COUNTRY NOTE

# EVALUATION OF UNFPA SUPPORT TO FAMILY PLANNING 2008-2013

## COUNTRY CASE STUDY
## **ETHIOPIA**

EVALUATION OFFICE
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**Evaluation of UNFPA Support to Family Planning Services 2008-2013**

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For further information on the evaluation please consult the Evaluation Office webpage: http://www.unfpa.org/public/home/about/Evaluation/EBIER/TE

# Table of Contents

## ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| AYSRH | Adolescent and Youth Sexual and Reproductive Health |
| BCC | Behaviour change communication |
| BoFED | Bureau of Finance and Economic Development |
| CHAI | Clinton Health Access Initiative |
| CO | Country Office |
| CORHA | Consortium of Reproductive Health Associations of Ethiopia |
| CP | Country Plan |
| CPR | Contraceptive Prevalence Rate |
| CPR | Contraceptive Prevalence Rate |
| CSO | Civil Society Organisation |
| CSW | Commercial Sex Worker |
| DFID | Department for International Development (UK) |
| DHS | Demographic and Health Survey |
| DKT | DKT International (social marketing NGO named after D.K. Tyagi, pioneer of family planning in India) |
| DP | Development Partners |
| EC | Emergency Contraceptives |
| EmOC | Emergency Obstetric Care |
| EmONC | Emergency obstetric and Neonatal care |
| ESARO | Eastern and Southern Africa Regional Office |
| FGAE | Family Guidance Association of Ethiopia |
| FGD | Focus Group Discussion |
| FHAPCO | Federal HIV and AIDS Prevention and Control Office |
| FMHACA | Food Medicine and Health Care Administration and Control Authority of Ethiopia |
| FMoH | Federal Ministry of Health |
| FP | Family Planning |
| FP-TWG | Family Planning Technical Working Group |
| FP2020 | Family Planning 2020 |
| GBV | Gender based violence |
| GoE | Government of Ethiopia |
| GPRHCS | Global Programme for Reproductive Health Commodity Security |
| HDA | Health Development Army |
| HEW | Health Extension Worker |
| HIV | Human Immunodeficiency Virus |
| HQ | UNFPA Headquarters |
| HRBA | Human Rights Based Approach |
| HSDP | Heath Sector Development Programme |
| IATT | Inter Agency Task Team |
| ICPD | International Conference on Population and Development |
| INGO | International Non-Government Organisation |
| IP | Implementing Partner |
| IUCD | Intra-Uterine Contraceptive Device |
| KII | Key Informant Interview |
| LAFPM | Long-Acting Family Planning Methods |
| mCPR | Modern Contraceptive Prevalence Rate |
| MDG | Millennium Development Goals |
| MISP | Minimum Initial Service Package |

| | |
|---|---|
| MoFED | Ministry of Finance and Economic Development |
| MoWCYA | Ministry of Women Children and Youth Affairs |
| MoH | Ministry of Health |
| MSI | Marie Stopes International |
| MSM | Men who have sex with men |
| MWRA | Married Women of Reproductive Age |
| NGO | Non-Government Organisation |
| NNPWE | National Network of Positive Women in Ethiopia |
| PFSA | Pharmaceuticals Fund and Supply Agency |
| PHC | Primary Health Care |
| PMTCT | Prevention of Mother-To-Child Transmission (of HIV) |
| PSI | Population Services International |
| RBA | Rights based approach |
| RH | Reproductive Health |
| RHB | Regional Health Bureau |
| RHCS | Reproductive Health Commodity Security |
| RMNCH | Reproductive, Maternal, Newborn and Child Health |
| RO | Regional Office |
| RRSRH | Reproductive Rights and Sexual and Reproductive Health |
| SCMS | Supply Chain Management System |
| SNNPR | Southern Nations, Nationalities and Peoples Region |
| SRH | Sexual and Reproductive Health |
| SRHR | Sexual and Reproductive Health and Rights |
| STI | Sexually Transmitted Infections |
| TA | Technical Assistance |
| TFR | Total Fertility Rate |
| TMA | Total Market Approach |
| ToC | Theory of Change |
| ToR | Terms of Reference |
| TWG | Technical Working Group |
| UN | United Nations |
| UNDAF | United Nations Development Assistance Framework |
| UNFPA | United Nations Population Fund |
| USAID | United States Agency for International Development |
| VCT | Voluntary counselling and testing |
| VMG | Vulnerable and Marginalised Group |
| WCARO | West and Central Africa Regional Office |
| WRA | Women of reproductive age |

# INTERVENTION MAP

## KEY FACTS – ETHIOPIA

| Indicator | 2014 | Source of Data |
|---|---|---|
| **Population and Development** | | |
| Population, total | 96,958,732 | World Bank[1] |
| Population growth (annual %) | 2.5 | World Bank[1] |
| Urban Population (% of total) | 19 | World Bank[1] |
| Population Density (per sq. km of land area) | 97 | World Bank[1] |
| Life Expectancy at birth, total (years) | 63 (2013 data) | World Bank[1] |
| Literacy rate, population 15+ years (%) | - | World Bank[1] |
| Human Development Index (HDI) | 0.442 (Rank 174 out of 188) | Human Development Report[2] |
| Economic growth rate (GDP growth annual %) | 10.3 | World Bank[1] |
| GINI Index | - | World Bank[1] |
| **Gender Equality and Empowerment** | | |
| Gender Inequality Index | 0.558 (Rank 129 out of 155) | Human Development Report[3] |
| Women representation in parliament, total (%) | 28 | World Bank[1] |
| Violence against women ever experienced (%) | 55.9 | Human Development Report[3] |
| Employment to population ratio, 15+, female (%) (modeled ILO estimate) | 72 | Human Development Report[5] |
| Ratio of girls to boys in primary and secondary education (%)[4] | - | World Bank[1] |
| **Reproductive Rights and Reproductive Health** | | |
| Adolescent fertility rate (births per 1,000 women ages 15-19) | 60 | World Bank[1] |
| Teenage mothers (% of women ages 15-19 who have had children or are currently pregnant) | - | World Bank[1] |
| Prevalence of HIV, both sexes (% ages 15-49) | 1.2 | World Bank[1] |
| Maternal mortality rate (per 100,000 live births) | 378 | World Bank[1] |
| Under 5 mortality rate (per 1,000 live births) | 62 | World Bank[1] |
| Contraceptive use, modern methods (% ) | 57.5 | UN DESA[5] |
| Unmet need for family planning (%) | 15.7 | UN DESA[6] |
| Births attended by skilled health staff (% of total) | 23 (2013 data) | World Bank[1] |

[1] World Bank. (2016). Ethiopia. Retrieved from http://data.worldbank.org/country/ethiopia

[2] United Nations Development Programme. (2016). Ethiopia. Retrieved from http://hdr.undp.org/en/countries/profiles

[3] United Nations Development Programme. (2016). Table 5: Gender Inequality Index. Retrieved from http://hdr.undp.org/en/composite/GII

[4] This indicator is also labeled as "*Gross enrolment ratio, primary and secondary, gender parity index (GPI)*" by the World Bank.

[5] United Nations. (2016). UN DESA Population Division Estimates and Projections of Family Planning Indicators. Retrieved from http://www.un.org/en/development/desa/population/theme/family-planning/cp_model.shtml

# 1 INTRODUCTION

Family planning is a principal focus of the work of UNFPA worldwide. This country case study is part of a thematic evaluation of UNFPA support to family planning 2008-2013, whose objective is to assess progress against past and current strategic plans and inform future decision-making and policy formulation in family planning.

## 1.1 Objectives of the evaluation

*Purpose*

The purpose of the evaluation is to assess the performance of UNFPA in the field of family planning (FP) during the period covered by the Strategic Plan 2008-2013 and to provide learning to inform the implementation of the current UNFPA Family Planning Strategy Choices not Chance (2012-2020). The evaluation will also inform other relevant programmes such as the Global Programme for Reproductive Health Commodity Security (GPRHCS) (2013-2020) and the HIV/Unintended pregnancies framework (2011-2015). Finally, the evaluation results will feed into the mid-term review of UNFPA current Strategic Plan 2014-2017.

*Objectives*

The primary objectives of the evaluation are to:

1. Assess how the framework as set out in UNFPA Strategic Plan (and revised Development Results Framework) 2008-2013 and further specified in the Reproductive rights and sexual and reproductive health framework (2008-2011) as well as in the GPRHCS (2007-2012) and the HIV/Unintended Pregnancies framework (2011-2015), has guided the programming and implementation of UNFPA interventions in the field of FP.
2. Facilitate learning and capture good practices from UNFPA experience across a range of key programmatic interventions in the field of FP during the 2008-2013 period to inform the implementation of both outcome 1 of UNFPA current Strategic Plan and the Choices not Chance 2012-2020 strategy; inform the GPRHCS (2013-2020) and the HIV/Unintended pregnancies framework (2011-2015) as well as future programming of interventions in the field of FP.

## 1.2 Scope of the evaluation

The evaluation covers the period 2008-2013, taking into account information from 2014 when pertinent and necessary. It is both retrospective and forward-looking, including evaluation of past performance, analysis of lessons learnt, and conclusions and recommendations for future interventions.

The geographical scope covers all countries where UNFPA has carried out FP interventions, focussing on the 69 poorest countries with low rates of contraception use and high unmet need for FP identified by the 2012 London Summit on Family Planning and FP2020 partnership, and also covering middle income countries where FP needs are still high due to inequality of access. Data collection and case studies cover all six UNFPA regions (Eastern and Southern Africa, Western and Central Africa, Asia and the Pacific, Latin America and the Caribbean, the Arab States, and Eastern Europe and Central Asia).

All UNFPA FP interventions are included in the evaluation, including those covered by core and non-core resources and those financed through the GPRHCS. Family planning is an integral part of UNFPA interventions in maternal health, adolescent and young people's sexual and reproductive health (SRH), HIV and AIDS, gender and humanitarian support. Family planning activities in these areas are included in the evaluation where appropriate, taking care not to duplicate work carried out in the

Thematic Evaluation of UNFPA Support to Maternal Health 2000-2011 (UNFPA 2012b) and the Adolescent and Youth Sexual and Reproductive Health (AYSRH) evaluation which is being carried out concurrently with this evaluation.

The evaluation covers eight principal areas of investigation:

- UNFPA support to integration of FP with other SRH services
- UNFPA efforts for coordination to ensure national ownership and institutionalisation of FP programmes
- Extent of UNFPA efforts as a broker to promote FP, with particular attention to partnerships
- Extent of UNFPA support to creation of an enabling environment
- Level of focus on the needs of the most vulnerable groups and marginalised populations
- Extent of implementation of a human rights based approach
- UNFPA choice of different modes of engagement
- The extent to which UNFPA support for supply-side activities (including training, procurement and logistic systems) promotes rights-based and sustainable approaches and contributes to improved access.

## 1.3 Overview

The evaluation uses a contribution analysis approach based on a reconstructed theory of change, which is being tested through collection of data and information at different levels, and analysis of the eight evaluation areas and their associated assumptions. By examining the on-going validity of assumptions supporting the theory of change in each of the evaluation areas, the evaluation presents an assessment of UNPFA contribution to results in family planning.

There are twelve country case studies (five in-country and seven desk studies) in the data collection phase, which also includes review of documentation, key informant interviews (KII) at global and regional levels with UNFPA staff and other stakeholders, two on-line surveys and additional financial analysis.

The case studies are not evaluations of the FP effort in each country and do not present recommendations for on-going or future FP work. They are one important input into the data collection and analysis process for the eight areas of the UNFPA FP evaluation as a whole, and contribute to the overall evaluation through:

- Providing evaluation evidence from the UNFPA country office (CO) and in-country stakeholders' perspective for addressing the global evaluation questions
- Generating data for triangulation with other sources
- Contributing to identifying more clearly "how" and "why" change occurs and contributions of UNFPA to this
- Providing insights to the eight principal evaluation areas
- Identifying lessons learned across different contexts.

Contribution analysis was originally presented as an approach to programme design and monitoring and, to a lesser extent, to evaluation. This has left considerable freedom for evaluators to explore different approaches to operationalising contribution analysis and the use of Theories of Change (ToC). Different approaches have been used to apply contribution analysis in evaluations which include both country and sub-programme and global or synthesis levels of analysis.

For this evaluation's work at country level the team has organised the country case study notes around the eight evaluation areas and has attempted to address most or all of the key assumptions

in the overall ToC as they are realised (or not) at the country level. This method has the following strengths:

- It draws a clear link from the overall ToC as developed and presented in the inception report while allowing the country cases to reflect local contexts and realities and the UNFPA response
- It allows the country cases to include areas of UNFPA engagement and support and positive or negative results which may not have been captured in the reconstructed ToC[6]
- It simplifies the reporting of findings at country case level since it does not require the development of separate, country level ToC
- It still allows for a strong testing/challenge of the ToC at country level because it allows the evaluation team to verify the validity of key assumptions. In effect, this combines analysis of assumptions and risks (the main risks are usually that key assumptions are not realised)
- Using the common structure of the eight issues areas and their associated key assumptions will facilitate synthesising the findings and conclusions of the country studies during the preparation of the overall evaluation report.

In this way the country case study notes are able to establish the link from the country level evaluation results to the overall ToC for UNFPA support to FP.

This report covers the case study in Ethiopia.

### 1.4 Structure of the country note

Section 2 of the report outlines the case study methodology. Section 3 gives a short overview of key elements of FP in Ethiopia and the UNFPA response and provides the necessary context for discussion of the specific evaluation questions and UNFPA contributions. Section 4 presents the findings of the case study along the eight evaluation questions, including progress and changes during the evaluation period and the UNFPA contribution to those changes. Section 5 presents a set of conclusions.

## 2 METHODOLOGY

### 2.1 Selection of country case studies

The five in-country case studies include three from West and Central/Eastern and Southern Africa regions, one from Asia-Pacific region, and one from Latin America and Caribbean region. The sample maximises the breadth and depth of insights into the evaluation questions and gives a broad picture of the UNFPA contribution to family planning (FP) over time in different contexts, giving insights into the country perspective on the evaluation questions, providing examples of externalities and risks and how they have been addressed, and complementing the information collected from other sources. This section summarises the process and results of country selection for visits and desk studies. A full description of the case study selection is given in the Evaluation Inception Report (UNFPA 2014a).

The selection started with a purposeful sample based on criteria which cover the dual purpose of the evaluation: looking back to assess UNFPA performance in the field of FP, and providing learning for the on-going UNFPA Strategic Plan. Criteria included poverty indices, levels of UNFPA spending and

[6] The reconstructed ToC was developed in the inception phase of the evaluation, based on the pertinent UNFPA strategy documents, which include family planning during the period. Expected pathways of change were identified and mapped for each of the 8 evaluation AREAS (see annex of inception report).

past performance in FP taking into account both change in modern contraceptive prevalence rate (mCPR) and unmet need.

From the purposeful sample, countries were selected for in-country and desk studies taking into account the following criteria, to ensure a spread and contrast in the set of case studies:

- UNFPA spending per capita
- The need to include at least one country with Global Programme for Reproductive Health Commodity Security (GPRHCS) Phase 1 Stream 1 support[7]
- Availability of sufficient and sufficiently reliable data and information on past UNFPA support and the overall country context
- The need to include at least one fragile state or humanitarian situation, at least one high-population country and one or more countries with a One UN (delivering as one) country programme
- Varying degrees of government support for FP
- Changes in UNFPA modes of engagement and implementation risks
- The need to avoid concurrent implementation of in-country case studies with other UNFPA thematic and country evaluations, and
- The potential of the country study to contribute to analysis of the hypotheses in the evaluation matrix.

The resulting sample is spread across the UNFPA Strategic Plan business model's four quadrants, which show need for support to FP interventions vs. capacity to finance such interventions, although application of the sample selection criteria clearly favours countries in the quadrants representing countries with relatively higher levels of need and lower levels of financing ability (UNFPA 2013). Aside from Ethiopia, the other countries selected for the field phase are: Bolivia, Burkina Faso, Cambodia and Zimbabwe.[8]

## 2.2 Selection of Ethiopia as a case study

Ethiopia was selected for a case study as it has characteristics regarding UNFPA support to family planning that offer important insights into the country perspective on the evaluation questions in a specific context. Relevant characteristics of the country and the UNFPA country programmes in the evaluation period include:

- The country's federal structure which has implications for national and regional budget allocations to FP
- Regional differences in key family planning parameters which affect UNFPA priority-setting and mode of engagement at different levels
- Participation as a stream 1 country in the GPRHCS Phase 1, with GPRHCS spending constituting over 38 percent of the total country programme spending in the period 2007-2011 (UNFPA 2012c)
- Ethiopian government commitment to expanding access to family planning services at community level through the health extension workers (HEWs) and engagement of the Health Development Army (HDA). Provision of family planning through the HEWs has involved task shifting to the HEWs to permit them to provide a wider range of family planning at health post level
- Many partners and donors engaged in FP, although the large majority of women get their FP supplies from the public sector

[7] Stream 1 countries are those selected for priority attention by GPRHCS for multi-year, flexible and predictable funds to help countries develop more sustainable approaches to Reproductive Health Commodity Security (RCHS)

[8] See inception report for discussion of country selection.

- The incremental UN One Fund approach in process.

Ethiopia was selected as a pilot for the in-country case studies. The pilot enabled the team to test the ability of the methodology and instruments to handle a diverse range of specific conditions and generate input for and insights into the evaluation questions.

## 2.3 Scope of the study and data collection methods

The country study covered all UNFPA FP work during the evaluation period, including interventions funded by core and non-core resources, GPRHCS activities, and FP as a component of other sexual and reproductive health (SRH) projects and programmes. Interventions at central government, departmental and municipal levels were included.

The study was carried out during December 2014 by a team of three consultants (two international and one national), together with the UNFPA Evaluation Manager. Country office (CO) staff participated fully in the preparation of the study and logistics, internal discussions and interviews within the CO, collection and analysis of information and financial data, and in the debriefing workshop session. CO staff participated in some interviews where appropriate and provided translation in visits to rural areas.

Preliminary work (prior to the country visit) included:

- Collection and review of key data on Ethiopia including country background; country health sector and other sectors relevant for SRH/FP; health and other SRH/FP-relevant indicators
- Desk analysis of UNFPA response in the country; overview of UNFPA interventions (2008-2013)
- Preparation of a detailed timetable for interviews and other activities during the country visit (in consultation with CO).

In-country work was designed to provide evaluative information on the eight evaluation areas. Activities included briefing and debriefing with CO staff and interviews with UNFPA staff, government officers, bilateral donors, UN agencies, national and international non-government organisations (NGOs), health service delivery personnel and service clients, to give a balance of different points of view of UNFPA support to FP and the current context of FP programmes and services. Focus group discussions (FGDs) were held with FP users and non-users, NGOs and government health providers. The team worked with CO staff to identify FP budgets and spending over the evaluation period, including FP spending within other thematic areas.

There were two parallel field visits of two days each to the Tigray and Southern Nations Nationalities and Peoples' (SNNPR) regions, where UNFPA has supported family planning activities. The purpose of the field trips was to gain insights on rights holders' needs, duty bearers' responses and programme successes and challenges in the decentralized country context and to add context-specific examples to the overall country picture.

Information collected from documents, interviews, field trips and FGDs was collated in an evaluation matrix shown in Annex 3. Activities and progress in each evaluation area were analysed to identify the changes, which have occurred and the UNFPA contribution to those changes. At the end of the visit the team presented preliminary findings to the UNFPA CO staff for their comments and feedback. This feedback and additional written comments from the CO are included in the analysis in section 4 of this report.

Documents consulted are shown in the list of references (Annex 1). A list of people interviewed and FGD participants is given in Annex 2. Interview guides and FGD guides are shown in the Evaluation Inception Report.

Limitations on the data collected include:

- Detailed financial information on FP spending within other SRH projects is based on estimates by CO staff, as FP spending was not explicitly tagged by the UNFPA financial systems during the evaluation period. Overall figures for FP spending in Ethiopia by the MoH and other development partners are also based on estimates as FP spending is usually integrated with other SRH activities. Information was triangulated where possible
- There was some reluctance of respondents to discuss sensitive issues of government policy and practice or to question government decisions
- Staff turnover in government meant that some interviewees had little information or institutional memory of the whole period under evaluation
- Due to the decentralised administrative structure not all relevant data on regional level activities is available at central government level. The evaluation team was only able to visit two regions in the time available for fieldwork.

Despite the above limitations, the evaluative data and information gathered during the Ethiopia country study provides a valid basis for the findings presented in section 4.

# 3 SHORT DESCRIPTION OF FAMILY PLANNING IN ETHIOPIA

***Country background***

Ethiopia is among the world's most ancient civilisations but also among its poorest countries (World Bank 2014), with a per capita income of US$ 410 (World Bank 2015a). 30 percent of its population live below the international poverty line (2007-2011) (United Nations 2011). Women's adult literacy rate (38%) is just over half of that of men (65%) (CSA and ICF International 2012), reflecting Ethiopia's pervasive gender disparities. It has a low ranking in the 2010 Global Gender Gap Report (121 out of 134 countries) (United Nations 2011).

While the country has seen a high economic growth rate and declining poverty over the past decade with average annual economic growth over ten percent for the 11 years ending in 2013-14 (African Development Bank 2015), there is still a high need to improve access to basic quality social services (United Nations 2011). A considerable number of development partners are contributing resources, the largest donors in the health sector being United States Agency for International Development (USAID), the Global Fund to fight AIDS, Tuberculosis and AIDS, the UK Department for International Development (DFID) and Gavi, Canada (WHO 2015, World Bank 2015b).

Ethiopia is a federal state with its administrative base in the capital of Addis Ababa, and decision-making decentralised to nine regional states and two city administrations (Universalia 2014), which are responsible for ensuring social services and have (some) resource allocation powers. Below regional level the administrative divisions are zones, *woredas* (districts) and *kebeles* (municipalities).

Ethiopia's largely rural population in 2013 was estimated at around 94 million (World Bank 2015c), of which one third consists of young people 15-29 years of age (United Nations 2011). The annual population growth rate is 2.6 percent and the total fertility rate has declined from 5.5 to 4.1 children per woman between 2000 and 2014 (CSA and ICF International 2012). Modern contraceptive use has increased rapidly from 8 percent in 2000 to 29 percent in 2011 and 42 percent in 2014 (CSA 2014).

***Health system***

The Ethiopian Health Sector Development Programme (HSDP) is now in its fourth phase (2010/11-2014/15). Major achievements during previous phases were improvements in infrastructure and health service delivery systems, increases in coverage and take up of a wide range of health services

and establishment of the Health Development Army (HDA) to take health promotion to community and household level. The programme is considered a success, with a record of considerable government and development partner investment over the past decade to expand health infrastructure and strengthen health service delivery systems (World Bank 2012).

The focus of the current HSDP is on preventive services and strengthening community-based work. Neonatal, infant, child, adolescent and maternal health are priority areas, and priority activities include strengthening facility-based services, family planning (FP), midwifery, emergency obstetric and neonatal care (EmONC) and immunisation. Key areas for the Ethiopian government FP programme in the 2010/11 – 2014/15 plan are commodity security and provision of long-acting and permanent contraception (Ministry of Health 2010a: 41). There is an ambitious government target for a contraceptive prevalence rate (CPR) of between 66 percent of women of reproductive age (WRA) by 2015 (base case) and 86 percent (best case) (ibid.: 102).[9] Increased access to services is also an HSDP strategy, to be achieved through improving facilities, development of social health insurance, and behaviour change communication (BCC). Community participation, with model households and strengthening of health extension work coupled with evidence-based decision-making and service quality improvements are also included as strategies.

The health system, in parallel with the administrative system, is decentralised. The public health sector comprises a three-tier system of primary, secondary and tertiary care, with various levels of hospitals and health centres. There are also some 17,000 health posts operated by 38,000 health extension workers (HEWs) who are part of the government flagship Health Extension Programme (Olson and Piller 2013, WHO Africa 2014).

