**Atlas budget**	**Expense**	**Implementation rate**
GENDER EQUALITY AND WOMEN'S EMPOWERMENT								
Strategic Plan Outcome:: Gender equality and women's empowerment								

Country Programme Output: 3 Policy, legal and accountability frameworks are strengthened to advance gender equality and empower women and young people, especially adolescent girls, to exercise their reproductive rights and to be protected from violence and harmful practices								
Annual work plan (code and name): Prevention and response to Gender based violence								
	FPA90	***NGO***	***Gender Links***	Advocacy on GBV laws	Nationally	6 826	7 550	110,6%
Annual work plan (code and name): UNFPA Implemented Work Plan In Lesotho								
	FPA90	***UNFPA***	***UNFPA***	GBV Advocacy activities	Nationally	28 767	28 767	100,0%
	FPA90	***UNFPA***	***UNFPA***	GBV Response and Essential SER	Nationally	43 238	43 213	99,9%
	FPA90	***UNFPA***	***UNFPA***	Support Policy Development	Nationally	4 011	1 518	37,8%

Annex 5: Evaluation Matrix

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
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. young people and women, Key populations; (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? 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, or to shifts caused by crisis or major political changes?			
Assumption 1.1: The UNFPA-supported interventions under the 7th CP are adapted to the needs of the population, particularly the marginalized and vulnerable populations and addressed national priorities	• Evidence of accurate needs assessment conducted by UNFPA and/or implementing partners, identifying the varied needs of diverse stakeholder groups prior to the programming of the SRHR and GEWE components of the CPD • Evidence of systematic use of findings from needs assessments in programme planning, design and selection of target groups and prioritization in CPD. • Extent to which targeted populations, including the most vulnerable, disadvantaged, marginalized, and excluded population groups, were consulted in relation to programme design and activities throughout the programme. • Evidence of the programme contributing to the government development plans or strategies • Evidence of planning for implementations of the CP interventions with the line ministries.	• UNFPA CO M&E Framework • UNFPA annual (M&E) reports • Strategic Information System (SIS) annual reports. • National policy/strategy documents. • NSDP II • Vision 2020 • Needs assessment studies (incl. Humanitarian Needs Overviews) • Key Informants from Government, Implementing Partners (IPs), CSOs and UNFPA CO • Beneficiaries. • Lesotho CPD 2019 – 2023	• Document review • KI interviews (KIIs) with UNFPA CO staff • KIIs with Implementing Partners (IPs) • KIIs with Government of Lesotho (GoL) officials • Focused discussions (FGDs) with beneficiaries and communities in targeted sites
Assumption 1.2: The UNFPA-supported interventions are aligned with the UNFPA Strategic Plan	• Extent to which the interventions implemented are in line with the SDGs and the UNFPA Strategic Plan 2018-2021 or 2022-2025.	• UNFPA SP 2018-2021 • UNFPA SP 2022-2025 • SDGs	• Document review • Interviews with UNFPA CO staff

2018-2021 or 2022-2025 and international normative frameworks, the SDGs, policies and standards and the New Way of Working.	• The expected results, targets and implementation strategies outlined in the CPD are in line with the priorities, results and targets of the UNDAF 2019 - 2023 • Programme implementation Framework aligned to the New Way of Working and ICPD Programme of Action and the SDGs	• UNDAF 2019 - 2023 • Government officials at national and state levels • Needs assessment reports	• Interviews with other UN agencies • Interview with GoL officials • Interviews with IPs • Interviews with other development actors (i.e., NGOs working in the areas in which UNFPA works, but that do not partner with UNFPA)
Assumption 1.3: The CP is adapted to the national priorities and effectively responded to the changes caused by external factors in an evolving country context.	• 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 two 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. • Evidence of financial capacity to respond to arising needs	• UNFPA CO M&E Framework • UNFPA annual (M&E) reports • Strategic Information System (SIS) reports. • Emergency Preparedness and Response Plans (EPRPs). • Rapid Needs assessment studies • KI from Government, CSOs and UNFPA CO	• Document review • KI interviews • Focus groups with beneficiaries and communities in targeted sites

Key findings:

1. There is evidence of UNFPA-supported interventions under the 7tCP being adapted to the needs of the population, particularly the marginalized and vulnerable populations and addressed national priorities, where UNFPA promoted evidence-based response, and consultations with the various stakeholders, including the most-at risk and the vulnerable populations. Further, there is evidence that UNFPA-supported interventions directly contributed to the national development strategies through supporting and collaborating with the line ministries and agencies.
2. There was evidence of the 7CP alignment with UNFPA Strategic Plan 2018 – 2021, contributing to the achievement of the SDGs, ICPD PoA and New Way of Working. Further, the CP results contributed to the Lesotho UNDAF result and priority areas
3. The CP was well adapted to the national priorities, in addition to responding to the changing needs within the context, particularly during COVID-19, flood and drought responses where UNFPA supported evidence-based approaches to identification of the vulnerable and at risk populations for support. Limited financial and human resource capacity within the CO and government limited level of achievement.

<table>
<tr><td colspan="4">Effectiveness

EQ2: 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 and promoting reduction in gender-based violence and harmful practices; (iv) increased use of population data in the development of evidence-based national development plans, policies and programmes?</td></tr>
<tr><td>Assumption 2.1: The UNFPA-supported interventions’ planned outputs and outcomes under SRHR, and GEWE are being or are likely to be achieved</td><td>• Degree of completion of planned outputs in the M&E Framework against indicators and targets
• Extent to which M&E of programme achievements indicate timely meeting of outputs.
• Extent to which the achieved output contributed are likely to contribute to observed/perceived outcomes.
• Degree of completion of the planned activities in the AWPs and CPD
• Evidence of planned changes due to the CP interventions by the beneficiaries</td><td>• The Global Programming System (GPS), and annual reports (SIS)
• UNFPA annual M&E reports
• Annual Review and Planning reports and related documents
• IPs (government, NGOs)
• AWPs
• UNFPA CO staff
• CP Results Framework
• IP Progress reports
• Relevant Evaluation Reports
• Beneficiary groups
• UNCT & UNDAF reports
• Lesotho CPD 2019 – 2023</td><td>• Documentary review
• Interviews with Line Ministry project coordinators and other IP and non-IP staff
• Group meeting with UNFPA staff
• Focus Group Discussion with beneficiaries</td></tr>
<tr><td>Assumption 2.2: The UNFPA-supported interventions’ results effectively responded to achieve targeted results (of SRHR and GEWE) within the constraints of the context.</td><td>• The speed and timeliness of response (response capacity)
• Evidence of changes in programme design or interventions reflecting context and influencing factors i.e., change in population needs and government priorities</td><td>• Annual Review and Planning reports and related documents
• CP Results Framework
• UNFPA CO staff
• Implementing partners</td><td>• Document review
• KI interviews</td></tr>
</table>

