EVALUATION REPORT

INDEPENDENT COUNTRY PROGRAMME EVALUATION

LIBERIA

2013 – 2017

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EVALUATION TEAM

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DISCLAIMER

This evaluation report was prepared by a team of three Consultants: Sam Clark, International Consultant Evaluation Team Leader, Kau Belleh and Matthew Flomo Gorveaboe, National Evaluation Consultants. The content, analysis and recommendations of this report do not necessarily reflect the views of the United Nations Population Fund (UNFPA), its Executive Committee or member states.

Liberia Country Map: Administrative map with districts

Source: http://www.un.org/Depts/Cartographic/map/profile/liberia.pdf

EXECUTIVE SUMMARY

This Country Program Evaluation (CPE) is intended to provide an independent evaluation of the UNFPA's fourth Country Program (CP) of Assistance to the Government of Liberia 2013-2017. The CPE focuses on four CP theme areas: 1) Maternal and new born health including family planning (MNBH + FP); 2) Data availability and analysis [referred to as Population and Development (P&D)]; 3) Young people's sexual and reproductive health and sexuality education (Youth); and 4) Gender equality and reproductive rights (GE&RR). The CPE covers from 2013 to March 2017 and includes eleven (11) of Liberia's 15 counties where the CP has been implemented. The field work was implemented in March 2017 with travel to intervention sites in eight counties. The primary users of this CPE are UNFPA Liberia, UNFPA West and Central Africa Regional Office, UNFPA Head Quarters and donors. Other key users include the Government of Liberia, the United Nations Country Team (UNCT) and Civil Society Organizations.

Evaluation Approach and methodology: The evaluation used mixed-methods with six approaches: 1. Desk review of documents and financial and other pertinent program data; 2. Site visits to UNFPA targeted areas; 3. Interviews with stakeholders (including national counterparts, implementing partners (IPs) and development partners); 4. Interviews with UNFPA Liberia program beneficiaries for all four focus areas; 5. Follow-up interviews with trainees in UNFPA supported training events; 6. Focus group discussions (FGDs) with small, homogeneous groups of stakeholders and beneficiaries. The analysis is based on a synthesis and triangulation of information obtained from the above-mentioned evaluation activities. The CPE limitations include its non-representative, qualitative nature due to small, non-random samples and low response rates for certain interview categories. All interviews were done absent presence of UNFPA staff.

Key Findings

Relevance: All four theme areas were found to be of high relevance; activities fit well within national priorities and strategies and are consistent with the needs of beneficiaries and IPs. There was evidence that activities were developed based on assessments as well as consultation with beneficiaries. All four theme areas were implemented in a manner that was reflective of UNFPA global strategy, PoA ICPD, MDGs as well as national strategies, such as the 2016-2020 Reproductive, Maternal, New-Born, Child, and Adolescent Health (RMNCAH).

Effectiveness: Despite major constraints and challenges in the health, economic, social and political context of Liberia, including the 2014 Ebola Virus Disease (EVD) crisis and a difficult funding environment, there was significant progress for all four theme areas. Among 11 CP outputs, it is projected that seven will be fully achieved, three partially, and one will not be achieved by 2018.

Efficiency: Overall, the level of activity implemented toward the achievement of outputs for the four theme areas appeared to be reasonable for resources expended. Among respondents able to comment on the question of efficiency, most felt that UNFPA Liberia has been careful to manage its funds efficiently.

Sustainability: There is evidence of sustainability of program results from program activities in all four theme areas. UNFPA support has established systems, including a national contact tracing and surveillance system, and trained key human resources, such as alternative health cadre for Caesarean Section (CS) and nurse midwives to address the acute regional need for Emergency Obstetrics and New born Care (EmONC)

services; these activities are likely to enable the country to sustain improved health services. UNFPA continues to fund short-term inputs for activities unlikely to be continued without ongoing UNFPA support, such as salaries for 50 National Youth Volunteers and the physical rehabilitation of rural health facilities.

Program Area Findings

MNRH+FP: UNFPA support made significant progress toward improved EmONC services in 2013 as well as the rebuilding the county-level infrastructure and capacity lost during the 2014 EVD crisis. This includes a) improved access and quality of EmONC with an increase in facility-based delivery, b) the expansion and consolidation of maternal death surveillance at the county level, and c) the revision and development of EmONC monitoring tools as well as monitoring of EmONC facilities at the County level. Despite this progress, Liberia's maternal mortality ratio (MMR) remains among the highest in the world, due in part to an acute shortage of health providers with essential clinical skills, especially for CS. UNFPA support has helped sustain the supply chain for RH commodities with National Youth Volunteers. Commodity supply remains problematic; needless stock-outs occur, due in part to lack of cooperation among agencies.

P&D: UNFPA support contributed to a quality analysis and dissemination of the 2013 Liberia Demographic Health Survey (LDHS) findings, but weak collaboration amongst key institutions responsible for data availability and analysis has limited achievements. The current location and condition of the Liberia Institute for Statistics and Geo-Information Services (LISGIS) offices is extremely deleterious to effective data creation and storage activities. UNFPA supported an effective response during the EVD crisis to redesign an epi-surveillance data collection tool, which was highly relevant and responsive; the tools developed are still used for data collection across the country by the MOH. UNFPA support was highly successful toward ramping up a national contact tracing program in response to the EVD crisis.

Youth: UNFPA support has contributed toward the introduction of a nation-wide comprehensive sexuality education (CSE) curricula within Liberian educational institutions. Unfortunately, progress toward CSE introduction has been delayed due to a prolonged review process for integration within the national curriculum. UNFPA support has led to significant and meaningful contribution to: a) the needs of young key populations, b) services for youth in clinics and youth service centres, and c) the advancement of youth policy and legal issues.

GE&RR: In hard to reach areas, the reporting of women's rights is informal and there are not enough CSOs to report on the rights of women. UNFPA has worked effectively with other UN Agencies, such as UN Women, in support for gender policy and advocacy; this has led tangible results. This includes the establishment of twelve One-Stop Centres for SGBV services in seven counties.

Engagement in highly-vulnerable contexts (the CP response to the 2014 EVD epidemic): This evaluation has a special focus on UNFPA engagement in highly-vulnerable contexts, especially the role of UNFPA in responding to humanitarian crises.[1] Prior to the 2014 EVD crisis, there was evidence of previous and ongoing UNFPA expertise in the training and dissemination of RH kits for Sexual and Gender Based Violence (SGBV) and responding to a humanitarian crisis under the Liberia Emergency Humanitarian Action

[1]King Zollinger & Co. Advisory Services. Approach Paper for the Clustered Country Programme Evaluation of UNFPA Engagement in Highly-Vulnerable Contexts. Final Version, 3 May 2016.

Plan (LEHAP). UNFPA did not have an emergency preparedness plan in place in 2013, but was nonetheless actively and effectively involved in the response to the 2014 EVD crisis as part of a regional and national response. UNFPA's role making deliveries to remote counties during the EVD crisis took professional commitment and courage. UNFPA senior leadership report a range of pertinent emergency related activities, but UNFPA does not currently have an Annual Preparedness Action Plan (APAP).

United Nations Country Team Coordination: There was strong evidence of active and effective UNCT collaboration with UNFPA Liberia. UNFPA contributes to the functioning and consolidation of UNCT coordination mechanisms with collegiality and professionalism. Senior UNFPA staff participation and contributions in regular UNCT coordination meetings was well-recognized. UNFPA is active in six inter-agency working groups and chairs two of them. There was strong appreciation of UNFPA Liberia proactive and collaborative leadership to respond to challenges and mobilize resources.

Added value: UNFPA has made good use of its comparative strengths to add value to Liberia's development results. Several examples were found where, despite the major setbacks of the EVD crisis, UNFPA demonstrated a compelling comparative advantage in EmONC and SRH.

Strategic Level Conclusions: Liberia cannot reduce the maternal mortality rate (MMR) unless skilled EmONC practitioners capable of performing CS and related procedures are available in every county. The current mix of UNFPA efforts, with a balanced focus on maternal and new born mortality reduction in combination with FP services, adolescent health and Maternal New born Death Surveillance and Response (MNDS&R) is credible and evidence-based. It is consistent with the current RMNCAH Investment Case; if expanded, it is likely to improve RMNCAH outcomes. Rigid interpretation of National Execution (NEX) implementation, where UNFPA staff do not feel empowered to intervene to resolve problems resulting from MoH programs lapses, may undermine efforts to effectively implement programs. A more flexible and balanced interpretation of the roles of UNFPA staff is needed to ensure that bottlenecks are resolved quickly, so that efforts to implement programs are not delayed.

Program Area Conclusions

MNCH+FP: UNFPA has invested in the training of qualified providers of EmONC and Caesarean Section (CS), which has contributed to an increase of deliveries attended by skill birth attendants and will likely contribute enormously to the reduction of the MMR. While progress has been made in MNDS&R, two-thirds of maternal deaths are not being investigated, which may overlook important contributing causes of maternal and neonatal death. It is important to review options to enhance sharing of RH commodities among clinics and institutions, such as Planned Parenthood association of Liberia (PPAL) and MoH.

P&D: If concrete actions are not taken soon, the 2018 Census will be seriously delayed. UNFPA stands as the primary agency expected to jumpstart and support the 2018 Census. Liberia currently does not have a comprehensive plan to generate, disseminate and report on the UNFPA-supported global SDG indicators. The Population Policy Coordination Unit (PPCU) has not been able to adequately coordinate activities of IPs due to lack of institutional capacity. The current PPCU management has no staff with a specialty in demography and planning. The Institute for Population Studies (University of Liberia) [(IPS(UL)] is

producing technicians who are not adequately trained and cannot readily be placed for mentorship at LISGIS; this makes it difficult to mainstream population variables in planning.

Youth: There is potential loss of momentum in the introduction of CSE at this critical juncture; technical and policy support is critical to ensure the transition to a fully implemented integrated CSE curriculum. UNFPA support for NGOs that serve key populations provides an important validation for the rights and needs of these vulnerable populations, who face discrimination and the threat of violence. UNFPA Training on adolescent sexual and reproductive health (ASRH) and youth-friendly services appears to have contributed to non-judgemental openness to ASRH services in rural clinics. Ongoing support for youth policy and legal frameworks holds potential for long-term impact and is a process that requires sustained effort among a wide range of stakeholders.

GE&RR: The provision of more safe homes, especially attached to the One-Stop Centres would enable a more holistic service. Most offenders are known to the families and the message of justice for the victim is still not a priority. Targeted provision of services considering the special needs of minors would reach more users. The community-led approach used by UNFPA is working and reaches women at the county level. More CSOs need to be supported, especially in hard-to-reach communities, to carry out advocacy with rural women.

Engagement in highly-vulnerable contexts (the CP response to the 2014 EVD epidemic): The development of an Annual Preparedness Action Plan (APAP) and delegation of a humanitarian focal person in the UNFPA Liberia UNFPA would facilitate emergency coordination at the onset of a crisis. Maintaining and updating an APAP, as well as active participation in meetings with UNCT disaster management planning are high priorities to ensure a sustained capacity to respond to future crises.

Strategic Recommendations: UNFPA Liberia should support the strengthening of at least two (2) health facilities fully compliant in basic emergency obstetric and new born care (BEmONC) per county before the end of this programme cycle (December 2018). The 5th UNFPA CP should continue the current mix of programme activities with a focus on maternal and new born mortality reduction and FP, adolescent health and MNDS&R in a manner consistent with the 2016-2020 RMNCAH Investment Case. UNFPA should adopt a more flexible policy to permit and encourage UNFPA staff interventions to resolve NEX bottlenecks that hinder EmONC services, such as transport, fuel, RHCS and data for decision-making.

Theme Level Recommendations

MNCH+FP: UNFPA should continue to support incentives for Trained Traditional Midwives (TTMs) and support and expand the placement of Obs/Gyns at the county level, as well as expand efforts to train non-physicians to conduct CS. UNFPA should support efforts by CHTs to increase the proportion of maternal deaths that are investigated. The UNFPA should develop protocols to avoid stockouts through sharing of commodities within county clinics as well as among counties.

P&D: UNFPA should mobilize resources for the geographic mapping exercise to ensure the timely commencement of activities for the 2018 census. UNFPA should provide support to a) revitalize the PPCU unit through human and institutional capacity building b) review and revise the National Population Policy

with an action plan to ensure implementation of population policy. The IPS (UL) should be given resources (hardware, software and expertise) as soon as possible to adequately train undergraduates for demographic data collection and analysis.

Youth: UNFPA should maintain its long-term technical and financial support for the integrated CSE strategy in the 5th CP. UNFPA should continue to support NGOs that serve the needs of young key populations.

GE&RR: The next UNFPA CP should extend funding to establish and maintain more safe homes to enhance the support to women and girl victims of SGBV. UNFPA should focus campaign messages on the results of SGBV for women and focus more energy on SGBV as a rights issue rather than as just a health issue. UNFPA should support projects that raise awareness of laws protecting the rights of women, especially in rural communities.

Engagement in highly-vulnerable contexts (the CP response to the 2014 EVD epidemic): UNFPA Liberia should develop an APAP and designate a humanitarian focal person before the end of 2017.

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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
BEmONC	Basic Emergency Obstetric and New born Care
CBI	Client Beneficiary Interview
CCPE	Clustered Country Programme Evaluation
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CHT	County Health Team
CEmONC	Comprehensive Emergency Obstetric and New born Care
CP	Country Programme
CPA	Country Population Analysis
CPAP	Country Program Action Plan
CPE	Country Programme Evaluation
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organization
CSW	Commercial Sex Worker
EMIS	Education Management Information System
EmONC	Emergency Obstetric and New born Care
ERG	Evaluation Reference Group
EVD	Ebola Virus Disease
FGD	Focus Group Discussion
FLY	Federation of Liberian Youth
FP	Family Planning
GBV	Gender Based Violence
gCHV	General Community Health Volunteers
GDP	Gross Domestic Product
GE	Gender Equality
GE&RR	Gender Equality and Reproductive Rights
GII	Gender Inequality Index
GNI	Gross National Income
GoL	Government of Liberia
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HR	Human Rights
ICPD	International Conference on Population and Development
ICTL	International Consultant Evaluation Team Leader
IP	Implementing Partner
IPS (UL)	Institute for Population Studies (University of Liberia)
IVDU	Intravenous Drug User
LDHS	Liberia Demographic and Health Survey
LISGIS	Liberia Institute for Statistics and Geo-Information Services
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
MNCH	Maternal New born Child Health
MNDSR	Maternal and New born Death Surveillance and Response

MNH	Maternal New born Health
MNH&FP	Maternal New born Health and Family Planning
MoH	Ministry of Health
MoYS	Ministry of Youth and Sports
MSM	Men who have Sex with Men
NARG	National Action for Research and Governance
NASG	Non-Pneumatic Anti-Shock Garment
NBIS	National Biometric Identification System
NEC	National Evaluation Consultant
NGO	Non-governmental Organization
NIR	National Identification Registry
NYV	National Youth Volunteers
PPAL	Planned Parenthood Association of Liberia
PPE	Personal Protective Equipment
PSI	Population Services International
ODA	Official Donor Assistance
PBF	Peacebuilding Fund
PD	Population and Development
RH	Reproductive Health
RHR	Reproductive Health and Rights
RMNCAH	Reproductive, Maternal, New born, Child and Adolescent Health
SAIL	Stop AIDS in Liberia
SAQ	Self-administered questionnaire
SBCC	Social Behaviour Change Communication
SCI	Save the Children International
SDGs	Sustainable Development Goals
SGBV	Sexual and Gender Based Violence
SP	Strategic Plan
SRH	Sexual and Reproductive Health
SRH/FP	Sexual Reproductive Health and Family Planning
SSI	Semi-Structured Instrument
STI	Sexually Transmitted Infection
SWAAL	Society for Women and AIDS in Africa/Liberia
SWAp	Sector Wide Approach
ToR	Terms of Reference
TTM	Trained Traditional Midwife
UN	United Nations
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization

Key Facts Table for Liberia

Land	
Geographic location	Liberia is located on the Atlantic coast of West Africa at 6 °N, 9 °W. She shares borders with three countries- Sierra Leone, Ivory Coast and Guinea on the East, West and north respectively. The Atlantic Ocean borders on the south with 580 kilometres (360 mi) of coastline.
Land area	98,351sq.km (1)
Terrain	Much of Liberia is dominated by flat to rolling coastal plains that contain mangroves and swamps. Liberia's terrain ranges from the low and sandy coastal plains of the Atlantic Ocean, to rolling hills and dissected plateau further inland. The country is home to a lush rainforest containing a rich diversity of flora and fauna. The highest point within Liberia is Mount Wuteve at 4,724 ft. (1,440 m). However, Mount Nimba is higher at 5,748 ft. (1,752 m) and is shared with Guinea and Cote d'Ivoire. The lowest point of the country is the Atlantic Ocean. The country's major rivers include the Mano River in the northwest and the Cavalla River in the southeast; the two rivers form the international boundaries with the Republics of Sierra Leone and Cote d'Ivoire respectively. The Cavalla is the longest river in the nation covering 320 mi (515 km). Additional rivers of note are the Lofa, St. Paul, St. John and Cestos River, all of which flow into the Atlantic.
People	
Population as of 01/01/2016	4,615,222(1)
Urban population 01/01/2016	2,311,925(2)
Population Growth Rate in 2016	2.44(2)
Government	
Government	Republic
% of seats held by women in Parliament	10.7(3)
Economy	
GDP per capita PPP US$ in 2015 (est.)	900(2)
GDP real growth rate in 2015 (est.)	0.0%(2)
Main industries	Agriculture
Social indicators	
Human Development Index Rank in 2014	Index 0.43 rank 177(3)
Unemployment 2014 - Total unemployment rate (% of labour force)	3.7(3)
Life expectancy at birth in 2015 (est.)	59(2)
Under-5 mortality (per 1,000 live births) in 2015	70(5)
Maternal mortality (per 100,000 live births) in 2015	1,072 (5)
Health expenditure (% of GDP) in 2015 (2014)	10(6)
% of births attended by skilled health personnel (2013)	61(5)
Adolescent fertility rate (births per 1,000 women aged 15-19) in 2014	111(5)
Contraceptive prevalence (% of women ages 15-49) in 2013	20(8)
Unmet need for family planning in 2013	31(9)
% of people living with HIV, 15-49 years old in 2015	1.9(10)
Adult literacy (% aged 15 and above)	47.6(11)
Gross enrolment ratio, primary, gender parity index (GPI) in 2013	0.92(12)
Millennium Development Goals (MDGs): Progress by Goals [9, 5,15]	
4 Reduce Child Mortality	The MDG target for 2015 was to reach under five mortality rate of 64 per 1,000 live birth and infant mortality rate of 39 per 1,000. The 2013 LDHS reported an under five mortality rate of 94 and an infant mortality rate of 54 for the nation. [9]
5 Improve Maternal Health	The MDG target by 2015 for the Maternal Mortality ratio (MMR) was 300 [14]. A current estimate of the MMR from the World Bank for 2015 is 1,072 [5].
6 Combat HIV/AIDS, Malaria, other Diseases	Between 2007 and 2013, the HIV prevalence in the general population aged 15-49 in Liberia increased from 1.5% to 2.1%. HIV prevalence in urban areas is put

	at 2.6 % (3.2% in Monrovia) and is much higher than in rural areas at 0.8 %; and HIV prevalence among women 2.4% (increased from 1.8%) is significantly higher than in men 1.9% (increased from 1.2% in 2007) [15] [LDHS (2013)].

See links for data.

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CHAPTER 1: INTRODUCTION

1.1 Purpose and objectives for the Country Programme Evaluation

This Country Program Evaluation (CPE) is intended to provide an independent final evaluation of the UNFPA's fourth Country Program (CP) of Assistance to the Government of Liberia 2013-2017 as part of its work plan.[2] As outlined in the CPE Terms of Reference (ToR), the overall purpose of the evaluation is twofold: first, to assess the achievements of the 4th CP, the factors which may have eased or stalled the achievements of intended results, and to draw lessons learned from design through implementation to inform development of the next country programme cycle (5th CP: 2018-2022).[3] Second, is to contribute to the clustered CP evaluation (CCPE) on UNFPA's engagement in highly-vulnerable contexts. The CCPE, which is managed by the Evaluation Office, is developing a meta-analysis and complementary learning drawn from a set of six CPEs selected based on comparable contexts.[4] The primary users of this evaluation are UNFPA CO, UNFPA West and Central Africa Regional Office, UNFPA HQ and donors. Other key users include the Government of Liberia, the United Nations Country Team (UNCT) and Civil Society Organizations (CSOs).

In accordance with UNFPA evaluation policy, this evaluation has the following additional purposes: 1. demonstrate accountability to stakeholders on performance in achieving development results and on invested resources; 2. support evidence-based decision-making; 3. identify lessons learned to expand the existing knowledge base on how to accelerate implementation of the Program of Action of the International Conference on Population and Development (PoA ICPD).

The specific objectives of the independent evaluation are to:

a) Provide an independent assessment of the progress of the programme towards the expected outputs as set forth in the results framework of the CP;

b) Assess the extent to which the programme has contributed to the recent humanitarian efforts (i.e. Ebola response initiative) and provide an analysis of how UNFPA Liberia has positioned itself among national development partners;

c) Draw key lessons from the current mode of implementation and cooperation and provide a set of clear and forward-looking, actionable and strategic recommendations to inform the development of the next programme cycle.

1.2 Scope of the evaluation

In view of the above objectives, the evaluation focuses on: the four CP thematic areas of:
1) Maternal and new born health including family planning; 2) data availability and analysis;
3) young people's sexual and reproductive health and sexuality education; and 4) gender equality and reproductive rights; as well as 5) the extent to which the CO has coordinated with the UN country team; and 6) how the CO's interventions have added value at these strategic levels. The evaluation has covered from January 2013 to March 2017 and includes eleven (11) of Liberia's 15 counties (namely Bomi, Bong,

[2] UNFPA Liberia. CPE Terms of Reference (TOR) Liberia. 2016.
[3] There was a decision in late 2016 to extend the CP through 2018 in view of the need to accommodate changes in the GoL planning cycle and the associated revision of the UNDAF, which will be scheduled to start in 2019.
[4] King Zollinger & Co. Advisory Services. Approach Paper for the Clustered Country Programme Evaluation of UNFPA Engagement in Highly-Vulnerable Contexts. Final Version, 3 May 2016.

Gbarpolu, Grand Cape Mount, Grand Gedeh, Grand Kru, Lofa, Maryland, Montserrado, Nimba and River Gee counties). The field work for the evaluation took place March 6-28, 2017 and involved travel to selected intervention sites in eight counties.[5] The government line ministries/agencies involved in the CP implementation were also covered, as well as national and international NGOs. The evaluation covers interventions funded by UNFPA regular funds and other funding resources.

1.3 Methodology and process

This evaluation follows UNFPA evaluation guidelines[6] and is consistent with the principles of the UN Evaluation Group's norms and standards (in particular with regard to independence, objectiveness, impartiality and inclusiveness), and is guided by the UN ethics guidelines for evaluators in accordance with the UNEG's Ethical Guidelines for Evaluation.[7] Data were collected through a variety of techniques ranging from direct observation to informal and semi-structured interviews and focus group discussions. The analysis has been developed based on triangulating information obtained from various stakeholders' views, secondary data and documentation reviewed by the team.

1.3.1 Methods of Data Collection, Sources and Analysis

The evaluation was implemented through six key approaches:

1. Desk review of documents and financial and other pertinent program data.
2. Direct observations during site visits to UNFPA's intervention areas.
3. Semi-Structured Interviews (SSIs) with stakeholders (including national counterparts, IPs and development partners).
4. Interviews with UNFPA Liberia program beneficiaries for all four programme components.
5. Follow-up interviews with trainees in UNFPA supported training events.
6. Focus group discussions (FGDs) with a limited number of participants from homogeneous groups of stakeholders and beneficiaries.

Stakeholder Involvement: As outlined in the Design Report, meetings were planned with key stakeholders, including with an evaluation reference group (ERG).[8] Unfortunately, it was not possible to convene a meeting with the ERG prior to the launching of the field work or after the field work had been completed.

Desk Review and Synthesis by the Four Outcomes: The Desk review addressed each of the four CP Outcomes with an assessment of the respective outputs and activities within each Outcome. The desk review was based on the above-mentioned evaluation ToR criteria for the evaluation: 1) the analysis by

[5] Montserrado, Bomi, Bong, Cape Mount, Grand Gedeh, Maryland, Grand Kru and Lofa. The initial site visit schedule called for only seven counties, but Bong County was added to permit two additional site visits en route from Zwedru to Monrovia.
[6] UNFPA Evaluation Office. Handbook to "How to Design and Conduct a Country Programme Evaluation at UNFPA." 2016.
[7] Available at www.unevaluation.org/ethicalguidelines.
[8] The ERG was made up of representatives from appropriate national and regional level Ministers, Civil Society Organizations, NGOs, donor community as well as all Implementing Agencies and representatives of beneficiary client groups, including women's health advocates, and youth representatives. The objective of these meetings was to ensure an opportunity for stakeholders to participate in the design, data collection, analysis and development of recommendations. See Clark, S., Belleh, K and Gorveaboe, M. UNFPA Country Programme Evaluation: Liberia Period covered by the evaluation (2013-2017) Design Report. Final Draft 0.4, 3 March 2017.

focus areas (Relevance, Effectiveness, Efficiency and Sustainability) and 2) the analysis of the CP's positioning (coordination with the UNCT, added value and engagement in highly-vulnerable contexts).

Direct observations during Site Visits: Visits were made to implementation agencies at the national and county levels, selecting sites chosen with attention to achieving a balanced review of project activity and beneficiaries in 8 counties. Due to time constraints, it was not feasible to visit more than 8 counties. With the kind assistance of UNFPA Liberia, a site visit schedule was developed to permit two teams to cover 8 counties: a 2-person team went to the North West (Grande Cape Mount, Bomi) and the South East (Bong, Grand Gedeh, Maryland and Grand Kru); one team member visited Lofa. (See the attached draft detailed site visit schedule in Annex 3a).[9] The resulting list of persons contacted is summarized in an excel spreadsheet (shown in Annex 3b.)

Semi-structured Interviews with Stakeholders Based on the Evaluation TOR Criteria: The interviews were conducted with a consistent set of precautions for informed consent and confidentiality. See attached draft instrument in Annex 5. As needed, all interviews were done in English or local dialects with translation. As outlined in the section on the development of the sampling frame in the Design Report (a copy of the original sampling plan is shown in Annex 6), a purposive sampling plan was made of key informants, with an attempt to achieve a balance according to region and focus area. In addition, key informants were selected from donor and UN agencies. Per the Design Report, the target was for a total of 79 interviews, but a total of 62 SSIs was conducted. Because several interviews had more than one respondent present, there were 122 SSI respondents in the 62 interviews (67 male, 55 female). Table 1 compares the planned number of stakeholder interviews with the achieved number of stakeholder interviews by county.

Table 1. Planned versus Achieved Stakeholder, Training Follow-up, Client Beneficiary Interviews (CBIs) and Focus Group Discussions (FGDs) and Group Discussions (GDs) by County

Type of interview	Monrovia[10]	Bomi	Grand Cape Mount	Monte-serrado	Grand Geddeh	Maryland	Grand Kru	Bong	Lofa	Total
Planned SSI	39	5	5	5	5	5	5	5	5	79
Achieved SSI	31	5	7	1	5	5	3	3	2	62
Planned T-F-up	18	7	7	7	7	7	7	7	7	74
Achieved T-F-up	15 (in 3 GDs)	0	0	0	0	4 (in one GD)	0	0	0	19
Planned CBI	14	6	6	6	6	6	6	6	6	62
Achieved CBI	0	0	0	0	0	0	0	0	0	0
Planned FGD	5	0	1	2	0	1	0	0	0	7
FGD/ GD	2/0	0/0	1/0	1/1	0/0	0/1	0/0	0/1	0/1	4/4

[9] It is worth noting that these were some of the hardest-to-reach counties in Liberia, many of which experienced high Ebola incidence. Lofa County suffered the most deaths during the Ebola crisis. To maximize productive time in the field, travel and site visits had to include weekends.

