Insert Logo for Participating UN Organisation(s)

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EBOLA MPTF
MPTF OFFICE GENERIC FINALPROGRAMME[1] NARRATIVE REPORT
REPORTING PERIOD: FROM *12,2015* TO *11,2017*

Programme Title & Project Number

- Programme Title: **Ebola Preparedness, Response and Recovery Support for the Resident Coordinator**
- Programme Number *(if applicable)*
- MPTF Office Project Reference Number:[3] **#00097555**

Country, Locality(s), Priority Area(s) / Strategic Results[2]

Sierra Leone
Country/Region: **All provinces**

Priority area/ strategic results

Participating Organization(s)

- **UNDP**

Implementing Partners

- **UNCT**

Programme/Project Cost (US$)

Total approved budget as per project document:
US$ 695,527
MPTF /JP Contribution[4]:
US$ 695,527
- *by Agency (if applicable)*

Agency Contribution: **zero**

Government Contribution: zero
(if applicable)

Other Contributions (donors):
zero
(if applicable)
TOTAL: US$ 695,527

Programme Duration

Overall Duration *(months)*
Start Date[5] *(dd.mm.yyyy)**18.12.2015***

Original End Date[6] *31.12.2016*

Actual End date[7]*(dd.mm.yyyy)**31.11.2017***

Have agency(ies) operationally closed the Programme in its(their) system? **YES** Yes ☐ No ☐

Expected Financial Closure date[8]:
20 July 2018

Programme Assessment/Review/Mid-Term Eval.

Evaluation Completed
☐ Yes ☐ No Date: *dd.mm.yyyy* **NO**
Evaluation Report - Attached
☐ Yes ☐ No Date: *dd.mm.yyyy* **NO**

Report Submitted By

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[1] The term "programme" is used for programmes, joint programmes and projects.
[2] Strategic Results, as formulated in the Strategic UN Planning Framework (e.g. UNDAF) or project document;
[3] The MPTF Office Project Reference Number is the same number as the one on the Notification message. It is also referred to as "Project ID" on the project's factsheet page on the MPTF Office GATEWAY.
[4] The MPTF/JP Contribution is the amount transferred to the Participating UN Organizations – see MPTF Office GATEWAY
[5] The start date is the date of the first transfer of the funds from the MPTF Office as Administrative Agent. Transfer date is available on the MPTF Office GATEWAY
[6] As per approval of the original project document by the relevant decision-making body/Steering Committee.
[7] If there has been an extension, then the revised, approved end date should be reflected here. If there has been no extension approved, then the current end date is the same as the original end date. The end date is the same as the operational closure date which is when all activities for which a Participating Organization is responsible under an approved MPTF / JP have been completed. As per the MOU, agencies are to notify the MPTF Office when a programme completes its operational activities. Please see MPTF Office Closure Guidelines.
[8] Financial Closure requires the return of unspent balances and submission of the Certified Final Financial Statement and Report.

EXECUTIVE SUMMARY

- After UNMEER, and then later OCHA, departed Sierra Leone following the end of the Ebola epidemic it was felt that the UN system needed to maintain a fulltime coordination and preparedness capacity located inside the RC's Office to keep the entire system vigilant. Through UN-wide simulation exercises, continuous liaison with Government ministries as well as China and USA CDCs, and also a dozen INGOs, the project contributed to the success of a sustained Ebola-free Sierra Leone after the epidemic had dissipated. Special attention was also given to the survivors of Ebola. Overall disaster response coordination remained high and this momentum has been maintained after the project closed and was further successfully tested during the mudslide and associated floods in August 2018.

