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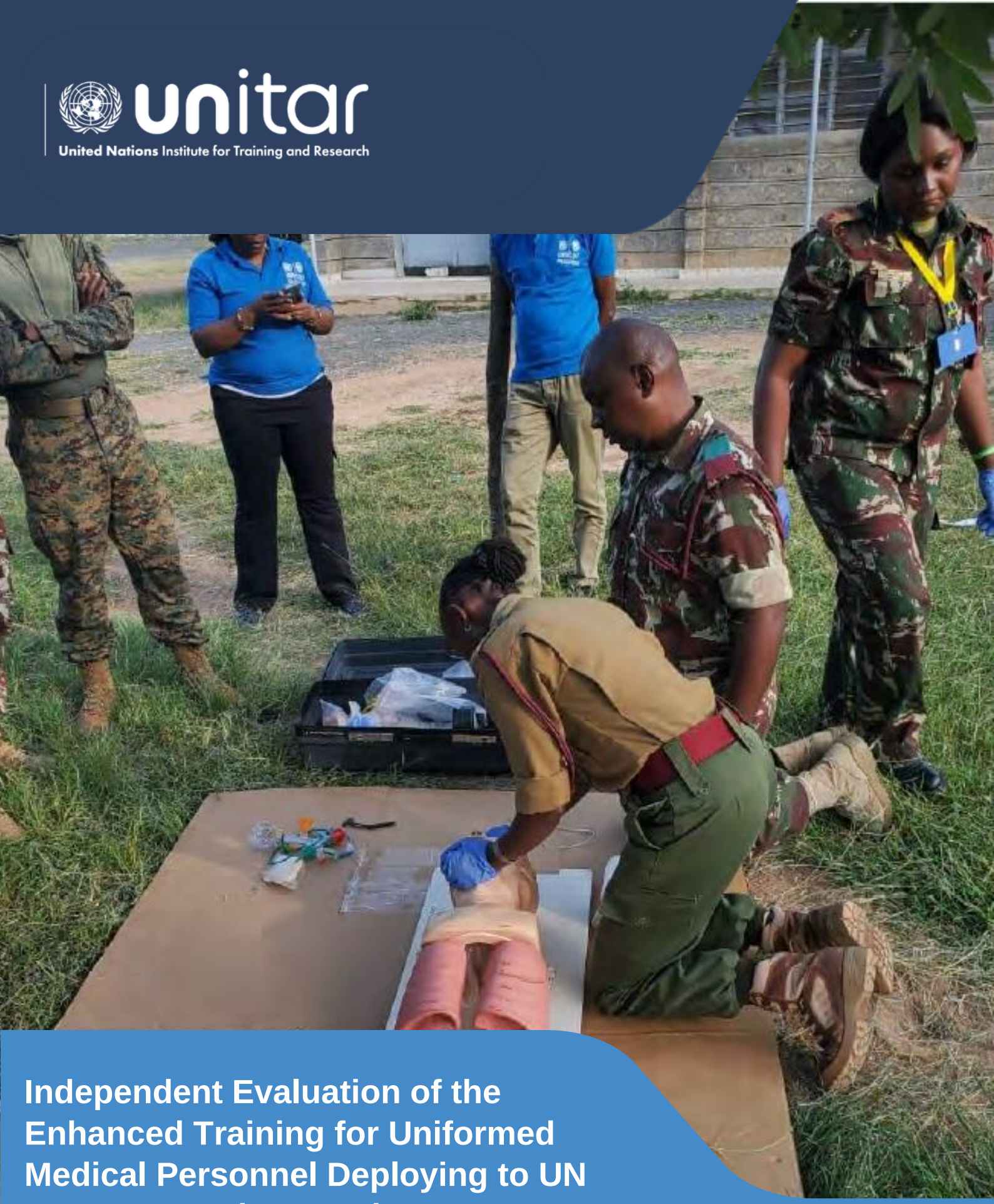

Independent Evaluation of the Enhanced Training for Uniformed Medical Personnel Deploying to UN Peace Operations Project

March 2025

Planning, Performance Monitoring and Evaluation Unit

This report is a product of the Planning, Performance Monitoring and Evaluation Unit of UNITAR, and the findings, conclusions and recommendations expressed therein do not necessarily reflect the opinion of the partners of the Enhanced Training for Uniformed Medical Personnel Deploying to UN Peace Operations project (Reference: C2021.TARPT104.CANDFA). The evaluation was conducted by Aurélie Ferreira and Gilbert Asiimwe. The report is issued without formal copy editing.

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Foreword

The Enhanced Training for Uniformed Medical Personnel Deploying to UN Peace Operations project, funded by Global Affairs Canada through the Department of Foreign Affairs, Trade and Development, aimed to “improve the performance of UN peace operations in increasingly complex and high-risk environments by enhancing the physical and mental well-being of female and male military and police personnel deployed to UN peacekeeping missions”. UNITAR implemented the project from December 2021 to June 2024 with a budget of CA$3,393,200.02. The project was a follow-up from an earlier phase from March 2020 to June 2021 which aimed to “improve performance of the United Nations peace operations in increasingly complex and high-risk environments”.

The evaluation assessed the relevance, coherence, efficiency, effectiveness, likelihood of impact and likelihood of sustainability of the project’s second phase. Aiming to serve both accountability and learning purposes, the evaluation is also forward-looking and intends to inform decisions on the design and planning of possible future phases and similar projects.

The evaluation is based on a mixed-methods approach combining qualitative and quantitative tools that are gender-sensitive. The evaluation was undertaken by a team of two evaluators between August and November 2024, including field visits to implementing partner organizations in Kenya and Tanzania.

The evaluation found the project’s relevance and coherence to be highly satisfactory. The effectiveness, efficiency, likelihood of impact and likelihood of sustainability were rated as satisfactory.

The evaluation issued a set of five recommendations of which two were accepted and three partially accepted. The evaluation was managed by the UNITAR Planning, Performance Monitoring and Evaluation (PPME) Unit and was undertaken by Aurélie Ferreira and Gilbert Asiimwe. The PPME Unit is grateful to the evaluators, the UNITAR Peacekeeping Training Programme Unit and partners, as well as other project stakeholders for providing important input into this evaluation.

Brook Boyer

Director, Division for Strategic Planning and Performance
Manager, Planning, Performance Monitoring and Evaluation Unit

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Introduction and background

Since 2014,[1] the UNITAR Peacekeeping Training Programme Unit, through its Predeployment Training and Advisory (PDTA) Section, has been supporting Troop and Police Contributing Countries (T/PCCs) with predeployment training and, since 2018, the section has expanded its support to enhancing the well-being of uniformed personnel, thereby increasing mission effectiveness. UNITAR first developed a "Resource Kit", a handbook compiling self-care and trauma therapy techniques, and piloted a peer-to-peer support system where two people or "buddies" assist one another. The work on health then expanded to the training of uniformed health professionals from military contingents and Formed Police Units in Phase I of the project "Enhancing the Capacities of Uniformed Medical Personnel deployed to UN Peace Operations", implemented between March 2020 and April 2021.

This evaluation covers Phase II of the above-mentioned project entitled "Enhanced Training for Uniformed Medical Personnel Deploying to UN Peace Operations" that ran from 24 December 2021 to 30 January 2024, and was extended until 30 June 2024. Both phases were funded by Global Affairs Canada (GAC) through the Department of Foreign Affairs, Trade and Development (DFATD) to "improve the performance of UN peace operations in increasingly complex and high-risk environments by enhancing the physical and mental well-being of female and male military and police personnel deployed to UN peacekeeping missions". This objective was to be achieved by "strengthening the capabilities, motivation (awareness) and opportunities of male and female medical and paramedical personnel (military and police) deployed to UN peacekeeping operations to address physical and psychological trauma in a gender-responsive manner and through provision of training equipment".

The project targeted T/PCCs deploying to four high-risk UN peace operations: the United Nations Multi-Dimensional Integrated Stabilization Mission in Mali (MINUSMA), which is now closed; the United Nations Organization Stabilization Mission in the Democratic Republic of the Congo (MONUSCO), which is withdrawing; the United Nations Mission in South Sudan (UNMISS); and the United Nations Multidimensional Integrated Stabilization Mission in the Central African Republic (MINUSCA). Project beneficiaries were French-speaking and English-speaking countries including Chad, Ghana, Kenya, Niger, Rwanda, Senegal, Tanzania and Togo. Implementation of activities was supported by four implementing partners (IPs): the Rwanda Peace Academy (RPA), the Tanzanian Police Force (TPF), the Administration Police Service, Kenya (APS) and the Department of Medical Services of Ghana Armed Forces.

Purpose, scope and methodology

The evaluation assesses the relevance, coherence, effectiveness, efficiency, likelihood of impact and likelihood of sustainability of the project in its second phase, which serves learning and accountability purposes. It is forward-looking to inform decisions on the design and planning of possible future phases and focus areas of similar projects.

The evaluation is based on a mixed-methods approach combining qualitative and quantitative tools that are gender-sensitive. The evaluation was undertaken

[1] Exploring Well-Being in Peace Operations, Sustaining peace with a healthy mind, UNITAR 2019

by a team of two evaluators between August and November 2024, including field visits to implementing partner organizations in Kenya and Tanzania in August 2024.

The evaluators reviewed documents and conducted in-person and remote interviews with 46 project stakeholders present in all implementing countries, except for Senegal and the donor (GAC). Three online surveys, in English and French, were sent to police and military medical and paramedical personnel participating in basic and advanced training, and to trainers, with 95 responses collected. From the stakeholders consulted throughout the evaluation, 23 per cent were women and 77 per cent were men. Unfortunately, it was impossible to observe a training event as the evaluation took place after the project's implementation period. It was also not possible to contact beneficiaries deployed to peacekeeping missions to enquire about the capacity needed and changes observed after deployment. The below assessment is mostly based on participant testimonies.

The main limitations encountered by the evaluation include: the lack of participant contacts and responses from francophone countries (no contact details were available for Senegal and Chad), which could not be complemented by field missions given the limited budget allocated to the evaluation (missions were organized in Kenya and Tanzania); and the limited access to some stakeholders identified during the evaluation's inception phase. The evaluation also had limited access to information on participants' medical qualifications and category, which limited data analysis disaggregation.

Main findings

Relevance - highly satisfactory

The project aligns with the Sustainable Development Goal (SDG) 16 to promote peaceful, just and inclusive societies; and UNITAR's 2022-2025 strategic framework sub-objective 1.1 to "Support institutions and individuals to contribute meaningfully to sustainable peace". Furthermore, the project aligns with the donor efforts to promote inclusion and representation of women in the peacekeeping field.

The project design is highly relevant in engaging with 8 out of 20 of the main African T/PCCs, who rank among the most vulnerable to fatalities. According to statistics from the UN Department of Peace Operations (DPO),[2] Burkina Faso, Chad, Ethiopia,[3] Ghana, Kenya, Niger, Rwanda, Senegal, Tanzania and Togo account for 34 per cent of fatalities over the project phases (2021-2024). Over the same period, illness accounts for 65 per cent of fatalities, while malicious acts and accidents reached 29 per cent in UNMISS, MONUSCO, MINUSMA and MINUSCA. The military account for 46 per cent of victims and up to 89 per cent when it came to malicious acts. As a response, the project targeted tactical combat casualty care (TCCC) and mental consequences, which are not yet documented but known to have major consequences on individual well-being and collective dynamics within peacekeeping missions.

The absence of regular and updated statistics on Mental Health and Psychosocial Support (MHPSS) is notable. The project addresses a situation that is believed to impact between 5 and 20 per cent of the personnel deployed. As such, the project's objectives are found to be highly relevant, to some extent avant-garde, for bridging an organizational gap, building capacity on a new skill and upgrading predeployment content.

Forty-three per cent of the beneficiaries who took one of the evaluation surveys reported that they had not received training on MHPSS before. The TCCC modules were found to be highly relevant by medical

[2] Fatalities | United Nations Peacekeeping

[3] Ethiopia was initially included as a project beneficiary and removed in 2022 due to instability in the country.

and paramedical professionals who lack opportunities to practice in their national context and welcome refreshers or new training courses. The variety of topics speak to a wide spectrum of health professionals' needs and capacity, as confirmed and appreciated by interviewees and survey respondents.

The project management expertise and close follow-up, including participation in multiple events, allowed for an effective learning process. The conclusions and recommendations of the project's first phase were applied to the second phase and included development of new training materials on mental health and psychosocial support, procurement of health kits, further mainstreaming of female participation, and preparatory workshops and visits to ensure smooth training delivery.

Some challenges, such as expanding the roster of female francophone trainers, although flagged from the start, were unaddressed, in part due to changes among beneficiary contexts, such as Burkina Faso and Niger where activities were suspended after the military coups in September 2022 and July 2023.

The contribution of the needs assessment to the development of the design of the second phase was small, and the second phase benefited more from the project management's internal learning process than from implementation of the first phase. In the needs assessment, UN DPO statistics do neither disaggregate enough to determine the skills that are missing to save lives nor in which of the four classified UN medical levels the fatalities were declared. In addition, the needs assessment does not set objectives, define a target group nor distinguish the target from the hosting population, creating confusion. The sections on sexual exploitation and abuse (SEA) and conflict-related sexual violence (CRSV) display national statistics and miss exploring consequences on health practitioners, skills needed or procedures to be aware of to report violations as a uniformed practitioner or victim.

Coherence - highly satisfactory

Project management was highly responsive to a UN environment that acknowledged the impact of mental health on the performance of peacekeeping operations and the well-being of uniformed personnel. It aligned with policy statements and visibility marked by: the 2017 UN Staff Well-Being Survey; the first UN Mental Health and Well-Being Strategy in 2018; point 4.2 of the Action for Peacekeeping Plus Plan on improved safety and well-being of personnel that contributes to an enabling environment for the meaningful participation of women in peacekeeping; the 2023 UN Peacekeeping Ministerial in Ghana; and the December 2022 mental health resolution (S/RES/2668), which specifically targets predeployment and mental preparation.

The gender focus aligns with Canada's Feminist International Assistance Policy and commitments of the UN to improve the inclusion of women in peace processes (UNSCR 2242 and sustainable development targets for 2028). It is consistent with UNITAR's Gender Equality and Empowerment of Women Policies (GEEW) that target gender parity through internal gender expertise, gender-sensitive reporting, and systematic requests for partners to organize gender-balanced events, recruit female trainers and train female participants.

The project did not overlap or compete with other reference frameworks. The decision to refer to the UN Buddy First Aid Course (BFAC), the World Health Organization's guide on Psychological First Aid (PFA) and the Inter-Agency Standing Committee (IASC) signalled a coherent approach: knowledge and use of existing resources.

The project is consistent with UNITAR's mandate to support T/PCCs predeployment capacity and with recent efforts to develop and mainstream content related to health and mental health. The

review of UNITAR's project portfolio indicates similar initiatives, including delivery of Buddy First Aid Kits (BFAK), and promoting mental health and psychological services in peacekeeping environments, such as the development of a psychiatric unit in Mali. The project avoided repetitions of programmes run by the Global Peace Operations Initiative (GPOI) with the Tanzanian military and engaged with the TPF instead.

The review of external initiatives and comparison of programmes undertaken by survey respondents concludes with the project's holistic approach to health. Other projects addressed the subjects separately: TCCC only, TCCC and PFA, or PFA only. The project introduced a mental health component, alongside gender, specifically targeting uniformed medical and paramedical personnel likely to deploy to Level 1 medical facilities in peacekeeping missions.

Effectiveness - satisfactory

The project implemented training activities in time and exceeded numerical targets. Twenty-two training events were organized and 319[4] uniformed personnel (359 if multiple participation is included) benefited from the training. Initial plans were for 16 events and a target of 240 beneficiaries. The UN MissionMed was upgraded on Android, developed for iOS and translated into French. The immediate outcome relating to downloads of the app (70 downloads as opposed to a target of 112) was paused while partnership and strategic orientation were discussed.

The project was less successful at achieving gender targets for structural reasons beyond UNITAR's control. Despite the promotion of gender inclusion through selection criteria and recruitment priority to women, only 70 women participated in the basic and advanced training, which corresponds to 22 per cent of the total number of participants. Eleven women participated in the Training of Trainers (ToT), which corresponds to 30 per cent of this training.

The full ToT reached 10 francophone participants, or 59 per cent. Of the four female participants in the ToT, there were no francophone women.

The training content and the professionalism of trainers were praised by respondents of the survey. The approach of including regional and international trainers allowed complementary perspectives and was appreciated by participants, blending UN peacekeeping experience and knowledge of regional, national and local contexts. Participants repeatedly ranked trainers as "perfect" and "excellent".

Tactical-related content received special appreciation from health personnel, who are generally trained about medical aspects but rarely about combat-related care. Survey respondents highlighted how to treat extensive bleeding, tourniquet application, stress management and psychological considerations when handling casualties as the most effective techniques included in the training.

The decision to engage medical and paramedical professionals jointly was found to be innovative, ignoring hierarchy and favouring the exchange of very diverse experiences. Participants praised inclusiveness, being treated equally and rated the experience as "so enriching". The main negative observation related to the duration of training, which was deemed too short, especially for the advanced training.

The contribution to intermediate and ultimate outcomes could not be assessed due to a lack of data and of defined targets. The project may have contributed to the decrease in fatalities within peacekeeping operations between 2020 and 2024 (a reduction of 50 per cent), but so did other training programmes and contextual shifts, such as MINUSMA's withdrawal from Mali.

[4] Unique beneficiaries.

Efficiency - satisfactory

The project's partnership modalities are time and cost-efficient, relying on decentralised implementation and proportional financial responsibilities. Partners in Ghana, Kenya and Tanzania (with Ghana and Tanzania being new partners) were delegated with the management of training activities and local costs, while the RPA, which has implemented 10 projects with UNITAR since 2018, was delegated with full events and budget management of 5 out of 11 training events in Burkina Faso, Ghana, Senegal, Tanzania and Togo. This proportional approach to partnership was sound and efficient. UNITAR efficiently mobilised a network of IPs to reach relevant health entities and facilities, and smoothly replaced Burkina Faso and Niger partners who were forced to step down due to in-country instability, leaving a blend of medical and in-country new partners and long-standing and solid training partners with a regional and bilingual mobilisation capacity.

Overall, project communication was reported as good. Reactivity and pro-activity were praised in relationships with the donor and IPs. Structural transparency issues were noted around the selection of participants without hampering the success of the project.

Although a minimal share of the global budget (i.e. 2 per cent or $52,708 for development of iOS and translation into French), the mobile application efficiency was found to be low. Only 13 per cent of respondents of the survey knew about the app, out of which 88 per cent used it in English. None of the evaluation interviewees, including trainers, knew about it. This will hopefully change as a new partnership is expected to officially launch the app through focal points and beneficiaries (See Likelihood of Sustainability, page 55).

Interviewees reported a few unbudgeted costs hampered training dynamics at the start, including materials that needed to be translated into Swahili for Tanzania since the country was not initially part of the T/PCCs supported, hence, unbudgeted, and French interpretation in Rwanda, despite attention having been given to recruiting native Kinyarwanda trainers. Other unforeseen expenses included medical consumables for training exercises, such as gloves and sterile gauze, due to UN restrictions on petty cash.

Equipment pre-inventory in-country and in the targeted health facilities was flagged as an efficiency factor: i) to ensure knowledge and skills could be replicated afterwards; and ii) to assess if non-delivery of training equipment could be mitigated with local resources. On the other hand, IPs outlined good planning practices promoted by UNITAR to anticipate needs and organize inter-service borrowing.

Elaboration of agreements with implementing partners and UNITAR's transition to a new financial management system resulted in delays in the disbursal of funds. IPs reported that they had to advance or borrow first training expenses. The situation was quickly redressed but hampered the partnership kick off.

Likelihood of impact - satisfactory

Eighteen per cent of respondents surveyed were deployed to the field where they uncontestably used the skills they learned. Among the other 82 per cent of respondents, 62 per cent applied knowledge in-country, at work or in their private lives, against 20 per cent who did not apply it at all due to a lack of opportunities and relevance in national contexts. These trends were confirmed by testimonies collected through follow-up interviews.

The most impactful skills in-country and when deployed related to the treatment of extensive bleeding and tourniquet application, followed by Cardiopulmonary Resuscitation (CPR) and triage skills. Training in stress management and listening skills changed professionals' approach to mental health, with examples

shared in the field and in-country. Identified MHPSS good practices were applied at work or during training and include response to burnout, engaging in sport to defuse stress, taking leave to recover and accepting one's emotions, such as crying.

No major differences were observed between male and female participants, but differences exist in the application of the learning on casualty management.[5] For instance, 22 per cent of women did not apply learning at all from the basic training, compared with 13 per cent of male participants; 40 per cent of female participants did not apply learning from advanced training compared with 24 per cent of male participants; and 100 per cent of women from the advanced group applied techniques of MHPSS, compared with 83 per cent men. Seventy per cent of all participants noted an increase in confidence, with a marked increase for 79 per cent of women.

Two stories from chief medical officers deployed to the field outlined how hierarchy and training triggered changes. In MINUSMA, the chief medical officer requested adding TCCC to the ongoing training and recruiting a female gynaecologist. In Niger, the medical service was thanked for its prompt and effective response to an attack on a military contingent. The connection with UNITAR training and equipment donation was established and an official gratitude letter was sent. In MINUSCA, one participant reportedly saved a colleague's life by applying a tourniquet after an accident.

Likelihood of sustainability -satisfactory

The sustainability of the project depends on governmental prerogatives to deploy trained participants and to support skill maintenance at work. UNITAR sets possible leverage in such conditions by engaging with T/PCCs that committed to deploy troops, such as Kenya to Haiti, and encouraging good practices, such as the relevant selection of participants or, after training, posting and offering ToTs as part of advanced trainings.

The instruction of trainers appeared as a simple and effective tool to replicate and propagate learning. Survey responses and testimonies reported that 53 per cent of participants delivered training on their own after participating in the project, out of which, 46 per cent were women. Examples included large audiences, such as 1,300 members of Formed Police Units in the Ecole de Maintien de la Paix Alioune Blondin Beye (EMPABB). Thirty-seven trainers were recruited and trained to implement the project. These actions reinforce a pool of specialised trainers and expand knowledge about MHPSS.

The mobile application's promotion was in the making as a new partnership was being discussed. The evaluation finds future projects must consider promotion of the app in training agendas, and define its use and users. This is in comparison to existing applications, such as the UN Buddy First Aid app, which presents a good balance between the number of words included and clarity of the content as well as visual explanation.

The evaluation surveys corroborate the Final Narrative Report (FNR) recommendations to expand the training to other partners, and expand options on TCCC and MHPSS as a sustainability factor. Forty-three per cent of participants had never been trained on mental health before the project. Sixty per cent of the basic training participants reported they didn't have any opportunities for continued training against 37 per cent among the advanced training participants.

The FNR from Kenya and responses of interviewees stress the importance of

[5] It is relevant to note that only 2 female participants from the basic training surveyed indicated that they were deployed, and 8 female participants are to be deployed, from a small sample of 15 female participants that completed the survey.

equipment support and guarding against skill fade, where a person loses proficiency in a skill due to a lack of use over time. A lack of practice increases the risk of forgetting care protocols and first aid reflexes. Continuous equipment support is instrumental in maintaining progress in deploying uniformed medical and paramedical personnel who are well prepared. The kits donated to partner T/PCCs contributed to this effort.

Conclusions and recommendations

Overall, the evaluation found that the project was strategic for the comprehensive outlook of peacekeeping performance and continuity in good practices by promoting gender and building training capacity in countries.

The recommendations mostly consist of continuing and expanding support, and upscaling the identification of the target population and number and quality of teaching sessions. The evaluation has led to the following five recommendations:

High priority

R1. UNITAR should deepen engagement with T/PCCs and project IPs on the role of health in the safety and well-being of peacekeepers and a mission's performance. This should be expanded to other T/PCCs that rank among the most vulnerable to fatalities. UNITAR should consider adapting training content to include the biggest risks experienced by T/PCC personnel. It should also explore the need for the confidential exchange of information on the causes of deaths and injuries of personnel deployed to tailor the training offer accordingly, for example, by confirming DPO statistics with the T/PCC. This recommendation focuses on building a new narrative around a mission's performance, and promoting a comprehensive approach and awareness about the impact of predeployment preparation.

R2. UNITAR should continue to raise the awareness of health professionals on gender-sensitive needs in peacekeeping environments and the consequences on medical management. It should establish the link between a conducive health environment and recruitment attractiveness. It should illustrate modules with examples from other GAC research, such as barriers to peacekeepers with caring responsibilities. It should also expand modules on the consequences of cultural expectations of men on mental health, sexual and reproductive rights, and sexual orientation, with examples.

R3. UNITAR should strengthen its stocktaking of existing medical equipment within T/PCCs to better define needs.

It should strengthen inventory stocktaking of equipment of the host facility to better establish how UNITAR can complement and bridge equipment gaps during and after training, including practical exercises, so as to obtain a precise list for material support that IP FNR recommendations do not reflect, except for the Administration Police Service (APS), Kenya. UNITAR should follow-up with recipients on the use of equipment.

R4. UNITAR should mainstream the mobile app, or other learning reinforcement tools, in the training. The future deployment of the app should define use and users to differentiate it from other apps.

UNITAR should clarify if the app aims to support training and learning or to address on-the-spot emergencies. Depending on the dissemination strategy adopted, the layout could display a more intuitive table of contents, with a search option, reduced length of text and increased visuals.

Medium priority

R5. UNITAR should either reformulate intermediate outcomes/indicators or ensure that those that are formulated are supported with data to enable measurement and monitoring of progress towards defined targets. Consideration should be given to the formulation of the project's intermediate outcome (enhanced

physical and mental well-being of male and female military and police personnel deployed to the four high-risk missions) and the void in data on the impact of mental health in the performance of peacekeeping missions. With these considerations in mind, it is recommended to either include questions on mental health in pre-training questionnaires to collect internal baseline information and inform targets, while respecting the anonymity of respondents and the principle of do no harm, or reformulate intermediate outcomes/indicators related to MHPSS that can be realistically measured.

Lessons learned

L1. Adaptive management is key when project interventions are highly dependent on the national security context. Selecting new intervention countries indicated agility in project management. An example of adaptative management is to partner with T/PCCs as soon as they commit to deploy troops, which also requires flexible and available funding, increasing the likelihood of knowledge application and project impact.

L2. Mobile applications can potentially be useful tools for learning reinforcement and sustainability when appropriately promoted.

L3. Communicating participant selection criteria, including gender and scheduled deployment to a UN peacekeeping mission, to beneficiary countries helps to influence the target group characteristics. However, these remain highly dependent on external factors related to gender imbalance in the military and police as well as UN peacekeeping mission troop requirements.

L4. Training of trainers has a double benefit: (i) having trainers with an understanding of the local context to deliver training activities; and (ii) strengthening training capacities within countries to train additional participants outside of the project and in the future as part of its multiplication effect. Furthermore, clear trainer selection criteria are key when applied throughout, resulting in higher satisfaction rates from training participants.

L5. Adequate and similar equipment is key to allow for the successful application of knowledge and skills in the medical context.

L6. Training medical and paramedical professionals jointly is innovative, ignoring hierarchy and favouring the exchange of very diverse experiences.

Résumé exécutif

Introduction et contexte

Depuis 2014,[6] l'Unité du Programme de formation au maintien de la paix de l'UNITAR, par l'intermédiaire de sa Section de formation et de conseil avant déploiement (PDTA), a soutenu les pays contributeurs de troupes et de police (T/PCC) avec une formation avant déploiement et, depuis 2018, la section a élargi son soutien à l'amélioration du bien-être du personnel en uniforme, augmentant ainsi l'efficacité de la mission. L'UNITAR a d'abord développé un « kit de ressources », un manuel compilant des techniques d'autosoins et de thérapie des traumatismes, et a piloté un système de soutien dans lequel deux personnes ou « buddies » s'entraident. Le travail sur la santé s'est ensuite étendu à la formation des professionnels de la santé en uniforme des contingents militaires et des unités de police constituées dans la phase I du projet « Enhancing the Capacities of Uniformed Medical Personnel deployed to UN Peace Operations », mis en œuvre entre mars 2020 et avril 2021.

Cette évaluation porte sur la phase II du projet susmentionné intitulé « Enhanced Training for Uniformed Medical Personnel Deploying to UN Peace Operations » qui s'est déroulée du 24 décembre 2021 au 30 janvier 2024, et a été prolongée jusqu'au 30 juin 2024. Les deux phases ont été financées par Affaires mondiales Canada (AMC) par l'intermédiaire du ministère des Affaires étrangères, du Commerce et du Développement (DFATD) pour « améliorer la performance des opérations de paix de l'ONU dans des environnements de plus en plus complexes et à haut risque en améliorant le bien-être physique et mental du personnel militaire et policier, féminin et masculin, déployé dans les missions de maintien de la paix de l'ONU ». Cet objectif devait être atteint en « renforçant les capacités, la motivation (sensibilisation) et les possibilités du personnel médical et paramédical masculin et féminin (militaire et policier) déployé dans les opérations de maintien de la paix des Nations unies pour traiter les traumatismes physiques et psychologiques d'une manière qui tienne compte des spécificités de chaque sexe et en fournissant du matériel de formation ».

Le projet ciblait les T/PCC déployés dans quatre opérations de paix de l'ONU à haut risque : la Mission multidimensionnelle intégrée des Nations Unies pour la stabilisation au Mali (MINUSMA), qui est maintenant fermée ; la Mission de stabilisation de l'Organisation des Nations Unies en République démocratique du Congo (MONUSCO), qui se retire ; la Mission des Nations Unies au Sud-Soudan (UNMISS) ; et la Mission multidimensionnelle intégrée des Nations Unies pour la stabilisation en République centrafricaine (MINUSCA). Les bénéficiaires du projet étaient des pays francophones et anglophones, notamment le Tchad, le Ghana, le Kenya, le Niger, le Rwanda, le Sénégal, la Tanzanie et le Togo. La mise en œuvre des activités a été soutenue par quatre partenaires de mise en œuvre : l'Académie de la paix du Rwanda (APR), les forces de police tanzaniennes (TPF), le service de police administrative du Kenya (APS) et le département des services médicaux des forces armées ghanéennes.

Objectif, champ d'application et méthodologie

L'évaluation porte sur la pertinence, la cohérence, l'efficacité, l'efficience, la probabilité d'impact et la probabilité de

[6] Exploring Well-Being in Peace Operations, Sustaining peace with a healthy mind, UNITAR 2019

durabilité du projet dans sa deuxième phase, qui sert à des fins d'apprentissage et de responsabilisation. Elle est tournée vers l'avenir afin d'éclairer les décisions relatives à la conception et à la planification d'éventuelles phases futures et de domaines d'intervention de projets similaires.

L'évaluation est basée sur une approche de méthodes mixtes combinant des outils qualitatifs et quantitatifs qui sont sensibles au genre. L'évaluation a été entreprise par une équipe de deux évaluateurs entre août et novembre 2024, y compris des visites de terrain aux organisations partenaires d'exécution au Kenya et en Tanzanie en août 2024.

Les évaluateurs ont examiné des documents et mené des entretiens en personne et à distance avec 46 parties prenantes du projet présentes dans tous les pays d'exécution, à l'exception du Sénégal et du donateur (GAC). Trois enquêtes en ligne, en anglais et en français, ont été envoyées au personnel médical et paramédical de la police et de l'armée participant à la formation de base et à la formation avancée, ainsi qu'aux formateurs, et 95 réponses ont été recueillies. Parmi les parties prenantes consultées tout au long de l'évaluation, 23 pour cent étaient des femmes et 77 pour cent des hommes. Malheureusement, il n'a pas été possible d'observer un événement de formation car l'évaluation a eu lieu après la période de mise en œuvre du projet. Il n'a pas non plus été possible de contacter les bénéficiaires déployés dans des missions de maintien de la paix pour s'enquérir des capacités nécessaires et des changements observés après le déploiement. L'évaluation ci-dessous est principalement basée sur les témoignages des participants.