[10] Does not include two additional SSI interviews conducted via skype in April from Washington DC.

Training Follow-up Assessment: It proved difficult to obtain a complete database for all training events sponsored by the CP in the last three years. This was due to delays in getting Implementing Partner (IP) cooperation to provide the requested data. Based on the training data received, it was feasible to develop a purposive sample of trainees for four training follow-up group discussions.[11] Participants from four specific UNFPA-supported trainings were invited to gather in four small homogeneous groups of trainees (four to six participants for a given training) in suitable meeting locations in two of the eight counties (Monrovia [3 groups] and Maryland [1 group]. A total of 19 respondents participated (9 men and 10 women) compared to the target of 74 Training follow-up interviews per the Design Report. The respondents were interviewed in small groups using a structured set of questions (See Annex 5). The group interviews were preceded by precautions for informed consent and confidentiality. After all participants had an opportunity to respond to the questions, there was an open-ended debriefing discussion. This debriefing discussion was used to probe for gaps in training, and elicit preferred training approaches and recommendations for future UNFPA-supported trainings.

Beneficiary Interviews: As outlined in the design report, sixty-two beneficiary interviews (CBIs) were to be conducted with beneficiaries of activities conducted within each of the counties (See Table 1 above and Table 4.3.C in the Design Report). These interviews were designed to assess client satisfaction with the services they received from Implementing Agencies working within each of the four focus areas. See the draft interview questionnaire in Annex 5. Unfortunately, due to the time constraints, there was only sufficient time to interview CHTs and other important stakeholders; it was not feasible to collect beneficiary interviews from any of the service delivery sites.[12]

Focus Group Discussions (FGDs) and Group Discussions: Using tailored FGD Guides, four FGDs were conducted (with from 5 to 14 participants each) with a total of 31 respondents (16 men and 17 women) from two of the four program areas, RH and ASRH (See Annex 3.B). The evaluation team worked closely with UNFPA CO staff to identify suitable opportunities to arrange FGDs in each of the regions visited, attempting to get at least one FGD for each program area. Despite repeated efforts, due to logistical problems and unavailability of client beneficiaries at the times the team was visiting different counties, it was not feasible to set up FGDs for GE&RR and PD respondents. The team failed to meet the target for a total of seven FGDs and failed to get coverage in all four program areas. While more informal than the FGDs, the team managed to arrange four group discussions (with from three to nine participants) with diverse respondents, a total of 21 respondents (7 men and 14 women). These group discussions, while they were less structured than the FGDs, still generated useful findings (See Annex 3B).

Section 1.3.2 Rationale for the selection of the sample

Effort was made to ensure that a wide range of stakeholders were consulted during the CPE, with a good balance for each of the activities within all four of the CP focus areas at the National and County levels. The criteria used for selecting the areas for field work included a detailed mapping of UNFPA Liberia programme activities by area (Annex 6) and an effort to give extra attention to the larger programme area components, especially MNH+FP. In consultation with UNFPA Liberia, the sample of stakeholders, while

[11] As outlined in the Design Report, the intent was to select trainees from a comprehensive database to achieve balance on trainings conducted within the four focus areas (MNH including FP, ASRH, GE&RR and data availability and analysis). This was not possible. It was however feasible to arrange training follow up interviews with some trainees in MNCH+FP, ASRH, and PD.

[12] There were two potential client-beneficiary interviews with participants that had to be disregarded due to the age of participants and possible child protection issues; respondents had to be 18 or older to be interviewed.

purposive and non-random, provides a reasonable range of information and perceptions among most of the implementing agencies (See the Site Visit Planning Schedule and the listing of stakeholders interviewed in Annexes 3a and 3b). The evaluation site visit schedule attempted to reach vulnerable beneficiaries from marginalized groups e.g. commercial sex workers and LGBT respondents with some limited success. This was done despite the relatively low level of CP investment/interventions in this area.

Section 1.3.3 Limitations and risks

There are several important limitations in the proposed methods. First, the CPE is a qualitative study and, due to limited time and resources, it was not feasible to collect representative samples. The evaluation is qualitative in nature due to the small, non-random sample sizes. While there was a limited opportunity for a randomization process for the training follow-up assessments, all other samples were purposive and not truly representative of the target populations of stakeholders and beneficiaries. Second, due to the short time frame permitted to plan the evaluation (less than four weeks in the country), response rates for certain interview categories were much lower than desired. There are possible biases in the selection of respondents due to the requirement to select locations on a purposive non-random basis. The restriction of the CPE team to just three persons was a constraint on the number of interviews that could be carried out. To avoid the possibility of bias from UNFPA staff, all interviews were conducted by the evaluation team members in private without any UNFPA agency staff present.

As noted above, in view of the critical need to ensure that a good balance of stakeholder interviews was achieved or completed in each county, it was very difficult to complete the number of training follow-up interviews and no beneficiary interviews were completed.

CHAPTER 2: COUNTRY CONTEXT

2.1 Development challenges and national strategies

Liberia has been in a fragile post-conflict recovery since the end of the second post-war elections in 2011 and lacks basic social services to meet the needs of its citizens. The major contributing causes for the poverty in Liberia are the economic consequences of the Liberian Civil War, which resulted in the loss of capital, brain drain, and damaged infrastructure.[13] In the wake of these difficulties, as of 2011, it was estimated that 80% of Liberia's health services were provided by NGOs.[14] These problems were accentuated by the recent 2014 Ebola virus disease (EVD) outbreak in Liberia, which contributed to a relapse of the already weak basic health services.

Tragically, the EVD outbreak came at a time when Liberia had just demonstrated improvements in health care indicators, such as for children under the age of five. Analysis of trends between the 2007 and 2013 Liberia Demographic and Health Surveys (DHSs) showed that most child and maternal health indicators improved in the DHS rural sub-sample from 2007 to 2013.[15] As of 2012, Liberia was one of the first sub-Saharan African countries to achieve its millennium development goal (MDG) target of reducing the mortality rate for children under age five by one-third of its 1990 levels.[16] In addition to its commitment to the MDGs, Liberia is signatory to a large number of international health agreements, such as the UN Sustainable Development Goals (SDGs) 2030; Family Planning 2020; African Health Strategy; Paris Declaration; Maputo Call to Action, and the UN Secretary General's Global Strategy for Reproductive, Maternal, New born and Child Health (RMNCH) Accountability and Results.[17]

Currently, Liberia's health infrastructure, particularly in the rural areas, is characterized by sub-standard quality of services, equipment and expertise. Liberia was identified by the WHO in 2010 as having a very small and under-skilled health workforce; trained health workers are concentrated in the capital, Monrovia, leaving the rural populations underserved.[18] As of December 2014, 175 Liberian health care workers were reported to have died due to the EVD outbreak, a disaster for the country's health care work force.[19]

Liberia was ranked 177 out of 188 countries in the UNDP human development index (HDI) as of 2014. In the West African context, Liberia is currently ranked below Cote d'Ivoire (172) and above Guinea (182).[20]

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[13] http://www.africanvault.com/poorest-countries-in-africa/

[14] World Bank. Reproductive Health at a Glance – Liberia. April 2011; USAID. Health Systems 20/20. Liberia Country Profile. http://www. healthsystems2020.org/section/wherewework/Liberia.

[15] Kentoffio et al. Charting health system reconstruction in post-war Liberia: a comparison of rural vs. remote healthcare utilization. BMC Health Services Research (2016) 16:478 DOI 10.1186/s12913-016-1709-7

[16] Streifel, C. How did Ebola impact maternal and child health in Liberia and Sierra Leone? CSIS October 2015.

[17] See Global Financing Facility. Liberia MNCAH Investment Case 2016-2020. 2016. Liberia is also party to Every Woman, Every Child with a commitment to spend at least 10% of the health sector allotment on RMNCAH.

[18] http://www.who.int/hrh/fig_density.pdf?ua=1 Density of doctors, nurse and midwives in the 49 priority countries. Liberia has 3 doctors, nurses and midwives per 10,000 population compared to critical threshold of 23. WHO Global Atlas of the health Workforce August 2010.

[19] Liberia Ministry of Health & Social Welfare. Liberia Ebola Daily Sitrep no. 206 for 7th December 2014. Available: https://community.apan.org/apcn/ern/m/govtofliberia/141038/download.aspx. Accessed: 16 December 2014 as cited by Kenny, A. et al. Remoteness and maternal and child health service utilization in rural Liberia: A population–based surveywww.jogh.org doi: 10.7189/jogh.05.020401 1 December 2015 • Vol. 5 No. 2 • 020401.

[20] Data not shown, available on request. Source: http://hdr.undp.org/en/composite/trends.

Liberia has shown only very modest improvement in estimated gross domestic product (GDP) per capita in the past two decades; it was US$ 456 in 2015, still below the level reported for 1988. Liberia currently has the lowest GDP per capita among its neighbouring countries of Cote d'Ivoire, Guinea and Sierra Leone.[21]

Liberia faces multiple challenges, including poverty, and internal and international migration. Per the United Nations Development Assistance Framework (UNDAF), a 2010 survey found that 37% of households considered themselves to be living in poverty, while 8.9% felt they were living in extreme poverty. A large percentage (more than 60%) of Liberia's population lives on less than US$1 a day.[22] Also, Liberia faces major challenges in education, with an adult literacy rate of 42.9% for ages 15 and older. Only 27% of the population aged 25 and above has at least some secondary education.[23] Half of Liberians work in the agricultural sector. The informal sector accounts for 68% of employment, primarily in agriculture, forestry and fishing, as well as in the wholesale and retail trade. More than three-fourths of the labour force (78%) are vulnerably employed, lacking the protection of labour regulations and social benefits.[24]

Per the World Bank, Liberia has had to recover from the twin shocks of the Ebola crisis of 2014-2015 and a sharp decline in global commodity prices. These trends have led to business closures, including of mines and consequent job losses and reduced fiscal revenues. Liberia's fiscal revenues were projected to decline by 12% in 2016, which may require expenditure cuts by the Government.[25]

Maternal and New born Health including Family Planning Liberia has a revised comprehensive reproductive, maternal, new born, child and adolescent Health Policy (2015-2021) and a revised national family planning strategy that provide frameworks for coordinating and monitoring reproductive health (RH) activities including family planning.[26] With an overall goal to reduce the burden of morbidity and mortality attributed to sexual and reproductive conditions, the Liberian Sexual and Reproductive Health (SRH) policy has four main objectives to: 1) provide SRH services (including Emergency Obstetric and New born Care [EmONC]), 2) increase access and use of SRH services, 3) improve quality and 4) ensure sustainable financing and management for SRH services. There are several related policy documents that underpin these documents, including: the National HIV/AIDS policy 2005-2010 (revised in 2011-2015), and 2015-2020; National Health Policy and Plan 2007 (revised 2010-2020); Basic Package of Health Services 2007 (revised as Essential package of Health Services 2011-2015); Roadmap for the Reduction of Maternal and New born Morbidity and Mortality 2008 and an updated operational plan (The National Resilient

[21] Data not shown. Available on request. Source: World Bank national accounts data, and OECD National Accounts data files http://data.worldbank.org/indicator/NY.GDP.PCAP.CD?contextual=default&locations=LR.

[22] Government of the Republic of Liberia Republic (RL) and UN. United Nations Development Assistance Framework (UNDAF) for Liberia 2013-2017. Monrovia. February 2013. "A threshold of USD $1 a day indicates that 64% of the Liberian population lives on less. This varies from 68% in rural areas to 55% in urban areas". Republic of Liberia - Ministry of Planning and Economic Affairs. Agenda for Transformation: Steps toward Liberia RISING 2030. Liberia's Medium Term Economic Growth and Development Strategy (2012-2017). 2013.

[23] http://hdr.undp.org/en/countries/profiles/LBR

[24] RL and UN. UNDAF for the Liberia 2013-2017. Monrovia. February 2013.

[25] "Furthermore, fiscal revenues are projected to decline by 12%, based on the original forecast of US$474million. This will necessitate expenditure cuts by Government in order to maintain the already high fiscal deficit target of 8.5% of GDP in FY2016." http://www.capitoltimesonline.com/index.php/editorial/item/863-liberia-s-economic-status. "Prospects for growth are much better in 2017, however, as GDP is projected to grow by more than 2%." http://www.worldbank.org/en/country/liberia/overview

[26] Ministry of Health & Social Welfare. Republic of Liberia National Sexual & Reproductive Health Policy Feb 2010. http://liberiamohsw.org/Policies%20&%20Plans/National%20Sexual%20&%20Reproductive%20Health%20Policy.pdf

Health Plan (2015-2021); the Strategy for Reproductive Health Commodity Security and the 2009 National Reproductive Health Policy.[27] UNFPA Liberia is active in supporting SRH policies and is a member of the Reproductive Health Technical Committee (RHTC) appointed by the Ministry of Health (MOH). In 2015, UNFPA's advocacy on family planning led to a revision of the MoH community health work force policy to include the administration of injectable contraceptives by community health workers; UNFPA also supported the revision of the 2012-2015 National Family Planning Strategy.[28]

Despite this favourable policy context for SRH, Liberia faces major problems in providing SRH services. For example, Liberia was reported to have only nine Ob/Gyns in the country,[29] with a national Caesarean-Section (CS) rate of only four %. As of 2013, it was estimated that there were 980 maternal deaths and 3,793 neonatal deaths in Liberia annually.[30] The MDG 5 target for the MMR in 2015 was 300 but, based on the 2013 Liberia Demographic and Health Survey (LDHS), the maternal mortality ratio (MMR) was estimated at 1,072 deaths/100,000 live births.[31] The high level of the MMR is linked to poor access to quality RH services, including family planning.[32] Although the leading causes of maternal mortality are haemorrhage, hypertensive disorders, sepsis, obstructed labour and complications from unsafe abortions, the agenda to reduce maternal mortality needs to prioritize family planning as a primary intervention to prevent maternal mortality.[33]

Per the 2013 LDHS, the contraceptive prevalence rate for all modern methods (mCPR) in Liberia is still low at 20 %; it increased from 11% in 2007, mainly due to a significant increase in the use of injectables. Almost a third of Liberian women are at risk of pregnancy, want to space their next birth or stop childbearing entirely, but are not using any method of contraception. Trends in unmet need (using the revised methodology) show a modest decline from 36% in 2007 to 31% in 2013.

Programmes under the MNH&FP Outcome include a large range of activities that are intended to contribute to increased contraceptive prevalence, reduced unmet need for family planning, reduced stock outs of contraceptives and increased births attended to by skilled health personnel. UNFPA supports national capacity development to implement comprehensive midwifery programmes and for Emergency Obstetric and New born Care as well as for prevention, treatment and social reintegration for obstetric fistula and implementation of the Minimum Initial Service Package (MISP) in humanitarian settings. The CO has focused on the role of County Health Teams (CHTs) and care providers in ensuring Reproductive Health Commodity Security in hard to reach counties and maintains a policy dialogue for government budget allocation for procurement of modern contraceptives and implementation of family planning. As part of its support to improve emergency obstetric care, UNFPA Liberia has provided long-term support

[27] World Bank. Liberia Reproductive Health at a GLANCE April 2011.
[28] UNFPA Liberia. COAR. 2015.
[29] Source: UNFPA, State of the World's Midwifery 2014 report (http://www.unfpa.org/sites/default/files/pub-pdf/EN_SoWMy2014_complete.pdf). Per WHO, these figures do not necessarily reflect the number of practicing midwives or the ICM definition of a midwife.
[30] Source: Maternal and Perinatal Health Profile Department of Maternal, New born, Child and Adolescent Health (MCA/WHO). Source for maternal deaths: WHO, UNICEF, UNFPA and The World Bank estimates. Trends in maternal mortality: 1990 to 2013. Source for neonatal deaths: UNICEF/WHO/The World Bank/UN Pop Div. Levels and Trends in Child Mortality. Report 2014.
[31] LISGIS, MoH, NACP, IFC International. Liberia Demographic and Health Survey (DHS) Report. Monrovia. August 2014.
[32] LSGIS. LDHS. 2013.
[33] As outlined by S. Ahmed et al. Lancet. 2012, depending on modelling assumptions, elimination of unmet need in Liberia has the potential to reduce MMR from between 16.5 to 22.8 percent.

for the surgical management of fistula and rehabilitation of fistula survivors to be reintegrated into their communities.

The CO faces challenges implementing programs, ranging from continued interruption of activities due to the EVD outbreak as well as challenges in EmONC implementation. There are limited resources for domestic funding for interventions, limited community engagement in maternal health care. This results in weak reporting of maternal death at the community level and high rates of home-based deliveries with delays in reaching care. Because of the relatively recent formulation of a robust system, the focus on the Maternal and New born Death Surveillance and Response (MNDSR) Reporting has been limited.

Data availability and analysis Based on the census of 2008, there were 17 major ethnic groups in Liberia. Of these, the Kpelle were the largest (20.3%), followed by the Bassa (13%). Christians were the largest religious group (85.6%), followed by the Muslims (12.2%). The current estimated population of Liberia is 4.6 million, half of which resides in urban areas.[34] Based on the 2008 census, Liberia has a young population, 43% under the age of 15, with an annual growth rate of 2.44%. Liberia's high fertility rate of nearly 5 children per woman and large youth cohort – more than 60% of the population is under the age of 25 – will sustain a high dependency ratio for many years to come.[35]

The current estimated growth rate implies that the population will double in just over two decades. Liberia's youthful age structure will continue to fuel further population growth. The population's high fertility rate and young age structure will contribute to population momentum. Liberia's high population growth in the face of a small resource base has implications for social indicators in the country, especially in education, health, agriculture, environment and sanitation and housing, particularly in urban areas. Liberia's under-five population accounts for 17.5 % of the population. This places a health and education burden on the government in terms of response to childhood diseases and early childhood education.

Liberia has been both a source and a destination for refugees. During Liberia's 14-year civil war (1989-2003), more than 250,000 people became refugees and another half million were internally displaced. Between 2004 and the cessation of refugee status for Liberians in June 2012, the UNHCR helped more than 155,000 Liberians to voluntarily repatriate, while others returned home on their own. Some Liberian refugees spent more than two decades living in other West African countries. Liberia hosted more than 125,000 Ivoirian refugees escaping post-election violence in 2010-11; as of mid-2016, about 20,000 Ivoirian refugees were still living in Liberia because of instability.[36]

The Liberia Institute for Statistics and Geo-Information Services (LISGIS) is the national institution responsible for data in Liberia, and functions as a producer of national population data. This institution approves sectoral data before publication. Every sector, while they may have their own data collection mechanism, must meet the approval of LISGIS before publishing their data. In addition to data collected by LISGIS, other Government of Liberia (GoL) ministries are also involved in collecting data for their own planning purposes. For example, the Ministry of Health collects data on clinical services and other health care interventions, the Ministry of Education conducts an Annual School Census, and the National Identification Registry, an autonomous agency within the Executive Branch of Government, is in the process of establishing a National Identification Registry.

[34] Liberia's total population is currently estimated by LISGIS at 4,299,944.
[35] Ibid
[36] Ibid

LISGIS has projected Liberia's population for a period of 100 years (from 2008 to 2108) to enable planners and policy makers understand what is likely to happen in the future to make informed decisions. With just a year and a half to the 2018 census, new estimates of population are needed for planning purposes. The UNFPA CO has been lending support to the Population Policy Coordination Unit (PPCU). The PPCU was created and located in the former Ministry of Planning and Economic affairs, now merged and known as the Ministry of Finance and Development Planning (MFDP). Given the demographic, social and economic realities of post-war Liberia, the pre-war 1988 National Population Policy (NPP) Act was repealed and replaced with a revised population policy that addresses the critical needs of individuals and society. The NPP was revised in 2005 and was passed into law in 2006.[37] The NPP has a section on Data, Training and Research, which provides a framework for all population activities in Liberia. The NPP addresses gender, reproductive health, and youth issues. The policy proposes human capacity building to ensure the timely collection, analysis and dissemination of population and related social and economic data for planning and plan management. The Data, Training and Research section of the National Population Policy provided the impetus for the establishment of LISGIS as an entity solely responsible for data. It is clear within the policy document that good development planning relies heavily on accurate data.

Gender Equality and Reproductive Rights Liberian women face tremendous challenges in gender equality and reproductive rights. The gender inequality index (GII) ranked Liberia 146 out of 155 countries in 2014.[38] Only 15.4% of adult women have reached at least secondary level education, compared to 39.3% of their male counterparts; the mean number of years of schooling for females is 44% lower than that of males.[39] Life expectancy at birth is 61.8 for females and 59.9 for males. Three in ten women earn cash and make independent decisions on how to spend their earnings and 62% of women earn less than their husbands.[40] Only two-thirds of married women aged 15-49 (2013 DHS) were employed at any time in the last 12 months, compared to 94% of married men aged 15-49.

Gender equality is a cross-cutting theme for both the UN System and the GoL.[41] Liberia subscribes to a number of international instruments to protect the human rights of its citizens,[42] including the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol). In September 2016, the Gender Equality Bill was passed to reserve 'special legislative constituencies' for women, youth and people with disabilities.[43] Despite these positive steps towards protecting the rights of women, challenges (including cultural barriers and weak justice system) prevent women from fully exercising their rights.

The UNFPA Country Office (CO) has made measurable contributions towards advancing gender equality and reproductive rights through advocacy and implementation of laws and policy.[44] In 2014, UNFPA

[37] Liberia Legislature, Senate. *Social and Economic Development Policy Act,* Liberian Legislative Acts (Handbills) Approved: December 1st, 2005 Published: January 19th, 2006
[38] Liberia Human Development Report 2015, UNDP
[39] www.datatopics.worldbank.org/gender/country/liberia
[40] www.lisgis.net/pg_img/Liberia%202013%20key%20Findings.pdf
[41] UNDAF 2013-2017
[42] CEDAW art 2 (c) provides that states must 'establish legal protection of the rights of women on an equal basis with men and ensure the effective protection of women against any act of discrimination'.
[43] http://www.unwomen.org/en/news/stories/2016/10/liberia-passes-the-affirmative-action-bill
[44] COAR Outcome 5

conducted a baseline survey to determine the number of Secret Societies in Liberia[45] and the extent to which FGM was practiced. The study revealed that 10 out of 15 counties engage in this practice. Support was also given to the Ministry of Gender and Social Protection to develop the Domestic Violence Bill. At the grassroots level, essential financial and technical support empowers civil society organizations including women's groups to participate in public hearings and constitutional processes. In 2015, UNFPA support enabled the Women's Legislative Caucus and gender advocates to participate in the constitution review process which advanced the debate on what later became the Equality Bill.[46]

Gender-based violence is prevalent in Liberia in many forms. Rape is the second most reported crime in Liberia and at least 51% of Liberian women are reported to have undergone FGM.[47] FGM varies dramatically by region and religion, with a prevalence of 80% in the Northern Lofa County to less than 10% in the SE counties of Maryland and Grand Kru.[48] The Human Rights Protection Service (HRPS) of the United Nations Mission in Liberia (UNMIL) found, based on monitoring of the fifteen counties, that the number of rape cases was high.[49] The Ministry of Gender, Children and Social Protection (MOGCSP) Gender-Based Violence Annual Statistical Report confirms that only two % of reported Sexual and Gender Based Violence (SGBV) cases result in a conviction. In 2016, courts convicted only 34 individuals for rapes perpetrated in 2015, out of 803 cases that were reported in that year. One of the main barriers to reporting cases and achieving accountability is social attitudes towards rape and general violence towards women.

UNFPA's response to SGBV is based on the Joint Program on Sexual and Gender Based Violence, which was developed in 2008 to provide a collaborative framework for addressing SGBV in Liberia. In 2005, the Rape Law was passed. Criminal Court E, which exclusively deals with SGBV crimes in Montserrado County, was established in 2008. SGBV units have been set up under the Ministry of Justice and MOGCSP and a number of UNFPA supported "One-Stop Centres" have also been established to provide services to survivors. In addition, the Liberian government has a national Action Plan to End Gender Based Violence, which acknowledges the impact of war on women and girls. Support from UNFPA has helped to strengthen the government's capacity to address gender-based violence through a multi-sectorial approach and the provision of high quality services to survivors. The CO supported CSOs to create awareness of gender based violence at the community level. In 2015, 1804 SGBV cases were reported and in 2016 1,808 SGBV cases were reported through the UNFPA-supported One-Stop Centres.[50] The CO also supported the development and validation of the national guidelines and protocol on the clinical response to SGBV in Liberia.

Young people's sexual and reproductive health and sexuality education. The public health and demographic context of Liberia make a compelling case for addressing the needs of youth. The MoH SRH Policy recognizes the importance of the needs of underserved populations, including youth in rural and remote areas.[51] The 2016 Liberia MNCAH Investment Case advocates strongly for the need to reach

[45] 2013 COAR
[46] 2015 COA
[47] United Nations Development Assistance Framework, 2013 - 2017
[48] UNICEF. Statistical Profile on Female Genital Mutilation/Cutting. 2014.
[49] Addressing Impunity for rape in Liberia, UNMIL, 2016
[50] 2015 COAR ; 2016 data based on UNFPA Liberia staff communication in May 2017.
[51] Ministry of Health and Social Welfare. National Sexual and Reproductive Health Policy. Republic of Liberia. 2016.

Liberian youth.[52] As noted in the 2013-2017 CPD, the age structure of the population of Liberia is young with 63 per cent of the population younger than 25. Liberian youth face formidable challenges, including limited access to employment, stable sources of income, education, and sexual and reproductive health information and services. As noted in the Liberia MNCAH Investment Case, routine adolescent and youth friendly (AYF) RMNCAH services are an important priority, as is comprehensive sexuality education for increased knowledge on Sexual Reproductive Health and Family Planning (SRH/FP).

Based on the 2013 LDHS, more than half of adolescent girls with no education are mothers, compared to 17 per cent of those with secondary and higher education (2013 LDHS). Due in part to the high prevalence of teenage pregnancy (31%), young women are disproportionally represented among victims of obstetric fistula (2013 LDHS).

The UNFPA CO has supported advocacy and policy dialogue on youth issues with the Ministry of Youth & Sports, through the Federation of Liberian Youth (FLY) and other stakeholders.[53] More recently, the CO provided technical and financial support to FLY to conduct a high-level advocacy dialogue at the lower House of Parliament (i.e., the House of Representatives) to enable the passing of the Youth Act, which is still work on-going. A range of programmes and policies have been supported that incorporate youth and adolescents SRH and human rights.[54]

Section 2.2: The role of external assistance

Over the past six years, there has been a wide variation in total annual Official Donor Assistance (ODA) disbursements to Liberia, from US$592 million in 2009 to a high of US$1.4 billion in 2010, to US$746 million in 2014.[55] As of 2014, compared to its neighbours, Liberia received substantially less than Cote d'Ivoire and Sierra Leone and significantly more than Guinea. Because the population of Liberia is much smaller than its neighbours, on a per capita basis, Liberia has the highest total ODA among the four countries; US$122 for Liberia versus $112 for Sierra Leone, $83 for Guinea and $44 for Cote d'Ivoire.

The role of bilateral versus multilateral net ODA has evolved over the last decade with increases in both categories, peaking in 2008 and 2010, followed by a decline in both categories.[56] Except for 2002, 2007 and 2010, bilateral aid has consistently exceeded multilateral aid[57] in all years since 2002. The current trend for both bilateral and multilateral ODA was a pronounced increase between 2013 and 2014.

The three-year average ODA donations to Liberia from the top 15 bilateral donors ranges from over $180 million from the United States to $1million from Spain (Data not shown, available on request[58]). UNFPA is not as large as the EU, IDA and other multilaterals for ODA, but it is among the top 15 multilateral donors

[52] "Adolescent health care services are seldom prioritized, especially in underserved counties. Health care services targeting adolescents are fragmented, poorly coordinated and most often embedded into the mainstream health care services. The need for ease of access to health care for adolescents and youth by providing an enabling environment to facilitate the process cannot be overemphasized." Global Financing Facility. Liberia MNCAH Investment Case 2016-2020. 2016. Page 27.

