

**Summary Report of Program Evaluations under Sixth and  
Seventh Country Programs**

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## Acronym

AMP	Accelerated Midwifery Program
A&Y	Adolescent and Youth
B/CEmONC	Basic/Comprehensive Emergency Obstetric and Newborn Care
BOFED	Bureau of Finance and Economic Development
BSc	Bachelor of Science
CO	Country Office
CP(D)	Country Program (Document)
CPR	Contraceptive Prevalence Rate
CPAP	Country Program Action Plan
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organization
CSW	Commercial Sex Workers
DP	Development Partner
EMA	Ethiopian Midwives Association
FGD	Focus Group Discussion
FGM/C	Female Genital Mutilation/Cutting
FMHACA	Food, Medicine and Health Administration and Control Authority
FMOE	Federal Ministry of Education
FMOH	Federal Ministry of Health
FP	Family Planning
GBV	Gender Based Violence
GP(RHCS)	Global Program (on Reproductive Health Commodity Security)
GTP	Growth and Transformation Plan
HC	Health Centre
HDA	Health Development Army
HEI	Higher Education Institution
HF	Health Facility
HEP/W	Health Extension Program/Workers
HP	Health Post
HQ	Headquarters
HR	Human Resource
HSDP	Health Sector Development Program
HSTP	Health Sector Transformation Plan
HTP	Harmful Traditional Practices
IEC	Information Education Communication
IEOS	Integrated Emergency and Obstetric Surgery
IGA	Income Generation Activity
IP	Implementing Partner
IRC	International rescue committee
IUCD	Intrauterine Contraceptive Device
JP	Joint Program
KII	Key Informant Interview
LNWB	Leave No Woman Behind (Program)
MDG/F	Millennium Development Goals/Fund
M&E	Monitoring and Evaluation
MOFED	Ministry of Finance and Economic Development
MOWCYA	Ministry of Women, Children and Youth Affairs
MOYSA	Ministry of Youth, Sport and Children

MSc	Master of Science
MTR	Mid term review
OECD/DAC	Organization for Economic Development/Development assistance Committee
PASDEP	Poverty Alleviation and Sustainable Development Program
P&D	Population and Development
PFSA	Pharmaceutical Fund and Supply Agency
PHC	Primary Health Care
RH	Reproductive Health
RHB	Regional Health Bureau
RH&R	Reproductive Health and Rights
RO	Regional Office
SIDA	Swedish International Development Agency
SOP	Scope of Practice
SP	Strategic Plan
SRH	Sexual and Reproductive Health
SWAp	Sector Wide Approach
TOF	Training of Facilitators
TOT	Training of Trainers
TWG	Technical Working Group
UN	United Nations
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VAW	Violence against Women
VCT	Voluntary Counselling and Testing
VMG	Vulnerable and Marginalized Groups
WFP	World Food Program
YFS	Youth Friendly Service

## Executive Summary

**Background** - UNFPA Ethiopia CO is currently implementing the 7th country program (2011-2016), serving as its framework for assistance. CP7 is implemented at federal level and in Tigray, Amhara, Oromiya, SNNP, Afar and Addis Ababa regions. The goal of the CP7 is to contribute to an improved quality of life for Ethiopians. It has ten outputs, which fall under three program components RH&R, P&D, and Gender Equality. The 7<sup>th</sup> CP implementation is still ongoing and no evaluation (either mid-term or end line) has been conducted. However, independent thematic evaluations have been carried out in program areas including maternal health; IEOS; FP; A&Y; midwifery, anaesthesia and fistula; women empowerment; GBV; and FGM/C. Now the 8<sup>th</sup> CP is under development hence this synthesis report of the various evaluations is an attempt to inform CP8 of lessons and challenges from CP7. Key limitations are lack of information on progress of P&D component and inability to get views of IPs due to scope and time limitation of the study.

## Reproductive Health and Rights

**Maternal Health** – This is a global thematic evaluation of UNFPA’s Support to Maternal Health between 2000-2011. UNFPA is a respected partner leading or actively participating in major FP/SRH related TWGs and wider DP taskforces. Initially UNFPA supported in-service training of health workers, which lately shifted to supporting pre-service training. However, system wide issue in HR planning, deployment and retention is undermining efforts on training of key professionals to scale up EmONC. CO also integrated SRH in emergency preparedness through provision of financial and technical support.

**IEOS** – In 2009, FMOH, Federal Ministry of Education (FMOE), with support from the UNFPA and other DPs launched a three-year Masters of Science training program in IEOS in three universities, which later expanded to 11. The project is ongoing and this study reviewed progresses and challenges in 2013.

The CO supported shifting task of doing emergency general and obstetric surgery to non-physician clinicians. This intervention aimed to expand access to CEmONC services in areas where there is shortage of obstetric surgeons. By June 2013, 535 students were enrolled in the program. Currently around 250 graduates are deployed across the country. This increased rural community’s access to emergency obstetric and surgical interventions. Volume of obstetric and surgical emergency managed within primary hospitals increased and referral of cases has reduced.

There are challenges faced in the program. First, system is not instituted to enforce adherence to SOP. Hence, there were cases whereby IEOS Officers perform non-emergency major operations. Second, deployed graduates have limitations on clinical decision-making skills.

**Midwifery, anaesthesia and fistula program** – this program run from 2010 to 2014 supported by SIDA. It was implemented in all regions with the exception of the accelerated midwifery program, which is implemented in six regions.

**Midwifery program** supported the accelerated midwifery training through provision of vital teaching and learning materials, strengthening skills laboratories, increasing teaching capacities of tutors and training clinical preceptors to assist students. The program helped revise the curriculum for BSc program in Midwifery. It also support FMOH develop and implement a supportive supervision system for new graduates. As a result, almost all HCs in the country had at least one midwife. In addition, midwives trained through the accelerated program were found to be committed and responsive to women’s needs.

Tremendous achievements have been made in building capacity of EMA through training of board members on leadership/management, proposal writing, and advocacy skills. The program helped the association to expand its reach and networking skills. As a result, EMA is being seen as a credible and professional entity by national regulatory bodies.

Despite tremendous achievement, program faced a number of challenges. First, there are weaknesses in the AMP curriculum. Second, there is high turnover of tutors. Third, there is shortage of teaching and learning materials and space. Fourth, there is debate on the qualification of students entering the program. Fifth, there were concerns regarding the increase in the number of male students in the program. Sixth, there is absence of a central regulatory body to govern midwifery education and practice.

**Fistula** - Gondar, Assela and Jimma fistula centres were supported, all of which are offering quality women-friendly services. All centres have significantly increased the number of repairs conducted. All centres have been actively engaged in outreach and community mobilization. Evaluation was impressed with the centre in Gondar, which catered for a large number of clients and has integrated fistula service into mainstream hospital service.

**Anaesthesia** - Capacity of anaesthetic training departments has been strengthened through provision of critical equipment and specialised textbooks, strengthening skill laboratories, and building capacity of tutors and clinician preceptors. The program faced shortage of anaesthesia tutors in colleges and universities due to high turnover. There were gaps in the level 5 curriculum that had to be revised.

**Family Planning** - FP evaluation was a global thematic one looking at UNFPA's support to FP over the period 2008-2013. UNFPA has good visibility and closeness to government at Federal level. UNFPA is recognized as among the top four donors in the area of FP. Findings show that UNFPA supported integration of FP in maternal health, youth, gender and HIV programmes. However, there remain important gaps in integrated service provision for adolescents. There is also need for evidence base on integration experience.

UNFPA promotes national ownership, institutionalization and sustainability. It actively participates/ leads TWGs and networks, supports the MDG pool fund, which is a health basket fund, directs its support through government mechanisms, and strengthens government systems (e.g. PFSA and FMHACA). UNFPA, together with other DPs, has successfully lobbied the government to assign a FP budget line.

## **Adolescent and Youth**

There are two evaluations conducted in this area, a global thematic evaluation of UNFPA's support to A&Y (2008-2014) and evaluation of A Rights-Based Approach to Adolescent and Youth Development Program (2007-2013), which was supported by Norwegian Government in 25 target woredas of five regions reaching 23 million A&Y.

In general, UNFPA's support to A&Y is evidence based and well aligned with national priorities and sectoral strategies. Most youth leaders found the JP program good or excellent in meeting the needs of the target group. Considerable programme effort has gone into youth dialogue and community conversation sessions. Most youth leaders thought the programme had helped to improve the participation of young people in decision-making at community level but less so at national level.

There has been marked increase in service provision for VCT and SRH with establishment of youth centres and YFS and roll out of program in universities. Distribution of condoms has been reduced significantly in later years to accommodate the distribution activities of other partners. Surveys of youth leaders and service users showed high levels of satisfaction with

YFS. However, ratings in improving sustainable livelihoods are lower as respondents alluded to lack of transparency in support, poor follow-up and inadequate seed money.

There are some challenges around program design and implementation. First, the needs of 10-14 year olds are not addressed adequately. Second, minimum YFS package is not implemented in all project sites, in particular sustainable support are needed to help young people in pastoralist areas access YFS. In addition, more remains to be done to build system and tool for quality assurance. Third, targeted services for key groups, such as young people living with HIV, mobile young people, and young people with disabilities need to be strengthened. Fourth, future programs should strengthen M&E system. On the strategic front, evaluation found that UNFPA is not much visible in terms of convening partnerships; it is considered an important partner in A&Y but not a leader.

## **Gender Equality**

**Leave no woman behind** – The program was implemented in 11 Woredas of Tigray and Amhara regions from 2009 to 2012 led by collaboration of UNFPA and WFP. Social mobilization provided a better understanding and community response to the rights of women and girls. Interventions also supported implementation of national law and policies such as prevention of HTP and child marriage. Testimonies on the ground showed positive changes among the community members on use of VCT, FP, RH and more deliveries in HFs. Volunteers organised through community conversations undertake home-to-home visits, identify pregnant women and refer them to hospitals. Some have also built makeshift ambulances in order to save lives of mothers and babies.

The program supported IGA and saving and credit service to targets community. Literacy and life skills education had trickledown effect on awareness about RH, use of social services, better enrolment and retaining of children in schools and more success in IGA.

Program widely participated stakeholders in the design stage. Furthermore, there was strong community ownership decisions about implementation budget expenditure were made at the district level. Program also employed approach that is more efficient i.e. implementing through government structures and using existing venues for implementation (e.g. schools for literacy program). All this contributed to sustaining program benefits and school initiatives planned to continue literacy programme using their teachers as volunteers. However, sustainability of other program components were not as successful.

**Violence against Women** - The program was implemented between 2010-2012 in six administrative regions of Ethiopia through 22 NGO IPs. The main findings from the report indicated that implementation of most projects was based on sufficient analysis of needs and with the active participation of major stakeholders. Program objectives are relevant to the needs of VAW survivors and are consistent with the national development agenda.

Overall, the projects have been effective in achieving their intended impacts. This was shown with (i) increased number of men considering VAW as harming women and affecting their relationship and co-existence; (ii) Various stakeholders having common understanding with respect to the different forms of VAW, its harmful effects and the legal consequences on perpetrators; (iii) men increasingly sharing the workload of women; (iv) increasing number of women visiting justice offices to claim their rights, (vi) changes in the perception of early marriage of girls (vii) decreases in abduction of girls for marriage.

In spite of this, however, the scale of operation of projects has not been commensurate enough with the magnitude of the problem in terms of geographic coverage, duration and type of services to bring about tangible impacts. Projects suffered from budget shortage due to decline in the value of birr against dollar and high rate of inflation.

**FGM/C** –This is a global evaluation of a program implemented in 15 countries between 2008 and 2013. The program was jointly implemented by UNFPA and WFP. The JP was aligned with national commitments and priorities. It addressed gaps in existing efforts to end FGM/C by tailoring its work and the work of IPs to the specific needs of the communities with which it worked. The evaluation noted significant strengths in the design of the JP, which pursued a culturally sensitive approach. Nevertheless, evaluation identified importance of efforts at the national and community levels, to turn existing potentials into actual changes in behaviours and (collective) practices.

## Recommendations

### Reproductive health and rights

Under **IEOS** program, FMOH and FMHACA need to define scope of practice (SOP) and institute system to enforce SOP for IEOS. FMOH, FMOE, UNFPA and other DPs need to develop a roadmap for training scale-up that considers pace of expansion and equipping of HFs to deploy new graduates. Limited clinical decision-making skills of graduates require strategic intervention at the training and post deployment stage. Reviewing the training curriculum, involving students during initial and follow up evaluation of patients and making morning sessions mandatory are some of the proposed measures.

For **FP**, the availability of method mix should be supplemented by training of providers to counsel on the full range of methods. There is need for evidence on the impact of integration of FP on access, quality and user satisfaction. UNFPA could support study to identify the benefits of integration for specific population groups (e.g. adolescents) and in specific areas such as post-partum FP.

Under **midwifery, anaesthesia and fistula program**, there is need to shift priority from quantity to quality in midwifery training. Increasing clinical capacities of midwife tutors and instituting evidence-based regulatory standards for the education of midwives are priority tasks. FMOH should address benefit and career path issue of level 5 anaesthesia nurses. Significant community preference for female midwives necessitates increasing the number of female students.

### Adolescent and Youth Program

First, there is need for disaggregation by age in programming as well as data keeping in particular to address the needs of 10-14 year old. Second, the program should continue to refine its strategies for reaching hard to reach and vulnerable youth. Third, the JP needs to continue demonstrating efficiency and value for money by ensuring: lessons documented in annual progress reports inform practice; recent improvements in fund disbursement systems are sustained; and the M&E system is significantly strengthened. Fourth, UNFPA needs to take the leadership role in supporting cross-sectoral responses to A&Y issues.

### Gender Equality

Under **VAW**, suggestion is to establish a minimum package in terms of composition of services, geographic coverage and balance of services that a CSO will implement. The evaluation recommended stronger collaboration of CSOs with government bodies. Setting up a fund that can be accessed through joint NGOs and Government partnership proposals is suggested. Mainstreaming VAW contents in formal and informal educations is proposed.

Finally, a general recommendation for most projects is to strengthen M&E. Programs/projects should have a coherent theory of change, M&E framework and system before they are launched.

## Conclusion and Implications for CP8

Strategies devised to achieve outputs under RH&R and gender equality have been accomplished for the most part. This indicates that, if the program logic is valid, then UNFPA is on the right track to achieve outcomes under the two components of CP7. More definitive conclusion would be reached once CP7 end line evaluation is conducted. Based on lessons and experience from CP7, here are implication for CP8.

### RH and rights

- Role of GPRHCS program in availing method mix should be consolidated to ensuring that non-hormonal methods are consistently available in government HCs and hospitals and health workers are equipped to offer and counsel on method choice.
- Gap in availability and quality of YFS implies justifies continued support in this regard.
- Care should be taken so that GPRHCS does not undermine integration in FP. Strategies should be devised to strengthen integration of interventions around FP and maternal health with HIV programs in the coming CPD.
- With the pressure to reach 66% CPR by 2015, there is risk of imposing undue pressure by providers to accept the use of FP. Evidence is required to reach definitive conclusion and take action on the issue.
- In order to maximize benefits from its investment in pre-service training, UNFPA should consider involvement and support to address wider HR for health sector issue including planning, deployment and retention.