Les principales limites rencontrées par l'évaluation sont les suivantes : le manque de contacts et de réponses des participants dans les pays francophones (aucune coordonnée n'était disponible pour le Sénégal et le Tchad), qui n'a pas pu être compensé par des missions sur le terrain compte tenu du budget limité alloué à l'évaluation (des missions ont été organisées au Kenya et en Tanzanie) ; et l'accès limité à certaines parties prenantes identifiées lors de la phase de démarrage de l'évaluation. L'évaluation a également eu un accès limité aux informations sur les qualifications médicales et la catégorie des participants, ce qui a limité la désagrégation des données.

Principales constatations

Pertinence - très satisfaisant

Le projet s'aligne sur l'Objectif de développement durable (ODD) 16 visant à promouvoir des sociétés pacifiques, justes et inclusives ; et sur le sous-objectif 1.1 du cadre stratégique 2022-2025 de l'UNITAR visant à « Soutenir les institutions et les individus pour contribuer de manière significative à une paix durable ». En outre, le projet s'aligne sur les efforts des donateurs pour promouvoir l'inclusion et la représentation des femmes dans le domaine du maintien de la paix

La conception du projet est très pertinente en s'engageant avec 8 des 20 principaux T/PCC africains, qui se classent parmi les plus vulnérables aux accidents mortels. Selon les statistiques du Département des opérations de paix des Nations unies (DPO), le Burkina Faso, le Tchad, l'Éthiopie, le Ghana, le Kenya, le Niger, le Rwanda, le Sénégal, la Tanzanie et le Togo représentent 34 pour cent des décès au cours des phases du projet (2021-2024). Sur la même période, la maladie représente 65 pour cent des décès, tandis que les actes de malveillance et les accidents atteignent 29 pour cent à l'UNMISS, à la MONUSCO, à la MINUSMA et à la MINUSCA. Les militaires représentent 46 pour cent des victimes et jusqu'à 89 pour cent lorsqu'il s'agit d'actes malveillants. En réponse, le projet a ciblé les soins aux victimes de combat tactique (TCCC) et les conséquences mentales, qui ne sont pas encore documentées mais dont on sait qu'elles ont des conséquences majeures sur le bien-être individuel et la

dynamique collective au sein des missions de maintien de la paix.

L'absence de statistiques régulières et actualisées sur la santé mentale et le soutien psychosocial (MHPSS) est notable. Le projet s'attaque à une situation qui toucherait entre 5 et 20 pour cent du personnel déployé. En tant que tels, les objectifs du projet sont jugés très pertinents, et dans une certaine mesure avant-gardistes, pour répondre à un besoin organisationnel, renforcer les capacités dans le cadre d'une nouvelle compétence et améliorer le contenu du pré-déploiement.

Quarante-trois pour cent des bénéficiaires qui ont répondu à l'une des enquêtes d'évaluation ont indiqué qu'ils n'avaient jamais reçu de formation sur MHPSS auparavant. Les modules TCCC ont été jugés très pertinents par les professionnels médicaux et paramédicaux qui manquent d'occasions de pratiquer dans leur contexte national et qui apprécient les remises à niveau ou les nouveaux cours de formation. La variété des sujets abordés répond à un large éventail de besoins et de capacités des professionnels de la santé, comme l'ont confirmé et apprécié les personnes interrogées et les répondants à l'enquête.

L'expertise en matière de gestion de projet et le suivi étroit, y compris la participation à de multiples événements, ont permis un processus d'apprentissage efficace. Les conclusions et les recommandations de la première phase du projet ont été appliquées à la deuxième phase et comprenaient l'élaboration de nouveaux matériels de formation sur la santé mentale et le soutien psychosocial, l'achat de kits de santé, la poursuite de l'intégration de la participation des femmes, ainsi que des ateliers et des visites préparatoires pour assurer le bon déroulement de la formation.

Certains défis, tels que l'élargissement de la liste des formatrices francophones, bien que signalés dès le départ, n'ont pas été relevés, en partie en raison des changements intervenus dans les contextes des pays bénéficiaires, tels que le Burkina Faso et le Niger, où les activités ont été suspendues après les coups d'État militaires de septembre 2022 et de juillet 2023.

La contribution de l'évaluation des besoins à l'élaboration de la conception de la deuxième phase a été faible, et la deuxième phase a davantage bénéficié du processus d'apprentissage interne de la direction du projet que de la mise en œuvre de la première phase. Dans l'évaluation des besoins, les statistiques de l'UN DPO ne sont pas suffisamment désagrégées pour déterminer les compétences qui manquent pour sauver des vies, ni pour savoir dans lequel des quatre niveaux médicaux classifiés des Nations unies les décès ont été déclarés. En outre, l'évaluation des besoins ne fixe pas d'objectifs, ne définit pas de groupe cible et ne distingue pas le groupe cible de la population d'accueil, ce qui crée une certaine confusion. Les sections consacrées à l'exploitation et aux abus sexuels (SEA) et aux violences sexuelles liées aux conflits (CRSV) présentent des statistiques nationales et n'explorent pas les conséquences pour les professionnels de la santé, les compétences nécessaires ou les procédures à connaître pour signaler les violations en tant que praticien en uniforme ou en tant que victime.

Cohérence - très satisfaisant

L'équipe de gestion du projet a été très sensible à l'environnement des Nations unies qui a reconnu l'impact de la santé mentale sur la performance des opérations de maintien de la paix et le bien-être du personnel en uniforme. Elle s'est alignée sur les déclarations de politique générale et la visibilité marquée par : l'enquête de 2017 sur le bien-être du personnel des Nations unies; la première stratégie des Nations unies sur la santé mentale et le bien-être en 2018 ; le point 4.2 du plan Action for Peacekeeping Plus sur l'amélioration de la sécurité et du bien-être du personnel qui contribue à créer un environnement favorable à la participation significative des femmes au maintien de la paix ; la conférence ministérielle des Nations unies

sur le maintien de la paix de 2023 au Ghana ; et la résolution de décembre 2022 sur la santé mentale (S/RES/2668), qui cible spécifiquement le pré-déploiement et la préparation mentale.

L'accent mis sur l'égalité des sexes est conforme à la politique d'aide internationale féministe du Canada et aux engagements des Nations unies visant à améliorer l'inclusion des femmes dans les processus de paix (résolution 2242 du Conseil de sécurité des Nations unies et objectifs de développement durable pour 2028). Il est cohérent avec les politiques de l'UNITAR en matière d'égalité des sexes et d'autonomisation des femmes (GEEW) qui visent la parité entre les sexes par le biais d'une expertise interne en matière de genre, de rapports sensibles au genre et de demandes systématiques aux partenaires d'organiser des événements équilibrés en termes de genre, de recruter des formateurs féminins et de former des participantes féminines.

Le projet n'a pas chevauché ou concurrencé d'autres cadres de référence. La décision de se référer au Buddy First Aid Course (BFAC) des Nations unies, au guide de l'Organisation mondiale de la santé sur les premiers secours psychologiques (PFA) et au Comité permanent interorganisations (IASC) témoigne d'une approche cohérente : la connaissance et l'utilisation des ressources existantes.

Le projet est cohérent avec le mandat de l'UNITAR de soutenir la capacité de pré-déploiement des T/PCC et avec les efforts récents pour développer et intégrer le contenu lié à la santé et à la santé mentale. L'examen du portefeuille de projets de l'UNITAR fait état d'initiatives similaires, notamment la fourniture de kits de premiers secours (BFAK) et la promotion de la santé mentale et des services psychologiques dans les environnements de maintien de la paix, tels que le développement d'une unité psychiatrique au Mali. Le projet a évité de répéter les programmes menés par l'Initiative mondiale pour les opérations de paix (GPOI) avec l'armée tanzanienne et s'est plutôt engagé avec la TPF.

L'examen des initiatives externes et la comparaison des programmes entrepris par les répondants à l'enquête concluent à l'approche holistique du projet en matière de santé. D'autres projets ont abordé les sujets séparément : TCCC uniquement, TCCC et PFA, ou PFA uniquement. Le projet a introduit une composante de santé mentale, en plus du genre, ciblant spécifiquement le personnel médical et paramédical en uniforme susceptible d'être déployé dans des installations médicales de niveau 1 dans le cadre des missions de maintien de la paix.

Efficacité – satisfaisante

Le projet a mis en œuvre des activités de formation dans les délais et a dépassé les objectifs numériques. Vingt-deux événements de formation ont été organisés et 319 membres du personnel en uniforme (359 si l'on tient compte de la participation multiple) ont bénéficié de la formation. Les plans initiaux prévoyaient 16 événements et un objectif de 240 bénéficiaires. L'application UN MissionMed a été mise à jour sur Android, développée pour iOS et traduite en français. Le résultat immédiat concernant les téléchargements de l'application (70 téléchargements par rapport à un objectif de 112) a été mis en pause pendant que le partenariat et l'orientation stratégique étaient discutés.

Le projet a moins bien réussi à atteindre les objectifs en matière de genre pour des raisons structurelles indépendantes de la volonté de l'UNITAR. Malgré la promotion de l'inclusion du genre à travers les critères de sélection et la priorité de recrutement accordée aux femmes, seules 70 femmes ont participé à la formation de base et à la formation avancée, ce qui correspond à 22 pour cent du nombre total de participants. Onze femmes ont participé à la formation des formateurs, ce qui correspond à 30 pour cent de cette formation.

La formation des formateurs complète a touché 10 participants francophones, soit

59 pour cent. Sur les quatre participantes à la formation des formateurs, il n'y avait aucune femme francophone.

Le contenu de la formation et le professionnalisme des formateurs ont été salués par les répondants à l'enquête. L'approche consistant à inclure des formateurs régionaux et internationaux a permis des perspectives complémentaires et a été appréciée par les participants, mêlant l'expérience du maintien de la paix de l'ONU et la connaissance des contextes régionaux, nationaux et locaux. Les participants ont à plusieurs reprises qualifié les formateurs de « parfaits » et d'« excellents ».

Le contenu tactique a été particulièrement apprécié par le personnel de santé, qui est généralement formé aux aspects médicaux, mais rarement aux soins liés au combat. Les personnes interrogées ont souligné que les techniques les plus efficaces incluses dans la formation étaient le traitement des hémorragies importantes, la pose de garrots, la gestion du stress et les considérations psychologiques lors de la prise en charge des blessés.

La décision d'impliquer conjointement les professionnels médicaux et paramédicaux a été jugée innovante, ignorant la hiérarchie et favorisant l'échange d'expériences très diverses. Les participants ont fait l'éloge de l'inclusion et de l'égalité de traitement et ont qualifié l'expérience de « très enrichissante ». La principale observation négative concernait la durée de la formation, jugée trop courte, en particulier pour la formation avancée.

La contribution aux résultats intermédiaires et finaux n'a pas pu être évaluée en raison du manque de données et d'objectifs définis. Le projet peut avoir contribué à la diminution du nombre de décès au sein des opérations de maintien de la paix entre 2020 et 2024 (une réduction de 50 pour cent), mais d'autres programmes de formation et des changements contextuels, tels que le retrait de la MINUSMA du Mali, y ont également contribué.

Efficience – satisfaisante

Les modalités de partenariat du projet sont efficaces en termes de temps et de coûts, en s'appuyant sur une mise en œuvre décentralisée et des responsabilités financières proportionnelles. Les partenaires au Ghana, au Kenya et en Tanzanie (le Ghana et la Tanzanie étant de nouveaux partenaires) ont été chargés de la gestion des activités de formation et des coûts locaux, tandis que RPA, qui a mis en œuvre 10 projets avec l'UNITAR depuis 2018, a été chargé de la gestion complète des événements et du budget de 5 des 11 événements de formation au Burkina Faso, au Ghana, au Sénégal, en Tanzanie et au Togo. Cette approche proportionnelle du partenariat a été judicieuse et efficace. L'UNITAR a mobilisé efficacement un réseau de partenaires d'exécution pour toucher les entités et les établissements de santé pertinents, et a remplacé en douceur les partenaires du Burkina Faso et du Niger qui ont été contraints de se retirer en raison de l'instabilité dans le pays, laissant un mélange de nouveaux partenaires médicaux et dans le pays et de partenaires de formation solides et de longue durée, avec une capacité de mobilisation régionale et bilingue.

Dans l'ensemble, la communication du projet a été jugée bonne. La réactivité et la proactivité ont été saluées dans les relations avec le donateur et les partenaires d'exécution. Des problèmes de transparence structurelle ont été constatés lors de la sélection des participants, sans que cela n'entrave la réussite du projet.

Bien qu'elle ne représente qu'une part minime du budget global (2 pour cent ou 52 708 dollars pour le développement de l'iOS et la traduction en français), l'efficacité de l'application mobile a été jugée faible. Seuls 13 pour cent des répondants à l'enquête connaissaient l'application, et 88 pour cent d'entre eux l'utilisaient en anglais. Aucune des personnes interrogées dans le cadre de l'évaluation, y compris les formateurs, ne la connaissait. Cette situation devrait changer, car un nouveau partenariat

devrait lancer officiellement l'application par l'intermédiaire des points focaux et des bénéficiaires (voir Probabilité de durabilité, page 55).

Les personnes interrogées ont signalé que quelques coûts non budgétisés ont entravé la dynamique de la formation au début, notamment des documents qui devaient être traduits en swahili pour la Tanzanie puisque le pays ne faisait pas initialement partie des T/PCC soutenus, donc non budgétisés, et l'interprétation en français au Rwanda, malgré l'attention portée au recrutement de formateurs natifs du Kinyarwanda. D'autres dépenses imprévues comprenaient des consommables médicaux pour les exercices de formation, tels que des gants et de la gaze stérile, en raison des restrictions imposées par les Nations unies sur la petite caisse.

L'inventaire préalable du matériel dans le pays et dans les établissements de santé ciblés a été signalé comme un facteur d'efficacité : i) pour garantir que les connaissances et les compétences puissent être reproduites par la suite ; et ii) pour évaluer si la non-livraison du matériel de formation pouvait être atténuée par des ressources locales. D'autre part, les partenaires d'exécution ont souligné les bonnes pratiques de planification promues par l'UNITAR pour anticiper les besoins et organiser les emprunts entre services.

L'élaboration d'accords avec les partenaires d'exécution et la transition de l'UNITAR vers un nouveau système de gestion financière ont entraîné des retards dans le décaissement des fonds. Les partenaires d'exécution ont indiqué qu'ils avaient dû avancer ou emprunter les premières dépenses de formation. La situation a été rapidement redressée mais a entravé le lancement du partenariat.

Probabilité d'impact - satisfaisante

Dix-huit pour cent des personnes interrogées ont été déployées sur le terrain où elles ont incontestablement utilisé les compétences acquises. Parmi les 82 pour cent restants, 62 pour cent ont appliqué les connaissances dans le pays, au travail ou dans leur vie privée, contre 20 pour cent qui ne les ont pas appliquées du tout en raison d'un manque d'opportunités et de pertinence dans les contextes nationaux. Ces tendances ont été confirmées par les témoignages recueillis lors des entretiens de suivi.

Les compétences qui ont eu le plus d'impact dans le pays et lors du déploiement concernaient le traitement des hémorragies importantes et la pose de garrots, suivies par la réanimation cardio-pulmonaire (CPR) et les compétences en matière de triage. La formation à la gestion du stress et à l'écoute a modifié l'approche des professionnels en matière de santé mentale, avec des exemples partagés sur le terrain et dans le pays. Les bonnes pratiques de la MHPSS identifiées ont été appliquées au travail ou pendant la formation et comprennent la réponse à l'épuisement professionnel, la pratique d'un sport pour désamorcer le stress, la prise de congés pour récupérer et l'acceptation de ses émotions, comme les pleurs.

Aucune différence majeure n'a été observée entre les participants masculins et féminins, mais des différences existent dans l'application de l'apprentissage sur la gestion des accidents. Par exemple, 22 pour cent des femmes n'ont pas du tout appliqué les connaissances acquises lors de la formation de base, contre 13 pour cent des participants masculins ; 40 pour cent des participantes n'ont pas appliqué les connaissances acquises lors de la formation avancée, contre 24 pour cent des participants masculins ; et 100 pour cent des femmes du groupe avancé ont appliqué les techniques de la MHPSS, contre 83 pour cent des hommes. Soixante-dix pour cent de tous les participants ont noté une augmentation de leur confiance en soi, avec une augmentation marquée pour 79 pour cent des femmes.

Deux récits de médecins-chefs déployés sur le terrain décrivent comment la hiérarchie et la formation ont déclenché des

changements. À la MINUSMA, le médecin-chef a demandé d'ajouter la TCCC à la formation en cours et de recruter une femme gynécologue. Au Niger, le service médical a été remercié pour sa réponse rapide et efficace à une attaque contre un contingent militaire. Le lien avec la formation et le don d'équipement de l'UNITAR a été établi et une lettre officielle de remerciement a été envoyée. Au MINUSCA, un participant aurait sauvé la vie d'un collègue en posant un garrot après un accident.

Probabilité de la durabilité – satisfaisante

La durabilité du projet dépend des prérogatives gouvernementales de déployer les participants formés et de soutenir le maintien des compétences sur le lieu de travail. L'UNITAR met en place un levier possible dans de telles conditions en s'engageant avec les T/PCC qui se sont engagés à déployer des troupes, comme le Kenya en Haïti, et en encourageant les bonnes pratiques, telles que la sélection des participants pertinents ou, après la formation, l'affectation et l'offre de formations des formateurs dans le cadre de formations avancées.

La formation des formateurs est apparue comme un outil simple et efficace pour reproduire et propager l'apprentissage. Les réponses à l'enquête et les témoignages indiquent que 53 pour cent des participants ont dispensé eux-mêmes des formations après avoir participé au projet, dont 46 pour cent sont femmes. Les exemples incluent de larges audiences, telles que 1 300 membres d'unités de police formées à l'Ecole de Maintien de la Paix Alioune Blondin Beye (EMPABB). Trente-sept formateurs ont été recrutés et formés pour mettre en œuvre le projet. Ces actions renforcent un pool de formateurs spécialisés et développent les connaissances sur la MHPSS.

La promotion de l'application mobile était en cours d'élaboration alors qu'un nouveau partenariat était en cours de discussion. L'évaluation montre que les projets futurs doivent envisager la promotion de l'application dans les programmes de formation et définir son utilisation et ses utilisateurs. Ceci est en comparaison avec les applications existantes, telles que l'application UN Buddy First Aid, qui présente un bon équilibre entre le nombre de mots inclus et la clarté du contenu ainsi que l'explication visuelle.

Les enquêtes d'évaluation corroborent les recommandations du rapport narratif final (FNR) d'étendre la formation à d'autres partenaires et d'élargir les options sur le TCCC et la MHPSS en tant que facteur de durabilité. Quarante-trois pour cent des participants n'avaient jamais été formés à la santé mentale avant le projet. Soixante pour cent des participants à la formation de base ont indiqué qu'ils n'avaient aucune possibilité de formation continue, contre 37 pour cent des participants à la formation avancée.

Le rapport narratif final du Kenya et les réponses des personnes interrogées soulignent l'importance du soutien matériel et de la protection contre l'affaiblissement des compétences, c'est-à-dire le fait qu'une personne perde la maîtrise d'une compétence en raison d'un manque d'utilisation au fil du temps. Le manque de pratique augmente le risque d'oublier les protocoles de soins et les réflexes de premiers secours. Un soutien continu en matière d'équipement est essentiel pour continuer à déployer du personnel médical et paramédical en uniforme bien préparé. Les kits donnés aux partenaires T/PCCs ont contribué à cet effort.

Conclusions and recommandations

Dans l'ensemble, l'évaluation a montré que le projet était stratégique pour la vision globale des performances du maintien de la paix et la continuité des bonnes pratiques en promouvant l'égalité des sexes et en renforçant les capacités de formation dans les pays.

Les recommandations portent principalement sur la poursuite et l'extension du soutien, ainsi que sur

l'identification de la population cible et sur le nombre et la qualité des sessions d'enseignement. L'évaluation a débouché sur les cinq recommandations suivantes :

Priorité élevée

R1. L'UNITAR devrait approfondir l'engagement avec les T/PCC et les partenaires d'exécution sur le rôle de la santé dans la sécurité et le bien-être des soldats de la paix et la performance d'une mission. Cet engagement devrait être étendu à d'autres T/PCC qui se classent parmi les plus vulnérables aux accidents mortels. L'UNITAR devrait envisager d'adapter le contenu de la formation afin d'inclure les risques les plus importants encourus par le personnel des T/PCC. Elle devrait également explorer la nécessité d'un échange confidentiel d'informations sur les causes des décès et des blessures du personnel déployé afin d'adapter l'offre de formation, par exemple en confirmant les statistiques du DPO avec le T/PCC. Cette recommandation est axée sur la construction d'un nouveau discours autour de la performance d'une mission, et sur la promotion d'une approche globale et d'une prise de conscience de l'impact de la préparation au déploiement.

R2. L'UNITAR devrait continuer à sensibiliser les professionnels de la santé aux besoins sexospécifiques dans les environnements de maintien de la paix et aux conséquences sur la gestion médicale. Elle devrait établir le lien entre un environnement sanitaire favorable et l'attrait du recrutement. Elle devrait illustrer les modules par des exemples tirés d'autres recherches du GAC, tels que les obstacles auxquels se heurtent les soldats de la paix ayant des responsabilités familiales. Elle devrait également développer les modules sur les conséquences des attentes culturelles à l'égard des hommes sur leur santé mentale, les droits sexuels et reproductifs et l'orientation sexuelle, en les illustrant d'exemples.

R3. L'UNITAR devrait renforcer son inventaire de l'équipement médical existant au sein des T/PCC afin de mieux définir les besoins.

Elle devrait renforcer l'inventaire de l'équipement de l'établissement d'accueil pour mieux établir comment l'UNITAR peut compléter en matière d'équipement pendant et après la formation, y compris les exercices pratiques, afin d'obtenir une liste précise du soutien matériel que les recommandations dans les rapports narratifs finaux des partenaires d'exécution ne reflètent pas, à l'exception du Service de police administrative Kényan. L'UNITAR devrait assurer un suivi avec les bénéficiaires sur l'utilisation de l'équipement.

R4. L'UNITAR devrait intégrer l'application mobile, ou d'autres outils de renforcement de l'apprentissage, dans la formation. Le déploiement futur de l'application devrait définir l'utilisation et les utilisateurs afin de la différencier des autres applications.

L'UNITAR devrait clarifier si l'application vise à soutenir la formation et l'apprentissage ou à répondre aux urgences sur le terrain. En fonction de la stratégie de diffusion adoptée, la mise en page pourrait présenter une table des matières plus intuitive, avec une option de recherche, une longueur de texte réduite et davantage de visuels.

Priorité moyenne

R5. L'UNITAR devrait soit reformuler les résultats/indicateurs intermédiaires, soit veiller à ce que ceux qui sont formulés soient soutenus par des données permettant de mesurer et de suivre le progrès dans la réalisation des objectifs définis. Il convient de prendre en considération la formulation du résultat intermédiaire du projet (amélioration du bien-être physique et mental du personnel militaire et policier masculin et féminin déployé dans les quatre missions à haut risque) et le manque de données sur l'impact de la santé mentale sur la performance des missions de maintien de la paix. Compte tenu de ces considérations, il est recommandé soit d'inclure des

questions sur la santé mentale dans les questionnaires préalables à la formation afin de recueillir des informations de base internes et de s'informer sur les cibles, tout en respectant l'anonymat des répondants et le principe de ne pas nuire, soit de reformuler les résultats/indicateurs intermédiaires liés à la MHPSS qui peuvent être mesurés en pratique.

Leçons apprises

L1. La gestion adaptative est essentielle lorsque les interventions du projet dépendent fortement du contexte de la sécurité nationale. La sélection de nouveaux pays d'intervention a révélé une certaine agilité dans la gestion du projet. Un exemple de gestion adaptative consiste à établir des partenariats avec les T/PCC dès qu'ils s'engagent à déployer des troupes, ce qui nécessite également un financement flexible et disponible, augmentant ainsi la probabilité d'application des connaissances et l'impact du projet.

L2. Les applications mobiles peuvent potentiellement être des outils utiles pour le renforcement et la durabilité de l'apprentissage lorsqu'elles font l'objet d'une promotion appropriée.

L3. La communication aux pays bénéficiaires des critères de sélection des participants, y compris le sexe et le déploiement prévu dans une mission de maintien de la paix des Nations unies, contribue à influencer les caractéristiques du groupe cible. Cependant, celles-ci restent fortement dépendantes de facteurs externes liés au déséquilibre entre les sexes dans l'armée et la police, ainsi qu'aux besoins en troupes des missions de maintien de la paix des Nations unies.

L4. La formation des formateurs présente un double avantage : (i) disposer de formateurs ayant une bonne compréhension du contexte local pour donner des formations ; et (ii) renforcer les capacités de formation au sein des pays afin de former d'autres participants en dehors du projet et à l'avenir dans le cadre de son effet multiplicateur. En outre, des critères clairs de sélection des formateurs sont essentiels lorsqu'ils sont appliqués à l'ensemble du projet, ce qui se traduit par des taux de satisfaction plus élevés de la part des participants à la formation.

L5. Un équipement approprié et similaire est essentiel pour permettre l'application réussie des connaissances et des compétences dans le contexte médical.

L6. La formation conjointe de professionnels médicaux et paramédicaux est innovante, ignorant la hiérarchie et favorisant l'échange d'expériences très diverses.

Acronyms and Abbreviations

AU	African Union
A4P	Action for Peacekeeping
APS	Administration Police Service
BFAC	Buddy First Aid Course
BFAK	Buddy First Aid Kit
BFMAC	Basic Field Medical Assistants Course
BPTC	Border Police Training Campus
CAN$	Canadian Dollar
CAR	Central African Republic
CPR	Cardiopulmonary Resuscitation
CRSV	Conflict-Related Sexual Violence
CUAMM	Collegio Universitario Apiranti e Medici Missionari
DPO	Department of Peace Operations
DRC	Democratic Republic of Congo
DSA	Daily Subsistence Allowances
ENVSUSE	Environmental Sustainability in Evaluation
FAMa	Forces Armées Maliennes
FMAC	Field Medical Assistants Course
FMAK	First Medical Aid Kit
FNR	Final Narrative Report
FPU	Formed Police Unit
GAC	Government of Canada Cooperation, Global Affairs Canada
GEEW	Gender Equality and Empowerment of Women
GPOI	Global Peace Operations Initiative
HQ	Headquarters
IASC	Inter-Agency Standing Committee
IOM	International Organization for Migration
IP	Implementing Partner
LoA	Letter of Agreement
MA	Malicious Act
MHPSS	Mental Health and Psychosocial Support
MINUSCA	United Nations Multidimensional Integrated Stabilization Mission in the Central African Republic
MINUSMA	United Nations Multidimensional Integrated Stabilization Mission in Mali
MONUSCO	United Nations Organization Stabilization Mission in the Democratic Republic of the Congo
OECD-DAC	Organisation for Economic Co-operation and Development's Development Assistance Committee
PCC	Police Contributing Country
PFA	Psychological First Aid
PKM	Peacekeeping Missions
PKO	Peacekeeping Operation
PPME	Planning, Performance Monitoring and Evaluation Unit
PSOP	Peace and Stabilization Operations Program
PTSD	Post-Traumatic Stress Disorder

RESDAL	Red de Seguridad y Defensa de America Latina
RPA	Rwanda Peace Academy
SEA	Sexual Exploitation and Abuse
SDGs	Sustainable Development Goals
SWOT	Strengths, Weaknesses, Opportunities and Threats
T/PCC	Troop and Police Contributing Country
TCCC	Tactical Combat Casualty Care
TI	Training Institutions
ToR	Terms of Reference
ToT	Training of Trainers
TPTC	Tanzania Peacekeeping Training Centre
TPF	Tanzania Police Force
UN	United Nations
UN DHMOSH	United Nations Division of Health Management and Occupational Safety and Health
UN DPO	United Nations Department for Peace Operations
UNITAR	United Nations Institute for Training and Research
UNMAS	United Nations Mine Action Service
UNMISS	United Nations Mission in South Sudan
UNSCR	United Nations Security Council Resolution
USD	United States Dollar
WHO	World Health Organization
WPS	Women, Peace and Security

Introduction

1. This document constitutes the report of the independent evaluation of the Enhanced Training for Uniformed Medical Personnel Deploying to UN Peace Operations Project (hereafter, "the project"), for uniformed personnel deploying to four high-risk missions in Mali, the Democratic Republic of Congo (DRC), the Central African Republic (CAR) and South Sudan. The Government of Canada's Peace and Stabilization Operations Program (PSOP) granted Can$ 3,393,200.02[7] to fund the project. It was implemented by the United Nations Institute for Training and Research (UNITAR) and implementing partners (IPs) between 24 December 2021 and 30 June 2024.

2. The project was implemented by the UNITAR Predeployment Training and Advisory Section within the Division for Peace. As such, it aligns with the Sustainable Development Goal (SDG) 16 to promote peaceful, just and inclusive societies; and UNITAR's 2022-2025 strategic framework sub-objective 1.1 to "Support institutions and individuals to contribute meaningfully to sustainable peace". It focuses on building individuals' capacity to prevent and resolve violent conflicts and empowering women as change agents. According to UNITAR's mandate, it delimits its support to the predeployment period and consolidates the Division's growing inclusion of health and mental health when dealing with the effective preparation of troops and their readiness to deploy in challenging contexts.

3. UNITAR's Division for Peace integrated well-being into its support to uniformed personnel in 2018. Under one of its first programmes, UNITAR developed a "Resource Kit", a handbook compiling self-care and trauma therapy techniques, and piloted a peer-to-peer support system where two people or "buddies" assist one another. This was based on research indicating that individuals prefer to seek support from either a colleague who has experienced similar traumatic events or from their partner/spouse. The work on health then expanded to the training of uniformed health professionals from military contingents and Formed Police Units.

4. The project trains uniformed medical and paramedical personnel from African T/PCCs before potential deployment to UN peace operations. It builds on a first phase implemented between March 2020 and June 2021, also funded by the Government of Canada, Global Affairs Canada (GAC). Phase 1 amounted to Can$ 1,717,715.33 and aimed to "improve performance of the United Nations peace operations in increasingly complex and high-risk environments". The related outcomes were to:
    - "Enhance physical and mental well-being of male and female military and police personnel deployed";
    - "Strengthen knowledge, skills and behaviour of male and female uniformed medical personnel, deployed to the top four high-risk UN peacekeeping operations, in basic field medical and psychological trauma".

5. The second phase of the project aimed at strengthening predeployment medical and paramedical preparation to provide tactical combat casualty care (TCCC) under fire or in the field, and to cope with psychological consequences for peacekeepers. It mainly targeted personnel deploying to Level 1 medical facilities, which play a first response

[7] According to the UN Operational Rates of Exchange per US$ of 14 Jun 2024. Can$D= 1.37 per US$; GHS=14.95 per US$, KES=128.03 per US$, TZS=2601.62 per US$.

critical role in reducing casualties. Medical care in peacekeeping missions is organized according to four levels of medical care facilities (Levels 1- 4), as well as individual level first aid capabilities. The primary role of Level 1 medical units is to ensure the immediate health and operational capability of peacekeepers. These units handle a wide range of medical scenarios, from minor ailments to acute medical emergencies. They are equipped to perform initial triage, provide first aid and manage basic medical conditions. In cases of severe injury or illness, Level 1 units stabilize patients and arrange for their evacuation to more advanced medical facilities (Level 2 or Level 3) equipped for comprehensive care.

6. The project promoted an inclusive approach to gender by questioning how gender norms impact care provided to men and women. It raised questions about responding to different bodies and to gender-based needs, and cultural expectations of men in handling traumatic experiences. In addition, UNITAR intended to promote equal participation of men and women, despite structural limitations known at the recruitment level.

7. The project benefited three types of users. The initial project users are UNITAR trainers who underwent a Training of Trainers (ToT) preparatory workshop as part of the project. They then trained the project's intermediate users, being uniformed (military and police) medical and paramedical personnel from the below targeted countries. End users are uniformed personnel deployed to UN Peace Operations who directly benefited from the training learnings.