<table>
<tr><td></td><td>● Evidence of mitigating measures on the challenges during implementation of the UNFPA-supported interventions</td><td></td><td></td></tr>
<tr><td colspan="4">Key Findings:
1.
a. The CO attained four out of the targeted nine indicators under the SRHR outcome, with two of then surpassing the targeted value by 2023. The CO surpassed the targets in the indicators on the gender-responsive policies, strategies and plans that integrate the SRHR of adolescents and youth, including disabled and most marginalised; and the indicator requiring identification of the most marginalised adolescents who successfully completed comprehensive sexuality education and life skills programmes in Mokhotlong and Quthing districts. Further, the other indicator achieved were about the midwifery schools implementing pre-service curricula in line with international standards as supported by UNFPA; and ensuring a functional electronic LMIS (eLMIS), Chanel, for forecasting, quantification, monitoring and tracing of health commodities to the last mile, operational in all ten districts (as stated in the section that follows). On the other hand, the CO did not achieve the rest of the indicators while the performance was satisfactory in most of them. For example, the indicator on health facilities with at least five modern methods of contraceptives was optimal almost throughout the period under CPE except in 2021 when it was achieved in half of the target health facilities. Further, integration of gender, ensuring gender-responsive SRH/FP and HIV services was an area of great achievement where the 7CP was recognized as a huge contribution to ensuring enhanced access to the integrated services. The results also show that there were some indicators that were not reported on in the SIS reports. These included gender-responsive, integrated SRHR, including SGBV, indicators incorporated in the Health Management Information System, and Percentage of women and men aged 15-24 years with comprehensive knowledge of HIV. It is not however clear the circumstances leading to this omission for the three years of reporting, in addition to no explanation being given in any of the reports. There were however effects of COVID-19 during the period under evaluation limiting achievement of the results. There were also reported delays by the government in approval of processes, inadequate resources by the government and the CO to finance some of the key activities, inadequate commitment by the government agencies on delivering the programme interventions were also cited as contributing to non-achievement of planned results.
b. The 7CP achieved three out of the targeted output indicators, with one of them being surpassed, according to data from the 2019, 2020 and 2021 SIS reports. The indicators achieved were on the targeted policies developed, adaptation and implementation of the essential service package on GBV response, and parents/guardians and teachers with comprehensive knowledge and information to eliminate child marriage in UNFPA priority districts. The indicator not achieved is on the number of identified SGBV survivors aged 15-24 years in the UNFPA priority districts who received essential services. While the target of the unachieved indicator is not achieved, UNFPA made a lot of efforts in the strengthening of data collection mechanisms on GBV cases, and it is hoped that the results will improve as the advocacy efforts continue to be conducted in the next programme cycle. With the policies and service packages in place and adopted for implementation, it is hoped that more and more survivors will come on board to report their cases for enhanced access to services.
2.</td></tr>
<tr><td colspan="4">Effectiveness

EQ3: To what extent has UNFPA successfully integrated gender and human rights perspectives in the design, implementation and monitoring of the country programme?</td></tr>
</table>

<table>
<tr><td>Assumption 3.1: The 7th CP integrated a gender-responsive and human rights-based approach to program planning, implementation, and monitoring</td><td>● Extent to which a gender-responsive and human rights-based approach was integrated in situation assessment, planning & design, implementation, monitoring and evaluation of UNFPA-supported interventions in the two thematic areas of programming
● 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
● Evidence of UNFPA targeting the vulnerable populations and those in hard-to-reach locations with services to ensure access</td><td>● Annual Review and Planning reports and related documents
● CP Results Framework
● UNFPA CO staff
● Implementing partners</td><td>● Document review and analysis
● KI interviews with UNFPA staff, Government and IPs
● Secondary data analysis from projects and implementing partners.</td></tr>
<tr><td colspan="4">Key Findings:
1. The design and implementation of the 7CP was based on gender responsiveness and utilized human rights approaches, ensuring marginalized and vulnerable populations were identified, participated and benefited from the programme. the programme also ensured that hard-to-reach populations and districts with worse indicators were targeted ensuring they were not left behind in the implementation. There were also confirmed evidence of consultations with the affected popuations, contributing to the response mechanisms.</td></tr>
<tr><td colspan="4">Efficiency

EQ4: 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, with the results effectively and efficiently measured and contributing to accountability?</td></tr>
<tr><td>Assumption 4.1: 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 7th Country Programme.</td><td>● Percentage of planned vs. actual resources
● Evidence that implementing partners received the planned resources to the foreseen level
● Evidence that implementing partners received resources in a timely manner
● Evidence of coordination and complementarity among the programme components of UNFPA</td><td>● AWPs and APRs/SIS and IP, government reports
● UNFPA CO financial reports
● UNFPA CO staff
● Government officials
● Implementing partners
● Resource mobilization strategy</td><td>● Document review
● KI interviews with UNFPA CO staff and key partners</td></tr>
</table>