To extend health promotion to community level, the Government of Ethiopia (GoE) set up the Health Development Army in 2010. The HDA aims to "*consolidate the gains that were made as a result of the roll-out of the Health Extension Programme and promote community ownership of the programs*" (Admasu 2013: 3). The all-female Army's volunteer health promoters support the HEWs by training 'model families' to implement a set of health initiatives including FP. These families serve as role models to their community.

National and international non-government organisations (NGOs) also work in health and health-related projects including sexual and reproductive health (SRH) and FP. The major national NGO engaged in SRH and FP is the Family Guidance Association of Ethiopia (FGAE), which is the national affiliate of the International Planned Parenthood Federation (IPPF). International NGOs working in the field include Marie Stopes International (MSI), Population Services International (PSI), DKT International (DKT), EngenderHealth and Pathfinder. The private health sector has expanded over the past decade and is estimated to cover more than 40 percent of curative and rehabilitative services (Weller 2014). Family planning is provided by all three sectors (public, NGO and private sectors), the government being the largest provider (87 percent of modern methods), followed by the private sector – mainly pharmacies – (8 percent) and the NGO sector (5 percent) (CSA 2014).

***Health sector spending, overseas development assistance and UNFPA contributions***

The overall health budget for Ethiopia 2014/15 was projected to be US$ 2.28 billion, of which the GoE accounts for about 60 percent (Ministry of Health 2010a, Ministry of Health 2014, WHO 2015).[10] The remaining funds are provided by bilateral and multilateral donors, the principal donors being the

[9] The mini-DHS survey of 2013 (CSA 2014) showed a prevalence (modern and traditional methods) of 29% of all WRA and 42% of currently married women. The large majority were using modern methods (28% of all WRA and 40% of currently married women).

[10] These estimates are based on government planning documents and overall analyses of health income and spending by the WHO. The figures from different sources were triangulated where possible.

USA, the Global Fund, the UK and Gavi. Overall donor contributions to the health sector rose from US$ 507 million in 2008 to US$ 778 million in 2011 (WHO 2015).

The GoE budget for maternal, newborn and reproductive health more than doubled from US$ 50 million in 2010/11 to US$ 116 million in 2013/14, increasing its share from an estimated 2 percent of total public sector health spending in 2010/11 to 5 percent in 2013/14. Data on donor contributions is not available for the same period, but during the period 2008 to 2011, approximately 7 percent of donor funds to the health sector were allocated to reproductive health (RH) and FP, the annual amounts rising from US$ 37 million to US$ 56 million in the period.

The overall UNFPA contribution during the evaluation period is shown in table 1. The CO estimates that a total of US$ 14.3 million has been spent on family planning, including family planning components of other SRH programmes. Ethiopia was a Stream 1[11] country in the first phase of the Global Programme for Reproductive Health Commodity Security (GPRHCS). GPRHCS spending in the period under evaluation was US$ 8.3 million, or 58 percent of total UNFPA FP spending. These figures exclude UNFPA institutional costs.

Estimates by the Kaiser Foundation for the period 2009-2011 (Kates, Michaud et al. 2014) do not disaggregate FP from RH. UNFPA funds were about 15 percent of the total donor support to RH and FP. The other principal RH and FP donors in the same period were USA (33%), the Netherlands (18%) and UK (11%).

Although disaggregated data on specific FP spending by government and other partners is not available, estimates can be made to give an indication of the relative weight of the UNFPA contribution to family planning:

- The Millennium Development Goals Pooled Fund (MDG Fund) is a basket fund of donor support to government, some of which is spent by government on family planning. The overall MDG Fund increased in size from US$ 33 million in 2009 to US$ 133 million in 2013. The UNFPA contribution in 2013 was US$ 2.5 million, which represents about 2 percent of the total MDG (UNFPA 2012b).[12]
- Overall government spending on contraceptives in 2013 was US$ 23.6 million. GPRHCS spending the same year was US$ 1.4 million, of which approximately 50 percent was spent on contraceptives, making GPRHCS contraceptive purchases equivalent to about 3 percent of all government spending on contraceptives (UNFPA 2014b, UNFPA Ethiopia 2015).

In summary, the financial contribution of UNFPA to the national Ethiopia FP programme was relatively small. However as discussed in section 4 below the funds have been strategically placed with a focus on capacity building in the supply chain as well as spending on commodities.

***Sexual and reproductive health and family planning policies***

As of 2012, Ethiopia was on track to achieve six of the eight MDGs, including child mortality, gender equality and HIV (MoFED and United Nations 2012).

[11] To ensure funding had a clear measurable impact, the first phase of GPRHCS provided multi-year funding to a relatively small number of 'Stream 1' countries. Funding levels were predictable and the use of funds was flexible, to help countries develop more sustainable approaches to RH commodity supply, including national capacity building and supply chain systems development. There were eleven Stream 1 countries: Ethiopia, Burkina Faso, Mozambique, Nicaragua and Mongolia received support since 2007; Madagascar, Laos, Niger and Haiti since 2008; with Mali and Sierra Leone since 2009.

[12] Only part of this was spent on FP; the MDG Fund is spent at the government's discretion on activities related to achievement of the MDGs.

HIV prevalence has dropped to 1.5 percent (2012) while the MDG target was 2.5 percent (CSA and ICF International 2012, MoFED and United Nations 2012). Despite this positive overall picture, young people have higher prevalence rates, and condom use among young men 15-24 years who have multiple partners is less than 50 percent (CSA and ICF International 2012). This is linked to low levels of comprehensive knowledge of HIV, (32 percent for male adolescents and only 24 percent for females) (ibid.).

Maternal health is not on track for Ethiopia to achieve MDG 5. Ethiopia still has one of the highest reported maternal mortality rates in the world at 680/100,000 live births (2004-2010) (ibid.) and there is acute inequality between regions, with far higher rates in isolated and rural areas.

High maternal mortality reflects a continuing high unmet need for family planning at 25 percent in 2011 despite the rapid increase in modern contraceptive use as well as problems of access to and quality of services (CSA and ICF International 2012, MoFED and United Nations 2012, World Bank 2012). Inadequate human resources for health are still a major obstacle to meeting needs (United Nations 2011).

Ethiopia has one of the world's highest child marriage prevalence rates with two out of five girls married before their 18th birthday and an exceptionally high prevalence in northern and eastern regions. Child marriage is most prevalent amongst groups with low education levels and low incomes. Access to FP is vital for child brides to avoid early childbirth and the risk of fistulas (UNFPA 2012a).

The Government of Ethiopia began to recognise the impact of high population growth rates on economic development and prosperity and the related need for a FP programme in the 1990s. However, the government lacked the capacity to mount an effective FP programme itself. During the 1990s and early 2000s, NGOs including EngenderHealth, the Family Guidance Association of Ethiopia (FGAE), MSI, Pathfinder and DKT developed service delivery and BCC programmes and carried out capacity building for the public sector. In 2005, when the Federal Ministry of Health (FMoH) started actively supporting family planning, there was high latent demand but little availability of contraceptives (Olson and Piller 2013). The 2006 Reproductive Health Policy (Ministry of Health 2006) and 2010 Policy Guidelines for Family Planning Services (Ministry of Health 2010a) established the importance of FP in state policies, and since then the FMoH has taken a strong lead. The national FP programme expanded rapidly from 2005 and has achieved important increases in the contraceptive prevalence rate (CPR). Principal service providers are the public sector (federal ministry, regional health bureaus), which provides free FP services, and the large NGOs, with some private sector initiatives including social marketing.

The 2010 policy guidelines promote FP on the basis of its health benefits, its contribution to economic prosperity and its contribution to women's rights. Government policies propose a rapid increase in FP use, aiming for a CPR of 66 percent by 2015 (FDRE 2010) to help reduce maternal mortality, slow the population growth rate and assist Ethiopia on the path to becoming a middle-income country.

***Family planning: supply side***

Government has made major advances in procurement and distribution of reproductive health commodities, including drugs and family planning methods, during the period under evaluation. This includes the development of systems to centralise and strengthen the supply chain including procurement, distribution, quality control and regulation through the Pharmaceuticals Fund and Supply Agency (PFSA) and the Food Medicine and Health Care Administration and Control Authority (FMHACA). Contraceptives are distributed to service providers from regional level warehouses.

Availability of information on stock-outs and capacity building of service providers have also improved.

Government is the largest FP service provider, offering services for free. At community level the HEWs implement 16 types of primary health care services including FP. They offer condoms, pills, injectables and insertion of certain implants. Implant removal and intra-uterine contraceptive device (IUCD) are carried out at health centres, and surgical sterilisation in hospitals.

Large NGO providers include FGAE and MSI, with DKT active in social marketing. The private for-profit sector is a small actor in FP. There has been increasing government regulation of NGO activities since 2009 when the Charities and Societies Agency announced the "70/30 Directive", which limits administrative spending to a maximum of 30 percent of project costs.[13] The government has also restricted advocacy activities by NGOs receiving external funding. Both these measures caused some difficulties for NGOs and affected relations between government and non-government sectors (Olson and Piller 2013).

***Family planning: demand side***

The government is the principal actor in demand creation, working through the HEWs and HDA. The HDA reaches down to household level with health promotion messages, which include promotion of skilled birth attendance and family planning. Recent studies indicate this has been a more effective method of promoting family planning than behaviour change and demand creation activities carried out in the past, but runs the risk of exerting undue pressure, especially when health staff are working towards targets for family planning coverage (Morrison and Brundage 2012, Futures Group 2014, Hardee, Harris et al. 2014).

The most popular family planning method is injectables,[14] with implants gaining ground. Under the 4th HSDP (Ministry of Health 2010a), a priority for the government is increasing access to long-acting and permanent methods.

***UNFPA responses***

UNFPA is currently implementing its 7th Country Programme (CP) in Ethiopia. The focus of the 6th CP (2007-2011) was on reproductive health, including support for maternal mortality reduction, FP, reproductive health commodity security (RHCS), adolescent reproductive health and attention for vulnerable groups, behaviour change, HIV and institutional capacity strengthening; on population and development including strengthening availability of population data, census and capacity building; and on gender equity including gender mainstreaming and community capacity building (United Nations 2006).

The 7th CP (2012-2015) focuses on similar areas: the reproductive health and rights area includes capacity building of training institutes for human resources for maternal health, supply of FP and life-saving commodities, and national capacity building for information and services; the population and development area includes support for the management information system and institutional capacity building; and the gender area focuses on support for exercising rights, community responses and institutional responses (United Nations 2011).

Several of the 6th and 7th CP outputs were directly or indirectly related to FP. Planned results included increases in the availability of modern FP methods in health facilities; the capacity of women, adolescents and young people to exercise their rights to information and services in sexual

[13] Annex 3, Assumption 4.1

[14] In 2013, injectables were used by 30 percent of currently married women (total percentage of currently married women using modern methods is 40 percent), i.e. three-quarters of married users chose injectables.

and reproductive health (SRH), HIV and gender equity; and the capacity of national institutions to produce evidence-based information for advocacy and policy dialogue. These expected results are included in the eight areas covered by this evaluation, but do not map directly on to evaluation questions.

The GPRHCS was launched globally in 2007. Ethiopia was selected as a Stream One country, thus qualifying to receive support of up to US$ 5 million per year for commodities, RHCS advocacy and institutional and systems capacity building. GPRHCS has been the principal UNFPA FP response in Ethiopia ever since and has resulted in a growing focus on supply-side activities, concurrent with increasing government promotion of FP through interventions on the demand side. Section 4 of this report analyses the specific response of UNFPA in each of the eight evaluation areas including supply-side activities.

**UNFPA spending on family planning**

Analysis of ATLAS data shows a total of US$ 10.2 million specific FP spending[15] during the period 2008-2013, of which US$ 7.2 million is GPRHCS (70 percent of the total). The country office (CO) figure for GPRHCS spending (US$ 8.3 million) differs from the ATLAS total, which may be due to coding and time period differences in the databases. The CO has estimated additional spending on FP within other SRH projects during the evaluation period, giving a total of US$ 14.3 million for all family planning including GPRHCS. Of this total 34 percent was core funding and 66 percent non-core funding.

The table below puts these figures within the context of overall CO spending and SRHR spending. Taking into account differences due to coding processes, we can conclude that family planning spending constitutes about half of total UNFPA SRHR spending, and 19 percent of overall UNFPA spending in Ethiopia during the evaluation period.

**Table 1: UNFPA spending in Ethiopia (2008-2013)**

| Type of spending | Amount US$ m | Source | Comments |
|---|---|---|---|
| Total UNFPA SRHR spending in Ethiopia including CO costs | 89.2 | ATLAS | Includes all codes which may include a family planning component |
| Total UNFPA spending on SRHR projects | 33.3 | CO | Only includes project spending; excludes institutional budget |
| Spending on family planning focused projects and GPRHCS | 10.2 | ATLAS | Includes only family planning and GPRHCS codes |
| Total spending on family planning including family planning focused projects, GPRHCS and family planning components of other SRH projects | 14.3 | CO | Includes CO estimates of percent of spending on other SRH projects which can be attributed to family planning (Annex 2) |

Annex 4 provides more detail of spending on SRHR UNFPA interventions in Ethiopia for the period under evaluation (2008-2013), showing the family planning component of other SRHR projects identified by the CO. There are important FP components in maternal health, comprehensive RH and HIV programmes as well as adolescent and youth SRH programmes. Family planning is also included in the activities of the MDG Pooled Fund, the “Leave No Woman Behind” programme, and capacity building programmes for human resource development and service quality.

[15] (ATLAS codes U3 and GPRHCS (code ZZRT05))

# 4 FINDINGS OF THE COUNTRY CASE STUDY

The country case study findings for each of the eight evaluation areas are shown in sub-sections 4.1 to 4.8 below. For each area, we first present an overview of progress and UNFPA responses in the period under evaluation, followed by an analysis of the contribution made by UNFPA. Each sub-section concludes with a paragraph relating the findings directly to the assumptions of the evaluation matrix. This approach allows the evaluation team to test the validity of the assumptions at country level, and facilitates synthesis of findings from the case studies and other data collection elements for the overall evaluation analysis and report.

The findings presented here take into account feedback and comments from the UNFPA Ethiopia country office (CO) and other stakeholders as well as information collected during fieldwork and document review. Points in the text are referenced through footnotes to the corresponding section of the evaluation matrix presented in Annex 3. The annex shows the key data and information on which the analysis is based, ordered by evaluation question and by assumption.

The country case study was designed to provide input and illustrative examples for the eight evaluation questions. It does not aim to assess the performance of the Ethiopia CO in relation to the family planning outputs of the two country programmes, which span the period under evaluation.

## 4.1 Integration of family planning with other sexual and reproductive health services

| **Q1) To what extent has UNFPA supported integration of family planning with maternal health, HIV/STI and GBV services in health plans and at primary health care level, in services for adolescents, and in emergency and humanitarian situations?** |
|---|
| Summary of the relation between the findings and the assumptions of the evaluation matrix:<br>• UNFPA and its partners have developed some common understanding of the meaning and importance of service integration although services are still not fully integrated at all levels. Some partners feel the distinctive identity of GPRHCS as a programme which focuses primarily on FP has the potential to dilute UNFPA commitment to integration of FP with other SRH services. This may not be an important concern, as GPRHCS activities do cover other health services.<br>• UNFPA, working with DPs, has been effective in supporting service integration but in practice delivery of integrated services at primary health care level is limited by the level of training and heavy workload of HEW and HDA staff.<br>• There are opportunities to extend discussion of integration of FP services into activity areas outside SRH and HIV and AIDS programming.<br>• There is little conclusive evidence on the full extent of service integration or the effect of integration on improving user access or quality of service, and some partners indicate this could be an important area for UNFPA support. |

**Progress and activities**

Interviews with UNFPA staff, Federal Ministry of Health (FMoH), donors and non-government organisations (NGOs) indicate that they have developed a common understanding of the meaning and importance of the integration of family planning (FP) with other sexual and reproductive health (SRH) services and the need for integration at policy, programmatic and service delivery levels, although there are still differences in interpretation at operational levels.[16]

[16] Assumption 1.1, Annex 3

There have been important moves towards integration of FP with other SRH services during the period under evaluation:

- At policy level the FMoH has prepared an investment case for HIV which outlines the integration of FP and maternal health with HIV services (Tsegay 2014).
- At service delivery level public sector health centres integrate FP with maternal health and other SRH services. Service delivery is integrated at health posts through the work of the health extension workers (HEWs) who are responsible for delivery of 16 basic health programmes including FP, and at community level FP is part of the basic health package promoted by the Health Development Army (HDA).
- In the non-government sector, family planning is fully integrated with other SRH services by the large service delivery non-government organisations (NGOs) such as Family Guidance Association of Ethiopia (FGAE) and Marie Stopes International (MSI). Another specialist NGO, DKT International, focuses on FP and integrates it with HIV/AIDS in a social marketing programme.[17]

UNFPA activities to promote integration have included technical support for policy development, capacity building for integrated service delivery, and financial support for integrated programmes in the public and NGO sectors.[18]

UNFPA and other development partners (DPs) have supported the FMoH in development of the policy guideline for linking HIV and AIDS, family planning and maternal health. At the programmatic level the Development Partners' Forum (in which UNFPA takes a leading role) integrates FP and HIV/AIDS in its work.[19] UNFPA has provided support for integrated family planning, maternal health, youth, gender and HIV programmes carried out by government and non-government implementing partners (e.g. it is currently supporting an integrated reproductive, maternal, newborn and child health (RMNCH) project in 100 *woredas*), and has included service integration in its support to HEW and other health worker training (UNFPA Ethiopia 2012a, Universalia 2014). It has supported work to prevent child marriage, which includes advocacy to increase access to FP for child brides.[20]

UNFPA has promoted task shifting in family planning to enable quality family planning services to be included in integrated services at community level, and has financed FP training for HEWs to improve their capacity to provide quality services and information. HEWs are now responsible for 16 primary health care programmes including FP. Integration of so many services at community level can lead to staff overload, which may affect the quality of counselling and service provision and reduce the advantages of integration.[21] The heavy workload resulting from service integration was also observed in field visits to health posts.

Work on the supply side financed through the Global Programme for Reproductive Health Commodity Security (GPRHCS) is focused on FP, which accounts for most of the procurement spending. As much of UNFPA work in FP is financed by GPRHCS, concerns were raised by DPs that this may encourage a vertical approach to FP rather than integrating FP within the broad sexual and reproductive health and rights (SRHR) agenda of the 1994 International Conference on Population and Development (ICPD) Programme of Action. UNFPA staff respond that GPRHCS has not diluted results in the integration of FP and SRHR, as its implementation has been complemented by support to appropriate demand-side activities in a wide range of intervention areas such as gender based

[17] Assumption 1.1, Annex 3
[18] Assumptions 1.1, 1.3, Annex 3
[19] Assumption 2.2, Annex 3
[20] (UNFPA Ethiopia 2010, UNFPA Ethiopia 2011b); Annex 4
[21] Assumption 1.1, 1.3, Annex 3

violence (GBV) and adolescent sexual and reproductive health (ASRH).[22] UNFPA has supported capacity building in integration within the public sector, but the importance of integration is still not well understood at all levels.[23]

There have been few calls for emergency and humanitarian support during the evaluation period. Support was provided for capacity building on the minimum initial service package (MISP) which includes some family planning methods, and reproductive health (RH), delivery and dignity kits were provided to FMoH and the Ministry of Women, Children, and Youth Affairs (MoWCYA) for emergency and refugee situations. UNFPA was not involved in programme implementation, and family planning included in the humanitarian support was not linked with other FP activities.[24]

There has been little discussion in Ethiopia of integration of family planning beyond general services in SRH and HIV and AIDS programming, although integration of FP in Health Population and Environment work linked to agricultural extension programmes, women's income generation networks and youth activities such as sports is a growing field of work in neighbouring East African countries. However, UNFPA has supported other ministries including the MoWCYA and the Population Directorate of the National Planning Commission in promotion of FP through their own programmes and activities.[25]

**Contribution of UNFPA to service integration and related family planning outcomes**
UNFPA has contributed both directly and through development partner forums to the integration of FP with other SRH services at policy, programmatic and service delivery levels. The organisation has identified specific gaps (e.g. integrated service provision for adolescents) and has directed resources to those areas. It has also supported integration of services at community level, promoting task shifting and financing HEW training.

User perceptions on whether integration leads to improved access, and quality varies from positive to unsure, depending on the real degree of integration achieved at service delivery level. It is not always a "one-stop shop"; for example, users of HIV detection and prevention services are not always offered information or services in FP, and vice versa. There is more integration in smaller facilities in rural areas where the same service delivery staff provide all programmes, but in larger health facilities and urban areas this is not always achieved. Users agree that when services are fully integrated within facilities this improves service quality and saves them time and travel costs.[26]

Key informants point to both a need and an opportunity for UNFPA to support efforts to monitor and develop an evidence base on integration in practice in public and NGO sectors (what is the best approach? do users benefit?), on identification of ways to increase integration (e.g. post-partum family planning) and on best practices, to provide input to policy and programme development in the FMoH. There are opportunities for UNFPA to use data from on-going and new projects such as the integrated FP/HIV/mother and child health project with UNICEF and the Clinton Health Access Initiative (CHAI) to generate evidence and identify lessons learnt on the benefits of integration. While there is notable evidence of UN support, through the United Nations Development Assistance Framework (UNDAF), to integrated SRH services, evaluators and researchers have also pointed to cases where UN agencies and development partners (DPs) have not worked together and have missed opportunities to forge linkages between HIV and family planning services (Gillespie, Bradley et al. 2009, Thomas, Reynolds et al. 2014).

[22] Assumption 1.1, Annex 3
[23] Assumption 1.3, Annex 3
[24] Assumption 1.3, Annex 3
[25] Assumption 1.3, Annex 3
[26] Assumption 1.4, Annex 3

## 4.2 Coordination and national ownership

| **Q2) To what extent has UNFPA successfully contributed on its own and in coordination with others to strengthening national leadership of family planning and improving sustainability?** |
|---|
| Summary of the relation between the findings and the assumptions of the evaluation matrix:<br>• The Government of Ethiopia, and especially FMoH, has taken a leadership role in FP programming since 2005 with the support of UNFPA and development partners.<br>• UNFPA has taken an active role in coordinating bodies and development partner forums which themselves have supported government leadership in FP.<br>• UNFPA is seen as the natural, technical leader for DP and multilateral organisation discussions in the FMoH-led coordinating bodies.<br>• National leadership and ownership and the high priority given to FP in the work of HEWs and HDAs is evident at community level. |

**Progress and activities**

After years of rapid population growth and high fertility, in the late 1990s the Government of Ethiopia (GoE) recognised the importance of population dynamics on national growth and development but did not have the capacity to develop a comprehensive FP programme. At that time, NGOs such as FGAE, MSI, EngenderHealth and DKT played an important role in service delivery and capacity building whilst the government developed its own policies and programme approaches. In 2005, the government moved strongly into the family planning field. It developed structures to promote FP and create demand through the Health Development Army (HDA) and ensure supply of commodities through strengthening of logistics and the supply chain (Ministry of Health 2010a).

At federal level, national leadership is now strong in family planning policy and programming, with ambitious FP targets which are implemented by the regional health bureaus (RHBs) (Ministry of Health 2010a, UNFPA Ethiopia 2011a, Olson and Piller 2013). National leadership is also strong on the supply side although FMoH still relies on donors to finance FP procurement (Olson and Piller 2013). Key informants report that the major development partners who work in FP have supported FMoH leadership.[27]

FMoH-led DP forums which address FP directly or indirectly include: the family planning technical working group (TWG), the health population and nutrition donor group, the maternal health and FP working group, and the HIV development partners' forum at federal level (co-chaired by UNFPA). UNFPA takes an active role in the national forums and corresponding forums at regional level in the seven regions where it has a sub-office, and also participates in the millennium development goals (MDG) pooled fund, a basket fund which includes FP commodity purchases. Development partners use the forums to interact with government and to coordinate their technical and financial support for national leadership, including support in formulation of key RH strategies.[28]

Since the government took the lead, FP demand has grown rapidly as a result of promotion at community and household levels through the HDA. The HDA includes FP as one of the criteria of the "model family" system, and HDA workers encourage women to use it. Government leadership has provided an important boost for FP and has achieved high rates of growth in a short space of time. The government has also taken the lead on the supply side with development of procurement,

[27] Assumption 2.2, Annex 3

[28] Assumption 2.1, Annex 3

quality control and distribution systems for commodities (see more discussion of the supply side in section 4.8 below), and staff training in FP service provision at facility level.[29]

**Contribution of UNFPA to results on government leadership and sustainability**

UNFPA has taken an active role in the DP forums which have supported government leadership of FP programmes. As many DPs are involved, it is not easy to identify specific contributions. However, UNFPA as a specialist SRH agency and a member of the UN system has a high profile in FP, and other DPs expect UNFPA to take the lead, perhaps more so than it has done to date. Whilst there is contact in the forums, several of the larger DPs indicated that coordination around specific issues has been limited, though very effective when it has occurred, and there is scope for a larger UNFPA contribution in DP coordination.[30]

UNFPA has adapted the focus of its programmes to the changing context of government leadership, moving away from demand-side activities, which are now covered by the government, towards a stronger focus on the supply side, although it still supports demand-side programmes in the NGO sector.[31] UNFPA supply-side activities are clearly aimed at contributing to government leadership and sustainability through capacity building in procurement and more recently in quality control.

