

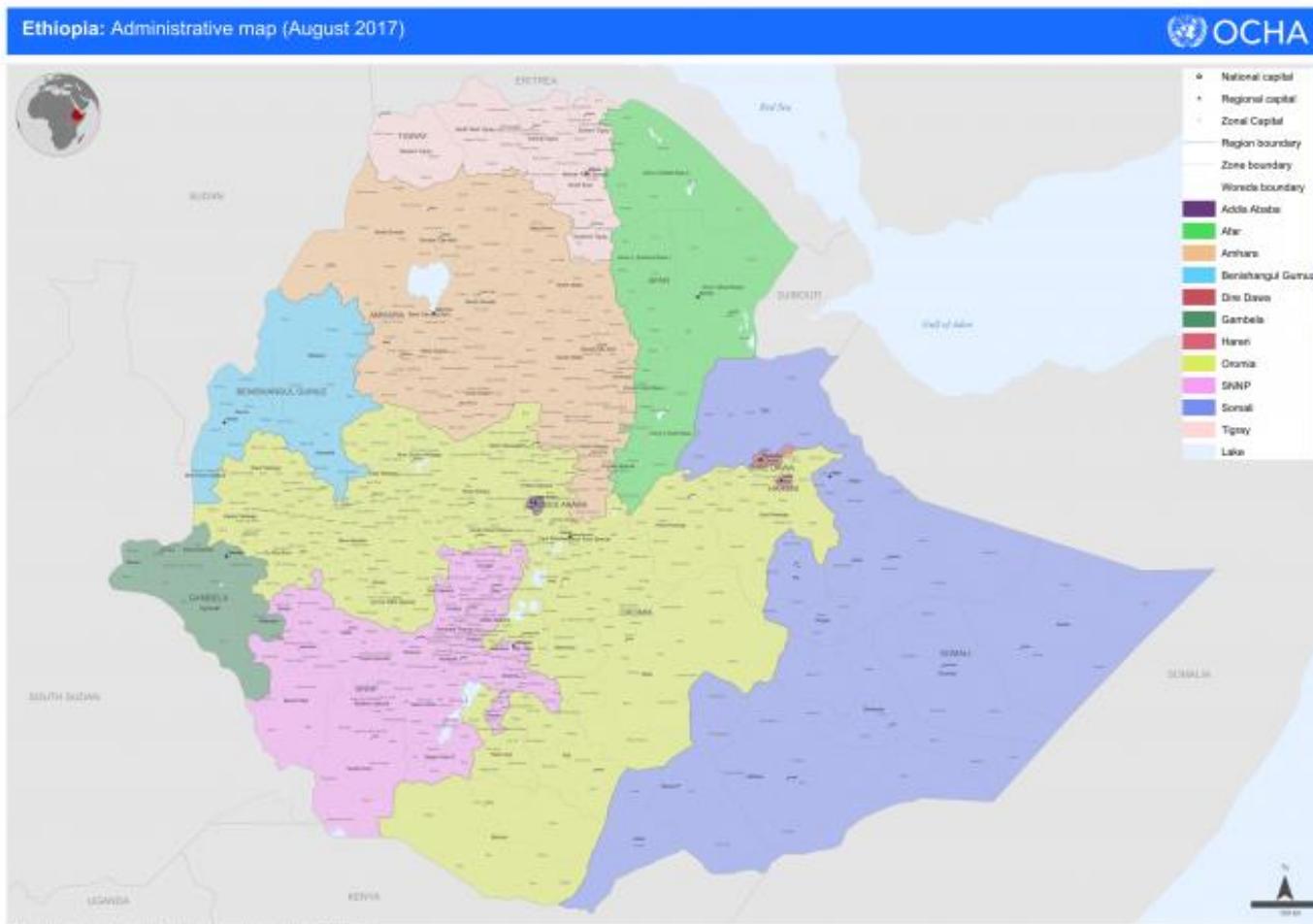


**GOVERNMENT OF ETHIOPIA/UNFPA 8TH COUNTRY
PROGRAMME [2016-2020]**

FINAL EVALUATION REPORT

DATE: FEBRUARY 2020

ADMINISTRATIVE MAP OF ETHIOPIA



Source: OCHA 2017

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DISCLAIMER

A team of three Consultants prepared this evaluation report: **Clifford Odimegwu**, International Consultant Evaluation Team Leader who also doubled as the Population and Development Expert, **Yibeltal Kilfie**, National Evaluation Consultant in charge of the SRH/AYD Component and **Dr Emebet Mulugeta**, in charge of the Gender Equality and Women’s Empowerment (GEWE) component. The content, analysis and recommendations of this report do not necessarily reflect the views of the United Nations Population Fund (UNFPA), its Executive Committee or the Government of Ethiopia.

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ACRONYMS AND ABBREVIATIONS

ADA	Amhara Development Association
ANC	Antenatal Care
APDA	Afar Pastoralist Development Association
ARRA	Agency for Refugee and Returnee Affairs
AWSAD	Association for Women’s Sanctuary and Development
AWP	Annual Work Plan
AYD	Adolescent and Youth Development
AYHS	Adolescent and Youth Health Strategy
BEmONC	Basic Emergency Obstetric and Newborn Care
BoFEC	Bureau of Finance and Economic Cooperation
BoWCA	Bureau of Women and Children’s Affairs
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CEDAW	Convention on the Elimination of All Forms Discrimination Against Women
CJPO	Child Justice Project Office
CM	Child Marriage
CO	Country Office
CP	Country Program
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organizations
DEX	Direct Execution
DHS	Demographic and Health Survey
EmONC	Emergency Obstetric and Newborn Care
EPSA	Ethiopian Pharmaceutical Supply Agency
ET	Evaluation Team
EWLA	Ethiopian Women Lawyers Association
FBOs	Faith Based Organizations
FGAE	Family Guidance Association – Ethiopia
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
FGM/C	Female Genital Mutilation/Cutting
FP	Family Planning
GAC	Global Affairs Canada
GEWE	Gender Equality and Women Empowerment
GBV	Gender Based Violence
GTP	Growth and Transformation Plan
HC	Health Centre
HEIs	Higher Education Institutions
HEW	Health Extension Worker
HIV	Human Immunodeficiency Virus
HPDP	Health Promotion and Disease Prevention
HSTP	Health Sector Transformation Plan
HTP	Harmful Traditional Practice
IDP	Internally Displaced Person
II	In-depth Interview

ILO	International Labour Organization
IP	Implementing Partner
KI	Key Informant Interview
KNE	Royal Netherlands Embassy
LARC	Long Acting Reversible Contraceptives
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MDSR	Maternal Death Surveillance and Response
MLWDA	Mugegewa Loka Women Development Association
MoE	Ministry of Education
MoH	Ministry of Health
MoWCYA	Ministry of Women, Children and Youth Affairs
MOY	Ministry of Youth
MTR	Mid Term Review
NEX	National Execution
NGO	Non-Government Organization
OPD	Outpatient Department
PD	Population and Development
PNC	Postnatal Care
PIM	Program Implementation Manual
RH	Reproductive Health
RHB	Regional Health Bureau
RPO	Regional Program Officer
SARA	Service Availability and Readiness Survey
SDG	Sustainable Development Goals
SGBV	Sexual and Gender Based Violence
SRH	Sexual and Reproductive Health
SNNPR	Southern Nations, Nationalities, and People's Region
ToT	Training of Trainers
UNDP	United Nations Development Programme
UNDAF	United Nations Development Assistance Framework
UNESCO	United Nations Education, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UPR	Universal Periodic Report
WDA	Women Development Army
WoHO	Woreda Health Office
YFSC	Youth-Friendly Service Centre
YFSRHS	Youth-Friendly Sexual and Reproductive Health Service

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KEY FACTS ON ETHIOPIA

LAND	
Geographical Location ¹	Located in North eastern part of Africa known as the “Horn of Africa”
Land area (sq km) ²	1 000 000
PEOPLE	
Population (millions) ³	107.53 (2018)
Urban ⁴	21% (2018)
Rural ⁴	79% (2018)
Population growth (annual) ¹	2.4% (2018)
Human Development Index rank ⁵	174/188 (2018) Low Human development
GOVERNMENT	
Capital ⁶	Addis Ababa
Government type ⁶	Federal parliamentary republic
Legislature ⁶	Bicameral Parliament consists of the House of Federation and the House of people’s Representatives
Females in Parliament ⁷	39% (2017)
OFFICIAL DEVELOPMENT ASSISTANCE	
From all donors (US\$ millions, net) ⁸	\$4 073.8 (2016)
As % of income ⁸	6.02% (2016)
Per capita ⁸	\$39.8 (2016)
From U.S. (US\$ millions) ⁸	\$876.8 (2016)
EDUCATION	
Completion rate, primary gross ⁷	54.3% (2015)
Female completion rate ⁷	53.2% (2015)
Male completion rate ⁷	55.4% (2015)
Pupil-teacher ratio, primary ⁹	55 (2011)
Pupil-teacher ratio, secondary ⁹	40 (2011)
Public education expenditure (% of GDP) ⁹	4.5% (2013)
Youth literacy rate (ages 15-24) ⁷	n/a
Children out of school, primary ⁷	2 221 454 (2015)
Of which, female ⁷	61% (2015)
Of which, male ⁷	39% (2015)
ECONOMY	
GDP (US\$ millions) ⁷	\$80.561 (2017)
GDP growth (annual %) ⁷	10.2% (2017)
10- year average ⁷	10.1% (2017)
Merchandise exports (US\$ millions) ¹⁰	\$4 212 (2017)
Merchandise imports (US\$ millions) ¹⁰	\$19 372 (2017)
Percent of population living under \$1.90/day ⁷	26.7% (2015)

¹ Expo group

² World Bank, World Development Indicators

³ UN, World Population prospects

⁴ UN, World Urbanization prospects

⁵ UNDP, Human Development Report

⁶ CIA, World Factbook; World Bank, Country and Leading Groups

⁷ World Bank, World Development Indicators

⁸ OECD/DAG, Destination of Official Development Assistance and Official Aid-Disbursements

⁹ UNESCO Institute for Statistics (UIS) Database

¹⁰ IMF, Direction of Trade Statistics;

Share of income held by the poorest 20% ⁷	7%	(2015)
Share of income held by the richest 20% ⁷	47%	(2015)
Youth employment (ages 15-24) ⁷	7.4%	(2017)
Annual inflation (IMF projection) ¹¹	11.2%	(2018)
Main economic activity ¹²	agriculture	
SOCIAL INDICATORS		
Gini Index ¹³	35% (2015)	
Life expectancy and birth		
Male ¹⁴	60.1 years (2017)	
Female ¹⁴	65.1 years (2017)	
Literacy (% aged 15-49)		
Males ¹⁵	67.4%	(2016)
Females ¹⁵	42%	(2016)
HEALTH		
Prevalence of HIV (ages 15-49) ¹⁶	1.1%	(2016)
Antiretroviral coverage (% of adults 15+meeting WHO guidelines) ⁷	59%	(2016)
Incidence of TB (per 100 000 population) ¹⁷	177	(2016)
Deaths from malaria (per 100 000 population) ¹⁸	7	(2013)
Prevalence of stunting (% of children under 5) ¹⁹	38%	(2016)
Infant Mortality Rate ¹⁴	48.3/1000 livebirths (2018)	
Under 5 mortality (per 1000 live births) ²⁰	55.2	(2018)
Maternal mortality deaths of women per 100 000 live births) ¹⁴	401	(2017)
Births attended by skilled health personnel % ²¹	28%	(2016)
Health expenditure (as a % of GDP) ²²	4%	(2016)
Contraceptive prevalence rate ²³	37.8%	(2018)
Unmet need for family planning ²³	20.6%	(2018)
% of women (15+) reporting Sexual or physical violence ²⁴	26.3%	(2016)
Proportion of women aged 15-49 years who have begun childbearing (Fertility rate) ²⁵	4.35	(2017)

¹¹ IMF, World Economic Outlook Database

¹² UNDP, Country Economic Brief

¹³ World Bank Collection of Development Indicators

¹⁴ CIA World Factbook

¹⁵ Our World in Data, Indicators for Ethiopia

¹⁶ UNAIDS, Epidemiological Estimates (EPI) Database

¹⁷ WHO, Global Tuberculosis Database

¹⁸ WHO, World Health Statistics

¹⁹ Demographic and Health Surveys, STAT compiler

²⁰ World bank, estimates developed by the UN Inter-agency Group for Child Mortality Estimation (UNICEF, WHO, World Bank, UN DESA Population Division)

²¹ World Bank, UNICEF, State of the World's Children, Childinfo, and Demographic and Health Surveys

²² World Bank, World Health Organization Global Health Expenditure database

²³ World Bank, Household surveys, including Demographic and Health Surveys and Multiple Indicator Cluster Surveys.

²⁴ STATcompiler, DHS program

²⁵ World Bank, United Nations Population Division.

Overview: This report presents the findings, conclusions and recommendations of the UNFPA Ethiopia 8th cycle (2016-2020) Country Programme Evaluation (CPE). The purpose of this Country Programme Evaluation is to assess the performance of the United Nations Population Fund (UNFPA) Ethiopia 8th CP for Ethiopia (2016-2020). This evaluation is an essential step in identifying the major achievements as well as challenges encountered while implementing the current UNFPA 8th CP and to ensure that the lessons learned are reflected in the forthcoming UNFPA 9th CP (2020-2025). This report covers results from 2016 to 2019 in four focus areas: 1) Sexual and Reproductive Health (SRH); 2) Adolescents and Youth Development (AYD); 3) Gender equality and women's empowerment (GEWE); and 4) Population and Development (PD). The initial CP budget was \$120 million (of which \$40.4 m are from regular resources, while \$79.6 m are from other resources).

Objectives and Scope: The broad objectives of the CPE include (i) to enhance accountability of UNFPA and its country office for the relevance and performance of its CP in Ethiopia; (ii) to broaden the evidence base, including lessons learned and practical recommendations, for the next Ethiopia CP cycle (July 2020 – June 2025) and (iii) to inform decision-making, improve programming and help UNFPA to become a better fit-for-purpose organization.

The specific objectives were to: (i) provide an independent assessment of the progress of the 8th CP towards the expected outputs and outcomes outlined in the results framework of the CP; (ii) provide an assessment of the extent to which programme implementation frameworks and modalities have enabled or hindered achievement of the programme outputs; and (iii) draw key lessons from past and current cooperation whilst providing a set of clear and forward-looking options leading to strategic and actionable recommendations for the next programme design.

The evaluation was designed to assess the outputs and outcomes by assessing six criteria: relevance, efficiency, effectiveness, sustainability, United Nations Country Team Coordination, added value, and development-humanitarian connectedness. The evaluation document was intended to help key stakeholders, including UNFPA CO, Ethiopia, make reasonable choices regarding the approach towards interventions in the country and highlight components that should be maintained, modified or added in the upcoming 9th CP.

The CPE took place during the period August-September 2019 and covers the Ethiopia CP from 2016-2019. The primary audience and users of the evaluation include the UNFPA Ethiopia CO, national partners and relevant government agencies, who are expected to benefit from the evaluation's findings, conclusions and recommendations, as well as UNFPA ESARO and Evaluation Office (EO). Also, UN Executive Committee or ExeCom agencies (i.e., UNDP, UNICEF and WFP) represented in the country may use the findings of this evaluation during the development of their next CP for Ethiopia (2020 – 2025).

Description of the Country Programme: The UNFPA Ethiopia CP, (1 July 2016 – 30 June 2020) has been developed and implemented within the context of the UN Development Assistance Framework (UNDAF) 2016-2020 for Ethiopia, which is guided by the goals and targets of the ICPD Programme of Action (PoA), SDG Agenda 2030, and UNFPA Strategic Plans, as endorsed by the Government of

Ethiopia. In 2016, the UNDAF 2016-2020 was extended to align with the Government of Ethiopia's National Development Strategy, GTP II (2016-2020). Implementation of the four UNFPA Ethiopia 8th CP focus areas are in close collaboration with: the Ethiopia Ministries of Finance and Economic Development; Health, Women, Children and Youth Affairs; Central Statistical Agency, Planning and Development Commission, and several well-established NGOs and other partners.

The UNFPA Ethiopia 8th CP must be understood within the context of the Ethiopia UNDAF, a collaboration of 21 UN agencies that work within one coherent framework. UNFPA Ethiopia staff have in-depth experience working within the UNDAF, this being their fourth full UNDAF programme cycle. Implementations of the four UNFPA Ethiopia focus areas were in collaboration with UN agencies in a unified planning process.

Evaluation Approach: The CPE followed the structure provided in the UNFPA Evaluation Handbook (2019 Revision) to assess the UNFPA Ethiopia CP using two separate components. First, is an analysis of the UNFPA Ethiopia CP Outcomes and Outputs within the four focus areas: (SRH, Adolescents and Youth, Gender and PD). This component employs four main criteria: relevance, effectiveness, efficiency, and sustainability. The second assesses the positioning of the UNFPA Ethiopia CP in the country based on two criteria: UNCT coordination (with the development priorities of Ethiopia, its collaboration within the UNDAF and other development agencies), and value added (its comparative strengths in the country). The third component is development-humanitarian connectedness. The evaluation covers the first three years of the four-year CP programme period (1 July 2016 - 30 June 2019). It focused on the four outcomes and six outputs within the CP Results and Resources Framework that are aligned with the UNFPA Strategic Plan (SP) for 2014-2017 and SP 2018-2021.

Methodology: The evaluation, divided into design, data collection, and analysis and reporting phases, was structured based on the following evaluation criteria: relevance, efficiency, effectiveness, and sustainability; and coordination and added value, and connectedness. Based on a purposive sampling method, five out of eight regions (i.e., Afar, Amhara, Gambella, Oromiya, Tigray,) and the capital city, Addis Ababa were visited for data collection. Using both secondary and primary sources, a mixed method of data collection included documentary review, financial and operations system review, structured and semi-structured, face-to-face, individual and group interviews, and observations. Triangulating the sources and methods of data collection, the evaluation used both qualitative and quantitative data in the analysis. It adopted an inclusive approach, involving a broad range of partners and stakeholders. Totalling 179, UNFPA CO staff, national and regional level development partners, UNCT, service beneficiaries and providers, contributed their input to this evaluation. To validate the design of the evaluation and preliminary findings, a workshop was held at the final stage where the findings involving a broader stakeholder group were disseminated.

Limitations: The evaluation team did not encounter any significant field challenges when conducting the field data collection, aside from a one-week extension in the fieldwork due to the week-long public holiday for the Ethiopian New Year. UNFPA facilitated logistical issues and access to people and intervention sites. The CPE was limited by time and expert resources devoted to evaluating of a very large and diversified programme implemented over a wide geographic area. Although time and resources did not compromise the integrity of the evaluation findings, it did result in delays in the implementation of the planned schedule.

MAIN FINDINGS

Relevance: UNFPA 8th Cycle of CP (2016-2020) is based on a clear understanding of Ethiopian dynamics, needs and priorities. It takes into account the policy frameworks, national and international development strategies and sectoral assessments as regards sexual and reproductive health, adolescents and youth development, gender equality and women's empowerment, and population and development. All four programme areas were found to be of high relevance in terms of the needs of the Ethiopian population, national development priorities and programme beneficiaries. There was strong evidence that activities were developed based on sound assessments as well as in consultation with clients and beneficiaries. All four programme areas were relevant to several international priorities such as UNFPA global strategy, International Conference for Population and Development (ICPD) Programme of Action, SDG Agenda 2030 and the UNDAF 2016-2020. UNFPA interventions addressed the service needs of certain population groups such as women in the reproductive age, youth and adolescents, refugees, internally displaced persons and GBV victims and survivors.

Effectiveness: The CP contributed to the achievement of the results of the interventions. Despite major constraints and challenges in the Ethiopian social and political context during the period of the 8th CP, there was a substantial achievement of all outputs and outcomes. The UNFPA programme has improved the delivery of integrated sexual and reproductive health, BEmONC, EmONC and fistula repair services in the targeted operational woredas. The capacity-building of health care providers and the strengthening of health systems have contributed to improved availability and accessibility of quality SRH services. UNFPA 8th CP has contributed to youth empowerment and engagement of youth in community education on SRH including HIV prevention and control, and gender. UNFPA support enabled youth in targeted districts to access social spaces and to engage in social, educational and cultural activities.

The 8th CP was effective in raising awareness of gender issues and harmful traditional practices in the country and the need to mainstream gender in national plans. The support in advocacy and awareness was effective in improving knowledge on gender inequality, GBV issues, FGM and child marriage. The CP contributed to community commitments for the abandonment of FGM and ending early child marriage. UNFPA support was effective in responding to the needs of the GBV survivors and providing comprehensive services in developmental and humanitarian settings. Through raising awareness and the establishment of protection groups, GBV survivors found support at the community level and access to the relevant services at the health centres, One Stop Centres and Safe Spaces. The 8th CP contributed to the improvement of data quality, production and availability through enhancement of technical capacities, techniques and strategies for the collection of population data. However, serial postponement of the census exercise is a serious issue.

Efficiency: The activities implemented toward the achievement of outputs for all programme areas appeared to be reasonable for the amount of resources expended. As of mid-2019, a 74 percent fund utilisation rate was achieved because some IPs returned their funds and possibly because the year had not yet been completed. UNFPA Ethiopia CO was generally efficient in mobilizing financial resources and in disbursing annual programme budgets to support the implementation of Annual Work Plans (AWPs) through contracts with Implementing Partners as well as with the use of National Execution

(NEX) and Direct Execution (DEX) modalities. A team of competent staff has implemented the CP with support from several national and international consultants, and the UNFPA Regional Office in Johannesburg. However, there are noticeable inefficiencies during the Cycle in the range of programme activities in eight regions and 122 districts in Ethiopia. The 8th CP extends too wide with many layers of bureaucratic oversight that delay implementation processes. There is also a huge number of IPs involved in the implementation of the CP. The number of CO staff is moderate to coordinate the CP but there is need to consider increasing the staff complement of some Programme Components like the MCH.

Sustainability: The CP is sustainable to some extent because the programme focused on priorities already identified by the government of Ethiopia; interventions carried out within existing government and community structures; and capacity-building of institutions and staff. The likelihood of sustainability is higher in thematic areas where UNFPA strategic interventions have gained traction, government endorsement and community acceptance such as in SRH, Youth-Friendly Health Centres, and community and male involvement in women's empowerment and equality. Where UNFPA strategic interventions are still mostly at the level of advocacy to break the cultural taboos such as FGM, child marriage and gender-based violence, the potential of sustainability may be at risk as the continuation of activities remains doubtful without funding.

Alignment of the GEWE interventions with the government policies and strategies will ensure the sustainability of the programme. The National Costed Roadmap to End Child Marriage and FGM/C including the other commitments are clear illustrations that the issue of GBV including HTPs are part of the government agenda and priority. Also, the high-level advocacy and alliances established at national level; the use of already existing government and community structures; support provided to build the capacity of existing community-based structures and institutions such as the Anti GBV and HTP Committees at different levels and the WDA; community commitments for the abandonment of FGM and CM; and the inclusion of gender issues in higher education institutions curriculum are all strategies UNFPA used to ensure sustainability and ownership of the different interventions for most vulnerable and marginalized women, adolescents and youth. Among the interventions, the potential of sustainability of the Safe Houses, which provide direct services to GBV survivors, remain doubtful without funding. However, UNFPA is working in collaboration with different Women Associations to own the Safe Houses to make it sustainable. Sustainability of the CP interventions is further enhanced by policies, guidelines, procedures, health system strengthening, capacity-building and community involvement in some culturally sensitive activities. Inadequate government counterpart funding is a major risk to sustainability.

Coordination and Value Added: The CPE shows that UNFPA Ethiopia is an active and constructive partner contributing to the functioning and coordination of UNCT activities within the UNDAF in Ethiopia. UNFPA Ethiopia is well recognized for its work within the UNDAF Outputs and Outcomes. There is strong evidence of active and effective UNCT collaboration by UNFPA Ethiopia. UNFPA CO contributes to the functioning and consolidation of UNCT and government coordination mechanisms with highly professional collegiality. Stakeholders expressed strong approval for the collaborative approach taken by UNFPA Ethiopia in UNCT processes.

UNFPA is acknowledged by other UN Agencies, federal and regional implementing partners and other stakeholders as a reliable and responsive key lead agency for SRH, Youth, Gender and GBV and population and development. UNFPA has added value through its strategic positioning in advocacy and data generation interventions.

Connectedness: While UNFPA CO provides some interventions in humanitarian situations, it is observed that there is a huge disconnect between the development and humanitarian programmes. In most of the emergency areas, there is more investment in refugee camps than in the host communities. This tends to exacerbate the hostility between the refugees and the host communities. The opportunity for possible resilience and social cohesion building among the refugees seems not to have been properly utilised.

MAIN CONCLUSIONS

Strategic Level:

Relevance

UNFPA CP (2016-2020) interventions are relevant and adequately responsive to the country's priorities, strategies, plans, dynamics and needs of the population as identified in the Second Growth and Transformation Plan (GTP 2), through participatory consultations with partners and stakeholders and national assessments and research. The CP interventions were developed based on these pillars.

Efficiency: Overall, the activities implemented toward the achievement of outputs for all program areas appeared to be reasonable for the amount of resources expended. UNFPA Ethiopia was generally efficient in mobilizing financial resources for the Country and efficient in disbursing annual programme budgets to support the implementation of Annual Work Plans (AWPs) through contracts with Implementing Partners as well as Direct Execution (DEX) modality. Programme Annual Review Reports stated a 74 percent and 82 percent implementation rate of available cash for the years 2016 and 2019, respectively. The present business model as applied by UNFPA in Ethiopia aligns with the country classification of UNFPA Headquarters as part of the implementation of the global strategy 2014-2017. Human resources to implement the 8th CP seem to be adequate in some areas but inadequate in others, especially in the maternal health sub-component of Sexual and reproductive health component. The quality of staff at the IP levels and high level of IPs staff turnover is a challenge. Though the 8th CP was limited to 122 operational woredas from 8 regional states and two city administrations, the districts are spread out over a large geographic area which made programme implementation cumbersome and less efficient. Given the shrinking funding space, review of the geographical focus of the next CP interventions need to take efficiency issues into account. Programme monitoring has made use of a results framework. CO has been able to mobilise resources for different components of the country programme.

Sustainability

Sustainability assessment results varied across the programme outputs, implementing partners and types of interventions. The interventions are sustainable to the extent that existing governmental and community structures are anchoring them. Sustainability is challenged by more than the mere availability of financial resources to maintain the provision of services and or to maintain the durability of effects acquired through the programme. Joint assessment and planning, in addition to interventions at the local level and with local actors, increased capacity-building investments could

improve potential for future sustainability.

Coordination and Value Added

UNFPA Ethiopia is well positioned within the UN system, with government institutions and local organisations, at the federal and regional levels to support programme implementation. UNFPA's mandate, comparative strengths, and programme interventions in the four thematic areas are well recognized and acknowledged by relevant Federal ministries, UNCT and CSO IPs in the country. UNFPA is acknowledged by the UN Agencies, implementing partners and other collaborators from the government as a reliable and responsive key lead agency for SRH, adolescents and youth development, gender equality and women's empowerment, and population and development.

UNFPA Ethiopia demonstrated that it has been an active and constructive partner contributing to the functioning and coordination of UNCT activities in Ethiopia within the UNDAF context. The current UNDAF framework fully reflects UNFPA mandates and does not inhibit UNFPA Ethiopia from pursuing its global and regional mandates. UNFPA Ethiopia is recognized for its work within the UNDAF Outputs and Outcomes.

PROGRAMME AREAS CONCLUSIONS

Effectiveness:

CO has managed to achieve most of the planned results in the CP8 implementation. CP8 has achieved remarkable accomplishments, as evident from results discussed in the report.

Sexual and Reproductive Health Component:

SRH and AYD components of the 8th CP are relevant in addressing SRH needs of women of reproductive age, adolescents, and youth in Ethiopia and are aligned with current priorities and strategies of national development plans related to the UNFPA mandate areas. The annual work plan development process facilitates the relevance of CP support activities to federal and regional IPs. The 8th CP of UNFPA has an adequate focus on building national capacity with SRH and AYD. The SRH and AYD interventions were effective in delivering relevant services and information to communities in the implementation districts.

The SRH component has made contributions to the development and revision of national strategic documents and guidelines, including Maternal Death Surveillance and Response (MDSR) guideline, training manuals, other national documents on SRH and maternal death reporting integration into the surveillance system. UNFPA also contributed technically to the conduct of the national EmONC assessment in 2016. The SRH programme contributed to increased demand and service utilisation of women on different maternal health services, including cervical cancer screening and preventive treatment services. There is increased investment in training of human resources for health through innovative capacity-building programmes at national universities and through the innovative Mentorship scheme whereby senior health managers visit resource-scarce health centers to train staff in various aspects of health care bordering on BEmonC and CEmonC.

Adolescents and Youth Development Component

The adolescent and youth component made contributions towards the development and eventual implementation of a CSE curriculum in tertiary institutions, guidelines and manuals for Youth-Friendly Services, and programmes that encourage demand and access for SRH services to at-risk youth and key populations. The 8th CP of UNFPA reached young people in different situations with SRH messages and services through different strategies including peer education, life skill training, mini-media clubs,

and information and service delivery through selected youth centres and youth-friendly service centres (YFSC).

Gender Equality and Women's Empowerment Component:

The Gender Equality and Women's Empowerment focus area have made important contributions toward addressing SGBV issues, including HTPs. High-level advocacy and coordination activities support the government to accelerate progress made with regards to GEWE. Awareness-raising on gender, CM and FGM issues have reached men, women, schoolboys and girls, and youth at the regional, district and community levels. The capacity-building programmes for community-based structures such as Anti-GBV and HTP Committees and WDGs also contributed to the prevention of GBV; economic and social empowerment of girls and women; the protection of the rights holders; and follow up commitment to FGM and CM abandonment. Comprehensive provisions of services to GBV survivors at One Stop Centers and Safe Spaces have also been put in place. However, there is still a need to focus on working at all levels with law enforcement bodies for the protection of the rights of GBV survivors. Also need exists to provide qualified personnel at the One Stop Centers so that quality and comprehensive services should be provided to GBV survivors and victims.

Population and Development Component:

The PD component interventions have resulted in putting up structures for the production and accessibility of data both at national and regional levels. Key among these includes the 2016 Ethiopia Demographic and Health Survey reports and the mini-report of the 2019 EDHS. Preparations for the 4th Census exercise have been advanced, but the serial postponement of the exercise is a major concern. The capacity for staff in the Central Statistical Agency for the census undertaking has been strengthened, although some capacity issues need to be revisited as soon as the Federal Government proclaims the 4th Census exercise. While there is an appreciation of the issues of rapid population growth in national development, there seems to be a bureaucratic hiccup that undermines active participation, advocacy and coordination activities of the Population and Development Directorate in the Planning and Development Commission. IMIS has been established in five of the six proposed regions for regional and district planning. Activities are underway for setting up the sixth IMIS. However, there seems to be a capacity challenge in the actual use of this system for planning in the regions as there was no demonstrated evidence of their use in regional planning.

Development-Humanitarian Connectedness

CP8 contribution in the humanitarian assistance has been very effective and UNFPA is considered as a leading advocate for preventing GBV in emergencies. Humanitarian interventions were prompt to address the needs of the affected persons and regions within the context of CP components. This cuts across the other components of the 8th CP (UNFPA), which addresses the most vulnerable segments of the refugees, i.e., adolescent girls and women. Through implementation of various humanitarian projects in drought-affected regions and refugee camps, a total of 289,272 populations in the reproductive age group were reached with sexual and reproductive health, and GBV interventions and services in humanitarian settings that involved strengthening of SRH coordination, distribution of lifesaving reproductive health kits, medical equipment and supplies; post-rape kits and other clinical commodities for management of sexual violence; donation of ambulances, support of community-based demand creation interventions, information sessions as well as capacity development initiatives. Mainstreaming of humanitarian response within all three programme

components (SRH, AYD and GE) should make the way forward for bridging the humanitarian and development nexus. However, most of the UNFPA interventions are on response to GBV and had limited focus on its prevention. There is scope for further integration of prevention and response to gender-based violence across development and humanitarian settings. However, a disconnect exists between development, peacebuilding and humanitarian interventions which fuel mistrust between the host community and the refugees.

MAIN RECOMMENDATIONS

Strategic Level: It is recommended that UNFPA continue the practice of basing programme interventions on research, needs assessment, national priorities, strategies and plans, and participatory consultations with stakeholders. The next programme cycle should consider restricting the number of intervention regions to address a narrower set of priorities to reduce management time and cost whilst potentially increasing the quality and impact of sub-activities and outputs. It is important that UNFPA coordinates with UNCT agencies and discuss with federal and regional IPs to include improved sustainability in the next CP. The CO should create conditions for sustainable programme effects by including exit strategy in AWP. The exit strategy should be designed for such innovative programmes as Youth-Friendly Services, Mentorship programme and other initiatives to strengthen the health service facilities, and One Stop Centers.

UNFPA should also continue with the integrated (convergent) programming approach across development programme components in the design of the next CP interventions, ensuring adequate shared skills and capacity of staff at Federal, regional and district levels. Advocacy and policy dialogue should also continue to be included in the 9th CP. It is crucial that the timing of programming should ensure that before the formulation of a new CP, the national development plan and UNDAF strategy should be ready. Also, the CO should continue with innovative interventions (e.g., Safe Spaces, Youth-Friendly Services Centre, One Stop Centre and mentorship of health workers) in rural districts. Importantly, the CO should consider joint programming in such areas as improving adolescent and maternal health, achieving gender equality and the empowerment of women and girls, ensuring greater availability and the use of disaggregated data for sustainable development, peacebuilding and sustaining peace in accordance with national needs, plans, priorities, and national ownership. UNFPA should also improve its inherent value in SRH, Gender equality and population and development data to enhance strategic and local positioning at the regional levels and improve coordination with government and UN stakeholders for joint advocacy and implementation of joint programming. Exit strategy should be designed for such programmes as Youth-Friendly Services, and many economic and social issues, and response and SRH/RHCS activities.

PROGRAMME AREA RECOMMENDATIONS

Sexual and Reproductive Health:

It is recommended that the CO should sustain the interventions and approaches that are identified as performing well and ensure adequate investment in quality improvement during the delivery of integrated SRH/AYD services. Some key interventions (like MDSR and quality of care) should be strengthened with other national institutions like EPHI and MOH. It is important to address the human resource needs of critical midwifery cadres. More resources should be mobilized to support the training for health and the provision of maternal health services (e.g., EmONC) and quality of care. The Mentorship programme for health service providers at the MOH should be sustained. The CO

should also develop and implement special approaches to the provision of SRH services including the rollout of the Minimum Initial Service Package (MISP) in those regions with internally displaced people and refugees.

Adolescents and Youth Development: UNFPA Ethiopia should continue to work closely with key CSE implementing partners (IPs) to encourage the rapid completion of the CSE curriculum and assessment of its effectiveness. UNFPA Ethiopia should continue to build upon and expand its support to IPs that work with key populations and vulnerable youth to ensure genuine inclusive participation in preventive programmes with an emphasis on integrated SRH service delivery packages. Particularly the focus of work on adolescents and youth should concentrate on skills development so that they will be enabled to unleash their energy towards contributing to economic progress and development. UNFPA CO should support activities that contribute to promoting demographic dividend in the country.

Gender Equality and Women's Empowerment: The advocacy and coordination efforts at the higher level and capacity-building programmes should be targeted to equip duty bearers especially law enforcement bodies to deliver on their responsibility and work towards ending FGM and CM. UNFPA CO should continue to invest in building the capacity of right holders and equip them with skills to protect themselves and their peers from GBV and also work with schools and communities to contribute to long-term change in attitude and behaviour. UNFPA intervention at higher education institutes will have a longer impact on adolescents and youth whilst ensuring the social and political empowerment of adolescent girls. Integrating this intervention with the SRH programme will help girl students to attend their education, complete their tertiary education, become competitive in the job market, and lead a fulfilling life. Enabling girls to complete their education will guarantee their holistic empowerment and capacity to protect them from GBV, and increase their decision-making power whilst giving them a chance to be socially, economically and politically active citizens.

Population and Development: UNFPA CO Ethiopia should strengthen its leadership role in PD and data issues. The CO should follow through and implement all targets that were not yet attained, including continued training of regional planning officers in the use of IMIS in those regions; continued advocacy for the conduct of the 4th National Population and Housing Census, ICPD PoA, and the SDG Agenda 2030; and activation of the coordination functions of the Population and Development Directorate of the Population and Development Commission. The role of the census in measuring the SDG Agenda 2030 cannot be underestimated. The CO should capitalize on existing partnerships with government, other UN agencies, civil society, donors, private sector and South-South and Triangular Cooperation to build a strong case on the need to undertake the 4th Census of Population and Housing.

Development-Humanitarian Nexus: The CO should continue to implement emergency preparedness and contingency including the rollout of the MISP. Deliberate efforts should be made to bridge the gap in development indicators between the host community, IDPs and refugees. Strategies should be put in place to build resilience and social cohesion among the refugees and the host communities. Refugees should also be economically empowered or be prepared for economic activity.

UNFPA Ethiopia commissioned the evaluation of its 8th CP (2016 – 2020) to a team of external evaluators. The evaluation Terms of Reference (ToR) identified and defined the evaluation scope and its framework. The evaluation design was informed by the UNFPA Evaluation Handbook 2019 revised version. The main objective was to evaluate the current programme cycle supporting the development of the 9th cycle.

This report presents the evaluation team findings analysed and structured based on OECD DAC evaluation criteria and provides specific answers to the evaluation questions. This report is organized as follows: **Chapter 1** provides the introduction where the evaluation objectives, scope, questions, assessment process and methodology are discussed; **Chapter 2** provides a bird's eye view of the general country development context and specific UNFPA thematic areas; **Chapter 3** highlights UN/UNFPA strategies and the 8th CP cycle programme interventions in response to Ethiopia country challenges; **Chapter 4** details the evaluation findings structured along the six evaluation criteria and twelve questions; **Chapter 5** summarizes the evaluation conclusions and **Chapter 6** offers related actionable recommendations.

1.1 PURPOSE AND OBJECTIVES OF THE COUNTRY PROGRAMME EVALUATION

This evaluation was undertaken within the contexts and provisions of the UNFPA Evaluation Policy Framework, based on the UNFPA Executive Board decisions that all programmes should be evaluated independently. The UNFPA's 8th CP of Support to the Government of Ethiopia was premised on Ethiopia's national needs and priorities identified and articulated in the Second Growth and Transformation Plan (GTP), 2016-2021 and relevant sectoral strategic programmes. The major objective of GTP2 is to serve as a springboard towards realizing the national vision of becoming a low middle-income country by 2025 through sustained, broad-based and inclusive economic growth, which will accelerate economic transformation and the journey towards the country's renaissance. The UNFPA's 8th CP in the country has four key outcome areas identified and prioritized as (i) sexual and reproductive health; (ii) adolescent and youth health and development; (iii) gender equality and women's empowerment; and (iv) population and development inter-linkages. Humanitarian and resilience-building interventions are cross-cutting throughout the outcomes.

Broad Objectives: The broad objectives of the CPE are to (i) enhance accountability of UNFPA and its country office for the relevance and performance of its country programme in Ethiopia; (ii) broaden the evidence base, including lessons learned and practical recommendations, for the next Ethiopia Country programme cycle (July 2020 – June 2025); and (iii) inform decision-making, improve programming and help UNFPA to become a better fit-for-purpose organization.

Specific Objectives: (i) To provide an independent assessment of the progress of the 8th CP towards the expected outputs and outcomes outlined in the results framework of the country programme; (ii) to provide an assessment of the extent to which programme implementation frameworks and modalities have enabled or hindered achievement of the programme outputs; and (iii) to draw key lessons from past and current cooperation and provide a set of clear and forward-looking options leading to strategic and actionable recommendations for the next programme design.

1.2 SCOPE OF THE EVALUATION

Within the framework of the above evaluation objectives, the CPE covered the period from 2016 to 2019. The evaluation focused on the implementation process, achievements and challenges at both output and outcome levels of the 8th CP (2016-2020). It covered the Woredas Districts in eight operational regions and two administrative cities currently covered by the 8th CP taking into consideration the relevant programme components of the 2016 – 2020 CP, and considering both development and humanitarian interventions. The four main technical areas of the CP (i.e. sexual and reproductive health, adolescents and youth development, gender equality and women's empowerment, and population and development) were covered. Also, the evaluation covered cross-cutting aspects such as human-rights based approach, gender mainstreaming, and humanitarian emergencies. For each of the outcome areas of the 8th CP, the evaluation included the following levels of the results chain: activities, outputs and outcomes (both planned and unexpected).

1.3 METHODOLOGY AND PROCESS

1.3.1 Evaluation Process

This CPE was planned and implemented in five subsequent phases.

Preliminary Phase: This phase started with the nomination of the evaluation manager and involved drafting the terms of reference, the constitution of the Evaluation Reference Group (ERG), and assembling relevant programme documentation. It was completed with the recruitment of the evaluation team.

Inception/Design Phase: This phase was mainly concerned with the development of the design report to guide the evaluation undertaking. It covered a desk review of programme documents, elaboration on the initial set of evaluation questions, stakeholders' mapping and a sample selection for data collection, design of the data collection tools and development of the evaluation work plan.

Field Phase: The field phase covered the implementation of the data collection plan through interviews, group discussions and focus groups with the programme staff, a sample of selected stakeholders and observation of identified intervention sites. At the end of the fieldwork, there was a debriefing session on 20th September 2019, to present the preliminary findings to the CO staff and Management.

Reporting Phase: The evaluation team leader drafted the evaluation report, after receiving thematic reports from other team members and taking into account comments made at the debriefing meeting and subsequent validation meeting. Comments consolidated by the UNFPA Evaluation Manager helped develop the final draft evaluation report. Additional comments from the UNFPA ESARO Office guided the finalization of the report.

Dissemination, Management Response and Follow-up Phase: This phase is the responsibility of the UNFPA Evaluation Manager. The CPE findings and recommendations will inform the development of the CP9. The preparation of the management response and the dissemination of evaluation results will be the responsibility of the CO. The evaluation manager will upload the CPE into Docushare once the report is finalized. In addition, the executive summary of the evaluation report will be prepared as a standalone piece that can be used for dissemination purposes. The final draft evaluation report will

form the basis for an in-country dissemination meeting/presentation, which will be attended by the CO as well as all the key programme stakeholders. During this phase, the CO will prepare a 'Management Response', to be included in the final evaluation report, also taking into account comments made by the participants. The final Evaluation Report, along with the Management Response, will be published in the UNFPA evaluation database. The evaluation report will also be made available to the UNFPA Executive Board and will be widely distributed within and outside the organization.

Ethics and maintaining the quality of evaluation: The evaluation team took several precautions to ensure the protection of respondents' rights. Informed consent was sought before all interviews were made and the data collected was kept confidential, with no identifiers. Where written consent was not applicable or feasible, verbal agreement was sought. UNFPA CO informed the respondents about the evaluation purpose and the rights and confidentiality of those participating in the evaluation.

The evaluation team made every effort to ensure that evaluation findings were credible based on reliable data and observations. Conclusions and recommendations will show evidence of consistency and dependability in data, findings, judgments and lessons learned appropriately reflecting the quality of the methodology, procedures, and analysis used to collect and interpret data. The ET followed the UNEG guidelines and standards as well as UNFPA's Handbook on "How to Design and Conduct a Country Programme Evaluation at UNFPA" in carrying out the CPE to ensure quality.

Evaluability Assessment, Limitations and Risks: While the theory of change of 8th CP was not fully developed to measure the links from outputs to outcome level, CO programme staff were able to provide necessary information for the ET to develop the assumptions required to assess the achievements. The ET re-constructed the programme logic (see Figure 3). Critical assumptions and limitations were included in the 8th CP programme logic.

The size of the country and the spread of the programme interventions in geographically remote areas were a constraint in establishing a representative sample for data collection. A thorough understanding of the programme interventions was, however, obtained by meeting programme staff individually and a purposive sample was selected to reflect the interventions to avoid or minimize the selection bias. In the field, only a few Woredas districts and kebeles were visited and those may not be the representative health centres out of the total number of health centres supported by UNFPA under the 8th CP. Given that all programme sites visited were selected by the implementing partners, there may have been a selection bias. This limitation was mitigated by triangulating the data based on the documented results of survey reports, direct observations, and interviews of stakeholders (e.g., policy makers, service providers, and beneficiaries) at regional and district levels.

1.4 THE EVALUATION CRITERIA AND EVALUATION QUESTIONS

The evaluation was structured around the four evaluation criteria of relevance, efficiency, effectiveness and sustainability according to the OECD-DAC criteria. In addition, two other UN-specific evaluation criteria – coordination and added value were added. An additional criterion of development-humanitarian connectedness was added. There were 11 questions selected for the evaluation.

The evaluation questions corresponded with the following criteria.

Relevance

1. To what extent is the UNFPA support (i) adapted to the needs of the population (including needs of Vulnerable Groups), (ii) aligned with government priorities (iii) as well as with policies and strategies of UNFPA?
2. To what extent has the country office been able to respond to changes in national needs and priorities caused by major political, natural disasters and other contextual changes?

Effectiveness

3. To what extent have the interventions supported by UNFPA helped to increase the access to and utilisation of quality maternal health and family planning services by women and girls of reproductive age in both development and humanitarian contexts?
4. To what extent have the interventions supported UNFPA helped to increase access to and utilisation of quality, adolescent and youth-friendly SRHR, in both development and humanitarian contexts?
5. Within the framework of UNFPA gender equality and women's empowerment, to what extent has it contributed to (i) improved prevention and responses to gender-based violence and harmful traditional practices and (ii) gender mainstreaming across the programming areas?
6. To what extent have the interventions supported by UNFPA in the field of population and development contributed to increased availability and utilisation of data and evidence at national and sub-national levels on population issues towards the ICPD agenda?

Efficiency

7. To what extent has UNFPA made good use of its human, financial and technical resources as well as an appropriate combination of tools and approaches to pursue the achievements of the CP outputs?

Sustainability

8. To what extent has UNFPA's support helped to ensure that SRH and rights and the associated concerns for the needs of young people, gender equality, and relevant population dynamics are appropriately integrated into national development instruments and sector policy framework in the programme country?
9. To what extent has UNFPA been able to support its partners and target populations in developing capacities and establishing mechanisms to ensure ownership?

Coordination

10. To what extent has the UNFPA country office contributed to the functioning and coordination of UNCT coordination mechanisms?

Connectedness

11. To what extent have UNFPA interventions contributed to humanitarian and development nexus?

These key evaluation questions around each of the criteria were identified from the UNFPA Handbook on Monitoring and Evaluation by the evaluation team and evaluation management committee and discussed at the Evaluation Reference Group meeting held on 28 August 2019.

For each of these evaluation questions, assumptions that needed to be assessed by the evaluation team were identified as well as indicators that were used in terms of verification during the fieldwork. Moreover, for each of the assumptions, sources of information and method and tools used in data

collection were identified. Assumptions together with indicators and means of verification were included in an Evaluation Matrix that is presented in Annex 4.

1.4.1 Sample selection

To answer the evaluation questions, an intensive effort was made to ensure that a wide range of stakeholders was consulted during the CPE, with a good balance for each of the activities within all four of the CP focus areas at the Federal, Regional and District levels. The selection of sites for data collection was based on the evaluation team’s knowledge of the programme interventions, beneficiary populations and the characteristics of geographic locations. Purposive sampling method was used to select the sites, and the selected sites were finalised after discussions with the CO evaluation manager.

The sites illustrated a mix of interventions – development and humanitarian response programming; soft activities; the size of resource allocation; types of interventions or combination of interventions. 8th CP covered eight regions and 122 districts. Based on document review and consultations with CO, the team chose five regions i.e., Afar, Amhara, Oromia, Tigray, Gambella and Addis Ababa to be covered by the evaluation and Addis Ababa (out of the nine UNFPA target regions).

Table 1: Selected Sites for Field Visits, Government of Ethiopia /UNFPA 8th CPE 2016-2020

Region	Justification
Addis Ababa	Capital City with Implementing Partners at the Federal level
Afar	High resource, full gender intervention, less and high convergence
Amhara	Comprehensive intervention programmes covering all the outcome areas, huge investment, well and less performing districts; high and less convergence
Oromiya	Comprehensive intervention programmes covering all the outcome areas, high investment
Tigray	Comprehensive intervention programmes covering all the outcome areas, high investment
Gambella	Least-performing region; both development and humanitarian response programmes

1.5 METHODS AND TOOLS USED FOR DATA COLLECTION AND ANALYSIS

Sources of data were both secondary and primary. The type of data was based on a mix of quantitative and qualitative, derived from multiple sources. The evidence in this evaluation included data collected from the field, a desk review of documents, direct observations, structured and semi-structured interviews, key informant interviews (KII), focus group discussions (FGD), and secondary sources.

A detailed list of documents reviewed is attached (Annex 3). The evaluation triangulated data sources, data types, and data collection methods. The data shed light on how UNFPA has been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to achieve planned results, ensure ownership and the sustainability of effects. A convenient sample of beneficiaries was used for focus group discussions to gather information on service quality and its accessibility and utility. The evaluation made use of various monitoring and assessment and survey reports (i.e., quarterly reports, project-specific reports, annual reports, trip reports) submitted by IPs

and UNFPA staff. The triangulation of data collection minimized the weaknesses of one method and was offset by the strengths of another, enhancing the validity of the data.

The CO staff provided a list of stakeholders representing the federal and regional governments, UN agencies, and most importantly, the beneficiaries of the programme. The Evaluation Team had extended consultations with the CO staff and finalized the list of stakeholders for interviews based on the programme interventions and review of documents. The evaluation focused on major categories of stakeholders distributed across the 8th CP programme themes. The selection covered all four strategic outcome areas. Though not a representative sample, a purposive sample was selected to reflect the interventions and the participants involved. The Evaluation Manager coordinated the Federal level interviews and UNFPA’s programme officers coordinated those in the region.

Data collection was through individual face-to-face interviews, group interviews and focus group discussions following a participatory approach. The respondents (e.g., Implementing partners, programme participants, and strategic partners) were given the opportunity to discuss the programme freely. They were also allowed to propose what would work for them to make the programme better in their context. There were UN Agencies that were active in supporting similar sectors such as UNDP, UNICEF, and OCHA.

Data Quality: Data quality was maintained by triangulating the data sources and methods of collection and analyses. Validation of preliminary findings by the Evaluation Reference Group (ERG) enhanced the quality of data collected ensuring the absence of factual errors or errors of interpretation and no missing evidence that could materially change the findings.