Assumption 4.2: The UNFPA Lesotho office was appropriately staffed (the right number of people with the right competencies and skills in the right positions)	• Evidence that UNFPA personnel (all types of contracts) have adequate expertise and experience to deliver development and humanitarian assistance • Evidence that UNFPA CO staffing structure is appropriate for timely and effective implementation, including in humanitarian settings • Extent to which existing human resource management policies, rules and procedures enable the timely and effective implementation, including in humanitarian settings	• UNFPA CO Staff interviews • HR structure	• Documentary review • Key Informant and group interviews
Assumption 4.3: Programme strategic approaches, administrative, procurement and financial procedures as well as the mix of implementation modalities led to efficient achievement of programme outputs	• The planned inputs and resources were received as set out in the AWPs and agreements with partners. • 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
Assumption 4.4: The UNFPA CO and the 7th CP has robust M&E systems in place and efficiently utilised	• Evidence of M&E system and 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 Staff	• Document review • Interviews with CO, Government and IPs staff
Key Findings: 1. There was mixed feedback on the planned UNFPA financial and technical support to the IPs. While the CO strived to deliver the programme in an efficient manner, there were factors limiting their achievement of this. The resources were limited, late disbursement of funds, inadequate capacities of the IPs to ensure compliance. At the time of the CPE, June 2022, the CO had achieved USD 6,040,560 against the planned 7,400,000. There was however time until the end of the planned period and this is likely to be surpassed.			

2. UNFPA Lesotho CO was staffed with people with the right competencies and skills in their positions with stakeholders confirming their contributions in the implementation of the CP. On the other hand, the evaluators note that the staff capacity was inadequate to support all the programmes areas and on a timely basis. 3. The CO employed effective strategic programme approaches, administrative, procurement and financial procedures as well as the mix of implementation modalities led to efficient achievement of programme outputs. The CO utilized partnership, technical assistance and putting in place internal controls to ensure compliance. There however registered administrative delays, particularly on the regional office administrative support. 4. The UNFPA Lesotho CO and the 7CP had M&E system allowing implementation and capturing of the performance of CP.			
Sustainability **EQ5:** To what extent has UNFPA been able to support implementing partners and rights-holders (notably, women, adolescents and youth) in developing capacities and establishing mechanisms to ensure the durability of effects in particular related to SRHR, SGBV prevention and protection and data?			
Assumption 5.1: The UNFPA 7th CP has been able to support its partners and the beneficiaries in developing systems, mechanisms and capacities that ensure the durability of outputs, and eventually outcomes	• Extent of ownership of each project by implementing partners • Extent to which Government and implementing partners have allocated adequate budget for continued implementation of interventions and safeguarding the gains that have been made in the thematic areas of programming. • Extent to which UNFPA has taken any mitigating steps to strengthen areas with gaps hindering sustainability • Evidence of the development of exit strategies in the thematic areas of programming to hand over UNFPA-supported interventions to Government and/or implementing partners. • Evidence of Government of Lesotho contribution to the UNFPA-supported programme areas • Evidence for enhanced capacity of the Government and IPs to implement interventions in the thematic areas of programming without the technical support of UNFPA • Extent to which programmes in the two thematic areas of programming were developed and implemented in a participatory multi-stakeholder process to promote ownership • Evidence of increased programme integration in Government of Lesotho sector policy frameworks in the programme country and national development plans	• UNFPA Country Office staff • Programme Reports (SIS and Annual Planning reports) • AWPs • Previous evaluations • Projects and Interventions exit strategies • Government Ministries Policies and budget documents • Training reports • NGOs and Academia • CP sites • Country Office staff (Relevant Program Officers)	• Document review • KI and Group Interviews • Focus groups with beneficiaries • Interviews with POs • Interviews with implementing partners • Interviews with beneficiaries

