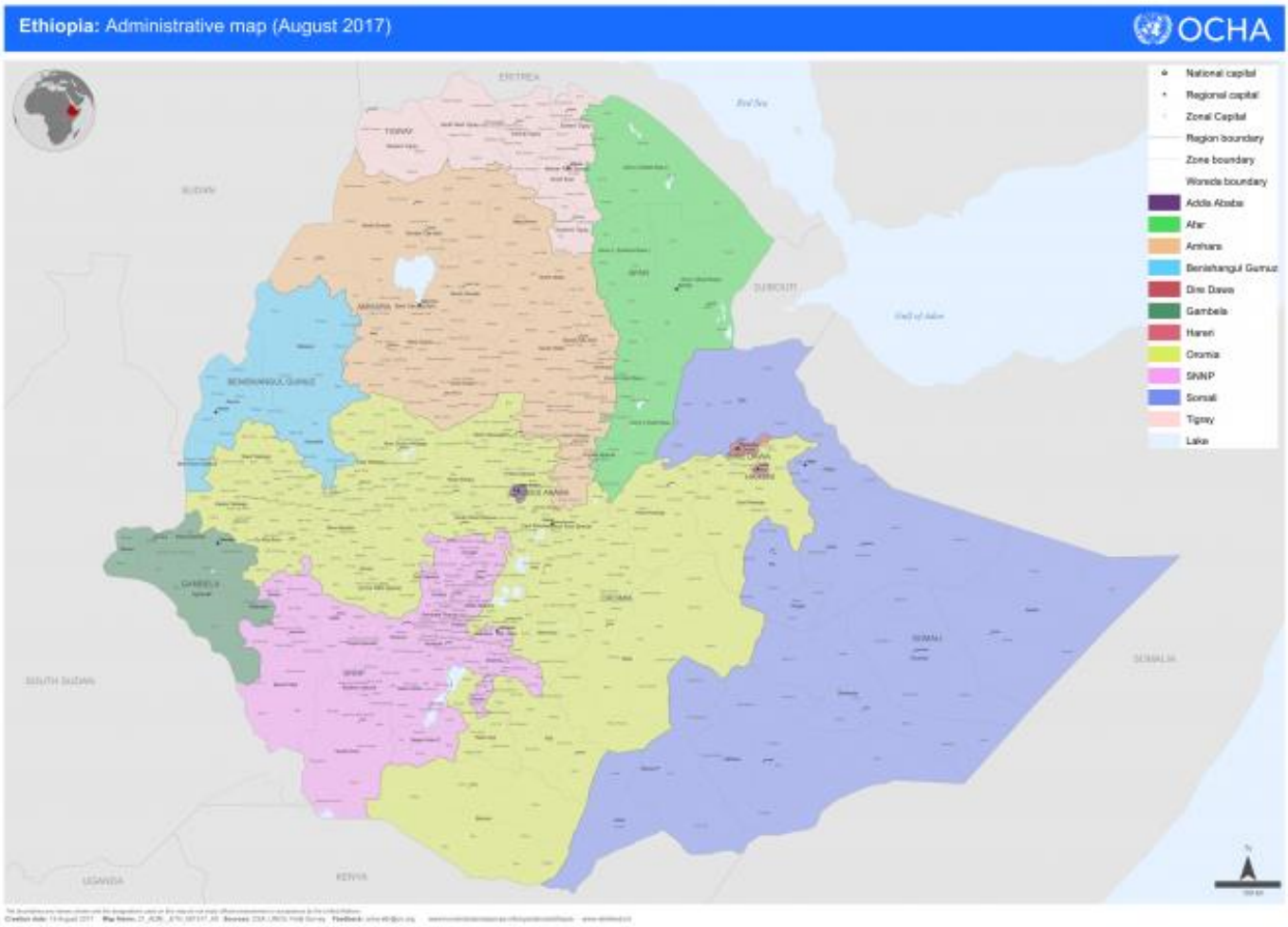
GOVERNMENT OF ETHIOPIA/UNFPA 8TH COUNTRY PROGRAMME [2016-2020]

FINAL EVALUATION REPORT

DATE: NOVEMBER 2019

ADMINISTRATIVE MAP OF ETHIOPIA



Source: OCHA 2017

Evaluation Team

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DISCLAIMER

This evaluation report was prepared by a team of three Consultants: Clifford Odimegwu, International Consultant Evaluation Team Leader, and Yibeltal Kilfie National Evaluation Consultant in charge of the SRH/AYD Component and Dr Emebet Mulunguta, in charge of the Gender Equality and Women's Empowerment (GEWE) component. The content, analysis and recommendations of this report do not necessarily reflect the views of the United Nations Population Fund (UNFPA), its Executive Committee or government of Ethiopia.

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ACRONYMS AND ABBREVIATIONS

ADA	Amhara Development Association
ANC	Antenatal Care
APDA	Afar Pastoralist Development Association
ARRA	Agency for Refugee and Returnee Affairs
AWSAD	Association for Women's Sanctuary and Development
AWP	Annual Work Plan
AYD	Adolescent and Youth Development
AYHS	Adolescent and Youth Health Strategy
BEmONC	Basic Emergency Obstetric and Newborn Care
BoFEC	Bureau of Finance and Economic Cooperation
BoWCA	Bureau of Women and Children's Affairs
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CEDAW	Convention on the Elimination of All Forms Discrimination Against Women
CM	Child Marriage
CO	Country Office
CP	Country Program
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organizations
DHS	Demographic and Health Survey
ET	Evaluation Team
EWLA	Ethiopian Women Lawyers Association
FBOs	Faith Based Organizations
FGAE	Family Guidance Association - Ethiopia
EPSA	Ethiopian Pharmaceutical Supply Agency
EmONC	Emergency Obstetric and Newborn Care
FGM	Female Genital Mutilation
FGM/C	Female Genital Mutilation/Cutting
FP	Family Planning
GEWE	Gender Equality and Women Empowerment
GBV	Gender Based Violence
GTP	Growth and Transformation Plan
HC	Health Centre
HEIs	Higher Education Institutions
HEW	Health Extension Worker
HIV	Human Immunodeficiency Virus
HPDP	Health Promotion and Disease Prevention
HSTP	Health Sector Transformation Plan
HTP	Harmful Traditional Practice
IDP	Internally Displaced Person
ILO	International Labour Organization
IP	Implementing Partner
LARC	Long Acting Reversible Contraceptives
MCH	Maternal and Child Health
MDSR	Maternal Death Surveillance and Response

MDG	Millennium Development Goal
MoE	Ministry of Education
MoH	Ministry of Health
MoWCYA	Ministry of Women, Children and Youth Afairs
MOY	Ministry of Youth
MTR	Mid Term Review
NGO	Non-Government Organization
OPD	Outpatient Department
PNC	Postnatal Care
PIM	Program Implementation Manual
RH	Reproductive Health
RHB	Regional Health Bureau
RPO	Regional Program Officer
SGBV	Sexual Gender Based Violence
SGD	Sustainable Development Goal
SARA	Service Availability and Readiness Survey
SRH	Sexual and Reproductive Health
SNNPR	Southern Nations, Nationalities, and People's Region
ToT	Training of Trainers
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Fund
UNESCO	United Nations Education, Scientific and Cultural Organization
UPR	Universal Periodic Report
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Fund for Population Affairs
WDA	Women Development Army
WoHO	Woreda Health Office
YFSC	Youth-Friendly Service Centre
YFSRHS	Youth-Friendly Sexual and Reproductive Health Service

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Land	
Geographical Location[i]	Located in North Eastern part of Africa known as the "Horn of Africa"
Land area (sq km)[ii]	1,000,000 (2.5X the size of California)
People	
Population (millions)[iii]	113.17 (2019)
Urban population[iv]	21% (2018)
Rural population[v]	79% (2018)
Population growth (annual)[vi]	2.62% (2018)
Government	
Type[vii]	Federal parliamentary republic
Key political events[viii] Date of independence Date of constitution	 5 May 1941 21 August 1995
Economy	
GDP per capita[ix]	$84.355 (2018)
GDP Growth rate (annual %)[x]	6.81%
Main economic activity[xi]	Agriculture
Social indicators	
Human Development Index rank[xii]	0.463 (2017)
Unemployment (15-24)[xiii]	2.78% (2018)
Life expectancy and birth[xiv] Male Female	 60.1 years (2017) 65.1 years (2017)
Under 5 mortality (per 1000 live births)[xv]	55.2 (2018)
Maternal mortality (deaths of women per 100,000 live births)[xvi]	353 (2015)
Births attended by skilled health personnel %[xvii]	28% (2016)
Health Expenditure (as a % of GDP)[xviii]	3.974% (2016)
Contraceptive prevalence rate[xix]	37.8% (2018)
Unmet need for family planning[xx]	20.6% (2018)
Literacy (% aged 15-49)[xxi] Males Female:	 67.4% (2016) 42% (2016)
Proportion of women aged 15-49 years who have begun childbearing (Fertility rate)[xxii]	4.35 (2017)
People living with HIV, 15-49[xxiii]	690 000 (2018)
HIV Prevalence rate, 15-49 years[xxiv]	1% (2018)
HIV Prevalence 15-24[xxv] Male Female	 0.2% 0.4%

SDG-4 Quality Education for all	2015-2016
Pre-school enrolment in percent (%)	49.6
Male enrolment (%)	50.8
Female enrolment (%)	48.3
Elementary school (1st grade to 8th) net enrolment (%)	97.12
Male enrolment (%)	100
Female enrolment (%)	93.6
Gender Party Index in primary education (Grades 1-8) (%)	0.91
Secondary school (first level: grades 9-10) gross enrolment (%)	44.8
Male gross Enrolment (%)	46.2
Female gross Enrolment (%)	43.4
Secondary school (second level: grades 11-12) gross enrolment (%)	12.6
Male gross Enrolment (%)	13.4
Female gross Enrolment (%)	11.6
Adults functional education gross enrolment (in millions)	6.9
SME with a capacity for technology transfer/manufacturing	2,751.00
Higher Education -undergraduates gross enrolment (number)	778,766
Share of males (percent)	66
Share of females	34
Annual Intake growth rate (percent)	10.4
Number of graduate of Higher Education Undergraduates Program	130714
Share of males (percent)	66
Share of females (percent)	34
Postgraduate Admission-Second Degree (Number)	52611
Share of males (percent)	75
Share of females (percent)	25
Postgraduate Admission-Third Degree (Number)	2725
Number of graduate in postgraduates program-second degree (Number)	8588
Share of Males (percent)	82.8
Share of females (percent)	17.2
Number of graduate in postgraduate program-Third Degree (Number)	263
Share of males (percent)	90.9
Share of females (percent)	9.1

Proportion of trained 1st cycle (grades 1-4) primary school teachers (percent)	73
Proportion of trained 2nd cycle (grades 5-8) primary school teachers (%)	94
Proportion of trained secondary school (grades 9-12) teachers (%)	96
SDG-6: Potable water &sanitation services	
Rural potable water supply coverage by GTP II standards (%)	63.1
Urban potable water supply coverage by GTP II standards (%)	52.5
National potable water supply coverage by GTP II standards (%)	61
Non-functional rural water stations (%)	11
Affordable renewable energy	
National electric power generation capacity (MW)	4,269.5
Number of Customers (millions)	2.49
Access coverage of electricity supply (percent)	56.0
Electric power transmission lines (km)	15,137
Medium electric power distribution lines (km)	94,352
Share of GDP (Electricity and Water) (%)	0.6
Ending Poverty	
National poverty headcount (%)	
Share of poverty oriented sectors'[2] expenditure in total Government expenditure (%)	67
The share of pro-poor sectors' expenditure in GDP (%)	12.9
Gov't expenditure for institutions benefitting women, the poor, the vulnerable (Share in GDP in %)	18.4
Number of beneficiaries (50 % females) from safety-net based social security services (Millions)	1.54
Number of beneficiaries (the disabled) from physical rehabilitation services (thousands)	78.74
Number of households who received 2nd-degree rural land entitlement licence (millions)	0.33
Number of Male Family Heads	0.27
Number of Female Family heads	0.06

Disaster prevention Strategy—prepared/not-prepared	prepared
End Hunger	
Major food-crops production (in mlns of quintals)	267
Average productivity of major-food crops (Qt/ha)	19.0
Number of households (farmers) who obtained general agricultural extension services (‘000)	15,735
Number of households (farmers) who obtained Improved agriculture extension services (‘000)	14,549
Total number of Male-headed rural households who received agricultural extension services (‘000)	8,594
Total number of Female-headed rural households who received agricultural extension services (‘000)	4,466
Total number of rural youth (agriculturalists) who received agricultural extension services (‘000)	1,489
Total number of Pastoralists who received extension services (‘000)	718
Total number of Male-Pastoralists who received extension services (‘000)	427
Total number of Female-Pastoralists who received extension services (‘000)	218
Total Number of youth Pastorals who received extension services (‘000)	73
Total number of agro-pastoralists who received extension services (‘000)	420
Quantity of compost utilized (in metric tons)	752,282
Quantity of improved seeds supplied (‘000 Qt)	2,617
Areas covered by soil and water conservation structures in community watersheds (‘000 ha)	1,062
Extent of GHG (CO_2) removed using biological methods from community watersheds (mln mt CO_2e)	5
Land developed through medium scale modern irrigation schemes (million -hectares)	3.0
Meat production (‘000 tons)	1,990
Milk production (cow, camel, goat) (in million liters)	4,467
Healthy lives and Well-being	

Maternal Mortality Rate per 100,000	412
Deliveries attended by skilled health personnel (%)	72.7
Under 5 mortality per 1000 children	67
Neonatal mortality rate per 1000 children	29
Under-5 Stunting rate (%)	38.4
Under-5 wasting rate (%)	9.9
HIV/AIDS incidence rate (%)	0.03
Detection rate of all forms of TB (%)	61.3
Incidence of newly contracting hepatitis B (in '000)	23.2
Number of people in need of treatment for priority lowland diseases (millions)	66.6
Mortality rate of heart disease, cancer, diabetics and respiratory infections	287
Death rate from traffic accidents (per 10,000)	63
Mothers utilizing modern birth control methods (%)	35.3
Teen-age (Adolescent) fertility rate per 1000	12
Critical health services coverage (%)	98
Number of people with health insurance coverage (per 1000)	125
Number of Health professionals per 1000 population	0.84
Kebeles (lowest administrative units in Ethiopia) that Implemented Health Extension program (%)	93
Gender Equality	
Number of women trained on different professions (millions)	1.89
Number of women benefited from vocational adult education program (millions)	2.35
Number of institutions/organizations that institutionalized women's affairs	69
Number of structures in higher education institutions that provide counselling services for female students	111
Number of Hostels (boarding schools) established and strengthened	16
Percent of women at parliament	38.8
Decision-making role of women at the Federal Executive bodies (%)	9.2

Number of women who received certificates of Land Use Right	9,492,772
Build infrastructure, promote industrialization and foster innovation	
Areas 5 Km further away from all-weather roads (%)	35.8
Supply of passenger seats per flight distance (in billions kilometres)	39.9
Value-added growth in MSE (%)	2.5
Shae of Medium and Large Industries' Products in GDP (%)	4.4
Shae MSE Products in GDP (%)	1
Value-added growth in Manufacturing Industries (%)	18.4
Value-added growth in Medium and Large Industries (%)	22.9
Mobile services Penetration (%)	49
Number of mobile services users ('000)	45,963
Construction of A.Ababa Light Rail (34 km) (%)	100
Construction of A. Ababa–Meiso-Dewnle Rail (%)	99.2

Overview. This report presents the findings, conclusions and recommendations of UNFPA Ethiopia 8th cycle (2016-2020) Country Programme of Evaluation (CPE). The overall purpose of this Country Programme Evaluation (CPE) is to assess the performance of the United Nations Population Fund (UNFPA) Ethiopia 8th Country Program for Ethiopia for 2016-2020. This evaluation examines factors that have facilitated or hindered achievements, and documents the lessons learned to inform the formulation of the next Country Programme of UNFPA within the follow-on UNDAF in support to the Government of Ethiopia. This evaluation is an essential step to identify the major achievements as well as challenges encountered while implementing the current UNFPA 8th Country Program (CP) and to ensure that the lessons learned are reflected in the forthcoming UNFPA CP for 2020-2023. This report covers results from 2016 to 2019 in four focus areas: 1) Sexual and Reproductive Health (SRH) 2) Adolescents and Youth Development, 3) Gender equality and women's empowerment and 4) Population and Development (PD). The initial CP budget was $120 million ($40.4 m regular $79.6 m other resources).

Objectives and Scope: The broad objectives of the CPE include (i) to enhance accountability of UNFPA and its country office for the relevance and performance of its country programme in Ethiopia; (ii) to broaden the evidence base, including lessons learned and practical recommendations, for the next Ethiopia Country programme cycle (July 2020 – June 2024) and (iii) inform decision making, improve programming and help UNFPA to become a better fit-for-purpose organization.

The specific objectives were **t**o provide an independent assessment of the progress of the 8th Country Programme towards the expected outputs and outcomes set forth in the results framework of the

country programme; (ii) to provide an assessment of the extent to which programme implementation frameworks and modalities have enabled or hindered achievement of the programme outputs and (iii) to draw key lessons from past and current cooperation and provide a set of clear and forward-looking options leading to strategic and actionable recommendations for the next programme design.

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

The CPE took place during the period August-September 2019 and covers the Ethiopia CP from 2016-2019. The primary audience and users of the evaluation include the UNFPA Ethiopia CO, national partners and relevant government agencies, who are expected to benefit from the evaluation's findings, conclusions and recommendations. UNFPA ESARO and Evaluation Office (EO) are also expected to benefit. In addition, the UN agencies represented in the country will use findings of this evaluation during the development of the next CP for Ethiopia for 2020 - 2023

Description of the Country Programme. The UNFPA Ethiopia CP has been developed and implemented within the context of the UNDAF 2016-2010 for Ethiopia, which is guided by the goals and targets of the ICPD PoA, SDG Agenda 2030, and UNFPA Strategic Plans, as endorsed by the Government of Ethiopia. In 2016, the UNDAF 2016-2020 was extended to align with the Government of Ethiopia's National Development Strategy, GTP II 2016-2020. The four UNFPA Ethiopia CP focus areas are implemented in close collaboration with the Ethiopia Ministries of Finance and Economic Development, Health, Women, Children and Youth Affairs, Central Statistical Agency, Planning and Development Commission, a number of well-established NGOs and other partners.

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

Evaluation Approach. The CPE follows the structure provided in the UNFPA Evaluation Handbook 2019 Revision) to assess the UNFPA Ethiopia CP using two separate components. First, is an analysis of the UNFPA Ethiopia CP Outcomes and Outputs within the four focus areas (SRH, Adolescents and Youth, Gender and PD). This component employs four main criteria: relevance, effectiveness, efficiency, and sustainability. The second component assesses the positioning of the UNFPA Ethiopia CP in the country based on two criteria: UNCT coordination (with the development priorities of Ethiopia, its collaboration within the UNDAF and other development agencies), and value added (comparative strengths in the country). The third component is the development-humanitarian connectedness .The evaluation covers the first four years of the five-year CP programme period (2016-2020). It focuses on the 4 outcomes and 6 outputs within the CP Results and Resources Framework that was aligned with the UNFPA Mid Term Strategic Plan (MTSP) for 2014-2017, and revised SP 2018-2021.

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

Limitations: The evaluation team did not encounter any significant field challenges when conducting the field data collection. However the field work was extended by one week due to the week-long pubic holiday for Ethiopian New Year. Logistic issues and access to people and intervention sites was facilitated by UNFPA. The CPE was mainly limited by time and expert resources devoted to conduct the evaluation of a very large and diversified programme implemented over a wide geographic area. However, time and resources did not compromise the integrity of the evaluation findings but affected the time plan with some delays.

MAIN FINDINGS

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

Efficiency: Overall, the activities implemented toward the achievement of outputs for all program areas appeared to be reasonable for the amount of resources expended. As at mid-2019, 74 percent fund utilization rate was achieved because some IPs returned their funds and possibly because the year is not yet completed. UNFPA Ethiopia CO was generally efficient in mobilizing financial resources and efficient in disbursing annual programme budgets to support the implementation of Annual Work Plans (AWPs) through contracts with Implementing Partners as well as National Execution (NEX) and Direct Execution (DEX) modalities. The CP has been implemented by a team of competent staff with support from a number of national and international consultants, and the Regional Office in Johannesburg. However, there are noticeable inefficiencies during the Cycle like spread of programme

activities in eight regions and 122 districts. The 8TH CP is spread too wide with many layers of bureaucratic oversight that delays implementation processes. There is a huge number of IPs involved in the implementation.

Effectiveness: The CP was effective in contributing towards the achievement of the results of the interventions. Despite major constraints and challenges in the social and political context of Ethiopia, there was more impressive achievement of all outputs and outcomes. UNFPA programme has effectively improved the delivery of integrated sexual and reproductive health, BEmONC, EmONC and fistula repair services in the targeted operational woredas . The capacity building of health care providers and the strengthening of health systems has contributed to improved availability and accessibility of quality SRH services. UNFPA 8TH CP has contributed to youth empowerment and engagement of youth in community education on SRH and gender. UNFPA support enabled youth in targeted districts to access social spaces and to engage in social, educational and cultural activities.

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

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

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

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

Connectedness: While UNFPA CO provides some interventions in humanitarian situations, it is observed that there is a huge disconnect between the development and humanitarian programmes . In most of the emergency areas there is huge investment than in host communities. This tends to exacerbate hostility between the refugees and the host communities. While opportunity avails for resilience and social cohesion building among the refugees, this seems to be a missed opportunity.

MAIN CONCLUSIONS

Strategic Level:

UNFPA CP (2016-2020) interventions are relevant and adequately responsive to the country's priorities, dynamics and needs of the population as identified in the GTP II development plan and participatory consultations with partners and stakeholders.

UNFPA Ethiopia is well positioned within the UN system, with government institutions and local organisations, at the federal and regional levels to effectively support programme implementation. UNFPA mandate, comparative strengths, services and interventions in the four thematic areas are well recognized and acknowledged by relevant Federal ministries, UNCT and CSO IPs in the country. In addition to a severe economic recession and the change of government, UNFPA Ethiopia has had to face delays in key activities, especially in the census exercise and work within new institutional relationships. Despite these constraints, UNFPA Ethiopia has made continuing progress toward the achievement of the 8TH CP outputs and outcomes.

UNFPA Ethiopia has clearly demonstrated that it has been and is an active and constructive partner contributing to the functioning and coordination of UNCT activities in Ethiopia within the UNDAF context. The current UNDAF framework fully reflects UNFPA mandates and does not inhibit UNFPA Ethiopia from pursuing its global and regional mandates. UNFPA Ethiopia is recognized for its work within the UNDAF Outputs and Outcomes. UNFPA is acknowledged by the UN Agencies, implementing partners and other collaborators from government as a reliable and responsive key lead agency for SRH, Youth, Gender and GBV.

PROGRAMME AREAS CONCLUSIONS

Sexual and Reproductive Health/Adolescents and Youth Development Component

SRH and AYD components of the 8th CP are relevant in addressing SRH needs of women of reproductive age mothers, adolescents, and youth in Ethiopia and are aligned with current priorities and strategies of international and national development plans related to UNFPA mandate areas. The annual work plan development process facilitates relevance of CP support activities to federal and regional IPs. The 8th CP of UNFPA has adequate focus on building national capacity in relation to SRH and AYD. The SRH component has made contributions to the development of first of its kind national MDSR guideline, training manuals, national documents on SRH and maternal death reporting integration in to surveillance system. UNFPA also technically contributed to the conduct national EmONC assessment in 2016. The SRH programme contributed to increased demand and service utilization of women on different maternal health services, including cervical cancer screening and preventive treatment services.

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

Gender Equality and Women's Empowerment Component

The Gender Equality and Women's Empowerment focus area has made important contributions toward addressing SGBV issues. Advocacy and awareness raising on gender, child marriage and FGM issues have reached men, women, school boys and girls, and youth at the regional, district and community levels by creating community structures, (Anti-GBV and HTP group's protection groups) that respond to GBV issues, and follow up commitment to FGM and CM abandonment. As a result, a number of community-based structures for prevention, protection of GBV and HTPs and provision of services to GBV victims and survivors have been put in place

Population and Development Component

The PD component interventions have resulted in putting up structures for production and accessibility of data both at national and regional levels. Key among these include the 2016 Ethiopia Demographic and Health Survey reports and the mini-report of the 2019 EDHS. Preparations for the 4th Census exercise have been advanced, but the serial postponement of the exercise is a major concern. The capacity for staff in the Central Statistical Agency for the census undertaking has been strengthened, although some capacity issues need to be revisited any time the Federal Government makes a proclamation for the 4th Census exercise. While there is appreciation of the issues of rapid population growth in national development, there seems to be a bureaucratic hiccup that undermines active participation and coordination activities of the Population and Development Directorate in the Planning and Development Commission. IMIS has been established in five of the six proposed regions for regional and district planning. Activities are underway for setting up the sixth IMIS . However, there seems to be a capacity challenge in the actual use of this system for planning in the regions.

Humanitarian interventions are prompt to address the needs of the affected persons and regions within the context of CP components. This cuts across the other components of 8TH CP .The 8th CP of UNFPA addresses the most vulnerable segments refugee's namely adolescent girls and women. Through implementation of various humanitarian projects in drought affected regions and refugee camps, a total of 289,272 populations in reproductive age group were reached with sexual and reproductive health interventions and services in humanitarian settings that involved strengthening of SRH coordination, distribution of lifesaving reproductive health kits, medical equipment's and supplies; donation of ambulances, support of community based demand creation interventions and information sessions as well as capacity development initiatives. There is however, a disconnect between development, peacebuilding and humanitarian interventions which do ignite mistrust between the host community and the refugees.

MAIN RECOMMENDATIONS

Strategic Level: It is recommended that UNFPA continues the good practice of basing programme interventions on research, needs assessment, national priorities, strategies and plans, and participatory consultations with stakeholders. The next program cycle should consider restricting the number of intervention regions to address a narrower set of priorities and thereby reduce management time and cost and potentially increase the quality and impact of sub-activities and outputs. It is important that UNFPA coordinates with UNCT agencies and discuss with federal and regional IPs to include how to improve sustainability in the next CP. CO should create conditions for sustainable programme effects by integrating exit strategy in AWPs. The exit strategy should be

designed for such programmes as Youth Friendly Services, community-based structures established for GBV prevention and response and SRH/RHCS activities.

UNFPA should also continue with the integrated programming approach across development programme components in the design of the next CP interventions, ensuring adequate skills and capacity of staff at Federal and regional and district levels of interventions. Advocacy and policy dialogue should also continue to be included in the CP9. It is very important that timing of programming should be made in such a way that before a new CP, national development plan and UNDAF strategy should be ready. Also CO should continue with innovative interventions (Safe Spaces, Youth Friendly Services Centre, One Stop Centre and mentorship of health workers) in rural districts. Importantly the CO should consider joint programming in such areas as improving adolescent and maternal health, achieving gender equality and the empowerment of women and girls, ensuring greater availability and use of disaggregated data for sustainable development, and peacebuilding and sustaining peace in accordance with national needs, plans, priorities and national ownership. UNFPA should also improve its inherent value in SRH, Gender and data to enhance strategic and local positioning at the regional levels and improve coordination with government and UN stakeholders for joint advocacy and implementation of joint programming. UNFPA should create conditions for sustainable programme effects and improve on integration of phase-out strategy in programme development and implementation. The exit strategy should be designed for such programmes as Youth Friendly Services, community-based structures established for GBV prevention and many economic and social issues, and response and SRH/RHCS activities.

PROGRAM AREA RECOMMENDATIONS:

Sexual and Reproductive Health/Adolescents and Youth Development:

It is recommended that the CO should sustain the interventions and approaches that are identified as performing well and ensure adequate investment in quality improvement during the delivery of integrated SRH/AYD services. Some key interventions (like MPDSR and quality of care), should be strengthened with other national institutions like EPHI and MOH. It is important to address the human resource needs for critical midwifery cadres. More resources should be mobilized to support the training of human resources for health and for maternal health services (human resource for health, MPDSR, EmONC, and quality of care). The Mentorship programme should be sustained. The CO should also develop and implement special approaches to provision of SRH services including MISP roll out in those regions with internally displaced people and refugees.

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

Gender Equality and Women's Empowerment. The advocacy and the coordination efforts at the higher level and the capacity building programmes should target to equip duty bearers especially law enforcement bodies to deliver their responsibility and work towards ending CM and FGM. UNFPA CO

should continue to invest in building the capacity of right holders and equip them with the skill to protect themselves and their peers from GBV and also work with schools and communities to contribute to long-term change in attitude and behavior. Integrating the FGM/C, early marriage and GBV interventions with the SRH and adolescent and youth programmes is recommended to more adolescents and youth. UNFPA intervention at higher education institutes since it will have a longing impact on adolescent and youth and make adolescent girls economically, socially and politically empowered should be replicated. Integrating this intervention with the SRH programme will help girl students to attend their education and successfully complete their tertiary education and become competitive and lead a fulfilling life. Enabling girls to complete their education will guarantee their holistic empowerment and their capacity to protect themselves from GBV, to increase their decision making power and also give them a chance to be socially, economically and politically active citizens. The issue of rights of women should be given emphasis.

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

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

CHAPTER 1: INTRODUCTION

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

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

1.1. PURPOSE AND OBJECTIVES OF THE COUNTRY PROGRAMME EVALUATION

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

Broad Objectives

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

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

1.2. SCOPE OF THE EVALUATION

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

1.3 METHODOLOGY AND PROCESS

1.3.1 Evaluation Process

This CPE was planned and implemented in five subsequent phases.