### Adolescent and Youth

- Given UNFPA's comparative advantage and its expertise and experience in A&Y, it might be worthwhile to reorganize support to A&Y under a separate program component, intensify support for age group 10-14 years, and create visibility for its role.
- Although UNFPA currently works in six regions, in the future, there is necessity to revise the intervention regions according to emerging needs in the regions. A case in point is Gambella Regional State, which is hosting a large number of refugees from Southern Sudan. There is high population density and large number of youth and adolescents resulting in need for support in SRH, HIV and related issues.

### Gender Equality

- Implementation at local levels suffered from lack of coordination and duplication of efforts between stakeholders. There is no evidence showing presence of national coordination mechanisms either. This implies that UNFPA needs to foster partnerships and coordination for gender equality and related interventions.
- Although poverty is one of the main factors leaving women vulnerable to GBV, only few projects run IGA. In the future, IGAs should be expanded with possibility to establish link with credit associations and micro finance institutions.
- There is good experience from LNWB program whereby schools took over adult literacy intervention when program phased out. Such experiences should be widely promoted.

### General

- Continue strengthening national systems and channelling more support through government mechanism, however, continue to encourage innovative projects with NGOs and support that with structured learning process.
- Strengthen M&E systems and plan for it before implementation starts.

## 1. Introduction

United Nations Population Fund (UNFPA) has operated in Ethiopia since 1973 through the design of multi-year country programs that serve as a framework for assistance. The Ethiopia country office (CO) is currently implementing the 7th country program (CP) which was developed in 2011. Although its implementation was expected to span over four years from January 2012 to December 2015, the end date was recently extended to June 2016 based on similar period extension of the United Nations Development Assistance Framework (UNDAF). The 7th CP is operational at the federal and regional levels (Tigray, Amhara, Oromiya, SNNPR, Afar and Addis Ababa) and in selected districts within these regions. The goal of the seventh CP is to contribute to an improved quality of life for Ethiopians. The 7th CP builds on successes and lessons from the 6<sup>th</sup> CP. The 7<sup>th</sup> CP has ten outputs which fall under three program components: Reproductive Health and Rights (RH&R), Population and Development (P&D), and Gender Equality. The RH&R component covers more than half of the budget at 61.2 %, while the P&D, Gender and Program Coordination components cover 38.8% of the total USD 85 million budget (see table 1).

**Table 1 - Indicative assistance level for CP7, in million USD**

Program Components	Regular resources	Other	Total
Reproductive health and rights	13.8	38.2	52.0
Population and development	5.2	11.4	16.6
Gender equality	4.2	11.4	15.6
Programme coordination and assistance	0.8	-	0.8
Total	24.0	61.0	85.0

Source: CP7 Document, UNFPA, 2011a

The 7<sup>th</sup> CP is developed based on UNDAF (2012-2015), which is a strategic planning framework designed jointly by the United Nations Country Team (UNCT) and the government to guide the UN work in alignments with the national developmental and humanitarian priorities. Ethiopia is a country where efforts are being made by the Government and UN to foster the principle of the UN working and delivering as one. The aim is a transformation of the UN into a more coherent body that supports national priorities (UNCT, 2011).

The four strategic areas and the cross-cutting issues selected by the UN for development cooperation over the period of UNDAF (2012-2015) i.e. (1) Sustainable economic growth and risk reduction, (2) Basic social services and human resources, (3) Governance and capacity development, and (4) Women youth and children, are designed to contribute to the Government's primary objectives of achieving the targets of GTP and the MDGs (UNCT, 2011). The choice stemmed from consultation with the Government, a review of the MDG assessment and other situation analysis and the review of the progress against last poverty reduction strategy paper (PASDEP 2005-2010) (ibid). Thus the UNDAF is aligned with the government's five-year Growth and Transformation Plan (GTP 2011-2015) which is also confirmed by the UNDAF mid-term review (MTR) report (Universalia, 2014)

The CP is also aligned with sectoral development plans, and UNFPA strategic plans (SP 2008-2013 and 2014-2017). In 2011, MTR of the 2008-2013 SP introduced significant refocusing of UNFPA by placing Sexual and reproductive health (SRH) and rights at the centre of the organization's engagement, commonly referred to as the "bull's eye" (UNFPA, 2011b). The Strategic Plan 2014-2017, has assessed UNFPA's refocus in line with changing context and has affirmed that the focus will continue (UNFPA, 2014). Accordingly, UNFPA's goal for 2014-

2017 will be the achievement of universal access to SRH, the realization of reproductive rights, and the reduction in maternal mortality. The goal is planned to be attained through an enhanced focus on family planning (FP), maternal health, and HIV/AIDS, which are also key focus areas for the 7<sup>th</sup> CP.

This first section has given introduction and background on the linkages between the strategic plans, county program, UNDAF, national and sectoral plans. Section two states the objective and scope of this review. Section three gives background to the evaluations that are summarized in the report. Section four summarizes the key findings. Section five provides major recommendations. Finally, section six gives concluding remarks and implications for the eighth country program.

## 2. Objective, scope and limitations of the review

**Objective** - Currently, the development of the 8<sup>th</sup> country program is underway. This CP will logically build on the lessons and challenges of the 7<sup>th</sup> CP in terms of programming and operations. However, the 7<sup>th</sup> CP implementation is still ongoing and no evaluation (either mid-term or end line) has been conducted. However, independent thematic evaluations have been carried out in program areas including maternal health; integrated emergency and obstetric surgery (IEOS) program; FP; adolescent and youth (A&Y); midwifery, anaesthesia and fistula; women empowerment, gender-based violence (GBV), and female genital mutilation/cutting (FGM/C). In order to fill the gap and inform the development of the 8<sup>th</sup> CP, it is found crucial to summarize and synthesize the findings of independent thematic and end line evaluations conducted during the implementation of the 7<sup>th</sup> CP. Although evaluations are conducted during implementation of CP7, some of the programs rolled from CP6.

**Scope** of the assignment was to conduct a desk review of the evaluation reports and other relevant documents. In order to accomplish the assignment, the consultant held consultations with UNFPA staff and produced a consolidated summary of findings, lessons learned, challenges and recommendations of the reviewed reports.

**Limitations** - At the time of this assessment, there was no evaluation study conducted to review progress in P&D component. Thus, achievements and challenges of one of the three program components of 7<sup>th</sup> CP could not be reflected in this report. This is a major gap in the effort to document progresses and achievements of 7<sup>th</sup> CP.

Given the scope of this assignment and due to the urgency of compiling the report, consultations were not made with the relevant implementing partners (IP) responsible for program areas on which the different evaluations have been made. Thus, the report has not benefitted from in-depth information and insider view from IPs.

## 3. Background of the evaluations

Initially, eight evaluations that have been conducted of the various programs that were implemented under the auspices of the CP6 and CP7 were suggested to be summarized. A ninth report, review of Integrated Emergency Obstetrics and Surgery (IEOS) program, was later included to supplement findings from the other evaluations. Under the 7<sup>th</sup> CP, there were three program components namely reproductive health and rights (RH&R), population and development (P&D), and gender equality. List of the evaluation studies summarized in this report are shown in table 2.

**Table 2 – List of the evaluations summarized in this report**

Publication Date	Title
<b>Reproductive health and Rights</b>	
2012	Thematic Evaluation – UNFPA Support to Maternal Health 2000-2011
2015	Evaluation of the UNFPA Support to Family Planning Services 2008-2013, Ethiopia Case Study Note
2014	Scaling Up of the Midwifery and Anaesthesia Education, and, Prevention and Management of Fistula Programme in Ethiopia
2013	Task-shifting on Integrated Emergency Obstetrics and Surgery: Documentation of Experience in Ethiopia
<b>Adolescent and Youth</b>	
2013	A Rights-Based Approach to Adolescent and Youth Development, End of Programme Evaluation
In process	Evaluation of the UNFPA Support to Adolescents and Youth 2008-2014
<b>Gender Equality</b>	
2013	Joint Evaluation of UNFPA-UNICEF Joint Program on Female Genital Mutilation/Cutting: Accelerating Change 2008-2012
2012	Evaluation of Violence Against Women
2013	Final Evaluation 2013 Africa Gender Thematic Window, Ethiopia. UN Joint Program on Leave No Woman Behind.

Background features of the evaluations under review are summarized in annex 3. The evaluations are conducted over the past three years, the earliest evaluation dating from September 2012 with the maternal health program and the latest one, which is ongoing i.e. evaluating UNFPA's support to A&Y. All the evaluations, except for review of IEOS program, are end term evaluations. The IEOS review was conducted while the program is ongoing. Of the nine evaluations, six are evaluation of a particular project while the remaining three are thematic evaluations namely maternal health, FP, and A&Y. Four of the evaluations i.e. maternal health, FP, support to A&Y, and FGM/C are part of global/multi country evaluations where in most cases (except for FGM/C) Ethiopia has been identified as a county for case study.

Regarding evaluation methodology, except for the FGM/C, Violence against women study and IEOS study, which used a mixed qualitative and quantitative technique, all other reports applied a qualitative method of study. Accordingly, the most commonly used data collection methods include, semi-structured interviews/Key informant interviews (KII), focus group discussions (FGD), case studies and desk review of literature and secondary data. Most of the evaluations apply the OECD/DAC evaluation criteria of relevance, effectiveness, efficiency, outcomes (impact) and sustainability albeit with slight modifications.

#### 4. Summary of findings and challenges

Findings of the evaluation reports are summarized under the key program components of CP 7. Accordingly, first part will summarize findings under RH&R. Second part will deal with findings under A&Y program and third part will show finding under gender equality component.

In summarizing and presenting the findings it was not possible to apply similar classification as the evaluations all used different classifications. Some applied the DAC/OECD evaluation parameters, others had list of evaluation questions through which evaluation was reviewed and some other reports conducted evaluation by reviewing extent of achievement of program outputs. Thus, the summary respected these variations in evaluation approaches and classifications.

## 4.1. Reproductive health and rights

Under the RH&R component, there are four outputs. Output one deals with building capacity for training of human resource for maternal health. Output two is about increasing availability of essential commodities for maternal and newborn health including FP. Output three deals with strengthened national capacity to provide high-quality information and services on maternal and newborn health. Final output is about increased availability of HIV prevention services for youth (see annex 2). There are four evaluations under this components i.e. maternal health; Integrated Emergency Obstetric and Surgery Program; FP and midwifery, anaesthesia and fistula program.

### 4.1.1. Maternal Health

#### 4.1.1.1 Overall

Previously i.e. until 2011, UNFPA has been less successful in helping to harmonize maternal health support when staffing shortages forced country offices to be absent from some of the key coordination bodies, both at technical and at policy level. However, the FP evaluation that was conducted recently has shown that this finding is obsolete. Finding thereof show that UNFPA is a respected partner leading or actively participating in major FP/SRH related and wider development partner (DP) technical working groups (TWGs) and taskforces. Maternal health-specific advocacy campaigns, such as the Campaign on Accelerated Reduction of Maternal, Newborn and Child Mortality (CARMMA) or the International Day of the Midwife have added to the visibility of UNFPA.

Together with DPs, UNFPA had intended to contribute to a more harmonized and intensified support to maternal health by helping to translate the Maputo Plan of Action into national-level maternal health road maps. However, operational plans were not developed to integrate the road maps into health sector policies because the road maps were superimposed on already ongoing policymaking processes. The ability to adopt and implement the road map was also affected by administrative and resource-related bottlenecks in the national health sector. The road maps were, therefore, integrated in a very general way and did not gain a sufficiently high status among DPs to drive aid harmonization

Logistical and financial support to technical training of nurses, midwives and doctors in HIV/AIDS, FP, obstetric fistula, and EmONC has been one of the major components of UNFPA maternal health-related support. During the latter half of the period covered by this evaluation (i.e. between 2005 and 2010), UNFPA country offices shifted more of their resources from in-service trainings to the support of pre-service trainings. UNFPA partnerships with national training institutions helped to closely align UNFPA assistance with the existing training schools. This increased the effectiveness and the sustainability of UNFPA support in this area. However, despite these successes, UNFPA and its partners faced inappropriate staff deployment difficulties to make trained RH worker available in the most remote and vulnerable regions. Particular challenges included inadequate planning capacities in Federal Ministry of Health (FMOH) human resource (HR) department, difficulties with coordination, communication and cooperation between FMOH and Regional Health Bureaus (RHB), or the lack of reliable data to track the availability of health workers across the country. The CO found it difficult to approach these interrelated challenges given the limited size of its RH team. In addition, it was not clear for the CO whether addressing such system level HR issues is within its mandate. Hence, deployment and retention continued to limit the effects of UNFPA training assistance.

UNFPA helped to strengthen the PFSA which helped to improve the management of RH commodities, and benefited the commodity management system overall. UNFPA was also better able to harmonize its support of RH commodities with the assistance of other donors that worked in this area.

UNFPA CO played a leading role to integrated humanitarian issues in its core programming. It integrated SRH in emergency preparedness through provision of financial and technical support. The CO was involved in the preparation of emergency response plans with SRH component. It also has been a member of the disaster management and coordination committees of the UN and the various clusters and committees to coordinate humanitarian responses in emergencies. UNFPA supported several assessments and baseline surveys on reproductive health, HIV and GBV in humanitarian settings.

#### **4.1.1.2. Integrated Emergency Obstetric and Surgery Program**

The CO has supported the scaling-up of EmONC. One such activity was the shifting task of doing emergency general and obstetric surgery to non-physician clinicians (health officers and later BSc nurses). This intervention aimed to expand access to CEmONC services in areas where there is shortage of obstetric surgeons. FMOH, Federal Ministry of Education (FMOE), with support from the UNFPA and other DPs launched a three-year Masters of Science Training Program in Integrated Emergency Obstetric and Surgery (IEOS) in 2009 at three universities which later expanded to 11 (FMOH and UNFPA, 2013). By June 2013, 535 students (422 in the UNFPA-supported universities and 114 in the CDC and WHO supported universities) were enrolled in the program. Currently around 250 emergency surgical officers have graduated and been deployed across the country. The training program is expected to graduate more than 1000 trainees by 2020.

Deployment of IEOS Officers to primary hospitals has increased rural community's access to emergency obstetric and surgical life-saving interventions. Volume of obstetric and surgical emergency managed with life-saving surgical intervention has increased and maternal death has reduced significantly. Referral of cases with obstetric and surgical emergency has also reduced. Moreover, the confidence and motivation of other health cadres has improved. Deployed graduates had good performance on technical skills of surgery.

There are challenges faced in the program. First, although there is work by FMOH/FMHACA to define scope of practice (SOP) for IEOS, system is not instituted to enforce adherence to SOP. Hence, there were cases whereby emergency surgical officers perform non-emergency major operations out of their SOP. Second, there is risk that IEOS training could outpace health facility expansion with functional operation theatre to deploy graduates. Third, deployed graduates have some limitations on clinical decision-making skills.

