UNFPA ETHIOPIA

COUNTRY PROGRAMME EVALUATION

2020-2025

EVALUATION REPORT

September 2024

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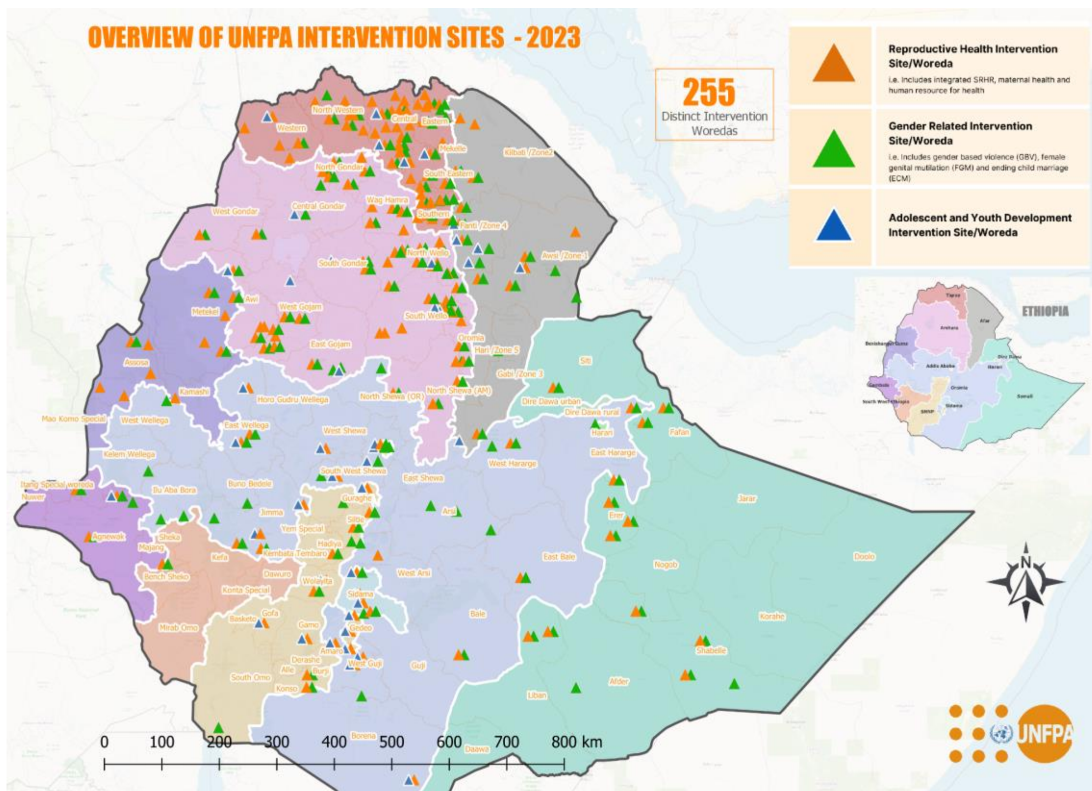
Country map indicating areas of UNFPA programme implementation



Source: UNFPA Ethiopia CO

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The Evaluation Team hopes that the evaluation findings and recommendations will contribute to the further development of the UNFPA programme in Ethiopia, particularly the design of the next programme cycle, as well as national development plans and the UNSDCF in Ethiopia.

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III. ACRONYMS AND ABBREVIATIONS

AADPD	Addis Ababa Declaration on Population and Development
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ASRH	Adolescent sexual and reproductive health
AWP	Annual Work Plan
A&Y	Adolescent and Youth
AYD	Adolescent and youth development
BEmONC	Basic emergency obstetric and newborn care
CAC	Comprehensive abortion care
CAPI	Computer Assisted Personal Interviewing
CBCM	Catchment-based clinical mentorship
CEmONC	Comprehensive emergency obstetric and newborn care
CIP	Costed Implementation Plan
CMR	Clinical Management of Rape
CO	Country Office
COAR	Country Office Annual Report
CoRHA	Consortium of Reproductive Health Association
COVID-19	Corona Virus of 2019
CP	Country Programme
CPD	Country Programme Document
CPE	Country Programme Evaluation
CPR	Contraceptive prevalence rate
CSO	Civil society organizations
CRVS	Civil registration and vital statistics
DHS	Demographic and health survey
EDHS	Ethiopian demographic and health survey
EmONC	Emergency obstetric and newborn care
EMwA	Ethiopian Midwives Association
EPHI	Ethiopian Public Health Institute
EPSS	Ethiopian pharmaceuticals supply service agency
EQ	Evaluation Question
ERG	Evaluation Reference Group
ESARO	East and Southern Africa Regional Office
ESS	Ethiopian Statistical Service
FGD	Focus Group Discussion
FGM/C	Female genital mutilation/cutting
FP	Family planning
GBV	Gender-based Violence
GBV AoR	Gender-Based Violence Area of Responsibility
GDP	Gross Domestic Product
GEWE	Gender Equality and Women's Empowerment
GIS	Geographic information system
HCT	Humanitarian Coordination Team
HDP	Humanitarian-development-peace
HEP	Health extension programme
HEW	Health extension workers
HIV	Human Immune-deficiency Virus
HSTP	Health Sector Transformation Plan
ICPD	International Conference on Population and Development
ICS	Immigration and Citizenship Services
IDP	Internally Displaced person
IMIS	Integrated management information system
IOM	Internation Organization for Migration
IP	Implementing partner
KII	Key Informant Interviews
LNOB	Leave No One Behind
M&E	Monitoring and Evaluation
MH/PSS	Mental Health/ and Psychosocial Support
MHT	Mobile health team