Key Findings: 1. There was confirmed ownership of the CP activities and results with UNFPA directly supporting the government initiative and in some, the government is contributing to the activities supported by UNFPA like the procurement of contraceptives. UNFPA also supported government facility staff through training among others. Further, there was also evidence of the IPs contributing funds to enhance support provide by UNFPA. For example, World Vision International contributed resource to finance the review of the Child Welfare Act 2011 when UNFPA was limited. 2. UNFPA immensely strengthened the capacities of stakeholders in the country enhancing transfer of skills. For example, UNFPA supported the MoET to institutionalize CSE in the LBSE curriculum ensuring sustainability of th einititatives. Further, UNFPA supported the development of policies, guidelines and tools that were used to deliver results of the programme. 3. There was high integration of the programme, particularly SRHR/ GBV/ HIV and FP. Inadequate inclusion of men in the fight against HIV pandemic and FP were evidenced			
Coordination **EQ6:** To what extent has UNFPA contributed to the functioning and consolidation of the coordination mechanisms of the UNCT and the HCT, including how the UNFPA Country Office provided leadership in SGBV and SRHR coordination and contributed to the collective response to the COVID-19 crisis?			
Assumption 7.1: The UNFPA CO has actively contributed to the UNCT working groups and joint initiatives	• Evidence of active participation in UN inter-agency working groups • Evidence of the leading role played by UNFPA in UN inter agency working groups or joint initiatives • Evidence of exchanges of information between UN agencies • Evidence of joint programming initiatives; plans for joint programming. • Evidence of UNFPA participating in the coordination mechanisms within the UNCT and HCT	• Programming documents regarding UNCT joint initiatives • Monitoring/evaluation reports of joint program and projects • UNCT and HCT members • CO staff • Resident Coordinator	• Documentary analysis • Interviews with UNFPA CO staff • Interview with the UNRC Interviews with UNCT other UN agency members
Assumption 7.2: The UNFPA CO has provided strategic leadership in the components of the 7CP during response to COVID-19.	• Evidence of UNFPA taking leadership in spearheading particular agenda on SRHR and SGBV, and other cross-cutting themes of the CP • Evidence of Other development partners adopting UNFPA strategies and good practices • Evidence of UNFPA technical and financial support to the UN response on COVID-19	• Programming documents • UNCT and HCT members • CO staff • Resident Coordinator	• Documentary analysis • Interviews with UNFPA CO staff • Interview with the UNRC Interviews with UNCT other UN agency members
Key Findings 1. UNFPA actively and effectively contributed to the functioning of the UNCT coordination through participation and supporting working groups and joint initiatives with other UN agencies. UNFPA had joint programmes on SRHR with WHO, UNICEF and UNAIDS; and implemented JUNTA with various UN agencies			

supported by UBRAF. UNFPA also collaborated with various UN agencies, particularly, UNESCO in supporting the institutionalization of the CSE into the LBSE curriculum 2. UNFPA provided strategic leadership within the UNDAF results groups, particularly leading the RH, M&E and GBV thematic groups, co-leading PSEA with UNICE. UNFPA was also instrumental in the COVID-19 response, contributing to the global UN COVID-19 Socioeconomic Plan in the country.			
Coverage **EQ7:** To what extent have UNFPA humanitarian interventions during the drought and Covid-19 systematically i) reached all geographic areas in which affected populations (women, adolescents and youth) reside and ii) reached the most vulnerable and marginalized groups (young people and women ethnic), Sex workers, LGBTQI populations?			
Assumption 7.1: The UNFPA humanitarian support systematically reaches all geographic areas in which women, adolescents and youth are in need, as well as the geographic areas that are most at risk and vulnerable to humanitarian crises..	• Evidence of needs assessment conducted by UNFPA and/or implementing partners, identifying the varied needs of vulnerable populations in various vulnerable and marginalised groups in the country prior to the programming of the SRHR and GEWE 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 • Extent to which the planned interventions in the CP 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 address 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 • Strategic Information System (SIS) annual reports. • Needs assessment studies (incl. Humanitarian Needs Overviews) • Key Informants from Government, CSOs and UNFPA CO • Direct and indirect beneficiaries.	• Document review • KI interviews • Focus groups with beneficiaries and communities in targeted sites • Focus groups with direct and indirect beneficiaries and communities in targeted sites

Assumption 7.2: The UNFPA humanitarian support systematically reaches demographic populations of vulnerability and marginalization (i.e. women, girls, and youth with disabilities; key populations, women, adolescents and youth; the elderly; female-headed households; women and adolescents and youth from hard-to-reach areas).	• 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 SRHR and GEWE 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 • Extent to which the planned interventions in the CP 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 addressed 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 • Evidence that affected communities are mapped and targeted with interventions	• UNFPA CO M&E Framework • Strategic Information System (SIS) annual reports. • Needs assessment studies (incl. Humanitarian Needs Overviews) • Key Informants from Government, CSOs and UNFPA CO • Direct and indirect beneficiaries • HRPs for the period	• Document review • KI interviews • Focus groups with beneficiaries and communities in targeted sites • Focus groups with direct and indirect beneficiaries and communities in targeted sites