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

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

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

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

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

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

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

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

Evaluability Assessment, Limitations and Risks: While the theory of change of CP8 was not fully developed to measure the links from outputs to outcome level, CO programme staff were able to provide necessary information for the ET to develop the assumptions required to assess the achievements. The ET re-constructed the programme logic (see Figure 3). Critical assumptions and limitations were included in the CP8 programme logic.

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

1.4 The Evaluation Criteria and evaluation questions

The evaluation was structured around the four evaluation criteria of relevance, efficiency, effectiveness and sustainability according to the OECD-DAC criteria. In addition, two other UN-specific evaluation criteria – coordination and added value were added. An additional criterion on development-humanitarian connectedness was added. There were 12 questions selected for the evaluation.

The evaluation questions corresponded with the following criteria.

Relevance

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

Effectiveness

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

Efficiency

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

Sustainability

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

Coordination

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

Connectedness

11. To what extent have UNFPA interventions contributed to humanitarian and development nexus?
12. To what extent does the UNFPA interventions contribute to enhance coordination and achievement of the intended results?

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

For each of these evaluation questions, assumptions which needed to be assessed by the evaluation team were identified as well as indicators that were used in terms of verification during the field work.

Moreover, for each of the assumptions sources of information and method and tools used in data collection were identified. Assumptions together with indicators and means of verification were included in an Evaluation Matrix which is presented in Annex 4.

1.4.1 Sample selection

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

The sites illustrated a mix of interventions – development and humanitarian response programming, soft activities; size of resource allocation, types of interventions or combination of interventions. CP8 covered 8 regions and 122 districts and based on document review and consultations with CO, the team chose 5 regions and Addis Ababa. The geographic coverage of the evaluation covered five regions– Afar, Amhara, Oromia, Tigray, Gambella and Addis Ababa (out of the 9 UNFPA target regions).

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

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

1.5 METHODS AND TOOLS USED FOR DATA COLLECTION AND ANALYSIS

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

A detailed list of documents reviewed is attached (Annex 3). The evaluation triangulated data sources, data types, and data collection methods and the data shed light on how UNFPA has been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to

achieve planned results, ensure ownership and the sustainability of effects. A convenient sample of beneficiaries was used for focus group discussions to gather information on service quality and its accessibility and utility.

The evaluation made use of various monitoring and assessment and survey reports (quarterly reports, project-specific reports, annual reports, trip reports) submitted by IPs and UNFPA staff. The triangulation of data collection minimized the weaknesses of one method, and was offset by the strengths of another, enhancing the validity of the data.

The CO staff provided a list of stakeholders representing the federal and regional governments, UN agencies, and most importantly, the beneficiaries of the programme. ET had extended consultations with the CO staff and finalized the list of stakeholders for interviews based on the programme interventions and review of documents. The evaluation focused on major categories of stakeholders distributed across the CP8 programme themes. The selection covered all six strategic outcome areas. Though not a representative sample, a purposive sample was selected to reflect the interventions and the participants involved. While interviews at the Federal level were coordinated by the Evaluation manager, those of the regions were coordinated by regional programme officers.

Data collection was via individual face-to-face interviews, group interviews and focus group discussion adopted a participatory approach. The respondents (e.g. Implementing partners, programme participants, strategic partners etc.) were given the opportunity to discuss freely about the programme and allowed an opportunity for them to propose what would work for them to make the programme better in their own context. UN Agencies active in similar sectors such as UNDP, UNICEF, OCHA, as determined by UNFPA themes of assistance and six programme outputs

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

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

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

	CP8 Phases	**Evaluation Criteria**	**Evaluation Questions**		
Level of Analysis			SRH/AYD	GEWE	P & D
Programmatic	Design	Relevance	EQ 1	EQ 1	EQ 1
	Process	Efficiency	EQ 3	EQ 3	EQ 3
	Results	Effectiveness Sustainability	EQ 2 EQ 4	EQ 2 EQ 4	EQ 2 EQ 4

Strategic Position		Coordination with UNCT Added Value	EQ 5 EQ 5		
Humanitarian-Development Nexus		Connectedness	EQ6		

CHAPTER 2: COUNTRY CONTEXT

2.1. DEVELOPMENT CHALLENGES AND NATIONAL STRATEGIES

Ethiopia is the second most populous country in Africa with an estimated population of 90 million and an annual growth rate of 2.4%. Eighty percent of the population lives in rural areas, a quarter of whom are women of reproductive age. By 2020, the population will include 26 million young people aged 10-19 and 11.5 million aged 20-24. Ethiopia is the world's most populous landlocked country, covering an area of 1,127 million km2. Ethiopia is bordered by Kenya, Somalia, Eritrea, Sudan, South Sudan and Djibouti.

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

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

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

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

2.2. SEXUAL AND REPRODUCTIVE HEALTH SITUATION ANALYSIS

Ethiopia has made noticeable strides in improving health indicators during the past two decades. However, the country still bears unacceptably high burden of maternal and new-born mortality. According to 2015 United Nations Maternal Mortality estimates for Ethiopia, 353 mothers die from pregnancy and childbirth related causes for every 100,000 live births[1].

[1] MDG Indicators: Country and Regional Progress Snapshots. United Nations. 2015.

High maternal mortality ratio in Ethiopia is due to: (a) high rates of home deliveries; (b) limited number of health facilities equipped to provide basic and comprehensive emergency obstetric care; and (c) insufficient number and quality of skilled health care providers. In 2016, the prevalence of experiencing obstetric fistula was estimated at four per 1000 women of reproductive age indicating a chasm in accessing comprehensive emergency obstetric care services. Despite recent expansions in secondary and tertiary healthcare facilities in recent years, access to delivery by caesarean section is still low; only 2% of women who delivered during the five years period preceding the 2016 Ethiopian Demographic and Health Survey delivered through caesarean section[23]. Cervical cancer is the leading cause of death among female cancer patients, with an estimated 4,648 new cases and 3,235 deaths annually[4].

Limited access to sexual and reproductive health services is a major challenge to women, men, and youth in Ethiopia. Both demand and supply side barriers hinder progress towards universal access to SRH services. Despite increasing trends in the health seeking behaviour of Ethiopians, utilization of SRH services is still very low. The 2016 Ethiopian Demographic and Health Survey (EDHS) identified low demand and vast unmet need for reproductive health services including family planning and maternal health services. Use of modern family planning method was only by 35% and unmet need for family planning was as high as 22% among married women. Similarly, the coverage of maternal health services including (ANC, skilled birth attendance, and postnatal care (PNC) was very low with coverage levels of 32%, 28%, and 17%, respectively[3].

The public health sector has been the primary provider of SRH services in Ethiopia. Family planning and maternal health services are provided free of user fees in public health facilities. Ensuring availability of services and readiness of facilities for the provision of SRH services was therefore a primary agenda for SRH units at all levels of the health system[5]. Studies revealed that this area has been one of the major challenges to the health sector. The 2016 Service Availability and Readiness Assessment of Ethiopia indicated high availability but low level of readiness of health facilities for the provision of SRH services[6]. Similarly, the Emergency Obstetric and New-born Care (EmONC) Assessment showed that majority of health centres and hospitals in Ethiopia have been only partially functioning as EmONC service providers. Ensuring uninterrupted supply of SRH commodities has been a priority area for improvement within the public health system[3,7,8].

Recent initiatives of the government to improve access to and quality of SRH services include shifting the task of providing long acting family planning methods to health posts [9], expanding maternity

[2] Ethiopia Demographic and Health Survey 2016.
[3] Ethiopian EmONC Assessment 2016.
[4] HPV Information Centre, summary report on HPV and cervical cancer statistics in Ethiopia. WHO 2014.
[5] National Reproductive Health Strategy 2016-2020. FMoH. 2016.
[6] Ethiopia Services Availability and Readiness Assessment 2016.
[7] Spatiotemporal variation of contraceptive availability in Ethiopia from 2014 to 2017.
[8] Performance Monitoring and Accountability 2020 (PMA2020) Project. Detailed Indicator Report. Ethiopia 2014.
[9] Tilahun Y, Lew C, Belayihun B, Lulu Hagos K, Asnake M. Improving Contraceptive Access, Use, and Method Mix by Task Sharing Implanon Insertion to Frontline Health Workers: The Experience of the Integrated Family Health Program in Ethiopia. Glob Health Sci Pract. 2017;5(4):592-602

waiting homes[10], introduction and scale up of maternal death surveillance as part of the Public Health Emergency Management (PHEM) system[11], and expansion of youth-friendly SRH services[12],[13].

2.3. ADOLESCENT AND YOUTH DEVELOPMENT SITUATION

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

Young women represent a high-risk group in Ethiopia, being especially vulnerable to gender-based violence, female genital mutilation, early marriage and other harmful traditional practices. In 2016, about 40.3% of Ethiopian women aged 20-24 were married by their 18th birthday. In certain regions of Ethiopia, such as the Amhara region, rates of child marriage are among the highest in the world with median age at first marriage of about 16 years. Therefore, young women are exposed to high rates of maternal injury and death due to childbirth without skilled assistance and unsafe abortion. In general, teenage pregnancy and early child bearing are more prevalent in rural than in urban areas and are largely observed among the less educated and poorest young women[15].

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

[10] Ministry of Health [Ethiopia]. Guideline for the establishment of Standardized Maternity Waiting Homes at Health Centers/ Facilities. 2015
[11] FMoH. Maternal Death Surveillance and Response (MDSR) Technical Guideline. AA Ethiopia: FMoH; 2014
[12] National Reproductive Health Strategy 2016-2020. 2016
[13] Maternal and Child Health Directorate FDRoEMoH. National Adolescent and Youth Health Strategy (2016-2020). Addis Ababa, Ethiopia2016
[14] Strengthening Adolescent Component of National HIV Programs through Country Assessment in Ethiopia. FHAPCO, 2017
[15] Ethiopian Demographic and Health Survey 2016

structures can enable Ethiopia's youth to overcome inequality, discrimination, and abuse of the society's most vulnerable groups[16].

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

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

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

Ethiopia's youth has the potential to play a significant role in the country's socio-economic and political development. The National Youth Policy (2004) recognizes the importance of youth, "to

[16] Ethiopian Demographic and Health Survey 2016, HIV Report, 2018.

participate, in an organized manner, in the process of building a democratic system, good governance and development endeavours, and benefit fairly from the outcomes". Participation of youth is increasingly recognized by the public authorities, following the government's strategy to involve youth in decision-making processes. As a result, state agencies and ministries now invite representatives of youth federations during the approval of youth-related policies. Importantly, the Ethiopian Youth Federation was established in 2009 and is composed of regional youth federations, which themselves consist of various youth associations in order to involve youth in the development of the country at both the local and national level.

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

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

2.4. Gender Equality and Women's Empowerment

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

The Ethiopian Demographic and Health Survey (2016) indicated that 48% of women and 28% of men have never attended school[17] indicating a wide disparity between the sexes. In general, gender parity has narrowed at primary level, while it still persists at secondary level due to various factors that affect girls including: cultural norms, work load, lack of gender sensitive school infrastructures, distance and violence or fear of violence while travelling to school[18]. In the economic sector, land certification is one of the most progressive steps taken to ensure women's access and ownership of land, which is vital in a country where 80% of the population lives in rural areas and is dependent on agriculture. Yet, less number of women has access to certified land ownership compared to men and the average size of land owned by female headed households is significantly lower than average land size owned by male headed households[19]. Unemployment rate is higher for women compared to men. When asked if they have worked in the past 7 days 33% of women and 88% of men worked while only 33% [20] reported that they have worked.

Traditional attitudes, beliefs and cultural practices that reinforce harmful gender roles contribute to constrain women's participation in decision making. According to the Ethiopian Demographic and Health Survey in 2016, 30 % of Ethiopian women do not make decisions on individual and family issues. Instead, their husbands make decisions for them on choices including the option to use birth control methods, and whether to give birth in a health facility or seek the assistance of a trained provider[21]. Women are also found to be more vulnerable to HIV and AIDS due to several factors that limit their negotiation power, such as economic dependence, violence or fear of violence. Women's representation in leadership and decision making positions has gradually increased, with 27% of national parliamentary seats, 30% of the Judiciary and 13% of decision making positions in the executive branch occupied by women as of April 2017[22].

Harmful traditional practices like early marriage/child marriage and childbearing, female genital mutilation and gender-based violence have adverse effects on Ethiopian women. Though there are some improvements in the area of HTPs in the country, there are still practices of female genital mutilation (FGM) and child marriage (CM).The 2016 demographic and health survey indicated that 65% of women age 15 - 49 are circumcised and 16% of girls under age 15 are circumcised. The finding also assessed the attitude of both women and men regarding their belief. Accordingly 24% of women and 17% of men believe that FGM is required by their religion while 79% of women and 87% of men believe that the practice of FGM should not be continued[23]. Although, early marriage is showing a declining trend at the national level, there are hotspot districts distributed throughout the country where there is high prevalence of early marriage, with as high as above 50% prevalence rate[24]. The findings from the 2016 Demographic and Health survey show national prevalence rate of intimate partner domestic violence to be 35% ever-married women said they faced physical, sexual or emotional violence by an intimate partner, with higher prevalence rate in rural than urban areas and among those with primary or lower education levels. From those, 29% live in urban areas and 17.5%

[17] Ethiopian Demographic and Health Survey, 2016
[18] Ethiopia Gender Snapshot, Oxfam, April 2017
[19] Ethiopia Gender Snapshot, Oxfam, April 2017
[20] Ethiopian Demographic and Health Survey, 2016
[21] Ethiopian Demographic and Health Survey, 2016
[22] Ethiopia Gender Snapshot, Oxfam, April 2017
[23] Ethiopian Demographic and Health Survey (2016)
[24] Ethiopia Gender Snapshot, Oxfam, April 2017

have education levels above secondary education. In terms of regional disaggregation, Oromia has the highest prevalence rate (39%) followed by Harari (38%), and Amhara (37%). Sixty three percent of women and 28%of men believe that a husband is justified in beating his wife under certain circumstances such as neglect of children; going out without telling him; arguing with him etc.[25].

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

2.5. Population and Development Issues

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

The total fertility rate declined from 5.4 in 2005 to 4.1 in 2014. The contraceptive prevalence rate increased from 6.3% in 2000 to 41% in 2014. However, unmet need is still high at 25%. Contraceptive use is low among rural adolescents and unmarried women. In the last five years, the proportion of service delivery points offering three to five modern contraceptives has increased over twenty percent. The birth rate for women aged 15-19 declined from 17% in 200 to 12% in 2011, with higher prevalence rate in rural settings (15%) for rural and 4% for urban settings respectively) due to higher prevalence of child marriage. Over a third of women are either mothers or pregnant with their first child at the age of 19. However, a third of currently married adolescents (15-19) face unmet needs for family planning. The difference between median ages at first contraceptive use in rural areas is over seven years.

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

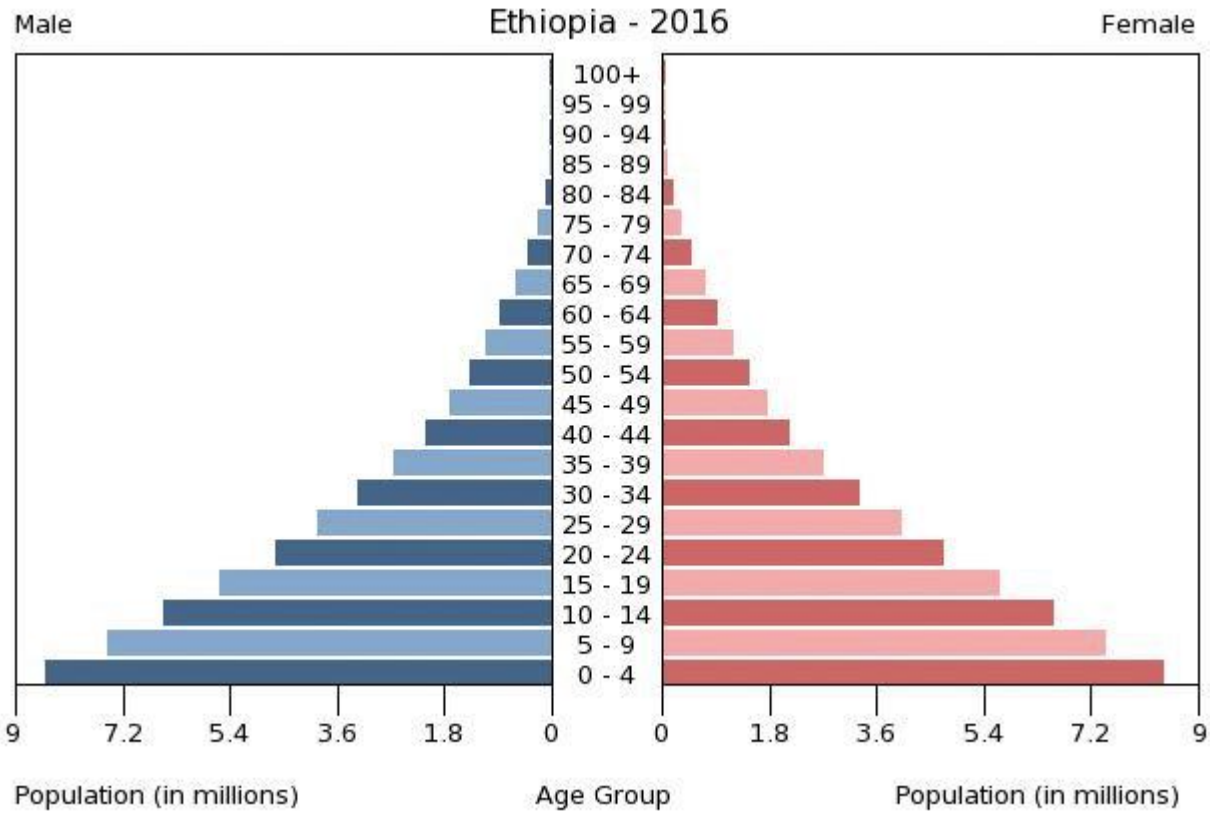
[25] Ethiopian Demographic and Health Survey (2016)

large working population, favourable policy environment, investment in human capital, and expansion of infrastructure will not yield meaningful results if the demographic challenges are not addressed. Moreover, research has shown the importance of investing in adolescent girls for realizing a country's demographic dividend.

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

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

Figure 1: Population Pyramid of Ethiopia



Source: CIA World Factbook , 2016

The role of external assistance

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

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

United Nations Development Assistance Framework

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

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

CHAPTER 3: UNFPA STRATEGIC RESPONSE AND PROGRAMME

3.1 UNFPA STRATEGIC RESPONSE

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

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

By aligning the strategic plan to the Sustainable Development Goals, UNFPA advances the work of the Programme of Action, contributes to the achievement of the goal of its Strategic Plan and, ultimately, to the eradication of poverty. CP8 has crossed three SP cycles since 2016. While the programme focus did not deviate much due to the strong alignment of the planned programmes to the UNFPA mandate, the mode of engagement shifted as per the UNFPA business model. Ethiopia is classified in the *Orange Category*, the mode of engagement is via capacity development, partnerships and coordination, including South-South and triangular cooperation, knowledge management, advocacy, policy dialogue and advice. However, in humanitarian settings, when the country responds to natural or man-made emergencies, in addition to the above, service delivery can be deployed without requiring justification in the form of a business case.

Figure 2: Alignment of the "bull's eye"—the goal of the UNFPA strategic plan—to the goals and indicators of the 2030 Agenda for Sustainable Development

3.2 UNFPA RESPONSE THROUGH THE COUNTRY PROGRAMME

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

3.2.1 UNFPA previous cycle strategy, goals and achievements

The 7th CP (2012-2015) was designed to respond to national priorities on sexual and reproductive health, gender equality, and population and development. The overall goal was to improve the sexual and reproductive health status of Ethiopians. The seventh UNFPA Country Programme (CP) (2012-2015 had a budget of $120 million27 and consisted of three components; 1) Reproductive Health and Rights; 2) Population and Development; and 3) Gender, with crosscutting issues such as human rights based approach, gender mainstreaming, and humanitarian emergency response. Programme activities were implemented in eight regions and 122 woredas/districts.

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

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

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

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

3.2.2. The 8th Country Programme

The CP8 contributes to the UNFPA SP goal of achieving universal access to sexual and reproductive health, promoting reproductive rights, reducing maternal mortality and accelerating progress on the ICPD PoA. In addressing the issues raised above and contributing to the development frameworks highlighted above, the eight CPD was developed within the framework of the four outcomes of the UNFPA Strategic Plan (2014 – 2017) and 6 outputs, namely:

- **Outcome 1**: Increased availability and use of integrated sexual and reproductive health services, including family planning, maternal health and HIV, that are gender-responsive and meet human rights standards for quality of care and equity in access
  Output 1: National capacity increased to deliver quality maternal health services, including in humanitarian settings.
  Output 2: National capacity strengthened to increase demand for and availability of family planning services, including reproductive health commodities.

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

Output 3: Capacity of adolescents and young people strengthened to make informed decisions on their sexual and reproductive health and rights.
Output 4: Institutional capacity strengthened to provide youth-friendly sexual and reproductive health services.

- **Outcome 3**: Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth.
  Output 5: Communities and institutions have enhanced capacity to promote and protect the rights of women and girls, and provide services to survivors of harmful traditional practices and gender-based violence.

- **Outcome 4**: Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality.
  Output 6: National institutions have the capacity to generate, analyse and use disaggregated data for planning, development, implementation, monitoring and evaluation of policies and programmes, including in humanitarian settings.
- Humanitarian and resilience building interventions are crosscutting through the above outcomes.

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

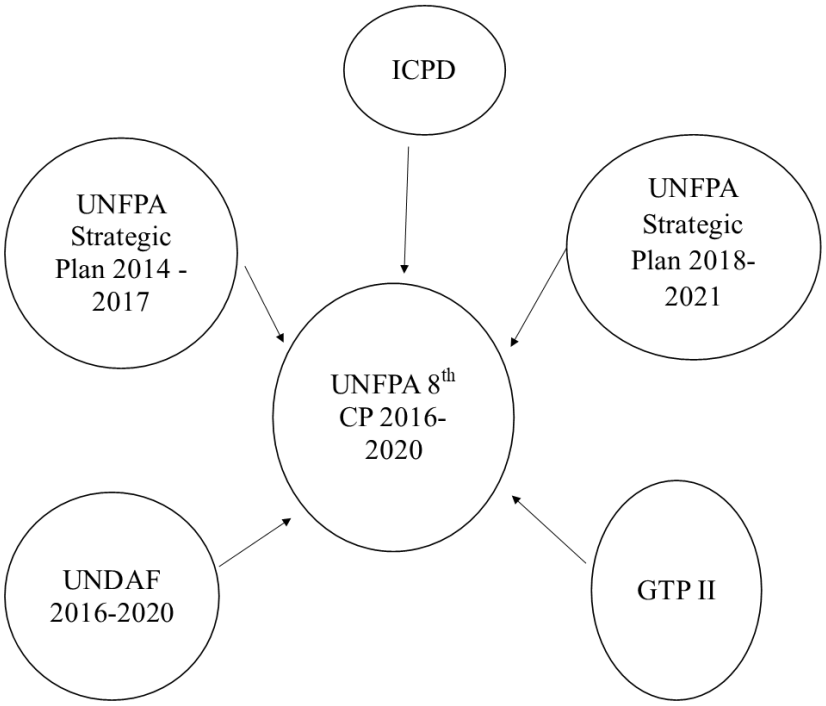


Figure 3: UNFPA Ethiopia Re-aligned Country Programme Linkages with Ethiopian National Development Plan and UN Global Strategic Plans

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

Table 3: Evolution of the Country Programme

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

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

The 8th Country Programme has six outputs and each output has specific strategies and indicators. All together the program has 27 strategies and 17 main indicators. The results of the country program are measured through these main indicators attached to each output developed at the beginning of the program. There are also other proxy indicators that reflect the results achieved, though these are not included in country program document. These result indicators are aligned to the global UNFPA strategies 2014-2017 and 2018-2021.

The 8th CP is being implemented in close partnership with the Government of Ethiopia, involving collaboration with the following ministries: Ministry of Finance and Economic Development, Ministry of Health, Ministry of Women, Children and Youth Affairs, among others. MOFED and UNFPA CO jointly coordinate the planning, implementation, monitoring and evaluation of the CP8, applying a results-based management approach as well as jointly implement resource mobilisation, communication and M & E plans. The CP8 covered 8 regions, two sub-cities of one administrative city and 122 districts. The 8 regions are Afar, Amhara, Beninshangul-Gumuz, Gambella, Oromia, Somali, SNNPR and Tigray.

The Country Programme Financial Structure

The CPD is costed for $120 million: $40.4 million from regular resources and $79.6 million through co-financing modalities and/or other resources. Regular resources are allocated to the Country Office on a yearly basis. SRH was expected to take 60% (USD 73.1m) of the total resources. Adolescents and youth 12.1% (USD 14.6m); gender equality and women's empowerment 10.9% (USD 13.0m), population and development 14.8% (USD 17.8m)., and PCA 1.25% (USD 1.5m). The Government uses agreed formula to prorate funds to Federal and Regional IPs. Other resources are mobilised mainly for earmarked interventions and are communicated to the Government for the intended programmes. The Country Office has mobilized Other Resources even beyond its target. These other resources were mobilised from the following sources:[xxvi] Sweden, DFID, Netherlands, Canada, Norway, Italy, US, Denmark, Japan, Toms Shoes, Gavi Alliance, Swedish UN Association. Total funds mobilised for this cycle stood at USD 91,091,878 million.

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

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

The projected amount of resources is higher for sexual reproductive health, followed by population dynamics and adolescent and youth. The projected amount I lower for programme coordination and assistance.

Table 5: Trends in CP8 Resources in USD m: 2016-2021

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

Note:

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

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

The CO mobilized additional resources for the CP8. Table 5 shows a steady increase since 2016. The regular resources also increased steadily.

Table 6: CP8 Resources by Thematic area, CP8 2016-2020

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

The SRH component has most of the resources each year over the 4 years. Overall, SRH was allocated USD$37.78m, that is 61.27 percent, followed by population and development (11.18%), GEWE (10.47%), , adolescents and youth component (7.79%) etc.

Table 7: CP8 Resources by CP Output Areas 2016-2020

Output	2016*	2017	2018	2019**	Total	% of overall resources
Output 1 - Expenditure	1,742,384	4,900,523	4,261,000	2,377,048	13,280,955	22%

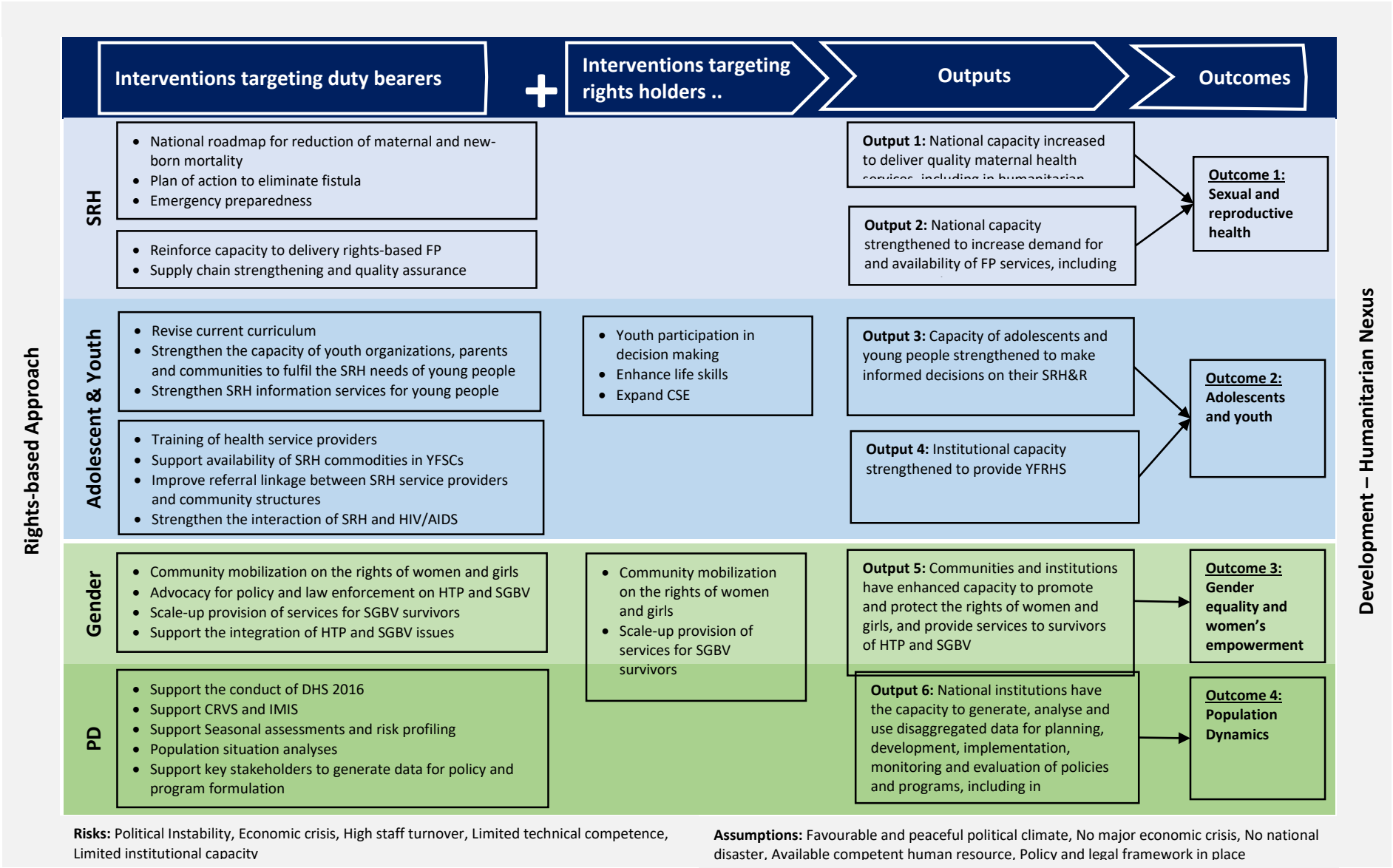
Output 2- Expenditure	4,254,547	6,041,368	7,008,758	7,199,097	24,503,770	40%
Output 3 - Expenditure	250,654	1,528,015	735,175	1,190,903	3,704,747	6%
Output 4 - Expenditure	63,418	409,336	233,839	394,869	1,101,462	2%
Output 5 - Expenditure	713,894	1,621,902	2,621,632	1,500,925	6,458,353	10%
Output 6 - Expenditure	965,496	1,387,138	2,209,802	2,332,662	6,895,098	11%
PCA - Expenditure	145,900	84,698	102,572	77,681	410,851	1%
PM - Expenditure	790,519	1,543,947	1,692,952	1,288,256	5,315,674	9%
TOTAL - Expenditure	**8,926,812**	**17,516,927**	**18,865,730**	**16,361,441**	**61,670,910**	100%

Assessment of CP8 resources by output from 2016-2019 shows that Output 2 has attracted the most resources (USD 24.5million; 40%) followed by output 1 and 6 (22% and 11%).