MISP	Minimum initial service package
MoU	Memorandum of Understanding
MPDSR	Maternal And Perinatal Death Surveillance and Response
MSIE	Mary Stopes International in Ethiopia
MWH	Maternity waiting home
NGO	Non-governmental organization
NPPE	National Population Policy of Ethiopia
OCHA	Office for the Coordination of Humanitarian Affairs
OF	Obstetric fistula
OSC	One-stop centres
PHC	Primary health care
POP	Pelvic organ prolapse
PPE	Personal Protective Equipment
PSEA	Prevention of sexual exploitation and abuse
PWD	People with disabilities
RH	Reproductive health
RHB	Regional Health Bureau
RHCS	Reproductive health commodity security
SDG	Sustainable Development Goal
SDP	Service delivery point
SIS	Strategic Information System
SOP	Standard operating procedures
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and reproductive rights
STI	Sexually transmitted infections
ToC	Theory of Change
ToR	Terms of reference
TWG	Technical working group
UHC	Universal health coverage
UNCT	United Nations Country Team
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNOPS	United Nations Office for Project Services
UNRC/O	United Nations Resident Coordinator/Office
UNSDCF	United Nations Sustainable Development Cooperation Framework
USD	United States dollar
WFP	World Food Programme
WHO	World Health Organization
WGFS	Women and girls friendly spaces
YPS TWG	Youth Peace and Security Technical Working Group

Table 1: Key facts table

POPULATION	STATUS	YEAR/SOURCE
Total estimated (in million)	126.5 million	2023/UN
Annual growth rate	2.6 %	2023/UN
Population aged below 15 years	42.4 %	2021/ESS
Population aged 15 – 29 years	26.5 %	2021/ESS
Urban population	22.1 %	2023/UN
Life expectancy at birth in years	65.0	2021/WDI
Total age dependency ratio	88 %	2016/CSA
HEALTH AND FAMILY PLANNING		
Infant mortality (death per 1000 live births)	43 %	2019/EMDHS
Under 5 mortality (death per 1000 live birth)	55 %	2019/EMDHS
Maternal mortality (per 100,000 live birth)	267	2020/WHO
Skilled birth attendance	62 %	2023/ Ministry of Health
Contraceptive demand among married women	58 %	2016/CSA
Contraceptive prevalence rate (CPR)	41 %	2016/CSA
Net contraceptive demand	36 %	2016/CSA
Unmet family planning need	22 %	2016/CSA
Total fertility rate	4.1	2022/ Ministry of Health
HIV prevalence	0.87 %	2023/EPHI
INEQUALITY, GBV, AND HARMFUL PRACTICES		
Female genital mutilation (15-49 years)	65 %	2016/CSA
Women aged 20-24 years, married aged <18 years	40 %	2016/CSA
Teenage/adolescent pregnancy	12.5 %	2016/CSA
Intimate partner violence of all type	33 %	2016/CSA
Gender parity index (secondary school enrolment)	0.91	2016/CSA
Gender parity index (tertiary school enrolment)	0.6	2016/CSA
Parliament seats held by women	38.8 %	2022
SOCIAL DEVELOPMENT INDICATORS		
Human Development Index	0.492	2022/UNDP
Literacy rate	48.93 %	
Net enrolment in primary school	92.6 %	2022/ Ministry of Education
Net enrolment in secondary school	33.1 %	2022/Ministry of Education
ECONOMY		
GDP, current US$	171.3 billion	2023/ World Bank
Gross domestic product (GDP) per capita, current US$	1353.5	2023/ World Bank
GDP growth rate	7.2 %	2023/ World Bank
Total expenditure on health (in us$)	501 million	2020
Government expenditure on health as per cent of total government expenditure	9 %	2022/ Ministry of Health
Government expenditure on health as per cent of GDP	3.48 %	2020/WHO
Unemployment rate	8 %	2021/CSA
Youth unemployment rate	13. %	2021/ESS

EXECUTIVE SUMMARY

Purpose, scope of the evaluation and intended audience: This report presents the process, findings, conclusions and recommendations of the UNFPA 9th programme cycle (2020– 2025) Country Programme Evaluation (CPE). The evaluation serves four main purposes, namely: (i) oversight and demonstrate accountability to stakeholders on performance in achieving development results and on invested resources; (ii) support evidence-based decision-making to inform development, humanitarian response and peace-responsive programming; (iii) aggregating and sharing good practices and credible evaluative evidence to support organizational learning on how to achieve the best results; and (iv) empower community, national and regional stakeholders. The main intended audience to the CPE are (i) the UNFPA Ethiopia Country Office (CO), (ii) the Government of Ethiopia; (iii) implementing partners of the UNFPA Ethiopia CO; (iv) rights-holders involved in UNFPA interventions and the organizations that represent them (in particular women, adolescents and youth); (v) the United Nations Country Team (UNCT); (vi) East and Southern Africa Regional Office (ESARO); and (vii) donors, in addition to other wider UNFPA stakeholders.