Data Analysis: Analysis of quantitative data was based on the availability of primary and secondary data, their quality, and comparability. Content analysis was employed to interpret qualitative data. Qualitative data, secondary quantitative data and other evaluation findings from existing reports were triangulated in making conclusions from the findings.

Table 2: Distribution of evaluation questions by evaluation criteria and level of analysis

	CP8 Phases	Evaluation Criteria	Evaluation Questions		
Level of Analysis			SRH/AYD	GEWE	P & D
Programmatic	Design	Relevance	EQ 1, EQ2	EQ 1, EQ2	EQ 1, EQ2
	Process	Efficiency	EQ 7	EQ 7	EQ 7
	Results	Effectiveness Sustainability	EQ3 , EQ4 EQ8 , EQ9	EQ5 EQ8, EQ9	EQ 6 EQ8, EQ9
Strategic Position		Coordination with UNCT Added Value	EQ 10 EQ 10		
Humanitarian-Development Nexus		Connectedness	EQ11		

CHAPTER 2: COUNTRY CONTEXT

2.1 DEVELOPMENT CHALLENGES AND NATIONAL STRATEGIES

Ethiopia is the second most populous country in Africa with an estimated population of 90 million and an annual growth rate of 2.4 percent. Eighty percent of the population lives in rural areas, a quarter of whom are women of reproductive age. By 2020, the population will include 26 million young people aged 10-19 and 11.5 million aged 20-24. It is the world's most populous landlocked country, covering an area of 1,127 million square kilometres and is bordered by Kenya, Somalia, Eritrea, Sudan, South Sudan and Djibouti.

Economically, Ethiopia has sustained double-digit growth over the past twelve years – roughly double the Sub-Saharan African average – with significant improvements in food security and human development indicators and declining poverty. Growth has been largely broad-based. Agricultural growth drove reductions in poverty, supported by pro-poor spending on basic services, effective rural safety nets, and essential infrastructures.

There have been improvements in Ethiopia's labour market situation too. Moreover, a high proportion of employment opportunities are still being created in the informal economy, while unemployment remains a particular problem for specific groups like women and young people in urban areas. The total labour force of Ethiopia aged 15-64 years has increased from 26.5 million in 1994 to 36 million in 2009. Employment creation for such a rapidly increasing labour force, particularly for new entrants, remains a key challenge.

Agriculture in Ethiopia continues to be largely rain-dependent and about one-third of the population are chronically food insecure. Their vulnerability to shocks, particularly droughts and their consequences, such as food price increases, food shortages and livestock disease outbreaks, is aggravated by competition over resources and inter-clan rivalries. About 29.6 percent of the population remains below the food poverty line, unable to afford the minimum caloric intake for a healthy and active life. The World Bank estimates that 14 percent of non-poor rural households are vulnerable to poverty.

Youth unemployment continues to be a challenge and affects both urban and rural young people – those without skills and education, and those with university degrees alike. This has led to many of the youth migrating to urban areas as well as to go abroad, often with false promises of employment. Designing targeted programmes for youth employment and reviewing the education curriculum to ensure that the education/skills being offered to match the needs of a growing economy like Ethiopia should be given priority.

2.2 SEXUAL AND REPRODUCTIVE HEALTH SITUATION ANALYSIS

Ethiopia has made noticeable strides in improving health indicators during the past two decades. However, the country still bears an unacceptably high burden of maternal and newborn mortality. According to 2015 United Nations Maternal Mortality estimates for Ethiopia, 353 mothers die from pregnancy and childbirth-related causes for every 100,000 live births²⁶.

²⁶ MDG Indicators: Country and Regional Progress Snapshots. United Nations. 2015.

High maternal mortality ratio in Ethiopia is due to: (a) high rates of home deliveries; (b) a limited number of health facilities equipped to provide basic and comprehensive emergency obstetric care; and (c) insufficient number and quality of skilled health care providers. In 2016, the prevalence of experiencing obstetric fistula was estimated at four per 1000 women of reproductive age indicating a chasm in accessing comprehensive emergency obstetric care services. Despite recent expansions in secondary and tertiary healthcare facilities in recent years, access to delivery by caesarean section is still low; only two percent of women who delivered during the five years preceding the 2016 Ethiopian Demographic and Health Survey delivered through caesarean section^{27,28}. Cervical cancer is the leading cause of death among female cancer patients, with an estimated 4,648 new cases and 3,235 deaths annually²⁹.

Limited access to sexual and reproductive health services is a major challenge to women, men, and youth in Ethiopia. Both demand and supply side barriers hinder progress towards universal access to SRH services. Despite increasing trends in the health-seeking behaviour of Ethiopians, utilisation of SRH services is still very low. The 2016 Ethiopian Demographic and Health Survey (EDHS) identified low demand and vast unmet need for reproductive health services including family planning and maternal health services. The use of a modern family planning method was only 35 percent and the unmet need for family planning was as high as 22 percent among married women. Similarly, the coverage of maternal health services including antenatal care (ANC), skilled birth attendance, and postnatal care (PNC) was very low with coverage levels of 32 percent, 28 percent, and 17 percent, respectively³.

The public health sector has been the primary provider of SRH services in Ethiopia. Family planning and maternal health services are provided free in public health facilities. Ensuring availability of services and readiness of facilities for the provision of SRH services was therefore, a primary agenda for SRH units at all levels of the health system³⁰. Studies revealed that this area has been one of the major challenges to the health sector. The 2016 Service Availability and Readiness Assessment (SARA) of Ethiopia indicated high availability but a low level of readiness of health facilities for the provision of SRH services³¹. Similarly, the Emergency Obstetric and New-born Care (EmONC) Assessment showed that the majority of health centres and hospitals in Ethiopia have been only partially functioning as EmONC service providers. Ensuring an uninterrupted supply of SRH commodities has been a priority area for improvement within the public health system^{3,32,33}.

Recent initiatives of the government to improve access to and quality of SRH services include shifting the task of providing long-acting family planning methods to health posts³⁴, expanding maternity

²⁷ Ethiopia Demographic and Health Survey 2016.

²⁸ Ethiopian EmONC Assessment 2016.

²⁹ HPV Information Centre, summary report on HPV and cervical cancer statistics in Ethiopia. WHO 2014.

³⁰ National Reproductive Health Strategy 2016-2020. FMOH. 2016.

³¹ Ethiopia Services Availability and Readiness Assessment 2016.

³² Spatiotemporal variation of contraceptive availability in Ethiopia from 2014 to 2017.

³³ Performance Monitoring and Accountability 2020 (PMA2020) Project. Detailed Indicator Report. Ethiopia 2014.

³⁴ Tilahun Y, Lew C, Belayihun B, Lulu Hagos K, Asnake M. Improving Contraceptive Access, Use, and Method Mix by Task Sharing Implanon Insertion to Frontline Health Workers: The Experience of the Integrated Family Health Programme in Ethiopia. *Glob Health Sci Pract.* 2017;5(4):592-602

waiting homes³⁵, introduction and scale up of maternal death surveillance as part of the Public Health Emergency Management (PHEM) system³⁶, and expansion of youth-friendly SRH services^{37, 38}.

2.3 ADOLESCENT AND YOUTH DEVELOPMENT SITUATION

Ethiopia has a largely young population. According to projections based on the 2007 national census, 45 percent of the population is below the age of 15 years and an additional 22 percent are between 15 and 24 years of age. Adolescents in the age range 10 - 14 years and 15 - 19 years constitute 14 percent and 12 percent of the total population, respectively. An additional 10 percent of the total population is in the age range of 20 - 24 years. Addressing the Sexual and Reproductive Health and Rights of adolescents (10 – 19) and youth (15 - 24) would involve reaching a major segment of the population with high impact interventions at a critical time point within the life course. On top of the general demand and supply side barriers to SRH services, adolescents and youth in Ethiopia face additional layers of culturally rooted barriers that hinder them from realizing their SRH rights. Harmful traditional practices, including early marriage and female genital mutilation, low school enrolment, and limited economic opportunities expose adolescents and youth to adverse SRH outcomes including unwanted pregnancy and unsafe abortion³⁹.

Young women represent a high-risk group in Ethiopia, being especially vulnerable to gender-based violence, female genital mutilation, early marriage and other harmful traditional practices. In 2016, about 40.3 percent of Ethiopian women aged 20 - 24 were married by their 18th birthday. In certain regions of Ethiopia, such as the Amhara region, rates of child marriage are among the highest in the world with a median age at first marriage of about 16 years. Therefore, young women are exposed to high rates of maternal injury and death due to childbirth without skilled assistance and unsafe abortion. In general, teenage pregnancy and early childbearing are more prevalent in rural than in urban areas and are largely observed among the less educated and poorest young women⁴⁰.

Concerning sexually transmitted infections, disparities persist for young people, particularly for young women in rural areas. The average usage of modern methods of contraception remains low and only a few young people take advantage of voluntary HIV testing and/or counselling services. Although Ethiopia has one of the lowest HIV prevalence rates in East Africa, there are still more than one million people estimated to be living with HIV. In 2016, 0.2 percent of young boys and girls in Ethiopia were HIV positive. The prevalence of HIV was more than twice as high for females as it was for males in the age range of 15 - 24. HIV prevalence also varies by location, with the highest rates being in urban settings. Gambella has the highest prevalence of HIV among youth. Knowledge about the source of condoms and comprehensive knowledge about HIV among young people is very low in the country. Increased skills and knowledge on health risks but also socio-economic, cultural and health structures can enable Ethiopia's youth to overcome inequality, discrimination, and abuse of the society's most vulnerable groups⁴¹.

³⁵ Ministry of Health [Ethiopia]. Guideline for the establishment of Standardized Maternity Waiting Homes at Health Centres/ Facilities. 2015

³⁶ FMoH. Maternal Death Surveillance and Response (MDSR) Technical Guideline. AA Ethiopia: FMoH; 2014

³⁷ National Reproductive Health Strategy 2016-2020. 2016

³⁸ Maternal and Child Health Directorate FDRoEMoH. National Adolescent and Youth Health Strategy (2016-2020). Addis Ababa, Ethiopia 2016

³⁹ Strengthening Adolescent Component of National HIV Programmes through Country Assessment in Ethiopia. FHAPCO, 2017

⁴⁰ Ethiopian Demographic and Health Survey 2016

⁴¹ Ethiopian Demographic and Health Survey 2016, HIV Report, 2018.

Adult HIV prevalence in Ethiopia has dropped from 1.5 in 2011 to 1.1 in 2014. Even though the prevalence in the general population is relatively low, there are some segments of the population and geographical areas with very high prevalence and transmission rates. Adolescents and youth including those in tertiary educational institutions are among the highly vulnerable groups. Young women 15 - 24 are at higher risk of HIV infection than young men. Despite the high level of awareness on HIV/AIDS, comprehensive knowledge is 24 percent for females and 34 percent for males. Only 62 percent of sexually active young people reported condom use at last sex. One-third of the youth essentially rural, working in restaurants or bars, domestic servants or street youth, are particularly vulnerable to HIV/AIDS for lack of access to reproductive health services.

Ethiopia has made progress in improving youth's education, especially regarding formal education attendance and literacy rates. The measures of both gross and net enrolment in primary, secondary and tertiary education show a massive improvement in access to education. From 2005 to 2014 the net enrolment rate in primary schools rose from 60.5 percent to 85.85 percent (UNESCO, 2014). The literacy rate of people aged 15 - 24 years is estimated to have reached the level of 69.5 percent in 2015. However, low levels of education quality and high dropout rates, as well as gender and rural-urban disparities remain major challenges for the achievement of universal basic education and a smooth school-to-work transition. The proportions of young people who attained post-secondary education and training are very small. Even though secondary school enrolment rose from 13 percent in 1999 to 36 percent in 2012, Ethiopia has the world's third-largest out-of-school population.

Over the last decade, there have been noteworthy improvements on the labour market. Wages increased significantly, while the level of unemployment decreased from 18 percent in 2004 to 14.4 percent in 2013 (National Labour Force Survey, 2013). However, the youth still face precarious conditions in the labour market. Almost three-quarters of youth earn below the average monthly wage, while the majority of employed young people work in the informal sector or as unpaid family workers. Nearly one-quarter of the employed youth worked in the informal sector in 2013 (NLFS, 2013), particularly young people aged 15 - 19 who have no bargaining power. In addition, the labour force participation of youth is strongly determined by geographical, socio-economic and gender disparities. Young Ethiopian women are more than twice as likely to be unemployed as young men. Besides high gender inequality, a strong duality between rural and urban areas characterizes youth employment in Ethiopia. In rural areas, young people leave school at a very early age and start to work in subsistence agriculture with low labour income, large underemployment, and limited chances to enter the formal sector mark their working life. On the other hand, in urban areas, youth face higher rates of unemployment, strong disadvantages compared to adults, and a school-to-work transition that is more than twice as long as in rural areas. This reflects the rural-urban migrations of unskilled young workers as well as of new graduates who are seeking job opportunities in the urban economic centres.

Ethiopia's youth have the potential to play a significant role in the country's socio-economic and political development. The National Youth Policy (2004) recognizes the importance of youth, "to participate, in an organized manner, in the process of building a democratic system, good governance and development endeavours, and benefit fairly from the outcomes". Following the government's strategy to involve youth in decision-making processes, the participation of youth is increasingly

recognized by the public authorities. As a result, state agencies and ministries now invite representatives of youth federations during the approval of youth-related policies. Importantly, the Ethiopian Youth Federation was established in 2009 and is composed of regional youth federations, which themselves consist of various youth associations aiming to involve youth in the development of the country at both the national and local levels.

The National Youth Policy of Ethiopia marks a major step in recognizing and promoting the rights of young people in the country. Established in 2004, the policy aims “to bring about the active participation of youth in the building of a democratic system and good governance as well as in the economic, social and cultural activities and to enable them to fairly benefit from the results.” It envisions youth as “a young generation with democratic outlook and ideals, equipped with knowledge and professional skills”. A wide range of priority areas of action are identified, including democracy and good governance, health, education and training, as well as culture, sport and entertainment.

Ensuring the development and wellbeing of adolescents and youth is shared between several parties at Federal, Regional, and local levels. The Ministry of Health (MOH), the Federal HIV/AIDS Prevention and Control Office (FHAPCO), Ministry of Education (MOE), Ministry of Women, Children and Youth Affairs (MOWCA), and the Ministry of Labour and Social Affairs (MOLSA) along with their respective regional and woreda structures are currently involved in addressing the multi-dimensional needs of adolescents and youth. Each ministry has a strategic plan that in some way address the issues of adolescents and youth in the country. Some of the legislation, policy, and strategic documents that describe the commitment and intentions of different sectors concerning adolescents and youth are: The Ethiopian Constitution, Growth and Transformation Plan II (GTP II), The National Youth Policy, the National Adolescent and Youth Health Strategic Plan (2016 – 2021), the National HIV/AIDS policy, and the Strategic Plan for an Integrated and Multi-Sectoral Response to Violence Against Women and Children (VAWC) and child justice.

2.4 GENDER EQUALITY AND WOMEN’S EMPOWERMENT

The 2013 Global Gender Gap Index and the 2014 Gender and Development Index ranked Ethiopia 121 and 173 out of 187 countries, respectively. These rankings illustrate the prevailing social realities that favour men/boys over women/girls. Gender-based Violence (GBV) including different forms of harmful traditional practices are widely practiced in Ethiopia with regional variations in different forms both in rural and urban areas. GBV and harmful traditional practices (HTPs) causes human suffering and social injustice and has a profound effect on the respective communities as well as the wider society. It affects the overall wellbeing of girls, adolescents and women and has social justice and human rights implications. GBV and HTPs have a direct effect on women’s access to different resources and social services; control over resources; and their decision-making power and participation in the household, in the community and in the society that ultimately affects their contribution to the development of the country and the nation in general.

The Ethiopian Demographic and Health Survey (2016) indicated that 48 percent of women and 28 percent of men have never attended school⁴² indicating a wide disparity between the sexes. In general, gender parity has narrowed at the primary level, while it persists at a secondary level due to

⁴² Ethiopian Demographic and Health Survey, 2016

various factors that affect girls including cultural norms, workload, lack of gender sensitive school infrastructure, distance and violence or fear of violence while travelling to school⁴³. In the economic sector, land certification is one of the most progressive steps taken to ensure women's access and ownership of land, which is vital in a country where 80 percent of the population lives in rural areas and is dependent on agriculture. Yet, fewer women have access to certified land ownership compared to men and the average size of land owned by female-headed households is significantly lower than average land size owned by male-headed households⁴⁴. The unemployment rate is higher for women compared to men. When asked if they have worked in the past seven days, 33 percent of women and 88 percent of men worked, while only 33 percent⁴⁵ reported that they have worked.

Traditional attitudes, beliefs and cultural practices that reinforce harmful gender roles contribute to constraining women's participation in decision-making. According to the Ethiopian Demographic and Health Survey in 2016, 30 percent of Ethiopian women do not make decisions on individual and family issues. Instead, their husbands make decisions for them on choices including the option to use birth control methods, and whether to give birth in a health facility or seek the assistance of a trained provider⁴⁶. Women are also found to be more vulnerable to HIV and AIDS due to several factors that limit their negotiation power, such as economic dependence, violence or fear of violence. Women's representation in leadership and decision-making positions has gradually increased, with 27 percent of national parliamentary seats, 30 percent of the Judiciary and 13 percent of decision-making positions in the executive branch occupied by women as of April 2017⁴⁷.

Harmful traditional practices like early marriage/child marriage and childbearing, female genital mutilation and gender-based violence have adverse effects on Ethiopian women. Though there are some improvements in the area of HTPs in the country, there are still practices of female genital mutilation (FGM) and child marriage (CM). The 2016 demographic and health survey indicated that 65 percent of women age 15 - 49 are circumcised, while 16 percent of girls under age 15 are circumcised. The finding also assessed the attitude of both women and men regarding their belief about FGM. Accordingly 24 percent of women and 17 percent of men believe that FGM is required by their religion, while 79 percent of women and 87 percent of men believe that the practice of FGM should not be continued⁴⁸. Although, early marriage is showing a declining trend at the national level, there are hotspot districts distributed throughout the country where there is a high prevalence of early marriage, with as high as above 50 percent prevalence rate⁴⁹.

The findings from the 2016 Demographic and Health survey show a national prevalence rate of intimate partner violence to be 35 percent of ever-married women who said they faced physical, sexual or emotional violence by an intimate partner, with higher prevalence rate in rural than urban areas and among those with primary or lower education levels. From those, 29 percent live in urban areas and 17.5 percent have education levels above secondary education. In terms of regional disaggregation, Oromia has the highest prevalence rate (39%) followed by Harari (38%), and Amhara

⁴³ Ethiopia Gender Snapshot, Oxfam, April 2017

⁴⁴ Ethiopia Gender Snapshot, Oxfam, April 2017

⁴⁵ Ethiopian Demographic and Health Survey, 2016

⁴⁶ Ethiopian Demographic and Health Survey, 2016

⁴⁷ Ethiopia Gender Snapshot, Oxfam, April 2017

⁴⁸ Ethiopian Demographic and Health Survey (2016)

⁴⁹ Ethiopia Gender Snapshot, Oxfam, April 2017

(37%). Sixty-three percent of women and 28 percent of men believe that a husband is justified in beating his wife under certain circumstances such as neglect of children; going out without telling him; and arguing with him⁵⁰.

The government of Ethiopia has made considerable progress and efforts in promoting girls and women's empowerment and bridging gender gaps. This progress is especially visible in the nearly 100 percent girls' primary school enrolment and completion rates, in increased political participation by women as seen in the recent increase in the number of women elected to parliament that has now surpassed the 30 percent minimum threshold recommended globally, and in the provision of land to millions of women to improve their status and economic empowerment. However, gender inequality is still the most prevalent form of inequality in Ethiopia. While the Government has put in place several national progressive laws, norms and standards according to international laws and conventions such as the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), the Beijing Platform for Action, etc., women and often remain at the lowest stratum of society when compared to men and boys of the same socio-economic profile. Women still only make up 30 percent of elected officials and a similar share of the Judiciary. After the 2015 election, 213 of the 547 Members of Parliament (MPs) are women, whereas there were only 116 female MPs in the previous Parliament.

2.5 POPULATION AND DEVELOPMENT ISSUES

As of mid-year 2016, Ethiopia had a population of 102.4 million, with an annual growth rate of 2.5 percent, and 42 percent of its population under 15 (Fig. 1). Its sex ratio is 1.03; the total dependency ratio is 82.1; the crude birth rate was 36 births per 1000; the crude death rate 7.5/1000. The population median age was 18 years with males (17.8 years) and females (18.2 years). The infant mortality rate is 48.3 per 1000, while life expectancy is 63 years. Its rapid population growth is putting pressure on land resources, expanding environmental challenges and raising vulnerability to food shortages.

The total fertility rate declined from 5.4 in 2005 to 4.1 in 2014. The contraceptive prevalence rate increased from 6.3 percent in 2000 to 41 percent in 2014. However, unmet need is still high at 25 percent. Contraceptive use is low among rural adolescents and unmarried women. In the last five years, the proportion of service delivery points offering three to five modern contraceptives has increased by over twenty percent. The birth rate for women aged 15 - 19 declined from 17 percent in 2000 to 12 percent in 2011, with a higher prevalence rate in rural settings at 15 percent for rural and four percent for urban settings due to a higher prevalence of child marriage. Over a third of women are either mothers or pregnant with their first child at the age of 19. However, a third of currently married adolescents (15-19) face unmet needs for family planning. The difference between median ages at first contraceptive use in rural areas is over seven years.

Despite the rapid growth with its attendant challenges, Ethiopia is also facing a demographic transition – a decline in fertility and an increase in the number of working age population – which provides an opportunity to accelerate economic growth. Even with declining fertility, the current fertility rate is still high and this might slow the process of completing the demographic transition, as the increasing

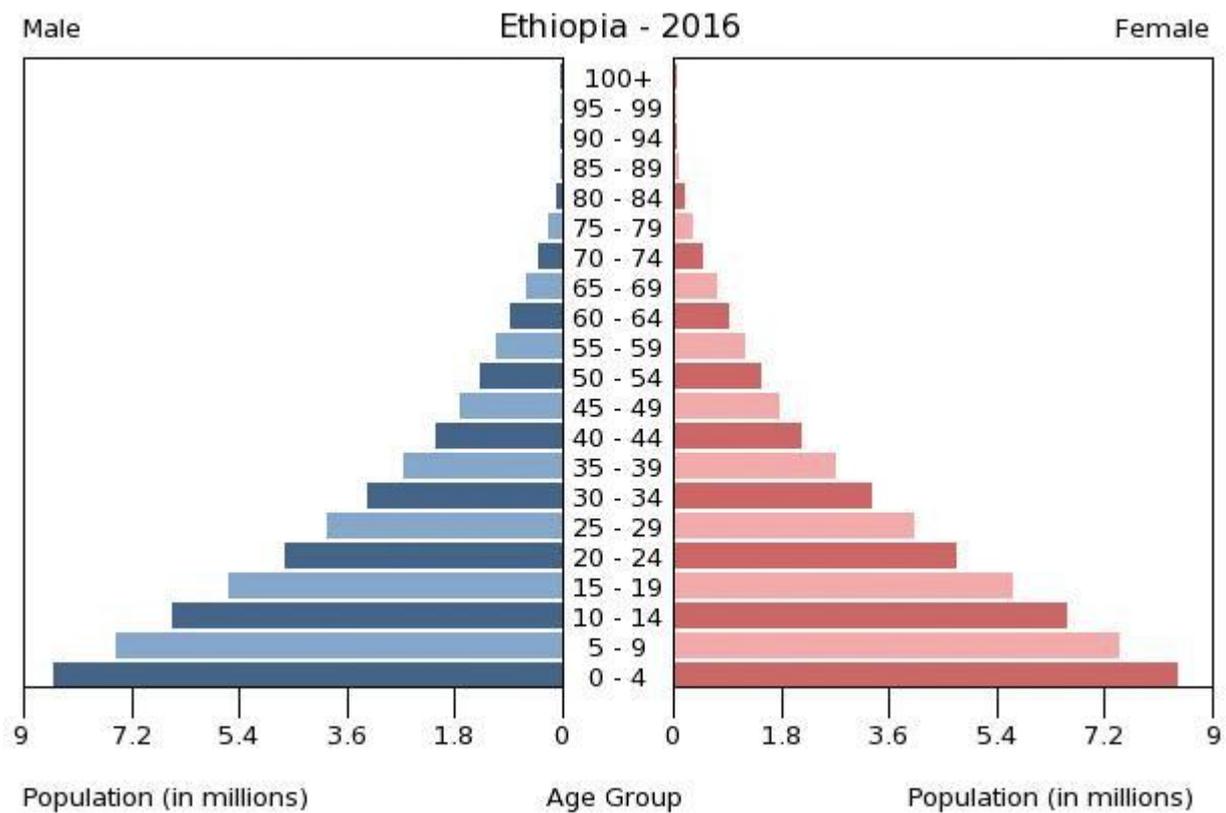
⁵⁰ Ethiopian Demographic and Health Survey (2016)

population exerts pressure on social and economic services, which could affect inclusive growth. The large working population, favourable policy environment, investment in human capital, and expansion of infrastructure will not yield meaningful results if the demographic challenges are not addressed. Moreover, research has shown the importance of investing in adolescent boys and girls for realizing a country's demographic dividend (Assefa et al 2017).

UNFPA support in earlier programmes has improved the understanding of decision-makers at the federal level to the importance of the population dynamics and enhanced the engagement of the National Planning Commission with sectorial ministries for the formulation of the National Population Policy. The challenge now is the functionality of the population council at the state level and for the state population councils, most of which are not operational.

Ethiopia regularly collects data from population censuses, surveys and routine administrative data that provide information on population dynamics. Technical skills for the integration of population issues into policy and programme formulation implementation and monitoring, however, are weak at both the federal and regional levels. Furthermore, staff attrition at the Central Statistical Agency and weak technical skills of the newly established Vital Events Registration Agency call for continued capacity strengthening.

Figure 1: Population Pyramid of Ethiopia



Source: PopulationPyramid.net, 2016

The role of external assistance

Despite being one of the fastest growing economies in sub-Saharan Africa, Ethiopia is one of the poorest with a capita income of USD783. To aid development, the Government of Ethiopia receives grants and financing from sources from non-Development Assistance Group (DAG) donors, such as China and India. The five top providers of ODA by their total disbursement, in general, are World Bank’s International Development Assistance (IDA) (\$1125m), China (\$249.5m), USAID (\$247m), DFID (\$222.8m) and African Development Bank (\$217.8m). Similarly, the five development partners by their grant disbursement are USAID, WFP, DFID, UNICEF and EU. Additionally, the top five development partners that give loans to Ethiopia are IDA, China, ADB, IFAD and DFID. Funding assistance was channelled to several development projects. In 2016/17, development partners contributed an estimated USD 739.9m to Ethiopia, which account for one-quarter of official development assistance.

Since 2004, ODA to Ethiopia has increased by 66 percent in real terms. Although it receives a considerable volume of ODA, this translates into only USD 41 per capita which is below the average of USD 50 for Sub-Sahara Africa.

United Nations Development Assistance Framework

One other external assistance Ethiopia receives is from the United Nations. The United Nations Development Assistance Framework in Ethiopia has been instrumental in rallying the capacities, resources and comparative advantages of all members of the UN system behind the country’s strategic

vision and priorities of the national development agenda. The current UNDAF 2016-2020 in Ethiopia represents the UN Country Team's strategic response to the national development priorities articulated in the Second Growth and Transformation Plan (GTP 2). This is directly linked to the SDGs relevant to the country's context.

3.1 UNFPA STRATEGIC RESPONSE

The 8th CP is based on two UNFPA Global Strategic Plans. The first, UNFPA Strategic Plan for the period of 2014-2017, colloquially known as the bull's eye, reaffirms the strategic direction organised fewer than five outcomes. The bull's eye is the goal of UNFPA: the achievement of universal access to sexual and reproductive health, the organisation of reproductive rights and the reduction in maternal mortality. The bull eye's Strategic Plan is related to the MDGs and the ICPD. A new UNFPA strategic plan, 2018-2021, is aligned with the 2030 Agenda for Sustainable Development Goals and the ICPD. The goal of the strategic plan, 2018-2021, is to "achieve universal access to sexual and reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the agenda of the Programme of Action of the International Conference on Population and Development, to improve the lives of women, adolescents and youth, enabled by population dynamics, human rights and gender equality" (see Figure 2). The goal is the same as that of the previous UNFPA strategic plan, 2014-2017. Evaluative evidence has confirmed that the goal remains relevant and is an effective entry point for contributing to the 2030 Agenda. This goal will also enable UNFPA to address challenges in the areas of sexual and reproductive health, and gender equality and women empowerment within the context of the Millennium Development Goal targets that were not achieved.

The UNFPA strategic plan, 2018-2021, is aligned with General Assembly resolution 70/1 on the 2030 Agenda for Sustainable Development Goals. It also responds to other global frameworks underpinning the 2030 Agenda, including the Sendai Framework for Disaster Risk Reduction 2015-2030 of the Third United Nations World Conference on Disaster Risk Reduction, the 2015 Paris Agreement on Climate Change and the 2015 Addis Ababa Action Agenda of the Third International Conference on Financing for Development.

By aligning the strategic plan to the Sustainable Development Goals, UNFPA advances the work of the ICPD Programme of Action, contributes to the achievement of the goal of its Strategic Plan (SP) and, ultimately, to the eradication of poverty. The 8th CP has crossed three SP cycles since 2016. While the programme focus did not deviate much due to the strong alignment of the planned programmes to the UNFPA mandate, the mode of engagement stayed the same as per the UNFPA business model. Ethiopia is classified in the *Red Category*; the mode of engagement is via service delivery, capacity development, partnerships and coordination, including South-South and triangular cooperation, knowledge management, advocacy, policy dialogue and advice. In humanitarian settings, when the country responds to natural or man-made emergencies and for emergency preparedness, service delivery is the mode of engagement.

Figure 2: Alignment of the “bull’s eye”–the goal of the UNFPA strategic plan–to the goals and indicators of the 2030 Agenda for Sustainable Development



3.2 UNFPA RESPONSE THROUGH THE COUNTRY PROGRAMME

The UNFPA programmatic response to its strategic objective and that of the Government of Ethiopia is presented in the 8th Country Programme Document and its associated Annual Work Plans. The rationale of the CP is to satisfy population needs, solve and tackle problems and challenges identified as joint priorities by the Government of Ethiopia, the UNFPA CO and the United Nations Development Assistance Framework.

3.2.1 UNFPA previous cycle strategy, goals and achievements

The 7th CP (2012-2015) was designed to respond to national priorities on sexual and reproductive health, gender equality, and population and development. The overall goal was to improve the sexual and reproductive health status of Ethiopians. The 7th UNFPA Country Programme (CP) (2012-2015) had a budget of \$85 million and consisted of three components; 1) Reproductive Health and Rights; 2) Population and Development; and 3) Gender Equality, with cross-cutting issues such as a human-rights based approach, gender mainstreaming, and humanitarian emergency response. Programme activities were implemented in six regions and 77 woredas/districts.

1. This component contributed to the expansion and strengthening of comprehensive emergency obstetric and neonatal care and implementation of reproductive health minimum initial service package in humanitarian settings in three regions. In HIV/AIDS, the focus was on the multi-sectoral HIV response focusing on prevention among young people and vulnerable populations like female sex workers.

2. In gender, the CP7 supported the development of national strategy on harmful traditional practices and national standard operating procedures to respond to sexual violence; establishment of national alliance to end child marriage and female genital mutilation and four safe houses and five model clinics to provide comprehensive services for survivors of gender-based violence, and advocacy campaigns leading to public declarations for the abandonment of female genital mutilation and protection of young girls from child and forced marriage.

3. In population and development component, the programme contributed to the generation of eight national data sets on key population issues; in-depth analysis of the 2007 Census and 2011 Demographic and Health Survey; capacity-building for the 2017 Population and Housing Census; establishment of a national web-based Integrated Management Information System to migrate forty national survey and census data sets, and development of a strategy and action plan on the Civil Registration and Vital Statistics system.

The thematic evaluation recognised the importance of recruiting trainees locally and deploying them back to their locality as the best way to retain service providers and provide culturally sensitive services, and; institutionalisation of reproductive health commodity security training is cost-effective and a viable strategy for sustainability. Another lesson was that South-South cooperation reinforces the acceptability of innovative interventions.

3.2.2 The 8th Country Programme

The 8th CP contributes to the UNFPA SP goal of achieving universal access to sexual and reproductive health, promoting reproductive rights, reducing maternal mortality and accelerating progress on the ICPD PoA. In addressing the issues raised above and contributing to the development frameworks highlighted above, the eight CPD was developed within the framework of the four outcomes of the UNFPA Strategic Plan (2014 – 2017) and six outputs, namely:

- **Outcome 1:** Increased availability and use of integrated sexual and reproductive health services, including family planning, maternal health and HIV, that are gender-responsive and meet human rights standards for quality of care and equity in access
Output 1: National capacity increased to deliver quality maternal health services, including in humanitarian settings.
Output 2: National capacity strengthened to increase demand for and availability of family planning services, including reproductive health commodities.
- **Outcome 2:** Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health.

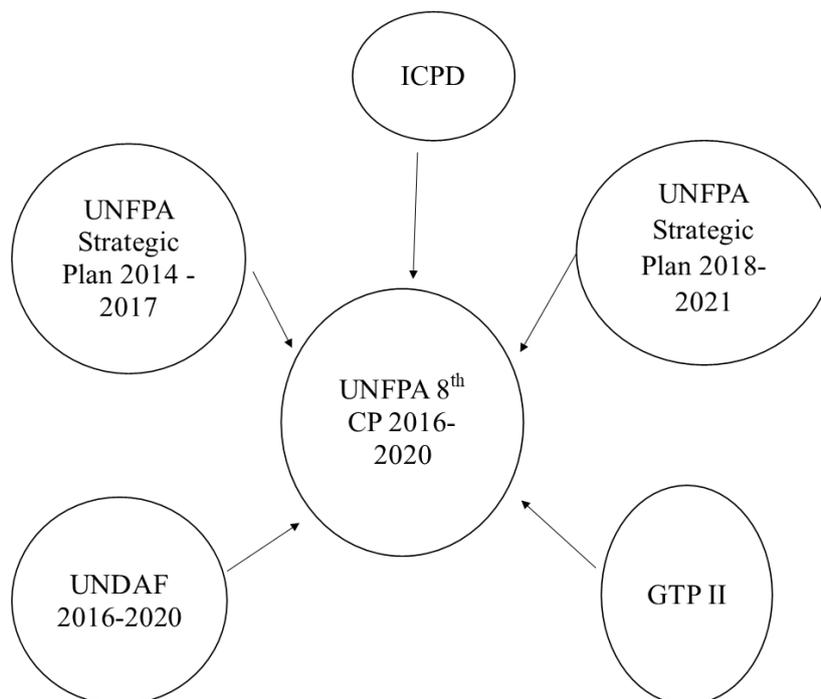
Output 3: Capacity of adolescents and young people strengthened to make informed decisions on their sexual and reproductive health and rights.

Output 4: Institutional capacity strengthened to provide youth-friendly sexual and reproductive health services.

- **Outcome 3:** Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth.
Output 5: Communities and institutions have enhanced capacity to promote and protect the rights of women and girls, and provide services to survivors of harmful traditional practices and gender-based violence.
- **Outcome 4:** Strengthened national policies and international development agendas through the integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality. *Output 6: National institutions have the capacity to generate, analyse and use disaggregated data for planning, development, implementation, monitoring and evaluation of policies and programmes, including in humanitarian settings.*
- Humanitarian and resilience-building interventions are cross-cutting through the above outcomes.

The CP was aligned with Ethiopia's national Growth and Transformation Plan 2 (2016-2020), the Health Sector Transformation Plan (2015-2020), United Nations Development Assistance Framework (2016-2020), the UNFPA Strategic Plan (2014-2017) and the Sustainable Development Goals Agenda 2030 (See Figure 3). UNFPA's 8th CP (2016-2020) was aligned and fully integrated within the UN Development Assistance Framework. In line with the UNFPA corporate Mid-term Review and the new corporate Strategic Plan 2018-2021, and consistent with the UNDAF Mid-term Review conclusions, UNFPA Ethiopia further aligned its interventions. Figure 3 below, illustrates some of the key foundation strategy documents that form the basis for the UNFPA Ethiopia's new alignment.

Figure 3: UNFPA Ethiopia Re-aligned Country Programme Linkages with Ethiopian National Development Plan and UN Global Strategic Plans



3.2.3 UNFPA Previous Country Programme and Evolution of the 8th Country Programme

Table 3: Evolution of the Country Programme

Programmatic Areas	7 th Country Programme	8 th Country Programme
Sexual and Reproductive Health / HIV Prevention	<p>Output 1: Increased capacity of training institutions to produce qualified human resources for maternal health.</p> <p>Output 2: Increased availability of essential life-saving maternal and newborn health commodities and modern FP methods and services in selected facilities.</p> <p>Output 3: Strengthened national capacity to provide high-quality information and services on maternal and newborn health</p> <p>Output 4: Increased availability of high-quality HIV prevention services for young people and other vulnerable groups.</p>	<p>Output 1: National capacity increased to deliver quality maternal health services including in humanitarian settings</p> <p>Output 2: National capacity strengthened to increase demand for and availability of family planning services, including reproductive health commodities.</p> <p>Output 3: Capacity of adolescents and young people strengthened to make informed decisions on their sexual and reproductive health and rights.</p> <p>Output 4: Institutional capacity strengthened to provide youth-friendly sexual and reproductive services.</p>

Programmatic Areas	7th Country Programme	8th Country Programme
Gender Equality/ Gender-based Violence/Adolescents	<p>Output 1: Increased capacity of women, adolescents and young people to exercise their rights to information and services on sexual and reproductive health, HIV and gender equality</p> <p>Output 2: Strengthened institutional response to address harmful traditional practices and gender-based violence and provide information and services to survivors of gender-based violence, including within a humanitarian context.</p> <p>Output 3: Strengthened community response to promote and protect the rights of women and girls concerning harmful traditional practices and GBV.</p>	<p>Output 5: Communities and institutions have enhanced capacity to promote and protect the rights of women and girls, and provide services to survivors of harmful traditional practices and gender-based violence.</p>
Population and Development	<p>Output 1: A strengthened integrated management information system.</p> <p>Output 2: Enhanced capacity of selected national institutions to produce evidence-based information for advocacy and policy dialogue.</p> <p>Output 3: Strengthened capacity for programme coordination, monitoring and evaluation of gender-responsive population and programmes.</p>	<p>Output 6: National institutions have the capacity to generate, analyse and use disaggregated data for planning, development, implementation, monitoring and evaluation of policies and programmes including humanitarian settings.</p>

The 8th CP has six outputs and each output has specific strategies and indicators. Altogether the programme has 27 strategies and 17 main indicators. The results of the CP are measured through these main indicators attached to each output developed at the beginning of the programme. Other proxy indicators reflect the results achieved, though these are not included in the CP document. These result indicators are aligned to the global UNFPA strategic plans, 2014-2017 and 2018-2021.

The 8th CP is being implemented in close partnership with the Government of Ethiopia, involving collaboration with the following ministries: Ministry of Finance and Economic Development (MOFED),

Ministry of Health, Ministry of Women, Children and Youth Affairs, among others. MOFED and UNFPA CO jointly coordinate the planning, implementation, monitoring and evaluation of the CP8, applying a results-based management approach as well as jointly implement resource mobilisation, communication and M & E plans. The 8th CP covered eight regions, two sub-cities of one administrative city, and 122 districts. The eight regions are Afar, Amhara, Benishangul-Gumuz, Gambella, Oromia, Somali, SNNPR and Tigray.

The Country Programme Financial Structure

The 8th CPD was costed for \$120 million: USD40.4 million from regular resources and USD 79.6 million through co-financing modalities and/or other resources. Regular resources were allocated to the Country Office on a yearly basis. SRH was expected to take 60 percent (or USD 73.1m) of the total resources. Adolescents and youth 12.1 percent (or USD 14.6m); gender equality and women’s empowerment 10.9 percent (USD 13.0m), population and development 14.8 percent (or USD 17.8m), and Programme Coordination and Assistance (PCA) at 1.25 percent (USD 1.5m). The Government used an agreed formula to pro-rate funds to Federal and Regional implementing partners. Other resources are mobilised mainly for earmarked interventions and are communicated to the Government for the intended programmes. The Country Office has mobilized Other Resources even beyond its target. These other resources were mobilised from the following sources: Sweden, DFID, Netherlands, Canada, Norway, Italy, US, Denmark, Japan, Toms Shoes, Gavi Alliance, Swedish UN Association. Total funds mobilised for this cycle stood at USD 91,091,878 million.

Unlike other modalities applied in previous CPs, it is quite evident that the un-earmarked Sweden funding for the overall County Programme has helped the country office to flexibly address unmet needs in developing regions as well as in situation of prevailing emergency. This is appreciated by UNFPA as well as the Government and partners.

Table 4: UNFPA Indicative Financial Commitments as per Ethiopia/ UNFPA 8th CP 2016-2020

Thematic Area	Projected Amount of Resources in USD million		
	Regular Resources	Other Resources	Total
Sexual and Reproductive Health	23.2	49.9	73.1
Adolescent and Youth	5.2	9.0	14.6
Gender equality and women’s empowerment	4.2	8.8	13.0
Population Dynamics	5.9	11.9	17.8
Programme coordination and assistance	1.5	-	1.5
Total	40.4	79.6	120.0

As shown in Table 4, the projected amount of resources is higher for sexual and reproductive health, followed by population and development dynamics and adolescent and youth development.

Table 5: Trends in 8th CP Resources in USD M: 2016-2019

Type of Resources	2016*	2017	2018	2019**	Total
Regular Resources -	2,522,314	4,283,919	4,304,795	2,401,277	13,512,305
Other Resources -	6,404,497	13,233,008	14,560,934	13,960,166	48,158,605
Total	8,926,811	17,516,927	18,865,729	16,361,443	61,670,910

Note:

* CP8 started in July 2016; hence the resources available reflect a six-month period amount.

** The 2019 resources are as at 30 June 2019.

The CO mobilized additional resources for CP8. Table 5 shows a steady increase of other resources since 2016. Regular resources also increased steadily.

Table 6: CP8 Resources by Thematic area, CP8 2016-2019

Thematic Area	2016*	2017	2018	2019**	Total	% Of overall resources
SRH Expenditure -	5,996,931	10,941,891	11,269,758	9,576,145	37,784,725	61.27%
AYD Expenditure	314,072	1,937,351	969,014	1,585,772	4,806,209	7.79%
GEWE Expenditure -	713,894	1,621,902	2,621,632	1,500,925	6,458,353	10.47%
PD Expenditure	965,496	1,387,138	2,209,802	2,332,662	6,895,098	11.18%
PCA Expenditure -	145,900	84,698	102,572	77,681	410,851	0.67%
PM Expenditure -	790,519	1,543,947	1,692,952	1,288,256	5,315,674	8.62%
Total Expenditure	8,926,812	17,516,927	18,865,730	16,361,441	61,670,910	100.00%

As shown in Table 6, the SRH component has most of the resources each year over the four years. Overall, SRH was allocated USD 37.78m, which is 61.27 percent, followed by population and development at 11.18 percent, GEWE at 10.47 percent, and the adolescents and youth component at 7.79 percent.

Table 7: 8th CP Resources by CP Output Areas 2016-2019

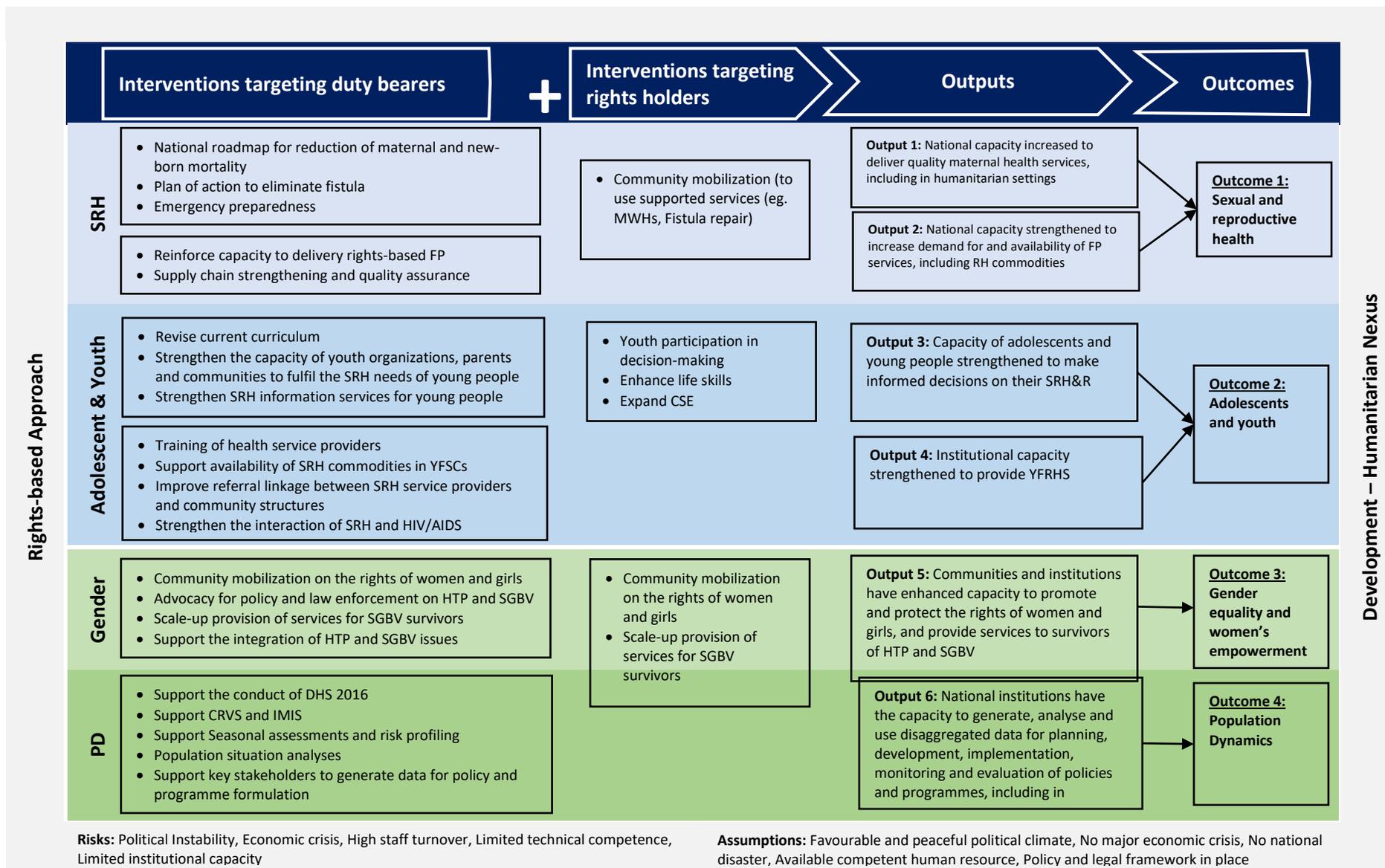
Output	2016*	2017	2018	2019**	Total	% Of overall resources
Output 1 - Expenditure	1,742,384	4,900,523	4,261,000	2,377,048	13,280,955	22.0%
Output 2- Expenditure	4,254,547	6,041,368	7,008,758	7,199,097	24,503,770	40.0%
Output 3 - Expenditure	250,654	1,528,015	735,175	1,190,903	3,704,747	6.0%
Output 4 - Expenditure	63,418	409,336	233,839	394,869	1,101,462	2.0%
Output 5 - Expenditure	713,894	1,621,902	2,621,632	1,500,925	6,458,353	10.0%
Output 6 - Expenditure	965,496	1,387,138	2,209,802	2,332,662	6,895,098	11.0%
PCA - Expenditure	145,900	84,698	102,572	77,681	410,851	1.0%
PM - Expenditure	790,519	1,543,947	1,692,952	1,288,256	5,315,674	9.0%
Total Expenditure	8,926,812	17,516,927	18,865,730	16,361,441	61,670,910	100.0%

Assessment of CP8 resources by output from 2016-2019 shows that Output 2 has attracted the most resources (USD 24.5 million; 40 percent of the total resources followed by Outputs 1 and 6 at 22 percent and 11 percent, respectively.

3.3 THEORY OF CHANGE/LOGIC MODEL

As shown below in Figure 4, a simplified logic model illustrates how planned activities in four focus areas are to achieve outputs that, in turn, will accomplish four major UNFPA SP Outcomes. These four major outcomes are to contribute to the overall UNFPA goal: “The achievement of universal access to sexual and reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the International Conference on Population and Development agenda.”

Figure 4: Model explaining the relationship between the 8th UNFPA Country Programme Outputs and Outcomes.



This chapter presents the findings of the evaluation for each of the 11 evaluation questions. There are two components, answering the evaluation questions at the programmatic and strategic levels. CPE Component 1 analyses CP thematic areas against the evaluation criteria of relevance, effectiveness, efficiency and sustainability. Component 2 analyses the strategic positioning of UNFPA CO using criteria: *coordination* with the UNCT and *added value* of UNFPA, and humanitarian-development connectedness. Under component 1, the findings are presented for the four (4) component areas of sexual and reproductive health, adolescent and youth development, gender equality and women’s empowerment, and population and development.

4.1 RELEVANCE

Evaluation Question: (i) To what extent is the 8th CP adapted to the needs of the population, including vulnerable groups; and aligned with global, UNFPA priorities, national priorities, and strategies, expectations of beneficiaries? (ii) To what extent the UNFPA country office has been able to respond to changes in national needs and priorities or shifts caused by major, natural disasters and other contextual changes?

4.1.1 Sexual and Reproductive Health

Summary:

SRH components of UNFPA’s 8th CP are directly linked to international, national, regional, and district efforts to increase access to and utilisation of evidence-based interventions against SRH-related problems. The associated interventions of the SRH component were consistent with priority components of ICPD PoA, SDG Agenda 2030 and UNDAF 2016-2020 and the transformative and people-centred results of UNFPA’s strategic plans 2014-2017 and revised SP 2018-2021. The 8th CP fitted very well with a national development framework, GTP II, policies and strategic plans including the Health Sector Transformation Plan (HSTP), Reproductive Health Strategy, and other supporting strategies on human resources for health, midwifery training, and obstetric fistula management.