#### **Box 1 – Key lessons from IEOS Program**

- The FMOH and UNFPA have employed multi-pronged strategies to address resistance to initiation of IEOS program. Engaging renowned professionals / government officials into constructive discussion with specialist physicians, experience sharing from countries that already implemented task-shifting, and involving the specialists that early on bought into the program are some of the strategies.
- Designing the training as an integral part of FMOE regular academic program than a donor-funded project enabled better coordination, quality assurance and sustainability.
- UNFPA disburses funding based on a costed annual work-plan. This facilitated coordination and monitoring of program implementation, timely release of funds and financial tracking.
- UNFPA applied innovative strategy to enable students to access adequate skill practice by using non-university hospitals. This decision created additional training capacity in the country and improved the quality of health services delivered at the practice hospitals.
- Program is closely followed. For example, the mid-term competency assessment conducted by FMOH, UNFPA and other DPs in 2011 helped to identify key factors that affect training quality and helped to revise training curriculum. In addition, there is bi-annual supportive supervision and review meeting between key stakeholders.

#### 4.1.2. Midwifery, anaesthesia and fistula

The scaling up of the midwifery education, anaesthesia and fistula prevention and management is one program implemented under CP7. The program directly contributes to the attainment of output one, two and three under the RH&R component. The Swedish International Development Cooperation Agency (SIDA) provided 3.7 million USD programme fund. The program was implemented starting from June 2010 in collaboration with the FMOH, RHBs, training institutions, and professional associations for midwifery and anaesthesia. The goal of the three-year program, extended to five years due to low fund absorptive capacity, was to contribute to the reduction of maternal and neonatal morbidity and mortality in Ethiopia through improved access and utilization of quality maternal and newborn health services, including EmONC and fistula services. Specifically the program aimed to address the serious lack of human resources for quality maternity and anaesthetic services. See box 1 for specific objectives of the program. The program is implemented in all regions with the exception of the accelerated midwifery program, which is implemented in six regions. The evaluation purposefully sampled Oromiya, Amhara, Harari, Somali regions, and Addis Ababa City Administration for field visits.

##### 4.1.2.1. Increasing capacity of midwifery training institutions

UNFPA with the donor's approval readily agreed to the FMOH's plan to produce 4,500 new midwives over a three-year period and supported 31 institutions as compared to the originally agreed 23. Training institutions were supported through provision of vital teaching and learning materials, strengthening skills laboratories and increasing the teaching capacities of 150 tutors. The program also helped revise the curriculum for Bachelor of Science program in Midwifery, supported selected Universities to strengthen tutors research capacities, and trained clinical preceptors to assist students. The program also assisted FMOH develop and implement a supportive supervision system to follow up new graduates.

The evaluation found the program to have contributed to making professional midwives more readily available, especially in rural and remote areas. Almost all health centres (HC) in the country had at least one midwife. In

addition, midwives trained through the accelerated program are highly valued by the HC Heads and anecdotal evidence shows that there is increase in institutional delivery. HC Heads stated that the midwives are committed and they go out to the community and follow up on pregnant women, establish good relationship with them and encourage the women and remind them to come to the HF for antenatal care and for birth. The midwives go to the extent of performing traditional coffee and porridge ceremonies after birth, which is highly appreciated by the community.

Increasing the capacities of tutors/instructors contributed to the achievement of much needed changes in pedagogical approaches for midwifery education i.e. use of more participatory teaching methods and developing lesson plans with specific measurable learning outcomes. Tutors also appreciate the short trainings on BEmONC, PMTCT, long-term FP, and safe abortion, which helped strengthen their clinical capacities. The maternal health evaluation also attested to UNFPA's contribution to increased availability of HR for maternal health.

#### Box 2 - Specific Objectives of the program on Midwifery, Anaesthesia and Fistula

1. **Increase capacity of the midwifery training institutions** to produce highly trained and competent midwives
2. **Increased number of midwifery associations** with capacity to advocate for and implement the scaling up of midwifery services in country.
3. In-country **regulatory standards and monitoring systems** maintain quality of midwifery services in place.
4. **Improved access to quality fistula care services** (both curative and rehabilitation)
5. **Increase the capacity of anaesthesia training institutions** to produce highly trained and competent anaesthetists

Despite this progress, the program faced a number of challenges. First, there are weaknesses in the accelerated midwifery program curriculum. Second, there is high turnover of tutors undermining efforts for effective training skills. Third, there is shortage of teaching and learning materials and space to give training as per the standard. Fourth, there is debate on the qualification of students entering the program. Fifth, there were concerns regarding the increase in the number of male students in the program, which undermines the delivery of culturally acceptable maternity services.

Based on the recommendation from this evaluation, UNFPA conducted a study on acceptability of male midwives in Ethiopia in April 2015 (FMOH and UNFPA, 2015). The study found that 48% of women prefer to be attended by female midwives while 39% had no preference. Women prefer female midwives for labour and delivery service as compared to antenatal/postnatal care or other SRH services. Preference for female midwives is most common among women from rural area, pastoralist and Muslim communities. Women in Somali (97%), Oromiya (61%), SNNP (60%), Harari (60%) and Afar (48%) regions were more likely to prefer female providers for labour and delivery services. However, study also showed that it is only about 10% of mothers who stated that they will refuse labour and delivery service from a male midwife. Similarly, 12% were of the opinion that male midwives could hinder institutional delivery. Notwithstanding this, KII showed that if women refuse service from male midwife, HFs counsel and convince accompanying family members and the women to accept male midwives. If the woman persists, female service provider is assigned whenever possible. Only few HFs gave the option to get service from a female midwife automatically if the woman has reservation about male service provider.

**Box 3 – Lessons Learned: Midwifery, Anaesthesias and Fistula Program**

- Having a competent and highly skilled technical staff provides good value for investments made.
- There was common goal and high level of commitment from all IPs.
- Even when activities are clearly specified at the outset, there is need for flexibility and adaption to emerging opportunities and new requests by the government.
- Program built on achievements, networks, and relations made in previous programs, for example the Maternal Health Thematic Trust Fund, as well as ongoing investments and work of other DPs.
- There is a good lesson from Gondar at integrating fistula services into the mainstream of hospital services and ensuring its sustainability. This happened in a specialised teaching centres in a culturally and women-focused way, whilst still maintaining the special needs of fistula sufferers.

On the other hand, data from 25 training institutions showed that male students constitute more than 50% for Bachelor of Science (BSc) level training under FMOE. On the other hand, male students constitute less than a third of the diploma level midwifery training programs, which are managed by RHBs. Entrance to BSc training is based on assignment by FMOE without due consideration to students interest or their sex while RHBs encourage female students and consider their interest when admitting student to diploma training. The findings show that there is still room to improve availability of a culturally sensitive maternity and SRH services that respect women's choice and preference.

**4.1.2.2. Increasing the number and capacity of midwifery associations**

Tremendous achievements have been made in building capacity of the Ethiopian Midwifery Association (EMA) through training of board members on leadership, proposal writing, program management and advocacy skills. The program also helped the association to expand its reach by helping it establish a web site, open new branches, and conduct advocacy

activities including production of significant publications<sup>1</sup> and advocacy materials. Additionally, the association was assisted in increasing its visibility and developing its networking skills not just within the country but also outside.

EMA has developed business ethos whereby they are not only financially secure, but also have dedicated staff. Additionally, EMA is increasingly being seen as a credible and professional entity by national bodies such as Food Medicine and Health Care Administration and Control Authority (FMHACA) and the High Education Quality Assurance Committee. Despite all the progress, there is still a lot of scope for strengthening the association's impact, visibility and credibility at local levels outside of Addis Ababa.

#### **4.1.2.3. Regulatory standards and monitoring systems**

The programme supported FMOH to develop a checklist to supervise a midwife in a HC. The program supported tool design and sometimes accompanied FMOH and RHBs to undertake supportive supervision. Working with EMA, the programme provided substantive inputs into the development of a set of clinical standards for midwifery practice – '*Standard of Midwifery Care Practice in Ethiopia*', which were approved and published by FMOH in August 2013.

A number of challenges remain including absence of a central regulatory body or defined regulation to govern midwifery education and practice; regulation of education, for e.g. is shared between FMOH and FMOE. Another challenge is that professional licenses for midwives are awarded by FMHCACA for degree level and RHBs for diploma level. This does not permit documentation of central database, which is needed for evidence-based planning.

#### **4.1.2.4. Improved access to quality fistula care services**

Three specialist fistula centres (Gondar, Assela and Jimma) were supported, all of which are offering quality women-friendly services (peaceful environment, supportive, committed and caring staff). All centres have significantly increased the number of repairs conducted. All centres have been actively engaged in outreach and community mobilization, mainly through the work of health extension workers (HEW) who conduct specific fistula awareness and identification campaigns. General curative services could learn about how to make improvements in service delivery, specifically the ability to offer quality, women-friendly and culturally appropriate services and linking hospital services to community outreach work.

The evaluation team were very impressed with the centre in Gondar which catered for a larger number of clients and has included treatment of urinary incontinence as a result of uterine prolapsed and it is hoped will eventually become a specialised genitourinary centre. Medical students have rotations into the centre, as part of their gynaecological experience and some are posted as part of their internship program. This is expected to increase the capacity of medical professionals to be able to recognize and refer cases of fistula early on.

Outstanding challenge that was identified by the evaluation was lack of a national experience-sharing forum for development partners working on fistula. By acting on the findings from this evaluation, UNFPA CO advocated for the establishment of the Fistula Task Force, which was launched in July 2014. The task force meets regularly and is very active. It developed a plan of action to eliminate fistula and has started implementing selected activities. Another challenge mentioned in Gondar was inability to absorb all allocated fund especially in the first year in part due to lack of experience in program management.

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<sup>1</sup> The EMA Midwifery Database and the publication of the first report on the 'State of the Ethiopian Midwifery 2012' are among the most notable publications.

#### **4.1.2.5. Increase capacity of anaesthesia training departments**

Capacity of anaesthetic training departments has been strengthened through provision of critical equipment and specialised textbooks, strengthening skill laboratories, and building capacity of tutors and clinician preceptors. The program also promoted collaboration with professionals in the South. The FMOH and its subsidiaries have very much appreciated the support from the program. Opportunities exist to incorporate lessons into the large USAID programme for human resource development for health and to inform future strengthening of fistula program.

Here are some of the major challenges. First, shortage of anaesthesia tutors in colleges and universities due to high turnover. Second, there were gaps in the level 5 curriculum that had to be revised in terms of duration (the training is very short) and content (some content is not useful). Third, delays in financial flows emanating from challenges in absorption of program funds due to their inability in fulfilling expenditure reporting procedures is mentioned.

#### **4.1.3. Family Planning**

The FP evaluation was a general one looking at UNFPA's support to FP over the period 2008-2013 and was conducted as part of a global multi-country study. FP is an integral part of UNFPA interventions in maternal health, SRH for A&Y, HIV and AIDS, gender and humanitarian support. UNFPA's support to FP contributes to the achievement of output 2 and to some extent output 3 of the RH&R component. This evaluation has included FP related activities in these areas while taking care not to duplicate work carried out in other evaluations<sup>2</sup>. The evaluation had eight core questions serving as a lens. A particular Ethiopian Case Study was available and findings of that report are summarized below.

##### **4.1.3.1. Integration**

Findings show that CO staff and in-country partners have a common understanding on importance of integration and are working on it, although there is still some way to go. UNFPA and other partners supported the FMOH in development of a guideline for linking HIV/AIDS, FP and maternal health services. The DPs' Forum works on an integrated programme, which includes FP and HIV/AIDS. UNFPA supported integration of FP in maternal health, youth, gender and HIV programmes carried out by government and non-government implementing partners and has included service integration in its support to HEW and other health worker training. Attribution of impact to UNFPA alone is difficult as other DPs and FMOH support integration. However, there remain important gaps in integrated service provision for adolescents. There is also need to develop an evidence base on integration experience in public and NGO sectors. Attention may be required to ensure that GPRHCS focus on FP does not undermine achievements in integration.

UNFPA has provided support to few calls for emergency and humanitarian support based on Minimum Initial Service Packages (MISP) for RH during emergencies. However, the support was not related to the rest of the FP programme.

##### **4.1.3.2. Coordination and National Ownership**

UNFPA promotes national ownership, institutionalization and sustainability of its interventions and support. UNFPA leads or participates in FMOH and DP forums and technical working groups (TWG) which address FP directly or indirectly. Examples include Family Planning Technical Working Group, the Health Population and Nutrition (HPN) donor group, the Maternal Health and FP Working Group and the HIV development partners forum, the HIV prevention TWG at federal level (which it co-chairs), and corresponding forums at regional level in those regions where it has an

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<sup>2</sup> Maternal Health evaluation of 2013, and the Adolescent and Youth SRH (AYSRH) evaluation, which was being carried out concurrently with this evaluation.

office (seven regions). The CO also supports the MDG pool fund, a basket fund that includes FP commodity purchase. UNFPA, together with other DPs, provided support for the formulation of key RH strategies. Similarly, UNFPA's work on reproductive health commodity security (RHCS) contributes to institutional sustainability, whereby the government has taken a firm lead by developing its commodity planning, procurement and supply chain management systems. UNFPA together with other DPs has successfully lobbied the government to assign a FP budget line, which is a first step towards a higher national financial commitment. Procurement of FP commodities by GPRHCS has shifted away from buying expensive implants to promoting a more financially sustainable method mix. To ensure social sustainability of FP programs, UNFPA supported training of HEWs and NGO service delivery staff who work at community level in FP.

UNFPA contributed for gathering support and financing new initiatives such as the female condom and emergency contraception. As part of its advocacy effort, UNFPA supported the 2012 National Family Planning Symposium and the 2013 International Family Planning Conference held in Addis. UNFPA also supported the then Ministry of Women, Children and Youth Affairs (MOWCYA), Ministry of Youth, Sports and Culture (MOYSC) and the National Planning Commission to promote FP.

#### ***4.1.3.3. Brokerage and Partnership***

UNFPA has participated in rather than brokered partnerships between DP and government working in FP. It has brokered partnerships between FMOH and other Ministries working in areas, which are determinants of demand for FP such as MOWCYA and the former MOYSC. UNFPA is better placed to promote and broker partnerships between NGOs. Brokering partnerships between government and private sector is not easy, as the private sector is not organised. There are also opportunities in brokering partnership between government agencies on specific FP issues, such as increasing male involvement in FP.

UNFPA has good visibility and closeness to government at Federal level but less at regional level where its offices have only one staff member who is principally engaged in liaison between IPs and may lack partnership skills. UNFPA is recognized as among the top four donors in the area of FP. The GPRHCS has given UNFPA more visibility and led to higher level of partnership with the government, but this led other DPs to perceive that UNFPA's FP work is focused on supply side and commodity security disregarding its work in demand creation.

#### ***4.1.3.4. Enabling environment***

UNFPA's support has focused more on the supply of FP services than on the demand side. An emphasis on service delivery support and procurement at the start of the GPRHCS is now moving more towards capacity building in the supply chain. Engagement in demand creation/community mobilization is more in other programs such as HTP, GBV, SRH and HIV prevention. Demand side interventions in FP are mainly delivered by the government through HEWs and HDA. Availability of technical support for this and other FP issues from headquarters (HQ) and Regional Office (RO) is limited by the technical capacity of the RO and the lack of clear definition of its role. UNFPA has not fully addressed the need to create enabling environment for NGOs and the private sector. More work is needed to create an enabling environment on the demand side too, to ensure all users including young people have sufficient information on FP choices and to exercise their right to decide freely.