3.3. THEORY OF CHANGE/LOGIC MODEL

As shown below in Figure 9, a simplified logic model illustrates how planned activities in four focus areas are to achieve outputs that, in turn, will accomplish four major UNFPA SP Outcomes. These four major outcomes are to contribute to the overall UNFPA goal: "The achievement of universal access to sexual and reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the International Conference on Population and Development agenda."

Figure 4: Model explaining the relationship between countries, output and outcomes


Rights-based Approach
Development – Humanitarian Nexus
Interventions targeting duty bearers
+
Interventions targeting rights holders ..
Outputs
Outcomes
SRH
National roadmap for reduction of maternal and new-born mortality
Plan of action to eliminate fistula
Emergency preparedness
Reinforce capacity to delivery rights-based FP
Supply chain strengthening and quality assurance
Output 1: National capacity increased to deliver quality maternal health
Output 2: National capacity strengthened to increase demand for and availability of FP services, including
Outcome 1: Sexual and reproductive health
Adolescent & Youth
Revise current curriculum
Strengthen the capacity of youth organizations, parents and communities to fulfil the SRH needs of young people
Strengthen SRH information services for young people
Training of health service providers
Support availability of SRH commodities in YFSCs
Improve referral linkage between SRH service providers and community structures
Strengthen the interaction of SRH and HIV/AIDS
Youth participation in decision making
Enhance life skills
Expand CSE
Output 3: Capacity of adolescents and young people strengthened to make informed decisions on their SRH&R
Output 4: Institutional capacity strengthened to provide YFRHS
Outcome 2: Adolescents and youth
Gender
Community mobilization on the rights of women and girls
Advocacy for policy and law enforcement on HTP and SGBV
Scale-up provision of services for SGBV survivors
Support the integration of HTP and SGBV issues
Community mobilization on the rights of women and girls
Scale-up provision of services for SGBV survivors
Output 5: Communities and institutions have enhanced capacity to promote and protect the rights of women and girls, and provide services to survivors of HTP and SGBV
Outcome 3: Gender equality and women's empowerment
PD
Support the conduct of DHS 2016
Support CRVS and IMIS
Support Seasonal assessments and risk profiling
Population situation analyses
Support key stakeholders to generate data for policy and program formulation
Output 6: National institutions have the capacity to generate, analyse and use disaggregated data for planning, development, implementation, monitoring and evaluation of policies and programs, including in
Outcome 4: Population Dynamics
Risks: Political Instability, Economic crisis, High staff turnover, Limited technical competence, Limited institutional capacity
Assumptions: Favourable and peaceful political climate, No major economic crisis, No national disaster, Available competent human resource, Policy and legal framework in place

CHAPTER 4: FINDINGS- ANSWERS TO THE EVALUATION QUESTIONS

This chapter presents the findings of the evaluation for each of the 12 evaluation questions. There are two components, answering the evaluation questions at the programmatic and strategic levels. CPE Component 1 analyses CP thematic areas against the evaluation criteria of relevance, effectiveness, efficiency and sustainability. Component 2 analyses the strategic positioning of UNFPA CO using criteria: *coordination* with the UNCT and *added value* of UNFPA, and humanitarian-development connectedness. Under component 1, the findings are presented for the four (4) component areas of sexual and reproductive health, adolescent and youth development, gender equality and women's empowerment, and population and development.

4.1 RELEVANCE

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

4.1.1 Sexual and Reproductive Health

Summary:

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

Ethiopia is one of the low-income countries that showed noticeable improvement in addressing SRH related problems including maternal and newborn mortality during the period of MDGs. However, the magnitude of SRH problems is still unacceptably high. According to the 2017 global burden of diseases analyses, maternal and neonatal disorders contribute to 18% of total disability adjusted life years lost in Ethiopia[26]. Low coverage of evidence-based SRH interventions because of both supply- and demand-side barriers to service utilization are the primary drivers of SRH related morbidity, mortality, and disability in the country.

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

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

healthcare – primarily focuses on SRH related targets including increasing utilization of contraceptives and maternal health services, and decreasing SRH problems including unmet need for family planning, obstetric fistula, and teenage pregnancy. SRH related components of HSTP are informed by findings of preceding national surveys including DHS, health facility assessments, and evaluation of the performance of the previous strategic plan.[27]

Despite increasing coverage of maternal health services, coverage is still far behind national targets for most SRH services and quality of care has been a major issue for those who utilized services both leading to sub-optimal results. Limited capacity of care providers has been a major reason behind poor quality of services. For example, according to the 2016 service availability and readiness assessment (SARA 2016) report[28], the mean availability of BEmONC[29] signal functions was 46%. A cross-sectional assessment of public and private health facilities in 2016 also showed that there has been challenges in provision of CEmONC services[30]. Unmet need for family planning is high particularly among rural-dwelling women. Ensuring uninterrupted supply of family planning commodities is an important aspect of the family planning program in the country. Government procurement policies and procedures are currently not efficient to an extent that is expected for family planning and other SRH commodities.

The SRH component of the 8th CP is well aligned with the second GTP of Ethiopia and the corresponding UN Development Assistant Framework[31]. Outputs under the SRH outcome of the CP are directly related to health and HIV outcomes of the third pillar of GTP 2 (investing in human capital and expanding access to social services. In more specific terms, SRH components of the 8th CP were directly linked to the first strategic objective of HSTP and the National RH Strategy 2016-2020 particularly in the areas of family planning and maternal and newborn health. The program has also been aligned with specific strategies supporting the expansion of SRH services including those on human resource including midwifery trainings[32,33] and elimination of obstetric fistula[34]. The design of the 8th CP was also aligned with relevant area specific strategic documents of UNFPA[35,36].

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

[27] FMoH. Health Sector Transformation Plan (HSTP) 2014/15 - 2019/20. 2015.
[28] Ethiopia Service Availability and Readiness Assessment Survey 2016
[29] Basic Emergency Obstetric and Newborn Care
[30] FMoH & EPHI. Ethiopian CEmONC Assessment 2016.
[31] UNDP. United Nations Development Assistance Framework for Ethiopia 2016-2020. 2016
[32] Midwifery roadmap 2016-2025
[33] Global Midwifery Strategy 2018-2030
[34] Strategic plan for Elimination of Obstetric Fistula
[35] UNFPA Strategic Framework for Global Program to Enhance RHCS (2013 - 2020)
[36] Choices not Chance – UNFPA FP strategy (2012-2020)

UNFPA provides …both technical and financial assistance to the ministry … They are members of different technical working groups including maternal health, adolescent and youth health, and reproductive health and family planning… They are always first in our list of partners. They plan with us; their plan is well aligned with that of ours...

Outputs of the SRH component are also clearly linked, as expected, to the UN Agenda 2030 and vision of UNFPA to end preventable maternal deaths and unmet need for family planning[37]. The UNFPA Strategic Plans (2014-2017 and 2018-2021) and the SRH component of the 8th CP were relevant in addressing priority SRH needs of Ethiopians and critical capacity gaps of mandated duty bearers.

Stakeholder interviews and document reviews[38] revealed that SRH components of the 8th CP largely focused on predominantly rural woredas [39] benefiting relatively disadvantaged segments of the population. Support for expansion of maternity waiting homes in health centers with hard to reach catchment populations and provision of material and technical support for the provision of SRH services to internally displaced communities were among SRH components serving highly vulnerable segments of the population. The Co's engagement in supporting family planning services in Ethio-Somali region, a region with the lowest coverage of family planning, and responses provided to conflict induced IDPs allowed UNFPA to support most vulnerable segments of the population in the areas of family planning and other SRH issues.

4.1.2 Adolescents and Youth Development

Summary:

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

Ethiopia has large and fast-growing adolescent and youth populations who make up more than a third of the total population. Adolescents and youth in the age group 10-14, 15-19, and 20-24 years account for 15.6%, 10.6%, and 7.6% of the total population of Ethiopia, respectively. The adolescent and youth development component is relevant in addressing the needs of youths in the country. The national youth

[37] UNFPA. UNFPA Strategic Plan 2018 - 2021. 2018

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

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

policy of Ethiopia recognizes and promotes the rights of young people and its achievement through their full participation[40]. The national adolescent and youth health strategy 2016-2020 considers high rates of SRH related problems including risky sexual practices, child marriage, early child bearing, unintended pregnancy, unsafe abortion and its complications and STIs including HIV as major causes of morbidity among adolescents and youth. Limited access to recreational facilities and adolescent and youth friendly SRH services are among the major causes of high incidence of these problems. In response, the strategy proposes six priority areas of actions including: access to AYH information and age appropriate CSE and life-skills education, enhancing equitable access to high quality, efficient and effective adolescent and youth-friendly health services, strengthening strategic information and research on adolescents and youth, promoting a supportive and enabling policy environment, supporting and facilitating youth engagement and ownership of health programs, and strengthening inter-sectoral coordination, networking and partnership[41].

The adolescent and youth component of the 8th CP of UNFPA supported activities that intended to: 1) build the capacity of adolescents and young people so that they will be able to make informed decision on their sexual and reproductive health and rights and 2) strengthen institutional capacity for the provision of adolescent and youth friendly SRH services. The inclusion of activities that target empowering adolescents and youth as right holders and building the capacity of service providing institutions as duty bearers makes the AYD component of the 8th CP aligned with the rights-based approach considered as a guiding principle of AYHS 2016-2020 and the goal of UNFPA's strategic plan - 2018-2021[42]. UNFPA's engagement with health, HIV, and youth sectors at federal, regional, and woreda levels allowed the 8th CP to access adolescents and youth and their service providers at youth centers, health facilities, and schools. Rising number of youth centers, health centers, and school enrollment rate throughout Ethiopia makes these sectors most appropriate for services targeting adolescents and youth in the country.

Youth centers and youth associations: Expansion of youth centers and their increasing utilization by adolescents and youth creates opportunities for safe recreational activities and provision of SRH messages and services to young people. Youth centers supported by the program mostly served youth with limited access to alternative recreational centers. Youth associations also create opportunities for organized engagement of youth in decision making that affects the lives of young people. Uneven distribution of youth centers (mostly located in urban areas) and their relatively low utilization by youth girls are major challenges of interventions that intend to reach adolescent and youth through youth centers. Youth associations too weak to support planned youth empowerment programs were also challenges for the AYD component of the CP.

Adolescent and youth friendly service centers: Lack of confidentiality and judgmental attitude of healthcare providers towards adolescents and youth seeking reproductive health services has been a major barrier of SRH service utilization among adolescents and youth. Establishment of YFSCs and training of healthcare providers on adolescent and youth health helped in addressing these barriers. The AYD

[40] Ministry of Youth Sports and Culture. National Youth Policy. Addis Ababa, Ethiopia 2004
[41] MCH Directorate MoH. National Adolescent and Youth Health Strategy (2016-2020). Addis Ababa, Ethiopia 2016
[42] UNFPA. UNFPA Strategic Plan 2018 - 2021. 2018

component of the 8th CP supported the establishment and functionality of adolescent and youth friendly service centers in government health centers has the potential to address barriers to utilization of SRH services among adolescents and youth.

Life skill training, peer education, and mini-media support: Knowledge on SRH topics including family planning and HIV is limited among Ethiopians including adolescents and youth[43]. The first pillar in the HIV prevention roadmap of Ethiopia is combination prevention for adolescent girls, young women and their male partners[44]. Even though there was no separate output for HIV related interventions, there were HIV prevention and control interventions targeting in-school and out-of school youth, female sex workers, adolescents living with HIV and other most at risk adolescent and youth populations. Life skill training, peer education, and SRH information dissemination through mini-media and other channels, which were supported through the 8th CP, were relevant to address knowledge/information gap and build capacities of young people so that they will demand for services and make informed decisions on their SRH and rights.

The CO has been responsive to emergencies that happened during the period of the 8th CP. Humanitarian interventions for people internally displaced following conflicts and drought during the period of the 8th CP were results of responsive programming at the CO level. Thus, the CO was able to respond to emerging needs of the population.

4.1.3 Gender equality and women's empowerment

Summary:

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

The GEWE component of the 8th CP is consistent with global priorities and international commitments such as CEDAW[45]; London Girl Summit 2014 which the government committed to end FGM and CM; and SDG Goal 5. Key informant interviews with the CO and RPOs revealed that the 8th Country UNFPA Programme was relevant and in line with the goals and priorities set in the UNDAF pillar 5 which is Equality and Empowerment.

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

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

[44] FHAPCO. HIV Prevention in Ethiopia: National Road Map 2018 - 2020. 2018

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

violence using different strategies. Gender programme interventions are clearly aligned to the priorities of the Ethiopian Government as identified in the Growth and Transformation Plan and various sectoral plans as well as adhering to the Paris Declaration and Accra Agenda for Action principles in providing support to government priorities in the areas of reproductive health, adolescent and youth development, population and development, and gender equality and women's empowerment. For example, UNFPA is providing support to the Ethiopian Government in realizing its commitment to end Child Marriage and Female Genital Mutilation by 2025 as a key player of this joint effort. It is also in line with national policies and strategies such as National policy on women (1993)[46], The Constitution of the Federal Democratic of Ethiopia (1995)[47], The Revised Family Law (2000)[48], The Revised Penal Code (2005)[49], The National Strategy and Action Plan on Harmful Traditional Practices (HTPs) against Women and Children (2013)[50], and National Children's Policy (2017)[51].

The 2018-2021 UNFPA Strategic Plan builds on the progress achieved by the Millennium Development Goals; addresses the remaining challenges in the areas of sexual and reproductive health and reproductive rights; and draws on the evidence and the lessons learned from the previous strategic plan cycle, 2014-2017, to improve its approaches and strategies. UNFPA organizes its work around three transformative and people-centred results in the period leading up to 2030. These include: (a) an end to preventable maternal deaths; (b) an end to the unmet need for family planning; and (c) an end to gender-based violence and all harmful practices, including female genital mutilation and child, early and forced marriage[52].

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

[46] National policy on women (1993) aim to create appropriate structures within government offices and institutions to establish equitable and gender-sensitive public policies stipulating equal participation of women in national, social, economic and political life.
[47] The Constitution of the Federal Democratic of Ethiopia (1995) guarantee equal rights for women. It nullify all customary practices and laws that discriminated against women. It also declare that all international agreements by Ethiopia are integral part of the law of the country.
48 The Revised Family Law (2000) ensure equal rights of women and also criminalized many customary harmful practices such as early marriage, FGM and marriage by abduction including domestic violence and rape.
[49] The Revised Penal Code (2005) grant equal rights to women and men as heads of the household, ensuring women's right to equal share of property in marriage and divorce and stipulate the minimum age for marriage.
[50] The National Strategy and Action Plan on Harmful Traditional Practices (HTPs) against Women and Children (MoWCYA, 2013) targets to reduce child marriage, abduction and FGM/C as part of broader gender and equity goals.
[51] National Children's Policy (2017) safeguard the rights of children to be protected from HTPs and indicate strategies in relation to the promotion of the rights of children as well as preventive and responsive measures.
[52] Strategic Plan 2018-2021

Woredas[53]. The DHS report is also used a complimentary document since it indicates the magnitude of the problem.

KII and FGDs with CO, RPOs and government IPs indicated that the CO provides quick responses during crisis based on its mandate, though there is shortage of resources to address and respond to all situations. The CO responds to crisis situations like conflict and internal displacement. UNFPA during emergency provides dignity kits though the provision is not compatible to the demand. There is high demand during emergency for support since women and children are the most affected by any crises. Interviews with the IPs revealed that though UNFPA tries to respond to emerging needs there is always a matter of mandate and shortage of resources to address the needs. Two examples were cited where UNFPA responded to a humanitarian situation in collaboration with the MoWCYA.

The first is the distribution of dignity kits for emergency situations in Somalia, Gedeo and Oromia region for internally displaced adolescents and women. The second one was the support provided for 7 sexually abused women aged 20 to 35 from Somalia region….. (KII with Federal IP).

4.1.4 POPULATION AND DEVELOPMENT

Summary

The GoET/UNFPA 8th Country Programme Population and Development component is adapted to the needs of the disadvantaged population groups such as youth, women in both development and humanitarian settings. The PD component was designed in consultation with national stakeholders and took into consideration the national needs for data availability and use for improving evidence-based and population-centred decision-making. The objectives and strategies of the population and development interventions are aligned with the ICPD PoA, the SDG Agenda 2030 and Ethiopian National Development Policy, GTP II. The PD Component is anchored on the ICPD PoA, Principle 2 which stipulates that the human beings are at the centre of sustainable development while Chapter 2 focuses on population and development integration.

A careful review of the key activities and interviews with stakeholders knowledgeable about UNFPA PD activities showed that the PD Focus area is consistent with the needs of its beneficiaries, especially the staff and specialists employed by the main implementing partner agencies (CSA, and Population and Development Directorate of Planning and Development Commission), and within national priorities and strategies. Additionally, respondents felt that contribution of UNFPA to PD is reflective of the ICPD Program of Action, SDG Agenda 2030. UNFPA supported technical assistance is particularly relevant given Ethiopia's trends toward an youthful population age structure, which require expertise in population projections as well as support for policy development for the needs of its young population. UNFPA's support for PD related activities is aligned with the development of the SDGs, which is guiding the UNDAF.

UNFPA supported interventions are informed by prevailing national and sectoral policies and plans such as the National Population Policy, and the national strategy for development, GTP II. The development or

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

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

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

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

4.2 EFFECTIVENESS

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

4.2.1 SEXUAL AND REPRODUCTIVE HEALTH COMPONENT

Summary:

Ethiopia 8TH CP achieved substantial improvements in SRH and AYD outcomes. Comparison of findings of the 2016 EDHS and the 2019 mini-EDHS showed that there has been noticeable improvement in access to and utilization of SRH services including maternal health and family planning. Implementation of activities planned as part of SRH and AYD components of the 8th CP are on track; targets are already met for most output indicators a year ahead of schedule, indicating on one hand strong implementation efforts and strict compliance with annual work plans and on the other hand very conservative target setting. Evidences from different sources of data indicated there was meaningful contribution from the 8th CP in the area of family planning and also maternal health and AYD. UNFPA's support has been helpful for

increasing access, quality, demand, and utilization of family planning and maternal health services. Engagement at the federal level has been acknowledged to have brought system-wide influences by securing uninterrupted supply of family planning commodities, improved national policies, strategies, guidelines, and training support in the areas of both SRH and AYD. Youth friendly service centers and youth centers supported through the 8th CP are mostly equipped up to national standards. Low utilization of some youth centers, lack of waiting area, and work overload among YFSCs because of integration of comprehensive OPD services may limit rate of contact of adolescents and youth with UNFPA supported facilities and utilization of contacts for SRH information and service provision.

Maternal health and family planning indicators have shown dramatic changes during the period of UNFPA's 8th country program. Between 2016 and 2019, noticeable changes were observed in utilization of maternal health services including antenatal care, facility delivery, and skilled birth attendance. Similar

changes were observed in the area of family planning. Between 2016 and 2019, contraceptive prevalence rate increased from 35% to 41 % (Figure 11).

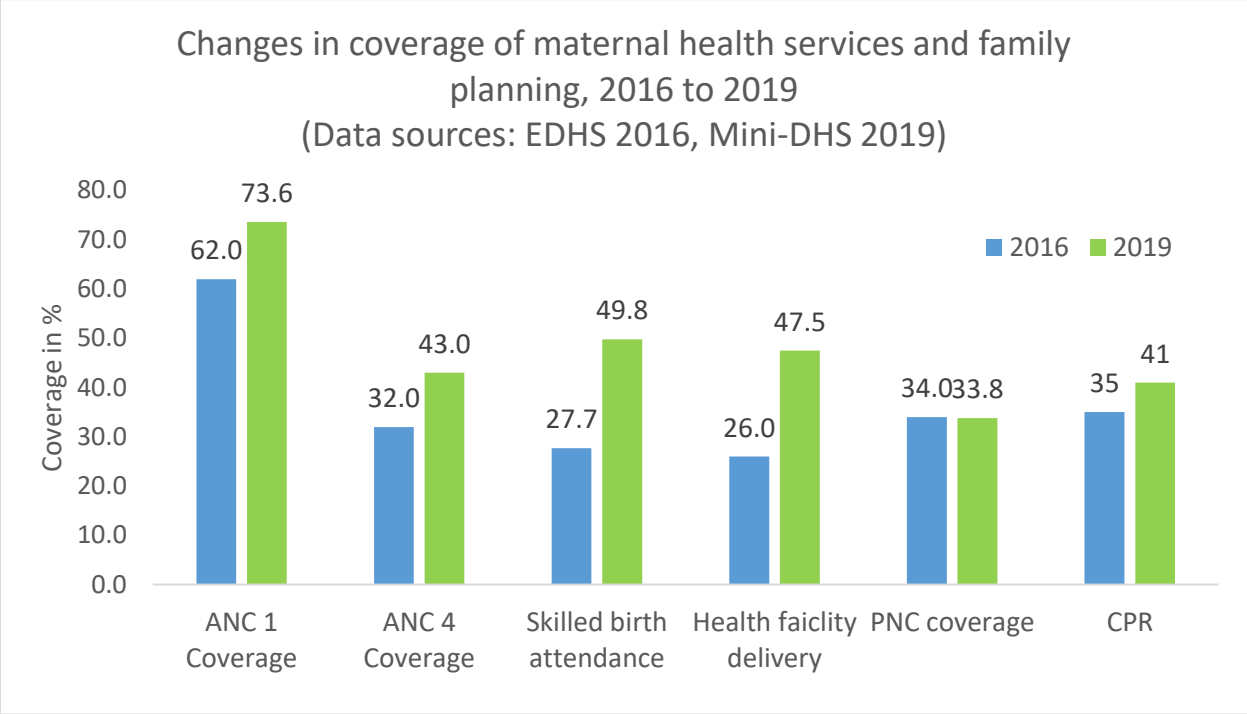


Figure 5: Changes in coverage of maternal health services, 2016 – 2019

UNFPA's support has been helpful for increasing demand for, quality, and utilization of maternal health and family planning services. These contributions include 1) engagement (technical support as a member of technical working groups or other modalities) at federal level in the development of strategies, guidelines, and trainings and 2) Specific interventions targeting operational woredas.

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

UNFPA's engagement was also optimal in monitoring progress of Ethiopia towards its commitments on family planning and mobilizing other partners for securing funds for family planning commodities. The 8th CP has also collaborated with the pharmaceuticals supply and regulatory agencies of the country to strengthen the pharmaceutical supply chain system and its regulatory mechanisms. Support for pre-

service education in the area of logistics management system was also provided to develop human capacity in the area. UNFPA provided trainings and other technical support to enhance the capacity of the Ethiopian Pharmaceutical Supply Agency (EPSA) – a government agency responsible for procurement and distribution of health commodities mainly for the public sector – in the areas of procurement management and costing of supply chain operations. UNFPA's support for expansion of family planning service delivery points during the 8th CP focused on training of Health Extension Workers (HEWs) on long acting reversible contraceptive methods. About 21,329 level 4 HEWs were trained with UNFPA's support on the provision of LARC allowing extension of LARC services to the health post level.

Progress towards output level targets of the 8th CP in general has been good for most of the SRH indicators. Stakeholders' interviews and document reviews showed that over the past four years, the program achieved more than 80% of its five years targets for seven of the nine output indicators. Coverage of MDSR reporting, availability of services including EmONC and availability of modern contraceptives among target health facilities have very good progress, sometimes passing the target set for the whole period of the program. Relatively low achievement was recorded for training of HEWs on LAFP. So far, 21,329 (59.2%) of the targeted 36,000 HEWs were training on LARFP methods during the program's life time. The main reason for this under achievement, according to a program analyst, was expansion in content of training that affected training duration and thus total number of trainees. Relatively lower progress was observed on availability of life-saving maternal/RH medicines among secondary service delivery points and number of HEWs trained on human rights-based family planning services with progress levels of 79% and 59%, respectively (Table 12).

Table 8 Progress of the 8th Country Program of UNFPA on SRH output indicators54

Indicator	8th CP Target for 2020	Achievement (2016 - 2019)	Progress in % by 2019[55]
Number of health facilities reporting on MDSR	125	150	120
Percent of SDPs offering modern contraceptives	85	98.1	115
Number of health facilities providing EmONC	108	105	97
Number of fistula repairs with support from UNFPA	2000	1840	92
Implementation rate of MISP indicators	45	40	89
Number of HEWs able to support human rights-based FP services	36000	21329	59
Percent of SDPs with life-saving maternal/RH medicines			
Primary	60	57.6	96
Secondary	100	79.1	79
Tertiary	100	83.3	83

While engagement at the federal level has been acknowledged to have brought nation-wide influences, specific interventions targeting specific geographic areas (operational woredas) were commonly reported

[54] UNFPA CO Annual Reports

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

as effective but too small in coverage to bring about large-scale impact. During the 8th CP, UNFPA supported different SRH interventions in eight regions and one city administration. However, coverage of woredas within each region was low; about 3 to 9 percent of the total woredas in the country were reached by specific SRH programs. Furthermore, only small portions of populations and health facilities in these target woredas were supported (Table13).

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

Region	Number of operational woredas[56] by SRH program area				
	EmONC	MDSR	Cervical Ca	Fistula[57]	Family Planning
Oromiya	21	29	14	2	
SNNP	8	17	12	1	21
Amhara	8	8	8	8	
Tigray	7	7	7		
Gambella	6	6	6	6	6
Afar	3	3	3		
Beni-Gum	7		7	7	7
Somali	9				9
Addis Ababa	2	2	2		2
Total	**71**	**72**	**59**	**24**	**45**

There is agreement among stakeholders in different regions and across all levels of the health system regarding the positive outcomes of support provided through the 8th CP. Table 14 provides a summary of outcomes consistently reported by interviewed stakeholders.

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

Programs in UNFPA operational woredas	Results consistently reported by stakeholders
EmONC	Trainings and donation of equipment and supplies enabled beneficiary health facilities to routinely provide EmONC services leading to comprehensive services at health centers; avoiding unnecessary referrals; and increased utilization of maternal health services.
MDSR	Supported health centers routinely review possible maternal deaths (both community and health facility deaths) and initiate quality improvement processes to address preventable causes of maternal mortality. Trainings on

[56] Note: This table doesn't reflect program coverage through federal/region level support

[57] Fistula treatment center was established in three universities. Interventions at woreda level include support for case identification and referral to these centers.

	MDSR in pre-service settings allowed reaching a wider target area. In-depth analyses of MDSR data was also supported at central and regional levels (one region). Maternity waiting homes furnished with support from UNFPA allowed mothers from far places to stay close to a health center during their last weeks of pregnancy leading to increased utilization of health facility delivery and postnatal care.
Cervical Cancer	Trainings provided on cervical cancer screening, diagnosis, and treatment allowed most health facilities to initiate screening programs. In addition, demand creation was supported through mass media messages.
Fistula	Support for identification and management of fistula cases by building the capacity of health workers and providing logistical support for patients during referral improved case detection and treatment. The establishment of additional fistula treatment centers contributed in addressing physical barriers to treatment centers.
Family planning	Trainings on long term family planning methods provided to HEWs allowed fast expansion of service delivery points providing alternative contraceptive methods at the lowest level of the health system. This has positively affected family planning utilization as well as clients' satisfaction in relation to availability of method choice.
Federal and regional level engagement	**Family planning** UNFPA's financial and technical support on family planning/RH commodities allowed ensuring uninterrupted availability of quality assured family planning/RH commodities. None of the health centers visited reported shortage of family planning commodities. During the 8th CP, UNFPA partnered with the MoH for the procurement of family planning and other RH commodities, financing source, and coordinator of actors for better mobilization of resources for family planning/RH commodities. **Maternal Health** Involvement of UNFPA in different technical working groups and task forces has been instrumental in the development and adoption of national and sub-national strategies and guidelines on maternal health contributing to quality of care at a national scale. Support for pre-service education, though not currently active in the areas of midwifery/obstetric and anaesthesia skills allowed staffing health centers and hospitals with more skilled personnel leading to provision of better care to mothers and newborns. Mentoring and professional development activities are being provided through professional associations.

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

Catchment-based mentoring for capacity building on BEmONC

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

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

Despite the expansion of health centers, physical access is still a challenge leading to home deliveries among rural women. Distance, physical barriers, and lack of transportation services in rural areas discourage mothers and their families from considering health facilities as a place of birth. As part of its support to MDSR, particularly with the response aspect, UNFPA supported health centers in its operational areas in the establishment of maternity waiting homes. Most of the supported maternity waiting homes were constructed through community contributions and managed by health centers. UNFPA provided equipment and furniture support to make the waiting homes functional. As described in documents[58] and mentioned by key informants, maternity waiting homes helped mothers from far places to stay close to a health facility during their final weeks of pregnancy. In addition, the homes created opportunities for women to learn about different health topics during their stay.