Ethiopia is one of the low-income countries that showed noticeable improvement in addressing SRH-related problems including maternal and newborn mortality during the period of MDGs. However, the magnitude of SRH problems is still unacceptably high. According to the 2017 global burden of diseases analyses, maternal and neonatal disorders contribute to 18 percent of total disability-adjusted life years lost in Ethiopia⁵¹. Low coverage of evidence-based SRH interventions because of both supply- and demand-side barriers to service utilisation are the primary drivers of SRH related morbidity, mortality, and disability in the country.

The Health Sector Transformation Plan (HSTP developed as part of the second Growth and Transformation Plan (GTP2) of the country has given substantial attention to addressing the persistent burden of SRH related problems. The first strategic objective of HSTP – improve equitable access to quality healthcare –

⁵¹ Institute for Health Metrics and Evaluation. Global Burden of Disease: Causes of death and disability combined - Ethiopia 2017 [Available from: <http://www.healthdata.org/ethiopia>.

primarily focuses on SRH related targets including increased utilisation of contraceptives and maternal health services, and decreasing SRH problems including the unmet need for family planning, obstetric fistula, and teenage pregnancy. SRH related components of HSTP are informed by findings of preceding national surveys including Demographic Health Surveys (DHS), health facility assessments, and evaluation of the performance of the previous strategic plan.⁵²

Despite increasing coverage of maternal health services, coverage is still far behind national targets for most SRH services and quality of care has been a major issue for those who utilized services both leading to sub-optimal results. Limited capacity of care providers has been a major reason behind the poor quality of services. For example, according to the 2016 service availability and readiness assessment (SARA 2016) report⁵³, the mean availability of BEmONC⁵⁴ functions was 46 percent. A cross-sectional assessment of public and private health facilities in 2016 also showed that there have been challenges in the provision of CEmONC services⁵⁵. Unmet needs for family planning is high, particularly among rural-dwelling women. Ensuring an uninterrupted supply of family planning commodities is an important aspect of the family planning programme in the country. Government procurement policies and procedures are currently not efficient to an extent that is expected for family planning and other SRH commodities.

The SRH component of the 8th CP is well aligned with the second GTP of Ethiopia and the corresponding UN Development Assistant Framework⁵⁶. Outputs under the SRH outcome of the CP are directly related to health and HIV outcomes of the third pillar of GTP 2 (investing in human capital and expanding access to social services). In more specific terms, SRH components of the 8th CP were directly linked to the first strategic objective of HSTP and the National RH Strategy 2016-2020 particularly in the areas of family planning and maternal and newborn health. The programme has also been aligned with specific strategies supporting the expansion of SRH services including human resources such as midwifery training^{57,58} and elimination of obstetric fistula⁵⁹. The design of the 8th CP was also aligned with relevant area-specific strategic documents of UNFPA^{60,61}.

Interviewees from the Ministry of Health and Regional Health Bureaus also confirmed the relevance of UNFPA's support in addressing critical gaps on priority SRH problems. Transparent and participatory planning processes and involvement in the provision of both technical and financial support were among the key factors that ensured the relevance of the CP in addressing priorities of government and the people of Ethiopia. A director from the Ministry of Health described this strength of the CP and CO as:

UNFPA provides ...both technical and financial assistance to the ministry ... They are members of different technical working groups including maternal health, adolescent

⁵² FMOH. Health Sector Transformation Plan (HSTP) 2014/15 - 2019/20. 2015.

⁵³ Ethiopia Service Availability and Readiness Assessment Survey 2016

⁵⁴ Basic Emergency Obstetric and Newborn Care

⁵⁵ FMOH & EPHI. Ethiopian CEmONC Assessment 2016.

⁵⁶ UNDP. United Nations Development Assistance Framework for Ethiopia (2016-2020) 2016.

⁵⁷ Midwifery roadmap 2016-2025

⁵⁸ Global Midwifery Strategy 2018-2030

⁵⁹ Strategic plan for Elimination of Obstetric Fistula

⁶⁰ UNFPA Strategic Framework for Global Programme to Enhance RHCS (2013-2020)

⁶¹ Choices not Chance – UNFPA FP strategy (2012-2020)

and youth health, and reproductive health and family planning... They are always first in our list of partners. They plan with us; their plan is well aligned with that of ours...

Outputs of the SRH component are also clearly linked, as expected, to the UN Agenda 2030 and vision of UNFPA to end preventable maternal deaths and unmet need for family planning⁶². The UNFPA Strategic Plans (2014-2017) and (2018-2021) and the SRH component of the 8th CP were relevant in addressing priority SRH needs of Ethiopians and critical capacity gaps of mandated duty bearers.

Stakeholder interviews and document reviews⁶³ revealed that SRH components of the 8th CP largely focused on predominantly rural woredas⁶⁴ benefiting relatively disadvantaged segments of the population. Support for expansion of maternity waiting homes in health centres with hard to reach catchment populations and provision of material and technical support for the provision of SRH services to internally displaced communities were among SRH components serving highly vulnerable segments of the population. The CO's engagement in supporting family planning services in Ethio-Somali region, a region with the lowest coverage of family planning, and responses provided to conflict induced IDPs allowed UNFPA to support most vulnerable segments of the population in the areas of family planning and other SRH issues.

The CO has been responsive to emergencies that happened during the period of the 8th CP. Humanitarian interventions for people internally displaced following conflicts and drought during the period of the 8th CP were results of responsive programming at the CO level. In response to the high influx of refugees and large numbers of internally displaced people due to drought and conflict, UNFPA collaborated with and supported ARRA and host community health facilities to ensure access to SRH services among communities in emergencies. However, these responses were not adequate to meet the vast needs of affected communities, particularly for IDPs.

4.1.2 Adolescents and Youth Development

Summary:

Ethiopia has large and fast-growing adolescent and youth populations. The 8th CP-supported activities that intend to build the capacity of targeted young people as well as that of mandated duty bearers. Interventions and strategies of the CP, implemented through engagement with MoY, MoH, HAPCO, and their respective sub-national structures, fitted very well with policies and strategic plans including the Adolescent and Youth Health Strategy, HIV Prevention Roadmap, and the National Youth Policy. Involvement of CO staff and RPOs, as member of technical working groups and other joint forums, in national and regional forums in the design, implementation, and monitoring of youth related interventions has been relevant in building national and regional capacity in the area of AYD. The CP's support to youth centres, associations, and school clubs has not only facilitated reaching in-school and out-of-school youth, but it also facilitated the provision of services through the participation of the youth

⁶² UNFPA. UNFPA Strategic Plan 2018 - 2021. 2018

⁶³ CSA [Ethiopia], The DHS Programme ICF Rockville. Ethiopia Demographic and Health Survey 2016. 2017

⁶⁴ Woredas are administrative units equivalent to a district with an average population of 100,000

themselves. These features of the 8th CP are very relevant to UNFPA strategic plan, UNDAF, and sectoral strategic plans and policies.

Ethiopia has large and fast-growing adolescent and youth populations who make up more than a third of the total population. Adolescents and youth in the age group 10-14, 15-19, and 20-24 years, account for 15.6 percent, 10.6 percent, and 7.6 percent of the total population of Ethiopia, respectively. The adolescent and youth development component is relevant in addressing the needs of youth in the country. The national youth policy of Ethiopia recognizes and promotes the rights of young people and its achievement through their full participation⁶⁵. The national adolescent and youth health strategy 2016-2020 considers high rates of SRH related problems including risky sexual practices, child marriage, early childbearing, unintended pregnancy, unsafe abortion and its complications and STIs including HIV as major causes of morbidity among adolescents and youth. Limited access to recreational facilities and adolescent and youth-friendly SRH services are among the major causes of a high incidence of these problems. In response, the strategy proposes six priority areas of actions including access to AYH information and age-appropriate CSE and life-skills education, enhancing equitable access to high-quality, efficient and effective adolescent and youth-friendly health services, strengthening strategic information and research on adolescents and youth, promoting a supportive and enabling policy environment, supporting and facilitating youth engagement and ownership of health programmes, and strengthening inter-sectoral coordination, networking and partnership⁶⁶.

The adolescent and youth component of the 8th CP of UNFPA supported activities that intended to: 1) build the capacity of adolescents and young people so that they will be able to make informed decisions on their sexual and reproductive health and rights and 2) strengthen institutional capacity for the provision of adolescent and youth-friendly SRH services. The inclusion of activities that target empowering adolescents and youth as right holders and building the capacity of service providing institutions as duty bearers makes the AYD component of the 8th CP aligned with the rights-based approach considered as a guiding principle of AYHS 2016-2020 and the goal of UNFPA's strategic plan - 2018-2021⁶⁷. UNFPA's engagement with health, HIV, and youth sectors at federal, regional, and woreda levels allowed the 8th CP to access adolescents and youth and their service providers at youth centres, health facilities, and schools. The rising number of youth centres, health centres, and school enrolment rate throughout Ethiopia makes these sectors most appropriate for services targeting adolescents and youth in the country.

Youth centres and youth associations: Expansion of youth centres and their increasing utilisation by adolescents and youth creates opportunities for safe recreational activities and provision of SRH messages and services to young people. Youth centres supported by the programme mostly served youth with limited access to alternative recreational centres. Youth associations also create opportunities for organized engagement of youth in decision-making that affects the lives of young people. Uneven distribution of youth centres (mostly located in urban areas) and their relatively low utilisation by youth girls are major challenges of interventions that intend to reach adolescent and youth through youth

⁶⁵ Ministry of Youth Sports and Culture. National Youth Policy. Addis Ababa, Ethiopia 2004

⁶⁶ MCH Directorate MoH. National Adolescent and Youth Health Strategy (2016-2020). Addis Ababa, Ethiopia 2016

⁶⁷ UNFPA. UNFPA Strategic Plan 2018 2021. 2018

centres. Youth associations too weak to support planned youth empowerment programmes were also challenges for the AYD component of the CP.

Adolescent and youth-friendly service centres: Lack of confidentiality and judgmental attitude of healthcare providers towards adolescents and youth seeking reproductive health services has been a major barrier of SRH service utilisation among adolescents and youth. Establishment of YFSCs and training of healthcare providers on adolescent and youth health helped in addressing these barriers. The AYD component of the 8th CP supported the establishment and functionality of adolescent and youth-friendly service centres in government health centres has the potential to address barriers to utilisation of SRH services among adolescents and youth.

Life skill training, peer education, and mini-media support: Knowledge on SRH topics including family planning and HIV is limited among Ethiopians including adolescents and youth⁶⁸. The first pillar in the HIV prevention roadmap of Ethiopia is a combination of prevention for adolescent girls, young women and their male partners⁶⁹. Even though there was no separate output for HIV related interventions, HIV prevention and control interventions are targeting in-school and out-of-school youth, female sex workers, adolescents living with HIV and other most at-risk adolescent and youth populations. Life skill training, peer education, and SRH information dissemination through mini-media and other channels, which were supported through the 8th CP, were relevant to address knowledge/information gap and build capacities of young people so that they will demand services and make informed decisions on their SRH and rights.

4.1.3 Gender equality and women's empowerment

Summary:

This component is fully consistent with national and global priorities as indicated in UNFPA Strategic Plans (2014-2017 and 2018-2021), CEDAW, and Agenda 2030, UNDAF, Ethiopian National Development Framework, GTPII. It also addresses the fundamental elements regarding discrimination against women, gender-based violence including FGM and CM in line with the ICPD Programme of Action. The CP also responded to emergency crises as much as possible by providing dignity kits and psychosocial support for adolescent girls and women who are survivors of gender-based violence.

The GEWE component of the 8th CP is consistent with global priorities and international commitments such as CEDAW⁷⁰; London Girl Summit 2014 which the government committed to end FGM and CM, and Beijing Platform for Action; and SDG Goal 5. Key informant interviews with the CO and RPOs revealed that the 8th CP (UNFPA) was relevant and in line with the goals and priorities set in the UNDAF pillar 5 which is Equality and Empowerment.

Document reviews and interviews with stakeholders revealed that the CP objectives and strategies are consistent with the national priority of the country and are in line with the Growth and Transformation Plan II (2016-2020), which clearly and unequivocally indicates addressing gender-based violence using

⁶⁸ CSA [Ethiopia], The DHS Programme ICF Rockville. Ethiopia Demographic and Health Survey 2016. 2017

⁶⁹ FHAPCO. HIV Prevention in Ethiopia: National Road Map 2018 - 2020. 2018

⁷⁰ CEDAW (1981) is an international legal instrument that requires countries to eliminate discrimination against women and girls and promotes women's and girls' equal rights and address gender inequalities at all levels and in all spheres. It legally binds States Parties to fulfil, protect and respect women's human rights.

different strategies. Gender programme interventions are aligned to the priorities of the Ethiopian Government as identified in the Growth and Transformation Plan and various sectoral plans as well as adhering to the Paris Declaration and Accra Agenda for Action principles in providing support to government priorities in the areas of reproductive health, adolescent and youth development, population and development, and gender equality and women's empowerment. For example, UNFPA is providing support to the Ethiopian Government in realizing its commitment to end Child Marriage and Female Genital Mutilation by 2025 as a key player of this joint effort. It is also in line with national policies and strategies such as the National Policy on Women (1993)⁷¹, the Constitution of the Federal Democratic of Ethiopia (1995)⁷², the Revised Family Law (2000)⁷³, the Revised Penal Code (2005)⁷⁴, the National Strategy and Action Plan on Harmful Traditional Practices (HTPs) against Women and Children (2013)⁷⁵, and the National Children's Policy (2017)⁷⁶.

The 2018-2021 UNFPA Strategic Plan builds on the progress achieved by the Millennium Development Goals; addresses the remaining challenges in the areas of sexual and reproductive health and reproductive rights; and draws on the evidence and the lessons learned from the previous strategic plan cycle, 2014-2017, to improve its approaches and strategies. UNFPA organizes its work around three transformative and people-centred results in the period leading up to 2030. These are: (a) an end to preventable maternal deaths; (b) an end to the unmet need for family planning; and (c) an end to gender-based violence and all harmful practices, including female genital mutilation and child, early and forced marriage⁷⁷.

The evaluation revealed that the 8th CP paid attention to the needs and concerns of youth. Women and adolescent girls are the main targets of the different interventions of the Gender Equality and Women Empowerment programmes such as abandonment of FGM and CM; accelerated action to end CM; preventing and responding to SGBV and GBV in Emergency and the host communities. The GEWE programme purposefully directs women and adolescent girls since they are most affected by SGBV and HTPs. KIIs from the CO, RPO, IPs and discussions with direct beneficiaries indicated that most of the indirect and direct beneficiaries of the programme are young women. For example, the Safe Houses and the One Stop Centre beneficiaries are female youth who are survivors of SGBV and HTPs. But this does not imply that the programme did not target male youth. It was also indicated by the CO that the selection of target Woredas in each region is based on the prevalence of the problem and not on the easy

⁷¹ National policy on women (1993) aims to create appropriate structures within government offices and institutions to establish equitable and gender-sensitive public policies stipulating equal participation of women in national, social, economic and political life.

⁷² The Constitution of the Federal Democratic of Ethiopia (1995) guarantee equal rights for women. It nullifies all customary practices and laws that discriminated against women. It also declares that all international agreements by Ethiopia are an integral part of the law of the country.

⁷³ The Revised Family Law (2000) ensures equal rights of women and also criminalized many customary harmful practices such as early marriage, FGM and marriage by abduction including domestic violence and rape.

⁷⁴ The Revised Penal Code (2005) grants equal rights to women and men as heads of the household, ensuring women's right to equal share of property in marriage and divorce and stipulate the minimum age for marriage.

⁷⁵ As part of broader gender and equity goals, the National Strategy and Action Plan on Harmful Traditional Practices (HTPs) against Women and Children (MoWCYA, 2013) targets to reduce child marriage, abduction and FGM/C.

⁷⁶ The National Children's Policy (2017) safeguard the rights of children to be protected from HTPs and indicate strategies in relation to the promotion of the rights of children as well as preventive and responsive measures.

⁷⁷ UNFPA Strategic Plan 2018-2021

accessibility of the Woredas⁷⁸. The DHS report is also used as a complementary document that indicates the magnitude of the problem.

KII and FGDs with CO, RPOs and government IPs indicated that the CO provides quick responses during crises based on its mandate, though there is a shortage of resources to address and respond to all situations. The CO responds to crises like conflict and internal displacement. UNFPA during emergency provides dignity kits though the provision is often lower than the demand. There is high demand during an emergency for support since women and children are the most affected by any crises. Interviews with the IPs revealed that though UNFPA tries to respond to emerging needs, there is always a matter of mandate and shortage of resources to address the needs. Two examples were cited where UNFPA responded to a humanitarian situation in collaboration with the MoWCYA.

The first is the distribution of dignity kits for emergency situations in Somalia, Gedeo and Oromia region for internally displaced adolescents and women. The second one was the support provided for seven sexually abused women aged 20 to 35 from Somalia region. (KII with Federal IP).

4.1.4 Population and Development

Summary

The GoET/UNFPA 8th CP Population and Development component is adapted to the needs of the disadvantaged population groups such as youth, women in both development and humanitarian settings. The PD staff are very sensitive to the needs of their constituent agencies, making every effort to be responsive and being careful not to impose external donor priorities. The PD programme activities are strongly reflective of UNFPA policies and strategies, as well as global priorities, including the goals of the ICPD Programme of Action and the SDGs Agenda 2030. Thus the PD activities have explicitly addressed the ICPD agenda, SDGs and UNFPA Strategic Plans. The PD programme activities have been very responsive to changes in the national development context. This is evidenced by the UNFPA Ethiopia PD long-term capacity-building efforts in collaboration with the Central Statistical Agency and Vital Registration Agency. The PD component was designed in consultation with national stakeholders and took into consideration the national needs for data availability and use for improving evidence-based and population-centred decision-making. The objectives and strategies of the population and development interventions are aligned with the ICPD PoA, the SDG Agenda 2030 and Ethiopian National Development Policy, GTP II. The PD Component is anchored on the ICPD PoA, Principle 2 that stipulates that human beings are at the centre of sustainable development, while Chapter 2 focuses on population and development integration.

A careful review of the key activities and interviews with stakeholders knowledgeable about UNFPA PD activities showed that the PD Focus area is consistent with the needs of its beneficiaries, especially the staff and specialists employed by the main implementing partner agencies (CSA, and Population and Development Directorate of Planning and Development Commission), and within national priorities and

⁷⁸ For example the selection of Woredas in Afar Region (Aballa, Adar, Afambo, Afedera, Awash, Aysiyta, Chifera, Erebtj, Mille, Semurobi, and Teru) is based on the magnitude of the problem and also to address hard to reach areas due to topography.

strategies. Additionally, respondents felt that the contribution of UNFPA to PD is reflective of the ICPD Programme of Action, SDG Agenda 2030. UNFPA-supported technical assistance is particularly relevant given Ethiopia's trends toward a youthful population age structure, which requires expertise in population projections as well as support for policy development for the needs of its young population. UNFPA's support for PD-related activities is aligned with the development of the SDGs, which is guiding the UNDAF.

UNFPA supported interventions are informed by prevailing national and sectoral policies and plans such as the National Population Policy, and the national strategy for development, GTP II. The development or review of these frameworks involved processes of situational analysis and identification of priorities. Also, it is in alignment with the 2014-2017 and 2018-2021 UNFPA Strategic Plan that highlights advocacy for population and development linkages. The P&D component was anchored on the ICPD PoA principles that stipulate that human beings are at the centre of sustainable development. This component was designed to promote the integration of population issues into development strategies, planning and programming to achieve social justice and eradicate poverty. Internationally, it was also responsive to the ideals and actions as outlined in the International Conference on Population and Development (ICPD) PoA and also by extension the SDG 2030. The planned interventions in the 8th CP were relevant and met the needs and priorities of a wide range of stakeholders and target groups. These included strengthening the capacity of Regional government planning and management to generate, access, utilise and disseminate relevant data for purposes of planning and tracking progress in government policies.

The Population and Development component was relevant in that it helped bridge gaps of the inadequacy of data for decision-making which was cited by Federal and regional implementation partners in various interviews; the capacity gaps in evidence-based planning and use of data to influence decision-making and the lack of appreciation of statistics among decision-makers. Key informant and in-depth-interviews revealed that Ethiopian governments at various levels have appreciated the use of data for development planning, although there is a noticeable lack of technical skills and financial resources.

At the Federal level, the Central Statistical Agency and Population and Development Directorate are at the forefront of data generation and integration of population into national development respectively. The relevance of this component is captured in the statement by one of the stakeholders that "data is the lifeblood of any development planning" especially in the context of SDG Agenda 2030.

4.2 EFFECTIVENESS

Evaluation Question: To what extent have the interventions supported by UNFPA helped to increase access to and utilisation of quality maternal health and family planning services by women and girls of reproductive age in both development and humanitarian contexts? (ii) To what extent did programmes supported by UNFPA helped to increase access to and utilisation of quality, adolescent and youth-friendly SRHR, maternal health and family planning services in both development and humanitarian contexts?

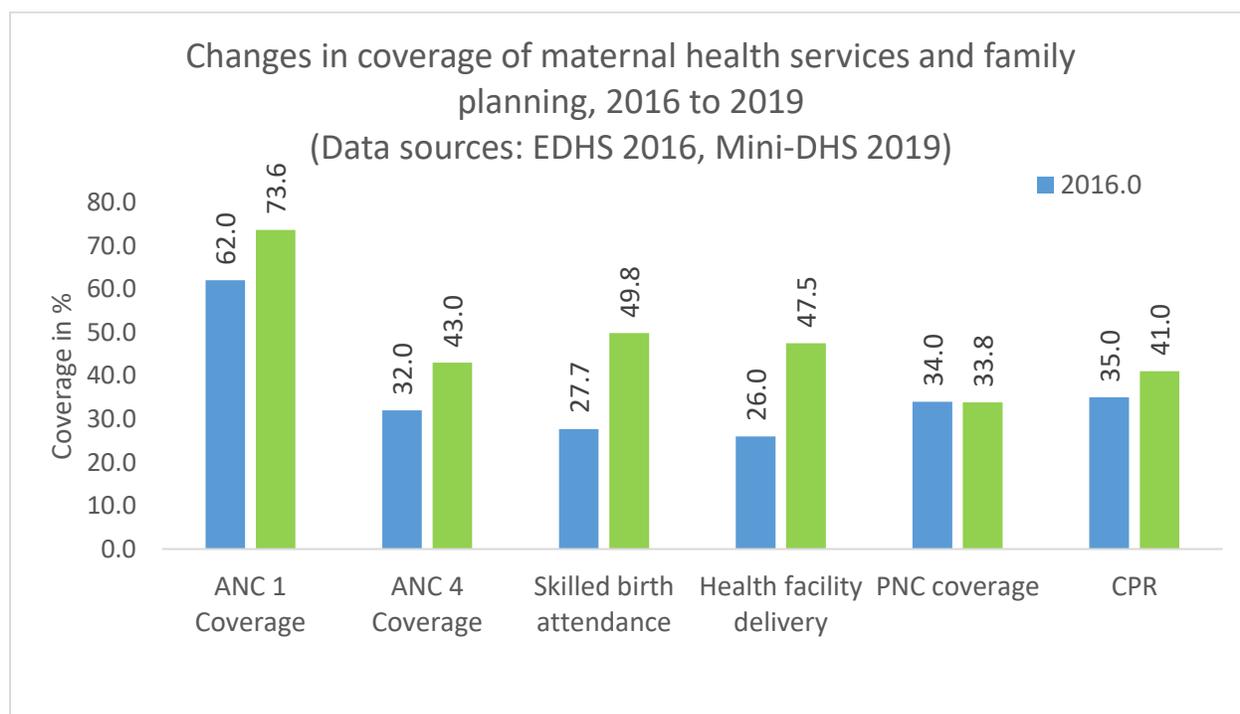
4.2.1 Sexual and Reproductive Health Component

Summary:

Ethiopia's 8th CP achieved improvements in SRH and AYD outcomes. A comparison of findings of the 2016 EDHS and the 2019 mini-EDHS showed that there have been noticeable improvements in access to and utilisation of SRH services including maternal health and family planning. Implementation of activities planned as part of SRH and AYD components of the 8th CP are on track; targets are already met for most output indicators a year ahead of schedule, indicating, on one hand, strong implementation efforts and strict compliance with annual work plans and on the other hand very conservative target setting. Evidence from different sources of data indicated there was a meaningful contribution from the 8th CP in the area of family planning and also maternal health. UNFPA's support has helped increase access, quality, demand, and utilisation of family planning and maternal health services. Engagement at the federal level has been acknowledged to have system-wide influences by securing an uninterrupted supply of family planning commodities, improved national policies, strategies, guidelines, and training support.

Maternal health and family planning indicators have shown dramatic changes during the period of UNFPA's 8th CP. Between 2016 and 2019, noticeable changes were observed in the utilisation of maternal health services including antenatal care, facility delivery, and skilled birth attendance. Similar changes were observed in the area of family planning. Between 2016 and 2019, the contraceptive prevalence rate increased from 35 percent to 41 percent (Figure 5).

Figure 5: Changes in coverage of maternal health services, 2016 – 2019



UNFPA's support helped increase demand for, quality, and utilisation of maternal health and family planning services. These contributions include 1) engagement (technical support as a member of technical working groups or other modalities) at the federal level in the development of strategies, guidelines, and training and 2) Specific interventions targeting operational woredas. During the 8th CP, UNFPA provided reproductive health commodities, including selected contraceptives and life-saving maternal health commodities worth of USD18.7 million⁷⁹. The family planning commodities distributed between 2016 and 2019 equate to 4.7 million couple years of protection (CYP) of which 98 per cent is from implants.

Document reviews and stakeholder interviews revealed that the 8th CP strengthened national capacity to increase demand for and availability of family planning services, including RH commodities. Support provided for the national family planning programme ensured availability of quality family planning commodities, strengthened the supply chain system, and expanded service delivery points. During the 8th CP, UNFPA provided technical and financial support for the acquisition and distribution of family planning (mainly long-acting FP methods) and other RH commodities (mostly life-saving drugs like Oxytocin and Magnesium Sulphate). The public sector has been the main provider of modern contraceptives in Ethiopia. MoH partnered with UNFPA for the acquisition of contraceptives (particularly IUCD kits) and associated medical supplies to equip 1,600 health posts using government-controlled/ pooled funds. The CO remained a trusted partner of government in supporting the government to undergo procurement and timely delivery of quality-assured and cost-effective RH commodities.

UNFPA's engagement was also optimal in monitoring progress of Ethiopia towards its commitments on family planning and mobilizing other partners for securing funds for family planning commodities. The 8th CP has also collaborated with the pharmaceuticals supply and regulatory agencies of the country to strengthen the pharmaceutical supply chain system and its regulatory mechanisms. Support for pre-service education in the area of pharmaceutical logistics management system was also provided to develop human capacity in the area. UNFPA provided training and other technical support to enhance the capacity of the Ethiopian Pharmaceutical Supply Agency (EPSA) – a government agency responsible for procurement and distribution of health commodities mainly for the public sector – in the areas of procurement management and costing of supply chain operations. UNFPA's support for the expansion of family planning service delivery points during the 8th CP focused on training of Health Extension Workers (HEWs) on long-acting reversible contraceptive methods. About 21,329 level 4 HEWs were trained with UNFPA's support on the provision of Long-Acting Reversible Contraception (LARC) allowing extension of LARC services to the health post level.

Progress towards output level targets of the 8th CP, in general, has been good for most of the SRH indicators. Stakeholders' interviews and document reviews showed that over the past four years, the programme achieved more than 80 percent of its five-year targets for seven of the nine output indicators. Coverage of MDSR reporting, availability of services including EmONC and availability of modern contraceptives among target health facilities have had very good progress, sometimes passing the target set for the whole period of the programme. Relatively low achievement was recorded for the training of Health Extension Workers on LARC. So far, 21,329 (59.2%) of the targeted 36,000 HEWs were training on

⁷⁹ UNFPA Programme Data on RHCS

LAFP methods during the programme’s lifetime. The main reason for this underachievement, according to a programme analyst, was an expansion in the content of training that affected training duration and thus the total number of trainees. Relatively lower progress was observed on availability of life-saving maternal/RH medicines among secondary service delivery points and number of HEWs trained on human rights-based family planning services with progress levels of 79 percent and 59 percent, respectively (See Table 8).

Table 8: Progress of the 8th Country Program of UNFPA on SRH output indicators⁸⁰

Indicator	8 th CP Target for 2020	Achievement (2016 - 2019)	Progress in % by 2019 ⁸¹
Number of health facilities reporting on MDSR	125	150	120
Percent of SDPs offering modern contraceptives	85	98.1	115
Number of health facilities providing EmONC	108	105	97
Number of fistula repairs with support from UNFPA	2000	1840	92
Implementation rate of MISIP indicators	45	40	89
Number of HEWs able to support human rights-based FP services	36000	21329	59
Percent of SDPs with life-saving maternal/RH medicines			
Primary	60	57.6	96
Secondary	100	79.1	79
Tertiary	100	83.3	83

While engagement at the federal level has been acknowledged to have brought nation-wide influences, specific interventions targeting specific geographic areas (operational woredas) were commonly reported as effective but too small in coverage to bring about large-scale impact. During the 8th CP, UNFPA supported different SRH interventions in eight regions and one city administration. However, coverage of woredas within each region was low; specific SRH programmes reached about 3 to 9 percent of the total woredas in the country. Furthermore, only small portions of the population and health facilities in these target woredas were supported (See Table 9).

Table 9: Number of UNFPA 8th CP operational woredas by region and SRH programme area

Region	Number of operational woredas ⁸² by SRH programme area				
	EmONC	MDSR	Cervical Ca	Fistula ⁸³	FP
Oromiya	21	29	14	2	
SNNP	8	17	12	1	21
Amhara	8	8	8	8	

⁸⁰ UNFPA CO Annual Reports

⁸¹ Progress represents what percent of the target has been achieved. Progress above 100% reflects achievement of more than what was targeted.

⁸² Note: This table does not reflect programme coverage through federal/region level support

⁸³ Fistula treatment centre was established in three universities. Interventions at woreda level include support for case identification and referral to these centres.

Tigray	7	7	7		
Gambella	6	6	6	6	6
Afar	3	3	3		
Beni-Gum	7		7	7	7
Somali	9				9
Addis Ababa	2	2	2		2
Total	71	72	59	24	45

There is agreement among stakeholders in different regions and across all levels of the health system regarding the positive outcomes of support provided through the 8th CP. Table 9 provides a summary of outcomes consistently reported by interviewed stakeholders.

Table 10: Outcomes consistently reported by interviewed stakeholders by SRH programme area

Programmes in UNFPA operational woredas	Results consistently reported by stakeholders
EmONC	Trainings and donation of equipment and supplies enabled beneficiary health facilities to routinely provide EmONC services leading to comprehensive services at health centres; avoiding unnecessary referrals; and increased utilisation of maternal health services.
MDSR	Supported health centres routinely review possible maternal deaths (both community and health facility deaths) and initiate quality improvement processes to address preventable causes of maternal mortality. Trainings on MDSR in pre-service settings allowed reaching a wider target area. An in-depth analysis of MDSR data was also supported at central and regional levels (one region). Maternity waiting homes furnished with support from UNFPA allowed mothers from far places to stay close to a health centre during their last weeks of pregnancy leading to increased utilisation of health facility delivery and postnatal care.
Cervical Cancer	Trainings provided on cervical cancer screening, diagnosis, and treatment allowed most health facilities to initiate screening programmes. Also, demand creation was supported by mass media messages.
Fistula	Support for identification and management of fistula cases by building the capacity of health workers and providing logistical support for patients during referral improved case detection and treatment. The establishment of additional fistula treatment centres contributed to addressing physical barriers to treatment centres.
Family planning	Training on long-term family planning methods provided to HEWs allowed a fast expansion of service delivery points providing alternative contraceptive methods at the lowest level of the health system. This has positively affected family planning utilisation as well as clients' satisfaction with the availability of method choice.

Programmes in UNFPA operational woredas	Results consistently reported by stakeholders
Federal and regional level engagement	<p>Family planning</p> <p>UNFPA’s financial and technical support on family planning/RH commodities allowed ensuring uninterrupted availability of quality-assured family planning/RH commodities. None of the health centres visited reported a shortage of family planning commodities. During the 8th CP, UNFPA partnered with the MoH for the procurement of family planning and other RH commodities, financing source, and coordinator of actors for better mobilization of resources for family planning/RH commodities.</p> <p>Maternal Health</p> <p>Involvement of UNFPA in different technical working groups and task forces has been instrumental in the development and adoption of national and sub-national strategies and guidelines on maternal health contributing to the quality of care at a national scale.</p> <p>Support for pre-service education in the areas of, midwifery/obstetric and anaesthesia skills contributed to staffing health centres and hospitals with more skilled personnel leading to provision of better care to mothers and newborns. Mentoring and professional development activities are being provided through professional associations.</p>

Two important good practices were identified in the area of maternal health: 1) the use of maternity waiting homes to address challenges in the accessibility of health facility delivery service and 2) mentorship.

Catchment-based mentoring for capacity-building on BEmONC

Health Centres in Gambella were not regularly providing BEmONC services. As a result, there were several unnecessary referrals from health centres to Gambella Hospital creating inconvenience to mothers and high client load on the only hospital of the region. Limited capacity and self-efficacy of midwives in health centres was the primary reason for high referral of maternity cases from health centres to the hospital. Supported by UNFPA, five senior midwives from Gambella Hospital rotate to ten catchment health centres to build the capacity of health centre staffs on BEmONC services. Senior management from the Regional Health Bureau and the hospital monitored the programme. Catchment health centre staff acknowledged this mentorship support. Interviews with the hospital team showed that the mentorship programme minimized unnecessary referrals, improved timeliness of referrals, and facilitated provision of pre-referral care for mothers with pregnancy and childbirth complications. Motivating the mentees was a challenge to the programme.

Maternity waiting homes to address barriers in the accessibility of health facility delivery

Despite the expansion of health centres, physical access is still a challenge leading to home deliveries among rural women. Distance, physical barriers, and lack of transportation services in rural areas discourage mothers and their families from considering health facilities as a place of birth. As part of its support to MDSR, particularly with the response aspect, UNFPA supported health centres in its operational areas in the establishment of maternity waiting homes. Most of the supported maternity waiting homes were constructed through community contributions and managed by health centres. UNFPA provided equipment and furniture support to make the waiting homes functional. As described in documents⁸⁴ and mentioned by key informants, maternity waiting homes helped mothers from far places to stay close to a health facility during their final weeks of pregnancy. Also, the homes created opportunities for women to learn about different health topics during their stay.

4.2.2 Adolescents and Youth Development Component

Summary:

Implementation of activities planned as part of AYD components of the 8th CP are either on track or ahead of schedule. The 8th CP supported the development of national policy and strategy documents, guidelines, and provision of training in different areas relevant to AYD, including youth participation, HIV prevention and control, and SRH. Awareness creation and advocacy sessions during the celebration of national and international days have been reported effective in reaching large numbers of relevant actors even though the effectiveness of those events has not been adequately studied. Youth-friendly service centres and youth centres supported through the 8th CP are mostly equipped up to national standards. Supporting both youth centres and school clubs allowed the 8th CP to reach both in-school and out-of-school adolescents and youth in UNFPA operational woredas. Low utilisation of some youth centres, lack of waiting area and work overload among YFSCs because of integration of comprehensive OPD services, may limit the rate of contact of adolescents and youth with UNFPA supported facilities and utilisation of contacts for SRH information and service provision.

The 8th CP of UNFPA reached young people in different situations with SRH messages and services through different strategies including peer education, life skills education⁸⁵, mini-media clubs, and information and service delivery through selected youth centres and YFSCs. The 8th CP has also supported initiatives to integrate SRH with school and university curricula. Schools were provided with dignity kits and other support required establishing and running dignity rooms allowing female students to attend their classes comfortably during their menstrual periods. The programme also supported youth organizations to engage in advocacy and decision-making on matters that affect their sexual and reproductive health and rights. The programme provided training for facilitators/trainers and donated equipment for school clubs and youth centres to reach young people with SRH messages and services, and encouraging their participation in provision of services. Youth associations were also supported through project management trainings, holding experience-sharing visits, conducting different studies, and providing

⁸⁴ UNFPA, 2018. Good practices and lessons learnt from UNFPA supported maternity waiting homes in Ethiopia.

⁸⁵ Life skills education includes comprehensive sexual education

supervisory support. Targets of AYD activities also included adolescents and youth in refugee camps, university students, female sex workers and adolescents living with HIV.

The 8th CP also supported health centres in establishing and running YFSCs dedicated for service provision to adolescents and youth. Support to these centres included furniture, audio-visual equipment, and trainings for service providers. Sexual and reproductive health commodities were donated to YFSCs to ensure uninterrupted supply. Progress by the 6th month of the fourth year of the CP indicated that the programme supported provision of SRH services for 99,521 (76.6% of target for 2020) young people with SRH services. Also, 32,225 (80.6% of target) additional adolescents and youth received life skills education. There was a high achievement in the area of training health care providers on YFSRHS. More than the planned numbers of health workers were trained in this area. However, progress in increasing facilities providing the national Minimum standard AYSRH package is relatively slower (78.9% by mid-2019) (Table 11).

Table 11: Progress of the 8th Country Programme of UNFPA on AYD output indicators

Indicator	8th CP Target for 2020	Achievement (2016 - 2019)	Progress in % by 2019
Number of young people who receive SRH services with UNFPA support	130,000	99,521	76.6
Number of young people equipped with life skills	40,000	32,225	80.6
Number of health workers with knowledge and skills to provide YFSRHS	500	704	140.8
% Of facilities providing the national Minimum standard AYSRH package	95	75	78.9

Life skill education in different settings is reported to be effective for providing SRH related information to adolescents and youth who otherwise would have been marginalized. Among the most commonly reported positive outcomes were increased confidence and school performance of female students and increased utilisation of SRH services including family planning and condoms. School clubs supported with mini-media equipment and trainings were effective in reaching large numbers of students with important SRH information. The support in this area allowed to maximally utilize capacities of students and their teachers in the regular provision of SRH information to school communities. Support provided to youth centres also created opportunities for adolescents and youth to spend their spare time in safer recreational activities that include a library, in-door and out-door games in settings where there are high possibilities for exposure to written or spoken SRH messages.

Youth centres located in convenient places and actively providing recreational activities attract adolescents and youth. UNFPA's support in visited youth centres was the primary source of materials required for these recreational activities (in-door and out-door games). Media instruments donated for youth centres created the potential for transmission of SRH messages to youth centre users. Mini-media support to schools has also led to self-sustained HIV/SRH information dissemination regularly.

Youth-friendly service centres visited during fieldwork provide comprehensive outpatient service for all clients in the age range of 10 to 24. All adolescents and youth are directed to these centres from medical record rooms irrespective of their reason for facility visit. In general, these age-specific service centres have created opportunities for adolescents and youth to experience shorter waiting time compared to general outpatient departments. SRH services were available in YFSCs in all visited health centres. Integrating all outpatient services for 10-24 years old adolescents and youth (including treatment of any illness) with YFSCs increases exposure of adolescents and youth to trained healthcare providers and improves confidentiality of SRH service provision to adolescents and youth. However, the inclusion of non-SRH services to these centres has also posed a threat to SRH service provision. Because most cases are coming for non-SRH services, attention given to SRH by health service providers gets diluted. There is a possibility that gradually the centres may become similar to other outpatient units in their functions.

UNFPA's support to HIV prevention and control efforts at Federal and operational Woreda levels were acknowledged for addressing critical components including support for identification of key populations and planning and implementation of HIV prevention interventions for identified priority populations. Technical and financial support provided for the development of the National HIV Prevention Road Map, identification of key populations, development of minimum packages for key populations, generation of evidence, and review of performance were among the major contributions of the 8th CP for HIV prevention and control among adolescents and youth.

Challenges of the AYD component of the 8th CP supporting youth centres were mostly related to sub-optimal utilisation of supported facilities. Opportunities created by adolescents and youth gathering in youth centres have not been adequately utilized for the provision of SRH messages and services because of limited linkage between youth centres and SRH service providers. Some youth centres are also located at inaccessible locations resulting in non-use of available facilities despite fulfilment of furniture and equipment through UNFPA's financial support. In addition to the generally sub-optimal utilisation, utilisation by girls is very low. Youth centres, targets for several adolescent and youth development activities, mostly serve more boys than girls. Interventions targeting youth centres are unlikely to directly benefit girls. There were no deliberate efforts to increase utilisation of these centres by youth girls. The common challenges of YFSCs include limitations in the comprehensiveness of SRH services at YFSCs leading to high referral rates to other units and other facilities and diversion of attention from SRH related services to general clinical services. Not all YFSCs had in-door and out-door recreational facilities. Whenever available, recreational facilities had limited accessibility for youth visiting the centres due to reasons including a shortage of space for donated equipment (e.g. Television stored in examination rooms because there was no secure waiting area). The limited implementing capacity of government IPs and their district offices poses the other category of challenges for the AYD component of the 8th CP. As a result, planning, implementation, and monitoring (activities that are expected from IPs) are compromised. There is a need for either more technical support at lower levels or more capacity- building activities targeting the IPs themselves.

4.2.3 Gender Equality and Women's Empowerment Component

Summary:

The 8th CP contributed to the effort of the government of Ethiopia to accelerate gender equality and women empowerment. At the different administrative structures, UNFPA works with government bodies, CSOs, and grass-root structures on prevention of GBV including HTPs, protection of rights and provision of integrated services to survivors. At the federal level UNFPA is engaged in a technical working group at ministerial level to strengthen national coordination efforts; support evidence-based interventions; and developing national level reports that the Government of Ethiopia committed to achieving in different platforms. At the regional level, capacity-building of relevant stakeholders and communities to prevent GBV including HTPs and coordination of activities of different stakeholders are indicated as achievements. UNFPA also provides direct services to survivors and supported the scaling up of Safe Houses and the establishment of One Stop Centres in public health centres. Gender is mainstreamed in the 8th CP programme components. The programme has created a mass of community structures that advocate against GBV and harmful traditional practices [HTPs].

Document reviews and stakeholder interviews revealed that this component contributes to accelerating the effort of the Government of Ethiopia to achieve gender equality and women empowerment. UNFPA CO played a great role in promoting and addressing the issues of gender equality and women empowerment at federal, regional and Woreda levels by employing different strategies. These strategies include accelerating abandonment of FGM and ending child marriage through UNFPA-UNICEF Joint Programme; promoting gender equality and women empowerment involving six UN Agencies: UNFPA, UNICEF, UNDP, UNESCO, ILO, and UN Women; prevention and management of GBV; child marriage and FGM through funding by Swedish UN Association; KNE, GAC and Italian Cooperation economic and social empowerment and protection of women and girls from HTPS and Gender-Based Violence in Emergency and host community and data management⁸⁶. Though it cannot be said that the achievements are purely credited to UNFPA, it is safe to conclude that UNFPA played a catalytic role in the process as well as introducing new initiatives that can be scaled up and replicated by government institutions, CSOs and the different grass-root structures. Since gender equality has multiple dimensions and cannot be addressed by one institution, UNFPA collaborates with other like-minded organizations to accelerate change and achieve its intended goal.

⁸⁶ Progress Report on Implementation of the 8thCP (1 January to 30 June 2019)

Table 12: Summary of the GEWE programme component outcome, indicators and achievements.

Indicator	Baseline (2016)	Targets (2020)	Achievement	Percentage Achieved vs. Target
Number of identified gender-based violence survivors who received services per national protocol	3900	10,000	5,227	52.3%
Percentage of health facilities in humanitarian settings with post-rape kits and other clinical commodities for management of sexual violence	30	45	35	77.8%

UNFPA’s interventions at the different administrative levels are different based on the programme component and the intended output. The GEWE interventions at the different levels are categorized into three, namely: prevention, protection and provision of services.

Federal level engagement

At the federal level, the CO engaged in high-level advocacy and coordination activities to support the effort of the government to accelerate the progress made concerning gender equality and women empowerment as stipulated in the national, regional and international policy frameworks. Among the most noticeable achievements is the support UNFPA provided to the technical working group at ministerial level to strengthen national coordination efforts; support evidence-based interventions⁸⁷, and develop national level reports that the Government of Ethiopia committed achieving in different platforms. The technical working group which works closely with the MoWCYA on gender thematic areas is indicated as a forum where issues related to gender equality and women empowerment are being dealt with at a national level and brought to the attention of the Federal government.

KIIs with government and NGO IPs showed that UNFPA provides support to strengthen national level coordination forums. An example repeatedly mentioned was the National Alliance to End FGM and CM. The alliance has members from government, UN agencies and CSO. While the Ministry is the chair, UNFPA was the co-chair during the establishment though the co-chairmanship is rotating. The respondents indicated that UNFPAs contribution in the alliance is very noticeable. It was also stated by the CO and the government IPs at federal level that UNFPA provided technical and financial support and was highly engaged in supporting the development of the *National Costed Roadmap to End Child Marriage and FGM/C* as well as its rollout and implementation that will accelerate the effort of the Federal Democratic Republic of Ethiopia to end early/child marriage and female genital mutilation/cutting.

⁸⁷ A major contribution and achievement is UNFPA’s support to include gender-based violence in the 2016 DHS with other like-minded UN agencies such as UN Women. UNFPA has also played a role and supported its further analysis as a member of the alliance.

Regional and Woreda level engagement

At regional levels, UNFPA engaged in capacity-building of relevant stakeholders and communities⁸⁸ to prevent gender-based violence and harmful traditional practices including FGM and CM. The intervention at the regional level also included the coordination of activities to minimize duplication of activities and maximize the use of scarce resources. Across all regions, the focus group discussion participants from BoWCYA indicated the Multi Sectorial Coordination of relevant government stakeholders as a great achievement.

Stakeholders also reported that UNFPA CO supported the prevention and protection of women and girls from GBV including HTPs, provision of direct services to GBV survivors, initiating innovative interventions and also scaling up of best practices. There is evidence of provision of services to survivors of GBV through local NGOs such as AWSAD⁸⁹ and APDA - Barbara May Maternity Hospital⁹⁰ and also through Regional Women Associations⁹¹. The establishment of One Stop Centres is another mode of engagement where direct services are provided to abused girls and women under one roof. UNFPA also provides health facilities in humanitarian settings with post-rape kits and other clinical commodities for the management of sexual violence.

Achievements

UNFPA has achieved a lot in terms of enhancing the capacity of targeted communities and relevant institutions to promote and protect the rights of women and girls, and provide services to survivors of HTP and SGBV targeting hotspot areas. Since gender equality and women empowerment is not an issue that can be addressed by one institution, the achievements are a collaborative effort of different organizations, community based structures as well as community members to meet the goals that the country has committed to achieve.

1. Prevention of SGBV and HTPs

Preventing GBV including HTPs requires the active participation of all stakeholders including community members and cannot be achieved by one institution. Hence UNFPA is playing its share to prevent GBV and HTPs in the targeted communities. Stakeholders interviewed reported that several capacity-building initiatives were implemented to ensure that adolescent girls and women enjoy the rights that are stipulated in different international, national and regional frameworks. These include the establishment of Women and Girl's Friendly Spaces in a humanitarian setting and development programmes; establishing and supporting family and community dialogue and community conversations at grass-root level; establishing and strengthening different committees to combat GBV and HTPs; supporting and

⁸⁸ 19,000 community members (including 7,500 female) were educated about the legal implications of FGM in Afar and SNNP regions. In addition, Training of Trainers (TOT) was conducted for 110 community leaders by the Bureau of Women, and Children Affairs in SNNPR. The community leaders consequently reached 81,000 community members (including 21,000 female) through outreach activities in 110 kebeles of four target woredas (districts) in SNNPR (Esara, Mereko, Dalocha and Dasenech districts). Training was also given for 200 community counsellors in SNNPR on psychosocial mentoring, coaching and counselling of survivors. Accordingly, the counsellors have reached 2300 survivors and among this figure, around 1200 were FGM survivors, 98 were rape, child marriage and abduction whereas the rest were survivors of polygamy and divorce.

⁸⁹ AWSAD is a local NGO operating in many regions and providing Safe Houses for girls and women who are survivors of GBV.

⁹⁰ APDA- Barbra May Maternity Hospital is located in Afar region Mille Woreda and provides medical services to repair infibulation, obstructed urine and urinary infection, and uterine prolapses for FGM survivors

⁹¹ Tigray Women Association for example supports the Safe House in Mekele to provide holistic services for girls and women who are survivors of gender-based violence including FGM and CM.

facilitating school-based interventions, and; supporting universities to combat SGBV by including gender issues in their formal education curriculum and develop Code of Conduct on Sexual Harassment. At these fora, issues bordering on gender quality, women's empowerment and rights are discussed. Beneficiaries are taught how to prevent SGBV and HTPs in the targeted Woredas.

Women and Girl's Friendly Spaces in humanitarian setting and development programmes: The Safe Spaces both in humanitarian and development settings has contributed a lot to facilitate the dissemination of information and raise the awareness of participants on different forms of GBV including HTPs, SRH, family planning and HIV/AIDS. It also created an opportunity for adolescent girls and women to receive training on financial literacy and economic empowerment through cash support⁹². The Safe Spaces provide opportunities for girls and women to fight the violation of their rights in groups rather than trying to address the problem individually. Safe Spaces also helped adolescent girls and women to prevent GBV including HTPs and challenge the existing socio-cultural norms. Beyond the discussions, it also created a chance for women and adolescent girls to report violations of their and their peers right when it occurs.

Community Conversation/Dialogue: Community conversation or dialogue which is being carried out in the local communities using the community dialogue manual, provides an opportunity for adolescent girls and women to participate and express their needs and concerns as well as come up with a viable solution to their problems.⁹³ It was also reported during the KIIs, IIs and FGDs, that the participation of boys and men in the dialogue contributed to the achievement of the objective of the programme. Trainings were also provided to 600 men to build their capacity on how to prevent and report child marriage, SGBV, FGM and other HCP cases. UNFPA also supported the establishment of Men Development Groups (MDGs)⁹⁴. It was also highly stressed that the role of influential people in the community including clan and religious leaders in the discussion has contributed a lot in preventing and stopping FGM and CM. In addition to engaging religious leaders in the prevention activities, faith-based organizations are also highly engaged in the fight against CM and FGM.