#### ***4.1.3.5. Vulnerable and Marginalized Population***

UNFPA has identified large groups of VMGs i.e. young people and pastoralists. By way of strengthening evidence base, UNFPA has carried out an equity analysis of FP and maternal health services (UNFPA Ethiopia 2013a). Further systematic development of the evidence base and dissemination of best practices from outside Ethiopia would be useful. UNFPA

intervention to increase access and advocacy work is limited to the two large VMGs. Groups, which remain disadvantaged, include commercial sex workers (CSW) and younger adolescents.

UNFPA projects, which focus specifically on disadvantaged groups, have generally been implemented outside the government system. However, for scale-up and sustainability government commitment will be needed. It has already started working on this for CSW (access to comprehensive HIV services, capacity building for peer education, economic empowerment).

#### **4.1.3.6. Rights based approach**

There is no clear consensus on definition of a rights-based approach. Bilateral and civil society, DPs and UNFPA take it for granted that they have the same understanding. UNFPA addressed rights issue through its support to ensuring service availability and method mix complemented by demand side intervention on women empowerment, adolescents and young people, improved information and focus on VMGs.

There is heavy push for contraceptive prevalence rate (CPR) to reach 66% by 2015 and there is plan to switch users to long acting methods. Providers are not clear about the concept of 'right to free and informed choice'. This situation may pose risk of imposing undue pressure to accept the use of FP. Further evidence would be required in this regard.

#### **4.1.3.7. Modes of engagement and supply side activities**

UNFPA has monitored changes in the country context informally rather than systematically, and its response has been tempered by the need to work within the national context and align its programme to government's needs and priorities. The maternal health evaluation documented that partnerships with non-governmental organizations have historically been an important part of UNFPA's community outreach and mobilization campaigns. However, the CO have begun to shift resources and attention away from civil society in favour of channelling their support through government mechanisms.

Initially, GPRHCS procurement funds were used largely to buy expensive implants but spending now covers a wider range of financially sustainable FP methods. However, the government continues to concentrate on short and long-acting hormonal methods; non-hormonal methods are not widely available in government HCs and hospitals. Service providers need more information on a wider method mix and more skills to promote a variety of short and long-acting methods.

UNFPA spending on capacity building rather than procurement of supplies has more prospects for increasing sustainability. UNFPA has now expanded towards support for quality control (FMHACA). Some work has also been done in knowledge management, specifically in development of evidence bases, but more will be needed to support Ethiopia in analysing and improving the sustainability of its FP programmes.

## **4.2. Adolescent and Youth**

The two evaluations under A&Y component are evaluation of the Norwegian Government supported joint program implemented by UNFPA and UNICEF i.e., "A rights based approach to adolescent and youth development in Ethiopia" and evaluation of UNFPA's support to adolescent and youth 2008-2014. Support to A&Y is cross cutting across the different program components. Overall support to A&Y and the particular joint program contribute to the achievement of various outputs under the three program components of CP 7.

The first evaluation (hereafter called the **JP evaluation**) is an initiative funded by the Royal Norwegian Embassy (RNE), and implemented by UNFPA and UNICEF Ethiopia COs. The JP has been implemented between 2007 - 2013 in 25 target woredas of five selected regions (Addis Ababa, Afar, Amhara, Oromiya and SNNPR). The selected regions cover around 23 million A&Y and the program woredas include 12 public universities and HIV hotspot areas. The program targets A&Y aged 10-24 years and addresses HIV prevention, SRH&R, child marriage, GBV including FGM/C, rape and abduction. There is a particular focus on vulnerable young people, such as adolescent girls (especially those within marriage and in domestic work), sex workers and their clients, young people with disabilities, orphans and street children, and students in higher learning institutions.

The program's rights-based approach thus aims to address the capacity of both rights holders and duty bearers. This approach has been articulated in seven output-level objectives that focus on (a) improved capacity and strengthened livelihoods of rights holders and (b) improved capacity of duty bearers (government, non-governmental bodies, parents and community). An eighth "supporting objective" focuses on establishment of a participatory monitoring and evaluation (M&E) system for close follow-up of the program and dissemination of lessons and best practice (see figure 2).

The second evaluation (which will be called **general evaluation** here after) has a wider scope and assesses UNFPA's support to A&Y during the period covered by the Strategic Plan 2008-2013 and the UNFPA Framework for Action on Adolescents and Youth. Findings of the two evaluations are summarized below:

#### **4.2.1. Relevance**

Both assessments reviewed the extent of alignment of UNFPA's support in general as well as that of the particular JP to UNFPA own policies and strategies as well as national policies. Both evaluations agree that UNFPA's support to A&Y is well aligned (internally) with the organization's policies and strategies. A&Y is mainstreamed within other programmatic core areas (RH, P&D and gender) and is reflected in budget allocation. Similarly, the support/project is found to be well aligned externally with national priorities/needs such as GTP II and I. The support/project is also aligned with the National Youth Policy (2004); the Strategic Plan for Intensifying the Multisectoral HIV and AIDS Response in Ethiopia (SPM II, 2010/11-2014/15); and the National Adolescents and Youth Reproductive Health Strategy (2007). The evaluation observed that IPs and UNFPA accommodate change at operational level. However, evaluation of UNFPA's support highlighted that needs of all age groups is not addressed; the age group 15-24 years is lumped together though they may have different needs and needs of 10-14 year olds are not addressed adequately.

The other dimension of the general evaluation was to see the extent of prioritization of vulnerable and marginalized groups. IPs received no guidance from UNFPA on human rights based approaches to programming and little such capacity exists within UNFPA. The financial support to GBV program tends to be on piecemeal basis and with a short-term focus, which creates insecurity among IPs. IPs work through religious leaders, local authorities, youth groups and clan leaders, which brings about cultural sensitivity. UNFPA supports focused programs such as FGC and child marriage to address the issue of the marginalized. However, different definitions of vulnerability and marginalization exist between the government and UNFPA.

Evaluation of the JP assessed relevance from various dimension. First entertained is relevance to the changing HIV/AIDS situation. The assessment found that there is good evidence showing the JP to be relevant to the changing HIV/AIDS situation. The focus on young people in HIV 'hotspots' and urban centres, addressing lack of comprehensive HIV knowledge; access to condoms; linking HIV testing to services; the prevalence of HTP and the use of strategic information is consistent with the national strategy (SPM II). However,

SPM II places emphasis on most-at-risk populations (MARPs), so there is a need to ensure continuity with Joint Programme approaches. Second assessed is relevance of a rights based approach. The JP uses a rights-based approach promoting rights to participation, information, non-discrimination, sustainable livelihoods and access to SRH. The program is, therefore, consistent with the human rights articulated in chapter three of Ethiopian constitution, as well as number of international instruments, such as the UN Convention on Elimination of all forms of discrimination against women (CEDAW) and the UN Convention on the Rights of the Child (UNCRC). Third, relevance to the needs to the target group was assessed. The design of the JP is for the most part addresses the needs of young people as described in the National Adolescent and Youth Reproductive Health Strategy (2006-2015), the 2010 Population Council Survey of Young Adults, the survey of MARPS in Amhara Region (Mekonnen et al. 2009), and the UNICEF/MOCYA evaluation of adolescent and youth development program (2012). In addition, 89% of youth leaders surveyed thought that the program's performance was good or excellent in meeting the needs of the target group.

There are some challenges identified by the JP evaluation relating to keeping HIV/AIDS high on the national policy agenda, addressing the mobility of young people and the seasonality of risk, as well as in reaching younger adolescents living with HIV. Some youth leaders suggested that the program need to expand its focus to a much wider youth development issues. The 2009 CSO Law could limit the participation of CSOs using a rights-based approach.

#### **4.2.2. Effectiveness and Sustainability**

In this section, the general evaluation reviewed the extent of UNFPA's contribution to an increased and sustainable SRH education (including comprehensive sexuality education (CSE) and integrated services for A&Y. Findings show that the minimum youth friendly service (YFS) package is not implemented everywhere and more remains to be done to build system and tool for quality assurance. UNFPA is making efforts to address the challenge by training many health professionals on YFS and providing SRH commodities in its operational areas. In addition, UNFPA pushes for quality and accessibility of SRH services in its role as a co-chair for the SRH taskforce. Demand was created through edutainment/IEC but interruption in commodity supply is affecting credibility of IPs. There is also lack of common understanding of CSE, which is constrained by fear of potential legal action. The evaluation feels that UNFPA is addressing the issue diplomatically and is not take its lead role in lobbying; however, UNFPA feels that given the political environment pushing CSE agenda may cause backtracking.

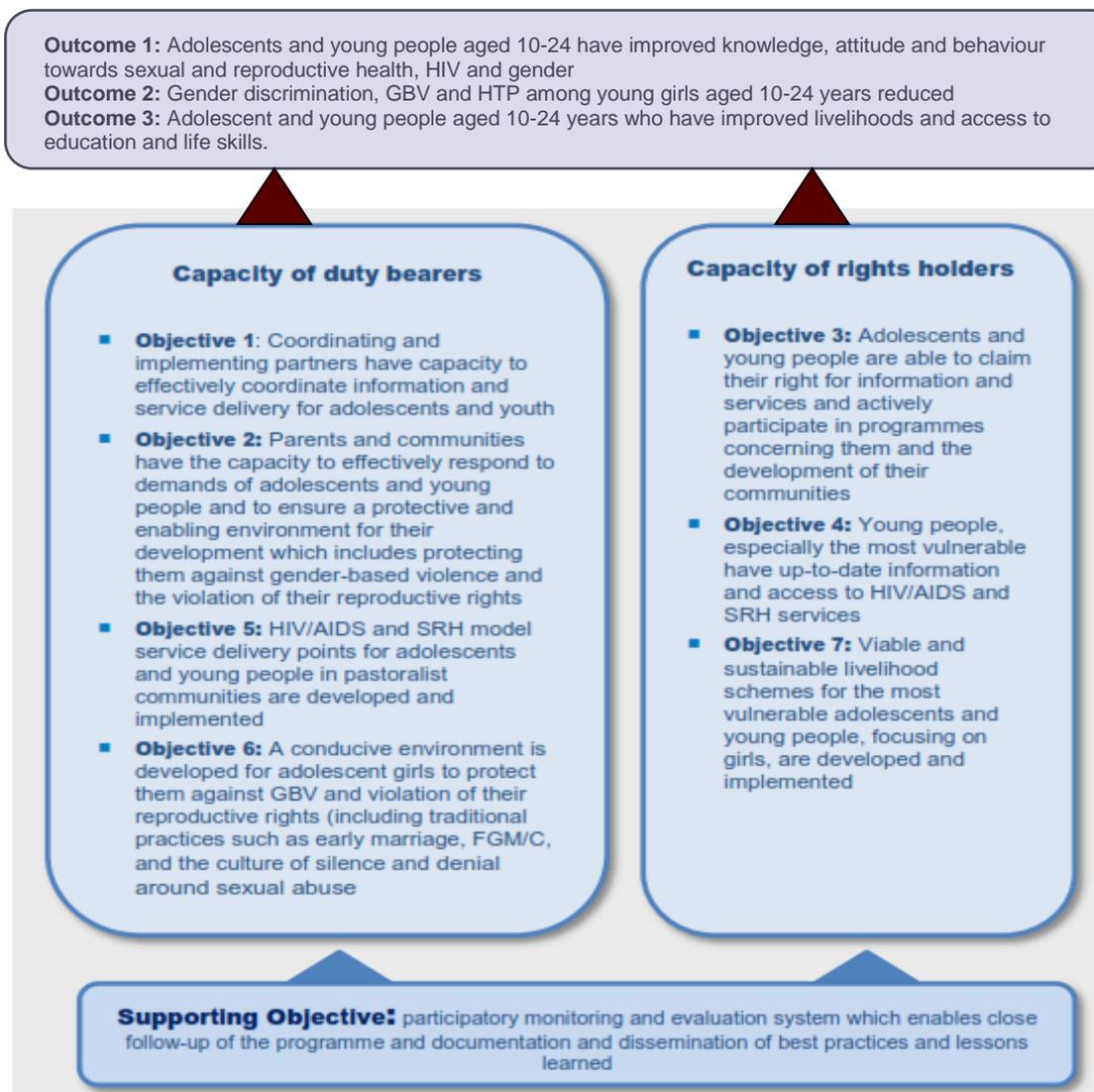
The second issue assessed is extent of UNFPA's contribution to evidence based policies that address needs and rights of A&Y. The finding is that UNFPA is advancing issues of A&Y through institution of new adolescent and youth SRH strategy, mainstreaming A&Y, developing specific programs, planning to fund an assessment of the previous strategies to inform the formulation of the new strategy. However, the evaluation also stated that UNFPA is considered an important partner in A&Y but not a leader.

The third focus under effectiveness and sustainability was the extent to which capacity for collection, analysis and use of disaggregated A&Y data was strengthened. It was positive action that UNFPA heavily supports Ethiopian Demographic and Health Survey (EDHS) and Census. IPs do not have monitoring data disaggregated by age (groups) and region.

The fourth focus was on the extent to which UNFPA has contributed to increase A&Y leadership, participation and empowerment especially the marginalized and vulnerable ones such as adolescent girls. Findings show that the how of youth participation is not clearly stipulated in the national strategy. Similarly, participation in associations, networks and forums is dominated by the older youth and it is unclear how the older leadership of youth will represent the 10-14 year olds.

When it comes to the JP evaluation, the Evaluation Team was satisfied with the level and pace of program implementation whereby delay in the first two years of the program has been addressed with a rapid rolling out. Hence, although the JP aimed to reach 200,000 young people by 2013, it actually managed to reach nearly three times this number.

**Figure 1 - Outputs and Outcomes of the Joint Program on Rights based approach to adolescent and youth development**



Source: adapted from HLSP, 2013

The first and second outputs of the JP deal with capacity building of the IPs and parents/communities (see figure 1). Capacity building for IPs was key focus of the program and involved provision of supplies and equipment, such as computers, printers, and media equipment as well as trainings to IPs at regional and woreda levels. IPs have been trained in subject matters that range from project management and M&E to thematic topics. Regarding capacity building for communities/parents, special meetings and stakeholder consultations for parents and communities have been the key approach.

Output six is about developing conducive environment to protect adolescent girls from HTP and GBV. It was found that law enforcement officers and legislators are playing an important role in developing and enforcing local by-laws on HTP and GBV. However, some key

secondary groups (such as older men) need to be engaged to ensure sustainability of the program.

Nonetheless, there are some challenges that were identified. There is lack of documentation on the amount of assets procured. In addition, capacity building of IPs is not based on needs assessment. There is also lack of information on the quality and content of workshops and dialogue on youth development and SRH and the extent to which existing tools and guidelines are used across the regions.

Output five is about the establishment of HIV/AIDS and SRH model service points for youth in pastoral communities. Although the annual progress reports indicate that 30 model service delivery points for young people were established in Afar in 2012, activities against this output seem fragmented. More effective and sustainable support are needed to help young people in pastoralist areas access YFS.

The core interventions carried out to enable youth claim their rights to information and services (output three) are youth dialogue, community conversations, training of facilitators (TOF), training of trainers (TOT), and refresher trainings. Evaluation documented that considerable programme effort has gone into youth dialogue and community conversation sessions. Almost 83% of youth leaders thought the programme had helped to improve the participation of young people in decision-making at community level. There was slightly less satisfaction (67%) with participation in decision making at national level. Overall, the Evaluation Team was satisfied with the content of the tools and guidelines used for building the skills of young people which appeared evidence-based and informed by professional best practice (such as guidelines for school community conversations, youth dialogue, life-skills training, training of peer educators and training in transformational leadership).