4.2.2 ADOLESCENTS AND YOUTH DEVELOPMENT COMPONENT

Summary:

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

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

The 8th CP of UNFPA reached young people in different situations with SRH messages and services through different strategies including peer education, life skills education[59], mini-media clubs, and information and service delivery through selected youth centres and YFSCs. The program also supported youth organizations to engage in advocacy and decision making on matters that affect their sexual and reproductive health and rights. The program provided trainings for facilitators/trainers and donated equipment for school clubs and youth centres with the intention of reaching young people with SRH messages and services, and encouraging their participation in provision of services. Youth associations were also supported through project management trainings, holding experience sharing visits, conducting different studies, and providing supervisory support. Targets of AYD activities also included female sex workers and adolescents living with HIV.

The 8th CP also supported health centres in establishing and running YFSCs dedicated for service provision to adolescents and youth. Support to these centres included furniture, audio visual equipment, and trainings for service providers. Sexual and reproductive health commodities were donated to YFSCs with the purpose of ensuring uninterrupted supply. Progress by the 6th month of the fourth year of the CP indicated that the program supported provision of SRH services for 99,521 (76.6% of target for 2020) young people with SRH services. In addition, 32,225 (80.6% of target) additional adolescents and youth also received life skills education. There was high achievement in the area of training health care providers on YFSRHS. More than the planned numbers of health workers were trained in this area. However, progress in increasing facilities providing the national Minimum standard AYSRH package is relatively slower (78.9% by mid-2019) (Table 15).

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

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

Life skill education in different settings is reported to be effective for providing SRH related information to adolescents and youth who otherwise would have been marginalized. Among the most commonly reported positive outcomes were increased confidence and school performance of female students and increased utilization of SRH services including family planning and condoms. School clubs supported with mini-media equipment and trainings were effective in reaching large numbers of students with important SRH information. The support in this area allowed to maximally utilize capacities of students and their

[59] Life skills education includes comprehensive sexual education

teachers in the regular provision of SRH information to school communities. Support provided to youth centers also created opportunities for adolescents and youth to spend their spare time in safer recreational activities that include library, in-door and out-door games in settings where there are high possibilities for exposure to written or spoken SRH messages.

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

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

Challenges in AYD Component:

- There is sub-optimal utilization of adolescents and youth gathering in youth centres for the provision of SRH messages and services because of limited linkage between the youth centres and SRH service providers in their catchment sites.
- Some youth centres are located at inaccessible locations resulting in non-use of available facilities despite fulfilment of furniture and equipment through UNFPA's financial support.
- Youth centers, targets for several adolescent and youth development activities, mostly serve boys than girls. Interventions targeting youth centres are unlikely to directly benefit girls. There were no deliberate efforts to increase utilization of these centers by youth girls.
- Girls' involvement in youth centre activities is very limited.
- Lack of comprehensiveness of SRH services at YFSCs leading to high referral rates to other units and other facilities
- Not all YFSCs have in-door and out-door recreational facilities
- Shortage of space compromising the utility of donated equipment (e.g. Television put/stored in examination rooms because there was no secure waiting area)
- Implementing capacity of government IPs and their district offices is very limited.
- As a result, planning, implementation, and monitoring (activities that are expected from IPs) are compromised. There is need for either more technical support at lower levels or more capacity building activities targeting the IPs themselves.

4.2.3 GENDER EQUALITY AND WOMEN'S EMPOWERMENT COMPONENT

Summary:

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

Document reviews and stakeholder interviews revealed that this component contributes to accelerate the effort of the Government of Ethiopia to achieve gender equality and women empowerment. UNFPA CO played a great role in promoting and addressing the issues of gender equality and women empowerment at federal, regional and Woreda levels employing different strategies. These strategies include accelerating abandonment of FGM via UNFPA-UNICEF Joint Programme;, promoting gender equality and women empowerment involving six UN Agencies: UNFPA, UNICEF, UNDP, UNESCO, ILO, and

UN Women; .prevention and management of GBV; child marriage and FGM through funding by Swedish UN Association; ending child marriage through UNFPA-UNICEF Joint Global Programme ; economic and social empowerment and protection of women and girls from HTPS and Gender Based Violence in Emergency and host community and Data management[60]. Though it cannot be said that the achievements are purely credited to UNFPA, it is safe to conclude that UNFPA played a catalyst role in the process as well as introducing new initiatives that can be scaled up and replicated by government institutions, CSOs and the different grass root structures.

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

Indicators	Baseline (2016)	Targets (2020)	Achievement	Percent
Number of identified gender-based violence survivors who received services per national protocol	3900	10,000	5227	21%
Percentage of health facilities in humanitarian settings with post-rape kits and other clinical commodities for management of sexual violence	30	45	35	33%

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

Federal level engagement

At federal level, the CO engaged in high level advocacy and coordination activities to support the effort of the government to accelerate the progress made with regards to gender equality and women empowerment as stipulated in the national, regional and international policy frameworks. Many achievements were identified during this evaluation. Among the most noticeable achievements are the support UNFPA provided to the technical working group at ministerial level to strengthen national coordination efforts; support evidence based interventions[61]; and developing national level reports that the Government of Ethiopia committed to achieve in different platforms. The technical working group which works closely with the MoWCYA on gender thematic areas is indicated as a forum where issues related to gender equality and women empowerment are being dealt with at a national level and brought to the attention of the Federal government.

KIIs with government and NGO IPs showed that UNFPA provides support to strengthen national level coordination forums. An example repeatedly mentioned was the National Alliance to End FGM and CM. The alliance has members from government, UN agencies and CSO. While the Ministry is the chair, UNFPA

[60] Progress Report on Implementation of the Eighth Country Programme , 1 January to 30 June 2019

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

was the co-chair during the establishment though the co-chairmanship is rotating. The respondents indicated that UNFPAs contribution in the alliance is very noticeable. It was also stated by the CO and the government IPs at federal level that UNFPA provided technical and financial support and was highly engaged in supporting the development of the *National Costed Roadmap to End Child Marriage and FGM/C* that will accelerate the effort of the Federal Democratic Republic of Ethiopia to end early/child marriage and female genital mutilation/ cutting.

Regional and Woreda level engagement

At regional levels, UNFPA engages in capacity building of relevant stakeholders and communities[62] to prevent gender-based violence and harmful traditional practices including FGM and CM. The intervention at regional level also included the coordination of activities to minimize duplication of activities and maximize the use of scarce resources. The Multi Sectorial Coordination of relevant government stakeholders was indicated as a great achievement by the focus group discussants from BoWCYA from all the regions.

Stakeholders also reported that UNFPA CO supported the provision of direct services to survivors and also scaling up of best practices. There is evidence of provision of services to survivors of GBV through local NGOs such as AWSAD[63] and APDA - Barbra May Maternity Hospital[64] and also through Regional Women Associations[65]. The establishment of One Stop Centers is also another mode of engagement where direct services are provided to abused girls and women under one roof. UNFPA also provides health facilities in humanitarian settings with post-rape kits and other clinical commodities for management of sexual violence.

Achievements

1. **Prevention of SGBV and HTPs**

Stakeholder interviews reported that several capacity building initiatives were implemented to ensure that adolescent girls and women enjoy the rights that are clearly stipulated in different international, national and regional frameworks. These include the establishment of Women and Girl's Friendly Spaces in humanitarian setting and development programs; establishing and supporting family and community dialogue and community conversations at grass root level; establishing and strengthening different committees to combat GBV and HTPs; supporting and facilitating school based interventions; supporting universities to combat SGBV. At these fora, issues bordering on gender quality, women's empowerment and rights are discussed. Beneficiaries are taught on how to prevent SGBV and HTPs in the targeted Woredas.

[62] 19,000 community members (including 7,500 female) were educated about the legal implications of FGM in Afar and SNNP regions. In addition, Training of Trainers (TOT) was conducted for 110 community leaders by the Bureau of Women, and Children Affairs in SNNPR. The community leaders consequently reached 81,000 community members (including 21,000 female) through outreach activities in 110 kebeles of four target woredas (districts) in SNNPR (Esara, Mereko, Dalocha and Dasenech districts). Training was also given for 200 community counsellors in SNNPR on psychosocial mentoring, coaching and counselling of survivors. Accordingly, the counsellors have reached 2300 survivors and among this figure, around 1200 were FGM survivors, 98 were rape, child marriage and abduction whereas the rest were survivors of polygamy and divorce.

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

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

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

Women and Girl's Friendly Spaces in humanitarian setting and development programs: The Safe Spaces both in humanitarian and development has contributed a lot to facilitate the dissemination of information and raise the awareness of participants on different forms of GBV including HTPs, SRH, family planning and HIV/AIDS. It also created an opportunity for the adolescent girls and women to receive training on financial literacy and economic empowerment through cash support[66].The Safe Spaces also provide opportunities for girls and women to fight violation of their rights in groups rather than trying to address the problem individually.The Safe Spaces also helped adolescent girls and women to prevent GBV including HTPs and challenge the existing socio-cultural norms. Beyond the discussions it also created a chance for women and adolescent girls to report violations of their and their peers right when it occurs.

Community Conversation/Dialogue: Community conversation or dialogue which is being carried out in the local communities using the community dialogue manual, provides opportunity for adolescent girls and women to participate and express their needs and concerns as well as come up with viable solution to their problems.[67]. It was also reported during the KIIs, IIs and FGDs, that the participation of boys and men in the dialogue contributed to the achievement of the objective of the programme. Trainings were also provided to 600 men to build their capacity on how to prevent and report child marriage, SGBV, FGM and other HCP cases. UNFPA also supported the establishment of Men Development Groups (MDGs)[68].

It was also highly stressed that the role of influential people in the community including clan and religious leaders in the discussion has contributed a lot in preventing and stopping FGM and CM. In addition to engaging religious leaders in the prevention activities, faith-based organizations are also highly engaged in the fight against CM and FGM.

Establishing and supporting Anti HTP committees; Anti GBV Watch Group and Steering Committees at Woreda and Community levels: Stakeholder interviews indicated that capacity building of community structures such as Anti HTP committees; and establishing committees to combat FGM and CM at community level with the involvement of relevant government structures and influential people including traditional birth attendants has made a significant contribution in preventing FGM and CM[69]. Communities were also able to establish Watch Groups to make sure that no child is being married and no girl suffer from FGM/C[70]. In total, through the community based structures, women development groups, anti HTP committees and girls clubs more than 2,823 arranged FGM cases were stooped and 10 former circumcisers have stopped the practice and become CC facilitator[71]. The outcome of these community initiatives is that "e*veryone in our community is aware of the consequence of CM and FGM on the overall*

[66] Detailed achievement of UNFPA in the 8th CP is clearly elaborated in the Donor Report on Progress of the 2016-2020 Country Programme (As at 31st December 2018) and Progress Report on Implementation of the Eighth Country Programme , 1 January to 30 June 2019

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

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

[69] 700 Women development groups (12500 members) have been supported with technical and material supports, which have strengthened their leading role in fighting against GBV and HTPS including child marriage. Accordingly, community based structures, women development groups, anti HTP committees and girls clubs have managed to cancel more than 2463 arranged FGM cases.

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

[71] Donor Report on Progress of the 2016-2020 Country Programme (As at 31st December 2018)

wellbeing of not only women but also the family and the community". One outcome of these community-based initiatives is that local communities have declared to end CM and FGM in their communities.

About a total of 800 and 259 communities have made public declarations to end FGM and CM respectively (Table 14). Stakeholders who participated in the evaluation also reported that many communities have developed bylaws to prevent and stop the incidence of child marriage and FGM through social sanctions[72] to maintain the observed change within their communities[73].

Table 13: Number of communities that have made public declarations against FGM and CM74

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

School based interventions: Among the noticeable achievements of UNFPA's prevention effort is the school based intervention. In-depth interviews revealed that school-based interventions have enabled many girls to attend classes regularly and for school going girls and boys to get information on GBV/HTPs and other life skills[75]. UNFPA's support also include capacitating the school mini media and school libraries and supplying dignity kits for school going girls. Dignity materials have improved not only their school attendance but also aware them that it is natural.

Achievements

2. Prevention of SGBV and HTPs

Stakeholder interviews reported that several capacity building initiatives were implemented to ensure that adolescent girls and women enjoy the rights that are clearly stipulated in different international, national and regional frameworks. These include the establishment of Women and Girl's Friendly Spaces in humanitarian setting and development programs; establishing and supporting family and community dialogue and community conversations at grass root level; establishing and strengthening different committees and steering committees to combat GBV and HTPs; supporting and facilitating school based interventions; supporting universities to combat SGBV. At these fora, issues bordering on gender quality, women's empowerment and rights are discussed. Beneficiaries are taught on how to prevent SGBV and HTPs in the targeted Woredas.

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

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

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

Women and Girl's Friendly Spaces in humanitarian setting and development programs: The Safe Spaces both in humanitarian and development has contributed a lot to facilitate the dissemination of information and raise the awareness of participants on different forms of GBV including HTPs, SRH, family planning and HIV/AIDS. It also created an opportunity for the adolescent girls and women to receive training on financial literacy and economic empowerment through cash support[76].The Safe Spaces also provide opportunities for girls and women to fight violation of their rights in groups rather than trying to address the problem individually. The Safe Space also helped adolescent girls and women to prevent GBV including HTPs and challenge the existing socio-cultural norms. Beyond the discussions it also created a chance for women and adolescent girls to report violations of their and their peers right when it occurs.

Community Conversation/Dialogue: Community conversation/dialogue which is being carried out in the local communities using the community dialogue manual, provides opportunity for adolescent girls and women who are burdened with reproductive, productive and social roles and responsibilities to participate and express their needs and concerns as well as come up with viable solution to their problems. IIs and FGDs with beneficiaries noted that the establishment of the "Married" and "Unmarried" girl/youth groups also created a fertile ground for community members to discuss on existing cultural norms and HTPs based on their age and marital status[77].

It was also reported during the KIIs, IIs and FGDs, that the participation of boys and men in the dialogue greatly contribute to the achievement of the objective of the programme. Trainings were also provided to 600 men to build their capacity on how to do prevention and reporting of Child Marriage, SGBV, FGM and other HCP cases. UNFPA also supported the establishment of Men Development Groups (MDGs)[78].
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from FGM/C[80]. In total, through the community based structures, women development groups, anti HTP committees and girls clubs more than 2,823 arranged FGM cases were stooped and 10 former circumcisers have stopped the practice and become CC facilitator[81]. The outcome of these community initiatives is that "e*veryone in our community is aware of the consequence of CM and FGM on the overall wellbeing of not only women but also the family and the community".*

Document reviews also indicated that many local communities have declared to end CM and FGM in their communities. About a total of 800 and 259 communities have made public declarations to end FGM and CM respectively (Table 14). Stakeholders who participated in the evaluation also reported that many communities have developed bylaws to prevent and stop the incidence of child marriage and FGM through social sanctions[82] to maintain the observed change within their communities[83].

Table 14: Number of communities that have made public declarations against FGM and CM84

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School based interventions: Among the noticeable achievements of UNFPA's prevention effort is the school based intervention. In-depth interviews with a school director and a member of Girls' Club revealed that the school-based intervention has enabled many girls to attend classes regularly and for school going girls and boys to get information on GBV/HTPs and other life skills[85]. UNFPAs support also include capacitating the school mini media and school libraries and supplying dignity kits for school going girls. Dignity materials have improved not only their school attendance but also aware them that it is natural.

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

Providing holistic services through supporting and scaling up Safe Houses; and establishing One Stop Centers in public health centers has created a comfortable and safe environment for girls and women who are survivors of GBV.

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

[81] Donor Report on Progress of the 2016-2020 Country Programme (As at 31st December 2018)

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[84] SUMMARY OF 8th UNFPA ETHIOPIA COUNTRY PROGRAMME PERFORMANCE 2016 – 2020

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Safe Houses: KII with IPs, document reviews and site visits indicated the contribution of the Safe Houses in providing holistic services. Many girls and women survivors are rehabilitated and empowered and become self-reliant through the comprehensive services (medical, psychosocial and legal services) provided at the Safe Houses[86]. The provision of needs based skill training also created opportunities for adolescent girls and women to be self-employed or secure employment opportunities with the collaboration of private business sectors. The Safe Houses also created a conducive environment for the survivors to follow the legal process without threat and possible harm from the perpetrators.

During the 8TH CP, the document reviews and KII with the CO and IPs revealed that UNFPA supported the scaling up of highly demanded Safe Houses from 1 to 5[87]. All the Safe Houses are run by AWSAD or Women Association. This poses a challenge in terms of sustainability of the programme. Even though the existing Safe Houses are well managed and are providing quality services to survivors of GBV including HTPs, sustainability will be difficult since it is dependent on donors.

One Stop Center: One Stop Centers provide holistic services such as psycho-social, medical and legal services under one roof in public health facilities. This is to make sure that girls and women do not face secondary traumatization when they report any abuse to the police, medical personnel, and the public prosecutor. Hence having all the stakeholders under one roof and reporting the case with the support of a psychologist or social worker is beneficial for the survivor especially when they are children. Stakeholder interviews indicated that the direct services provided for survivors have made a significant change in the lives of many adolescent girls and women. A visit to one of the OSC, however, showed that there are not qualified personnel to handle the various aspects of services needed by an abused girl or women.

Table 15: GBV survivors who have received direct services

Output Indicators	**Baseline/2016**	**Target**	**Achieved**	
	July 2016	**July 2020**		
Number of identified gender-based violence survivors who received services per national protocol	3,900	10,000	5,544	81%
Percentage of health facilities in humanitarian settings with post-rape kits and other clinical commodities for management of sexual violence	30	45	35	78%

More than 6,000 survivors (both women and girls) affected by FGM related issues such as infibulation, obstructed urine and urinary infection, uterine prolapses have been repaired, and fistula survivors have been treated, counselled, and trained[88]. UNFPA during the same period also supported health facilities to

[86] UNFPA supported three safe houses (Hawassa, Assosa and Gilgelgibe) which provides comprehensive services (shelter, meal, psycho-social support, medical, skill trainings, legal follow-up, and so on) for 1843 (1252 women & girls and 591 children) survivors of violence.

[87] 894 SGBV survivors benefited from the Safe Houses. New Safe Houses are located in Dessie Town, Amhara Region and Mekelle Town in Tigray region and the Safe Houses are the first of its kind both in the Amhara and Tigray region which makes the total number of fully supported safe houses to be 4 including the two in Hawassa and Benisangul Gumuz.

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

be at the forefront in creating demand for service uptake. 81 health extension workers and 416 health development armies from 31 Kebeles (6 urban, 25 rural)[89] were trained as frontline outreach agents in creating demand for service uptake. This is also an indication of the integration of the of the gender issues with sexual and reproductive health components.

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

Protection of the rights of survivors of GBV and HTPs is one of the intervention areas of UNFPA and results has been indicated in UNFPA reports[90]. Though it is clear that provision of the direct services to survivors has a component of protecting the rights of girls and women, it was also possible to notice that it is not as such effective in achieving the desired goal. KIIs from the CO, BoWCYA and CSOs reported that this intervention is challenging. According to the respondents the previous Charities and Societies Proclamation (CSP) which prohibited CSOs to work on issues related to rights, the weak law enforcement, and slow legal process pose a challenge for its effectiveness. Though UNFPA engages in building the capacity of law enforcement, it is not as intensive as the other capacity building programmes. For example from 1st January to 30th June 2019, only 98 law enforcement bodies[91] participated in the capacity building with the assumption that it will lead to increased understanding of SGBV/HTPs and consequently to the respect of the rights of survivors.

Gender mainstreaming

The promotion of gender equality and women empowerment being the central principal of UNFPAs work is both a key programmatic area for UNFPA and also a cross cutting issue that influence its interventions to ensuring all services are provided in a gender-responsive manner and in promoting the collection and use of gender disaggregated data to enable identification of the specific needs of women and girls.[92] KII with the CO as well as the reviewed documents illustrated that gender equality and women's empowerment is mainstreamed in the country program in general. The SRH and AYD and the humanitarian programmes have gender components that directly address the needs and concerns of adolescent girls and women as they are most vulnerable segments of the society. When a programme is designed there is always a discussion within the CO to make sure that the programme has mainstreamed gender. From the document review it was also possible to know that humanitarian interventions also focus on mainstreaming gender and addressing issues related to girls and women since they are most vulnerable. But it was observed during the data collection that it is not always possible to get gender disaggregated data.

Challenges encountered

Though UNFPA achieved a lot as indicated above, there are also challenges that were identified in area of prevention, provision and protection.

[89] Progress Report on Implementation of the Eighth Country Programme , 1 January to 30 June 2019

[90] There is improved the enforcement of the laws special units established in the police and justice structures to deal with cases of violence and HTPs. Different capacity building trainings provided for law enforcement bodies

[91] Donor Report on Progress of the 2016-2020 Country Programme (As at 31st December 2018)

[92] United Nations Population Fund, UNFPA Strategic Plan 2014-2017

1. **Prevention of SGBV and HTPs**

There is lack of evidence whether the interventions address gender norms (socio-cultural rules) and gender roles (socially constructed roles, behaviors, activities and attributes that society considers appropriate for girls and women). Regardless of the intensive capacity building and awareness raising programs there seems to be situations where the community practice CM and FGM using other means. There is a challenge to measure behavioral change. As indicated by key informants there are cases where community members from the target Woredas who have participated in the community conversation or dialogue go to the neighboring Woredas to carry out FGM or marry off young girls. This is an indication that though they have the information, due to the dominant cultural norms people tend to practice it. This requires an intensive programme that goes beyond awareness and dialogue that also focus on making sure that they are brought to the law enforcement bodies. For example focus group discuss from Gamella indicated that it is not only the community members who marry off their young girls but also people who hold position in government offices who practice it. This is posing a challenge in an effort to end CM because they are contradicting what they say in public and they practice it in their households. This is shared by many key informants and community members.

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

There is not enough skilled personnel to handle the different aspects of services provided at the OSC.

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

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

4.2.4 POPULATION AND DEVELOPMENT PROGRAMME

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

Summary:

The PD interventions have advanced the course of increasing data availability both at the Federal and Regional levels. At the Federal levels, the Ethiopian DHS 20016 and 2019 mini-reports have been produced. At Regional levels, IMIS has been established to provide data for regional planning in 5 out of six planned regions. A number of resources (human, technical and logistics) have been invested towards census undertaking and other efforts at data generation and utilisation (CSA) and integration and advocacy (Population and Development Directorate of Planning and Development Commission). However despite all arrangements for the 4th PHC being completed, it has been postponed for three times, thereby affecting the data accessibility in the country. Thus conducting the census, improving the

accessibility to IMIS and its functionality, and implementing population and development advocacy is an important step.

Data for development & advocacy including in humanitarian Programme

Output 6 of UNFPA 8th Country programme relates to outcome 4 of the UNFPA Strategic Plan (2014-2017) which is on population dynamics. The support provided to the preparation and analysis of censuses and other population-based surveys is a critical means of ensuring that women, adolescents, and youth are at the centre of sustainable development policies, and that programmes have the evidence needed to improve SRH services. In addition to the support provided for the preparation and analysis of censuses and other population-based surveys (in the framework of generation and utilization of data), UNFPA works at country level to ensure that programmes, policies and strategies are robustly evidence-based and informed by a thorough understanding of population issues such as migration, urbanization and ageing, the implications of the demographic dividend for national development, etc.

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

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

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

Resource mobilization to support the census

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

Technical Assistance for the Census

According to document reviews and key informant interviews with programme leads, the CO contributed in addressing the challenges of Central Statistical Agency (CSA) especially in the area of capacity development**.** Due to high staff attrition during the intercensal period (2007-2017), a number of gaps in the technical capacity of the Agency to conduct a census exist. To fill the gaps, UNFPA CO provided support for a long-term and short-term technical assistance for the census hiring high level international experts (a Census Technical Advisor, a GIS expert and two national staff for census communication and process documentation. In terms of short-term support, UNFPA CO hired a data processing consultant to develop data processing strategy for the digital census and a post-enumeration consultant to train CSA staff and to assist in the development of PES data collection and matching tools.

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

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

Integrated Management Information System (IMIS):

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

Capacity building trainings and participation of technical and managerial staff in international conferences were supported to both Vital Events Registration Agency (VERA) and CSA staffs. A statistical abstract of indicators for all sectors from 2008-2018 which was also uploaded on the IMIS, on the CSA's website. The

statistical abstract is expected to facilitate easier access to data by end-users. Procurement of census equipment for the implementation of the 2018 Ethiopian Population and Housing Census (EPHC), including severs, portable solar power banks, etc.

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

Support seasonal assessments and risk profiling for vulnerability analysis and risk reduction interventions is all about identifying regions and districts that are vulnerable to natural calamities so as to preposition prevention and emergency preparedness. The seasonal assessments that followed the occurrence of drought are able to identify the needs in the various sectors including the precarious protection situation of vulnerable groups including women and children, persons with disabilities, the elderly, internally displaced persons etc. The various requirements including protection needs were subsequently highlighted in the 2016 Humanitarian Requirements Document[93].

Challenges:

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

Advocacy and Policy Dialogue

The second flank of the population and development component is advocacy and policy dialogue. A number of activities were implemented to promote advocacy and policy dialogue on population issues. These include i) UNFPA support to the comprehensive assessment of the 1993 Population Policy, ii) support to undertake a study on 'Demographic Dynamics and Priority Population Issues in the Country' which will be instrumental in the formulation of a 15 year perspective development plan; iii) support in

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

the national assessment in the implementation of the Addis Ababa Declaration on Population and Development (AADPD+5) in the framework of the ICPD at 25.

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

Challenges: The general challenges during the implementation of the programme output include 1. Meagre attention paid to population matters at national level and low capacity of the Planning and Development Commission to be on the driver's seat on population and development matters, 2.. Low capacity (capacity gap) of Regional PD partners for the execution of planned activities (a case in point is SNNPR Region vis-à-vis the implementation of the PSA activity), 4. Late disbursement of funds and subsequently the resultant late implementation of activities, leading to late reporting on the utilization of funds (OFA cases), 5. Bottleneck related to low administrative capacity (administrative finance personnel, etc.,) hampering timely reporting of utilized funds and DCT modality of fund transfer, 6. Low technical capacity in areas of population and development among partners.

4.3 EFFICIENCY

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

Summary:

Based on desk review of financial documents, stakeholder interviews, review of a sample of annual work plans, annual reports, and the SRH/AYD component made good use of available resources – human, financial and technical. All the IPs subscribe to the Project Implementation Manual with which CO managed its staff, funds and technical resources. Strong government financial control systems along with strict compliance with PIM and annual work plans facilitated the use of resources from the CP only for agreed upon purposes. Funds are transferred to IPs only based on AWPs. Overall budget utilization, though it was sub-optimal during the early years, has also increased during the life of the 8th CP. UNFPA's administrative and financial procedures have been effective in facilitating compliance with AWPs but

delay in transfer of funds was a common challenge affecting quality of program implementation because IPs had to rush implementation of program activities during final months or weeks of the reporting period. A major challenge to efficiency of the 8th CP arises from the intention to achieve large geographic coverage within the very narrow funding space. Support for interventions targeting operational woredas both in the areas of SRH and AYD are very thinly spread over wide geographic areas than what can potentially be supported meaningfully.

This section analyses the process and timeliness in developing Annual Work Plans and its effects in timely commencement of annual implementation, the quarterly release of funds to IPs, implementation rates for the country programme resources and the efficiency check mechanisms used in the country programme. According to various 8TH CP documents and stakeholder interviews, once AWPs are approved, resources are provided to each IP and operational area. Funds transferred to IPs are generally used reasonably and only to the purposes they are assigned for. The Project Implementation Manual[94] which relies on government system for financial control has been frequently mentioned as a reason for strict compliance to AWPs.

The CO follows the quarterly schedule for release of funds to the partners. Funds are released to partners upon submission of quality and complete reports of the ending quarter and requests for the new quarter. The reports required in each quarter are: (i) quarterly progress report: work plan monitoring tool (Cover all activities in the ending quarterly work plan); (ii) summary activity reports for all completed and partially completed activities; (iii) field monitoring reports for each of the visits undertaken; FACE – Expenditure for ending Quarter and request for new Quarter; bank statement for ending quarter; bank reconciliation statement – ending quarter; quarterly work plan for new quarter (activities including monitoring and coordination) and detailed budgets and quarterly monitoring plan for new quarter almost all the partners submitted the required reports. The 8th CP is managed largely through NEX modalities and some interventions are also implemented via direct execution (DEX).

In terms of human resources and management of the CP, are the Deputy Country Representative, with programme officers or output managers in charge of quality of programming and programme implementation, resource mobilization and technical support at all levels , and provision of technical support in their respective thematic areas . The regional programmes are coordinated by regional coordinator with the support of regional programme officers. Country Programme oversight , programme quality assurance and capacity building functions (a focus on monitoring , evaluation , HACT and corporate reporting) are managed by M&E team and Programme Support Team. Operations Unit coordinates finance, HR, Procurement, Protocol, and senior accountants who support HACT compliance . The SRH/AYD components were managed by seven staff with the support of 24 consultants hired for different assignments. The GEWE component had 4 Country Office Staff, and had worked with 3 consultants, while 13 consultants have worked with the three CO staff of the Population and Development Component.

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

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

Country Programme Resources and Utilisation Rates

The ET established that budget utilization was low during the early phase of the 8th CP; however, it increased from 73.8% in 2016 to 90.4% in 2018. The six months budget expenditure in 2019 also reached 60.4% indicating that there will be further improvement in budget utilization in 2019 (Figure 10).