Establishing and supporting Anti-HTP committees; Anti GBV Watch Group and Steering Committees at Woreda and Community levels: Stakeholder interviews indicated that capacity-building of community structures such as Anti-HTP committees; and establishing committees to combat FGM and CM at community level with the involvement of relevant government structures and influential people including traditional birth attendants has made a significant contribution in preventing FGM and CM⁹⁵. Communities

⁹² Detailed achievement of UNFPA in the 8th CP is elaborated in the Donor Report on Progress of the 2016-2020 CP (as at 31st December 2018) and Progress Report on Implementation of the 8th CP (1 January to 30 June 2019).

⁹³ More than 76,920 individuals (41,640 men and 35280 women) through community dialogues and an additional 382,500 individuals through regular outreach programmes are reached through the community dialogue participants as part of the efforts to widely disseminate the learnings in an organized manner. About 25,560 youth and adolescents aged 15-24 years were engaged in dialogues to change their attitudes to support the elimination 25560 youth and adolescents aged 15-24 years were engaged in dialogues to change their attitudes to support the elimination of FGM, and enable them to champion social norm changes in their respective communities.

⁹⁴ It was also reported that 18,780 women and girls and 2740 men and boys in humanitarian settings were involved in GBV prevention and risk mitigation community dialogues.

⁹⁵ Seven hundred women development groups (12500 members) have been supported with technical and material supports, which have strengthened their leading role in fighting against GBV and HTPS including child marriage. Accordingly, community-based structures, women development groups, anti-HTP committees and girls clubs have managed to cancel more than 2463 arranged FGM cases.

were also able to establish Watch Groups to make sure that no child is being married and no girl suffer from FGM/C⁹⁶. In total, through the community-based structures, women development groups, anti-HTP committees and girls clubs more than 2,823 arranged FGM cases were stopped and 10 former circumcisers have stopped the practice and become CC facilitators⁹⁷. The outcome of these community initiatives is that *“everyone in our community is aware of the consequence of CM and FGM on the overall wellbeing of not only women but also the family and the community”*. One outcome of these community-based initiatives is that local communities have declared to end CM and FGM in their communities.

A total of 800 and 259 communities have made public declarations to end FGM and CM, respectively (Table 13). Stakeholders who participated in the evaluation also reported that many communities have developed bylaws to prevent and stop the incidence of child marriage and FGM through social sanctions⁹⁸ to maintain the observed change within their communities⁹⁹.

Table 13: Number of communities that have made public declarations against FGM and CM

Output Indicators	Baseline/2016	Target	Achieved	
	July 2016	July 2020	June 2019	%
Number of communities that have made public declarations against female genital mutilation and child marriage	400 [FGM]	890	800	90%
	156 [ECM]	382	259	68%

Source: Progress Report SIDA Report June 2019

School-based interventions: Among the noticeable achievements of UNFPA’s prevention effort is the school-based intervention. In-depth interviews revealed that these interventions have enabled many girls to attend classes regularly and for school going girls and boys to get information on GBV/HTPs and other life skills¹⁰⁰. UNFPA’s also includes capacitating the school mini media and school libraries and supplying dignity kits for school going girls. Dignity materials have improved not only their school attendance but also made them aware that these materials are normally used.

Higher Education Institutions (HEIs):

With the technical and financial support of UNFPA, a pilot project was initiated in Mekelle University to address gender equality and women empowerment and is being replicated in other Universities. The initiative is designed to prevent GBV by incorporating gender and SRH issues in the formal curriculum of

⁹⁶ The country reports for the 8th CP have indicated that up to June 2019, 146 communities established community surveillance mechanisms which monitor implementation of consensus built during community discussions.

⁹⁷ Donor Report on Progress of the 2016-2020 CP (as at 31st December 2018)

⁹⁸ An example indicated in Tigray is fining families money as stated in their bylaw when families are caught arranging CM.

⁹⁹ As a result of continuous community conversation (CC) sessions focusing on HTPs and the rights of girls and women, a total of 322,000 people in Afar, SNNP, Tigray and Amhara declared to abandon child marriage, FGM and other selected HTPs from their localities.

¹⁰⁰ The reports from UNFPA showed that from 1st January to 30th June 2019, life skills and GBV/HTP awareness sessions have been provided to 16,908 girls in 588 school clubs. Until December 2018, a total of 4,171 disadvantaged adolescent girls were also supported with educational materials and dignity kits to minimize school dropout and absenteeism. Empowering adolescent girls through building their social, educational, health and financial assets has been another important focus area of the CP. Accordingly, 15,240 adolescent girls have been reached through girls clubs established at community level and enabled 8,500 adolescent girls to regularly attend school through the provision of educational and sanitary materials.

universities. With the support of UNFPA, a code of conduct on sexual harassment is also developed and endorsed by the university. This support also extends to adolescent girls who have economic problems covering the cost of photocopies of course materials.

2. Provision of integrated services (multi-sectorial interventions) to survivors of GBV and HTPs

Providing holistic services through supporting and scaling up Safe Houses, and establishing One Stop Centres in public health centres has created a comfortable and safe environment for girls and women who are GBV survivors. UNFPA chose to engage in supporting the provision of direct services to survivors to make sure that their rights are respected and to make rehabilitative and legal aid services accessible. To provide these direct services to survivors, UNFPA collaborates with different stakeholders such as AWSAD, Women Association of Tigray and MLWDA in different regions and provides financial and technical support.

Safe Houses: Safe houses are shelters where survivors of GBV receive different kinds of rehabilitation services including legal aid without fear and with the support of professionals. KII with IPs, document reviews and site visits indicated the contribution of the Safe Houses in providing holistic services. Many girls and women survivors are rehabilitated and empowered and become self-reliant through the comprehensive services (medical, psychosocial and legal services) provided at the Safe Houses¹⁰¹. The provision of needs-based skill training also created opportunities for adolescent girls and women to be self-employed or secure employment opportunities with the collaboration of private business sectors. Safe Houses also created a conducive environment for the survivors to follow the legal process without threat and possible harm from the perpetrators.

During the 8th CP, the document reviews and KII with the CO and IPs revealed that UNFPA supported the scaling up of highly demanded Safe Houses from one to five¹⁰². AWSAD or Women Associations, such as the Women Association of Tigray and Mugegegwa Loka Women Development Association, run safe houses. This poses a challenge in terms of sustainability of the programme. Even though the existing Safe Houses are well managed and are providing quality services to GBV survivors including HTPs, sustainability will be difficult since it is dependent on donor funding.

One Stop Centres: One Stop Centres provide holistic services such as psychosocial, medical and legal services under one roof in public health facilities. This is to make sure that girls and women do not face secondary traumatization when they report any abuse to the police, medical personnel, and the public prosecutor. Hence having all the stakeholders under one roof and reporting the case with the support of a psychologist or social worker is beneficial for the survivor especially when they are children. Stakeholder interviews indicated that the direct services provided for survivors have made a significant change in the lives of many adolescent girls and women. The support of UNFPA in establishing five One Stop Centres is

¹⁰¹ UNFPA supported five safe houses (Hawassa, Assosa and Gilgelgibe) that provide comprehensive services (shelter, meal, psycho-social support, medical, skill trainings, legal follow-up, and so on) for 1843 (1252 women & girls and 591 children) survivors of violence.

¹⁰² 894 SGBV survivors benefited from the Safe Houses. New Safe Houses are located in Dessie Town, Amhara Region and Mekelle Town in Tigray region and the Safe Houses are the first of its kind both in the Amhara and Tigray region which makes the total number of fully supported safe houses to be 4 including the two in Hawassa and Benisangul Gumuz.

also in line with the plan of the national strategic direction of establishing fifteen OSC in the country. A visit to one OSC, however, showed that there are not enough qualified personnel to handle the various aspects of services needed by an abused girl or women. Regardless of the shortcomings of the intervention, UNFPA was able to achieve a lot during the evaluation period as indicated in the table below.

Table 14: GBV survivors who have received direct services

Output Indicators	Baseline/2016	Target	Achieved	
	July 2016	July 2020	June 2019	% Achieved vs. Target
Number of identified gender-based violence survivors who received services per national protocol	3,900	10,000	5,544	55.44%
Percentage of health facilities in humanitarian settings with post-rape kits and other clinical commodities for management of sexual violence	30	45	48	120%

Source: Progress Report SIDA Report June 2019

More than 6,000 survivors (both women and girls) affected by FGM related issues such as infibulation, obstructed urine and urinary infection, uterine prolapses have been repaired, and fistula survivors have been treated, counselled, and trained¹⁰³. UNFPA during the same period also supported health facilities to be at the forefront in creating demand for service uptake. Eighty-one health extension workers and 416 health development armies from 31 Kebeles (6 urban, 25 rural)¹⁰⁴ were trained as frontline outreach agents in creating demand for service uptake. This is also an indication of the integration of gender issues with sexual and reproductive health components.

3. Protection of the rights of girls and women whose rights are violated

Protection of the rights of GBV survivors and HTPs is one of the intervention areas of UNFPA. Protecting the rights of girls and women whose rights are violated need a collaborated effort of law enforcement organs both at Federal and regional level as well as CSO working on the area of the protection of the rights of women and children. Hence UNFPA made an effort to work at federal as well as at regional level working with justice organs such as Federal Supreme Court - Child Justice Project Office (CJPO), Ethiopian Women Lawyers Association (EWLA) and law enforcement bodies. Results have been achieved as indicated in UNFPA reports¹⁰⁵. It was also observed that there is collaboration between the IPs to achieve the objective of addressing the rights of survivors. This was indicated by the partnership between the Federal Supreme Court – Child Justice Project Office and EWLA to facilitate the protection of the rights of children and women who have been violated.

¹⁰³ APDA- Barbra May Maternity Hospital provided for 5540 women and girls affected by FGM/C and child marriage services which included the opening of scars and treatment of urinary infections

¹⁰⁴ Progress Report on Implementation of the 8th CP, (1 January to 30 June 2019)

¹⁰⁵ There is improved enforcement of the law. Special units established in the police and justice structures to deal with cases of violence and HTPs. Different capacity-building trainings provided for law enforcement bodies.

Though it is clear that provision of the direct services to survivors has a component of protecting the rights of girls and women, it is also clear that it should go beyond that. Protecting the rights of survivors mainly require the involvement of government especially law enforcement bodies to make sure that justice is served. With this regard, KIIs from the CO, BoWCYA and CSOs reported that intervention is challenging. According to the respondents the previous Charities and Societies Proclamation (CSP) that prohibited CSOs to work on issues related to rights, weak law enforcement, and slow legal processes pose a challenge for its effectiveness. Taking these challenges into consideration, UNFPA engaged in building the capacity of law enforcement, even though it is not as intensive as the other capacity-building programmes. For example from 1st January to 30th June 2019, only 98 law enforcement bodies¹⁰⁶ participated in the capacity-building with the assumption that it will lead to increased understanding of SGBV/HTPs and consequently to the respect of the rights of survivors.

Gender mainstreaming: The promotion of gender equality and women empowerment being the central principle of UNFPAs work is both a key programmatic area for UNFPA and also a cross-cutting issue that influence its interventions in ensuring all services are provided in a gender-responsive manner and promoting the collection and use of gender-disaggregated data to enable identification of the specific needs of women and girls.¹⁰⁷ KII with the CO as well as the reviewed documents revealed that gender equality and women’s empowerment has been mainstreamed in the CP in general. The SRH and AYD and the humanitarian programmes have gender components that directly address the needs and concerns of adolescent girls and women, as they are the most vulnerable segments of society. When a programme is designed there is always a discussion within the CO to make sure that the programme has mainstreamed gender. From the document review, it was also possible to know that humanitarian interventions also focus on mainstreaming gender and addressing issues related to girls and women since they are most vulnerable. But it was observed during the data collection that it is not always possible to get gender-disaggregated data.

Challenges encountered: UNFPA is delivering its responsibility and played its role in protecting and promoting the rights of women and girls and protects them from GBV including HTPs. Though UNFPA achieved a lot as indicated above taking into account its mandate and the available financial and human resources, some challenges were identified in the areas of prevention, provision and protection. But the challenges should be considered vis-a-vis the existing economic, social and political context of the country.

1. Prevention of SGBV and HTPs

There is a lack of evidence whether the interventions address gender norms (socio-cultural rules) and gender roles (socially constructed roles, behaviours, activities and attributes that society considers appropriate for girls and women). Regardless of the intensive capacity-building and awareness-raising programmes there seem to be situations where the community practice CM and FGM using other means. There is a challenge to measure behavioural change. As indicated by key informants there are cases where community members from the target Woredas who have participated in the community conversation or

¹⁰⁶ Donor Report on Progress of the 2016-2020 CP (as at 31st December 2018)

¹⁰⁷ United Nations Population Fund, UNFPA Strategic Plan 2014-2017

dialogue go to the neighbouring Woredas to carry out FGM or marry off young girls. This is an indication that though they have the information, due to the dominant cultural norms, people tend to practice it. This requires an intensive programme that goes beyond awareness and dialogue that also focus on making sure that they are brought to the law enforcement bodies. For example, focus group discussions from Gambella indicated that it is not only the community members who marry off their young girls but also people who hold a position in government offices who practice it. This is posing a challenge to end CM because they contradict what they say in public and they practise it in their households. Many key informants and community members share this.

2. Provision of integrated services (multi-sectorial interventions) to survivors of GBV and HTPs

The One Stop Centres that are located in the health institutions are expected to provide medical, psychosocial and legal services to survivors and requires the collaboration and commitment of many government organizations. Different factors pose a challenge in providing holistic services like not enough skilled personnel and cooperation of stakeholders such as the police and prosecutors to handle the different aspects of services provided under one roof.

3. Protection of the rights of girls and women whose rights are violated

It was noticeable from the KII that there is weak government engagement when it comes to protecting the rights of survivors. Though the government has the mandate to protect the rights of all citizens, the effort exerted to protecting the rights and provision of services to survivors of SGBV and HTPs is weak. It seems that these were left to the CSOs and Women Associations. It was observable that the activities implemented through NGOs and Women Associations is more effective in terms of addressing the needs and concerns of adolescent girls and women than the formal government structures. This can be considered as a major challenge of the interventions.

4.2.4 Population and Development Programme

Evaluation Question: To what extent have the interventions supported by UNFPA in the field of population and development contributed to increased availability and utilisation of data and evidence at national and sub-national levels on population issues towards the ICPD agenda?

Summary:

The PD interventions have advanced the course of increasing data availability both at the Federal and Regional levels. At the Federal levels, the Ethiopian DHS 2016 and 2019 mini-reports have been produced. At Regional levels, IMIS has been established to provide data for regional planning in five out of six planned regions. Several resources (human, technical and logistics) have been invested towards census undertaking and other efforts at data generation and utilisation (CSA) and integration and advocacy (Population and Development Directorate of Planning and Development Commission). However, despite all arrangements for the 4th PHC being completed, it has been postponed three times, thereby affecting the data accessibility in the country. Thus conducting the census, improving the accessibility to IMIS and its functionality, and implementing population and development advocacy is an important step.

Data for development & advocacy including in humanitarian Programme:

Output 6 of UNFPA 8th CP relates to outcome 4 of the UNFPA Strategic Plan (2014-2017, which is on population dynamics. The support provided to the preparation and analysis of censuses and other

population-based surveys is a critical means of ensuring that women, adolescents, and youth are at the centre of sustainable development policies and that programmes have the evidence needed to improve SRH services. In addition to the support provided for the preparation and analysis of censuses and other population-based surveys (in the framework of generation and utilisation of data), UNFPA works at country level to ensure that programmes, policies and strategies are robustly evidence-based and informed by a thorough understanding of population issues such as migration, urbanization and ageing, the implications of the demographic dividend for national development, etc.

The Population and Housing census is the single most important source of demographic and socioeconomic data for the preparation of development policies, in monitoring national development plans and the achievement of the SDG Agenda 2030 indicators. The UNFPA CO jointly with other UN agencies and development partners provided support to the Government of Ethiopia in preparing to conduct the 4th Population and Housing Census. UNFPA and donors' support (through UNFPA) has been focused on enabling national technical and management capacities in the country to plan and implement a high-quality PHC following scientifically established and internationally recognised standards and procedures. UNFPA CO implemented several initiatives to ensure a quality, participatory and inclusive census. These initiatives include:

Development of a Comprehensive Plan Document and Communication Strategy for the Census:

In anticipation of a robust and high-quality census, UNFPA improved the preparations and the institutional capacity of the Central Statistics Agency (CSA) towards the fourth Ethiopian Population and Housing Census (EPHC) through the provision of financial and technical support. UNFPA CO has started the 4th Population and Housing Census starting from the planning stage by hiring a team of four international experts: a demographer as the Census Technical Adviser, a GIS/Cartography Technical Expert, data processing expert and specialist in advocacy and Resources Mobilization to develop a Comprehensive Plan Document for the census that will be used for advocacy, resource mobilisation and improve effectiveness and efficiency of the execution of preparatory activities, actual enumeration and post-enumeration activities, including the post enumeration survey. A communication and resource mobilization strategy were also developed to ensure the collaboration and support of relevant authorities and the general public both for the enumeration of the general population and the refugees.

Resource mobilization to support the census: UNFPA CO through its serial advocacy and consultative meetings with development partners also mobilized funding from the United Kingdom DFID, the European Union and the Netherlands Embassy. The DFID support is aimed at ensuring that a high-quality, accurate and robust census is conducted. The funding from the EU and the Netherlands was used to support the census of Refugees.

Technical Assistance for the Census: According to document reviews and key informant interviews with programme leads, the CO contributed in addressing the challenges of Central Statistical Agency (CSA) especially in the area of capacity development. Due to high staff attrition during the intercensal period (2007-2017), several gaps in the technical capacity of the Agency to conduct a census exist. To fill the gaps, UNFPA CO provided support for long-term and short-term technical assistance for the census hiring high-

level international experts (a Census Technical Advisor, a GIS expert and two national staff for census communication and process documentation). In terms of short-term support, UNFPA CO hired a data processing consultant to develop data processing strategy for the digital census and a post-enumeration consultant to train CSA staff and to assist in the development of PES data collection and matching tools.

In support of the digital census, UNFPA CO supported the procurement of various ICT materials to refurbish the CSA data centre and support the data transfer and the field digital data capture including servicers, solar power banks, printers, computers, air-conditioners etc. Technical capacity of 68 staff was strengthened through supporting their participation in training workshops on various subjects related to census undertaking such as data centre management involving data capturing, transfer and general data processing, PES implementation, GIS/Cartography as well as data analysis and dissemination.

UNFPA CO also supported the implementation of modern mapping methodology for census map production and actual enumeration, supporting and facilitating experience sharing of CSA management and technical team from Brazil and Management. The CO also facilitated and supported knowledge and experience-sharing visits of five (5) CSA staffs to the Institute of Geography and Statistics (IBGE) in Brazil in March 2017, and seven (7) staff to the Central Agency for Public Mobilization and Statistics (CAPMAS) in Egypt in December 2018 to gain experience in the planning and management of digital census.

South-South Cooperation: One of the strategic interventions for UNFPA CO's work in Ethiopia is in the involvement of South-South initiatives in its capacity development focus for the preparation of Census undertaking. There were numerous examples of South-South Cooperation in the form of support to national partners, especially the Central Statistical Agency to participate in capacity building of staff for the census undertaking. These opportunities were highly valued by the national stakeholders. UNFPA working closely with CSA to ensure that Ethiopian census is implemented in accordance with international standards and best practices supported and facilitated various SSTC initiatives. In February 2016, UNFPA in collaboration with ECA and AfDB organized a regional meeting on digital data capture for 2020 round of population and housing censuses in Africa. At the end of this workshop, the meeting participants, UNFPA, ECA and AfDB recommended to the Government of Ethiopia the use of handheld digital devices in the 2017 Population and Housing Census. The government of Ethiopia decided to undertake a fully digital census. In 2017, a visit to the Institute of Geography and Statistics (IBGE), Rio de Janeiro, Brazil led to the Government of Ethiopia to opt to implement a fully ICT – led census process (including mobile GIS technology and tablet-based enumeration for conducting the 2017 Population and Housing Census. As this is new for the CSA staff, it requires in-depth technical capacity building in choice of suitable devices. Because the Brazilian 2010 census is the international benchmark for digital census, CSA requested the support of UNFPA for the knowledge gathering and experience sharing visit to Institute of Geography and Statistics (IBGS), Brazil. The Brazilian Institute of Geography and Statistics (IBGE) implemented state of the art technology for EA demarcation for Urban and Rural areas. The overall focus of the study tour was for the CSA senior managers to understudy how Brazil has successfully utilized modern mapping methodology for Census Enumeration Area delineation and Census map production.

IBGE, Brazil, is a leading institution in the development and use of digital technologies in census implementation. Indeed the Brazillian 2010 Census is considered the international benchmark for digital

census implementation. IBGE has directly and indirectly supported several African countries to successfully implement their respective censuses using digital technologies, and has expressed commitment to similarly support Ethiopia/CSA. Therefore, it was considered a great opportunity for Ethiopia and CSA to tap into their body of knowledge and experience for the 2017 PHC and future statistical activities. A study visit to Office of Registrar General and Census India has jointly been planned with UNFPA Ethiopia Country Office to enable the senior management and experts of the CSA decide on the type of census data capturing methods for the upcoming Ethiopian population census. These initiatives contributed to the capacity of the CSA to conduct the thrice-postponed census exercise.

Integrated Management Information System (IMIS): IMIS - Integrated Management Information System is a collection of several statistical databases of various surveys and censuses conducted by the Central Statistics Agency and other Government Institutions like Ministries. The IMIS is a tool that has been developed to enable users to generate customised statistics that meet their individual needs in the form of frequencies, cross-tabulations, indicators, etc. The system enables the retrieval of tailor-made data (by way of the calculation of indicators, production of customized tables, and the generation of thematic maps at any administrative level) through direct access to different data sources including census, household sample surveys or administrative/routine service-based data. This project is a continuing process that shall incorporate more census and survey data over time. Stakeholder interviews [with CO staff and IPs] showed that UNFPA CO has helped the CSA to develop a functional IMIS both at National and 5 regional levels. Implementation of regional web-based Integrated Management Information System (IMIS) in the Amhara, Oromia, Tigray, Afar and SNNP regions (also uploaded on CSA's website) have been developed. These IMIS's are functional.

Capacity-building trainings and participation of technical and managerial staff in international conferences were supported by both the staff of the Vital Events Registration Agency (VERA) and the CSA. A statistical abstract of indicators for all sectors from 2008-2018 was also uploaded on the IMIS, on the CSA's website. The statistical abstract is expected to facilitate easier access to data by end-users. Census equipment for the implementation of the 2018 Ethiopian Population and Housing Census (EPHC), including servers, portable solar power banks, etc. were procured with UNFPA and DFID support.

Further data generation activity supported by the UNFPA involved support for seasonal assessments and risk profiling for vulnerability analysis and risk reduction interventions. This involves data generation among refugees and internally displaced people. In line with the SDGs theme of "leave no one behind, UNFPA CO supported the comprehensive enumeration of refugees under Asylum, Migration and Integration of Fund (AMIF) project funded by EU and the Dutch Ministry of Foreign Affairs. This is being implemented in collaboration with UNHCR/OCHA and Administration for Refugees and Returnees Affairs (ARRA).

Support for seasonal assessments and risk profiling for vulnerability analysis and risk reduction interventions is all about identifying regions and districts that are vulnerable to natural calamities to preposition prevention and emergency preparedness. The seasonal assessments that followed the occurrence of drought can identify the needs in the various sectors including the precarious

protection situation of vulnerable groups including women and children, persons with disabilities, the elderly, internally displaced persons etc. The various requirements including protection needs were subsequently highlighted in the 2016 Humanitarian Requirements Document¹⁰⁸.

Challenges

Data for development: Delays in census implementation resulted in an increase in costs (personnel, technology). The initial enumeration date (November 2017) was postponed three times (first to February 2018, then to November 2018 and to April 7, 2019). Whenever the government is ready for the census, most of the activities performed will be repeated to refresh memories and understanding. This has huge cost implications. Issues such as the disputed boundaries and the unexpectedly large number of IDPs due to political unrests in some parts of the country continue to have adverse effects on census preparations.

Advocacy and Policy Dialogue: The second flank of the population and development component is advocacy and policy dialogue. Several activities were implemented to promote advocacy and policy dialogue on population issues. These include: i) UNFPA support to the comprehensive assessment of the 1993 Population Policy; ii) support to undertake a study on 'Demographic Dynamics and Priority Population Issues in the Country' which will be instrumental in the formulation of a 15-year perspective development plan; and iii) support in the national assessment of the implementation of the Addis Ababa Declaration on Population and Development (AADPD+5) in the framework of the ICPD at 25.

UNFPA CO supported parliamentarians to participate in a workshop on 'From MDGs to SDGs: Challenges and Opportunities for Parliamentarians to enhance Reproductive Health and Family Planning'. This workshop was meant to provide space for parliamentarians to understand the transition from the MDGs to the SDGs and what they need to do to build and sustain the momentum for political will for SRHR within the context of the SDGs. UNFPA esteems and considers highly the role of parliamentarians in population and development issues in the country (as parliament is the highest legislative and policy-making body in any country and hence best placed to champion population issues, more especially in legislation and creation of awareness on Reproductive Health as a catalyst to the attainment of the SDGs and the ICPD Plan of Action). UNFPA also supported the dissemination of research on 'Taming the Youth Bulge'. The purpose of the research was to establish evidence on the trends and patterns of the youth segment of the Ethiopian population over time and identify the major challenges and opportunities of the increase in the youth population or referred to as the "youth bulge". The results were shared with policy and decision-makers at all levels. This promoted the importance of the demographic dividend as fuel for accelerating economic growth through radio messages.

The general challenges during the implementation of the programme output include: (i) Meagre attention paid to population matters at national level and low capacity of the Planning and Development

¹⁰⁸ For example, the "Belg" (one of the short rain seasons in Ethiopia covering February to May) Assessments that were conducted in June 2016 in six Regions (Afar, Amhara, Somali, Oromiya, SNNPR and Tigray) were able to show the existing situation in the assessed regions that helped in reviewing the 2016 HRD that was issued in Feb 2016. A protection analysis of the protection concerns that were captured during the "Belg" Assessments was done by the Protection Cluster to support efforts towards advocating protection response within the emergency context.

Commission to be on the driver's seat on population and development matters; (ii) Low capacity of Regional PD partners to implement planned activities (a case in point is SNNPR Region vis-à-vis the implementation of the PSA activity); (iii) Late disbursement of funds and subsequently the resultant late implementation of activities, leading to late reporting on the utilisation of funds (i.e., cases of high Operating Fund Account (OFA) balances); and (iv) bottleneck related to low administrative capacity (administrative finance personnel, etc.) hampering timely reporting of utilized funds and DCT modality of fund transfer

4.3 EFFICIENCY

Evaluation Question: (for all 4 components) To what extent has UNFPA made good use of its human, financial and technical resources as well as an appropriate combination of tools and approaches to pursue the achievements of CP outputs?

Summary:

Based on a desk review of financial documents, stakeholder interviews, review of a sample of annual work plans, annual reports, and the SRH/AJD component made good use of available resources – human, financial and technical. All the IPs subscribes to the Project Implementation Manual with which CO managed its staff, funds and technical resources. Strong government financial control systems along with strict compliance with PIM and annual work plans facilitated the use of resources from the CP only for agreed upon purposes. Funds are transferred to IPs only based on AWP. Overall budget utilisation, though it was sub-optimal during the early years, has also increased during the life of the 8th CP. UNFPA's administrative and financial procedures have been effective in facilitating compliance with AWP but the delay in transfer of funds was a common challenge affecting the quality of programme implementation because IPs had to rush implementation of programme activities during final months or weeks of the reporting period. A major challenge to the efficiency of the 8th CP arises from the intention to achieve large geographic coverage within the very narrow funding space. Support for interventions targeting operational woredas both in the areas of SRH and AJD is very thinly spread over wide geographic areas than what can potentially be supported meaningfully.

This section analyses the process and timeliness in developing Annual Work Plans and its effects in timely commencement of annual implementation, the quarterly release of funds to IPs, implementation rates for the CP resources and the efficiency check mechanisms used in the CP. According to various 8th CP documents and stakeholder interviews, once AWP are approved, resources are provided to each IP and operational area. Funds transferred to IPs are generally used reasonably and only to the purposes they are assigned for. The Project Implementation Manual¹⁰⁹ that relies on the government system for financial control has been frequently mentioned as a reason for strict compliance with AWP.

The CO follows the quarterly schedule for the release of funds to the partners. Funds are released to partners upon submission of quality and complete reports of the ending quarter and requests for the new quarter. The reports required in each quarter are: (i) quarterly progress report: work plan monitoring tool

¹⁰⁹ Projects Implementation Manual (PIM) is a joint effort of the Government of Ethiopia and UN Agencies in Ethiopia to guide the formulation and implementation of UN-assisted programmes under the UNDAF. First published in 2017.

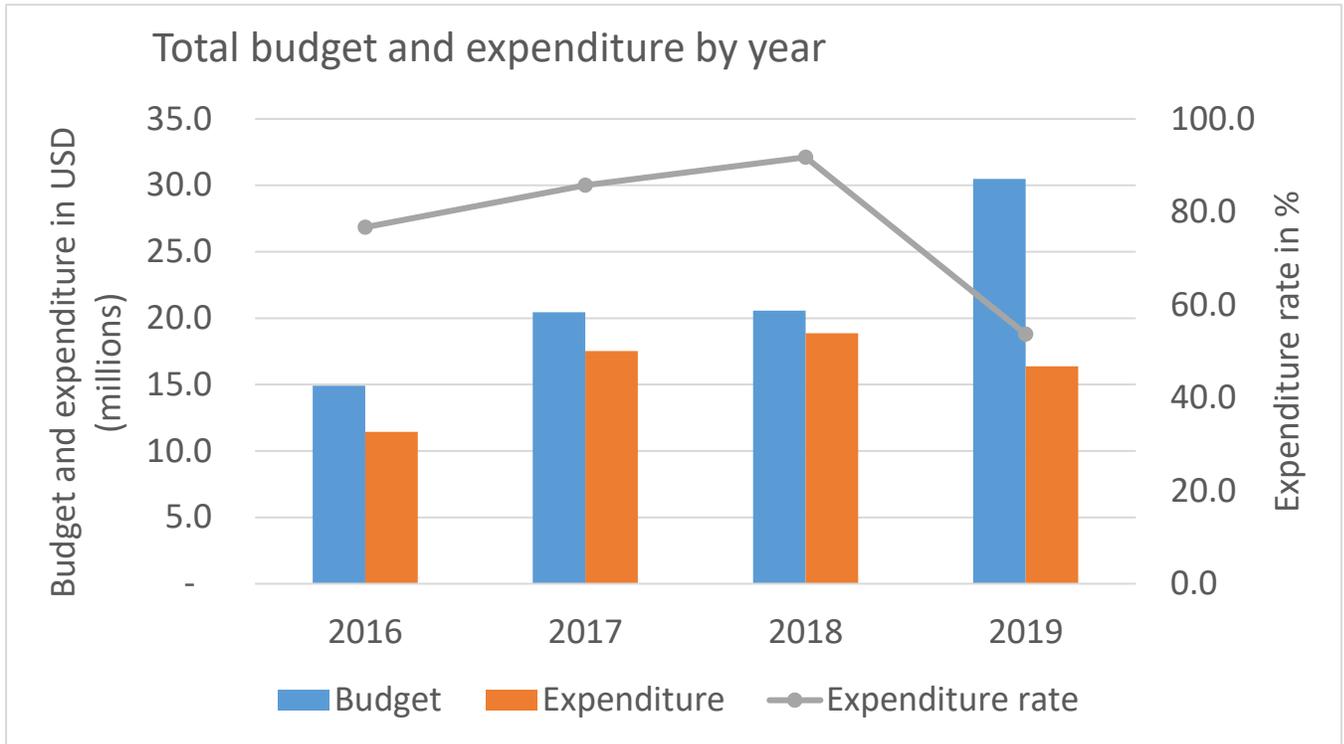
(Cover all activities in the ending quarterly work plan); (ii) summary activity reports for all completed and partially completed activities; (iii) field monitoring reports for each of the visits undertaken; FACE – Expenditure for quarter and request for new quarter; bank statement for ending quarter; bank reconciliation statement – ending quarter; quarterly work plan for new quarter (activities including monitoring and coordination) and detailed budgets and quarterly monitoring plan for new quarter. Almost all the partners submitted the required reports. The 8th CP is managed largely through NEX modalities and some interventions are also implemented via direct execution (DEX).

In terms of human resources and management of the 8th CP, the Deputy Country Representative, with programme officers or output managers are in charge of quality of programming and programme implementation, resource mobilization and technical support at all levels, and provision of technical support in their respective thematic areas. The regional programmes are coordinated by the regional coordinator with the support of regional programme officers. CP oversight, programme quality assurance and capacity-building functions (focused on monitoring, evaluation, HACT and corporate reporting) are managed by the M&E team and the Programme Support Team. Operations Unit coordinates finance, HR, Procurement, Protocol, and senior accountants who support HACT compliance. The SRH/AYD components are managed by seven staff with the support of 24 consultants hired for different assignments. The GEWE component has four Country Office Staff, and work with three consultants, while 13 consultants work with the three CO staff of the Population and Development Component.

At the country office, CP governance structures include senior management, Programme Team, Operations Team, M and E Unit, Humanitarian Unit, and other project-based arrangements. Outside the CO, the structure includes UNDAF level review meetings and results groups, federal level and regional level coordination mechanisms with IPs, and thematic-based platforms: through Regional programme Officers, Field Operations, regular management meetings and updates, programme meetings and updates, donor reports; Field visit reports; Regional and Federal review meetings outcomes; and Financial reports.

Country Programme Resources and Utilisation Rates: The ET established that budget utilisation was low during the early phase of the 8th CP; however, it increased from 73.8 percent in 2016 to 90.4 percent in 2018. The budget expenditure for the first six months of 2019 also reached 60.4 percent indicating that there will be further improvement in budget utilisation in 2019 (See Figure 6).

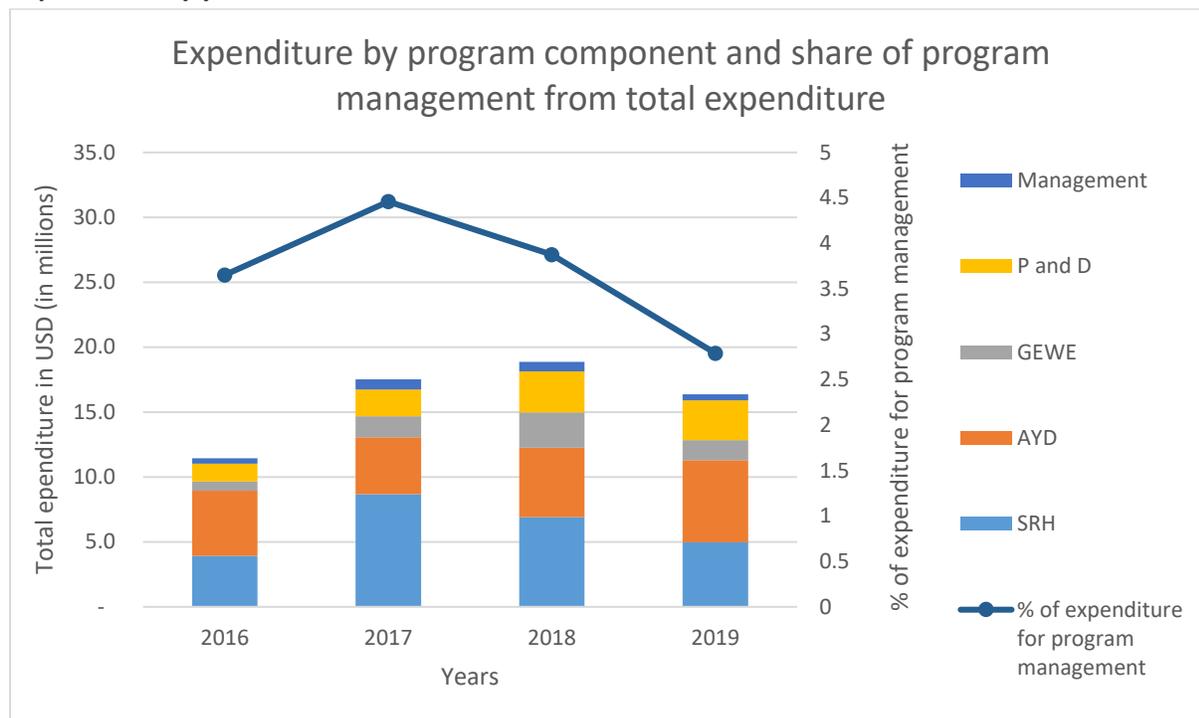
Figure 6: Total budget, expenditure, and expenditure rate by year ¹¹⁰



In addition to increasing budget utilisation, there has also been declining share in management cost indicating continuously improving efficiency throughout the life of the programme. The percentage share of expenditure on programme management from total programme cost is in general declining (See Figure 7).

¹¹⁰ Expenditure for 2019 is only for the first six months

Figure 7: Expenditure by programme component and share of programme management from total expenditure by year ¹¹¹



The evaluation established that the fund utilisation rate for the CP resources was generally high as indicated in Table 23 below. Output 1 (SRH), Output 5 (GEWE) and Output 6 (population and development) have on average had a high utilisation rate over the three years (respectively). Thus the performance of fund utilisation rates was good.

Implementing partners consistently mentioned that the allocated budget is transferred to their accounts based on AWP. However, delay in transferring funds for implementation of AWP was almost universally reported as a challenge throughout the period of the 8th CP. This has affected the quality of implementation of planned activities. IPs reported that most of the time they had to rush implementation of activities whenever there were delays in the transfer of funds.

Approval of annual plans, report reviews, and transfer of funds through a long chain of government structures and local security challenges were the primary reasons for delayed transfer of funds. High staff turnover among implementing partners along with limited opportunities for regular trainings on UNFPA’s electronic performance management system also created gaps in capacity to timely report performance and request budget among implementing partners. A key informant from Addis Ababa described how common delay in budget transfer is by saying:

There is always delay in transfer of funds. Delays are much longer for the first quarter of each budget year. For example, today is almost the end of the second

¹¹¹ Expenditure for 2019 is only for the first six months

month of the first quarter. We just got a notification that funds are released. Although there is always delay in transferring funds ... the good thing is that UNFPA is somehow flexible on time of liquidation and reporting. They allow us to liquidate our expenses over a period of six months.

- Key informant, IP from Addis Ababa

Flexibility of UNFPA's financial management system allowing implementing partners to use the budget allocated in one quarter to be used over a period of six months was an appropriate action as a coping mechanism to overcome challenges arising from delayed budget transfers. IPs with capacity and systems to pre-finance their activities were better in coping with delays in fund transfers whereas those with limited capacity or lack of mechanisms for pre-financing UNFPA supported activities usually struggled with last-minute activities. Despite the flexibility in time for financial liquidation of funds, delays have harmed the quality of implementation. It has been reported that the effect of this has been more pronounced for activities that are related to pre-defined schedules of target populations or events including university students and celebration of international or national days.

Financial support from the 8th CP was used for procurement of equipment and furniture like beds, mattresses, cooking utensils, audiovisual equipment, computers, and others for use by maternity waiting homes, youth-friendly service centres (YFSC)¹¹², and school clubs. These items had fairly similar specifications; however, procurements were handled by several woreda/zone level recipients requiring parallel and fragmented procurement processes. A centralized approach to the procurement of these items would have allowed integrating better quality items at a relatively lower price.

Operational and financial compliance was universal among implementing partners. The programme implementation manual and the electronic performance management system of UNFPA were instrumental in ensuring compliance. The regular and efficient use of these systems relies on their simplicity and applicability of the systems and familiarity of responsible personnel from each IP to the systems. Long processes of plan approvals and report reviews and the need for multiple IPs to fulfil requirements before any IP can proceed to the next steps have been common causes of delayed processes. High turnover of staff amongst IPs and lack of regular trainings on the electronic system are the primary reasons for a limited capacity to use the system.

IPs organisations at Woreda levels have limited capacity for planning. However, they are given the mandate to make major planning decisions regarding activities to be performed and geographic areas to be targeted (consulted by regional IPs). This creates a situation where there is a need for very close follow-up and support during planning and M&E. Human resource capacity of UNFPA at a regional level, however, does not allow to adequately support planning activities for all IPs.

Government IPs (federal as well as regional) have clear mandates in the areas they are currently supported by UNFPA. These IPs have strategic importance in their respective area of intervention. Procedures for identification of non-government IPs were stringent in terms of their ability to identify well-positioned

¹¹² Dedicated units in a health facility, where adolescents and youth (10-24 years) are provided with outpatient healthcare services including SRH services by a health worker trained on youth-friendly SRH services

and capable organizations for respective areas of interventions. Diversity of implementing partners allowed the 8th CP of UNFPA to address different categories of factors affecting access to and utilisation of quality-assured SRH and AYD interventions. Partners involved in the implementation of the 8th CP include federal and regional government structures for finance and economic development, health, HIV prevention and control, and women, children and youth affairs, faith-based organizations, international NGOs, local NGOs, professional associations, and universities. Government IPs were selected based on their strategic importance arising from their mandate, while non-government IPs were selected based on a competitive process leading to long-term partnerships.

There are several measures put in place to ensure efficient implementation of the AWP and fund utilisation. One of these is the development of work plans with clear activity and results in linkage and detailed budgets. The CO and partners engage in a rigorous process of developing the AWP and this takes almost 3 months usually from May to July. The clarity of results in the AWP and the detailed activity-based budgets developed makes it relatively easy for the partners to implement the work plans and use the resources within the agreed upon activity costs.

Key informant interviews and focus group discussions showed that the budgeting and planning process was transparent, jointly discussed and agreed between staff at UNFPA and IPs. Second, the evaluation team realized that from 2016, the IP and UNFPA CO programme officers undertake implementation planning once the Quarterly work plans have been approved. This involves a review of the QWP by all persons involved in its implementation and developing the concept notes for each of the activities in the work plan. This makes it easy for the person implementing the activity to adhere to the required quality standards. However, not all IPs consistently prepared the concept notes. The third measure is a quarterly review of partners financial and programme report. Quarterly, the IP manager and UNFPA M&E team review the reports submitted by the IPs. The reports are reviewed mainly for completeness, quality of reporting especially results' reporting, fund utilisation rates. The Evaluation Team saw these quarterly analyses and evidence of feedback to the IPs. However, it was also noted that the issues identified in the IP reports reoccur in the subsequent quarter, hence the need for UNFPA to always follow up to ensure the issues are addressed. Field monitoring is another important measure. Here UNFPA and IPs conduct regular monitoring of the AWP implementation. The monitoring reports reviewed indicated the monitoring focuses on assessing progress in implementation of the work plans, assessment of progress in achieving the AWP results, supporting partners in the preparation of reports, monitoring fund utilisation and accountability and supporting the partners to document good practices.

Regional Offices: UNFPA has eight Regional Offices. These play a vital role in ensuring greater efficiency of the CP implementation. The RO staff support and supervise the implementation of the programme activities (for both regional and district IPs) in their area of jurisdiction. The staff acts as a contact between UNFPA CO, regional, district government and the beneficiary population. This ensures faster information flow between UNFPA and other national level line ministries. The ROs also represent UNFPA in the various districts and regional working groups. However, the evaluation team noted that whereas the ROs have close collaboration with the district, the information gap on the activities of the national level IPs makes it difficult for them to monitor and provide the necessary support. Secondly, the funding mechanism for RO activities makes it difficult for them to implement their activities on time.

Administrative and financial procedures: The evaluation also looked at the appropriateness of the UNFPA administrative and financial procedures. Almost all respondents indicated that the administrative and financial procedures although very detailed and time-consuming are very appropriate to make sure that the planned interventions are carried out promptly and resources are used for the intended purpose. There was also a concern expressed by the government IPs at regional level. The on line detailed reporting format is creating a challenge when the person who is used to the format left the organization. According to them the reporting requires skill and know-how and is considered a challenge. But still, they agree that the format contributes to accountability and transparency since it is detailed and has a standard.

Once the AWP's are approved budget is released and transferred to the account of the IPs. IPs were also asked whether they received resources within the planned time frame. Two opposing responses were exhibited during the evaluation. Government IPs indicated that budget release is usually delayed which affect the programme implementation and quality of service delivery.

UNFPA release the budget late and expect us to finish the budget on time. This created stress on us. This will also affect the quality of work. We sometimes focus on how to finish the money rather than focusing on the quality of the work. We will be in a rush to use the money rather than focusing on planning and using the money in the most effective way.

-In-depth interview, Regional IP

4.4 SUSTAINABILITY

Evaluation Question: (For all the 4 components) i) To what extent has UNFPA's support helped to ensure that SRH and rights and the associated concerns for the needs of young people, gender equality and relevant population dynamics are appropriately integrated into national development instruments and sector policy frameworks in the programme country? (ii) To what extent has UNFPA been able to support its partners and target populations in developing capacities and establishing mechanisms to ensure ownership?

Summary:

Intensive consultations with stakeholders and joint programme planning with implementing partners helped develop a sense of ownership of programme interventions and goals. This ownership and IPs implementation of programme interventions has built IPs capacities and enhanced likelihood of sustainability, provided IPs can maintain acquired results technically, institutionally and raise needed financial resources. Sustainability is challenged by more than the mere availability of financial resources or risks of staff turnover. Factors that enhanced likelihood of sustainability are political commitment and involvement of the community leaders and community members. The commitment of staff, mode of engagement of IPs, a culture of introducing innovative intervention strategies, and the attachment of the interventions to government institutions are identified as an internal factor by the 8th CP evaluation. The alignment of the programme with international and national priorities, the high-level advocacy and coordination; capacity-building programmes; the utilisation of internal community resources and declaration of Woredas to end CM and FGM are external factors with a high value to sustainability. The 8thCP interventions are considered sustainable because the CP is aligned to and addresses national and

global priorities and population needs, investment in systems strengthening, capacity-building, strategic engagement with national institutions and ministries for long-term policy and legislation. Federal and Regional IPs opined that since the issues being addressed are at the core of government policies and programmes, their sustainability is guaranteed even if UNFPA pulls out. However, there is no systematic exit strategy in any of the CP documents reviewed.

The analysis for sustainability has been done in a way that reflects key programme elements that will ensure the durability of programme interventions and results as well as threats to sustainability across the programme themes. The main element of the 8th CP that will ensure the sustainability of UNFPA support rests in the relevance of the SRH, AYD, Gender Equality and Women's Empowerment, and PD interventions that the CP focuses on. All the component programmes focus are aligned to the National Priorities and the needs of the population. The fact that the CP focus is in tandem with the national needs has created an environment of national ownership of the UNFPA supported programme. A Director in the Ministry of Finance and Economic Development, who observed that UNFPA support is only a contribution to the mandate of the government, echoed these views and therefore even if UNFPA stopped funding any or all the interventions, the programmes would continue. The second element is areas of UNFPA support were arrived at through extensive consultative processes both during the formulation of the CP as well as during the development of the Annual Work Plans. These two have also secured a high level of ownership of the programme.

The support to strategic high-level government institutions like Ministry of Health, Ministry of Women, Children and Youth Affairs, Population and Development Directorate, Population and Development Commission, Central Statistical Agency means that UNFPA support is strategically positioned in the long-term government strategies. This approach is important in that some of the key areas of UNFPA support became Government policy direction that will endure over time. Such cases include the development of IMIS, sexual and reproductive health activities, and maternal health issues.

The 8th CP was implemented through existing national structures and mandates: Governments (Federal and Region States, Districts), CSO coalitions with established mandates and systems and the CP only built on these mandates and systems. By strengthening existing structures, it is most likely that the ownership of the programmes is assured. UNFPA took the mainstreaming strategy e.g., mainstreaming gender into plans and budgets of districts to ensure sustainability. The location of youth-friendly centres within government-owned health facilities is a step towards continuity.

The provision of fistula repair equipment to the health centres will ensure continuity of the services at least in the medium term. The trainings conducted under the CP including training government planners in data and planning, health workers in the delivery of SRH and FP services, fistula surgeons for routine fistula repair CSA and bureau staff in IMIS and other data analysis skills all targeted the staff already in public service. This implies that these technical staff will still apply the skills they gained even with the end of the UNFPA support. The availability of a critical mass of human resources across the four themes will be available to carry on the achievements of the programme. This mass includes midwives, fistula surgeons, nurses for FP services, peer educators, community members involved in prevention, protection

and provision of services to GBV victims and survivors. This will ensure that services continue to accrue to the target beneficiaries but not necessarily at the current scale with UNFPA support.

The GEWE programme also has built-in strategies to ensure sustainability and ownership of the programme by the government as well as the targeted communities. The alignment of the programme with international and national priorities and the high-level advocacy and coordination are major factors that will contribute to sustainability. Intensive consultations with stakeholders, joint programme planning with implementing partners and the bottom-up approach used by the CO helped develop a sense of ownership of the programme interventions. The multiple capacity-building programmes organized over the years for government stakeholders, grass-root structures and community members and the consequent increase in knowledge and awareness is also believed to contribute to sustainability. Respondents also indicated that since issues related to GBV and HTPs are close to the heart of adolescent girls, women and men they would henceforth push and work hard for the continuation of the interventions with or without the support of UNFPA.

The utilisation of internal community resources and existing structures within the targeted communities is also indicated as a mechanism that ensures the sustainability of the prevention as well as the protection of adolescent girls and women from GBV including CM and FGM. The active involvement and participation of community members including influential people, religious and clan leaders will also have an impact on the ownership of the programme. Declaration of Woredas to end CM and FGM is also a factor with a high value to sustainability.

The attachment of the interventions to government institutions such as the establishment of the One Stop Centre in public health facilities will sustain the provision of direct services to GBV survivors. However, the sustainability of the Safe Houses, which provide direct services to GBV survivors, is still a concern since running them is cost-intensive. Nevertheless, UNFPA is working in collaboration with different Women Associations to own the Safe Houses so as to make it sustainable.

However, the sustainability of the 8th CP interventions could be threatened by the lack of an explicit exit strategy within the programme design. Ownership of the programme benefits was not embedded in the programme design though it was embarked on during the course of implementation. A case in point is the implementation of the Safe Spaces. This case is likely to face sustainability problems given that most Safe Spaces are run by CSOs. Another case is where the programme provided equipment that has operation and maintenance cost implications (e.g., ambulances), which may be difficult for the beneficiary institutions to meet. Although districts have put mechanisms in place for ensuring continuous operation of the ambulances, they may need donor support to supplement their efforts. All the interventions are donor-driven. None of the NGOs raised their funds. NGO IPs can only sustain action by receiving financial support for the implementation of project interventions and to cover operational costs.