8. Over the two phases, the project aimed to work with the same group of African T/PCCs and IPs in Burkina Faso (replaced by Tanzania in phase II), Chad, Ghana, Ethiopia (replaced by Kenya in phase I), Niger, Rwanda, Senegal and Togo. However, contextual changes affected the list of beneficiary countries and of missions to deploy to. The governments of Mali[8] and DRC[9] asked for the withdrawal of the peacekeeping missions between 2023 and 2024. Coups in Burkina Faso and Niger, and political instability in Ethiopia led to the cancellation of activities in-country. As a result, during the second phase of the project, Tanzania joined the group as a project partner and beneficiary.

9. Project implementation relied on coordination with the following national training centres: the Rwanda Peace Academy (RPA); the Department of Medical Services of Ghana Armed Forces; the Administration Police Service (APS) in Kenya; and the Tanzania Police Force (TPF). The RPA and TPF had partnership records with UNITAR. Implementing partners, except the RPA, were given grants of $382,199, which was 15.4 per cent of the total grant amount. A grant of $343,994 was allocated to the RPA, which was 13.9 per cent of the total grant amount.

[8] Resolution 2690 (2023) - on termination of the mandate of the UN Multidimensional Integrated Stabilization Mission in Mali (MINUSMA) by December 2023
[9] Resolution 2717 (2023) - on extension of the mandate of the UN Organization Stabilization Mission in the Democratic Republic of the Congo (MONUSCO) until 20 Dec 2024.

Project Logic

10. According to the October 2021 project proposal, the intervention sets physical and mental well-being as conditions for peacekeeping performance. The project planned to revise the training packages, deliver a preparatory training and 16 basic and advanced training sessions, and upgrade the mobile application to achieve three immediate outcomes and two intermediate outcomes to improve the performance of UN Peace Operations (See Table No.1)

Table 1 - Logical Framework

Ultimate Outcome	Intermediate Outcomes ⟹	Immediate Outcomes ⟹	Outputs
Improved performance of UN Peace Operations in increasingly complex and high-risk environments	**1.1.** Enhanced **physical and mental well-being** of male and female military and police personnel deployed to the four high-risk missions: MINUSMA (now closed), MONUSCO, MINUSCA and UNMISS. **1.2.** Improved performance of male and female uniformed personnel deployed to the four high-risk UN peacekeeping missions.	**1.1.1.** Strengthened knowledge and skills of male and female uniformed medical personnel (military and police) deployed to the top four high-risk UN peacekeeping operations, in basic field medical and psychological trauma. **1.1.2.** Improved knowledge and skills of male and female uniformed medical personnel (military and police) deployed to the top four high-risk UN peacekeeping operations, in advanced field medical trauma. **1.1.3.** Increased knowledge and use of the UN MissionMed mobile applications (Android and iOS) by trained uniformed medical personnel (military and police). **1.1.4.** Increased awareness of male and female uniformed medical personnel (military and police) deployed to the top four high-risk UN peacekeeping operations of the importance of physical and mental health for effective performance.	**1.1.1.1** Training packages are reviewed (content and methodology) to integrate the specific and gendered needs, as well as the country/mission context. **1.1.1.2** One preparatory workshop is attended by a gender-balanced group of UNITAR trainers, with the emphasis on women trainers, francophone trainers and trainers for advanced medical training. **1.1.1.3** Eight training sessions are attended by a gender-balanced military and/or police medical and paramedical personnel (20 participants). **1.1.2.1** Eight advanced training sessions are attended by a gender-balanced military and/or police medical and paramedical personnel (10 participants). **1.1.3.1** Android version of the UN MissionMed mobile application is upgraded to include French translation and other relevant materials. **1.1.3.2** iOS version of the UN MissionMed mobile application is developed. **1.2.1.1** Training packages are reviewed to underscore the link between good mental and physical health and effective performance in UN missions.

Evaluation Management and Methodology

11. The evaluation was undertaken by a team of two external evaluation consultants, independent from the design and implementation of the project. The team was composed of Aurélie Ferreira, team leader and evaluation specialist with field experience in peacekeeping missions, and Gilbert Asiimwe, team member with experience in the health sector. Gilbert conducted the field visits to Tanzania and Kenya, while Aurélie coordinated the data analysis and report writing with the support of the UNITAR Planning, Performance Monitoring and Evaluation Unit (PPME). The UNITAR PPME provided support with survey preparation, circulation and analysis, interviews and quality assurance.

12. The evaluation's Terms of Reference (ToR) called for a standard evaluation approach, applying the six evaluation criteria of the Organisation for Economic Cooperation and Development's Development Assistance Committee (OECD-DAC): relevance, coherence, effectiveness, efficiency, likelihood of impact and likelihood of sustainability. The evaluation questions under each of the criteria that are listed below structure the assessment in the 'Evaluation Findings' chapter. Evaluation findings are focused on avoiding repetitions, where appropriate, and referencing previous findings, when applicable. Questions related to gender equality and the empowerment of women are marked as GEEW and questions related to environmental sustainability in evaluation are marked as ENVSUSE.

Relevance

- *To what extent is the project aligned with the Institute's efforts to help Member States implement the 2030 Agenda for Sustainable Development, the UNITAR strategic framework 2022-2025, particularly Strategic Objective (SO) 1.1, and Global Affairs Canada/PSOP's guiding policies?*
- *Are project objectives and activities relevant to the initial, intermediate and final users' needs and priorities, and designed with quality?*
- *Is the project equally relevant for female and male trainers/uniformed medical personnel/personnel deployed, and francophone and anglophone stakeholders? (GEEW)*
- *How well did the project design build on the needs assessment and lessons learned from the previous phase (2020-2021)? To what extent did the project reach its intended beneficiaries, namely gender-balanced trainers' groups, francophone trainers, and medical and paramedical personnel, to the extent possible? If not, what/who was missing and what could have been done differently?*

Coherence

- *To what extent is the project complementing other similar programmes and projects, and adhering to international norms and standards?*
- *How well is the project aligned with and complementing other UNITAR programming focused on enhancing capabilities of deployed personnel, particularly those supporting medical and paramedical personnel, such as through UNITAR's predeployment training projects?*
- *How well is the project aligned with and complementing programming implemented by other institutions focusing on enhancing capabilities of deployed personnel, particularly those supporting medical and paramedical personnel?*
- *How well is the project aligned with relevant international frameworks and UN resolutions and priorities in the peacekeeping field, including the Women, Peace and Security (WPS) agenda, the UN Uniformed Gender Parity Strategy, the Cruz report, Action for Peacekeeping (A4P) and A4P+, the Elsie Initiative for Women in Peace Operations, the UN Security Council Resolution*

*2518, pledges from peacekeeping ministerial, and Global Affairs Canada's Framework for assessing Gender Equality Results, among others? (**GEEW)***

Effectiveness

- *How effective has the project been, through its four components, in delivering results and in reinforcing capabilities and increased awareness of uniformed medical and paramedical personnel?*
- *To what extent have the planned outcomes and outputs been achieved? What are the factors, affecting the project and the individual's performance of initial, intermediate and end users?*
- *Has the project's design, with multiple components, and partnerships been effective in delivering and attaining results, including the performance of the four implementing partners?*
- *To what extent and how is the project contributing to improved knowledge and skills, capabilities, motivations (increased awareness) and opportunities of uniformed medical and paramedical personnel to address physical and psychological trauma of deployed personnel in a gender-responsive manner? How effective is the mobile application as a learning reinforcement tool? Is progress per country varying? What is missing, if anything? (**GEEW**)*

Efficiency

- *To what extent has the project delivered its results in a cost-efficient manner and optimized partnerships?*
- *To what extent has the project produced outputs in a timely and cost-efficient manner, including through grant arrangements with implementing partners (Rwanda Peace Academy, the Department of Medical Services of Ghana Armed Forces, the Administration Police Service of Kenya and Tanzania National Police) in comparison with alternative approaches? Were the project's resources (human and financial) used as planned and fully utilised?*
- *To what extent was the project, including both activities and planned expenditures, delivered as planned? To what extent did interim narrative/performance management framework reporting capture progress towards results? What caused deviations from the original plan? Did the project apply adaptive management to adjust to implementation challenges?*

Impact

- *What are the potential cumulative and/or long-term effects expected from the project, including contribution towards the intended impact and intermediate outcome, positive or negative impacts, or intended or unintended changes?*
- *What real difference has the project made to improve physical and mental well-being of military and police personnel deployed to UN Peace Operations? Are there any differences between female and male uniformed deployed personnel? (**GEEW**)?*
- *What other observable changes (positive or negative, intended or unintended) have occurred as a result of the project implementation?*

Sustainability

- *To what extent are the project's results likely to be sustained in the long-term? How is environmental sustainability addressed in the project?*
- *To what extent are the project's results likely to endure beyond implementation of the activities in the mid- to long-term and under which conditions?*
- *To what extent has the project contributed to sustainability by creating an enabling environment through Training of Trainers (ToT) and the mobile application to maintain capacities and expanded knowledge after completion of the project?*
- *What can we learn to inform the future design of similar programming?*

13. The assessment of the likelihood of impact was identified as a priority during the entry conference with UNITAR's Division for Peace and the interview with the donor due to the limited visibility of application of knowledge and skills after training and deployment, and due to the risk of 'skills fade' while waiting to deploy.

Data collection

14. The evaluation used a mixed methods approach (quantitative and qualitative) with rigorous triangulation of information. Data collection comprised various instruments: i) desk review; ii) secondary data analysis of UN and international references in TCCC and Mental Health and Psychosocial Support (MHPSS); iii) field visits to Tanzania and Kenya; iv) key individual and group informant interviews (KIIs) in the field and remotely; and v) online surveys for female and male beneficiaries from all training activities and trainers.

15. In the desk review, the evaluation considered a range of project-related documents, including, but not limited to, agreements with the donor and implementing partners, the project document and log frame, and narrative and financial reports. It also reviewed reference documents to TCCC and MHPSS, such as the "Psychological first aid: Guide for field workers" developed by the World Health Organization (WHO), and the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings. The list of documents consulted is provided under Annex D.

Table 2 - Overview of the evaluation engagement with project stakeholders

Engagement type	Total	Female	Male
Virtual interviews with partners and beneficiaries	14	1	13
Face-to-face interviews in Tanzania	7	1	6
Face-to-face interviews in Kenya	16	5	11
Survey of participants in basic training	35	10	25
Survey of participants in advanced training	30	5	25
Survey of trainers	23	5	18
Virtual interview with project management and the donor	4	3	1
Total number of respondents	135	30	105
Percentage		**22%**	**78%**

16. Table 2 summarizes the stakeholders consulted for this evaluation and the engagement methods. Three online surveys were deployed in English and French to collect views from trainers, and participants of basic and advanced training activities. The participant surveys focused on learnings applicability and practical examples. The surveys were designed around two pillars: training relevance for participants (preparation, communication, accessibility of learning) and impact. The surveys asked about the most useful learnings, the ability to apply new skills in national and international peacekeeping functions, gender-sensitivity of participants' selection, active inclusion in modules and materials' sensitivity, as well as the use of the mobile application for sustained learning (see Annex B). The surveys were designed to include elements of the COM-B model for behaviour change, based on Michie et al. (2011). The surveys targeted 319 training beneficiaries but were restricted to just 190 contacts. In total, 88 responses were received - the response rate for basic training participants was 37 per cent, for advanced training participants it was 52 per cent and for trainers it was 62 per cent. Table 3 shows the nationalities and professions of basic and advanced training survey respondents.

Table 3 - Survey Results on Basic and Advanced Training

Surveys of participants	#	Profession	Nationality
Participants in basic training	37	34% doctors, 31% nurses, 8% paramedics, 27% others	32% Kenyan, 20% Rwandan, 17% Tanzanian and Ghanaian, 11% Nigerien, 3% Chadian
Participants in advanced training	34		43% Kenyan, 20% Tanzanian, 17% Ghanaian, 13% Togolese, 7% Rwandan
Total number of respondents	71		

17. Following discussions with the project management team in defining criteria for selecting countries for field visits, given that not all countries could be visited due to limited resources, field visits were conducted in Tanzania from 4 to 7 August 2024, and in Kenya on 29 and 30 August 2024. A total of 17 individual interviews and one group interview with six participants were held with uniformed medical personnel from the TPF and APS, Kenya, who participated in various training sessions under the project. Among the interviewees, six were female and 17 were male. The training and storage facilities at the Border Police Training Campus (BPTC) in Kenya were also visited. Due to availability limitations, and despite attempts, the evaluation team was unable to visit the Tanzania Peacekeeping Training Centre (TPTC) or interview the staff at TPTC, including online. Additionally, follow-up fact-checking interviews were conducted with UNITAR focal points for both Kenya and Tanzania.

Field visit to Kanyonyo, Kenya

18. Gender considerations were mainstreamed into all engagement methods. Due to the nature of the project, there was limited room for human rights and environmental considerations. Where possible, sustainability of materials procured was assessed. Human rights considerations were considered, mostly from a gender perspective.

Evaluation criteria rating system

19. A rating, based on a six-point Likert-like scale, was used to provide overall ratings for each of the six evaluation criteria. The rating scale is described in Table 4. Ratings were assigned and justified by the evaluator, in agreement with PPME, and presented to the project implementing team.

Table 4 - Evaluation Rating Scale

Rating	Description
Highly satisfactory	Under the concerned criterion, the activity (project, programme, etc.) achieved or surpassed all main targets, objectives, expectations, results or impacts, and could be considered as a model within its project typology.
Satisfactory	Under the concerned criterion, the activity (project, programme, etc.) achieved almost all (indicatively, over 80-95 per cent) of the main targets, objectives, expectations, results or impacts.
Moderately satisfactory	Under the concerned criterion, the activity (project, programme, etc.) achieved the majority (indicatively, 60 to 80 per cent) of the targets, objectives, expectations, results or impacts. However, a significant part of these were not achieved.
Moderately unsatisfactory	Under the concerned criterion, the activity (project, programme, etc.) did not achieve its main targets, (indicatively, less than 60 per cent) objectives, expectations, results or impacts.
Unsatisfactory	Under the concerned criterion, the activity (project, programme, etc.) achieved only a minority of its targets, objectives, expectations, results or impacts.
Highly unsatisfactory	Under the concerned criterion, the activity (project, programme, etc.) achieved almost none of its targets, objectives, expectations, results or impacts.

Limitations

20. In capacity development projects, it is challenging to isolate the effects of the project over the ultimate outcome, given that there are other interventions influencing the context. However, to mitigate this constraint, the evaluators adopted a contribution approach, clearly reflected in the relevance section and likelihood of impact.

21. Additional limitations for conducting the evaluation are related to data collection and resource constraints.

22. The data collection constraints refer to the challenging access to participants' contacts, especially from francophone countries, which affected the survey response rates by country. This limitation also impacted project management, in particular in countries going through political and diplomatic changes, such as Niger and Chad. The evaluation did not obtain contacts of participants from Senegal and only obtained one contact for Chad, six for Niger, and 14 for Togo (out of 53 unique participants for these four countries). Moreover, given the field visits to Tanzania and Ghana, most of the participants' interviews, especially from basic training activities, came from these two countries. Similarly, for the desk review, the evaluation did not have complete information on the affiliation of participants, such as military, police, etc., medical qualifications and rank, which limited the disaggregation of some evaluation findings. Moreover, the final financial report was not available at the time of this evaluation and a lack of identification of log frame indicator targets did not allow for measurement.

23. Despite several attempts, some stakeholders that were identified as part of the stakeholder analysis could not be interviewed due to a lack of response to interview requests. Nevertheless, the response rate of participants to interview requests was high. Moreover, some project staff involved in the project implementation are no longer working for UNITAR.

24. The resource constraints limitation refers to evaluation budget and time limitations. Following reallocation of budget lines, the funds available for the evaluation exercise were reduced resulting in only two of the eight beneficiary countries selected for field visits.

Evaluation Findings

25. The evaluation's findings are presented below under each of the six criteria: relevance, coherence, effectiveness, efficiency, likelihood of impact and likelihood of sustainability. The evaluation questions from the ToR structure the report.

Relevance

Rating: Highly satisfactory

Relevance to global policy and reference frameworks

Evaluation Question 1.1: To what extent is the project aligned with the Institute's efforts in helping Member States implement the 2030 Agenda for Sustainable Development, UNITAR's Strategic Framework 2022-2025, particularly Strategic Objective 1, and Global Affairs Canada/PSOP's guiding policies?

26. The project aligns with the Sustainable Development Goal (SDG) 16 to promote peaceful, just and inclusive societies, and UNITAR's 2022-2025 Strategic Framework, Strategic Objective 1, to "Support institutions and individuals to contribute meaningfully to sustainable peace". It focuses on building individuals' capacity to prevent and resolve violent conflicts and empowering women as change agents. With this in mind, **the project meets Canada's efforts to promote the inclusion of women and their representation among peacekeepers,** and aligns with Canada's Feminist International Assistance Policy Action area 1, which includes training and predeployment courses on gender equality and context-specific gender norms. The project also aligns with two of three paths of the Action area 6 on peace and security, which are to promote inclusive and gender-responsive violent-conflict prevention, crisis response and sustainable peace in fragile and conflict-affected states, and gender-responsive security-threat reduction and security system reform.

27. **The evaluation found the project and the formative evaluation of the Elsie Initiative for Women in Peace Operations[10] drew similar conclusions and faced similar challenges** to implement gender parity, namely: (i) access, hence the evidence of increased capacity in UN organizations and missions to address barriers to women's meaningful participation is still limited; (ii) awareness of barriers to uniformed women in UN peace operations about parity has not fully reached larger T/PCCs and UN peacekeeping missions; and (iii) T/PCCs' capacity is yet to be strengthened to overcome barriers to women's meaningful participation.

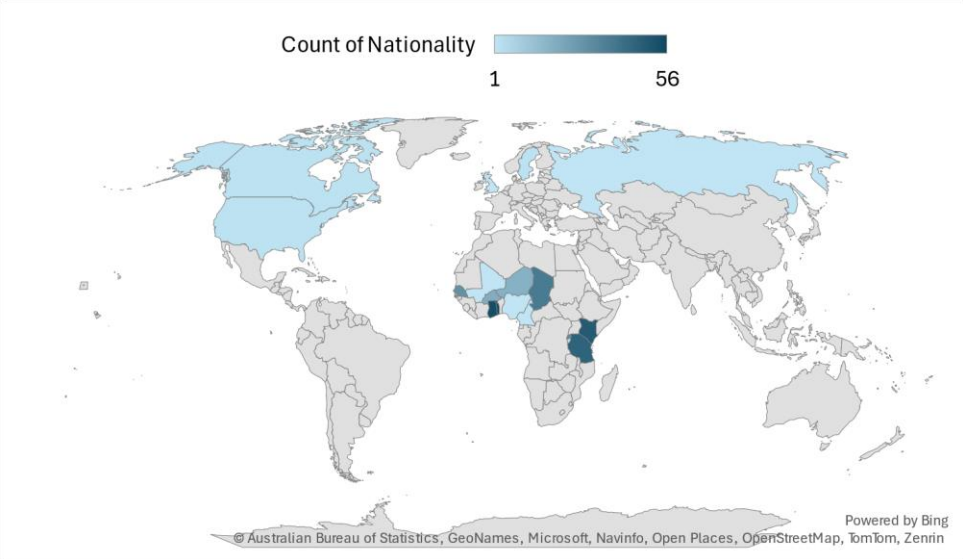
[10] Formative evaluation of the Elsie Initiative for Women in Peace Operations – Executive summary

Relevance of the project design and approach

Evaluation Question 1.2: Are project objectives and activities relevant to the initial, intermediate and final users' needs and priorities, and designed with quality?

28. **The selection of the beneficiary countries was found to be highly relevant,** given that they belong to the group of the 20 highest contributing countries in Africa and to the **most vulnerable group in the field**, in terms of medical preparedness and victims' rate. The review of the UN Department of Peace Operations' (DPO) statistics[11] reveals that fatalities registered among the project beneficiary countries (i.e., Burkina Faso, Chad, Ethiopia, Ghana, Kenya, Niger, Rwanda, Senegal, Tanzania and Togo) in MONUSCO, MINUSMA, MINUSCA, UNMISS and UNAMID accounted for 34 per cent of the total number of fatalities (422 out of 1,233) over the project's two phases. The project had to suspend activities in Burkina Faso, Niger and Ethiopia due to political instability. Close follow-up allowed for a swift replacement by Kenya and Tanzania but reduced the pool of francophone beneficiary countries.

Figure 1- Training participants' nationalities



29. **Although not directly targeted by the project outcomes and activities, the project was found to be relevant to the T/PCCs' training needs on combat-related care and MHPSS, and strategic thinking on ways and reasons to mainstream this content in medical and paramedical personnel predeployment preparation**. Interviews with T/PCCs' focal points and research on similar initiatives detailed in the coherence section found that the area of stress and trauma is yet unexplored and that needs on TCCC remain substantial. The project addressed, at a scale commensurate to its financial resources, the structural challenge on shortage of medical equipment in case of deployment, strengthened tactical training tailored to mission contexts and the yet broadly unaddressed psychological preparedness of personnel.

30. **The project approach was found to be highly relevant for linking mental health and psychosocial support to the performance of peacekeeping missions, and for promoting a holistic approach to health**. Interviews with T/PCCs and UNITAR focal

[11] Fatalities | United Nations Peacekeeping

points stressed that priority had long been given to physical care and that mental care was overlooked as a “matter of comfort”, “a European illness” or an “indication of weakness to debunk at the recruitment stage”.

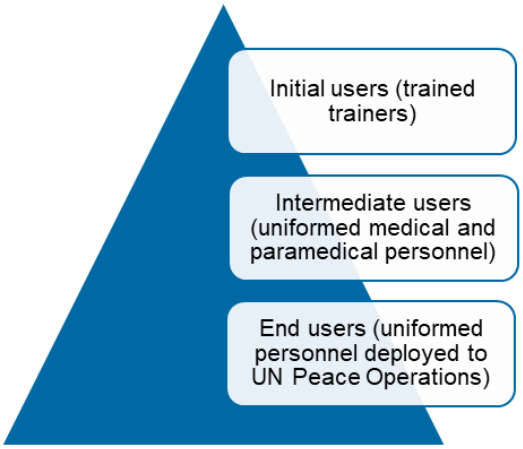


Figure 2 - Project users as identified in the evaluation ToR

31. Relevance of the project design to participants’ needs is discussed in-depth under the effectiveness section.

32. **Relevance to end users, uniformed personnel deployed to UN Peace Operations benefitting from care, is hypothetical**. The anonymity that prevails around deployment plans and the testimonies of uniformed personnel strongly limits access to information. It was not possible to collect testimonies of people who were saved under fire or received care for psychological or other physical affectations in one of the four high-risk peacekeeping missions. Similarly, the extent to which the project indirectly benefited local communities living in proximity of deployed military contingents or police units, or in beneficiary countries, close to trained personnel is unknown.

Evaluation Question 1.3: Is the project equally relevant for female and male trainers/uniformed medical personnel/personnel deployed and francophone and anglophone stakeholders? (GEEW)

33. **The project documents demonstrate a sound understanding of gender, going far beyond a ‘female count’ approach.** The project documents elaborate on differentiated needs for female and male personnel and illustrate how healthcare in peacekeeping missions’ environments speak to them differently. For women, the case of intimacy is made with the example of often missing sexual and reproductive health services, or the absence of female physicians in mission to address gynaecological matters. The absence of female facilities, as basic as toilets, is also observed, and awareness raised through training for the mental and physical health implications that can result. For men, the case of masculinity expectations is made when it comes to seeking help after a trauma, and gendered stereotype barriers discouraging the discussion of mental health openly.

34. **The gender approach is reflected in project outputs, such as recruitment guidelines supportive of women inclusion and training curriculum content.** The basic training curriculum includes two one-hour sessions on gender: i) gender-responsive healthcare to define an enabling and inclusive environment, including occupational safety, heath and well-being for all personnel; and ii) gender sensitivity and responsiveness in MHPSS to “recognize potential for gender-differentiated impacts, vulnerabilities and needs of persons affected by crisis”. The training of trainers (ToT)

covers the same modules and is complemented by a one-hour refresher on facilitation techniques to foster gender-inclusive participation. Examples of awareness raised and feedback from participants is shared under the effectiveness section.

35. **UNITAR's terminology is found to be gender-sensitive**. Institutional documents, such as narrative reports or letters of agreement, require gender disaggregation or systematically target gender-balanced groups. Lists of participants are systematically disaggregated by gender, as a good practice imposed on IP. Except for Tanzania, IP's narrative reports don't specify the gender of trainers while UNITAR rosters and ToT participants lists specify trainers by country and gender.

36. **The project documents and first phase reports mentioned a module on Sexual Exploitation and Abuse (SEA)** prevention, mandatory as part of the UN DPO Core Predeployment Training Materials, but the evaluation found no reference to it in the training agendas. In the needs assessment, particular attention was given to incidents of Conflict-Related Sexual Violence (CRSV) and Sexual Exploitation and Abuse (SEA) although the link with professional practices and gender-responsive care was not established. However, all letters of agreement with IPs included a zero-tolerance article on SEA as part of UNITAR's standard regulations.

37. **The project design and first phases identified and repeated the urge to recruit francophone trainers and strengthen the trainers' roster.** The first phase Final Narrative Report (FNR) noted it had been impossible to recruit a francophone psychologist. Despite a clear understanding of such a training gap, the second phase FNR concludes with the repeated challenge of extending the trainers' roster, including recruiting francophone trainers. Ten out of 17 participants in the full ToT were from francophone countries, but only four of these were women. Suspending activities in Burkina Faso and Niger, due to the military coups, likely slowed progress in recruiting and training new female francophone trainers.

Evaluation Question 1.4: How well did the project design build on the needs assessment and lessons learned from the previous phase (2020-2021)? To what extent did the project reach its intended beneficiaries, namely gender-balanced trainers' groups, francophone trainers, and medical and paramedical personnel? If not, what/who was missing and what could have been done differently?

38. **The needs assessment**[12] (described in Box 1) was developed in July 2020, a few months after the first phase started and during COVID-19, which limited it to desk research. It was found that writing the assessment contributed to the development of the project's second phase to a limited extent only, benefiting more from learned from the first phase of the project's implementation. This was due to the fact that the text in the needs assessment did not ask or answer which country-specific risks needed to be addressed through medical personnel training. While the needs assessment provided a good description of the environment of peacekeeping missions, it neglected to ask about the context of operations and remained descriptive. This level of **analysis was displayed in other project outputs, including narrative reports, where quality is acknowledged** and praised by the evaluation team and project

[12] Strengthening response capacities of medical and paramedical personnel deployed to UN Peace Operations, UN mission incidents mapping, July 2020.

stakeholders. Narrative reports demonstrated expertise of the environment of peacekeeping operations, in the field and at headquarters.

Box 1 – Needs assessment developed during Phase I of the project

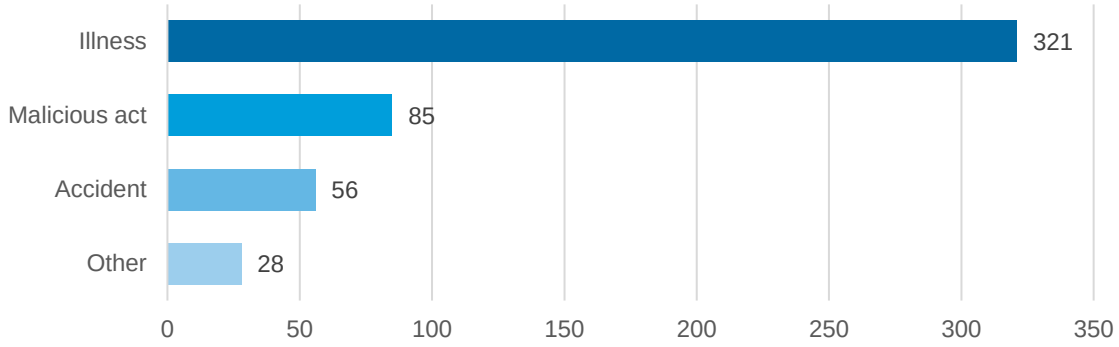
The Phase 1 needs assessment is a comprehensive document that goes into the detail of intervention contexts of MONUSCO, MINUSCA, MINUSMA, UNMISS and UNAMID, including:deployed and authorised number of personnel and top 10 troop and police contributors to UN peacekeeping missions in figures; conflict and mission backgrounds; mandates; maps; the physical environment; fatalities (hostile and non-hostile); and incidents of SEA and CRSV. The document was an informative context review but unlinked to paramedical and medical personnel training and equipment needs. For example, the section on the physical environment presents geography and topography but left unexplored local diseases and required/missing skills or equipment to address them. A similar observation was made on SEA and CRSV. Although the needs assessment elaborated on the scope of the problem, the project's possible responses were unexplored, for instance, how to address such cases as a carer or as a uniformed victim.

As clearly flagged in the Phase 1 FNR, UN DPO disaggregation and anonymity levels prevented knowing the type of injury, if first aid was received before evacuation, if death occurred during evacuation, the cause of death and whether a particular fatality would have been preventable with improved Level I medical intervention. As a result, the assessment displayed the number of deaths per mission due to hostile and non-hostile acts. The section on risks to deployment derived from COVID-19 presents the state and challenges of medical services in the targeted missions, acknowledging ongoing initiatives related to medical training, including psychosocial components, such as stress management, and better connections with the purpose of the project purpose.

39. **The evaluation experienced UN DPO limitations in data access and disaggregation but found that interesting trends on fatalities could have been drawn at the design stage, such as DPO general statistics[13] and SIPRI.[14]** During the project period (2020-2024), the main cause of death across all UN missions was illness, claiming 321 lives out of 490 fatalities, or 65 per cent, followed by malicious acts, with 85 fatalities, and accidents, leading to 56 deaths. Unsurprisingly, malicious acts (MA) dropped significantly in 2023 and 2024 after withdrawal from MINUSMA, the deadliest mission among all, was enacted by the Security Council. In 2022, there were 33 fatalities from malicious acts, falling to 7 in 2023 and 5 in 2024. In 89 per cent of cases between 2020 and 2024, the military were targeted by malicious acts. Military personnel are indeed found to be the highest fatality risk group, with 227 military personnel lost over the project period, accounting for 46 per cent of the total fatalities. Local staff are also a high-risk group when it comes to illness, with 117 fatalities against 100 among the military. **These trends indicate that priority is to be given to tactical combat casualty care, which the project addressed, and signalled the invisibility of mental health-related fatalities.** No updated statistics could be found on the latter.

Figure 3 - Fatalities by incident type across all UN missions 2020-2024

[13] UN fatalities general statistics by year, incident and appointment type, statistics since 1948.
[14] Peacekeepers under threat? Fatality trends in UN Peace operations, SIPRI Policy brief September 2015



40. **Current statistics on the status and risks for the mental health of peacekeepers are poor.** There are few studies exploring the link between deployment to a UN peacekeeping mission and mental disorders but, as rightly titled in this research paper, *Peacekeepers deserve more mental health research and care.*[15] Studies show a wide range of mental health outcomes, such as post-traumatic stress disorder, depression, substance use and abuse, increased hostility and suicidal ideation. A meta-analysis of peacekeeper studies reported that the pooled post-traumatic stress disorder (PTSD) prevalence rate was 5.3 per cent[1617] with an extremely wide range, from 0.05 to 25.8 per cent. **Despite the absence of elaborated and updated data, the project acknowledged the consequences of mental health on UN peacekeeping performance and on personnel well-being**. This aligns with a global shift by the UN, for instance, UN Secretary-General calling for a global study on PTSD, resolutions 74/280 and 75/293, the 2018 UN System Workplace Mental Health and Well-being Strategy,[18] but also follows observations made through the implementation of other UNITAR projects and internal lessons learned processes (read coherence below).