The objectives of the CPE were (i) to provide the UNFPA Ethiopia CO, national stakeholders and rights-holders, the UNFPA ESARO, and UNFPA Headquarters as well as a wider audience with an independent assessment of the UNFPA Ethiopia 9th country programme (2020-2025), and (ii) to broaden the evidence base to inform the design of the next programme cycle. The specific objectives were (i) to provide an independent assessment of the relevance, coherence, effectiveness, efficiency and sustainability of UNFPA support; (ii) to provide an assessment of the geographic and demographic coverage of UNFPA humanitarian assistance and the ability of UNFPA to connect immediate, life-saving support with long-term development objectives; (iii) to provide an assessment of the role played by the UNFPA Ethiopia CO in the coordination mechanisms of the UNCT and Humanitarian Country Team (HCT), to enhance the United Nations collective contribution to national development results and humanitarian response and ensure contribution to longer-term recovery; and (iv) to draw key conclusions from past and current cooperation and provide a set of clear, forward-looking and actionable recommendations for the next programme cycle.

The scope of the CPE geographically covered national interventions and the regions where UNFPA implemented interventions in Ethiopia including Afar, Amhara, Gambella, Central and Southern, Sidama, Oromia, Benishangul-Gumuz, Somali and Tigray. Thematically, it covered (i) policy and accountability; (ii) quality of sexual and reproductive health (SRH) care and services; (iii) gender and social norms; (iv) population change and data; (v) humanitarian action; and (vi) adolescents and youth. In addition, the evaluation covered cross-cutting issues, such as adherence to humanitarian principles; human rights; gender equality; disability inclusion; etc., and transversal functions, such as coordination; monitoring and evaluation (M&E); innovation; resource mobilization; strategic partnerships, etc. The temporal scope covered interventions planned and/or implemented within the period of the 9th CP: July 2020- June 2025.

The 9th UNFPA Ethiopia Country Programme: The 9th Country Programme (CP) was designed in consultation with the Government of Ethiopia, line ministries and regional bureaus; civil society organizations (CSO), academia, bilateral and multilateral development partners (including sister United Nations organizations), and the private sector. The overall goal of the 9th CP is ensuring universal access to SRH and reproductive rights (SRHR) and accelerating the implementation of the International Conference on Population and Development (ICPD) Programme of Action, and as a long-term plan, achieving UNFPA Transformative Results (ending preventable maternal deaths, ending unmet need for family planning, ending gender-based violence (GBV) and harmful practices, and ending new HIV infection). Its focus was particularly drawn from the UNFPA global Strategic Plan (2022-2025), the Sustainable Development Goals (reducing maternal deaths, ensuring universal access to SRH services, eliminating all forms of violence and harmful practices against women and girls), the ICPD Programme of Action, and the Health Sector Transformation Plan (HSTP II, 2020-2025). The 9th CP is also aligned with the United Nations Sustainable Development Cooperation Framework for Ethiopia (UNSDCF) 2020-2025, the Ethiopian Government's Home-Grown Economic Reform Agenda, and the 10-Year Perspective Development Plan. Under the 9th CP, UNFPA engaged in advocacy and policy dialogue, capacity development at different levels, national and regional programme coordination, knowledge management and service delivery. The 9th CP aimed to achieve six outputs spanning improved quality of care and service, gender and social norms, population change and data, humanitarian action, and adolescents and youth interventions.

CPE Methodology: The design of the CPE was guided by the UNFPA Evaluation Handbook and based on the Evaluation Policy. The design of the CPE was theory-based and non-experimental using a contribution analysis. It was guided by a set of eight questions that addressed the evaluation criteria of relevance, coherence, effectiveness, efficiency, sustainability, coordination, coverage and connectedness. It used purposive and convenience sampling methods to select participants for the CPE based on the stakeholders' mapping provided by the CO. The sampling included implementing partners (IPs), partners from government and CSOs, donors, United Nations agencies and direct and indirect beneficiaries. The CPE adopted mixed methods utilising four main data collection techniques, namely, i) document review; ii) key informant interviews at group and individual levels with the selected stakeholders and CO staff (reaching a total of 160 people); iii) focus group discussions

with a total of 30 beneficiaries; and iv) site visits and observations. The data were collected both virtually and in person, depending on the stakeholders and their locations at the time of the fieldwork. The data from the different sources were triangulated using both qualitative and quantitative analysis techniques to generate the CPE report. Ethics and quality control requirements were adhered to by the consultants and assured by the Evaluation Manager.