Table 15: Evidence of Sustainability per Intervention area 8 CP (2016-2020)

Areas of Interventions	Evidence of sustainability/low sustainability
EmONC	Pre-service trainings, in-service trainings, and mentorship programmes by nature build the capacity of the health workforce, which will have a lasting effect on the quality of services each health worker provides in the Ethiopian health care system.
MDSR	<p>Maternal and perinatal death surveillance and response is part of the Ethiopian public health emergency management (PHEM) system that requires health facilities to regularly report on reportable events. Once a health facility starts reporting on MDSR through support from UNFPA, the system will not allow regression. A team of health professionals conduct reviews of maternal and perinatal deaths. Knowledge and skills acquired by individual health workers trained through UNFPA support are shared to a wider team of health workers in target health facilities facilitating the sustainability of the process.</p> <p>UNFPA’s support in furnishing and equipping maternity waiting homes, as part of strengthening the response aspect of MDSR, supplements health centres’ and communities’ efforts to establish and run waiting homes for pregnant women during their last weeks of pregnancy. These homes are mostly constructed by contributions from health centres and communities and their routine functions are financed by community contributions. There is increasing utilisation of maternity waiting homes paralleled with increasing acceptance of community contribution to cover their costs guaranteeing their sustainability.</p>
Cervical Cancer	UNFPA provided training of health workers on Cervical Cancer screening and management of health facilities targeted by the Ministry of Health for a donation of equipment and supplies. This coordination allowed services to be available in target health centres. Trained health workers are salaried government staff and do not expect any extra payment for service provision.

Areas of Interventions	Evidence of sustainability/low sustainability
Family planning	<p>Family planning utilisation has increased during the period of the 8th CP. Trainings provided to Health Extension Workers (HEWs) will have positive effects on the long term availability of alternative contraceptive methods including long-acting methods, as attrition among HEWs is very low. The increase in demand for family planning will positively influence service providers to ensure the continuous supply of contraceptives.</p> <p>Strengthening EPSA's logistics management system through UNFPA-supported trainings and experience-sharing visits will have a positive impact on human capacity. However, the opportunity created by UNFPA's partnership with EPSA/MOH for procurement of selected family planning and other SRH commodities was not adequately utilized to ensure sustainability. Procurement of these family planning and SRH commodities is fully dependent on UNFPA's procurement support and there is no sustainability plan or exit strategy for the supply of any of these commodities in the future.</p>
Building the capacity of youth centres	<p>Youth centres provided with equipment and furniture support as part of the 8th CP generate revenue covering their expenses. Safe recreational activities will continue irrespective of external support. However, there is no mechanism in place to ensure the provision of SRH and HIV related services (free of charge) continue in the centres. For example, SRH clinic from one of the model youth centres is now closed because health workers are not happy with their salaries.</p>
Support to school clubs	<p>The school community is rich in human capacity because of the availability of teachers and students with diverse areas of interest. Supporting school clubs with a minimum initial set of equipment to run programmes aligned with their primary objective allowed them to sustain their functions in the provision of SRH related messages. School clubs (particularly mini-media) that were donated mini-media equipment by UNFPA during the 8th CP are currently running on their own.</p>

4.5 COORDINATION AND VALUE ADDED

Evaluation Question: To what extent has the UNFPA country office contributed to the functioning and coordination of UNCT coordination mechanisms?

Summary:

UNFPA Ethiopia has demonstrated that it has been an active and constructive partner that contributes to the functioning and coordination of UNCT activities within the UNDAF, federal and regional institutions in development and humanitarian contexts. Each of these coordination structures has defined objectives, lead and participant organisations and ad-hoc coordinating meetings. Government coordination seeks to coordinate the interventions of the various development assistance actors; the UN coordination mechanisms aim to hold joint planning, programming, resource mobilization, and assignment of implementation mandates, advocacy and lobbying. UNFPA Ethiopia programme staff participate regularly in meetings of relevant working groups. Stakeholder interviews noted UNFPA CO works well within the UNCT. UNFPA CO is recognized for its collaboration with UNICEF on GBV and Ending Child Marriage. Stakeholder interviews also confirmed that the UNDAF fully reflects UNFPA mandates and does not inhibit UNFPA Ethiopia from pursuing its global and regional mandates. UNFPA Ethiopia is recognized for its work within the UNDAF Outputs and Outcomes and its SRH work in humanitarian settings and among youths.

The assumption for this criterion was that the UNFPA CO has actively contributed to UNCT working groups and joint initiatives, and ensured it did not duplicate efforts and created synergies with other UN agencies, where possible. UNFPA is a signatory of the UN Development Assistance Framework (UNDAF) in Ethiopia 2016-2020. According to information collected from heads of other UN agencies in Addis Ababa, UNFPA is seen as a valuable partner in all UN Systems, ready to coordinate and willing to cooperate with other UN agencies on shared interests. UNFPA participates regularly in weekly inter-agency meetings and keeps other participants informed of any plans, achievements, and missions. UNFPA is also a member of thematic groups such as monitoring and evaluation (M&E) and the humanitarian response groups.

UNFPA contributes to other interim coordination groups such as joint programmes in UNCT settings. The UNCT includes representatives of the United Nations Operations and Programmes and other UN entities accredited to Ethiopia. Under the leadership of a non-resident coordinator, UNCT is responsible for the effective coordination of the United Nations System in Ethiopia. The UN assistance to Ethiopia is coordinated through the United Nations Development Assistance Framework that provides the basis for collaboration, coherence and effectiveness of the United Nations systems initiatives. UNDAF is instrumental in rallying capacities, resources and comparative advantages of all members of the UN system behind the strategic visions and priorities of the national development agenda.

UNFPA is a member of the inter-Agency Programme Management Team (PMT) and Operation Management Team (OMT) and co-chairs the M&E Working Group. The UNCT oversees the PMT that is comprised of Heads of Programmes from all United Nations Agencies and/or Deputy Heads of Office. It provides strategic and technical leadership for the implementation of the UNDAF and is responsible for overseeing the work of UNDAF Pillar Groups and UNDAF M&E Group to ensure effective coordination and timely achievement of UNDAF results. The Operation Management Team (OMT) comprises senior operations managers of UN agencies in Ethiopia and aims to ensure a more efficient, streamlined and coordinated administrative management system amongst UN agencies. Additionally, the UNCT has

established a UN Monitoring and Evaluation (M&E) Group to enhance United Nations inter-Agency coordination and collaboration in monitoring and evaluation and to provide technical assistance to the Pillar Groups in programme monitoring and performance progress measurement towards achieving UNDAF Outcomes. UNFPA Ethiopia acts as a lead agency for the UNDAF M&E group and has been active in the midterm review (MTR) of the 2016–2020 UNDAF. It has provided vital recommendations, particularly on the tracking of UNDAF outcomes in the country.

Continuing to lead the GBV sub-cluster, UNFPA Ethiopia is an active member of the Ethiopia Inter-Cluster Information Management Working group (ICIMWG) in close coordination with OCHA and ILO. In this role, UNFPA has participated in 2018 Meher Emergency Needs Assessment held in the regions and suggested indicators on Gender-Based Violence for inclusion in the Humanitarian Needs Overview (HNO) severity analysis. UNFPA Ethiopia has continued to actively participate in the Humanitarian and Disaster Resilience donor meetings. In this role, UNFPA has shared information on the humanitarian needs in the regions and has continuously highlighted the need for increased humanitarian financing in the country.

In addition to UNFPA membership in the above-mentioned UNDAF strategic level coordination mechanisms, UNFPA CO participates in coordination mechanisms by thematic areas and or cross-cutting issues such as Gender and humanitarian emergencies. UNFPA participates under the leadership of UN Women in the Gender Thematic Group and coordinates its humanitarian emergencies with OCHA.

Based on numerous stakeholder interviews and document reviews, there is strong evidence of active and effective UNCT collaboration by the UNFPA CO. UNFPA CO collaborates with UNICEF on Joint Programme on Child Marriage and GBV. While UNFPA plays an administrative role in the GBV project, as well as playing an active role in humanitarian emergencies, UNICEF leads in ending child marriage.

UNFPA CO in Ethiopia is active in UN coordination system and engages in coordination mechanisms of the government at Federal and Regional levels as relevant to its thematic areas. Working with 43 Implementing Partners (IPs) including Government IPs i.e. national IPs, regional bodies, and universities and Non-governmental organizations, UNFPA Ethiopia has continued to work in direct coordination with in-country partners. At Federal level, it works with the ministries in charge of Finance and Economic Cooperation, Health, Women, Children, Youth, Refugee/IDP, Food Security and Humanitarian/Livelihood affairs) as well as the Planning and Development Commission, and the Central Statistical Agency. At the regional level, UNFPA works with regional sectoral bureaus, CSOs, NGOs, and private sector actors.

Other coordination structures are also established through joint programmes with other UN Agencies. UNFPA is currently involved in the coordination of the implementation of two joint programmes: joint programmes for the abandonment of Female Genital Mutilation / Cutting (FGM/C) with UNICEF and with co-financing from DFID, Norway, Italy, Germany and the Netherlands.

Coordination is also part of the UNFPA internal programme monitoring and evaluation arrangements. Programme M&E plans indicate the organization of Quarterly Review Meetings at both national and regional levels under the leadership of the MoFED (coordinating authority) for all Implementing Partners

to discuss projects' progress against signed Annual Work Plans (AWPs), to identify implementation challenges and to devise mitigating measures. UNFPA Ethiopia team members have been co-chair of some working groups like the Monitoring and Evaluation Group, while the Country Representative has deputized for the Regional Coordinator of UNDP in Ethiopia. Some stakeholders expressed concern, however, that while active participation in inter-agency working groups raises the visibility of UNFPA and is highly appreciated, it may focus too much UNFPA staff attention inward within the UNCT at a time when aggressive external efforts at fundraising might be a greater priority.

UNFPA is involved in Delivering as One joint planning process accompanying the UNDAF that is signed by all the resident UN agencies in Ethiopia. By working together with other UN agencies there are opportunities for UNFPA and its UN partners to provide a continuum of focus on development needs, such as the overlapping mandates of UNICEF (children up to age 18) and UNFPA (adolescents and adults). UNFPA works with UNICEF to address issues of violence against children including child marriage. Generally, the Delivering as One initiative provides an impetus for more collaboration and joint working but agencies are constrained by their systems, mandates and reporting mechanisms. Sharing of information with UNCT happens regularly through participation in the Technical Working Groups. While UNFPA is actively involved in UN working groups, it is not a lead agency in any of the task teams. There is ample evidence of information exchange between UN agencies. Being a One UN country, joint UN task teams meet regularly. Besides most relevant UN agencies are housed in the UNECA Complex in Addis Ababa thereby making informal information exchange straightforward.

Stakeholders expressed strong approval for the collaborative approach taken by UNFPA Ethiopia because the UNFPA staff fully share the values of the Delivering as One approach and collaborate with other UN Agencies to maximize the results. Stakeholders from outside the UNCT, especially the Federal and Regional Implementation Partners reinforced the idea that UNFPA Ethiopia is adept in collaboration to advance common UNCT goals. The evaluation team was unable to find any significant instances where UNDAF outputs or outcomes that belong to the UNFPA mandate were not fully attributed to UNFPA.

The UNFPA is acknowledged by other UN Agencies, implementing partners and national stakeholders as a reliable and responsive key lead agency for SRH, adolescent, young people, gender equality and GBV. *"UNFPA play a key role in setting UNCT agenda ... on gender, youth, data collection and hugely works on emergency situations"* (IDI with UNCT Member). Overall, based on extensive stakeholder interviews with a wide range of respondents, UNFPA Ethiopia was perceived to have close long-term ties to national counterparts is a reliable partner for all four programme areas and a highly effective policy advocate. However, some IPs and UNCT stakeholders called for UNFPA to amplify its advocacy role in key mandate areas. Among the four programme areas, the most frequently cited areas of value added were SRH/FP, Gender, Population and Development. UNFPA is a "go-to" agency for data generation and use as well as community empowerment of key populations. The PD staff is praised for its work on data generation. UNFPA Policy on ICPD PoA and SRH is also seen as a clear comparative advantage.

4.6 CONNECTEDNESS

Evaluation Question: To what extent have UNFPA interventions contributed to humanitarian and development nexus?

Summary:

Ethiopia is hosting the second largest number of refugees on the continent. Currently, there are more than 905,831 registered refugees and asylum seekers in more than 24 refugee camps in the country. There are nearly three million internally displaced persons since 2017 because of civil unrest that was hosted in more than 1,100 IDP sites. Currently, the majority of the IDPs have returned to their places of origin but receiving humanitarian assistance as returnees because almost all of their assets were destroyed and requires years to recover from. UNFPA adequately responded to the needs of the internally displaced population in the civil unrest and drought-affected areas, and the refugee groups. In the humanitarian field, UNFPA successfully set up structures to address SGBV issues in the camps. The CO has demonstrated adequate response capacity to the needs of the refugees and IDPs through strengthening the SRH and GBV services, technical support and necessary supplies. UNFPA CO is highly responsive to demands from partners and to changing priorities in emergency and has been able to respond to changing national needs. However, there is a noticeable disconnect between Development, peacebuilding and humanitarian programmes.

Document reviews and many stakeholder interviews revealed the commendable role of UNFPA in all the humanitarian emergencies in Sierra Leone. This has been documented in many publications. UNFPA provided leadership and technical advice to the government of Ethiopia at the outset and over the course of the emergency crisis. UNFPA, in collaboration with other UN agencies, worked closely with the government and other partners in planning the response, developing and reviewing response strategies as the emergency unfolded.

The structure of UNFPA CO is organized based on expected outcomes for development programmes while it is based on the target population for the humanitarian team. Outcomes (SRH, AYD, GEWE, P&D) have their own teams. A separate team exists for humanitarian interventions. The existence of separate humanitarian team facilitates timely response and effective follow-up of emergency responses; however, utilizing subject matter expertise in each of the development programme team as inputs for development and implementation of humanitarian interventions requires additional coordination efforts. UNFPA CO has a designated person to coordinate humanitarian and emergency disaster preparedness and response.

During the 8th CP, UNFPA supported three categories of communities affected by forced displacements: internally displaced people, refugees from South Sudan and Somalia, and communities hosting IDPs and refugees. UNFPA's support to refugee camp health systems through Agency for Refugee and Returnee Affairs (ARRA) included the donation of five ambulances, equipment, delivery kits, and other supplies. Somehow, similar support was provided to health facilities serving IDPs and the host communities. However, the very wide difference in infrastructure, staffing, and other aspects between health centres in refugee camps and those in the host community's results in disparities in availability, quality, and utilisation of services.

Through implementation of various humanitarian projects in drought-affected woredas, IDP sites and refugee camps, a total of 289,272 populations in reproductive age group were reached with sexual and reproductive health interventions and services and GBV services in humanitarian settings that involved strengthening of SRH coordination, distribution of lifesaving reproductive health kits, donation of ambulances, support of community-based demand creation interventions and information sessions as well as capacity development initiatives. Health facilities in Gambella refugee camps and surrounding host community districts were equipped with emergency reproductive health kits to provide maternal health services for those affected in the community and medical care services for survivors of sexual violence. Capacity development trainings on MISP for RH and psychological first aid were also provided to more than 96 front-line service providers working in refugee camps, IDP sites and drought-affected host community districts.

Observations and staff interviews at Itang Health Centre serving Ethiopians who hosted South Sudanese refugees and ARRA Health Centre in Gnueyyiel Refugee Camp located just a few kilometres away from Itang Health Centre demonstrated the very wide disparity between services provided to the two population groups. A compound with broken fence flooded with river water, falling apart health centre buildings, old and dirty examination beds and delivery couches, non-functional equipment, piles of unnecessary documents, very few staff, and no patients around during working hours characterize the Itang Health Centre as was observed by the Evaluation Team in September 2019. The interview with staff of Itang Health Centre and WoHO revealed that there is no shortage of supplies and equipment for maternal health services; however, these resources did not translate into better access and utilisation of services. In contrast, the ARRA Health Centre in the Gnueyyiel Refugee Camp has well-constructed blocks, clean and well-organized examination rooms, adequate staff, and the necessary supplies and equipment for the provision of maternal health and family planning services. Utilisation of maternal health services is reported to be high. All signal functions of BEmONC were available in the health centre.

It is important to note that these differences are beyond the control of UNFPA; however, future programmes and advocacy efforts would benefit by considering equity across the three targets of humanitarian interventions (refugees, IDPs, and the host communities).

4.7 LESSONS LEARNT

For the implementation activities of each component of the 8th CP, several lessons were learnt.

SRH Component

Maternity Waiting Homes, if well promoted and equipped, can increase uptake for institutional delivery and postnatal care, thereby decreasing maternal and neonatal morbidity and mortality. Integration of trainings into pre-service education/ curriculum is an effective approach to reduce cost and ensures sustainability in the long term in addressing the training needs of health professionals. Integration of MDSR training into pre-service education in Gondar and Jimma universities is a good example. Strengthening the capacity of the hospital on Reproductive, Maternal, and Newborn Health (RMNH) mentoring has worked well to regularly and effectively cascade mentoring support to health centres

located in their catchment area with minimum cost. Fistula survivors are major advocates for the prevention of fistula. They bring more clients for repair after their successful repairs.

FP/RHCS

The availability of more contraceptive choices increases the number of contraceptive users. This is because the clients' needs for long-acting methods are better addressed. Generally, this contributed to an increase in the Contraceptive Prevalence Rate (CPR).

Adolescents and Youth Development

Intervention approaches and tools need to be based on evidence for better outcomes. Engagement of young people at all levels gives a better perspective in the course designing tools and service packages to address their needs. Capacity-building interventions targeting those who are coordinating and leading SRH and HIV prevention programmes at different levels ensured a better harmonization of interventions. The correlated approaches of the two outputs improved access to an integrated pack of youth-friendly SRH information and services.

Gender Equality and Women's Empowerment

Working through the existing community structures (i.e., community groups, women development groups, and associations) is key to sustaining the achieved results. Schools serve as an effective mechanism to reach significantly large numbers of girls and boys with information that helps to build the desired social movement and active participation of boys and men; especially the husbands of women members of the community conversation sessions.

Population and Development Component

UNFPA's continued engagement with government, donors and other UN Agencies sustained momentum and support for the census, despite uncertainties regarding the enumeration date. South-South collaboration enables information and experience sharing on new and emerging census methodologies to improve census methodologies and outcomes, including in cases where conventional census undertaking may not be feasible. There is huge value in drawing logistic and technical support from South-South groups.

The organization of themed advocacy events in the regional states gives recognition to the prevailing population and development issues in the regions. Joint implementation of planned activities by stakeholders involved in population issues increases the level of success and common ownership of population and development matters and initiatives in the country. A mixture of modalities such as "direct payment", "direct implementation" and "reimbursement" (depending on the context of the IPs) has proved to be an effective way of reducing protracted hiccups associated to late disbursement of financial resources and late liquidation of Operating Fund Accounts (OFAs). The role of academia in generating research on population issues is essential for the successful implementation of activities in the population programme, particularly as related to evidence-based policy planning. Renewed engagement and consultations with new senior management staff of the Planning and Development Commission (PDC) on UNFPA's mandate and priority programmatic areas (through courtesy visit by UNFPA management) has

been instrumental in reinvigorating UNFPA's partnership with the PDC and redressing the priority areas of engagement caused by frequent turnover in the appointment of high-level officials at the PDC. Continued advocacy by UNFPA and engagement with the Planning and Development Commission is necessary to position population issues in the development and transformative agenda of the country.

CHAPTER 5: CONCLUSIONS

5.1 STRATEGIC-LEVEL CONCLUSIONS

Conclusion 1: C1 - Relevance

The activities in Ethiopia were all well-aligned with the priorities and principles of the Ethiopian government development priorities and plans, UNFPA Strategic Plans (2014-2017, 2018-2021); ICPD PoA and SDG Agenda 2030 and CEDAW. They addressed the needs of the population as identified in national development and sectoral plans through various needs assessments, research surveys and consultation with different implementation partners.

Origin: EQ 1, EQ 2

Associated Recommendation: - R 1

SRH components of the 8th CP are directly linked to international, national, regional and district efforts to increase access to and utilisation of evidence-based interventions against SRH needs. The associated interventions were consistent with priority components of the ICPD PoA, SDG Agenda 2030 and UNDAF revised SP 2018-2021. The SRH component fitted very well with a national development framework, GTPII, policies and strategic plans including the Health Sector Transformation Plan, Reproductive Health Strategy and other supporting strategies on human resources for health, obstetric fistula and cervical cancer treatment.

The adolescents and youth component addressed the social and economic priorities identified in the National Youth Policy and created a momentum for youth engagement which will be used to cover the reproductive health needs of young people, including adolescents. CP interventions targeted the young population. It addressed the social and economic priorities identified in the National Youth Strategy. The gender component focused prevention, protection and provision of services to GBV survivors and on advocacy and awareness creation on GBV specifically harmful practices and responded to the needs of women and adolescent girls among the vulnerable population. Hence advocacy for the rights of women and girls should be strengthened. The PD activities are reflective of UNFPA and Ethiopian government priorities and strategic as well as global priorities encapsulated in ICPD PoA and SDG Agenda 2030 in terms of generation and utilisation of national and regional data for planning and development. The UNFPA approach of participatory consultations with national stakeholders on CP priorities is a good practice and this helps focus the different Federal IPs on their mandates.

Conclusion 2: C2 - Efficiency

Overall, the activities implemented toward the achievement of outputs for all programme areas appeared to be reasonable for the amount of resources expended. UNFPA Ethiopia CO was generally efficient in mobilizing financial resources and in disbursing annual programme budgets to support the implementation of Annual Work Plans (AWPs) through contracts with Implementing Partners as well as National Execution (NEX) modality and DEX. Despite dwindling donors' interest globally, UNFPA CO was relatively efficient in raising financing for the 8th CP's increasing financing levels from non-core resources and accessing new donors. A team of competent staff has implemented the 8th CP with support from several national and international consultants, and the Regional Office. However, there were noticeable inefficiencies during the Cycle. The 8th CP was rated efficient given their timely preparation of annual work

plans, relative high fund utilisation across components, outputs and implementation partners and the quality of its human resources.

Origin: EQ 7

Associated Recommendation: - R2

Despite shrinking funding space, globally, UNFPA was relatively efficient in raising financing for its CP. UNFPA business model of implementing through government and non-government partners, NEX and DEX implementation modalities and programme integration approaches, Ethiopia-specific PIM, enhanced implementation efficiency and enabled UNFPA to reach most of its mid-cycle CP performance indicators. Delays in funds transfer to partners indicate need to improve internal management processes with partners. Partnership with government and non-government organizations enabled UNFPA to expand programme implementation capacity and outreach to eight regions, two city administrations and 122 districts but this implementation modality through IPs require greater attention to be devoted to building partners capacity for the future sustainability of programmatic interventions to monitoring and validating IP performance and data.

Conclusion 3: C3 - Sustainability

All IPs affirmed that programme outputs are sustainable since all the components are issues that are relevant to national needs and there do exist strategies and structures to address them. Joint programming involving government, programme approach of needs assessment, stakeholder consultations and validation are factors that promote sustainability. It is agreed that the size of the programme may be reduced because of financial resources to maintain the provision of services and or to maintain the durability of effects acquired through the programme.

Origin: EQ 8, EQ9

Associated Recommendation: - R3

Sustainability assessment refers to the extent to which programme results are likely to continue after programme' support is completed and/or the willingness and capacity of implementing partners to maintain the provision of these services without further programme technical and financial support. Programme approaches, such as participatory needs assessment, intensive consultations with stakeholders and joint programme planning with implementing partners, in addition to interventions at the woredas and kebeles levels and local CSO and non-governmental stakeholders, helped develop a sense of government ownership, improved chances of trained resources stability, and have thus increased chances for future sustainability of UNFPA interventions.

Conclusion 4: C4 – Coordination and Value Added

The UNFPA CO is contributing significantly to improving the UNCT coordination mechanism, especially in joint programming and implementation. UNFPA CO is involved in multi-layered coordination structures with Federal and regional states IPs, UNCT and CSO IPs. The Government coordination mechanism is through the Ministry of Finance and Economic Development that coordinates interventions of the various development assistance actors. Its mandates in SRH, adolescents and youth development, gender equality and women empowerment, and population and development issues are well noted. UNFPA is at the forefront of implementing the ICPD PoA and SDG Agenda 2030.

Origin: EQ 10

Associated Recommendation: - R 4

UNFPA CO is contributing to improving the UNCT coordination, especially in joint programming and implementation. Its role is well appreciated by national stakeholders and UNCT agencies in the country. With the emphasis on Delivering as One, there is room for synergy. It participates in multi-layered coordination structures with UN agencies, federal and state government institutions in development and humanitarian contexts. Each of these coordination structures has a defined objective, lead and participant organizations and regular and ad hoc coordination meetings. Whereas government coordination seeks *mainly* to coordinate the interventions of the various development assistance actors on the ground, the UN coordination mechanisms aim beyond the level to joint planning, joint programming, resource mobilization, lobbying and advocacy. UNCT coordination mechanisms are effective in combining agencies technical resources in joint projects, planning and ensuing complementary interventions by comparative advantage of each agency.

Conclusion 5: C5 - Connectedness

UNFPA CO in Ethiopia is responsive to demands from partners and to changing national priorities both in humanitarian and development axis. Humanitarian activities are integrated into development ones, although the actual implementation is problematic and does not promote development-humanitarian connectedness. There is a disconnect between development and humanitarian interventions.

Origin: EQ 11

Associated Recommendation: - R 9

UNCT partners appreciated the responsiveness of UNFPA CO in emergencies. They noted that the CO has been active in the humanitarian field in refugee and natural disaster crises especially in the areas of SRH and GBV. UNFPA has been responsive in emergencies in the country and this has been appreciated by other UN agencies under UNCT Platform. UNFPA has been quick in its response to the emergency situations in the humanitarian field.

During the 8th CP, UNFPA supported three categories of communities affected by forced displacements: internally displaced people, refugees from South Sudan and Somalia, and communities hosting IDPs and refugees. UNFPA's support to refugee camp health systems through Agency for Refugee and Returnee Affairs (ARRA) included the donation of an ambulance, equipment, delivery kits, and other supplies. Somehow, similar support was provided to health facilities serving IDPs and the host communities. However, the very wide difference in infrastructure, staffing, and other aspects between health centres in refugee camps and those in the host community's results in disparities in availability, quality, and utilisation of services.

Through implementation of various humanitarian projects in drought-affected woredas, IDP sites and refugee camps, a total of 289,272 populations in reproductive age group were reached with sexual and reproductive health interventions and services and GBV services in humanitarian settings that involved strengthening of SRH coordination, distribution of lifesaving reproductive health kits, the donation of an ambulance, support of community-based demand creation interventions and information sessions as well as capacity development initiatives.

5.2 PROGRAMMATIC LEVEL

Conclusion 6: C6 - Relevance

All the 8th CP interventions were relevant and in line with Ethiopia's national development framework, GTP II, sectoral policies such as Health Sector Strategic Development, Youth Policy, Women policy, Population Policy and all advancing the ICPD PoA, SDG Agenda 2030 and UNFPA Strategic Plans of 2014-2017 and 2018-2021.

Origin: EQ 1

Associated Recommendation: - R1

Sexual and Reproductive Health

The SRH component was aligned and relevant to Health Sector Development and in line with ICPD PoA. Interventions on human resources for health workers, fistula identification and repair, cervical cancer treatment and family planning and reproductive health commodity services were in line with international, national, and district priorities.

Adolescents and Youth Development

The adolescent and youth component, which includes capacity-building for both duty bearers and rights holders, is aligned to Ethiopia's National Youth Policy and linked to major challenges of the youth. However, attention given to facilitating the creation of economic opportunities for young people has been limited during the 8th CP as opposed to the increasing size of the unemployed youth population in the country which in turn increases the vulnerability of several social problems.

Gender Equality and Women's Empowerment

Similarly, the gender component is relevant and based on National Women Policy and is in harmony with CEDAW. This component also addresses the key elements regarding gender-based violence; harmful traditional practices especially FGM and child marriage in line with the ICPD PoA. The component addresses prevention of GBV, protection of the rights of women and girls and provision of integrated services to GBV survivors including economic and social empowerment of women and adolescent girls.

Population and Development

The PD programme activities are strongly reflective of UNFPA policies and strategies, as well as global priorities, including the goals of the ICPD Programme of Action and the SDGs. The PD programme activities have been very responsive to changes in the national development context. This is evidenced by the UNFPA Ethiopia PD capacity-building efforts in collaboration with the CSA at federal and regional state levels.

Conclusion 7: C7 – Effectiveness

The evaluation has shown that overall a relatively high number of outputs and outcomes was achieved in all the components of the programme, with the exception of the census undertaking which was postponed due to political reasons in the country.

Origin: EQ 3, EQ4, EQ5 EQ6

Associated Recommendations: - R6, R7, R8, R9

Sexual and Reproductive Health Component

Sexual and reproductive health interventions were effective in delivering RH services and information in UNFPA-targeted operational districts and kebeles. The 8th CP has effectively improved the delivery of

integrated RH, EmONC, CemONC, fistula repair and cervical cancer services. The CP supported health systems strengthening, capacity building through training of health care providers at various levels, infrastructural development (building of new and renovation of old health facilities), all these to increase access to quality health care for women, reproductive health commodities security at the central and district levels have led to increased access to FP/RH commodities. Additional evidence of effectiveness of the CP is in the identification and complete repair of obstetric fistulae patients.

Adolescents and Youth Development Component

Most of the results related to Adolescents and Youth development activities have been achieved. Community health centres and health posts in intervention districts were renovated to include separate and confidential space for the provision of services to adolescents and youth. Youth Centers were established for asset building of adolescents and youth; development of life skills manual

Gender Equality and Women's Empowerment

UNFPA support was effective in advocacy and raising awareness in improving knowledge on gender inequality issues, harmful traditional practices, GBV issues, FGM and child marriage. It also contributed to the commitments of some communities for FGM/C abandonment. The 8th CP support was also effective in responding to the needs of the survivors and victims of GV especially in humanitarian areas. Using the Safe Spaces and One Stop Centers, the CP support provided psycho-social support, establishment of protection groups and GBV survivors find support at community levels and access to the relevant services at the health centres and One Stop Centers.

Population and Development

The PD interventions have advanced the course of increasing data availability both at the Federal and Regional levels. At the Federal levels, the Ethiopian DHS 2016 and 2019 mini-reports have been produced. At Regional levels, IMIS has been established to provide data for regional planning in five out of six planned regions. Several resources (human, technical and logistics) have been invested towards census undertaking and other efforts at data generation and utilisation (CSA) and integration and advocacy (Population and Development Directorate of Planning and Development Commission).

Conclusion 8: C8 - Efficiency

The 8th CP is rated efficient going by timely preparation of annual work plans, relative high fund utilisation across components, outputs and implementation partners and quality of its human resource.

Origin: EQ 7

Associated Recommendation: - R2

The CO staff complement is adequate but not sufficient especially in the maternal health cluster. The delayed release of fund is associated with the lateness of implementing partners in their submission of the work plan and progress reports. No qualified audit was reported or observed for UNFPA's implementing partners in the first three years of the 8th CP. Though the 8th CP components at the sub-national level were limited to 122 districts, in geographical terms the districts were spread out over a large geographic area of eight regions and two cities, which made programme implementation less efficient. Given the limited resources of the UNFPA programme, review of the geographical focus of the RH component of the CP will need to take efficiency issues into account.

Administrative procedures and policies of UNFPA including the use of GPS, PIM, AWP, and government financial control systems facilitated the use of CP resources only for intended purposes. However, long

processes of approval and delays in fund transfers affect the quality of implementation of supported activities particularly for IPs with no possibilities to pre-finance their activities.

Conclusion 9: C9 - Sustainability

The 8th CP interventions are subject to varying levels of durability. While some activities may be sustainable, others may not continue without funding support.

Origin: EQ 8, EQ9

Associated Recommendation: - R3

The 8th CP interventions are durable to some extent. The programme design and implementation addressed the priorities that are relevant to Ethiopian national priorities; enabling systems strengthening, capacity-building, working within the government structures to develop policies, guidelines, plans, procedures. All of these will help guarantee the sustainability of the interventions. The integration of maternal health, SRH/FP/RH, and GBV services in health care systems also guarantees durability. Programme sustainability is deemed weak and challenged by a dearth of local resources, inadequate institutional and human resource development in addition to over-donor dependence. With no explicit rationale for the selection of the 122 focus districts, there is no clear approach on scaling-up of the sub-national initiatives beyond the present 122 districts and it is not certain whether government in other areas will adopt these initiatives. In this regard, there is a need to review UNFPA's approach at the sub-national level in terms of SRH/AYD initiatives.

The 8th CP mostly supported the implementation of government-owned interventions that are part of annual plans of sector ministries, regional bureaus, and woreda offices. These activities have a high chance of being sustained for a long period. Capacities built among target institutions including their personnel will allow the provision of improved service delivery over a long period as recurrent expenses are covered by other parties. However, these assumptions may not always be fulfilled in which case donation of materials and provision of trainings through CP support may not result in the availability and utilisation of expected services.

Conclusion 10: C10:- Connectedness

UNFPA CO intervened in several humanitarian crises in Ethiopia, ranging from refugee influx and natural disasters. There is a disconnect between development and humanitarian interventions, where there are more intervention activities in humanitarian camps than in the host communities.

Origin: EQ 11

Associated Recommendation: R 9

During the 8th CP, UNFPA supported three categories of communities affected by forced displacements: internally displaced people, refugees from South Sudan and Somalia, and communities hosting IDPs and refugees. UNFPA's support to refugee camp health systems through Agency for Refugee and Returnee Affairs (ARRA) included the donation of ambulances, equipment, delivery kits, and other supplies. Somehow, similar support was provided to health facilities serving IDPs and the host communities. However, the very wide difference in infrastructure, staffing, and other aspects between health centres

in refugee camps and those in host community's results in disparities in availability, quality, and utilisation of services.

Through implementation of various humanitarian projects in drought-affected woredas, IDP sites and refugee camps, a total of 289,272 populations in reproductive age group were reached with sexual and reproductive health interventions and services and GBV services in humanitarian settings that involved strengthening of SRH coordination, distribution of lifesaving reproductive health kits, the donation of an ambulance, support of community-based demand creation interventions and information sessions as well as capacity development initiatives.

6.1 STRATEGIC LEVEL

Recommendation 1: - Relevance

UFPA should continue to align the CP to Ethiopia's national policies and plans as well as to international, continental (i.e. Africa) and regional (i.e. East Africa) development agendas to respond to the country's national needs and priorities and get buy-in support from international development partners.

Priority: High

Audience/Action: Ethiopia UNFPA CO, MoPED, and IPs

Origin: EQ 1, EQ 2; Conclusion 1

Operational Implications:

- **Continue wide consultations** and participation of government departments, civil society organisations and other relevant stakeholders for the next CP to ensure that programme interventions are relevant and aligned to Ethiopia's national policies and international, continental and regional development agendas.
- CP interventions should continue to be based on research and needs assessments, national strategies and plans and participatory consultations with stakeholders. It is also suggested that UNFPA coordinates with partner UN Agencies and discuss with IPs to include in future programming measures to improve degrees of programmes' sustainability.

Recommendation 2: - Efficiency

UNFPA CO to focus efforts on accessing more financial resources for population dynamics and development interventions, especially for census undertaking. Non-traditional sources of funding like the private sector should be explored.

Priority: High

Action: CO and MoFED

Origin: EQ 7, C2

Operational Implications

- **Rethink assumptions behind thinly spreading UNFPA's resources 122 operational woredas since this is unsustainable.**
- **Select fewer districts with high negative social, economic and health indicators. This will allow close monitoring of activities for high impact delivery.**
- Continue efficient use of resources for the effective delivery of CP activities.

Recommendation 3: - Sustainability

Sustainability is more challenging in humanitarian settings than in a development-oriented project. However, CO should strive in the next CP to discuss and include its programming with implementing partners, measures of sustainability especially as it concerns technical and organisational capacity-building in all thematic areas. The exit strategy must be built-in in the design of all projects/initiatives at the onset.

Priority: High

Action: CO, IPs

Origin: EQ 8, EQ9; C3

Operational Implications

- UNFPA to include in the next CP interventions plans to improve sustainability, specifically for institutional /organizational capacity-building and for culturally sensitive thematic interventions such as GBV including FGM and CM.
- Sustainability issues ought to be discussed with implementing partners at the time of drafting the AWP to clarify expectations and to gain IPs' support to work towards improving the sustainability of UNFPA supported interventions.
- UNFPA to plan for training and capacity-building of IPs with clear goals on expected achievements in terms of capacity-building and sustainability
- Invest in community ownership and involvement in interventions.

Recommendation 4: – Coordination and Value Added

There is a need for the UNFPA CO to continue building partnerships with other UN agencies under the umbrella of Delivering As One so that resources can be pooled to support activities of the CP. UNFPA CO has collaborated with other partners in implementing the CP activities. These strategic partnerships have worked well and should continue in the next CP.

Priority: High

Audience/Action: Ethiopia CO, MoFED

Origin: EQ 10, Conclusion 4

Operational Implications:

- Continue to engage strategic partners in the design, development and implementation of the next CP.
- Continue to play active role in the UNCT framework
- Continue participation in joint programming and implementation; joint advocacy

6.2 PROGRAMMATIC LEVEL

Recommendation 5: - Sexual and Reproductive Health

CO should continue promoting SRH interventions, including identified best practices such as the midwifery mentorship programme for the training of health workforce for cervical cancer and fistula identification and treatment, and capacity-building programmes at the various University IPs.

Priority: High

Action: UNFPA CO, MoFED, Ministry of Health and IPs

Origin: EQ 1, EQ3; C1, C7

Operational Implications:

- Conduct regular reviews of the current SRH interventions to improve the delivery of SRH services and information.
- Strengthen the supply and distribution of the FP/RHC commodities to ensure availability at all the levels towards improving the quality of services provided.
- Continue institutional capacity building efforts for the identification and treatment of fistula and cervical cancer cases.

Recommendation 6: - Adolescents and Youth Development

In the next CP, UNFPA CO should continue supporting youth empowerment initiatives and engagement in the community education on reproductive health and social-economic issues.

Priority: High

Action: CO, Ministry of Youth Affairs

Origin: EQ 1, EQ4; C1, C7

Operational Implications:

- CO to continue supporting the rehabilitation of Youth-Friendly Service Centres and strengthen their capacities to manage and promote the YFSC's roles as social spaces for engagement of young women and men in Ethiopia
- CO to support the Government to implement programmes that will empower the youths and make them contribute to the demographic dividend.
- Work closely with IPs linked with CSE to encourage the rapid completion of the CSE/life skills education
- Work with IPs in the humanitarian axis to ensure inclusive participation of key populations and vulnerable youth in preventive programmes with an emphasis on SRH service delivery.

Recommendation 7: – Gender Equality and Women's Empowerment

UNFPA CO should continue its efforts to address gender equality and women empowerment in collaboration with like-minded governmental, non-governmental, UN agencies and community-based structures to accelerate the progress made.

Priority: High

Action: UNFPA CO, MoWCYA, IPs and UNCT

Origin: EQ 1, EQ5; C1, C7

Operational Implications:

- Continue the multi-sectoral approach in response to GBV in both development and humanitarian context
- Continue adopting the community-based approach in addressing GBV issues in all the operational woredas and kebeles.
- Continue with those best practices such as Girls' and Women's Friendly Spaces, Safe Houses, One Stop Centres, higher education initiatives, family and community dialogues and conversations.
- UNFPA CO should continue the establishment of women-friendly centres to allow women to engage in providing support for GBV survivors, raising awareness in HTPs, especially abandonment of FGM and Child Marriage.

Recommendation 8: – Population and Development

The most important uncompleted output of the 8th CP is the 2017 Census. The CO should prioritize support (technical and advocacy) to get this done in this CP9 cycle. CO should deepen expertise and capacity on census and data generation and utilisation skills.

Priority: High

Action: UNFPA CO, MoFED, Planning and Development Commission, CSA

Origin: EQ 1, EQ62; C1, C7

Operational Implications:

- Revisit all preparations for the census exercise including retraining census personnel
- Reactivate the functions of the Population and Development Directorate by making it functional in population and development advocacy.
- Support programmes that will address challenges of population dynamics in the country with a view to informing policy formulation, planning and programming
- IMIS should be made accessible and functional. Because of high staff turnover, training and retraining and cascading training is important to build the capacity of relevant staff.
- UNFPA should continue to support the Population and Development Directorate to advocate for ICPD PoA, SDG Agenda 2030 and coordinate with line Ministries for the commitment and integration of population dynamics into the sectorial development plans;
- Strengthening the capacities of the MoFED and CSA for coordination with and monitoring the state councils.
- UNFPA should coordinate with other UN Agencies and international organizations for orientations on ICPD PoA and targets of Sustainable Development Goals at the national and regional state levels. It should also encourage the use of both frameworks in the formulation of policies and plans.
- Invest in and utilise the South-South resources for the implementation of the national census exercise and the use of population data in national planning and programming.

Recommendation 9: - Connectedness

UNFPA responded to the needs of the refugees and internally displaced population. In the humanitarian field, UNFPA successfully led the GBV coordination groups and contributed to the complementarity of interventions of the UN agencies, and international organizations. However, there is a noticeable, disconnect in the development-humanitarian nexus. Strategies for resilience building must be built in emergency responses in the next CP.

Priority: High

Action: UNFPA CO, MoFED, UNCT, and OCHA

Origin: EQ 11, C6

Operation Implications:

- UNFPA CO should develop a strategy to transition from humanitarian and emergency assistance to more development-oriented strategic interventions.
- CO should consider applying new technologies for the vulnerability and rapid assessments, risk profiling, resilience and durable solutions to strengthen the operationalization of development-humanitarian nexus thereby building resilience in the communities.
- UNFPA to maintain and increase efforts in leading, strengthening its lead coordination role of the GBV sub-sector coordination group in a humanitarian context.
- Continuous updating of the UNFPA strategic response to SRH, GBV and data needs of the vulnerable populations;
- UNFPA being the sole agency providing the MISP package will give it the leading role in SRH in emergency settings. This role should be institutionalized through extending the appropriate interventions among the vulnerable groups, especially in war-affected states.

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ANNEX 1: TERM OF REFERENCE OF CP EVALUATION OF 8TH GOVERNMENT OF ETHIOPIA/UNFPA COUNTRY PROGRAMME

1. INTRODUCTION AND EVALUATION RATIONALE

1.1 The United Nations Population Fund (UNFPA), is the lead United Nations agency for delivering a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled. UNFPA expands the possibilities for women and young people to lead healthy and productive lives.

1.2 The strategic goal of UNFPA is to achieve universal access to sexual and reproductive health care, realize reproductive rights and reduce maternal mortality to improve the lives of women, adolescents and youth, enabled by profound analysis of population dynamics, protection of human rights and promotion of gender equality. In pursuing its goal, UNFPA has been guided by the Programme of Action of the International Conference on Population and Development (ICPD), UNFPA Strategic Plan (2014-2017 and 2018-2021) and the 2030 Agenda for Sustainable Development.

1.3 UNFPA Ethiopia is currently implementing its 8th Country Programme (2016-2020) which includes Maternal and Sexual and Reproductive Health, Adolescent and Youth Development, Gender, Population and Development. Humanitarian Response and Resilience Building interventions are crosscutting.

1.4 In terms of synergies with other development frameworks, the programme is aligned with the second Ethiopia Growth and Transformation Plan - GTP II (2016-2020), Health Sector Transformation Plan (2015-2020), United Nations Development Assistance Framework - UNDAF (2016-2020), UNFPA Strategic Plan (2014-2017 and 2018-2021), and the Sustainable Development Goals ¹¹³. The programme aligns to the related issues in the ICPD+10 Review Report and ICPD Beyond 2014.

1.5 The overall goal of the Country Programme (CP) is to contribute to “universal access to rights-based and gender-sensitive sexual and reproductive health information and services, including for adolescents and young people” as defined in the UNFPA Strategic Plan (2014-2017 and 2018-2021). Overall, the programme contributes to Government’s development efforts especially in the areas of maternal and sexual and reproductive health, adolescent and youth development, gender, population and development, as well as promoting advocacy and multi-sectoral partnerships for strengthening implementation of the ICPD Agenda in Ethiopia.

¹¹³ The Country office avails the SP-CP-UNDAF Alignment Matrix.

- 1.6 Following the end of current programme in June 2020, the 9th Ethiopia CP (2020-2024) will be developed. The 2019 UNFPA Evaluation Policy emphasises that the CP should be evaluated before the end of its cycle. However, UNFPA Ethiopia did not conduct an evaluation of its 7th CP (2012-2015). Instead, a light assessment was conducted considering a joint review of the individual component evaluation reports. As such, the review findings were not used as evaluative evidence for the 7th CP. Considering the need for adequate evaluative evidence to inform the development of the 8th programme cycle, the UNFPA Country Office and government decided to undertake a high-quality CPE in 2019.
- 1.7 The evaluation will be an external, independent exercise conducted by an independent team of evaluators adhering to UNFPA policy on Country Programme Evaluations, ethical norms and United Nations Evaluation Group (UNEG) standards. The evaluation will be managed by the CO in close collaboration with the Regional Monitoring and Evaluation Advisor at the East Southern Africa Regional Office (ESARO) and the Evaluation Office (EO) at UNFPA Headquarters.
- 1.8 The primary users of the CPE are the decision-makers within UNFPA and the Executive Board, government counterparts in the country, and other development partners including donors, the civil society, the private sector, and other sister UN agencies.
- 1.9 Findings, lessons learned and recommendations of the CPE shall be used to assess the achievements of the 8th CP and to inform the development of the next Country Programme. For transparency and accountability purposes, the CPE report shall be communicated to all stakeholders including UNFPA corporate managers and the Executive Board, national and district level partners, government, civil society organizations, private sector, donors and other sister UN agencies. Most of the program partners especially the government are part of the evaluation process either as sources of data (primary/secondary) or through their representation in the ERG.
- 1.10 The evaluation is expected to be designed and implemented in accordance with the UNFPA methodological Handbook (<https://www.unfpa.org/EvaluationHandbook>). The handbook is a practical guide to help the evaluation team apply methodological rigour throughout the different phases of the evaluation and it is expected that the evaluation team is well acquainted with the Handbook at the inception stage of the CPE.

2. COUNTRY CONTEXT

- 2.1 With more than 100 million people, Ethiopia is the second most populous nation in Africa after Nigeria, and the fastest growing economy in the region. However, it is also one of the poorest, with a per capita income of \$783. Ethiopia has a vision to become a lower middle income country by 2025.
- 2.2 Ethiopia's economy experienced strong, broad-based growth averaging 10.3% a year from 2006/07 to 2016/17, compared to a regional average of 5.4%. Ethiopia's Gross Domestic Product (GDP) is

estimated to have rebounded to 10.9% in FY2017. Agriculture, construction and services accounted for most of the growth, with modest contribution from the manufacturing sector. Private consumption and public investment explain demand-side growth, the latter assuming an increasingly important role.

2.3 Higher economic growth brought with it positive trends in poverty reduction in both urban and rural areas. The share of the population living below the national poverty line decreased from 30% in 2011 to 24% in 2016. The government is implementing of its GTP II which will run up to 2019/20. GTP II aims to continue expanding physical infrastructure through public investments and to transform the country into a manufacturing hub. GTP II targets an average of 11% GDP growth annually, and in line with the manufacturing strategy, the industrial sector is set to expand by 20% on average, creating more jobs.

2.4 Recently, the Planning and Development Commission (PDC) has undertaken a medium-term performance evaluation on the implementation of the country's second five-year GTP II covering the period 2016-2020. According to the evaluation results, while the government has planned to register an 11 % economic growth in 2015/16 and 2016/17 budget years, the country achieved 8 and 10.9% over the two budget years respectively which averaged 9.5%. This means, the actual economic growth over the last two years is short of the plan by 1.5%.

2.5 According to the evaluation of the GTP II, the agriculture, industry and service sectors registered an average of 4.5, 19.7 and 9.5 % growth respectively. As to the Commission's report, agricultural value addition has not also met the target due to the El Nino induced drought in 2016 and the unrest in some parts of the country in the past three years.

2.6 The small and medium manufacturing sector is among the major sectors that received due attention in the preparation of GTP II as it was believed it would facilitate economic and structural transformation. The sector had a projected growth of 21 and 21.3 percent in the above-mentioned budget years respectively. Unfortunately, it was not managed to meet the targets so far as only 2.5 and 2.8 percent growth respectively was registered in the sector. And the major factor attributed to this low level of growth is the fact that small and medium manufacturing industries that use agricultural products as input have not developed at the desired level.

2.7 UNDAF (2016-2020) is the fourth of its kind Ethiopia and represents the strategic response of the UN Country Team to the national development priorities articulated in GTP II. Under the joint leadership and partnership of the Government and the UN system, the UNDAF 2016-2020 has been developed in a widely participatory manner. In addition to Government and UN agencies, it draws on inputs from development partners, the private sector and civil society organizations. As part of the Delivering as One process in Ethiopia, which requires all members of the UN family to work together in an integrated manner, the UNDAF represents the key programming instrument and foundation for joint strategic UN system support to the national development agenda.

2.8 While ensuring the mainstreaming of the Sustainable Development Goals (SDG) into the GTP II, the UNDAF is also directly linked to the SDGs relevant to the Ethiopia context. This provides a solid foundation for close collaboration between the Government and the UN system in localizing and rolling out the SDGs during the life cycle of the UNDAF (2016-2020).

2.9 To realize Ethiopia's successful journey towards becoming a middle income country and a climate resilient green economy by 2025, the UNDAF is strategically focused on supporting the country's growth and transformation in five areas including inclusive growth and structural transformation, building resilience and green economy, investing in human capital and expanding basic social services, good governance, participation and capacity building, and equality and empowerment. The UN Country Team in Ethiopia will pool resources and technical expertise as well as global networks and reach to help the country realize the objectives of the GTP II and stay on course for achieving its vision by 2025.

2.10 In addressing the issues raised above and contributing to the development frameworks highlighted above, the eighth CPD was developed within the framework of the four outcomes of the UNFPA Strategic Plan (2014-2017) and 6 outputs, namely:

- Outcome 1: Increased availability and use of integrated sexual and reproductive health services, including family planning, maternal health and HIV, that are gender-responsive and meet human rights standards for quality of care and equity in access

Output 1: National capacity increased to deliver quality maternal health services, including in humanitarian settings.

Output 2: National capacity strengthened to increase demand for and availability of family planning services, including reproductive health commodities.