Output four deals with young people's access to information and HIV/AIDS and SRH services. Findings show that there has been marked increase in provision of services such as voluntary counselling and testing (VCT) and SRH between 2011 and 2012. KIIs suggest this could be partly due to changes in the interpretation of data following application of the 2011 M&E framework and partly due to the roll out of the program in universities. Interviews with service users indicate that significant increase in service users likely followed establishment of youth centres and YFS with training of service providers. However, data reports from regions are highly erratic. The distribution of information, education and communication (IEC) materials seems to have increased between 2011 and 2012, but interviews indicate that there is considerable ambiguity in the definition of this activity and how the materials are counted. Almost 1.4 million condoms have been distributed between 2009-2011 (including 11,625 female condoms). KII suggest that UNFPA programme support for this activity has been adjusted to accommodate the distribution activities of other partners. However, the rationale for annual targets relating to this activity is not clear in the work plans and reports. In addition, there is erratic and incomplete data from regions. Surveys of youth leaders and service users showed high levels of satisfaction with the provision of YFS. However, the Evaluation Team observed considerable variation in the quality of facilities, with male youth making most use of recreational facilities. Targeted services for key groups, such as young people living with HIV and young people with disabilities, need to be strengthened.

Regarding livelihoods for the most vulnerable (output seven), there was a sharp increase in support to income-generating activities (IGAs) between 2010 and 2011 but this declined in 2012. Amhara region's efforts to improve the effectiveness of IGAs for CSWs (by delaying IGA support until a full training programme has been completed) may be an example of good practice. There is lack of data disaggregated by age of beneficiaries and gender disaggregated reporting from regions is incomplete.

The 2011 M&E Framework is a technically useful document but the Evaluation Team found no evidence that the tool has yet been used for monitoring purposes. Some outcomes, outputs, and related indicators overlap, or are difficult to interpret. Reporting against the M&E Framework is not well supported by routine data collection systems. This is compounded by human resource/ capacity constraints, especially at woreda level.

Regarding achievement of outcomes, the evaluation did not have adequate evidence to reach definite conclusions. Although there has been a survey conducted by Population Council in 2010 which serves as a baseline, this has not been followed by end-term survey. Existing survey data are not useful for assessing programme outcomes because they have different period, indicator list and geographic coverage. However, analysis shows that if the program logic is correct, then the programme is likely to have contributed to expected outcomes. Although findings suggest that targeted regions may have performed better on peer education than comparison regions, contribution analysis suggests that preceding programmes (such as MOWCYA/UNICEF Adolescent/ Youth Development Programme (2007-2011)) may have contributed to outcomes in the target woredas. Nonetheless, FGD with young people showed consensus that the programme has contributed to increased knowledge (85% of youth leaders surveyed), and improved attitudes and behaviours. However, ratings in improving sustainable livelihoods are lower as respondents alluded to lack of equity/transparency in IGA support, poor follow-up and inadequate seed money.

**Box 4 – Lessons Learned – Rights Based Approach to Adolescent and Youth Program**

**Working at the Federal Level** - worked with the Federal HIV/AIDS Prevention and Control Office (FHAPCO) to support a number of federal level (policy) activities that ensure young people continue to be prioritised as a vulnerable group.

**Working with Universities** - as 'hot spots' where they are centres for risky behaviour has become a cornerstone of programme work.

**Working with tracer projects** - NGOs and FBOs seem to have contributed significantly to innovative working with hard-to-reach vulnerable groups such as CSW and students although they have been short-lived.

Use of existing government structures and capacity development of government staff strengthens sustainability and further scaling-up of the programme. Some key challenges relating to planning for exit strategies, dependence on a single donor and capacity leakage due to loss of staff need to be addressed.

#### **4.2.3. Efficiency**

In general, resource (financial and HR) allocation and distribution has been adequate and timely, however, expectations of partners exceed the Country Office's capacity in A&Y, e.g. proactive engagement in guiding and supporting IPs.

Regarding the JP, the program faced delays in the start-up period. Implementation and financial disbursements did not gain pace until the first 6 months of 2010. By the end of 2012, total programme expenditure against costed work plans had reached around 90%. Financial data from certified statements (2009 to 2011) showed that approximately 80% of program expenditure is related directly to program activities, while around 20% were used for 'operational' purposes (including administration, technical and capacity building support). The introduction of bi-annual fund settlement (as opposed to quarterly) in the last years of the program has gone some way to alleviate delays. Review of financial systems, financial reports and audit reports suggests that IPs have managed funds well. Bureau of Finance and Economic Development (BOFED) structures are responsible for the management and release of funds. All government structures follow the rules and regulations prescribed in the government's financial administration and procurement procedures.

There appears to be reasonable efficiency in management structures of the JP. Working through government structure brings efficiency gains, especially through sharing of human

resources and vehicles. However, high staff turnover among implementing partners and UN staff continues to be a challenge.

Lack of data on programme outcomes means the Evaluation Team cannot make a definitive statement on the program's value for money in technical terms. Nevertheless, the programme has reached nearly 580,000 duty bearers and rights holders (almost three times the original target), and young people themselves attest to the important benefits of the programme for themselves, their peers and their communities. This indicates good value for money. However, value for money in the future will depend on important lessons being learnt, improvements in disbursement systems being sustained, the M&E system being significantly strengthened and the follow-up survey on outcomes showing measurable achievements.

#### **4.2.4. Partnership, Coordination, Comparative Advantage**

This criterion assesses the extent to which UNFPA has provided leadership, coordinated effectively and established partnerships to advance A&Y issues at the country level and promote south-south cooperation. First, the general evaluation found that UNFPA was not bold enough to push the right of A&Y to be given due attention in programming. Second, although A&Y is a multi-sectoral issue, there is no evidence of UNFPA facilitating multi-sectoral response, e.g. most funds go to FMOH. Third, UNFPA is not much visible in terms of convening partnerships. The JP is a strong example of the UN 'Delivering as one'. Although partnerships with International DPs and NGOs could be further strengthened, close working with HAPCO structures provides an exemplary practice.

Another finding revolves around M&E system and learning from best practices. Evidence shows that UNFPA global and regional offices provided adequate capacity building to CO staff around planning, mainstreaming, and M&E of A&Y programs. Quarterly and biannual meetings with IPs was found to be a good opportunity to share lessons. However, this forum involves government IPs only. Hence, this opportunity has not been optimized due to lack of system for integrating lessons learned between governmental and non-governmental IPs. There is, however, good experience of selling program best practice from 'Berhane Hewan' project on early marriage, which is being scaled up by DFID.

### **4.3. Gender Equality**

The gender equality component of CP7 aims to increase capacity of women, adolescents and young people to exercise their rights to information and services on SRH, HIV and gender equality. This will be complimented by interventions to strengthen community response to promote and protect rights of women/girls and by strengthening institutional response to HTP and GBV (see annex 2).

Under this component, there were three evaluations that are summarized in the following section. The evaluations<sup>3</sup> are leave no woman behind, violence against women and FGM/C. The former two programs were Ethiopia specific while the FGM/C program is a global one implemented jointly by UNFPA and UNICEF in 15 countries including Ethiopia. The evaluation, has conducted case studies/visits in four countries and Ethiopia is not one of them. However, the evaluation team attempted to include findings from non-visited countries by capturing their view through a web based survey and virtual FGD in addition to literature review. Though it was difficult to pull out findings, which are relevant for Ethiopia as extensively as the other evaluations, attempt was made to capture findings stated to be relevant for all program

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<sup>3</sup> The studies are (a) Final Evaluation 2013 of UN Joint Program on Leave No Woman Behind, (b) Evaluation of Violence Against Women, and (c) Joint Evaluation of UNFPA-UNICEF Joint Program on Female Genital Mutilation/Cutting: Accelerating Change 2008-2012.

countries or where Ethiopia is mentioned in particular. The following sections summarize findings from the three evaluative studies.

#### 4.3.1. Leave No Woman Behind

The programme was developed to address challenges faced by women and girls mainly their low status in society, high rate of child marriage, limited RH knowledge, limited livelihoods opportunities, and vulnerability to HIV/AIDS infections compared to boys of the same age. The program was implemented in 11 Woredas (districts) – 5 in Tigray and 6 in Amhara from 2009 to 2012. The program received financial support of USD 8.9 million primarily from the MDG Fund and led by collaboration of UNFPA and WFP with the former being the lead agency. The program aimed to achieve the four outcomes listed in box 5.

The evaluation suffered from some limitations: the first one was data given that the M&E framework was developed late in the program life cycle and sufficient data was not collected on the indicators. What was collected during the evaluation was rudimentary data that was provided on spot. Secondly, the extent of coverage of visit to implementation sites was restricted by time limitation for the assessment, geographic spread of the project sites, and presence of multiple structures of LNWB. Thirdly, there was limitation of human resource, whereby only one person was assigned to analyse massive data and write the evaluation report. The evaluation used five evaluation criteria i.e. ownership, relevance, efficiency, effectiveness and sustainability. Findings under each criterion are entertained below.

##### **Box 5 – Outcomes of the Leave No Woman Behind Program**

**Outcome 1** - Increased enjoyment of human rights at grassroots level through **strengthened government efforts in promotion and protection of human rights and community empowerment** with special emphasis on adolescent girls and women.

**Outcome 2** - Regional Efforts to **address gender disparities in literacy and educational attainment strategically**, sexual and reproductive health services and GBV are strengthened.

**Outcome 3** - Improved **access to and demand for quality gender sensitive and integrated reproductive health care**, including HIV/AIDS prevention services at all levels

**Outcome 4** - Target women and their family members enjoy **improved and sustainable livelihoods** with increased income, improved food and nutrition security and enhanced resilience.

##### 4.3.1.1. Ownership

The programme manifested strong ownership by the people, with day-to-day decision made at the district level on implementation of the programme and budget expenditure. Stakeholders have started initiatives to continue the program because of the benefits realized. There is evidence of school initiatives to continue literacy programme using their teachers as volunteers. Transparency in resource allocation and decisions on financial expenditures helped to strengthen programme credibility and ownership. However, delayed fund release, liquidation and reporting continued to be challenging for the program.

##### 4.3.1.2. Relevance

This section discusses the extent to which the programme addressed the needs of Ethiopia, with specific focus on the on integration of priorities in the programme design, stakeholder participation in the design, value added by participating UN organizations and counterparts, and the use of Monitoring and Evaluation Strategy. The section also looks at the programme adherence to the key principals of the Accra Agenda and the Paris Declaration.

The program was aligned to national priorities and strategies for health, Education and Adult Education, cooperatives, National Action Plan for Gender Equality, Women Policy 1993, the priority MDGs adopted by FDRE, UNDAF (2007-2011), and the PASDEP. The program addresses the fundamental priority needs of the beneficiaries, especially the poor population and especially women and girls based on several baseline studies conducted in 2006 and

2007. LNWB strategies provided life skills development through training of women and girls in various micro-enterprises identified by women, literacy training, savings and credit including asset building, RH services including supporting skilled delivery assistance, information and access to FP, awareness of HIV/AIDS, and women's rights among several others.

Stakeholders participated widely in program design. The MOWCYA was consulted in initial design, national partners concretized program design by national partners after funds were received, resulting in almost six months delays in the effective start of implementation. Inception meetings held in both regions refocused the programme structure, content, scope and depth.

A comprehensive M&E and JP results framework was developed following recommendation of the midterm review. District and regional level implementing staff were trained on the use of tool, and different forms of measuring and reporting results. Although data has been collected on many program components of program, data analysis has not been conducted. The program also missed the opportunity to capture baseline information and data that are more comprehensive.

LNWB in practice manifests principles of the Accra Agenda. The principles of aid effectiveness were effected in strategies, which fully integrate the program through government structures at the regional levels. There was also transparency, accountability, and joint decision making such as on procurement details, terms of procurement, the supplier, the content, source, payment terms and the timing of delivery as seen in the case of procurement of health supplies.

#### Box 6 – Lessons from LNWB Project

- **Citizen participation** - the program reached the poorest of the poor due to an open and transparent selection of beneficiaries.
- **Empowerment** - The LNWB committees were self governing and were allowed space for decision making, detailed implementation and to find solutions for their constraints and challenges as they came up.
- **Sustainability** – intended beneficiaries own the program. Some stakeholders have developed a strong sense of ownership for the programme, and have started initiatives to continue the program. There is evidence of school initiatives to continue literacy programme using their teachers as volunteers.

#### 4.3.1.3. Efficiency

The program employed approaches that increased efficiency. Program used existing government structures and staff for implementation, fund disbursement, over sight etc. instead of hiring. Expense on venue rental was avoided by hosting literacy classes and community conversations in government institutions. The long-term funding from MDGF helped LNWB focus on attainment of results. The value and success of LNWB has been in its approach that is premised on the comparative advantage of the different agencies and national partnerships.

In terms of structure, the LNWB programme design established a National Steering Committee (NSC), to provide strategic guidance and oversight to the programme. A Programme Management Committee (PMC) was established at the federal, regional, woreda and kebele levels to provide operational and implementation guidance and follow-up, approve and ensure appropriate budgets, monitoring and evaluation, and ensure reporting among many things. Programme Management Team (PMT) oversaw the day-to-day coordination of the programme in MOWCYA and BOWCYA. Programme technical committees (PTCs) were established at the regional, district and kebele levels. Making Woreda and Kebele administrators chair PMCs helped popularize the programme and mobilize communities to participate in the various components.

Regarding pace of implementation, after adjusting for the initial six month start delay, the pace picked in the second and third year of implementation and remained at 3-4 month delay. The delays in the pace of implementation were triggered by delays in reporting and accounting for funds by districts. While regions received funds every six month, districts received funds on

quarterly basis. Challenges with fund liquidation were addressed to some extent through negotiation with regional offices to hold fund until the woreda is ready to spend it.

#### **4.3.1.4. Effectiveness**

Regarding outcome one, prevention and reporting of early marriage was echoed in all interviews in both Tigray and Amhara as one of the major achievements from community conversation. Amhara region recorded 904 early marriage cases reported to the community conversation facilitators, Justice Department and MOCYA. Tigray reported a consistent trend in reduction of early marriage in the districts supported by the program. Testimonies on the ground showed positive changes among the community members on Health/RH, and HIV/AIDS Voluntary Counselling and Testing, increased respect for women's rights against HTP, and the right to participate in development processes.

On outcome two, additional to community conversations, literacy and adult education was a high mobilizing factor for all other programme components such as RH, livelihoods component and social services especially education and cooperatives. LNWB provided literacy classes to a total of 53,472 community members in the two regions. Findings of the evaluation show a clear link between adult literacy and formal education, manifested through the increased value community members place on education. Evidences show increased school enrolment, retention, and attendance by children and improved class performance.

On outcome three, close to 982 HEWs were trained in RH, HIV and gender issues over the four years. The program positively influenced hospital deliveries and use of FP and RH. Data shows that frequency of women and girls accessing services increased tremendously. Community volunteers organised through community conversations undertake home-to-home visits, identify pregnant women and refer them to hospitals. Some have also built makeshift ambulances in order to save lives of mothers and babies. HCs have started providing innovative delivery hospitality service whereby volunteers prepare the traditional porridge and coffee ceremony with community and family support.