I. Purpose

- This project aimed to provide additional capacity to the Resident Coordinator during 2016 and early 2017 in order to support national authorities to respond / recover from Ebola issues in Sierra Leone. The withdraw of UNMEER / OCHA created a need for additional staff and capacity to be available in-country inside the UN system to ensure that Ebola could not take the country backwards again, including the requirement to cater for Ebola survivors, during the fragile recovery period. A dedicated Ebola Focal Point for the Resident Coordinator was therefore appointed who was supported by a Programme Analyst and a Driver. This three-person team formed the Ebola Response and Recovery Coordination Team (ERRCB). Being located in the RCO the ERRCB was supervised by to the RC / RR / DO to do the following:
    - Create, maintain and lead platforms for Ebola management coordination (monthly coordination meetings with key stakeholders, both UNCT and national partners)
    - Capacity assessment of national institutions in the field of Ebola management;
    - Capacity building of UNCT and national institutions for better Ebola response / recovery;
    - Knowledge management on the existing solutions, and dissemination of best practices
    - Advocacy for key reforms (improvements) in the area of Ebola management, including high quality reports
    - Building strategic partnerships among all stakeholders in substantive disaster management policies

- Throughout the project's duration the ERRCB worked with all the UN agencies to ensure the UN's unique set of capacities and strengths were effectively patched into the national efforts to stay at zero new Ebola infections whilst also caring for the survivors. In parallel to the ERRCB the rest of the RCO and the majority of the UNCT was completely free to focus on the broader national recovery efforts that were being driven by a Recovery Team inside the Office of the President. The Goals of the President's Recovery Priorities are shown below:
    - Save the lives of 600 women and 5000 children
    - Prevent, detect, respond to epidemics and ensure zero cases of EVD
    - Ensure continuous care for EVD-affected persons and survivors
    - Provide income support to 59,000 vulnerable households
    - Improve learning outcomes by ensuring that 70% of schools have the an appropriate ratio of capable teachers to pupils
    - Nationwide school feeding for 1.2 million children in all GoSL/GoSL assisted primary schools
    - Create 10,000 agricultural jobs across key value chains
    - Increase growth and competitiveness of 1,000 SMEs across key value chains
    - Provide sustainable short- and long-term solutions to Freetown Water, improving access for 600,000 people

- Extend sustained access to water to 895,000 more people in the provinces
- Double the total operational power generation capacity from 75MW to 150MW
- Double access to electricity from 125,000 to 250,000 households
- Improved service delivery and efficiency of Government spending for recovery priority sectors

In 2016 the combined expenditures of the UNCT was US$ 134 million of which 82% was directly aligned to the above President's Recovery Priorities.

Having sufficient depth and breadth of staff serving in the RCO to cover all bases, i.e. keeping the country at a resilient zero for new Ebola infections, and caring for the Ebola survivors, whilst also pushing ahead with the wider Presidential Recovery Priorities, and the longer-term issues concerning the ongoing peace, put the RC in a strong position with all stakeholders, i.e. with the UNCT and / or the Government and / or the International Donors and / or the Diplomatic Corps. The extra capacity in the RCO also ensured that staff did not burn out during this extremely busy and complicated time, allowing staff to benefit from a work-life balance and enjoy their social economic rights.

II. Assessment of Programme Results

Through the ERRCB the key results achieved under the respective Key Results Areas are as follows:

❖ Prevent, detect, respond to epidemics and ensure zero cases of Ebola

Strengthen health data systems:

The annual average proportion of weekly district reports (completeness rate) submitted at the national level was at 100 percent, whilst timeliness was at 95 percent, both of which are above the WHO Africa Regional target of greater than or equal to 80 percent. This was a result of the revitalization of Integrated Disease Surveillance and Response (IDSR) through training of district and facility surveillance focal persons, regular feedback to all surveillance stakeholders, and supportive supervision.

Maternal deaths reporting was prioritized through IDSR. In 2016, a total of 618 maternal deaths were detected and reported through the weekly IDSR system from all the districts. However, data inconsistencies at national and district level were pervasive in the majority of districts. As a result, 706 maternal deaths were reported through the Maternal Deaths Surveillance and Response (MDSR) line listing mechanism. The difference might be attributed to sub-optimal documentation of notification reports, timeliness of reports, data entry, and / or the lack of a feedback mechanism, among other reasons

MDSR data was used for investigation, review and evidence-based action geared towards reduction of the maternal mortality ratio (MMR) in the country. Perinatal deaths are reported through the Health Management Information System (HMIS) monthly and also partially through the Community Based Surveillance (CBS) system, as neonatal deaths.