[53] UNFPA supported development of the Liberia Youth Policy and Action Plan in the previous CP cycle.

[54] These include a Youth Empowerment for Demographic Dividend Initiative, the National Community Health Policy, the National Family Planning Strategy and the National Reproductive Maternal, New born, Child and Adolescent Health (RMNCAH) Policy.

[55] Data extracted on 05 Nov 2016 11:12 UTC (GMT) from OECD.Stat http://stats.oecd.org/Index.aspx?DataSetCode=CPA# Source: OECD http://www.aidflows.org/ Downloaded 22 March 2016

[56] Source: http://www.aidflows.org/ Downloaded 10 Nov 2016

[57] OECD (Downloaded 2 November 2016)

[58] Source: http://www.aidflows.org/ Downloaded 2 Nov 2016 http://stats.oecd.org/Index.aspx?DatasetCode=TABLE2A

with a three-year average of $2.42 million in ODA (See footnote 58). The total three-year average contributions for health and population are a very significant portion of total gross ODA disbursements for Liberia at 20.4% compared 5.6% for education.[59] The relative amount of funds from UNFPA to Liberia, based on a five-year average of net official flows, are substantially less than UNICEF, UNDP, UNPBF and UNHCR, comparable to the WFP and significantly more than WHO and UNAIDS.[60]

[59] Data not shown, available on request. http://www.aidflows.org/ (Downloaded 11 Nov 2016) See also OECD http://stats.oecd.org/Index.aspx?DataSetCode=CPA#. Source AIDFLOWS Downloaded 10 Nov 2016

[60] Source: World Bank Development Indicators, Downloaded 1 Nov 2016

CHAPTER 3: UN / UNFPA RESPONSE AND PROGRAMME STRATEGIES

3.1 UN and UNFPA response

The Government of Liberia, in collaboration with the UNCT, formulated the United Nations Development Assistance Framework (UNDAF) 2013-2017 as a mechanism to foster the UN delivering as one to support the achievement of national priorities. The UNDAF is guided by the goals and targets of the Millennium Declaration,[61] which the Government endorsed, and other national programmes and strategies. A Human Rights Based Approach (HRBA) has been central to the development of the UNDAF. Gender equality and women's empowerment are a UN mandate, a GoL goal, and a programming principle for development assistance (UNDAF 2013-2017).

The UNDAF is organized around four distinct but interlinked areas of cooperation to be achieved through multiple outcomes. The four pillars of focus with their respective outcomes are:

UN Pillar I: Peace, Security and Rule of Law
Outcomes - Rule of Law; Peace and reconciliation; Security;

UN Pillar II: Sustainable Economic Transformation
Outcomes - Natural Resource and Food Security; Private sector development; Basic Infrastructure and Energy; and Macro-economic policy environment;

UN Pillar III: Human Development
Outcomes- Health and Nutrition; Education; Social Welfare; Social Protection; Water, Sanitation & Hygiene; and HIV-AIDS.

UN Pillar IV: Inclusive Governance and Public Institutions
Outcomes- Strengthening Key Governance Institutions; Constitutional and Legal Reform; Natural Resources Management; Public Sector Institutions and Civil Service Reform.

Section 3.1.1 Brief description of UNFPA previous cycle strategy, goals and achievements

Globally, three important targets of the MDGs, including halving extreme poverty, were met three years ahead of the 2015 deadline. But progress on MDG 5 (A and B) to improve maternal health was much slower. While poverty declined somewhat, inequality, including gender inequality, had not. In September 2011, an extensive review of UNFPA's global portfolio in light of the changing context within which UNFPA operates globally, produced a revised and more focused global UNFPA Strategic Plan (SP) 2011-2013 that was adopted by the Executive Board. Subsequently, a new UNFPA Global SP 2014-2017[62] focused on advancing the right to SRH by accelerating progress towards MDG5; to be accomplished mainly through reduced maternal deaths and the achievement of universal access to reproductive health, including family planning.

[61] And its successor programme, the Sustainable Development Goals (SDGs)
[62] UNFPA SP 2014-2017.

UNFPA has been working in Liberia since 1979. With the outbreak of civil war in 1989, there was a disruption of the first and second CPs. Through the third CP, 2008-2012, UNFPA was able to provide support for reproductive health, population and development, gender equality, and HIV/AIDS.

Section 3.1.2 Current UNFPA country programme

The current 4th CP for 2013-2017 has been aligned with the national priorities, the MDGs, the ICPD Program of Action, Midterm Review of UNFPA SP 2011-2013, in addition to the UNFPA SP 2014-2017. The 4th CP contributes to improving the quality of life of people in Liberia by supporting the above mentioned four UNDAF pillars and directly contributing to the achievement of the second Poverty Reduction Strategy (The Agenda for Transformation - AfT).

Initially, the 2013-2017 CP had five outcomes as per the UNFPA mandate: Maternal and New born health; Family Planning; Gender equality and reproductive rights; Young people's sexual and reproductive health and sexuality education, and data availability and analysis. In 2014, after the approval of the current Country Program, the CP's Results and Resources Framework was aligned with the UNFPA SP 2014-2017. As part of this alignment, the initial two Outcomes were collapsed into one combined Outcome: Maternal and New born Health including Family planning. The Country Program is contributing to all four of the SP 2014-2017 outcomes and relevant outputs. Annex 4 summarizes this re-alignment, with four outcomes and 11 outputs. (Figure 3.1 illustrates some of the key foundation strategy documents that form the basis for the UNFPA Liberia's new alignment.)

Figure 3.1 UNFPA Liberia Re-Aligned Country Program linkages with National Strategy and Global Strategic Plans

The Fourth Country Program is being implemented in close partnership with the Government of Liberia. This includes collaboration with several Ministries, including Education; Finance and Development Planning; Gender, Children and Social Protection; Health; Justice; Internal Affairs and Youth and Sports.

Logic Model: Per Figure 3.2, a simplified logic model illustrates how planned activities in the four focus areas are to achieve outputs that, in turn, will accomplish four major UNFPA SP Outcomes. These four major outcomes are to contribute to the UNDAF pillars and the overall UNFPA goal: "The achievement of universal access to sexual and reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the International Conference on Population and Development (ICPD) agenda." The four outcomes are as follows:

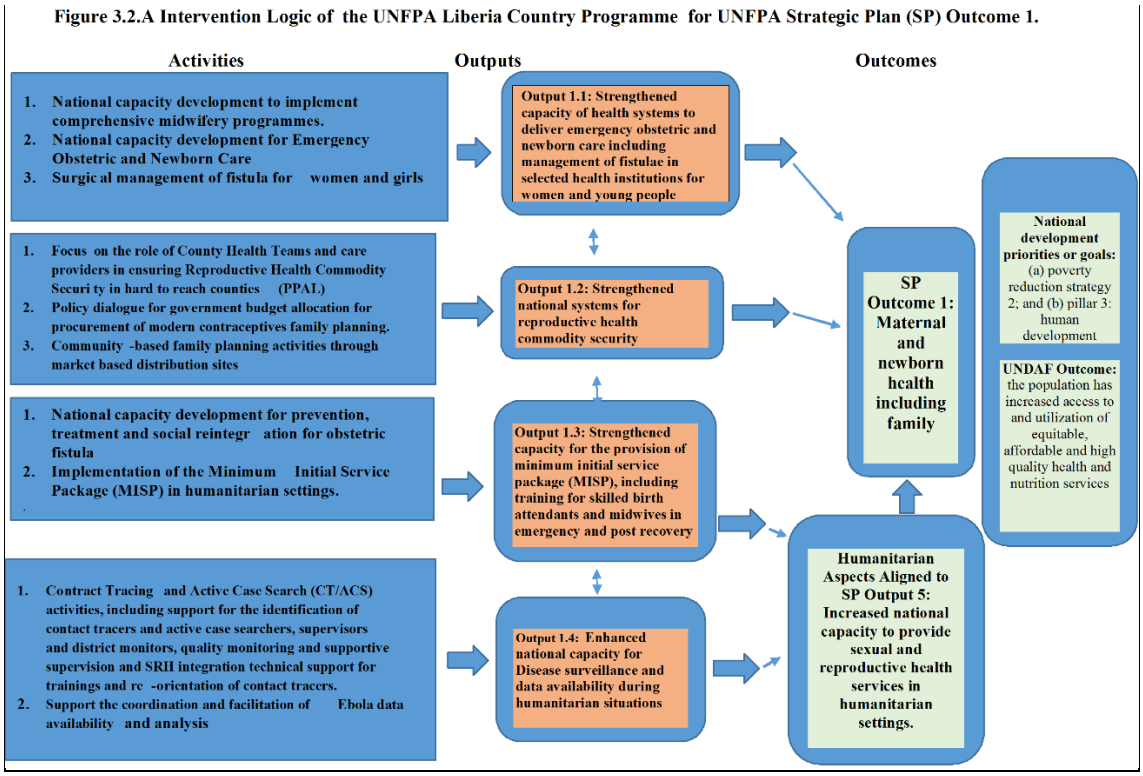
Outcome 1, Maternal and New born health including family planning is to be achieved through four outputs aligned with the SP Results Framework;

Outcome 2, Gender equality and reproductive rights is to be achieved through two outputs;
Outcome 3, Young people's sexual and reproductive health and sexuality education is to be achieved through four outputs; and
Outcome 4, Data availability and analysis is to be accomplished through one output.

The logic model in Figure 3.2 is consistent with the Theory of Change for UNFPA's contribution to resilience.[63] As in Figure 3.2.A for Outcome 1, Maternal and New born Health including Family Planning, Outputs 1.3 and 1.4 contribute to SP Output 5 (Increased National capacity for SRH services in humanitarian settings.)

[63] See Chapter 5, page 13 of King Zollinger &Co. Approach Paper for CCPE of UNFPA Engagement in Highly-Vulnerable Contexts. May 2016.

Figure 3.2 Simplified Logic Model for UNFPA Liberia 2014 Aligned CP Framework



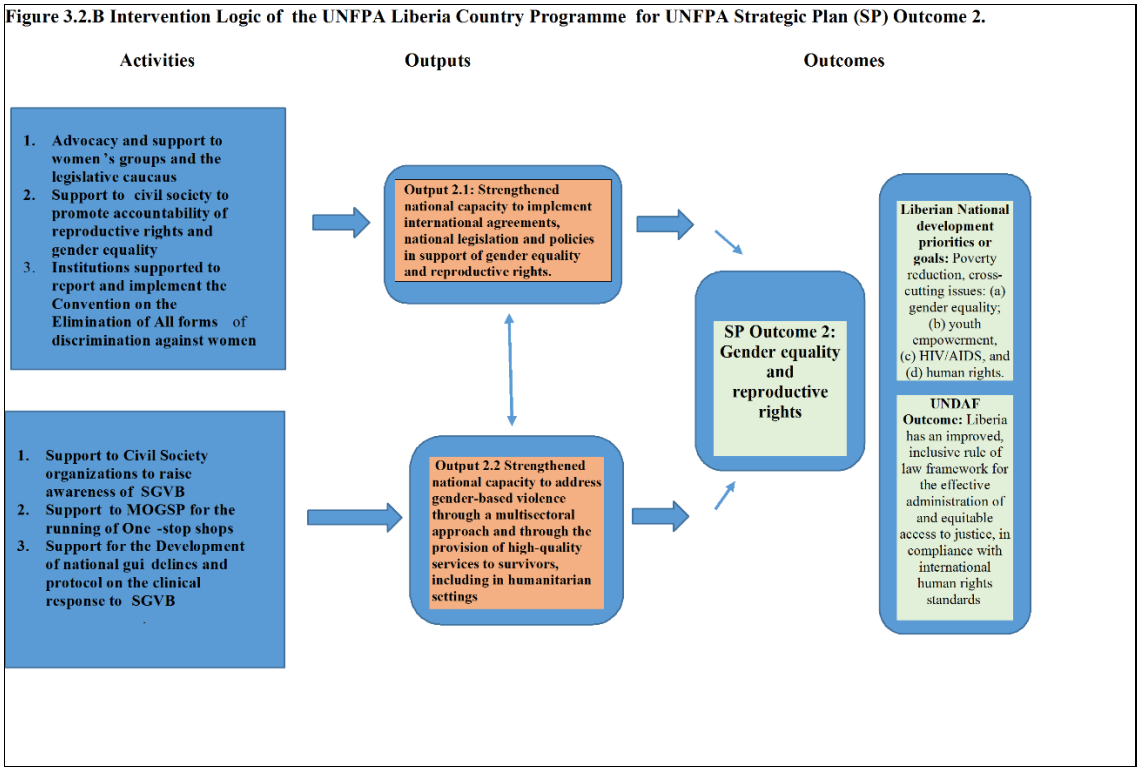


Figure. 3.2.C Intervention Logic of the UNFPA Liberia Country Programme for UNFPA Strategic Plan (SP) Outcome 3.

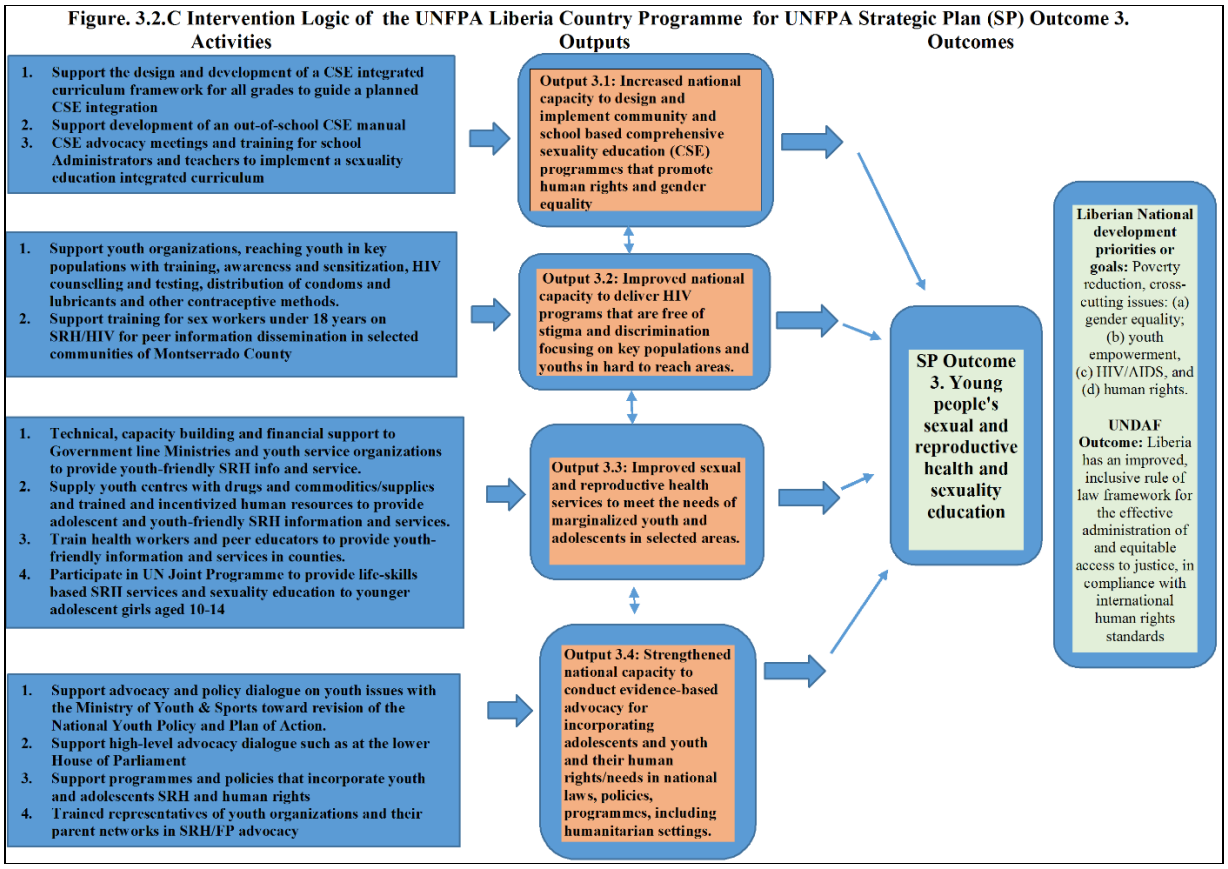
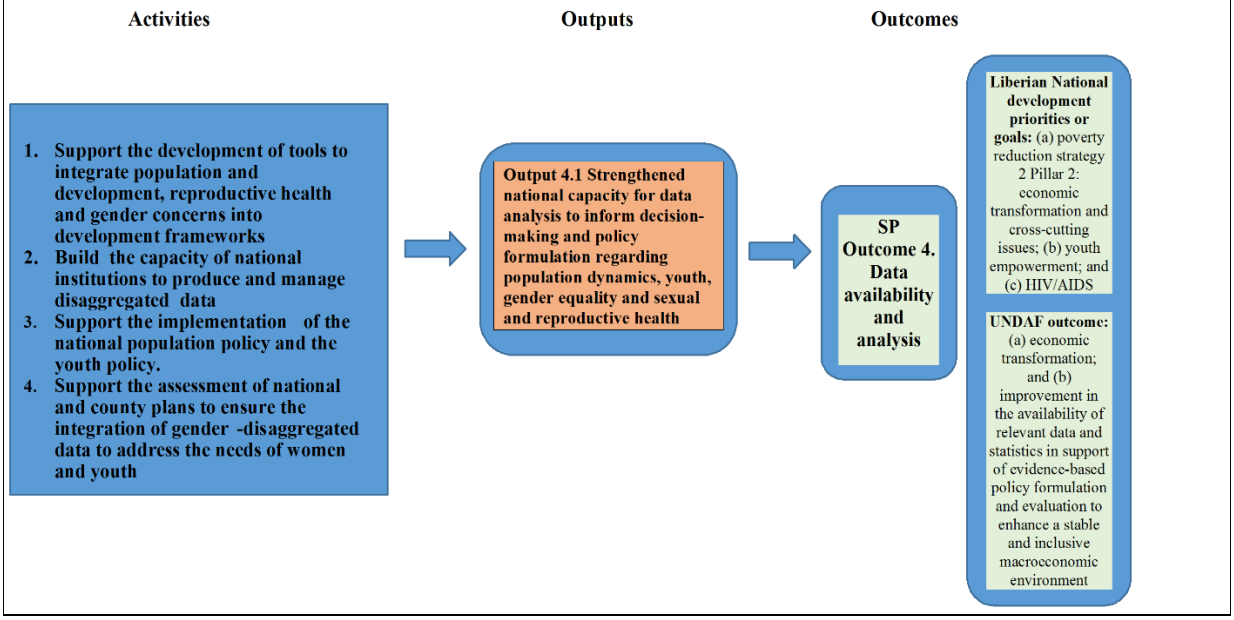


Figure 3.2.D Intervention Logic of the UNFPA Liberia Country Programme for UNFPA Strategic Plan (SP) Outcome 4.



Section 3.2: The financial structure of the programme

As shown in Table 3.1A, the original CP 2013-2017 approved by Executive Board in October 2012 had a budget total of $32.5 million for the 5-year programme, $7.5 million in core funds and $25.0 million to be raised from non-core resources. This budget contained five major outcomes and made a major commitment to Maternal and New born Health (30.5%) and Family Planning (21.8%) for a combined total of 52.3% of the total budget. As outlined by the ToR, the 4th CP was developed based on a comprehensive Country Population Analysis (CPA) which addressed the national needs and priorities within the mandate and comparative advantage of UNFPA's strategic plan (SP) 2014-2017. The two outcome levels of Maternal and New born Health and Family Planning were merged into one outcome level, with the expectation to achieve the same results as the previous two separate outcomes (See Annex 4: Results and Resources Framework for Liberia Aligned to the Strategic Plan 2014-2017.)

This new results and resources framework contributes to all four of the global UNFPA SP Outcomes and relevant Outputs. As in Table 3.1B, based on the 2015 UNFPA Liberia budget, there has been a relative decrease in the MNH including FP related budget from 52.3% to 42.2% of the total. This is due in part to a major increase in funds for data availability and analysis, which increased substantially from the initial planned 9.8% of the budget to 44.8% (Table 3.1B is based data available for UNFPA Liberia from http://www.unfpa.org/transparency-portal/unfpa-liberia).

Table 3.1 Original UNFPA Liberia Budget as of 2012 and Revised Budget in 2014

3.1.A Original UNFPA Liberia Budget as of October 2012, (US$ Millions)

Original five outcomes and PCA	Regular resources	Other	Total	% of Original 2012 Budget	% of Original 2012 Budget to be from other sources
Maternal and New born health	1.9	8.0	9.9	30.5%	81%
Family planning	1.1	6.0	7.1	21.8%	85%
Gender equality and reproductive rights	0.9	5.0	5.9	18.2%	85%
Young people's sexual and reproductive health and sexuality education	1.3	4.0	5.3	16.3%	75%
Data availability and analysis	1.2	2.0	3.2	9.8%	63%
Program coordination and assistance	1.1	0.0	1.1	3.4%	0%
Total	7.5	25.0	32.5	100.0%	77%

Table 3.1.B 2015 UNFPA Liberia Budget by Source and Type of Implementation Agency

		Source of funds		% Source of Funds					% of total implementation			
Category of UNFPA Liberia Outcome	Total	Regular	Other	Regular	Other	UNFPA	GOV	NGO	UNFPA	GOV	NGO	Total
MNH including FP (42.2% of Total Budget)	$ 5,037,478	$ 957,121	$ 4,080,357	19%	81%	$ 2,475,980	$ 439,547	$ 2,121,951	49%	9%	42%	100%
SRH	$ 360,075	$ 327,668	$ 32,407	91%	9%	$ 347,075	$ 13,000	$ -	96%	4%	0%	100%
Family Planning	$ 1,556,193	$ 155,619	$ 1,400,574	10%	90%	$ 520,028	$ 69,050	$ 967,115	33%	4%	62%	100%
Maternal health	$ 2,974,936	$ 416,491	$ 2,558,445	14%	86%	$ 1,532,113	$ 357,497	$ 1,085,326	52%	12%	36%	100%
HIV and AIDS	$ 69,510	$ 69,510	$ -	100%	0%	$ 69,510	$ -	$ -	100%	0%	0%	100%
SRH in Emergencies	$ 76,764	$ 76,764	$ -	100%	0%	$ 76,764	$ -	$ -	100%	0%	0%	100%
Gender Equality Total (7.7% of Total Budget)	$ 916,596	$ 201,651	$ 714,945	22%	78%	$ 406,137	$ 244,344	$ 266,115	44%	27%	29%	100%
Evidenced based policy making Total (44.8% of Total Budget)	$ 5,348,272	$ 213,931	$ 5,134,341	4%	96%	$ 1,605,632	$ 487,648	$ 3,254,992	30%	9%	61%	100%
Data production and dissemination	$ 5,260,877	$ 210,435	$ 5,050,442	4%	96%	$ 1,527,989	$ 477,896	$ 3,254,992	29%	9%	62%	100%
Population data analysis	$ 86,124	$ 17,225	$ 68,899	20%	80%	$ 76,372	$ 9,752	$ -	89%	11%	0%	100%
Monitoring and evaluation	$ 1,270	$ 1,270	$ -	100%	0%	$ 1,270	$ -	$ -	100%	0%	0%	100%
Adolescents and Youth Total (4.6% of Total Budget)	$ 553,092	$ 248,891	$ 304,201	45%	55%	$ 83,005	$ 258,199	$ 211,888	15%	47%	38%	100%
Adolescents and Youth Activities	$ 390,110	$ 89,725	$ 300,385	23%	77%	$ 3,697	$ 218,971	$ 167,442	1%	56%	43%	100%
Sexuality Education	$ 162,982	$ 162,982	$ -	100%	0%	$ 79,308	$ 39,228	$ 44,446	49%	24%	27%	100%
Org. effectiveness & efficiency (0.8% of Total budget)	$ 91,633	$ 91,539	$ 94	100%	0%	$ 91,633	$ 0	$ 0	100%	0%	0%	100%
Total – 100% of Total budget	$ 11,947,071	$ 1,713,133	$ 10,233,938	14%	86%	$ 4,662,387	$ 1,429,738	$ 5,854,946	39%	12%	49%	100%

Source: http://www.unfpa.org/transparency-portal/unfpa-liberia

2015 UNFPA Liberia Budget by Source and Implementation Agency.

The total expenditure evolution table (Table 3.2) and the related Figures 3.3 and 3.4 depict the cumulative total budget versus expenditure distribution in the CP for the initial three-year period of 2013-2015. The overall actual allocations of expenditures for MNH including FP during the first three years were below the initial 52.3% proposed level in the 2012 budget: a total of 44.1% of expenditures. This 44.1% includes MNCH+FP: 36.1% with 5.7% for Obstetric Fistula and 2.3% for RHCS.

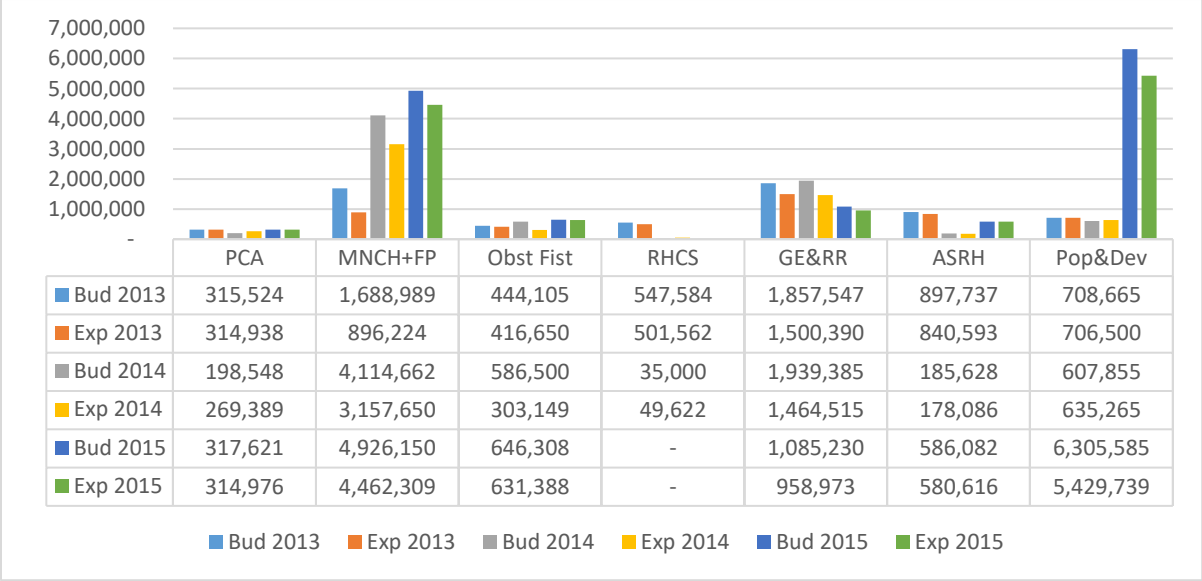
Table 3.2 Total Budget and Expenditure evolution 2013-2015 in US$

Budget Category	Total Budgeted 2013-2015	Total Expended 2013-2015	% of budget category Expended	Category as % of Total Expenditures
MNCH+FP**	10,729,801	8,516,182	79.4%	36.1%
Pop&Dev	7,622,105	6,771,504	88.8%	28.7%
GE&RR	4,882,163	3,923,879	80.4%	16.6%
ASRH	1,669,447	1,599,295	95.8%	6.8%
Obst Fist	1,676,913	1,351,187	80.6%	5.7%
PCA	831,693	899,303	108.1%	3.8%
RHCS	582,584	551,184	94.6%	2.3%
Total	27,994,706	23,612,534	84.35%	100.00%

**When Obst. Fistula and RHCS are added to MNCH+FP, it comes to 44.1% of the total.

Source: Sheet - Budget and Expenditures by programmatic areas v.1 in Financial Structure TWS excel file kindly provided by UNFPA Liberia.[64]

Figure 3.3 Budget and Expenditure by program area for 2013-2015[65]

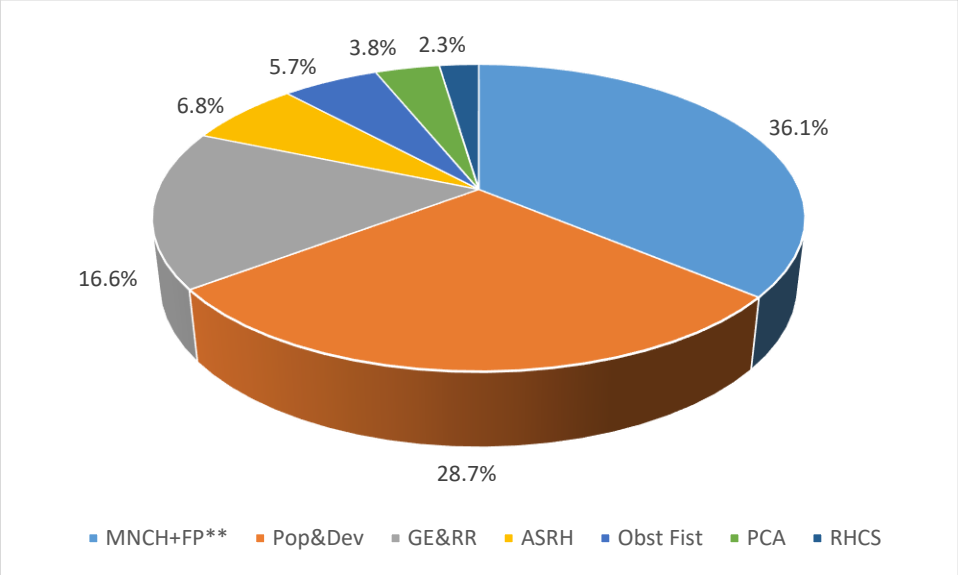


	PCA	MNCH+FP	Obst Fist	RHCS	GE&RR	ASRH	Pop&Dev
Bud 2013	315,524	1,688,989	444,105	547,584	1,857,547	897,737	708,665
Exp 2013	314,938	896,224	416,650	501,562	1,500,390	840,593	706,500
Bud 2014	198,548	4,114,662	586,500	35,000	1,939,385	185,628	607,855
Exp 2014	269,389	3,157,650	303,149	49,622	1,464,515	178,086	635,265
Bud 2015	317,621	4,926,150	646,308	-	1,085,230	586,082	6,305,585
Exp 2015	314,976	4,462,309	631,388	-	958,973	580,616	5,429,739

[64] The data in Table 3.2 exclude management costs; $2,314,300 total budgeted, $2,247,054 expended, (97.1% of budget was expended), these management expenditures were the equivalent of 8.7% of total expenditures).