Main Findings

Relevance: The UNFPA Ethiopia 9th CP was strategically aligned to the UNFPA Strategic Plans 2018 – 2021 and 2022 - 2025, the UNSCDF, ICPD Programme of Action and the Sustainable Development Goals (SDGs) (particularly contributing to Goals 1, 3, 5, 10, 13, 16 and 17), in addition to other international development frameworks that UNFPA and the Government of Ethiopia is committed to. The 9th CP was well adapted to the national development and humanitarian priorities as contained in the Ten Years Development Plan (2021-2030) and the Home-Grown Economic Reform Programme (2023-2025) with the development and implementation done in consultation and guided by the line ministries, regional bureaus and CSOs - among other stakeholders - directly contributing their strategic objectives. The 9th CP targeted the hard-to-reach and marginalised populations with SRHR and GBV services delivery contributing to addressing their felt needs. The implementation of the 9th CP prioritised areas of need, particularly in the development of SRHR, gender-related, adolescent and youth-related and population dynamics strategies and policies, including standard operating procedures, and guidelines, strengthening service delivery and response in the thematic areas of the CP focus. The 9th CP was highly responsive to the contextual changes, particularly COVID-19, climatic-related disasters and the eruption of armed conflict in Tigray and other regions in the country. UNFPA was also reprogrammed to adapt to the changing contexts for effective response. There were however weaknesses in the monitoring and implementation of the policies and strategies, particularly by the Government, due to inadequate capacity and resources. There was also inadequate identification of needs for those affected by conflict due to the inaccessibility of the affected location.

Coherence: The UNFPA CO strategically integrated its mandate in the implementation framework to improve the quality and delivery of SRHR services and gender-related prevention and response services to marginalized and vulnerable populations. The CO nurtured strategic partnerships with the Government of Ethiopia, government and non-government IPs, CSOs, donors and within the UNCT and HCT enhancing coordination and leveraging of resources for increased delivery of its mandate. The CO also promoted the engagement of communities to improve downstream advocacy and awareness creation targeting social behaviour change and increased knowledge for service access and reducing gender inequalities among the marginalized and vulnerable women and girls. UNFPA also enhanced capacity strengthening to improve access to quality SRHR services and gender-related response and advocacy. The integration of the CP also enhanced coherence, informed by the contextual demand.

Effectiveness: There is evidence that the 9th CP contributed to the achievement of the UNFPA SP and CP outcome results based on the achievement of most of the output indicator targets across the components in the development and humanitarian contexts. UNFPA utilized varied strategies to address the felt needs in the targeted locations. The 9th CP contributed to strengthening the capacity of the country to ending preventable maternal deaths, reducing the unmet need for family planning (FP) and reducing Human Immune-deficiency Virus (HIV) infections in the country by enhancing access to quality SRHR services. UNFPA supported the Ministry of Health, the regional health bureaus and the CSOs through strengthening policy and strategy development and implementation, reproductive health (RH) commodity security supply chain, infrastructure and medical supplies support to the health facilities, and deployment of skilled healthcare workers in the areas of need for quality SRHR services. Toward reducing unmet FP needs in the country, the 9th CP supported the procurement, distribution and monitoring of the distribution of FP and life-saving maternal health products, improved the quality of FP services and a cumulative figure of 9.1 million Couple of Years of Protection (CYP) by the end of 2023 and supported the coordination of FP technical working groups (TWGs). The 9th CP contributed to the ending of preventable maternal deaths by strengthening the delivery of Basic emergency obstetric and newborn care (BEmONC) and CEmONC services to the targeted vulnerable and marginalised populations through rehabilitation and equipment of primary health facilities, and deployment of mobile health teams. strengthened quality of health service delivery through the training of healthcare workers. The CO further supported quality-of-care mechanisms through performance assessment, strengthened obstetric fistula care, guidelines development and TWGs, and integration of SRH services. The integrated service included FP, Emergency obstetric and newborn care (EmONC) SRH/Life skill, post-abortion care, outreaches in the hard-to-reach areas, antenatal care (ANC), postnatal care (PNC), early detection of cervical cancer, prevention and management of sexually transmitted infections (STI) and HIV, and strengthening Maternal, and Perinatal Death Surveillance and Response (MPDSR). There was however low availability of SRH commodities at service delivery points (SDPs) in rural areas and primary health care (PHC) units; inadequate government capacity and policy implementation; inadequate obstetric fistula case detections and referrals systems; low FP utilization rates; inadequate CEmONC services and high rates of home delivery in Afar region. The Gender and Social norms component significantly contributed to the efforts to end GBV and harmful practices in the country and targeted communities through enhanced