Improved Infection Prevention and Control (IPC) in health facilities

The National IPC Unit, which was created in 2015, supported the roll-out of an updated national IPC/WASH assessment tool through the training of 90 IPC officers countrywide.

WHO supported IPC assessments, supportive supervision and on-the-job training to non-Ebola healthcare facilities, which increased from 10.5 percent (136 out of 1294 facilities) in Quarter 1 of 2016 to 25.7 percent (333 out of 1294 facilities) by end of November 2016.

Approximately 13.3 percent of assessed facilities complied with IPC standards, 24.1percent partially complied, while 62.7 percent had low compliance. Government hospitals were 85 percent compliant.

IOM supported the training of 280 community task force members and CHWs on IPC.

There were 79 operational isolation areas in Sierra Leone. As of December 2016, 60 of these (76percent) were IPC compliant, 17 (22percent) were partially compliant and two (2percent) were non-compliant.

UNOPS supported the construction of isolation, screening and waste facilities during the reporting period. The construction of combined screening and isolation units in eight hospitals in Western Urban Area district was 75 percent complete by the end of 2016. Construction of screening units in ten Government hospitals in ten other districts was 72 percent complete. Construction of isolation units in six Government hospitals in six districts was 62 percent complete. Rehabilitation and installation of new incinerators for medical waste management in nine Government hospitals was 89 percent complete.

UNOPS supported WASH services in health facilities across Sierra Leone. In 2016, the agency completed water supply works (boreholes, pumps, water tank structure, supply of water storage tanks and chlorination units) in Kenema Government hospital and plumbing reticulation works in 21 Government hospitals. Rehabilitation and new incinerator installation in 22 Government hospitals was 95 percent complete by the end of the reporting period. Solar systems in 22 Government hospitals were 96 percent complete for submersible pumps and 83 percent complete for lift pumps.

National WASH guidelines were completed and will be printed and disseminated in 2017. Training has been conducted for 142 incinerator operators in Government hospitals – both district hospitals and referral hospitals.

Strengthened integrated disease surveillance, reporting, and response at national, facility, and community levels

The 2016 annual average completeness of health facility reports was 93 percent while the timeliness was 91 percent. The two performance indicators were above the WHO Africa regional target of greater than 80 percent. A robust system is in place for enhancing the timeliness and completeness of data reporting from health facilities.

WHO and partners supported Electronic IDSR (eIDSR) reporting roll-out in all districts. Currently, a mobile phone application for health facility use is in the pilot phase. A Data Quality Audit (DQA) system has been put in place to improve the quality of IDSR data.

Cross-border surveillance activities were also initiated in ports of entry through cross-border sensitization meetings with districts in neighboring countries. In 2016, two districts (Kambia and Koinadugu) out of the seven cross-border districts held regular cross-border meetings. An assessment was also conducted at Lungi International Airport in May 2016; the findings of this assessment resulted in the development of a National Aviation Public Health Emergency Preparedness Plan in November 2016.

IOM supported the training of 20 Community-Based Surveillance (CBS) national trainers, 167 Peripheral Health Unit (PHU) in-charges, and 1,859 CHWs. Some seven points of entry (POE) core capacity assessments were conducted in Koinadugu and Bombali districts, and construction and refurbishments were carried out for five official POE in these two districts.

Ensure CBS provides >80 percent complete and timely weekly surveillance reports on target diseases and events

In 2016, the completeness rate of CHWs reporting was 87 percent. WHO and other partners supported the MoHS to establish a Community-Based Surveillance (CBS) system, [illegible]ing 10 diseases and public health events for immediate and weekly reporting at com[illegible] level. CBS [illegible]ing was rolled out in nine of the current 14 districts, with a total of 8,449 CHWs trained. The remaining five districts have been prioritized for 2017 support. CBS is intended to increase the sensitivity of the IDSR system.