- Outcome 2: Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health

Output 3: Capacity of adolescents and young people strengthened to make informed decisions on their sexual and reproductive health and rights.

Output 4: Institutional capacity strengthened to provide youth-friendly sexual and reproductive health services.

- Outcome 3: Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth

Output 5: Communities and institutions have enhanced capacity to promote and protect the rights of women and girls, and provide services to survivors of harmful traditional practices and gender-based violence.

- Outcome 4: Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality

Output 6: National institutions have the capacity to generate, analyse and use disaggregated data for planning, development, implementation, monitoring and evaluation of policies and programmes, including in humanitarian settings.

- Humanitarian and resilience building interventions are crosscutting through the above outcomes

2.11 Details of the programme components and results framework of UNFPA's eighth CP is provided in the Annex - 1.

EVALUATION OBJECTIVES AND SCOPE

3.1 Overall objectives²

1. Broaden the evidence base, including lessons learned and practical recommendations, for the next Ethiopia country programme cycle (July 2020-June 2025)
2. Enhance accountability of UNFPA and its country office for the relevance and performance of its country programme in Ethiopia
3. Inform decision making, improve programming and help UNFPA to become a better fit-for-purpose organization

3.2 Specific objectives

1. To provide an independent assessment of the progress of the programme towards the expected outputs and outcomes set forth in the results framework of the country programme
2. To provide an assessment of the extent to which programme implementation frameworks and modalities have enabled or hindered achievement of the programme outputs
3. To draw key lessons from past and current cooperation and provide a set of clear and forward-looking options leading to strategic and actionable recommendations for the next programming design

3.3 Scope

3.3.1 Timeframe

Within the framework of the above evaluation objectives, the CPE will cover the period from 2016 to 2020.

3.3.2 Geographic scope

The evaluation will cover the Woredas/District in 8 operational regions³ and two sub cities of one administrative city⁴ currently covered by the eighth CP taking into consideration the relevant

programme components⁵ of the 2016-2020 CPD—considering both development and humanitarian interventions.

3. EVALUATION CRITERIA AND QUESTIONS

4.1 Criteria

4.1.1 In accordance with the methodology for CPEs as set out in the 2019 UNFPA Evaluation Handbook on “How to Design and Conduct Country Programme Evaluations¹¹⁴” as well as UNFPA Evaluation Policy 2019¹¹⁵, this CPE will be guided by a maximum of ten questions.

4.1.2 The indicative questions for this evaluation are based on four of the five main components which are also highlighted by the Development Assistance Committee of the Organization for Economic Cooperation and Development (OECD/DAC). That is, Relevance, Effectiveness, Efficiency and Sustainability¹¹⁶. OECD-DAC evaluation criteria includes measuring ‘Impact’. However, this evaluation will not assess Impact due to the lack of required data for in-depth analysis. In addition, two other UN-specific evaluation criteria— Coordination and Added Value will be considered in the evaluation to help address questions related to UNFPA’s strategic positioning.

4.1.3 Because UNFPA Ethiopia CPD implements humanitarian interventions across its core programmes, this CPE will consider the criteria of UNFPA’s engagement in humanitarian context in Ethiopia.

4.2 Evaluation Questions

The final evaluation questions (maximum of eleven) and the evaluation matrix will be finalized by the evaluation team in the design report (to be approved by the Evaluation Manager, in consultation with the Evaluation Reference Group (ERG). The below questions are selected from the standard list of evaluation questions (section 1.2.2 of the UNFPA Evaluation Handbook) by the Evaluation Manager in line with the specifics of the Ethiopia programme.

4.2.1 Relevance

- 1) To what extent is the UNFPA support (i) adapted to the needs of the population (including needs of vulnerable groups), (ii) aligned with government priorities (iii) as well as with policies and strategies of UNFPA?
- 2) To what extent has the country office been able to respond to changes in national needs and priorities caused by major political, natural disasters and other contextual changes?

4.2.2 Effectiveness

¹¹⁴ <https://www.unfpa.org/updates/unfpa-evaluation-handbook-released>

¹¹⁵ <https://www.unfpa.org/admin-resource/unfpa-evaluation-policy-2019>

¹¹⁶ <http://www.oecd.org/dac/evaluation/49756382.pdf>

- 3) To what extent have the interventions supported by UNFPA helped to increase the access to and utilization of quality maternal health and family planning services by women and girls of reproductive age in both development and humanitarian contexts?
- 4) To what extent have the interventions supported by UNFPA helped to increase access to and utilization of quality, adolescent and youth-friendly SRHR, maternal health, and family planning services in both development and humanitarian contexts?
- 5) Within the framework of UNFPA gender equality and women's empowerment, to what extent it has contributed to (i) improved prevention and responses to gender-based violence and harmful traditional practices and (ii) gender mainstreaming across the programming areas?
- 6) To what extent have the interventions supported by UNFPA in the field of population and development contributed to increased availability and utilization of data and evidence at national and sub-national levels on population issues towards the ICPD agenda?

4.2.3 Efficiency

- 7) To what extent has UNFPA made good use of its human, financial and technical resources as well as an appropriate combination of tools and approaches to pursue the achievements of the CP outputs?

4.2.4 Sustainability

- 8) To what extent has UNFPA's support helped to ensure that SRH and rights and the associated concerns for the needs of young people, gender equality, and relevant population dynamics are appropriately integrated into national development instruments and sector policy frameworks in the programme country?
- 9) To what extent has UNFPA been able to support its partners and target populations in developing capacities and establishing mechanisms to ensure ownership?

4.2.5 Coordination

- 10) To what extent has the UNFPA country office contributed to the functioning and coordination of UNCT coordination mechanisms?

4.2.6 Connectedness

- 11) To what extent has UNFPA interventions contributed to humanitarian and development nexus?

4. EVALUATION METHODOLOGY

5.1 Compliance to standard and guidelines for evaluation in the UN system

The evaluation methodology will be guided by the 2019 UNFPA's evaluation handbook mentioned earlier. The handbook provides detailed approach to UNFPA evaluations. Hence, the evaluation

team is strongly encouraged at all times to refer to the Handbook which also provides specific templates¹¹⁷ (e.g. evaluation matrix; proposed evaluation questions; etc.). Also, the evaluation will be guided by the standards and guidance for evaluation in the United Nations system¹¹⁸: Norms and Standards for Evaluation (2016)¹¹⁹, Integrating Gender Equality and Human Rights in Evaluation¹²⁰, UNEG Ethical Guidelines¹²¹, and UNEG Code of Conduct for Evaluation in the UN system¹²². As such, the evaluation will be transparent, inclusive, and participatory, as well as gender and human rights responsive.

5.2 Contribution analysis

5.2.1 The Evaluation will utilize a theory-based approach. The results framework of the 8th CP will provide the basis in this regard, assessing the results at the respective CP outputs and their contributions to respective outcomes. The approach aims to provide credible evidence and logical reasoning from which realistic conclusions can be made within some level of confidence, whether the eighth CP has made significant contributions to the documented results.

5.2.2 Therefore, evaluators will base their assessment on the analysis and interpretation of the logical consistency of the chain of effects: linking programme activities and outputs with changes in higher level outcome areas, based on observations and data collected along the chain. This analysis should serve as the basis of a judgment by the evaluators on how well the programme under way is contributing to the achievement of the intended results foreseen in the country programming documents.

5.2.3 Hence, the evaluation team will develop the evaluation methodology in line with the evaluation approach, and design corresponding tools to collect data and information as a foundation for valid, evidence-based answers to the evaluation questions and an overall assessment of the country programme. The methodological design will include: an analytical framework; a strategy for collecting and analysing data; specifically designed tools; an evaluation matrix; and a detailed work plan.

5.3 Final evaluation questions

5.3.1 As mentioned in section 4 above, during the evaluation design phase, the evaluation team will produce an Evaluation Design Matrix also containing the evaluation lead-questions as well as sub-questions. Through the Evaluation manager, UNFPA and the evaluation team shall reach a common understanding on the evaluation design matrix. In drafting the evaluation questions, the evaluation team is strongly encouraged to refer to the UNFPA Evaluation Handbook among others.

¹¹⁷ Handbook, pages 18; 183

¹¹⁸ (<http://www.unevaluation.org/document/detail/102>)

¹¹⁹ <http://www.unevaluation.org/document/detail/1914>

¹²⁰ <http://www.uneval.org/document/detail/980>

¹²¹ <http://www.unevaluation.org/document/detail/102>

¹²² <http://www.unevaluation.org/document/detail/100>

5.3.2 The finalization of the evaluation questions that will guide the evaluation should clearly reflect the evaluation criteria and indicative evaluations questions listed in the present terms of reference. They should also draw on the findings from the reconstruction of the intervention logic of the country programme. The evaluation questions will be included in the evaluation matrix (see annex - 6) and must be complemented by sets of assumptions that capture key aspects of the intervention logic associated with the scope of the question. The data collection for each of the assumptions will be guided by clearly formulated quantitative and qualitative indicators also indicated in the matrix.

5.4 Data

5.4.1 Data collection/sources: The evaluation will consider both primary and secondary data sources.

- Primary data will be collected through semi-structured interviews and focus group discussions (FGD) at national and regional state level with government officials, representatives of implementing partners, academia, civil society organizations, beneficiaries, and other key informants. Field visits will be conducted, during which FGD will be conducted with beneficiaries. Observations during field visits will be conducted as appropriate.
- Secondary data will be collected through desk reviews of existing literatures focusing on programme documents such as programme review reports, programme and project performance/progress reports, country office annual reports, work plans, budgets, progress reports, field monitoring reports, databases, reports of thematic evaluations and findings of assessments conducted during the current CP, other UNFPA CO M&E tools, as well as the various evaluation/ assessment/ analysis/ research reports by implementing partners and other key partners.

5.4.2 Data disaggregation: The evaluation will seek and utilize quantitative and qualitative data disaggregated by age, gender, vulnerable groups, region, and status

5.4.3 Stakeholder selection and participation:

- Given the complex nature of the programming, geographical scope, and time constraints for the data collection, the evaluation team will have to ensure sufficient level of representation of the diversity of stakeholders.
- An inclusive approach is important to generate diverse views in regard to the evaluation findings. Hence, the evaluation team will ensure significant participation of direct and indirect partners and stakeholders at different levels—particularly line ministries at regional and federal level, implementing partners, UNFPA staff, academia, civil society organizations; UN agencies; as well as programme beneficiaries.

5.5 Sampling strategy

- The CO will provide an initial overview of interventions, locations and stakeholders. Based on the discussions and informed by the desk review, the evaluation team will select a sample

of sites and stakeholders for data collection clearly identifying the selection criteria applied. Stakeholders will be selected from national as well as subnational levels.

- The sampling strategy shall form part of the evaluation team’s design report. The CO will provide necessary inputs such as information on the priority programmes, accessibility and logistical support to collect data. The sample of sites and stakeholders shall reflect the variety of the CP interventions in terms of themes and contexts across the country where the programme is being implemented.

5.6 Validation

- All evaluation findings should be supported with evidence. The evaluation team will use a variety of validation mechanisms to ensure quality of data collected. The evaluation team will validate the data with key stakeholders and ensure that there are no factual errors or errors of interpretation and no missing evidence that could materially change the findings. Also validation of data will be sought through regular exchanges with the relevant UNFPA staff.
- To facilitate validation of data the evaluation will systematically triangulate data sources and data collection methods and tools by employing a combination of quantitative and qualitative methods.

5.7 Ethical Considerations

The evaluation process should conform to the relevant ethical standards in line with UNEG and UNFPA Ethical Guidelines for Evaluation, including but not limited to consideration of informed consent of participants, privacy, and confidentiality. Mechanisms and measures to ensure that standards are maintained during the evaluation process, should be provided in the design report. Details on the ethical standards are provided in Annex - 5.

5.8 Limitations to the methodology and constraints to the data collection

Data availability, the structure of the UNFPA programme planning system as well as a number of other constraints constitute challenges for the design and conduct of a CPE at UNFPA. In the evaluation design report, the evaluators need to be aware of the most common constraints and challenges, so they can better anticipate them and develop strategies to mitigate them, or adopt alternative options with a view to minimizing their effect on the quality and credibility of CPE¹²³. A few specific constraints have been identified that may have implications on methodological approach and data collection process during the evaluation. These include:

- Following the recent reform measures by the Government, it is expected that the new leadership assigned in some government partners may not have full knowledge of what and how UNFPA does.
- Due to current changes and competing priorities, all key government officials and other stakeholders may not be available during data collection.

¹²³ UNFPA Evaluation Handbook (February 2019), pg. 51 - Revised and updated edition ¹⁶ UNFPA Evaluation Handbook (2019)

- Inaccessibility of some of the operational districts due to insecurity in some of operational regions.

5. EVALUATION PROCESS

Below is the description of the phases of the evaluation process¹⁶

6.1 Preparatory Phase:

During this phase, the following will be undertaken:

- Gathering and reviewing of initial documentation regarding the country programme;
- Stakeholder mapping to identify partners and stakeholders for the purpose of the evaluation;
- Drafting of ToR for the evaluation; and
- Selecting and recruiting the evaluation team

6.2 Design Phase:

During this phase, the following will be undertaken:

- Reconstructing the country programme ToC – ensuring that the planned activities relevant to intended results to be achieved
- Identification of key performance measures and their effectiveness to guide the judgment on the programme performance
- Evaluation matrix: Finalize the list of evaluation questions, identify related assumptions and indicators to be assessed, and data sources (using the template and example provided in the UNFPA CPE Handbook)
- Identification of appropriate methods and tools for data collection
- Developing a concrete work plan for the field phase along with clear delineation of the roles and responsibilities of team members
- Finalizing an approved design report produced in accordance with the UNFPA CPE Guidance

6.3 Field Work Phase

During this phase, the evaluation team will collect and analyse data required to answer the pre-set evaluation questions. At the end of the phase, the team will provide the CO a debriefing report presenting the preliminary findings and results, as well as tentative conclusions and recommendations. A debriefing workshop with the key stakeholders will be conducted in an effort to validate these.

6.4 Reporting Phase

During this phase, the evaluation team will continue the analytical work initiated during the field phase. Additional inputs from the debriefing together with other information coming from the

analysis of the data already collected are expected to feed into the development of the first draft of the final evaluation report. The evaluation team will prepare the first draft of the evaluation report, taking into account the comments made by the CO and ERG at the debriefing workshop. The draft evaluation report will be submitted to the ERG for formal review and comments. The comments from the ERG will be addressed by the evaluation team an audit trail of response to comments provided. The process will continue until the ERG determines that the report meets the required quality standards. Once the ERG is satisfied with a version of the draft report, a dissemination workshop will be organized and attended by the CO staff and stakeholders, including the key in-country partners. Inputs and comments arising from the discussions shall form the basis of the final report. The CO will then perform an Evaluation Quality Assessment (EQA) of this final report and share with ESARO.

6.5 Management Response, Dissemination and Follow Up

During this phase, the country and regional offices as well as the Evaluation Office and other relevant divisions at UNFPA headquarters will be informed of the results of the evaluation. The evaluation report, accompanied by a document listing all recommendations will be communicated to all relevant units within UNFPA, with an invitation to submit their response. Once filled, this document will become the management response to the evaluation. The evaluation report, along with the management response, will be published in the UNFPA evaluation database. The evaluation report will also be made available to the UNFPA Executive Board and will be widely distributed within and outside the organization. Sharing of the final evaluation reports will be guide by a Communication Plan for Sharing Evaluation Results¹²⁴ completed by the CO in consultation with UNFPA ESARO.

6.6 The final quality assessment is performed by UNFPA Evaluation Office. The report when shared with the public will be accompanied by the EO EQA to inform of its quality and level of confidence in the evaluation results. Please see below section 8 on quality assurance.

6. EXPECTED OUTPUTS AND DELIVERABLES

7.1 The evaluation team will produce the following deliverables:

1. A **Design Report**¹²⁵ (maximum of 30 pages):
 - Stakeholder Map¹²⁶
 - Evaluation Matrix, including final list of evaluation questions and indicators
 - Overall Evaluation Design and Methodology, including a detailed description of the sampling and data collection plan
 - A Work Plan¹²⁷ and Roles and responsibilities of the team members

¹²⁴ UNFPA Evaluation Handbook (2019): Template 16, pg. 279

¹²⁵ Format of the Design Report is provided in Annex - 7

¹²⁶ UNFPA Evaluation Handbook (2019): Template 4, pg. 256

¹²⁷ UNFPA Evaluation Handbook (2019): Template 5, pg. 278

2. A **Debriefing Presentation Document**¹²⁸ (not more than 45 MS PowerPoint slides) synthesizing the main preliminary findings, conclusions and actionable recommendations of the evaluation, to be presented and discussed with the CO and ERG during the debriefing meeting foreseen at the end of the field phase
3. A **Draft Evaluation Report**¹²⁹ (followed by a second draft, taking into account potential comments from the ERG)
4. A **Microsoft PowerPoint presentation slides**¹³⁰ of the results of the evaluation for the dissemination workshop (not more than 45)
5. A **Final Evaluation Report**¹³¹, based on comments expressed during the dissemination workshop, and all collected data
6. An **Evaluation Brief**, a two-page summary of key evaluation findings/ conclusions/ suggested recommendations of the final CPE report
7. **Electronic Copies** of data collected and analysed as well as all transcribed deliverables including synthesis notes per the CP components¹³²

7.2 All deliverables will be submitted in English Language and shall follow the structure and detailed outlines in the 2019 Handbook on How to Design and Conduct a Country Programme Evaluation at UNFPA.

7. EVALUATION QUALITY ASSURANCE

8.1 The CPE has a three-stage evaluation quality assurance, which are:

8.2 The first level of quality assurance of all evaluation deliverables will be conducted by the evaluation team leader prior to submitting the deliverables to the review of the CO. The CO recommends that the evaluation quality assessment checklist listed briefly below and placed as Annex - 9 is used as an element of the proposed quality assurance system for the draft and final versions of the evaluation report.

8.2.1 Structure and Clarity of the Report

To ensure report is user-friendly, comprehensive, logically structured and drafted in accordance with international standards

8.2.2 Executive Summary

To provide an overview of the evaluation, written as a stand-alone section including key elements of the evaluation, such as objectives, methodology and conclusions and recommendations.

8.2.3 Design and Methodology

¹²⁸ Sample: https://www.unfpa.org/sites/default/files/admin-resource/Presentation_FP_key_results.pdf

¹²⁹ Report format is provided in Annex - 7

¹³⁰ Sample: https://www.unfpa.org/sites/default/files/admin-resource/Presentation_FP_key_results.pdf

¹³¹ Format of the Final Report is provided in Annex - 8

¹³² Further discussion with the evaluation team will be held on the format and expected content

To provide a clear explanation of the methods and tools used including the rationale for the methodological choice justified. To ensure constraints and limitations are made explicit (including limitations applying to interpretations and extrapolations; robustness of data sources, etc.)

8.2.4 **Reliability of Data**

To ensure sources of data are clearly stated for both primary and secondary data. To provide explanation on the credibility of primary (e.g. interviews and focus groups) and secondary (e.g. reports) data established and limitations made explicit.

8.2.5 **Findings and Analysis**

To ensure sound analysis and credible evidence-based findings. To ensure interpretations are based on carefully described assumptions; contextual factors are identified; cause and effect links between an intervention and its end results (including unintended results) are explained.

8.2.6 **Validity of conclusions**

To ensure conclusions are based on credible findings and convey evaluators' unbiased judgment of the intervention. Ensure conclusions are prioritised and clustered and include: summary; origin (which evaluation question(s) the conclusion is based on); detailed conclusion.

8.2.7 **Usefulness and clarity of recommendations**

To ensure recommendations flow logically from conclusions; are targeted, realistic and operationally feasible; and are presented in priority order. Recommendations include: Summary; Priority level (very high/high/medium); Target (administrative unit(s) to which the recommendation is addressed); Origin (which conclusion(s) the recommendation is based on); Operational implications.

8.2.8 **SWAP - Gender**

To ensure the evaluation approach is aligned with SWAP. (guidance on the SWAP Evaluation Performance Indicator and its application to evaluation can be found at <http://www.unevaluation.org/document/detail/1452> - UNEG guidance on integrating gender and human rights more broadly can be found here: <http://www.uneval.org/document/detail/980>)

8.3 The main purpose of this checklist is to ensure that the evaluation report complies with evaluation professional standards. ***The evaluation report will be read in conjunction with their EQA.***

8.4 The second level of quality assurance of the evaluation deliverables will be conducted by the CO Evaluation Manager. During the field and analysis phases, the CO Evaluation Manager will ensure that the data collection and recording are consistent across the different evaluators and evaluation components. The final evaluation report will be reviewed by the Regional M&E Adviser, the Evaluation Manager, and the ERG to ensure the reliability of the data collected and reported as well as the overall credibility of the evaluation findings, the soundness of conclusions, and the alignment of the recommendations to the findings and conclusions as well as their feasibility.

8.5 Finally, the evaluation report will be subject to assessment by an independent evaluation quality assessment provider. The evaluation quality assessment will be published along with the evaluation deliverables on the Evaluation Office website¹³³.

8.6 UNFPA Evaluation Office quality assurance system, based on the UNEG norms and standards and good practices of the international evaluation community, defines the quality standards expected from this evaluation. A key element is the EQA,¹³⁴ which sets out processes with in-built steps for quality assurance and outlines for the evaluation report and the review thereof. The EQA will be systematically applied to this evaluation.

8.7 Examples of good quality CPE reports can be found at:
<https://web2.unfpa.org/public/about/oversight/evaluations/>

8. THE EVALUATION TEAM & INDICATIVE DIVISION OF WORKING DAYS

9.1 The evaluation will be conducted by an independent multidisciplinary evaluation team composed of Evaluation Team Leader and two Thematic Evaluation Specialists.

9.2 The Evaluation Team Leader will have the overall responsibility during all phases of the evaluation to ensure the timely completion and high quality of the evaluation processes, methodologies, and outputs. In close collaboration with national evaluators, she/he will lead the design of the evaluation, guide the methodology and application of the data collection instruments, and lead the consultations with stakeholders. At the reporting phase, she/he is responsible for putting together the draft evaluation report, based on inputs from other evaluation team members, and in finalizing the report based on inputs from the ERG and stakeholders. To complement the assessment of the programme components, she/he will also assess the operational (e.g. financial, administration, procurement) and monitoring and evaluation systems of the CO in both development and humanitarian settings.

9.3 Evaluation Team Leader

Qualifications, Experience and Competencies of the Evaluation Team Leader:

- An advanced degree in social sciences, political science, economics, statistics, programme management, monitoring and evaluation, or related fields;
- Significant knowledge of and professional experience (minimum 10 years) in complex evaluations in the field of development aid for UN agencies and/or other international organizations;
- A demonstrable experience in leading multicultural, multi-disciplinary evaluation teams;
- Familiarity with the region in general, and Ethiopia in particular, is essential;

¹³³ <https://web2.unfpa.org/public/about/oversight/evaluations/>

¹³⁴ Annex – 9 presents the Evaluation Quality Assessment Grid

- Substantive knowledge and experience at least in one of the programmatic areas covered by the evaluation (SRH and rights, , gender equality, adolescent sexual and reproductive health, GBV and SRH and rights in humanitarian settings , population and development), preferably Population and Development;
- Familiarity with UNFPA or UN mandates and operations is necessary;
- Excellent management skills and ability to work with multi-disciplinary and multicultural teams;
- Excellent analytical, communication, and reporting skills; and
- Fluency in English.

9.4 The Team Leader will also act as a technical expert evaluator for a programme component. The other 2 team members will be selected in a way that they can cover other program components. The task distribution will be made in a way to ensure that the humanitarian component is adequately covered during the evaluation. I.e. the two national evaluation consultants will cover the following areas of expertise:

9.4.1 Sexual and Reproductive Health (SRH) Specialist

He/she will primarily be responsible for assessing the RH (including maternal health, family planning, adolescent sexual and reproductive health, and HIV/AIDS) thematic area of the CP under consideration in both regular development and humanitarian settings. She/he will take part in the data collection and analysis work during the design and field phases, and shall be responsible for drafting key parts of the design report and of the final evaluation report, including (but not limited to) sections relating to RH and rights.

Qualifications, Experience and Competencies:

- An advanced degree in public health, social sciences, political science, economics, statistics or related fields;
- Substantive knowledge of and professional experience (minimum 5 years) in reproductive health, including themes/issues relevant to: maternal health, family planning, ASRH, HIV/AIDS, cross-cutting themes such as youth and gender, and health systems in general;
- Significant knowledge and experience in complex evaluations in the field of development aid for UN agencies and/or other international organizations;
- Good knowledge of the national development context and fluency in English. Amharic is mandatory and knowledge of other major local languages would be an advantage;
- Familiarity with UNFPA or UN mandates and operations will be an advantage;
- Strong interpersonal skills and ability to work with multicultural, multi-disciplinary teams;
- Proven drafting skills in English; and
- Ability to work in a team.

9.4.2 Population and Development Specialist¹³⁵

He/she will primarily be responsible for assessing the population and development thematic area of the CP (e.g. collection and analysis socio-demographic data, evidencebased policy advocacy, national capacity development in evidence-based planning, monitoring and evaluation, analysis of population dynamics and their interlinkages with other sectors, strengthening of national statistical systems, etc.), including the use of population data in humanitarian situations. She/he will take part in the data collection and analysis work during the design and field phases, and shall be responsible for drafting key parts of the design report and of the final evaluation report, including (but not limited to) sections relating to population and development.

Qualifications, Experience and Competencies:

- An advanced degree in demography, social sciences, political science, economics, statistics or related fields;
- Substantive knowledge of and professional experience (minimum 5 years) in the area of population and development, including themes/issues relevant to demographic trends, the population dynamics, the population, environment and development nexus, migration, urbanization, the demographic dividend, Also conversant on national statistical systems and utilization/analysis of census data, evidence-based advocacy and policy dialogue, integrating population variables in development planning, democratic governance,, legal reform processes, evidence-based national and local development planning, monitoring and evaluation processes, and cross-cutting themes such as youth and gender;
- Significant knowledge and experience in complex evaluations in the field of development aid for UN agencies and/or other international organizations;
- Good knowledge of the national development context and fluency in English. Amharic is mandatory and knowledge of other major local languages would be an advantage;
- Familiarity with UNFPA or UN mandates and operations will be an advantage;
- Strong interpersonal skills and ability to work with multicultural, multi-disciplinary teams;
- Proven drafting skills in English; and
- Ability to work in a team.

9.4.3 Gender Equality Specialist

He/she will primarily be responsible for assessing the gender equality thematic area of the CP (e.g. women's human rights and reproductive rights, gender and development, prevention of discrimination, prevention and response to gender-based violence, etc.), including GBV prevention and response in humanitarian situations. She/he will take part in the data collection and analysis work during the design and field phases, and shall be responsible for drafting key parts of the design report and of the final evaluation report, including (but not limited to) sections relating to gender equality.

¹³⁵ This can be removed once decision is made at HQ level

Qualifications, Experience and Competencies:

- An advanced degree in women/gender studies, social sciences or related fields;
- Substantive knowledge of and professional experience (minimum 5 years) in gender equality, including themes/issues relevant to: women’s human rights and reproductive rights, gender and development, prevention of discrimination, prevention and response to gender-based violence, etc., and cross-cutting themes such as youth;
- Excellent knowledge and understanding of local country contexts; current policies and legislation
- Significant knowledge and experience of complex evaluations in the field of development aid for UN agencies and/or other international organizations;
- Good knowledge of the national development context and fluency in English. Amharic is mandatory and knowledge of other major local languages would be an advantage;
- Familiarity with UNFPA or UN mandates and operations will be an advantage;
- Strong interpersonal skills and ability to work with multicultural, multi-disciplinary teams;
- Proven drafting skills in English; and
- Ability to work in a team.

9.5 Allocation of working days per evaluation team member.

Evaluation Team	Design Phase (1-2 weeks)	Fieldwork Phase (3-5 weeks)	Reporting Phase (6-9 weeks)	Total Person-Days Required
Team Leader	10(incl. travel days)	22 (incl. travel days)	24 (incl. travel days)	56
Specialist-1	8	22	12	42
Specialist-2	8	22	12	42
Total	16	66	48	84

9. CONTRACT DURATION AND REMUNERATION ARRANGEMENTS

Workdays will be distributed between the date of signature and the approval of the submitted final report. The fee to be paid to the evaluation team shall cover professional fees. Travels to CP operational regions/sites will be covered by a travel advance or reimbursement, as appropriate, following UNFPA’s prevailing daily subsistence allowance (DSA) rates.

Payment of the fees will be based on the delivery of outputs, as follows:

Remuneration timeframe	Percentage by deliverable
Upon signing of the contract	15%
Upon CO acceptance of the design report	20%
Upon CO acceptance of the draft final evaluation report to be used in the dissemination workshop	40%
Upon CO acceptance of the final evaluation report	25%

10. INDICATIVE WORK PLAN, DELIVERABLES AND TIMEFRAME

The indicative work plan presents the phases and the corresponding activity/ milestones, timeframe, and responsible unit.

Phase	Activity/ Milestone	Ap ril	Ma y	Ju ne	Jul y	Au g	Sep t	Responsible Unit
Pre par ati on	Documentation regarding the country programme; Stakeholder mapping; Drafting of ToR for the evaluation; and Selecting and recruiting the evaluation team	Wk 3-4						
Des ign	Pre-evaluation briefings with the Evaluation Team (ET) on CPE expectations and requirements - Presentation by Evaluation Manager (EM), National Programme Officers, International Operations Manager		Wk 2-3					CO Programme Team, CO Operations Team, Eval'n Manager (EM), ET
	Desk review of secondary data and information for the development of the CPE Design Report							ET
	Draft and submit CPE Design Report to the CO/Evaluation Reference Group							ET
Fie ld	ET briefing, presentation, and approval of Design Report (including data collection tools and field work plan)			Wk 1-2				ERG, EM, UNFPA CO, ET
	Data collection from federal and selected districts of regional states, including preliminary analysis							ET
	Debrief at the CO							ET

Re por tin g	Continuation of analytical work initiated during the field phase			Wk 3-4			ET
	Preparation and submission of first draft evaluation report						ET
	Quality assurance of the first draft evaluation report by the ERG, CO, and ESARO M&E Adviser						ERG, EM, UNFPA CO, ESARO M&E Adviser
	Preparation and submission of the second draft evaluation report						ET
	Presentation and validation of evaluation results in an in-country dissemination workshop						ET, UNFPA CO, ERG, EM
	Preparation and submission of the final evaluation report based on comments expressed during the dissemination workshop, and all collected data				Wk 1-2		ET
	Review of Final Evaluation Report using the EQA Grid and submission of the Final Report and draft EQA to EO						ERG (for review and acceptance of final report) ¹³⁶
	Quality assessment of the final evaluation report by HQ					Wk 1-2	EO
	Preparation/ submission to ESARO of CO Management Response to Evaluation Recommendations						CO Management , UNFPA Program & Operations Teams, EM

¹³⁶ EM, ESARO M&E Advisor (for review of final report and preparation of draft EQA)

Dissemination and Follow up	Quality assessment of the CO Management Response							ESARO
	Dissemination of CPE findings						Wk 1-4	UNFPA CO, EM

11. MANAGEMENT OF THE EVALUATION

The CPE management will be overseen by the Country Office M&E Specialist, the ERG, and the evaluation team. Their roles and responsibilities are:

12.1 Evaluation Reference Group (ERG)

This is an independent evaluation, even though it is being commissioned by the unit that is being evaluated. While every effort will be made to protect the independence of the evaluation processes, analysis and reporting, it is also necessary to ensure quality standards are met by the evaluation. To avoid conflict of interest and protect the independence of the evaluation, quality assurance of the evaluation will be entrusted to the ERG. This group comprises of external group of stakeholders (national government, civil society, multilateral and bilateral donors, sister UN agencies and UNFPA ESARO) and will consist of members from the following organizations and entities, subject to confirmation and availability:

1. Ministry of Finance (MoF)
2. Planning and Development Commission (PDC)
3. Ministry of Health (MOH)
4. Ministry of Women, Children and Youth Affairs
5. Central Statistical Agency (CSA)
6. Regional Bureaus of Finance and Economic Development
7. Civil Society Organizations (CSOs) and academia
8. UNICEF
9. UNWOMEN
10. UNDP
11. UNDAF Results Group
12. UNDAF Monitoring and Evaluation Working Group (UNMEG)
13. Bilateral donors (Sweden, Canada)

14. Regional M&E Advisor, ESARO UNFPA

The ERG is expected to convene at least three times during the evaluation to ensure the milestones are achieved and has the following specific responsibilities:

1. Provide inputs to the ToR and assure quality;
2. Facilitate implementation of the evaluation, particularly during field work (enabling access to key informants, documents, mapping stakeholders, etc.);
3. Feedback on the quality of evaluation products and processes; and
4. Broaden the ownership of the evaluation and facilitate broader dissemination of the findings.

12.2 The Country Office M& E Specialist will serve as UNFPA's Evaluation Manager and will:

1. Lead the development of the CPE ToR and the preparation of the management response to the evaluation;
2. Facilitate access to background documents and to key informants during data gathering;
3. Lead the process of putting together the ERG;
4. Perform quality assurance of the evaluation deliverables as well as process for the evaluation products and processes: ToR, Design Report, Evaluation Report, sampling strategy, validation methods, etc.;
5. Serve as the CO focal point for ESARO, EO and relevant HQ Units;
6. Coordinate and convene the ERG meetings;
7. Manage the evaluation budget;
8. Ensure logistical and administrative support to the evaluation team;
9. Upload the evaluation ToR, final report, and EQA grid into UNFPA's evaluation database webpage and the CO website; and
10. Upload on a quarterly basis the implementation status of management response.

The Country Office M& E Specialist will be the convener of the ERG and will coordinate and facilitate communications between the evaluation team and the ERG. The ERG team will meet to discuss the ToR of the evaluation, the design report and debriefing after the evaluation fieldwork. Other consultations or requests for inputs from the ERG will be through e-mail communications.

12.3 UNFPA ESARO M&E Adviser

Will provide guidance and quality assurance as needed throughout the evaluation process.

12.4 UNFPA Evaluation Office

Will approve the final ToR and prequalify the evaluation team. The EO will provide the final Evaluation Quality Assessment of the CPE.

12.5 UNFPA Ethiopia CO

Will provide the necessary documents and reports and refer the team to web-based material or relevant official databases. The CO management and staff will make themselves available for interviews and provide technical assistance, as appropriate. The CO will provide necessary logistical support in terms of providing spaces for the meetings, assist in making the appointments and arranging travels and site visits, when necessary. The CO will assist the evaluation team in preparing and facilitating discussions at the field level. Use of office space will be provided as needed.

12. ETHICAL CONSIDERATIONS

The work of the evaluation team will be guided by the Norms and Standards established by the UNEG available at www.unevaluation.org/ethicalguidelines. Team members will adhere to the Ethical Guidelines for Evaluators in the UN system and the Code of Conduct, also established by UNEG. The evaluators will be requested to sign the Code of Conduct prior to engaging in the evaluation exercise.

13. LIST OF DOCUMENTS AND RESOURCES¹³⁷

Below is a list of reference documents used in the preparation of this ToR for the CPE, Ethiopia:

- Approved Extension Document for the seventh Ethiopia CP and the eighth CPD (2016-2020)
- Evaluative summary for the 7th CP (Light assessment)
- The eighth Country Programme Implementation by thematic areas and geographic focus
- Handbook on How to Design and Conduct a Country Programme Evaluation at UNFPA (Independent Evaluation Office, July 2016, February 2019)
- UNFPA Strategic Plans (2014-2017 and 2018-2021)
- UNDAF Documents
- Midterms Evaluation of UNDAF
- Major thematic Evaluations and Assessments conducted since beginning of the eighth CP
- Annual Reports and Baseline and End-line Studies
- HACT Micro Assessments reports
- Project Performance Reports
- <http://www.unfpa.org.ph/index.php>
- 2013 National Demographic and Health Survey (NDHS)
- 2013 Young Adult Fertility and Sexuality Study (YAFS4)

¹³⁷ Consultants will get access to the google drive folder that contains all the relevant documents up on signing of their contracts.

ANNEX 2: LIST OF PERSONS INTERVIEWED

SN	Name of person interviewed	Position and Organization
1	Teshome Yeshaneh	P & D Programme Specialist (CO)
2	Sumenya Meron	RPO Gambelle Region
3	Abebe Tenaw; Seyfu Bekele, Tesfeye Deressa	BoFED, Gambella Region
4	Rebecca Yachan	Ass. Response Officer, IMC
5	Eirmiyas Wordrufael	UNICEF Prog. Officer, Gambella
6	Collins Opiyo	Census Technical Advisor
7	Gezu	Prog. Analyst P & D
8	Geletew Engdaw	P & D Integration Director (Amhara Region)
9	Mulat Kiroj	Socioeco., Statistics, Information Mgt. Directorate
10	Habtamu Mou	Director of Development Corporation, Amhara
11	Dessalegn Akai	UNICEF Coordinator
12	Abebe Negash	UN Officer
13	Amare Dagnen	Bahir Dar, Branch Manager (SA)
14	Gojjman Tadsse	RPO (Amhara Region)
15	Asalfew Abera	DDG, CSA
16	Awoke T. Tebeje	Ass. Rep. UNFPA CO
17	Ulla Muella	Humanitarian Emerg. Coordinator
18	Fikre Gesso Teliha	Pop. Policy & Implementation Officer (P & D Commission)
19	Abebaw Eshite	Director for Pop. & Devt. Directorate
20	Karin Heissler	UNICEF, Child Protection
21	Ayele Negesse	Reg. Prog. Office Manager, CO
22	Njeri Kamau	UNDP Office Manager
23	Berhau Alemu	UNDP
24	Dawit Girma	Adolescent and youth program analyst, UNFPA CO
25	Dr. Mehabub	Maternal health analyst, UNFPA CO
26	Gemechis Shogo	FP/RH commodity security program analyst, UNFPA CO
27	Sr. Aster Berhe	Human Resource for Health, UNFPA CO
28	Estibel Mitiku	Capacity Building Specialist (UNV), MOY
29	Abel	Youth Participation Expert, MOY
30	Sumeya Menoken	RPO, UNFPA - Gambella
31	Abebe	Planning Officer, Gambella BoFEC
32	Tesfaye Deressa	Public Finance Management Core Process Owner, Gambella BoFEC
33	Seifu Bekele	UN focal Person, Gambella BoFEC
34	Rang Push	HPDP Process Owner, Gambella RHB

SN	Name of person interviewed	Position and Organization
35	Balcha Bergoro	MCH Coordinator, Gambella RHB
36	Abdissa Tarekegn	PMTCT and MDSR Officer, Gambella RHB
37	Figkru Letose	Maternal Health and AYH Officer, Gambella RHB
38	Ojilu Omod	Curative and Rehabilitative Core Process Owner, Gambella RHB
39	Ochag Ochag	Community Participation Director, Gambella Region BoWCA Head Office
40	Zeritu Kebede	Gender Mainstreaming Officer, BoWCA Head Office
41	Girum Gebreyesus	Women Mobilization and Participation En/Director, BoWCA Head Office
42	Addisu Ashagre	Finance Team Leader, BoWCA Head Office
43	Dr. Yared Denekew	Gynecologist, Gambella Hospital
44	Oumod John	CEO, Gambella Hospital
45	Samuel Geleta	SGBV Focal Person, Gambella Hospital - One Stop Center
46	Mini-Blood ban team (Laboratory Unit)	Gambella Hospital - Mini Blood Bank
47	2 beneficiaries of Gambella Hospital Fistula Center	Youth girl waiting for fistula repair and her mother, Gambella Hosopital - Fistula Unit
48	Awoke Getu	Acting Program Coordinator, IMC – Gambella
49	Ekram Ousman	Acting Manager for GBV, IMC – Gambella
50	Endale Berhanu	Senior SRH Manager, IMC – Gambella
51	Okelo Ager	Itang WoHO Acting Head, Itang Health Center
52	Mekuanint Abebe	Itang HC Acting Head and Midwife, Itang Health Center
53	Obang Opora	Itang WoHO Administration Head, Itang WoHO
54	11 beneficiaries	Peer educators, Nguyyiel Camp Womena and Girls Safe Space
55	Tessema Ergetie	Public Health Team Leader, ARRA Helath Center - Nguyyiel Camp
56	Tibebe Beyene	Clinic Coordinator, FGAE- Gambella
57	Dingetu Mamo	Laboratory Tech, FGAE- Gambella
58	Dr. Meseret	MCH Director, MoH
59	Dr. Tadelle	Family Planning Coordinator, MoH
60	Bethelhem Taye	Family Health Team Coordinator, AA RHB
61	Samson Tekeste	Maternal and Adolescents Health Officer, AA RHB
62	Tesfaye Bogalle	UNDAF (UNICEF/UNFPA Program Coordinator), AA HAPCO
63	Ato Mezgebu	ADA Vice Program Director, Amhara Development Association

SN	Name of person interviewed	Position and Organization
64	Ato Bizualem	ADA GBV Coordinator, Amhara Development Association
65	Awoke Mengistie	Youth Mainstreaming Mobilization and Participation Directorate Director, Amhara Bureau of Women, Children, and Youth Affairs
66	Bereket Yohannes	UNICEF – UNFPA JP Coordinator at BoWCYA, Amhara Bureau of Women, Children, and Youth Affairs
67	Asnake Leoul	Women Mobilization and Participation Expert, Amhara Bureau of Women, Children, and Youth Affairs
68	Yirgalem Ashagrie	HIV Multisectoral Response Coordinator, Bahirdar Town Health Office
69	Ato Yitayal	JP Coordinator for Bahir Dar, Bahirdar Town Health Office
70	Sr. Haimanot Firde	MCH Adolescents and Nutrition Officer, Bahirdar Town Health Office
71	Sr. Zewdie	Health care provider @ YFSC, Bahirdar Health Center YFSC
72	Melisew Chanialew	Health promotion and disease prevention directorate director, Amhara RHB
73	Abebaw Alemu	MCH case team officer, Amhara RHB
74	Wudineh Geremew	HIV/.AIDS multisectoral directorate, Coordinator, Amhara RHB
75	Temta Mengistu	HIV/AIDS multisectoral, JP Coordinator, Amhara RHB
76	Demelash Yirdaw	Multisectoral Response Officer, Gugusa shikudad - Health office
77	Emenesh Megist	Multisectoral Response Officer, Gugusa shikudad - Health office
78	Biruktawit Wole	Women, Children and Youth Affairs Expert, Gugusa shikudad - WCYA office
79	Abraham Seyoum	Women Participation and Mobilization Expert , Gugusa shikudad - WCYA office
80	Four team members of Kebele Administration	Jibayta Kebele, Guagusa Shikudad Woreda
80	Alebel	Kebele Administrator, Jibayta Kebele, Guagusa Shikudad Woreda
81	Senait	Kebele CEO, Jibayta Kebele, Guagusa Shikudad Woreda
82	Workinesh	Kebele Women Affairs, Jibayta Kebele, Guagusa Shikudad Woreda

SN	Name of person interviewed	Position and Organization
83	Gojam	Kebele Women League and CC facilitator, Jibayta Kebele, Guagusa Shikudad Woreda
84	Getasew Asfaw	Dera Woreda Health Office Head, Dera WoHO
85	Tadesse Setegn	Multisectoral Response Coordinator, Dera WoHO
86	Mr. Takele	HC Director, Ambessame HC
87	Sr. Bitaniya	AYFSC Service Provider, Ambessame HC YFSC
88	Ato Aseffa	Health and Anti-AIDS Club Coordinator, Ambessame High School
89	Ato Temesgen	School Director, Ambessame High School
90	No Name	Youth Association Support and Mobilization Team leader, Dera Woreda WCYA Office – youth
91	No Name	Hamusit Youth Center Attendant, Hamusit Youth Center
92	Mr. Takele	Midwife, MCH Coordinator, Hamusit HC
93	Sr. Bitaniya	Nurse, Hamusit Health Center YFSC, Hamusit HC
94	Tiruneh Asrat	Maternal Health Officer , East Wollega Zonal Health Office
95	Netsanet Sahilu	Women Economic Organization and Mobilization Officer, East Wollega Zonal WCA Office
96	Fikiru Tafesse	Jimma University HAPCO Coordinator, Jimma University
97	Abera Jaleta	Jimma University HAPCO Vice Coordinator (Amdinistrator), Jimma University
98	Neima Temam	Reproductive Health and Immunization Coordinator, Jimma Zone Health
99	Dr. Gelmessa	Focal Person for One Stop Center, Nekemte Hospital One Stop Center
100	Sr. Tirunesh	One Stop Center Coordinator, Nekemte Hospital One Stop Center
101	Meskerem Gonfa	Health Officer, YFSC Service Provider, Ejere Health Center
102	Sintayehu Worku	Vice Head of Health Center, Ejere Health Center
103	Ajema Negassa	Ejere WoHO MCH Coordinator, Ejere Health Center
104	Medhanit Ahmed	YFSC – Health Officer, Ginchi Health Center
105	Meti Ararsa	Health Center Head, Ginchi Health Center
106	Ararsa Gudeta	Dendi WoHO MCH Coordinator, Dendi WoHO
107	Tolera Garuma	Maternal Health, RH, and AYH Focal Person , West Shoa Zonal Health Office
108	Abebe Tolera	WCA Head, West Shoa Zonal WCA Office

SN	Name of person interviewed	Position and Organization
109	Mergitu Debella	Gender Directorate Director, Wollega University HAPCO and Gender
110	Abinet Jallela	HAPCO Officer/expert, FHAPCO
111	Abeba Kebede	UNFPA program coordinator, A.A Bureau of Finance and Economic Development
112	Anane Miressa	UNFPA focal person, A.A Bureau of Finance and Economic Development
113	Micael Seyoum	Finance officer , A.A Bureau of Finance and Economic Development
114	Teshaye Birhanu	Gender mainstreaming directorate director, A.A Bureau of Women, Children and Youth Affairs
115	Sileshi Tadesse	Women mobilization and participation enhancement directorate director, Ministry of Women, Children and Youth Affairs
116	20+	Women and girl friendly spaces/Main Center Beneficiary, Gambella Njuenyiel Refugee camp
117	12+	Women and girl friendly spaces/ satellite center Beneficiary, Gambella Njuenyiel Refugee camp
118	Abebe Demenew	Women and children affairs officer, Etang Special Woreda
119	Blogne Mac	Social worker , Etang Special Woreda Women and Girl Safe Spaces
120	Abajedo Agagna	Branch office director, Ethiopian Evangelical Mekane Yesus Church East Gambella Bethel Sinodos
121	Ojulu Omod	Child marriage program coordinator, Ethiopian Evangelical Mekane Yesus Church East Gambella Bethel Sinodos
122	Tsehay Getie	Gender and Human Rights, Program Analyst, CO
123	Hussien Ali Ahmed	Regional project officer, UNFPA Afar
124	Hussien Abdella	UNDAF program coordinator, Afar Bureau of Finance and Economic Development
125	Seada Mohammed	Technical assistant to BoWCAYA-UNFPA, Afar Bureau of Women, Children and Youth Affairs
126	Addu Endris	Technical assistant to BoWCAYA-UNICEF, Afar Bureau of Women, Children and Youth Affairs
127	Eskindir Kebede	HAPCO-UNDAF coordinator, Afar HAPCO
128	Wasasedak Ahmed	Health development and prevention of disease core process directorate director, Afar health bureau
129	Sr. Hawa Abdul	Mother and child care case team coordinator, Afar health bureau

SN	Name of person interviewed	Position and Organization
130	Zehara Mohammed	Community facilitator, Mille Woreda Hintimegeyetana Yidesa kebele
131	10+	Unmarried discussion group, Mille Woreda Hintimegeyetana Yidesa kebele
132	Adnan Hussien	Gender officer, Mille Woreda Women and Children office
133		Barbara May maternity health clinic, Mille Woreda
134	Mekonnen Tadesse	North east area manager, Semera FGAE
135	Seid Mohammedseid	Franchising officer, Semera FGAE
136	Ahmed Hussien	Clinical coordinator, Semera FGAE
137	Valerie Browning	Program coordinator, Afar Pastoralist Development Association
138	Adane Uruke	Clan leader/community conversation facilitator, Afambo Woreda Alasabolo Kebele
139	Mohammed Ali	Child care and protection officer, Afambo Woreda Women and Children's Affairs office
140	Fatuma Ali	Married adolescent girls club member, Afambo Woreda Mego Kebele
141	Fatuma Dawud	Married adolescent girls club dialogue facilitator, Afambo Woreda Alasabolo Kebele
142	Almaz Yoseph	Humadoita Kebele Women Development Sector head, Humadoita Kebele Women Development Sector
143	Sr. Medina Awol	Health Post head, Dubti Helath Post
144	Maed Hassen	Mother child care focal person, Dubti Health Post
145	Dr. Yetemwork G/meskel	Bureau head, Tigray Bureau of Women Affaris
146	Gebeyanesh Tadege	Program officer, Tigray Bureau of Women Affaris
147	Berihun Teklay	Finance director, Tigray Bureau of Women Affaris
148	Liya Mehari	Human resource director, Tigray Bureau of Women Affaris
149	Abeba	Director, Tigray Women Association
150	Letay	Program coordinator, Tigray Women Association
151	Selamawit Kitaw	Coordinator, Efoyta Safe House
152	2 Commercial sex workers	Beneficiary, Organization for social services, health and development (OSSHD)
153	2 Street children	Beneficiary, OSSHD
154	2 Students	Beneficiary, OSSHD
155	Kalayu Woldu	Project coordinator, OSSHD
156	Kiros Tesfaye	Project Officer, OSSHD

SN	Name of person interviewed	Position and Organization
157	Gebratekle-zebreabruk Hishe	Finance and admin head, OSSHD
158		Women beneficiaries, Hintalo Wajerat Woreda
159	10+	Adolescent girls safe space mentors, Hintalo Wajerat Woreda
160	10 members	Anti GBV watch group , Hageresalam Kebele Anti GBV watch group
161	12 members	Anti GBV and HTP Groups, Dr Atikilti Kebele
162	7 members	HTP Declared Kebele, Metsawork Kebele
163	15 members	Anti HTP Steering Committee, Begasheha Kebele
164	Melate Kasaye	Women affairs officer, Hintalo Wojerat Woreda Women Affairs Office
165	G/Selassie Berihun	HIV Awareness Creation and Women Economic Empowerment, Kolla Tembean Woreda Women Affairs Office
166	Salih Siraj	Women Expert, Kolla Tembean Woreda Women Affairs Office
167	Mulu Girmay	Deputy Head , Kolla Tembean Woreda Women Affairs Office
168	Abriha Gebru	Head, Kolla Tembean Woreda Women Affairs Office
169	Mekonnen Meresa	Management committee member, Adaha Health Center
170	Sr. Tsegehana Ambay	Midwifery nurse, Adaha Health Center
171	Teklay G/Tsadiq	Nurse, Adaha Health Center
172	Sr. Sindaye Hailu	Nurse, Adaha Health Center
173	Sr. Abeba Mulualem	MCH, KollaTembean Woreda Health Office
174	Maria Munir	Executive Director, Association for Women's Sanctuary and Development (AWSAD)
175	Senait Zewdie	Programme Coordinator, Association for Women's Sanctuary and Development (AWSAD)
176	Admasu Mentire	Programme Coordinator, KMG Ethiopia
177	Menbere Zenebe	Programme Director, KMG Ethiopia
178	Bethlehem Kebede	Gender and Human Rights Programme Specialist, UNFPA CO
179	Ato Seifu	Director, Procurement Directorate, Ethiopian Pharmaceutical Supply Agency

ANNEX 3: LIST OF DOCUMENTS CONSULTED

- Approved Extension Document for the seventh Ethiopia CP and the eighth CPD (2016-2020)
- Evaluative summary for the 7th CP (Light assessment)
- The eighth Country Programme Implementation by thematic areas and geographic focus
- Handbook on How to Design and Conduct a Country Programme Evaluation at UNFPA (Independent Evaluation Office, July 2016, February 2019)
- UNFPA Strategic Plans (2014-2017 and 2018-2021)
- UNDAF Documents
- Midterms Evaluation of UNDAF
- Major thematic Evaluations and Assessments conducted since beginning of the eighth CP
- Annual Reports and Baseline and End-line Studies
- HACT Micro Assessments reports
- Project Performance Reports
- <http://www.unfpa.org.ph/index.php>
- 2013 National Demographic and Health Survey (NDHS)

2013 Young Adult Fertility and Sexuality Study (YAFS4)

ANNEX 4: EVALUATION MATRIX

The Evaluation Matrix

EQ1: (i) To what extent is the 8th Country Programme responded to (addressed) the country's needs, national priorities, internationally agreed commitments on sexual and reproductive health and rights, and gender equality including GBV. (ii) To what extent has the 4th Country Programme been aligned to the UNFPA strategic priorities?				
COMPONENT 1: ANALYSIS BY FOCUS AREAS				
Criteria/Focus Area	Assumptions to be assessed	Indicators	Sources of Information	Methods and tools for data collection
RELEVANCE				
Sexual and Reproductive Health	<p>Objectives of the sexual and reproductive health focus area of the 2013-2017 CPAP are adapted to the needs of the population</p> <p>Objectives of the sexual and reproductive health focus area component are aligned with the priorities of the national policies and programmes</p>	<p>Extent to which reproductive and maternal health services for women and young people are incorporated in UNFPA supported/funded activities, plans, and programmes; and the geographical consistency of the programme vis-à-vis the needs and problems of the target groups.</p> <p>The UNFPA programme is in line with the national reproductive health strategy and programmes</p> <p>Extent to which the current UNFPA strategy</p>	<p>Target beneficiary groups.</p> <p>Programme Officers (UNFPA, National Partners, Implementing Partners)</p> <p>Local health authorities' staff</p> <p>National Department of Health</p> <p>CPAP</p> <p>Country Office</p> <p>Annual Reports</p> <p>Annual Work Plans</p> <p>Standard Progress Reports</p> <p>Target beneficiary groups.</p> <p>Programme Officers (UNFPA, National Partners, Implementing Partners)</p> <p>Local health authorities' staff</p>	<p>Study of relevant documentation</p> <p>Comparative analysis of programming documents (Desk review)</p> <p>Key informant interviews and Focus group discussions with final beneficiaries</p>

		<p>on maternal health, family planning and HIV prevention efforts is appropriate</p>	<p>Personnel at the Department of Health Laws and by-laws Sector programme documents</p>	
<p><i>Data and information collected</i></p>	<p>The 8th country program of UNFPA in Ethiopia is well aligned with the second Growth and Transformation Plan of Ethiopia and the corresponding UN Development Assistant Framework (UNDAF 2016-2020). Outcomes and outputs of the 8th country program are directly related to health and HIV outcomes of the third pillar of GTP II (investing in human capital and expanding access to social services) and women empowerment and youth outcomes of the fifth pillar of GTP II (Equity and empowerment).</p> <p>Components of the 8th CP have adequate focus on development of national capacities; however, there are missed opportunities for integrating stronger capacity building activities to ensure sustainable local capacity.</p> <ul style="list-style-type: none"> - Trainings have been provided through ToT approaches that allowed building local capacity both among trainers and trainees. <p>The Ethiopian Pharmaceutical Supply Agency is currently managing procurement of about 70% of drugs and other medical supplies to the country. The agency has several challenges that limit its ability to supply family planning commodities. UNFPA’s support to the health sector in procuring family planning commodities could have also served as a capacity building platform for EPSA. Apart from procuring commodities on the Ministry’s behalf, capacity building activities intending to capacitate EPSA has been limited.</p> <p>SRH interventions by nature are strong facilitators of gender equity and women’s empowerment. This has been particularly true in Ethiopia as SRH problems operate both as causes and consequences of gender inequality and lack of women’s empowerment.</p> <p>Youth centers, targets for several adolescent and youth development activities, mostly serve boys than girls. There were no deliberate efforts to increase utilization of these centers by youth girls.</p> <p>The program has given attention to adolescents and youth</p> <ul style="list-style-type: none"> - Support for the establishment and functionality of youth friendly service centers within government health centers has the potential to address barriers to utilization of SRH services among adolescents and youth. 			