Finally, regarding outcome four, LNWB supported 19,347 women engaged in IGAs, more than twice the initial target of 8,000. Beneficiaries undertook various agricultural/ animal related projects and petty trading. This was followed by strong saving portfolio, which provided credit for women. The evaluation team found innovations in Tigray where women have started children's saving schemes to be invested on children's education and other related expenses.

Literacy and life skills education opened women's lives to not only read, write and numeracy, but directly increased their capacity to understand and practically apply their learning in other fields such as agriculture, environment management, and response to rights violations such as child marriage, GBV, HTPs. Understanding simple math and writing for example, enabled women to better manage and keep a record of the credit and the income from their investments.

#### **4.3.1.5. Sustainability**

Although the program developed a sustainability strategy, lot of the actions stipulated were not yet implemented despite a six months no cost extension and additional funding support from the MDGF. There is a good initiative by schools to continue literacy programs using teachers as volunteers. However, commitments and agreements at institutional level have not been reached for continuation of the comprehensive services provided. The community is highly interested for the program to continue and the MOWCYA has strong political support and interest to continue LNWB and replicate it to other districts and regions. However, it is not clear how this could be funded.

### 4.3.2. Evaluation of violence against women

The prevention of violence against women (VAW) program has two major objectives: (i) strengthen an enabling environment to reduce VAW in partnership with local leaders, law enforcement structures, and media. These targets FGM, domestic violence and rape and are mainly implemented through partnership with the government agencies and local leaders; (ii) Strengthen institutional and community based programs in support of care and social support (including clinical, counselling, legal, rehabilitative support) to survivors of violence, particularly targeting adolescent girls and rural women in Ethiopia (see box 7). The major initiatives that planned to be implemented include:

- Community mobilization and awareness creation through different participatory devices (radio, community conversation, public events)
- Provision of shelter, psychosocial support and health care services to survivors of VAW
- Referral linkages to reinforcement bodies and HFs at different levels
- Livelihood interventions and
- Higher education and institutional interventions

#### **Box 7 - Results and Outputs of End Violence Against Women Program**

**Result 1** - Advocating for the commitment of local leaders including justice system decision makers for systematic enforcement of favourable laws for women's rights

**Output 1.1** - Laws on early marriage, institutionalised in law enforcement organs and local leaders make public declarations banning early marriage

**Output 1.2** - Laws on FGM institutionalized

**Output 1.3** - Laws on domestic violence and rape institutionalized and public leaders condemn the act

**Result 2** - Strengthen institutional and community based programs in supporting care and social support

**Output 2.1** - Increased service availability (legal, clinical and social support)

**Output 2.2** - Increase community based social service for supporting abandonment of GBV

The project was implemented between 2010-2012 in six administrative regions of Ethiopia: Addis Ababa, Oromiya, Amhara, Tigray, SNNPR, and Benishangul-Gumuz through 22 NGO IPs.

There are some key limitations of the evaluation. First, lack of baseline information for each project was major hindrance to measure changes objectively. Data were self-reported and the survey questions were not standardized and tested. Second, it was not possible to use random sampling procedures to select evaluation participants as participants were selected by IPs purposively. However, participants rating on the relevance, effectiveness, efficiency, impacts, and sustainability regardless of study fields were consistent and compensate the limitations of the evaluation.

#### 4.3.2.1. Relevance

The objectives of VAW program and strategies implemented are relevant. First, it addresses felt needs of survivors of VAW. Second, it is consistent with the government development agenda. Third, it indirectly contributes to the achievement of the MDGs. Fourth, the implementation of most project components was based on well-studied analysis and an effective process of dialogue and discussion between government, DPs and NGOs. Fifth, the program timing is right i.e. when the country was in need of support for addressing the issues of VAW. HTP and GBV such as FGM, abduction, early marriage, exchange- marriage, widow inheritance, rape and unequal treatment of women vis-à-vis men to possess assets and economic resources such as land are still widespread. Sixth, the program collaborates with partners working in the area and contributes to the enhancement of government's capability to plan, administer, and implement such programs.

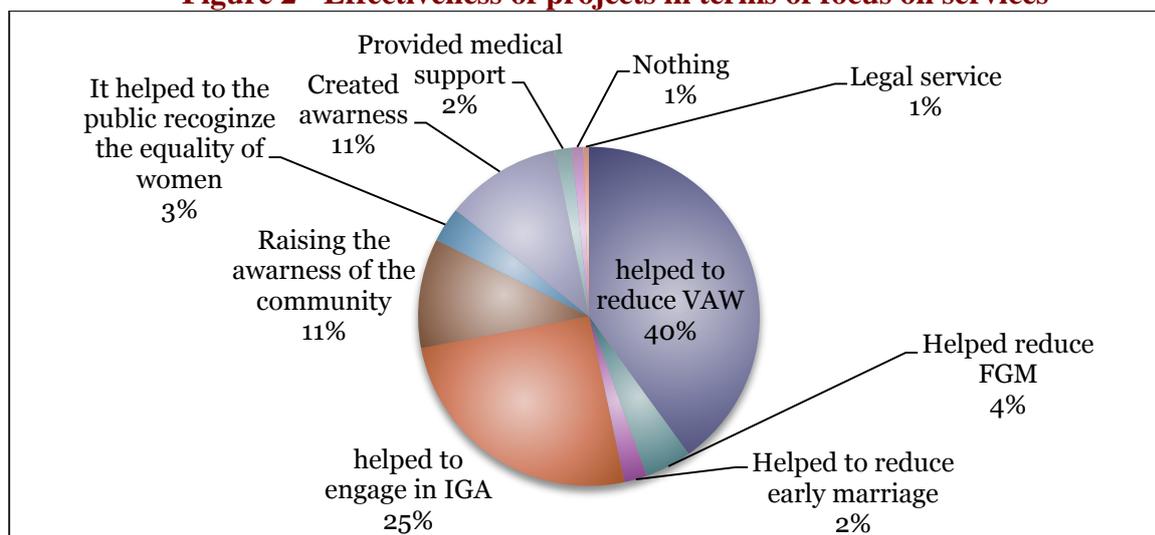
On the other hand, in most target areas, although the outputs are achieved, the quality of the services was compromised to attain quantity. This challenge is mainly due to scarcity of both

human and financial resources. The other is government ownership of the work of advocacy and legal aid was found adequate. However, there is room for improvement in terms of allocating additional resources for addressing the need, as the demand is high.

#### 4.3.2.2. Effectiveness

Even though, it is difficult to confirm reduced prevalence of VAW without a study conducted in this regard, the informants have claimed that instances are less frequent than before. This is achieved through better awareness and fear of legal consequences achieved through community conversations, trainings, increase in the number of women claiming their rights, empowering women through IGA, and also through psychosocial support. According to the quantitative survey of beneficiaries, overall, the expected outcomes stipulated in the proposals of the projects are mostly achieved to a desired extent (Figure 2). Although one of the main causes of GBV is the low economic prominence of women, very few projects in the program were working on economic empowerment, affecting the long-term effectiveness of projects. The effectiveness of some projects was also negatively affected by the promulgation of the new CSO law, especially those involved in advocacy and legal aid. Yet, the projects reprogrammed these activities and continued their work. Many of the CSO projects were effective in mobilizing community members and religious leaders to become their partners and change agents, which increased acceptability and success of project.

**Figure 2 - Effectiveness of projects in terms of focus on services**



Source: Quantitative Survey, BIC, 2012.

While these are positive contributions by the projects, there are also limitations and challenges in project implementation that might have compromised effectiveness of the program. These include (i) limited impact due to the projects scope and duration, which run for only three years (ii) weak participation or resistance of men in fighting VAW. Although men were involved through community conversations and trainings, there is need to have particular interventions that will actively involve them (iii) shortage of vehicles and financial resources to cover the costs of transportation; and (iv) delay in the release of funds from the UNFPA.

#### 4.3.2.3. Efficiency

This report finds it difficult to have an objective conclusion on efficiency of the program. This is because many of the IPs do not report the physical activities with their corresponding financial outlays both at the plan and implementation phases. This issue needs to be resolved if the program is to continue. However, in terms of utilization of budgets, all of them used more than 90% of the budget allocated from UNFPA. About 81% of respondents to quantitative

survey believe that the implementing NGOs are transparent in the selection of beneficiaries and treat all beneficiaries fairly and impartially. However, it was not possible to conclude about cost-effectiveness of projects as some projects performed their physical activities as per target while others performed below target.

There are major challenges mentioned by IPs that affected the level of achievement of targets. **First**, decline in the purchasing power of the budget allocated to them three years ago because of high rate of inflation was most common problem among IPs except International Rescue Committee (IRC)<sup>4</sup>. **Second** was delay in the release of budgets from UNFPA. **Third** was reluctance of target community beneficiaries to participate when the project does not involve IGAs, construction of grain-mill, supply of clean water, etc. This was mainly because of the perception that NGOs could have received a budget for such activities from the donor. **Fourth**, some IPs stated that the budget allocated was small for some activities and this affected their pace of implementation. Many projects and stakeholders mentioned high turnover of project coordinators and field supervisors as a major challenge. This is largely attributed to low salary scale due to low level of budget/grant allocated to projects.

#### **4.3.2.4. Impact**

There have been marked changes in community thinking and practices around VAW. First, increased number of men began to consider VAW as not only harming women but also themselves in terms of wellbeing, relationship and co-existence. Public gatherings and public domain became more accessible to women. Second, women, men, girls, young people, and various stakeholders including religious leaders have started to talk similar languages with respect to the different forms of VAW, its harmful multidimensional effects and the legal consequences on perpetrators. For example, 79% of survey respondents state that GBV causes physical and psychological problem for adolescent girls and women and 77% agree that it is a violation of rights. Third, men began to share the workload of women, and in some communities, this has been included in their by-laws. Fourth, increasing awareness emerged of where violence survivors should go and that there is a legal means of settling grievances for incidences of VAW. Common to most projects was the establishment of social/community groups that stand against VAW in general and HTP in particular because of community conversations. Such groups developed by-laws, which specifies acts of VAW and HTP as harmful and unlawful practices. Fifth, increasing number of women are now visiting justice offices to claim their rights. According to the quantitative survey, there is almost universal awareness that VAW can lead to charges. Sixth, the perception that girls should marry at early age has started to change, as families started to seek approval from concerned bodies with respect to age confirmation. Seventh, abduction has reduced significantly. Eighth, discussions and joint decision making among spouses has increasingly become a norm in many households. Ninth, many fistula survivors were identified, treated and rehabilitated in Tigray, Amhara, Benishangul-Gumuz, SNNPR and Oromiya. Community's understanding about causes of fistula improved and stigma against survivors declined. Tenth, victims of GBV get counselling, medical aid, opportunity to engage in IGA or continue education in safe houses. This contributes to the improvement of women's self worth. Eleventh, stakeholders become more responsive to VAW related cases. Health offices have become swifter in the provision of medical certificates for early marriage, rape and other VAW incidences, which supports actions of police, justice offices or community groups. Justice offices have also improved their efficiency in handling cases and prosecution of perpetrators. Twelfth, women were given access to education through alternative basic education schools. Finally, vulnerable or surviving women organized in self-help groups and formed their own credit and saving cooperatives. The cooperatives received trainings and loans and started IGAs.

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<sup>4</sup> IRC was an exception because they received their budget in USD and depreciation of the Ethiopian currency vis-à-vis dollars compensated the purchasing power loss of Birr. The budget allocated to the other IPs was in Ethiopian Birr.

The changes in public attitude listed above may not necessarily be attributed to UNFPA supported programs only. However, as complementary to interventions by government and other non-governmental institutions, the role of UNFPA supported projects in bringing about impact at least in and around intervention areas has been significant.

Some unintended effects emerged from the project. When fistula sufferers had to be away from home for treatment, this opened room for their husbands to start an affair. Some families attempt to bypass the bylaw on early marriage by bringing older siblings for medical check up and using the certificate to marry off a younger daughter. In Benishangul-Gumuz, FGD participants argued in favour of early marriage. They stated that the rejection of early marriage exposed girls to start sexual affair with their peers, teachers or other men which has never been the case before.

#### **Box 8 – Best practices from Violence Against Women Program**

- By-laws developed by community groups contributed to bring about better understanding, commitment for a more balanced gender relations including bringing fear among perpetrators.
- Although limited in coverage, shelter and safe house were critical for women with no family support. They also created valuable environment for individual and group counselling.

#### **4.3.2.5. Sustainability**

Collaboration and coordination of projects by reducing duplication of efforts and wastages of resources, improves overall effectiveness and efficiency and ensures ownership and sustainability. This has not been done in VAW project as much as it was done in other projects. All projects conducted a phase-out workshop to ensure that relevant stakeholders assume the responsibility of sustaining the project outcomes. However, in many projects the enthusiasm towards ensuring project sustaining has not been adequate among stakeholders.

Following are some particular examples around sustainability. Following the ratification of the civil society law, almost all projects have shifted towards raising awareness on economic empowerment and skill development instead of using CCs to raise awareness about VAW. Community groups that were set up by the projects such as CC groups, gender club, women self-help groups etc do not feel fully empowered after project phase out to continue their community mobilization task. Some reported being intimidated by perpetrators. Communities feel that the program duration and scale is limited to bring about significant change given the complexity and extent of the problem. Targets question sustainability of safe houses and legal services without financial support from UNFPA. Community based institutions were not able to continue services initiated by ESOG such as training of health workers on VAW and running of model clinics. Similarly, no government institution has managed to take over radio program that used to be run by Pro Pride.

#### **4.3.3. Evaluation of female genital mutilation/Cutting**

In 2007, UNFPA and UNICEF launched a joint programme entitled “Female Genital Mutilation/Cutting (FGM/C): Accelerating Change” with the objective of helping reduce FGM/C practice among girls aged zero -15 by forty per cent, and eliminating FGM/C altogether in at least one country by 2012. The duration of the programme was initially planned to be five years (2008-2012), but was extended to 2013. The originally estimated budget of USD 44 million dollars was reduced thus implying reduction in the number of countries participating in the program from 17 to 15.

##### **4.3.3.1. Relevance**

The joint programme was aligned with national government commitments and priorities. It made contributions to strengthening existing or emerging legal and policy commitments to ending FGM/C, and to enhancing the individual and collective capacities of partners by

improving coordination and exchange among them. It addressed gaps in existing efforts to end FGM/C by tailoring its work and the work of IPs to the specific needs of the communities with which it worked. The program also helped increase the awareness about FGM/C of key actors at both national and community levels and strengthen local level commitment to ending the practice.

The evaluation noted significant strengths in the design of the joint programme such as its emphasis on pursuing a holistic and culturally sensitive approach to addressing FGM/C as well as some weaknesses to implement this design including the extent to which the envisaged regional dimension of the JP was put into practice. Nevertheless, the evaluation found that further efforts are needed at the national and community levels, to turn existing potentials into actual changes in behaviours and (collective) practices. In most cases, the existing leadership from duty-bearers, capacities of change agents at all levels, and available resources do not yet ensure sustaining and expanding the existing momentum for change.