Ensure response teams have ability to dispatch within 24 hours after notificati[illegible] of [illegible]spected epidemic disease according to international health regulations

The Ebola Coordination Unit in the UN Resident Coordinator's Office led the updating of the Inter-Agency Rapid Response Plan and the associated standard operating procedures (SOPs), which were endorsed by the UNCT. This ensured clarity on how the UN and partners would quickly respond to and support the Government in the event of a confirmed Ebola case, to prevent it escalating to an epidemic.

In 2016, eight Inter-Agency Rapid Response Technical Team meetings were held and were used to successfully carry out reviews and updates by coordinating with technical focal persons across all agencies. This ensured revisions were made to the functional responsibilities and SOPs for leadership; coordination; case management; epidemiology; contact tracing; laboratory; logistics; WASH; child protection; education; psychosocial care; and social mobilization. Functional and sub-functional focal persons were appointed and the contact lists for these were regularly updated throughout 2016, to ensure they would be able to be reached in case of an Ebola case.

In September 2016, an Inter-Agency Rapid Response simulation was carried out, involving the UN Resident Coordinator, heads and representatives of the Centers for Disease Control and Prevention (CDC), WHO, UNICEF, UNDP, WFP, IOM, UNAIDS and the International Medical Corps, as well as functional leads and sub-functional focal people. Participants demonstrated how they would play their roles if a real-life Ebola case was confirmed. It was observed by a representative from the office of the Chief Medical Officer (CMO) at the MoHS and by the Health Advisor from DfID.

Although the simulation was primarily a table-top exercise to illustrate how the Resident Coordinator and the UNCT would lead and coordinate a response to a confirmed Ebola case, it also tested - in a role-playing fashion - the capability of organizations to effectively bring their resources to bear to stop Ebola transmission, as per the SOPs of the Inter-Agency Rapid Response plan in support of the Government's plan. The simulation tested: i) coordination; isolation, diagnostic, treatment and referral capabilities; ii) epidemiological capacity to understand transmission patterns and trace risky contacts; iii) logistical plans to support a response; and iv) community support mechanisms to ensure appropriate engagements and assistance with food, water, sanitation, child protection, education and psychosocial services.

The simulation ended with recommendations for actions to improve community engagement, especially in difficult decisions such as quarantine, and to support the Government to simulate coordination of its own

Ebola Preparedness Plan. These recommendations were taken forward and the SOPs given a final review. The Government was then given technical support to design scenarios and plan a simulation of the national Ebola Preparedness Plan, which was carried out in December 2016, facilitated by the CDC, WHO, Public Health England (PHE) and the Ebola Coordination Unit.

WHO developed training materials for Public Health rapid response teams (RRTs) and supported the MoHS to adapt them for the Sierra Leone context. Regional five-day RRT trainings with an emphasis on five priority diseases were rolled out in September and October 2016. Every district now has a trained RRT comprising 12 members with the following expertise: The District Medical Officer; team lead (chosen from team members); surveillance officer/epidemiologist; laboratory technician; district health sister; environmental health officer; clinicians; community engagement officer; logistician; any other technical person as required (e.g. veterinarian).

In 2016, national and district RRTs assisted with the investigation of events of public health importance, including disease outbreaks, fire and floods.

Establish 13 district and one national emergency operations centres and achieve excellent rating of greater than 80 percent in exercise assessments

The Ebola Coordination Unit, WHO, CDC, PHE and Médecins du Monde developed a scenario of a yellow fever outbreak complicated by a suspected Ebola case, flooding and public unrest. They used this scenario to facilitate a simulation in December 2016 for the Public Health National Emergency Operations Centre (PHNEOC), three District Health Management Teams (DHMTs) (from Western Area, Bo and Moyamba), the Office of National Security, and other partners. The simulation was intended to ascertain the capability of PHNEOC and the DHMTs to coordinate a response to a public health emergency.