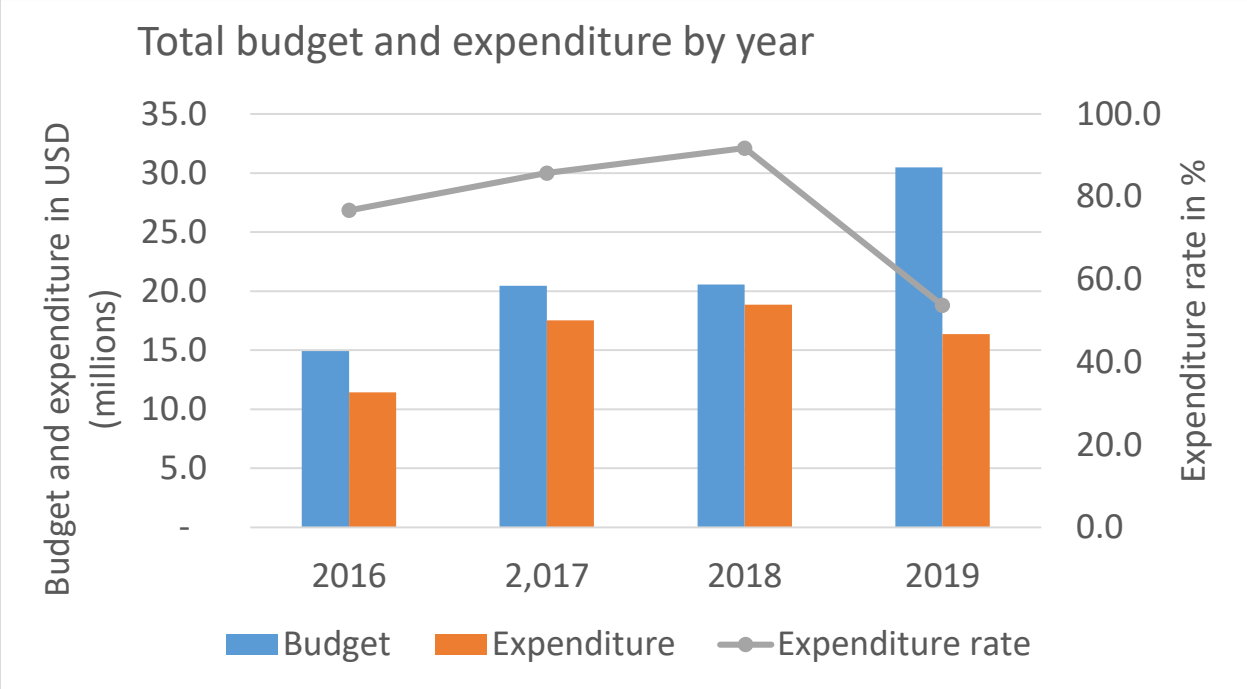

Figure 6: Total budget, expenditure, and expenditure rate by year (expenditure for 2019 is only for the first six months)

In addition to increasing budget utilization, there has also been declining share in management cost indicating continuously improving efficiency throughout the life of the program. The percentage share of expenditure on program management from total program cost is in general declining (Figure 12).

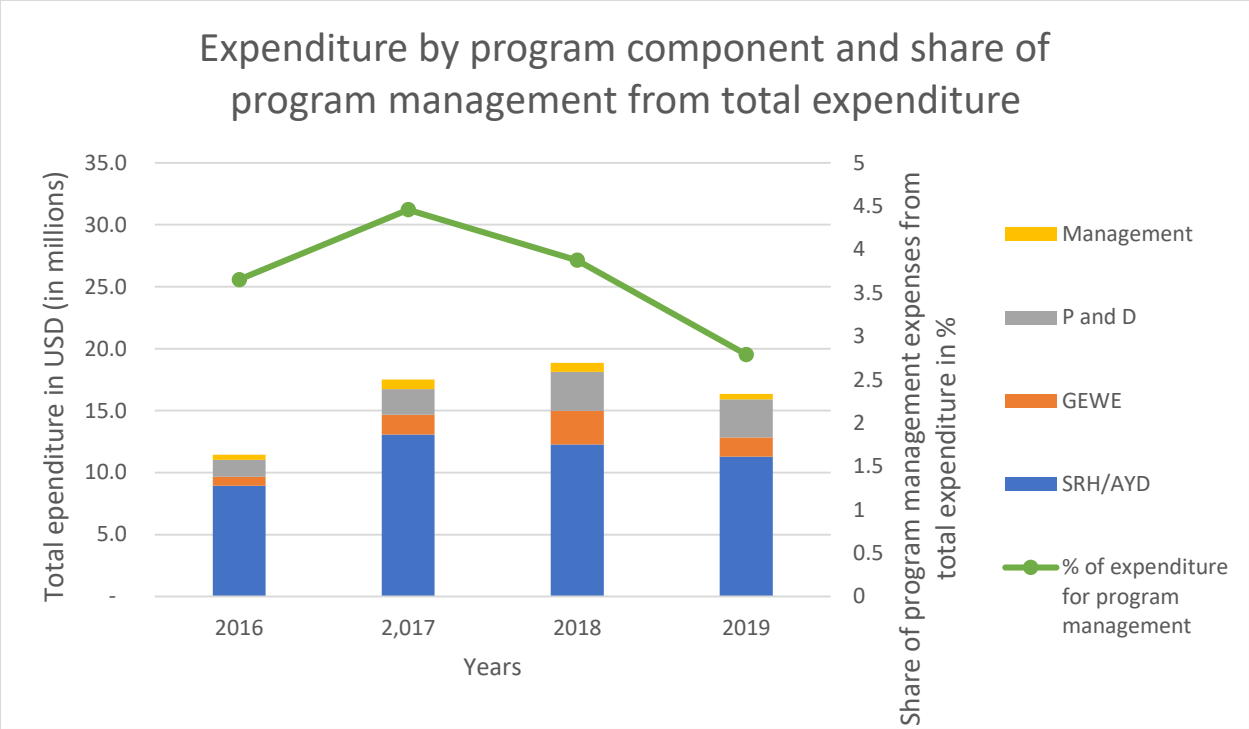

Figure 7: Expenditure by program component and share of program management from total expenditure by year (expenditure for 2019 is only for the first six months)

The evaluation established that the fund utilisation rate for the CP resources were generally high as indicated in table 23 below. Output I (SRH), output 5 (GEWE) and output 6 (population and development) have on average had high utilization rate over the three years (respectively).Thus performance in relation to fund utilization rates was good.

Implementing partners consistently mentioned that allocated budget is all the time transferred to their accounts based on AWPs. However, delay in transferring funds for implementation of AWPs was almost universally reported as a challenge throughout the period of the 8th CP. This has affected the quality of implementation of planned activities. IPs reported that they most of the time had to rush implementation of activities whenever there are delays in transfer of funds. Long chain of approval of annual plans, report reviews, and transfer of funds through a long chain of government structures and local security challenges were the primary reasons for delayed transfer of funds. High staff turnover among implementing partners along with limited opportunities for regular trainings on UNFPA's electronic performance management system also created gaps in capacity to timely report performance and request budget among implementing partners. A key informant from Addis Ababa described how common delay in budget transfer is by saying:

> *There is always delay in transfer of funds. Delays are much longer for the first quarter of each budget year. For example, today is almost the end of the second month of the first quarter. We just got a notification that funds are released. There is always delay in transferring funds … The good thing is that UNFPA is somehow flexible on time of liquidation and reporting. They allow us to liquidate our expenses over a period of six months.*

Key informant, IP from Addis Ababa

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

Financial support from the 8th CP was used for procurement of equipment and furniture like beds, mattresses, cooking utensils, audiovisual equipment, computers, and others for use by maternity waiting homes, youth friendly service centers (YFSC)[95], and school clubs. These items had fairly similar specifications; however, procurements were handled by several woreda/zone level recipients requiring parallel and fragmented procurement processes. A centralized approach to procurement of these items would have allowed integrating better quality items at a relatively lower price.

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

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

Government IPs (federal as well as regional) have clear mandates in the areas they are currently supported by UNFPA. These IPs have strategic importance in their respective area of intervention. Procedures for identification of non-government IPs were stringent in terms of their ability to identify well positioned and capable organizations for respective areas of interventions. Diversity of implementing partners allowed the 8th CP of UNFPA to address different categories of factors affecting access to and utilization of quality assured SRH and AYD interventions. Partners involved in the implementation of the 8th CP include federal and regional government structures for finance and economic development, health, HIV

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

prevention and control, and women, children and youth affairs, faith-based organizations, international NGOs, local NGOs, professional associations, and universities. Government IPs were selected based on their strategic importance arising from their mandate while non-government IPs were selected based on a competitive process leading to long term partnerships.

There are a number of measures put in place to ensure efficient implementation of the AWPs and fund utilization. One of these is the development of work plans with clear activity and results linkage and detailed budgets. The CO and partners engage in a rigorous process of developing the AWPs and this takes almost 3 months usually from June to July. The clarity of results in the AWPs and the detailed activity based budgets developed makes it if relatively easy for the partners to implement the work plans and use the resources within the agreed upon activity costs. Key informant interviews and focus group discussions showed that the budgeting and planning process was transparent, jointly discussed and agreed between staff at UNFPA and IPs. Second, the evaluation team realized that from 2016, the IP and UNFPA CO programme officers undertake implementation planning once the Quarterly work plans have been approved. This involves review of the QWP by all persons involved in its implementation and developing the concept notes for each of the activities in the work plan. This makes it easy for the person implementing the activity to adhere to the required quality standards. However, not all IPs consistently prepare the concept notes. The third measure is quarterly review of partners financial and programme report. On a quarterly basis, the IP manager and UNFPA M&E team review the reports submitted by the IPs. The reports are reviewed mainly for completeness, quality of reporting especially results' reporting, fund utilization rates. The Evaluation Team saw these quarterly analyses and evidence of feedback to the IPs. However, it was also noted that the issues identified in the IP reports reoccur in the subsequent quarter, hence the need for UNFPA to always follow up to ensure the issues are addressed. Field monitoring is another important measure. Here UNFPA and IPs conduct regular monitoring of the AWP implementation. The monitoring reports reviewed indicated the monitoring focuses on assessing progress in implementation of the work plans, assessment of progress in achieving the AWP results, supporting partners in preparation of reports, monitoring fund utilization and accountability and supporting the partners to document good practices.

Regional Offices

UNFPA has 8 regional Offices. These play a very vital role in ensuring greater efficiency of the CP implementation. The RO staff support and supervise the implementation of the programme activities (for both regional and district IPs) in their area of jurisdiction. The staffs act as contact between UNFPA CO, regional, district government and the beneficiary population. This ensures faster information flow between UNFPA and other national level line ministries. The ROs also represent UNFPA in the various districts and regional working groups. However, the evaluation team noted that whereas the ROs have close collaboration with the district, the information gap on the activities of the national level IPs makes it difficult for them to monitor and provide necessary support. Secondly, the funding mechanism for RO activities makes it difficult for them to implement their activities in a timely manner.

Administrative and financial procedures

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

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

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

4.4 SUSTAINABILITY

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

Summary:

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

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

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

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

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

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

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

However, the sustainability of the 8TH CP interventions can be threatened by lack of explicit exit strategy within the programme design**.** Ownership of the program benefits was not imbedded in the programme design though it was embarked on during the course of implementation. A case in point is the implementation of the Safe Spaces. This case is likely to face sustainability problems given that most Safe Spaces are run by CSOs. Another case is where the programme provided equipment that have operation and maintenance cost implications eg Ambulances which may be difficult to meet by the beneficiary institutions. Although districts have put in place mechanisms for ensuring continuous operation of the ambulances, they may need donor support to supplement their efforts. All the interventions are donor driven.. None of the NGOs raised its own funds. NGO IPs can only sustain action if receiving financial support for operational costs from other sources and strategies can be determined by funding availability.

Table 16: Evidences of Sustainability per Intervention area 8TH CP (2016-2020)

Areas of interventions	**Evidence of sustainability/low sustainability**
EmONC	Pre-service trainings, in-service trainings, and mentorship programs by nature build the capacity of the health workforce which will have a lasting effect of quality of services each health worker provides in the Ethiopian health care system.
MDSR	Maternal and perinatal death surveillance and response is part of the Ethiopian public health emergency management (PHEM) system that requires health facilities to regularly report on reportable events. Once a health facility starts reporting on MDSR through support from UNFPA, the system won't allow regression. Review of maternal and perinatal deaths are conducted by a team of health professionals. Knowledge and skills acquired by individual health workers trained through UNFPA support are shared to a wider team of health workers in target health facilities facilitating sustainability of the process. UNFPA's support in furnishing and equipping maternity waiting homes, as part of strengthening the response aspect of MDSR, supplements health centers' and communities' efforts to establish and run waiting homes for pregnant women during their last weeks of pregnancy. These homes are mostly constructed by contributions from health centers and communities and their routine functions are financed by community contributions. There is increasing utilization of maternity waiting homes paralleled with increasing acceptance of community contribution to cover their costs guaranteeing their sustainability.

Areas of interventions	Evidence of sustainability/low sustainability
Cervical Cancer	UNFPA provided training of health workers on Cervical Cancer screening and management for health facilities targeted by the Ministry of Health for donation of equipment and supplies. This coordination allowed services to be available in target health centers. Trained health workers are salaried government staff and do not expect any extra payment for service provision.
Family planning	Family planning utilization has increased during the period of the 8th CP. Trainings provided to Health Extension Workers will have positive effect on the long term availability of alternative contraceptive methods including long acting methods as attrition among HEWs is very low. The increase in demand for family planning will positively influence service providers to ensure continuous supply of contraceptives. Strengthening EPSA's logistics management system through UNFPA supported trainings and experience sharing visits will have a positive impact on human capacity. However, the opportunity created by large scale procurements was not adequately used to build the procurement capacity of EPSA. Procurement of some family planning and SRH commodities is fully dependent on UNFPA's procurement support and there is no sustainability plan or exist strategy for the supply of any of these commodities in the future.
Building the capacity of youth centers	Youth centers provided with equipment and furniture support as part of the 8th CP generate revenue covering their own expenses. Safe recreational activities will continue irrespective of external support. However, there is no mechanism in place to ensure the provision of SRH and HIV related services (free of charge) continue in the centers. For example, SRH clinic from one of the model youth centers is now closed because health workers are not happy with salary.
Support to school clubs	The school community is rich in human capacity because of availability of teachers and students with diverse areas of interest. Supporting school clubs with minimum initial set of equipment to run programs aligned with their primary objective allowed them to sustain their functions in the provision of SRH related messages. School clubs (particularly mini-media) donated with mini-media equipment by UNFPA during the 8th CP are currently running by their own.

4.5 LESSONS LEARNT

For the implementation activities of each component of the 8th Country Programme, a number of lessons were learnt.

SRH Component

Maternity Waiting Homes, if well promoted and equipped, can increase uptake for institutional delivery and postnatal care, thereby decreasing maternal and neonatal morbidity and mortality. Integration of trainings in to pre service education/ curriculum is an effective approach to reduce cost and ensures sustainability in the long term in addressing training needs of health professionals. Integration of MDSR training into pre service education in Gondar and Jimma universities is a good example. Strengthening the capacity of hospital on Reproductive, Maternal, and Newborn Health (RMNH) mentoring has worked well to regularly and effectively cascade mentoring support to health centers located in their catchment area with minimum cost. Fistula survivors are major advocates for the prevention of fistula. They bring more clients for repair after their own successful repairs.

FP/RHCS

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

Adolescents and Youth Development

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

Gender Equality and Women's Empowerment

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

Population and Development Component

UNFPA's continued engagement with government, donors and other UN Agencies sustained momentum and support for the census, despite uncertainties regarding the enumeration date.

South-South collaboration enables information and experience sharing on new and emerging census methodologies to improve census methodologies and outcomes, including in cases where conventional census undertaking may not be feasible.

The organization of advocacy events in the regional states according to the theme of the advocacy event gives recognition to the prevailing population and development issues in the regions. Joint implementation of planned activities by stakeholders involved in population issues increases the level of success and common ownership of population and development matters and initiatives in the country. A mixture of modalities such as "direct payment", "direct implementation" and "reimbursement"

(depending on the context of the IPs) has proved to be an effective way of reducing protracted hiccups associated to late disbursement of financial resources and late liquidation of Operating Fund Accounts (OFAs). The role of academia in generating research on population issues is essential for the successful implementation of activities in the population program, particularly as related to evidence-based policy planning. Renewed engagement and consultations with new senior management staff of the Planning and Development Commission (PDC) on UNFPA's mandate and priority programmatic areas (through courtesy visit by UNFPA management) has been instrumental in reinvigorating UNFPA's partnership with the PDC and redressing the priority areas of engagement caused by frequent turnover in the appointment of high level officials at the PDC. Continued advocacy by UNFPA and engagement with the Planning and Development Commission is necessary to position population issues in the development and transformative agenda of the country.

4.6 UNCT Coordination and Value Added.

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

Summary of Findings:

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

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

UNFPCA contributes in other interim coordination groups such as joint programmes in UNCT settings. The UNCT includes representatives of the United Nations Operations and Programmes and other UN entities

accredited to Ethiopia. Under the leadership of a non-resident coordinator, UNCT is responsible for the effective coordination of the United Nations System in Ethiopia. The UN assistance to Ethiopia is coordinated through the United Nations Development Assistance Framework which provides the basis for collaboration, coherence and effectiveness of the United Nations systems initiatives. UNDAF is instrumental in rallying capacities, resources and comparative advantages of all members of the UN system behind the strategic visions and priorities of the national development agenda.
UNFPA is a member of the inter-Agency Programme Management Team (PMT) and Operation Management Team (OMT) and co-chairs the M&E Working Group. The UNCT oversees the PMT which comprises Heads of Programmes from all United Nations Agencies and/or Deputy Heads of Office. It provides strategic and technical leadership for the implementation of the UNDAF and is responsible for overseeing the work of UNDAF Pillar Groups and UNDAF M&E Group to ensure effective coordination and timely achievement of UNDAF results. The Operation Management Team (OMT) comprises senior operations managers of UN agencies in Ethiopia and aims to ensure a more efficient, streamlined and coordinated administrative management system amongst UN agencies. Additionally, the UNCT has established a UN Monitoring and Evaluation (M&E) Group to enhance United Nations inter-Agency coordination and collaboration in monitoring and evaluation and to provide technical assistance to the Pillar Groups in programme monitoring and performance progress measurement towards achieving UNDAF Outcomes. UNFPA Ethiopia acts as a lead agency for the UNDAF M&E group and has been active in the midterm review (MTR) of the 2016–2020 UNDAF. It has provided vital recommendations, particularly on the tracking of UNDAF outcomes in the country.

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

In addition to UNFPA membership in the above mentioned UNDAF strategic level coordination mechanisms, UNFPA CO participates in coordination mechanisms by thematic areas and or cross cutting issues such as Gender and humanitarian emergencies. UNFPA participates under the leadership of UN Women in the Gender Thematic Group and coordinates its humanitarian emergencies with OCHA.
Based on numerous stakeholder interviews and document reviews, there is strong evidence of active and effective UNCT collaboration by the UNFPA CO. UNFPA CO collaborates with UNICEF on Joint Programme on Child Marriage and GBV. While UNFPA plays administrative role in GBV project, UNICEF leads in ending child marriage while also UNFPA plays active role in humanitarian emergencies

UNFPA CO in Ethiopia is active in UN coordination system and engages in coordination mechanisms of the government at Federal and Regional levels as relevant to its thematic areas. Working with 43 Implementing Partners (IPs) including Government IPs i.e. national IPs, regional bodies, and universities and Non-governmental organizations, UNFPA Ethiopia has continued to work in direct coordination with

in-country partners. At Federal level, it works with the ministries in charge of Finance and Economic Cooperation, Health, Women, Children, Youth, Refugee/IDP, as well as Food Security and Humanitarian/Livelihood affairs) as well as the Planning and Development Commission, and the Central Statistical Agency. At the regional levels, UNFPA works with regional sectoral bureaus, CSOs, NGOs, and private sector actors.

Other coordination structures are also established through joint programmes with other UN Agencies. UNFPA is currently involved in coordination for the implementation of two joint programmes: 2 joint programmes for the abandonment of Female Genital Mutilation / Cutting (FGM/C) with UNICEF and with co-financing from DFID, Norway, Italy, Germany and the Netherlands.

Coordination is also part of the UNFPA internal programme monitoring and evaluation arrangements. Programme M&E plans indicate organization of Quarterly Review Meetings at both national and regional levels under the leadership of the MoFED (coordinating authority) for all Implementing Partners to discuss projects' progress against signed Annual Work Plans (AWPs), to identify implementation challenges and to devise mitigating measures. UNFPA Ethiopia team members have been co-chair of some working groups like the Monitoring and Evaluation Group, while the Country Representative has deputised for the Regional Coordinator of UNDP in Ethiopia. Some stakeholders expressed a concern, however, that while active participation in inter-agency working groups raises visibility of UNFPA and is highly appreciated, it may focus too much UNFPA staff attention inward within the UNCT at a time when aggressive external efforts at fundraising might be a greater priority.

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

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

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

4.7 CONNECTEDNESS

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

Summary:

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

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

The structure of UNFPA CO is organized based on expected outcomes for development programs while it is based on target population for the humanitarian team. Outcomes (SRH, AYD, WEGE. & P&D) have their own teams. A separate team exists for humanitarian interventions. The existence of separate humanitarian team facilitates timely response and effective follow-up of emergency responses; however,

utilizing subject matter expertise in each of the development program team as inputs for development and implementation of humanitarian interventions requires additional coordination efforts.. UNFPA CO has a designated person to coordinate humanitarian and emergency disaster preparedness and response.

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

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

Observations and staff interviews at Itang Health Center serving Ethiopians who hosted South Sudanese refugees and ARRA Health Center in Gnueyyiel Refugee Camp located just a few kilometers away from Itang Health Center demonstrated the very wide disparity between services provided to the two populations. A compound with broken fence flooded with river water, falling apart health center buildings, old and dirty examination beds and delivery couches, non-functional equipment, piles of unnecessary documents, very few staff, and no patients around during a working hour characterize Itang Health Center as it was observed in September 2019. Interview with staff of Itang Health Center and WoHO revealed that there is no shortage of supplies and equipment for maternal health services; however, these resources didn't translate into better access and utilization of services. In contrary, ARRA Health Center in Gnueyyiel Refugee Camp has well-constructed blocks, clean and well organized examination rooms, adequate staff, and the necessary supplies and equipment for provision of maternal health and family planning services. Utilization of maternal health services is reported to be high. All signal functions of BEmONC were available in the health center.

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

CHAPTER 5: CONCLUSIONS

5.1 STRATEGIC-LEVEL CONCLUSIONS:

Conclusion 1: C1

The 8TH CP activities in Ethiopia are all well-aligned with the priorities and principles of Ethiopian government development plan, UNFPA Strategic Plans (2014-2017, 2018-2021); Ethiopian Government development priorities, ICPD PoA and SDG Agenda 2030 and CEDAW.. They addressed the needs of the population as identified in national development and sectoral plans through various needs assessments and consultation with different implementation partners. Thus the 8th CP interventions are relevant to the context, priorities of the country and have adequately addressed the needs of the populations as identified in the GTPII and vial needs assessments.

Origin: EQ 1

Associated Recommendation:

The strategic approach of focusing on the population needs tallying with the country policies and strategies has enabled UNFPA to target the vulnerable groups especially women in reproductive age. The practice of needs assessment and surveys especially for reproductive health issues has facilitated the availability of information for UNFPA to develop evidence-based country programme. CP interventions targeted the young population. It addressed the social and economic priorities identified in the National Youth Strategy and created a momentum for youth engagement which will be used to cover reproductive health needs of young people, including adolescents. The adolescents and youth component addressed the social and economic priorities identified in the National Youth Policy and created a momentum for youth engagement which will be used to cover reproductive health needs of young people, including adolescents. The gender component focused on awareness with maternal health issues specifically harmful practices, and responded to the needs of women, men and girls among the vulnerable population .The PD interventions aimed to generate national data and promote how to use same in planning and development. The UNFPA approach of participatory consultations with national stakeholders on CP priorities is a good practice and this helps focus the different Federal IPs on their mandates.

Conclusion 2: C2

The UNFPA CO is contributing significantly in improving the UNCT coordination mechanism especially in joint programming. Its mandates in SRH, adolescents and youth development gender, and population and development issues is well-noted. UNFPA is at the forefront of implementing the ICPD PoA and SDG Agenda 2030.

Origin: **EQ 1**

Associated Recommendation

UNFPA CO is contributing to improving the UNCT coordination especially in joint programming. Its role is well appreciated by national stakeholders and UNCT agencies in the country. With the emphasis on Delivering as One, there is room for synergy**.** It participates in multi layered coordination structures with UN agencies, federal and state government institutions in development and humanitarian contexts. Each

of these coordination structures has a defined objective, lead and participant organizations and regular and ad hoc coordination meetings. Whereas government coordination seek *mainly* to coordinate the interventions of the various development assistance actors on the ground, the UN coordination mechanisms aim beyond this level to joint planning, joint programming, resource mobilization, lobbying and advocacy. UNCT coordination mechanisms is effective in combining agencies technical resources in joint projects, planning and ensuing complementary interventions by comparative advantage of each agency. Government coordination structures are mostly effective for programme planning and information sharing on projects' progress. Effective coordination is challenged by dearth of financial resources and weak leadership.

Conclusion 3: C3

Both National IPs and UNCT acknowledged the comparative advantage of UNFPA CO in the country. The value added by UNFPA in the development field is considered high. Its strategic relevance in policy and key decision functions related to the UNFPA's mandate is widely acknowledged**.** Similarly UNFPA CO role in emergency preparedness and responsiveness is acknowledged by national stakeholders.

Origin: **EQ 5 and EQ 6**

Associated Recommendation

All national partners appreciated the added value of UNFPA CO especially in its core global mandates. Its role in upstream advocacy, well established financial and procurement systems, its high technical expertise in its mandated areas etc have been identified as added value. Its forerunner role in sexual and reproductive health, GBV, and data have been acknowledged as positive contributions. UNFPA's technical mandate in sexual and reproductive health already positions UNFPA at a comparative advantage in those thematic areas with regards to other organizations of the UN System. In addition to this competitive positioning, UNFPA offered through the current CP, technical expertise, extensive experience and programmatic achievements in RH, HIV/AIDS, GBV and gender.

Taking a lead in advocating sensitive issues on human rights, SRH, GBV, FP/RHS , CO had been a knowledge broker in successfully bridging and facilitating various players engaged in the development field. Advocating SRH, AYD, gender equality, women's empowerment, and the access to information and knowledge as a human right, 8TH CP has employed gender and human rights-based approach in the 8th CP design and implementation. UNFPA long experience in SRH, its technical expertise on data issue, its relationship with government and various established national and international networks have been adjudged as positive contributions to the 8th CP. Its advocacy role is continued in ICPD PoA and the SDG Agenda 2030.

Conclusion 4: C4

UNFPA CO in Ethiopia is responsive to demands from partners and to changing national priorities both in humanitarian and development axis. Humanitarian activities are integrated into development ones, although actual implementation is problematic.

Origin: EQ 6

Associated Recommendation

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

Conclusion 5: C5 - Efficiency

In spite of shrinking global funding space, UNFPA CO managed to raise financing for its country programme specific components.

Origin: EQ 3

Associated Recommendation:

Despite shrinking funding space, globally, UNFPA was relatively efficient in raising financing for its Country Programme. UNFPA business model of implementing through government and non government partners, NEX and DEX implementation modalities and programme integration approaches, Ethiopia-specific PIM, enhanced implementation efficiency and enabled UNFPA to reach most of its mid cycle CP performance indicators. Delays in funds transfer to partners indicate need to improve internal management processes and with partners.

Partnership with government and non-government organizations enabled UNFPA to expand programme implementation capacity and outreach to 8 regions, 2 city administrations and 122 districts but this implementation modality through IPs require greater attention to be devoted to building partners capacity for future sustainability of programmatic interventions and greater attention to be devoted to monitoring and validating IP performance and data.

Conclusion 6: C6 - Sustainability

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

Origing: EQ 4

Associated Recommendation

Sustainability assessment refers to the extent to which programme results are likely to continue after programme' support is completed and / or the willingness and capacity of implementing partners to maintain provision of these services without further programme technical and financial support.

Sustainability is challenged by more than the mere availability of financial resources to maintain the provision of services and or maintain the durability of effects acquired through the programme. Sustainability of programme support is also highly dependent on the continued stability of the human resources whose capacities have been built by the programme, adequacy of the institutional capacities and management systems 'for the provision of the service' *and willingness* of the institution to continue provision of the UNFPA-supported service.

Programme approach of participatory needs assessment, intensive consultations with stakeholders and joint programme planning with implementing partners, *in addition to* interventions at the local level and with local state and non-governmental stakeholders, helped develop a sense of ownership, improved chances of trained resources stability, and have thus increased chances for future sustainability of UNFPA interventions

Conclusion 7: C7 – Coordination

Coordination mechanisms proved mostly effective in combining agencies technical resources in joint projects, planning and ensuing complementary interventions by competitive advantage of each agency and finally sharing of information on projects' progress and achievements in coordination meetings. Coordination mechanisms, specifically UN Agency coordination mechanisms, were less effective in joint implementation and advocacy.

Origin: EQ 5

Associated recommendation

UNFPA participates in, is a member of, and at times is leading in multi layered coordination structures with UN agencies, federal and state government institutions in development and humanitarian contexts. Each of these coordination structures has a defined objective, lead and participant organizations and regular and ad hoc coordination meetings. Whereas government coordination seek *mainly* to coordinate the interventions of the various development assistance actors on the ground, the UN coordination mechanisms aim beyond this level to joint planning, joint programming, resource mobilization, lobbying and advocacy.

UN coordination mechanisms proved mostly effective in combining agencies technical resources in joint projects, planning and ensuing complementary interventions by competitive advantage of each agency. Government coordination structures are mostly effective for programme planning and information sharing on projects' progress. Effective coordination is challenged by dearth of financial resources and weak leadership.