- Lack of confidentiality and judgmental attitude of healthcare providers towards adolescents and youth seeking reproductive health services was a major barrier in the past. Establishment of YFSCs and training of healthcare providers on adolescent and youth health helped in addressing these barriers.

In addition to activities under adolescent and youth development, activities under SRH also benefit large numbers of female adolescents and youth who started child bearing

The first outcome of the 8th CP, Sexual and Reproductive Health) has facilitated close collaboration the health sector for the design and implementation of programs related to UNFPA’s mandate areas. The SRH component of the CP has been well aligned with the health sector’s five year strategic plan, the Health Sector Transformation Plan, and prevailing SRH problems of Ethiopians.

- The first strategic objective of the Health Sector Transformation Plan is to improve equitable access to quality health services. Among the key components of this strategic plan are scaling up effective health interventions including 1) reproductive, maternal, newborn, and child health services and 2) adolescent health.
- Despite increasing coverage of maternal health services, quality of care has been a major problem at different levels. Limited capacity of care providers has been a major reason behind poor quality of services. For example, according to the 2016 SARA report, the mean availability of BEmONC signal functions was 46% in 2016. The Health Sector Transformation Plan has also recognized this challenge and included quality of care as one of the transformation agendas.
- Unmet need for family planning is high particularly among rural-dwelling women. Ensuring uninterrupted supply of family planning commodities is an important aspect of the family planning program in the country. Government procurement policies and procedures are currently not efficient to meet consistency, quality and time requirements of the family planning program.
- The 8th CP of UNFPA is relevant in addressing these priorities of the Ethiopian health sector.
 - o Support for pre-service training in the areas of midwifery and anesthesia and in-service training of health professionals on BEmONC are relevant in addressing the skill gaps of the current as well as the future workforce for maternal health service provision
 - o Support for Maternal and Perinatal Death Surveillance and Response (MPDSR) including support for expansion of maternity waiting homes in response to delays to receive maternal health

	<p>services helped in identifying and addressing barriers to timely maternal healthcare provision.</p> <p>UNFPA has been supporting the health sector by procuring family planning commodities and financing part of the procurement.</p> <p>Attention given to HIV prevention and control among adolescents and youth has been inadequate in the 8th CP. The first pillar in the HIV prevention roadmap of Ethiopia is combination prevention for adolescent girls, young women & their male partners. Even though there were HIV prevention interventions in the 8th CP, there has been no separate output for it possibly leading to limited human resource in the area and very few HIV prevention interventions at different levels.</p> <p>Activities supported by the 8th CPD were in general aligned with sectoral strategic plans that are mostly designed with due consideration to existing evidences. The 8th CPD has also been informed by evaluations and studies conducted during the 7th CPD.</p> <p>Annual work plans reflect intersections between priorities of implementing partners and UNFPA mandate areas addressed through the country program. The process of annual work plan development that involves continuous communication between UNFPA CO and Regional team facilitates identification of IP priorities that are in line with CP components. However, the process takes the assumption that IPs have adequate capacity to identify critical bottlenecks to be targeted by UNFPA support. Field visits indicated this was not always the case. Even though there are adequate evidences showing that problems targeted by AWP of IPs are priority problems, specific activities do not always reflect priority actions. Reasons for this include:</p> <ul style="list-style-type: none">• None of the IPs visited had baseline or needs assessments• IPs do not have adequate understanding of response situations in operational Woredas• There is limited capacity among IPs to identify root causes of social problems and design evidence-based interventions appropriate for realities of operational woredas <p>AWPs are mostly prepared without adequate consultation to operational woredas Targets of SRH and youth components of the 8th CP included both duty bearers and rights holders. However, as shown in the reconstructed theory of change (page ___) the focus on rights holders has been minimal particularly for SRH interventions.</p> <p>Activities planned in AWP reached pre-defined target populations both in terms of operational areas and specific population groups.</p> <p>The program mostly served women and young people.</p> <p>Youth friendly service centers allowed youth girls to have access SRH services.</p>
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	<p>Youth centers supported by the program mostly serve youth with limited access to alternative recreational centers.</p> <p>The CO has been responsive to emergencies that happened during the period of the 8th CO. Humanitarian interventions for people internally displaced following conflicts and drought during the period of the 8th CO were results of responsive programming at the CO level.</p> <p>Implementing partners reported that there is little flexibility of activities once they are approved in annual work plans. Procedures to make adjustments have been reported to be unclear.</p>			
<p>Adolescent and Youth Development</p>	<p>Objectives of the Youth and HIV focus area of the 2013-2017 CPAP are adapted to the needs of the population</p> <p>Objectives of the Youth and HIV focus area component are aligned with the priorities of the national policies and programmes</p>	<p>Extent to which Youth and HIV services for women and young people are incorporated in UNFPA supported/funded activities, plans, and programmes; and the geographical consistency of the programme vis-à-vis the needs and problems of the target groups.</p> <p>Extent to which the UNFPA programme is in line with the national reproductive health strategy and programmes;</p> <p>Extent to which the current UNFPA strategy On Youth and HIV</p>	<p>Target beneficiary groups.</p> <p>Programme Officers (UNFPA, National Partners, Implementing Partners)</p> <p>Local health authorities' staff</p> <p>National Department of Health</p> <p>CPAP</p> <p>Country Office</p> <p>Annual Reports</p> <p>Annual Work Plans</p> <p>Standard Progress Reports</p> <p>Target beneficiary groups.</p> <p>Programme Officers (UNFPA, National Partners, Implementing Partners)</p> <p>Local health authorities' staff</p> <p>Personnel at the Department of Health</p> <p>Laws and by-laws</p>	<p>Study of relevant documentation</p> <p>Comparative analysis of programming documents (Desk review)</p> <p>Key informant interviews and Focus group discussions with final beneficiaries</p>

		prevention efforts is appropriate	Sector programme documents	
<i>Data and information collected</i>	<p>Ethiopia has large adolescent and youth population.</p> <ul style="list-style-type: none"> - Adolescents and youth in the age group 10-14, 15-19, and 20-24 years account for 15.6%, 10.6%, and 7.6% of the total population of Ethiopia, respectively - SRH related problems among adolescents and youth include <ul style="list-style-type: none"> o risky sexual practices, o child marriage, o early child bearing, o unintended pregnancy, o unsafe abortion o STIs including HIV - Sources of vulnerability include limited access to safe recreational facilities, low level of access to adolescent and youth friendly SRH services, and limited economic opportunities - The 8th CP has given attention to adolescents and youth particularly in the areas of increasing access to SRH services and facilitating youth participation. - Support for the establishment and functionality of youth friendly service centers within government health centers has the potential to address barriers to utilization of SRH services among adolescents and youth. - Lack of confidentiality and judgmental attitude of healthcare providers towards adolescents and youth seeking reproductive health services was a major barrier in the past. Establishment of YFSCs and training of healthcare providers on adolescent and youth health helped in addressing these barriers. - In addition to activities under adolescent and youth development, activities under SRH also benefit large numbers of female adolescents and youth who started child bearing 			

	<ul style="list-style-type: none"> - Youth centers, targets for several adolescent and youth development activities, mostly serve boys than girls. There were no deliberate efforts to increase utilization of these centers by youth girls. - Activities planned in AWP reached pre-defined target populations both in terms of operational areas and specific population groups. <ul style="list-style-type: none"> o The 8th CP largely served women and young people. o Youth friendly service centers allowed youth girls to have access SRH services. o Youth centers supported by the program mostly serve youth with limited access to alternative recreational centers. - Implementing partners reported that there is little flexibility of activities once they are approved in annual work plans. Procedures to make adjustments have been reported to be unclear. - Annual work plans reflect intersections between priorities of implementing partners and UNFPA mandate areas addressed through the country program. The process of annual work plan development that involves continuous communication between UNFPA CO and Regional team facilitates identification of IP priorities that are in line with CP components. However, the process takes the assumption that IPs have adequate capacity to identify critical bottlenecks to be targeted by UNFPA support. Field visits indicated this was not always the case. Even though there are adequate evidences showing that problems targeted by AWP of IPs are priority problems, specific activities do not always reflect priority actions. Reasons for this include: <ul style="list-style-type: none"> o None of the IPs visited had baseline or needs assessments o IPs do not have adequate understanding of response situations in operational Woredas o There is limited capacity among IPs to identify root causes of social problems and design evidence-based interventions appropriate for realities of operational woredas o AWP are mostly prepared without adequate consultation to operational woredas - Targets of SRH and youth components of the 8th CP included both duty bearers and rights holders. However, as shown in the reconstructed theory of change the focus on rights holders has been minimal particularly for SRH interventions. 			
Gender Equality/GBV	The intervention strategies of the gender equality and	Extent to which gender equality objectives and approaches of the current CPAP	Target beneficiary groups. Programme Officers (UNFPA, National Partners,	Study of relevant documentation Comparative analysis of programming

	<p>reproductive rights focus area of the 2013-2017 CPAP are adapted to the country's ethnic and cultural diversity</p> <p>Objectives of the gender equality and reproductive rights focus area component are aligned with the priorities of the national and international policy frameworks</p>	<p>account for regional diversity in terms of ethnicity and culture</p> <p>Extent to which objectives of International Conference on Women, CEDAW, UNDAF and the Strategic Plan of UNFPA are reflected in UNFPA programming documents</p>	<p>Implementing Partners)</p> <p>Local authority personnel.</p> <p>Personnel at Departments of health, Social Development, Women Affairs, National Youth Development Agency, South African National AIDS Council</p> <p>Sector programme documents</p> <p>CPAP Annual Work Plans ICPD and CEDAW progress reports</p> <p>UN agencies locally involved in reproductive health issues (UNFPA, WHO, UN Women, UNDP).</p> <p>Laws and by-laws</p>	<p>documents (Desk review)</p> <p>Key informant interviews and Focus group discussions with final beneficiaries</p>
<p><i>Data and information collected</i></p>	<p>The CP objectives and strategies are anchored on government priority since the aim is to support the Federal Democratic Republic of Ethiopia's effort to achieve gender equality and women empowerment. Key informant interviews with IPs revealed that the 8th Country UNFPA Programme was relevant and in line with the goals and priorities set in the UNDAF pillar 5 which is Equality and Empowerment as well as the national priority of the country and is in line with the Growth and Transformation Plan II (2015-20), which clearly sets the government's five year development plan that unequivocally indicates addressing gender-based violence using different strategies. The objectives and strategies of the CP and the AWP in GEWE components is consistent with global priorities and international commitments such as CEDAW; London 2014 Girl Summit which the government committed to end CM by 2014; and SGD Goal 5.</p> <p>The review of documents also clearly identifies gender equality and women empowerment as one of the key intervention areas. The specific country program</p>			

under review was found to be an important component to address gender inequalities that are exhibited in the country and to support the effort of the government to quicken gender equality and women empowerment through the different interventions employed by the CP such as Gender Equality and Women Empowerment, Abandonment of FGM /CM and CM, Accelerated action to end CM, Preventing and responding to SGBV/GBV and GBV in Emergency and host communities. Under these major programme components different activities that are targeted to prevent SGBV and HTPs; protect the rights of adolescent girls and women and promote their rights; and provision of direct services for the survivors are carried out.

There are different strategies of intervention in GEWE among which one is supporting the development of national capacities for sustainability of the programme. This include but is not limited to enhancing community and institutional capacities to promote and protect women and girls at all levels; creating a supportive and enabling environment to report SGBV; build capacities of communities and gate keepers to facilitate abandonment of HTPs, including FGM/C and CM through cultural sensitive approaches and solutions; promote capacities of adolescent girls and boys to create supportive environment to facilitate positive attitudinal changes on HTPs; direct service delivery for survivors of SGBV and HTPs, piloting innovative interventions such as safe houses for survivors, one stop centers, safe spaces for girls and women; scaling up best practices; and reinforce coordination and partnership mechanisms among partners for better leverages on range of issues; and promote positive traditional practices that strengthen community mobilization and dialogue to enforce and accelerate changes.

Key informants as well as reviewed documents highlighted that CO is also highly engaged in supporting the development of the *National Costed Roadmap to End Child Marriage and FGM/C* that will accelerate the effort of the Federal Democratic Republic of Ethiopia to end early/child marriage and female genital mutilation/cutting. UNFPA provided technical and financial support for the development of the roadmap.

Gender equality and women's empowerment is mainstreamed in the country program in general. The SRH and Y&A and the humanitarian programmes have gender components that directly address the needs and concerns of adolescent girls and women as they are most vulnerable segments of the society. From the document review it was also possible that humanitarian interventions also focus on mainstreaming gender and addressing issues related to girls and women since they are most vulnerable.

The responses from the different IPs also indicated that the country programme goes beyond mainstreaming gender in the CP. The CP also provide support the

MoWCYA to mainstream gender in its different programs through the sector bureaus gender directorate. It was also reported by many key informants that during the 8th CP UNFPA, as a member of the National Alliance to End CM and FGM focused on the issue of gender mainstreaming as a strategy to accelerate the gender equality and women empowerment. The interviewees indicated that the National Alliance to End FGM and ECM is also a good forum to address issues related to gender and address gender mainstreaming gaps.

Adolescent and youth are main targets of the different interventions of the Gender Equality and Women Empowerment program such as Abandonment of FGM /CM and CM; Accelerated action to end CM; Preventing and responding to SGBV/GBV and GBV in Emergency and host communities. Young people and adolescents are purposefully directed by the GEWE program since they are the most affected by SGBV and HTPs.

Key informants and direct beneficiaries indicated that most of the indirect and direct beneficiaries of the programme are youth. For example the Safe Houses and the One Stop Center beneficiaries are female youth since they are victims of SGBV and HTPs. But this does not mean to imply that the programme does not target youth male. Since they are the major partners in the fight against SGBV and HTPs, they also participate in the different events, awareness raising programmes and community dialogue that are carried out at national, regional and community level respectively.

The country program objectives and strategies are consistent with national policies and strategies such as National policy on women (1993), The Constitution of the Federal Democratic of Ethiopia (1995), The Revised Family Law (2000), The Revised Penal Code (2005) National Children's Policy (2017), The National Strategy and Action Plan on Harmful Traditional Practices (HTPs) against Women and Children (MoWCYA, 2013) which targets to reduce child marriage, abduction and FGM/C as part of broader gender and equity goals., and The Gender Strategy for the Education and Training Sector (MOE, 2015), as well as international policies ratified by the country such as Convention on Elimination of all Discrimination Against Women (1981),

The following two documents, though they are finalized very recently will provide a good fertile for the development of the 9th Country Programme in terms of accelerating gender equality and women empowerment in Ethiopia.

1. Women Development and Transformation Strategy which is ratified by the Council of Ministries last year and in the process of translation into English. This document will give clear direction on how to operationalize national and international policy.

The National Costed Roadmap to End Child Marriage and FGM/C (2020-2024) which is finalized in August 2019. This roadmap is evidence based costed plan which outlines the key strategies, packages of interventions, and expected results, targets

and millstones towards elimination of child marriage and FGM/C in Ethiopia and applies across all context in Ethiopia, including humanitarian and emergency situations which may be exacerbate risks of child marriage and FGM/C for girls, reduce access to protective services.

The CP used different strategies to identify the felt needs of the community. Key informants highlighted different method to identify the needs of the community before designing a programme like discussion and consultation with sector ministry, regional bureau and Woreda offices; direct field visits and observation, and as well as discussion and consultation with grass root structures and community members. The DHS report is also used a complimentary document.

The use of the bottom up approach rather than the conventional top down approach is used by UNFPA to identify the needs of the community. A key informant stressed the importance of involving the community to identify their own needs rather than only relying on reports.. For example when we started the programme in Afar National Regional State we thought that the major problem of the community was FGM and our aim was to focus on that. But it was the community who indicated that CM is also a serious problem for the community during the community dialogue and community conversation. During the community dialogue, the community also discussed and identified a strategy on how to address the issue like working with religious leaders since they are the one who gives the blessing for the marriage. This is an indication that the community not only identifies the felt needs but also are able to come up with strategies with little support. The target groups for the intervention are selected through discussion with the relevant government stakeholders as well as members of the community and grass root structures.

But it should also be noted that this is not true for all the sampled regions. For example interviews in Gambella and Afar indicated that most vulnerable groups are not as such targeted by the programme. In Gambella, there is high concern expressed by the respondents that the host communities are not as such given enough attention since most of the interventions are targeted towards the refugee camps. For example a site visit to the Safe spaces for girls is not well organized and given due attention compared to the Safe Spaces for Girls and Women in the refugee camps. On the contrary in Afar, though the region hosts many refugees the program interventions are focused on the host community and not the refugees who are most vulnerable. The programme tenaciously identifies target groups including most vulnerable segments of the community through high engagement and involvement of grass root structures such as the Women Development Army (except in the case of Afar), religious leaders and influential people in the community. Since they are part of the community, they know the community well and hence are able to identify vulnerable segments of the society easily which might be otherwise invisible for outsiders. The needs of most vulnerable groups have been taken into

	<p>account. For example interviewees and focus group discussants indicated that the community conversation is held within their community to accommodate the needs of most vulnerable groups of society such as young girls and people with physical disabilities as much as possible. But it was also found out that it was not always possible to accommodate the needs of people with special needs since it requires professional skill. A young girl who participated in a community dialogue indicated that since the discussion is held within her community she is able to attend the discussion. She and also her family feel safe for her to attend the discussion or otherwise she will not be able to attend the program. She expressed that she get a lot of information since attending the discussion and feel that it also change her life as she was able to report her arranged marriage to the community facilitator, and with the help of the woreda Office of Women and Children’s Affairs her marriage was stopped. The CO provides quick responses during crisis based on its mandate as much as possible though there is shortage of resources to address and respond to all situations.</p> <p>UNFPA has been involved in humanitarian programme efforts. A key informant interview from the MoWCYA cited two example where UNFPA responded to a humanitarian situation in collaboration with the ministry. The first is the distribution of dignity kits for emergency situations in Somalia, Gedeo and Oromia region for internally displaced adolescents and women. The second one was the support provided for 7 sexually abused women aged between 20-35 from Somalia region. UNFPA in collaboration with the ministry and another local NGO AWSAD brought the survivors and provided psycho social support in Addis Ababa. The respondent also indicated that UNFPA also support in providing training for staff on how to provide psychosocial support to address emergency issues.</p> <p>The office responds to crisis situations like conflict, internal displacement and drought by providing non-food items such as dignity kits in a timely manner though the adequacy of the service is questionable. Interviews help with IPs revealed that though UNFPA tries to respond to emerging needs there is always a matter of mandate and shortage of resources. UNFPA during emergency provides dignity kits though the provision is not compatible to the demand.</p> <p>In the context of humanitarian response UNFPA provided support during crisis on a “need basis” and provided assistance government and NGOs/IPs.</p>			
Population and Development	The objectives of the CPAP are aligned to the objectives in the National Development	Extent to which the priority areas of the National Development Plan: Vision 2030 have been included in	National Development Plan: Vision 2030 Paper Sectoral Policies and Strategies CPAP	Study of relevant documentation Comparative analysis between policy and

	<p>Plan: Vision 2030 document and responding to the national priorities</p> <p>The CPAP planned interventions are appropriately designed to reach the goals of the National Development Plan in terms of better service provision to citizens through evidence-based planning of policies</p>	<p>CPAP objectives and interventions.</p> <p>Balance between policy-level and project-level initiatives</p> <p>Extent to which interventions in the CPAP have been appropriately designed</p>	<p>Annual Work Plans</p> <p>Personnel at the Departments of Social Development, Women Affairs, Civil society organizations</p> <p>Laws and by-laws</p>	<p>programming documents</p> <p>Key informant interviews and Group discussions with programme officer and civil society organisations</p>
<p><i>Data and information collected</i></p>	<p>A careful review of the key activities and interviews with stakeholders knowledgeable about UNFPA PD activities showed that the PD Focus area is consistent with the needs of its beneficiaries, especially the staff and specialists employed by the main implementing partner agencies (CSA, and Population Directorate of Planning and Development Commission), and within national priorities and strategies. Additionally, respondents felt that contribution of UNFPA to PD is reflective of the ICPD Program of Action, SDG Agenda 2030. UNFPA supported technical assistance is particularly relevant given Ethiopia’s trends toward a youthful population age structure, which require expertise in population projections as well as support for policy development for the needs of its young population. UNFPA’s support for PD related activities is aligned with the development of the SDGs, which is guiding the UNDAF. UNFPA has and will probably continue to facilitate capacity building for INSTAT demographers and analysts as the demand for perfecting SDG indicators will become more acute over time</p> <p>UNFPA supported interventions are informed by prevailing national and sectoral policies and plans such as the National Population Policy, and the national strategy for development, GTP II. The development or review of these frameworks involved processes of situational analysis and identification of priorities. In addition, it is in</p>			

alignment with the 2014-2017 and 2018-2021 UNFPA Strategic Plan that highlights advocacy for population and development linkages. The P&D component was anchored on the ICPD PoA principles which stipulate that human beings are at the centre of sustainable development. This component was designed to promote integration of population issues into development strategies, planning and programming to achieve social justice and eradicate poverty. Internationally, it was also responsive to the ideals and actions as outlined in the International Conference on Population and Development (ICPD) PoA and also by extension the SDG 2030. The planned interventions in the CP8 were relevant and met the needs and priorities of a wide range of stakeholders and target groups. These included strengthening the capacity of Regional government planning and management to generate, access, utilise and disseminate relevant data for purposes of planning and tracking progress in government policies. The Population and Development component was relevant in that it helped bridge gaps of inadequacy of data for decision-making which was cited by Federal and regional implementation partners in various interviews; the capacity gaps in evidence-based planning and use of data to influence decision-making and the lack of appreciation of statistics among decision-makers. Key informant and in-depth-interviews revealed that Ethiopian governments at various levels have appreciated the use of data for development planning, although there is noticeable lack of technical skills and financial resources. At the Federal level, the Central Statistical Agency and Population Directorate are at the forefront of integration of population into national development respectively. The relevance of this component is captured in the statement by one of the stakeholders “data is the lifeblood of any development planning”.

EQ2: To what extent have the 8th Country Programme outputs been achieved and the extent to which these outputs have contributed to the outcomes?

EFFECTIVENESS

<p>Sexual and Reproductive Health</p>	<p>Expected outputs of the CPAP were achieved (both in terms of quantity and quality)</p> <p>The targeted groups of beneficiaries were reached</p>	<p>Degree of completion of outputs planned in the CPAP against indicators</p> <p>Evidence that completed outputs contributed to planned outcomes</p> <p>Significant changes in marginalised</p>	<p>CPAP Results Framework indicators</p> <p>CPAP Results Plan progress reports</p> <p>Statistics South Africa figures</p> <p>Relevant Health Survey data</p> <p>Personnel at the Department of Health at national,</p>	<p>Study of documentation</p> <p>Comparative analyses of the value of CPAP indicators (targets versus actual values)</p> <p>Key informant interviews</p> <p>Group discussions to</p>
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	<p>by UNFPA support</p> <p>Beneficiaries took advantage of benefits from the intervention supported</p> <p>There were unintended effects, positive or negative, direct or indirect</p>	<p>populations i.e. poor women in both rural and urban settings, women affected by HIV/AIDS, young girls.</p> <p>Number of tools with evidence produced to inform maternal health, family planning and HIV policy and programming at national and sub-national levels.</p> <p>Number of health care workers trained on the new FP guidelines in the UNFPA supported districts</p> <p>Number of UNFPA supported districts with functional Logistics Management Information Systems (LMIS) for forecasting and monitoring reproductive health commodities.</p>	<p>provincial and district levels.</p> <p>Progress reports of the Department of Health</p> <p>Beneficiary groups / communities</p> <p>SCF progress reports / mid-term review</p> <p>Implementing partners</p> <p>Quarterly and annual implementation progress reports</p> <p>UNICEF annual reports and evaluations</p> <p>UNFPA country office staff</p> <p>Country Office Annual Reports</p> <p>Previous evaluations</p>	<p>assess the quality of the outputs</p>
<p><i>Data and information collected</i></p>	<p>The 8th CP supported capacity building among of adolescents and young people so that they can make informed decisions on their sexual and reproductive health and rights. The program has supported provision of selected SRH services through youth centres, YFSCs, and school clubs. During the period 2016 to 2019, the program reached:</p>			

- 99,521 adolescents and youth with SRH services through UNFPA support (76.6% of the target for 2020)
- 32,225 adolescents and youth with life skill education (80.6% of the target for 2020)

SRH services through YFSCs and life skill education in different settings are reported to be effective strategies for providing SRH related information and services to adolescents and youth who otherwise would have been marginalized. Life skill education has been reported to have a wide range of positive impact particularly for girls. Among the most commonly reported positive outcomes were increased confidence and school performance of female students and increased utilization of SRH services including family planning and condoms. School clubs supported with mini-media equipment and trainings were effective in reaching large numbers of students with important SRH information. The support in this area allowed to maximally utilize capacities of students and their teachers in the regular provision of SRH information to school communities. The program also supported youth organizations and associations – mostly youth centers and school clubs. Both categories of targets mostly provide opportunities to reach large numbers of adolescents and youth.

Youth Centers: Youth centres located in convenient places and actively providing recreational activities attract adolescents and youth. UNFPA's support in visited youth centers was the primary source of materials required for these recreational activities (in-door and out-door games); Media instruments donated for youth centers created the potential for transmission of SRH messages to visitors of youth centers. Challenges in relation to youth centers include:

- Utilization of the opportunity created has been sub-optimal particularly because of the limited engagement of technical experts.
- Some youth centers are located at inaccessible locations resulting in non-use of available facilities.
- Girls involvement in youth center activities is very limited.

School clubs

Mini-media support to schools has led to self-sustained HIV/SRH information dissemination on a regular basis.

- The 8th CP supported health centres in establishing and running youth friendly service centres. Support included furniture, audio visual equipment, and trainings for service providers.
- By the end of June 2019, the percentage of health facilities providing the national standard minimum adolescent and youth service packages reached

	<p>75% among UNFPA targeted areas. The number of health workers equipped through training with knowledge and skills to provide youth friendly sexual and reproductive health exceeded the total target of 500 by reaching 704 more than a year before the completion of the CP period.</p> <ul style="list-style-type: none"> - Supported YFSCs provide comprehensive outpatient service for all clients in the age range of 10 to 24. - Integrating all outpatient services for 10-24 years adolescents and youth (including treatment of any illness) with YFSCs increases exposure of adolescents and youth to trained healthcare providers and improves confidentiality of SRH service provision. However, it has also posed a threat to SRH service provision. Because most cases are coming for non-SRH services, attention given to SRH by health service providers gets diluted. Additional challenges in this area include: <ul style="list-style-type: none"> o Lack of comprehensiveness of services at YFSCs leading to high referral rates to other units and other facilities o Not all YFSCs have in-door and out-door recreational facilities <p>Lack of space compromising the utility of donated equipment (eg. Television put/stored in the examination room because there was no secure waiting area)</p> <ul style="list-style-type: none"> - Implementing capacity of government IPs and their district offices is very limited. - As a result, planning, implementation, and monitoring (activities that are expected from IPs) are compromised. <p>There is need for either more technical support at lower levels or more capacity building activities targeting the IPs themselves.</p> <ul style="list-style-type: none"> - Ethiopia has shown improvements in several SRH outcomes during the period of the 8th CP. Between 2016 and 2019, <ul style="list-style-type: none"> o Coverage of at least one visit of ANC from a skilled provider increased from 62% to 74% o Coverage of at least four visits of ANC increased from 32% to 43% o The proportion of deliveries attended in a health facility increased from 26% to 48% - UNFPA’s support has been helpful for increasing demand for and quality of maternal health services. These contributions include 1) engagement (technical support as a member of technical working groups or other modalities) at federal level in the development of strategies, guidelines, and trainings and 2) Specific interventions targeting specific geographic areas. - Specific areas of support on maternal health included: <ul style="list-style-type: none"> o Support for BEmONC and CEmONC o Human resource development (Midwifery, anesthesia) o Short term trainings for the current workforce
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	<ul style="list-style-type: none"> ○ Furnishing maternity waiting homes ○ Training on BEmONC including the use of mentorship (expanded note as good practice in the report) leveraging local capacity (eg. in Gambella) ○ Strengthening CEmONC including support for mini-Blood bank establishment at Gambella Hospital ○ Trainings on MPDSR ○ Trainings on cervical cancer screening and donation of equipment/supplies ○ Identification, referral, and treatment of fistula cases ○ Strengthening referral system for maternal health services - While engagement at the federal level has been acknowledged to have brought system-wide influences, specific interventions targeting specific geographic areas were commonly reported as effective but too small in coverage to bring about large-scale impact. - BEmONC trainings provided at the Woreda level had issues on quality of training arising from administrative challenges <ul style="list-style-type: none"> ○ BEmONC trainings were planned and implemented at woreda level. The maximum amount of payment that a trainer can be paid by providing training at Woreda level is 70birr per day. This has led to the use of trainers who are not competent enough to deliver the training. - Between 2016 and 2019, modern contraceptive use among currently married women increased from 35% to 41%, nationally. - UNFPA’s support has been helpful for increasing demand for and access to family planning services. These contributions include <ul style="list-style-type: none"> ○ Building the capacity of service providers ○ Engagement in monitoring progress of Ethiopia towards its commitments on family planning <ul style="list-style-type: none"> ▪ Strengthening the supply chain system for family planning/RH by working with the supply agency (EPSA) and the regulatory agency (FMHACA) ○ Improve availability of commodities <ul style="list-style-type: none"> ▪ Provided in kind support (family planning and other SRH commodities) by using resources that UNFPA mobilizes ▪ Provided procurement service to the government of Ethiopia ○ Support expansion of family planning services to the HEP through <ul style="list-style-type: none"> ▪ Evidence generation ▪ Supporting targeted interventions including training of level 4 HEWs on LARC
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- Progress of the CP in terms of family planning related activities was sub-optimal. Achievements so far include:
 - o The percentage of service delivery points offering modern contraceptives (at least three types of modern contraceptives for primary SDPs and at least five types of modern contraceptives for secondary and tertiary SDPs) has been consistently above the 95% target throughout the CP's life.
 - o The percentage of service delivery points with seven (including 2 essential) life-saving maternal / reproductive health medicines was also consistently good compared to planned targets.
 - o Relatively low achievement was recorded for training of HEWs on LAFP. Only 21,329 (59.2%) of the targeted 36,000 HEWs were training on LARFP methods during the program's life time. The main reason for this under achievement was reported to be expansion in content of training affecting training duration and thus total number of trainees.
- Family planning commodities are available in adequate quantity and quality. UNFPA's support has been very helpful for ensuring adequate supply of family planning commodities. Demand for family planning has also increased; however, there is still a huge gap. None of the health facilities visited had shortage of family planning commodities.
- Once AWP's are approved, resources are provided to each IP and operational area based on the AWP. Funds transferred to IPs are generally used reasonably and only to the purposes they are assigned for.
- Delay in transfer of funds affects implementation of planned activities. IPs have reported that they most of the time had to rush implementation of activities because there will always be delays in transfer of funds.

There is long chain of approval of annual plans, report reviews, and funding transfers.

- Resources are very thinly spread over wide geographic areas than what can potentially be supported meaningfully.

Budget utilization rate increased over time. In 2016, SRH/AYD component of the program used 74% its budget. This figure increased to 83% in 2017 and 90% in 2018. Donation of equipment and furniture for school clubs and YFSCs has resulted in continued engagement of other actors in the provision of SRH information and services. For example, most of the YFSCs have dedicated health professionals. Similarly school clubs run mini-media once they are provided with the basic equipment required for the service.

- The online system for administrative and financial procedures is found to be difficult for some government IPs. High turnover of staff in the government sectors and lack of regular trainings on the electronic system are the primary reasons for limited capacity to use the system.

Implementing government organizations at Woreda level have limited capacity on planning. However, they are given the mandate to make major planning decisions regarding activities to be performed and geographic areas to be targeted (consulted by regional IPs). This creates a situation where there is need for very close follow-up and support during planning and M&E. Human resource capacity of UNFPA at regional level however doesn't allow to adequately support planning activities for all IPs.

Government IPs (federal as well as regional) have clear mandates in the areas they are currently supported by UNFPA. These IPs have strategic importance in their respective area of intervention.

- UNFPA supports activities that **government IPs have already planned**. Annual work plans are extracted from the IP's overall annual plan. This alignment has been reported as an important reason for sustainability of supported activities and already achieved benefits.
- Maternity waiting homes are constructed and financed by **communities**. There is increasing acceptance of community contribution to feed mothers staying at maternity waiting homes.
- Most **youth centers generate revenue** covering their own expenses. Recreational activities continue irrespective of external support. However, there is no mechanism in place to ensure the provision of SRH and HIV related services (free of charge) continue in the centers. For example, SRH clinic from one of the model youth centers is now closed because health workers are not happy with salary.
- School clubs (particularly mini-media) run by their own once they get the minimum set of equipment
- Some community-based activities are not achieving sustainable results particularly because of low intensity of program implementation. Examples:
 - o Community conversations leading to no change at community level
 - o Youth-parent forum – committee formed and trained but mostly lack follow-up leading to inactivity

Procurement of family planning and other RH commodities (by UNFPA) has not been adequately used to build the capacity of the Ethiopian Pharmaceutical Supply Agency.

	The newly approved staffing structure for health centers allows hiring one health officer for youth friendly service centers. This facilitates sustaining the center irrespective of external support.			
Adolescent and Youth Development	<p>Expected outputs of the CPAP were achieved (both in terms of quantity and quality)</p> <p>The targeted groups of beneficiaries were reached by UNFPA support</p> <p>Beneficiaries took advantage of benefits from the intervention supported</p> <p>There were unintended effects, positive or negative, direct or indirect</p>	<p>Degree of completion of outputs planned in the CPAP against indicators</p> <p>Evidence that completed outputs contributed to planned outcomes</p> <p>Significant changes in marginalised populations i.e. poor youth in both rural and urban settings, young girls affected by HIV/AIDS</p> <p>No. of institutions/organisations supported to promote integrated SRH and HIV prevention education and services to youth and key populations</p> <p>Number of young people reached through media platforms created and managed by trained youth</p> <p>Number of participatory advocacy platforms</p>	<p>CPAP Results Framework indicators</p> <p>CPAP Results Plan progress reports</p> <p>Statistics South Africa figures</p> <p>Relevant Health Survey data</p> <p>Personnel at the Department of Health at national, provincial and district levels.</p> <p>Progress reports of the Department of Health</p> <p>Beneficiary groups / communities</p> <p>SCF progress reports / mid-term review</p> <p>Implementing partners</p> <p>Quarterly and annual implementation progress reports</p> <p>UNICEF annual reports and evaluations</p> <p>UNFPA country office staff</p> <p>Country Office Annual Reports</p> <p>Previous evaluations</p>	<p>Study of documentation</p> <p>Comparative analyses of the value of CPAP indicators (targets versus actual values)</p> <p>Key informant interviews</p> <p>Group discussions to assess the quality of the outputs</p>

		that advocate for increased investments in marginalized adolescents and youth		
<i>Data and information collected</i>	<p>The 8th CP supported capacity building among adolescents and young people so that they can make informed decisions on their sexual and reproductive health and rights. The program has supported provision of selected SRH information and services through youth centres, YFSCs, and school clubs.</p> <p>During the period 2016 to 2019, the program reached:</p> <ul style="list-style-type: none"> - 99,521 adolescents and youth with SRH services through UNFPA support (76.6% of the target for 2020) - 32,225 adolescents and youth with life skill education (80.6% of the target for 2020) <p>SRH services through YFSCs and life skill education in different settings are reported to be effective strategies for providing SRH related information and services to adolescents and youth who otherwise would have been marginalized.</p> <p>Life skill education has been reported to have a wide range of positive impact particularly for girls. Among the most commonly reported positive outcomes were increased confidence and school performance of female students and increased utilization of SRH services including family planning and condoms.</p> <p>School clubs supported with mini-media equipment and trainings were effective in reaching large numbers of students with important SRH information. The support in this area allowed to maximally utilize capacities of students and their teachers in the regular provision of SRH information to school communities.</p> <p>The program supported youth organizations and associations – mostly youth centers and school clubs. Both categories of targets mostly provide opportunities to reach large numbers of adolescents and youth.</p> <p>Youth Centers: Youth centres located in convenient places and actively providing recreational activities attract adolescents and youth. UNFPA’s support in visited youth centers was the primary source of materials required for these recreational activities (in-door and out-door games); Media instruments donated for youth centers created the potential for transmission of SRH messages to visitors of youth centers. Challenges in relation to youth centers include:</p>			

- Utilization of the opportunity created has been sub-optimal particularly because of the limited engagement of technical experts.
- Some youth centers are located at inaccessible locations resulting in non-use of available facilities.
- Girls involvement in youth center activities is very limited.

School clubs

Mini-media support to schools has led to self-sustained HIV/SRH information dissemination on a regular basis.

- The 8th CP supported health centres in establishing and running youth friendly service centres. Support included furniture, audio visual equipment, and trainings for service providers.
- By the end of June 2019, the percentage of health facilities providing the national standard minimum adolescent and youth service packages reached 75% among UNFPA targeted areas. The number of health workers equipped through training with knowledge and skills to provide youth friendly sexual and reproductive health exceeded the total target of 500 by reaching 704 more than a year before the completion of the CP period.
- Supported YFSCs provide comprehensive outpatient service for all clients in the age range of 10 to 24.
- The newly approved staffing structure for health centers allows hiring one health officer for youth friendly service centers. This facilitates sustaining the center irrespective of external support.
- Integrating all outpatient services for 10-24 years adolescents and youth (including treatment of any illness) with YFSCs increases exposure of adolescents and youth to trained healthcare providers and improves confidentiality of SRH service provision. However, it has also posed a threat to SRH service provision. Because most cases are coming for non-SRH services, attention given to SRH by health service providers gets diluted. Additional challenges in this area include:
 - o Lack of comprehensiveness of services at YFSCs leading to high referral rates to other units and other facilities
 - o Not all YFSCs have in-door and out-door recreational facilities
- Lack of space compromising the utility of donated equipment (eg. Television put/stored in the examination room because there was no secure waiting area)
- Implementing capacity of government IPs and their district offices is very limited.
- As a result, planning, implementation, and monitoring (activities that are expected from IPs) are compromised.

	<ul style="list-style-type: none"> - Donation of equipment and furniture for school clubs and YFSCs has resulted in continued engagement of other actors in the provision of SRH information and services. For example, most of the YFSCs have dedicated health professionals. Similarly school clubs run mini-media once they are provided with the basic equipment required for the service. - The online system for administrative and financial procedures is found to be difficult for some government IPs. High turnover of staff in the government sectors and lack of regular trainings on the electronic system are the primary reasons for limited capacity to use the system. - Implementing government organizations at Woreda level have limited capacity on planning. However, they are given the mandate to make major planning decisions regarding activities to be performed and geographic areas to be targeted (consulted by regional IPs). This creates a situation where there is need for very close follow-up and support during planning and M&E. Human resource capacity of UNFPA at regional level however doesn't allow to adequately support planning activities for all IPs. - Government IPs (federal as well as regional) have clear mandates in the areas they are currently supported by UNFPA. These IPs have strategic importance in their respective area of intervention. - UNFPA supports activities that government IPs have already planned. Annual work plans are extracted from the IP's overall annual plan. This alignment has been reported as an important reason for sustainability of supported activities and already achieved benefits.
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<p>Gender Equality/GBV</p>	<p>Expected outputs of the CPAP were achieved (both in terms of quantity and quality)</p> <p>The targeted groups of beneficiaries were reached by UNFPA support</p> <p>Beneficiaries took advantage of benefits from</p>	<p>Degree of completion of outputs planned in the CPAP against indicators</p> <p>Extent to which geographical and demographic coverage of gender activities in Eastern Cape and KwaZulu Natal provinces and districts targeted by the interventions have effectively and equally benefitted</p>	<p>CPAP Results Framework indicators</p> <p>CPAP Results Plan progress reports</p> <p>Statistics South Africa figures</p> <p>Beneficiary groups / communities</p> <p>Implementing partners</p> <p>Quarterly and annual implementation progress reports.</p> <p>United Nations Women reports and evaluations</p>	<p>Study of documentation</p> <p>Comparative analyses of the value of CPAP indicators (targets versus actual values)</p> <p>Key informant interviews</p> <p>Group discussions to assess the quality of the outputs</p>
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	<p>the intervention supported</p> <p>There were unintended effects, positive or negative, direct or indirect</p>	<p>from the interventions</p> <p>Number of advocacy sessions supported to strengthen national coordination mechanisms for implementation of multi-sectoral policies and programmes on GBV prevention and response and improve SRH/GBV linkages</p> <p>Number of UNFPA supported districts that integrate GBV and SRH into their planning processes</p> <p>Number of institutions supported to implement and institutionalize initiatives to engage men and boys, and communities on GBV prevention and SRHR</p>	<p>UNFPA country office staff</p> <p>Country Office Annual Reports</p> <p>Previous evaluations</p>	
<p><i>Data and information collected</i></p>	<p>UNFPA's works at federal and regional level with government bodies, CSOs and grass root structures on prevention of SGBV and HTPs; protection of the right of right holders from violence and provision of direct services to survivors of SGBV and HTPs through creating an enabling environment and building the capacity of institutions and communities though its engagement at the different level is different.</p> <p>At federal level the CO engage in high level advocacy works and coordination activities to support the effort of the government to accelerate the progress made with regards to gender equality and women empowerment.</p>			

- UNFPA provide technical and financial support to celebrate international and national events like 16 Days Activism, March 8, Anti FGM Day, and International Day and the Girl Child. UNFPAs support also include that the events go beyond celebrating the event and creating awareness among the public but are result oriented that have direct benefit to the adolescent girls and women.
- It also work on law enforcement issues, development of international reports such as CEDAW report and the like.
- UNFPA also supports and strengthens national level coordination forums. For example the CO provides technical and financial support to the National Alliance to End FGM and CM. While the Ministry is the chair, UNFPA was the co chair though the co chair ship is rotating.

At regional level, UNFPA engages in capacity building of relevant stakeholders and communities to prevent gender-based violence and harmful traditional practices (FGM and CM).

- There is evidence that the program prevented GBV (physical, sexual and psychological harm and threats) and FGM and CM

UNFPA also tries to respond to gender-based violence and harmful traditional practices as much as possible by

providing direct services to survivors and also support scaling up best practices. There is evidence of provision of services to survivors of GBV through the local NGOs (AWSAD and APDA - Barbra May Maternity Hospital) and also Women Association.