Key Findings

1. The UNFPA humanitarian support systematically reaches all geographic areas in which women, adolescents and youth are in need, as well as the geographic areas that were most at risk and vulnerable to humanitarian crises. For example, during the drought that affected Mokhotolong, UNFPA contributed and supported the delivery of dignity kits and supported them with food items.
2. UNFPA also facilitated identification of the most at risk populations for targeting with advocacy and services. The extent of reach was however influenced by the inadequacy of resources in the CO. the support by UNFPA covered the whole country, especially being art of the DRM team, facilitating revision of the tools to identify vulnerable girls and women. Further, the UNFPA humanitarian support systematically reached demographic populations of vulnerability and marginalization (i.e. women, girls, and youth with disabilities; key populations, women, adolescents and youth; the elderly; female-headed households; women and adolescents and youth from hard-to-reach areas). For example, UNFPA targeted the herd boys with integrated SRHR services, including HIV. In addition, UNFPA successfully reached the key populations with services through strategy development and advocacy, enhancing their uptake for the services.

Connectedness

EQ8: To what extent has UNFPA contributed to developing the capacity of local and national actors (government line ministries, youth and women's organizations, health facilities, communities, etc.) to better prepare for, respond to and recover from humanitarian crisis?

Assumption 8.1: The UNFPA 7th CP contributed to strengthening the capacities of the local and national actions to better prepare, respond and recover from the humanitarian situation on the areas of coverage	• Evidence of the existence of an exit strategy with timelines, allocation of responsibility • Evidence of UNFPA strengthening the capacities of humanitarian actors on preparedness, response and recovery mechanisms • Evidence of details of a handover process from UNFPA to the government departments and/or development agencies, if any • Evidence of allocation or plan for resource allocation post-response • Evidence of the existence of a transition strategy from humanitarian action to development, which specifies timelines, allocation 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 state levels and the capacity to deliver services in the mandate areas of UNFPA has been increased	• UNFPA CO • UNCT sites • Key Implementing Partners • Results and resources Framework • UNFPA Staff • Government staff • NGO/IP Staff • Programme reports	• Key Informant Interviews Documentary analysis • Document review • Interviews with staff • Group Interviews
Key Finding: The UNFPA 7CP contributed to strengthening the capacities of the local and national actions to better prepare, respond and recover from the humanitarian situation on the areas of coverage. UNFPA contributed to the review of data collection tools under the DRM team and these were integrated into the programme activities by the disaster agency, DMA.			
Connectedness **EQ9:** To what extent have the interventions supported by UNFPA taken into account complementarity and integration of ongoing development plans, programmes including related thematic areas from various stakeholders?			
Assumption 9.1: UNFPA 7CP is coherent with other programmes and plans related to the components of the CP.	• Evidence of CPD integrating development plans by government and other stakeholders • Extent to which the interventions implemented on the ground are in line with the SDGs and the NSDP II.	• UNFPA CO • Key Implementing Partners • Results and resources Framework • UNFPA Staff	• Key Informant Interviews Documentary analysis • Document review • Interviews with staff

		• NGO/IP Staff • Programme reports	
Key Finding: UNFPA CPD was designed and delivered in the context of the national sustainable development plan II, and was implemented in consultation with different stakeholders			

Annex 6: Interview Guides

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

1. Rationale for the 7th CP 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 [SRHR, or GEWE] component of the CP aligned to the a) national needs and priorities in Lesotho 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 [SRHR, or GEWE] and human rights? **(probe for the needs first)**
- What aspects of the national and sectoral policies do you consider are covered in the 7th CP?
- 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 [SRHR, or GEWE] 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, or GEWE] 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 7th CP in respect of the [SRHR, HIV, GEWE] 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 7th CP? Which ones hindered?
- What do you consider to be the best practices from the 7th CP?
- 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?
- To what extent has UNFPA responded to [SRHR, or GEWE] emerging issues during calamities? What were the factors that facilitated UNFPA response to such emerging issues? What were the factors that hindered the UNFPA response to such SRHR or GEWE 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 7th CP 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 7th CP?
- Do you think UNFPA CO administration and financial procedures are appropriate for the 7th CP 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 7th CP, 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 Lesotho? 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 Lesotho? 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 Lesotho?