utilisation of both upstream and downstream advocacies targeting behaviour change and increased knowledge for improved outcomes in addressing GBV and negative social norms like female genital mutilation and child, early and forced marriage. The application of transformative approaches in the engagement of duty bearers and culture promoters, in addition to boys and men on positive masculinity significantly contributed to tackling negative social norms promoting gender inequality. The development of manuals, strategies, policies, advocacy for change in laws, guidelines, standard operating procedures (SOPs), capacity building, strengthening GBV coordination and service provision, enhanced prevention and response, and reduction in harmful practices. inadequate response capacities Deeply rooted socio-cultural beliefs hindered some of the gains made through the CP and may take time to change, and inadequate enforcement of national laws and policies on gender equality, particularly with weaknesses in the implementation and monitoring of laws and policies by the Government of Ethiopia. The Population Change and Data component of the 9th CP contributed to the strengthening of the country's statistical systems and enhanced advocacy for integration of population dynamics into development planning and management through population policy review and development. The advocacy and capacity strengthening and support for evidence-based development planning and management through coordination and south-south cooperation and partnerships enhanced innovation in the generation of population data, including population estimation in the absence of a Census. Challenges in capturing civil registration and vital statistics (CRVS) data limited their use for decision-making. On the other hand, inadequate and outdated national disaggregated data on population issues limited the extent of assessment of the 9th CP results. The 9th CP considerably contributed to the humanitarian response in the country by strategically strengthening reproductive maternal, newborn, and child health service delivery through integration of SRH/GBV/STI/HIV/Mental Health and Psychosocial Support (MHPSS); establishment and equipment of service delivery points such as one-stop centres, maternity waiting homes, women and girls' friendly spaces (WGFS), and safe homes; enhanced partnerships and coordination of the SRH and GBV inter-agency working groups; strengthened capacities of the national and regional stakeholders; and distribution of supplies in the internally displaced person (IDP) settlements and affected location in the country. Additionally, UNFPA contributed to strengthening evidence-based response by supporting humanitarian needs overview (HNOs) and Humanitarian Response Plan (HRP), and for guided resource mobilization and targeting. Further, UNFPA strategically strengthened the nexus programming by making deliberate efforts to mainstream peace into the Humanitarian-development-peace (HDP) programming. The conflict situations in Tigray, Amhara, and West Oromia limited access to effective identification of the needs of the affected populations for the humanitarian response. The adolescent and youth output contributed to increased access to comprehensive adolescent sexual and reproductive health (ASRH) services through supporting adolescent and youth-friendly services (AYFS) establishment and strengthening in public health centres, youth centres, and industry parks in the targeted regions. The young people received services on contraception and FP; condom promotion and provision; HIV counselling, testing and treatment; STI screening, management, and follow-up; cervical cancer screening; GBV; PSS; and referral services from the facilities, and increased awareness and demand creation for ASRH and AYFS. UNFPA also contributed to addressing the unique vulnerabilities of the industrial park workers who were mostly female, below 25 years of age, and had limited access to SRHR-related services. This was achieved by supporting the development of a Minimum Service Package and fostering partnerships. There were unintended consequences documented. The design and implementation of the 9th CP highly integrated human rights approaches in its delivery; mainstreamed considered gender into programming decisions; and targeted hard-to-reach and marginalized populations with interventions, in addition to promoting inclusion in decisions. However, there was limited disaggregation of data on target groups to identify the needs and extent of targeting.

Efficiency: Evidence showed that the UNFPA CO efficiently utilised its human, financial, and administrative resources to maximize the delivery of the 9th CP and SP results. UNFPA was strategic in its field presence ensuring coordination and prompt follow-up with the IPs and stakeholders at the regional levels. UNFPA also enhanced South–South Cooperation and strategic partnerships with the Government, the United Nations agencies, donors and CSOs, ensuring a favourable implementation framework, leveraged resources, synergies, and funding opportunities for the CO and increased coverage, including hard-to-reach areas and marginalised populations. The CO had skilled and experienced staff and effectively provided technical support to the stakeholders in the areas of mandate. Additionally, UNFPA utilised strong internal controls on finance, procurement and administration functions, ensuring compliance, with staff and IPs trained and supported on compliance for operational efficiency. The M&E Unit ensured a robust process for performance monitoring and quality programming. While UNFPA delivered on its mandate, there were staff shortages in some units, for example in the Population and Youth teams, while others were overstretched due to wide areas of coverage. There was also inadequate focus on learning, knowledge management and disaggregation of data, particularly for the most marginalized populations.

Sustainability: UNFPA CO instituted strategic mechanisms to facilitate the sustainability of the CP results through facilitating ownership and institutionalization of service delivery in the areas of mandate. The partnership and collaboration with the line ministries, including the regional bureaus, and delivery of most of the services through the ministry facilities contributed to the sectoral objectives and priorities enhancing ownership. UNFPA influenced government policy and strengthened implementation through advocacy, e.g. integration of mobile health clinics by Ministry of Health for hard-to-reach populations through the development of a national guideline on the same, revision of the Ministry of Health Essential Health Service Package to include maternal and newborn

health, FP, and comprehensive abortion care (CAC) services into the universal health coverage (UHC) cost-free package also confirmed institutionalisation of the SRH service delivery, in addition to the Government committing to fund reproductive health commodity security (RHCS). The Government also adopted the maternity waiting homes approach and constructed units for mothers in labour, including financing ambulances bought by UNFPA. UNFPA strengthened institutional capacities in addition to the development of guidelines, SOPs, tools and infrastructure development will ensure the continued provision of services. Additionally, UNFPA strengthened partnerships with local organizations and capacity built them to deliver in their areas of mandate and confirmed the transfer of skills to enable them to continue the provision of services. Inadequate capacity and commitment of some national entities in the implementation of the policies, and guidelines and financing them is low and requires strengthening. There was also high staff turnover in Government that caused a brain drain, affecting sustainability. Deeply rooted socio-cultural norms hampered the continuity of the 9th CP results.

Coordination: The 9th CP effectively utilised its comparative advantage to contribute to and facilitate coordination mechanisms within the Ethiopian UNCT and HCT. UNFPA further implemented joint programmes with the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO) and further collaborated with other United Nations agencies for the effective delivery of its mandate. UNFPA effectively delivered on its mandate in co-chairing the SRH and GBV Area of Responsibility (AOR) within the UNCT and HCT to ensure the delivery of services and targeting of the affected population. The GBV AOR enhanced the coordination of stakeholders within the HCT to enhance GBV response. UNFPA also co-chaired the Prevention of Sexual Exploitation and Abuse (PSEA) Network, Data and Statistics TWG, and Youth Peace and Security Technical Working Group, among others and was a member of the UNCT results group contributing to the coordination and reporting on the UNSDCF. There were however reported weaknesses in the coordination mechanism within the UNCT, with some joint programmes decided on by the donors based on their respective mandates. The overfocus on humanitarian response also hampered the coordination at the UNCT, particularly on the UNSDCF which was mostly developmental.