- Many girls and women survivors are rehabilitated and empowered and become self reliant through skill training and IGA

Enhancement of the capacity of communities to promote and protect the rights of women and girls

- Women and Girl's Friendly Spaces in humanitarian setting and development programs facilitate the dissemination of information as well as protect the rights of adolescent girls and women
- Capacity building of community structures (Anti HTP committees, establishing committees to combat FGM and CM at community level with clan leaders, religious leaders and traditional birth attendants) has made a significant contribution
- Establishing groups within the community ("Married and Unmarried" girl/youth groups) to increase dialogue among members on cultural norms
- Engaging boys and men and building their capacity to be partners in the effort to end CM has a great significance. The participation of boys and men in the programme greatly contribute to the achievement of the objective of the programme. For example in Afar it was highly stressed that the role of clan and religious leaders in teaching and clarifying for the community about the importance of stopping FGM

Enhance the capacity of institutions to promote and protect the rights of women and girls

- Multiple capacity building training has contributed to building the capacity of institutions to understand and work towards the promotion of the rights of girls and women and to end GBV and HTPs

Integrating of gender and human rights based approach

- The whole programme is gender focused and addresses the issue of human rights violations

Though UNFPA achieved a lot, there are also challenges that were identified in provision of integrated services (multi-sectorial interventions) to survivors of harmful traditional practices and gender-based violence

- There is weak multi sectorial intervention since most of the interventions with regards to GBV, FGM and CM are related to one aspect the AWSAD safe home except
- One stop centre at Gambella is not providing the intended service. One Stop Center in Gambella is not addressing the needs of survivors of GBV
- There is a gap in building the capacity of law enforcement in protecting the rights of survivors
- All the programmes lack economic empowerment of girls and women. Though it can be argued that it is beyond the mandate of UNFPAs mandate to is not possible to empower women without empowering them economically to increase women's decision making within the household and in the communities. Economic empowerment will also have greater implication on women involvement in the political arena.
- There is lack of evidence whether the interventions address gender norms (socio-cultural rules) and gender roles (socially constructed roles, behaviours, activities and attributes that society considers appropriate for girls and women)

Women Development Army in Afar is not well established which poses a challenge
Unintended consequences

- Sexual harassment and rape after stopped CM
- Committing suicide when forced to marry at a younger age
- There is a report that people will go to neighbouring untargeted Woredas to carry out CM and FGM

Gender equality is not something that can be achieved with the effort of one institution where women and men, girls and boys enjoy the same status in society; enjoy all human rights fully and without discrimination; enjoy the same level of respect in the community; are equally valued by all; can take advantage of the same opportunities to make choices about their lives and expect equivalent results; and have the same amount of power to shape the outcomes of these choices. Since gender norms are deep rooted within the community it is also unrealistic to expect

	<p>complete change in people’s belief’s, attitude and behaviour with short period of time and hence requires an intensive effort. But this being the case with the resources available, t is safe to say that UNFPA contribute to gender equality though it cannot take the credit since it is an integrated effort of all stakeholders.</p>			
<p>Population and Development</p>	<p>Expected outputs of the CPAP were achieved (both in terms of quantity and quality)</p> <p>The targeted groups of beneficiaries were reached by UNFPA support</p> <p>Beneficiaries took advantage of benefits from the intervention supported</p> <p>There were unintended effects, positive or negative, direct or indirect</p>	<p>Degree of completion of outputs planned in the CPAP against indicators</p> <p>Extent to which achievement of outputs at national level is followed by an effective use at provincial level</p> <p>Number of districts with strengthened capacity to integrate SRH, youth, gender, population and development into plans and programmes</p> <p>Number of reports with evidence produced at provincial and/or district level to promote integration of SHR, gender, youth and population dynamics into plans and programmes</p> <p>Number of individuals trained to integrate population dynamics and its</p>	<p>CPAP Results Framework indicators</p> <p>CPAP Results Plan progress reports</p> <p>Implementing partners</p> <p>Quarterly and annual implementation progress reports.</p> <p>Personnel at the Department of Social Development at national and provincial levels.</p> <p>UNFPA Country Office staff</p> <p>Country Office Annual Reports</p> <p>Previous evaluations</p>	<p>Study of documentation</p> <p>Comparative analyses of the value of CPAP indicators (targets versus actual values)</p> <p>Key informant interviews</p> <p>Group discussions to assess the quality of the outputs</p>

		<p>interlinkages into development planning and programming</p> <p>Number of target institutions with the capacity to integrate youth issues into development programmes</p> <p>Number of tools, survey reports and instruments reflecting analysis of population variables at national level</p> <p>Number of institutions that produce and utilize high-quality data to monitor, evaluate and inform youth development, gender, sexual and reproductive health and HIV-prevention policies and programmes</p>		
<p><i>Data and information collected</i></p>	<p>The support provided to the preparation and analysis of censuses and other population-based surveys is a critical means of ensuring that women, adolescents, and youth are at the centre of sustainable development policies, and that programmes have the evidence needed to improve SRH services. In addition to the support provided to the preparation and analysis of censuses and other population-based surveys (in the framework of generation and utilization of data), UNFPA works at country level to ensure that programmes, policies and strategies are robustly evidence-based and informed by a thorough understanding of population issues such as migration, urbanization and ageing, the implications of the demographic dividend for national development, etc.,</p> <p>To achieve this output, the 8th CP planned to support the 2017 Population and Housing Census and the 2016 Demographic and Health Survey; support the civil</p>			

registration and vital statistics and web-based integrated management information systems; support seasonal assessments and risk profiling for vulnerability analysis and risk reduction interventions; support regional and national population situation analyses; support key stakeholders to generate data for policy and programme formulation, monitoring and evaluation; and advocate for the inclusion of the demographic dividend in national policies, strategies and programmes.

Data for development & advocacy including in humanitarian Programme

In anticipation of a robust and high quality census, UNFPA improved the preparations and the institutional capacity of the Central Statistics Agency (CSA) towards the fourth Ethiopian Population and Housing Census (EPHC) through provision of financial and technical support. Following are the key milestones achieved: Implementation of preparatory activities including a comprehensive pilot census, a pilot Post Enumeration Survey (PES), and the revision and finalization of the census project document; Deployment of a Census Technical Advisor (CTA), a Geographic Information Systems (GIS) Specialist, and a Communication Adviser; Training of 68 CSA staff on various subjects related to census undertaking such as data centre management, data capturing and transfer, data processing, PES implementation, GIS/Cartography, as well as data analysis and dissemination; A study visit of CSA managers and 7 staff to Egypt to gain experience in the planning and management of digital census.

IMIS - Integrated Management Information System is a collection of several statistical databases of various surveys and censuses conducted by the Central Statistics Agency and other Government institutions like ministries. The IMIS is a tool that has been developed to enable users generate customised statistics that meet their individual needs in the form of frequencies, cross tabulations, indicators, etc.

This project is a continuing process that shall incorporate more census and survey data over time. Stakeholder interviews [with CO staff and IPs] showed that UNFPA CO has helped the CSA to develop a functional IMIS both at National and 5 regional levels. While IPs reported the use of IMIS for regional planning, officers in-charge were not able to demonstrate the use of the system for planning. This leads to low utilization of the IMIS which compromises effectiveness. Implementation of regional web-based Integrated Management Information System (IMIS) in the Amhara, Oromia, Tigray, Afar and SNNP regions (also uploaded on CSA's website) have been developed. The system enables the retrieval of tailor made data (by way of the calculation of indicators, production of customized tables, and the generation of thematic maps at any administrative level) through direct access to different data sources including census, household sample surveys or administrative/routine service-based data. A statistical abstract of indicators for all sectors from 2008-2018 which was also uploaded on the IMIS, on the CSA's website. The statistical abstract

is expected to facilitate easier access to data by end-users. Procurement of census equipment for the implementation of the 2018 Ethiopian Population and Housing Census (EPHC), including servers, portable solar power banks, etc. Other achievements under this component during this cycle include preparations for the 4th population and housing census. These include : Completion of the EPHC cartographic mapping activity ahead of the census enumeration in early 2018; Finalization and translation of the tools for the census enumeration including the census data capture programme; Completion of the designing, translation and printing of census questionnaires as well as enumerators’ and supervisors’ manuals in preparation for the census, implementation of three rounds of pilot censuses (both paper and tablet based) in November 2016, March 2017, June 2018; conducted two rounds of pilot post enumeration surveys in February 2017 and August-September 2017; organisation of training of Trainers (TOT) both at national and regional levels ahead of the census enumeration in early 2018, training of regional, woreda and zonal census communication and publicity officers on publicity and communication issues about the census, implementation of the 2016 Ethiopian Demographic and Health Survey (EDHS) and dissemination of its results; procurement of census equipment for the implementation of the 2018 Ethiopian Population and Housing Census (EPHC), including servers, portable solar power banks, and capacity building of CSA staff on Post Enumeration Survey (PES) methodology, Java and SQL and database training that are relevant for PES matching.

EQ3: To what extent has UNFPA made good use of its resources (human, financial, technical, operational) to pursue the achievement of the results defined in the Country Programme?

EFFICIENCY

Sexual and Reproductive Health	Beneficiaries of UNFPA Support received the resources that were planned, to the level foreseen and in a timely manner UNFPA administrative and financial procedures as well as	The planned resources were received to the foreseen level in AWP The resources were received in a timely manner Appropriateness of administrative and financial procedures for smooth,	Atlas Records Audit Reports Country Office information management systems Annual Work Plans Country Office Standard Progress Reports (SPR) Implementing partner quarterly and annual progress reports	Study of documentation Comparative analyses of planned and actual expenditure and activities Key informant interviews
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	<p>implementation modalities allow for a smooth execution of the Country Programme</p> <p>The resources provided by UNFPA have had a leverage effect</p>	<p>accountable and responsive management of financial and human resources</p> <p>Extent of deviations from planned activities (newly added activities, cancelled activities) and their consequences on the quantity and quality of the outputs</p> <p>Evidence that the resources provided by UNFPA triggered the provision of additional resources from government and other partners</p>	<p>Donors (providing funding to UNFPA Country Office)</p> <p>Implementing partners</p> <p>Beneficiary groups/communities</p> <p>UNFPA Country Office staff</p>	
<p><i>Data and information collected</i></p>	<p>Once AWP are approved, resources are provided to each IP and operational area based on the AWP. Funds transferred to IPs are generally used reasonably and only to the purposes they are assigned for</p> <ul style="list-style-type: none"> - Delay in transfer of funds affects implementation of planned activities. IPs have reported that they most of the time had to rush implementation of activities because there will always be delays in transfer of funds. <p>There is long chain of approval of annual plans, report reviews, and funding transfers</p> <ul style="list-style-type: none"> - Resources are very thinly spread over wide geographic areas than what can potentially be supported meaningfully. <p>Budget utilization rate increased over time. In 2016, SRH/AYD component of the program used 74% its budget. This figure increased to 83% in 2017 and 90% in 2018. Donation of equipment and furniture for school clubs and YFSCs has resulted in continued engagement of other actors in the provision of SRH information and services. For example, most of the YFSCs have dedicated health professionals. Similarly school clubs run mini-media once they are provided with the basic equipment required for the service.</p>			

	<p>- The online system for administrative and financial procedures is found to be difficult for some government IPs. High turnover of staff in the government sectors and lack of regular trainings on the electronic system are the primary reasons for limited capacity to use the system.</p> <p>Implementing government organizations at Woreda level have limited capacity on planning. However, they are given the mandate to make major planning decisions regarding activities to be performed and geographic areas to be targeted (consulted by regional IPs). This creates a situation where there is need for very close follow-up and support during planning and M&E. Human resource capacity of UNFPA at regional level however doesn't allow to adequately support planning activities for all IPs.</p> <p>Government IPs (federal as well as regional) have clear mandates in the areas they are currently supported by UNFPA. These IPs have strategic importance in their respective area of intervention.</p>			
<p>Adolescent and Youth Development</p>	<p>Beneficiaries of UNFPA Support received the resources that were planned, to the level foreseen and in a timely manner</p> <p>UNFPA administrative and financial procedures as well as implementation modalities allow for a smooth execution of the Country Programme</p>	<p>The planned resources were received to the foreseen level in AWP</p> <p>The resources were received in a timely manner</p> <p>Appropriateness of administrative and financial procedures for smooth, accountable and responsive management of financial and human resources</p> <p>Extent of deviations from planned activities (newly</p>	<p>Atlas Records Audit Reports Country Office information management systems</p> <p>Annual Work Plans Country Office Standard Progress Reports (SPR)</p> <p>Implementing partner quarterly and annual progress reports</p> <p>Donors (providing funding to UNFPA Country Office)</p> <p>Implementing partners Beneficiary groups/communities UNFPA Country Office staff</p>	<p>Study of documentation Comparative analyses of planned and actual expenditure and activities</p> <p>Key informant interviews</p>

	<p>The resources provided by UNFPA have had a leverage effect</p>	<p>added activities, cancelled activities) and their consequences on the quantity and quality of the outputs</p> <p>Evidence that the resources provided by UNFPA triggered the provision of additional resources from government and other partners</p>		
<p><i>Data and information collected</i></p>	<ul style="list-style-type: none"> - Resources from CP are used for intended purposes as described in AWP - Delay in transfer of funds was very often reported as a source of inefficiency in implementing program activities. - Long chain of approval of annual plans, report reviews, and funding transfers have been reasons for delayed and rushed implementation of program activities - Resources allocated at woreda level are too small to support adequate sites. They are also limited to very specific activities of a broad intervention area resulting in sub-optimal efficiency. - Budget utilization rate is in general high. It also increased recently compared to the early years of the program. - Donation of equipment and furniture for school clubs and YFSCs has resulted in continued engagement of other actors in the provision of SRH information and services. For example, most of the YFSCs have dedicated health professionals. Similarly, school clubs run mini-media once they are provided with the basic equipment required for the service. - The online system for administrative and financial procedures is found to be difficult for some government IPs. High turnover of staff in the government sectors and lack of regular trainings on the electronic system are the primary reasons for limited capacity to use the system. - Implementing government organizations at Woreda level have limited capacity on planning and implementation resulting in inefficient use of allocated resources. - Government IPs (federal as well as regional) have clear mandates in the areas they are currently supported by UNFPA. These IPs have strategic 			

	importance in their respective area of intervention facilitating more efficient implementation of planned activities.			
Gender Equality/GBV	<p>Beneficiaries of UNFPA Support received the resources that were planned, to the level foreseen and in a timely manner</p> <p>UNFPA administrative and financial procedures as well as implementation modalities allow for a smooth execution of the Country Programme</p> <p>The resources provided by UNFPA have had a leverage effect</p>	<p>The planned resources were received to the foreseen level in AWP</p> <p>The resources were received in a timely manner</p> <p>Appropriateness of administrative and financial procedures for smooth, accountable and responsive management of financial and human resources</p> <p>Extent of deviations from planned activities (newly added activities, cancelled activities) and their consequences on the quantity and quality of the outputs</p> <p>Evidence that the resources provided by UNFPA triggered the provision of additional resources from government and other partners</p>	<p>Atlas Records</p> <p>Audit Reports</p> <p>Country Office information management systems</p> <p>Annual Work Plans</p> <p>Country Office Standard Progress Reports (SPR)</p> <p>Implementing partner quarterly and annual progress reports</p> <p>Donors (providing funding to UNFPA Country Office)</p> <p>Implementing partners</p> <p>Beneficiary groups/communities</p> <p>UNFPA Country Office staff</p>	<p>Study of documentation</p> <p>Comparative analyses of planned and actual expenditure and activities</p> <p>Key informant interviews</p>

<p><i>Data and information collected</i></p>	<p>UNFPA made available human resources and technical assistance to build capacity of stakeholders though it is not sufficient. At regional level, IPs indicated that the absence of coordinators hired by the UNFPA poses a challenge with regards to timely reporting and liquidation of budget.</p> <p>Budget release is usually delayed which affect the programme implementation and quality of service delivery. This cannot only be seen from the side of UNFPA since the delay in budget is also due to delayed reporting and liquidation of fund from the side of the IPs.</p> <p>UNFPAs working modality encourages IPs to contribute resources to avoid dependency of the programmes on only UNFPAs support. For example government IPs are expected to assigned focal person to coordinate the activities supported by UNFPA. Though this can affect the quality of work it is a modality that also will have a positive impact on the sustainability of the programme.</p> <p>The administrative and financial procedures though very detailed and time consuming are very appropriate to make sure that the planned interventions are carried out in a timely manner and resources are used for the intended purposes.</p> <p>From the outset UNFPA brings government bodies on board to select priority areas, to select regions and Woredas with high prevalence and less intervention, to carry out stakeholder mapping and identify implementing partners to complement interventions rather than to compete, and chose appropriate intervention strategies and identify existing grassroots structures, and finally to develop feasible AWP.</p> <p>IP selection is both strategic and programmatic. At Federal level the Ministry is the implementing partner since it is the mandated coordinating body while at regional and woreda level the bureau and the offices are the implanting partners. UNFPA also works with NGOs based on their expertise and also to avoid duplication of work and complement interventions as well as minimize cost.</p> <p>The community mobilized its resources to replicate the provision of services that were being supported by UNFPA. For example in Tigray Region it was observed during the field visit that schools assigned class rooms to be used as dignity rooms.</p>			
<p>Population and Development</p>	<p>Beneficiaries of UNFPA Support received the resources that were planned, to the level foreseen and in a timely manner</p>	<p>The planned resources were received to the foreseen level in AWP</p> <p>The resources were received in a timely manner</p>	<p>Atlas Records Audit Reports Country Office information management systems Annual Work Plans</p>	<p>Study of documentation Comparative analyses of planned and actual expenditure and activities</p>

	<p>UNFPA administrative and financial procedures as well as implementation modalities allow for a smooth execution of the Country Programme</p> <p>The resources provided by UNFPA have had a leverage effect</p>	<p>Appropriateness of administrative and financial procedures for smooth, accountable and responsive management of financial and human resources</p> <p>Extent of deviations from planned activities (newly added activities, cancelled activities) and their consequences on the quantity and quality of the outputs</p> <p>Evidence that the resources provided by UNFPA triggered the provision of additional resources from government and other partners</p>	<p>Country Office Standard Progress Reports (SPR)</p> <p>Implementing partner quarterly and annual progress reports</p> <p>Donors (providing funding to UNFPA Country Office)</p> <p>Implementing partners</p> <p>Beneficiary groups/communities</p> <p>UNFPA Country Office staff</p>	<p>Key informant interviews</p>
<p><i>Data and information collected</i></p>	<p>Based on stakeholder interviews, review of Annual Work Plans, the PD thematic area has to a very large extent made good use of available human, financial and technical resources to achieve Output 6.</p> <p>Annual Work Plans Annual work plans are prepared and endorsed by both the partner and UNFPA allocating both resources. The programme Analyst manages the resources on day-to-day basis while overall management and guidance is provided by the Programme Associate. The same holds true for EDHS, IMIS and CRVS except that these activities are resourced only from core resources and other resources which are not earmarked, but dedicated for the entire CP and proportionally allocated to each CP output as lump sum.</p> <p>Financial Resources</p> <p>In case of the census and IMIS, the critical resources being used are financial, technical and procurement of goods and services. The financial resources are</p>			

accessed from the chart of accounts based on annual work plan. Long and short term technical assistance is accessed on demand. Procurement of goods and services is also available on demand for all program phases. For EDHS, financial and technical support was provided to support the different phases of the survey: from listing phase up to dissemination of results, while in CRVS, UNFPA provided financial assistance for capacity building trainings and participation of staffs in international workshops.

There are two components of resources for supporting the census: UNFPA core resources and other (donor resources). The core resources are allocated according in consultation with partners' need and priorities, while other resources are earmarked for specific activities based on tripartite consultation with the donor and the partner. The partner is agreeable to UNFPA managing donor resources. The resources are utilized towards achieving operational efficiency and value for money. For example, we opt for sea transport instead of air lifting; when we choose training locally (in-country) over abroad in order to train more for less. When we choose government facility over commercial enterprises to lower training costs. Based on stakeholder interviews, review of financial documents, review of Annual Work Plans, and annual reports, the PD Program Area has, to a very high extent, made good use of available human, financial and technical resources to achieve Output 6. The evolution of the budget and expenditures from 2016 to 2020 show that all budgeted funds have been fully expended at a remarkable 90%. This reflects the care taken by UNFPA Ethiopia PD staff to ensure that the relatively limited resources are used to the fullest extent possible. Feedback from stakeholders on efficiency was very favourable. High staff turnover at the local level is a threat to efficiency as the investment in training is lost when staff transfer to other positions. Government support for the sub-components of this thematic area include co-financing up to 60% of the total cost of the census, EDHS, IMIS and CVRS; providing staff time; physical infrastructure (office and storage space; providing transport and logistics, providing over all management and leadership of the program and assisting in resource mobilization political goodwill.

EQ 4: To what extent have the programme interventions owned by national institutions and are likely to continue after the programme support is ended?

SUSTAINABILITY

Sexual and Reproductive Health	The benefits are likely to continue beyond	Evidence of the existence of an exit strategy	Beneficiary groups / communities Line departments' personnel	Study of documentation Key informant interviews
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	<p>program termination</p> <p>Activities and outputs were designed taking into account a handover to local partners</p> <p>Interventions in the focus area incorporate exit strategies</p> <p>UNFPA has been able to support its partners and the beneficiaries in developing capacities that ensure the durability of outputs, and eventually outcomes</p>	<p>Evidence of a hand-over process from UNFPA to the related projects</p> <p>Extent of ownership of each project by implementing partners</p> <p>Extent to which the government and implementing partners have the financial means for continued support in maintenance of facilities, procurement of medicines, information management and reproductive health commodities security, and conducting follow-through refresher training sessions.</p> <p>Extent to which UNFPA has taken any mitigating steps if there are problems in this regard</p>	<p>Provincial and local authorities</p> <p>Implementing partners</p> <p>UNFPA Country Office staff</p> <p>CPAP</p> <p>Annual Work Plans</p> <p>Previous evaluations</p>	<p>Group discussions with target beneficiaries and local authorities</p>
<p><i>Data and information collected</i></p>	<p>- UNFPA supports activities that government IPs have already planned. Annual work plans are extracted from the IP’s overall annual plan. This alignment has been reported as an important reason for sustainability of supported activities and already achieved benefits.</p>			

	<ul style="list-style-type: none"> - Maternity waiting homes are constructed and financed by communities. There is increasing acceptance of community contribution to feed mothers staying at maternity waiting homes. - Most youth centers generate revenue covering their own expenses. Recreational activities continue irrespective of external support. However, there is no mechanism in place to ensure the provision of SRH and HIV related services (free of charge) continue in the centers. For example, SRH clinic from one of the model youth centers is now closed because health workers are not happy with salary. - School clubs (particularly mini-media) run by their own once they get the minimum set of equipment - Some community-based activities are not achieving sustainable results particularly because of low intensity of program implementation. Examples: <ul style="list-style-type: none"> o Community conversations leading to no change at community level o Youth-parent forum – committee formed and trained but mostly lack follow-up leading to inactivity <p>Procurement of family planning and other RH commodities (by UNFPA) has not been adequately used to build the capacity of the Ethiopian Pharmaceutical Supply Agency.</p> <p>The newly approved staffing structure for health centers allows hiring one health officer for youth friendly service centers. This facilitates sustaining the center irrespective of external support.</p>			
<p>Adolescent and Youth</p>	<p>The benefits are likely to continue beyond program termination</p> <p>Activities and outputs were designed taking into account a handover to local partners</p> <p>Interventions in the focus area</p>	<p>Evidence of the existence of an exit strategy</p> <p>Evidence of a hand-over process from UNFPA to the related projects</p> <p>Extent of ownership of each project by implementing partners</p> <p>Extent to which the government and implementing</p>	<p>Beneficiary groups / communities</p> <p>Line departments’ personnel</p> <p>Provincial and local authorities</p> <p>Implementing partners</p> <p>UNFPA Country Office staff</p> <p>CPAP</p> <p>Annual Work Plans</p> <p>Previous evaluations</p>	<p>Study of documentation</p> <p>Key informant interviews</p> <p>Group discussions with target beneficiaries and local authorities</p>

	<p>incorporate exit strategies</p> <p>UNFPA has been able to support its partners and the beneficiaries in developing capacities that ensure the durability of outputs, and eventually outcomes</p>	<p>partners have the financial means for continued support in maintenance of facilities, procurement of medicines, information management and reproductive health commodities security, and conducting follow-through refresher training sessions.</p> <p>Extent to which UNFPA has taken any mitigating steps if there are problems in this regard</p>		
<p><i>Data and information collected</i></p>	<ul style="list-style-type: none"> - Most youth centers generate revenue covering their own expenses. Recreational activities continue irrespective of external support. However, there is no mechanism in place to ensure the provision of SRH and HIV related services (free of charge) continue in the centers. For example, SRH clinic from one of the model youth centers is now closed because health workers are not happy with salary. School clubs (particularly mini-media) run by their own once they get the minimum set of equipment Some community-based activities are not achieving sustainable results particularly because of low intensity of program implementation. Despite provision of trainings and experience sharing activities, procurement of family planning and other RH commodities (by UNFPA upon request from the government) has not been adequately used to build the capacity of the Ethiopian Pharmaceutical Supply Agency as there has been no clear sustainability plan/exist strategy. - Capacity building among youth in general has lasting effects as benefits stay longer throughout the period of adulthood. 			

<p>Gender Equality/GBV</p>	<p>The benefits are likely to continue beyond program termination</p> <p>Activities and outputs were designed taking into account a handover to local partners</p> <p>Interventions in the focus area incorporate exit strategies</p> <p>UNFPA has been able to support its partners and the beneficiaries in developing capacities that ensure the durability of outputs, and eventually outcomes</p>	<p>Evidence of the existence of an exit strategy</p> <p>Evidence of a hand-over process from UNFPA to the related projects</p> <p>Extent of ownership of each project by implementing partners</p> <p>Extent to which National Policy Framework for Women Empowerment and Gender Equality has any implications in terms of sustainability</p> <p>Extent to which UNFPA is offsetting potential adverse consequences in this regard</p> <p>Extent to which factors ensuring ownership were factored in the design of interventions in the context of the country's vast ethnic diversity</p>	<p>Beneficiary groups / communities</p> <p>Line departments' personnel</p> <p>Provincial and local authorities</p> <p>Implementing partners</p> <p>UNFPA Country Office staff</p> <p>CPAP</p> <p>Annual Work Plans</p> <p>Previous evaluations</p>	<p>Study of documentation</p> <p>Key informant interviews</p> <p>Group discussions with target beneficiaries and local authorities</p>
<p><i>Data and information collected</i></p>	<p>The mandate and the commitment of government is the biggest contributor to the sustainability of the programme.</p>			

	<p>There are also changes that are observed regional level which can be mentioned as major contributions of UNFPA which have direct and indirect impact on the sustainability of the programme</p> <ul style="list-style-type: none"> • UNFPAs role to advocate for the inclusion of VAW in the DHS • The bottom up approach used by UNFPA contributed for the sustainability of the programme since it strengthens community ownership. • Capacity building programs for government stakeholders help to sustain the prevention activities though there is challenge • Increased understanding and commitment of local communities to end CM, HTPs and GBV. The level of feeling of ownership of the program, though different from region to region is encouraging. • Use of the exiting grass root structures helped for the sustainability of the programme. Intensive capacity building addressing community members, community conversations and the establishment and support of groups to fight FGM and CM help to sustain the prevention activities • Woredas who have declared to end CM and FGM are still working to end CM and stop FGM through the active participation and commitment of the grass root structures <p>Even though programmes that are focused on prevention and promotion can be sustained provision of direct services to survivors cannot be sustained since it is cost intensive to rehabilitate survivors and reintegrate them to the community. Hence these services (Safe Houses) will be mainly dependent on money generated outside of the community.</p> <p>Staff turnover is indicated as a challenge for mainly the government IPs. But it was also possible to understand that UNFPA made an effort to provide trainings for many IP staffs as possible to make sure that the programme is not greatly affected by staff turnover.</p> <p>The integration of the GEWE and SRH and Y&A component has a great impact on the sustainability of the programme.</p>			
Population and Development	<p>The benefits are likely to continue beyond program termination</p> <p>Activities and outputs were designed taking</p>	<p>Evidence of the existence of an exit strategy</p> <p>Evidence of a hand-over process from UNFPA to the related projects</p>	<p>Beneficiary groups / communities</p> <p>Line departments' personnel</p> <p>Provincial and local authorities</p> <p>Implementing partners</p> <p>UNFPA Country Office staff</p>	<p>Study of documentation</p> <p>Key informant interviews</p> <p>Group discussions with target beneficiaries and local authorities</p>

	<p>into account a handover to local partners</p> <p>Interventions in the focus area incorporate exit strategies</p> <p>UNFPA has been able to support its partners and the beneficiaries in developing capacities that ensure the durability of outputs, and eventually outcomes</p>	<p>Extent of ownership of each project by implementing partners</p> <p>Extent to which measures and coping strategies have been taken to minimise the adverse effects of the country's staff turnover in the Department of Social Development and provincial authorities.</p>	<p>CPAP</p> <p>Annual Work Plans</p> <p>Previous evaluations</p>	
<p><i>Data and information collected</i></p>	<p>Stakeholders reported that the PD program activities have long-term durable effects, citing the fact that new techniques, soft wares and trainings remain with the implementing partner, CSA. Thus investment in system strengthening through new techniques, soft wares, rigorous capacity-building staff. Stakeholders' interviews show that the various capacity-building initiatives can have long-term durable effects with ownership of new techniques, software and activities. From the interviews, it was noted that the CSA may continue using the statistical system, supported by UNFPA CO for data collection and production. The lack of integrated statistical system, lack of requisite skills in integration of population issues in development will affect sustainability. IPs acknowledged that community sensitization activities will not be sustained due to limited access to funds without UNFPA's to support for these interventions. One stakeholder stated confidently that, while UNFPA support is entirely relevant, they will continue without UNFPA. Generally the possibility of sustainability of the 8th CP interventions depends on government policies, priorities and involvements, community ownership and involvement, the quality of capacity-building, fund availability, and international donor environment. Sustainability can be threatened by total absence of in-built exit strategy, absence of a long-term institutional capacity development and tracking strategy to ensure continuity in IPs and government ministries. The supported</p>			

	<p>initiatives on data generation especially the census and IMIS are government owned. UNFPA consistency in advocacy for data use in planning and in the actualisation of ICPD PoA and SDG Agenda 2030 guarantees sustainability of PD component.</p> <p>m</p>			
COMPONENT 2: ANALYSIS OF THE STRATEGIC POSITIONING				
<p>EQ5: (i) To what extent has the UNFPA Country Office successfully used the establishment and maintenance of different types of partnerships to ensure that UNFPA can make use of its comparative strengths in the achievement of the Country Programme results?</p> <p>(ii) To what extent has UNFPA successfully taken advantage of opportunities for South-South Cooperation across all of its programmatic areas to facilitate the exchange of knowledge and lessons learned?</p>				
COORDINATION	<p>The implementation of the country programme is aligned with UNFPA Strategic Plan dimensions (And in particular with special attention to disadvantaged and vulnerable groups and the promotion of South-South cooperation)</p>	<p>Extent to which the country office prioritised intervention strategies targeted at the most <i>vulnerable, disadvantaged, marginalised and excluded</i> population groups in line with the stipulations of the UNFPA Strategic Plan</p> <p>Extent to which support of South-South cooperation is done in a rather ad-hoc manner or through the enhanced use of local capacities and as a means to share best practices</p>	<p>CPAP CPD UNFPA Strategic Plan All the information collected when assessing the effectiveness criterion Department of International Relations and Cooperation (DIRCO)</p>	<p>Study of documentation Key informant interviews</p>

		<p>Extent to which South-South cooperation related indicators are included in the CPAP results' framework or any other management tool.</p> <p>Number of south-south interactions supported in the areas of sexual reproductive health and rights (SRHR), youth, gender and population and development</p> <p>Number of country delegations supported to promote the ICPD agenda and inclusion of SRHR in discussions on SDGs beyond 2015 at regional and global forums</p>		
	<p>The country programme, as currently implemented, is aligned with the United Nations Strategic Cooperation Framework (SCF). The UNFPA CO is coordinating with other UN</p>	<p>The CPAP is aligned with the SCF and the SCF fully reflect the interests, priorities and mandate of the UNFPA in the country and all aspects have been included.</p> <p>Evidence of UNFPA coordination</p>	<p>SCF, SCF mid-term review CPD, CPAP AWP Resident Coordinator Resident Coordinator Annual Report UN organisations: UNICEF, UN Women, WHO, UNAIDS and UNDP.</p>	<p>Study of documentation Key informant interviews Focus group discussion with representatives of UNICEF, UN Women, WHO, UNAIDS and UNDP.</p>

	agencies in the country, particularly in the event of potential overlaps	mechanisms and their quality Evidence of any inadequate coordination mechanisms and implications for UNFPA strategic positioning.	Donors Line Departments	
<i>Data and information collected</i>	<p>Based on numerous stakeholder interviews and document review, there is strong evidence of active and effective UNCT collaboration by the UNFPA CO. UNFPA CO collaborates with UNICEF on Joint Programme on Child Marriage and GBV. While UNFPA plays administrative role in GBV project, UNICEF leads in ending child marriage while also UNFPA plays active role in humanitarian emergencies.</p> <p>Other coordination structures are also established through joint programmes with other UN Agencies. UNFPA is currently involved in coordination for the implementation of two joint programmes: 2 joint programmes for the abandonment of Female Genital Mutilation / Cutting (FGM/C) with UNICEF and with co-financing from DFID, Norway, Italy, Germany and the Netherlands.</p> <p>On the government level, federal and the regional ministries assume leadership for the coordination of international donors, international organizations, NGOs and CBOs assistance support. On the federal level, UNFPA interventions in Ethiopia are coordinated with the following ministries and programmes: Ministry of Finance and Economic Development, Federal Ministry of Health: National Reproductive Health Directorate; Ministry of Women, Children and Youth Affairs; Planning and Development Commission, Central Statistical Agency. At regional level, coordination is managed by regional bureaus, institutions and local councils based on their geographic and technical mandate. Regional state institutions lead coordination mechanisms for donors, international organizations, NGOs and CBOs who are intervening in the technical area under their mandate and geographic jurisdiction.</p> <p>Coordination is also part of the UNFPA internal programme monitoring and evaluation arrangements. Programme M&E plans indicate organization of Quarterly Review Meetings at both national and regional levels under the leadership of the MoFED (coordinating authority) for all Implementing Partners to discuss projects' progress against signed Annual Work Plans (AWPs), to identify implementation challenges and to devise mitigating measures. UNFPA Ethiopia team members have been co-chair of some working groups like the Monitoring and Evaluation Group, while the Country Representative has deputised for the Regional Coordinator of UNDP in Ethiopia. Some stakeholders expressed a concern, however, that while</p>			

active participation in inter-agency working groups raises visibility of UNFPA and is highly appreciated, it may focus too much UNFPA staff attention inward within the UNCT at a time when aggressive external efforts at fundraising might be a greater priority.

UNFPA is involved in Delivering as One joint planning process accompanying the UNDAF which is signed by all the resident UN agencies in Ethiopia. By working together with other UN agencies there are opportunities for UNFPA and its UN partners to provide a continuum of focus on development needs, such as the overlapping mandates of UNICEF (children up to age 18) and UNFPA (adolescents and adults). UNFPA works with UNICEF to address issues of violence against children including child marriage. Generally, the Delivering as One initiative provides impetus for more collaboration and joint working but agencies are constrained by their individual systems, mandates and reporting mechanisms. Sharing of information with UNCT happens on a regular basis through participation in the Technical Working Groups.

While UNFPA is actively involved in UN working groups, it is not a lead agency in any of the task teams. There is ample evidence of information exchange between UN agencies. Being a One UN country, joint UN task teams meet regularly. Besides most relevant UN agencies are housed in the UNECA Complex in Addis Ababa thereby making informal information exchange is easy.

Stakeholders expressed strong approval for the exceptionally collaborative approach taken by UNFPA Ethiopia because the UNFPA staff fully share the values of the Delivering as One approach and collaborate with other UN Agencies to maximize the results. Stakeholders from outside the UNCT, especially the Federal and Regional Implementation Partners reinforced the idea that UNFPA Ethiopia is adept in collaboration to advance common UNCT goals. The evaluation team was unable to find any significant instances where UNDAF outputs or outcomes that belong to the UNFPA mandate were not fully attributed to UNFPA.

EQ6: (i) What are the main UNFPA comparative strengths in the country – particularly in comparison to other UN agencies and development partners?

(ii) What is the main UNFPA added value in the country context as perceived by national stakeholders?

ADDED VALUE	There is added value of UNFPA in the development	Evidence of added value	Beneficiary groups/communities Senior management in line departments	Key informant interviews Focus group discussions
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	<p>partners' country context as perceived by national stakeholders</p> <p>UNFPA has comparative strengths in the country – particularly in comparison to other UN agencies</p> <p>UNFPA corporate features or are explained by the specific features of the CO</p> <p>UNFPA has had no intended substitution or displacement effects at national, provincial or local level and that If there is any the magnitude of such effect and what are their repercussions are minimal</p>	<p>Extent of contribution to added value by UNFPA comparative strengths in the country – particularly in comparison to other United Nations organisations</p> <p>Uniqueness of UNFPA corporate features explained by specific aptitudes of the country office</p> <p>Evidence of possible substitution or displacements effects on the private sector, civil society organisations, academia, specific government bodies and other development partners in the country, including other United Nations organisations.</p>	<p>and national government counterparts Implementing partners Donors Other United Nations organisations</p>	
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<p><i>Data and information collected</i></p>	<p>The UNFPA is acknowledged by other UN Agencies, implementing partners and national stakeholders as a reliable and responsive key lead agency for SRH, adolescent, young people, gender equality and GBV. <i>“UNFPA plays key role in setting UNCT agenda ... on gender, youth, data collection and hugely works on emergency situations”</i> ,(IDI with UNCT Member). Overall, based on extensive stakeholder interviews with a wide range of respondents, UNFPA Ethiopia was perceived to have close long-term ties to national counterparts, is a reliable partner for all four program areas and a highly effective policy advocate. However, some IPs and UNCT stakeholders called for UNFPA to amplify its advocacy role in key mandate areas. Among the four program areas, the most frequently cited areas of value added were SRH/FP, Gender, Population and Development .UNFPA is a “go-to” agency for data generation and use as well as community empowerment of key populations. The PD staff is praised for its work on data generation. UNFPA Policy on ICPD PoA and SRH is also seen as a clear comparative advantage.</p>
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ANNEX 5: DATA COLLECTION TOOLS

Key Informant Interview Guide for UNFPA Country Office Staff

NB: Use these questions for all the Programme officers' in-charge of each component area in the Country Office. Thus

Focal Points and Programme Officer: SRH

Focal Points and Programme Officer: AYD

Focal Points and Programme officer:GEWE

Focal Points and Programme Officer: Population and Development

General introduction and closing - 1. Human connection

- Spend a few minutes to understand how the interviewee is today. Is the interview convenient or problematic in any way? Is s/he really busy and we should make the interview shorter than agreed?
- Explain briefly something about yourself, where do you come from, other interviews you are doing that also frame this present interview, etc.
- Thank the interviewee for the time dedicated to this interview.

2. Inform the interviewee of the objective and context of the interview

- Purpose of the evaluation – clarify briefly the purpose of the evaluation
- Confirm the time available for the interview
- Stress the confidentiality of the sources or the information collected.
- Explain what the objective of the interview (context) is. This not only shows respect, but is also useful for the evaluator, as it helps the interviewee to answer in a more relevant manner

3. Opening general questions: refining our understanding of the interviewee's role

Before addressing the objectives of the interview, the valuator needs to ensure that s/he understands the role of the interviewee vis-à-vis the organisation, the programme, etc., so as to adjust the questions in the most effective way.

4. Ending the interview

- If some aspect of the interview was unclear, confirm with interviewee before finishing. Confirm that nothing that the interviewee may consider important has been missed: "have I missed any important point?"
- Finish the interview, confirming any follow-up considerations – e.g., if documents need to be sent and by when, if the evaluator needs to provide any feedback. Etc.
- Mention when the report will be issued and who will receive it.
- If relevant, ask the interviewee for suggestions/facilitation about other key persons (referred to during the meeting) that could also be interviewed.
- Thank the interviewee again for the time dedicated to this interview.

Introduction: Describe the UNFPA 8TH Country Programme and your involvement in it?

Relevance

- What are the national needs and priorities in Ethiopia in terms of the development agenda?
- Were the objectives and strategies of the Country Programme discussed and agreed with national partners? [Probe]
- How did you identify the needs prior to the programming of the Sexual and Reproductive Health (SRH), Population and Development (P&D), and Gender Equality (GE) including GBV components?
- To what extent is UNFPA support to Ethiopia aligned to the objectives in Ethiopia national development, GTP !! and responding to national priorities?
- To what extent is the UNFPA support in the field of SRH, AYD and Gender Equality, P&D adapted to the needs of
 - Population of Ethiopia
 - Needs of the government
 - In line with priorities set by the international and national development frameworks?
- Does the 8TH Country Programme (CP) address these needs and priorities of the Ethiopia population? What aspects of the national and sectoral policies are covered in the 8TH CP?
- Are there any changes in national needs and global priorities along the line? How did UNFPA Country Office (CO) respond to these?

Effectiveness

- Looking at the implementation so far, to what extent has 8TH CP reached the intended beneficiaries?
- Are outputs/targets achieved or likely to be achieved??
- To what extent has the 8TH CP contributed to improving the quality and affordability of SRH services provided particularly for the different components of the cluster?
 - To what extent have the interventions P and D, AYD achieved their targets?
 - To what extent were the targeted groups of beneficiaries reached through the CP support?
- Overall, how effective is the 8TH CP in Ethiopia?
- What are the facilitating factors for the realization of the SRH/AYD/GEWE/P&D results?
- What are some of the challenges or limiting factors that ,may have affected the achievement of and implementation of the programme? How were these challenges addressed?
- To what extent have the programme results reached the intended beneficiary groups? Have there been any tangible changes as a result of interventions? [mothers, adolescentns, FP users, fistulae and GBV victims?]
- What have been unintended effects – positive or negative, direct or indirect? Why were they generated and what are the likely consequences?
- Share with us the approaches used to deliver SRH. AYSRH? What was the most appropriate and why?

Efficiency

How adequate were the available resources (funds, logistics, staff) used to carry out activities in the CP?

- Explain the resources management process of your programme area?
- How many staff is in your unit? Qualified with appropriate skills?
- Do you think your staff strength and capacity are enough for the 8TH CP implementation and achievement of results?
- How many consultants have worked on the 8TH CP since inception in 2012?
 - International consultants?
 - National consultants?What was/is their output?
How useful is the output in the implementation of the 8TH CP?
- Describe UNFPA CO administrative and financial procedures in the 8TH CP?
- Do you think UNFPA CO administration and financial procedures are appropriate for the 8TH CP implementation?
- How timely were resources for interventions disbursed for implementation?
- Were there any delays? If yes, why? And how did you solve the problem?
- Any new activities added to the current programme activities?
- Are there occasions when the budget was not enough or you overspent?
- Are there any programmes cancelled or postponed? Why?
- Have the programme finances been audited?
- Any funding deficit?
- Any additional funding from the Government of Ethiopia and other partners?
- What lessons has your Unit learnt in implementing the 8TH CP?
- Any challenges encountered so far?
- What is the plan for the future phase?

Sustainability

To what extent has the CP been able to support partners and beneficiaries in developing capacities and establishing mechanisms to ensure ownership and durability of effects?

To what extent has national capacity been developed so that UNFPA may realistically plan progressive disengagement

- What are the benefits of the programme interventions?
- To what extent are the benefits likely to go beyond the programme completion?
- What measures are in place at the end of the programme cycle for the various programmes to continue?
- What are the plans for sustainability of the programmes?
- What are the main factors affecting sustainability
- Have programmes been integrated in institutional government plans?

Strategic Alignment

Coordination and Partnership

- Is there any Inter-Agency Technical Working Group on this 8TH CP, involving other UN Country Team?
- What is the role of UNFPA CO in the United Nations Country Team coordination in Ethiopia? What partnerships exist? Any specific contributions to the achievement of results? Any Challenges?
- How could these challenges be overcome?
- What role has UNFPA played in the South-South Cooperation? Any specific contributions? Any lessons learned? Any challenges?

Added value

- What are the special strengths of UNFPA when compared to other UN agencies and development partners?
- To what extent has the CO been able to respond to specific humanitarian requests in the country?
- How is UNFPA perceived by implementing and national partners? – How do the national counterparts and development partners in the country perceive, recognise and recall UNFPA CO performance?
- What are the main UNFPA CO comparative strengths in the country?
- To what extent would results observed within the CP have been achieved without UNFPA support?
- What is the main added UNFPA added value in Ethiopia context as perceived by national stakeholders?

Cross-cutting Issues:

- Were there any partnerships, coordination, monitoring and evaluation capacity challenges that facilitated the delivery of the 8TH CP results?
- How did you take care of gender equality, human rights, and youth vulnerabilities in your programming? Evidence?

Lessons Learnt and recommendation

- What was the most and least successful approach in the delivery of the SRH, AYSRH, Gender and P&D components? What are the lessons learnt?
- What do you consider the most innovative approach in delivering programme outputs? Why?
- What are the best practices from the 8TH CP that should be continued in the next CP cycle or replicated elsewhere?
- What recommendations for the next CP ?

Key Informant Interview Guide for Implementing Partners (SRH/AYD/GEWE/Population and Development)

National Stakeholders: Federal, Regional and NGO IPs

Place: To be used in Addis and Regions

General introduction and closing - 1. Human connection

- Spend a few minutes to understand how the interviewee is today. Is the interview convenient or problematic in any way? Is s/he really busy and we should make the interview shorter than agreed?
- Explain briefly something about yourself, where do you come from, other interviews you are doing that also frame this present interview, etc.
- Thank the interviewee for the time dedicated to this interview.

2. Inform the interviewee of the objective and context of the interview

- Purpose of the evaluation – clarify briefly the purpose of the evaluation
- Confirm the time available for the interview
- Stress the confidentiality of the sources or the information collected.
- Explain what the objective of the interview (context) is. This not only shows respect, but is also useful for the evaluator, as it helps the interviewee to answer in a more relevant manner

3. Opening general questions: refining our understanding of the interviewee’s role

Before addressing the objectives of the interview, the valuator needs to ensure that s/he understands the role of the interviewee vis-à-vis the organisation, the programme, etc., so as to adjust the questions in the most effective way.

4. Ending the interview

- If some aspect of the interview was unclear, confirm with interviewee before finishing. Confirm that nothing that the interviewee may consider important has been missed: “have I missed any important point?”
- Finish the interview, confirming any follow-up considerations – e.g., if documents need to be sent and by when, if the evaluator needs to provide any feedback. Etc.
- Mention when the report will be issued and who will receive it.
- If relevant, ask the interviewee for suggestions/facilitation about other key persons (referred to during the meeting) that could also be interviewed.
- Thank the interviewee again for the time dedicated to this interview.

Relevance

- What are the national needs and priorities in Ethiopia in terms of the development agenda? Does the 8TH Country Programme (CP) address these needs and priorities of the South African population at district, provincial and national levels? What aspects of the national and sectoral policies are covered in the 8TH CP?
- Were the objectives and strategies of the Country Programme discussed and agreed with national partners? [Probe]
- How did you identify the needs prior to the programming of the Sexual and Reproductive Health (SRH), HIV/AIDS, Population and Development (P&D), and Gender Equality (GE) including GBV components?
- Are there any changes in national needs and global priorities along the line? How did UNFPA Country Office (CO) respond to these?

Effectiveness

- Looking at the implementation so far, to what extent has 8TH CP reached the intended beneficiaries?
- Are outputs/targets achieved?
- Overall, how effective is the 8TH CP in Ethiopia?
- What are the facilitating factors for the realization of the SRH/AYD/GEWE/P&D results?
- What are some of the challenges or limiting factors that ,may have affected the achievement of and implementation of the programme? How were these challenges addressed?
- To what extent have the programme results reached the intended beneficiary groups? Have there been any tangible changes as a result of interventions? (mothers, adolescents, FP users, fistulae and GBV victims?)
- What have been unintended effects – positive or negative, direct or indirect? Why were they generated and what are the likely consequences?
- Share with us the approaches used to deliver SRH. AYSRH? What was the most appropriate and why?

Efficiency

- To what extent were the activities managed in a manner that would ensure the delivery of high quality results?
- Explain the resources management process of the programme
- How many staff is in your unit? Qualified with appropriate skills?
- Do you think your staff strength and capacity are enough for the 8TH CP implementation and achievement of results?
- Do you think UNFPA CO administration and financial procedures are appropriate for the 8TH CP implementation?
- What would have been done differently with the same resources to achieve the stated results?
- How about the programme approach, partner and stakeholder engagement, was it appropriate for CP implementation and achievement of results?
- How timely did the resources for this particular intervention come to your office?
- Were there any delays? If yes, why? And how did you solve the problem?
- Any new activities added to the current programme activities?
- Are there occasions when the budget was not enough or you overspent?
- Are there any programmes cancelled or postponed? Why?
- Any additional funding from the Government of Ethiopia and other partners?

Sustainability

- To what extent are the benefits likely to go beyond the programme completion?
- What measures are in place at the end of the programme cycle for the various programmes to continue?
- What are the plans for sustainability of the programmes?: Has the CP been able to support National institutional beneficiaries in developing capacities and establishing mechanisms to ensure ownership and the durability of effects?

- Have programme activities been integrated in institutional government plans?
- Does your institution have the capacity to continue the programme interventions without any donor support?

Coordination and Partnership

- What is the role of UNFPA CO in the United Nations Country Team coordination? What partnerships exist? Any specific contributions to the achievement of results? Any Challenges?
- How could these challenges be overcome?
- What role has UNFPA played in the South-South Cooperation? Any specific contributions? Any lessons learned? Any challenges?

Added value

- What are the special strengths of UNFPA when compared to other UN agencies and development partners in Ethiopia?
- How is UNFPA perceived by implementing and national partners in the country?

Cross-cutting Issues:

- Were there any partnerships, coordination, monitoring and evaluation capacity challenges that facilitated the delivery of the 8TH CP results?
- How did you take care of gender equality, human rights, and youth vulnerabilities in your programming? Evidence?

Lessons Learnt and recommendation

- What was the most and least successful approach in the delivery of the SRH, AYSRH, Gender and P&D components? What are the lessons learnt?
- What do you consider the most innovative approach in delivering programme outputs? Why?
- What are the best practices from the 8TH CP that should be continued in the next CP cycle or replicated elsewhere?
- What recommendations for the next CP?

In-depth Interview Guide for Beneficiaries

Place: Beneficiaries in Addis and Districts

Relevance

- What are the national needs and priorities in Ethiopia in terms of the development agenda? How important is the 8TH Country Programme (CP) to these needs and priorities at district, provincial and national levels?
- Does the 8TH CP address the needs in: Women's Reproductive Health (SRH), Adolescents, Youth and Gender (AYD), GEWE and Population and Development (P&D)
- **Effectiveness**
- To what extent has UNFPA support reached the intended beneficiaries?
- Are different beneficiaries appreciating the benefits of the UNFPA interventions? For example?
- Overall, how effective is the 8TH CP in Ethiopia?

- What are the specific indicators of success in your programme?
- What factors contributed to the effectiveness or otherwise?

Sustainability

- What are the benefits of the programme interventions?
- To what extent are the benefits likely to go beyond the programme completion?
- What measures are in place at the end of the programme cycle for the various programmes to continue?
- Have programmes been integrated in institutional/government plans?
- How does the UNFPA CO ensure ownership and durability of its programmes?

Focus Group Discussion – Adolescents and Youths

Introduction: I am part of a team to evaluate GoE/UNFPA 8TH Country Programme to help UNFPA CO plan the next Country Programme. We are looking at how effectively UNFPA or its partners has helped Ethiopia to understand the issues of SRH, Gender and AYSRH.

Can we introduce ourselves?

Can you explain what activities you have participated in?

Core Questions:

1. What was the rationale for participating in the activities?
2. Relevance: How well does the activity fit in with the youth activities in Ethiopia?
3. What effect do you think the activities should have with Ethiopia youths?
4. Did activities contribute to changing any of your sexual and reproductive behaviour? If yes, how?

Effectiveness

- i. Provide examples of success of this programme as far as the youths in this country/district are concerned?
- ii. How useful are the activities
- iii. How do the activities here contribute to Ethiopia's development?

Site Visits [Look for these]

RH/FPCS – Service delivery points with 3 modern contraceptives. Midwives availability

EmONC – Tertiary level facilities providing comprehensive emergency obstetrics and neonatal care.

YFSRH Facilities:

Ministries with budget allocation for adolescents sexual and reproductive health

Communities that abandoned FGM:

GBV Victims and Survivors:

Fistulae Patients and Reintegrated

Agencies with sex-age-disaggregated data.

Any adoption of human rights approach?