- To what extent has UNFPA responded to the SRH or GEWE on the humanitarian and emerging needs in the during 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 Lesotho?
- 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 or GEWE needs
- 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, HIV, 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, Youth and adolescent or GEWE 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, or GEWE] component of the 7th CP aligned to the a) national needs and priorities in Lesotho 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 7th CP?
- How were 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, or GEWE]? [**Probe** if the identified needs of these target groups included in the criteria]?
- Were there any [SRHR, or GEWE] 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 needs of your institution identified prior to the programming of the [SRHR, or GEWE]?
- Do you see the work of UNFPA and its implementing partners as supporting the right interventions to address SRH/GEWE/GBV needs, harmful practices and discrimination against women and girls?

3. Effectiveness

- Looking at the implementation so far, to what extent have the planned 7th CP 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 2021?
- 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 7th CP? 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 7th CP? How did UNFPA support in each of the instances? Probe for the services or support provided
- To what extent has UNFPA responded to SRHR or GEWE emerging issues during calamities? What were the factors that facilitated UNFPA response to such SRHR or GEWE 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
- 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 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 7th CP 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 7th CP, 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 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?

a. Added Value

- What unique strategies/interventions in SRH, A&Y, or GEWE 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 (We) would like to know the type of support you received from (**UNFPA implementing partner**)

1. Relevance

- What are the national needs and priorities in Lesotho/in your community in terms of the development agenda with regards to CP component (SRH, HIV, 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, HIV, A&Y, GEWE and PD)?
- How has (UNFPA implementing partner) consulted you in the identification of your local needs in (SRH, HIV 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 Lesotho?
- What specific needs is your institution addressing in the country?
- Which specific areas did your institution support the Lesotho 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 needs in the areas of (SRH, HIV, 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 Lesotho?
- What has been realized in the country because of UNFPA's CP since 2019 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, GEWE
- What are UNFPA CO strengths, weaknesses/ limitations, and opportunities to improve its programming in the country?

Annex 7: Stakeholders' Mapping

	Implementing agency								Other partners							Rights holders	Other
	Gov	Local NGO	Int. NGO	Women's right org.	Other UN	Academia		Other	Gov	Local NGO	Int. NGO	Women's right org.	Other UN	Academia	Other		
SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS																	
Strategic Plan (2018-2021) Outcome 1: Every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated sexual and reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence.																	
Output 1: Improved government institutional capacities to develop and implement gender-responsive policies, plans and programmes that prioritize the demographic dividend and access to integrated sexual and reproductive health and rights information and services by women, adolescents and youth, including the furthest left behind.																	
SRH																	
	MOH		**LPPA**										**UNAIDS, UNICEF, WHO**	NHTC, Scott School of Nursing, Seventh Day Adventist School of Nursing, Roma College of Nursing, Paray School of Nursing, National University of Lesotho		**Women, adolescents and young people.**	
Atlas/GPS project (code and name)																	

	LES07SRH, LES07MHS,UZJ27LES		UZJ27LES										UZJ27LES	UZJ27LES, LES07MHS			
HIV																	
	MoH NAC	LPPA							MoLGC, MYGSR	Care For Basotho, The People's Matri, LENEPWA,	PACT, EGPAF		JUNTA			Key Populations, Adolescent Girls and Young Women, Men	MISA
Atlas/GPS project (code and name)																	
	LS07HIV, UBRAF, UZJ27,	**UBRAF, UZJ27, LS07HIV**															
Adolescent																	
	MOH	**help LE,** **LPPA, WORLD VISION**												**UNESCO, UNAIDS,**			
Atlas/GPS project (code and name)																	
	CHA44	**CHA44**															
Atlas/GPS project (code and name)																	
Output 2: Women, adolescents and young people have improved access to gender-responsive, high quality, integrated sexual and reproductive health services, including in humanitarian settings																	