UNFPA can call on worldwide experience in FP programmes in different contexts to strengthen government leadership and programme sustainability. It can identify gaps and possible pitfalls and ensure that support is available as and when needed. Rather than moving its focus away from the demand side, NGOs and bilateral donors would like UNFPA to take the lead in developing its advocacy and knowledge management activities to alert government to good practices and to any potential problems or constraints in FP programme implementation.

UNFPA has supported the government's promotion of FP and has contributed to its institutionalisation within health sector plans and programmes through the DP forums. UNFPA work on reproductive health commodity security (RHCS) also contributes directly to institutional sustainability with support to government in commodity planning, procurement and supply chain management systems.[32]

Long-term financial sustainability requires a method mix within the country's capacity to pay, together with growing government commitment to commodity procurement. UNFPA has contributed to this by carrying out a cost-effectiveness analysis (UNFPA 2012b). This clarifies the relative cost of different methods and will assist government in promoting an economically sustainable method mix whilst respecting women's and men's right to free and informed choice of method. Donor support still covers a large percentage of FP procurement, although on-going advocacy by UNFPA and other DPs encourages government to increase its commodity budget.[33]

There has been some discussion in the literature (Morrison and Brundage 2012, Hardee, Harris et al. 2014) as to whether the strong Ethiopian national leadership and commitment through the work of HEWs and the HDA at community level goes beyond a reasonable effort to address and change social norms and risks becoming coercive. There is evidence that women do feel there is excess pressure on them to adopt a method, and many receive little or no information about the range of methods available (CSA and ICF International 2012, UNFPA Ethiopia 2013d).[34] UNFPA has been

[29] Assumptions 8.2, 8.3, Annex 3
[30] Assumption 2.1, Annex 3
[31] Assumptions 4.2, 7.1, 7.2, Annex 3
[32] Assumption 2.2, Annex 3
[33] Assumptions 2.2, 2.3 Annex 3
[34] Assumption 6.2, Annex 3

monitoring the situation through the national health facility surveys which are carried out annually. UNFPA and other DPs have been reluctant to raise this issue with government due to the sensitivity of rights issues in Ethiopia, although FMoH has indicated that rights to FP are fully accepted by the government. Other DPs expect UNFPA to take the lead in monitoring the situation.[35]

In view of Ethiopia's varied socio-cultural and religious contexts, social sustainability of the FP programmes depends on work at grassroots level by service providers such as HEWs, HDA volunteers and NGOs who are close to the community, and engagement and commitment of community leaders. The government has taken the lead on the demand side and UNFPA has contributed through support for training of HEWs and NGO service delivery staff, but UNFPA has not evaluated the impact of training on service quality.

## 4.3 Brokerage and partnerships

| **Q3) To what extent has UNFPA acted as a broker at global, regional and country levels to promote family planning, acting in partnership with the public, private and non-state sector service providers?** |
|---|
| Summary of the relation between the findings and the assumptions of the evaluation matrix:<br>• At country level, UNFPA has been effective in brokering partnerships among and between different ministries of the national government.<br>• UNFPA has been an active participant in government-DP coordinating forums and working groups but has not used these as an opportunity to broker new partnerships.<br>• There is a need for UNFPA to engage in the long term work of building partnerships between national government ministries and NGOs and the private sector in family planning.<br>• At both regional and country level, UNFPA has the necessary visibility (especially through GPRHCS) to contribute to strengthening partnerships to increase commitment to family planning. |

**Progress and activities**

Family planning promotion and service provision in Ethiopia are dominated by the public sector. The 2011 demographic health survey (DHS) shows that 82 percent of users of modern FP methods use the public sector, 13 percent use the private and NGO sectors and 1 percent use non-medical sources. There are significant contributions to clinical service provision and social marketing from the larger NGOs (FGAE, MSI, DKT) and other NGOs who work with vulnerable and marginalised groups (VMGs). Non-government service delivery partners have an important role in reaching VMGs and ensuring that promotion and growth of FP responds to unmet needs. Whether this division of labour can be characterised as a partnership, remains an open question.

While key informants report that there is cooperation between the public and NGO sectors, relations are affected by government restrictions on NGO activities advocacy and rights issues.[36] Maintaining healthy demand growth and meeting unmet need for family planning within the country's capacity to pay will require input from all sectors, and cooperation is important to make the best use of available resources.

The major DP forums and TWGs (see section 4.2) have supported government repositioning and promotion of FP. The forums provide opportunities for closer working relationships with other DPs. UNFPA has participated in the forums rather than brokered any new partnerships between DPs.

[35] Assumption 2.2, Annex 3

[36] Assumption 4.1, Annex 3

Some of the forums have been fruitful in promoting cooperation in RH work for underserved groups (e.g. UNFPA/USAID cooperation in fistula work, UNFPA/UNICEF/CHAI cooperation in the RMNCH programme). As the TWGs have been operating for some years it is not surprising that at this stage UNFPA is seen by government and DPs as an active participant rather than a broker of government/ DP partnerships.[37]

On the other hand, UNFPA has brokered partnerships between FMoH and other ministries to work on determinants of FP demand, including gender work with the MoWCYA, and programmes for young people with the former Ministry of Youth, Sport and Culture. Opportunities to broker partnership between different government agencies on specific FP issues, such as increasing male involvement in FP (which is of interest to both the FMoH and the Population and Development Directorate of the National Planning Commission), and to generate learning from NGO work in FP (which could be useful for the public sector) have not been taken up, although UNFPA has worked on population issues and family planning with other ministries (see above) and is in a favourable position to promote partnership.[38]

Key informants in government, DPs and civil society all noted that there are opportunities for UNFPA to broker closer and more horizontal partnerships between the private sector, NGOs and government. UNFPA itself works with both NGO and private sector implementing partners, and coordinates with NGOs through their umbrella organisations, but successful brokerage of partnerships between government and NGOs requires building of willingness and trust on all sides. This is a long-term process and difficult in the present context of government restrictions on NGO activities.[39] Brokerage of partnerships between government and private sector is not easy as the private sector is not organised to speak with one voice.[40]

On the supply side, NGOs and the private sector serve population groups, which are hard to reach for social and geographical reasons, as well as groups with capacity to pay for services. Closer partnership between NGOs, the private sector and government can help rationalise service provision in different market segments and reduce demands on scarce resources in the public sector. Inclusion of NGOs and the private sector in planning with access to centralised supply systems can foster efficiency and cost-effectiveness in commodity supply. UNFPA has made a start on brokering these partnerships through the introduction of the concept of a total market approach (TMA) and support for inclusion of NGOs in the FMoH commodity planning process.[41]

UNFPA has good visibility and closeness to government (prerequisites for brokerage) at federal level, largely due to its work in RHCS, but less so at the decentralised regional level. Development partners agree that there is a need for brokerage of partnerships in FP at decentralised regional level.[42] UNFPA regional sub-offices have only one staff member who is principally engaged on liaison between implementing partners (government and non-government) and the CO, and may not have the skills needed for effective brokerage.

[37] Assumptions 2.1, 3.2, Annex 3

[38] Assumption 3.2, Annex 3

[39] The Charities and Societies Proclamation No.621/2009 on January 6, 2009, implemented since early 2010, regulates domestic and international civil society organisations and NGOs. Its provisions include a regulation to limit spending on administration to 30 percent of the total budget, and restrictions on advocacy activities related to human rights by foreign NGOs and national NGOs who receive more than 10 percent of their funding from foreign sources (see Assumption 4.1, Annex 3).

[40] Assumption 3.2, Annex 3

[41] Assumption 8.3, Annex 3

[42] Assumption 3.2, Annex 3

At country level, UNFPA supported the 2012 National Family Planning Symposium, which was a good opportunity to showcase and promote FP work. This and other national symposiums supported by UNFPA have been important opportunities to involve NGOs, promote partnerships, and highlight good practices in FP. Addis Ababa is the East Africa HQ of United Nations and is well-placed for hosting regional and international events such as the 2013 International Family Planning Conference, which UNFPA was instrumental in supporting. These national and international events have provided important opportunities for promotion of FP in-country and brokerage of partnerships at regional and international level.[43]

**Contribution of UNFPA to results in brokerage and promotion of family planning**

UNFPA has contributed to on-going work of the DP forums in family planning promotion but has not used the forums for brokerage of new partnerships. Through its closeness to government, UNFPA is better placed than other agencies to promote and broker partnerships between sectors on both the demand and the supply sides, but there are still gaps to which UNFPA has not yet made a significant contribution. NGOs and bilateral DPs would welcome a more proactive brokerage role by UNFPA, at both federal and regional levels.[44]

The GPRHCS has given UNFPA more visibility and has kick-started a higher level of involvement and partnership with the government. However, this focus on commodities has led other DPs and NGOs to think that UNFPA FP work is concentrated on the supply side and commodity security. As a result, UNFPA comparative advantages and actual and potential contribution for family planning promotion and hence its capacity for brokerage on the demand side have been less visible.[45]

UNFPA has contributed to family planning promotion at the East Africa regional level through encouraging and supporting Ethiopia hosting important international and regional events. These put Ethiopian FP achievements in the spotlight, which, in turn, contributes to promotion at national level and thus to the development of an enabling environment for FP in Ethiopia (see next section).[46]

## 4.4 Enabling environment

| **Q4) To what extent has UNFPA supported the creation of an enabling environment at national and community levels to ensure family planning information and exercise of rights?** |
|---|
| Summary of the relation between the findings and the assumptions of the evaluation matrix:<br>• UNFPA has identified key enabling factors for FP in the context of Ethiopia, especially securing and supporting national government commitment to family planning.<br>• UNFPA has concentrated more effort on the supply side of FP service availability than on understanding the determinants of demand and improving demand creation.<br>• UNFPA has been less successful in identifying and supporting factors required to improve the enabling environment for the private and NGO sectors to play their potential role on both the demand and supply side of FP. |

**Progress and activities**

Creation of an enabling environment is related to development of the conditions that allow progress in family planning, including political commitment, a supportive political and legal framework, sufficient institutional capacity of FP providers, respect for users' rights and positive community

[43] Assumption 2.1, Annex 3
[44] Assumption 3.3, Annex 3
[45] Assumption 3.2, Annex 3
[46] Assumption 3.3, Annex 3

attitudes. In Ethiopia there is a supportive policy environment for FP service provision in the public sector, and community attitudes are becoming more positive due to the promotional work of the HDA at community and household levels.

Key informants, including staff of UNFPA, DPs and Civil Society Organizations (CSOs), all reported that UNFPA has identified key factors in the overall enabling environment and has worked with other DPs to support the FMoH in development and implementation of the FP policy. UNFPA has supported capacity building of service providers in the public sector through training and has strengthened institutional capacity to respond to demand through its support to development of RHCS.[47]

UNFPA has worked with other ministries on the social determinants of demand for FP including women's empowerment, availability of information for behaviour change, gender issues and reduction of child marriage, all of which are important aspects of an enabling environment. At community level, commitment by community and institutional leaders is a key factor in creating an enabling environment for take-up of FP services. UNFPA has supported community mobilisation initiatives through engaging traditional clan and religious leaders in facilitating social change processes to address SRH and HIV prevention as well as harmful traditional practices, such as GBV, but has not focused specifically on FP at community level. The HDA networks and HEWs are the principal agents for FP demand creation. UNFPA has supported HEW training on service quality (UNFPA Ethiopia 2012c, UNFPA Ethiopia 2013a), but has not been involved in working directly with the HDA.[48]

Aspects of the legal and policy framework do affect family planning programmes in the NGO sector. Advocacy activities of NGOs which receive foreign funds are restricted by the Charities and Societies Proclamation, and discussion of rights-based approaches are limited to supply-side considerations of quality and range of services.[49] Yet NGOs are important providers of FP information and services, especially for VMGs and other hard-to-reach groups, and their role in advocating for social and policy change can enrich public sector initiatives and increase their reach and effectiveness. Furthermore, there are also regulatory obstacles to NGO and private sector service providers, which many consider unnecessarily demanding (e.g. clinic infrastructure specifications). As the CO has not identified limitations imposed by the "CSO law" on its NGO implementing partners, UNFPA has not taken a stand on these issues or advocated with government for review of the restrictions of the CSO law or for implementation of a rights-based approach.[50]

The environment is not equally enabling for all social groups, and there are obstacles to family planning access for specific groups due to their cultural and social environment. Although public sector policy includes provision of FP information and services to unmarried young people, social pressures at community level do restrict their access. In particular, HEWs and HDA volunteers are important community leaders and it may be difficult for unmarried young people to approach them if they feel they will risk community disapproval, or wish for privacy. As a result, young unmarried people often seek family planning outside their own community to avoid conflict with cultural or social norms. UNFPA has supported projects which increase access and has carried out studies to identify needs and traditional/cultural barriers to access (e.g. Erulkar, Ferede et al. 2010a), but these barriers still need to be addressed.[51]

[47] Assumption 4.1, Annex 3
[48] Assumptions 4.1, 4.2 Annex 3
[49] Assumption 4.1, Annex 3
[50] Assumption 4.1, Annex 3
[51] Assumption 5.5, Annex 3

**Contribution of UNFPA to development of an enabling environment**
UNFPA support for an enabling environment has focused more on the supply of family planning services than on the demand side.

In the public sector, UNFPA has contributed to the enabling environment at policy level through its support to FMoH and through its work with other ministries to include social determinants of FP use in their policy agendas. It has contributed at service delivery level on the supply side through service provider training to improve FP capacity, and through its major role in RHCS planning and implementation, which has led to improved availability of methods and services.[52]

UNFPA has also contributed the first steps in strengthening the enabling environment for specific groups such as young people through identification of needs and obstacles to access, and has followed up its research with support for programme development.[53]

In the NGO sector, UNFPA has contributed to FP work through support for NGO programmes. However, it has not used its comparative advantages to strengthening the enabling environment for NGOs through advocacy with government to reduce restrictions on NGO advocacy and rights-based approaches.[54]

## 4.5 Vulnerable groups and marginalised populations

| **Q5) To what extent has UNFPA focused on the family planning needs of the most vulnerable and marginalised groups, including identification of needs, allocation of resources, and promotion of rights, equity and access?** |
|---|
| Summary of the analysis in relation to the assumptions of the evaluation matrix:<br>• UNFPA has developed and promoted an evidence base on the needs for and access to FP services of young people and pastoralists and has supported the Government of Ethiopia in its efforts to improve services for those VMGs.<br>• UNFPA has allocated resources to government and NGO service providers serving youth and adolescents' FP needs.<br>• More politically controversial VMGs such as MSM have not been prioritised by UNFPA, neither for advocacy nor for support to services.<br>• There is no evidence of VMG members or their representatives taking part in the project cycle, but UNFPA has supported capacity building of CSWs in the design, implementation and monitoring of programmes addressing both SRH and HIV. |

**Progress and activities**
Vulnerable and marginalised groups include adolescents, child brides, unmarried people, the urban poor, rural communities, commercial sex workers (CSWs), people living with HIV, men who have sex with men (MSM), people living with disabilities, indigenous people, migrant labourers, internally displaced people and refugees and minority groups. In different contexts, all these groups can experience difficulties in accessing family planning information and services. In Ethiopia, DHS figures (2011) show major differences in the use of modern family planning between rural and urban groups (23 and 50 percent respectively), between different educational levels (22 percent for women with no education compared with 57 percent for women with secondary education) and between income groups (13 percent in the lowest quintile compared with 48 percent in the highest). 2014 DHS figures

[52] Assumption 4.2, Annex 3
[53] Assumption 5.1, Annex 3
[54] Assumption 4.1, Annex 3

show improvements in these parameters, but poor, uneducated and rural women still have lower levels of family planning use (rural 38 percent, urban 56 percent; no education 35 percent, secondary education 59 percent; lowest income quintile percent, highest quintile 57).

The FMoH expects that its policy of full FP coverage coupled with community-based work by the HDA will leave no marginalised groups without services.[55] This takes little account of social and cultural obstacles to access for these groups and is unlikely to be realised in the short to medium term. The government resource allocation formula between regions ("the equity formula") is based on a number of parameters including population density, which disadvantages remote and sparsely populated areas where many VMGs live. Whilst access to FP information and services has improved greatly for the general population, key informants note that unmarried young people still have difficulty accessing services due to traditional values. MSM and CSWs have difficulties access FP services due to service provider bias, and pastoralists living in remote areas have little access due to the lack of service provision.[56]

UNFPA has supported family planning work which focuses on VMGs through NGO partners, including work with adolescents and support for access to comprehensive HIV services, capacity building for peer education and economic empowerment of CSWs.[57] UNFPA has supported advocacy to reduce child marriage and increase access to FP for married girls.[58] UNFPA considers a solid evidence base essential to raise awareness of the needs of VMGs and convince government and other key actors (including those at community level) to address those needs. UNFPA has undertaken an equity analysis of the FP and maternal health needs of VMGs and is aware of the analysis on the needs and situation of VMGs undertaken by other agencies in Ethiopia.[59] This information, along with good practice from other countries, is shared informally with government and other partners, but there is no systematic programme in place to disseminate good practices in providing FP for VMGs.[60]

UNFPA has developed an evidence base on the needs for and access to family planning of young people and pastoralists (the two largest VMGs), and has supported analysis of gender issues in family planning (Erulkar, Ferede et al. 2010a, Erulkar, Ferede et al. 2010b, UNFPA Ethiopia 2012a). The research on young people and pastoralists has been used as the basis of advocacy with government to address their rights and increase their access. UNFPA has also provided financial support to projects, which increase access to family planning for these groups.[61]

At service delivery level, UNFPA recognises that scale-up and sustainability of work with VMGs will need government commitment and resources. Whilst there is government awareness of the family planning needs of the large VMGs, other groups such as CSWs and MSM remain stigmatised and marginalised. Key informants from government, civil society, DPs and UNFPA reported that the government has its own very specific definition of priority groups who are marginalised for FP, including rural adolescent girls, young unemployed boys, unmarried adolescents and adolescents living on the street. This is a very different definition from the one used for HIV and AIDS services, which includes CSWs, MSM, truck drivers and the uniformed services. While CSWs have received some attention with UNFPA support, more politically controversial groups such as MSM have not been prioritised by UNFPA.[62]

[55] Assumption 5.5, Annex 3
[56] Assumption 5.5, Annex 3
[57] Assumption 5.2, Annex 3
[58] (UNFPA Ethiopia 2010, UNFPA Ethiopia 2011b)
[59] Assumption 5.1, Annex 3
[60] Assumption 5.2, Annex 3
[61] Assumption 5.1, Annex 3
[62] Assumption 5.2, Annex 3

UNFPA has done some work to build capacity of CSWs in the design, implementation, and monitoring of programmes addressing both SRH and HIV which include family planning (UNFPA Ethiopia 2010, UNFPA Ethiopia 2013a). However, from a rights-based perspective, there is no systematic encouragement of VMGs to participate in planning, implementing and monitoring family planning.[63]

**Contribution of UNFPA to meeting family planning needs of VMGs**
UNFPA has contributed directly to meeting the family planning needs of VMGs through specific projects, and is using the evidence generated by these experiences together with wider research to raise government awareness of the needs of VMGs. To date these efforts have been concentrated on the needs of adolescents, pastoralists and CSWs.

UNFPA support for work with service providers in the government and NGO sectors should contribute to the reduction of service provider bias against stigmatised groups, but evidence of results is not yet available. Support for service provision and for NGO work at community level will contribute to awareness raising and reduction of cultural and traditional obstacles for unmarried young people, but the key actors in this process are the HDA volunteers who are not directly supported by UNFPA or other development partners.

Apart from the existing work on adolescents and pastoralists, there is insufficient national evidence or dissemination of international best practices to encourage government and other partners to broaden their work in reducing barriers for other VMGs.

## 4.6 Human rights-based approach

| **Q6) To what extent has UNFPA implemented a human rights-based approach to family planning, in particular regarding access to and quality of care, and through support from HQ and RO for a rights-based approach in country?** |
|---|
| Summary of the analysis in relation to the assumptions of the evaluation matrix:<br>• There is no explicit consensus among UNFPA staff, the government, DPs and CSOs on the meaning and importance of a rights-based approach to family planning in Ethiopia, and the RO has not provided technical support in this area.<br>• The government considers rights in FP mainly in terms of the right of access to effective, longer term FP services for all. UNFPA supports this approach mainly through its ***supply side*** activities aimed at strengthening service provision.<br>• On the ***demand side***, UNFPA has not taken a stand on support to the "right to choose" FP services in Ethiopia in partnership with DP and CSO.<br>• UNFPA has not systematically gathered information on good practice in HRBA or supported monitoring of FP services by government and NGO service providers to ensure users are offered full information and there is no undue pressure to adopt any FP method. |

**Progress and activities**
There is no clear consensus on the meaning of a human rights-based approach (HRBA) to family planning in Ethiopia and it is rarely discussed within and between institutions. Bilateral and civil society DPs as well as UNFPA take it for granted that they have the same understanding. Public sector staff use the language of a rights-based approach, including reference to unmet need,

[63] Assumption 5.4, Annex 3

informed consent and choice and improved access.[64] At service delivery level service providers understand users' rights to access but have a less clear understanding of the concept of "right to free and informed choice". This may be a result of government policy which recognises the importance of women's rights to choice, but focused its promotion of family planning on other reasons such as health and socio-economic benefits, and its potential for improving per capita productivity through lower population growth rates (Ministry of Health 2010b).[65]

High government FP targets at service delivery level related to the overall goal of 66 percent contraceptive prevalence rate (CPR) by 2015 (FDRE 2010), a focus on encouraging use of long-acting methods and promotion through HEWs and HDA networks at community level raise concerns about possible pressure on users to adopt FP and opt for specific methods. The policy environment favours supply-side aspects of a rights-based approach (i.e. access to services, availability of a wider method mix) whilst making it more difficult to address users' rights to choose. A significant proportion of public sector FP users are not offered information on side effects nor are they informed about any alternative methods (CSA and ICF International 2012: 100, UNFPA 2013), although NGO sector figures show a higher percentage of users with informed choice. Nationally, a small but important percentage of public sector users feel they have been forced to accept an FP method, with higher percentages in Gambella and Tigray regions (UNFPA Ethiopia 2013d: 113). No users report this type of pressure from NGO service providers.[66]

UNFPA has addressed rights issues on the supply side through GPRHCS and service provider training which aim to improve access to information and quality services and expand the method mix. These activities have been complemented by support for programmes on the demand side with other government ministries and NGOs which focus on determinants of rights, access and demand for family planning, including work on gender and empowerment, adolescents and young people, improved information and focus on VMGs.

Other authors have pointed out that vigilance is needed to alert family planning providers, programme managers and policy makers to the risks of using targets and their propensity to foster undue pressure for accepting the use of FP, particularly in a context where advocacy and rights-based work by civil society is restricted (Olson and Piller 2013). UNFPA, like other development partners, has taken a low profile on these issues and does not emphasise a rights-based approach in its work with the government.[67] UNFPA has access to evidence of the benefits of a rights-based approach from other countries, but an evidence base is not being developed in Ethiopia itself. There has been informal rather than systematic experience sharing with other COs working in countries with similar contexts.[68]

**Contribution of UNFPA to results on a rights-based approach**

UNFPA has made an important contribution to tangible results on access and method mix, which are important aspects of a rights-based approach on the ***supply*** side. Other development partners have also provided support but consider the UNFPA contribution to be significant.