[65] The surge of funding to Pop & Dev in Figure 3.3 is the result of an increase in funding related to the Ebola Crisis. The funds were raised to support the GoL in the fight against Ebola. The interventions were intended to break the chain of transmission and end the epidemic through contact tracing and active case search. Although data collection was key, the bulk of the money went toward payment for salaries of field staff, vehicles and logistics and arrangements that facilitated the work of county health teams within communities.

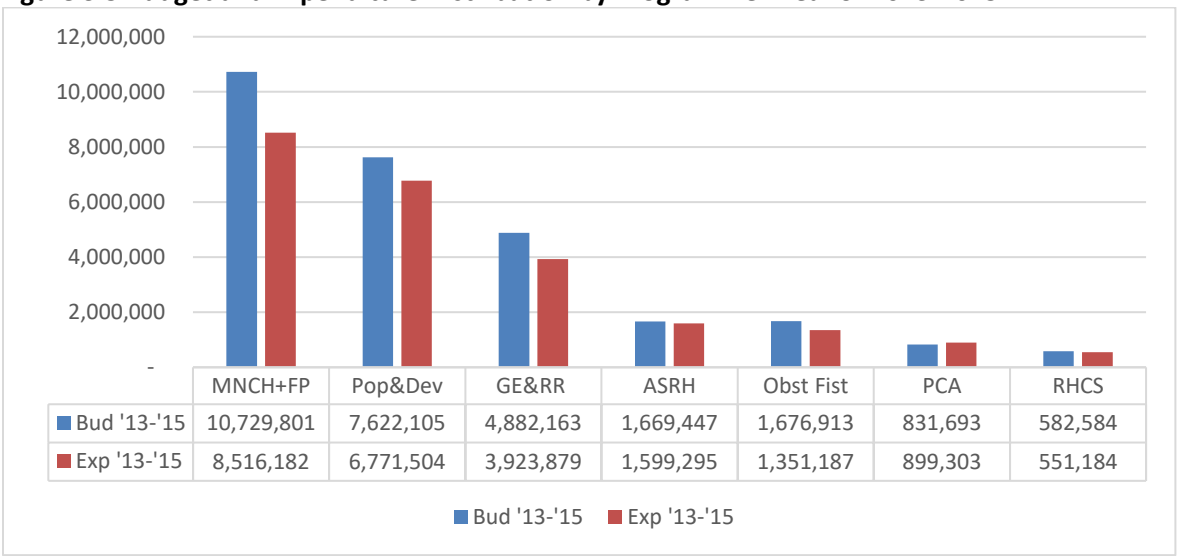
Figure 3.4 Percentage of Total Expenditure by Program Area for 2013-2015**



**When Obst. Fistula and RHCS are added to MNCH+FP it comes to 44.1% of the total.

Percentage of Budget Expended: A comparison of the cumulative budget versus cumulative expenditure shows relatively little under-utilisation of allocation throughout the CP period 2013-2015. The graph below (Figure 3.5) shows budget distribution and expenditure distributions for seven budget categories. As shown in Figure 3.5 and Table 3.2 above, all but three programme areas are expended at 85% or more. The three exceptions are MNH&FP, Gender Equality and Reproductive Rights (GE&RR), and Obst Fistula, which range from 79 to 80% expended. Only one budget category, PCA, was overspent (108.1%), primarily due to an overage in 2014.

Figure 3.5 Budget and Expenditure Distribution by Programme Area for 2013-2015



	MNCH+FP	Pop&Dev	GE&RR	ASRH	Obst Fist	PCA	RHCS
Bud '13-'15	10,729,801	7,622,105	4,882,163	1,669,447	1,676,913	831,693	582,584
Exp '13-'15	8,516,182	6,771,504	3,923,879	1,599,295	1,351,187	899,303	551,184

Diversification of funding sources and implementation of projects: As shown in Table 3.1B, based on the results for UNFPA Liberia for 2015, the CO has been highly successful in securing funding from other "mobilized resources." The initial 2012 overall target for proportion of funds secured from mobilized resources was 77%. While it varies by programme area (from a high of 96% for Population and Development to a low of 55% for ASRH), as of 2015, 86% of the total UNFPA funds in 2015 were from non-core sources.

Based on 2015 budget information shown above in Table 3.1B, the largest proportion of UNFPA programme implementation is being done by NGOs (49%) followed by UNFPA (39%) with the rest of the program budget being implemented by Government agencies (12%).

CHAPTER 4. FINDINGS

4.1 Relevance

The following questions apply to all 4 programme components. Question 9a: (EQ1). To what extent has the Country Programme addressed national priorities and needs of the population while ensuring alignment with UNFPA policies and strategies? **Question 9b: (EQ2).** To what extent has UNFPA ensured that the needs of beneficiaries have been taken into account in the planning and implementation of UNFPA-supported interventions under the country programme? **Question 9c: (EQ3-CCPE).** How did UNFPA take into account the country's vulnerability to disasters and emergencies [**the Ebola Virus Disease (EVD) Crisis**] in planning and implementing its interventions? (CCPE is addressed in a separate section below.)

Summary Findings for Relevance- Overview:

All four theme areas activities fit well within national priorities and strategies, are consistent with the needs of beneficiaries and implementing partners; they were developed based on assessments and consultations and implemented in a manner reflective of UNFPA global strategy, PoA ICPD, MDGs.

MNH&FP: Based on document review, site visits and stakeholder interviews, the UNFPA CP MNH&FP four outputs have been developed and implemented in close collaboration with key ministries of the GoL. All four MNH&FP outputs are closely aligned and implemented consistent with pertinent UNFPA policies and strategies. The four outputs demonstrated a careful consideration of the needs of beneficiaries through consultation and baseline needs assessments.

PD: The PD activities have extremely high relevance to national development priorities as outlined in the 2013 UNDAF, the 2012 Liberia Agenda for Transformation and the 2016 RMNCAH Investment Case. UNFPA support for building of national data availability infrastructure and training of human resources to generate data is guided by ongoing consultations with key stakeholders among Liberia's primary demographic data collection entities to address their need.

ASRH: The UNFPA CP-supported youth programmes are closely aligned with the GoL policies as well as UNFPA global strategy, the 2013 UNFPA Strategy on Adolescents and Youth, and the International Conference on Population and Development Program of Action (ICPD PoA). The UNFPA CP youth activities are informed by a wide range of quantitative and qualitative assessments of the SRH health context for youth in Liberia. The MoYS and youth agencies, such as FLY, are consulted as part of the development of UNFPA-supported programs.

GE&RR: UNFPA CP GE&RR programmes are closely aligned with the GoL's national priorities as well as international Charters and Conventions. UNFPA support to GoL is intended to meet the needs of some of the most marginalized women across the country. However, service delivery outside Montserrado tends to be less reliable, given the county-level dependence on unfunded NGOs to implement programmes. Beneficiaries are not always consulted or considered in the design and implementation of GE&RR programmes.

Overview: All four theme areas were found to be of high relevance; activities fit well within national priorities and strategies and are consistent with the needs of beneficiaries and implementing partners. There was evidence that activities were developed based on assessments as well as consultation with beneficiaries. All four theme areas were implemented in a manner that was reflective of UNFPA global

strategy, PoA ICPD, MDGs as well as national strategies, such as the 2016-2020 Reproductive, Maternal, New-Born, Child, and Adolescent Health (RMNCAH).

MNH&FP: Given the context of Liberia's high maternal mortality and the devastating impact of 2014 EVD crisis on the delivery of EmONC services, the 4th UNFPA CP portfolio of MNH&FP programmes were and continue to be extremely relevant. Based on document review, site visits and stakeholder interviews, the UNFPA CP has been instrumental in helping to restore essential MNH&FP services from a virtual standstill in 2014.[66] The activities implemented by the CP to achieve the four outputs in the focus area for MNH&FP have been developed in close collaboration with key ministries of the GoL based on national strategic plans and documents.[67] All four outputs are closely aligned with pertinent UNFPA policies and strategies.[68]

A review of the planning and implementation process for all four outputs demonstrates instances of careful consideration of the needs of beneficiaries through consultative, baseline needs assessments.[69] The UNFPA CO demonstrated a highly commendable resilience and responsiveness to the EVD Crisis through its active participation in the planning and timely delivery of pertinent equipment, supplies and services.[70] The UNFPA Liberia response to the EVD crisis is covered in a separate section (See Section 4.5 below).

P&D An analysis of interviews with various stakeholders revealed that UNFPA is known as the lead agency in the area of population data. Stakeholders from nongovernmental institutions articulated that they relied heavily on UNFPA for quality data from the LISGIS, which is considered the "Statistics House" in Liberia. NGOs frequently cited data from the census carried out by LISGIS as a key source of information for their work. The last census report available is for the year 2008, which is almost out of date. Respondents are concerned and asking for fresh population data beyond 2018 for their work. Stakeholders confirmed that LISGIS has developed a plan for the first stages of the 2018 census - geographic planning - but no sources of support have been identified. Respondents from government institutions cited the importance of UNFPA support to carry out sector-specific data collection and analysis. UNFPA's support

[66] Momoh, Hindowa B. and Angelance Browne. Mid-Term Review. Country Program Document UNDP-LIBERIA. December, 2015.
[67] Based on interviews and document review, the RNH&FP programmes of the UNFPA CP are integrated with the Liberia UNDAF UN Pillar III: Human Development Outcomes- Health and Nutrition; Education; Social Welfare; Social Protection; Water, Sanitation & Hygiene; and HIV-AIDS and contributes to the achievement of the second Poverty Reduction Strategy (The Agenda for Transformation - AfT). In addition to the National reproductive, maternal, New born, child and adolescent Health Policy (2015-2021), the CP is tied to National HIV/AIDS policy 2005-2010 (revised for 2011-2015 and 2015-2020), National Health Policy and Plan 2007 (revised 2010-2020), Basic Package of Health Services, 2007 (revised as Essential package of Health Services 2011-2015), Roadmap for the Reduction of Maternal and New born Morbidity and Mortality, 2008 and an updated operational plan (The National Resilient Health Plan (2015-2021), the Strategy for Reproductive Health Commodity Security. UNFPA CP is closely integrated with pertinent RH entities such as Liberian Midwives Association and Nurse Association; it supported the development and launch of a 5 year (2013- 2017) national strategic plan for midwifery education and regulation (2013 AWP, 2013 COAR).
[68] Based on stakeholder interviews and document review, the UNFPA Liberia CP contributes to the pertinent SP 2014-2017 outcomes and relevant outputs, the MDGs, the SDGs, and the ICPD Programme of Action.
[69] For example, UNFPA supported a needs assessment in 5 counties (2013 AWP). The 2013 rapid assessment of EmONC services to ascertained the actual gaps in 10 (BEmONC) and 2 CEmONC facilities in 5 underserved counties to assess the availability of all signal functions; 75% of facilities had important gaps. In 2015, UNFPA supported qualitative research with Ebola survivors and widows to ascertain the history of infection, challenges and needs in five counties: Cape Mount, Bomi, Nimba, Margibi and Lofa (COAR 2015).
[70] As part of the consolidated UN response to the EVD, UNFPA was designated responsibility for the UN Thematic Area 5: Reproductive Health. This included the procurement of clean delivery kits, rape kits, male and female condoms, management of miscarriage and complication of abortion kits, RH kits and essential RH drugs. A key priority was to increase access to quality maternal health services at facility-level and to clean and safe delivery at community level. See United Nations. Consolidated Support to The National Accelerated Ebola Virus Disease Outbreak Response Plan In Liberia. August 2014.

for LISGIS to conduct surveys such as the 2013 Liberia DHS, HIES and Labour Force Survey were named as major support relevant to data availability and analysis in Liberia. UNFPA P&D support during the EVD contributed to a redesign of an epi-surveillance data collection tool. This is highly relevant and responsive; the tools developed are still used for data collection across the country by the MOH. Epi-surveillance is now a sustainable data collection activity carried out by the MOH.

Youth The GoL has clearly identified the SRH needs of youth as a national priority.[71] The UNFPA CP supported youth programmes are closely aligned with the GoL policies as well as UNFPA global strategy, the 2013 UNFPA Strategy on Adolescents and Youth, International Conference for Population and Development Program of Action (ICPD PoA), Millennium Development Goals and the Liberia UNDAF.[72] UNFPA has had a long-term role in helping the GoL to establish evidence-based ASRH programme policies and standards. The CP is based on a wide range of quantitative and qualitative assessments of the SRH health context for youth in Liberia.[73] The MoY and youth agencies, such as FLY, are consulted as part of the development of UNFPA-supported programs.[74]Based on interviews and document review, there was evidence of the incorporation of needs assessments into UNFPA supported youth activities.[75] Due to a lack of national capacity in data collection and analysis, UNFPA CO has faced problems in obtaining high quality ASRH needs assessment data.[76] UNFPA-supported ASRH programs were instrumental in responding

[71] For example, [There is a] "critical need for Liberia to redouble efforts to improve the SRH of its people, especially that of women, youth, and rural populations." Ministry of Health and Social Welfare (MoHSW). National Sexual and Reproductive Health Policy. 2010. The MOH has well-defined standards for ASRH services including, 'Standard 1. Adolescents and young people are able to obtain health information and counselling relevant to their needs, when seeking health care at any SDP." MoHSW. Standards for the Provision of Essential Package of Sexual and Reproductive Health Services for Adolescent and Young People. July 2012.

[72] The 2013 UNFPA Strategy explicitly advocates promotion of comprehensive sexuality education, building capacity for sexual and reproductive health service delivery (including HIV prevention, treatment and care) and taking bold initiatives to reach marginalized and disadvantaged adolescents and youth, especially girls. UNFPA 2013.

[73] Examples include, LISGIS. 2013 LDHS; Most-At-Risk Adolescents and Young People (MARYP) Survey, MARYP Final Report.pdf - 2217kb. December 2012; de Mel, Sajith and Sara Elder and Marc Vansteenkiste. Labour market transitions of young women and men in Liberia. Work4Youth Publication Series No. 3. International Labour Office Geneva. October 2013. UNICEF. Liberia Statistical Profile on Female Genital Mutilation/Cutting. Data and Analytics Section. Division of Data, Research and Policy. 2014.

[74] UNFPA has a youth advisory committee is in place within an ASRH funded programme by SIDA. This structure fits the requirements of a Youth Advisory group although all ASRH plans by CO are informed by close consultations with key youth actors in the Country. In addition, the UNFPA Liberia CO developed a Country ASRH strategy developed alongside youth actors in the Country that contextualises the global UNFPA strategy and emphasises relevance of UNFPA's interventions on ASRH. See UNFPA Liberia. Adolescents and Youth Cluster Strategy. 2014. (UNFPA Youth Programme staff, May 2017).

[75] "In 2013 The Country Office, in response to the call of the President of the Republic of Liberia, collaborated with UNDP, the GoL through Ministry of Youth and Sports, to organize series of consultative meetings aimed at soliciting the inputs of the Liberia youth into a Liberian Youth Common Position for the Post 2015 Development Agenda. The Consultative process brought together youth from the 15 Counties of Liberia in 3 regional consultative meetings to deliberate on the issues they want to see in the next Global Development Agenda beyond 2015. The result from the 3 regional consultative meetings were validated at a National Youth summit which brought together youth representatives from the 15 counties as well as law makers, key youth stakeholders and the President of Liberia (COAR 2013). Per the 2016 COAR page 46, Output 6 MTR Indicator "Country has participatory platforms that advocate for increased investments in marginalized adolescents and youth, within development and health policies and peacebuilding programmes. Participatory platforms exist and have provided support to youth- led organizations to advocate for the participation of marginalized adolescents and youth in policy-making and programming. Participatory platforms exist and have had an action plan developed based on the assessment and analysis to advocate for increased investments in marginalized adolescents and young people." Also, as outlined in MOE 4th Q SPR, an assessment was carried out in 25 elementary and secondary schools in five (5) counties (Bong, Margibi, Grand Bassa, Montserrado and Grand Cape mount), information gathered shows an alarming report on teenage pregnancy among students in all schools visited.

[76] The UNFPA CO recently had a problem with a low-quality study done by Khana Group with UNFPA support through a collaborative initiative comprising the Ministry of Youth and Sports, Mercy Corps Liberia, the United Nations Mission in Liberia (UNMIL) and United Nations Population Fund (UNFPA) to carry out a youth mapping and profiling study. They were forced to reject the study, "The Liberian Youth Services Mapping and Profiling Study. Final Report. 2016, " due to low quality.

quickly to the EVD crisis. An important example is the rapid redeployment of 50 UNFPA supported National Youth Volunteers from six rural counties to do community education work in at-risk communities in Monteserrado County.[77] More examples of the ASRH programme response are presented below in Section 4.5.

GE&RR Based on document reviews, site visits and stakeholder interviews, the UNFPA CP Gender Equality and Reproductive Rights programmes are closely aligned with the GoL's national priorities as well as international Charters and Conventions. UNFPA support to GoL is intended to meet the needs of some of the most marginalized women across the country. However, service delivery outside Montserrado tends to be less reliable given the county-level dependence on unfunded NGOs to implement programmes. Beneficiaries are not always consulted or considered in the design and implementation of programmes; in some instances, this has led to a 'one size fits all' approach.[78]

The One-Stop Centre is an innovative strategy, funded by UNFPA, which utilizes a multi-agency approach to tackle SGVB. In 2014, the year of the EVD crisis when health centres were closed for up to 8 months, the Ministry of Gender and Social Protection documented 1,392 reported cases of SGVB, which was noticeably lower than the 2,159 cases the previous year.[79] Even though on the whole, there is a lack of up-to-date data to show the number of SGVB cases in Liberia, the decline and subsequent increase in uptake of the provision services for clients shows that the one-stop centre intervention is relevant and needs to be expanded.[80] One explanation for this increase in the uptake of the provision is that more people are now aware that the centres exist and find it a safe place to seek help.

The majority of service users at One-Stop Centres are under 16 years of age.[81] Though managers were aware of the need to make the physical space more 'child friendly', (thereby reducing the trauma of visiting the centre), lack of funding prevented them from addressing this. This group of clients, who tend to be accompanied by their parents, are more likely to benefit from follow-up treatments than older clients. However, health managers have observed that, increasingly, parents and guardians are seeking to profit once it can be established that their child has suffered SGBV. A positive result could be used to blackmail the perpetrator or their family into a financial settlement rather than taking the matter to court. Some parents are resistant to pursue the legal route because the majority of perpetrators are known to the victim's family.[82] So whilst the one-stop centres provide a gateway to justice for some beneficiaries, the majority of clients see it as an intervention that is mainly related to health.[83]

[77] Due do Ebola virus outbreak in the country, the RHCS-NYV program was suspended; initially there was a lack of or limited supply of protective gears and sanitary materials for youth volunteers' in the field during the deadly Ebola virus outbreak especially in Montserrado; the MoYS and UNFPA were very responsive, they brought the NYVs all in to Monrovia, and retrained them to do outreach, as well trained on IPC techniques for handwashing at entertainment centres and video clubs in 17 communities. See MoYS AR for 2014.

[78] For example, all the centres visited by the evaluation team suffered from a lack of space, based on the model of attaching one stop centres to existing health facilities. The issue of space meant that in most cases only one office or cubicle divided into two areas served as an examination room and office, thereby compromising privacy and confidentiality.

[79] MoGSP, National Gender Based Violence Statistical Report 2014, http://www.un.org/sexualviolenceinconflict/countries/liberia/

[80] UNFPA COAR 2015, 2016

[81] This is based on Think 2013 Annual report and interviews with centre managers.

[82] UNHCR, 2016, Addressing Impunity for Rape in Liberia. This was also confirmed by THINK and the managers of two other One Stop Centres.

[83] The Star of the Sea Annual report in 2013 documented that out of the 100 cases that year, only 15% received legal intervention.

During the EVD outbreak, UNFPA continued to provide support to 'One-Stop Centres' through the provision of PPEs, RH, Rape Kits, and personal hygiene gear which led to increased confidence by the clients and health workers.[84]

4.2 Effectiveness

EQ4- MNH&FP. To what extent has the country programme contributed to improving quality and affordability of RH services? **Data Availability and Analysis (Pop&Dev**). EQ 10.E. (EQ7-DA&A) To what extent has UNFPA-supported interventions contributed (or likely to contribute) to an increase in use of demographic and socio-economic information and data in the evidence-based development and implementation of plans, programs and policies to (improve access to reproductive health services including in areas associated with gender equality, population dynamics and HIV/AIDS)? **ASRH. EQ 10.c. EQ5**. To what extent has country programme contributed to improving young people's sexual and reproductive health and sexuality education? **GE&RR). EQ 10.d**. (EQ6). To what extent has UNFPA support in gender equality contributed to women's empowerment and reduction of gender based violence especially in rural and difficult-to-reach communities?

Summary findings - Overview: Despite major constraints and challenges in the health, economic, social and political context of Liberia, including the 2014 EVD crisis and a difficult funding environment, there was significant progress for all four theme areas. Of the 11 CP outputs, only one is not going to be achieved by 2018; seven are projected to be fully achieved, and three to be partially achieved by 2018.

MNH&FP Effectiveness: With few exceptions, despite the EVD crisis, all four of the MNH&FP outputs are projected to achieve a majority of the output targets by the conclusion of the extended 4th CP at the end of 2018. The CP is contributing to the achievement of the Outcome of "Maternal and New born Health including FP" by improving the availability and quality of RH services in Liberia, including the most rural hard-to-reach counties in the SE region. UNFPA has supported improvements in EmONC data monitoring and maternal and new born death surveillance. County level data show favourable trends in referrals by TTMs for ANC and for facility births. While stock-outs of FP supplies persist, UNFPA has collaborated with the Ministry of Youth to train and place National Youth Volunteers to promote reproductive health commodity security with promising results at the county level.

PD Effectiveness: UNFPA activities for P&D have contributed to the achievement of P&D outcomes and outputs by making data available for analysis and dissemination. For example, as part of the EVD Response, UNFPA succeeded in mobilizing, training, deploying and incentivizing more than 3,000 Ebola contact tracers/case searchers with data collection and processing tools. But there is a need for improvement in addressing the issue of capacity for data users. Respondents confirmed that a tool referred to as the Integrated Management Information System (IMIS) has been introduced but not adequately disseminated for routine use. There is evidence of poor coordination and collaboration mechanisms among the three principal institutions responsible for data availability and analysis in Liberia-LISGIS, PPCU and the Institute for Population Studies, University of Liberia (IPS). LISGIS produces data, which are used by PPCU to ensure integration of population variables in development planning through the National Population Policy. The

[84] This was reported by the CO team and one stop centre managers, although it was not specifically documented in the 2014 COAR.

IPS has a mandate to handle the training component on data analysis. The weak coordination among these institutions may adversely impact future UNFPA supported P&D activities, especially when approaching the 2018 National Population and Housing Census.

ASRH Effectiveness: Despite the lack of representative data on key ASRH indicators, there is evidence that the UNFPA CP has contributed to improved youth SRH. The extent of improvement cannot be quantified without representative data, such as the next LDHS. Based on an analysis of the M&E Plan Matrix indicators, while progress on ASRH Output 1 for CSE has been delayed, the remaining three of the four ASRH outputs are likely to be fully achieved. There is strong commitment to ASRH among key stakeholders at national and county levels, at both the policy and service delivery levels. Inter-ministerial collaboration, such as between the MoH and the MoYS for the NYVs, is a major positive factor for expanding ASRH services.

GE&RR Effectiveness: UNFPA supported GE&RR interventions have contributed increased knowledge about gender-based violence, but capacity of service provision is low and not adequate to meet the needs of the population. There is evidence of a decrease in the overall number of reported cases of gender-based violence. However, the incidence of rape appears to be on the increase. The targeted number of institutions supported to report and implement the Convention on the Elimination of all forms of Discrimination against women was not met.

Effectiveness Findings - MNH&FP: Based on document review, stakeholder interviews, training follow-up interviews and qualitative group discussions, there is compelling evidence of effectiveness toward the achievement of all four MNCH+FP Outputs and in turn the overall MNCH+FP Outcome. The 4th CP has made important contributions toward capacity development to implement comprehensive midwifery programs in Liberia. As of 2015, UNFPA has supported the development of a career ladder/pathway for the midwifery profession in the country. In the UNFPA-supported program, midwives complete a more rigorous Bachelors of Science Degree in Midwifery. Despite the major setback of the 2014 EVD crisis, which closed health care services for eight months, UNFPA has made significant contributions to improve capacity for EmONC, including training of providers in four south-eastern counties on basic lifesaving skills, with capacity building to respond to post-partum haemorrhage, a leading cause of maternal mortality. Following the EVD crisis in 2015, UNFPA has played an important role in helping to re-establish MNC+FP services at the county level. An especially compelling example is UNFPA support for Bomi County, where there was a 200% increase in facility-based deliveries with an estimated impact to avert 14 maternal deaths.[85] The CP has made important contributions to FP services. For example, in 2015, UNFPA's advocacy on family planning led to a revision of the MoH community health work force policy to include the administration of injectable contraceptives by community health workers. UNFPA also supported the revision of the 2012-2015 National Family Planning Strategy.[86]

Based on stakeholder interviews and review of county level data, it seems quite plausible that these UNFPA supported capacity building activities have improved the quality of care for at-risk women in remote

[85] See Support to the Restoration of Basic Maternal and New born Health Services. Bomi Project Progress Report. November 2014 – June 30, 2015.
[86] UNFPA Liberia. COAR. 2015.

counties.[87] A major accomplishment in this regard is the development and implementation of an EmONC checklist for monitoring the availability and quality of county level services.[88]

With funding from Zonta International, UNFPA maintained a long-term support for the MoH-implemented surgical management of fistula. The 4th CP has managed to reach or approach its targets for treatment and rehabilitation of fistula survivors despite the impact of the EVD crisis. The UNFPA supported fistula programme is comprehensive, in that it entails community outreach to identify fistula survivors and multi-facetted training and support at the Phoebe Hospital rehabilitation centre.[89]

Major achievements and challenges under the MNH&FP Outcome: UNFPA-supported activities have contributed to improved access to contraception, reduced unmet need and higher contraceptive prevalence as well as a higher proportion of births that are attended by skilled personnel.[90] The major challenge to achievement of progress was the 2014 EVD Crisis, which reversed positive trends toward improved MCH indices and forced a national shut down of essential facility-based services. Suspension of health services due to the Ebola crisis was further compounded by health workers fear of contracting the virus amidst lack of personal protective equipment (PPE) at service delivery points.