Coverage: The 9th CP humanitarian response component strategically ensured coverage of the conflict and disaster-affected geographical areas and supported the most vulnerable and marginalized populations through resource mobilization, partnerships and collaborations, strengthened coordination, supporting evidence-based response and identification of the hard-to-reach areas and those with low-performance SRH and GBV indicators. The conflict situation limited access to affected areas and populations, in addition to weak data management mechanisms, limited the identification of vulnerable populations and geographical areas. and COVID hampered access to some populations limiting the extent of demographic and geographic coverage.

Connectedness: The 9th CP ensured connectedness through strengthened early warning and early action mechanisms, supporting coordination, handover of health facilities, strengthened capacities of actors and equipment on various government facilities to continue providing UNFPA-related services. UNFPA also strengthened the response frameworks through the development of strategies, SOPs, Manuals, guidelines and policies to guide implementation. Additionally, the CO enhanced the HDP programming through strengthening the integration of nexus programming for lasting results. There was inadequate engagement of youth in peacebuilding in the humanitarian setting limiting their roles in conflict resolution.

Conclusions

1. The 9th CP aligned with national and international priorities, addressing the needs of vulnerable populations and adapting to contextual changes. However, further capacity strengthening is needed for enhanced effectiveness and sustainability.
2. UNFPA Ethiopia integrated its mandate and built partnerships with key stakeholders, facilitating coordination within the UNCT, HCT, and other mechanisms to improve SRHR and Gender Equality and Women's Empowerment (GEWE) interventions. Nonetheless, coordination gaps remain.
3. The UNFPA CO utilized resources effectively, achieving 9th CP results. However, disbursement delays and challenges in data disaggregation and knowledge management persisted, alongside limited resources relative to program coverage.
4. The 9th CP strengthened humanitarian response capacities; however, inadequate identification of affected populations limited targeted interventions. Efforts to enhance the HDP nexus have not fully integrated the peace component.
5. UNFPA improved access to SRH services and ensured quality delivery by strengthening capacities. The CP integrated SRHR, cervical cancer, HIV, and GBV services, leading to positive results. However, evidence-based programming integration and challenges in implementation and distribution remained.
6. The 9th CP advanced gender equality and addressed negative social norms. Yet, deeply rooted norms, insufficient GBV data, and policy gaps hinder UNFPA effectiveness.
7. The 9th CP effectively provided GBV response services in humanitarian settings and supported capacity building for government and CSO IPs. However, engagement of men and boys was not systematic, and referral pathways were weak.

8. The 9th CP enhanced the country's data systems, but the institutionalization of data generation remains weak. There was also inadequate use of data for evidence-based programming and sub-optimal resource allocation.
9. UNFPA advocacy for the population census and policy review were key achievements of the 9th CP, though investment in the Population Unit with Ministry of Planning and Development was insufficient.
10. The 9th CP mainstreamed SRH and HIV prevention, targeting youth knowledge and skills. Some programs showed replicable performance, but youth participation in peacebuilding and governance was limited.
11. Many UNFPA-supported youth activities are being integrated into government agendas. However, challenges in identifying youth needs, limited funding, and changing contexts limited results.

Recommendations: Strategic (1-4) and programmatic (5-9)

1. The UNFPA CO should make deliberate efforts to strengthen partnerships and advocacy for the implementation of the policies and strategies, enhancing the achievement of the UNFPA mandate in the country, ensuring that the role and capacity of the Government and local CSOs in implementing and monitoring the policies and strategies should be clear and strengthened to enhance the effectiveness and sustainability of the 10th CP. [**Priority**: High]
2. The CO should enhance continued building and strengthening partnerships with United Nations Agencies, Government of Ethiopia, CSOs, Private sectors and academia, among others, in its areas of mandate and maintain a proactive role in facilitating UNCT/HCT coordination utilising its comparative advantage and explore opportunities for collaboration and joint programming and advocacy initiatives. [**Priority**: Medium]
3. The UNFPA CO should strategically reassess its geographical presence in the country and align it to its resource (financial, human and administrative) capacity for maximisation of results, and improve the planning and funding disbursement mechanisms with the IPs and the Government for increased efficiency in the delivery of results. [**Priority**: High – Medium]
4. The CO should strengthen its knowledge management function for enhanced learning across the organization and ensure that the M&E reports capture disaggregated data according to the beneficiary groups targeted by the CP, in addition to enhancing advocacy for increased focus on results. [**Priority**: Medium]
5. The CO should ensure increased focus on resilience building to enable the crisis-affected populations to adapt and recover from the effects of the conflict and disasters. Strengthen the integration of the HDP nexus approach for longer-term results among the affected population. Increase engagement of the youth in peacebuilding activities. [**Priority**: High]
6. Advance evidence generation in the SRH programming for increased evidence-based decisions in the formulation and execution of interventions. Increase delivery of integrated SRH programming (SRH, FP, HIV, Cervical Cancer and GBV) at the field implementation level for enhanced results and efficiency. [**Priority**: High]
7. The CO should continue advancing the advocacy mechanisms against social gender norms with increased engagement of religious leaders and groups, traditional leaders, and promotion of positive masculinity through male engagement. Increase engagement and advocacy on strengthening gender-related policy and legal systems and implementation. [**Priority**: High]
8. The CO should continue strengthening the capacity of the government's statistics system including enhanced generation of evidence for formulation of programmes and development monitoring, including SDG performance and enhanced advocacy for the integration of population dynamics into the formulation of development programmes for informed decision-making through policy reviews and implementation. [**Priority**: High]
9. Advocate for increased engagement of adolescent and youth (A&Y) and development of a costed-national implementation plan for the national youth strategy and policy to enhance the consolidation and coordination of A&Y programming in the country. [**Priority**: High]