41. Donor reports and exchanges with project management demonstrate a sound understanding of the challenges and gaps to medical and paramedical care in the field and in predeployment training, and an active learning process between the two phases. The comparison between narrative reports from the first and second phases confirms the scaling up. The first phase FNR identified areas for increased support that were addressed during the second phase and includes: i) strengthening relevance and sustainability of the training curriculum to integrate the curriculum into the annual predeployment training cycle (partially); ii) including training equipment, such as Buddy First Aid Kits (BFAK) and trauma bags, for participants and arranging donation to T/PCCs; iii) adopting contingency plans for larger training teams and five-day preparatory work for team leaders to test materials and check training locations; and (iv) expanding the training roster to recruit more qualified women and female francophone trainers. Needs were observed through implementation and resulted in the development of new materials during the second phase, such as two advanced curricula (ToT and an advanced module on MHPSS) and selection criteria for participants of the advanced training (ToT).

[15] National Library of Medicine, Peacekeepers deserve more mental health research and care, Jun Shigemura, April 2016
[16] The Journal of nervous and mental disease, Post-Traumatic Stress Disorder in Peacekeepers, a meta-analysis, May 2011
[17] UN peacekeeper health and risk factors - a systematic scoping review, Global health research and policy, April 2024
[18] UN, A healthy workforce for a better world, September 2014

42. A discussion of the project's outreach to planned beneficiaries is included under the effectiveness section.

Coherence

Rating: Highly satisfactory

Evaluation Question 2.1: How well is the project aligned with and complements other UNITAR programming focusing on enhancing capabilities of deployed personnel and particularly those supporting medical and paramedical personnel, such as through UNITAR's predeployment training projects?

43. The project is consistent with general support provided by UNITAR's Division for Peace to T/PCCs' predeployment, which is central to UNITAR's strategic objective, and with efforts to develop and mainstream health-related training content. The review of UNITAR's ongoing project portfolio identifies six relevant initiatives. Five projects are funded by the Federal Republic of Germany and one by the Government of Canada: three share a common beneficiary, country (Mali) and type of aid, one project is also implemented in Ghana, and all three strengthen safety and security of African T/PCCs' male and female members through BFAK and capacity on Basic Field Medical Assistants Course (BFMAC). Two other projects have established a health service and a psychiatric unit in Mali with the Malian Armed Forces (FAMA), acknowledging trauma consequences in high-risk environments. The sixth project supports gender advisors training through Canada's Military Training Cooperation Program (MTCP) funding. Other initiatives have built institutional awareness and inclusion of the importance of health and mental health, such as the predeployment training to MINUSMA for Formed Police Units. An independent external evaluation[19] of the "Strengthening operational capacities of police contributing countries" project found the explosive device module defused predeployment stress and deconstructed myths around the type of attacks and injuries.

44. Institutional consistency extends beyond project level and applies to project IPs and other key international players. Project design was careful not to overlap with other initiatives, such as the GPOI and the Tanzanian Military on a similar health training programme, and tried building synergies with IPs, e.g., UNITAR cooperation with the Tanzanian national police since end of 2023 (adaptation of training modules, provision of training and equipment).

Evaluation Question 2.2: How well is the project aligned with and complements programming implemented by other institutions focusing on enhancing capabilities of deployed personnel and particularly those supporting medical and paramedical personnel?

45. A review of external coherence through web research or based on interviews confirmed that the project aligned with training and capacity-building programmes of other institutions, although it takes a more holistic approach to health in predeployment training and through the inclusion of gender considerations in this field, addressing mental health in addition to Psychological First Aid (PFA), and targeting a specific group

[19] Strengthening operational capacities of police contributing countries – independent evaluation report.

of beneficiaries, that is, medical and paramedical personnel. Similar training that was referenced rarely took a mental health approach but rather divided training between those addressing PFA or TCCC. Examples include: the United States Institute of Peace training on trauma and psychological support; the US Army basic and advanced training in field medical care, and first aid training; the UK Army Joint counter terrorism and advanced emergency care;[20] Rwanda life support basic and advanced training; and Tanzania Police training (including FPA basics). Training participants referred to only three other organizations as providers of mental health training: the International Organization for Migration (IOM), the United Nations Mine Action Service (UNMAS) and the NGO Doctors with Africa CUAMM.[21] Capacity-building initiatives were identified in four of the project countries without adopting a similar comprehensive approach to health as the evaluated project, including: a US project to enhance the expeditionary medical capabilities of Ghana, Rwanda, Senegal and Uganda; and UNDP and JICA support to a Togo training centre's capacity including through trainers' integration of human rights, gender, civil protection and psychological care (March 2021-March 2022).

46. Research on relevant GAC programmes reveal complementary initiatives on gender inclusion and parity and mental health.[22] The Monash University and the Red de Seguridad y Defensa de America Latina (RESDAL) are undertaking research (2023-2026) on barriers, issues and best practices for peacekeeping personnel with caring responsibilities; and sexual harassment and abuse within/by security sector institutions of troop and police contributing countries and the UN DPO. The outcomes of these research works could help to mitigate the social barriers to the recruitment of women as trainers and training participants, to strengthen the training curriculum and to brainstorm on incentives to apply to a third phase of this project.

Evaluation Question 2.3: How well is the project aligned with relevant international frameworks and UN resolutions and priorities in the peacekeeping field, including the WPS agenda, the UN Uniformed Gender Parity Strategy, the Cruz report, Action for Peacekeeping (A4P) and A4P+, the Elsie Initiative for Women in Peace Operations, UN Security Council Resolution 2518, pledges from peacekeeping ministerial, Global Affairs Canada's Framework for Assessing Gender Equality Results, among others? (**GEEW)**

47. Project management has been highly responsive to a UN environment that acknowledged the impact of mental health on the performance of peacekeeping operations and the well-being of uniformed personnel. The 2017 UN Staff Well-Being Survey Data Report and the 2018 first UN Mental Health and Well-Being Strategy constituted tangible steps, strengthened by the Action for Peacekeeping + Plan,[23] point 4.2, for improved safety and well-being of personnel that contributes to an enabling environment for the meaningful participation of women in peacekeeping. The subsequent resolution on mental health (S/RES/2668 (2022) encourages T/PCCs to screen and mentally prepare personnel before deployment and notes the importance of timely and sufficient mental health and psychological support. It is also noted that the second phase of the project was in its last stages when the UN Peacekeeping Ministerial took place in Ghana with mental health high on its agenda. The project was a timely response and, to some extent, an anticipated response to UN priorities and major

[20] https://www.army.mod.uk/media/19107/22-07-274_idt_a4_digital_idtcatalogue.pdf
[21] Doctors with African, CUAMM website
[22] Canada 's commitment at the 2023 United Nations Peacekeeping Ministerial - article
[23] Action for Peacekeeping + Plan 2021-2023, agenda

declarations, demonstrated by the professionalism and expertise of project management.

48. **The project contributed to the UN and Canada Feminist policy commitments to improve female inclusion in peacekeeping missions and peacemaking processes** in line with UNITAR's gender equality and empowerment of women (GEEW) policies. By requesting partners to organize gender-balanced events and encourage recruitment of female trainers and training participants, the project aligns with UNSCR 2242 and the UN Uniformed Gender Parity Strategy[24] for 2018 to 2028, which include goals for women to make up 15 per cent of those serving in military contingents, 25 per cent for military observers and staff officers, 20 per cent for formed police units and 30 per cent for individual police officers. The project design, terminology and requirements are consistent with UNITAR's commitments to achieve gender parity, as laid out in the Geneva Gender Champions initiative pledge in 2015 and UNITAR's Strategic Framework 2022-2025.

49. **The project rightly decided not to develop its own training materials. It identified the variety of different training plans as a potential problem** for people trained differently once deployed or, worse, when dealing with casualties. For instance, interviewees reported that French and English training differed in relation to the application of a tourniquet. As a result, the UNITAR training curriculum is based on the United Nations Buddy First Aid Course (BFAC), tactical combat casualty care (TCCC) and the United Nations Field Medical Assistants Course (FMAC), which is aimed at non-medical personnel. The curriculum also refers to the WHO Psychological first aid: Guide for field workers and the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychological Support in Emergency Settings.

Effectiveness

Rating: Satisfactory

Evaluation Question 3.1: How effective has the project been, through its four components, in delivering results and in reinforcing capabilities and increased awareness of uniformed medical and paramedical personnel? Has the project's design, with multiple components, and partnerships been effective in delivering and attaining results, including the performance of the four implementing partners?

50. The project's comprehensive presentation of poor mental health consequences on decision-making and a contingent's dynamics triggered a sense of emergency among T/PCCs, raising awareness about predeployment training gaps and the urge for deconstructing taboos around mental health, such as presenting trauma as a medical affliction and not an individual fragility, especially among male uniformed personnel. An indication of success and interest was the renewed involvement from the same group of **project partners** between the two phases.

51. **At the intermediate and ultimate outcome level**, the evaluation could **not measure the achievement due to a lack of data and defined targets**. Nevertheless, with regard to the reduction of fatalities within UN peacekeeping operations, the evaluation found that there was a considerable reduction from 2020 to 2024 of 50 per cent, to which the

[24] Uniformed Gender Parity Strategy 2018-2028 (full text) | United Nations Peacekeeping

project may have contributed (see Likelihood of impact) but so may have other stakeholders' initiatives and contextual shifts, such as withdrawal from MINUSMA, the deadliest mission.

52. **The immediate outcomes** relating to participants meeting the completion requirements were surpassed, with 100 per cent of male and female military and/or police participants of the preparatory workshop in Dar es Salaam, Tanzania successfully meeting the completion requirements and receiving a certificate, and 100 per cent of basic training participants in Senegal, Rwanda, Togo and Niger. As for the immediate outcome relating to participants indicating an increased confidence in their capacities to address physical and psychological trauma, this target was equally surpassed, with 100 per cent of surveyed participants agreeing or strongly agreeing that their ability to address physical and psychological trauma in a gender-responsive manner increased as a result of the training, 98 per cent of surveyed participants from basic and advanced training agreeing or strongly agreeing that their confidence in addressing physical trauma increased as a result of the training, and 98 per cent of surveyed participants from basic and advanced training agreeing or strongly agreeing that their confidence in addressing psychological trauma increased as a result of the training.

53. **At the output level, training activities were all completed in time and exceeded numerical targets.** The outputs from the **IP's grants included 11 training events**: four Training of Trainers (two in Tanzania, one in Kenya and one in Ghana); four pilot (basic) training in Togo, Ghana, Burkina Faso and Senegal; two basic training in Ghana and Kenya; and one advanced training in Kanyonyo, Kenya (ToT). However, **11 other trainings were delivered only with the support of their corresponding T/PCCs without requiring a grant**. These trainings consisted of six basic trainings in Chad, Niger, Senegal, Rwanda, Tanzania and Togo; and four advanced (ToT) trainings in Senegal, Togo and Rwanda and Tanzania. In summary, 12 basic training events were organized instead of eight and five ToT instead of four. Five advanced trainings were delivered, making a total of 10 trainings selected by the beneficiary instead of eight.

54. The planned and actual training dates varied due to the time required for finalizing agreement signatures and fund disbursement, changes in content (closure of MINUSMA) that impacted T/PCCs' training, deployment and rotation schedules, as well as due to the predeployment training calendars of beneficiary T/PCCs, who set the training dates. Nevertheless, all planned activities were implemented within the time frame of the donor-funded project. In total, and as evidenced in Table 5, **22 events were delivered**.

55. As for the non-training related outputs, while the UN MissionMed was upgraded on Android and developed for iOS, the immediate outcome relating to downloads of the app was not fully achieved (70 downloads compared to a target of 112) due to the fact that project management decided to pause the promotion of the app while partnership discussions were ongoing.

Table 5 - List of Training Events Delivered by Category

Event name, location and dates	IP	Overall beneficiaries	Unique beneficiaries
Training of trainers and advanced training			
Training of trainers (ToT), African Peacekeeping Rapid Response Partnership (APRRP) Medical Centre, 20-25 May 2024.	Medical services of Ghana Armed Forces	11	7

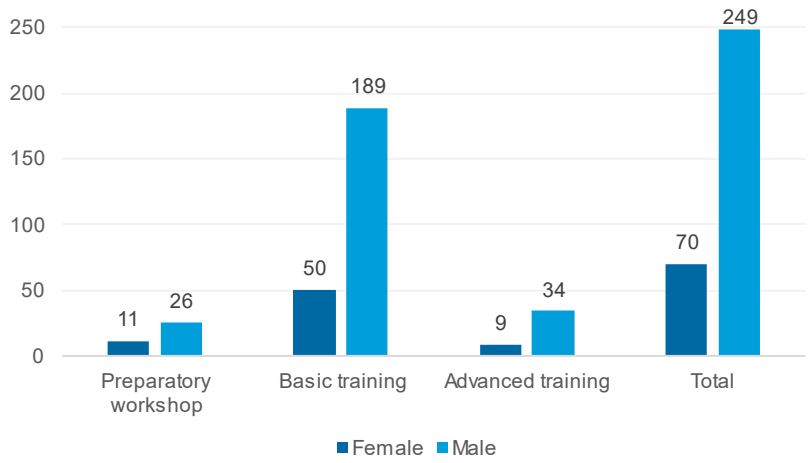
	(part of the 2nd agreement).		
ToT, Kenya, 27 May-1 June 2024.	APS (not part of the LoA).	10	1
Advanced training on mental health, Kenya 17-21 June 2024.	APS (not part of the LoA).	10	9
Advanced training, Senegal, 2024.	Not reported in RPA, FNR or LoA.	10	8
Advanced training, Togo, 2023.		10	7
ToT for medical and paramedical personnel, Chad, 23-28 October 2023.		10	1
ToT for paramedics, Rwanda, 2024.		11	10
TPF medical ToT, Tanzania Police School, Moshi, 15-20 April 2024.	Tanzania Police Force	10	0
Total		**82**	**43**
Basic training and Preparatory Workshops			
ToT for medical and paramedical personnel, Dar Es Salaam, Tanzania, 19-30 September 2022.	RPA	20	20
Predeployment training for medical and paramedical personnel deploying to UN peacekeeping missions, Thiès, Senegal, 2-19 May 2023.	RPA	10	10
Predeployment training for medical and paramedical personnel, Lome, Togo, 3-21 October 2022.	RPA	20	20
Predeployment training for medical and paramedical personnel, Accra, Ghana, 10-28 October 2022.	RPA	20	20
Predeployment training for medical and paramedical personnel, Ouagadougou, Burkina Faso, 14 November-2 December 2022.	RPA	22	19
Predeployment training for medical and paramedical personnel, Dakar, Senegal, 21 November-9 December 2022.	RPA	19	10
Predeployment training for medical and paramedical personnel deploying to UN peacekeeping missions, Accra, Ghana, 21 August-1 September 2023.	Medical services of Ghana Armed Forces	22	22
Predeployment training for medical and paramedical personnel deploying to UN peacekeeping missions, Kanyonyo, Kenya, 4-22 September 2023.	APS	26	26
Predeployment training for medical and paramedical personnel deploying to UN peacekeeping missions, N'Djamena, Chad, 14-29 August 2023.	No information on the IP.	28	28
Predeployment training for medical and paramedical personnel deploying to UN peacekeeping missions, Moshi, Tanzania, 31 July-18 August 2023.	Tanzanian People's Defence Forces (no LoA).	24	24
Predeployment training for medical and paramedical personnel deploying to UN peace operations: Training of Trainers, Dar es Salaam, Tanzania, 9-18 January 2023.	Tanzania Peacekeeping Training Institute (no LoA, partner on another project).	17	17
Formation préalable au déploiement du personnel médical et paramédical dans les opérations de maintien de la paix, Niamey, Niger, 20 February-10 March 2023.	Niger Armed Forces (no LoA).	18	18

Formation préalable au déploiement du personnel médical et paramédical dans les opérations de maintien de la paix, Lome, Togo, 6-24 March 2023.	Togolese Army Division du Maintien de la Paix and centre d'entrainement aux opérations de maintien de la paix (CEOMP/FAT).	22	22
Predeployment training for medical and paramedical personnel deploying to UN peace operations, Gishari, Rwanda, 27 March-14 April 2023.	No LoA, likely in partnership with Gishari police training school.	20	20
Total		**276**	**276**
Grand total		**360**	**319**

Note: A gap is observed between the activities recollected in IP's Letters of Agreement (LoA) and Final Narrative Report (FNR). Both sources cover fewer activities than registered in UNITAR's events database.

56. **As of November 2024, all the activities outlined in the agreement were implemented and more intended beneficiaries were reached:** 319 unique participants (and 360 if multiple participation is included) benefited from training activities against a global target of 240. **The project struggled to gather gender-balanced groups,** which remains challenging due to the structural complexities within peacekeeping roles (Figure 4). Through the ToT (participants taking part in preparatory workshops), the project reached out to 11 female participants out of 37 total participants (30 per cent) and 70 out of 319 non-unique participants through the basic and advanced training (22 per cent). However, these ratios are within the targets of the uniformed gender parity strategy 2018-2028.

Figure 4 - Unique beneficiaries by type of training by gender



57. Regarding the outreach to francophone trainers, the full ToT reached 10 francophone participants (59 per cent), compared to 41 per cent of anglophone participants, which was reflected in the proportion of trainers selected for delivering training. Out of the four female participants in the ToT, none were francophone.

58. **Limitations were always clearly flagged** to set reasonable expectations, including on the above challenges, which include realistic progress towards female trainers'

recruitment or trained female deployment. The quality of analysis was supported by close follow-up from the project manager and participation in a high number of events, as reported by focal points.

59. **Training participants who took part in the surveys paid tribute to the quality of the training, specifically to the professionalism of trainers.** Participants repeatedly stated that trainers were "excellent", "so good", "perfect". Knowledge of the context of the training is necessary, as nationals from the country where training was held and/or UN background and missions (deployment) experience might have influenced this appreciation. For example, Niger training was delivered by a Nigerien and a Burkinabé. The trainers' methodological approach was also praised for its inclusiveness. Namely, participants appreciated reduced hierarchical barriers and said that trainers engaged with each participant on the same level, regardless of his/her medical background, rank or gender. In Niger, military hierarchy challenged engagement but trainers managed to lower barriers. The mix of professions[25] was judged as "so enriching" and as a success factor of the training. ToT participants praised the educational techniques and interactive exercises, the energizers on MHPSS and appreciated how female participation was encouraged. **The main limitations observed by participants and trainers were the training duration, with the allotted time for practical sessions and the overall time frame for advanced training being deemed as too short, shortage of equipment and late communication about participants profiles**. Many respondents signalled that more time would have been useful, particularly as there was a wealth of training content.

60. **The approach of the project, including regional and other international trainers, allowed complementary** perspectives and expertise, as well as the combination of skills from the team of trainers, which included previous participation in peacekeeping missions and mental health expertise. While regional trainers have a deep understanding of the local context, language and social dynamics, international trainers bring experience from diverse settings, exposing trainees to approaches and solutions proven effective in other contexts. Furthermore, the adjustment of the advanced training to ToT aligned with the capacity-building needs on TCCC and MHPSS of the peacekeepers. This combination of perspectives and activities enhanced the effectiveness and sustainability of the project.

61. **The training content was deemed to be effective for acquiring new skills or refreshing life-saving procedures uncommon in daily practice of the trained personnel.** The most relevant topics for participants were management of casualties, particularly under combat and under fire, control of massive bleeding using a tourniquet, and the psychosocial support component, such as managing stress and psychological consideration when handling casualties. (Re)learning how to place a tourniquet came as the most recurring example of relevant teaching. The evaluation also found that the range of topics addressed during the training was broad enough to speak to all professional categories. Doctors who were interviewed appreciated the refreshers on life-saving techniques while some paramedical personnel took on the new learning. Forty-three per cent of the training beneficiaries reported they had no previous experience on mental health. The project addressed a training gap.

[25] According to the survey, given that this information was only available for around half of the training participants, 34 per cent were doctors, 31 per cent were nurses, 8 per cent were paramedics, and 27 per cent came from other professions related to medical and psychological health, such as physiotherapists, biomedical engineers and pharmaceutical technologists.

62. Despite knowledge assessments administered through pre- and post-tests, participants received **certificates of participation** due to the sensitivities around certifying deploying UN peacekeepers instead of certificates of completion, as foreseen by the UNITAR certification policy. In the second interim narrative report, it was described that **learning objectives** were measured through an individual pre- and post-training questionnaire for the ToT. The results showed an increase in correct answers in most modules and helped identify the areas in need of reinforcement. For the other training events, learning objectives were measured through observations during training, and individual pre- and post-training questionnaires, i.e. an objective assessment of learning. The fact that the modules on mental health tended to have the lowest pre-questionnaire scores on average and a significant post-test improvement confirms the effectiveness of the learning event.

Table 6 - Log frame measurement

Expected Results	Indicators	Targets	Baseline Data	Endline	Observations
Ultimate Outcome					
Improved performance of United Nations peace operations in increasingly complex and high-risk environments.	Number of peacekeeping missions evaluated as performing to standards of the Comprehensive Planning and Performance Assessment System (CPAS).	Not defined (ND)	ND		Information is not accessible to the evaluators. A target was not defined for this indicator.
Intermediate Outcomes					
1.1. Enhanced physical and mental well-being of male and female uniformed personnel deployed to the top four high-risk UN peacekeeping operations.	Percentage reduction of fatalities within UN peacekeeping operations.	ND	Sex-disaggregated/ military/police-disaggregated baseline data will be collected during the initial phase of the project.	50% reduction (2020 to 2024) in fatalities of MINUSCA-CAR 44% reduction in fatalities in MINUSMA 46% reduction in fatalities in MONUSCO-DRC 50% reduction in fatalities in UNMISS Number of fatalities 2020 to 2024: MINUSCA: 32 to 16 MINUSMA: 23 to 13 MONUSCO: 22 to 12 UNMISS: 20 to 10	A target was not defined for this indicator. This reduction cannot only be attributed to the project. Based on UN peacekeeping data. No sex and appointment type distribution available per year.

Expected Results	Indicators	Targets	Baseline Data	Endline	Observations
1.2. Improved performance of male and female uniformed personnel deployed to the top four high-risk UN peacekeeping missions.	Percentage reduction of fatalities within UN peacekeeping operations.	ND	Sex-disaggregated/ military/police-disaggregated baseline data will be collected during the initial phase of the project.	50% reduction (2020 to 2024) in fatalities of MINUSCA-Car 44% reduction in fatalities of MINUSMA 46% reduction in fatalities of MONUSCO-DRS 50% reduction in fatalities UNMISS	This reduction cannot only be attributed to the project. Based on UN peacekeeping data. No sex and appointment type distribution available per year.
Immediate Outcomes					
1.1.1. Strengthened knowledge and skills of male and female uniformed medical personnel (military and police) deployed to the top four high-risk UN peacekeeping operations, in basic field medical and psychological trauma.	Percentage of male and female participants (from military and police) successfully meeting the completion requirements of the basic training session.	85% of male military and/or police participants (82 total) and 85% of female military and/or police participants (54 total) successfully meet the completion requirements of the training session.	ND	100% of male and female military and/or police participants of the preparatory workshop in Dar es Salaam, Tanzania successfully met the completion requirements. 100% of basic training participants in Senegal, Rwanda, Togo, and Niger (from 2023) successfully meet the completion requirements.	Percentages are based on the EMS data. Basic training not mentioned here, did not require certificate of completion but participants were assessed and received a certificate of participation. Data on the self-assessment is not available. The final narrative report indicates an increase of knowledge based on a sample of the training participants but does not specify what type of training neither the scale for completion.

Expected Results	Indicators	Targets	Baseline Data	Endline	Observations
	Percentage of male and female participants (from military and police), indicating an increased confidence in their capacities to address physical and psychological trauma.	85% of male military and/or police participants (82 total) and 85% of female military and/or police participants (54 total) indicated increased confidence in their capacities to address physical and psychological trauma in a gender-responsive manner.	ND	100% of those surveyed agree (30%) and strongly agree (70%) that their ability to address physical and psychological trauma in a **gender-responsive manner** increased. 98% of surveyed participants from basic and advanced training agree (29%) and strongly agree (69%) that their confidence in addressing **physical** trauma has increased as a result of the training. 98% of surveyed participants from basic and advanced training agree (28%) and strongly agree (70%) that their confidence in addressing **psychological** trauma has increased as a result of the training.	
1.1.2. Improved knowledge and skills of male and female uniformed medical personnel (military and police) deployed to the top four high-risk UN peacekeeping operations, in advanced field medical trauma.	Percentage of male and female participants (from military and police) successfully meeting the completion requirements of the advanced training session.	85% of male military and/or police participants (82 total) and 85% of female military and/or police participants (54 total) successfully meeting the completion requirements of the training session.	ND	60% of training participants of one advanced training fully and mostly met the completion requirements of the training session.	Information only available for one training session. Advanced training is not mentioned on the EMS. Data on the self-assessment is not available. The final narrative report indicates an increase of knowledge based on a sample of the training participants but does not specify what type of training neither the scale for completion.

Expected Results	Indicators	Targets	Baseline Data	Endline	Observations
1.1.3. Increased knowledge and use of the UN MissionMed mobile applications (Android and iOS) by trained uniformed medical personnel (military and police).	Percentage of male and female participants (from military and police) downloading the UN MissionMed mobile application.	70% (112 total) of military and/or police participants who were trained downloading the UN MissionMed mobile application.	NA	70 downloads have been made (Android).	63% of the target (112). 22% of the total unique beneficiaries. Disaggregation of data per gender is not available. Three additional downloads have been made for iOS but this information was not included as the downloads were made by the evaluation team. Project management decided to pause the promotion of the app while partnerships were discussed.

Expected Results	Indicators	Targets	Baseline Data	Endline	Observations
1.2.1. Increased awareness of male and female uniformed medical personnel (military and police) deployed to the top four high-risk UN peace-keeping operations of the importance of physical and mental health for effective performance.	Percentage of male and female participants (from military and police) can demonstrate the link between physical and psychological well-being and effective performance.	85% of male military and/or police participants (82 total) and 85% of female military and/or police participants (54 total) can demonstrate the link between physical and psychological well-being and effective performance.	NA	**98% of surveyed participants from basic and advanced training agree (72%) and strongly agree (26%) that they now give more importance than before to their physical health in relation to their performance.** 100% of female participants agree (36%) and strongly agree (64%). 98% of male participants agree (24%) and strongly agree (74%). **97% of surveyed participants from basic and advanced training agree (70%) and strongly agree (27%) that they now give more importance than before to their fellow peacekeepers' mental health in relation to their performance.** 100% of female participants agree (29%) and strongly agree (71%). 98% of male participants agree (26%) and strongly agree (70%).	
Outputs					
1.1.1.1.a Training package is reviewed (content/methodology) to integrate the specific and gendered needs, as well as the country/mission context.	Number of training packages reviewed to integrate the specific and gendered needs, as well as the country/mission context.	Eight gender-responsive/ military/police adapted training packages developed.	NA	Two training packages reviewed: basic curriculum and UNITAR curriculum. Two preparatory workshops delivered. Nine basic training packages adapted and 12 delivered. Seven advanced training packages adapted and eight delivered.	Integrated with MHPSS and includes a session on gender. UNITAR curriculum. Participants were evaluated at the beginning of the training to assess their previous knowledge and adapt the content accordingly. However, during the interviews, some trainers suggested better

Expected Results	Indicators	Targets	Baseline Data	Endline	Observations
					adapting the training to local contexts.
1.1.1.1.b Preparatory workshop is attended by a gender-balanced group of UNITAR trainers.	Percentage of UNITAR trainers attending the preparatory workshop, disaggregated by sex, language (English/French/other), and area of expertise.	A gender-balanced group of 16 UNITAR trainers attend the preparatory workshop - nine male (56%) and seven female (44%).	NA	13 male participants (76%) and 4 female participants (24%).	Targeted number of beneficiaries surpassed; however, not gender-balanced.
1.1.1.1.c Training sessions are attended by gender-balanced/ military and/or police groups of medical and paramedical personnel.	Percentage of male and female medical and paramedical personnel from the military and/or police attending the training sessions.	A gender-balanced group of 160 medical and paramedical personnel from the military and/or police attend the training session - 96 male (60%) and 64 female (40%).	NA	189 male participants (79%) and 50 female participants (21%).	Targeted number of beneficiaries surpassed; however, not gender-balanced.
1.1.2.1.a Advanced training sessions are attended by gender-balanced/military and/or police groups of medical and paramedical personnel.	Percentage of male and female medical and paramedical personnel from the military and/or police attending the training sessions.	A gender-balanced group of 80 medical and paramedical personnel from the military and/or police attend the training session (48 male (60%) and 32 female (40%).	NA	62 male participants (75%) and 21 female participants (25%).	Targeted number of beneficiaries surpassed; however, not gender-balanced.

Expected Results	Indicators	Targets	Baseline Data	Endline	Observations
1.1.3.1.a Android version of the UN MissionMed mobile application is upgraded to include French translation and other relevant materials.	Percentage of upgraded Android UN MissionMed mobile applications.	One Android version of the UN MissionMed mobile application is upgraded to include French translation and other relevant materials.	Current version of Android UN MissionMed mobile application.	One Android version of the UN MissionMed mobile application is upgraded to include French translation and other relevant materials.	Supplements the basic UNITAR predeployment medical training and is based on the revised Medical Support Manual for United Nations Field Missions as well as relevant UN policies, doctrines and procedures on mental health, with a particular focus on Psychological First Aid (PFA).
1.1.3.1.a iOS version of the UN MissionMed mobile application is developed.	Percentage of iOS UN MissionMed mobile applications.	One iOS version of the UN MissionMed mobile application is developed.	NA	One iOS version of the UN MissionMed mobile application is developed.	
1.2.1.1.a Training packages are reviewed to underscore the link between good mental and physical health and effective performance in UN missions.	Percentage of training packages reviewed to underscore the link between good mental and physical health and effective performance in UN missions.	Eight gender-responsive/ military/police adapted training packages are reviewed.	NA	The revision and actualization of the basic curriculum with integrated Mental Health and Psychosocial Support (MHPSS) modules has now been finalized and is also based on the Tactical Combat Casualty Care (TCCC) curriculum.	Integrated with MHPSS and includes a session on gender. UNITAR curriculum. 2 training packages reviewed: Basic curriculum and UNITAR curriculum. 2 preparatory workshops delivered. 9 basic training packages adapted and 12 delivered. 7 advanced training packages adapted and 8 delivered.

Evaluation Question 3.2: Has the project's design, with its multiple components and partnerships, been effective in delivering and attaining results, including the performance of the four implementing partners?

63. Except for the IP's assessment report (available for the RPA and the first grant for APS Kenya), which consists of a check list on performance and that states that the partners fulfil all responsibilities related to planned deliverables, the evaluation did not find additional information about the quality of the partnerships. Findings related to other partnership aspects are presented under the efficiency section.

Efficiency

Rating: Satisfactory

Evaluation Question 4.1. To what extent has the project delivered its results in a cost-efficient manner and optimized partnerships?

64. The project partnership modalities are found to be time and cost-efficient, relying on decentralised implementation and proportional financial responsibilities. Training activities were managed by four IPs through six grants: TPF, the Department of Medical Services of Ghana Armed Forces, the Kenyan APS and the RPA. Except for the RPA and the TPF, project partners have little to no records of previous partnerships with UNITAR and oversaw training implementation in their country. Budget analysis indicates that TPF, APS and the Ghana Medical services managed local costs only, such as stationary, ground travel expenditures, fuel, meals and venue rental. UNITAR managed other expenses and contractual matters, such as hiring and deploying trainers, which limited risks and responsibilities. The case of the RPA is different. As a UNITAR partner since 2018, and a renowned African training centre,[26] the RPA managed their training budget in full, including trainers' travel expenses, DSA and trainers' fees. Partnership records and management capacity took financial responsibility seriously, which was found to be efficient and mitigated management risks.

65. **The RPA was delegated with overseeing training activities in Tanzania, Togo, Ghana, Senegal and Burkina Faso**. RPA organized five training events out of 11 in francophone and anglophone countries. This accounted for 15.4 per cent of the total budget and 90 per cent of the IP's budget (see Table 7) since RPA organized more events and fully managed related budgets. This project contributed to strengthening an institutional partnership, working with UNITAR on 10 projects since 2018, and to extending the TCCC and MHPSS curriculum to an influential African training centre.