On the ***demand*** side the FMoH does not clearly distinguish between the right to family planning and the right to choose family planning, and there are important issues of lack of information on different methods. The risk of rights violations when service providers are working to targets is well documented and can curtail support from development partners who have rights high on their

[64] Assumption 6.1, Annex 3
[65] Assumption 6.1, Annex 3
[66] Assumption 6.2, Annex 3
[67] Assumption 6.2, Annex 3
[68] Assumption 6.3, Annex 3

agendas. NGOs and DPs are concerned about these issues but are not prepared to take a public stance. UNFPA has not contributed to the debate or alerted the government to evidence of pressure, despite its comparative advantages and close working relationship with the FMoH.[69]

## 4.7 Different modes of engagement

| **Q7) To what extent has UNFPA adapted its mode of engagement[70] to evolving country needs in different settings, using evidence and best practice?** |
|---|
| Summary of the analysis in relation to the assumptions of the evaluation matrix:<br>• The UNFPA CO in Ethiopia monitors changes in the broader country context on an informal basis and changes in its mode of engagement have been tempered by government priorities and availability of resources.<br>• On the supply-side UNFPA has changed its mode of engagement with more focus on capacity building.<br>• UNFPA has begun to develop an information base on good practices in FP programming in Ethiopia on both the demand and supply sides. This should facilitate an on-going shift to more knowledge management and advocacy work as UNFPA moves upstream in future programmes. |

**Progress and activities**

Ethiopia is in the "red quadrant" of the UNFPA business model (i.e. high need and low financing capacity), indicating that it still needs support for service delivery and capacity building as well as upstream advocacy and knowledge management. Within the country there are important differences between the decentralised regional contexts which affect needs for different modes of engagement. For example, service delivery support may be a priority in some regions where service quality and coverage are still poor, and knowledge management may be a higher priority in regions where immediate service delivery needs are already well covered.[71]

UNFPA has monitored changes in the broader context informally rather than systematically, and its response has been tempered by the need to work within the national context and align its programme to government criteria of needs, priorities and programmes.[72] Changes in modes of engagement have been a response to changes in the context and availability of resources (e.g. the focus on supply-side work when GPRHCS funds became available) rather than a planned evolutionary process of moving upstream.[73]

Although previous country programmes included demand-side work on behaviour change communication (BCC) and promotion of family planning, the advent of GPRHCS in 2007 coincided with government drive to increase FP coverage and brought a stronger supply-side focus to UNFPA support. An emphasis on support for service delivery and procurement at the start of GPRHCS funding is now moving towards capacity building in quality control and regulation in the supply chain.[74] Demand-side work is carried out through broader projects related to the determinants of

[69] Assumption 6.2, Annex 3

[70] "Modes of engagement" refers to the four modes of engagement in the current UNFPA strategic plan (support for service delivery, capacity building, advocacy, knowledge management). This concept is fully discussed in the inception report.

[71] Assumption 7.1, Annex 3

[72] This observation relates to monitoring of the broader national context. At specific facility level, UNFPA is now funding a regular annual survey ("National Survey on Availability of RH Commodities and Services").

[73] Assumption 7.1, Annex 3

[74] Assumption 7.1, Annex 3

demand, with limited input to FMoH demand creation programmes through the HEWs and the HDA network.[75]

There is both need and opportunity to move into knowledge management, developing an evidence base in Ethiopia itself, and bringing in more experience from outside. UNFPA has already done some important work in this field through its support for important events such as the Third International Conference on Family Planning (ICFP 2013) in Addis Ababa where experiences and good practices from Ethiopia and other countries were presented, stimulating interchange of ideas. However there is no systematic approach to identifying, sharing and applying relevant good practices from other contexts or using evidence, which is available in Ethiopia for advocacy work.[76]

At decentralised level in Ethiopia the current strength and staff skills of the UNFPA offices are neither sufficient to detect the need for diversity in modes of engagement nor to implement it.

**Contribution of UNFPA to using evidence and best practice to adapt modes of engagement**
UNFPA has been a leading player in moving upstream in commodity security work, supporting Ethiopia in moving away from reliance on UNFPA and other donors to fill the gaps in commodity purchase towards strengthening national capacity for its own procurement and supply chain management. This was a rational and sustainable approach by UNFPA whose resource availability for procurement is relatively limited in comparison with other donors. The national procurement and distribution system is strong and growing rapidly, and UNFPA has made an important contribution to this. It has also helped to establish regional RHCS coordinating mechanisms in states supported by the UNFPA country programme.[77]

UNFPA has started developing an evidence base on good practice in FP programming and support, which is an important element of knowledge management and an essential input for effective advocacy. The international and regional family planning events hosted by Ethiopia have been excellent opportunities for show-casing this national work and enabling exchange of experiences with others.

As the government of Ethiopia and the FMoH further develop their leadership role in family planning, more upstream engagement will be the most appropriate type of support from UNFPA and other development partners. UNFPA has started this process in its supply-side work,[78] and there are opportunities to do the same on the demand-side through development and use of evidence bases for analysing and improving family planning programmes and their sustainability.

## 4.8 Supply-side activities

| **Q8) To what extent has UNFPA support for supply-side activities promoted rights-based and sustainable approaches and contributed to improved access to quality voluntary family planning?** |
|---|
| Summary of the analysis in relation to the assumptions of the evaluation matrix:<br>• UNFPA has contributed to the continuous strengthening of the government supply side role in procurement, management and delivery of FP services. |

[75] Assumption 7.1, Annex 3
[76] Assumption 7.3, Annex 3
[77] Assumption 7.2, Annex 3
[78] Assumption 7.2, Annex 3

- UNFPA support to procurement, logistics and training in service delivery has promoted access to a wider method mix for FP.
- While UNFPA has supported provider training, the GoE has emphasised service access over service quality and there is insufficient information to determine whether training is client centred, quality focused and promoting rights and freedom of choice in FP.
- UNFPA has contributed to improved sustainability of FP services by successfully lobbying government for the allocation of a family planning budget line in the national health budget.

**Progress and activities**

The government role on the supply side has strengthened continuously during the period under evaluation with development of the national procurement system and supply chain. Client access to quality family planning services has increased with better availability of methods, a wider method mix and more trained service providers. Task-shifting to enable provision of certain family planning methods by less highly qualified personnel has also facilitated better access at community level.[79]

UNFPA support has been catalytic in stimulating capacity building of the supply chain, together with other partners. UNFPA has supported capacity building in the procurement and distribution agency, the Pharmaceuticals Fund and Supply Agency (PFSA) and is now moving towards support for quality control – the Food Medicine and Health Care Administration and Control Authority (FMHACA) through secondment of qualified personnel to both agencies. There has also been support from HQ for capacity building in quality assurance.[80]

The procurement and distribution system is now generating its own margins and is likely to become financially sustainable. Full sustainability of supply, however, will require more financial commitment from government, which still relies on external aid for purchase of family planning commodities. UNFPA has participated in successfully lobbying government for allocation of an FP budget line in the national health budget, which is a first step towards a higher national financial commitment.[81]

UNFPA has supported widening the method mix during the evaluation period through promotion of access to new methods such as emergency contraceptives (EC) and the female condom, and through support to the government strategy to up-scale access to implants and intra uterine contraceptive devices (IUCDs).[82] Short-term hormonal methods (pills and injectables) are still the most popular with implants growing in popularity as they become available at health posts. Permanent methods and IUCDs are less accessible, as they are available in health centres and hospitals only. Married couples do not use condoms as they are associated with multiple partners (cultural barrier), and EC is not recommended to young people (who are often the group who need them most) due to lack of information and cultural barriers.

Service providers still need more information on a wider method mix and must acquire new skills to be able to inform clients and promote a wider variety of short- and long-acting methods (see section 6 above). UNFPA has supported training for HEWs in implant insertion at health post level, but removal is only possible at health centres, which may compromise clients' ability to exercise their

[79] Assumption 8.2, Annex 4

[80] Assumption 8.2, Annex 3

[81] Assumption 8.3, Annex 3

[82] Assumptions 8.2, 8.2, Annex 3

right to choose. UNFPA has also contributed indirectly to service provider training and task-shifting through support for development of courses for midwifery training, which include family planning.[83]

UNFPA has carried out a cost-effectiveness study of different family planning methods (UNFPA 2012b).[84] At the beginning of the period under evaluation, GPRHCS procurement funds were used largely for expensive implants (Chattoe-Brown, Weil et al. 2012). Now, spending covers a wider range of methods, and UNFPA has worked with other donors to promote a more financially sustainable method mix while ensuring choice. The government is currently working to expand access to implants and IUCDs, which are more cost-effective alternatives.[85] At regional level, some RHBs are identifying gaps and establishing their own budget lines for FP supplies; they have received support from UNFPA to develop regional RHCS coordination mechanisms (ibid.).[86]

**Contribution of UNFPA to supply-side activities**

Availability of GPRHCS resources has enabled UNFPA to make an important contribution on the supply side, supporting improvements in access to quality services, which is a fundamental element of a rights-based approach to FP. UNFPA has contributed to joint planning mechanisms that have improved availability and reduced stockouts (Ministry of Health 2012). Although its financial contribution is relatively modest, UNFPA has had an important catalytic role in shifting support towards capacity building in the procurement and distribution systems, and more recently in quality control, which should help government achieve sustainability.

UNFPA has contributed to widening the method mix available at different service delivery levels through promotion of EC and support for government strategies to scale up use of implants and IUCDs.[87] More recently, UNFPA participated in promotion of the female condom and support to service provider training to enable more choice at health post level. On the other hand, the impact of UNFPA supported training on service quality has not been identified, making it difficult to claim a positive contribution for UNFPA in this respect. In general, there has not been sufficient emphasis on improving the quality of service on the part of the GoE, which has emphasised expanded FP service coverage, particularly on administering implants. While UNFPA has tried to emphasise service quality issues (for example regarding the removal of implants) and has funded best practices studies, this remains a challenging area.[88]

In the effort to address quality, annual GPRHCS financed surveys of the availability of FP methods at service delivery level have been broadened to include questions related to the infrastructure and equipment necessary to ensure quality, as well as service provider training, supervision and user satisfaction. The information from the surveys is an important contribution to monitoring data for government and other development partners.[89]

Long-term commodity security and sustainability of the supply system will be more achievable with integration of NGOs and the private sector in planning and development of a TMA. UNFPA has contributed to this by promoting inclusion of NGOs in planning processes, and its credible contribution on the supply side makes it well placed to advocate for a holistic TMA.

[83] Assumption 8.2, Annex 3
[84] Assumption 2.3, Annex 3
[85] Assumptions 8.1, 8.2, Annex 3
[86] Assumption 8.3, Annex 3
[87] Assumption 8.2, Annex 3
[88] Assumption 8.1, Annex 3
[89] Assumption 7.1, Annex 3

UNFPA supply-side work has promoted rights and choice through increasing the availability of methods (Ministry of Health 2012) and strengthening the quality of services through service provider training (UNFPA Ethiopia 2013e). However the question of informed choice is still to be addressed (CSA and ICF International 2012).

## 4.9 Support from UNFPA headquarters and the Eastern and Southern Africa Regional Office

*We have included this as a separate section because findings apply to several evaluation questions, which include an assumption on the roles of HQ and RO (questions on service integration, enabling environment, rights-based approach, modes of engagement, and supply-side activities).*

The CO has received technical guidelines from the RO and HQ on service integration, which has helped guide its support to partners. Not all the support and technical guidelines have taken the country context sufficiently into account, and have encountered resistance from the GoE. For example, the government did not permit a proposed SRH-HIV linkages survey.[90]

There has been little input from UNFPA Eastern and Southern Africa Regional Office (ESARO) or HQ to identify needs, create an enabling environment, or promote demand and access in different contexts. This may be attributable to resource and capacity constraints at RO level.[91] In some areas, the CO itself has a higher level of technical skills than the RO, or has access to skilled local consultants and institutions. The CO also has a more in-depth understanding of the country context than the RO, which is important for development of strategies to address improvements in the enabling environment.

During the period under evaluation, there was no specific guidance from HQ or ESARO on incorporation of a rights-based approach to FP in Ethiopia.[92] UNFPA rights-based strategies in the principal framework documents are used as general guidelines, but require adaptation to each country context. There is a role for the RO in addressing this situation and bringing a broader perspective and lessons learnt in other countries to support strategy development in Ethiopia, but no such support was provided.

The CO reports it has received little guidance from the RO or HQ on adapting modes of engagement to respond to changing needs. Experience from other countries with a federal structure could assist the Ethiopia CO in developing strategies, which take into account the differences between regions. There has been support for the GPRHCS funded activities from HQ (Commodity Security Branch and Procurement Branch) and the RHCS focal point in the RO. This has included training for CO staff and for FMoH and FMHACA (for example Procurement Branch provided training and technical support on quality control for FMHACA). GPRHCS annual regional meetings are used for sharing experiences and highlighting best practices as well as joint planning.

[90] Assumption 1.2, Annex 3
[91] Assumption 4.3, Annex 3
[92] Assumption 6.4, Annex 3

# 5 CONCLUSIONS

## 5.1 Integration of family planning with other sexual reproductive health services actioned at policy and programme levels but not fully implemented

The concept of integration of family planning (FP) services with other sexual reproductive health (SRH) services is well accepted by stakeholders in Ethiopia, although full implementation of integrated services has not yet been achieved. UNFPA has contributed to integration at policy, programmatic and service delivery levels, and has identified gaps that need to be addressed.

There is little evidence available at country level on the impact of integration on access, quality and user satisfaction. There are opportunities for development of an evidence base to identify the benefits of integration and the potential for improved integration in services for specific population groups, e.g. adolescents, and in areas where it has not yet been fully applied, such as post-partum family planning.

Discussion on integration has been confined to the health sector, although there are opportunities for integration of family planning in other non-health development programmes.

- Origin: Evaluation question 1 (Section 4.1)

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## 5.2 Strong national leadership in family planning

The government is leading and has assumed full ownership of the family planning programme. UNFPA and other donors have supported government FP programmes with funding and technical assistance, and donors coordinate through development partner forums and working groups. UNFPA had been working on the demand side in FP prior to the government assuming ownership, but made limited progress until the government took the lead in 2005. Government promotion through the Health Development Army (HDA) network led to a rapid increase in demand and uptake of family planning. In common with other donors, UNFPA now plays a limited role on the demand side.

UNFPA has adapted its programme to the changing context of government leadership and moved the focus of its support to the supply side, although there is still need for donor support upstream on the demand side.

Financial sustainability of the family planning programme will require greater government financial commitment overall. Sustainability will be more achievable if the government continues its move towards an economically rational method mix whilst ensuring broad choice of methods. Social sustainability is likely to be achieved through the grassroots work of the HDA which includes promotion of family planning, together with the commitment of community leaders, provided that the approaches used allow free and informed choice.

- Origin: Evaluation question 2 (Section 4.2)

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## 5.3 Opportunities for a stronger brokerage role

UNFPA has comparative advantages for brokerage due to its specialist focus on SRH and FP, being a UN organisation, and close working relationship with government. To date, UNFPA has participated

in partnerships between government and development agencies but has not taken the lead in brokerage. Development partners would welcome and support UNFPA leadership.

There is an important gap for brokering partnerships in family planning between government, non-government organisations (NGOs) and the private sector which UNFPA is well placed to pursue, given its strong working relationships with all three sectors.

UNFPA has good visibility as a supply-side donor in family planning, but less for its contribution on the demand side and its mandate to integrate family planning within the wider International Conference on Population and Development (ICPD) SRH framework.

- Origin: Evaluation question 3 (Section 4.3)

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## 5.4 Strengthening the enabling environment on the supply side

Since government took the lead on FP, an enabling environment has been developed on the supply side with political and institutional commitment by the government to the family planning programme. However, there are still gaps in implementation, particularly in service quality.
On the demand side, specific groups such as young people still have insufficient information on the family planning choices available to enable them to exercise their right to decide freely. There are also legal limitations on the FP and advocacy work of NGO partners.

There are opportunities for a greater contribution from UNFPA to the enabling environment through development of evidence on barriers to access and best practices to reduce them, and use of such evidence in advocacy with service providers.

- Origin: Evaluation question 4 (Section 4.4)

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## 5.5 Supporting access for some but not all vulnerable groups and marginalised populations

Poor rural families with low educational levels, unmarried adolescents, commercial sex workers (CSWs) and men who have sex with men (MSM) are still disadvantaged in their access to family planning. Institutional and cultural barriers affect access for these groups.

UNFPA has identified the family planning needs of specific vulnerable and marginalised groups (VMGs) and has allocated resources to non-public sector programmes to meet their needs. UNFPA recognises that an evidence base is needed to raise awareness of decision-makers and hence scale up allocation of public sector resources to VMG programmes. UNFPA is developing evidence from the projects supported by UNFPA and from other countries for advocacy purposes.

- Origin: Evaluation question 5 (Section 4.5)

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## 5.6 Elements of a human rights-based approach on the supply side

The political and social context of Ethiopia has made it easier for UNFPA to contribute with a human rights-based approach (HRBA) on the supply side, rather than the demand side. Support has included

elements of a rights-based approach such as availability of a range of methods and service quality. Although progress has been made, aspects of informed choice in the public sector have not been fully addressed through correct implementation of national guidelines.

It is more difficult for development partners to support implementation of a rights-based approach on the demand side, which is dominated by the public sector. UNFPA indirectly addresses demand-side issues through work on the determinants of family planning demand, such as gender issues and women's empowerment.

There is a fine balance between strong promotion of a family planning programme with targets on the one hand, and respect for users' freedom of choice on the other. Programme monitoring can alert decision-makers to any potential or actual undue pressure on users to adopt family planning or to switch methods. As UNFPA is recognised as a leading family planning development partner, and since it works closely with the government, it is well-placed to address this important aspect of a HRBA. To date, UNFPA has been reluctant to raise the issue with government although there is evidence of insufficient information and coercion of users in some regions.

- Origin: Evaluation question 6 (Section 4.6)

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## 5.7 All four modes of engagement, adapting to the needs of different regions

Ethiopia is in the UNFPA business model's "red quadrant" where all four modes of engagement (service delivery support, capacity building, advocacy and knowledge management) are needed.

The UNFPA family planning programme does works in all four modes. There has been support for service delivery in FP throughout the period under evaluation, and it still continues. There has been a growing focus on capacity building on the supply side through the global programme for reproductive health commodity security (GPRHCS) and service provider training. UNFPA has carried out FP advocacy through supporting major international events, and has started to develop an evidence base to use in current and future knowledge management.

Given the socio-political and economic context in Ethiopia, advocacy and knowledge management, including development of an evidence base and best practices, can help ensure family planning is promoted as part of a broader spectrum of SRH services, and that it responds to genuine unmet needs for voluntary quality FP in Ethiopia.

As government leadership in family planning strengthens, more upstream engagement will be the most appropriate type of support, and UNFPA is moving in this direction. Modes of engagement need to adapt to differences between the decentralised regions, which are at different stages in development of their family planning programmes and have different needs for support.

- Origin: Evaluation question 7 (Section 4.7)

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## 5.8 Strategic support for supply-side activities

During the period under evaluation, UNFPA has worked with the government at federal level on support to the supply chain and capacity building for service providers. The advent of the GPRHCS

coincided with the strong government push to increase family planning coverage, and support for the supply side has become a key element of UNFPA family planning work. UNFPA support on the supply side has promoted rights and choice through increasing the availability and mix of family planning methods and through provider training to improve service quality.

Support for capacity building in the supply chain should lead to better access for users and greater sustainability of the supply system. Long-term sustainability will require more financial commitment by government for commodity procurement.

- Origin: Evaluation question 8 (Section 4.8)

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## 5.9 Institutional constraints on family planning work

Institutional constraints on UNFPA family planning work include little support from the UNFPA Eastern and Southern Africa regional office (ESARO) whose capacity for direct technical support is limited in comparison with existing in-country UNFPA technical capacity. There is insufficient in-country capacity within the UNFPA CO itself to work effectively in technical assistance (TA) and knowledge management at decentralised level with Ethiopian regional governments, who have a significant resource allocation and decision-making role in FP.

Both HQ and RO have provided TA and support in GPRHCS and supply-side activities, but little in areas of integration of FP with other SRH services, strengthening the enabling environment, promoting a human rights-based approach to FP, and adapting modes of engagement to country needs.

- Origin: Evaluation questions 1, 4, 6, 7 and 8 (Section 4.9)

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## ANNEX 2 – LIST OF PEOPLE INTERVIEWED

| PERSON | TITLE/ORGANISATION |
|---|---|
| **UNFPA** | |
| Muna Abdullah | Assistant Representative |
| Tesfu Alema | Programme Officer Tigray Region |
| Beyeberu Assefa | National Programme Office RH |
| Sabine Beckmann | RH/HIV/AIDS Coordinator |
| Gamachis Galalcha | Programme Officer RHCS |
| Behailu Gebremedhin | Programme Officer M&E |
| Tadese Hailemariam | Regional Coordinator SNNPR |
| Dorothy Lazaro | International Midwifery Adviser |
| Rediet Mesfin | Programme Associate |
| Victor Rakoto | Deputy Representative |
| Faustin Yao | Representative |
| **MINISTRY OF HEALTH (Addis Ababa, Tigray, SNNPR), related government agencies and supply chain organisations** | |
| Achameyeleh Alabachew | Director Planning and M&E, Directorate FHAPCO |
| Aster Aliso | HEW Nury Dulecha Health Post |
| Berhane Assefa | Technical Officer FPMCH Directorate |
| Ermis Ayale | FMHACA |
| Wondwossen Ayee | Deputy Director General PFSA |
| Amarech Bakalcha | HEW Nury Dulecha Health Post |
| Helen Berhane | FMHACA |
| Berizat | Head of Woreda Health Office, Hitalo Wakerat |
| Tesfaya Beyene | Head, Dulecha Health Centre |
| Dawit Dikasso | FMHACA |
| Mekdim Enkossa | Adviser MDG Fund |
| Getachew Genete | FMHACA |
| Yordanos Giday | Planning Officer Policy and Planning Directorate |
| Hagos Godefay | Head of RHB Tigray |
| Yohannes Letamo Hulawa | Deputy Head Curative and Rehabilitation Services SNNPR |
| Burriso Bu'lansho Shoashamo and 3 staff | Head Woreda Health Office Shabadino |

| | |
|---|---|
| Masresha Soresse | Integrated Family Health Programme |
| Marta Minwyelet Terefe | Assistant Director MCH Directorate FMoH |
| Tesfaya | Clinical Officer SNNPR |
| Director, FP nurse and MCH staff | Hiwane Health Centre Mekele |
| 2 HEWs | Maynebrit Health Post |
| OTHER GOVERNMENT MINISTRIES | |
| Fikre Gesso | Acting Director of Population and Development Directorate National Planning Commission |
| DEVELOPMENT PARTNERS | |
| Yirga Ambaw | USAID |
| Beth Haytmanek | USAID |
| Joshua Karnes | USAID |
| Kassa Mohammed | Health Adviser DFID |
| Zelalem Demeke Roberto Peñarrieta | Programme Manager MNCH, CHAI |
| Rita Santos | Head of Development Cooperation AECID |
| Bouwe-Jan Smeding | First Secretary Health, Embassy of the Kingdom of the Netherlands |
| UN AGENCIES | |
| Sarah de Nasi | UNH4+ WHO |
| Amsalu Shiferaw | Health Specialist UNICEF |
| Neghist Tesfaye | Strategic Intervention Adviser UNAIDS |
| Luwan Teshome | Programme Officer WHO |
| NGOs and CSOs | |
| Gedamu Abera | Head of Department Mekele University Midwifery Department |
| Adem | Team leader, Research and Planning FGAE |
| Ambachew | MSH Tigray |
| Atsede | FGAE Tigray |
| Esayas Alemayehu | Executive Director YNSD |
| Begashaw Dabena | CORHA |
| Ketsela Desalegn | FHIP |
| Gashaw Dubale | JSI |
| Mekonnen Feleke | Head FGAE Regional Office SNNPR |
| Holie Folie | Executive Director CORHA |

| | |
|---|---|
| Dejena Getahun | Research and M&E Officer CORHA |
| Dagmawit Girmay | Deputy Director DKT |
| Mengistu Kasa | Head Model Clinic FGAE |
| Melaku Legesse | USAID/DELIVER |
| Misiker Lemma | MSI |
| Jelatu Lepesse | USAID/DELIVER |
| Mengistu | Professor Mekele University Midwifery Department |
| Genet Mengistu | Executive Director FGAE |
| Tesfaye Seifu | Deputy Director Technical Operations SCMS |
| Abebe Shibru | Deputy Country Director MSI Ethiopia |
| Tadese | DKT Tigray |
| Liyu Wogayehu | Project Coordinator NNPWE |
| Nahom Wolde | M&E Officer NNPWE |
| Yirga | OSSA Tigray |
| Yeshiharig Yosgon | FGAE |
| SERVICE USERS AND FGD PARTICIPANTS | |
| Addis Ababa | |
| Selamawit Zedalem, Yabsra Tefera, Berhanu Mellese, Mulugeta Zemichael, Kidane Tesfaye, Heok Meseret, Yeshewooyk Tefra (YNSD) | |
| SNNPR (Addis Ketam subcity Hawassa) | |
| Community leaders: Hira Hirboro, Eyob Gababo, Saba Araya, Almetsehay Worku, Almaz Minyam Boltana | |
| SNNPR (Nury Dulecha Health Post) | |
| 13 health centre clients | |
| 9 FP users (all HDA leaders/members) | |
| Tigray (Maynebrit) | |
| 25 female FP users and non-users | |
| Kebele Chief and 2 Village elders | |
| Tsinat, Social and Development NGO | |

## ANNEX 3 – EVALUATION MATRIX

The data and information produced through the document review, and collected through interviews and focus groups during the field visit in Ethiopia are presented in the evaluation matrix below. Data and information are categorised along the evaluation questions and related assumptions for verifications and support the findings analysis presented in Section 4 of the present country note.