At the conclusion of the simulation, the participants were of the view that PHNEOC was capable of correctly activating, leading and coordinating a response for such incidents. The DHMTs showed knowledge of what they would do in such events to lead epidemiology; carry on contact tracing; manage logistics; conduct laboratory tests; isolate and treat suspected and confirmed cases; and engage with communities to provide support. The simulation also showed that inter-district coordination to report and share information on cases was ad hoc and needed streamlining and strengthening.

WFP established an Emergency Operation Center (EOC) in Tonkolili district within 72 hours of the confirmed Ebola case in January 2016, providing engineering support for the construction of the facility and supplying it with electricity. The Event Management Team was subsequently able to coordinate all humanitarian rapid response activities, using ICT services set up by WFP specialists deployed in the field within 24 hours of activation of the response. In Tonkolili, WFP logistics teams managed (involving receipt, dispatch and accountability) of incoming non-medical and non-food items (NFIs) from various partners, ensuring they were stored in the dedicated warehouse within the EOC and trucks were provided for delivery of food and NFIs to quarantined households.

WHO assisted the MoHS to establish a national EOCin Freetown and satellite EOCs in all districts country-wide. All these EOCs are active.

Ensure five reference laboratories have capacity and capability to efficiently receive samples and confirm cases within 72 hours

Sierra Leone has five laboratories with the capacity to diagnose Ebola by molecular techniques within 24 hours of the receipt of a blood sample from a suspected case. The laboratories are also able to detect Ebola in buccal swab samples of corpses suspected to have died of the disease.

❖ **Ensure continuous care for Ebola-affected persons and survivors**

Register and track survivors

UNICEF supported the MSWGCA and survivor advocates through Project Shield9 to carry out registration and verification of Ebola survivors in Kambia, Tonkolili and Kono districts between January and March 2016, bringing the total number to 2,408 verified and registered Ebola survivors since the start of the project. Project Shield provides testing and counselling to survivors to prevent resurgence of Ebola from fragments of the virus in semen.

UNICEF also supported the training of 75 survivors on psychological first aid and enabled them to provide help to other survivors and to support verification and registration.

In addition, UNICEF provided funds to the MSWGCA to print 1,200 identity cards for survivors to access free health care. Some 650 identity cards were printed in 2016 and distributed to 550 survivors in the Western Area.

Livelihood support

UNDP provided periodic stipends totaling SLL1,050,000 to each of 1,674 vulnerable survivors, helping them to meet short-term needs. UNDP also provided career counselling and customized livelihood training. All short-term training of the survivors was concluded and, on that basis, UNDP will embark on the provision of livelihood start-up grants to the eligible beneficiaries (survivors and caregivers). In the first quarter of 2017, approximately SLL2,583,000 will be provided to each of 1,485 beneficiaries to assist them to generate income and to be more self-reliant.

UNICEF supported the MSWGCA to provide cash assistance of SLL700,000 to each of 973 Ebola survivors to enhance their livelihoods. UNICEF also provided support to MSWGCA to establish a 24-hour internet and information technology training centre for Ebola survivors.

Social workforce development

The MSWGCA planned to recruit 600 social workers to strengthen its social workforce. UNICEF provided funds to MSWGCA to support the social workforce development, including the recruitment, training, monitoring and coordination of 600 social workers for the period September to December 2016. Recruitment of these social workers has yet to be done. However, there were 157 social workers previously recruited and deployed at chiefdom level in 2015 to support implementation of the recovery programmes. UNICEF provided funds to the MSWGCA to cover their monthly salaries up to May 2016 while they were

[9] DFID funded Shield project introduced in August 2015 to minimize the risk of sexual transmission of Ebola through identification, registration/verification of all male survivors above 15 years, counselling of male survivors and their partners on safe sex practices, including use of condoms and avail them to semen testing.

being absorbed into the Government payroll. All 157 social workers were also trained in case management and psychosocial support and were responsible for following up and addressing the needs of children affected by Ebola, in collaboration with non-governmental partners.