Table 7 - Funds Allocation per Implementing Partner

Name of implementing partner	Budget managed in $	% of the IP's budget
The Rwanda Peace Academy	$343.994,15	90%
Department of Medical Services of Ghana Armed Forces	$8.520	2,23%

[26] Académie Rwandaise pour la Paix, article Observatoire Boutros-Ghali Septembre 2022

The Administration Police Service (APS) Kenya	$24.023,20	6,30%
Tanzania National Police	$5.661,86	1,50%
Total budget to IPs	**$382.199,21**	100%
Total donor funding (CAN$ 3,393,200.02)	**$2.478.597,53**	
Percentage total IP funding from total donor funding	**15%**	

66. Overall, project communication was reported as good. Proactiveness was praised in the relationship between the donor and the IPs. The review of project documentation indicates that UNITAR ensured representation of the donor in all project activities, inviting representatives from the GAC to all opening and closing ceremonies. A few interviews outlined instances of challenged communication and low transparency about the participants' selection criteria, which is a matter beyond the project's control, the list of participants and the ongoing curriculum supported by other partners.

67. The review of the app statistics, as of 4 August 2024, indicates a total of 70 downloads for Android and three for iOS since the app launched on 31 May 2021. Low visibility is explained by the decision of project management to purposefully withhold the roll-out of the app while a new partnership was discussed. Development and translation were performed as planned and corresponded to a minimal share of the budget (i.e. 2 per cent or $52,708 for development of iOS and translation into French, see Table 8). Consequently, 69 per cent of survey respondents have never heard about the application, 19 per cent knew about it but have never used it, and only 12 per cent knew about it and used it.

Figure 5 - Installed audience (all users, unique users, per interval, daily)

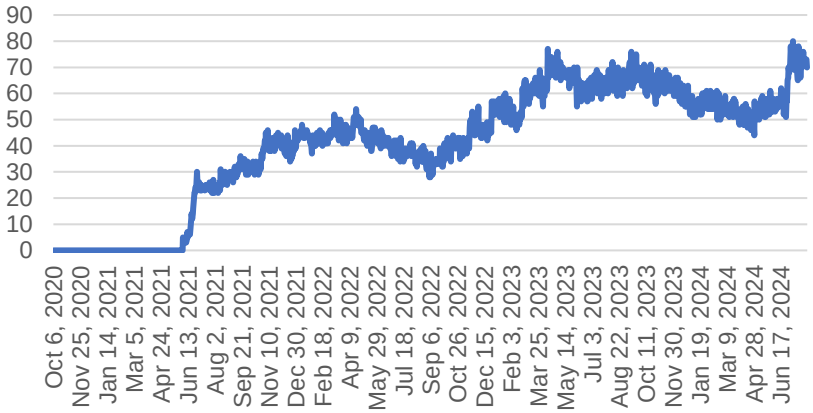
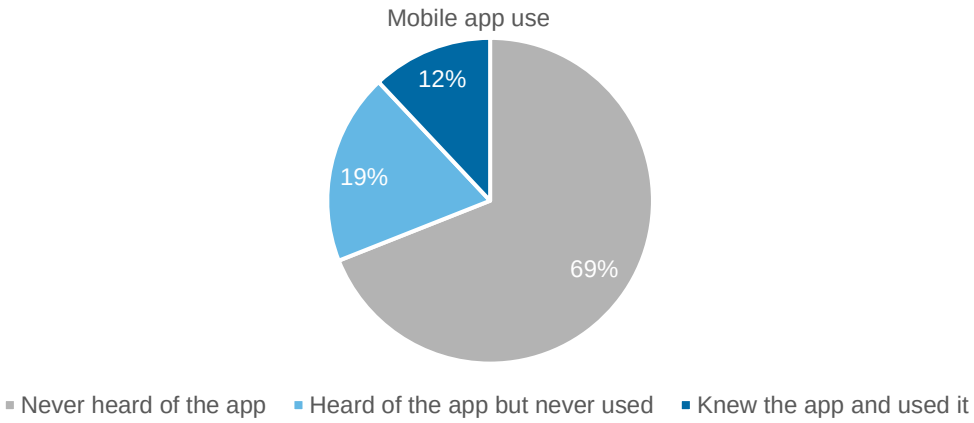


Figure 6 - Use of the mobile app by participants



68. The final financial report could not be consulted since all expenses were not disbursed at the time of the evaluation, but Table 8 **confirms the cost ratio and main expenses**. Main expenses relate to Activity 3, that is, eight four-weeks training and one-week team preparation and personnel costs, followed by travel costs. It is noted that the evaluation budget was reallocated and reduced to $24,424.

Table 8 - Budget Allocation per Activity

Activity	Amount in Can$	Amount in US$
Activity 1: Package review	Can$ 36,052.00	US$ 26,318
Activity 2: Trainers preparatory workshop	Can$ 132,635.40	US$ 96,824
Activity 3: 8 x 4 weeks training + 1 week team preparation	Can$ 1,440,340.40	US$ 1,051,448
Activity 4: 8 x 1 week advanced training	Can$ 595,777.58	US$ 434,917
Activity 5: Upgrade UN MissionMed to French and new content	Can$ 54,078.00	US$ 39,477
Activity 6: Develop iOS version for mobile app	Can$ 18,125.00	US$ 13,231
Activity 7: Direct costs	Can$ 821,804.42	US$ 599,917
+7% overheads, 2,5% independent evaluation	Can$ 294,387.22	US$ 214,902
TOTAL	**Can$ 3,393,200.02**	**US$ 2,477,034**

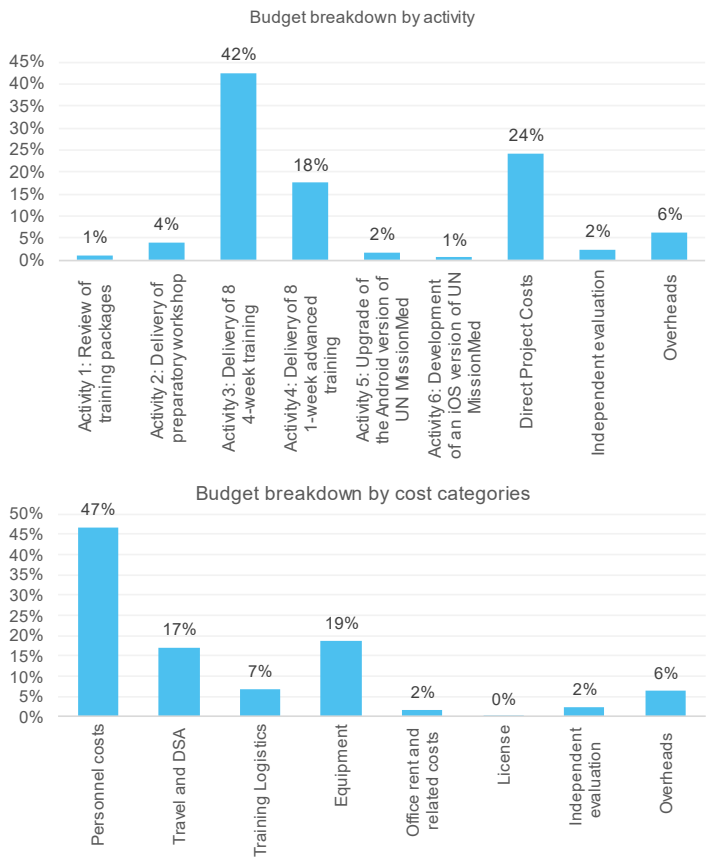
Evaluation Question 4.2. To what extent was the project, including both activities and planned expenditures, delivered as planned? To what extent did interim narrative/performance management framework reporting capture progress towards results? What caused deviations from the original plan? Did the project apply adaptive management to adjust to implementation challenges?

69. Overall, in the absence of the final financial report, a review of the budget reveals that **Activity 3 (Delivery of eight four-weeks trainings) has the highest planned cost** at Can$ 1,440,340.40, accounting for 42 per cent of the total. Common costs also represent a significant portion at Can$ 821,804.42 (24 per cent). Together these two activities account for 66 per cent of the budget. Activity 4 (Delivery of eight one-week

advanced trainings) has a moderate cost of Can$ 595,777.58 (18 per cent). Other activities, such as Activity 2, delivery of one two-weeks preparatory workshop for UNITAR trainers (4 per cent), Activity 5, upgrade of the Android version (2 per cent), Activity 6, development of an iOS version of the UN MissionMed (1 per cent) and Activity 1, review of training packages (1 per cent) represent smaller portions of the budget. Overheads (direct support costs and project support costs) are budgeted at 6 per cent and the independent evaluation at 2 per cent. The evaluation assumes that some budget was reallocated to, for example, take into account the additional and unplanned training events and changes resulting from the change in beneficiary countries and underspending on equipment, as further described below.

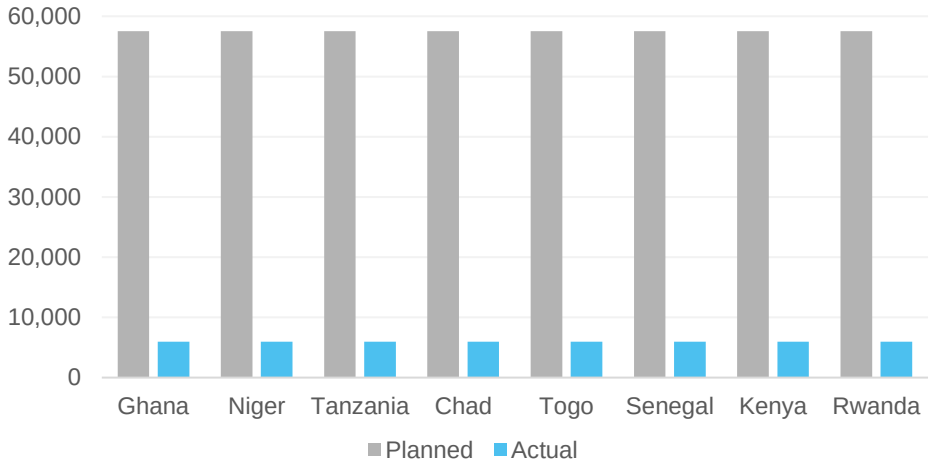
70. **Personnel costs (especially for trainers), travel and Daily Subsistence Allowances (DSA), and equipment consume the majority of the budget, with other expenses contributing smaller amounts.** Personnel costs are the largest expense at Can$ 1,589,889.12, accounting for 47 per cent of the total budget. Within this, trainer costs alone represent Can$ 721,036.80 and almost half of the personnel costs (21 per cent). Equipment costs are Can$ 640,130.40, representing 19 per cent. Travel and DSA costs are Can$ 579,965.40, making up 17 per cent of the total. Training logistics, which includes catering, printing, shipment, etc., amount to Can$ 227,620.78 (7 per cent). Office rent and related costs are Can$ 61,108.10 (2 per cent) License costs are minimal at Can$ 99.00 (less than 1 per cent). Overheads (direct support costs and project support costs) are budgeted at 6 per cent and the independent evaluation at 2 per cent.

Figure 7 - Budget breakdown by activity and cost categories



71. **Planned expenditures for training equipment were underspent.** Ten per cent of what was budgeted for training equipment (kits) for Activities 3 and 4 was spent on purchasing the FMAK, according to information available in the final narrative report. The details of the costs of the different items in the FMAK, as listed in the final narrative report, give a total of $2,627.94 which is slightly less than the $2,748 per kit as in the letters of reception signed by the countries (each received two FMAKs). In addition to kits that were distributed to T/PCCs, UNITAR also purchased training kits and materials needed for training only, which are not included in the below cost overview.

Figure 8 - Planned and actual equipment costs (in $)



72. **Project management was found to be efficient in mobilising a network of new and existing partners to reach relevant health entities and facilities, and smoothly replacing partner countries which stepped out for security reasons**: a blend of medical and in-country new partners and long-standing and solid training partners with a regional and bilingual mobilisation capacity. Despite the quality of UNITAR's reporting on this project, the information about how project partners were identified is missing. It is known, however, that UNITAR managed to replace Niger and Burkina Faso partners after the military coups interrupted project activities and UNDSS issued a no travel except for essential travel advisory and after basic predeployment trainings were delivered. The TFP and APS replaced Niger and Burkina Faso national partners. APS also replaced the initial Kenyan partner after a series of miscommunications resulted in a cancelled training session. These are indications of a resourceful organization and flexible management type.

73. **Interviews reported a few unbudgeted costs hampered training dynamics at the start**. In Tanzania, unbudgeted translation of training materials in Swahili, despite recruitment of native Swahili trainers, reportedly slowed dynamics on the first days of training. Similarly, despite careful recruitment of Kinyarwanda native speakers as trainers, interviews and surveys reported needs for French interpretation in Rwanda. Translation and provisions for interpretation were suggested as costs or criteria for future training events. On a similar note, although learned from the first phase, financial provisions for training consumables were flagged as necessary on a few occasions. Petty cash was used by trainers for 'last minute purchases', such as gloves, sterile gauze and training equipment, such as mannequins. UN regulations' restrictions on petty cash may be mitigated by providing an inventory of equipment with IPs and complementing

kits before shipping. Alternatively, trainers' kits may be procured with the most useful/main items that have sometimes been missing but needed in training.

74. **Equipment pre-inventory in-country and in the targeted health facilities was flagged as an efficiency factor:** i) to ensure learnings could be replicated afterwards; and ii) to assess if non-delivery of training equipment could be mitigated with local resources. Interviewees reported that the differences in equipment, or the lack thereof, slightly hampered the learning process or the smooth start of the training. In a few instances, delays in shipping, for instance, DHL from Tanzania to Kenya, combined with the lack of equipment in the hosting structure resulted in the IP borrowing equipment (e.g., TPF borrowed from the Red Cross) at the last minute or trainers rushing to purchase extra consumables. On the other hand, IPs outlined that good planning practices promoted by UNITAR allowed needs to be anticipated and inter-service borrowing to be organized. As an example, Niger secured an ambulance for practical exercises.

75. The late disbursal of funds was reported in Kenya and Tanzania as a pressure factor on the IP and on the new partnership with UNITAR. This occurred when UNITAR transitioned to a new Financial Management System, which resulted in delays. In Kenya, the Chief of the Kenyan Police had to borrow funds to launch the training activities and respect the agreed planning. In Tanzania, the Chief of International Relations at the TPF also borrowed funds. This situation was reported as "embarrassing" in the context of a new partnership" (Kenya) and, unsurprisingly, resulted in a recommendation for better financial planning.

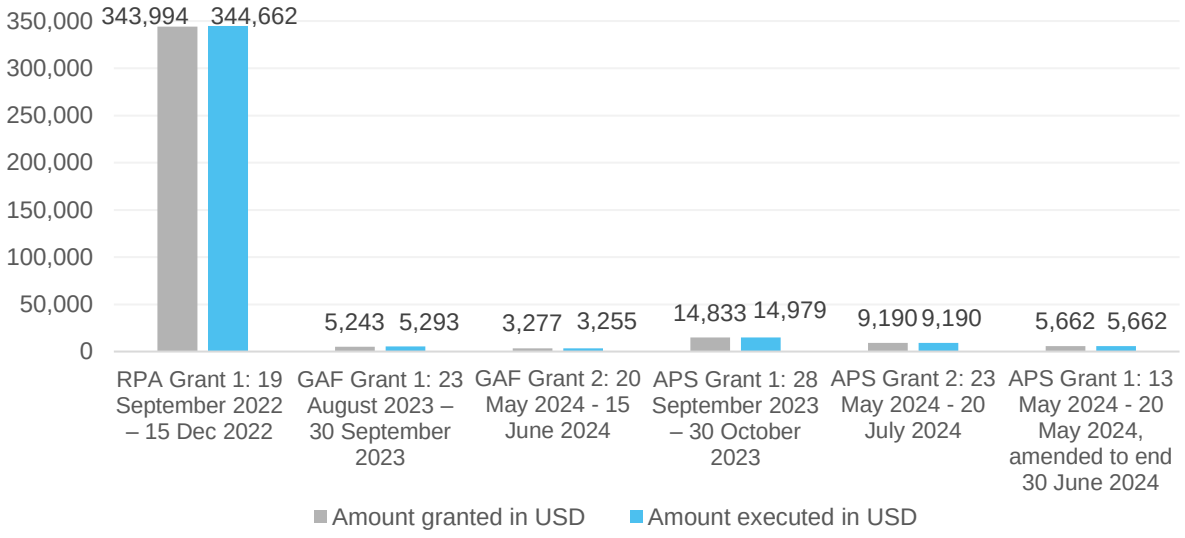
76. IP reporting provides information about scheduled events. It is found to be a useful monitoring tool to follow the implementation of activities and cross check with Letter of Agreement (LoA) commitments. As noted under the effectiveness section, gaps are identified between the final training list and LoA commitments. Despite IP reporting monitoring value, it serves no analytical function. with comments and recommendations sections mostly left unanswered or acknowledging the usefulness of the cooperation and expressed interest in renewed partnership. Exception is noted for APS Kenya who shared specific recommendations, which shall be encouraged as an example of good practice. For instance, APS submitted requests for equipment (ambulance equipment, IFAK and TACMED consumables) and for training and methodological support (TACMED officers to visit Border Police hospital). Systematic collection of information about the trainers' nationality and gender could be added to IP reports to help assess the usefulness of the UNITAR roster and the mobilisation of local human resources.

Evaluation Question 4.3. To what extent has the project produced outputs in a timely and cost-efficient manner, including through grant arrangements with implementing partners (Rwanda Peace Academy, Department of Medical Services of Ghana Armed Forces, Administration Police Service Kenya and Tanzania National Police) in comparison with alternative approaches? Were the project's resources (human and financial) used as planned and fully utilised?

77. The budget allocated for activity implementation through Implementing Partners amounted to $382,199.21[27] equivalent to Can$ 523, 230.71, representing 15.4 per cent of the project's total budget. The Rwanda Peace Academy received 13.9 per cent of the total budget ($343,994.15) to conduct the Preparatory Workshop in Tanzania and pilot trainings in Ghana, Senegal, Burkina Faso and Togo. APS Kenya was allocated approximately 1 per cent of the budget ($24,023.20) to deliver one basic, one advanced, and one Training of Trainers (ToT) session. The Department of Medical Services of the Ghana Armed Forces was granted 0.34 per cent ($8,520.00) for one basic and one ToT training, while the Tanzania Police Force received 0.23 per cent of the total budget ($5,661.86) for delivering one ToT.

78. **The financial resources were fully utilized, with overall expenditures exceeding the budget by a maximum of 1 per cent**. However, when analysed by budgetary line, some partners exceeded or underspent by over 20 per cent on specific items. This variation was allowed in agreements with IPs. For example, in the first grant to the GAF, funds allocated for transport were unspent (null execution), while "administrative and office" (135.7 per cent) and "snacks and lunch" (155.97 per cent) expenses exceeded planned amounts. Similarly, the second grant saw variations in logistics-related budget lines. In the first grant for the APS, Kenya, there was an overspend on logistics and refreshments and an underspend on administrative costs, while the second grant showed no budget deviations. The Tanzania Police Office also maintained adherence to the budget in its second grant.

Figure 9 - IP budget vs execution per IP grant ($)



[27] According to the UN Operational Rates of Exchange per US$ of 14 Jun 2024: Can$= 1.37 per US$; GHS=14.95 per US$, KES=128.03 per US$, TZS=2,601.62 per US$.

Likelihood of Impact

Rating: Satisfactory

Evaluation Question 5.1. What are the potential cumulative and/or long-term effects expected from the project, including contribution towards the intended impact and intermediate outcome, positive or negative impacts, or intended or unintended changes?

79. **The project has enhanced medical and paramedical personnel's skills set and preparedness for deployment inside and outside of the scope of the project missions.** As reported by interviewees, the project also contributed to a shift in the target group's mentalities by linking physical health and mental health, whereas mental health used to be siloed and physical health used to be prioritised in minds and resources deployed, that is, in training and budgets. The project has contributed to a global effort that aims to deconstruct the taboos around mental health and the stereotyped correlation with fragility. In the context of peacekeeping missions, the project has highlighted the major consequences that stress and exposure to violence can bring to bear on individuals and on the safety of troops and operations. The project has reminded participants that mental health affects decision-making and can eventually put the lives of peacekeepers at risk. It has changed the paradigm asserting that the problem is the stressful environment and not the strength of the person deployed. Interestingly, when asked how to integrate mental health in deployment preparation, one interviewee among the T/PCCs responded: "by screening people at the recruitment stage and not selecting weak personalities". Another correlation was drawn between poor mental health and drug abuse, the latter being considered as a major concern by the T/PCC interviewed. This suggests awareness of a caring approach targeting causes rather than consequences, focusing on prevention and on what MHPSS encompasses, have yet to be understood at the senior levels.

80. Based on the survey findings, an unintended outcome of the project was the deployment of six trained participants to peacekeeping missions outside the project's scope, specifically with the United Nations Interim Security Force for Abyei (UNISFA), the United Nations Interim Force in Lebanon (UNIFIL) and the ECOWAS Mission in The Gambia (ECOMIG).This project has contributed to a global effort to acknowledge gender-differentiated challenges in joining peacekeeping missions and operating in gender-sensitive conditions. It has contributed to deconstructing a stereotyped approach to peacemaking by men and for men. Despite the variety in gender norms among the contributing countries, the project has promoted universality of women's right to health, to work in safe and decent conditions, respectful of their gender needs. The project counted among the few to discuss the weight of masculinity expectations, considering the projects discussed under the coherence section. A future phase could address women's rights to sexual and reproductive health in more detail. Homosexuality was mentioned as another taboo that the project touched upon and could further explore.

81. Although many of the interviewed and surveyed participants have not yet been deployed, they have applied their knowledge and skills at life-saving events in their daily work activities, in hospitals or in the field, contributing to the reduction of the number of deaths in the corresponding countries. Seven of the interviewees indicated that they have applied the knowledge and skills from the training in traffic accidents and other emergency settings, saving the lives of victims with various health concerns.

82. However, from a methodological standpoint, the intermediate and ultimate outcomes are found to be broad and disconnected with deployment data limitations. Interviews

suggested an intermediate outcome would be the individual and hierarchical awareness raised about MHPSS, and the technical and knowledge gaps bridged among uniformed medical personnel to respond to medical emergencies in conflict zones (see evaluation question 5.2). The ultimate outcome is an improvement in physical and mental well-being, the enhanced effectiveness of medical and emergency management, and detection and care for mental and psychological vulnerability.

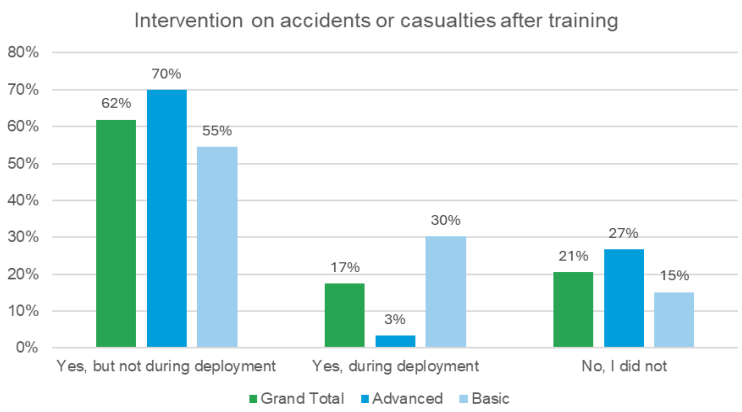
Table 9 - Project's ultimate and intermediate outcomes

Ultimate outcome ⟹	Intermediate outcome ⟹
Contributes to improving the performance of UN peace operations in increasingly complex and high-risk environments.	1.1. Enhanced **physical and mental well-being** of male and female military and police personnel deployed to the four high-risk missions – MINUSMA (now closed), MONUSCO, MINUSCA and UNMISS. 1.2. Improved performance of male and female uniformed personnel deployed to the four high-risk UN peacekeeping missions.

Evaluation Question 5.2. What real difference has the project made to improve physical and mental well-being of military and police personnel deployed to UN Peace Operations? Are there any differences between female and male uniformed deployed personnel? (GEEW)?

83. Out of 29 testimonies from training participants, four shared examples of knowledge application in a conflict and emergency context, and three admitted that knowledge faded in the absence of practice and because combat-related care was not applicable in their daily work. On application of knowledge, the surveys found that 79 per cent confirmed application of knowledge and skills by intervening in accidents or with casualties after training, yet only 17 per cent of participants did so during deployment, with significant differences between basic and advanced groups (Figure 10). Fewer women from both groups applied knowledge - 22 per cent of female respondents against 33 per cent men from the basic course and no women against 4 per cent of men among the advanced group. On the other hand, 84 per cent of all participants confirmed having used the life-saving/emergency techniques learned during the training (Figure 11).

Figure 10 - Application of casualty-related knowledge and skills from the training



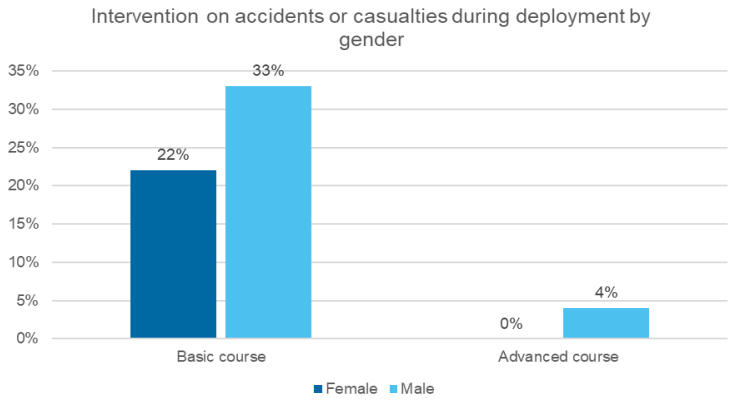
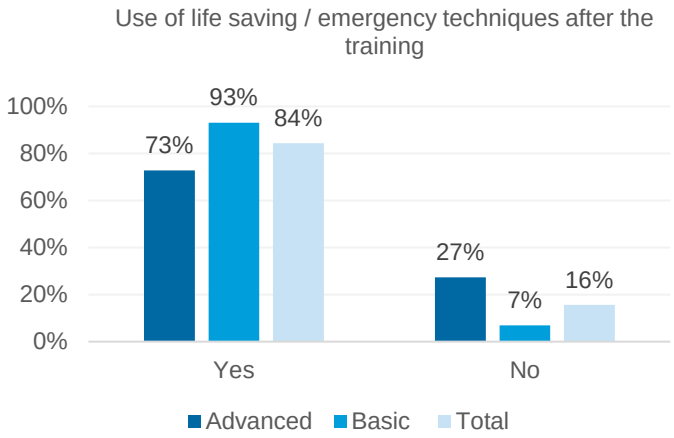


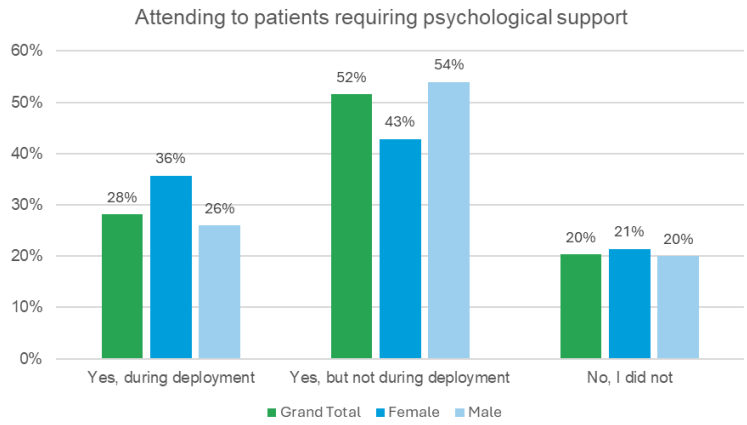
Figure 11 - Use of life-saving/emergency techniques after training

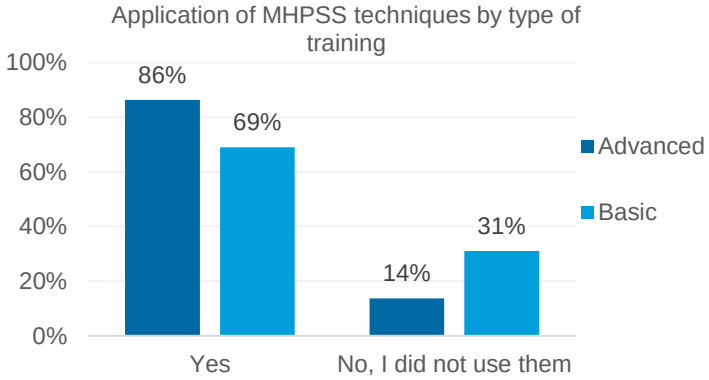


84. **The examples of knowledge application during deployment referred to MINUSCA, MINUSMA and to a military situation in Niger.** In MINUSCA, one participant successfully stopped bleeding by applying tourniquet after a colleague had an accident; in MINUSMA, the chief medical officer, and also a participant in UNITAR training, requested to add TCCC to the ongoing training in MINUSMA and recruit a female gynaecologist. In Niger, the army medical service promptly reacted to an attack. A letter of gratitude was sent to the Nigerian medical service to highlight its exceptional performance and linked it to participation in UNITAR training. Here, as well, the chief medical officer participated in the training.

85. **A few examples of MHPSS techniques were shared by training participants.** They outlined how the training changed their approach and experience in a peacekeeping mission by **managing stress**, for instance, in the frame of mental preparation to attacks and demonstrating **openness to listen to colleagues, or inviting those who appear to have difficulties to talk to them**. Twenty-eight per cent of surveyed participants have attended to personnel requiring psychological assistance during deployment, 52 per cent have used the knowledge outside deployment and 20 per cent have not attended to any patients (Figure 12). Two testimonies reported applying **gender-sensitive MHPSS practices**. In one case, the training participant was able to reassure one female deployed personnel who was stressed about her family being away. In another case, a training participants helped a woman who somatised her child sickness through unexplained gastric pain.

Figure 12 – Application of MHPSS-related skills by type of training and gender





Evaluation Question 5.3. What other observable changes (positive or negative, intended or unintended) have occurred as a result of the project implementation?

86. **Most of the changes reported happened in participants' personal life or at work in the beneficiary country (non-deployment settings)**. Out of the 29 testimonies collected, 11 mentioned tourniquet application or stopping massive bleeding, of which three were involved in responding to car accidents and five of the cases involved massive bleeding. One of the examples of successful tourniquet application was reported to have saved someone's life following a car accident. Two surveyed participants stressed the personal satisfaction and the perceived value of the new skills valued by the community.

87. **A few MHPSS-friendly practices were identified** and applied at work or in training delivered by participants. These practices include acknowledging and reacting to burnout, using sport to defuse stress, taking leave to allow time to recover, and accepting crying as a step in a recovery process.

88. **On average, almost 70 per cent of survey respondents increased their confidence to address physical and psychological trauma** as a result of the basic and/or advanced training. A higher percentage of female participants compared with male participants, in both basic and advanced training, strongly agreed that their confidence on these topics had increased.

Box 2. Extracts from testimonies

"I have applied the knowledge on how to **control mass bleeding**. This made me so respected in my community and everyone was surprised at my skill".

"I helped a lady who had been involved in a **traffic accident** with a motorist. I secured the casualty, applied a bandage and stopped the bleeding immediately. The people around were so amazed at my skill. It was a good feeling".

"I have since learned how to manage my **stress in the workplace** and I have, on several occasions, helped my colleagues to handle their own stresses. I now manage my patients better. Most of them come with underlying psychological issues, which I am quick to identify and help them to overcome".