### Area of Investigation 1: Integration

To what extent has UNFPA supported integration of family planning with maternal health, HIV/STI and GBV services in health plans and at primary health care level, in services for adolescents, and in emergency and humanitarian situations?

**Data collection methods:**
Document review
Key Informant Interviews (KII)
Focus Group Discussions (FGD)
Site visits

| **Assumption 1.1:**<br>**UNFPA headquarters (HQ), regional office (RO) and country office (CO) staff and in-country partners are working towards a common understanding of the meaning and importance of service integration.** | **Information sources:** |
|---|---|
| **Indicators**:<br>• Knowledge generated and shared regarding nature of and lessons learned from integration interventions<br>• UNFPA staff, partners' and users' (women's and men's) perception of meaning and importance of service integration. | |
| Integration occurs at different levels; policy, programmatic, service delivery.<br>There may not be common understanding of the theme at all levels by all parties. There is some integration of HIV and family planning (FP) at programme level. Integration at service delivery level varies between type of facility, regions, and sub-sectors of the health system (public, private and non-government organisation (NGO) sub-sectors). | UNFPA |
| *"The UN has provided technical and financial support in the development of national policies, normative guidelines, implementation strategies and technical protocols in different areas of prevention including the comprehensive and integrated PMTCT, sexual and reproductive health and HIV".* | (Jallow and Bekele 2009: 69-70) |

| | |
|---|---|
| Integration is emphasised by UNFPA in policy documents and guidelines, in advocacy and in support to service provision.<br>UNFPA plays a leading role in discussion of integration. Some development partners (DP) have more resources than UNFPA to put integration into practice through support to service delivery projects.<br>Donors have a shared understanding of integration and support its implementation, and most NGOs and service providers also have a clear understanding of the meaning of integration. | UNFPA,<br>DP,<br>Civil Society,<br>Government,<br>CO annual reports |
| Integration is important in the whole continuum of care throughout the life cycle and in providing a "one-stop-shop" for people seeking various services, e.g. for FP and sexually transmitted infections (STI) clients who can receive both types of services at the same time, and for prevention of mother-to-child transmission (PMTCT) programmes which incorporate FP. | UNFPA,<br>Government,<br>Civil society |
| There is integration at some levels of service delivery and to different depths. Services are integrated at community and primary health care (PHC) level, and to some extent service providers (e.g. health extension workers (HEWs)) offer integrated services, but this can lead to overload for HEWs who handle 16 PHC programmes. When HEWs go on home visits they never go solely for FP, they always provide various services. At health centres, a wider range of services is available, and FP is integrated with ante-natal care, post-partum and other SRH services.<br>The Ministry of Health (MoH) is developing a guideline to link HIV and AIDS, mother and child health (MCH) and FP, but implementation has not yet been completed. | UNFPA,<br>Government,<br>DPs,<br>MoH staff<br>FMoH (2014) |
| Integration is not affected by the global programme for reproductive health commodity security (GPRHCS) working as an independent vertical programme focussing on FP, as GPRHCS implementation has been complemented by appropriate demand-side activities from a wider range of intervention areas, including gender-based violence (GBV), adolescent reproductive health (ARH). | UNFPA<br>(UNFPA Ethiopia 2011b, UNFPA Ethiopia 2013c) |
| *"In (…) Ethiopia, RHCS is deemed sufficiently integral to national policy and implementation such that no separate strategies are required by government but are integrated into existing documents".*<br><br>[Evaluator comment: this refers not directly to services but can be seen as context for integration generally.] | (Chattoe-Brown, Weil et al. 2012: 23) |
| Most stakeholders understand integration to refer to integration of services within a single service delivery point or organisation. A study of HIV/FP integration in Addis Ababa involving public, private and NGO sector service delivery points showed that few offer a full range of either type of service, so referral is necessary to provide comprehensive care. The study concluded that the low overall referral densities suggest there may be a prevailing culture or a health system that work against inter-organizational connections in general. | (Thomas, Reynolds et al. 2014: 1-8) |

| **Assumption 1.2:**<br>**Country offices receive and put into practice technical guidance from HQ and ROs to support partners in delivering quality, integrated services.** | **Information sources:** |
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| **Indicators:**<br>• Number, frequency and type of technical assistance (TA) provided<br>• RO plans address COs' needs for support in promoting service integration where appropriate<br>• CO plans and programmes reflect current technical guidance and best practices for integrated services<br>• Evidence-based guidance developed to support the integration of FP or more in the following SRH services (in policies, plans, actual service delivery):<br>▪ Maternal health<br>▪ HIV/STIs<br>▪ Gender-based violence (GBV)<br>▪ Level of emergency preparedness to address FP needs in emergency situations<br>▪ Adolescent SRH (girls and boys) | |
| There has been technical support and programmatic guidelines from HQ and RO in integration of services. Handbooks and guidelines are available, such as the UNFPA/Population Council publication on "Planning and Implementing an Essential Package of SRH services". Not all the methods proposed by RO are acceptable in all country contexts; for example, it was proposed to carry out a SRH-HIV linkages survey but the government would not permit this. | UNFPA,<br>(Williams, Warren et al. 2011) |
| HQ has an important role in policy-setting, development of tools which COs can adapt to their needs, and for opening doors to international resource mobilisation. The RO plays a role in transmitting these elements to the CO.<br><br>The thematic funds, including GPRHCS, are run from HQ and have more resources for technical assistance (TA) than the ROs (see assumption 8.5).<br><br>In the case of Ethiopia, the CO itself has a good level of technical skills, and technical support is not required from the RO. The RO has a role in keeping COs up to date with innovation, sharing experiences, identifying resource mobilisation opportunities, and recommending TA providers when necessary.<br>Note: These points also apply to assumptions 4.3, 6.4, 7.1 and 8.5 | UNFPA |

| **Assumption 1.3:**<br>**UNFPA support has been effective in stimulating service integration by in-country partners (Government, CSO, private) in policies, plans and actual services.** | **Information sources:** |
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| **Indicators:**<br>• Number and type of FP service providers trained on service integration | |

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| • Number and percentage of service delivery points that offer FP integrated with other services (and acknowledge UNFPA guidance for this)<br>• Integrated service provision included in provider training programmes (with acknowledgement of UNFPA guidance for this)<br>• Inclusion of integrated service provision in government policies and health plans. | |
| Family planning services are integrated with other SRH services, and will remain so despite increased focus on FP in national policy. The government implements the FP programme as part of its overall SRH programme, not as a stand-alone programme. | UNFPA |
| UNFPA has supported integration of RH and HIV services in six regions. In coordination with Federal HIV and AIDS Prevention and Control Office (FHAPCO), it has arranged eight experience-sharing visits on PMTCT for health staff drawn from zones, districts and regions. Also four regional advocacy forums were organised for stakeholders on programme synergy for reproductive health (RH) and HIV. | (UNFPA Ethiopia 2012a) |
| UNFPA has supported capacity building in integration of services, but the concept is still not well understood in government. | Government |
| UNFPA has advocated integration of family planning in maternal health emergency obstetric care (EmOC), youth SRH, HIV and fistula work, and has supported service provider training in integration of services at PHC and community levels.<br><br>UNFPA has supported integration of FP with programmes within and outside the MoH at regional level. Within MoH this has included support for the integration of FP in maternal health programmes of the regional health bureau (RHB). In ministries other than the MoH, UNFPA has supported integration of FP in the gender programme of the Ministry of Women and Youth, in discussion of population issues and policies of the Population Department in the Adolescent Development Programme/FHAPCO (with UNICEF) and via NGOs.<br><br>Many other DPs also support programmes which integrate FP with other SRH services, making it hard to identify the specific contribution of UNFPA. | Government,<br>Civil society,<br>DP,<br>UNFPA |
| *"The UN also supported the integration of the Reproductive Health Response programme with ongoing nutrition programmes in nine districts of east/west Hararghe and in 15 affected districts in Southern Nations, Nationalities and Peoples Region (SNNPR)".* | (Jallow and Bekele 2009: 55-56) |
| *"In another example of how the UNDAF collaborates across several cross-cutting areas, HEWs were also trained on the provision of youth friendly reproductive health services".*<br>*"The UNDAF provided technical and funding support to increase access to information and skills targeting women and youth on sexual reproductive health, including on topics of HIV/AIDS and gender based violence".* | (Universalia 2014: 35, 40) |
| Despite promotion and support there are still problems in practice at service delivery level in the public sector. Integrated services are not available for some of the groups which most need them, including commercial sex workers (CSWs) and young people. | Civil society |

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| NGOs involved in SRH service provision have fully integrated FP with other SRH services. Their experience could help government improve integration. | |
| HEWs provide integrated services in the health post and on community visits, but are overloaded. They attend clients of 16 primary health care programmes so attention to FP may be limited | Government |
| FP is not fully integrated in post-partum care. Post-partum care in health centres and hospitals includes access to long-acting FP methods, but these cannot be provided at health post or community level where much post-partum work is carried out. At community level, when FP is included in post-partum work, it is limited to counselling and provision of temporary methods. | UNFPA,<br>Government,<br>DP |
| The high level of visibility of GPRHCS has led partners to think that UNFPA deals with family planning as a separate programme, not integrated with SRH as defined in the wider International Conference on Population and Development (ICPD) programme of action.<br><br>Other DPs consider that the UNFPA practice of responding directly to government requests limits its capacity to promote integration any further than current government initiatives. | DP |
| Humanitarian situations are addressed by other UN organisations outside the RHB system, and UNFPA input is limited to provision of material resources. UNFPA has not promoted integration of FP in emergency relief. | UNFPA |
| Integration of FP and SRH services at health post and community level through the HEWs and the Health Development Army (HDA) was used as a case study by the Inter Agency Task Team (IATT) in a 2013 international workshop on integrated service delivery held in Tanzania. UNFPA participated in the organisation of the workshop | IATT, WHO, UNICEF, (UNFPA 2014b) |

| **Assumption 1.4:**<br>**Service integration leads to improved user access and quality of services.** | **Information sources:** |
|---|---|
| **Indicators**:<br>• Evidence of user consultations<br>• Perception of different user groups – women and men, vulnerable and marginalised groups (VMG), people living with HIV (PLHIV) that access,[93] and quality have improved by integration | |
| Users perceive better integration in primary health care (PHC) facilities in rural areas than in urban health centres, and users report better integration in some regions. | Civil society and service users |
| HEWs and other service providers are responsible for a range of services and not all can be experts in all the services they offer. This affects service quality. | DP |

[93]Access: availability, accessibility (distance, transport, time), affordability (willingness and ability to pay incl. opportunity cost) and socio-cultural acceptability

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| Integration reduces time wasted going to different facilities and service points, and reduces loss of clients from the system (if clients are short of time they do not wait in queues). Integration at community level does improve access. | Civil society,<br>Users |
| UNFPA has not monitored lack of integration in MoH facilities or compared this with good integration in NGO clinics. | Civil society |
| A study of eight public sector voluntary counselling and testing (VCT) facilities in the Oromia region where FP was introduced showed that *"Clients interviewed after the introduction of family planning services received significantly more family planning counselling and accepted significantly more contraceptives than those clients served before the intervention. However, three-quarters of the clients were not sexually active. Of those clients who were sexually active, 70 percent were using contraceptives".*<br><br>The study demonstrated that family planning can be integrated into VCT clinics. However, policy-makers and programme managers should carefully consider the characteristics and reproductive health needs of target populations when making decisions about service integration. | (Gillespie, Bradley et al. 2009: 1) |

## Area of Investigation 2: Coordination

**To what extent has UNFPA successfully contributed on its own and in coordination with others to strengthening national leadership of family planning and improving sustainability?**

**Data collection methods:**
Document review
Key informant interviews (KII)
Focus Group Discussions (FGD)
Site visits

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| **Assumption 2.1:**<br>**UNFPA has developed and/or actively supported mechanisms to raise the profile of family planning in coordination with other FP/SRH stakeholders at:**<br>• **Global**<br>• **Regional**<br>• **National levels.** | **Information sources:** |
| **Indicators**: | |

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| • Type of existing and emerging coordination mechanisms at each level with evidence of UNFPA support and FP-relevant contents of meetings and initiatives. | |
| UNFPA participates in various forums relevant to family planning. It participates in discussions, contributes funds and follows up on implementation. Forums where UNFPA participates are:<br>- Health Population Nutrition donor group<br>- Development Partner Forum HIV – UNFPA is co-chair<br>- MDG Pooled Fund<br>- Family Planning Technical Working Group (FP-TWG)<br>- Joint Coordination Core Committee (Health – technical level)<br>- Joint Consultative Forum (Health – policy level)<br>- Pharmaceutical logistics meeting<br>- Regional RH-Forums<br><br>Most of the forums are convened by the MoH who is a key participant along with other DPs and NGOs.<br>The FP-TWG is the principal forum for FP. The MoH chairs the group. Members include relevant branches of MoH, other government ministries involved in FP such as the National Planning Commission Population Directorate, national and international NGOs, UN agencies, national professional bodies and donors. FP-TWG is tasked with networking, technical support, advocacy with non-health policy makers and community leaders, monitoring, and coordination of support for commodity supplies and logistics.<br><br>There are mixed opinions on the effectiveness of the forums. DPs suggest that many have few concrete results – they consider that sitting in joint committees is not partnership, collaboration is more effective when there is something specific to do, and collaboration in doing it can form lasting partnerships. | UNFPA,<br>Government,<br>Civil society,<br>DPs,<br>(Ministry of Health 2015) |
| UNFPA has a seat at the table in important forums but its impact on implementation is limited by its small financial contribution. | Civil society |
| UNFPA worked in coordination with others to stage major events such as the Third International Conference on FP (3rd ICFP) in Addis Ababa where FP achievements in Ethiopia were showcased. | UNFPA |
| UNFPA is seen by other partners as being close to government. There are mixed opinions on its effectiveness in the forums. Some expect UNDP to take the lead more than it does. | DP |
| There is a lot of partnership work on the supply side – UNFPA works with the other big FP donors, such as United States Agency for International Development (USAID) and Department for International Development (DFID) in its support for forecasting and procurement by the Pharmaceuticals Fund and Supply Agency (PFSA). UNFPA has a smaller financial contribution than other | Government |

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| donors but allocates its resources in strategic areas of the supply chain (PFSA, Food Medicine and Health Care Administration and Control Authority of Ethiopia (FMHACA)). | |
| UNFPA provided important technical support to the National Planning Commission in development of the Mission and Vision of the National Population Plan which integrates FP as a fundamental element of population policy. | Government |
| UNFPA with Federal Ministry of Health (FMoH) and the FP-TWG organised a 'Repositioning of FP' consultative meeting, which agreed that collaborative work is needed at all levels to mobilise sufficient resources. Follow up consultations were arranged at regional and national levels. | (UNFPA Ethiopia 2010) |
| *"UNFPA Country Office has also been supporting the family planning repositioning initiative aiming to transform family planning initiatives into a social movement by ensuring participation of clients of FP, involvement of different sectors of the government and stakeholders with renewed pledge from the highest authority of the country".* | (UNFPA Ethiopia 2009: 9) |
| In 2013, UNFPA supported the organisation of the high level advocacy event on campaign on accelerated reduction of maternal, newborn and child mortality in Africa (CARMMA) at the African Union Summit. A number of communication materials have also been developed. UNFPA supported the high level conference on ICPD Beyond 2014 regional review in Addis Ababa, and the Third International Conference on FP (3rd ICFP) in Addis Ababa, where it advocated the UNFPA mandate through six oral presentations by UNFPA staff. | (UNFPA Ethiopia 2013a: 12) |
| *"UNFPA Country Office has also been supporting the family planning repositioning initiative aiming to transform family planning initiatives into a social movement by ensuring participation of clients of FP, involvement of different sectors of the government and stakeholders with renewed pledge from the highest authority of the country. The Fund also supported the federal and regional governments through procurement and distribution of various FP commodities with the view of ensuring the availability of method mix of contraceptives including long term and permanent contraceptive methods such as the IUCD, Implants, tubal ligation, vasectomy and emergency contraceptives. This was one of the areas identified under the HSDP MTR as a gap that needed to be filled".* | (UNFPA Ethiopia 2009: 9) |

| **Assumption 2.2:**<br>**UNFPA and other donors (including those influenced by UNFPA advocacy) have effectively supported national governments to assume ownership of family planning-related policies and programmes.** | **Information sources:** |
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| **Indicators**:<br>• Existence of national FP policy and programme (separate or integrated with other SRH areas)<br>• National budget allocations to FP<br>• Number of other major donors actively supporting national ownership of FP, (on their own account or as a result of UNFPA advocacy). | |

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| Government and the MoH have real political commitment and strong leadership role in family planning; government population policy sees the need to reduce the total fertility rate (TFR) to address issues related to land scarcity, population density and internal migration. The government is strongly committed to FP and the national budget allocation for FP is slowly growing. Government has set up large scale community networks – the HDA – to increase demand for FP. Although government is the largest actor, there is also participation of larger NGOs, e.g. in social marketing and demand-creation through service delivery. The government sets its own agenda for FP and UNFPA was among the group of partners who participated in giving support, but did not provide leadership of the process. Government commitment has been encouraged by UNFPA and other DPs during the period under evaluation. | UNFPA,<br>Government,<br>NGOs,<br>DP |
| Personal commitment of the Minister of Health and the Prime Minister to FP are considered key elements in the success of the programme in Ethiopia. | (USAID, Ethiopia Federal Ministry of Health et al. 2012: 12) |
| *"In conclusion, the TFR is still high, implying further rapid population growth in the years ahead which requires quite a streamlined activity to increase the CPR of the country and also [increase] availability of a method mix with emphasis on long term and permanent family planning method[s]".*<br><br>The rationale for increased attention for FP is based on health benefits and socio-economic benefits (including response to reduced productivity, infant mortality and uncontrolled population growth) and women's rights. | (Ministry of Health 2010a: 15, 19-21) |
| In its Growth and Transformation Plan 2010/11-2014/15, the government established a target of 66 percent contraceptive prevalence rate (CPR) by 2014/15. FMoH has also set targets for the share of long-acting FP methods (25 percent by 2011) and the share of intra-uterine contraceptive device (IUCD) within that (50 percent), expecting 1.5 million women to use IUCDs by the end of 2015. UNFPA GPRHCS has provided support for implementation of these targets through increased availability of implants and IUCDs. | (FDRE 2010, UNFPA Ethiopia 2010) |
| During the 6th Country Plan (CP), the CO provided technical support to the formulation of important RH frameworks, including the development and costing of the National RH Strategy 2005-2015 and the launching of the National Adolescent and Youth Reproductive Health Strategy (AYRHS, 2007-2015) | (UNFPA Ethiopia 2009: 9) |
| Donors agree that the government assumes ownership and, at federal level, the FMoH takes the lead in developing policy and targets, but donors still finance most of the commodities, and implementation is decentralised to regional level. Some DPs consider that government enthusiasm has led to a fine balance between increasing access on the one hand, and potential for undue social and service delivery pressure to adopt family planning on the other. There are national targets for CPR and FP take-up, and FP is one of the "model family" criteria in the HDA network. Very strong leadership and development of the national network of the HDA to work at community level has given government a dominant position in demand creation, with little participation of NGOs and private sector. | DPs,<br>Civil society,<br>UNFPA |

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| *"Although efforts to affect fertility rates using education and informational campaigns are commonplace in family planning, the use of social pressure tactics that apply direct pressure (e.g., from leaders or authority figures) on individuals to use family planning can be considered coercive. (…) As in Indonesia, leadership in Rwanda and Ethiopia has demonstrated strong commitment to improving health and lowering fertility rates through family planning services. In both countries, strong central leadership and community mobilization have combined to implement family planning. In Ethiopia, as a way to implement the country's Health Sector Development Programme, the "Health Development Army" has encouraged citizens to adopt a host of health behaviours, family planning among them. This group consists of members in the communities who exert political leadership and help to improve the community's understanding and knowledge of health issues. Although coercion has not been reported, some have raised concerns about community pressure in both Rwanda and Ethiopia".* | (Hardee, Harris et al. 2014: 208-209) |
| *"There is a risk that, as members of the party become involved at community level in stimulating demand for services, the push to drive individuals to facilities may take on a coercive quality. If people arrive at facilities that are not yet ready to meet demand, particularly if they feel forced to do so, the resulting feelings of disappointment and scepticism will hinder future efforts to mobilize communities around facility-based services. (…) … some measures can be taken to minimize vulnerabilities. (…) Special attention should be given to ensuring that women are not coerced into visiting health centers and that local health officials are not pressured to exaggerate accomplishment in order to reach performance benchmarks".* | (Morrison and Brundage 2012: 11) |
| *"We argue that four factors were primarily responsible for Ethiopia's success in reducing fertility rates: political will, generous donor support, nongovernmental and public-private partnerships, and the Health Extension Program. Political will: In formulating development policies, the Ethiopian government paid increasing attention to demographic factors, recognizing population growth as one of the main challenges to poverty reduction and implementing mostly supportive policies. The government has set the goals of increasing CPR to 66 percent and reducing TFR to 4.0 children per woman by 2015, and has funded contraceptive commodities.(…) Generous donor support: Donors—notably the British Department for International Development (DFID), the Embassy of the Kingdom of the Netherlands, Irish Aid, the David & Lucile Packard Foundation, the United Nations Population Fund (UNFPA), and the United States Agency for International Development (USAID)—have provided consistent support for purchasing commodities, strengthening government capacity, and improving policy, research, and training".* | (Olson and Piller 2013: 448) |
| DPs feel that UNFPA has an important role in monitoring, supporting and advising government on the basis of evidence, and, where necessary, go beyond advice to promote change. UNFPA has an important role to take the lead in alerting government to any potential mistakes. | DP,<br>UNFPA,<br>Civil society |
| At decentralised regional level there is no need for promotion of government ownership of FP programmes, as regional governments have fully subscribed to federal policy. Over-enthusiastic adoption of federal targets for CPR at regional level has resulted in some unrealistic targets in some places (such as 100 percent FP coverage of women of reproductive age). Some | Government,<br>Civil society |