Major achievements and challenges under MNH&FP outputs: With few exceptions, despite the EVD crisis, all four of the outputs are projected to achieve most of their output targets by the conclusion of the extended 4th CP at the end of 2018.

Output 1. There is evidence of significant progress toward improved access and quality of EmONC with an increase in facility-based delivery. UNFPA has supported efforts to provide incentives to TTMs to encourage facility-based births and has been innovative in introducing qualified Obs/Gyns in remote counties and training PAs and Midwives to conduct CSs. UNFPA has effectively supported the expansion and consolidation of maternal death surveillance at the county level. This positive trend is qualified by the fact that currently (as of June 2016[91]) less than 1/3 of maternal deaths are being investigated. UNFPA supported the revision and development of EmONC monitoring Tools as well as monitoring of EmONC facilities at the county level. This has contributed to an impressive quarterly monitoring system of key EmONC indicators. The long-term progress of the UNFPA supported MOH program to support centres of excellence for fistula surgery and rehabilitation has been maintained; this is despite the EVD crisis as well as difficulties and challenges in recruiting fistula survivors for surgery. While success rates for surgery are relatively high, rates of rehabilitation are a challenge and have not met expectations (35% of target; 190 vs target of 520).[92]

[87] Given the MoH mandate that all services should be provided for free, there is no evidence that UNFPA supported programmes influenced the affordability of care. During site visits and interviews, there were no reports of charging clients for services.
[88] See Training Support to the revision and development of EmONC monitoring Tools as well as Monitoring of EmONC Facilities (Act11GLR07-ZZT06). 2015.
[89] Site visit and 2015 Zonta Annual Report.
[90] Monitoring data from the Bomi and other counties support the hypothesis that UNFPA funded activities have increased the number of facility-based births and decreased home births (in part due to incentives for TTMs to provide referrals as well as disincentives for home births). County level data available on request.
[91] MoH. Maternal Death Situation January-May 2016. Liberia. Source: CHTs.
[92] The reasons for the relatively low rate of success for rehabilitation include difficulty in getting clients to enroll in training programmes and, when enrolled, to participate in the full programme through to graduation (based on site visits and document review).

Table 4.1: UNFPA MNH&FP output indicators

Output 1. Indicators- Strengthened capacity of health systems to deliver emergency obstetric and new born care including management of fistulae in selected health institutions for women and young people.					
Output Indicators	**Baseline**	**Target**	**Net to achieve**	**Achieved to 2016**	**Findings**
Output 1. Indicators- Strengthened capacity of health systems to deliver emergency obstetric and new born care including management of fistulae in selected health institutions for women and young people.					
1. No health facilities supported to provide EmONC Services	26	41	15	33	On track
2. No skilled birth attendants/midwives trained per ICM-WHO Standards	90	200	110	126	Achieved
3. No counties with functional Maternal Death Surveillance systems	2	15	13	15	On track
4. No fistula surgeries conducted with UNFPA support	875	1375	500	388	On track
5. No of fistula survivors empowered and reintegrated.	220	520	300	190	Not on track
Output2. Indicators - Strengthened national systems for reproductive health commodity security.					
1.0% of facilities supported that reported no stock-outs of at least three modern contraceptives within the last six months.	30%	40%	-	Not avail	Not avail
3. % of counties with community-based distribution of reproductive health commodities	14%	100%	-	67%**	On track
*****In four counties. ****** In 2016, UNFPA successfully supported the maintenance of community based family planning service delivery in 10 out of 15 counties (COAR 2016).					
Output 3. Indicators - Strengthened capacity for the provision of minimum initial service package (MISP), including training for skilled birth attendants and midwives in emergency and post recovery.					
1. Number of health facilities equipped with lifesaving RH kits and drugs.	TBD	345	-	450	Achieved
2. Number of health facilities supplied with IPC materials.	TBD	345	-	450	Achieved
3. Number of facilities equipped to provide SGBV services	7	20	13	12	On track
4. Number of skilled birth attendants trained on MISP	TBD	600	-	Not avail	Not avail
Output 4. Indicators - Enhanced national capacity for Disease surveillance and data availability during humanitarian situations.					
1. No and % of disease suspects traced and monitored during the incubation period of a disease.	424	100%	-	Not avail	Not avail
2. No of disease contact tracers/case searchers mobilized, trained, deployed, incentivized and equipped with data collection and processing tools.	0	3,000	-	3,065	Achieved

Output 2. UNFPA supported the fielding of a definitive 2013 baseline national assessment of the availability of modern contraceptives that provided a sound basis for evaluating progress toward improving RHCS (UNFPA Global Program to Enhance Reproductive Health Commodity Security, 2014.). UNFPA CO has focused on the role of County Health Teams (CHTs) and care providers in ensuring Reproductive Health Commodity Security (RHCS) in hard-to-reach counties and maintains a policy dialogue for government budget allocation for procurement of modern contraceptives and implementation of family planning (COAR 2013). As part of efforts to increase access to FP, UNFPA Liberia supports innovative market sites to provide FP services to market-going populations.[93] The training of 50 National Youth Volunteers (NYVs) in RHCS appears to have been effective in support of sustaining the supply chain for RH commodities at the county level. Based on stakeholder interviews and group discussions, the NYVs appear to find their work rewarding as a basis for finding a pathway toward professional development. There are

[93] In 2015, the UNFPA CO reported that ten out of the fifteen counties were supported to implement community-based family planning activities through market-based distribution at 31 sites (2015 COAR). By 2016, "Ten out of the fifteen counties (67% of the counties) were supported to implement community-based family planning activities through 51 (16 mobile and 35 fixed) and market based distribution sites."(2016 COAR).

still reports of stock-outs at the county level, especially for depo. Needless stock-outs occur in settings where nearby clinics should be able top up clinics that are stocked out.[94]

Output 3. UNFPA has a well-established track record for providing MISP related materials and training in humanitarian settings, both during times of population displacement and with the recent Ebola Virus Disease Crisis.[95] Despite UNFPA's success in the deployment of MISP related supplies, there were reported delays in international procurement and dispatch of MISP RH Kits and drugs and there are reports of stock outs of rape kits and RH kits in some settings.

Output 4. UNFPA has effectively supported the mobilizing, training, deployment and incentivizing more than 3,000 Ebola contact tracers/case searchers with data collection and processing tools. These field staff were collecting real time data on a daily basis, which helped to break the transmission of Ebola, and has provided a basis for stronger surveillance infrastructure needed for a future crisis.

Constraining and facilitating factors: Apart from the national constraint of the EVD crisis, key constraints are the lack of capacity of essential MCH service delivery staff to provide EmONC services, high staff turnover, lack of infrastructure (lack of communications, electricity and running water), pervasive cultural barriers (traditional rural preferences for home births and FGM) and extremely difficult road conditions, especially during the rainy season. Management problems, such as slow disbursement of funds, were a problem, at times undermining morale of community health cadre, such as TTMs who did not receive incentive payments in a timely manner.[96] Facilitating factors include effective collaborative relationship between UNFPA Liberia and County Health Teams and Implementing Partners, strong depth of clinical experience among UNFPA medical staff,[97] and strong professional commitment on the part of Ministry, IP and UNFPA and UNCT staff toward the achievement of results. In summary, UNFPA has shown strong leadership in support of MCNH+FP with a commendable balance among the urgent competing needs for a variety of services. This portfolio is well-balanced to meet the current and future needs of Liberia as it emerges from the aftermath of the EVD crisis; the MNCH+FP portfolio fits extremely well with the priority program activities called for in the 2016-2020 RMNCAH Investment Case.[98]

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[94] Based on document review, interviews and site visits, there were instances where it appeared that there were avoidable delays in funds transfer, delays in maintenance, and delays in delivery of reproductive health supplies. These delays appeared to be caused in part by a lack of flexibility and overly rigid interpretations of roles and responsibilities of national Implementing Partners. For example, in one instance the MoH was not willing to share supplies with a nearby NGO IP, needlessly contributing to a prolonged stock out. In another instance, useful equipment, such as laptops, were not repaired for months on end, even though UNFPA could have stepped in to help.

[95] "During the Ebola outbreak, UNFPA supported 370 (55% [of the total]) health facilities nationwide with infection prevention and control (IPC) and reproductive health (RH) supplies and equipment including; 328 assorted RH kits (Kit 2A, 2B, 3, 6A, 6B, 8, 11A, 11B and 12)." The unprecedented scale of the emergency/humanitarian situation in a context of absent emergency/contingency response plan and financial resources limited the CO's capacity to effectively contribute to the response efforts. Delay and insufficient financial support by the Regional Office strangulated the visibility and relevance of UNFPA contribution to the national response efforts." (2014 COAR page 10.) UNFPA was designated as the focal point for RH thematic area in the EVD response (see UN Consolidated Ebola Support Plan August 2014. Page 45).

[96] In most cases the delays were due to failure on the part of sub-contractors and IPs to submit reports in time. Also, delays occur when the submission and processing of requests for payments requires the retirement of previous disbursements by IPs. Key remedial action is capacity building to ensure timely IP retirement of disbursements and completion of reports. UNFPA routinely provides training for IPs for capacity building but staff turnover requires it be continued on a regular, bi-annual basis every six months.

[97] UNFPA does not directly provide medical services so it doesn't have medical staff but it has staff with medical background.

[98] Especially for the Quality of EmONC, Adolescent Health, Emergency preparedness and Maternal and Neonatal Death Surveillance and Response (MNDS&R). See Global Financing Facility. Liberia MNCAH Investment Case 2016-2020. 2016.

Effectiveness Findings - P&D: The UNFPA CP has and continues to contribute to the overall outcome "*Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights.* UNFPA has contributed toward achievement of this outcome. For example, the HIES and 2013 LDHS clearly demonstrate that Liberia has collected, analysed and disseminated a national household survey that allows for the estimation of key population and reproductive health indicators in the last 5 years; the 2013 LDHS has been instrumental in documenting trends for the MDG5b indicators.

There also is evidence of progress for the Data Availability and Analysis (Output 7.1, "Strengthened national capacity for data analysis to inform decision-making and policy formulation regarding population dynamics, youth, gender equality and sexual and reproductive health."). For example, there is evidence for the achievement of Output Indicator 7.1.1 "*Number of institutions supported to produce, manage and analyse data, including gender-related statistics"* during the period. UNFPA has met the target for this output through its support to more than four institutions (LISGIS, PPCU, MOH at national and county level, and the Ministries of Justice, Gender, Education, Internal Affairs and the Central Bank of Liberia (CBL). LISGIS carried out the planning and data collection exercises and preparation of report for the 2013 DHS. Additional support was provided by UNFPA for further analysis of data collected for greater access to end-users. Despite the above-mentioned progress, stakeholders felt that UNFPA has not adequately engaged the IPS to address a chronic lack of capacity among recent IPS graduates. IPS graduates employed by LISGIS were considered untrainable, exacerbated by issues of an inadequate teaching and learning environment at the IPS training institution.[99] Document review (pertinent AWPs, COARs and IP reports) and multiple in-depth interviews confirmed that coordination and collaboration amongst the three institutions responsible for data availability and analysis is weak; this detracts from effective planning, implementation and achievements in the sector. Despite this problem, there is progress towards indicator 7.1.2 "*Tools to integrate population and development, reproductive health and gender concerns into development frameworks are available.*" According to respondents, the IMIS tool[100] provided by UNFPA, was rolled out to staff of LISGIS and to five government institutions-Ministries of Justice, Gender, Education, Internal Affairs and the Central Bank of Liberia (CBL). This is an important accomplishment, although qualitative

Table 4.2: UNFPA P&D output indicators

Output Indicators	Baseline	Target	Net to achieve	Achieved to 2016	Findings
CP Output 7.1: Strengthened national capacity for data analysis to inform decision-making and policy formulation regarding population dynamics, youth, gender equality and sexual and reproductive health.					
Indicator 7.1.1: Number of institutions supported to produce, manage and analyse data, including gender-related statistics	2	4	2	8	Achieved
Indicator 7.1.2: Tools to integrate population and development, reproductive health and gender concerns into development frameworks are available.	0	7	7	1	Not on track to be achieved

http://www.globalfinancingfacility.org/sites/gff_new/files/documents/Liberia%20RMNCAH%20Investment%20Case%202016%20-%202020.pdf

[99] Based on in-depth interviews with key informants.

[100] The Integrated management Information System (IMIS) is a tool provided by UNFPA to be used by end-users to customize analysis of population census data

interviews and group discussions suggest that the IMIS is not fully utilized. In the absence of evidence of any other tools introduced besides the IMIS, however, UNFPA P&D is well short of the explicit target for introduction of seven tools.

Major achievements and constraints for the P&D Outcome and Outputs

- The DHS was conducted in 2013 as a rigorous successor to the 2007 DHS. The LISGIS was supported by UNFPA and other partners to carry out this survey.[101] The 2013 LDHS survey report is a critically important demographic resource for both government and UNFPA and partners. In addition, UNFPA along with other partners supported the Household Income and Expenditure Survey (HIES) and the data generated are used by many GoL institutions for planning purposes.
- UNFPA supported efforts have increased the use of population data at various levels. The Integrated Management Information System (IMIS) was introduced to promote the use of data for all sectors especially the results of the 2008 National Population Census. The IMIS system continues to be used at LISGIS but needs to be popularized more.[102]
- UNFPA success in promoting the use of demographic data was clearly demonstrated during the Ebola crisis. In addition to taking on the major challenge of implementing EVD contact tracing and surveillance with more than 3,000 county level general community health volunteers (gCHVs), UNFPA contributed towards the revision of a CDC template during the Ebola crisis to ensure insertion of disaggregated demographic and socio-economic information in the regular Situation Reports (COAR 2014, P.14; COAR 2015, UNFPA Report to World Bank, 2016).
- Beyond these national efforts, UNFPA supported LISGIS to conduct a census in Jenewonde town in response to the EVD crisis, as well as provided support to BRAC to conduct a local needs assessment of adolescents.[103]

Challenges: The achievements of results under the outcome did not go without challenges. The Ebola crisis was the chief challenge. During the crisis, the institution of national restrictions on movement led to the suspension of most non-Ebola related activities (COARS 2014). Secondly, the weak collaboration amongst key institutions responsible for data availability and analysis has limited achievements. This was clearly articulated during key informant interviews and group discussions at the IPS and PPCU. Thirdly, there is weak capacity for data analysis and interpretation by data availability and analysis institutions;[104] some informants considered staff at these institutions to be "untrainable."[105] Finally, there appears to have been inadequate feedback from UNFPA to stakeholders of institutions responsible for data

[101] http://www.lisgis.net/page1.php?&7d5f44532cbfc489b8db9e12e44eb820=MjY2

[102] There was a training conducted for LISGIS and PPCU (Report on the Integrated Management Information System (IMIS) Training Workshop Held June 6-11, 2016, in Kakata, Margibi County.). UNFPA P&D staff reported that, as of 2016, they were no longer going to fund training of LISGIS staff in the use of LISGIS. However, based on discussion with LISGIS staff, it appears that the IMIS is felt to be useful and that training for additional LISGIS modules would be pertinent to the needs of LISGIS going forward.

[103] At the request of the GoL, UNFPA supported a Census in Jenewonde; the data informed national interventions in Grand Cape Mount County to halt the spread of Ebola by providing an assessment of humanitarian requirements of the inhabitants at the height of the EVD crisis (2015 COAR. In addition, UNFPA supported a local needs assessment, the Empowerment of Livelihood of Adolescent (ELA) Survey (*BRAC's Mentors for Adolescents Training follow-up 270317).*

[104] For example, UNFPA had intentions of supporting LISGIS to conduct this in-depth analysis of 2013 DHS and laid out a comprehensive analysis framework but LISGIS fell short of its expectations by not only presenting a highly inflated budget for mere analysis but also failed to technically own and start the exercise (UNFPA Liberia staff communication, May 2017).

[105] COAR 2015 Page 25 and group discussions at UNFPA.

availability and analysis.[106] For example, there was a provision to prepare for the census in the 2016 AWP for LISGIS (training for geographic field mapping) but it was not implemented. During group interviews with LISGIS respondents, there was no mention of this important activity, which speaks to the poor feedback. This important training, which serves as the initial activity for the conduct of the census, should have been a major point of discussion with LISGIS.

Major achievements under outputs: Significant strides were made to attain tangible results under the two outputs.

- Firstly, UNFPA supported LISGIS to conduct the LDHS 2013. Though there were other partners who provided support for this exercise, interviews across all stakeholders said that UNFPA is noted for the LDHS. The LDHS is currently hosted on the LISGIS website (http://www.lisgis.net/page1.php?&7d5f44532cbfc489b8db9e12e44eb820=MjY2).
- Secondly, the creation and rolling out of IMIS was a significant exercise in data availability and analysis as the tool helps stakeholders customize the analysis of the result of the 2008 National Population and Housing Census, and all other national data that are cleared by LISGIS. Training began with LISGIS and PPCU. Additionally, 73 persons were trained from UL, CUC and UNFPA partner organizations.[107] In 2016, an additional 20 LISGIS and PPCU staff were trained again (COAR, 2016 P.14).
- Thirdly, UNFPA supported LISGIS to conduct a census of Jenewonde in Grand Cape Mount County in response to the Ebola crisis. The data informed national interventions into Grand Cape Mount County to halt the spread of Ebola.[108]
- Finally, support was provided to the Epi-Surveillance Team of the Ministry of Health in the design of the weekly Situation Report format and the cleaning of previously collected data during the Ebola. Field visits and discussions with respondents showed that Surveillance Officers are still working in every county. After the transformation of the M&E Unit in the MoH into the Health Monitoring and Evaluation, and Research (HMER) Unit as part of the health system strengthening during the EVD outbreak, UNFPA strengthened the new and expanded unit through the provision of 35 motorcycles (one to each M&E and Surveillance Officer per county, and five at central MoH HMER headquarters), a laptop and jeep for general monitoring activities of the unit, and one laptop to each M&E and Surveillance Officers per county.

Constraining and facilitating factors: There was overwhelming agreement that UNFPA flexibility contributed to the national response to the Ebola epidemic. The UNCT stakeholders believed that "delivery as one" approach led to reduction in waste of resources. Additionally, the support for the availability of

[106] This was articulated by discussants among data availability and analysis entities. Respondents felt that there was insufficient collaboration between them and UNFPA. According to UNFPA P&D staff, UNFPA Liberia has been in constant conversation with LISGIS on this and other matters related to the 2018 census. Unfortunately, UNFPA could not release resources for census activities when GoL had not given support to a Census Proclamation and the Census Act. As a result, census preparation activities were put on hold in 2016. On 19th December 2016, through UNFPA advocacy, GoL released the Proclamation from the Office of the President on the holding of a Census of Population and Housing (in 2018) throughout the territory of the Republic of Liberia. In January 2017, in an accelerated move due to continuous UNFPA advocacy, a Joint Houses of Representative and Senate Committee on the Census was formed. On 10th February 2017, the Committee held a public hearing on the possibility of holding the 2018 Census. On 16th February 2017, the Instrument for a Joint Resolution of both Houses of Parliament on the 2018 Census (Joint Resolution #001/2017) passed the House and Senate. The Instrument was endorsed by the Vice President of the Republic early in May and is currently awaiting Presidential Assent.

[107] ibid

[108] ibid

data has, to a large extent, informed the implementation of the SDGs.[109] The UNFPA is perceived to be a major driver of support of SDG implementation across sectors. According to the COAR 2016, the country has not established a comprehensive plan to generate, disseminate and report on the UNFPA-supported global SDG indicators. This is an important gap and represents a major opportunity for UNFPA to support the SDG implementation.

The major constraining factor across interviews was the Ebola crisis. However, several discussants mentioned the slowness of national government, which is the major partner, to make decisions to move some activities forward as a major impediment. This is especially true given the uncertainties associated with the upcoming elections in October 2017.

Effectiveness Findings - ASRH: For the ASRH focus area, there is evidence that the achievements of the four outputs will contribute to the overall outcome of young people's sexual and reproductive health and sexuality education. While there are nationally representative baseline data for pertinent ASRH indicators, there are no current representative data to assess changes since 2013. As a result, the extent of the improvement in young peoples' SRH and sexuality education cannot be assessed.

While the primary outcome indicator for the ASRH Focus Area (comprehensive knowledge of HIV) was chosen without specifying a baseline or target,[110] it is important to note that there has already been significant progress on this indicator from 2007 to 2013, especially among women aged 15-24. Based on this trend, it seems plausible that continued improvement will be observed toward 2018, due in part to UNFPA supported ASRH program activities to achieve the four ASRH objectives.

The CP has made major contributions towards the achievement of Output 1, to increase capacity to design and implement community and school-based comprehensive sexuality education (CSE) (Shown as Output 6.2 in Table 4.3). But progress has been slow; it is a long-term process. The CO has supported the design and development of a CSE integrated curriculum framework for all grades to guide the planned CSE integration during a curriculum reform that has been underway since 2016; an out-of-school CSE manual was also developed with UNFPA CO support.[111] The primary indicator for this output, percentage of schools

[109] Key Informant Interviews , 02-12-16

[110] "Young people's sexual and reproductive health and sexuality education. Outcome indicator: Percentage of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (female/male). Baseline: TBD (NACP) Target: TBD" UNFPA Liberia CPD Results Framework. it has been measured twice before, in 2007 and 2013. The trends are shown in the table below. Comprehensive HIV knowledge and knowledge of where to get a condom among women increased more than men and is currently higher for women than for men for both indicators. Significant improvements were found in HIV C&T, an increase from 1.9% in 2007 to 18.3% in 2013 for girls and from 1.6%% to 6.2%% for boys (GARPR 2016).

	Female			Male		
Liberia DHS Findings	Comprehensive Knowledge	Know where to obtain condoms	Sample	Comprehensive Knowledge	Know where to obtain condoms	Sample
2013 (Table 13.16)	35.7	71.3	722	28.5	68.3	1587
2007 (Table 13.14)	20.5	48.5	2675	27.2	52.3	2195

[111] UNFPA Liberia. COARS. 2013, 2015. Based on document review, the draft Out of School Manual has not been completed and was considered ready to be used, having not been pre-tested Oct 2015 Report by Kasiryem et al., Summary on the CSE Curriculum Design Workshop).

implementing integrated CSE, is not likely to be achieved by 2017.[112] In addition to the EVD crisis, which closed all schools in 2014, a curriculum reform process has stalled the progress toward rolling out CSE in Liberia's schools; out of 5,000 schools, only 250 have benefited from UNFPA-supported CSE as of 2014 (Stakeholder interviews, COAR 2014). UNFPA-supported technical assistance has contributed to the revision of the integrated CSE curriculum and clarified areas where additional age-specific CSE content is needed.[113] UNFPA also supported the development and dissemination of a practical booklet containing useful sexuality content.[114]

The UNFPA CP has also contributed toward the achievement of Output 2 HIV services for youth in key populations (Shown as Output 6.3 in Table 4.3.). While the numbers of beneficiaries served tend to be relatively small, the CP is on track to meet the target for social behaviour change communication (SBCC) strategies for adolescents and youth from key populations. The stated target, to support two SBCC strategies, has been achieved. In 2013, Population Services International (PSI) and Planned Parenthood Association of Liberia (PPAL) conducted two separate SBCC programs oriented toward marginalized youth, including key populations. Both PSI and PPAL used radio as part of an effort to build ASRH capacity among marginalized youth (PPAL reported implementing 52 weeks of radio drama and PSI reported 164 radio shows, primarily on UNMIL Radio).[115] The PSI and PPAL programmes used peer education efforts to reach genuinely marginalized at-risk and out-of-school youth. The PSI programme reported success reaching at-risk 'yanna boys', 'pen-pen' riders and CSWs using local outreach agents; but the numbers reached were regrettably small: 51 males 31 females (PSI SPR 2013).[116]

UNFPA has also supported peer-education work with key populations through SAIL and SWAA, two NGOs (funded through PPAL). These agencies work closely with most-at-risk key populations [Men who have Sex with Men (MSM), Intravenous Drug Users (IVDUs), transgender, and Commercial Sex Workers (CSWs)] in Monteserrado county.[117] Based on stakeholder interviews, site visits, and FGDs with beneficiaries and peer educators of these two programmes, there was evidence that they provide important educational and support services for high-risk youth who face tremendous prejudice and risk of violence. While the numbers of reported clients served are not large, these programmes are nonetheless an important asset among UNFPA supported programmes.

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[112] The target was very ambitions, to achieve CSE in 3500 schools [Primary 49% (2450), Junior High 48% (770), Senior High 57% (280)]. Due to the current delay for development of an integrated curriculum, it is not likely that this will be achieved.

[113] UNFPA supported a well-considered assessment by Dr. Kasiryem, on Gaps in the Curriculum and Recommendations, presented in a useful format. See Oct 2015 Report by Kasiryem, Gillian and Ekua Yankah. Summary on the CSE Curriculum Design Workshop. Serious concerned about the receptivity of the MoE to CSE.

[114] A review of this Pocket size book showed that it was excellent idea, a real accomplishment, although it was not clear if it was sufficiently pre-tested to be youth friendly. Based on the preface, the booklet was clearly done with diverse input, by a large group of stakeholders, which helped obtain buy-in. The quality of the content is inconsistent, however, and, in some instances, not accurate. It is potentially a source of misinformation. For example, see question 7 on page 21. Ministry of Education, School Health and Physical Education Division. Pocket Size Booklets on SRH for Young People. June 2014.

[115] Unfortunately, neither PSI nor PPAL reported using a pre- post design with representative samples or listeners to measure the impact of the radio programming on adolescent listeners, so there is no basis for assessing impact.

[116] In 2015 Save the Children International (SCI) conducted a well-designed ASRH SBCC effort with a community outreach component in five counties that appears to have reached a greater number of adolescents, although they are not most-at-risk key populations. SCI reported a strong emphasis on community outreach with process meetings in five counties with community leaders, chief etc. that worked toward community ownership. Thirty-six staff [30 Peer educators and 6 nurses] did more than 30 outreach sessions in five counties, reaching 4,570 adolescents in just one quarter (2ndQ2015SPR)/

[117] It cannot be overemphasized how much greater the risk is for these key populations compared to more typical communities. HIV prevalence for female commercial sex workers is reported at 9.8%, MSM at 19.8, IVDU/drug users at 5%; this compares with 1.1% for in-school and 1.9% for out-of-school youth (Liberia GARPR. 2016).

The two indicator targets for Output 3, Improved SRH services for marginalized youth (Shown as Output 6.1 in Table 4.3), are likely to have been met by 2017. UNFPA supported programmes have achieved significant increases in the indicator, the number of Service Delivery Points (SDPs) for youth ASRH. SDPs increased from only 6 at baseline in 2012[118] to 23 youth centres and 51 market sites in 2016 (PPAL 2016 Annual Work Plan Monitoring Tool.). The second indicator (described in Table 4.3 below) is also likely to be achieved. The national ASRH Standards for the provision of SRH services are to be revised/updated with technical support from the Country Office and a draft document is to be finalized through a consultancy in 2017 (UNFPA COAR 2016).