SRH																	
	MoH	**LPPA**														**Women and Young Girls**	
If relevant, Atlas/GPS project																	
HIV																	
	MoH **NAC**	**LPPA**												**JUNTA**			
If relevant, Atlas/GPS project (code and name)																	
	LS07HIV, UBRAF, UZJ27, CERF																
Adolescents																	
	MOH	**LPPA, Help LES**															
If relevant, Atlas/GPS project (code and name)																	
	CHA 44	**CHA44, LESO7ASH**															
GBV																	
	MGYSR	**Gender Links**												**Ministry of Police, MOH,**			
If relevant, Atlas/GPS project (code and name)																	
	LES07GBV	**LES07GBV**												**LES07G BV**			
Gender equality and women's empowerment																	

UNFPA Strategic Plan (2018 – 2021) Outcome 3: Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings.																	
CPAP output 3: Policy, legal and accountability frameworks are strengthened to advance gender equality and empower women and young people, especially adolescent girls, to exercise their reproductive rights and to be protected from violence and harmful practices.																	
GBV																	
	MGSYR	**Gender links**												**Ministry of Police , MOH**			
If relevant, Atlas/GPS project																	
	LES07GBV	**LES07GBV**												**LES07GBV**			
Adolescents																	
	MOH	**Help Lesotho,** **World vision**												**UNESCO** **UNAIDS**			
If relevant, Atlas/GPS project (code and name)																	
	CHA44,LESOASH	**CHA44,LLES07ASH**															
CPAP output 4: Policy, legal and accountability frameworks are strengthened to advance gender equality and empower women and young people, especially adolescent girls, to exercise their reproductive rights and to be protected from violence and harmful practices.																	
GBV																	
	MGSYR	**Gender links**												**Ministry of Police , MOH**			
If relevant, Atlas/GPS project																	
	LES07GBV	**LES07GBV**												**LES07GBV**			

Annex 8: Work Schedule

CPE Phase and Tasks	2022 Month by Week																											2023								
	May	June	July				August					September				October				November				December				January				February				March
			W1	W2	W3	W4	W1	W2	W3	W4	W5	W1	W2	W3	W4	W1	W2	W3	W4	W1	W2	W3	W4	W1	W2	W3	W4	W1	W2	W2	W4	W1	W2	W2	W4	
Preparatory Phase																																				
Establish ERG																																				
Drafting the ToR by the CO, review by ERG, ESARO M&E Advisor, and approval by the UNFPA HQ																																				
Recruitment of consultants and vetting of the ET by EO																																				
Preparation of documents																																				
Evaluation kick-off meeting between the evaluation manager, the evaluation team and the regional M&E adviser																																				
Desk review of secondary data and information for the development of the Draft CPE Design Report																																				
Draft and submit CPE Design Report to the CO/Evaluation Reference Group (ERG)																																				
Review of the draft design report by the evaluation manager and the regional M&E adviser																																				
Presentation of the draft design report to the ERG for comments and feedback																																				
Field Phase																																				
Revision and approval of the Design Report by the Evaluation Manager																																				
Inception meeting for data collection with CO staff																																				
Individual meetings with relevant CO programme officers																																				
Data collection (incl. interviews with key informants, site visits for direct observation, group discussions, document review, etc.)																																				
Debriefing meeting with CO staff and the ERG to present emerging findings and preliminary conclusions after data collection																																				
Reporting Phase																																				
Drafting of the evaluation report and circulation to the Evaluation Manager																																				
Review of the draft evaluation report by the Evaluation Manager, the ERG and the regional M&E adviser																																				
Preparation and submission of the second draft evaluation report																																				
Preparation and submission of the final evaluation report																																				
Clearance of the report and EQA draft submission to Evaluation Office (EO)																																				
EO finalization of EQA																																				
Dissemination and Use Phase																																				
Preparation of the **management response** by the CO and submission to the Policy and Strategy Division																																				
Development of the **presentation** on the evaluation results																																				

Annex 9: Reconstructed Lesotho CP Theory of Change