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| regional governments are also unclear about the range of FP methods, for example some think that emergency contraception (EC) is not an FP method.<br>UNFPA staff in decentralised regional sub-offices in Ethiopia do not have a broad remit or technical skills to provide this type of support. | |
| Some regions have allocated their own budget line for FP methods. These will be used as a backup if commodities from PFSA are not enough, in order to ensure sustainability of FP supply. | Government |
| The UNDAF Joint Programme, in which UNFPA participates, commissioned a review of studies to inform national HIV prevention efforts, and participated in development of government strategic documents, including the National Adolescent and Reproductive Health Strategy, Reproductive Health guideline and the Integrated PMTCT Guidelines. | (Jallow and Bekele 2009: 70) |
| In 2011 UNFPA reported:<br>*"Family Planning has become a development agenda, not health sector issue alone, thus the Ministry of Finance and Economic Development is playing a key role in allocation of resources for FP programs in the country".* | (UNFPA Ethiopia 2011b: 14) |
| Population growth is a major contributing factor to food insecurity. High fertility is seen as the second greatest perceived threat to individual and social well-being. | (Ministry of Health 2006) |

| **Assumption 2.3:**<br>**Programmes are culturally/socially, institutionally and economically sustainable in different national contexts.** | **Information sources:** |
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| **Indicators**:<br>• Trends in modern contraceptive prevalence rate (mCPR)<br>• Percent of FP provided by the public, NGO and private sector<br>• Government spending as percent of total expenditure on FP<br>• Evidence of participation by CSOs (including end user groups, VMGs) and private sector in FP policy, planning and accountability mechanisms at national level. | |
| FP is a very important contributory factor in Government of Ethiopia (GoE) economic development plan. Reducing rapid population growth is seen as an essential element in working towards middle-income status in a sustainable way | Government |
| In the first years of the period under evaluation, the government FP programme was unlikely to become financially sustainable as it had a heavy focus on implants, which is an expensive method. This was pointed out in the mid-term review of the GPRHCS. Since 2011, UNFPA has with some success advocated with government for a wider method mix. The government has now more focus on long-acting methods including IUCDs and sterilisation, which will make the FP programme more financially sustainable when donor funding ends. UNFPA has carried out research and analysis on the cost-effectiveness of different methods (Costs and Benefits of FP services: 2012 Ethiopia estimates) and continues to advocate for a financially sustainable method mix. | UNFPA<br>DPs<br>Civil society<br>(Chattoe-Brown, Weil et al. 2012, UNFPA 2012b) |

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| There are still many social and cultural traditions which affect women's and young people's access to FP. These include restrictions on women's decision-making and social taboos on pre-marital sex for young people. UNFPA works with CSO implementing partners to address these issues.<br>Work by HEWs and HDA has helped remove social barriers at community level.<br>Users and non-users consider family planning to be socially sustainable as all community members are now aware of FP, and many use it. Older women often encourage their daughters to use methods. Support and socio-political pressures through community leaders, community members and the HDA have increased acceptability; this will support social sustainability.<br>Government is now aware that *"The involvement of males and religious and cultural leaders in shaping reproductive preferences and in family planning discussions should be promoted"* (Ayele, Tesfaye et al. 2013: vi) and that *"Family planning programmes should target each region according to their level of unmet need, contraceptive use and demand for family planning"* (Ayele, Tesfaye et al. 2013: 20) | Civil Society,<br>Government,<br>Users<br><br>(Ayele, Tesfaye et al. 2013) |

## Area of Investigation 3: Brokerage and Partnership

**To what extent has UNFPA acted as a broker at global, regional and country levels to promote family planning, acting in partnership with the public, private and non-state sector service providers?**

**Data collection methods:**
Document review
Key Informant Interviews (KII)
Focus Group Discussions (FGD)
Site visits

| **Assumption 3.2:**<br>**At the country level, UNFPA COs brokered partnerships between public agencies, CSOs and private sector entities to promote FP and its integration with other SRH programmes.** | **Information sources:** |
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| **Indicators**:<br>• Other stakeholders and partners recognise the comparative advantages of UNFPA, its positioning and its potential contribution at global, regional and country levels, and respond to UNFPA initiatives in bringing them together<br>• UNFPA participation and role in policy forums, networks, and other partnership mechanisms at global, regional and country levels. | |

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| UNFPA is a strong partner for the government. UNFPA has a holistic focus on family planning and is flexible, supporting RHCS, demand creation and capacity building where other donors have only supported one or the other. Its financial contribution is limited but can cover smaller, yet important issues and events which require partnerships with a number of stakeholders, such as the International FP Conference, and dignity kits for refugees. | Government |
| UNFPA plays an important brokerage role on the supply side through its support for PFSA and facilitating contacts between PFSA and other international funders. | Government |
| Although it is well placed to do so, UNFPA has not been successful in brokering partnerships between the public sector and NGOs, the private sector in family planning, or demand-creation at federal or regional levels. It has not advocated with government in support of NGO interests, nor brokered government-private sector partnerships. It has not fostered discussions on points which affect the private sector such as new clinic regulations. The big NGOs already work with the private sector through social franchises and social marketing, and these relations were not brokered by UNFPA. There are difficulties in brokering relations with the for-profit private sector which does not have one single representative body. | Civil society,<br>DPs,<br>Government,<br>UNFPA |
| Problem-solving between government and other sectors is seen as an important brokerage function by CSOs, but UNFPA has not contributed significantly in this respect. There is need for this type of brokerage between UNFPA, IPs and government. | Civil society |
| UNFPA participates in all the major forums and coordination mechanisms, but the extent to which it has led or brokered these processes is unclear. UNFPA has participated in partnerships rather than brokered them. | DPs,<br>UNFPA |
| UNFPA has missed opportunities for brokering linkages which could lead to public sector learning from NGO experience – e.g. in integration and in services for vulnerable and marginalised groups. | Civil society |
| There are also missed opportunities for proactive brokerage of family planning partnerships between different government departments – e.g. between federal and regional levels, between FMoH and Population and Development Directorate of the National Planning Commission for promotion of male participation in FP, which is of interest and strategic importance to both parties. | Government |
| UNFPA staff in decentralised regional sub-offices are not responsible for proactive brokerage and do not all have the necessary skills and experience to do it. | UNFPA,<br>DPs,<br>Civil society |

| **Assumption 3.3:**<br>**The visibility of UNFPA is sufficiently high at global, regional and country levels to bring together potential partners to increase commitment to family planning.** | **Information sources:** |
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| **Indicators**: | |

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| • Other stakeholders and partners recognise the comparative advantages of UNFPA, its positioning and its potential contribution at global, regional and country levels, and respond to UNFPA initiatives in bringing them together<br>• UNFPA participation and role in policy forums, networks, and other partnership mechanisms at global, regional and country levels. | |
| UNFPA has a high level of visibility, especially for RHCS, amongst government, NGOs and DPs. Some of these stakeholders recognise the potential of UNFPA but are disappointed in its lack of willingness to use that potential and bring partners together. UNFPA has not taken the lead on difficult issues. | Government,<br>DPs,<br>Civil society |
| GPRHCS has given UNFPA more visibility and has kick-started a higher level of involvement and partnership with the government in Ethiopia. GPRHCS has a catalytic role in increasing visibility in general. | UNFPA |
| Within the United Nations system, the role of UNFPA as the lead FP agency is clear, however other UN agencies including WHO also provide support for FP. | UN |
| UNFPA has most visibility with partners where it has worked or provided support. | Government |
| At decentralised regional level, UNFPA does not have enough visibility to play a brokerage or coordination role although this would be very welcome. At sub-office level, the role, responsibilities and authority of UNFPA regional officer would have to be better defined and he would need some decision-making authority. UNFPA has visibility but does not use it well to broker partnerships. | Civil society |
| UNFPA does not want to be visible in physical terms, nor with the general public. The organisation only seeks visibility at institutional level. UNFPA staff see some contradiction between the visibility of UNFPA and national ownership. | UNFPA |
| In 2012, the K4Health[94] project carried out a mapping exercise to identify the key actors in FP at national, regional and *woreda* levels. Some of the objectives included in the study were to identify who are the key stakeholders involved in FP/RH programmes in Ethiopia, and how they facilitate or inhibit the flow of information and other resources on FP/RH. The study used key informant interviews, FGD and participatory net-map techniques:<br>- *"Participants identified USAID as the major funding body, followed by the Centres for Disease Control and Prevention (CDC), anonymous donors, and the United Nations Population Fund (UNFPA)".*<br>- *"[In three identified regions], USAID is the biggest regional financial source, comprising a third of the regional funding links. It is followed by anonymous donors, UNFPA, and the Swedish International Development Cooperation Association (SIDA)".*<br>UNFPA had most visibility at national level, and least at *woreda* level, where any support is channelled through other implementing partners. | (Hailegiorgis, Harlan et al. 2012: 25, 36) |

[94] K4Health is the flagship knowledge for health programme of USAID, implemented by Johns Hopkins, FHI360, Management Science for Health and IntraHealth International

## Area of Investigation 4: Enabling Environment

**To what extent has UNFPA supported the creation of an enabling environment at national and community levels to ensure family planning information and exercise of rights?**

**Data collection methods:**
Document review
Key Informant Interviews (KII)
Focus Group Discussions (FGD)
Site visits

| **Assumption 4.1:**<br>**UNFPA has identified key enabling factors in different country contexts and developed effective interventions to strengthen these.** | **Information sources:** |
|---|---|
| **Indicators**:<br>• Identification of enabling factors in CO annual reports<br>• Interventions in CO plans at the national and community levels designed to strengthen the enabling environment<br>• Evidence of enablers being strengthened at national and community levels (e.g. political commitment, community support)<br>• Evidence of how enablers have facilitated strengthened FP information and services. | |
| UNFPA has clearly identified the government commitment to promoting family planning as a key enabling factor. Since the government took the lead, UNFPA has not developed additional interventions to promote an enabling environment. It has identified the potential impact of FP targets and social pressures on free choice, but has not developed interventions such as monitoring or development of an evidence base for advocacy with government on this issue. | UNFPA,<br>DP,<br>Civil society |
| The Charities and Societies Proclamation No.621/2009 on January 6, 2009, implemented since early 2010, regulates domestic and international CSOs and NGOs. Among the provisions of this law is a regulation to limit spending on administration to 30 percent of the total budget, and restrictions on advocacy activities related to human rights by both international and national NGOs receiving more than 10 percent of their funding from foreign sources. The law has met strong opposition from the NGOs who find it restrictive and intrusive.<br><br>*"The law has affected almost every CSO/NGO irrespective of its classification as per the new proclamation. The centrality and root cause of the problem is not basically the enactment of the legislation by itself but actually it is the classification of charities and societies and the prohibited area of engagement such as the advancement of human rights, promoting the rights of children and the disabled, gender equality, nations and nationalities, good governance and conflict resolution, as well as the* | UNFPA,<br>Civil Society<br><br>(Chelkeba 2011: 32) |

| | |
|---|---|
| *efficiency of the justice system. Therefore, the centrality of the cause of impact of the law on CSOs/NGOs is two dimensional. On the one hand, the significance of foreign funding restriction has made it hard for the Ethiopian CSOs/NGOs to operate under the new proclamation. On the other hand, the legal restriction placed on international CSOs/NGOs to engage in advocacy activities have made operation space limited".* | |
| The National RH Strategy (2005-2015) has a strong focus on FP. Its FP goal is: to reduce unwanted pregnancies and enable individuals to achieve their desired family size. Key strategies are:<br>• Create acceptance and demand for FP, with special emphasis on populations rendered vulnerable by geographic dispersion, gender, and wealth;<br>• Increase access and utilization of quality FP services, particularly for married and unmarried young people and those who have reached desired family size;<br>• Delegate to the lowest service delivery level possible, the provision of all FP methods, especially long-term and permanent methods, without compromising safety or quality of care.<br><br>Attached to the strategies are targets for CPR, awareness levels, satisfied demand, supply of services and contraceptive commodities, inclusion of FP in job description of middle-level health workers, and a review of the policy and legal framework for FP. | (Ministry of Health 2006: 13-14, Ministry of Health 2008) |
| *"USAID…in its 'USAID/Ethiopia Country Development Cooperation Strategy 2011–2015,' although citing 'continual progress' in health because of government commitment, also sounds a note of caution. The ambitious [health] targets are threatened by (…) tight control over civil society participation".* | (Olson and Piller 2013: 451) |
| UNFPA has not identified factors required for an enabling environment for the private sector. | Civil Society |
| UNFPA has not used its comparative advantage to alert government to problems in policy implementation which reduce the enabling environment in practice – e.g. promotion of a narrow method mix by service providers, although choice of a wider range of methods is proposed at policy level. | Civil Society |
| UNFPA has provided TA to the Population and Development Directorate of the National Planning Commission for further development of the population policy.<br><br>The MoH is of the opinion that the population policy (1993) should be broadened to include ICPD concepts.<br>There are opportunities to strengthen/provide an enabling environment which have not been fully taken up by UNFPA, e.g. further work with Population and Development Directorate of the National Planning Commission. | Government<br>MoH (2006) |
| RHB, NGOs and PHC managers are aware of factors which affect the enabling environment and work to strengthen them. They focus on commitment of community and institutional leaders to FP as key factors at community level. UNFPA has had little participation at this level. | Government,<br>Civil Society |

| | |
|---|---|
| Users see transport as a major enabling factor in increasing accessibility. | Users |
| A better enabling environment is needed for adolescent, especially unmarried, girls. This will require change in community attitudes, rather than government policy. | Users |
| More work is needed on identification of elements in the enabling environment for FP and factors which obstruct access to FP, especially at decentralised regional levels, as there are important differences between the different regions in Ethiopia. Household level is also important for creation of an enabling environment. Husbands, and even more importantly mothers-in-law, participate in FP decision-making, and opposition from them may have led to stagnation of CPR growth. UNFPA regional sub-office staff do not have the skills, expertise or remit to develop this work. | Government |
| Needs assessments are being carried out by other organisations within and outside government, and many of them are of interest to UNFPA as they fall in its area of core competence – e.g. the Population and Development Directorate of the National Planning Commission has carried out a study of the FP needs of migrants; the MoH National Adolescent and Youth Reproductive Health Strategy 2006-2015 is based on analysis of youth needs; and NGOs have carried out studies of the needs of sexual minorities and high-risk groups, "Boundaries of Sexual Safety": Men who have sex with men (MSM) and HIV/AIDS in Addis Ababa). | Government,<br>Civil society,<br>(Ministry of Health 2007, Tadele 2010) |

| **Assumption 4.2:**<br>**UNFPA has successfully supported partners at country and community levels to improve demand creation and access to services, thus enabling people to exercise their rights better.** | **Information sources:** |
|---|---|
| **Indicators**:<br>• Improved service use and FP uptake (especially where unmet need is high and by VMG)<br>• Change in unmet need of different groups<br>• Access barriers reduced, equity improved<br>• Increased responsiveness to the needs of VMG. | |
| The government plays the major role in demand creation through its community networks. It is not clear whether free choice is being protected in family planning and other SRH. For example, in the last two years the government has banned traditional midwives from attending births and has encouraged institutional delivery. Following the successful "outdoor defaecation-free *woredas"* (ODFW) campaign, which supported community construction of latrines, the HDA is now promoting the concept of the "home delivery-free *woredas*", a campaign that may not respect the right of women to choose home delivery. | UNFPA |
| UNFPA has supported strengthening HEWs, yet its contributions are financially small in comparison with other donors (DFID; USAID). Donors in general do not work with the HDA, which is supported by the government.<br>USAID contributions: | UNFPA,<br>DP |

| Sector | 2011 | 2012 | 2013 | |
|---|---|---|---|---|
| FP and RH | 27,943,000 | 30,000,000 | $30,450,462 | |
| DFID FP contributions:<br>*"DKT - £ 5.8 million (£3 million in 2013)*<br>*MDGPF – We have no idea on the actual expenditure that went for FP- because what we do is unearmarked pool fund - £ 68 million 2012 and £87 million in 2013 (Please see respective Annual Performance reports by FMOH to get an estimate of FP/Maternal health."* | | | | Financial data from CO, and from DFID Ethiopia via CO by email |
| In the past, UNFPA has supported demand creation using a rights-based approach. Now most demand creation is done by government. At decentralised regional level, projects supported by UNFPA have helped government and NGOs increase access and fill gaps – e.g. through outreach services to rural areas and provision of a range of FP commodities. Although the public sector is now the major force in demand creation, NGOs also provide training and outreach work. There is still need for non-government work in demand creation for VMGs. | | | | Civil Society, Government |
| While UNFPA provides support and TA to the Population and Development Directorate of the National Planning Commission, it has not supported its nationwide and regional IEC campaigns to promote FP. | | | | Government |
| Women now have access to a much wider range of FP methods and this has helped stimulate demand. Formerly, only pills and condoms were available at community level. Now, women have access to injectables and implants, with IUCDs and surgical sterilisation available in health centres. | | | | Users |
| The Government HEW programme was among the main factors contributing to higher contraceptive use, but there is a need to reinforce the information and counselling work carried out by HEWs. | | | | (UNFPA Ethiopia 2012c) |
| *"[UNFPA] Supported HEWs and mass local media for awareness raising and community mobilization, promotion of rational use of contraceptives through newsletters and mass medias".* | | | | (UNFPA Ethiopia 2013a: 12) |

| **Assumption 4.3:**<br>**HQ and ROs have supported COs in identifying needs, creating an enabling environment and promoting demand and access in different contexts.** | **Information sources:** |
|---|---|
| **Indicators:**<br>Frequency and nature of TA visits and communications with focus on factors related to creation of enabling environment and promoting demand and access. | |
| There has been little support from ESARO or HQ. | UNFPA |

## Area of Investigation 5: Vulnerable and Marginalised Groups

**To what extent has UNFPA focused on the family planning needs of the most vulnerable and marginalised groups, including identification of needs, allocation of resources, and promotion of rights, equity and access?**

**Data collection methods:**
Document review
Key Informant Interviews (KII)
Focus Group Discussions (FGD)
Site visits

| **Assumption 5.1:**<br>**UNFPA globally and at country-level performs situation analyses to identify needs, challenges and rights violations forms, and identifies good practices on how to address these.** | **Information sources:** |
|---|---|
| **Indicators:**<br>• Evidence of gender-sensitive needs assessment of target groups for UNFPA supported interventions including identification of rights violations<br>• Availability of accurate and sufficiently disaggregated data for targeting most vulnerable and marginalized groups<br>• HQ/RO TA visits to support assessment, design, implementation, monitoring (including results-oriented monitoring) and evaluation of interventions to address the needs of VMGs<br>• Evidence that good practices have been identified and disseminated. | |
| UNFPA has identified some groups who have poor access to family planning and is developing projects to work with them, e.g. youth and pastoralists. These projects are being implemented outside the government system, which does not reach all the neediest due to funds allocation on the basis of the "equity formula", a budget allocation procedure which does not take into account the needs of specific groups, and disadvantages rural areas with low population density. | UNFPA,<br>Civil Society |
| UNFPA financed a survey by the Population Council, on young adults' SRH needs in seven regions. A chapter in the survey discusses FP knowledge and attitudes, use of methods, condoms, pregnancy and childbirth. The surveys showed adolescent males have higher levels of knowledge and awareness than females, and that unmarried youth are aware of a wider range of methods than married youth. Use of FP methods is also higher among unmarried youth, and is significantly higher in urban areas compared with rural areas. | Government<br>Civil Society<br>(Erulkar, Ferede et al. 2010b, Erulkar, Ferede et al. 2010a) |

| | |
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| UNFPA has recently carried out an equity analysis on FP and maternal health services (access, utilization, outcomes) *"to undertake secondary data analysis on the three years contraceptive and life-saving commodities survey data to uncover equity issues and based on the finding recommend specific high priority actions".*<br><br>The study found that there were important differences between regions, with problems in quality of care in both urban and rural areas, inadequate facilities and mal-distribution of the workforce. Lack of commodities, lack of use of local evidence and research for monitoring, lack of staff skills and incomplete implementation of national protocols and strategies at health facility level were also identified as obstacles to FP service provision. | (UNFPA Ethiopia 2013b: 11) |
| UNFPA is aware of the analyses on VMGs, carried out by other organisations (donors, NGOs, government). It has done little identification of best practices in Ethiopia. Good practice from other countries is shared informally but there is no systematic programme in place to do this. | UNFPA |
| Other development partners consider that UNFPA through its international coverage has access to much evidence from other countries but does not promote or share it with government and other stakeholders.<br>UNFPA has used the national and international meetings, which it has sponsored (see Area of Investigation 2 above) to showcase best practice and exchange ideas and experience with others. | DP |
| VMGs are defined differently by different agencies and for different types of intervention – e.g. VMGs for HIV and AIDS are different from those for FP. In the case of HIV and AIDS, the government has its own definition of VMGs which includes in- and out-of-school youth, CSWs, truck drivers and the uniformed services but excludes MSM and therefore does not fully coincide with the UNAIDS definition. | Government,<br>UN |
| It is difficult for UNFPA to focus specifically on VMGs as most of its support goes through government, many of whose programmes are aimed equitably at the whole population. At regional level, government representatives consider that *"no-one is marginalised, everyone is included, our targets are 100 percent coverage."* | DP,<br>Government |
| In 2012 UNFPA reported that:<br>*"A desk review which assessed national studies on youth sexual reproductive health was produced with the financial support of UNFPA. The study results are disseminated to key partners and youth organizations to inform strategies and programs. The study identified key research gaps".* | (UNFPA Ethiopia 2012a: 21) |

| **Assumption 5.2:**<br>**UNFPA allocates resources to effective and targeted programming for the most vulnerable and marginalised groups:** | **Information sources:** |
|---|---|
| **Indicators**: | |

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|---|---|
| • Number and type of programme interventions targeted to VMGs percent of total budget allocations to partner activities which focus on VMGs. | |
| UNFPA has allocated funding to address and improve access to family planning by certain VMGs. CSOs have better access to the marginalised groups than the public sector and their programmes. UNFPA normally focuses on work with the pubic sector but civil society offers good potential for addressing the needs of VMGs and hard-to-reach groups. | Civil Society,<br>UNFPA |
| Government of Ethiopia (GoE) considers adolescents and young people priority groups for RH services, and young people are explicitly mentioned in the National RH Strategy and are included in government RH plans. The government youth priority groups include rural adolescent girls, young unemployed boys, unmarried adolescents and marginalised adolescents (street adolescents, orphans).<br><br>UNFPA has promoted FP work with adolescents, considered to be very marginalised. CSWs receive some attention but MSM and the more politically controversial groups have not been prioritised by UNFPA.<br><br>UNFPA support for CSWs has included training, peer education, prevention and behaviour change materials.<br>UNFPA support for sexuality education and RH services for university students includes behaviour change communication, staff training, and establishment of condom kiosks. | (Ministry of Health 2006, Ministry of Health 2007, UNFPA Ethiopia 2010, MoFED 2011, UNFPA Ethiopia 2013a)<br><br>Civil Society,<br>DP,<br>UNFPA |
| Some important networks of VMGs do not know anything about UNFPA. | Civil Society |
| MoH is working on services for some VMGs and is confident UNFPA will support this service, if they receive a request. | Government |
| MoH services do not cover the needs of unmarried young people. | Civil Society,<br>Users,<br>DP |
| VMG programmes need to be implemented through CSOs/NGOs to be effective, and UNFPA does not have the resources for a significant contribution. | DP |
| GoE feels that current static health services are not compatible with the mobile lifestyle of the pastoralists.<br>UNFPA has financed a project for pastoralists in remote areas, encouraging the IPs to work with this VMG. | (MoFED 2011)<br>UNFPA,<br>Civil Society |
| In 2013, UNFPA financed services for young people through the public sector: *"A total of 42,691 young people and adolescents received direct access to information and services on SRH and a total of 5.5 million male condoms distributed through health to facilities, youth friendly centres and universities".* | (UNFPA Ethiopia 2013a: 25) |
| UNFPA and UNICEF have carried out a "joint programme on a rights-based approach to adolescents and youth development in Ethiopia" funded by the Royal Norwegian Embassy. The programme, focusing on young people with acute needs, including | (UNFPA and UNICEF 2007: 82) |