Value Added: In addition to UNFPA technical mandate and value added in Sexual and Reproductive Health rights and services, UNFPA Ethiopia positioning at the states/community/locality level proved to be a competitive advantage as compared to other organizations.

Origin: EQ 5
Associated Recommendation

UNFPA's technical mandate in sexual and reproductive health already positions UNFPA at a comparative advantage in those thematic areas with regards to other organizations of the UN System. In addition to this competitive positioning, UNFPA offered through the current CP, technical expertise, extensive experience and programmatic achievements in RH, HIV/AIDS, GBV and gender

Besides its technical mandate and strengths areas, UNFPA managed to strategically position itself at the states, communities and locality levels. This geographic expansion provided opportunities to extend support to the states ministries and to deliver services, technical support and advocacy where the need is the greatest. 'Local positioning' offered UNFPA another strength and competitive advantage over other organizations in terms of established relationships and capacities to implement in the states and at the local level.

5.2 PROGRAMMATIC LEVEL

Conclusion 6: C6

There is evidence that the four components of the 8TH CP were relevant and in line with GTP II, sectoral policies such as Health Sector Strategic Development, Youth Policy, Gender policy, Population Policy and all advancing the ICPD PoA, SDG Agenda 2030 and UNFPA Strategic Plans of 2014-2017 and revised 2018-2021.

Origin: EQ 1

Associated Recommendation:

The SRH component was aligned and relevant to Health Sector Development and in line with ICPD PoA. Interventions on human resources for health workers, fistula identification and repair, cervical cancer treatment and family planning and reproductive health commodity services were in line with international, national, district priorities. Adolescent and youth component is aligned to National Youth Policy. The Adolescent and youth component, which includes capacity building for both duty bearers and rights holders, is aligned to National Youth Policy and linked to major challenges of the youth. However, attention given to facilitating the creation of economic opportunities for young people has been limited during the 8th CP as opposed to the increasing size of unemployed youth population in the country which in turn increases vulnerability for a number of social problems.

Similarly, the gender component is relevant and based on National Gender Policy and is in harmony with CEDAW.This component also addresses the key elements regarding gender-based violence, harmful traditional practices especially FGM, early child marriage in line with the ICPD PoA. The focus addresses prevention of GBV, protection of victims and provision of integrated services to survivors.

Conclusion 7: C7

The 8th CP is rated efficient going by timely preparation of annual work plans, relative high fund utilization across components, outputs and implementation partners and quality of its human resource. The CO staff complement is adequate and well skilled in the different components including the regional offices to monitor programme implementation at the regions. Delayed release of fund is associated with lateness in submission of reports. No qualified audit is reported or observed. Though the 8th CP components at the sub-national level was limited to 122 districts, in geographical terms the districts were spread out over a large geographic area of 8 regions and 2 cities which made programme implementation less efficient. Given the limited resources of the UNFPA programme, review of the geographical focus of the RH component of the country programme will need to take efficiency issues into account.

Administrative procedures and policies of UNFPA including the use of GPS, PIM, AWPs, and government financial control systems facilitated the use of CP resources only for intended purposes. However, long processes of approval and delays in fund transfers affect quality of implementation of supported activities particularly for IPs with no possibilities to pre-finance their activities.

Origin: EQ 3

Associated Recommendation

Conclusion 8: C8: Review of the available monitoring data and programme related studies on indicators in the results framework at output and outcome levels has shown that overall a relatively high number of outputs and outcomes was achieved in the four components of the country programme.
Origin: EQ 2

Associated Recommendation

The 8th CP is mostly ahead of schedule in terms of meeting output targets set for 2020. These imply strong implementation intensity on one hand and under-planning on the other hand. Some of the output indicators used to monitor the 8th CP have also limited linkage with actual support provided to service delivery points making assessment of effectiveness more challenging for some program areas. Even though it was not possible to attribute any population level result for the CP, there are enough evidences showing that UNFPA played vital role in improving SRH outcomes during the period of the 8th CP including access, quality, and utilization of maternal health services. Procurement and financial support for family planning/RH commodities ensured uninterrupted supply of quality assured supplies throughout the country. The 8th CP's support for equipping, furnishing, and training of youth friendly service centers and youth centers was effective in helping supported sites in operational woredas fulfill important national

standards. Factors beyond the control of the 8th CP including 1) low utilization of some youth centers because of inconvenient location, 2) very low utilization of youth centers by adolescent and youth girls, 3) lack of waiting area in YFSCs, and 4) work overload among YFSCs because of integration of comprehensive OPD services may limit rate of contact of adolescents and youth with UNFPA supported facilities and utilization of contacts for SRH information and service provision.

The GEWE component has contributed to raising awareness on gender-based violence including early child marriage, female genital cutting; created a critical mass of community and district leadership that advocate against GBV in terms of functional community-based anti-GBV groups. However, there is no focus on reproductive rights, and not enough capacity in the running of protection services for victims and survivors. Continued support for institutionalization and scale up of One Stop Centers is needed. The CO has not fully achieved its targets in protecting the rights of survivors of GBV including HTPs.

The PD component interventions resulted in increasing data availability at national and 5 district levels, and increased the appreciation of use of data for decision-making. At national level, the EDHS 2016 full report, key indicators report etc. were produced. At 5 regional levels district harmonised databases, IMIS, have been established to provide data for regional planning. However, despite huge resources invested in the preparation for a national headcount, its serial postponement does not augur well for the country. Therefore areas that will need attention include aggressive advocacy to Government, especially the Planning Commission on the critical role of population in development, undertake the census exercise, improving the accessibility and functionality of IMIS.

Conclusion 9: C9

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

Origin: EQ 4

Associated Recommendation

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

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

Conclusion 10: C10

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

Origin: EQ 6
Associated Recommendation:

CHAPTER 6: RECOMMENDATIONS

6.1 STRATEGIC LEVEL

Recommendation 1

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

Priority: High
Audience/Action: Ethiopia CO, MoFED
Origin: EQ 1, Conclusion 1
Operational Implications:

- Continue to engage strategic partners in the design, development and implementation of the next Country Programme.

Recommendation 2

UFPA should continue to align the Country Programme to Ethiopia's national policies and plans as well as international development agendas in order to respond to the country's national needs and priorities and get buy-in support from international development partners.

Priority: High
Audience/Action: Ethiopia UNFPA CO, MoPED, IPs
Origin: EQ 1; Conclusion 1

Operational Implications:

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

Recommendation 3:

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

Priority: High

Action: CO and MoFED

Origin: EQ 2, C2

Operational Implications

- Rethink assumptions behind thinly spread resources targeting UNFPA 122 operational woredas. This is unsustainable.
- Select fewer districts with high negative social, economic and health indicators. This will allow close monitoring of activities for high impact delivery.

Recommendation 4

Sustainability is challenging in humanitarian settings than development oriented project. However CO should strive in the next CP9 to discuss and include its programming with implementing partners' measures of sustainability especially as it concerns technical and organisational capacity building in all thematic areas. Exit strategy must be in-build in all the activities.

Priority: High

Action: CO, IPs

Origin: EQ 4,C4

Operational Implications

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

Recommendation 5a

UNFPA should continue and enhance its coordination efforts with other UNCT members for joint advocacy and joint programme design and implementation for gender, SRH.

Priority: Medium

Action: CO and UNCT

Origin: EQ 5, 6 and C5, 6

Operational Implications

Recommendation 5b

UNFPA CO should maintain its value added in SRH, Adolescents and Youths, Gender, Data, and expand on it strategic positioning at the federal and regional levels.

Priority: High

Action: CO, MoFED, Regional IPs

Origin: EQ 5B, C5

Operational Implications

6.2 PROGRAMMATIC LEVEL

Recommendation 6:

CO should continue using government policies, strategies, and plans, and inputs from national assessments and previous CPEs as the basis for determining priorities and bidirectional communications during annual work plan development processes. Regional IPs should strengthen existing processes for involvement of operational woredas and service delivery points in the development of annual work plans and review of progress. The UNFPA needs to continue to invest and promote SRH interventions to accommodate the anticipated expansion to the underserved localities to deliver better quality RH services and information to vulnerable groups.

Priority level: High

Action: UNFPA CO and UNCT

Origin: EQ 1, C1

Operational Implications:

Recommendation 7

Gender Equality and Women's Empowerment: Continue the interventions as in the 8th CP

Priority: High

Action: UNFPA CO, MoFED, IPs and UNCT

Origin:

Operational Implications:

- Continue multi-sectoral approach in response to GBV in both development and humanitarian context
- Continue developing and using evidence based and human-rights based programmes on men's and boys' involvement in promoting gender equality and promoting SRH in the next CP.
- Continue adopting the community-based approach in addressing GBV issues in all the operational districts.
- Continue with those best practices such as Safe Spaces, Women's Friendly Spaces
- Continue with male involvement activities

Recommendation 8

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

Priority: High

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

Origin: EQ 3, C3

Operation Implications:

- Revisit all preparations for the census exercise including retraining census personnel
- Reactivate the functions of the Population and Development Directorate by making it functional.
- IMIS should be made accessible and functional. In view of high staff turnover, training and retraining and cascading training is important to build capacity of relevant staff**.**
- UNFPA should continue to support Population and Development Directorate to advocate for ICPD PoA, SDG Agenda 2030 and coordinate with line Ministries for the commitment, and integration of population dynamics into the sectorial development plans;
- Strengthening the capacities of the MoFED and CSA for coordination with and monitoring the state councils.
- UNFPA should coordinate with other UN Agencies and international organizations for orientations on ICPD PoA and targets of Sustainable Development Goals at the national and region state levels. It should also encourage the use of both, as frameworks, in formulation of policies and plans.
-

Recommendation 9

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

Priority: High

Action: UNFPA CO, MoFED, UNCT, OCHA

Origin: EQ 6, C6

Operation Implications:

- UNFPA CO should develop a strategy to transition from humanitarian and emergency assistance to a more development oriented strategic interventions.

- UNFPA to maintain and increase efforts in leading, strengthening its lead coordination role of the GBV sub-sector coordination group in humanitarian context.
- Continuous updating of the UNFPA strategic response to SRH, GBV and data needs of the vulnerable populations is advised to overcome the emerging challenges and ensure proper

coverage.

- UNFPA being the sole agency providing the MISP package will give it the leading role in RH in emergency settings. This role should be institutionalized through extending the appropriate interventions among the vulnerable groups in the war- affected states.

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ANNEXURES

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

1. INTRODUCTION AND EVALUATION RATIONALE

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

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

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

1.4 In terms of synergies with other development frameworks, the programme is aligned with the second Ethiopia Growth and Transformation Plan - GTP II (2016-2020), Health Sector Transformation Plan (2015-2020), United Nations Development Assistance Framework - UNDAF (2016-2020), UNFPA Strategic Plan (2014-2017 and 2018-2021), and the Sustainable Development Goals [96]. The programme aligns to the related issues in the ICPD+10 Review Report and ICPD Beyond 2014.

1.5 The overall goal of the Country Programme (CP) is to contribute to "universal access to rights-based and gender-sensitive sexual and reproductive health information and services, including for adolescents and young people" as defined in the UNFPA Strategic Plan (20142017 and 2018-2021). Overall, the programme contributes to Government's development efforts especially in the areas of maternal and sexual and reproductive health, adolescent and youth development, gender, population and development, as well as promoting advocacy and multi-sectoral partnerships for strengthening implementation of the ICPD Agenda in Ethiopia.

[96] The Country office avails the SP-CP-UNDAF Alignment Matrix.

1.6 Following the end of current programme in June 2020, the 9th Ethiopia CP (2020-2024) will be developed. The 2019 UNFPA Evaluation Policy emphasises that the CP should be evaluated before the end of its cycle. However, UNFPA Ethiopia did not conduct an evaluation of its 7th CP (2012-2015). Instead, a light assessment was conducted considering a joint review of the individual component evaluation reports. As such, the review findings were not used as evaluative evidence for the 7th CP. Considering the need for adequate evaluative evidence to inform the development of the 8th programme cycle, the UNFPA Country Office and government decided to undertake a high quality CPE in 2019.

1.7 The evaluation will be an external, independent exercise conducted by an independent team of evaluators adhering to UNFPA policy on Country Programme Evaluations, ethical norms and United Nations Evaluation Group (UNEG) standards. The evaluation will be managed by the CO in close collaboration with the Regional Monitoring and Evaluation Advisor at the East Southern Africa Regional Office (ESARO) and the Evaluation Office (EO) at UNFPA Headquarters.

1.8 The primary users of the CPE are the decision-makers within UNFPA and the Executive Board, government counterparts in the country, and other development partners including donors, the civil society, the private sector, and other sister UN agencies.

1.9 Findings, lessons learned and recommendations of the CPE shall be used to assess the achievements of the 8th CP and to inform the development of the next Country Programme. For transparency and accountability purposes, the CPE report shall be communicated to all stakeholders including UNFPA corporate managers and the Executive Board, national and district level partners, government, civil society organizations, private sector , donors and other sister UN agencies. Most of the program partners especially the government are part of the evaluation process either as sources of data (primary/secondary) or through their representation in the ERG.

1.10 The evaluation is expected to be designed and implemented in accordance with the UNFPA methodological Handbook (https://www.unfpa.org/EvaluationHandbook). The handbook is a practical guide to help the evaluation team apply methodological rigour throughout the different phases of the evaluation and it is expected that the evaluation team is well acquainted with the Handbook at the inception stage of the CPE.

2. COUNTRY CONTEXT

2.1 With more than 100 million people, Ethiopia is the second most populous nation in Africa after Nigeria, and the fastest growing economy in the region. However, it is also one of the poorest, with a per capita income of $783. Ethiopia has a vision to become a lower middle income country by 2025.

2.2 Ethiopia's economy experienced strong, broad-based growth averaging 10.3% a year from 2006/07 to 2016/17, compared to a regional average of 5.4%. Ethiopia's Gross Domestic Product (GDP) is

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

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

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

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

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

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

2.8 While ensuring the mainstreaming of the Sustainable Development Goals (SDG) into the GTP II, the UNDAF is also directly linked to the SDGs relevant to the Ethiopia context. This provides a solid foundation for close collaboration between the Government and the UN system in localizing and rolling out the SDGs during the life cycle of the UNDAF (20162020).

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

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

- Outcome 1: Increased availability and use of integrated sexual and reproductive health services, including family planning, maternal health and HIV, that are gender-responsive and meet human rights standards for quality of care and equity in access
  Output 1: National capacity increased to deliver quality maternal health services, including in humanitarian settings.
  Output 2: National capacity strengthened to increase demand for and availability of family planning services, including reproductive health commodities.

- Outcome 2: Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health
  Output 3: Capacity of adolescents and young people strengthened to make informed decisions on their sexual and reproductive health and rights.
  Output 4: Institutional capacity strengthened to provide youth-friendly sexual and reproductive health services.

- Outcome 3: Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth
  Output 5: Communities and institutions have enhanced capacity to promote and protect the rights of women and girls, and provide services to survivors of harmful traditional practices and gender-based violence.

- Outcome 4: Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality
  Output 6: National institutions have the capacity to generate, analyse and use disaggregated data for planning, development, implementation, monitoring and evaluation of policies and programmes, including in humanitarian settings.

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

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

EVALUATION OBJECTIVES AND SCOPE

3.1 Overall objectives[2]

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

3.2 Specific objectives

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

3.3 Scope

3.3.1 Timeframe

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

3.3.2 Geographic scope

The evaluation will cover the Woredas/District in 8 operational regions[3] and two sub cities of one administrative city[4] currently covered by the eighth CP taking into consideration the relevant programme components[5] of the 2016-2020 CPD—considering both development and humanitarian interventions.

3. EVALUATION CRITERIA AND QUESTIONS

4.1 Criteria

4.1.1 In accordance with the methodology for CPEs as set out in the 2019 UNFPA Evaluation Handbook on "How to Design and Conduct Country Programme Evaluations[97]" as well as UNFPA Evaluation Policy 2019[98], this CPE will be guided by a maximum of ten questions.

4.1.2 The indicative questions for this evaluation are based on four of the five main components which are also highlighted by the Development Assistance Committee of the Organization for Economic Cooperation and Development (OECD/DAC). That is, Relevance, Effectiveness, Efficiency and Sustainability[99]. OECD-DAC evaluation criteria includes measuring 'Impact'. However, this evaluation will not assess Impact due to the lack of required data for in-depth analysis. In addition, two other UN-specific evaluation criteria— Coordination and Added Value will be considered in the evaluation to help address questions related to UNFPA's strategic positioning.

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

4.2 Evaluation Questions

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

4.2.1 Relevance

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

4.2.2 Effectiveness

3) To what extent have the interventions supported by UNFPA helped to increase the access to and utilization of quality maternal health and family planning services by women and girls of reproductive age in both development and humanitarian contexts?

[97] https://www.unfpa.org/updates/unfpa-evaluation-handbook-released
[98] https://www.unfpa.org/admin-resource/unfpa-evaluation-policy-2019
[99] http://www.oecd.org/dac/evaluation/49756382.pdf

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

4.2.3 Efficiency

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

4.2.4 Sustainability

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

4.2.5 Coordination

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

4.2.6 Connectedness

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

4. EVALUATION METHODOLOGY

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

The evaluation methodology will be guided by the 2019 UNFPA's evaluation handbook mentioned earlier. The handbook provides detailed approach to UNFPA evaluations. Hence, the evaluation team is strongly encouraged at all times to refer to the Handbook which also provides specific templates[100] (e.g. evaluation matrix; proposed evaluation questions; etc.). Also the evaluation will

[100] Handbook, pages 18; 183

be guided by the standards and guidance for evaluation in the United Nations system [101] : Norms and Standards for Evaluation (2016) [102] , Integrating Gender Equality and Human Rights in Evaluation[103], UNEG Ethical Guidelines[104], and UNEG Code of Conduct for Evaluation in the UN system[105]. As such, the evaluation will be transparent, inclusive, and participatory, as well as gender and human rights responsive.

5.2 Contribution analysis

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

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

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

5.3 Final evaluation questions

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

[101] (http://www.unevaluation.org/document/detail/102)

[102] http://www.unevaluation.org/document/detail/1914

[103] http://www.uneval.org/document/detail/980

[104] http://www.unevaluation.org/document/detail/102

[105] http://www.unevaluation.org/document/detail/100

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

5.4 Data

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

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

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

5.4.3 Stakeholder selection and participation:

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

5.5 Sampling strategy

- The CO will provide an initial overview of interventions, locations and stakeholders. Based on the discussions and informed by the desk review, the evaluation team will select a sample of sites and stakeholders for data collection clearly identifying the selection criteria applied. Stakeholders will be selected from national as well as subnational levels.

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

5.6 Validation

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

5.7 Ethical Considerations

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

5.8 Limitations to the methodology and constraints to the data collection

Data availability, the structure of the UNFPA programme planning system as well as a number of other constraints constitute challenges for the design and conduct of a CPE at UNFPA. In the evaluation design report, the evaluators need to be aware of the most common constraints and challenges, so they can better anticipate them and develop strategies to mitigate them, or adopt alternative options with a view to minimizing their effect on the quality and credibility of CPE[106]. A few specific constraints have been identified that may have implications on methodological approach and data collection process during the evaluation. These include:

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

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

5. EVALUATION PROCESS

Below is the description of the phases of the evaluation process[16]

6.1 Preparatory Phase:

During this phase, the following will be undertaken:

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

6.2 Design Phase:

During this phase, the following will be undertaken:

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

6.3 Field Work Phase

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

6.4 Reporting Phase

During this phase, the evaluation team will continue the analytical work initiated during the field phase. Additional inputs from the debriefing together with other information coming from the analysis of the data already collected are expected to feed into the development of the first draft of the final evaluation report. The evaluation team will prepare the first draft of the evaluation report, taking into account the comments made by the CO and ERG at the debriefing workshop. The draft evaluation report will be submitted to the ERG for formal review and comments. The

comments from the ERG will be addressed by the evaluation team an audit trail of response to comments provided. The process will continue until the ERG determines that the report meets the required quality standards. Once the ERG is satisfied with a version of the draft report, a dissemination workshop will be organized and attended by the CO staff and stakeholders, including the key in-country partners. Inputs and comments arising from the discussions shall form the basis of the final report. The CO will then perform an Evaluation Quality Assessment (EQA) of this final report and share with ESARO.

6.5 Management Response, Dissemination and Follow Up

During this phase, the country and regional offices as well as the Evaluation Office and other relevant divisions at UNFPA headquarters will be informed of the results of the evaluation. The evaluation report, accompanied by a document listing all recommendations will be communicated to all relevant units within UNFPA, with an invitation to submit their response. Once filled, this document will become the management response to the evaluation. The evaluation report, along with the management response, will be published in the UNFPA evaluation database. The evaluation report will also be made available to the UNFPA Executive Board and will be widely distributed within and outside the organization. Sharing of the final evaluation reports will be guide by a Communication Plan for Sharing Evaluation Results[107] completed by the CO in consultation with UNFPA ESARO.

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

6. EXPECTED OUTPUTS AND DELIVERABLES

7.1 The evaluation team will produce the following deliverables:

1. A **Design Report[108]** (maximum of 30 pages):
   - Stakeholder Map[109]
   - Evaluation Matrix, including final list of evaluation questions and indicators
   - Overall Evaluation Design and Methodology, including a detailed description of the sampling and data collection plan
   - A Work Plan[110] and Roles and responsibilities of the team members
2. A **Debriefing Presentation Document**[111] (not more than 45 MS PowerPoint slides) synthesizing the main preliminary findings, conclusions and actionable recommendations of the evaluation,

[107] UNFPA Evaluation Handbook (2019): Template 16, pg. 279
[108] Format of the Design Report is provided in Annex - 7
[109] UNFPA Evaluation Handbook (2019): Template 4, pg. 256
[110] UNFPA Evaluation Handbook (2019): Template 5, pg. 278
[111] Sample: https://www.unfpa.org/sites/default/files/admin-resource/Presentation_FP_key_results.pdf

to be presented and discussed with the CO and ERG during the debriefing meeting foreseen at the end of the field phase

3. A **Draft Evaluation Report**[112] (followed by a second draft, taking into account potential comments from the ERG)
4. A **Microsoft PowerPoint presentation slides**[113] of the results of the evaluation for the dissemination workshop (not more than 45)
5. A **Final Evaluation Report**[114], based on comments expressed during the dissemination workshop, and all collected data
6. An **Evaluation Brief**, a two-page summary of key evaluation findings/ conclusions/ suggested recommendations of the final CPE report
7. **Electronic Copies** of data collected and analysed as well as all transcribed deliverables including synthesis notes per the CP components[115]

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

7. EVALUATION QUALITY ASSURANCE

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

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

8.2.1 Structure and Clarity of the Report

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

8.2.2 **Executive Summary**

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

8.2.3 **Design and Methodology**

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

[112] Report format is provided in Annex - 7
[113] Sample: https://www.unfpa.org/sites/default/files/admin-resource/Presentation_FP_key_results.pdf
[114] Format of the Final Report is provided in Annex - 8
[115] Further discussion with the evaluation team will be held on the format and expected content

8.2.4 **Reliability of Data**

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

8.2.5 **Findings and Analysis**

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

8.2.6 **Validity of conclusions**

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

8.2.7 **Usefulness and clarity of recommendations**

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

8.2.8 **SWAP - Gender**

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

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

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

8.5 Finally, the evaluation report will be subject to assessment by an independent evaluation quality assessment provider. The evaluation quality assessment will be published along with the evaluation deliverables on the Evaluation Office website[116].

[116] https://web2.unfpa.org/public/about/oversight/evaluations/

8.6 UNFPA Evaluation Office quality assurance system, based on the UNEG norms and standards and good practices of the international evaluation community, defines the quality standards expected from this evaluation. A key element is the EQA, [117] which sets out processes with in-built steps for quality assurance and outlines for the evaluation report and the review thereof. The EQA will be systematically applied to this evaluation.

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

8. THE EVALUATION TEAM & INDICATIVE DIVISION OF WORKING DAYS

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

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

9.3 Evaluation Team Leader

Qualifications, Experience and Competencies of the Evaluation Team Leader:

- An advanced degree in social sciences, political science, economics, statistics, programme management, monitoring and evaluation, or related fields;
- Significant knowledge of and professional experience (minimum 10 years) in complex evaluations in the field of development aid for UN agencies and/or other international organizations;
- A demonstrable experience in leading multicultural, multi-disciplinary evaluation teams; Familiarity with the region in general, and Ethiopia in particular, is essential;
- Substantive knowledge and experience at least in one of the programmatic areas covered by the evaluation (SRH and rights, , gender equality, adolescent sexual and reproductive health, GBV and SRH and rights in humanitarian settings , population and development), preferably Population and Development;

[117] Annex – 9 presents the Evaluation Quality Assessment Grid

- Familiarity with UNFPA or UN mandates and operations is necessary;
- Excellent management skills and ability to work with multi-disciplinary and multicultural teams;
- Excellent analytical, communication, and reporting skills; and
- Fluency in English.

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

9.4.1 Sexual and Reproductive Health (SRH) Specialist

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

Qualifications, Experience and Competencies:

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

9.4.2 Population and Development Specialist[118]

He/she will primarily be responsible for assessing the population and development thematic area of the CP (e.g. collection and analysis socio-demographic data, evidencebased policy advocacy,

[118] This can be removed once decision is made at HQ level

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

Qualifications, Experience and Competencies:

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

9.4.3 Gender Equality Specialist

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

Qualifications, Experience and Competencies:

- An advanced degree in women/gender studies, social sciences or related fields;
- Substantive knowledge of and professional experience (minimum 5 years) in gender equality, including themes/issues relevant to: women's human rights and reproductive rights, gender

and development, prevention of discrimination, prevention and response to gender-based violence, etc., and cross-cutting themes such as youth;

- Excellent knowledge and understanding of local country contexts; current policies and legislation
- Significant knowledge and experience of complex evaluations in the field of development aid for UN agencies and/or other international organizations;
- Good knowledge of the national development context and fluency in English. Amharic is mandatory and knowledge of other major local languages would be an advantage;
- Familiarity with UNFPA or UN mandates and operations will be an advantage;
- Strong interpersonal skills and ability to work with multicultural, multi-disciplinary teams;
- Proven drafting skills in English; and
- Ability to work in a team.

9.5 Allocation of working days per evaluation team member.

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

9. CONTRACT DURATION AND REMUNERATION ARRANGEMENTS

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

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

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

10. INDICATIVE WORK PLAN, DELIVERABLES AND TIMEFRAME

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

Phase	Activity/ Milestone	April	May	June	July	Aug	Sept	Responsible Unit
Preparation	Documentation regarding the country programme; Stakeholder mapping; Drafting of ToR for the evaluation; and Selecting and recruiting the evaluation team	Wk 3-4						
Design	Pre-evaluation briefings with the Evaluation Team (ET) on CPE expectations and requirements - Presentation by Evaluation Manager (EM), National Programme Officers, International Operations Manager		Wk 2-3					CO Programme Team, CO Operations Team, Eval'n Manager (EM), ET
	Desk review of secondary data and information for the development of the CPE Design Report							ET
	Draft and submit CPE Design Report to the CO/Evaluation Reference Group							ET
Field	ET briefing, presentation, and approval of Design Report (including data collection tools and field work plan)			Wk 1-2				ERG, EM, UNFPA CO, ET
	Data collection from federal and selected districts of regional states, including preliminary analysis							ET
	Debrief at the CO							ET

Reporting	Continuation of analytical work initiated during the field phase			Wk 3-4				ET
	Preparation and submission of first draft evaluation report							ET
	Quality assurance of the first draft evaluation report by the ERG, CO, and ESARO M&E Adviser							ERG, EM, UNFPA CO, ESARO M&E Advisor
	Preparation and submission of the second draft evaluation report							ET
	Presentation and validation of evaluation results in an in-country dissemination workshop							ET, UNFPA CO, ERG, EM
	Preparation and submission of the final evaluation report based on comments expressed during the dissemination workshop, and all collected data				Wk 1-2			ET
	Review of Final Evaluation Report using the EQA Grid and submission of the Final Report and draft EQA to EO							ERG (for review and acceptance of final report)[119]
	Quality assessment of the final evaluation report by HQ					Wk 1-2		EO
	Preparation/ submission to ESARO of CO Management Response to Evaluation Recommendations							CO Management, UNFPA Program & Operations Teams, EM

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

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

11. MANAGEMENT OF THE EVALUATION

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

12.1 Evaluation Reference Group (ERG)

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

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

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

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

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

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

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

12.3 UNFPA ESARO M&E Adviser

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

12.4 UNFPA Evaluation Office

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

12.5 UNFPA Ethiopia CO

Will provide the necessary documents and reports and refer the team to web-based material or relevant official databases. The CO management and staff will make themselves available for interviews and provide technical assistance, as appropriate. The CO will provide necessary logistical

support in terms of providing spaces for the meetings, assist in making the appointments and arranging travels and site visits, when necessary. The CO will assist the evaluation team in preparing and facilitating discussions at the field level. Use of office space will be provided as needed.