Food assistance

WFP provided food assistance to affected communities, particularly contact cases, in order to ensure adherence to quarantine restrictions, thereby minimizing contact and breaking the transmission and spread of the disease during the Ebola flare-up in Tonkolili district in early 2016.

As a way of mitigating the impact of the Ebola outbreak and the stigmatization faced by Ebola survivors, WFP targeted and reached 2,700 survivors with cash transfers. Each survivor received a monthly cash transfer of around Le 390,000 for three months during the first half of 2016. Approximately 12,000 Ebola orphans were provided with food in orphan care centres and in foster families, in order to alleviate the burden on their caregivers.

CPES

The CPES was rolled-out nationally across all distr ts ast year. It comp.. c.. main elements:

1. Provision of free standardised care to all Ebola survivors
2. National Semen Testing and Counselling Programme

Training of frontline healthcare workers has been an integral part of the CPES. With support from WHO and partners, 12 clinical training officers and 226 healthcare workers from 104 community-level health facilities in districts across Sierra Leone were trained on survivor care. In addition, 14 referral coordinators, based at Government district hospitals, were also trained on the facilitation and monitoring of referrals for all people entitled to free healthcare, including survivors. Refresher trainings are continuing periodically.

Guidelines for the comprehensive clinical care of Ebola survivors were developed. These guidelines aim to provide clinicians with increased knowledge, to be able to better address the individual needs of survivors.

Challenges

The major challenges noted by the agencies in conceiving and implementing programmes to achieve results in the two KRAs were as follows:

- There was a decline in funding to support Ebola and epidemic preparedness and prevention as well as to support survivors, with major donors reducing or phasing out funds in 2016 and 2017. This led to reduced personnel as well as downsizing of some operations, and is a threat to sustaining results, since Ebola preparedness and survivor support are long-term needs.
- There were difficulties experienced in logistical capabilities, such as i) transporting materials and supplies; ii) having staff in remote, tough areas to implement livelihood support to survivors and carry out IPC measures at remote POE.
- Lack of equipped and standard training institutions on livelihoods - within the localities of Ebola survivors and beneficiaries - hampered delivery of programmes for skills enhancement for survivors.

- There was slow implementation of activities by partners. For instance, verification and registration of survivors had not been done by the end of 2016 in all districts, even though UNICEF had disbursed the requisite funds.
- IPC faced challenges, such as knowledge gaps in sterilization and decontamination of medical devices and waste segregation not being in place in most facilities. There were no placentae pits in most health facilities. WASH infrastructure remained lacking in health facilities and needs planning and funds to improve.
- The national Ebola Preparedness Plan simulation showed that SOPs were not clear for all aspects of a response to other hazards that may arise that require an emergency response. Competing activities within the MoHS resulted in delayed implementation of IDSR planned activities.
- Limited communication infrastructure in districts makes it difficult for health facilities to effectively report for IDSR on time. Resources for timely and appropriate response to suspected outbreaks are limited. Survivor care is a relatively new field and there are many questions that had to be answered, such as on viral persistence.
- Many survivors developed clinical sequela, for which there was no in-country capacity to manage.
- Stigmatization of survivors and their families in the communities persisted.

ii) Indicator Based Performance Assessment:

Using the **Programme Results Framework from the Project Document / AWPs** - provide details of the achievement of indicators at both the output and outcome level in the table below. Where it has not been possible to collect data on indicators, clear explanation should be given explaining why.