The indicator for Output 4 (Shown as Output 6.4), achievement of three or more policies incorporating adolescents' rights, has been met by 2017 based on UNFPA leadership and technical support for the RMNCAH Strategy and Investment Case, the National Strategic Plan for HIV/AIDS and revisions and validation of the National Family Planning Policy in 2016 (UNFPA COAR 2016).[119]

Table 4.3 UNFPA ASRH outputs (NB: Numbering is different for Outputs)

Output Indicators	Baseline	Target	Net to achieve	Achieved to 2016	Findings
CP Output 6.1: Improved sexual and reproductive health services to meet the needs of marginalized youth and adolescents in selected areas.					
Indicator 6.1.1 Number of institutions and groups supported to provide essential sexual and reproductive health services to young people.	6	80 Health Facilities/16 Youth centres	80 Health Facilities/16 Youth centres	10 Health Facilities/13 Youth centres	On track
Indicator 6.1.2: Guidelines, protocols and standards for health care workers for the delivery of quality sexual and reproductive health services for adolescents and youth in place.	0	1	1	1	Achieved
Output 6.2: Increased national capacity to design and implement community and school based comprehensive sexuality education (CSE) programmes that promote human rights and gender equality					
Indicator 6.2.1: Percentage/number of primary, junior high and senior high schools implementing the sexuality education integrated curriculum. Baseline: 2,000 [Primary 28% (1400), Junior high 27% (440), Senior high 32% (160)] Target: Primary 49% (2450), Junior high 48% (770), Senior high 57% (280)	Primary 28% (1400)	Primary 49% (2450)	21 percentage points. (1050)	NA	Not on track
Output 6.3: Improved national capacity to deliver HIV programs that are free of stigma and discrimination focusing on key populations and youths in hard to reach areas.					
Indicator 6.3.1: Number of projects supported to implement social behaviour change communication strategies for adolescents and youth including those from key populations	0	2	2	2	Achieved
Output 6.4: Strengthened national capacity to conduct evidence-based advocacy for incorporating adolescents and youth and their human rights/needs in national laws, policies, programmes, including in humanitarian settings					
Indicator 6.4.1: Number of policies, programs, planning frameworks or strategies developed/reviewed that incorporate adolescent & youth human rights and needs. Baseline: 0 Target: 3 (Youth Opportunities Project, TVET Policy and Operational Plan, National Strategic Plan for HIV/AIDS)	0	3	3	3	Achieved

(Source Annex IIIB Work Plan Monitoring Tools for Population and Development. (Aligned to the SP 2014-2017). UNFPA Liberia M&E Plan Final 2014.)

Challenges, Constraining and facilitating factors. The EVD crisis of 2014 was a major challenge and constraint that severely limited progress on all ASRH outputs. Faced with this unprecedented threat,

[118] The 2016 COAR reported 364,732 adolescent and young people reached with ASRH services through these SDPs. Based on a review of data from SPRs, there is a basis for concern that these data are somewhat inflated and data quality checks should be undertaken to validate these data. For example, based on a review of the data from the PPAL 2016 Annual Work Plan Monitoring Tool, making the optimistic assumptions that the SDPs are all open 52 weeks a year for 7 hours a day, five days a week, on average the 23 site have 15,858 clients annually, 305 clients per week, 61 per day and 8.7 clients per hour. These data are not plausible.

[119] In addition, the CO succeeded in integrating ASRH into the 2015 new TVET Policy and Action Plan. (Republic of Liberia. The Economic Stabilization and Recovery Plan. April 2015).

UNFPA CO and IPs responded with impressive flexibility and imagination. In addition to strong traditional/cultural support in some regions and among ethnic groups for harmful practices such as early marriage, SGBV and FGM, concerns persist within Liberian culture related to ASRH, including the introduction of CSE. CSE stakeholders expressed objections to the new CSE content that was proposed for topics such as contraception, signs of pregnancy and other issues. Until these concerns are addressed, progress may be slow.[120] Other challenges include delays in receiving funds on time, shortages of supplies at ASRH SDPs, such lack of HIV test kits. The chronic lack of funds and resources, for example with no MoE budget allocation for CSE, and uncertainties associated with the transition of government with the upcoming election are all serious constraints.

Facilitating factors – Based on interviews, site visits and document review, there is a strong commitment to ASRH among key stakeholders at national and county levels, at both the policy and service delivery levels. Inter-ministerial collaboration, such as between the MoH and the MoYS for the NYVs, is a major positive factor. The UNFPA CO ASRH team is clearly committed, competent and diligent in supporting ASRH programmes.

Effectiveness Findings - GE&RR Despite evidence of a decrease in the overall number of reported cases of gender-based violence, the incidence of rape appears to be on the increase.[121] This is due in part to the fact that UNFPA support has utilized county power structures and community networks making it easier for women to report cases.[122] Since twelve One-Stop Centres are available in seven counties, this presents a challenge in terms of access, especially for difficult to reach communities.[123] The presence of only one circuit court per county [124] has also reduced the effectiveness of gender-based violence interventions. So, while UNFPA supported interventions have contributed increased knowledge about gender-based violence, capacity of service provision is low and not adequate to meet the needs of the population.[125] In difficult to reach communities, women who participate in economic empowerment activities are less likely to suffer gender based violence.[126]

As shown below in Table 4.4, under Output 5.1, the targeted number of institutions supported to report and implement the Convention on the Elimination of all forms of Discrimination against women, has yet to be met. Between 2014 and 2015, no achievement was reported in this area in the CP Monitoring and Evaluation matrix, but the COAR 2015 reported four, well on track. In 2016, 28 organizations were supported, showing an increase in UNFPA's work. In line with the community driven approach, seven networks of community gatekeepers were mobilized to advocate against SGVB, including FGM in churches

[120] See Oct 2015 Report by Kasiryem, G. et al. Summary on the CSE Curriculum Design Workshop.
[121] http://gnnliberia.com/?s=Liberia%3A+Gender+Ministry+Records+1%2C088+Gender+based+violence+Cases
Ministry of Gender and Social Protection National Gender Based Violence Statistical Report, 2014
Think 2013 Annual Report
[122] UNFPA COAR, 2014, 2016
[123] This is based on stakeholder interviews and observations that One Stop Centres tend to be in county capitals rather than in district outside Monrovia. Four out of four of the site scheduled by the CO were in capitals.
[124] Addressing Impunity for Rape in Liberia, October 2016, UNHCR
[125] This is taking into account a county like Nimba that has a population of approximately 462,000 with 17 districts. Estimating that the female population make up half of the population, one facility would not be enough.
[126] For example, several stakeholder interviews revealed that women who were viewed as a liability tended to suffer gender based violence. Empowerment centres offered women the opportunity to acquire skills in order to contribute to their family's income. The acquisition of skills also helped to increase the survivor's confidence.

and mosques.[127] In 2016 alone, 2,113 survivors accessed services at One Stop Centres compared to 1,804 the previous year.

In 2016, UNFPA support to the Women's Legislative Caucus contributed to the passage of the Affirmative Action Bill. In addition to this, the draft Domestic Violence Law was also approved by the Cabinet. In 2016, the COAR reported that 3,500 copies of the Domestic Violence Law were printed and disseminated; but there is no explanation of whether that was only for Montserrado or whether some of these copies reached the other counties.

Table 4.4: Indicators for UNFPA GE&RR outputs

Output Indicators	Baseline	Target	Net to achieve	Achieved to 2016	Findings
Output 5.1: Strengthened national capacity to implement international agreements, national legislation and policies in support of gender equality and reproductive rights.					
Indicator 5.1.1: Number of institutions supported to report and implement the Convention on the Elimination of All Forms of Discrimination against Women.	1	6	5	4	On track
Indicator 5.1.2: Number of new gender-related laws and policies formulated and implemented.	2	6	4	2	Not on track
Output 5.2: Strengthened national capacity to address gender-based violence through a multi-sectoral approach and through the provision of high-quality services to survivors, including in humanitarian settings.					
Indicator 5.2.1: Number of people trained to manage and prevent gender-based violence.	66	201	135	125	On track
Indicator 5.2.2: Number of gender-based violence survivors accessing support services in One-Stop Centres.	212	620	408	2,113	Achieved
Indicator 5.2.3: Number of community-based organizations and networks supported to advocate against female genital mutilation/cutting and gender-based violence.	4	31	27	28	Achieved

(Source Annex IIIB Work Plan Monitoring Tools for Population and Development. (Aligned to the SP 2014-2017). UNFPA Liberia M&E Plan Final 2014.)

Constraining and facilitating factors: Apart from the obvious constraint of Ebola in 2014, One-Stop Centres cited the following constraints as contributing reasons for not achieving targets: inadequate funding, lack of mobility, a slow bureaucracy, and lack of political will and failure of GoL to make timely decisions.[128] In terms of legislation, the widespread practices of secret societies, along with Liberia's penal law system presents a conflict for enforcing gender equality and women's rights. For example, the 2016 Domestic Violence Law was widely condemned because the ban on FGM was taken out of the law.[129]

4.3. EFFICIENCY

These questions apply to all 4 Focus areas and the CCPE Question 11 a. (EQ9). To what extent did the intervention mechanisms (including funds, expertise and timing) contribute to or impede the achievement of the programme outputs?

[127] COAR 2016.

[128] This was documented from interviews with stakeholders and CO staff.

[129] http://nytlive.nytimes.com/womenintheworld/2016/07/28/secret-societies-implicated-as-liberia-passes-domestic-violence-bill-without-fgm-ban/

Summary of Findings- Efficiency of MNH&FP: The intervention mechanisms were generally appropriate for the achievement of all four of the programme outputs, such as capacity building for EmONC and ANC and FP service delivery. Based on a review of available cost data on expenditures for specific sub-activities, the UNFPA Liberia CP has made significant progress for all four outputs at reasonable cost for the respective activities. There were instances where intervention mechanisms impeded achievement of the outputs, the most important being delay in transferring funds. Some inefficiencies were noted in the areas of training, obstetric fistula and RHCS.

Efficiency of PD: Based on stakeholder interviews and a review of the expenditures for PD related activity, such as cost of training activities and the implementation of a large WB-funded project for EVD contact tracing, the UNFPA PD funds have been expended efficiently. The major impact of the EVD crisis was a potent factor in diverting funds away from the normal PD focus. The significant rise in expenditure in 2015 demonstrates the flexibility shown by UNFPA to move funds around to respond to EVD crisis. The AWPs were amended and funds were reprogrammed to focus on the restoration of services after the EVD (COAR 2015). Due in part to the EVD crisis, the UNFPA PD efforts have failed to make a much-needed contribution to Liberia's data availability and analysis requirements.

Efficiency of ASRH: Based on an assessment of ASRH activities, the ASRH intervention mechanisms, such as technical assistance and capacity building for CSE, implementation of SBCC programmes, and provision of outreach services for at-risk youth and key populations, were suitable for the achievement of the four of the programme outputs. The overall annual ASRH budget expenditure rate has been commendable, ranging from 94% to 99%. A review of cost data on expenditures for specific sub-activities confirmed that, despite the major upheaval caused by the EVD epidemic, the UNFPA Liberia CP has made progress for all four outputs at reasonable cost. Costs for trainings and SBCC campaigns were acceptable although some inefficiencies were noted in the areas of peer education, advocacy, and the relatively small scope of activities for most-at-risk key populations. There are few instances where intervention mechanisms impeded achievement of the outputs, the most important being delay in transferring funds.

Efficiency of GE&RR: UNFPA has employed a number of strategies to ensure efficiency; for example, working with experienced Implementing Partners, thereby reducing the potential risks to implementation. Program implementation could be more efficient if GoL processes relating to procurement were not so drawn out. Based on a review of budget and expenditures, there has been minimal underspend and wastage.

MNH&FP: The CP intervention mechanisms in the MNH&FP focus area were found to contribute to the achievement of the four outputs at reasonable costs. The intervention mechanisms were generally appropriate for the achievement of the programme outputs, such as capacity building for EmONC and RH service delivery, training for infection prevention and long-acting reversible contraceptives (LARCs), such as the 5-year implant, Jadell. Based on a review of available cost data on expenditures for specific sub-activities, the overall conclusion is that UNFPA Liberia has accomplished a great deal for the respective activities and outputs with the resources spent. For example, the costs for institutional support to midwives and nurse associations and for capacity building for EmONC were reasonable, especially in relation to potential for long-term impact. A review of training costs, such as cost-per-participant-training day, cost for participant and cost per training, demonstrated that the training has been economical.[130]

[130] For example, JHPEIGO implemented training activities in Lofa County where 14 persons trained in comprehensive RH clinical skills and counselling services had an average of US$44 per participant training day (UNFPA 4th COUNTY PROGRAMME ACTIVITY

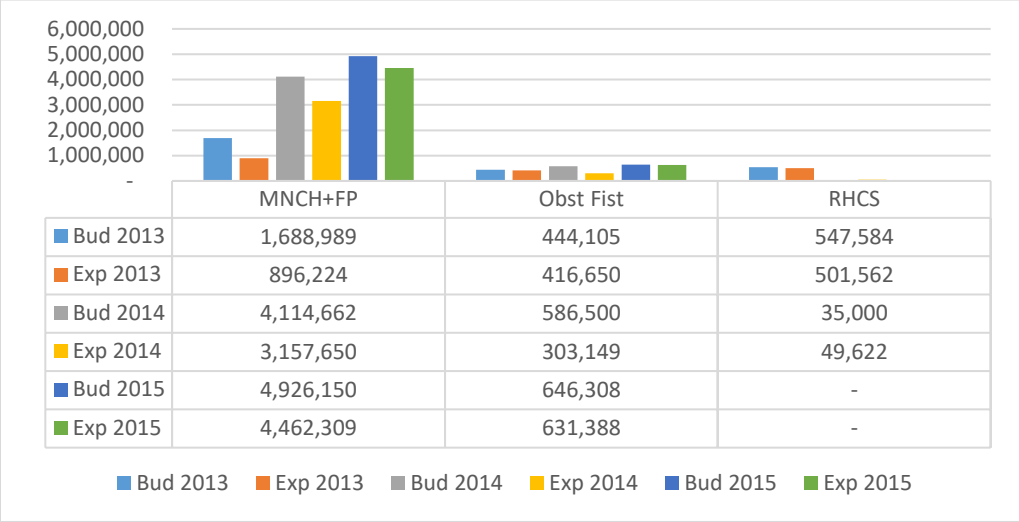
There were instances where intervention mechanisms impeded achievement of the outputs, the most important being delay in transferring funds, which was frequently mentioned as a bottleneck to implementation. There were some instances where intervention mechanisms could be made more efficient.[131]

As shown in Figure 4.1, there was some evidence of underspending, especially for MNCH+FP in the first two years of the CP; this was due in part to the impact of the Ebola crisis in 2014, when health facilities were closed for 8 months. The largest underspending was for MNCH&FP for 2013 (46.9%) and 2014 (23.3%). The largest underspending for Obstetric Fistula was during the 2014 Ebola crisis at 48%. Funding for MNH&FP and Obstetric Fistula has gradually increased while funds for RHCS dropped significantly in 2014 and were zero in 2015. The only instance of overspending was for RHCS in 2014, by a relatively small amount of less than $15,000.

REPORT_ Lofa County Quarter 3: JULY-SEPTEMBER 2016). Despite repeated requests, it was not feasible to obtain a definitive sample of reports on training costs for the MNH&FP area. However, where data were available, the costs appeared to be with the normal range for RH trainings.

[131] Three examples are provided here: 1) Based on the very low prevalence of use, training on the IUD as well as cycle bead method does not seem to be an efficient use of resources. While the IUD could be used as a LARC, based on stakeholder interviews, participants in FP trainings reported the trainings did not give them any practical experience with actual clients to give them sufficient competence to safely insert the method. Guidelines for IUD training require supervised experience with at least five clients. 2) The UNFPA supported surgical management of fistula and rehabilitation for women and girls is a worthwhile challenging and comprehensive program. A review of the components of the annual budgets, however, suggests that a narrower focus on essential components might improve efficiency. The annual budget for the fistula programme is substantial, ranging from $478,000 to $644,000. This is no doubt justified for a range of activities, from the outreach to surgery and rehabilitation. But the cost for the annual number of women survivors served, around 100, is high, $4,000 per successful surgery and rehabilitation. Given the total estimated number of Liberian Fistula survivors in need of surgery, somewhere between 3,000 (based on WHO estimates) and 5,000 (based on Zonta reports), it will take between 30 and 50 years to address needs of Liberia's fistula survivors. A more focused approach, that uses more cost-effective methods to identify and recruit clients (such as through TTMs instead of radio) might help increase the number of clients served each year. For example, in the 2016 budget $23,760 was allocated for local radio stations in 3 counties to conduct promotions for maternal health services. Working with TTMs to provide referrals might be more efficient. The radio budget would be enough to provide referral incentives for 230 TTMs, perhaps more likely to generate referrals. 3) Finally, the highly rigorous 2013 RHCS survey has provided a great deal of useful data at a reasonable cost, but the overall approach was complex and time intensive, which is a threat to replicability. A simpler methodology, with less rigour, would be more likely to be repeated at regular intervals to permit more rapid feedback to the MoH to track progress with key RHCS indicators.

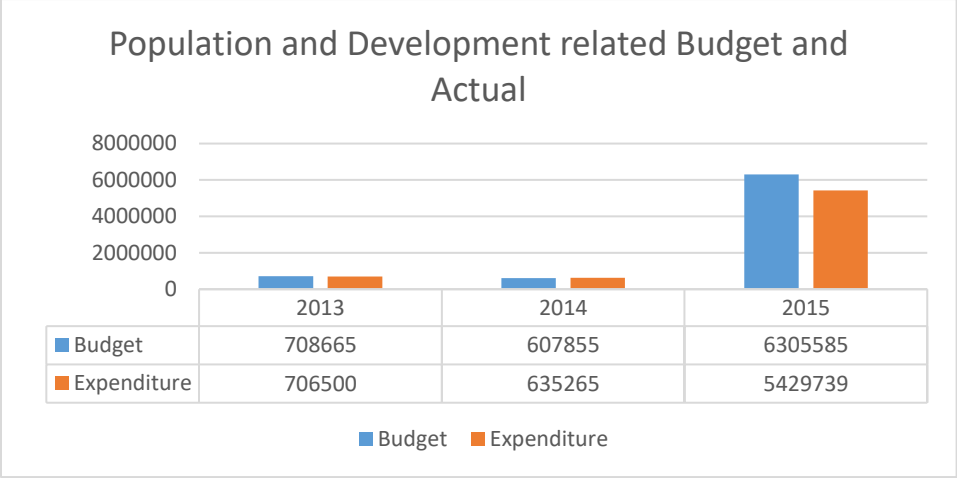
Figure 4.1: MNH&FP Related Budget and Expenditure



	MNCH+FP	Obst Fist	RHCS
Bud 2013	1,688,989	444,105	547,584
Exp 2013	896,224	416,650	501,562
Bud 2014	4,114,662	586,500	35,000
Exp 2014	3,157,650	303,149	49,622
Bud 2015	4,926,150	646,308	-
Exp 2015	4,462,309	631,388	-

P&D: UNFPA funding for PD activities for 2013-2015 amounts to USD 6,771,503 which amounts to 28.7% of total program budget. From Figure 4.2 yearly expenditure for PD received 13.5%, 10.5% and 43.9% for 2013, 2014, and 2015[132] respectively. The LDHS was conducted in 2012-2013 and, apart from the large surge in work done in response to the EVD crisis, no major PD activities have occurred since the 2013 support for the 2013 LDHS.

Figure 4.2: PD Related budget and expenditure



	2013	2014	2015
Budget	708665	607855	6305585
Expenditure	706500	635265	5429739

Based on stakeholder interviews and a review of the expenditures for PD related activity, such as cost of training activities and the implementation of a large WB funded project for EVD contact tracing, the UNFPA PD funds have been expended efficiently. For example, a review of the costs for the six-day IMIS training

[132] The surge of funding to Pop & Dev in Figure 1 is the result of an increase in funding related to the Ebola Crisis. The funds were raised to support the GoL in the fight against Ebola. The interventions were intended to break the chain of transmission and end the epidemic through contact tracing and active case search. Although data collection was key, the bulk of the money went toward payment for salaries of more than 3,000 field staff, vehicles and logistics and arrangements that facilitated the work of county health teams within communities.

for twenty persons with cost for food, lodging and transportation amounted to USD18,000. Given that this was done with an overnight stay in Margibi out of Monrovia with USD166 as cost for lodging and food and transport, this cost per participant seems reasonable. This was the exact amount budgeted in LISGIS' 2016 budget. Also, the large WB programme for contact tracing by more than 3,000 county level CHAs were reasonable and in line with expenditure norms for these activities.[133] The major impact of the EVD crisis was a factor in diverting funds away from the normal PD focus. There was a significant rise in expenditure in 2015; this demonstrates the flexibility shown by UNFPA to move funds around to respond to EVD crisis. The WPs were amended and funds were reprogrammed to focus on the restoration of services after the EVD (COAR 2015).

Based on discussions with stakeholders in PD activities, capacity building and support for coordination and collaboration among the three data availability and analysis entities still lags well behind expectations. The IPS, which trains middle-level statisticians who in turn support PD training for county development officers, has not received funding since 2006. The failure to fund the IPS may have impeded progress toward the achievement of the PD Outcome and objectives. From key informant discussions, it was disclosed that there continues to be capacity gaps in mainstreaming population concerns in development planning at the decentralized level. The current physical location of LISGIS next to the ocean, exposed to chronic high levels of salt water humidity is highly detrimental to the maintenance of essential data collection hardware, such as computers and large format printers. Until LISGIS can be transferred to a more suitable location, the maintenance of computer equipment and printers is needlessly expensive.

ASRH: UNFPA CP supported activities are appropriate and contribute to the achievement of the four programme outputs. A review of cost data on expenditures for specific sub-activities confirmed that progress has been made on all four outputs of the UNFPA Liberia CP and at reasonable costs despite the major upheaval caused by the EVD epidemic. For example, costs for technical assistance and capacity building for CSE were generally reasonable.[134] With some exceptions, costs of SBCC programmes, costs for trainings and the provision of outreach services for at-risk youth key populations were reasonable and within an appropriate range.[135] Activities in support of training for youth advocacy were within appropriate cost boundaries,[136] although some aspects of the expenditures for ASRH advocacy seemed on the high side.[137] There were a few instances where intervention mechanisms impeded achievement of the outputs, the most important being delay in transferring funds. Some inefficiencies were noted in the areas of peer

[133] 2016 Financial data and the respective 2016 AWPs

[134] This 6-day participatory Monrovia based event with an international consultant came to $123 per participant training day (CSE Curriculum Design Validation Report 2015).

[135] In 2013, PPAL reported training 45 peer educators for 3 days in two counties at a cost of $46 per person per training day. This is quite reasonable, but the 45 peer educators only managed to reach 257 students (175 girls and 82 boys). This comes to an average of less than 6 peers reached per trainee, at a cost of $24 per peer contact (PPAL 2013 AWP). Even if the likely extended effects of this outreach are considered, this seems costly. That same year, PSI reported training 32 peer educators, who only managed to reach 142 in- and out-of-school youth; less than 5 peers each (PSI SPR 2013). A 2016 program implemented in Margibi by a small NGO, NARG, reported reaching 50 students with a two-day workshop at $50 per training day per participant. This is quite reasonable given that significant additional activities were implemented within the same budget (NARG. End of Project Report 2016).

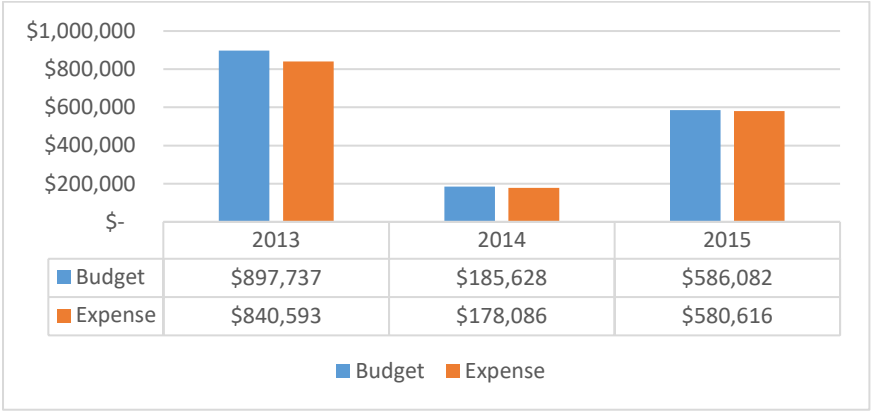
[136] A MoYS training for three days in Monrovia with 16 participants from 4 youth agencies, trained institutional analysis ASRH&Rs and Policy and Advocacy came to $70 per person training day, which is quite reasonable.

[137] The MoYS 2016 AWP budget for county and national level advocacy seemed somewhat large for the level of effort and was not well defined. For example, it included a budget for five consultation meetings for advocacy work with political parties and youth groups at $5,000 each. This $25,000 is the equivalent of one full time person to work on advocacy and it is not clear what resulted from these meetings (see MoYS 2016 AWP).

education. For example, there were problems in mobilizing peer educators to do outreach due to school schedules, resulting in a small number of peers reached. Finally, it is worth noting that given that the HIV prevalence among most-at-risk key populations is dramatically higher than the general population,[138] it may be more efficient to devote more resources to these groups, as compared to lower risk in-school youth.[139]

As shown in Figure 4.3, from 2013 through 2015, overall annual ASRH budget expenditure has ranged from a high of $840,593 in 2013 to a low of $178,086 in 2014 during the EVD crisis. The expenditure rate has been commendable without any overspending; under-expenditure was modest ranging from 94% to 99%.

Figure 4.3: ASRH Related budget and expenditure.



GE&RR: UNFPA has employed a number of strategies to ensure efficiency; for example, working with experienced Implementing Partners, thereby reducing the potential risks to implementation.[140] Planning of programs also takes into consideration the rainy season and accessibility in order to reduce the possibility of overspending. However, program implementation could be more efficient if GoL processes relating to procurement were not so drawn out.[141] Figure 4.4 shows that, with the exception of 2014, budget and expenditure have been closely matched. While this does not by itself show efficiency, it shows that there has been minimal underspend and wastage.

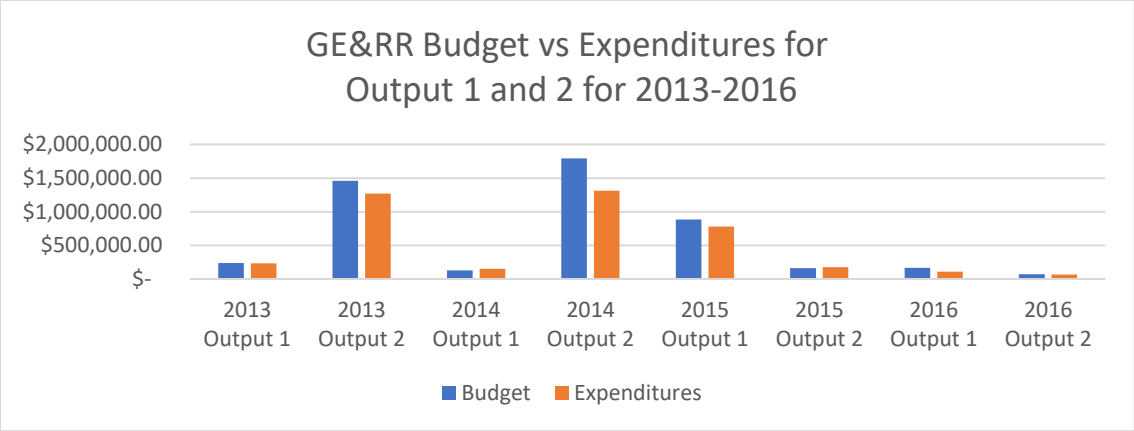
[138] SAIL provides onsite HIV Testing for Key Populations. **While based on small numbers, results from 30 tests among key population clients in 2016 revealed a 60% prevalence.** Based on a number of HIV related death among members of the key population, SAIL conducted two HIV testing activities. The first HIV Testing was among 12 persons with a result of 2 persons positive and 10 negative. The second HIV Testing was among 18 persons with 16 positive and 2 negative (PPAL Annual Work Plan Monitoring Tool 2016).