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| those in remote rural areas and pastoralist communities as well as urban communities, was carried out in four regions and Addis Ababa. The programme included capacity building for duty bearers and empowerment of rights holders (young people). In FP, the programme "*had contributed to increased knowledge, improved attitudes and behaviours relating to sexual and reproductive health, HIV and gender. For example, during a focus group discussion with female students at Adama University, it was observed that the programme had been successful in supporting safe sex behaviour through condom distribution, youth friendly services, such as family planning services (including emergency contraception), supporting girls with financial problems, and providing recreational facilities*". | |

| **Assumption 5.3:**<br>**UNFPA promotes reproductive rights and supports capacity development to remove barriers and improve access, quality and integration of FP services with other services for the most vulnerable and marginalised groups.** | **Information sources:** |
|---|---|
| **Indicators**:<br>• Rights of, and services for VMGs actively promoted in advocacy strategies with specific attention to gender issues<br>• Type of capacity building interventions to address service barriers and improve access for, and enable exercise of rights by the most disadvantaged groups. | |
| UNFPA has not taken a strong stand on these issues although it has access to government. | DP |
| UNFPA supports capacity building in youth-friendly services in the public sector (see assumption 5.2 above). | UNFPA,<br>Civil Society |
| There is little support from the government for a holistic HRBA specifically for VMGs, although there are efforts to improve the availability of commodities, the range of methods and the capacity of service providers in general. UNFPA has done some work on capacity development to encourage government agencies to take VMGs into account – e.g. its work with the Population and Development Directorate of the National Planning Commission to raise awareness of VMG needs. | UNFPA |
| Emergency contraception is not recommended by NGOs for adolescents. UNFPA has not worked on reducing misconceptions about EC which is a very suitable method for adolescents. | Civil Society |
| There is need to retrain HEWs in existing facilities to serve young people in a non-judgemental and friendly way. This is more important than creating special youth corners and clinic opening times to suit young people, which have been the focus of government programmes to date. | (Erulkar, Ferede et al. 2010b) |

| **Assumption 5.4:**<br>**UNFPA actively encourages VMGs to participate in programme planning, implementation and monitoring and VMGs receive capacity building to this end.** | **Information sources:** |
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|---|---|
| **Indicators**:<br>• Evidence for gender sensitive participation by VMG<br>• Evidence for UNFPA support for training in participation. | |
| There is no evidence that VMGs participate in the project cycle, but neither do any other users. At regional level, the RHBs consider that no-one is marginalised as the target is 100 percent coverage of women of reproductive age (WRA) (including adolescents, disabled, etc.). UNFPA has not raised this issue with RHBs. | Government,<br>UNFPA |
| Civil Society has encouraged VMG participation with very positive results. For example, CSWs have participated in design and implementation of NGO programmes to improve their access to FP and HIV prevention services, with positive results and a strong sense of ownership amongst participants, who consider the initiatives fully sustainable. | Civil Society |

| **Assumption 5.5:**<br>**Access to and utilization of services by VMGs, according to their sexual and reproductive intentions, has improved.** | **Information sources:** |
|---|---|
| **Indicators**:<br>• Documented evidence on improved VMG access and utilization of services (link with area 1 – integration)<br>• VMG user (women and men) satisfaction with service access and quality. | |
| Access has increased for the population in general with rapid growth in CPR and in institutional delivery in the last 6-7 years. | Government |
| GoE considers that the needs of VMGs will be met through growing prosperity. There is a focus on VMGs who fall into categories which are subject of specific government programmes, such as workers and peasant farmers. There is no government focus on other minorities, and homosexuality being illegal, government policy excludes special attention for MSM and other sexual minorities. | DP,<br>UN |
| Service quality is an issue for CSWs who often feel stigmatised and discriminated against in public heath centres. If MoH services are poor quality, they go to the NGOs. UNFPA has supported special clinics for CSWs in regional universities. | Civil Society |
| Unmarried young people are still marginalised by traditional community attitudes which disapprove of sexual relations prior to marriage, but MoH and NGOs are working with community leaders to reduce these obstacles. | Government<br>Civil Society |
| There is little discussion of male involvement in FP in the MoH, but there is interest in the Population and Development Directorate of the National Planning Commission. | Government |

## Area of Investigation 6: Rights-Based Approach

**To what extent has UNFPA implemented a human rights-based approach to family planning, in particular regarding access to and quality of care, and through support from HQ and RO for a rights-based approach in country?**

**Data collection methods:**
Document review
Key Informant Interviews (KII)
Focus Group Discussions (FGD)
Site visits

| **Assumption 6.1:**<br>**UNFPA staff and key partners have a shared understanding of the meaning and importance of a rights-based approach to FP.** | **Information sources:** |
|---|---|
| **Indicators**:<br>• Identification of definitions/descriptions of rights-based approaches<br>• Perception of UNFPA and partners' staff of the meaning and importance of the rights-based approach. | |
| Not all UNFPA CO staff have a clear and holistic understanding of a rights-based approach to FP, many considering that the UNFPA focus on supply-side rights (such as access to services and to a range of FP methods) represents an HRBA. | UNFPA |
| WHO sets priorities at global level and pushes them down to country level. This sort of coherence is not observable in the UNFPA HRBA (this also applies to VMGs and other evaluation areas). Application of global policies and strategies is patchy at country level. | DP |
| Understanding of a rights-based approach (RBA) is limited in RHB and in UNFPA sub-offices at regional level, though NGOs have a clearer understanding. Service delivery staff have some understanding but are not aware of the potential pressure arising through target-setting. | |
| The government does not share the same concept of HRBA with UNFPA and other donors in general, not only in SRH. The government does not consider SRH or FP to be especially sensitive areas within the spectrum of human rights. | UNFPA |
| Other development partners have a clear understanding of a HRBA but there is little discussion of rights between donors and the government. DPs think UNFPA is well-placed to take the lead on discussions of HRBA with government, as UNFPA has defined its HRBA at institutional level and is close to government. | DPs,<br>Civil Society |

| | |
|---|---|
| Small NGOs working with VMGs have a pragmatic approach, and rather than getting involved in advocacy for rights, they have worked directly at grass roots level and made advances in changing community attitudes and increasing awareness and participation in FP. | Civil Society |
| At facility level, staff are clear that women have the right to access FP services and to choose from a wide range of methods, but are less clear on women's rights not to use contraceptives. At facility level, health staff have FP targets and there may be some contradictions between this and an HRBA. Facility staff say all methods are offered to women, although not all are available at all levels. IUCDs and permanent methods are only available in health centres and hospitals. | Government |
| Government appreciation of FP rights is based on the right of women not to die in childbirth, the right to access FP and meeting unmet need.<br><br>The government considers that the right to access is undermined by the excess of demand over supply of FP services.<br>The rationale for FP in the MoH FP policy guidelines is based on health benefits and socio-economic benefits (including response to reduced productivity, infant mortality and uncontrolled population growth) and women's rights (Ministry of Health 2006: 19-21).<br>UNFPA has not highlighted sensitive issues of over-promotion (of more FP, more long-acting methods, higher CPR). UNFPA supports government policy to promote more longer-term FP methods. | Government<br>Civil Society<br>(Ministry of Health 2006: 19-21, Ministry of Health 2010a) |

| **Assumption 6.2:**<br>**UNFPA programming incorporates human rights principles in the assessment, design, implementation and evaluation of FP program interventions.** | **Information sources:** |
|---|---|
| **Indicators**:<br>• Evidence of a rights-focused needs assessment, quality assurance mechanisms, participatory processes, and accountability mechanisms within programmes<br>• Evidence of attention to barriers and protocols for addressing coercion<br>• User satisfaction with FP access and quality (men, women, VMGs). | |
| The percentage of public sector FP users not offered information on side effects is 23-28, and only 37 percent are informed about any alternative methods. NGO sector figures, however, are better at 70 percent of users with informed choice. Nationally, 8 percent of public sector users "*indicated health service providers force him/her to accept or insisted he/she should accept an FP method*", and this figures rises to 16 percent in Gambella and Tigray regions (UNFPA 2013: 113). No users report this type of pressure from NGO service providers. | (CSA and ICF International 2012: 100, UNFPA 2013: 113) |

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|---|---|
| Vigilance is needed to alert FP providers, programme managers and policy makers to the risks of using targets, and their propensity to foster undue pressure for accepting the use of FP, particularly in a context where advocacy and rights-based work by civil society is restricted (Olson and Piller 2013). UNFPA, like other development partners, has taken a low-key profile on these issues and does not emphasise a rights-based approach in its work with the government. | (Olson and Piller 2013) |
| UNFPA does incorporate rights principles as far as possible, but dealing with the rights agenda is difficult within the constraints of the Ethiopian context. UNFPA has not taken a strong stand on SRH rights as discussions with the government on human rights issues in Ethiopia are carried out jointly by the UN system, and other UN agencies have been nominated to take the lead. UNFPA does not wish to prejudice its relationship with the MoH. | UNFPA,<br>DP |
| The joint UNFPA-UNICEF programme "A Rights-based approach to Adolescent and Youth Development in Ethiopia" was aimed at empowering young people to demand their rights from duty bearers. At the end of the project, young people felt better informed and more able to exercise their SRH rights. | (UNFPA and UNICEF 2007) |

| **Assumption 6.3:**<br>**UNFPA is developing a body of evidence and lessons learned regarding human rights-based approaches for FP.** | **Information sources.** |
|---|---|
| **Indicators**:<br>• Identification of evaluation and research and/or briefs on lessons learned related to human rights-based programming. | |
| Evidence and lessons learnt are collected informally by CO but there is no systematic programme or documentation of evidence and lessons learnt. There is contact and experience sharing with UNFPA offices in other countries with similar contexts through regional and international meetings, including the annual GPRHCS meetings. | UNFPA |
| Other DPs think UNFPA has access to evidence and should and could share it and use it better to influence government and policies. | DPs |
| NGOs also think UNFPA is the organisation best placed to use an evidence base to work with government and generate discussion on the relation between access to rights-based FP, population growth and economic development. UNFPA has international coverage, is part of the United Nations, and works closely with government. | Civil Society |
| Design and implementation of an HRBA must adjust to the many regional differences in Ethiopia. There are cultural and social traditions which differ between regions and which affect women and young people's access to FP, and which also affect access for unmarried people. | Civil Society |
| Evidence on potential infringement of human rights in FP (see above) is available in official document and survey reports, but UNFPA has not used these as an evidence base for discussion with government. | |

| **Assumption 6.4:**<br>**Country offices receive and put into practice technical guidance from HQs and ROs to support rights-based FP.** | **Information sources:** |
|---|---|
| **Indicators**:<br>• Number, frequency and type of TA provided<br>• RO plans address capacity gaps and support needs of COs, and ROs provide timely support<br>• CO strategies and programmes reflect current technical guidance and best practices for rights-based FP. | (CSA and ICF International 2012, UNFPA 2013) |
| The UNFPA manual on HRBA (Human Rights-based Approach to Programming: Practical Implementation Manual and Training Materials, 2010) is available to the CO, but no specific guidance has been provided for Ethiopia UNFPA. | UNFPA<br>(UNFPA 2010b) |

| **Assumption 6.5:**<br>**Rights holders consider that duty bearers understand their rights to family planning and SRH.** | **Information sources:** |
|---|---|
| **Indicators**:<br>• User satisfaction with FP availability and quality (men, women, VMGs) | |
| Users appreciate increased level of choice of methods, but not all methods are available in accessible facilities. | Users |
| There is service provider bias and pressure from providers trying to reach targets. This favours adoption of family planning rather than free choice. | DPs |
| Government policy does not emphasise right to choice, and there are restrictions on promotion of rights by NGOs. | Civil Society,<br>(Chelkeba 2011) |
| If duty bearers in the public sector do not respect their rights, many users do not complain or make an issue of it. If services are of poor quality they go to the NGO sector. | Civil Society,<br>Users |

## Area of Investigation 7: Modes of Engagement

**To what extent has UNFPA adapted its mode of engagement[95] to evolving country needs in different settings, using evidence and best practice?**

**Data collection methods:**
Document review
Key Informant Interviews (KII)
Focus Group Discussions (FGD)
Site visits

| **Assumption 7.1:**<br>**UNFPA COs monitor changes in country context and needs over time and adapt their mode of engagement and programme development accordingly.** | **Information sources:** |
|---|---|
| **Indicators**:<br>• Number of visits and TA input from ROs and HQ to collection and analysis of evidence on changing needs in FP engagement<br>• Other activities (staff workshops, training, etc.) conducted by HQ and ROs to support program innovation and/or incorporation of best practices into programs. | |
| The UNFPA mode of engagement in FP in Ethiopia has concentrated on the supply side, in line with changes in the context and in country needs. GPRHCS has been the principal FP programme during the period under evaluation. GPRHCS has included commodity purchase and technical support, equipment and systems development for supply chain management strengthening. It has also financed some service provider training and demand promotion work. Support for procurement and supply chain management has included secondment of staff to PFSA and FMHACA, and annual surveys of availability of commodities in health facilities, recently expanded to include questions on user satisfaction with FP services; a contribution to knowledge management for all stakeholders. Spending in GPRHCS Phase I was moving upstream. This may be reversed with current directives from HQ to allocate larger budget percentages to commodities in GPRHCS Phase II (beyond the period under evaluation). In general, UNFPA is focused on the mode of "support to service delivery" in Ethiopia, but it also carries out capacity building and some knowledge management. Advocacy activities are limited.<br><br>Changes in the context are monitored informally, rather than through a systematic programme. There is no specific analysis on how this should affect modes of engagement. | UNFPA<br>(UNFPA Ethiopia 2010) |

[95]"Modes of engagement" refers to the four modes of engagement in the current UNFPA strategic plan (support for service delivery, capacity building, advocacy, knowledge management). These modes of engagement have been included in the ToC diagram and discussion in section 3.2.1

| | |
|---|---|
| DPs consider that UNFPA does not always use the most appropriate mode of engagement, taking into account their comparative advantages and closeness to government, their technical skills, their access to evidence from other countries in which UNFPA is present, and their relatively limited material resources. They would be best placed in working with government at policy level, taking the lead in policy dialogue for the other donors, rather than working at implementation level where they have limited resources and impact. | DP |
| An emphasis on support for service delivery and procurement at the start of the GPRHCS is now moving towards capacity building in quality control and regulation in the supply chain. Demand-side work is carried out through broader projects related to the determinants of demand, with limited input to FMoH demand creation programmes through the HEWs and the HDA network. | UNFPA and Government |
| UNFPA is responsive to changing needs as expressed by the government. It is "filling the gaps" left by other donors who have more funds. | Government,<br>Civil Society |
| In the past, UNFPA has changed its mode of engagement in the light of changes in the country context, but this is less apparent now. NGOs have changed and adapted to government policy changes. There is an important opportunity for UNFPA to move into knowledge management in Ethiopia, developing and using an evidence base to take up key issues with the government. | Civil Society |
| At regional level, UNFPA has adapted to the changing context (defined as changes in the level of CPR) by moving its support to more remote areas where CPR is still low. The type of support has not changed. | UNFPA |
| UNFPA has moved into knowledge management activities with implementation of annual surveys on commodity availability. As in other countries where GPRHCS has financed these annual surveys, they constitute an important monitoring resource for MoH and other stakeholders. The cost of the surveys is high and was questioned by the GPRHCS mid-term review.<br><br>From 2010 to 2012, the surveys focused on the availability of commodities at health facilities. In 2013 the surveys were re-designed to also include aspects of service delivery facilities, which affect the quality of SRH services, including client perceptions.<br><br>This additional information is an important resource for all stakeholders to identify gaps and needs for support to improve the quality of FP services. | (UNFPA Ethiopia 2012d, UNFPA Ethiopia 2013b) |
| Different modes of engagement are required in different regions, some still needing support for service delivery whilst others need support in knowledge management. | Government |
| There is little possibility of moving into knowledge management at regional level unless there is a change in definition of the UNFPA regional programme officer's role. | Government,<br>UNFPA |

| | |
|---|---|
| GPRHCS has dominated UNFPA thinking on modes of engagement. Other modes could be fruitful for family planning, in particular advocacy and knowledge management. | DPs |

| **Assumption:**<br>**7.2 UNFPA interventions and engagement modes support country moves towards increased sustainability of FP and SRH interventions.** | **Information sources:** |
|---|---|
| **Indicators**:<br>• Evidence of continued monitoring of country context and needs<br>• Evidence collected and analysed on the appropriateness of the mix<br>• Change of engagement modes used over time<br>• Existence and frequency of coordination on engagement modes with national stakeholders and development partners. | |
| On the supply side, UNFPA has had an important contribution to RHCS and its sustainability through capacity building and supply chain strengthening, although most FP methods are still purchased with donor funding. UNFPA has encouraged change of method mix and reduction of focus on expensive implants, which will increase sustainability. | UNFPA,<br>DP,<br>Civil Society |
| GPRHCS is moving from support to strengthening the supply chain through PFSA, towards quality improvements through support to FMHACA. | Government |
| *"In Ethiopia, the GPRHCS has helped to set up several regional RHCS coordinating mechanisms. These are in the states where the UNFPA Country Programme has a regional coordinator [and] are headed by the Regional Health Bureaus (RHBs)".* | (Chattoe-Brown, Weil et al. 2012: 24) |
| In the long run, GPRHCS aims for sustainability through support to RHCS by the national government, thus working itself out of a job. | UNFPA |
| There are opportunities for UNFPA to increase sustainability of family planning through capacity building of human resources, more support to the shift towards long-acting methods and TA. Strengthened UNFPA presence in the regions would be necessary for this. | Government,<br>UNFPA |
| Political sustainability is not an issue, as the government gives FP total backing, allocates funds for contraceptive purchase (although still dependent on donor contributions) and is now carrying out its own procurement of FP methods through PFSA. | UNFPA |

| **Assumption 7.3:**<br>**UNFPA identifies and applies good practice at country, regional and global levels.** | **Information sources:** |
|---|---|
| **Indicators**:<br>• Evidence of change in engagement modes supporting moves towards sustainability | |

| | |
|---|---|
| • Percent of overall FP financial needs covered by national budget<br>• Allocation of funds to FP in medium and long-term health sector plans. | |
| There is little systematic development of evidence bases by UNFPA in any SRH field, and little evidence from outside Ethiopia is used although partners consider UNFPA has information available from elsewhere which would be useful for work with government.<br><br>As Ethiopia is considered an FP success story, there is demand internationally for information on the Ethiopian experience, and the means used to raise the CPR. UNFPA has showcased the Ethiopian experience in international meetings (including the Third International Conference on Family Planning (ICFP 2013) in Addis Ababa) and through the UNFPA websites - see for example the brochure on scaling-up access to implants in Ethiopia (UNFPA Ethiopia 2013e) and presentation of UNFPA work with adolescents and youth at the National Family Planning Symposium of 2012 (UNFPA Ethiopia 2012b). Apart from these specific activities UNFPA has not developed an evidence base for dissemination outside the country. | UNFPA,<br>Civil Society,<br>DP<br>UNFPA CO website<br>(UNFPA Ethiopia 2012b,<br>UNFPA Ethiopia 2013e) |
| At the regional level in Ethiopia, UNFPA has not brought in experience from elsewhere and is not developing an evidence base; neither does it promote interchange between regions. There is only sporadic interchange with the CO, let alone with other regional sub-offices. The activities of the sole regional programme officer are limited to coordination with RHB, acting as a communications channel between IPs and CO, and some monitoring. | UNFPA,<br>Government,<br>Civil Society,<br>Users |

## Area of Investigation 8: Supply-side Activities

**To what extent has UNFPA support for supply-side activities promoted rights-based and sustainable approaches and contributed to improved access to quality voluntary family planning?**

**Data collection methods:**
Document review
Key Informant Interviews (KII)
Focus Group Discussions (FGD)
Site visits

| **Assumption 8.1:**<br>**Provider training supported by UNFPA is client-centred, quality-focused and promoting rights and freedom of choice in FP.** | **Information sources:** |
|---|---|
| **Indicators**: | |

| | |
|---|---|
| • Nature of training programmes offered by MoH and other partners<br>• Behaviour change communication and client counselling included in training, including gender perspectives. | |
| UNFPA has supported provider training in insertion of implants but not in removal (*"we teach clients how to fly but not how to land")* and in task shifting – this is an innovation in Ethiopia and should make a wider range of methods available at health posts. Although training is aimed at improving access and quality, in practice, women have to travel to health centres for implant removal. Government sets the parameters for the content of provider training.<br>Task-shifting of FP to midwives and HEWs has been documented in the report "State of Ethiopia's Midwifery 2012". UNFPA supported the survey reported in the document. UNFPA has supported capacity building for midwife training in Tigray University, which includes FP in the training curriculum. | UNFPA,<br>Government<br>DP<br>(EMA and UNFPA 2012) |
| One study concluded that *"Provision of Implanon through community health workers at the community-level is effective in reaching those women who have greatest need for contraception".* | (Asnake, Henry et al. 2012: 1) |
| UNFPA supports training but there is little follow up to see if it is put into practice and if refresher training is needed. | Civil Society |
| Service providers still need more information on a wider method mix and more skills to inform clients and promote a wider variety of short- and long-acting methods (see Section 6 above).<br>The UNFPA-funded Health Facility Survey of 2013 included additional questions on user perceptions of service provision and staff training. Whilst users expressed satisfaction with services, up to one quarter of FP users were not provided with information on the side effects of each method and the alternatives available. Only 40 percent of service delivery facilities had the national FP guidelines available on the day of the survey. | Government,<br>Users,<br>(UNFPA Ethiopia 2013d) |
| UNFPA tries to address quality issues -- e.g. around *Implanon* removal; it has funded a best-practice document that highlighted this issue. | (UNFPA Ethiopia 2013e) |
| For Government, quality is a lower priority than access/coverage/infrastructure. However, quality is an issue as HEWs have many clients and little time. There is a "counselling gap", although HEWs have been trained in counselling and cascade-train the HDA in their respective local areas. | UNFPA<br>Government |
| Quality of FP services has improved in NGO services. In public services, on the other hand, the government focuses on coverage of unmet need, which absorbs most of the available resources; this has led to quality problems. Health staff may not have the skills to administer the methods allocated to their professional level or to provide quality of care through adequate counselling, information and provision of free choice to users. | Civil Society<br>DP |
| UNFPA has worked with MoH on expansion of availability of implants (*Implanon*), and has supported training for over 30,000 HEWs in insertion, as part of the strategy of task-shifting within the public sector. HEWs can now insert implants but not remove them. As a result, clients still have to travel to a higher level health facility for removal. | UNFPA, Government,<br>(UNFPA Ethiopia 2010,<br>UNFPA Ethiopia 2013e: 21) |

| | |
|---|---|
| UNFPA has highlighted this issue: *"Access to removal is a challenge to the Implanon scale-up initiative as it should be done by a middle level health professional at UNFPA Ethiopia (2010b) health facility level. […] As corresponding Health Centers will be providing Implanon removal, so proper referral functional system should be in place. Health Centers should also be capable of providing removal services including trained personnel and required supplies".* | |
| At regional level, UNFPA has supported development of curricula for midwife trainers, including FP in their course. Training of trainers is an important step towards sustainability of training inputs. | UNFPA,<br>Civil society |
| *"Young married women in Ethiopia need the approval of their husbands, mothers-in-law and immediate family members in order to travel to towns where health centres are located and they are normally escorted when traveling. Providing services in their communities through providers the women and their families already know, may reduce barriers to access for these women".* Women thus may face barriers to access removal services that are located in more distant health centres. | (Asnake, Henry et al. 2012: 9) |
| Contraceptive use has improved significantly over last decade due to conducive FP programme, yet unmet need is still high (25 percent). | (UNFPA Ethiopia 2012c) |