#### **4.3.3.2. Efficiency**

The JP made successful efforts to use available human and financial resources efficiently and strategically. In doing so, however, it was limited by the unpredictability of annual funding levels, and the effects of the annual planning, budgeting and reporting cycle. As a result, JP staff and their partners were limited in their ability to develop realistic annual work plans. In addition, due to the delay of budget allocations to COs, they were repeatedly forced to cancel planned activities or postpone them to inappropriate times of the year.

#### **4.3.3.3. Sustainability**

The program helped create a number of favourable conditions likely to support the sustainability of achievements at national and community levels. These conditions include strengthening national ownership, capacity and leadership for the abandonment of FGM/C; partnerships and coordination among national and community level actors; and integration of JP approach, strategies and initiatives into national initiatives.

#### **4.3.3.4. Coordination between UNICEF and UNFPA**

Overall, the coordination between UNFPA and UNICEF at global and country levels was adequate and added considerable value to the effects of the JP by allowing it to benefit from the complementary strengths of both agencies. The evaluation found no evidence of the coordination between UNFPA and UNICEF contributing to significant cost savings at global or country levels. Areas for improvement were noted around institutionalization of linkages between UNFPA and UNICEF at country level.

#### **4.3.3.5. Management of the program**

Management efforts and systems at headquarters and at the country level were appropriate, enabling effective and efficient implementation of the joint programme. The (revised) programme log frame allowed for some flexibility, however, leaving even more room for tailoring the program to country contexts could have further enhanced its relevance and usability.

### **4.4. Program wide findings**

There were some findings, which were common to all or most of the evaluated programs/projects. Such findings are entertained below.

First, Ethiopia has a good experience in establishing internal organizational mechanisms to promote integrated planning and programming between the three sub-programmes. The CO has been using an internal, country-level Project Appraisal Committee. The Committee allowed heads of the thematic units to review and endorse project proposals prior to their approval by the UNFPA country representative. Country office procedures also encouraged the selection of joint implementation sites for reproductive health and gender

sub-programmes.

Second, there is room for improving M&E systems. Examples of gaps identified in the various evaluations are shown here. The VAW evaluation documented that neither the overall VAW Program document nor the individual project proposals show the intended objectives, inputs, outputs or results in a *quantifiable and verifiable manner* to do a proper effectiveness and impact analysis. Lack of baseline information for each project was major hindrance to measure changes objectively. In the Norwegian Government supported project, M&E framework was developed after the midterm and no adequate data has been collected against the indicators listed in the M&E framework. There remain issues of weak planning/poor target setting and inconsistent data collection, as well as poor harmonisation of indicators and alignment of reporting systems. Regarding LNWB program, comprehensive M&E and results framework was developed following recommendation of the MTR. Although statistical data has been collected on many program components, data analysis has not been conducted. The program also missed the opportunity to capture baseline information and collect data in a more comprehensive manner.

## 5. Summary of recommendations

### 5.1. Reproductive health and rights

#### 5.1.1. IEOS

- FMOH and FMHACA need to define scope of practice (SOP) for IEOS. In addition, system should be instituted to enforce it at regional, district and facility levels before deployment of new graduates. In addition, FMOH and training institutions need to provide orientation to graduates on their SOP and medical ethics before their deployment.
- FMOH, FMOE, UNFPA and other DPs need to develop a roadmap for training scale-up that considers pace of expansion and equipping of HFs. In addition, as preparation of deployment sites demand huge resources, this area needs a matching resource. In the meanwhile, it is recommended to reduce intake of trainees and focus on improving quality of training.
- Limited clinical decision-making skills of graduates requires strategic intervention at the training and post deployment stage. FMOE, FMOH and DPs must further explore the training curriculum, teaching-learning tools and student performance. Students need to be involved during initial and follow up evaluation of patients as a requirement to attend or perform surgical procedures. Moreover, FMOH and RHB need to strengthen mechanisms to strengthen clinical decision making skills of deployed IEOS i.e. make regular morning sessions a mandatory practice in all hospitals; enforce feedback on referral cases from referral hospitals to primary hospitals and encourage IEOS work as a team (with midwives and general practitioners) in initial and follow-up patient evaluation.

#### 5.1.2. Family Planning

- **Provide full service range** - UNFPA supply-side work on FP has promoted rights and freedom of (informed) choice through increasing the availability of methods and strengthening the quality of services through service provider training. Such training should include counselling on the full range of methods and ensure ready access to removal and not only insertion of implants.
- **Incorporate flexibility/ adapt to local context** - In-country there are differences between the decentralized regional contexts, which should be reflected in regional modes of engagement - for example, service delivery support may be a priority in some, knowledge management in others.. There is need for internal capacity building of regional offices in this regard.

- **Generate evidence base** - There is little evidence available at country level on the impact of integration of FP on access, quality and user satisfaction. UNFPA could support study to identify the benefits of integration and the potential for improved integration in services for specific population groups (e.g. adolescents) and in areas where it has not yet been fully applied such as post-partum FP.

### 5.1.3. Midwifery, Anaesthesia and Fistula Program

- **Shift focus from quantity to quality** - Given that almost all HFs now have at least one midwife, the emphasis of scaling up midwifery education should shift to increasing the quality of the program and institutions, including the clinical capacities of midwife tutors. This can best be achieved by having evidence-based regulatory standards for the education of midwives. Urgent attention should be given to reviewing the TVET curriculum for Diploma in Midwifery.
- **Address benefit and career path issue of anaesthesia nurses.** There is need for urgent decision by FMOH to clarify issues pertaining to the graduation, salaries, and career path of Level 5 anaesthetic nurses and try to increase the number of anaesthetists in order to support scale up of comprehensive emergency obstetric and neonatal care.
- **Encourage female participation in midwifery training** – need to increase the number of female tutors, as well as number of females students in both undergraduate and postgraduate midwifery programmes given the significant community preference for female midwives.

## 5.2. Adolescent and Youth Program

- **Focused capacity building for IPs** - Provide guidance for IPs on human rights based approach to programming, results based management (RBM) etc. Explore new approaches that go beyond capacity building to sustainable skill transfer. There is also scope for establishing a more standardised and up-to-date methodology for building the capacity of parents and communities.
- **Disaggregation in data recording** - The need for disaggregation by age in programming as well as data keeping is recommended and in particular to address the needs of 10-14 year old. Strengthen in country systems such as DHS to become more suitable for measuring changes in the practice of FGM/C.
- **More Effective coverage** - The program should continue to refine its strategies for reaching hard to reach and vulnerable youth. Greater attention needs to be given to groups such as domestic and migrant workers, younger adolescents and young people living with HIV. The programme should encourage more participation of young people in programme and community decision making.
- **Value for money** - The program needs to continue demonstrating efficiency and value for money by ensuring: lessons documented in annual progress reports inform practice; recent improvements in fund disbursement systems are sustained; and the M&E system is significantly strengthened to effectively track progress and identify problems early. Attention needs to be given to the challenges of high staff turnover, lack of job security and career paths, and low salary scales (especially at woreda level).
- **Learning from best practice** - There is now a rich archive of beneficiary case studies from the program. However, it is not clear how they are being used to promote learning and for whom they are intended. Case studies should be collected thematically to better support programme learning, identification of innovation, factors in success and policy/strategy development. In the next phase, program team should reach agreement on specific objectives of documenting best practices, audience, linkages to wider communication strategies and the resources that should be allocated for the task.
- **Multisectoral approach** - UNFPA needs to take the leadership role in supporting cross-sectoral responses to A&Y issues in general. In particular, it should lead the alignment in multi-partner approaches to YFS provision and establish standards for service quality.

- **Push for more visibility in A&Y** – UNFPA should take a stronger leadership role in A&Y. UNFPA expertise and mandate in A&Y should be more explicitly expressed to partners.
- **Strengthen sustainability** - key challenges relating to programme sustainability need to be addressed, especially those relating to planning for exit strategies, expanding the resource base and replacing lost HR capacity. The program implementation manual (PIM) needs to be updated to incorporate the role of program officers at woreda level

### 5.3. Gender Equality

#### 5.3.1. Leave no woman behind

- **Sustainability** - The Federal level Programme Management/Technical Committee should spearhead the implementation of the sustainability strategy of LNWB.

#### 5.3.2. Violence against women

- **Service standardization** - Establish a minimum package in terms of composition of services and geographic coverage that a CSO will implement. The package should have balance of services such as fistula management, counselling, medication, rehabilitation and economic empowerment activities to bring a meaningful change to GBV survivors.
- **Collaboration** - The next program needs to develop a clear strategy and guideline for CSOs to operate in close collaboration and harmony with government bodies. Roles of each party should be defined. Active involvement of government counterparts in the planning and implementation stage is crucial. The evaluation suggests setting up a fund that can be accessed through joint NGOs and Government partnership proposals.
- **Work on young adolescents** - Better to invest in behavioural change while children are still in schools and are young. In this regard, the next program may consider mainstreaming VAW contents in formal and informal educations.
- **Work through women development army** - to expand program reach, capacitate the women development army to integrate VAW issues in their work by educating members on gender issues in general and VAW in particular and building their skill to handle survivors.

Finally, a general recommendation for most projects is

- **Strengthen M&E** – Programs/projects should have a coherent theory of change and M&E framework before they are launched. Baseline assessment of the needs and priorities of users and M&E data should be a requirement before the commencement of future program. UNFPA should make sure that each implementing partner has established a standardized monitoring, evaluation and reporting system; In addition, it is recommended that the users be part of the planning of the program to make the process participatory and understand the needs.

## 6. Conclusions and Implications for eighth CP

### 6.1. Conclusions

This report attempted to summarize and where possible synthesize findings of the various evaluations that were conducted of particular programs and projects implemented under the auspices of CP7. The evaluations covered wide range of issues, and this summary report made utmost effort to be representative of findings covered as much as volume of this report allowed.

UNFPA's 7<sup>th</sup> CP is organized around three program components namely RH and Rights, P&D and gender equality. Support and interventions under A&Y program are mainstreamed within

the three components. A&Y support primarily contributes to the achievement of outputs under RH&R and gender equality components.

### 6.1.1. RH and rights

The RH&R Component of CP7 set out to achieve four outputs. First is increased capacity of **training institutions to produce qualified HR** for maternal health. Second is increased **availability of essential life-saving maternal and newborn health commodities and modern FP methods and services** in selected HFs. Third is strengthened **national capacity to provide high quality information and services** on maternal and newborn health. Fourth is increased **availability of high-quality HIV-prevention services** for young people and other vulnerable groups. Various activities have taken place within all the components that aim to contribute to the achievement of these outputs.

Under output one, the midwifery, anaesthesia and fistula program has gone a long way to improve capacity of government training institutions through provision of technical, material and financial support. In addition, the IEOS program supports training of the particular cadre of professionals. UNFPA has been strengthening partnerships with stakeholders such as relevant government line ministries /agencies, EMA, and the like.

Under output two, UNFPA has been strengthening capacity of PFSA in planning, forecasting, procurement and overall logistics and supply chain management for RH commodities in particular and for other commodities as well. The GPRHCS program had significant role to play in this regard. The GPRHCS also contributed significantly to the availability of contraceptive method mix. Supporting accelerated midwifery training, trainings of anaesthesia and IEOS have contributed to ensure availability of high quality maternal health service. Support to fistula program has strengthened and improved availability of essential maternal health service. Intervention to avail YFS, availing information and services in youth centres etc contributed to the accessibility of essential SRH services to adolescents. Trainings to HEWs and NGO grass root staff on FP, integrated services, RH, HIV and gender issues helped improve the quality of service given to target population. The LNWB program positively influenced hospital deliveries and use of FP and RH by organizing community volunteers through community conversations. Finance mobilization for new initiative such as female condom and emergency contraceptive directly contributed to improvement of service availability and quality.

Regarding output three, community mobilization strategies applied by A&Y, VAW and LNWB programs have managed to bring about awareness among key target population including adolescents, young people and CSWs. Key issues covered include SRH, FP, HIV, GBV and HTP. Tracer projects under A&Y program worked directly with CSW and their clients to raise awareness, to run peer education, IEC material and condom distribution. Various interventions took place to strengthen referral: provision of ambulance to woredas, training HEW to enable close follow-up of mothers and timely referral, training and deployment of IEOS to reduce referral to general hospitals and provide support to clients referred from HCs. In addition, violence against woman program improved referral of fistula cases and pregnant mothers to HFs through training and involvement of community volunteers. UNFPA is committed to harmonization and alignment initiatives. It actively participates or leads TWGs and networks, supports the MDG pool fund, which is a health basket fund, directs its support through government mechanisms, strengthens government systems (e.g. PFSA), and supports joint planning and monitoring exercises with the government. There is effort to strengthen national capacity to ensure quality by supporting the regulatory body (FMHACA). Improving quality of training and trainers contribute to availability of better quality professionals. CO with DPs work to integrate FP, HIV and maternal health. In addition, UNFPA has worked to integrate SRH in emergency preparedness.

Under output four, extensive work was done on behavioural change communication for HIV prevention, SRH and rights, child marriage and GBV focusing on vulnerable young people (adolescent girls in marriage and domestic work, CSW and clients, youth with disabilities, orphans and street children and student in higher education). LNWB contributed to positive change in use of VCT services. There has been limited distribution of condoms.

### 6.1.2. Gender equality

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 is the first output under gender equality. Second is strengthened community response to promote and protect the rights of women and girls in relation to harmful traditional practices and gender-based violence. Third is strengthened institutional response to address harmful traditional practices and GBV and provide information and services to survivors of GBV including within a humanitarian context.

There are major achievements under output one. Community mobilization and behavioural change interventions by various projects has led to creation of better awareness and response on SRH, HIV, GBV, HTP and gender equality among different community groups. For example, there are impressive achievements under VAW program such as men starting to share workloads of women, similar understanding among different community groups about effects of VAW and its legal consequences, establishment of community groups that stand against VAW and HTP and more women visiting justice offices to claim their rights. Adult literacy program run by LNWB has trickledown effect on RH, use of social services, better enrolment and retention of schoolchildren in schools and more success in IGA. Various programs with varying degree of success have supported life skill trainings, savings and credit and IGAs. UNFPA has also supported radio program on SRH, HIV and gender issues although it could not be sustain it after program ends.

Under output two, the VAW and LNWB programs have worked extensively to create a legal and policy provisions on HTP, GBV and gender equality. As a result, increased respect for women's rights against HTP and their right to participate in development process has been met. Results from VAW program are mentioned in the previous paragraph.

Under output three, number of trainings were conducted by projects to law enforcement agencies including police, social and Sharia court judges, prosecutors, and kebele administrators on legal and psychological aspect of GBV, HTPs and other forms of VAW, laws and their enforcement mechanisms. VAW program also strengthen public campaign and activism against GBV and some projects organized events to share and encourage good practices among families as tool for preventing VAW. There was support to shelters/safe houses where victims of VAW who do not have else where to stay get health services, psychosocial and legal support. Women also get involved in IGAs. Work has been going to improve referral linkage between HFs and law enforcement bodies.

One KII respondent well summarized inter dependence between different interventions and their cumulative effect on achieving impact as follows. Cases of VAW are becoming less frequent because women and the community at large has better awareness, fear of legal consequences on perpetrators, increase in the number of women claiming their rights, and empowerment of women through psychosocial support and engagement in IGA.