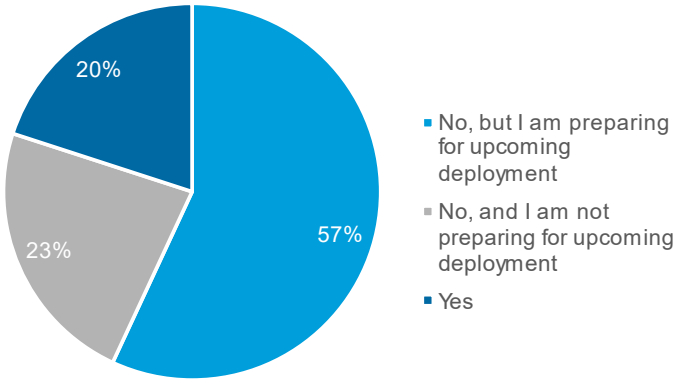
Likelihood of Sustainability

Rating: Satisfactory

Evaluation Question 6.1. To what extent are the project's results likely to endure beyond implementation of the activities in the mid- to long-term and under which conditions? How is environmental sustainability addressed in the project?

89. Learning sustainability conditions are governmental prerogatives. Interviewees insisted that a conducive working environment is needed to practice and maintain acquired skills, including opportunities to deploy to a peacekeeping mission. UNITAR sustainability leverage lies in targeting countries that are committed to deploying uniformed personnel and in encouraging good practices, such as extended and continuous training, including access to training materials, as well as deployment of gender-balanced groups of training participants. As an example, engaging with Kenya after it announced deployment to Haiti was a sustainable factor and compensated for the shift in deployment plans linked to MINUSMA closing and withdrawing from MONUSCO.

Figure 13 - Deployment after the training



90. Targeting T/PCCs based on deployment commitments increases the likelihood that trained personnel will use their new skills. With regards to the situation in the Middle East, it could be interesting to analyse which T/PCC deploys to UNIFIL in case a third phase or a similar project develops. The deployment ratio observed through the evaluation survey is of one fifth (i.e. to MINUSCA, UNIFIL, UNMISS, ECOMIG, RSF-Moz, UNISFA and MINUSMA). Fifty-seven per cent of the respondents expected to deploy and 23 per cent had no expectation of deploying (See Figure 11).

91. **Restrictive working environments were reported as a challenge by a few survey respondents and interviewees**. The hierarchy that prevails among uniformed medical and paramedical personnel, mostly in the military, was quoted as a restrictive factor in the free use and application of learning after training. A few participants regretted their posting was irrelevant to the training. According to training participants, the combination of these factors hampers the learning curve and contributes to skills fade. Further

communication, guidelines or recommendations from UNITAR could promote good practices and mitigate those risks.

92. The evaluation could not find any direct actions in the project that intentionally considered environmental sustainability in its implementation approach. However, the inclusion of trainers from the region into the trainers' team may have reduced the environmental impact of international travel, although this reduction is minimal considering the number of trainings delivered by each trainers' team. The evaluation did not have sufficient evidence to link any project actions to environmental sustainability.

Evaluation Question 6.2. To what extent has the project contributed to sustainability through creating an enabling environment through Training of Trainers (ToT) and the mobile application to maintain capacities and expanded knowledge after project completion?

93. **Training trainers is powerful for replicating training and propagating learning**. UNITAR had a double approach by training its own trainers and delivering advanced training. Both groups were able to teach the training content. Among the group of trainers replying to the survey, 16 (70 per cent) were recruited purposely for the project and had more than five years of experience. Only one had less than three years of experience. According to the evaluation survey, 53 per cent of the advanced training participants have delivered at least one training after their participation in the UNITAR training, of which 17 per cent are female participants and 83 per cent are male participants. Testimonies enumerated trainings delivered to large audiences in-country and abroad. Examples included training police officers on TCCC in one of the participant's hospitals; FPUs in EMPABB (1,300 participants); military and police in Senegal and Burkina Faso (300 participants); and four other trainings to large audiences above 100 participants in project beneficiary countries, including Chad, Kenya, Tanzania, Rwanda, Ghana, Togo and Rwanda.

94. **A few interviewees and survey respondents suggested materials from the basic training should be made available, for instance, on a shared drive, to sustain learning benefits in the longer-term. This has already been practised for ToT, where all participants received content on USB drives to mitigate poor Internet connections.** This recommendation shows the lack of visibility around the project mobile app, which aimed to address the need for reference materials and technical guidance. As discussed under the efficiency chapter, the evaluation found the communication about the mobile app has been insufficient as only 13 per cent of survey respondents knew about it and had used it while none of the evaluation interviewees knew about it. Suggestions for the app to play a role in learning maintenance include more attractive content and layout; more illustrations and less text; a search option; links between rubrics; and reference in the training agenda.

95. **Documentation review and interviews indicate that promotion and dissemination of the app are still being developed**. Future deployment of the app may consider spaces for promotion, such as including sessions on "how to use the UN MissionMed app" or a broader discussion on "where to find TCCC information" or "how to maintain skills set" in the basic training agenda. Interviews and documentation reviews highlighted the existence of other related apps - Nigeria Military personnel app focused on mental health, not public; UN BFA app; and the UN's MindCompanion, dedicated to Mental Health. Comparison with the UN BFA app found the UN MissionMed app wordy, not as synthetic as expected online, and not visual, which stresses the need to define

purposes and target audiences. Is the app meant to serve educational purposes (during and after training) or bridge knowledge gaps during emergencies and while in the field? The answer to this question will significantly impact display and content. The print screens below (Figure 14) selected the top one learning according to survey respondents: tourniquet application. In the best scenario, it takes four clicks to reach information about tourniquets and nine in the worst, if you search emergencies and interventions first instead of Tactical trauma-care procedures (Figure 15). The UN BFA display is found to be more intuitive and only takes three clicks to reach information about tourniquets. Box 3 below compiles observations drawn from a usability test of the UN MissionMed carried out by five users.

Figure 14 - Screenshots of UN MissionMed (left) and UN BFA (right) apps on tourniquet application

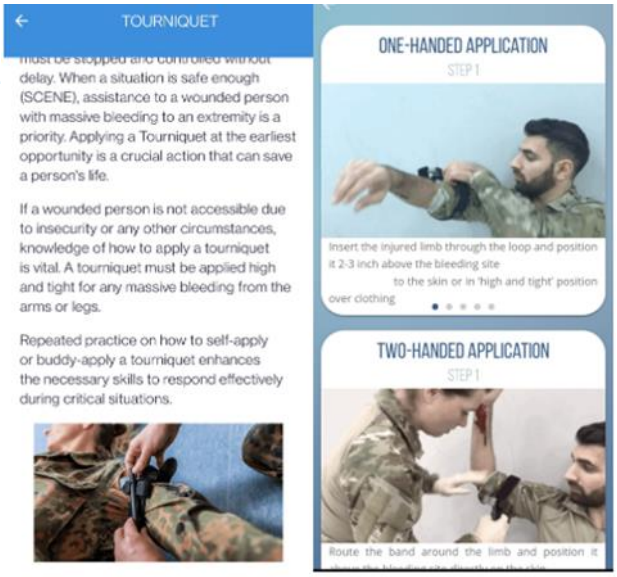
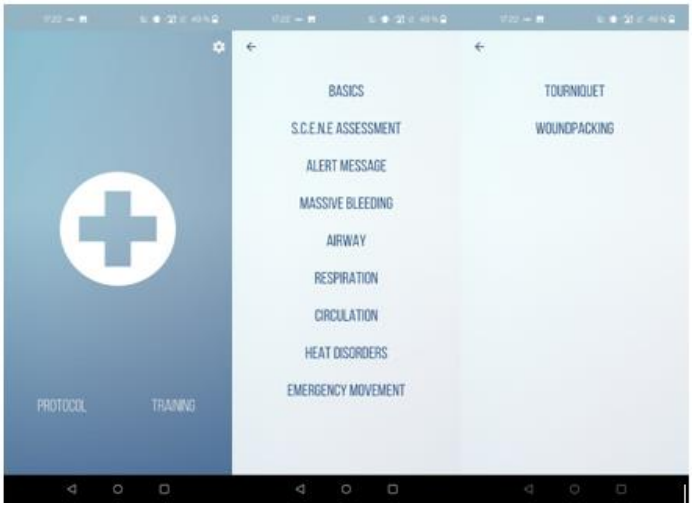


Figure 15 - Steps to reach information about tourniquet application - UN MissionMed (above) and UN BFA



Box 3. MissionMed app usability test

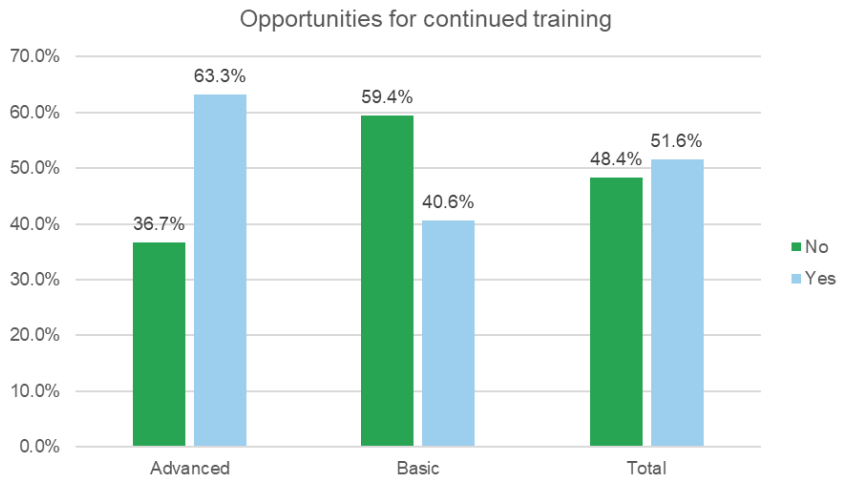
- The app structure is found to be unclear to a new user. If not familiar with the app, it is unclear where the information is stored. For example,why acute pain is stored under medical emergencies interventions rather than under medical emergencies. A glossary or an advanced search option may help the user. The app does not link to itself. For instance, the massive bleeding content refers to tourniquets, but you must go out of the section and enter another one to access the associated information.
- There is too much text and little illustration, which reduce the likelihood of use except in an emergency. It is rather suited to study time, as a reference document. There are no videos.
- Reading is barred by repeated requests for consent, such as whenever opening the app.

Evaluation Question 6.3. What can we learn to inform the future design of similar programming?

96. The needs for capacity-building on TCCC and MHPSS remain substantial. Expanding training would pursue a transformative process, bringing awareness and skills to the overlooked issue of mental health within peacekeeping missions. The FNR recommends expanding the geographical scope of the basic and advanced trainings (R1), and expanding the mental health and psychological support focus (R2) and the advanced curriculum options on topics such as advanced trauma life support, infectious disease, telemedicine and remote triage (R3). The evaluation surveys corroborate the FNR recommendations to expand the training to other partners, and expand options on TCCC and MHPSS.

Forty-three per cent of participants had never been trained on mental health before the project, and 60 per cent of the basic training participants reported they had no opportunities for continued training against 37 per cent among the advanced training participants. Respondents who answered that they had continuous training opportunities mostly referred to internal options among the local institutions they work for, such as medical residency for continued education, emergency and critical care training, predeployment training and ToT.

Figure 16 - Participants' opportunities for continued learning



97. **The FNR from Kenya and interviewees stressed the importance of equipment against skill fade**. Lack of practice increases the risk of forgetting care protocols and first aid reflexes. Continuous equipment support was highlighted as instrumental to maintain progress in deploying uniformed medical and paramedical personnel who are well prepared. The APS FNR provides a clear inventory of technical needs. This level of detail may be encouraged in future phases. For example, TACMED trainers visit border police hospitals, two ambulances are equipped, officers received IFAKs and are trained on basic and first aid skills, TACMED consumables are replenished and a storage room is arranged. The project equipment donations contributed to sustained use and application of learning and may be adapted to national contexts and facilities.

Conclusions

98. **Relevance**. The group of project IPs and beneficiaries count among the larger number of troops and police contributing countries, which happen to be among the most vulnerable to fatalities in the field. During the project phases, 36 per cent of fatalities in peacekeeping operations occurred in UNMISS, UNAMID, MINUSMA, MONUSCO and MINUSCA. The training content triggered strategic thinking among T/PCCs on multisectoral ways to protect deployed personnel and build their resilience.

99. The project's dual approach results from UNITAR's sound understanding of the highest risks to peacekeepers' safety and well-being. Training uniformed medical and paramedical personnel in TCCC addresses the fact that many fatalities occur due to an absence of immediate first aid or during evacuation as peacekeepers often operate in remote areas, deprived of medical infrastructures. Tackling mental health, aside from physical health, contributes to a cultural breakthrough over a yet invisible question. The project's general approach and context analysis was found to be highly relevant and documented.

100. **Coherence**. Despite UN statements and policies since 2017, statistics, research and mental health-related programmes are still under-represented. Data concerning mental health suggests that between 5 and 20 per cent of mental disorders occur after deployment, with side effects ranging from stress, sleep disorder, anxiety, substance abuse, depression and even suicidal ideation. However, this area is broadly unexplored and undocumented. Forty-three per cent of training participants had never been trained on the matter before. A few interviewees still understand mental health as a fragility to detect and exclude from deployment.

101. The review of similar initiatives found a siloed approach to TCCC, FPA and MHPSS. The project acknowledged and used UN reference frameworks from the WHO and the IASC to support the consistency of the training approach and avoided overlaps with ongoing initiatives, such as with the GPOI and Tanzanian Defence).

102. **Effectiveness.** Implementation was timely and paced. Twenty-two training events were organized through four implementing partners, six grants, and direct agreements. The targets were exceeded: 22 events were organized instead of a target of 16, with 319 participants instead of a target of 240. Engaging with gender-balanced groups turned out to be challenging but was still satisfactory considering the structural limitations in identifying and recruiting female officers (26 per cent of the total number of participants), in part because of the withdrawal of two T/PCCs due to political instability.

103. Yet, the training content quality and trainers' professionalism were praised. The international and regional backgrounds of trainers were much appreciated, with particular appreciation given to local context and languages knowledge. The training facilitation and engagement techniques were found to dismiss hierarchical barriers and allow enriching engagement and exchange of practices.

104. **Efficiency.** The project partnership modalities are time and cost-efficient, relying on decentralised implementation and proportional responsibilities. New partners were delegated with management of local costs, while institutional ones, such as the RPA, managed events across the region in both English and French. The partnership

modality was found to be efficient in the way mobilisation was organized. However, late disbursement of funds to new partners put pressure on the start of training in a few instances.

105. **Likelihood of impact.** The training dual approach built new skills that mostly impacted domestic practice and private life and likely saved lives in a few cases. Seventeen per cent of the beneficiaries used their knowledge once they were deployed while 62 per cent used it in other contexts and 22 per cent didn't use it at all. Impact was observed in cases where chief medical officers deployed after training could expand learning to the peacekeeping mission personnel thanks to their hierarchical position or guide gender-sensitive recruitment for medical personnel.

106. Gender participation in the project activities went beyond attaining gender parity in activities. It contributed to a global parity effort, beard by the Canada Feminist Policy, and triggered medical reflection over physically differentiated needs and stereotypes.

107. Overall, the project was found to be a strategic success for the comprehensive outlook of peacekeeping performance and continuity in good practices in gender promotion.

108. **Likelihood of sustainability**. Despite dependence on national prerogatives, sustainability was encouraged through good practices, such as targeting T/PCCs who commit to deploy troops, promoting skills-based selection criteria and strengthening a pool of specialized trainers. For example, 37 trainers were recruited and trained to implement the project.

109. The UN MissionMed application experienced limited dissemination and usage among participants due to its development while training events were already under implementation and due to its temporary pause by project management.

110. The importance of equipment was repeated and flagged at all stages, before training started, during training and after training, to ensure participants own the learnings in the long-term.

111. The recommendations below mostly consist of expanding support and up-scaling targeting and teaching.

Recommendations

High priority

On engagement with T/PCCs

Recommendation 1. UNITAR should deepen engagement with T/PCCs on the role that health plays in the safety, well-being and peacekeeping missions' performance.

Organize training with the same group of beneficiary countries and implementing partners to deepen awareness, knowledge and skills acquired and benefit other health professionals.

Expand training to other groups of T/PCCs ranking among the most vulnerable to fatalities. A future phase may further target the most vulnerable groups. According to DPO statistics, local staff are the most vulnerable to illness while the military are the most vulnerable to malicious acts and accidents. T/PCCs may be consulted in confidentially sharing causes of death and injury for deployed nationals so to analyse trends and target training even better, for example, by confirming DPO statistics with the T/PCC. Whenever possible, UNITAR may seek to engage with T/PCCs that officially commit troops and contingents, such as Kenya to Haiti, to increase the likelihood that learning will be soon applied in the field. This recommendation focuses on building a new narrative around mission performance, promoting a comprehensive approach and awareness about the impact of predeployment preparation.

On gender

Recommendation 2. UNITAR should continue and intensify efforts to raise health professionals' awareness on gender-sensitive needs in peacekeeping environments.

Pursue efforts to illustrate differentiated gender health and mental health experiences in peacekeeping settings and consequences on medical management. Continue to convey information about the right to intimacy and deconstruct stereotypes. Establish the link between taking gender needs into account and the attractiveness of recruitment to women. For instance, link to Canada's research on barriers and good practices to support peacekeepers with caring responsibilities. Maintain and illustrate the modules on sexual and reproductive rights, and sexual orientation, another taboo with mental health consequences on mission. Explore the relevance of dedicated modules with the donor and implications on training duration and time management.

On logistics and equipment

Recommendation 3. UNITAR should strengthen its stocktaking of existing medical equipment within T/PCCs to better define needs.

Strengthen inventory stocktaking of equipment of the host facility to better establish how UNITAR can complement and bridge equipment gaps during and after training, including for practical exercises, so as to obtain a precise list for material support that IP FNR recommendations do not reflect, except for the APS, Kenya. Follow-up with recipients on the use of equipment.

On the training app

Recommendation 4. UNITAR should mainstream the mobile app (or other learning reinforcement tools) in the training. The future deployment of the app should define use and users to differentiate it from other apps.

UNITAR should clarify if the app aims to support training and learning or to address on-the-spot emergencies. Depending on the dissemination strategy adopted, layout could display a more intuitive table of contents, with a search option, reduced length of text and increased visuals.

Medium-term priority

On measuring intermediate outcomes

Recommendation 5. UNITAR should either reformulate intermediate outcomes/ indicators or ensure that those that are formulated are supported with data to enable measurement and monitoring of progress towards defined targets.

Considering the formulation of the project's intermediate outcome (enhanced physical and mental well-being of male and female military and police personnel deployed to the four high-risk missions) and considering the void in data on the impact of mental health in the performance of peacekeeping missions, either include questions on mental health in pre-training questionnaires to collect internal baseline information and inform targets (respecting anonymity of respondents and the principle of do no harm), or reformulate intermediate outcomes/indicators related to MHPSS that can be realistically measured.

Lessons Learned

1. Adaptive management is key when project interventions are highly dependent on the national security context. Selecting new intervention countries indicated agility in project management. An example of adaptive management is to partner with T/PCCs as soon as they commit to deploy troops, which also requires flexible and available funding, increasing the likelihood of knowledge application and project impact.

2. Mobile applications can potentially be useful tools for learning reinforcement and sustainability, when promoted accordingly.

3. Communicating participant selection criteria, including gender and scheduled deployment to a UN peacekeeping mission, to beneficiary countries helps to influence the target group's characteristics. However, these remain highly dependent on external factors related to gender imbalance in military and police, as well as UN peacekeeping mission troop requirements.

4. Training of trainers has a double benefit: (i) having trainers with local context understanding to deliver training activities; and (ii) strengthening training capacities within countries to train additional participants outside of the project and in the future as part of its multiplication effect. Furthermore, clear trainer selection criteria are key when applied throughout, resulting in higher satisfaction rates from training participants.

5. Adequate and similar equipment is key to allow for successful application of knowledge and skills in the medical context.

6. Training medical and paramedical professionals jointly is innovative, ignoring hierarchy and favouring exchange of very diverse experiences.

Annexes

A. Terms of reference

Annex 1

***Terms of Reference* – Independent Evaluation of the "Enhancing the capacities of uniformed medical personnel deployed to UN Peace Operations" project**

(C2021.TARPT104.CANDFA)

Background

1. The **United Nations Institute for Training and Research (UNITAR)** is a training arm of the United Nations, with the aim to increase the effectiveness of the United Nations in achieving its major objectives through training and research. UNITAR's mission is to develop the individual, institutional and organizational capacity of countries and other United Nations stakeholders through high-quality learning solutions and related knowledge products and services to enhance decision-making and to support country-level action for overcoming global challenges.

2. UNITAR's first Strategic Objective calls to "Promote peace and just and inclusive societies". The Strategic Objective 1 "Support institutions and individuals to contribute meaningfully to sustainable peace" focuses on increasing institutions and individuals' capacities to prevent continuation and escalation of violent conflicts, restore the rule of law, and build lasting peace. Special focus is placed on strengthening knowledge and skills of women as change agents in conflict analysis, negotiation and mediation; strengthening engagement of men and boys as agents of change in efforts to work towards ending sexual and gender-based violence and reducing the stigmatization; and improving the use of modern technologies to protect civilians and vulnerable populations.

3. The "Enhancing the Capacities of Uniformed Medical Personnel Deployed to UN Peace Operations" project, implemented between 24 December 2021 and 30 January 2024, and was amended until 30 June 2024, was conceived to **improve the performance of UN peace operations** in increasingly complex and high-risk environments **by enhancing the physical and mental well-being of female and male military and police personnel deployed to UN peacekeeping missions** [end users]. This would be achieved by *strengthening the capabilities, motivation (awareness) and opportunities of male and female medical and paramedical personnel* (military and police) deployed to UN peacekeeping operations [intermediate users] *to address physical and psychological trauma in a gender-responsive manner* and through *provision of training equipment*.

4. The intermediate users of the project are medical and paramedical personnel from countries (Chad, Ghana, Kenya, Niger, Rwanda, Senegal, Tanzania and Togo) among the 20 African troop and police contributing countries[28] deployed to the four high-risk missions: MINUSMA (now closed), MONUSCO, MINUSCA, and UNMISS. Intermediate users will be trained by UNITAR trainers [initial users],[29] who underwent a Training of Trainers (ToT) preparatory workshop as part of the project. OBJ

[28] Countries included in the previous phase and confirmed by the Government of Canada: Burkina Faso, Chad, Ethiopia, Ghana, Niger, Rwanda, Senegal, and Togo. Due to political situations in Ethiopia and Burkina Faso, Tanzania and Kenya were added instead.
[29] Trainers' selection was planned to put emphasis on gender-balanced groups, additional francophone trainers, and trainers for advanced medical training.

5. The project planned to achieve its goals through the delivery of predeployment training and enhancement of training materials and resources (mobile application). More specifically, the project encompassed four components: i) revision of training packages (content/methodology) to integrate gendered needs and country or mission context; ii) delivery of preparatory ToT workshops for UNITAR trainers; iii) delivery of training and advanced training to medical and paramedical personnel on medical skills and mental health support to address trauma including the delivery of training materials; and iv) upgrade of the Android version of the UN MissionMed app and development of the iOS version. The project logic model can be found in Annex F.

6. The project built upon a previous phase of the intervention, "Strengthening response capacities of medical and paramedical personnel deployed to UN Peace Operations", implemented between March 2020 and April 2021.[30] Both phases were funded by the Government of Canada. As part of its activities, the precedent phase of the project comprised a gender-responsive/military/police-responsive needs assessment leading to adaptation of training packages, trainers' preparatory workshops and delivery of eight training sessions. The Android version of the UN MissionMed app was also developed during this phase of the project (in English only).

7. The project is subject to an independent evaluation as per UNITAR Evaluation Policy.

Purpose of the evaluation.

8. The purpose of this evaluation is to assess the relevance, coherence, effectiveness, efficiency, likelihood of impact and likelihood of sustainability of the project; to identify good practices as well as any challenges that the project has encountered; to issue recommendations, and to identify lessons to be learned on design, implementation and management. The evaluation's purpose is thus to meet accountability requirements, and to provide findings, conclusions, recommendations, and lessons learned to contribute to the project's improvement, strategic direction, and broader organizational learning. The evaluation should not only assess how well the project has performed, but also seek to answer the 'why 'question by identifying factors contributing to (or inhibiting) successful delivery of the results.

9. While the evaluation will include an assessment of all six OECD-DAC criteria, gender, disability and human rights, and environmental considerations will be taken into account. The evaluation's purpose is to serve learning and accountability purposes, and to be as forward-looking as possible, to inform decisions on the design and planning of possible future phases and focus areas of this or similar projects.

Scope of the evaluation

10. The evaluation will cover Phase II of the project (December 2021 to June 2024). Although the scope of the evaluation does not include the 2020-2021 project phase, the evaluator should take the previous phase into account when framing the evaluation's findings and conclusions. In addition to examining the results achieved in 2022-2024, the evaluation should provide forward-looking recommendations to inform possible future phases.

Evaluation criteria

[30] End of activities after two non-cost extensions. Project expiration date was August 2021.

11. The evaluation will assess project performance using the following criteria: relevance, coherence, effectiveness, efficiency, likelihood of impact, and likelihood of sustainability. The evaluation questions related to gender equality and the empowerment of women dimensions are marked with "GEEW". Questions related to environmental sustainability are marked with "ENVSUSE". Disability and human rights considerations should also be considered throughout the evaluation.

- ***Relevance:*** *Is the project reaching its intended individual users and are project objectives and activities relevant to the initial, intermediate and final users' needs and priorities, and designed with quality?*
- ***Coherence:*** *To what extent is the project complementing other similar programmes and projects and adhering to international norms and standards?*
- ***Effectiveness:*** *How effective has the project been, through its four components, in delivering results and in reinforcing capabilities and increased awareness of uniformed medical and paramedical personnel?*
- ***Efficiency:*** *To what extent has the project delivered its results in a cost-effective manner and optimized partnerships?*
- ***Likelihood of Impact:*** *What are the potential cumulative and/or long-term effects expected from the project, including contribution towards the intended impact and intermediate outcome, positive or negative impacts, or intended or unintended changes?*
- ***Likelihood of Sustainability:*** *To what extent are the project's results likely to be sustained in the long-term? How is environmental sustainability addressed in the project?*

Principal evaluation questions

12. The following questions are *suggested* to guide the design of the evaluation, although the criteria applied to the outcomes and the final questions selected/identified will be confirmed by the evaluator following the initial document review and engagement with project management with a view to ensuring that the evaluation is as useful as possible with regard to the project's future orientation or other similar undertakings.

Relevance

a. *To what extent is the project aligned with the Institute's efforts to helping Member States implement the 2030 Agenda for Sustainable Development and UNITAR's Strategic Framework 2022-2025, and particularly SDG 16 and SO 1, and Global Affairs Canada/PSOP's guiding policies?*
b. *How relevant are the project objectives, design and training activities to the capacity, performance and individual needs and priorities of the initial users, intermediate users, and end users of the project respectively? Is it equally relevant for female and male trainers/uniformed medical personnel/personnel deployed and francophone and anglophone stakeholders?* ***(GEEW)***
c. *How well did the project design build on the needs assessment and lessons learned from the previous phase (2020-2021)? Did the project reach its intended beneficiaries, namely gender-balanced trainers' groups, francophone trainers, and medical and paramedical personnel, to the extent possible? If not, what/who was missing and what could have been done differently?*

Coherence

d. *How well is the project aligned with and complements other UNITAR programming focusing on enhancing capabilities of deployed personnel and particularly those supporting medical and paramedical personnel, e.g. through UNITAR's predeployment training projects?*

e. *How well is the project aligned with and complements programming implemented by other institutions focusing on enhancing capabilities of deployed personnel and particularly those supporting medical and paramedical personnel?*
f. *How well is the project aligned with relevant international frameworks and UN resolutions and priorities in the peacekeeping field, including the WPS Agenda, the UN Uniformed Gender Parity Strategy, Cruz Report, Action for Peacekeeping (A4P) and A4P+, Elsie Initiative for Women in Peace Operations, UN security Resolution 2518, pledges from peacekeeping ministerial, Global Affairs Canada's Framework for Assessing Gender Equality Results, amongst others?*[31] ***(GEEW)***

Effectiveness

g. *To what extent have the planned outcomes and outputs of the project been achieved? What are the factors affecting the project and the individual's performance of initial, intermediate and end users?*
h. *Has the project's design, with its multiple components, and partnerships been effective in delivering and attaining results, including the performance of the four implementing partners? (see annex I).*
i. *To what extent and how is the project contributing to improved knowledge and skills, capabilities, motivations (increased awareness) and opportunities of uniformed medical and paramedical personnel to address physical and psychological trauma of deployed personnel in a gender-responsive manner? How effective is the mobile application as a learning reinforcement tool? Is progress per country varying? What is missing, if anything?* ***(GEEW)***

Efficiency

a. *To what extent has the project produced outputs in a timely and cost-efficient manner, including through grant arrangements with implementing partners (Rwanda Peace Academy, Department of Medical Services of Ghana Armed Forces, The Administration Police Service (APS) Kenya and Tanzania National Police) in comparison with alternative approaches? Were the project's resources (human and financial) used as planned and fully utilised?*
b. *To what extent was the project including both activities and planned expenditures delivered as planned? To what extent did interim narrative/performance management framework reporting capture progress towards results? What caused deviations from the original plan? Did the project apply adaptive management to adjust to implementation challenges?*

Likelihood and early indication of impact

c. *What real difference has the project made to improve physical and mental well-being of (military and police) personnel deployed to UN Peace Operations? Are there any differences between female and male uniformed deployed personnel?* ***(GEEW)***
d. *What other observable changes* (*positive or negative, intended or unintended) have occurred as a result of the project implementation?*

Likelihood of sustainability and early indication of sustainability

e. *To what extent are the project's results likely to endure beyond the implementation of the activities in the mid- to long-term and under which conditions?*
f. *To what extent has the project contributed to sustainability through creating an enabling environment through Training of Trainers (ToT) and the mobile application to maintain capacities and expanded knowledge- after project completion?*
g. *What can we learn to inform the future design of similar programming?*

Gender Equality and Women Empowerment (GEEW)

[31] A non-exhaustive list of relevant frameworks is included in Annex C.

The evaluation questions with gender equality and women empowerment dimensions are marked with **"*GEEW"*** *in the above.* Disability considerations should also be considered throughout the evaluation.

Environmental Sustainability in Evaluation (ENVSUSE)

The evaluation questions with the evaluation sustainability dimension are marked with "***ENVSUSE"*** in the above.

Evaluation Approach and Methods

13. The evaluation is to be undertaken in accordance with the UNITAR Evaluation Policy, the operational guidelines for independent evaluations and the United Nations Norms and Standards for Evaluation, and the UNEG Ethical Guidelines. The evaluation will be undertaken by a supplier or an international consultant (the "evaluator") under the supervision of the UNITAR Planning, Performance Monitoring and Evaluation Unit (PPME). PPME shall support the evaluation team in gathering background documentation and other data collection processes.

14. Since the project focuses on capacity development, it is recommended to look at the different dimensions of capacity development, including:
    - **Individual dimension** relates to the people involved in terms of knowledge, skill levels, competencies, attitudes, behaviours and values that can be addressed through facilitation, training and competency development.
    - **Organizational dimension** relates to organizations and networks of organizations. The change in learning that occurs at individual level affects, from a results chain perspective, the changes at organizational level.
    - **Enabling environment dimension** refers to the context in which individuals and organizations work, including the political commitment and vision; policy, legal and economic frameworks and institutional set-up in the country; national public sector budget allocations and processes; governance and power structures; incentives and social norms; power structures and dynamics.

Table 1- Capacity areas within the three dimensions

Individual	Skills levels - technical and managerial skills Competencies Awareness and motivation	Essential knowledge, cognitive skills, interpersonal skills, self-control, attitude towards behaviour, self-confidence, professional identity, norms, values, intentions, emotions, environmental barriers and enablers with specific focus on gender and disability inclusion, among others.
Organizations	Mandates Horizontal and vertical coordination mechanisms Motivation and incentive systems	Organizational priorities Gender and disability inclusion Processes, systems and procedures

	Strategic leadership Inter/intra institutional linkages Programme management Multi-stakeholder processes	Human and financial resources Knowledge and information sharing Infrastructure Environmental sustainability Institutional support
Enabling environment	Policy and legal framework Political commitment and accountability framework Governance	Economic framework and national public budget allocations and power Legal, policy and political environment

15. In order to maximize utilization of the evaluation, the evaluation shall follow a participatory approach and engage a range of project stakeholders in the process, including the project implementation team, project partners, the beneficiaries, the donor and other relevant stakeholders. It should follow a mixed-methods and gender-responsive approach and data collection should be triangulated to the extent possible to ensure validity and reliability of findings. The evaluation will draw on primary (surveys, key informant interviews, focus group discussions) and secondary data (comprehensive desk review) to inform the evaluation methodology. It is recommended to follow a theory-based approach to impact evaluation, with a previous validation/review of the ToC and logic model.