[139] For example, PPAL has provided excellent support to SAIL and SWAA, but the support as a proportion of their total 2016 AWP was just 15%, just $37,500 for SAIL and SWAA out of a total AWP budget for $253,725. This is relatively small ratio of activities for the most-at-risk key populations.

[140] During the evaluation process, interviews were conducted with Think and Action Aid who are implementing in the GE &RR outcome areas.

[141] Stakeholder interviews and CO staff interview confirmed that GoL decision making was slow and not always considerate of partner deadlines or the urgency of situations.

Figure 4.4: GE&RR Related Budget and Expenditure According to Outputs



4.4 SUSTAINABILITY

These questions apply to all 4 Focus areas and CCPE 12. a (EQ10). To what extent has the CO been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to ensure: a) partners have ownership of their programmes and b) the programmes will have durability of effects?

Summary Finding- Sustainability of MNH&FP: Based on site visits, stakeholder interviews, training follow-up interviews and document review, the UNFPA CP has been able to support its partners and the beneficiaries in developing capacities that are both owned and durable. Interviews with RH supervisors demonstrated a strong commitment to sustained improvements in FP services and an enthusiasm for the new knowledge and skills they gained during UNFPA supported trainings. UNFPA supported activities at the county level demonstrated a strong sense of ownership by members of CHTs. For example, the Bomi County Health Team demonstrated a strong involvement and ownership that contributed to the impressive results achieved by the project. The above positive examples of sustainability are tempered by the fact that, based on stakeholder interviews, site visits and document review, the UNFPA CP has tended to be focused on inputs rather than long-term system strengthening: in many instances, there are concerns that CP supported activities will not be continued without ongoing external funding.

Sustainability of P&D: There is some evidence that UNFPA has contributed to sustained improvements in Liberia's data availability and analysis structures. Institutional arrangements for data collection, analysis and reporting are well in place at LISGIS. The institution can now function as the "Statistics House' with minimum technical support. However, there is no evidence that the critically important future census and LDHS activities can continue without support from UNFPA. The major activities of the 2018 National Population and Housing Census activities have not begun owing to lack of resources; for example, the geographic planning activities, an essential first step towards the conduct of the census. To add to the uncertainty, the next LDHS should also be conducted immediately following the Census in 2018 or 2019. Amidst these concerns, the GoL is now focusing primarily on the upcoming 2017 election.

There is tremendous uncertainty as to what will be the population and development priorities of the government of Liberia in 2018.

Sustainability of ASRH: There were frequently raised concerns that programmes will not be able to continue without ongoing UNFPA CP funding. However, based on site visits, stakeholder interviews and document reviews, in some instances UNFPA CP supported partners have developed capacities that are owned with prospects for continuation. Programme activities with potential for durability of effects include ASRH advocacy for policy and strategy development, ASRH capacity building county health clinic nurses and for County Youth Officers with investments in monitoring, and participatory approaches use to develop an integrated CSE materials. Apart from funding constraints, important obstacles to sustainability include a lack of ASRH data collection and analysis capacity and inherent high costs and staff turnover for ASRH strategies such as NYVs and peer education.

Sustainability of GE&RR: The failure of GoL to take full ownership has implications for a lack of sustainability for UNFPA supported GE&RR programmes. For example, GoL should cover operational costs of One-Stop Centres in the national budgets to demonstrate ownership. The current reliance on donor funding to implement programmes creates a risk, especially given the upcoming election transitional period. Another important issue is the supply of essential drugs, protective clothing and testing kits, which UNFPA provides to the One- Stop Centres.

MNH&FP There was evidence that the UNFPA CP has been able to support its partners and the beneficiaries in developing capacities that are both owned and durable. Interviews with RH supervisors demonstrated a strong commitment to improving FP services and enthusiasm for the new knowledge and skills they gained during UNFPA supported trainings. These respondents made it clear that they had changed their approaches to service delivery and were continuing to implement the new skills they learned, such as inserting long acting contraceptive rods.

UNFPA supported activities at the county level demonstrated a strong sense of ownership by members of CHTs. For example, the Bomi County Health Team demonstrated a strong involvement and ownership that contributed to the impressive results achieved by the project. A project report for Bomi County stated that, “the level of community buy-in and participation was very overwhelming.” There is evidence of durability of effects from UNFPA CP supported activities; significant sustained impact from institutional development. The CP has supported accreditation/ certification of four midwifery training institutions, supported Liberian Midwives Association and Nurse Association institutional support and development, and succeeded in upgrading the career ladder of Midwives in Liberia based on a revised midwifery curriculum. The MoH, with support from UNFPA, completed a National Guideline for Fistula Care and Treatment and the national capacity for the care and treatment of obstetric fistula survivors has been enhanced; primarily through UNFPA support for the operationalization of two centres of excellence in two counties (2013 COAR).

UNFPA has facilitated changes in RH policy that will have enduring impact, such as its successful advocacy to update the FP method mix; this now permits the use of injectable contraceptives in non-traditional settings. The above positive examples of sustainability are tempered by the fact that, based on stakeholder interviews, site visits and document review, in some instances UNFPA has tended to be focused on inputs, such as salaries for NYVs, short-term improvements in health facilities and capacity building that may not contribute to long-term system strengthening.

P&D: Based on stakeholder's responses, there is an unequivocal evidence that PD activities at the national level are not sustainable. Support to LISGIS for their major functions such as the census and LDHS and other sector data availability exercises will be needed from UNFPA and other donors. Respondents asserted that LDHS and census activities cannot be supported by the GoL alone. However, there was acknowledgement by respondents that data availability and analysis activities currently supported by UNFPA, such as the DHS and the National Housing and Population Census, are gradually gaining attention by law makers.[142] Unfortunately, cost for these activities have not been included in the current GoL budget allocation for 2017-2018.[143]

At the county level, however, respondents feel strongly that disease surveillance data collection and analysis is sustainable. Surveillance officers are currently employed in fifteen counties.[144] The assurance of continued county surveillance stems from efforts by the MOH as part of their plan and allocation of resources in their budget period 2017-2018.

ASRH: Based on interviews, site visits and document reviews, there were instances of partner ownership that enhance sustainability. Site visits to clinics, whether they were listed as youth friendly or not, revealed that staff were very open to providing services to youth, with few, if any, reservations. As noted above, Save the Children (SCI) used a community based outreach approach that reportedly contributed to local ownership and a relatively large number of youth clients served (SCI 2015 Qtr. SPR). Based on document review and FGDs with NYVs, the EVD crisis response resulted in close collaboration between MOH and MoYS; the volunteers took ownership of the program since they were charged with the task to take the lead in the activities.

The UNFPA CP support for ASRH advocacy for laws, strategies and policies has great potential for long-term sustainable impact. The open participatory approach used during technical support for CSE has revealed important cultural issues that are potential barriers; this awareness of cultural concerns enhances the opportunity to develop successful strategies to develop an integrated CSE curriculum. While costly, the investment in training County Youth Officers in ASRH combined with monitoring visits offers potential for sustained ASRH programme effort (MoYS 2016 AWP).

Apart from the chronic lack of resources in Liberia and the uncertainty associated with the upcoming national elections, threats to sustainability include instances of what appear to be "one off" programmes that are designed with no plans for follow-up.[145] Peer education is inherently difficult to sustain due to the high turnover of young peer educators, the need for retraining and for close supervision. Without sufficient supervision and monitoring, it will result in low efficiency and a high cost per peer client seen.

[142]The census concept note was revised in January 2017 and the preparation of the main project and allied documents has started. A nationwide assessment for capabilities for the census exercise was concluded in April 2017 and the report will be out shortly. The main drag on activities was the legal instrument which is now in sight (UNFPA Liberia P&D staff communication).

[143] At the time this report was drafted, progress had been made toward allocating funds for holding the census but had not yet been approved (UNFPA Liberia P&D staff communication).

[144] Key Informant Discussion with Surveillance Officers in Sinje and Group Discussion with WHO Maryland County Officers; 220317

[145] In 2016, the NGO, National Action for Research and Governance (NARG), implemented an activity in Margibi county. NARG was a beneficiary of a seed grant for such organisations to nurture their advocacy potential and continue doing so without additional support. Unfortunately, while exemplary in focusing youth through school-based peer educators, this NARG project was only funded for one 5-month period, which did not appear to permit any sustained institutional support (See NARG. "Promoting Young People's Behaviour through SRHR Information Dissemination." End of Project Report. 2016).

The NYV programme, while it appears to have genuine advantages, is costly and is likely to require continued external donor support.[146]

GE&RR Lack of sustainability and the failure of GoL to take ownership has implications for UNFPA supported GE&RR programmes. For example, GoL should capture operational costs of One-Stop Centres in the national budgets to show ownership. The current reliance on donor funding to implement programs creates a risk, especially given the upcoming election transitional period.[147] The One-Stop Centres need permanent staffing and, where possible, GoL employees who are already on the payroll should be used. Another important issue is the supply of essential drugs, protective clothing and testing kits, which UNFPA provides to the One-Stop Centres. Without these supplies, these centres would not be able to function

4.5 EVD RESPONSE

RELEVANCE

The following questions apply to all 4 Focus areas and the CCPE. Question 9a: (EQ1). To what extent has the Country Programme addressed national priorities and needs of the population while ensuring alignment with UNFPA policies and strategies? **Question 9b: (EQ2).** To what extent has UNFPA ensured that the needs of beneficiaries have been taken into account in the planning and implementation of UNFPA-supported interventions under the country programme? **Question 9c: (EQ3-CCPE).** How did UNFPA take into account the country's vulnerability to disasters and emergencies [**in particular, the Ebola Virus Disease (EVD) Crisis**] in planning and implementing its interventions?

Summary Finding- Relevance of EVD Response: The UNFPA Liberia CO's role in the response to the EVD crisis was highly relevant to the needs of the country. Based on stakeholder interviews and document reviews, the UNFPA CO response to the 2014 EVD crisis was well-synchronized with national priorities and aligned with UNFPA policies and strategies related to humanitarian situations. UNFPA supported qualitative assessments of the needs of Ebola survivors as well as family members who lost relatives. Prior to the 2014 EVD crisis, there is clear evidence of previous and ongoing UNFPA Liberia CO expertise in the training and dissemination of RH kits for SGBV; the CO also had experience responding to a prior humanitarian crisis.

Based on stakeholder interviews and document reviews, the UNFPA CO response to the 2014 EVD crisis was well-synchronized with national priorities and aligned with UNFPA policies and strategies related to humanitarian situations (COARs 2013,2014,2015; MoH, 2014 August Consolidated Ebola Support Plan). Responding to humanitarian settings is a strategic priority for UNFPA that cuts across all of its technical mandate areas.[148] The UNFPA Liberia CO's role in the response to the EVD crisis was highly relevant to the needs of the country.

[146] The UNFPA supported maintenance of 50 NYVs comes to $214,753 per year which is $4,295 per NYV. This is currently not sustainable within Liberia economic context.

[147] Liberia will be conducting general elections in October 2017. A change of government and potentially new direction poses a risk to sustainability for the One Stop Centres.

[148] See UNFPA. Humanitarian Action 2017 Overview. 2017. UNFPA. Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies. UNFPA. 2015.

Prior to the 2014 EVD crisis, there is clear evidence of previous and ongoing UNFPA Liberia CO expertise in the training and dissemination of RH kits for SGBV; the CO also had experience responding to a prior humanitarian crisis (COAR 2013). UNFPA had a clearly defined role and well-defined planning in place as of 2011 as part of the Liberia Emergency Humanitarian Action Plan (LEHAP).[149] In the four years prior to the EVD crisis, UNFPA CO had provided ongoing support to improve basic RH services in areas with displaced refugees stemming from election violence in Cote d'Ivoire; the areas were in neighbouring Liberian Counties that border Cote d'Ivoire and Guinea. This was done by providing supplies of RH kits and training health staff to offer quality services.

Per the 3rd Country Program Evaluation, "given the proximity of Liberia to its Ivorian neighbours, adherence to the UNSG's mandate on human rights, Liberia's call on the UN agencies for assistance and UNFPA's stance on cross-cutting issues, the CO joined other UN partners in the Ivorian humanitarian response and made available RH kits and over 5,000 dignity kits to the county health team in Nimba County to enable assistance to both the refugees and the host communities. UNFPA has since provided assistance to vulnerable populations in other border counties (Maryland, Grand Gedeh and River Gee) through: the provision of Minimum Initial Services Package (MISP) for sexual and reproductive health; rapid assessment on affected areas to gauge their immediate needs in RH; distribution of RH and hygiene kits, and training of humanitarian workers in MISP."[150]

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[149] The following activities were defined for UNFPA Liberia and the 2011 Liberia Emergency Humanitarian Action Plan : "Sexual and gender-based violence (lead UNFPA)

• Gender-based violence (GBV) referral pathways and a protocol for GBV survivors for adult and children developed for this refugee emergency and reporting tools have been designed by the Ministry of Gender and Development (MoGD).

• Response services for GBV survivors (medical, psychosocial and legal services, including safe houses) are available through the presence of specialized NGOs.

• Training on GBV and SEA conducted for the humanitarian workers in Nimba.

• Training of community structures (Child Welfare Committees and Community Based Organisations) on GBV prevention, response and referral pathway on going.

• UNFPA pre-positioned 5,000 dignity kits (2,000 for Nimba, 2,000 for Grand Gedeh and 1,500 for Maryland and distribution is on-going.

• Assessment and training conducted on the clinical management of rape in the health structure of Nimba County."

• Four Interagency health kits (one targeting over 10,000 people for 3 months), and two reproductive health (RH)kits (each targeting 10,000 people for three months), and assorted drugs were donated by WHO, the United Nations Population Fund (UNFPA), UNHCR, and the United Nations Children's Fund (UNICEF) agencies to MoH and Partners to ensure that refugees accessed critical health services.

• UNFPA donated RH kits and over 5000 dignity kits to the County Health Teams (CHT) / Primary Health Care (PHCs) that enabled INGOs to assist both the refugees and the host communities.

• Owing to the volatile situation and increased exposure of women and girls to sexual and gender-based violence (SGBV) related incidences, special technical assistance was provided to the grass root health teams to further prevent transmission of HIV to the new born babies. In addition, over 45,000 condoms were distributed among the refugees." Donor Relations and Resource Mobilisation Service. Liberia Emergency Humanitarian Action Plan 2011: Sectoral key achievements as of July 2011. Health (page 7).

[150]"UNFPA also fielded and supported a small team RH/Gender support team. Activities under the humanitarian response in Nimba County yielded accomplishments which included: saved lives, alleviated reproductive health needs, provided immediate assistance on pregnant women and mothers who had newly given birth, prevented and managed SGBV, prevented HIV, and to some extent prepared people and health providers for future crisis. During a focus group discussion at the Bahn Refugee Camp in Nimba County, the evaluation team listened attentively to representatives of UN and development partners who spoke in high esteem of UNFPA and its assistance to the refugees and host communities as well as commended UNFPA on the SGBV training and dignity kits provided. In Monrovia, the WHO Country Representative, informed the evaluation team that UNFPA has played a key reproductive health role in the Ivorian humanitarian response, is vital to the UN humanitarian response team and should continue to be active due to its strategic position in reproductive health." 5. Liberia Emergency Humanitarian Action Plan 2011: August 2011 Revision. See: Pritchard, Zeline Jatu and Alain Badjeck. Report on the Evaluation of the UNFPA 3rd Country Programme of Assistance to the Government of Liberia 2008 – 2012. Monrovia. Dec 2011.

By 2013, due to the improved humanitarian situation in these areas, the CO focus shifted from MISP to provision of comprehensive RH services including family planning. From the beginning of 2013, the UNFPA CO had carried out no formal training in MISP, but rather had focused on the provision of basic emergency obstetric and new born care (BEmONC) and comprehensive emergency obstetric and new born care (CEmONC) services. In December 2013 the CO stressed in its 2013 COAR that MISP was nonetheless an integral part of the country program deliverables for the 4th program cycle (COAR December 20, 2013). MISP was clearly stated as an output in UNFPA CO revised 2014 M&E framework with clearly specified indicators related to MISP.[151]

Just six months after the 2013 COAR was completed, in August 2014, the UN Consolidated Ebola Support plan was released, in which UNFPA was designated as the focal point for the RH Thematic area. This was at a critical point in the epidemic, just before the peak in the number of deaths in September 2014. UNFPA CO Ebola response activities are discussed below in the section on Effectiveness. UNFPA supported qualitative assessments of the needs of Ebola survivors as well as family members who lost relatives (SCI implemented an Ebola survivor needs assessment to determine their RH and psycho-social needs conducted COAR 2015).

EFFECTIVENESS

NB: The question 10d applies just to CCPE. EQ8. To what extent was UNFPA, along with its partners, able to respond to crises, (in particular, the EVD Crisis) during the period covered by the country programme?
NB: Guidance: This EQ talks to the effectiveness of UNFPA's emergency preparedness and response (where applicable) in the country. **Assumption 1** talks to UNFPA's effectiveness in supporting the country to prepare for the case that a disaster or emergency strikes. (UNFPA has contributed to the country's enhanced emergency preparedness (Pertains to Effectiveness) **Assumption 2** examines UNFPA's contribution to humanitarian action where such situations actually occurred. (A.8.2: Where applicable (EVD), UNFPA successfully responded to crises during the period covered by the country programme (Pertains to Effectiveness of UNFPA Liberia response to Ebola Virus Disease (EVD) outbreak 2014-2015]

Summary Finding- Effectiveness of EVD Response: The UNFPA CO was actively and effectively involved in the response to the 2014 EVD crisis as part of a regional and national response. UN Liberia responded to EVD in a coordinated approach through the establishment and operation of Humanitarian Framework of UN clusters in September 2014. UNFPA was designated as the focal point agency for UN Thematic Area 5 on Reproductive Health. Based on interviews, and an extensive document review, major accomplishments were made responding to the EVD in all four CP Outcome areas. The CO was also effective in implementing a large WB-funded Ebola Contact Tracing Programme in 2015 and 2016. Based on interviews and document review, UNFPA supported activities were well-received and perceived to be effectively implemented. Given the large scope, more than 3,000 gCHVs and supervisory staff in six counties, it was an immense challenge. Since the

[151] Interestingly, it should be note most of the targets were achieved in 2014 as part of the intensive UNFPA response to the EVD crisis. See the ANNEX I: REVISED CPD RESULTS AND RESOURCES FRAMEWORK FOR LIBERIA; ALIGNED TO THE STRATEGIC PLAN 2014-2017.Output 2.3: Strengthened capacity for the provision of minimum initial service package (MISP), including training for skilled birth attendants and midwives in emergency and post recovery. UNFPA Monitoring and Evaluation Plan Final. 2014. See also: M&E Plan Matrix for the Country Program (CP) 2013-2017: Reproductive Health (RH)

EVD crisis in 2014, the UNFPA CO has been fully occupied as part of the national response to restore basic MNCH services and has not developed a standalone Humanitarian Preparedness Plan or Annual Preparedness Action Plan.

Overview: Based on interviews and document reviews, while the UNFPA CO did not have an emergency preparedness plan in place at the time, it was actively and effectively involved in the response to the 2014 EVD crisis as part of a regional and national response (2014, 2015, 2016 COARs).

Preparedness for future crises: Since the EVD crisis in 2014, the UNFPA CO has been fully occupied as part of the national response to restore basic MNCH services. As yet, UNFPA Liberia CO has not developed a standalone Humanitarian Preparedness Plan.[152] In 2016, the CO reported that no preparedness actions were taken for 2016 in view of the fact that the CO was greatly engaged in implementing the EVD response plan by restoring basic maternal and new born health services in highly affected counties (COAR 2016). As of the fourth quarter of 2016, the UNFPA CO had not developed and implemented an Annual Preparedness Action Plan, (MPA2: Develop and implement an Annual Preparedness Action Plan). However, the UNFPA senior leadership reported implementation of a wide range of pertinent humanitarian emergency related activities (COAR 2016). Based on interviews, currently and since the EVD crisis, the health sector is perceived to have considerable emergency health response capacity. A disaster response planning entity has been developed within the Department of Internal Affairs. UNFPA has been part of this process. However, this broader work is being led by UNDP.

Overview of a Regional Response: Per the UN Liberia 2015 Annual Report, "The EVD epidemic gravely affected Liberia throughout 2014 and dragged into 2015. The total number of cases increased to about 10,119 (suspected, probable and confirmed cases) and about 4,809 deaths from all 15 counties with Montserrado, Lofa and Margibi counties being most affected. UN Liberia responded to EVD in a coordinated approach through the establishment and operation of Humanitarian Framework of UN clusters in September 2014 in collaboration with the government EVD response structures at the national and subnational levels and UNMEER." (Page 43. Office of the Resident Coordinator. UN Liberia. 2015 One UN Annual Report. 2015).

Per the 2014 UNFPA Executive Board humanitarian update,

> "The UNFPA response to the Ebola epidemic focused on contact tracing and maintaining and restoring maternal health services. More than 8,000 contact tracers were recruited by UNFPA and followed more than 90,000 contacts in Guinea, Liberia and Sierra Leone. Given its leadership role, the UNFPA response to the Ebola outbreak was integrated into the United Nations Mission for Emergency Ebola Response (UNMEER)." In addition, "In 2014, UNFPA institutionalized its operational modality for standby partner agreements and expanded its partnerships for standby expert personnel with CANADEM, Norwegian Refugees Council and RedR, among others. With funding from the Government of Belgium, UNFPA provided technical support for the creation of a sexual and reproductive health roster at the Norwegian Refugees Council."[153]

[152] COAR/2015 COAR: Existing humanitarian Preparedness was embedded in other plans like Resource Mobilization and Risk Management Plans but no standalone Humanitarian preparedness plan was developed in 2015.

[153] There was a UNFPA regional Mano River response as well – "UNFPA launched, at the end of 2014, with governments and other partners, the Mano River Midwifery Response initiative to ensure access of an estimated 1.1 million pregnant women in 2015 to antenatal, childbirth, postnatal and emergency obstetric care. It aims to quickly re-open functioning midwifery services and restore health systems for reproductive and maternal and new born health. More than 500 international and national midwives,

The UNFPA Liberia CO benefitted from these short-term staff placements, for example, in the important area of community mobilization (Interview data).

UNFPA Liberia CO EVD Response: Based on interviews and document reviews, UNFPA was an active and successful partner in the national response to the EVD crisis. During and after the EVD crisis, UNFPA was actively involved in activities to support planning, coordination, logistics, training, service delivery and M&E for data and decision-making. The 2014 MOH Annual Progress Report provides compelling evidence that UNFPA was extremely responsive to the EVD emergency, over and beyond a wide range of important UNFPA supported MNCAH activities (MoH APR 2014).

As explained by the MoH in the 2014 APR, during the EVD crisis, "Limited knowledge of the deadly disease among the public and health workers, compounded by delay in provision of needed PPEs and sanitation supplies and training of service providers caused fear and panic among health workers thus leaving many health facilities abandoned." The APR pointed out that, the "High level of awareness among CHT staff, political and community leaders about the Ebola virus followed by vigilant IPC training and emergency preparedness plan instituted by the CHTs in south-eastern counties was very helpful in curtailing the spread of virus in the counties." To their credit, UNFPA staff participated in efforts to support CHTs in the Ebola response at a time when there was great fear and an unwillingness on the part of some health workers to go to the field. The act of making deliveries to remote counties during the EVD crisis required great professional commitment and courage.

Based on stakeholder interviews, three UN agencies, WHO, UNFPA and UNICEF, were especially active in the field response. Many other UN agencies contributed, but because of their mandates, under WHO leadership, they were among "the foot soldiers." Per the August 2014 UN Consolidated Ebola Support Programme document,[154] UNFPA was designated as the focal point agency for UN Thematic Area 5 on Reproductive Health. As outlined in the 2014 document:

> "The UN [required] emergency funds to provide support and strengthen lifesaving interventions for sexual and reproductive health to reduce mortality and morbidity among pregnant women and girls in Ebola affected communities and other communities at risk. This [included] procurement of clean delivery kits, rape kits, and male and female condoms management of miscarriage and complication of abortion kits, RH kits and essential RH drugs.
>
> A key priority [was] to increase access to quality maternal health services at facility-level and to clean and safe delivery at community level. The UN [was to work] in collaboration with partners to strengthen community based mechanisms and interventions that increase access to and utilization of services through information dissemination using IEC/BCC tools as well as community based distribution of condoms.

doctors and health workers will be recruited to staff at least 20 midwife-led units, supported with strong referral mechanisms and centres to manage complications of pregnancy and childbirth in each of the three countries. The response consists also on developing community-based interventions, including mobile clinics, voluntary family planning, clean delivery kits and childbirth, post-partum and new born care. (Annex 6 UNFPA humanitarian Action -2014 update. 2014.) https://executiveboard.unfpa.org/downloadDoc.unfpa?fileName=Annex%206%20-%20UNFPA%20humanitarian%20action%20-%202014%20update.pdf~09-34-2015-11-34-58-469

[154] See United Nations. Consolidated Support to The National Accelerated Ebola Virus Disease Outbreak Response Plan in Liberia. August 2014.

In addition, funds [were to] be utilized to ensure access to treatment services for rape survivors. Key to the intervention [was] effective coordination and implementation of the minimum initial service package in Reproductive health. The UN [was to] work with the County Health Teams and partners to ensure the coordination of Reproductive Health and related services as well as Sexual Gender Based Violence interventions."

Achievements: Based on interviews, and an extensive document review, major accomplishments were made responding to the EVD in all four CP Outcome areas. UNFPA support to National EVD Emergency Response included following activities, as excerpted from the 2014 MoH SPR:[155]

- "Emergency reproductive health kits and assorted IPC supplies were distributed to 30 Health facilities in Montserrado, Bomi, Bong and Margibi counties. The 30 health facilities comprised of 9 Hospitals, 14 Clinics and 7 Health Centres.
- 216 RH kits including Rape and STI Kits distributed to equip 12 EmONC facilities in 5 counties and 4 one stop facilities.
- MOH received technical support from UNFPA and other health partners in the development of various training materials, job aids, standards and protocols on infection prevention/control and the training of health workers and support staff in 7 counties.
- UNFPA contributed 2,500 individual delivery kits (UNFPA ERH Kit 2A) towards restoration of routine health services delivery in addition to provision of emergency reproductive health kits to more than 10 out of 15 counties.
- 90 RH kits including Rape and STI Kits distributed to equip 38 EmONC facilities in 6 counties
- 23,000 OBS/GYN gloves and 10,000 surgical gloves distributed to 15 Counties
- 3 UNFPA staff formed part of national technical team to improve the skills of Health Workers in Infection Prevention and Control Nationwide
- Procured, distributed 361 infection prevention kits for use by health facilities nationwide."

As discussed above in the PD section, UNFPA Liberia CO was very effective in implementing a large WB-funded Ebola Contact Tracing Programme in 2015 and 2016. Based on interviews and document review, UNFPA supported activities were well-received and perceived to be effectively implemented. Given the large scope, more than 3,000 gCHVs and supervisory staff in six counties, it was an immense challenge, implemented with urgency given the gravity required for rapid monitoring of Ebola contacts. This programme provided a basis for stronger surveillance infrastructure needed for a future crisis (See Contact Tracing SPRs for 2015 and 2016).