## 6.2. Implications for eighth CP

Strategies devised to achieve outputs under RH&R and gender equality have been accomplished for the most part. This indicates that, if the program logic is valid, then UNFPA CO is on the right track to achieve outcomes under the two program components. More definitive conclusion would be reached once CP7 end line evaluation is conducted. However,

there are some gaps by way of missing components or challenges in implementation. Based on lessons and experience from CP7, here are implication for CP8.

### 6.2.1. RH and rights

- Role of GPRHCS program in strengthening supply system, ensuring commodity security and availability FP method mix is paramount. Under CP8, it would be worthwhile to consolidate this achievement further by ensuring that method choice and especially non-hormonal methods are consistently available in government HCs and hospitals. Benefits from such investments would be far-reaching, through strengthening capacity of health workers to offer and counsel on method choice.
- Gap in availability and quality of YFS implies need to continue support in this regard.
- UNFPA is perceived as working more on supply side of FP and commodity security (due to massive support by GPRHCS). Its comparative advantages and potential contribution in other areas of FP and SRH such as demand generation have been less visible. There is a need to ensure that GPRHCS does not undermine an integrated approach in FP. Strategies should be devised to strengthen integration of interventions around FP and maternal health with HIV programs in the coming CPD
- Nationally, there is pressure for contraceptive prevalence rate (CPR) to reach 66% by 2015 and there is plan to switch users to long acting methods. This situation may pose risk of imposing undue pressure by providers to accept the use of FP. Evidence is required to reach definitive conclusion and take action on the issue. Research in this area could be one consideration under CP8.
- UNFPA's impressive work in supporting the training of key professionals to scale up EmONC is being undermined by system wide issue of HR management. UNFPA should consider involvement and support to address wider HR for health sector issue beyond training including planning, deployment and retention.

### 6.2.2. Adolescent and youth

- Under CP8 given UNFPA's comparative advantage and its expertise and experience in A&Y, it might be worthwhile to reorganize support to A&Y under a separate program component and intensify effort to support the needs of age group 10-14 years.
- UNFPA's mandate and expertise in A&Y not duly recognized by other UN agencies or DPs ; more work remains to create visibility.
- Although one of the evaluations showed that UNFPA CO has integrated SRH into emergency preparedness, reviewed studies did not document much work in creating demand for FP services in humanitarian context as was intended in the RH&R component. Although UNFPA currently works in six regions, in the future, there is necessity to revise the intervention regions according to emerging needs in the regions vis-a-vis the comparative advantages of UNFPA. A case in point is Gambella Regional State, which is one of the emerging regions in the country and hosting a large number of refugees due to its proximity to Southern Sudan. There is high population density and large number of youth and adolescents resulting in need for support in SRH, HIV and related issues.

### 6.2.3. Gender equality

- Supporting partnerships and coordination mechanisms has been one of the interventions planned under gender equality in CP7. However, evaluation shows that program implementation at local levels suffered from lack of coordination mechanism leading to duplication of efforts between stakeholders. It was not possible to see from the evaluations presence of national coordination and collaboration mechanisms in GBV such as TWG, taskforces and the like. This implies that CP8 needs to lead the task of fostering partnerships and coordination between the various government line ministries as well as DPs.

- Although poverty is one of the main factors leaving women vulnerable to GBV, only few projects run IGA. In the future, this should be expanded. It is perhaps worthwhile to explore options to link credit/saving groups and IGA and with established saving and credit associations and micro finance institutions in their respective regions.
- There is need to plan for exit strategy. There is good experience from LNWB program whereby schools took over adult literacy intervention using teachers as volunteers and hosting it within the school. Such experiences should be promoted across programs.

#### 6.2.4. General

- UNFPA CO's decision to channel more of its support through government mechanism goes a long way in harmonization and alignment. However, NGOs/CSOs still have unique role in that they have the flexibility to try out innovative approaches and reach grass roots. Hence, experience of Norwegian A&Y tracer projects should be continued in the future. However, such programs would benefit more from robust system to document lessons and design structured learning process.
- Finally, a major task for CP8 would be to Strengthen M&E. UNFPA CO needs to design a robust system, a more complete and simplified M&E matrix for its programs/projects from the start and follow it up with timely baseline, monitoring and evaluations.

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## Annex 1 - Outputs and interventions and under reproductive health and rights component

### **Output 1 - Increased capacity of training institutions to produce qualified HR for maternal health**

- building the capacity of government training institutions for midwives, anaesthetists and non-physician clinicians for EmOC;
- strengthening partnerships with key stakeholders; and
- resource mobilization

### **Output 2 - Increased availability of essential life-saving maternal and newborn health commodities and modern FP methods and services in selected HFs**

- strengthening the capacity of PFSA to plan, manage and coordinate the forecasting, procurement, storage and distribution of RH commodities and supplies;
- supporting the provision of high-quality FP information and services in selected districts; and
- creating demand for FP information and services for HIV-positive women and men, young people and vulnerable groups, including in humanitarian settings.

### **Output 3 - Strengthened national capacity to provide high-quality information and services on maternal and newborn health**

- supporting B/CEmONC services, including HIV testing;
- supporting BCC for MNH and for adolescents, young people and key population groups, such as sex workers;
- supporting emergency preparedness to reduce vulnerability in the areas of SRH and gender inequality;
- strengthening the referral system;
- supporting policy dialogue and partnerships for programme harmonization and alignment;
- promoting the integration of, and linkages between SRH and HIV/AIDS interventions

### **Output 4 - Increased availability of high-quality HIV-prevention services for young people and other vulnerable groups**

- supporting behaviour change communication for HIV prevention;
- promoting HIV-prevention skills and services;
- supporting comprehensive condom programming; and
- strengthening partnerships and coordination mechanisms

Source: UNFPA , 2011a

## Annex 2 - Outputs and interventions and under gender equality component

**Output 1 - Increased capacity of women, adolescents and young people** to exercise their rights to information and services on SRH, HIV and gender equality

- promoting dialogue among youth and mobilizing communities on issues related to SRH, HIV, GBV and gender equality
- supporting life-skills training
- building the capacity of selected organizations that serve youth to address SRH, HIV and gender issues
- forging partnerships with the media on SRH, HIV and gender issues

**Output 2 - Strengthened community response** to promote and protect the rights of women and girls in relation to HTP and GBV

- promoting community mobilization, including communities affected by disaster, to prevent and respond to GBV
- sensitizing communities and creating awareness of policy and legal provisions on HTP, GBV and gender equality
- strengthening capacity for mobilizing communities
- supporting male-involvement initiatives

**Output 3 - Strengthened institutional response** to address HTP and GBV and provide information and services to survivors of GBV, including within a humanitarian context

- mainstreaming GBV and gender-equality issues in training curricula, guidelines and working procedures in the health and legal sectors
- building the capacity of health and legal service providers
- advocating the implementation and reinforcement of policy and legal provisions
- supporting partnerships and coordination mechanisms on GBV
- supporting services for survivors of GBV

Source: UNFPA , 2011a

## Annex 3 - Background on the evaluations

Parameter	RH			Adolescent and Youth		Gender		
<b>Title of the Document</b>	Thematic Evaluation – UNFPA Support to maternal Health 2000-2011	Evaluation of the UNFPA Support to Family Planning Services 2008-2013, Ethiopia Case Study Note	Scaling Up of the Midwifery and Anaesthesia Education, and, Prevention and Management of Fistula Programme in Ethiopia	A Rights-Based Approach to Adolescent and Youth Development, End of Programme Evaluation	Evaluation of the UNFPA Support to Adolescents and Youth 2008-2014	Joint Evaluation of UNFPA-UNICEF Joint Program on Female Genital Mutilation/Cutting : Accelerating Change 2008-2012	Evaluation of Violence Against Women	Final Evaluation 2013 Africa Gender Thematic Window, Ethiopia. UN Joint Program on Leave No Woman Behind.
<b>Report Date</b>	Sept ember 2012	January 2015	May 2014	August 22, 2013	In process	June 2013	November 2012	April/May 2013
<b>Field visit period</b>		Firs two weeks of December 2014	March and April 2014		???			field visit to Ethiopia in April 2013
<b>Type of evaluation</b>	End line and thematic and part of global review	End line and thematic and part of global review	End line	End line	End line and global	End line and global	End line	End line
<b>Objective and scope of the evaluation</b>	assesses the extent to which UNFPA support has been relevant, effective, efficient and sustainable in contributing to the improvement of maternal health.	assess the performance of UNFPA in the field of FP during the period covered by the Strategic Plan 2008-2013 and to inform implementation of the current UNFPA FP – Strategy (2012-2020). The evaluation will also inform other relevant programs such	to determine the extent to which the programme was able to meet its outputs, outcome and the intended goal, document successes and challenges	to determine whether the JP has achieved its objectives, to fill knowledge gaps, document lessons learnt and suggest ways forward for the JP.	Provide key inputs into the implementation of the current UNFPA Strategy on A&Y (2012-2020), inform MTR of strategic plan, document lessons/successes, value added of UNFPA	to assess the extent to which and under what circumstances – for example in what specific country contexts – the UNFPA-UNICEF joint program has accelerated the abandonment of FGM/C in programme countries over the years(2008-2012)	to review overall performance of the three years interventions, draw lessons and suggest recommendation to inform the design of the next phase of UNFPA and EKN interventions to end VAW in Ethiopia	

		<p>as the GPRHCS (2013-2020) and HIV /Unintended pregnancies framework (2011-2015) and the mid-term review of UNFPA current Strategic Plan 2014-2017.</p> <p>Included 69 poorest countries with low rates of contraception use and high unmet need for FP.</p>					
<p><b>Background and key features on the project/program under evaluation</b></p>	<p>covers all programmatic interventions that have been directly relevant to mortality and morbidity within the UNFPA mandate, including all activities financed from core and non-core resources</p>	<p>All UNFPA support to FP during the stated period from core or non-core resources</p>	<p>to contribute to the reduction of maternal and neonatal morbidity and mortality in Ethiopia through improved access and utilization of quality maternal and newborn health services, including EmONC and fistula services especially lack of HR and access to fistula care.</p>	<p>Project aims to contribute to improved development of A&amp;Y by promoting rights relating to HIV/AIDS, SRH, gender, and sustainable livelihoods.</p> <p>Implemented in 25 target woredas of AA, Afar, Amhara, Oromiya and SNNPR covering 23 million A&amp;Y, 12 public</p>	<p>Program has objective of helping reduce FGM/C among girls aged zero-15 by 40% and eliminating FGM/C altogether in at least one country by 2012. The program was established as the main UN instrument to promote acceleration of FGM/C abandonment, acting upon the UN Interagency</p>	<p>Objective-strengthen an enabling environment to reduce VAW in partnership with local leaders, law enforcement structures, and media. It aims to strengthen social support to violence survivors esp. adolescent girls and rural women.</p> <p>Implemented in AA, Oromiya,</p>	<p>Aimed to address challenges faced by women and girls mainly low status in society; high rate of Child Marriage; limited RH knowledge and livelihood opportunities; vulnerability to HIV/AIDS infections compared to boys</p>

				universities and HIV “hotspots”.  Joint program by UNICEF & UNFPA		Statement on Eliminating FGM  Joint program by UNICEF & UNFPA	Amhara, Tigray, SNNPR, and B-Gumz through 22 IPs	Operated in Tigray and Amhara Regions
<b>Project period</b>	2000-2011	2008-2013	2010-2012	2007-2013	2008-2014	2008-2012	2010-2012	2009-2012
<b>Evaluation Methodology</b>	staged sampling process to select the countries to be included in the evaluation. From a list of 55 programme countries with MMR higher than 300 deaths per 100,000 live births in the year 2000, <b>22 countries</b> were selected for a <b>desk study</b> . From this sample <b>10 countries were selected for more in-depth country case study</b>	<b>Desk review</b> and analysis of secondary data  <b>KII/discussion</b> with UNFPA CO staff  <b>FGD</b>	<b>Mixed qualitative methods</b> used to collect data from nine institutions (one private/non-government, 8 government) in Oromiya, Amhara, Harari, and Somali regions, and Addis Ababa City Administration.	<b>mixed method</b> approach that included <b>desk review, interviews</b> with government officials, youth organisations, donor agencies, UN agencies, coordinating and implementing partners at national, regional, woreda and kebele levels; <b>FGD</b> with community members and intended beneficiaries; and <b>snapshot surveys</b> .	<b>mixed qualitative method</b> , which included semi structured interviews, FGD, document review, e-discussion and observation/visit. Questions revolved around relevance, effectiveness, sustainability, efficiency, partnership coordination and comparative advantage	addresses all four programme levels (global, national, regional and community) and their interconnections. Covers 15 countries that implemented the project.  mix of qualitative and quantitative methods of data-collection and analysis. Qualitative methods(e.g. country case studies) quantitative approaches (e.g. survey of the joint programme focal points in 11 non-visited countries	evaluation was guided by the UN Evaluation Group Norms and Standards, and the OECD – DAC evaluation criteria	Used mixed qualitative techniques i.e. in-depth KII, FGD, most Significant Change Stories, Statistical Data collection and Participatory Self Assessment Meetings. Evaluation questions centered on relevance, efficiency, ownership, effectiveness and sustainability.
<b>Sample size and coverage</b>	10 countries selected for in-depth case studies	Visits to SNNPR and Tigray	Desk review  KII –	A random sample of 13 woredas of 25 project woredas selected	UNFPA staff – 8, IPs – 29, PO – 11, FGD - 91	Country case studies – 1384  (four countries for the case	KII – 41  FGD – 26	<ul style="list-style-type: none"> <li>Assessment conducted at federal level, Tigray and Amhara.</li> <li>KII - 223</li> </ul>

	<p>Conducted interview with UNFPA staff, partners etc</p> <p>FGD with beneficiaries</p> <p>Desk review</p>	<p>FGD –</p> <p>Case study</p> <p>Interview with graduating AMP students</p> <p>Other participatory methods like direct observation</p>	<p>KII – 80</p> <p>FGD -</p> <p>Snap shot survey – 75 youth leaders and 32 – YFS users</p> <p>Visited 12 program woredas and one 'tracer project' run by a faith-based organisation</p>	<p>study selected purposively)</p> <p>Interviews/consultations – 1472 (at different levels)</p> <p>Literature review incl country overviews</p>	<p>Semi-structured survey questionnaire – 368</p> <p>Desk review</p>	<ul style="list-style-type: none"> <li>• FGD - 31</li> <li>• Household visits – 9 in both regions</li> <li>• Most significant stories – 17</li> <li>• site visits to schools and hospitals - 5</li> </ul>
<p><b>Limitations, if any</b></p>		<p>data contained in this report cannot be seen to be representative of national situation, based on assessment of sampled institutions</p>	<p>population level survey was needed to provide credible data on outcome, but this was beyond the scope of work for this evaluation. Lack of reliable secondary data on outcome level results covering the right period, geographical areas and age sets.</p>		<p>lack of baseline</p> <p>Data were self-reported and the survey questions were not standardized and tested</p> <p>KII and FGD participants could not be identified randomly as they were selected by IPs</p>	<p>Documentation/ data gaps on indicators. What was collected during the evaluation is rudimentary data that could be provided on spot.</p>