CHAPTER 1: INTRODUCTION

1.1 Purpose and objectives of the CPE

In line with the 2024 UNFPA Evaluation Policy[1], the CPE served four main purposes, namely: (I) demonstrating accountability to stakeholders on performance in achieving development results and on invested resources; (ii) supporting evidence-based decision-making to inform development, humanitarian response and peace-responsive programming; and (iii) aggregating and sharing good practices and credible evaluative evidence to support organizational learning on how to achieve the best results; and (iv) empowering community, national and regional stakeholders.

The main audience and primary intended users of the evaluation are the following: (I) The UNFPA Ethiopia CO; (ii) the Government of Ethiopia; (iii) implementing partners of the UNFPA Ethiopia CO; (iv) rights-holders involved in UNFPA interventions and the organizations that represent them (in particular women, adolescents and youth); (v) the United Nations Country Team (UNCT); (vi) East and Southern Africa Regional Office (ESARO); and (vii) donors. The evaluation results are also of interest to a wider group of stakeholders, including: (I) UNFPA headquarters divisions, branches and offices; (ii) the UNFPA Executive Board; (iii) academia; and (iv) local civil society organizations and international non-governmental organizations (NGOs).

Objectives: In line with the Terms of reference (ToR), the objectives of this CPE are, namely (I) to provide the UNFPA Ethiopia CO, national stakeholders and rights-holders, the UNFPA ESARO, UNFPA Headquarters as well as a wider audience with an independent assessment of the UNFPA Ethiopia 9th country programme (2020-2025), and (ii) to broaden the evidence base to inform the design of the next programme cycle. The specific objectives were:

i. To provide an independent assessment of the relevance, coherence, effectiveness, efficiency and sustainability of UNFPA support.
ii. To provide an assessment of the geographic and demographic coverage of UNFPA humanitarian assistance and the ability of UNFPA to connect immediate, life-saving support with long-term development objectives.
iii. To provide an assessment of the role played by the UNFPA Ethiopia CO in the coordination mechanisms of the UNCT, to enhance the United Nations collective contribution to national development results. In addition, to provide an assessment of the role of the UNFPA Ethiopia CO in the coordination mechanisms of the HCT, to improve humanitarian response and ensure contribution to longer-term recovery.
iv. To draw key conclusions from past and current cooperation and provide a set of clear, forward-looking and actionable recommendations for the next programme cycle.

1.2 Scope of the evaluation

i. **Geographic Scope:** The evaluation covered the regions where UNFPA implemented interventions in Ethiopia: Afar, Amhara, Gambella, Central and Southern, Sidama, Oromia, Benishangul Gumuz, Somali and Tigray in addition to Addis Ababa. The scope was not altered as per the design and remained national. However, specific focus was given to the Afar, Amhara, Sidama Oromia, and Tigray regions due to accessibility, and experience with drought and conflict during the period of implementation. The rest of the regions were covered virtually.
ii. **Thematic Scope:** The thematic areas of the 9th CP covered by the CPE were the following: (I) policy and accountability; (ii) quality of care and services; (iii) gender and social norms; (iv) population change and data; (v) humanitarian action; and (vi) adolescents and youth. In addition, the evaluation covered cross-cutting issues, such as adherence to humanitarian principles; human rights; gender equality; disability inclusion; etc., and transversal functions, such as coordination; monitoring and evaluation (M&E); innovation; resource mobilization; strategic partnerships, etc. The specific evaluation questions (EQs) are listed at the beginning of each section under the findings and the assumptions for assessment are documented in the Evaluation Matrix in Annex 1.
iii. **Temporal Scope:** The evaluation covered interventions planned and/or implemented within the period of the 9th CP: July 2020-June 2025.

[1] https://www.unfpa.org/admin-resource/unfpa-evaluation-policy-2024

1.3 Evaluation approach

1.3.1 Contribution analysis and theory of change

The CPE assessed the contribution of the 9th CP in Ethiopia to the respective strategic objectives, development and humanitarian needs, and to the related international frameworks. The evaluation made use of a theory-based approach, providing a structured framework for understanding how and why the program was expected to work. This was based on a reconstructed Theory of Change (ToC), outlining the program's activities, outputs, outcomes, and impacts in a logical sequence to clarify the causal pathways through which the program was expected to achieve its desired outcomes and contribute to its related strategies. The ToC guided the evaluation design, data collection and analysis. A contribution analysis was used to assess whether and how the program contributed to observed outcomes. This entailed the following steps: (I) analysing the existing ToC (Annex 5), verifying that assumptions behind why the program is expected to work are sound; (ii) developing a reconstructed ToC; (iii) gathering the existing evidence on the theory of change, including verifying that activities of the programme were implemented and the chain of expected results occurred; (iii) assembling the contribution story and challenges to it, assessing other factors influencing the programme.