As shown in the table below, it is likely that some of the MISP output indicators and targets were achieved in 2014 as part of the intensive UNFPA response to the EVD crisis. An estimated 450 health facilities nationwide were reached, the equivalent of 55 per cent of available facilities.[156]

[155] It is important to acknowledge that the UNFPA Liberia CO support accomplished a great deal in important MNCH+FP activities in 2014 over and beyond the EVD epidemic. For example, as reported by the MoH in 2014: Use of NASG for PPH management increases the chances of survival for women during labour and delivery; Setting up of a Kangaroo Mother Care Unit in Maternities improves the utilization of the approach thereby contributing to saving the lives of the new born; Engagement of FTYM to improve their access to safe maternity care is a promising practice; Expansion of Market Based FP services increases access to Family Planning services for young people; 260 First Time Young Mothers from New Kru town and West Point were guided into safe maternal Health Care.

[156] "In Liberia, UNFPA provided support to 450 health facilities nationwide (55 per cent) with infection prevention and control; and reproductive health supplies and equipment, including assorted kits for Ebola patients and gender-based violence survivors

Table 4.5 UNFPA MISP output and indicators

Output 3. Indicators - Strengthened capacity for the provision of minimum initial service package (MISP), including training for skilled birth attendants and midwives in emergency and post recovery.					
	Baseline	Target	2014 Achieve-ment	Achieve-ment to date	
1.Number of health facilities equipped with lifesaving RH kits and drugs.	TBD	345	450	450	On track
2.Number of health facilities supplied with IPC materials.	TBD	345	450	450	On track
3. Number of facilities equipped to provide SGBV services	7	20	-	12	On track
4. Number of skilled birth attendants trained on MISP	TBD	600	-	Not avail	Partial

Challenges and facilitating factors

Challenges: There were many challenges to the response for the EVD outbreak. Here are some examples of specific issues (as reported in the 2014 COAR):

- Critical national maternal health support systems were weakened as a result of the Ebola virus disease
- Routine Health services were either closed or suspended as a result of the Ebola outbreak, leaving pregnant women and girls with very limited options for quality maternal health care
- Lack of PPEs to protect both the youth centre nurses and their clients as well as training in Infection, Prevention and Control (IPC) led to the closure of some of the youth centres, especially the ones in Montserrado County.[157]
- High number of deaths among health workers due to lack of PPEs to prevent the transmission of Ebola virus disease
- Implementation of UNFPA planned activities were grossly hampered or delayed due to shifting of priorities on national response to Ebola crisis, which resulted to suspension of all routine health related activities including reproductive health.
- Slow and insufficient response by the Regional office in providing additional financial support to the Country office made it difficult for UNFPA to respond in time and effectively
- Challenges in using restricted funds for Ebola response also made it difficult for the country office to provide significant contribution to the plight of pregnant women during the crisis
- The absence of a humanitarian focal person in the country office made it difficult for UNFPA to be fully involved in the emergency coordination at the onset of the crisis.

Lessons Learned (based on the 2014 capacity of the CO to respond to the EVD crisis).[158]

- The existence of an integrated humanitarian unit or team is important to the functionality of the CO to ensure timely and effective response during emergencies
- Timely involvement of the Regional Office in the management of country level emergencies is necessary to ensuring effective country level contribution
- Ensuring adherence to universal precautions at all times is very crucial even in the absence of disease outbreak

and 39,000 boxes of surgical and gynaecological gloves." (UNFPA Executive Board. Annex 6 UNFPA humanitarian Action -2014 update. 2014.)

[157] It should be pointed out that the issue of a lack of PPEs was a critical problem for all active medical personnel during the crisis, not just youth nurses.

[158] Other partners important in emergency service delivery, such as AFRICARE, emerged during the crisis.

- Direct collaboration with subnational/CHT proved to be a positive means for achieving project goals and objectives
- Training of health workers and support staffs in IPC and the provision of personal protective equipment (PPEs) and supplies is crucial to motivating health workers to deliver essential health during the Ebola crisis.
- Active engagement of Implementing Partners and consumers of services improves communication and increases service utilization.
- Expansion of service delivery points to communities through strategies increases access to and utilization of the services.

EFFICIENCY

These questions apply to all 4 Focus areas and the CCPE Question 11 a. (EQ9). To what extent did the intervention mechanisms (including funds, expertise and timing) contribute to or impede the achievement of the programme outputs?

Summary Findings - Efficiency of EVD Response: In response to the EVD Crisis in 2014, UNFPA made an initial commitment for funding $2,048,130 for technical assistance budget for MoHSW training, RH Kits and additional supplies (actual expenditures for this budget were not available). UNFPA was among the top five UN donors. This amounted to 6% of the total UN response budget. Of importance is to recognize that the four main public health focused agencies (WHO, UNICEF, UNAIDS and UNFPA) accounted for just 28% of the total. The majority of UNFPA Liberia's budgeted activities (87%) were to reduce exposure to Ebola virus amongst health workers and service providers during delivery of maternal health services in Ebola affected communities. In the aftermath of the EVD Crisis in 2015 and 2016, UNFPA continued to make significant expenditures in contact tracing, more than $5 million in 2015. As noted in the sections above, a review of costs indicated that the expenditures were reasonable for the level of activity.

As shown in the figure below, an estimated immediate UN agency response budget of over US$36 million was developed. The actual expenditures for this estimate budget were not available to the evaluation team. It was understood that, with the declaration of State of Emergency (SOE) on 6th August 2014, there would be a need for more food and logistical support than was envisaged in response to effects of the enforcement of the SOE. As part of this effort, UNFPA made an initial commitment for funding $2,048,130[159] for technical assistance for MoHSW training, RH Kits and additional supplies. This amounted to 6% of the total UN response budget. Very importantly, this includes contributions in kind that reflect UNFPA's comparative advantage, "technical assistance to MoHSW training, and 90 boxes of RH kits." UNFPA was among the top five UN donors and took responsibility for three specific priority areas:

- **Priority 1.A:** Reduce exposure to Ebola virus amongst health workers and service providers during delivery of maternal health services in Ebola affected communities $1,784,130 (see tables in response plan for detailed sub-activities).
- **Priority 1.B:** Increase capacity for treatment and care services for survivors of sexual violence in health facilities and one stop centres including adherence to universal precautionary measures $174,000.

[159] This ~US$2.05 million was World Bank funds. Subsequently, there was an additional input of about US$5.4 million from the Multi-Partner Trust Fund (MPTF)

- **Priority 1.C:** Increase knowledge and awareness of prevention of Ebola and its inter-linkages with sexual and reproductive health (UNFPA) $90,000.

Of importance is to recognize that the four main public health focused agencies, WHO, UNICEF, UNAIDS and UNFPA, accounted for just 28% of the total. In the aftermath of the EVD Crisis in 2015 and 2016, UNFPA continued to make significant expenditures in contact tracing, more than $5 million in 2015. As noted in the sections above, a review of costs indicated that the expenditures were reasonable for the level of activity. See the discussion in the above sections on these efforts.

Figure 4.5: CCPE Related budget and expenditure – Mapping of UN Commitments to the EVD Joint Response Plan (Provisional Totals) August 2014.

UN Agency	Provisional Amount	%
WFP	$11,443,578	31.7%
UNICEF	$6,085,255	16.9%
UNHCR	$5,685,000	15.8%
FAO	$5,353,455	14.8%
UNFPA	$2,048,130 *	5.7%
UNOPS	$1,422,000	3.9%
WHO	$1,400,000	3.9%
UNMIL	$1,116,000	3.1%
UNAIDS	$605,000	1.7%
UNDP	$550,000	1.5%
UNWOMEN	$275,000	0.8%
UNODC	$94,000	0.3%
	$36,077,418	100%

* A further US$5.4 million from MPTF was subsequently expended by UNFPA in 2015.

SUSTAINABILITY

These questions apply to all 4 Focus areas and EVD Response 12. a (EQ10). To what extent has the CO been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to ensure: a) partners have ownership of their programmes and b) the programmes will have durability of effects?

Summary Finding - Sustainability of EVD Response: A national Liberia disaster response planning entity has been developed within the Ministry of Internal Affairs. UNFPA has been part of this process. However, this broader work is being led by UNDP. The UNFPA CO is anticipated to develop and implement an Annual Preparedness Action Plan (APAP) in the near future. Maintaining and updating an APAP as well as active participation in meetings with UNCT disaster management planning are high priorities to ensure a sustained capacity to respond to future crises.

As noted above, based on interviews, it was reported that disaster response planning entity has been developed within the Ministry of Internal Affairs. UNFPA has been part of this process. However, this broader work is being led by UNDP. The UNFPA CO is anticipated to develop and implement an Annual

Preparedness Action Plan (APAP) in the near future. Per the 2006 COAR, UNFPA senior leadership reported implementing a wide range of pertinent emergency related activities (See Figure 4.6 below). The development of an Annual Preparedness Action Plan and delegation of a humanitarian focal person in the country office would facilitate emergency coordination at the onset of a crisis. Maintaining and updating an APAP as well as active participation in meetings with UNCT disaster management planning are high priorities to ensure a sustained capacity to respond to future crises.

Figure 4.6. Minimum Preparedness Actions (MPA) Humanitarian

MPA Milestones reported implemented as of Q4.2016
MPA1: Carry out or support the inter-agency team in risk analysis and monitoring, and in contingency planning
MPA3: Ensure that humanitarian coordination mechanisms in SRH and GBV are in place
MPA4: Advocate for sexual reproductive health and gender-based violence in emergencies.
MPA5: Develop tools and make arrangements for needs assessment, information management and response monitoring
MPA6: Strengthen humanitarian partnerships
MPA7: Enhance the ability to quickly provide the affected population with critical relief supplies
MPA8: Ensure the availability of human resources able to perform critical functions in an emergency
MPA9: Strengthen UNFPA ability to perform media and communication activities in emergency
MPA10: Ensure the availability of financial resources for preparedness and response
MPA11: Ensure arrangements for effective finance and administration management in emergency
MPA12: Actively participate in the UN Security Management System
MPA13: Harmonize UNFPA Contingency Plan(s), Business Continuity Plan and Information, Communication and Technology disaster recovery measures

Source: Minimum preparedness (Humanitarian) - Minimum preparedness established. The office has established and conducted emergency preparedness processes and activities to help mitigate risks in the event of an onset of a crisis. Page 41 UNFPA Liberia COAR January 2017.

CHAPTER 5. UNCT COOPERATION AND VALUE ADDED

5.1 UNCT Cooperation

The questions: For all 4 areas – EQ11. To what extent has the UNFPA Country Office contributed to the functioning and consolidation of UNCT coordination mechanisms?

Summary of Findings: On the basis of interviews and document reviews, there is strong evidence of active and effective UNCT collaboration with UNFPA Liberia. UNFPA CO contributes to the functioning and consolidation of UNCT coordination mechanisms with collegiality and professionalism. The UNFPA CO participates actively in a minimum of six regular UNCT inter-agency working groups. Until last year, UNFPA Liberia chaired the Task Group on GBV and it is currently co-Chair of the UN M&E Working Group. Senior UNFPA staff participation and contributions in regular UNCT coordination meetings was well-recognized. There was strong appreciation of UNFPA Liberia proactive and collaborative leadership to respond to challenges and mobilize resources.

Based on numerous in-depth stakeholder interviews, document and financial data reviews, there is strong evidence of active and effective UNCT collaboration by the UNFPA Liberia. UNFPA CO contributes to the functioning and consolidation of UNCT coordination mechanisms with commitment and collegiality. The UNFPA Liberia Country Representative has in-depth UNCT experience as he is the longest serving in terms of length of time in the country. He has served as Resident Coordinator (*ad interim*) multiple times. Recently, the Liberian government has started the process of developing a new UNDAF. The country leaders attended an UNDAF development workshop in Nairobi in February. The RC's office requested volunteers to go to the workshop and report out. The UNFPA Representative volunteered, demonstrating his acceptance of the responsibility to help lead the UNDAF process. UNFPA's Assistant Representative was previously co-Chair of the UN Interagency Program Team (IAPT). UNFPA Liberia CO participates actively in a minimum of six regular UNCT inter-agency working groups. As shown in the Figure below, UNFPA is active in working groups in three of the four pillars of the UNDAF.

Figure 5.1: UNFPA Liberia Participation in Outcome Working Groups by UNDAF Pillar

UN Pillar I: Peace Security & Rule of Law
Justice and Security & Rule of Law – UNMIL, UNICEF, IOM, UNHCR, UNFPA, ILO, UNMIL-HRPS, UNOPS
UN Pillar II: Sustainable Economic Transformation
Economic Governance and Private Sector Development – UNDP, UNWOMEN, ILO, UNMIL-HRPS, UNFPA, UNIDO
UN Pillar III: Human Development
Health, Nutrition and HIV/AIDS – WHO, UNICEF, UNFPA, UNMIL-HRPS, WFP, UNAIDS, ILO, IOM
Education - UNICEF WB, UNMIL-HRPS, UNESCO, UNFPA, WFP
Social Protection -WFP, UNICEF, ILO, IOM, WB, UNFPA, UNMIL-HRPS
Social Welfare - UNICEF, IOM, WHO, UNMIL-HRPS, UNFPA
Source: Office of the Resident Coordinator. UN Liberia. 2015 One UN Annual Report. 2015.

UNFPA's Technical Data Specialist Co-Chairs and participates regularly in the UNCT M&E Technical Working Group; including participation in bi-annual reviews of the UNDAF across the four pillars. UNFPA also leads and supports the Inter-Agency Task Force on Youth in Liberia. [160] Based on stakeholder interviews, UNFPA Technical Data Specialist was recognized for his contributions on PD issues within the UNCT. As demonstrated by the H6 programme in six south-eastern counties, UNFPA CO routinely and effectively collaborates with UN agencies in programme implementation (UNAIDS, UNICEF, UNWomen, WHO, World Bank) for Maternal New born and Adolescent SRH (H6 Annual Report 2015, COAR 2015). The CO actively collaborates with UN agencies on HIV (UNAIDS, UNICEF, WHO, UNDP), Gender and GBV (UNWomen, UNICEF, WHO) and PD (UNICEF, WHO, UNDP, UNWOMEN).

Based on stakeholder interviews, UNFPA CO leadership was recognized for being inclusive to avoid stove-piping within the UNCT. For example, UNFPA CO has reached out to other UN agencies to join forces on procurement and thereby reduce costs and increase efficiency (Source: Interview findings). Stakeholders expressed appreciation for the proactive approach taken by UNFPA leadership to encourage innovation in problem solving and resource mobilization, in the response to Ebola and MNACH. There were frequent examples where UNFPA is perceived as having taken a proactive leadership role in the response to the EVD crisis and rebuilding MNCH capacity in such areas as MNDSR, deployment of obs/gyns in three counties, and investing in MNCH staff training. During the Ebola crisis, the senior UNFPA staff representatives were reported to have participated in coordination meetings daily, making useful and important contributions.

5.2 Value Added

The questions: For all 4 areas – EQ12. To what extent has UNFPA made good use of its comparative strengths to add value to Liberia's development results – particularly in comparison to other UN agencies in the country?

Summary of Findings: Based on interviews, document reviews and site visits, the UNFPA CO has made good use of its comparative strengths to add value to Liberia's development results. Several examples were found where despite the major setbacks of the EVD crisis, UNFPA CO has still managed to use its comparative advantage to add value.

In most instances, UNFPA has made good use of its comparative strengths to add value to Liberia's development results. For example,

1. **Technical competence in MNACH+FP:** UNFPA is perceived for having a good clinical knowledge of service provision, especially knowledge on MNH and FP and Youth Sexuality. Despite the huge obstacles of the EVD crisis, based on stakeholder interviews, document reviews and site visits, the UNFPA CO has made achievements for the MNH, FP and ASRH.

[160] See UN Liberia Inter- Agency Youth Task Force. Roadmap for the Liberia UN Inter- Agency Youth Task Force. April 2016 – March 2017. 2016 ; and UN Liberia Inter-Agency Youth Task Force. Terms of Reference. 2015.

2. **Long-term collaborative approach:** UNFPA has a comparative advantage in having maintained long-term ties with key GoL Ministries and IPs and established working relationships. It has used this advantage to very good effect, such as working on long-term programs, such as CSE with MoE or professional development with the Liberia Midwives Association and long-term support for fistula reconstruction and rehabilitation, where there is evidence of donor confidence in UNFPA supported work with MoH.[161]
3. **Field focus:** UNFPA has been seen as having a comparative advantage in having strong experience in working with communities in the frontline. They used this capacity to support active community based surveillance and equipped the communities to respond.
4. **Flexibility:** UNFPA is perceived, relative to other agencies, to have a comparative advantage of being flexible and adaptable. This comparative advantage was used to extremely good effect in the response to the EVD crisis. UNFPA was willing to reprogram funds quickly in the face of emergency. For example, due to the Ebola Virus outbreak in the country that led to the closure of schools and the disruption of health care in the counties. Based on this outcome, UNFPA agreed to change project implementation approaches, PPAL changing from a School Based to Community Based Approach; the 50 National Youth Volunteers relocated from the county level to work on outreach in Montserrado (See 2014 SPRs).
5. **Expertise in Data availability and Analysis**. UNFPA is consistently perceived to have a comparative advantage on data issues. One respondent stated that while multiple agencies, including UNFPA, work on maternal health, "no one comes close to UNFPA on Data." UNFPA Liberia PD team made excellent use of this comparative advantage: important contributions in 2013 to the LDHS and demonstrated success in implementing a challenging national effort to roll out contact tracing for Ebola with more than 3,000 gCHVs in 2015. UNFPA PD staff are viewed as a good resource for M&E indicators and the UNFPA CO has made important contributions to maternal and new born death surveillance.[162] However, due to a lack of budget and staffing changes, progress has lost momentum; the UNFPA CO has not been able to provide much needed major support for key institutions (LISGIS, PPCU and IPC) toward the time sensitive preparations for the 2018 census and the next LDHS.
6. **Interagency collaboration:** Rather than work in a silo, the UNFPA CO is perceived as being adaptive to working with multiple agencies in a proactive manner. This openness to interagency connectivity and collaboration has been used to good advantage to expedite and get things done. Examples include multi-agency initiatives to improve monitoring data at the county level, participation in the H6 Consortium, or to collaborating pro-actively in joint procurement among UN agencies to reduce costs. The UNFPA CO is also seen as instrumental and successful in resource mobilization.

[161] As noted above in the MNCH+FP section, with funding from Zonta International, UNFPA has maintained a long-term support for the MoH-implemented surgical management of fistula. The 4th CP has managed to reach or approach its targets for treatment and rehabilitation of fistula survivors despite the impact of the EVD crisis (2015 Zonta Annual Report).

[162] Stakeholder interviews and See Training Support the revision and development of EmONC monitoring Tools as well as Monitoring of EmONC Facilities (Act11GLR07-ZZT06). 2015.

CHAPTER 6. CONCLUSIONS AND RECOMMENDATIONS

6.1 Strategic Conclusions and Recommendations

Strategic Conclusion 1: - Criteria-Effectiveness /Program Area-MNH&FP Outputs 1-4.
Liberia cannot reduce it extraordinarily high MMR unless skilled EmONC practitioners capable of performing CS and related procedures are available in every county. The current mix of UNFPA CO effort, with a balanced focus on maternal and new born mortality reduction in combination with FP services, adolescent health and MNDS&R is credible and evidence-based. It is consistent with the current RMNCAH Investment Case and is likely to improve RMNCAH outcomes.

Strategic Recommendation 1.1 and 1.2: (Linked to Strategic Conclusion 1 Criteria-Effectiveness /Program Area-MNH&FP Outputs 1-4). **Strategic Recommendation 1.1:** UNFPA Liberia should support the strengthening of at least two (2) fully BEmONC compliant health facilities per county before the end of this programme cycle (December 2018) **Strategic Recommendation 1.2:** The 5th UNFPA CP should continue the current mix of programme activities with a focus on maternal and new born mortality reduction and FP, adolescent health and MNDS&R in a manner consistent with the 2016-2020 RMNCAH Investment Case.	To: Country Office Priority level: High

Strategic Conclusion 2: - Criteria-Effectiveness /Program Area-MNH&FP Output 2.
Rigid interpretation of NEX implementation, where UNFPA staff do not feel empowered to intervene to resolve problems resulting from MoH programs lapses, may undermine efforts to effectively implement programs. A flexible and balanced interpretation of the roles of UNFPA staff is needed to ensure that bottlenecks are resolved quickly, so that efforts to implement programs are not delayed.

Strategic Recommendation 2: (Linked to Strategic Conclusion 2 Criteria-Effectiveness /Program Area-MNH&FP Output 2). **Strategic Recommendation 2:** UNFPA should adopt a more flexible policy to permit and encourage UNFPA staff interventions to resolve NEX bottlenecks that hinder EmONC services, such as transport, fuel, RHCS and data for decision-making.	To: Country Office Priority level: High

6.2 MNH&FP Conclusions and recommendations

MNH&FP Conclusion 1: Criteria-Effectiveness /Program Area-MNH&FP Output 1.
If continued and expanded, UNFPA innovations have high potential to reduce maternal mortality by reducing home-based births and increasing the number of qualified providers of EmONC and CS at the County level.

MNH&FP Recommendation 1: (Linked to Conclusion 1 Criteria-Effectiveness /Program Area-MNH&FP Output 1): UNFPA should continue to support incentives for TTMs and support and expand its placement of Obs/Gyns at the county level, as well as expand efforts to train non-physicians to conduct CS.	To: Country Office Priority level: High

MNH&FP Conclusion 2: Criteria-Effectiveness /Program Area-MNH&FP Output 1.
While good progress has been made, two-thirds of maternal deaths are not being investigated, which may be overlooking important contributing causes.

MNH&FP Recommendation 2: (Linked to Conclusion 2 Criteria-Effectiveness /Program Area-MNH&FP Output 1): UNFPA should support efforts by CHTs to increase the proportion of maternal deaths that are investigated.	To: Country Office Priority level: High

MNH&FP Conclusion 3: Criteria-Effectiveness /Program Area-MNH&FP Output 2.
Need to review options to enhance sharing of RH commodities among clinics and between institutions, such as between PPAL and MoH.

MNH&FP Recommendation Number 3 (Linked to Conclusion 3 Criteria-Effectiveness /Program Area-MNH&FP Output 2): Develop protocols to avoid stock-outs through sharing of commodities within county clinics as well as among counties.	To: Country Office Priority level: High

6.3 PD Conclusions and recommendations

PD Conclusion 1: Criteria-Effectiveness/Program Area-PD.
If concrete actions are not taken soon, the 2018 Census will be seriously delayed. UNFPA stands as the primary agency expected to jumpstart and support the 2018 Census.

PD Recommendation Number 1 (Linked to PD Conclusion 1 Criteria-Effectiveness/Program Area-PD): UNFPA should mobilize sources of funding for the geographic mapping exercise to ensure the timely commencement of activities for the 2018 census.	To: Country Office Priority level: **High**

PD Conclusion 2: Criteria-Effectiveness/Program Area-PD.
The PPCU has not been able to adequately coordinate activities of Implementing Partners due to lack of institutional capacity. The current management of the institution has no staff with a specialty in demography and planning.

PD Recommendation Number 2.1 (Linked to PD Conclusion 2 Criteria-Effectiveness/Program Area-PD) UNFPA should provide support to revitalize the PPCU unit through human and institutional capacity building.	To: Country Office Priority level: **Medium**

PD Recommendation Number 2.2 (Linked to PD Conclusion 2 Criteria-Effectiveness/Program Area-PD): Provide support to review and revise the National Population Policy and develop an action plan (operational Plan) to ensure implementation of population policy.	To: Country Office Priority level: **Medium**

PD Conclusion 3: Criteria-Effectiveness/Program Area-PD.
The IPS (UL) is producing technicians who are not adequately trained and cannot readily be placed for mentorship at LISGIS thus making mainstreaming of population variables in planning difficult at the PPCU and in GoL MDAs.

PD Recommendation Number 3.1 (Linked to PD Conclusion 3 Criteria-Effectiveness/Program Area-PD): The IPS (UL) should be given resources (hardware, software and expertise) as soon as possible to adequately train undergraduates for demographic data collection and analysis.	To: Country Office Priority level: **High**

PD Conclusion 4: Criteria-Effectiveness/Program Area-PD.
The current location and condition of LISGIS offices is not supportive of effective data creation and storage activities due to the proximity to the Atlantic Ocean. Frequent storms, high humidity and corrosive salt cause rapid deterioration of computer and printer equipment. Access to the LISGIS headquarters will require security scrutiny when the Executive Mansion is occupied by the President of the Republic of Liberia after the elections of 2017.

PD Recommendation Number 4 (Linked to PD Conclusion 4 Criteria-Effectiveness/Program Area-PD): Discussions need to be held with GoL on the impact of current location on equipment to be supplied for the coming census. Additionally, there will be issues of access to the current headquarters once the Executive Mansion is in full swing with the President of the Republic of Liberia occupying the premises after elections.	To: Country Office Priority level: **High**

Section 6.4: Youth ASRH Conclusions and recommendations

ASRH Conclusion 1: Criteria-Effectiveness /Program Area-ASRH Output 1.
There is potential loss of momentum at this critical juncture and technical and policy support is critical to ensure the transition to a fully implemented integrated curriculum.

ASRH Recommendation 1: (Linked to Conclusion 1 Criteria-Effectiveness /Program Area-ASRH Output 1) UNFPA should maintain its technical and financial support for the integrated CSE strategy for the long-term in the next CP.	To: Country Office Priority level: High

ASRH Conclusion 2: Criteria-Effectiveness /Program Area-ASRH Output 2.
UNFPA support for NGOs that serve key populations provides an important validation for the rights and needs of these key populations, who face discrimination and the threat of violence.

ASRH Recommendation 2: (Linked to Conclusion 1 Criteria-Effectiveness /Program Area-ASRH Output 2) UNFPA should continue to support NGOs that serve the needs of young, most-at-risk key populations.	To: Country Office Priority level: High

6.5: Gender equality and reproductive rights conclusions and recommendations

GE&RR Conclusion 1: - Criteria- Relevance /Program area-GE&RR.
The provision of more safe homes, especially attached to the One-Stop Centres would enable a holistic service.

GE&RR Recommendation 1: (Linked to Conclusion 1 Criteria-Relevance /Program Area- GE&RR Output 1): The next UNFPA CP should look at extending support to the establishment of safe homes to complete the support to women and girls.	To: Country Office Priority level: High

GE&RR Finding 2. Conclusion: (Criteria: Effectiveness Program area-GE&RR**).**
The majority of offenders are known to the families and the message of justice for the victim is still not a priority.

GE&RR Recommendation 2: (**Linked to GE&RR Conclusion 2** Criteria - Effectiveness or Efficiency etc. /Program Area- **GE&RR** Output 5.2) UNFPA should focus campaign messages on the result and focus more energy on SGVB as a rights issue rather than as just a health issue.	To: Country Office Priority level: High

GE&RR Conclusion 3: – Criteria-Effectiveness/Program Area- GE&RR Output 5. 1.

Based on evidence that lobbying has been effective, resulting in tangible results and change in law, there is political will to ensure the rights of women in Liberia.

GE&RR Recommendation 3: (**Linked to Conclusion 3** Criteria-Effectiveness / Program Area- **GE&RR** Output 5. 1). UNFPA should support projects that raise awareness of these laws especially in rural communities.	To: Country Office Priority level: High

6.6 CCPE/EVD Response conclusions and recommendations

CCPE Conclusion 1. Criteria-Effectiveness / Program Area- **CCPE.**
The development of an Annual Preparedness Action Plan (APAP) and delegation of a humanitarian focal person in the UNFPA Liberia CO would facilitate emergency coordination at the onset of a crisis. Maintaining and updating an APAP, as well as active participation in meetings with UNCT disaster management planning are high priorities to ensure a sustained capacity to respond to future crises.

CCPE Recommendation 1: (**Linked to CCPE Conclusion 1** Criteria-Effectiveness / Program Area- **CCPE** UNFPA Liberia should develop an APAP and designate a humanitarian focal person before the end of 2017.	To: Country Office. Priority level: High

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