12. ETHICAL CONSIDERATIONS

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

13. LIST OF DOCUMENTS AND RESOURCES120

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

- Approved Extension Document for the seventh Ethiopia CP and the eighth CPD (20162020)
- Evaluative summery for the 7th CP (Light assessment)
- The eighth Country Programme Implementation by thematic areas and geographic focus
- Handbook on How to Design and Conduct a Country Programme Evaluation at UNFPA (Independent Evaluation Office, July 2016, February 2019)
- UNFPA Strategic Plans (2014-2017 and 2018-2021)
- UNDAF Documents
- Midterms Evaluation of UNDAF
- Major thematic Evaluations and Assessments conducted since beginning of the eighth CP
- Annual Reports and Baseline and End-line Studies
- HACT Micro Assessments reports
- Project Performance Reports
- http://www.unfpa.org.ph/index.php
- 2013 National Demographic and Health Survey (NDHS)
- 2013 Young Adult Fertility and Sexuality Study (YAFS4)

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

ANNEX 2: LIST OF PERSONS INTERVIEWED

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

SN	Name of person interviewed	Position and Organization
35	Balcha Bergoro	MCH Coordinator, Gambella RHB
36	Abdissa Tarekegn	PMTCT and MDSR Officer, Gambella RHB
37	Figkru Letose	Maternal Health and AYH Officer, Gambella RHB
38	Ojilu Omod	Curative and Rehabilitative Core Process Owner, Gambella RHB
39	Ochag	Community Participation Director, BoWCA Head Office
40	Zeritu Kebede	Gender Mainstreaming Officer, BoWCA Head Office
41	Girum Gebreyesus	Women Mobilization and Participation En/Director, BoWCA Head Office
42	Addisu Ashagre	Finance Team Leader, BoWCA Head Office
43	Dr. Yared Denekew	Gynecologist, Gambella Hospital
44	Oumod John	CEO, Gambella Hospital
45	Samuel Geleta	SGBV Focal Person, Gambella Hospital - One Stop Center
46	0	, Gambella Hospital - Mini Blood Bank
47	2 beneficiaries of Gambella Hospital Fistula Cneter	Youth girl waiting for fistula repair and her mother, Gambella Hosopital - Fistula Unit
48	Awoke Getu	Acting Program Coordinator, IMC – Gambella
49	Ekram Ousman	Acting Manager for GBV, IMC – Gambella
50	Endale Berhanu	Senior SRH Manager, IMC – Gambella
51	Okelo Ager	Itang WoHO Acting Head, Itang Health Center
52	Mekuanint Abebe	Itang HC Acting Head and Midwife, Itang Health Center
53	Obang Opora	Itnag WoHO Administration Head, Itang WoHO
54	11 beneficiaries	Peer educators, Nguyyiel Camp Womena and Girls Safe Space
55	Tessema Ergetie	Public Health Team Leader, ARRA Helath Center - Nguyyiel Camp
56	Tibebe Beyene	Clinic Coordinator, FGAE- Gambella
57	Dingetu Mamo	Laboratory Tech, FGAE- Gambella
58	Dr. Meseret	MCH Director, MoH
59	Dr. Tadelle	Family Planning Coordinator, MoH
60	Bethelhem Taye	Family Health Team Coordinator, AA RHB
61	Samson Tekeste	Maternal and Adolescents Health Officer, AA RHB
62	Tesfaye Bogalle	UNDAF (UNICEF/UNFPA Program Coordinator), AA HAPCO
63	Mezgebu	ADA Vice Program Director, Amhara Development Association

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

SN	Name of person interviewed	Position and Organization
84	Getasew Asfaw	Dera Woreda Health Office Head, Dera WoHO
85	Tadesse Setegn	Multisectoral Response Coordinator, Dera WoHO
86	Takele	HC Director, Ambessame HC
87	Sr. Bitaniya	AYFSC Service Provider, Ambessame HC YFSC
88	Aseffa	Health and Anti-AIDS Club Coordinator, Ambessame High School
89	Temesgen	School Director, Ambessame High School
90	XXX	Youth Association Support and Mobilization Team leader, Dera Woreda WCYA Office – youth
91	YYY	Hamusit Youth Center Attendant, Hamusit Youth Center
92	Takele	Midwife, MCH Coordinator, Hamusit HC
93	Sr. Bitaniya	Nurse, Hamusit Health Center YFSC, Hamusit HC
94	Tiruneh Asrat	Maternal Health Officer , East Wollega Zonal Health Office
95	Netsanet Sahilu	Women Economic Organization and Mobilization Officer, East Wollega Zonal WCA Office
96	Fikiru Tafesse	Jimma University HAPCO Coordinator, Jimma University
97	Abera Jaleta	Jimma University HAPCO Vice Coordinator (Amdinistrator), Jimma University
98	Neima Temam	Reproductive Health and Immunization Coordinator, Jimma Zone Health
99	Gelmessa	Focal Person for One Stop Center, Nekemte Hospital One Stop Center
100	Tirunesh	One Stop Center Coordinator, Nekemte Hospital One Stop Center
101	Meskerem Gonfa	Health Officer, YFSC Service Provider, Ejere Health Center
102	Sintayehu Worku	Vice Head of Health Center, Ejere Health Center
103	Ajema Negassa	Ejere WoHO MCH Coordinator, Ejere Health Center
104	Medhanit Ahmed	YFSC – Health Officer, Ginchi Health Center
105	Meti Ararsa	Health Center Head, Ginchi Health Center
106	Ararsa Gudeta	Dendi WoHO MCH Coordinator, Dendi WoHO
107	Tolera Garuma	Maternal Health, RH, and AYH Focal Person , West Shoa Zonal Health Office
108	Abebe Tolera	WCA Head, West Shoa Zonal WCA Office
109	Mergitu Debella	Gender Directorate Director, Wollega University HAPCO and Gender
110	Abinet Jalleta	HAPCO Officer/expert, FHAPCO

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

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

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

ANNEX 3: LIST OF DOCUMENTS CONSULTED

- Approved Extension Document for the seventh Ethiopia CP and the eighth CPD (20162020)
- Evaluative summery for the 7th CP (Light assessment)
- The eighth Country Programme Implementation by thematic areas and geographic focus
- Handbook on How to Design and Conduct a Country Programme Evaluation at UNFPA (Independent Evaluation Office, July 2016, February 2019)
- UNFPA Strategic Plans (2014-2017 and 2018-2021)
- UNDAF Documents
- Midterms Evaluation of UNDAF
- Major thematic Evaluations and Assessments conducted since beginning of the eighth CP
- Annual Reports and Baseline and End-line Studies
- HACT Micro Assessments reports
- Project Performance Reports
- http://www.unfpa.org.ph/index.php
- 2013 National Demographic and Health Survey (NDHS)

2013 Young Adult Fertility and Sexuality Study (YAFS4

ANNEX 4: EVALUATION MATRIX

The Evaluation Matrix

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

		Extent to which the current UNFPA strategy on maternal health, family planning and HIV prevention efforts is appropriate	Personnel at the Department of Health Laws and by-laws Sector programme documents	
Data and information collected	The 8th country program of UNFPA in Ethiopia is well aligned with the second Growth and Transformation Plan of Ethiopia and the corresponding UN Development Assistant Framework (UNDAF 2016-2020). Outcomes and outputs of the 8th country program are directly related to health and HIV outcomes of the third pillar of GTP II (investing in human capital and expanding access to social services) and women empowerment and youth outcomes of the fifth pillar of GTP II (Equity and empowerment). Components of the 8th CP have adequate focus on development of national capacities; however, there are missed opportunities for integrating stronger capacity building activities to ensure sustainable local capacity. - Trainings have been provided through ToT approaches that allowed building local capacity both among trainers and trainees. The Ethiopian Pharmaceutical Supply Agency is currently managing procurement of about 70% of drugs and other medical supplies to the country. The agency has several challenges that limit its ability to supply family planning commodities. UNFPA's support to the health sector in procuring family planning commodities could have also served as a capacity building platform for EPSA. Apart from procuring commodities on the Ministry's behalf, capacity building activities intending to capacitate EPSA has been limited. SRH interventions by nature are strong facilitators of gender equity and women's empowerment. This has been particularly true in Ethiopia as SRH problems operate both as causes and consequences of gender inequality and lack of women's empowerment. Youth centers, targets for several adolescent and youth development activities, mostly serve boys than girls. There were no deliberate efforts to increase utilization of these centers by youth girls. The program has given attention to adolescents and youth			

	- Support for the establishment and functionality of youth friendly service centers within government health centers has the potential to address barriers to utilization of SRH services among adolescents and youth. - Lack of confidentiality and judgmental attitude of healthcare providers towards adolescents and youth seeking reproductive health services was a major barrier in the past. Establishment of YFSCs and training of healthcare providers on adolescent and youth health helped in addressing these barriers. In addition to activities under adolescent and youth development, activities under SRH also benefit large numbers of female adolescents and youth who started child bearing The first outcome of the 8th CP, Sexual and Reproductive Health) has facilitated close collaboration the health sector for the design and implementation of programs related to UNFPA's mandate areas. The SRH component of the CP has been well aligned with the health sector's five year strategic plan, the Health Sector Transformation Plan, and prevailing SRH problems of Ethiopians. - The first strategic objective of the Health Sector Transformation Plan is to improve equitable access to quality health services. Among the key components of this strategic plan are scaling up effective health interventions including 1) reproductive, maternal, newborn, and child health services and 2) adolescent health. - Despite increasing coverage of maternal health services, quality of care has been a major problem at different levels. Limited capacity of care providers has been a major reason behind poor quality of services. For example, according to the 2016 SARA report, the mean availability of BEmONC signal functions was 46% in 2016. The Health Sector Transformation Plan has also recognized this challenge and included quality of care as one of the transformation agendas. - Unmet need for family planning is high particularly among rural-dwelling women. Ensuring uninterrupted supply of family planning commodities is an important aspect of the family planning program in the country. Government procurement policies and procedures are currently not efficient to meet consistency, quality and time requirements of the family planning program. - The 8th CP of UNFPA is relevant in addressing these priorities of the Ethiopian health sector. o Support for pre-service training in the areas of midwifery and anesthesia and in-service training of health professionals on BEmONC are relevant in addressing the skill gaps of the current as well as the future workforce for maternal health service provision

	○ Support for Maternal and Perinatal Death Surveillance and Response (MPDSR) including support for expansion of maternity waiting homes in response to delays to receive maternal health services helped in identifying and addressing barriers to timely maternal healthcare provision. UNFPA has been supporting the health sector by procuring family planning commodities and financing part of the procurement. Attention given to HIV prevention and control among adolescents and youth has been inadequate in the 8th CP. The first pillar in the HIV prevention roadmap of Ethiopia is combination prevention for adolescent girls, young women & their male partners. Even though there were HIV prevention interventions in the 8th CP, there has been no separate output for it possibly leading to limited human resource in the area and very few HIV prevention interventions at different levels. Activities supported by the 8th CPD were in general aligned with sectoral strategic plans that are mostly designed with due consideration to existing evidences. The 8th CPD has also been informed by evaluations and studies conducted during the 7th CPD. Annual work plans reflect intersections between priorities of implementing partners and UNFPA mandate areas addressed through the country program. The process of annual work plan development that involves continuous communication between UNFPA CO and Regional team facilitates identification of IP priorities that are in line with CP components. However, the process takes the assumption that IPs have adequate capacity to identify critical bottlenecks to be targeted by UNFPA support. Field visits indicated this was not always the case. Even though there are adequate evidences showing that problems targeted by AWPs of IPs are priority problems, specific activities do not always reflect priority actions. Reasons for this include: • None of the IPs visited had baseline or needs assessments • IPs do not have adequate understanding of response situations in operational Woredas • There is limited capacity among IPs to identify root causes of social problems and design evidence-based interventions appropriate for realities of operational woredas AWPs are mostly prepared without adequate consultation to operational woredas Targets of SRH and youth components of the 8th CP included both duty bearers and rights holders. However, as shown in the reconstructed theory of change (page ___) the focus on rights holders has been minimal particularly for SRH interventions. Activities planned in AWPs reached pre-defined target populations both in terms of operational areas and specific population groups.

	The program mostly served women and young people. Youth friendly service centers allowed youth girls to have access SRH services. Youth centers supported by the program mostly serve youth with limited access to alternative recreational centers. The CO has been responsive to emergencies that happened during the period of the 8th CO. Humanitarian interventions for people internally displaced following conflicts and drought during the period of the 8th CO were results of responsive programming at the CO level. Implementing partners reported that there is little flexibility of activities once they are approved in annual work plans. Procedures to make adjustments have been reported to be unclear.			
Adolescent and Youth Development	Objectives of the Youth and HIV focus area of the 2013-2017 CPAP are adapted to the needs of the population Objectives of the Youth and HIV focus area component are aligned with the priorities of the national policies and programmes	Extent to which Youth and HIV services for women and young people are incorporated in UNFPA supported/funded activities, plans, and programmes; and the geographical consistency of the programme vis-à-vis the needs and problems of the target groups. Extent to which the UNFPA programme is in line with the national reproductive health strategy and programmes; Extent to which the current UNFPA strategy 0n	Target beneficiary groups. Programme Officers (UNFPA, National Partners, Implementing Partners) Local health authorities' staff National Department of Health CPAP Country Office Annual Reports Annual Work Plans Standard Progress Reports Target beneficiary groups. Programme Officers (UNFPA, National Partners, Implementing Partners) Local health authorities' staff	Study of relevant documentation Comparative analysis of programming documents (Desk review) Key informant interviews and Focus group discussions with final beneficiaries

		Youth and HIV prevention efforts is appropriate	Personnel at the Department of Health Laws and by-laws Sector programme documents	
Data and information collected	Ethiopia has large adolescent and youth population. - Adolescents and youth in the age group 10-14, 15-19, and 20-24 years account for 15.6%, 10.6%, and 7.6% of the total population of Ethiopia, respectively - SRH related problems among adolescents and youth include o risky sexual practices, o child marriage, o early child bearing, o unintended pregnancy, o unsafe abortion o STIs including HIV - Sources of vulnerability include limited access to safe recreational facilities, low level of access to adolescent and youth friendly SRH services, and limited economic opportunities - The 8th CP has given attention to adolescents and youth particularly in the areas of increasing access to SRH services and facilitating youth participation. - Support for the establishment and functionality of youth friendly service centers within government health centers has the potential to address barriers to utilization of SRH services among adolescents and youth. - Lack of confidentiality and judgmental attitude of healthcare providers towards adolescents and youth seeking reproductive health services was a major barrier in the past. Establishment of YFSCs and training of healthcare providers on adolescent and youth health helped in addressing these barriers. - In addition to activities under adolescent and youth development, activities under SRH also benefit large numbers of female adolescents and youth who started child bearing			

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

Gender Equality/GBV	The intervention strategies of the gender equality and	Extent to which gender equality objectives and approaches of the current CPAP	Target beneficiary groups. Programme Officers (UNFPA, National Partners,	Study of relevant documentation Comparative analysis of programming

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

	under review was found to be an important component to address gender inequalities that are exhibited in the country and to support the effort of the government to quicken gender equality and women empowerment through the different interventions employed by the CP such as Gender Equality and Women Empowerment, Abandonment of FGM /CM and CM, Accelerated action to end CM, Preventing and responding to SGBV/GBV and GBV in Emergency and host communities. Under theses major programme components different activities that are targeted to prevent SGBV and HTPs; protect the rights of adolescent girls and women and promote their rights; and provision of direct services for the survivors are carried out. There are different strategies of intervention in GEWE among which one is supporting the development of national capacities for sustainability of the programme. This include but is not limited to enhancing community and institutional capacities to promote and protect women and girls at all levels; creating a supportive and enabling environment to report SGBV; build capacities of communities and gate keepers to facilitate abandonment of HTPs, including FGM/C and CM through cultural sensitive approaches and solutions; promote capacities of adolescent girls and boys to create supportive environment to facilitate positive attitudinal changes on HTPs; direct service delivery for survivors of SGBV and HTPs, piloting innovative interventions such as safe houses for survivors, one stop centers, safe spaces for girls and women; scaling up best practices; and reinforce coordination and partnership mechanisms among partners for better leverages on range of issues; and promote positive traditional practices that strengthen community mobilization and dialogue to enforce and accelerate changes. Key informants as well as reviewed documents highlighted that CO is also highly engaged in supporting the development of the *National Costed Roadmap to End Child Marriage and FGM/C* that will accelerate the effort of the Federal Democratic Republic of Ethiopia to end early/child marriage and female genital mutilation/ cutting. UNFPA provided technical and financial support for the development of the roadmap. Gender equality and women's empowerment is mainstreamed in the country program in general. The SRH and Y&A and the humanitarian programmes have gender components that directly address the needs and concerns of adolescent girls and women as they are most vulnerable segments of the society. From the document review it was also possible that humanitarian interventions also focus on mainstreaming gender and addressing issues related to girls and women since they are most vulnerable. The responses from the different IPs also indicated that the country programme goes beyond mainstreaming gender in the CP. The CP also provide support the

	MoWCYA to mainstream gender in its different programs through the sector bureaus gender directorate. It was also reported by many key informants that during the 8th CP UNFPA, as a member of the National Alliance to End CM and FGM focused on the issue of gender mainstreaming as a strategy to accelerate the gender equality and women empowerment. The interviewees indicated that the National Alliance to End FGM and ECM is also a good forum to address issues related to gender and address gender mainstreaming gaps. Adolescent and youth are main targets of the different interventions of the Gender Equality and Women Empowerment program such as Abandonment of FGM /CM and CM; Accelerated action to end CM; Preventing and responding to SGBV/GBV and GBV in Emergency and host communities. Young people and adolescents are purposefully directed by the GEWE program since they are the most affected by SGBV and HTPs. Key informants and direct beneficiaries indicated that most of the indirect and direct beneficiaries of the programme are youth. For example the Safe Houses and the One Stop Center beneficiaries are female youth since they are victims of SGBV and HTPs. But this does not mean to imply that the progamme does not target youth male. Since they are the major partners in the fight against SGBV and HTPs, they also participate in the different events, awareness raising programmes and community dialogue that are carried out at national, regional and community level respectively. The country program objectives and strategies are consistent with national policies and strategies such as National policy on women (1993), The Constitution of the Federal Democratic of Ethiopia (1995), The Revised Family Law (2000), The Revised Penal Code (2005) National Children's Policy (2017), The National Strategy and Action Plan on Harmful Traditional Practices (HTPs) against Women and Children (MoWCYA, 2013) which targets to reduce child marriage, abduction and FGM/C as part of broader gender and equity goals., and The Gender Strategy for the Education and Training Sector (MOE, 2015), as well as international policies ratified by the country such as Convention on Elimination of all Discrimination Against Women (1981), The following two documents, though they are finalized very recently will provide a good fertile for the development of the 9th Country Programme in terms of accelerating gender equality and women empowerment in Ethiopia. 1. Women Development and Transformation Strategy which is ratified by the Council of Ministries last year and in the process of translation into English. This document will give clear direction on how to operationalize national and international policy. The National Costed Roadmap to End Child Marriage and FGM/C (2020-2024) which is finalized in August 2019. This roadmap is evidence based costed plan which outlines the key strategies, packages of interventions, and expected results, targets

	and millstones towards elimination of child marriage and FGM/C in Ethiopia and applies across all context in Ethiopia, including humanitarian and emergency situations which may be exacerbate risks of child marriage and FGM/C for girls, reduce acess to protective services. The CP used different strategies to identify the felt needs of the community. Key informants highlighted different method to identify the needs of the community before designing a programme like discussion and consultation with sector ministry, regional bureau and Woreda offices; direct field visits and observation, and as well as discussion and consultation with grass root structures and community members. The DHS report is also used a complimentary document. The use of the bottom up approach rather than the conventional top down approach is used by UNFPA to identify the needs of the community. A key informant stressed the importance of involving the community to identify their own needs rather than only relying on reports.. For example when we started the programme in Afar National Regional State we thought that the major problem of the community was FGM and our aim was to focus on that. But it was the community who indicated that CM is also a serious problem for the community during the community dialogue and community conversation. During the community dialogue, the community also discussed and identified a strategy on how to address the issue like working with religious leaders since they are the one who gives the blessing for the marriage. This is an indication that the community not only identifies the felt needs but also are able to come up with strategies with little support. The target groups for the intervention are selected through discussion with the relevant government stakeholders as well as members of the community and grass root structures. But it should also be noted that this is not true for all the sampled regions. For example interviews in Gambella and Afar indicated that most vulnerable groups are not as such targeted by the programme. In Gambella, there is high concern expressed by the respondents that the host communities are not as such given enough attention since most of the interventions are targeted towards the refugee camps. For example a site visit to the Safe spaces for girls is not well organized and given due attention compared to the Safe Spaces for Girls and Women in the refugee camps. On the contrary in Afar, though the region hosts many refugees the program interventions are focused on the host community and not the refugees who are most vulnerable. The programme tenaciously identifies target groups including most vulnerable segments of the community through high engagement and involvement of grass root structures such as the Women Development Army (except in the case of Afar), religious leaders and influential people in the community. Since they are part of the community, they know the community well and hence are able to identify vulnerable segments of the society easily which might be otherwise invisible for outsiders. The needs of most vulnerable groups have been taken into

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

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

	alignment with the 2014-2017 and 2018-2021 UNFPA Strategic Plan that highlights advocacy for population and development linkages. The P&D component was anchored on the ICPD PoA principles which stipulate that human beings are at the centre of sustainable development. This component was designed to promote integration of population issues into development strategies, planning and programming to achieve social justice and eradicate poverty. Internationally, it was also responsive to the ideals and actions as outlined in the International Conference on Population and Development (ICPD) PoA and also by extension the SDG 2030. The planned interventions in the CP8 were relevant and met the needs and priorities of a wide range of stakeholders and target groups. These included strengthening the capacity of Regional government planning and management to generate, access, utilise and disseminate relevant data for purposes of planning and tracking progress in government policies. The Population and Development component was relevant in that it helped bridge gaps of inadequacy of data for decision-making which was cited by Federal and regional implementation partners in various interviews; the capacity gaps in evidence-based planning and use of data to influence decision-making and the lack of appreciation of statistics among decision-makers. Key informant and in-depth-interviews revealed that Ethiopian governments at various levels have appreciated the use of data for development planning, although there is noticeable lack of technical skills and financial resources. At the Federal level, the Central Statistical Agency and Population Directorate are at the forefront of integration of population into national development respectively. The relevance of this component is captured in the statement by one of the stakeholders "data is the lifeblood of any development planning".			
EQ2: ***To what extent have the 8th Country Programme outputs been achieved and the extent to which these outputs have contributed to the outcomes?***				
EFFECTIVENESS				
Sexual and Reproductive Health	Expected outputs of the CPAP were achieved (both in terms of quantity and quality) The targeted groups of beneficiaries were reached	Degree of completion of outputs planned in the CPAP against indicators Evidence that completed outputs contributed to planned outcomes Significant changes in marginalised	CPAP Results Framework indicators CPAP Results Plan progress reports Statistics South Africa figures Relevant Health Survey data Personnel at the Department of Health at national,	Study of documentation Comparative analyses of the value of CPAP indicators (targets versus actual values) Key informant interviews Group discussions to

	by UNFPA support Beneficiaries took advantage of benefits from the intervention supported There were unintended effects, positive or negative, direct or indirect	populations i.e. poor women in both rural and urban settings, women affected by HIV/AIDS, young girls. Number of tools with evidence produced to inform maternal health, family planning and HIV policy and programming at national and sub-national levels. Number of health care workers trained on the new FP guidelines in the UNFPA supported districts Number of UNFPA supported districts with functional Logistics Management Information Systems (LMIS) for forecasting and monitoring reproductive health commodities.	provincial and district levels. Progress reports of the Department of Health Beneficiary groups / communities SCF progress reports / mid-term review Implementing partners Quarterly and annual implementation progress reports UNICEF annual reports and evaluations UNFPA country office staff Country Office Annual Reports Previous evaluations	assess the quality of the outputs
Data and information collected	The 8th CP supported capacity building among of adolescents and young people so that they can make informed decisions on their sexual and reproductive health and rights. The program has supported provision of selected SRH services through youth centres, YFSCs, and school clubs. During the period 2016 to 2019, the program reached:			

	- 99,521 adolescents and youth with SRH services through UNFPA support (76.6% of the target for 2020) - 32,225 adolescents and youth with life skill education ((80.6% of the target for 2020) SRH services through YFSCs and life skill education in different settings are reported to be effective strategies for providing SRH related information and services to adolescents and youth who otherwise would have been marginalized.Life skill education has been reported to have a wide range of positive impact particularly for girls. Among the most commonly reported positive outcomes were increased confidence and school performance of female students and increased utilization of SRH services including family planning and condoms.School clubs supported with mini-media equipment and trainings were effective in reaching large numbers of students with important SRH information. The support in this area allowed to maximally utilize capacities of students and their teachers in the regular provision of SRH information to school communities. The program also supported youth organizations and associations – mostly youth centers and school clubs. Both categories of targets mostly provide opportunities to reach large numbers of adolescents and youth. **Youth Centers:** Youth centres located in convenient places and actively providing recreational activities attract adolescents and youth. UNFPA's support in visited youth centers was the primary source of materials required for these recreational activities (in-door and out-door games); Media instruments donated for youth centers created the potential for transmission of SRH messages to visitors of youth centers.Challenges in relation to youth centers include: - Utilization of the opportunity created has been sub-optimal particularly because of the limited engagement of technical experts. - Some youth centers are located at inaccessible locations resulting in non-use of available facilities. - Girls involvement in youth center activities is very limited. **School clubs** Mini-media support to schools has led to self-sustained HIV/SRH information dissemination on a regular basis. - The 8th CP supported health centres in establishing and running youth friendly service centres. Support included furniture, audio visual equipment, and trainings for service providers. - By the end of June 2019, the percentage of health facilities providing the national standard minimum adolescent and youth service packages reached

	75% among UNFPA targeted areas. The number of health workers equipped through training with knowledge and skills to provide youth friendly sexual and reproductive health exceeded the total target of 500 by reaching 704 more than a year before the completion of the CP period. - Supported YFSCs provide comprehensive outpatient service for all clients in the age range of 10 to 24. - Integrating all outpatient services for 10-24 years adolescents and youth (including treatment of any illness) with YFSCs increases exposure of adolescents and youth to trained healthcare providers and improves confidentiality of SRH service provision. However, it has also posed a threat to SRH service provision. Because most cases are coming for non-SRH services, attention given to SRH by health service providers gets diluted. Additional challenges in this area include: o Lack of comprehensiveness of services at YFSCs leading to high referral rates to other units and other facilities o Not all YFSCs have in-door and out-door recreational facilities Lack of space compromising the utility of donated equipment (eg. Television put/stored in the examination room because there was no secure waiting area) - Implementing capacity of government IPs and their district offices is very limited. - As a result, planning, implementation, and monitoring (activities that are expected from IPs) are compromised. There is need for either more technical support at lower levels or more capacity building activities targeting the IPs themselves. - Ethiopia has shown improvements in several SRH outcomes during the period of the 8th CP. Between 2016 and 2019, o Coverage of at least one visit of ANC from a skilled provider increased from 62% to 74% o Coverage of at least four visits of ANC increased from 32% to 43% o The proportion of deliveries attended in a health facility increased from 26% to 48% - UNFPA's support has been helpful for increasing demand for and quality of maternal health services. These contributions include 1) engagement (technical support as a member of technical working groups or other modalities) at federal level in the development of strategies, guidelines, and trainings and 2) Specific interventions targeting specific geographic areas. - Specific areas of support on maternal health included: o Support for BEmONC and CEmONC o Human resource development (Midwifery, anesthesia) o Short term trainings for the current workforce

	○ Furnishing maternity waiting homes ○ Training on BEmONC including the use of mentorship (expanded note as good practice in the report) leveraging local capacity (eg. in Gambella) ○ Strengthening CEmONC including support for mini-Blood bank establishment at Gambella Hospital ○ Trainings on MPDSR ○ Trainings on cervical cancer screening and donation of equipment/supplies ○ Identification, referral, and treatment of fistula cases ○ Strengthening referral system for maternal health services - While engagement at the federal level has been acknowledged to have brought system-wide influences, specific interventions targeting specific geographic areas were commonly reported as effective but too small in coverage to bring about large-scale impact. - BEmONC trainings provided at the Woreda level had issues on quality of training arising from administrative challenges ○ BEmONC trainings were planned and implemented at woreda level. The maximum amount of payment that a trainer can be paid by providing training at Woreda level is 70birr per day. This has led to the use of trainers who are not competent enough to deliver the training. - Between 2016 and 2019, modern contraceptive use among currently married women increased from 35% to 41%, nationally. - UNFPA's support has been helpful for increasing demand for and access to family planning services. These contributions include ○ Building the capacity of service providers ○ Engagement in monitoring progress of Ethiopia towards its commitments on family planning ▪ Strengthening the supply chain system for family planning/RH by working with the supply agency (EPSA) and the regulatory agency (FMHACA) ○ Improve availability of commodities ▪ Provided in kind support (family planning and other SRH commodities) by using resources that UNFPA mobilizes ▪ Provided procurement service to the government of Ethiopia ○ Support expansion of family planning services to the HEP through ▪ Evidence generation ▪ Supporting targeted interventions including training of level 4 HEWs on LARC

	- Progress of the CP in terms of family planning related activities was sub-optimal. Achievements so far include:
	  o The percentage of service delivery points offering modern contraceptives (at least three types of modern contraceptives for primary SDPs and at least five types of modern contraceptives for secondary and tertiary SDPs) has been consistently above the 95% target throughout the CP's life.
	  o The percentage of service delivery points with seven (including 2 essential) life-saving maternal / reproductive health medicines was also consistently good compared to planned targets.
	  o Relatively low achievement was recorded for training of HEWs on LAFP. Only 21,329 (59.2%) of the targeted 36,000 HEWs were training on LARFP methods during the program's life time. The main reason for this under achievement was reported to be expansion in content of training affecting training duration and thus total number of trainees.
	- Family planning commodities are available in adequate quantity and quality. UNFPA's support has been very helpful for ensuring adequate supply of family planning commodities. Demand for family planning has also increased; however, there is still a huge gap. None of the health facilities visited had shortage of family planning commodities.
	- Once AWPs are approved, resources are provided to each IP and operational area based on the AWP. Funds transferred to IPs are generally used reasonably and only to the purposes they are assigned for.
	- Delay in transfer of funds affects implementation of planned activities. IPs have reported that they most of the time had to rush implementation of activities because there will always be delays in transfer of funds.
	
	There is long chain of approval of annual plans, report reviews, and funding transfers.
	
	- Resources are very thinly spread over wide geographic areas than what can potentially be supported meaningfully.
	