| **Assumption 8.2:**<br>**UNFPA support to procurement promotes availability of a wider method mix** | **Information sources:** |
|---|---|
| **Indicators**:<br>• Range of methods procured by UNFPA, development partners and national governments<br>• Range of methods available at service delivery points for all user groups. | |
| UNFPA has supported availability of a wider method mix (EC, female condoms, implants, IUCD) and also reduced stockouts of methods, and has also contributed to the FMoH scale-up programmes for *Implanon* and IUCD during the period under evaluation. UNFPA has further promoted condom use amongst university students through construction of condom kiosks for distribution in five Universities.<br><br>GPRHCS Phase I started in June 2007 in Ethiopia. Commodity procurement support focused on purchase of implants: *"The Ethiopia GPRHCS ihas been a major supplier of implants to the country, spending 94% of its USD13.8m budget on this method over the two years"* (Chattoe-Brown, Weil et al. 2012: 39).<br><br>UNFPA is providing support to widen the available method mix including IUCDs, and has worked with DKT to increase access to and use of the female condom. | UNFPA,<br>Government,<br>Civil Society,<br><br>(UNFPA 2010a, UNFPA Ethiopia 2010, Chattoe-Brown, Weil et al. 2012)<br><br>CO website<br>(UNFPA Ethiopia 2013b, DKT Ethiopia 2015) |

| | |
|---|---|
| The annual facility surveys financed by GPRHCS indicate that stockouts have been reduced in the service delivery facilities in the years 2010-2013 in general, but there are still important levels of stockouts in specific methods and locations. | |
| *"[…] positive changes have been observed in offering modern contraceptive methods across all levels of SDPs as compared with the results of 2010 and 2011 surveys; particularly in male condoms, oral pills, injectables, IUDs, and implants. However, female condom and voluntary sterilizations for both women and men seemed to be inconsistent and did not exhibit marked changes over the past three years".* | (Ministry of Health 2012: xiii) |
| Government policy has changed from a focus on implants to promotion of permanent methods. There is a need for monitoring to ensure a full method mix is maintained. Civil society is not aware of UNFPA efforts to monitor method mix, although monitoring is carried out through the GPRHCS annual surveys and results are shown in annual reports. | Civil Society, (UNFPA Ethiopia 2012d, UNFPA Ethiopia 2013d) |
| The government has carried out a major initiative to scale up promotion and availability of IUCDs ("IUCD Scale-up Project 2010-2015"), which included extensive service provider training, ensuring supply, community awareness raising, demand generation by HEWs and HDAs and documentation of best practices. UNFPA has participated in these initiatives. The objectives are all similar: an overall national objective of 66 percent CPR by 2015, 20 percent of whom are users of long-acting family planning methods (LAFPM); with 50 percent of LAFPM being users of IUCD. | (Ministry of Health 2015) |
| UNFPA technical support has been important in PFSA for forecasting, and in increasing involvement of NGOs and private sector in forecasting and planning. As forecasting and procurement are a mixture of pull and push systems, and since some decisions on what is to be purchased are taken at RHB level, it is important to work with regional governments to promote a wide method mix. This cannot be done by UNFPA through its general support to the procurement system. Indeed, once UNFPA cash for commodities is in the system, UNFPA cannot influence how it is spent. Therefore, additional work is needed to promote method mix at regional level. At present RHB base their commodities plan on needs, estimated from the previous year's demand, population size and targets. There is a lot of disparity between regions on method mix. Some RHB have their own additional family planning budget. | Government |
| Method mix and availability are good but there is insufficient supply of related equipment and accessories. | Civil Society |
| Method mix has been skewed towards short-acting FP methods; poor method-mix leads to less cost-effective FP programme, which could be achieved through a switch to long-acting and permanent methods | (UNFPA Ethiopia 2012c) |

| **Assumption 8.3:**<br>**Strengthened procurement and logistics systems and related health system improvements are designed to be financially sustained by national governments.** | **Information sources:** |
|---|---|
| **Indicators**:<br>• Trend in FP methods (as percentage of MoH budget) | |

| | |
|---|---|
| • Trends in contributions by other development partners<br>• Value-for-money in method mix, which meets user needs (men and women, adolescents, VMGs). | |
| There is a national budget for FP commodities: development partners are the largest contributors, with the government making a small contribution. The government share is not increasing fast. Government has many development priorities, and for now it wants the DPs to continue funding commodities. | UNFPA,<br>DP |
| The procurement system is growing very rapidly and attracting a lot of external funding for capital investments. Its service charges are expected to cover its operating costs and provide a margin for autonomous growth in the organisation in future. UNFPA has provided TA and training for procurement of commodities, which contributes to sustainability of PFSA and the national procurement system. | Government |
| Despite advances, there are still problems with procurement, distribution and logistics. *"[…] interruptions of supplies and unavailability even to procure from the market were major holdups to ensure family planning commodities in the country".*<br><br>However there are important improvements in reduced stockouts shown in the annual RHCS surveys *"(…) findings of the 2012 survey revealed an improved incidence of no stockout by method mix in greater proportion of SDPs than the result of 2010 and 2011".* | (Ministry of Health 2012: xiii, xv) |
| At the beginning of the period under evaluation, GPRHCS procurement funds were used largely for expensive implants, but spending now covers a wider range of methods. UNFPA has worked with other donors to promote a more financially sustainable method mix while ensuring choice. | (Chattoe-Brown, Weil et al. 2012) |
| Method mix is getting economically more rational with less exclusive focus on expensive implants. It is still heavily focused on injectables, which are relatively expensive, and more work is needed to find a mix which meets needs and demands and is financially sustainable. | DP |
| UNFPA support was instrumental for establishing the integral pharmaceutical logistics system (IPLS), which integrates the supply management system, combining funds of various donors on various health programmes.<br><br>This is has been reflected in the UNFPA memorandums of understanding with MoH since 2009. Most of the GPRHCS financial support to PFSA is for commodity provision. There has also been a lower level of funding for systems strengthening (used as a catalyst for strengthening the logistics management information system (LMIS), warehousing and capacity building, including training in FP and commodity security in the university curricula of health professionals. | UNFPA, NGO,<br>(UNFPA Ethiopia 2013c) |
| *"UNFPA provided leadership for the coordination of all actors in this field of contraceptive logistics for forecasting contraceptive requirements through the family planning Technical Working Group".* | (UNFPA Ethiopia 2009: 14) |
| Key informants (in all groups) did not consider that sustainability is a major objective of support to the supply system. DPs expect to continue to fund commodities in the foreseeable future. | All relevant interviews |

| | |
|---|---|
| *"In Ethiopia the GPRHCS has helped to set up several regional RHCS coordinating mechanisms. These are in the states where the UNFPA Country Programme has a regional coordinator [and] are headed by the Regional Health Bureaus (RHBs)".* | (Chattoe-Brown, Weil et al. 2012: 24) |
| UNFPA mobilises funds from the GPRHCS and provides support to the Ministry of Health in the area of capacity development and commodity security. A total of around USD 5 million was made available since 2008 for training warehouse managers on Logistics Management Information Systems (LMIS), automation of supply chain, and comprehensive condom programming. Moreover, commodities, including contraceptives (worth close to USD 30 million) have been procured and distributed.<br><br>UNFPA is providing support to the Pharmaceutical Fund Supply Agency (PFSA) on Integrated Pharmaceutical Logistic Supply System to strengthen LMIS, train stock managers, and build the capacity of PFSA in forecasting and procurement of Family Planning commodities and RH medicines and drugs. | Ethiopia CO website |
| In practice, the amount spent on contraceptives is low in comparison with needs and with the amounts spent by other donors (US, UK). UNFPA has much to contribute to supply-side strengthening and should concentrate on this rather than the purchase of FP methods. In the medium term, when RHCS is achieved, UNFPA will be able to move out, and commodity supply will be managed by the national government. | DPs |
| DPs consider that UNFPA can make a real contribution on the supply side using its access to government and its comparative advantage as FP/SRH specialist. These advantages can be used to help ensure that FP remains integrated with SRH and users are offered a wide range of quality services to enable them to make their own choices. Donors expect that UNFPA will monitor FP service provision, presenting evidence to government on service quality and method mix, both from the host country and from elsewhere. This will be a move towards knowledge management on the supply side, and will lead to better integration of GPRHCS with other UNFPA SRH and family planning initiatives. | DPs |
| UNFPA has worked with the University of Addis Ababa School of Public Health to integrate RHCS elements in the existing RH and health informatics pre-service training curricula, an important contribution to sustainability of knowledge transfer. | (UNFPA 2010a) |
| An assessment of the financial, supply chain management and procurement of the MDG Fund carried out for DPs in 2011, found that progress had been made and PFSA was assuming procurement and supply chain management tasks. However, the study found that there were still challenges in procurement, transparency, supply chain management processes and at service delivery points. Some of the issues were attributed to the rapid growth and expansion of facilities, which had not allowed sufficient time for thorough staff training and full development of management and monitoring systems.<br><br>Weaknesses in supply chain management were also noted in the GPRHCS MTR Case study of Ethiopia and continuing support to strengthen PFSA was recommended. | (Assessment Team 2011)<br><br>HLSL (2011) |

| **Assumption 8.5:**<br>**HQ provides appropriate support to CO level in capacity building and procurements.** | **Information sources:** |
|---|---|
| **Indicators**:<br>• Effective monitoring of CO needs by HQ<br>• Number and type of TA and other support inputs. | |
| HQ Commodities Security Branch (CSB) provides technical assistance and support to the CO and direct support to the MoH through training. CSB provided training for FMHACA on quality control. CSB support includes technical assistance in planning and procurement. The Global GPRHCS Training Manual is available and is updated periodically. | UNFPA,<br>Government,<br>(UNFPA Ethiopia 2010) |
| The ESARO has also provided training, and GPRHCS holds annual regional planning meetings each year, which are used for experience sharing. | UNFPA |
| Procurement of UNFPA contraceptive donations is done through UNFPA Procurement Branch in Copenhagen and PFSA receives the material goods rather than the money. | Government |
| HQ has not provided training or TA for PFSA. UNFPA support for PFSA was coordinated by the CO and included staff secondments. | Government |

# ANNEX 4 SRHR AND FAMILY PLANNING EXPENDITURE (2008-2013)

| PROJECT | IMPLEMENTING PARTNERS | Spending on SRHR INCL Family Planning by Project ID | | | | | | Total spending on SRHR INCL Family Planning by Project ID | ESTIMATED % FAMILY PLANNING SPENDING OF TOTAL SPENDING | TOTAL FAMILY PLANNING SPENDING (2008-2013) | Quality Assurance (total FP spending when multiplying FP % with total SRHR) | % off |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | | | | | |
| ETH5G102: Child Marriage Project | GOVT, NGO, UNFPA | $432,068.71 | $315,687.60 | $325,549.12 | $333,011.24 | | | $1,406,317 | 15.00% | $259,780 | $210,947.50 | 81% |
| ETH5R201: Strengthening Integrated RH Services | GOVT, UNFPA | $540,381.63 | $75,164.41 | | | | | $615,546 | 30.00% | $170,180 | $184,663.81 | 109% |
| ETH6G21A: Leave No Women Behind Project | GOVT, NGO, UNFPA | | $661,170.20 | $708,132.48 | $529,403.48 | | | $1,898,706 | 15.00% | $284,806 | $284,805.92 | 100% |
| ETH6R201: Comprehensive Reproductive Health | GOVT, NGO, UNFPA | $1,946,971 | $2,129,736 | $1,889,025 | $1,460,211 | | | $7,425,943 | 30.00% | $2,227,783 | $2,227,783 | 100% |
| ETH6R209: Scaling-up for HIV prevention (2008-2011) | GOVT, UNFPA | $248,537 | $661,413 | $807,424 | $1,103,481 | | | $2,820,855 | 35.00% | $987,299 | $987,299 | 100% |
| ETH6R21C: Enhancing Global Programme: RHCS (2008-2011) | GOVT, NGO, UNFPA | | $1,761,903 | $1,347,101 | $1,453,231 | | | $4,562,235 | 100.00% | $4,562,235 | $4,562,235 | 100% |
| ETH6R21G: Maternal Health Trust Fund (2008-2011) | GOVT, NGO, UNFPA | | $189,039 | $313,593 | $266,843 | $370,706 | $454,608 | $1,594,789 | 26.00% | $414,645 | $414,645 | 100% |

| PROJECT | IMPLEMENTING PARTNERS | Spending on SRHR INCL Family Planning by Project ID | | | | | | Total spending on SRHR INCL Family Planning by Project ID | ESTIMATED % FAMILY PLANNING SPENDING OF TOTAL SPENDING | TOTAL FAMILY PLANNING SPENDING (2008-2013) | Quality Assurance (total FP spending when multiplying FP % with total SRHR) | % off |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | | | | | |
| ETH7U201: Qualified Human Resources for Maternal Health; Maternal Health Trust Fund (2012-2013) | GOVT, NGO, UNFPA | | | | | $2,325,559 | $1,881,725 | $4,207,284 | 10.00% | $387,457 | $420,728 | 109% |
| ETH7U203: High-quality information & services; Maternal Health Trust Fund | GOVT, NGO, UNFPA | | | | | $1,746,176 | $1,825,568 | $3,571,744 | 44.00% (2012) 21.00% (2013) | $1,156,557 | $1,151,687 | 100% |
| ETH7U302: Improved Quality FP Information & commodities; Global Programme on RHCS (2012-2013) | GOVT, NGO, UNFPA | | | | | $1,512,201 | $1,450,235 | $2,962,436 | 100.00% | $2,962,436 | $2,962,436 | 100% |
| ETH7U404: Increased Availability of High-quality HIV-prevention services (2012-2013) | GOVT, UNFPA | | | | | $1,068,303 | $924,006 | $1,992,309 | 6.32% (2012) 10.27% (2013) | $162,439 | $162,412 | 100% |
| ETHR21C: Enhancing Global Programme: RHCS (2008-2011) | GOVT, NGO, UNFPA | $729,075 | | | | | | $729,075 | 100.00% | $729,075 | $729,075 | 100% |
| TOTAL SPENDING ON SRHR INCL FAMILY PLANNING (2008-2013) | | $3,897,033 | $5,794,113 | $5,390,825 | $5,146,181 | $7,022,945 | $6,536,142 | $33,787,238 | | | | |
| TOTAL SPENDING ON FAMILY PLANNING | | | | | | | | | | $14,304,692 | | |

## ANNEX 5 LIST OF IMPLEMENTING PARTNERS

**Federal Ministry of Health (FMOH)**

ETH6R201: Comprehensive Reproductive Health
ETH6R209: Scaling-up for HIV prevention
ETH6R21C: Enhancing Global Programme: RHCS
ETH7U201: Qualified Human Resources for Maternal Health; Maternal Health Trust Fund
ETH7U203: High-quality information & services; Maternal Health Trust Fund
ETH7U302: Improved Quality FP Information and commodities; GPRHCS

**Federal HIV and AIDS Prevention and Control Office (FHAPCO):**

ETH6R209: Scaling-up for HIV prevention
ETH7U404: Increased availability of high-quality HIV prevention services

**Ministry of Finance and Economic Development (MoFED)**

ETH6R21G: Maternal Health Trust Fund

**Ministry of Women Affairs (MOWA)**

ETH6G21A: Leave No Women Behind Project

**Ministry of Women, Children and Youth (MoWCY)**

ETH6R209: Scaling-up for HIV prevention

**Ministry of Youth and Sports**

ETH5G102: Child Marriage Project
ETH6G21A: Leave No Women Behind Project

**MOA DISASTER RISK MANAGEMENT AND FOOD**

ETH6R21G: MDG Pooled Fund

**Food Medicine & Health Care Administration (FMHACA)**

ETH7U302: Improved Quality FP Information & commodities; Global Programme on RHCS

**Pharmaceutical Funds Supplies Agency (PFSA)**

ETH6R21C: Enhancing Global Programme: RHCS
ETH7U302: Improved Quality FP Information and commodities; GPRHCS

**Government (other)**

ETH5R201: Strengthening Integrated RH Services
ETH6R21C: Enhancing Global Programme: RHCS

**Population Council**

ETH5G102: Child Marriage Project
ETH6G21A: Leave No Women Behind Project

**Regional Government Institutions:**

ETH5G102: Child Marriage Project
ETH6G21A: Leave No Women Behind Project
ETH6R201: Comprehensive Reproductive Health
ETH6R209: Scaling-up for HIV prevention
ETH6R21C: Enhancing Global Programme: RHCS
ETH7U201: Qualified Human Resources for Maternal Health; Maternal Health Trust Fund
ETH7U203: High-quality information & services; Maternal Health Trust Fund
ETH7U302: Improved Quality FP Information and commodities; GPRHCS
ETH7U404: Increased availability of high-quality HIV prevention services

**Administration for Refugee-Returnee (ARRA)**

ETH6R21C: Enhancing Global Programme: RHCS
ETH7U203: High-quality information & services; Maternal Health Trust Fund

**CUAMM**

ETH7U201: Qualified Human Resources for Maternal Health; Maternal Health Trust Fund

**DKT:**

ETH6R21C: Enhancing Global Programme: RHCS
ETH7U302: Improved Quality FP Information and commodities; GPRHCS

**Ethiopian Midwives Association (EMA):**

ETH7U201: Qualified Human Resources for Maternal Health; Maternal Health Trust Fund

**Family Guidance Association Ethiopia (FGAE):**

ETH6R21C: Enhancing Global Programme: RHCS
ETH7U302: Improved Quality FP Information and commodities; GPRHCS

**HEC**

ETH6R209: Scaling-up for HIV prevention

**IMC**

ETH7U203: High-quality information & services; Maternal Health Trust Fund

**ISAPSO**

ETH6R201: Comprehensive Reproductive Health

**Adama University**

ETH7U203: High-quality information & services; Maternal Health Trust Fund

**Addis Ababa University/School of Public Health (AAU/SPH)**

ETH6R21C: Enhancing Global Programme: RHCS
ETH7U201: Qualified Human Resources for Maternal Health
ETH7U302: Improved Quality FP Information and commodities; GPRHCS

**Gondar University**

ETH6R21G: Maternal Health Trust Fund
ETH7U201: Qualified Human Resources for Maternal Health
ETH7U203: High-quality information & services; Maternal Health Trust Fund

**Haramaya University**

ETH7U201: Qualified Human Resources for Maternal Health; Maternal Health Trust Fund

**Harari University**

ETH6R21G: Maternal Health Trust Fund

**Hawassa University**

ETH6R21G: Maternal Health Trust Fund
ETH7U201: Qualified Human Resources for Maternal Health; Maternal Health Trust Fund

**Jimma University**

ETH6R21G: Maternal Health Trust Fund
ETH7U201: Qualified Human Resources for Maternal Health; Maternal Health Trust Fund
ETH7U203: High-quality information & services; Maternal Health Trust Fund

**Mekele University**

ETH7U201: Qualified Human Resources for Maternal Health; Maternal Health Trust Fund

**Mekelle University**

ETH6R21G: Maternal Health Trust Fund

**VSO-E**

ETH7U201: Qualified Human Resources for Maternal Health; Maternal Health Trust Fund

**UNFPA**

ETH5G102: Child Marriage Project
ETH5R201: Strengthening Integrated RH Services
ETH6G21A: Leave No Women Behind Project
ETH6R201: Comprehensive Reproductive Health
ETH6R209: Scaling-up for HIV prevention
ETH6R21C: Enhancing Global Programme: RHCS
ETH6R21G: Maternal Health Trust Fund
ETH6R21G: MDG Pooled Fund
ETH7U201: Qualified Human Resources for Maternal Health; Maternal Health Trust Fund
ETH7U203: High-quality information & services; Maternal Health Trust Fund
ETH7U302: Improved Quality FP Information and commodities; GPRHCS
ETH7U404: Increased availability of high-quality HIV prevention services

## ANNEX 6 – DETAILED KEY FACTS

| Indicator | 2012 | 2014 | Source of Data |
|---|---|---|---|
| **Population and Development** | | | |
| Population, total | 92,191,211 | 96,958,732 | World Bank[1] |
| Population, aged 0-14 (% of total) | 43 | 42 | World Bank[1] |
| Population, aged 15-64 (% of total) | 53 | 54 | World Bank[1] |
| Population, ages 65+ (% of total) | 3 | 3 | World Bank[1] |
| Population growth (annual %) | 2.6 | 2.5 | World Bank[1] |
| Urban Population (% of total) | 18 | 19 | World Bank[1] |
| Population Density (per sq. km of land area) | 92 | 97 | World Bank[1] |
| Life Expectancy at birth, total (years) | 63 | 64.1 | World Bank[1] |
| Literacy rate, population 15+ years, both sexes (%) | - | - | World Bank[1] |
| Youth Literacy rate, population 15-24, both sexes (%) | - | - | World Bank[1] |
| Human Development Index (HDI) | 0.396 (Rank 173 out of 187) | 0.442 (Rank 174 out of 188) | Human Development Report[2] |
| Human Development Classification (very high, high, medium, low, upper middle, high) | Low | Low | Human Development Report[96] |
| Total GDP at market price (current US$) | 43,310,721,414 | 55,612,228,234 | World Bank[1] |
| Economic growth rate (GDP growth annual %) | 8.6 | 10.3 | World Bank[1] |
| GINI Index | - | - | World Bank[1] |
| Multidimensional Poverty Index (MPI), HDRO specifications | 0.564 | 0.537 | Human Development Report[3] |
| **Government Effectiveness** | | | |
| World Bank CPIA Quality of Public Administration rating (1=low to 6 = high) | 3.5 | 3.5 | World Bank[1] |
| **UNFPA: Need and Ability to Finance** | | | |

[96] United Nations Development Programme. (2016). Country Classification.Retrieved from https://pharmacoepi.org/pub/1c08ab60-2354-d714-5192-9cc81d38354f

| | | | |
|---|---|---|---|
| UNFPA country quadrant | - | Red | UNFPA Strategic Plan[97] |
| **Gender Equality and Empowerment** | | | |
| Gender Inequality Index | - | 0.558 (Rank 129 out of 155) | Human Development Report[3] |
| Women representation in parliament, total (%) | 28 | 28 | World Bank[1] |
| Violence against women ever experienced (%) | - | 55.9 | Human Development Report[3] |
| Employment to population ratio, 15+, female (%) (modeled ILO estimate) | 71 | 72 | Human Development Report[5] |
| Ratio of girls to boys in primary and secondary education (%)[4] | - | - | World Bank[1] |
| **Reproductive Rights and Reproductive Health** | | | |
| Fertility rate, total (births per woman) | 4.6 | - | World Bank[1] |
| Adolescent fertility rate (births per 1,000 women ages 15-19) | 67 | 60 | World Bank[1] |
| Teenage mothers (% of women ages 15-19 who have had children or are currently pregnant) | - | - | World Bank[1] |
| Prevalence of HIV, female (% ages 15-49) | 0.5 | 0.6 | World Bank[1] |
| Prevalence of HIV, male (% ages 15-49) | 0.4 | 0.5 | World Bank[1] |
| Maternal mortality rate (per 100,000 live births) | 447 | 378 | World Bank[1] |
| Under 5 mortality rate (per 1,000 live births) | 68 | 62 | World Bank[1] |
| Contraceptive use, modern methods (%) | - | 57.5 | UN DESA Population Division Estimates and Projections of Family Planning Indicators[5] |

[97] United Nations Population Fund. (2015). UNFPA Strategic Plan. Retrieved from https://webcache.googleusercontent.com/search?q=cache:PBcjL1D-HDYJ:https://www.unfpa.org/sites/default/files/about-us/Annex%25204%2520(funding%2520arrangements).docx+&cd=1&hl=en&ct=clnk&gl=ca

| | | | |
|---|---|---|---|
| Unmet need for family planning (number of married or in-union women aged 15 to 49 who want to stop or delay childbearing but are not using a method of contraception, %) | - | 15.7 | UN DESA Population Division Estimates and Projections of Family Planning Indicators[5] |
| Demand for family planning satisfied (% of total demand for family planning among married or in-union women aged 15 to 49 that is satisfied) | - | 78.7 | UN DESA Population Division Estimates and Projections of Family Planning Indicators[5] |
| Births attended by skilled health staff (% of total) | - | 23 (2013 data) | World Bank[1] |
| Antenatal care (any skilled provider) | - | - | World Bank[1] |