16. The evaluator should follow mixed-methods approach for analysis in responding to the principal evaluation questions and present the findings qualitatively or quantitatively as most appropriate. Suggested methods and data collection tools include:

Theory-based approach to impact evaluation

The evaluator should consider whether Outcome mapping/Outcome harvesting/outcome evidencing, process tracing, congruence analysis, contribution analysis, episode study, or other theory-based approaches to evaluate the project's final outcome and impact, are suitable tools for answering the evaluation questions.

Comprehensive desk review

The evaluator will compile, review and analyse background documents and secondary data/information related to the project, including a results framework indicator tracking review. A list of background documentation for the desk review is included in Annex C. A template for document review suggested by PPME, can be found here.

Stakeholder analysis
The evaluator will identify and relate the different stakeholders involved in the project. Key stakeholders at the global and national level include, but are not limited to:

- Implementing partner institutions (see annex I);
- The donor (Government of Canada);
- Beneficiaries/participants at all levels: UNITAR trainers, medical and paramedical personnel and other deployed uniformed personnel;
- UNITAR project team;
- Troop or Police Contributing Countries.

Survey(s)
With a view to maximizing feedback from the widest possible range of project stakeholders, the consultant will develop and deploy a survey(s) following the comprehensive desk study to provide an initial set of findings and allow the evaluator to easily probe during the key informant interviews.

Key informant interviews
Based on stakeholder identification, the evaluator will identify and interview key informants. In preparation for the interviews with key informants, the consultant will define interview protocols to determine the questions and modalities with flexibility to adapt to the particularities of the different informants, either at the global, at the national or local level.

Focus groups

Focus groups should be organized with selected project stakeholders at the local levels to complement/triangulate findings from other collection tools.

Field visit

Field visits shall be conducted to two of the project countries and be either Ghana, Kenya, Rwanda or Tanzania. Travel to Burkina Faso, Niger and Chad is not considered for security reasons and to Senegal and Togo due to resource limitations.

Gender, disability and human rights, and environmental sustainability

17. The evaluator should incorporate human rights, gender, disability, and environmental sustainability perspectives in the evaluation process and findings, particularly by involving women and other groups subject to discrimination. All key data collected shall be disaggregated by sex, UN country classification, disability and age grouping, and be included in the draft and evaluation report. Though this is a general requirement for all evaluations, this evaluation should particularly put emphasis on **gender equality and women's empowerment**.

18. The guiding principles for the evaluation should respect transparency, engage stakeholders and beneficiaries; ensure confidentiality of data and anonymity of responses; and follow **ethical** and professional standards that include the usage of AI tools (guidelines will be shared with the evaluators).

Time frame, work plan, deliverables and review

19. The proposed time frame for the evaluation spans from June 2024 (recruitment of the evaluator) to November 2024 (publication of final evaluation report). An indicative work plan is provided in the table below.

20. The consultant shall submit an evaluation design/question matrix following the comprehensive desk study, stakeholder analysis and initial interviews with the project team. The evaluation design/question matrix should include a discussion on the evaluation objectives, methods and, if required, revisions to the suggested evaluation questions or data collection methods. The evaluation design/question matrix should indicate any foreseen difficulties or challenges/limitations in collecting data and confirm the final time frame for the completion of the evaluation exercise, as well as a list of documents reviewed highlighting insights from every reviewed document.

21. Following data collection and analysis, the consultant shall submit a zero draft of the evaluation report to the evaluation manager and revise the draft based on comments made by the evaluation manager.

22. The draft evaluation report should follow the structure presented under Annex D. The report should state the purpose of the evaluation, the methods used and include a discussion on the limitations to the evaluation. The report should present evidence-based and balanced findings, including strengths and weaknesses, consequent conclusions and recommendations, and lessons to be learned. The length of the report should be approximately 30 pages, excluding annexes.

23. Following the submission of the zero draft, a presentation of emerging findings with discussion of evaluation recommendations and a draft report will then be submitted to Project Management to review and comment on the draft report and provide any additional information using the form provided under Annex G by 31 October 2024. Within one week of receiving feedback, the evaluator shall submit the final evaluation report. The target date for this submission is 8 November 2024. Subsequently, PPME will finalize and issue the report. The report will be shared with all concerned stakeholders.

Indicative time frame:

Activity	June 2024	July 2024	August 2024	September 2024	October 2024	November 2024
Evaluator selected and recruited						
Initial data collection, including desk review, stakeholder analysis						
Evaluation design/question matrix						
Data collection and analysis, including survey(s), interviews and focus groups and field visit						
Zero draft report submitted to UNITAR						
Draft evaluation report consulted with UNITAR evaluation manager and submitted to Project Management						
Presentation of emerging findings, recommendations and lessons learned						

Project Management reviews draft evaluation report and shares comments and recommendations						
Evaluation report finalized and management response by Project Management						
Dissemination and publication						

Summary of evaluation deliverables and indicative schedule

Deliverable	From	To	Deadline*
Evaluation design/question matrix	Evaluator	Evaluation manager	1 July 2024
Comments on evaluation design/question matrix	Evaluation manager	Evaluator	5 July 2024
Zero draft report	Evaluator	Evaluation manager	7 October 2024
Comments on zero draft	Evaluation manager	Evaluator	11 October 2024
Draft report	Evaluator	Evaluation manager	21 October 2024
Presentation of emerging findings, recommendations and lessons learned	Evaluator/evaluation manager	Programme Management	To be defined
Comments on draft report	Programme Management	Evaluation manager	31 October 2024
Final report	Evaluator	Evaluation manager	8 November 2024
Dissemination and publication of report	Evaluation manager		November 2024

*To be adjusted depending on the contract signature and to be agreed upon with the Evaluation Manager.

Communication/dissemination of results

24. The evaluation report shall be written in English and the Executive Summary shall be translated into French. The final report will be shared with all partners and be posted on an online repository of evaluation reports open to the public in UNITAR website as well as the UNEG website.

Evaluation management arrangements

25. The evaluator will be contracted by UNITAR and will report directly to the Director of the Strategic Planning and Performance Division and Manager of Planning, Performance Monitoring, and Evaluation Unit (PPME) (‘evaluation manager’).

26. The evaluation manager reports directly to the Executive Director of UNITAR and is independent from all programming related management functions at UNITAR. According to UNITAR's Evaluation Policy, in due consultation with the Executive Director/programme management, PPME issues and discloses final evaluation reports without prior clearance from other UNITAR Management or functions. This builds the foundations of UNITAR's evaluation function's independence and ability to better support learning and accountability.

27. The evaluator should consult with the evaluation manager on any procedural or methodological matter requiring attention. The evaluator is responsible for planning any meetings, organizing online surveys and undertaking administrative arrangements for any travel that may be required (e.g., accommodation, visas, etc.). The travel arrangements, if any, will be in accordance with the UN rules and regulations for consultants.

Evaluator Ethics

28. The evaluator selected should not have participated in the project's design or implementation or have a conflict of interest with project activities. The selected consultant shall sign and return a copy of the code of conduct under Annex F prior to initiating the assignment and comply with UNEG Ethical Guidelines.

Professional requirements

29. The evaluator should have the following qualifications and experience:

- MA degree or equivalent in development evaluation, peace and conflict studies, development studies, or a related discipline. Knowledge of and experience in training design and delivery, training evaluation, and in areas related to peacekeeping, trauma healing, and police/military training.
- At least seven years of professional experience conducting evaluation in the field of capacity-building. Knowledge of United Nations Norms and Standards for Evaluation.
- Technical knowledge of the focal area including the evaluation of peacekeeping-related topics, as well as contemporary developments in multilateral efforts to develop policing capacities in broader peacekeeping missions.
- Field work experience in Africa.
- Excellent research and analytical skills, including experience in a variety of evaluation methods and approaches. Experience in evaluation using Kirkpatrick method is an advantage.
- Excellent writing skills.
- Strong communication and presentation skills.
- Cross-cultural awareness and flexibility.
- Availability to travel.
- Fluency in oral and written English and French.

Annexes:

A. List of contact points
B. Event data available on the UNITAR Event Management System
C. List of documents and data to be reviewed
D. Structure of evaluation report
E. Project logical framework
F. Audit trail
G. Evaluator code of conduct

Annex A: List of contact points

Project Management to complete

B: Event data available on the Event Management System from 31.01.2022 to 29.04.2024[32]

Start date (Y-m-d)	End date (Y-m-d)	Event title	Event ID	Location city	Location country
2022-04-03	2022-04-13	STM Training of Trainers (4 - 14 April 2022 - Accra, Ghana)	8878	Accra	Ghana
2022-09-19	2022-09-30	Training of Trainers for Medical and Paramedical Personnel - Dar Es Salaam, Tanzania [19 - 30 September 2022]	9754	Dar Es Salaam	United Republic of Tanzania
2022-10-03	2022-10-22	Predeployment Training for Medical and Paramedical Personnel - Lome, Togo [3 - 21 October 2022]	9756	Lome	Togo
2022-10-10	2022-10-28	Predeployment Training for Medical and Paramedical Personnel - Accra, Ghana [10 - 28 October 2022]	9757	Accra	Ghana
2022-11-14	2022-12-02	Predeployment Training for Medical and Paramedical Personnel - Ouagadougou, Burkina Faso [14 Nov - 2 Dec 2022]	9758	Accra	Ghana
2022-11-21	2022-12-09	Predeployment Training for Medical and Paramedical Personnel - Dakar, Senegal [21 Nov - 9 Dec 2022]	9759	Accra	Ghana
2023-01-09	2023-01-18	Predeployment for medical and paramedical personnel deploying to UN peace operations: Training of Trainers [Dar es Salaam, Tanzania - 09.01.2023 - 18.01.2023]	10507	Dar es Salaam	United Republic of Tanzania
2023-02-20	2023-03-10	Formation préalable au déploiement du personnel médical et paramédical dans les opérations de maintien de la paix [Niamey, Niger - 20.02.2023 - 10.03.2023]	10508	Niamey	Niger
2023-03-06	2023-03-24	Formation préalable au déploiement du personnel médical et paramédical dans les opérations de maintien de la paix [Lome, Togo - 6.03.2023 - 24.03.2023]	10509	Lome	Togo
2023-03-27	2023-04-13	Predeployment for medical and paramedical personnel deploying to UN peace operations [Gishari, Rwanda - 27.03.2023 - 14.04.2023]	10510	Gishari	Rwanda

[32] List of events delivered in 2024 might be incomplete.

2023-05-01	2023-05-18	Predeployment training for medical/paramedical personnel deploying to UN peacekeeping missions - Thiès, Senegal [2-19 May 2023]	10754	Thiès	Senegal
2023-08-20	2023-08-31	Predeployment training for medical/paramedical personnel deploying to UN peacekeeping missions - Accra, Ghana [21 August-1 September 2023]	10755	Accra	Ghana
2023-08-13	2023-08-28	Predeployment training for medical/paramedical personnel deploying to UN peacekeeping missions - N'Djamena, Chad [14-29 August 2023]	10825	N'Djamena	Chad
2023-07-30	2023-08-17	Predeployment training for medical/paramedical personnel deploying to UN peacekeeping missions - Moshi, Tanzania [31 July-18 August 2023]	10826	Moshi	United Republic of Tanzania
2023-09-03	2023-09-21	Predeployment training for medical/paramedical personnel deploying to UN peacekeeping missions - Kanyonyo, Kenya [4-29 September 2023]	10968	Kanyonyo	Kenya

Annex C: List of documents/data to be reviewed

- Interim and final narrative and financial reports
- Legal Agreement
- Logical Model and Theory of Change
- Project Description
- UNITAR website content
- Event Management System Data
- Documents related to the 2020-2021 phase, including needs assessment
- Documents related to the four implementing partners
- Relevant international frameworks including *Strategic Guidance Framework for International Policing*, *Women, Peace and Security (WPS) Agenda*, the *UN Uniformed Gender Parity Strategy*, *Cruz Report*, *Action for Peacekeeping (A4P)*, *Integrated Peacekeeping Performance and Accountability Framework*, *Elsie Initiative for Women in Peace Operations*, *Africa Peace Support Trainers Association's values and objectives*, *UNSC Resolution 2242 (2015) on Women and Peace*, the *Policy on United Nations Police (2014)*, *UN Security Resolution 2518*; *Global Affairs Canada's Framework for Assessing Gender Equality Results; and other relevant UN frameworks.*
- Any other document deemed to be useful to the evaluation

Annex D: Structure of evaluation report

i. Title page
ii. Executive summary
iii. Acronyms and abbreviations
1. Introduction
2. Project description, objectives and development context
3. Theory of change/project design logic
4. Methodology and limitations
5. Evaluation findings based on criteria/principal evaluation questions
6. Conclusions
7. Recommendations
8. Lessons Learned
9. Annexes
    a. Terms of reference
    b. Survey/questionnaires deployed
    c. List of persons interviewed
    d. List of documents reviewed
    e. Evaluation question matrix
    f. Evaluation consultant agreement form

Annex E: Project Theory of Change submitted for project proposal

At its heart, peacekeeping is about safety – but it comes at a high risk to those who serve the cause of peace. Deployed military and police units cannot promote safety for those under their mandate if they do not know how to effectively address and treat their own physical and psychological trauma. The peacekeeping missions to which they are deployed are by definition traumatic and dangerous environments, and threats to physical and mental health in such environments are manifold. By taking advantage of the momentum and building on the results and political will achieved by the first phase of this project, we can ensure that they are equipped with the knowledge and skills, and have internalised the behaviour required, to look after themselves and their fellow peacekeepers in a gender-responsive way. Specifically, we aim to strengthen the knowledge and skills of male and female uniformed medical personnel (military and police) deployed to the top four high-risk UN peacekeeping operations, in basic as well as advanced field medical and psychological trauma; increase the knowledge and use of the UN MissionMed mobile applications (Android and iOS) by trained uniformed medical personnel (military and police); and finally, to increase their awareness of the importance of physical and mental health for effective performance.

Mental health in particular remains insufficiently understood and often stigmatized across the globe – and this is especially true for highly masculinized contexts of the military and police, where poor mental health resulting from psychological trauma experienced in the field can be seen as a weakness. Physical and psychological well-being can promote de-escalation of conflict, as physically and psychologically healthy personnel are more likely to handle difficult and tense situations in a suitable manner, avoiding exacerbating the conflict. A unit that is weakened or incapacitated due to casualties or illness, including those suffering psychological trauma, cannot perform as effectively in UN peacekeeping. Improving the peacekeepers' capacities to properly address both types of traumas in line with UN standards and remain aware of the link between poor health and poor performance, is crucial for improving the overall performance of peacekeepers – and thereby of peacekeeping missions.

Learning these critical skills and being thoroughly versed in how to apply them in a gender-responsive way will allow for enhanced physical and mental well-being of male and female uniformed personnel deployed to the top four high-risk UN peacekeeping operations. Furthermore, improved physical and mental well-being among peacekeepers served by medical staff will improve the performance of male and female uniformed personnel deployed to the top four high-risk UN peacekeeping missions.

The improved physical and psychological well-being of deployed male and female personnel leads to the ultimate intended outcome of this project: improved performance of UN operations in increasingly complex and high-risk environments. Improved performance in such conflict-affected environments is not just about the capabilities of deployed military and police, but is about completing the mandate of the mission, for the benefit of those deployed and the local populations under their protection. From medical and paramedical personnel learning the skills and behaviours necessary to address physical and psychological trauma in a gender-responsive manner, to the resulting improved physical and psychological well-being of all male and female deployed personnel, UN missions can better fulfil their mandate: keeping local populations safe.

Annex F: Project Logic Model and Logical Framework submitted for project proposal

LOGIC MODEL

ULTIMATE OUTCOME

1000 *Improved performance of United Nations peace operations in increasingly complex and high-risk environments.*

ITERMEDIATE OUTCOMES

1100 *Enhanced physical and mental well-being of male and female uniformed personnel deployed to the top four (4) high risk UN peacekeeping operations.*

1200 *Improved performance of male and female uniformed personnel deployed to the top four (4) high-risk UN peacekeeping missions*

IMMEDIATE OUTCOMES

1110 *Strengthened knowledge and skills of male and female uniformed medical personnel (military and police) deployed to the top four (4) high-risk UN peacekeeping operations, in basic field medical and psychological trauma.*

1120 *Improved knowledge and skills of male and female uniformed medical personnel (military and police) deployed to the top four (4) high-risk UN peacekeeping operations, in advanced field medical trauma.*

1130 *Increased knowledge and use of the UN MissionMed mobile applications (Android and iOS) by trained uniformed medical personnel (military and police).*

1210 *Increased awareness of male and female uniformed medical personnel (military and police) deployed to the top four (4) high-risk UN peacekeeping operations of the importance of physical and mental health for effective performance*

OUTPUTS

1111
1111a Training packages are reviewed (content / methodology) to integrate the specific and gendered needs as well as the country / mission context

1111b Preparatory workshop is attended by a gender-balanced group of UNITAR trainers, with emphasis on women trainers, francophone trainers, and trainers for advanced medical training

1111c Training sessions are attended by a gender-balanced military and/or police medical and para-medical personnel

1121
1121a Advanced training sessions are attended by a gender-balanced military and/or police medical and para-medical personnel

1131
1131a Android version of the UN MissionMed mobile application is upgraded to include French translation and other relevant materials

1131b iOS version of the UN MissionMed mobile application is developed

1211
1211a Training packages are reviewed to underscore the link between good mental and physical health and effective performance in UN missions

ACTIVITIES

- *Review of training packages (content / methodology) to integrate the specific and gendered needs as well as the country / mission context;*
- *Delivery of 1 2-week preparatory workshop for a gender-balanced group of UNITAR trainers. Selection of participants will put particular emphasis on recruitment of qualified women trainers, additional francophone trainers, and trainers for advanced medical training;*
- *Delivery of 8 4-week trainings of male and female, military and/or police medical and para-medical personnel in T/PCCs participating in the project (20 participants / training) with an additional 1 week of team preparation on the ground;*
- *Delivery of 8 1-week advanced trainings (10 participants / training);*
- *Upgrade of the Android version of the "UN MissionMed" mobile application to include French translation and other relevant materials;*
- *Development of an iOS version of the "UN MissionMed" mobile application;*
- *Review of training packages to underscore the link between good mental and physical health and effective performance in UN missions*

EXPECTED RESULTS[1] (from logic model)	INDICATORS (environmental sustainability and gender equality where possible)	BASELINE DATA	TARGETS include time range where possible	DATA SOURCES	DATA COLLECTION METHODS	FREQUENCY	RESPONSIBILITY
ULTIMATE OUTCOME							
1000 Improved performance of United Nations peace operations in increasingly complex and high-risk environments	*Number of peacekeeping missions evaluated as performing to standards by the Comprehensive Planning and Performance Assessment System (CPAS)*	*Baseline data will be collected during the initial phase of the project*	*A target will be established based on baseline data*	*Comprehensive Planning and Performance Assessment System (CPAS) results*	*Compilation of existing statistics*	*Beyond end of project*	*Project Coordinator*
INTERMEDIATE OUTCOMES							
1100 Enhanced physical and mental well-being of male and female uniformed personnel deployed to the top four (4) high risk UN peacekeeping operations.	*% reduction of fatalities within UN peacekeeping operations*	*Sex-disaggregated / military / police-disaggregated baseline data will be collected during the initial phase of the project*	*A target will be established based on baseline data*	*Records by UN DPO, and if accessible, T/PCCs*	*Compilation of existing statistics*	*Bi-annual and end of project (final)*	*Project Coordinator*
1200 Improved performance of male and female uniformed personnel deployed to the top four (4) high-risk UN peacekeeping missions	*% reduction of instances of hospitalization during deployment (due to physical or psychological trauma)*	*Sex-disaggregated / military / police-disaggregated baseline data will be collected during the initial phase of the project*	*A target will be established based on baseline data*	*Records by T/PCCs*	*Compilation of existing statistics*	*Mid-term and end of project*	*Project Coordinator*
IMMEDIATE OUTCOMES							
1110 Strengthened knowledge and skills of male and female uniformed medical personnel (military and police) deployed to the top four (4) high-risk UN peacekeeping operations, in basic field medical and psychological trauma.	*% of male and female participants (from military and police) successfully meeting the completion requirements of the basic training session*	*To be determined based on results form the first project*	***85% of male military and/or police participants (82 total) and 85% of female military and/or police participants (54 total) successfully meet the completion requirements of the training session***	*Final reports of level II evaluation (knowledge, skills and behaviours)*	*Level II evaluation questionnaire*	*At the end of each training session*	*Project coordinator*
	% of male and female participants (from military and police) indicating an increased confidence in their capacities to address physical and psychological trauma	*To be determined based on results form the first project*	***85% of male military and/or police participants (82 total) and 85% of female military and/or police participants (54 total) indicate increased confidence in their capacities to address physical and psychological trauma in a gender-responsive manner***	*Final reports of self-evaluation*	*Self-evaluation matrix*	*Before and after the training session*	*Project coordinator*
1120 Improved knowledge and skills of male and female uniformed medical personnel (military and police) deployed to the top four	*% of male and female participants (from military and police) successfully meeting*	*To be determined based on results form the first project*	***85% of male military and/or police participants (82 total) and 85% of female military and/or police***	*Final reports of level II evaluation (knowledge, skills and behaviours)*	*Level II evaluation questionnaire*	*At the end of each training session*	*Project coordinator*

(4) high-risk UN peace-keeping operations, in advanced field medical trauma.	*the completion requirements of the advanced training session*		***participants (54 total) successfully meet the completion requirements of the training session***				
1130 Increased knowledge and use of the UN MissionMed mobile applications (Android and iOS) by trained uniformed medical personnel (military and police).	*% of male and female participants (from military and police) downloading the UN MissionMed mobile application*	*Not applicable*	*70% (112 total) of military and/or police participants trained download the UN MissionMed mobile application*	*UNITAR records*	*Document evidence*	*Once*	*Project coordinator*
1210 Increased awareness of male and female uniformed medical personnel (military and police) deployed to the top four (4) high-risk UN peace-keeping operations of the importance of physical and mental health for effective performance	*% of male and female participants (from military and police) can demonstrate the link between physical and psychological wellbeing and effective performance*	*Not applicable*	***85% of male military and/or police participants (82 total) and 85% of female military and/or police participants (54 total) can demonstrate the link between physical and psychological wellbeing and effective performance***	*Final reports of self-evaluation*	*Self-evaluation matrix*	*Before and after the training session*	*Project coordinator*

OUTPUTS							
*1111a Training package is reviewed (content / methodology) to integrate the **specific and gendered needs as well as the country / mission context***	*# of training packages reviewed to integrate the **specific and gendered needs as well as the country / mission context***	*Not applicable*	*8 gender-responsive / **military / police-adapted** training packages developed*	*Gender-responsive / **military/police-adapted** training packages*	*Document evidence*	*Once after training packages development*	*Project coordinator*
*1111b **Preparatory workshop is attended by a gender-balanced group of UNITAR trainers***	*# of UNITAR trainers attending the preparatory workshop, disaggregated by sex and language (English / French / other), and area of expertise*	*Not applicable*	***A gender-balanced group of** 16 UNITAR trainers attend the preparatory workshop **(9 male/7 female ratio: 56%/44%)***	*Report of the preparatory workshop*	*Attendance list*	*Once after workshop completion*	*Project coordinator*
*1111c **Training sessions are attended by a gender-balanced / military and/or police groups of medical and para-medical personnel***	*# of male and female medical and paramedical personnel **from the military and/or police** attending the training sessions*	*Not applicable*	*A gender-balanced group of 160 medical and para-medical personnel from the military and/or police attend the training session **(96 male/64 female ratio: 60%/40%)***	*Report of the training session*	*Attendance list*	*At the end of each training session*	*Project coordinator*
*1121a **Advanced training sessions are attended by a gender-balanced / military and/or police groups of medical and para-medical personnel***	*# of male and female medical and paramedical personnel **from the military and/or police** attending the training sessions*	*Not applicable*	*A gender-balanced group of 80 medical and para-medical personnel from the military and/or police attend the training session*	*Report of the training session*	*Attendance list*	*At the end of each training session*	*Project coordinator*

			(48 male/32 female ratio: 60%/40%)				
*1131a **Android version** of the "UN MissionMed" mobile application is upgraded to include French translation and other relevant materials*	*# of upgraded Android UN MissionMed mobile applications*	*Current version of Android UN Mission-Med mobile application*	*1 Android versions of the "UN MissionMed" mobile application is upgraded to include French translation and other relevant materials*	*Mobile application*	*Document evidence*	*Once*	*Project coordinator*
*1131a **iOS version** of the "UN MissionMed" mobile application is developed*	*# of iOS UN MissionMed mobile applications*	*Not applicable*	*1 iOS version of the "UN MissionMed" mobile application is developed*	*Mobile application*	*Document evidence*	*Once*	*Project coordinator*
1211a Training packages are reviewed to underscore the link between good mental and physical health and effective performance in UN missions	*# of training packages reviewed to underscore the link between good mental and physical health and effective performance in UN missions*	*Not applicable*	*8 gender-responsive / **military / police-adapted** training packages are reviewed*	*Gender-responsive / **military/police-adapted** training packages*	*Document evidence*	*Once after training packages review*	*Project coordinator*

Annex G: Evaluation Audit Trail Template

(To be completed by Project Management to show how the received comments on the draft report have (or have not) been incorporated into the evaluation report. This audit trail should be included as an annex in the evaluation report.)

To the comments received on (*date*) from the evaluation of the "Enhanced Training for Uniformed Medical Personnel Deploying to UN Peace Operations" **project**

The following comments were provided in track changes to the draft evaluation report; they are referenced by institution ("Author" column) and track change comment number ("#" column):

Author	#	Para No./ comment location	Comment/Feedback on the draft evaluation report	Evaluator response and actions taken

Annex H: Evaluation Consultant Code of Conduct and Agreement Form*

The evaluator:

1. Must present information that is complete and fair in its assessment of strengths and weaknesses so that decisions or actions taken are well founded.
2. Must disclose the full set of evaluation findings along with information on their limitations and have this accessible to all affected by the evaluation with expressed legal rights to receive results.
3. Should protect the anonymity and confidentiality of individual informants. He/she should provide maximum notice, minimize demands on time, and respect people's right not to engage. He/she must respect people's right to provide information in confidence and must ensure that sensitive information cannot be traced to its source. He/she are not expected to evaluate individuals and must balance an evaluation of management functions with this general principle.
4. Sometimes uncovers evidence of wrongdoing while conducting evaluations. Such cases must be reported discreetly to the appropriate investigative body. He/she should consult with other relevant oversight entities when there is any doubt about if and how issues should be reported.
5. Should be sensitive to beliefs, manners and customs and act with integrity and honesty in their relations with all stakeholders. In line with the UN Universal Declaration of Human Rights, he/she must be sensitive to and address issues of discrimination and gender equality. He/she should avoid offending the dignity and self-respect of those persons with whom he/she comes in contact in the course of the evaluation. Knowing that evaluation might negatively affect the interests of some stakeholders, he/she should conduct the evaluation and communicate its purpose and results in a way that clearly respects the stakeholders' dignity and self-worth.
6. Is responsible for his/her performance and his/her product(s). He/she is responsible for the clear, accurate and fair written and/or oral presentation of study imitations, findings and recommendations.
7. Should reflect sound accounting procedures and be prudent in using the resources of the evaluation.

Evaluation Consultant Agreement Form[33]

Agreement to abide by the Code of Conduct for Evaluation in the UN System

Name of Consultant: _____

Name of Consultancy Organization (where relevant)**:** _____

I confirm that I have received and understood and will abide by the United Nations Code of Conduct for Evaluation. and I declare that any past experience, of myself, my immediate family or close friends or associates, does not give rise to an actual or perceived conflict of interest.

Signed at *place* on *date*

Signature: _____

*This form is required to be signed by each eval

[33]www.unevaluation.org/unegcodeofconduct

Annex I: List of implementing partners

Name	Type of organization	Dates	Amount in local currency	Amount in $[34]
The Rwanda Peace Academy	Government	10 October 2022 – 15 Dec 2022 and additional grant (tbc)	445,012,162.01 RWF	
Department of Medical Services of Ghana Armed Forces	Government	23 August 2023 – 30 September 2023	78,387 GHS	
The Administration Police Service (APS) Kenya	Government	28 September 2023 – 30 October 2023	1,899,050 KES	
Tanzania National Police	Government	tbc	14,730,000 TZS	

[34] Exchange rates may vary.

B. Survey/questionnaires deployed

1. Participant survey (Basic)

Number	Question	Response options
Introduction		
	Dear UNITAR participant, Thank you for accepting to provide feedback on your post-training experience. UNITAR is committed to providing quality training and your participation in this short survey is crucial for continuous quality improvement. We are collecting experiences of participants in the UNITAR basic training for medical personnel for informing the final evaluation of the project "Enhancing the capacities of uniformed medical personnel deployed to UN Peace Operations". All responses, including any personal information you provide, will be kept anonymous and strictly confidential. Your name and organizational affiliation will not be attached to the results, your individual responses will not be published, and the survey results will only be published in the aggregate and not attributable form. This survey can be completed in about 9 minutes. Many thanks in advance for your response!	
Survey general		
1	Please indicate your affiliation	Military Police I prefer not to answer this question Other, please specify
2	Could you indicate your medical field / qualification?	Nurse Doctor Paramedic Emergency medical technician Laboratory technician I prefer not to answer this question Other medical personnel, please specify
3	How many years of experience do you have in your field? Please express your response in years	
4	Before the UNITAR training, did you have experience in mental health and medical and psychological trauma?	Yes, please describe your experience No
5	Kindly indicate your gender	Female Male Non-binary I prefer not to answer this question
6	Please, indicate your nationality	Burkina Faso Chad Ghana Kenya Niger Rwanda Senegal Togo Tanzania I prefer not to answer this question Other, please specify
7	Since participating in the UNITAR training, have you been deployed to any United Nations or local peacekeeping mission such as MINUSCA, MONUSCO, UNMISS, UNIFIL, SAMIM, or any other?	Yes, which one No, but I am preparing for upcoming deployment (skip to Q9)

		No, and I am not preparing for upcoming deployment (skip to Q9)
8	Are you currently deployed in this mission?	Yes No, I have already finished (Please specify the duration)
9	Besides the UNITAR training, have you participated in a similar medical training?	Yes No

About the training

10	How relevant was the UNITAR training to develop the capacities you need most for your role as a Level 1 medic in peacekeeping missions?	Extremely relevant Very relevant Moderatley relevant Slightly relevant Not at all relevant Not applicable, I did not feel I needed to develop any additional capacity
11	How relevant was the UNITAR training to develop other capacities you were interested to gain at the individual level?	Extremely relevant Very relevant Moderatley relevant Slightly relevant Not at all relevant Not applicable, I did not have any need in particular
12	In your view, what was particularly relevant/ well targeted when addressing gender and context specific elementsduring the training?	