OUTPUT INDICATORS					
Indicator	**Geographic Area**	**Projected Target (as per results matrix)**	**Quantitative results for the reporting period**	**Cumulative results since project commencement (quantitative)**	**Delivery Rate (cumulative % of projected total) as of date**
Description of the quantifiable indicator as set out in the approved project proposal					
# of Ebola management coordination meetings held {Inter-Agency Rapid Response Technical Team and Public Health National Emergency Operations Centre (PHNEOC)}	National	12	38	51	425%
# of knowledge products (Resource mapping, Simulation Report, CPES analysis for UNCT, Ebola Results Group reports)	National	3	3	4	133%
# of programme and policy consultations provided to UN and national institutions, including Office of National Security of Sierra Leone (presentation to PHNEOC, participation in Ministry of Health and Sanitation public health and all hazards risk assessment and participation in Disaster Risk Reduction policy consultations)	National	5	2	3	60%
# of capacity assessment and capacity building events organized for national	National	2	2	2	100%

institutions and UN agencies-Inter-Agency and National Simulations					
# of Ebola Focal point and support team in place at an appropriate moment in the transition process	National	3	3	3	100%
EFFECT INDICATORS (if available for the reporting period)					

iii) Evaluation, Best Practices and Lessons Learned

- Report on any assessments, evaluations or studies undertaken relating to the programme and how they were used during implementation. Has there been a final project evaluation and what are the key findings? Provide reasons if no programme evaluation have been done yet?

  - Nothing to Report. The timeframe of the project was very short.

- Explain challenges such as delays in programme implementation, and the nature of the constraints such as management arrangements, human resources etc. What actions were taken to mitigate these challenges? How did such challenges and actions impact on the overall achievement of results? Have any of the risks identified during the project design materialized or were there unidentified risks that came up?

  - There were no significant delays during the implementation of the project. The project set up at the end of 2015 was extremely well done by the RCO through UNDP. Like wise the drawdown at the start of 2017 was done in a most timely manner.

    - The project's tasks were handed over in an orderly manner to the UN Country Team just prior to the close of the project.
    - The project's assets were handed over in an orderly manner to UNDP.
    - The UN's Inter-Agency Ebola Plan entitled the 'No Regrets Approach' was functional and the contact lists up-to-date.

  - The final reporting was extremely difficult because ERRCB staff left before the 2017 annual report was done and the guideliens for the Final Report were poorly followed, i.e. the Final Report needed to be written again to meet the guidelines. Fortuneately the Head of the RCO had sufficient knowledge of the project to recover the reporting situation.

- Report key lessons learned and best practices that would facilitate future programme design and implementation, including issues related to management arrangements, human resources, resources, etc. Please also include experiences of failure, which often are the richest source of lessons learned.

  - For a one-year project 'staff Management costs' and 'Non-recurrent payroll' were particularly high in relation to the project award because two internationals, a P5 and a P3, were appointed and repatriated at the start and end of a very short project period. Alternative contract modalities or in-house arrangements, may have led to a better project costs to staff costs ratio. It should be noted however that Trust Funds at their core exist to provide support to such activities, i.e. that are necessary but fall outside of the normal bi-lateral donor engagement.
  - The P5 project manager had experience of project management with UNICEF but not UNDP. It took a long time for the project manager to make the conversion from UNICEF's project software (PROMS) to UNDP project software (ATLAS). In a one-year project there is no time available for such on-the-job training and therefore with hindsight proficiency in ATLAS should have been a listed skill in the job description.
  - The project was placed in the RCO and the RC was the direct supervisor of the project manager. This strategic decision had some advantages, but it also blurred the DG guidelines on the role of the RCO and it remains unusual for RCO to run projects and adopt an 'operational'

role. The operational oversight was complicated as financially the project was placed inside a UNDP Cluster even though the Cluster Leader was not involved in the inception nor design of the project. Given the multiple and complex demands on the RC's time and the initial non-involvement of the UNDP Cluster Lead, hence the need to catch-up in the early stages, coupled with the lack of inclusion of the Strategic Planning Advisor in the project's chain of command, the wisdom of the placement in the RCO could be questioned.

iv) A Specific Story (Optional)

Due to late reporting by people not directly managing the project it is difficult at this stage to provide a story from the field.