	Budget utilization rate increased over time. In 2016, SRH/AYD component of the program used 74% its budget. This figure increased to 83% in 2017 and 90% in 2018. Donation of equipment and furniture for school clubs and YFSCs has resulted in continued engagement of other actors in the provision of SRH information and services. For example, most of the YFSCs have dedicated health professionals. Similarly school clubs run mini-media once they are provided with the basic equipment required for the service.

	- The online system for administrative and financial procedures is found to be difficult for some government IPs. High turnover of staff in the government sectors and lack of regular trainings on the electronic system are the primary reasons for limited capacity to use the system. Implementing government organizations at Woreda level have limited capacity on planning. However, they are given the mandate to make major planning decisions regarding activities to be performed and geographic areas to be targeted (consulted by regional IPs). This creates a situation where there is need for very close follow-up and support during planning and M&E. Human resource capacity of UNFPA at regional level however doesn't allow to adequately support planning activities for all IPs. Government IPs (federal as well as regional) have clear mandates in the areas they are currently supported by UNFPA. These IPs have strategic importance in their respective area of intervention. - UNFPA supports activities that **government IPs have already planned**. Annual work plans are extracted from the IP's overall annual plan. This alignment has been reported as an important reason for sustainability of supported activities and already achieved benefits. - Maternity waiting homes are constructed and financed by **communities**. There is increasing acceptance of community contribution to feed mothers staying at maternity waiting homes. - Most **youth centers generate revenue** covering their own expenses. Recreational activities continue irrespective of external support. However, there is no mechanism in place to ensure the provision of SRH and HIV related services (free of charge) continue in the centers. For example, SRH clinic from one of the model youth centers is now closed because health workers are not happy with salary. - School clubs (particularly mini-media) run by their own once they get the minimum set of equipment - Some community-based activities are not achieving sustainable results particularly because of low intensity of program implementation. Examples: o Community conversations leading to no change at community level o Youth-parent forum – committee formed and trained but mostly lack follow-up leading to inactivity Procurement of family planning and other RH commodities (by UNFPA) has not been adequately used to build the capacity of the Ethiopian Pharmaceutical Supply Agency.

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

		that advocate for increased investments in marginalized adolescents and youth		
Data and information collected	The 8th CP supported capacity building among adolescents and young people so that they can make informed decisions on their sexual and reproductive health and rights. The program has supported provision of selected SRH information and services through youth centres, YFSCs, and school clubs. During the period 2016 to 2019, the program reached: - 99,521 adolescents and youth with SRH services through UNFPA support (76.6% of the target for 2020) - 32,225 adolescents and youth with life skill education ((80.6% of the target for 2020) SRH services through YFSCs and life skill education in different settings are reported to be effective strategies for providing SRH related information and services to adolescents and youth who otherwise would have been marginalized. Life skill education has been reported to have a wide range of positive impact particularly for girls. Among the most commonly reported positive outcomes were increased confidence and school performance of female students and increased utilization of SRH services including family planning and condoms. School clubs supported with mini-media equipment and trainings were effective in reaching large numbers of students with important SRH information. The support in this area allowed to maximally utilize capacities of students and their teachers in the regular provision of SRH information to school communities. The program supported youth organizations and associations – mostly youth centers and school clubs. Both categories of targets mostly provide opportunities to reach large numbers of adolescents and youth. **Youth Centers:** Youth centres located in convenient places and actively providing recreational activities attract adolescents and youth. UNFPA's support in visited youth centers was the primary source of materials required for these recreational activities (in-door and out-door games); Media instruments donated for youth centers created the potential for transmission of SRH messages to visitors of youth centers. Challenges in relation to youth centers include:		

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

	- Donation of equipment and furniture for school clubs and YFSCs has resulted in continued engagement of other actors in the provision of SRH information and services. For example, most of the YFSCs have dedicated health professionals. Similarly school clubs run mini-media once they are provided with the basic equipment required for the service. - The online system for administrative and financial procedures is found to be difficult for some government IPs. High turnover of staff in the government sectors and lack of regular trainings on the electronic system are the primary reasons for limited capacity to use the system. - Implementing government organizations at Woreda level have limited capacity on planning. However, they are given the mandate to make major planning decisions regarding activities to be performed and geographic areas to be targeted (consulted by regional IPs). This creates a situation where there is need for very close follow-up and support during planning and M&E. Human resource capacity of UNFPA at regional level however doesn't allow to adequately support planning activities for all IPs. - Government IPs (federal as well as regional) have clear mandates in the areas they are currently supported by UNFPA. These IPs have strategic importance in their respective area of intervention. - UNFPA supports activities that **government IPs have already planned**. Annual work plans are extracted from the IP's overall annual plan. This alignment has been reported as an important reason for sustainability of supported activities and already achieved benefits.			
Gender Equality/GBV	Expected outputs of the CPAP were achieved (both in terms of quantity and quality) The targeted groups of beneficiaries were reached by UNFPA support Beneficiaries took advantage of benefits from	Degree of completion of outputs planned in the CPAP against indicators Extent to which geographical and demographic coverage of gender activities in Eastern Cape and KwaZulu Natal provinces and districts targeted by the interventions have effectively and equally benefitted	CPAP Results Framework indicators CPAP Results Plan progress reports Statistics South Africa figures Beneficiary groups / communities Implementing partners Quarterly and annual implementation progress reports. United Nations Women reports and evaluations	Study of documentation Comparative analyses of the value of CPAP indicators (targets versus actual values) Key informant interviews Group discussions to assess the quality of the outputs

	the intervention supported There were unintended effects, positive or negative, direct or indirect	from the interventions Number of advocacy sessions supported to strengthen national coordination mechanisms for implementation of multi-sectoral policies and programmes on GBV prevention and response and improve SRH/GBV linkages Number of UNFPA supported districts that integrate GBV and SRH into their planning processes Number of institutions supported to implement and institutionalize initiatives to engage men and boys, and communities on GBV prevention and SRHR	UNFPA country office staff Country Office Annual Reports Previous evaluations	
Data and information collected	UNFPA's works at federal and regional level with government bodies, CSOs and grass root structures on prevention of SGBV and HTPs; protection of the right of right holders from violence and provision of direct services to survivors of SGBV and HTPs through creating an enabling environment and building the capacity of institutions and communities though its engagement at the different level is different. At federal level the CO engage in high level advocacy works and coordination activities to support the effort of the government to accelerate the progress made with regards to gender equality and women empowerment.			

	• UNFPA provide technical and financial support to celebrate international and national events like 16 Days Activism, March 8, Anti FGM Day, and International Day and the Girl Child. UNFPAs support also include that the events go beyond celebrating the event and creating awareness among the public but are result oriented that have direct benefit to the adolescent girls and women. • It also work on law enforcement issues, development of international reports such as CEDAW report and the like. • UNFPA also supports and strengthens national level coordination forums. For example the CO provides technical and financial support to the National Alliance to End FGM and CM. While the Ministry is the chair, UNFPA was the co chair though the co chair ship is rotating. At regional level, UNFPA engages in capacity building of relevant stakeholders and communities to prevent gender-based violence and harmful traditional practices (FGM and CM). • There is evidence that the program prevented GBV (physical, sexual and psychological harm and threats) and FGM and CM UNFPA also tries to respond to gender-based violence and harmful traditional practices as much as possible by providing direct services to survivors and also support scaling up best practices. There is evidence of provision of services to survivors of GBV through the local NGOs (AWSAD and APDA - Barbra May Maternity Hospital) and also Women Association. • Many girls and women survivors are rehabilitated and empowered and become self reliant through skill training and IGA Enhancement of the capacity of communities to promote and protect the rights of women and girls • Women and Girl's Friendly Spaces in humanitarian setting and development programs facilitate the dissemination of information as well as protect the rights of adolescent girls and women • Capacity building of community structures (Anti HTP committees, establishing committees to combat FGM and CM at community level with clan leaders, religious leaders and traditional birth attendants) has made a significant contribution • Establishing groups within the community ("Married and Unmarried" girl/youth groups) to increase dialogue among members on cultural norms • Engaging boys and men and building their capacity to be partners in the effort to end CM has a great significance. The participation of boys and men in the programme greatly contribute to the achievement of the objective of the programme. For example in Afar it was highly stressed that the role of clan and religious leaders in teaching and clarifying for the community about the importance of stopping FGM

	Enhance the capacity of institutions to promote and protect the rights of women and girls • Multiple capacity building training has contributed to building the capacity of institutions to understand and work towards the promotion of the rights of girls and women and to end GBV and HTPs Integrating of gender and human rights based approach • The whole programme is gender focused and addresses the issue of human rights violations Though UNFPA achieved a lot, there are also challenges that were identified in provision of integrated services (multi-sectorial interventions) to survivors of harmful traditional practices and gender-based violence • There is weak multi sectorial intervention since most of the interventions with regards to GBV, FGM and CM are related to one aspect the AWSAD safe home except • One stop centre at Gambella is not providing the intended service. One Stop Center in Gambella is not addressing the needs of survivors of GBV • There is a gap in building the capacity of law enforcement in protecting the rights of survivors • All the programmes lack economic empowerment of girls and women. Though it can be argued that it is beyond the mandate of UNFPAs mandate to is not possible to empower women without empowering them economically to increase women's decision making within the household and in the communities. Economic empowerment will also have greater implication on women involvement in the political arena. • There is lack of evidence whether the interventions address gender norms (socio-cultural rules) and gender roles (socially constructed roles, behaviours, activities and attributes that society considers appropriate for girls and women) Women Development Army in Afar is not well established which poses a challenge Unintended consequences • Sexual harassment and rape after stopped CM • Committing suicide when forced to marry at a younger age • There is a report that people will go to neighbouring untargeted Woredas to carry out CM and FGM Gender equality is not something that can be achieved with the effort of one institution where women and men, girls and boys enjoy the same status in society; enjoy all human rights fully and without discrimination; enjoy the same level of respect in the community; are equally valued by all; can take advantage of the same opportunities to make choices about their lives and expect equivalent results; and have the same amount of power to shape the outcomes of these choices. Since gender norms are deep rooted within the community it is also unrealistic to expect

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

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

	registration and vital statistics and web-based integrated management information systems; support seasonal assessments and risk profiling for vulnerability analysis and risk reduction interventions; support regional and national population situation analyses; support key stakeholders to generate data for policy and programme formulation, monitoring and evaluation; and advocate for the inclusion of the demographic dividend in national policies, strategies and programmes. **Data for development & advocacy including in humanitarian Programme** In anticipation of a robust and high quality census, UNFPA improved the preparations and the institutional capacity of the Central Statistics Agency (CSA) towards the fourth Ethiopian Population and Housing Census (EPHC) through provision of financial and technical support. Following are the key milestones achieved: Implementation of preparatory activities including a comprehensive pilot census, a pilot Post Enumeration Survey (PES), and the revision and finalization of the census project document; Deployment of a Census Technical Advisor (CTA), a Geographic Information Systems (GIS) Specialist, and a Communication Adviser; Training of 68 CSA staff on various subjects related to census undertaking such as data centre management, data capturing and transfer, data processing, PES implementation, GIS/Cartography, as well as data analysis and dissemination; A study visit of CSA managers and 7 staff to Egypt to gain experience in the planning and management of digital census. IMIS - Integrated Management Information System is a collection of several statistical databases of various surveys and censuses conducted by the Central Statistics Agency and other Government institutions like ministries. The IMIS is a tool that has been developed to enable users generate customised statistics that meet their individual needs in the form of frequencies, cross tabulations, indicators, etc. This project is a continuing process that shall incorporate more census and survey data over time. Stakeholder interviews [with CO staff and IPs) showed that UNFPA CO has helped the CSA to develop a functional IMIS both at National and 5 regional levels. While IPs reported the use of IMIS for regional planning, officers in-charge were not able to demonstrate the use of the system for planning. This leads to low utilization of the IMIS which compromises effectiveness. Implementation of regional web-based Integrated Management Information System (IMIS) in the Amhara, Oromia, Tigray, Afar and SNNP regions (also uploaded on CSA's website) have been developed. The system enables the retrieval of tailor made data (by way of the calculation of indicators, production of customized tables, and the generation of thematic maps at any administrative level) through direct access to different data sources including census, household sample surveys or administrative/routine service-based data. A statistical abstract of indicators for all sectors from 2008-2018 which was also uploaded on the IMIS, on the CSA's website. The statistical abstract

	is expected to facilitate easier access to data by end-users. Procurement of census equipment for the implementation of the 2018 Ethiopian Population and Housing Census (EPHC), including severs, portable solar power banks, etc. Other achievements under this component during this cycle include preparations for the 4th population and housing census. These include : Completion of the EPHC cartographic mapping activity ahead of the census enumeration in early 2018; Finalization and translation of the tools for the census enumeration including the census data capture programme; Completion of the designing, translation and printing of census questionnaires as well as enumerators' and supervisors' manuals in preparation for the census, implementation of three rounds of pilot censuses (both paper and tablet based) in November 2016, March 2017, June 2018; onducted two rounds of pilot post enumeration surveys in February 2017 and August-September 2017; organisation of training of Trainers (TOT) both at national and regional levels ahead of the census enumeration in early 2018, training of regional, woreda and zonal census communication and publicity officers on publicity and communication issues about the census, implementation of the 2016 Ethiopian Demographic and Health Survey (EDHS) and dissemination of its results; procurement of census equipment for the implementation of the 2018 Ethiopian Population and Housing Census (EPHC), including severs, portable solar power banks, and capacity building of CSA staff on Post Enumeration Survey (PES) methodology, Java and SQL and database training that are relevant for PES matching.			
EQ3: ***To what extent has UNFPA made good use of its resources (human, financial, technical, operational) to pursue the achievement of the results defined in the Country Programme?***				
EFFICIENCY				
Sexual and Reproductive Health	Beneficiaries of UNFPA Support received the resources that were planned, to the level foreseen and in a timely manner UNFPA administrative and financial procedures as well as	The planned resources were received to the foreseen level in AWPs The resources were received in a timely manner Appropriateness of administrative and financial procedures for smooth,	Atlas Records Audit Reports Country Office information management systems Annual Work Plans Country Office Standard Progress Reports (SPR) Implementing partner quarterly and annual progress reports	Study of documentation Comparative analyses of planned and actual expenditure and activities Key informant interviews

	implementation modalities allow for a smooth execution of the Country Programme The resources provided by UNFPA have had a leverage effect	accountable and responsive management of financial and human resources Extent of deviations from planned activities (newly added activities, cancelled activities) and their consequences on the quantity and quality of the outputs Evidence that the resources provided by UNFPA triggered the provision of additional resources from government and other partners	Donors (providing funding to UNFPA Country Office) Implementing partners Beneficiary groups/communities UNFPA Country Office staff	
Data and information collected	Once AWPs are approved, resources are provided to each IP and operational area based on the AWP. Funds transferred to IPs are generally used reasonably and only to the purposes they are assigned for - Delay in transfer of funds affects implementation of planned activities. IPs have reported that they most of the time had to rush implementation of activities because there will always be delays in transfer of funds. There is long chain of approval of annual plans, report reviews, and funding transfers - Resources are very thinly spread over wide geographic areas than what can potentially be supported meaningfully. Budget utilization rate increased over time. In 2016, SRH/AYD component of the program used 74% its budget. This figure increased to 83% in 2017 and 90% in 2018. Donation of equipment and furniture for school clubs and YFSCs has resulted in continued engagement of other actors in the provision of SRH information and services. For example, most of the YFSCs have dedicated health professionals. Similarly school clubs run mini-media once they are provided with the basic equipment required for the service.			

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

	The resources provided by UNFPA have had a leverage effect	added activities, cancelled activities) and their consequences on the quantity and quality of the outputs Evidence that the resources provided by UNFPA triggered the provision of additional resources from government and other partners		
Data and information collected	- Resources from CP are used for intended purposes as described in AWPs - Delay in transfer of funds was very often reported as a source of inefficiency in implementing program activities. - Long chain of approval of annual plans, report reviews, and funding transfers have been reasons for delayed and rushed implementation of program activities - Resources allocated at woreda level are too small to support adequate sites. They are also limited to very specific activities of a broad intervention area resulting in sub-optimal efficiency. - Budget utilization rate is in general high. It also increased recently compared to the early years of the program. - Donation of equipment and furniture for school clubs and YFSCs has resulted in continued engagement of other actors in the provision of SRH information and services. For example, most of the YFSCs have dedicated health professionals. Similarly, school clubs run mini-media once they are provided with the basic equipment required for the service. - The online system for administrative and financial procedures is found to be difficult for some government IPs. High turnover of staff in the government sectors and lack of regular trainings on the electronic system are the primary reasons for limited capacity to use the system. - Implementing government organizations at Woreda level have limited capacity on planning and implementation resulting in inefficient use of allocated resources. - Government IPs (federal as well as regional) have clear mandates in the areas they are currently supported by UNFPA. These IPs have strategic		

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

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

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

	accessed from the chart of accounts based on annual work plan. Long and short term technical assistance is accessed on demand. Procurement of goods and services is also available on demand for all program phases. For EDHS, financial and technical support was provided to support the different phases of the survey: from listing phase up to dissemination of results, while in CRVS, UNFPA provided financial assistance for capacity building trainings and participation of staffs in international workshops. There are two components of resources for supporting the census: UNFPA core resources and other (donor resources). The core resources are allocated according in consultation with partners' need and priorities, while other resources are ear-marked for specific activities based on tripartite consultation with the donor and the partner. The partner is agreeable to UNFPA managing donor resources. The resources are utilized towards achieving operational efficiency and value for money. For example, we opt for sea transport instead of air lifting; when we choose training locally (in-country) over abroad in order to train more for less. When we choose government facility over commercial enterprises to lower training costs. Based on stakeholder interviews, review of financial documents, review of Annual Work Plans, and annual reports, the PD Program Area has, to a very high extent, made good use of available human, financial and technical resources to achieve Output 6. The evolution of the budget and expenditures from 2016 to 2020 show that all budgeted funds have been fully expended at a remarkable 90%. This reflects the care taken by UNFPA Ethiopia PD staff to ensure that the relatively limited resources are used to the fullest extent possible. Feedback from stakeholders on efficiency was very favourable. High staff turnover at the local level is a threat to efficiency as the investment in training is lost when staff transfer to other positions. Government support for the sub-components of this thematic area include co-financing up to 60% of the total cost of the census, EDHS, IMIS and CVRS; providing staff time; physical infrastructure (office and storage space; providing transport and logistics, providing over all management and leadership of the program and assisting in resource mobilization political goodwill.			
EQ 4: ***To what extent have the programme interventions owned by national institutions and are likely to continue after the programme support is ended?***				
SUSTAINABILITY				
Sexual and Reproductive Health	The benefits are likely to continue beyond	Evidence of the existence of an exit strategy	Beneficiary groups / communities Line departments' personnel	Study of documentation Key informant interviews

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

	- Maternity waiting homes are constructed and financed by **communities**. There is increasing acceptance of community contribution to feed mothers staying at maternity waiting homes. - Most **youth centers generate revenue** covering their own expenses. Recreational activities continue irrespective of external support. However, there is no mechanism in place to ensure the provision of SRH and HIV related services (free of charge) continue in the centers. For example, SRH clinic from one of the model youth centers is now closed because health workers are not happy with salary. - School clubs (particularly mini-media) run by their own once they get the minimum set of equipment - Some community-based activities are not achieving sustainable results particularly because of low intensity of program implementation. Examples: o Community conversations leading to no change at community level o Youth-parent forum – committee formed and trained but mostly lack follow-up leading to inactivity Procurement of family planning and other RH commodities (by UNFPA) has not been adequately used to build the capacity of the Ethiopian Pharmaceutical Supply Agency. The newly approved staffing structure for health centers allows hiring one health officer for youth friendly service centers. This facilitates sustaining the center irrespective of external support.			
Adolescent and Youth	The benefits are likely to continue beyond program termination Activities and outputs were designed taking into account a handover to local partners Interventions in the focus area	Evidence of the existence of an exit strategy Evidence of a hand-over process from UNFPA to the related projects Extent of ownership of each project by implementing partners Extent to which the government and implementing	Beneficiary groups / communities Line departments' personnel Provincial and local authorities Implementing partners UNFPA Country Office staff CPAP Annual Work Plans Previous evaluations	Study of documentation Key informant interviews Group discussions with target beneficiaries and local authorities

	incorporate exit strategies UNFPA has been able to support its partners and the beneficiaries in developing capacities that ensure the durability of outputs, and eventually outcomes	partners have the financial means for continued support in maintenance of facilities, procurement of medicines, information management and reproductive health commodities security, and conducting follow-through refresher training sessions. Extent to which UNFPA has taken any mitigating steps if there are problems in this regard		
Data and information collected	- Most **youth centers generate revenue** covering their own expenses. Recreational activities continue irrespective of external support. However, there is no mechanism in place to ensure the provision of SRH and HIV related services (free of charge) continue in the centers. For example, SRH clinic from one of the model youth centers is now closed because health workers are not happy with salary. School clubs (particularly mini-media) run by their own once they get the minimum set of equipment Some community-based activities are not achieving sustainable results particularly because of low intensity of program implementation. Despite provision of trainings and experience sharing activities, procurement of family planning and other RH commodities (by UNFPA upon request from the government) has not been adequately used to build the capacity of the Ethiopian Pharmaceutical Supply Agency as there has been no clear sustainability plan/exist strategy. - Capacity building among youth in general has lasting effects as benefits stay longer throughout the period of adulthood.			

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

	There are also changes that are observed regional level which can be mentioned as major contributions of UNFPA which have direct and indirect impact on the sustainability of the programme • UNFPAs role to advocate for the inclusion of VAW in the DHS • The bottom up approach used by UNFPA contributed for the sustainability of the programme since it strengthens community ownership. • Capacity building programs for government stakeholders help to sustain the prevention activities though there is challenge • Increased understanding and commitment of local communities to end CM, HTPs and GBV. The level of feeling of ownership of the program, though different from region to region is encouraging. • Use of the exiting grass root structures helped for the sustainability of the programme.Intensive capacity building addressing community members, community conversations and the establishment and support of groups to fight FGM and CM help to sustain the prevention activities • Woredas who have declared to end CM and FGM are still working to end CM and stop FGM through the active participation and commitment of the grass root structures Even though programmes that are focused on prevention and promotion can be sustained provision of direct services to survivors cannot be sustained since it is cost intensive to rehabilitate survivors and reintegrate them to the community. Hence these services (Safe Houses) will be mainly dependent on money generated outside of the community. Staff turnover is indicated as a challenge for mainly the government IPs. But it was also possible to understand that UNFPA made an effort to provide trainings for many IP staffs as possible to make sure that the programme is not greatly affected by staff turnover. The integration of the GEWE and SRH and Y&A component has a great impact on the sustainability of the programme.			
Population and Development	The benefits are likely to continue beyond program termination Activities and outputs were designed taking	Evidence of the existence of an exit strategy Evidence of a hand-over process from UNFPA to the related projects	Beneficiary groups / communities Line departments' personnel Provincial and local authorities Implementing partners UNFPA Country Office staff	Study of documentation Key informant interviews Group discussions with target beneficiaries and local authorities

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

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

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

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

	active participation in inter-agency working groups raises visibility of UNFPA and is highly appreciated, it may focus too much UNFPA staff attention inward within the UNCT at a time when aggressive external efforts at fundraising might be a greater priority. UNFPA is involved in Delivering as One joint planning process accompanying the UNDAF which is signed by all the resident UN agencies in Ethiopia. By working together with other UN agencies there are opportunities for UNFPA and its UN partners to provide a continuum of focus on development needs, such as the overlapping mandates of UNICEF (children up to age 18) and UNFPA (adolescents and adults). UNFPA works with UNICEF to address issues of violence against children including child marriage. Generally, the Delivering as One initiative provides impetus for more collaboration and joint working but agencies are constrained by their individual systems, mandates and reporting mechanisms. Sharing of information with UNCT happens on a regular basis through participation in the Technical Working Groups. While UNFPA is actively involved in UN working groups, it is not a lead agency in any of the task teams. There is ample evidence of information exchange between UN agencies**.** Being a One UN country, joint UN task teams meet regularly. Besides most relevant UN agencies are housed in the UNECA Complex in Addis Ababa thereby making informal information exchange is easy. Stakeholders expressed strong approval for the exceptionally collaborative approach taken by UNFPA Ethiopia because the UNFPA staff fully share the values of the Delivering as One approach and collaborate with other UN Agencies to maximize the results. Stakeholders from outside the UNCT, especially the Federal and Regional Implementation Partners reinforced the idea that UNFPA Ethiopia is adept in collaboration to advance common UNCT goals. The evaluation team was unable to find any significant instances where UNDAF outputs or outcomes that belong to the UNFPA mandate were not fully attributed to UNFPA.			
EQ6: ***(i) What are the main UNFPA comparative strengths in the country – particularly in comparison to other UN agencies and development partners?*** ***(ii) What is the main UNFPA added value in the country context as perceived by national stakeholders?***				
ADDED VALUE	There is added value of UNFPA in the development	Evidence of added value	Beneficiary groups/communities Senior management in line departments	Key informant interviews Focus group discussions

	partners' country context as perceived by national stakeholders UNFPA has comparative strengths in the country – particularly in comparison to other UN agencies UNFPA corporate features or are explained by the specific features of the CO UNFPA has had no intended substitution or displacement effects at national, provincial or local level and that If there is any the magnitude of such effect and what are their repercussions are minimal	Extent of contribution to added value by UNFPA comparative strengths in the country – particularly in comparison to other United Nations organisations Uniqueness of UNFPA corporate features explained by specific aptitudes of the country office Evidence of possible substitution or displacements effects on the private sector, civil society organisations, academia, specific government bodies and other development partners in the country, including other United Nations organisations.	and national government counterparts Implementing partners Donors Other United Nations organisations	

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

ANNEX 5: DATA COLLECTION TOOLS

Key Informant Interview Guide for UNFPA Country Office Staff

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

Focal Points and Programme Officer: SRH

Focal Points and Programme Officer: AYD

Focal Points and Programme officer:GEWE

Focal Points and Programme Officer: Population and Development

General introduction and closing - 1. Human connection

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

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

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

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

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

4. Ending the interview

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

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

Relevance

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

Effectiveness

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

Efficiency

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

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

Sustainability

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

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

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

Strategic Alignment

Coordination and Partnership

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

Added value

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

Cross-cutting Issues:

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

Lessons Learnt and recommendation

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

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

National Stakeholders: Federal, Regional and NGO IPs

Place: To be used in Addis and Regions

General introduction and closing - 1. Human connection

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

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

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

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

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

4. Ending the interview

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

Relevance

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

Effectiveness

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

Efficiency

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

Sustainability

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

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

Coordination and Partnership

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

Added value

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

Cross-cutting Issues:

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

Lessons Learnt and recommendation

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

In-depth Interview Guide for Beneficiaries
Place: Beneficiaries in Addis and Districts
Relevance

- What are the national needs and priorities in Ethiopia in terms of the development agenda? How important is the 8TH Country Programme (CP) to these needs and priorities at district, provincial and national levels?
- Does the 8TH CP address the needs in: Women's Reproductive Health (SRH), Adolescents, Youth and Gender (AYD), GEWE and Population and Development (P&D

- **Effectiveness**
- To what extent has UNFPA support reached the intended beneficiaries?
- Are different beneficiaries appreciating the benefits of the UNFPA interventions? For example?
- Overall, how effective is the 8TH CP in Ethiopia?

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

Sustainability

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

Focus Group Discussion – Adolescents and Youths

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

Can we introduce ourselves?

Can you explain what activities you have participated in?

Core Questions:

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

Effectiveness

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

Site Visits [Look for these]

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

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

YFSRH Facilities:

Ministries with budget allocation for adolescents sexual and reproductive health

Communities that abandoned FGM:

GBV Victims and Survivors:

Fistulae Patients and Reintegrated

Agencies with sex-age-disaggregated data.

Any adoption of human rights approach?

[i] https://cpb-us-w2.wpmucdn.com/u.osu.edu/dist/9/1401/files/2014/03/Ethiopia-1i7cwe5.pdf
[ii] https://tradingeconomics.com/ethiopia/land-area-sq-km-wb-data.html
[iii] http://worldpopulationreview.com/countries/ethiopia-population/
[iv] https://data.worldbank.org/indicator/SP.URB.TOTL.IN.ZS?locations=ET
[v] https://data.worldbank.org/indicator/SP.RUR.TOTL.ZS?locations=ET
[vi] https://data.worldbank.org/indicator/SP.POP.GROW?locations=E
[vii] https://globaledge.msu.edu/countries/ethiopia/government
[viii] https://www.thoughtco.com/ethiopia-regains-its-independence-3970507
[ix] https://data.worldbank.org/indicator/NY.GDP.MKTP.CD?locations=ET
[x] https://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG?locations=ET
[xi] http://www.selamta.net/economy.htm
[xii] http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/ETH.pdf
[xiii] https://fred.stlouisfed.org/series/SLUEM1524ZSETH
[xiv] https://www.indexmundi.com/ethiopia/life_expectancy_at_birth.html
[xv] https://data.worldbank.org/indicator/SH.DYN.MORT?locations=ET
[xvi] https://www.indexmundi.com/ethiopia/maternal_mortality_rate.html
[xvii] https://data.worldbank.org/indicator/SH.STA.BRTC.ZS?end=2017&start=2000
[xviii] https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=ET
[xix] https://data.worldbank.org/indicator/SP.DYN.CONM.ZS?locations=ET
[xx] https://data.worldbank.org/indicator/SP.UWT.TFRT?locations=ET
[xxi] https://ourworldindata.org/country/ethiopia
[xxii] https://data.worldbank.org/indicator/SP.DYN.TFRT.IN?locations=ET
[xxiii] https://www.unaids.org/en/regionscountries/countries/ethiopia
[xxiv] https://data.worldbank.org/indicator/SH.DYN.AIDS.ZS?locations=ET
[xxv] https://data.worldbank.org/indicator/SH.HIV.1524.FE.ZS