Training results

13 Please indicate your level of agreement or disagreement with the statements below

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	My job does not require me to address this
My ability to address physical trauma has improved as a result of the UNITAR training						
My ability to address psychological trauma has improved as a result of the UNITAR training						
My ability to address physical or psychological trauma in a gender-responsive manner has improved as a result of the UNITAR training						
As a result of the UNITAR training, I now give more importance to the physical health of my fellow peacekeepers for their effective performance than before						
As a result of the UNITAR training, I now give more importance to the mental health of my fellow peacekeepers for their effective performance than before						

	After participating in the UNITAR training, I pay more attention to gender aspects when addressing trauma (physical or psychological)					
	If you agree that now pay more attention to gender aspects, could you provide an example on how you do it now.					
14	Please indicate your level of agreement or disagreement with the statements below	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
	My confidence to address physical trauma has increased as a result of the UNITAR training					
	My confidence to address psychological trauma has increased as a result of the UNITAR training					

Application of knowledge and skills

15	After the UNITAR training, have you witnessed and intervened on accidents or casualties?	Yes, during deployment Yes, but not during deployment No, I did not (skip to Q17)
16	Did you use any of the life saving/emergency techniques you learned during the training such as placing a torniquet, performing CPR, among others?	Yes, please provide examples. Please try to be as specific as possible. No
17	After the UNITAR training, have you attended any patient requiring psychological assistance?	Yes, during deployment Yes, but not during deployment No, I did not (skip to Q19)
18	Did you use any of the mental health and psychological support techniques learned during the UNITAR training, either on yourself or others?	Yes, please provide examples. Please try to be as specific as possible. No, I did not use them (skip to Q23)
19	Which changes did you observe in the physical or mental well-being of the uniformed personnel you cared for during deployment after using the knowledge and skills from the UNITAR training? If you did not observe any changes, kindly write NA	
20	How confident are you with the response you just provided?	Very confident Somewhat confident Not at all confident
21	Will you continue using the knowledge and skills gained and applied to your work in the future?	Very likely Not likely (please explain why) Unsure, difficult to tell
22	Do you have opportunities for continued training?	Yes, please specify No

23	Please indicate which factor(s) has/have helped or prevented the application of knowledge and skills from the training to your work		Helped	Restricted	Not applicable
		Opportunity to apply knowledge and skills			
		Having sufficient knowledge or expertise in that area			
		Relevance of the training content to my work			
		Autonomy to apply knowledge and skills			
		Resources available in my health care facility			
		Other factor, please specify			
Unintended changes					
24	Have you identified any other change in your practice or your career derived from the UNITAR training? This should be something you were not expecting to occur as a result from your participation in the training.	Yes, please specify			
		No			
Use of the mobile application UN MissionMed					
25	Do you know the UN Mission Med mobile application and have you ever used it for your work?	I know the mobile app and I have used it for my job			
		I know the mobile app but I have never used it for my job, please explain why not			
		I have never heard about it (skip to Q28)			
26	In which language did you access the mobile application?	English			
		French			
27	Could you describe for what specifically you have consulted the mobile app and how you have used it?				
Final comments					
28	Is there anything else you would like to share with us related to your participation in the training activities? Any suggestions for the future?				
29	Would you agree to be contacted as a follow up to this survey to share yout training and post-training experience?	Yes, please specify your email or phone number (with country code)			
		No			
	Thank you for your responses!				

2. Participant survey (Advanced)

Number	Question	Response options
Introduction		
	Dear UNITAR participant, Thank you for accepting to provide feedback on your post-training experience. UNITAR is committed to providing quality training and your participation in this short survey is crucial for continuous quality improvement. We are collecting experiences of participants in the UNITAR advanced training for medical personnel (training of trainers) for informing the final evaluation of the project "Enhancing the capacities of uniformed medical personnel deployed to UN Peace Operations". All responses, including any personal information you provide, will be kept anonymous and strictly confidential. Your name and organizational affiliation will not be attached to the results, your individual responses will not be published, and the survey results will only be published in the aggregate and not attributable form. This survey can be completed in about 11 minutes.	
0	Many thanks in advance for your response!	
Survey general		
1	Please indicate your affiliation	Military Police Other, please specify I prefer not to answer this question
2	Could you indicate your medical field / qualification?	Nurse Doctor Paramedic Emergency medical technician Laboratory technician Other medical personnel, please specify I prefer not to answer this question
3	How many years of experience do you have in your field? Please express your response in years	
4	Before the UNITAR training, did you have experience in mental health and medical and psychological trauma?	Yes, please describe your experience No
5	Kindly indicate your gender	Female Male Non-binary I prefer not to answer this question
6	Please, indicate your nationality	Burkina Faso Chad Ghana Kenya Niger Rwanda Senegal Togo Tanzania Other, please specify I prefer not to answer this question
7	Since participating in the UNITAR training, have you been deployed to any United Nations or local peacekeeping mission such as MINUSCA, MONUSCO, UNMISS, UNIFIL, SAMIM, or any other?	Yes, which one No, but I am preparing for upcoming deployment (skip to Q10)

		No, and I am not preparing for upcoming deployment (skip to Q10) I prefer not to answer this question
8	Are you currently deployed in this mission?	Yes No, I have already finished (Please specify the duration)
9	Besides the UNITAR trainign, have you participated in a similar medical training or a Training of Trainers?	Yes No

About the training

10	How relevant was the UNITAR training to develop the capacities you need most for your profession?	Extremely relevant Very relevant Moderatley relevant Slightly relevant Not at all relevant Not applicable, I did not feel I needed to develop any additional capacity
11	How relevant was the UNITAR training to develop other capacities you were interested to gain at the individual level?	Extremely relevant Very relevant Moderatley relevant Slightly relevant Not at all relevant Not applicable, I did not have any need in particular
12	In your view, what was particularly relevant/ well targeted when addressing gender and context specific elements during the training?	

Training results

13 Please indicate your level of agreement or disagreement with the statements below

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	My job does not require me to address this
My ability to address or deliver physical trauma has improved as a result of the UNITAR training						
My ability to address or deliver psychological trauma has improved as a result of the UNITAR training						
My ability to address or dleiver physical or psychological trauma in a gender-responsive manner has improved as a result of the UNITAR training						
As a result of the UNITAR training, I now give more importance to the physical health of my fellow peacekeepers for their effective performance than before						
As a result of the UNITAR training, I now give more importance to the mental health of my fellow peacekeepers for their effective performance than before						
After participating in the UNITAR training, I pay more attention to gender aspects when addressing trauma (physical or psychological)						

		If you agree that now pay more attention to gender aspects, could you provide an example on how you do it now.					
14	Please indicate your level of agreement or disagreement with the statements below	My confidence to address physical trauma has increased as a result of the UNITAR training	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
		My confidence to address psychological trauma has increased as a result of the UNITAR training					
Application of knowledge and skills							
15	After the UNITAR training, have you witnessed and intervened on accidents or casualties?	Yes, during deployment Yes, but not during deployment No, I did not (skip to Q17)					
16	Did you use any of the life saving/emergency techniques you learned during the training such as placing a torniquet, performing CPR, among others?	Yes, please provide examples. Please try to be as specific as possible. No					
17	After the UNITAR training, have you attended any patient requiring psychological assistance?	Yes, during deployment Yes, but not during deployment No, I did not (skip to Q19)					
18	Did you use any of the mental health and psychological support techniques learned during the UNITAR training?	Yes, please provide examples. Please try to be as specific as possible. No, I did not use them (skip to Q19)					
19	Which changes did you observe in the physical or mental well-being of the uniformed personnel you cared for during deployment after using the knowledge and skills from the UNITAR training? If you did not observe any changes, kindly write NA						
20	How confident are you with the response you just provided?	Very confident Somewhat confident Not at all confident					
21	Will you continue using the knowledge and skills gained and applied to your work in the future?	Very likely Not likely (please explain why) Unsure, difficult to tell					
22	Do you have opportunities for continued training?	Yes, please specify No					
23	Please indicate which factor(s) has/have helped or prevented the application of knowledge and skills from the training to your work		Helped	Restricted	Not applicable		
		Opportunity to apply knowledge and skills					
		Having sufficient knowledge or expertise in that area					
		Relevance of the training content to my work					
		Autonomy to apply knowledge and skills					
		Resources available in my health care facility					
		Other factor, please specify					
Advanced training: ToT							

24	After receiving the UNITAR training of trainers, have you had the opportunity to train?	Yes, please describe the session you delivered and the target group here: No
Unintended changes		
25	Have you identified any other change in your practice or your career derived from the UNITAR training? This should be something you were not expecting to occur as a result from your participation in the training.	Yes, please specify No
Use of the mobile application MedApp		
26	Do you know the UN Mission Med mobile application and have you ever used it for your work?	I know the mobile app and I have used it for my job I know the mobile app but I have never used it for my job, please explain why not I have never heard about it (skip to Q29)
27	In which language did you access the mobile application?	English French
28	Could you describe for what specifically you have consulted the mobile app and how you have used it?	
Final comments		
29	Is there anything else you would like to share with us related to your participation in the training activities? Any suggestions for the future?	
30	Would you agree to be contacted as a follow up to this survey to share yout training and post-training experience?	Yes, please specify your email or phone number (with country code) No
	Thank you for your responses!	

3. Trainer survey

Number	Question	Response options		
Introduction				
	Dear UNITAR trainer, Thank you for accepting to provide feedback on your experience as a UNITAR trainer. UNITAR is committed to providing quality training and your participation in this short survey is crucial for continuous quality improvement. We are collecting experiences of UNITAR trainers who participated in the preparatory workshops (Training of Trainers) in Tanzania organized by UNITAR for informing the final evaluation of the project "Enhancing the capacities of uniformed medical personnel deployed to UN Peace Operations". All responses, including any personal information you provide, will be kept anonymous and strictly confidential. Your name and			
0	organizational affiliation will not be attached to the results, your			
General				
	How many years of experience as a trainer do you have, how many as a			
1	UNITAR trainer, and how many in the health sector?	Experience as a trainer Less than three years 3 to 5 years More than 5 years	Experience with UNITAR I was recruited for this I have already worked with	Experience as a medical personnel Less than three years 3 to 5 years More than 5 years
2	Were you familiar with mental health related themes before?	Yes No, this was my first time		
3	Kindly indicate your gender	Female Male Non-binary I prefer not to answer this		
4	Please, indicate your nationality	Chad Cameroon Canada Nigeria Niger Togo Ghana Burkina Faso Mali Senegal Kenya Tanzania Burundi Rwanda Russia Sweden United Kingdom United States Other, please specify		
5	Please indicate the training of trainers workshop in which you participated in	Training of trainers on Full Revised Basic Curriculum in Tanzania Training of trainers on Mental Health and Psychosocial Support		
6	Have you ever deployed to a Peacekeeping mission, if yes which ones, which year and position (i.e., medic or trainer)	Peacekeeping mission Year Position		
ToT knowledge and application				

7	How relevant was the UNITAR preparatory workshop (training of trainers) to develop the capacities you needed most for conducting training?	Extremely relevant Very relevant Moderately relevant Slightly relevant (skip to Q9) Not at all relevant (skip to Q9)
8	What areas covered by the training of trainer were the most relevant to you?	
9	In your view, what was particularly relevant/ well targeted when addressing gender and context specific elements	
10	After receiving the UNITAR preparatory workshop, have you had the opportunity to facilitate any UNITAR training?	Yes No, but I facilitated training with another organization. Please specify which one (skip to Q13) No (skip to Q15)
11	How many training sessions have you delivered and how many participants have you trained as part of the UNITAR training activities? If you don't remember, please write NA	Number of sessions Number of participants
12	How would you describe the support provided by UNITAR to you when you organized the training session(s)?	Very good Good Acceptable Poor Very good
13	Have you used any of the knowledge and skills gained during the preparatory workshops in these training sessions?	Yes, please explain what you have used and how you have done it No
14	When delivering the training, did you consider any of the gender aspects learned during the training of trainers?	Yes, please provide an example No
15	What were the main limitations you observed in participants' understanding / applying in practice how gender equity and mental	
16	Did you note best practices on way to communicate on the importance	
17	If not, what have been the reasons? Please select all that apply or indicate any other reason	The knowledge and skills do not seem relevant to my work I was not asked to train and did not have the opportunity to apply the knowledge and skills. I already had prior knowledge in mental health and used my prior knowledge to deliver the training.

		I did not feel confident enough to train. I was not available when I was asked to train I did not speak the language in which the training was conducted Other reason, please specify
Final comments		
18	Is there anything else you would like to share with us related to your	
17	Would you agree to be contacted as a follow up to this survey to share your experience as a UNITAR trainer?	Yes, please specify your email or phone number No

C. List of persons interviewed

	Name	Affiliation	Type of interviewee
1	Mureta Fidel Byishimi	Doctor, Rwanda National Police	Participant, basic training
2	Gilbert Dushimirimana	Doctor, Rwanda National Police	Participant, basic training
3	Ahmat Daye Awada	Head of medical service, Chad National Army	Participant, basic and advanced training
4	Vital Muvunyi	Doctor, Rwanda National Police	Participant, basic training
5	Caroline Kimanthi	Trainer at UNMAS	Participant preparatory workshops (ToT)
6	Lilian Okoronkwo	UNITAR trainer	Participant preparatory workshops (ToT)
7	James Abel	UNITAR trainer	Participant preparatory workshops (ToT)
8	Pierre Sannemo	UNITAR trainer	Participant preparatory workshops (ToT)
9	Mohammed Alfa-Traore	Independent trainer	Participant preparatory workshops (ToT)
10	Mohamadou Oumarou Idrissa	UNITAR trainer	Participant preparatory workshops (ToT)
11	Patrick Ndumia Githinji	UNITAR trainer	Participant preparatory workshops (ToT)
12	Arnaud Bonkoungou	UNITAR trainer	Participant preparatory workshops (ToT)
13	Armel Dusabe	UNITAR trainer	Participant preparatory workshops (ToT)
14	Jason Jarvis	UNITAR trainer	Participant preparatory workshops (ToT)
15	Leopold Ndayambaje	Nurse, Police Hospital of Rwanda	Participant advanced training
16	Palouki N'gassibou	Doctor and trainer	Participant advanced training
17	Pius Masinde	UNITAR	UNITAR focal point
18	Freddie Bategereza	UNITAR	UNITAR focal point
19	Claude Kaberuka Bisenge	UNITAR	UNITAR focal point
20	Colonel George Boamah	Director of Training, Department of Medical Services, Ghana Armed Forces (GAF)	T/PCC
21	Colonel Halidou Nouhou Abdou	Niger Armed Forces, Operations branch	T/PCC
22	Colonel Sogoyou Cossi	Togo Armed Forces	T/PCC
23	Boniface Ngesa	APS	Participant advanced training
24	Beatrice Nkatha Gichamui	APS	Participant basic and advanced training
25	Nelly Mwihaki Nyaga	APS	Participant basic training
26	Josphat Muriuki	APS	Participant basic and advanced training
27	Francis Naimanjo		Participant basic training
28	Moses Ambili		Participant basic and advanced training
29	Peter Kiptoo Chepkwony		Participant basic training
30	Jonah Kibiwott Kimutai		Participant basic training
31	Elizabeth Nafula Khalayi		Participant basic training
32	Basilio Gachie	APS	Participant basic and advanced training

33	Gideon Kisio	APS	Participant basic and advanced training
34	Josephat Ondieki		Participant basic training
35	Boniface Wafula	APS	Participant basic and advanced training
36	Samuel Miangi Githinji	APS	Participant basic and advanced training
37	Davis Mwita	TPF	Participant basic and advanced training
38	Peres Bugumba	TPF	Participant basic and advanced training
39	Johnson Majeshi		Participant basic training
40	Salma Salehe		Participant basic training
41	Lothary Kapangawazi	TPF	Participant basic and advanced training
42	Johnson Mwanjonde		Participant basic training
43	Paul Nshashi		Participant basic training
44	Francois Denis	UNITAR	UNITAR learning solutions
45	Maša Dikanovic	UNITAR	UNITAR project manager
46	Claudia Croci	UNITAR	UNITAR project manager
47	Ollivia Hamilton	GAC	Senior Program Officer / Agente principale de programme, Peace Operations Training / Formation aux opérations de paix

D. List of documents reviewed

Department of Peace Operations and Peacekeeping Missions

UNITAR

Project-specific documentation

- Interim and final narrative reports
- Legal Agreement
- Logical Model and Theory of Change
- Project Description
- Documents related to the 2020-2021 phase, including needs assessment
- Documents related to the four implementing partners
- Event Management System Data
-

UNITAR documentation

- UNITAR website content

Other documentation

- Relevant international frameworks including Strategic Guidance Framework for International Policing, Women, Peace and Security (WPS) Agenda, the UN Uniformed Gender Parity Strategy, Cruz Report, Action for Peacekeeping (A4P), Integrated Peacekeeping Performance and Accountability Framework, Elsie Initiative for Women in Peace Operations, Africa Peace Support Trainers Association's values and objectives, UNSC Resolution 2242 (2015) on Women and Peace, the Policy on United Nations Police (2014), UN Security Resolution 2518; Global Affairs Canada's Framework for Assessing Gender Equality Results, Canada Feminist Policy; 2017 UN Staff Well-Being Survey Data Report, 2018 UN Mental Health and Well-Being Strategy, UN S/RES/2668, the UN Ministerial in Ghana, and other relevant UN frameworks.

E. Summary of field visits

The Evaluator conducted field visits in Tanzania and Kenya, from 4 to 7 August 2024 and 29 to 30 August 2024, respectively. Targeted participants from TPF and APS Kenya were mobilized through the relevant UNITAR focal points, in collaboration with national police leadership.

Interviews were conducted at the workstations of the selected participants, including Kilwa Road Police Station, Osterbay Police Station, and Tanzania Police School (TPS) in Moshi, Tanzania, and the Border Police Training Campus in Kanyonyo, Kenya. Prior to engaging with participants, the Evaluator made courtesy visits to the heads of the police stations for approval.

In Tanzania, the evaluator conducted seven individual interviews (1 female, 6 male). In Kenya, 10 individual interviews and one group interview with six participants (5 female, 1 male) were carried out. Additionally, the consultant administered the self-administered survey tool to participants who had not completed it online.

During the visit to Kenya, the evaluator toured the training and storage facilities at the BPTC. Unfortunately, the evaluator was unable to visit the Tanzania Peacekeeping Training Centre (TPTC) or interview staff there, despite several attempts. Follow-up fact-checking interviews were conducted with UNITAR focal points in both Kenya and Tanzania.

F. Evaluation question matrix

Key evaluation questions	Sub-questions		Data collection tools & stakeholder group
1.**RELEVANCE** *Is the project reaching its intended individual users and are project objectives and activities relevant to the initial, intermediate, and final users' needs and priorities, and designed with quality?*	*a. To what extent is the project aligned with the Institute's efforts to helping Member States implement the 2030 Agenda for Sustainable Development, UNITAR's Strategic Framework 2022-2025, particularly Strategic Objective 1, and Global Affairs Canada/PSOP's guiding policies?* *b. How relevant are the project objectives, design, and training activities to the capacity, performance and individual needs and priorities of the initial users, intermediate users, and end users of the project respectively? Is it equally relevant for female and male trainers/uniformed medical personnel/personnel deployed and francophone and anglophone stakeholders? (GEEW)* *c. How well did the project design build on the needs assessment and lessons learned from the previous phase (2020-2021)? To what extent did the project reach its intended beneficiaries, namely gender-balanced trainers' groups, francophone trainers, and medical and paramedical personnel, to the extent possible? If not, what/who was missing and what could have done differently?*		Desk review, surveys & interviews Group A - project management and implementation Group C - Training beneficiaries Group D - external/UN stakeholders
2.COHERENCE *To what extent is the project complementing other similar programmes and projects and adhering to international norms and standards?*	*d. How well is the project aligned with and complements other UNITAR programming focusing on enhancing capabilities of deployed personnel and particularly those supporting medical and paramedical personnel, e.g. through UNITAR's predeployment training projects?* *e. How well is the project aligned with and complements programming implemented by other institutions focusing on enhancing capabilities of deployed personnel and particularly those supporting medical and paramedical personnel?* *f. How well is the project aligned with relevant international frameworks and UN resolutions and priorities in the peacekeeping field, including the WPS agenda, the UN Uniformed Gender Parity Strategy, the Cruz report, Action for Peacekeeping (A4P) and A4P+, the Elsie Initiative for Women in Peace Operations, UN Security Council Resolution 2518, pledges from peacekeeping ministerial, Global Affairs Canada's Framework for Assessing Gender Equality Results, among others? (GEEW)*		Desk review, interviews Group A – project management and implementation Group B – The donor Group D – other stakeholders
3.EFFICIENCY *To what extent has the project delivered its results in a cost-effective manner and*	*g. To what extent has the project produced outputs in a timely and cost-efficient manner, including through grant*	*g. To what extent has the project produced outputs in a timely and cost-efficient manner, including through grant*	Desk review and interviews Group A – project management

Key evaluation questions	Sub-questions		Data collection tools & stakeholder group
optimized partnerships?	*arrangements with implementing partners (Rwanda Peace Academy, Department of Medical Services of Ghana Armed Forces, The Administration Police Service Kenya and Tanzania National Police) in comparison with alternative approaches? Were the project's resources (human and financial) used as planned and fully utilised? h. To what extent was the project including both activities and planned expenditures delivered as planned? To what extent did interim narrative/performance management framework reporting capture progress towards results? What caused deviations from the original plan? Did the project apply adaptive management to adjust to implementation challenges?*	*arrangements with implementing partners (Rwanda Peace Academy, Department of Medical Services of Ghana Armed Forces, The Administration Police Service Kenya and Tanzania National Police) in comparison with alternative approaches? Were the project's resources (human and financial) used as planned and fully utilised? h. To what extent was the project including both activities and planned expenditures delivered as planned? To what extent did interim narrative/performance management framework reporting capture progress towards results? What caused deviations from the original plan? Did the project apply adaptive management to adjust to implementation challenges?*	and implementation
4.EFFECTIVENESS *How effective has the project been, through its four components, in delivering results and in reinforcing capabilities and increased awareness of uniformed medical and paramedical personnel?*	*i. To what extent have the planned outcomes and outputs been achieved? What are the factors, affecting the project and the individual's performance of initial, intermediate and end users?* *j. Has the project's design, with multiple components, and partnerships been effective in delivering and attaining results, including the performance of the four implementing partners?* *k. To what extent and how is the project contributing to improved knowledge and skills, capabilities, motivations (increased awareness) and opportunities of uniformed medical and paramedical personnel to address physical and psychological trauma of deployed personnel in a gender-responsive manner? How effective is the*		Desk review, interviews, focus groups & survey Group A – project management and implementation Group B – The donor (in-country rep) Group C – Beneficiaries

Key evaluation questions	Sub-questions	Data collection tools & stakeholder group
	mobile application as a learning reinforcement tool? Is progress per country varying? What is missing, if anything? (GEEW)	
5. LIKELIHOOD OF IMPACT *What are the potential cumulative and/or long-term effects expected from the project, including contribution towards the intended impact and intermediate outcome, positive or negative impacts, or intended or unintended changes?*	*l. What real difference has the project made to improve physical and mental well-being of military and police personnel deployed to UN Peace Operations? Are there any differences between female and male uniformed deployed personnel? (GEEW)?* *m. What other observable changes (positive or negative, intended or unintended) have occurred as a result of the project implementation?*	Focus group and surveys. Group C - training beneficiaries.
LIKELIHOOD OF SUSTAINABILITY *To what extent are the project's results likely to be sustained in the long-term? How is environmental sustainability addressed in the project?*	*n. To what extent are the project's results likely to endure beyond implementation the activities in the mid- to long-term and under which conditions?* *o. To what extent has the project contributed to sustainability through creating enabling environment through Training of Trainers (ToT) and the mobile application to maintain capacities and expanded knowledge – after project completion?* *p. What can we learn to inform the future design of similar programming?*	Group A: project management and implementation. Group C - training beneficiaries Group B: donor.

G. Evaluation consultant agreement form

Annex: Evaluation Consultant Code of Conduct and Agreement Form

The evaluator:

1. Must present information that is complete and fair in its assessment of strengths and weaknesses so that decisions or actions taken are well founded.
2. Must disclose the full set of evaluation findings along with information on their limitations and have this accessible to all affected by the evaluation with expressed legal rights to receive results.
3. Should protect the anonymity and confidentiality of individual informants. They should provide maximum notice, minimize demands on time, and respect people's right not to engage. Evaluators must respect people's right to provide information in confidence, and must ensure that sensitive information cannot be traced to its source. Evaluators are not expected to evaluate individuals, and must balance an evaluation of management functions with this general principle.
4. Sometimes uncover evidence of wrongdoing while conducting evaluations. Such cases must be reported discreetly to the appropriate investigative body. Evaluators should consult with other relevant oversight entities when there is any doubt about if and how issues should be reported.
5. Should be sensitive to beliefs, manners and customs and act with integrity and honesty in their relations with all stakeholders. In line with the UN Universal Declaration of Human Rights, evaluators must be sensitive to and address issues of discrimination and gender equality. They should avoid offending the dignity and self-respect of those persons with whom they come in contact in the course of the evaluation. Knowing that evaluation might negatively affect the interests of some stakeholders, evaluators should conduct the evaluation and communicate its purpose and results in a way that clearly respects the stakeholders' dignity and self-worth.
6. Is responsible for his/her performance and his/her product(s). They are responsible for the clear, accurate and fair written and/or oral presentation of study imitations, findings and recommendations.
7. Should reflect sound accounting procedures and be prudent in using the resources of the evaluation.

Evaluation Consultant Agreement Form[1]

Agreement to abide by the Code of Conduct for Evaluation in the UN System

Name of Consultant: FERREIRA Aurélie

Name of Consultancy Organization (where relevant): DELTA

I confirm that I have received and understood and will abide by the United Nations Code of Conduct for Evaluation and I declare that any past experience, of myself, my immediate family or close friends or associates, does not give rise to a potential conflict of interest.

Signed at *Bordeaux* on *November 11, 2022*

Signature:

[1] www.unevaluation.org/unegcodeofconduct

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United Nations Institute for Training and Research

ETHICAL GUIDELINES FOR EVALUATION

PLEDGE OF ETHICAL CONDUCT IN EVALUATION

UNEG
United Nations Evaluation Group

By signing this pledge, I hereby commit to discussing and applying the UNEG Ethical Guidelines for Evaluation and to adopting the associated ethical behaviours.

INTEGRITY

I will actively adhere to the moral values and professional standards of evaluation practice as outlined in the UNEG Ethical Guidelines for Evaluation and following the values of the United Nations. Specifically, I will be:

- **Honest and truthful** in my communication and actions.
- **Professional,** engaging in credible and trustworthy behaviour, alongside competence, commitment and ongoing reflective practice.
- **Independent, impartial and incorruptible.**

ACCOUNTABILITY

I will be answerable for all decisions made and actions taken and responsible for honouring commitments, without qualification or exception; I will report potential or actual harms observed. Specifically, I will be:

- **Transparent regarding evaluation** purpose and actions taken, establishing trust and increasing accountability for performance to the public, particularly those populations affected by the evaluation.
- **Responsive** as questions or events arise, adapting plans as required and referring to appropriate channels where corruption, fraud, sexual exploitation or abuse or other misconduct or waste of resources is identified.
- **Responsible** for meeting the evaluation purpose and for actions taken and for ensuring redress and recognition as needed.

RESPECT

I will engage with all stakeholders of an evaluation in a way that honours their dignity, well-being, personal agency and characteristics. Specifically, I will ensure:

- **Access to** the evaluation process and products by all relevant stakeholders – whether powerless or powerful – with due attention to factors that could impede access such as sex, gender, race, language, country of origin, LGBTQ status, age, background, religion, ethnicity and ability.
- **Meaningful participation and equitable treatment** of all relevant stakeholders in the evaluation processes, from design to dissemination. This includes engaging various stakeholders, particularly affected people, so they can actively inform the evaluation approach and products rather than being solely a subject of data collection.
- **Fair representation** of different voices and perspectives in evaluation products (reports, webinars, etc.).

BENEFICENCE

I will strive to do good for people and planet while minimizing harm arising from evaluation as an intervention. Specifically, I will ensure:

- **Explicit and ongoing consideration of risks and benefits** from evaluation processes.
- **Maximum benefits** at systemic (including environmental), organizational and programmatic levels.
- **No harm.** I will not proceed where harm cannot be mitigated.
- **Evaluation makes an overall positive contribution** to human and natural systems and the mission of the United Nations.

I commit to playing my part in ensuring that evaluations are conducted according to the Charter of the United Nations and the ethical requirements laid down above and contained within the UNEG Ethical Guidelines for Evaluation. When this is not possible, I will report the situation to my supervisor, designated focal points or channels and will actively seek an appropriate response.

November 11, 2022 (Signature and Date)

Annex: Evaluation Consultant Code of Conduct and Agreement Form

The evaluator:

1. Must present information that is complete and fair in its assessment of strengths and weaknesses so that decisions or actions taken are well founded.
2. Must disclose the full set of evaluation findings along with information on their limitations and have this accessible to all affected by the evaluation with expressed legal rights to receive results.
3. Should protect the anonymity and confidentiality of individual informants. They should provide maximum notice, minimize demands on time, and respect people's right not to engage. Evaluators must respect people's right to provide information in confidence, and must ensure that sensitive information cannot be traced to its source. Evaluators are not expected to evaluate individuals, and must balance an evaluation of management functions with this general principle.
4. Sometimes uncover evidence of wrongdoing while conducting evaluations. Such cases must be reported discreetly to the appropriate investigative body. Evaluators should consult with other relevant oversight entities when there is any doubt about if and how issues should be reported.
5. Should be sensitive to beliefs, manners and customs and act with integrity and honesty in their relations with all stakeholders. In line with the UN Universal Declaration of Human Rights, evaluators must be sensitive to and address issues of discrimination and gender equality. They should avoid offending the dignity and self-respect of those persons with whom they come in contact in the course of the evaluation. Knowing that evaluation might negatively affect the interests of some stakeholders, evaluators should conduct the evaluation and communicate its purpose and results in a way that clearly respects the stakeholders' dignity and self-worth.
6. Is responsible for his/her performance and his/her product(s). They are responsible for the clear, accurate and fair written and/or oral presentation of study imitations, findings and recommendations.
7. Should reflect sound accounting procedures and be prudent in using the resources of the evaluation.

Evaluation Consultant Agreement Form[1]

Agreement to abide by the Code of Conduct for Evaluation in the UN System

Name of Consultant: Gilbert Asiimwe

Name of Consultancy Organization (where relevant): _____

I confirm that I have received and understood and will abide by the United Nations Code of Conduct for Evaluation and I declare that any past experience, of myself, my immediate family or close friends or associates, does not give rise to a potential conflict of interest.

Signed at *place* on *date*

Signature: 

29/05/2024

[1] www.unevaluation.org/unegcodeofconduct

unitar
United Nations Institute for Training and Research

ETHICAL GUIDELINES FOR EVALUATION

PLEDGE OF ETHICAL CONDUCT IN EVALUATION

UNEG
United Nations Evaluation Group

By signing this pledge, I hereby commit to discussing and applying the UNEG Ethical Guidelines for Evaluation and to adopting the associated ethical behaviours.

INTEGRITY

I will actively adhere to the moral values and professional standards of evaluation practice as outlined in the UNEG Ethical Guidelines for Evaluation and following the values of the United Nations. Specifically, I will be:

- **Honest and truthful** in my communication and actions.
- **Professional**, engaging in credible and trustworthy behaviour, alongside competence, commitment and ongoing reflective practice.
- **Independent, impartial and incorruptible.**

ACCOUNTABILITY

I will be answerable for all decisions made and actions taken and responsible for honouring commitments, without qualification or exception; I will report potential or actual harms observed. Specifically, I will be:

- **Transparent regarding** evaluation purpose and actions taken, establishing trust and increasing accountability for performance to the public, particularly those populations affected by the evaluation.
- **Responsive** as questions or events arise, adapting plans as required and referring to appropriate channels where corruption, fraud, sexual exploitation or abuse or other misconduct or waste of resources is identified.
- **Responsible** for meeting the evaluation purpose and for actions taken and for ensuring redress and recognition as needed.

RESPECT

I will engage with all stakeholders of an evaluation in a way that honours their dignity, well-being, personal agency and characteristics. Specifically, I will ensure:

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29/05/2024 (Signature and Date)

Planning, Performance Monitoring, and Evaluation Unit

United Nations Institute for Training and Research UNITAR Headquarters

7 bis, Avenue de la Paix

CH-1202 Geneva 2

Switzerland

T: +41 (0)22 917 8400

F: +41 (0)22 917 8047

email: evaluation@unitar.org