The evaluation team identified some gaps in the existing ToC, addressed in the revised ToC:

- The revised ToC captures the contribution of the 9th CP to the UNSDCF as part of the UNCT and HCT.
- The revised ToC includes risks and assumptions influencing the results.
- The revised ToC makes explicit the modes of engagement and the accelerators under the 9th CP.
- The revised ToC reflects the interdependence across the results through additional arrows interlinking outputs and outcomes.

The reconstructed ToC depicted in Figure 5 illustrates how the 9th CP aligns its results areas and strategies across the entire results chain. This ToC outlines the anticipated sequence of changes in the intervention logic of the 9th CP, demonstrating how its components were intended to generate a series of outputs and outcomes contributing to the strategic goals of UNFPA, as outlined in the UNFPA Strategic Plan 2022-2025. The analysis of the ToC involved making assumptions about how the program would deliver across the results chain and assumed that achieving transformative goals would ultimately contribute to the strategic objective, albeit not explicitly depicted. Evaluators assessed the alignment of the 9th CP with the previous Strategic Plan (2018-2021), considering that the 9th CP's implementation spanned this period. The analysis of the ToC involved identifying the mechanisms of change while considering risks, critical assumptions, and the broader implementation context that underpinned the program's logic. This process guided the Evaluation team in understanding how the program contributed to observed results and in gathering evidence to validate conclusions about its performance during implementation. Additionally, the analysis assessed the validity and adequacy of the program's outputs in achieving expected results, despite constraints within the implementation context. In the reporting phase, the Evaluation team conducted a reassessment of the ToC validity and confirmed its continued relevance, noting that assumptions and risks remained accurate. For instance, political instability affected the delivery of CPs, necessitating adaptive measures such as reprogramming to maintain critical services. The assumptions outlined in the evaluation matrix were affirmed as valid, supporting the thorough analysis and documentation of the 9th CP.

1.3.2 Methods for data collection and analysis

1.3.2.1 Evaluation Design

The evaluation design, methodology and process were consistent with the UNFPA Evaluation Handbook 2024 UNFPA'' and adhered to the standards and principles of evaluation at UNFPA, particularly utility, credibility, independence, impartiality, ethics, transparency, human rights and gender equality. Further, implementation of CPE was by the Norms and Standards, and Ethical Guidelines for Evaluators in the United Nations system and the Code of Conduct, established by the United Nations Evaluation Group. In particular, the methodology and process of the evaluation considered ethical issues including respect for dignity and diversity, fair representation, confidentiality, and avoidance of harm. The sampling criteria considered the needs of the most vulnerable groups. Data collection tools and methods ensured confidentiality, informed consent and safe data collection.

In line with the ToR, the evaluation focused on the assessment of seven evaluation criteria, with the latter two focused on humanitarian response: i. Relevance; ii. Effectiveness; iii. Efficiency; iv. Sustainability; v. Coherence; vi. Coverage; and vii. Connectedness. For each of the evaluation criteria, one or more evaluation questions were included in the ToR, resulting in a total of eight questions. For each of the eight evaluation questions, a set of assumptions was identified as part of the evaluation matrix (see Annex 1), which was used

in the assessment by the evaluation team. Aspects of the use of a human right, gender mainstreaming and disability-inclusive approach were added in the evaluation matrix under several of the evaluation questions to assess the mainstreaming of these approaches across the programme. The evaluation matrix guided data gathering, analysis and reporting in the various phases of the evaluation process.

The design of the CPE was theory-based and non-experimental given the expected descriptive and non-normative nature of the objectives and the related evaluation questions. This design was also relevant due to the time and resource constraints. This design allowed the evaluators to analyse the contributory relationship between the programme interventions and their effects on the UNFPA programme's strategy within the Ethiopian context. In summary, the approach is based on two distinct parts: a conceptual part, which concentrates on developing the theory of change or logic model and using it to guide the evaluation; and a second part that involves collecting evidence to establish whether and/or how a program intervention produced the desired changes.

Innovation practices were used to improve the quality of the evaluation process and deliverables. A participatory approach was used to enhance inclusion and participation in the evaluation process, including the inclusion of young people in the Evaluation Reference Group (ERG). Artificial intelligence was ethically utilized for proofreading and improving the readability of the final report.

1.3.2.2 Mixed Methods

The Evaluators recognized that incorporating multiple methods often results in a stronger, more comprehensive evaluation, hence the use of a mixed method approach in this evaluation. The CPE predominantly used qualitative data methods. Quantitative data was extracted from documentation to substantiate the qualitative data. The strengths of the qualitative aspect of the CPE include providing contextual data to explain complex issues and complementing quantitative data by explaining the "why" and "how" behind the "what." The qualitative component provided stories of success and failure, stories of change in implementation communities as well narrative accounts on how the 9th CP contributed to the targeted results. Considering the selected evaluation question and the objectives of the CPE, the evaluators used both primary and secondary data sources and related data collection tools. These are further elaborated upon below.

i. **Key Informant Interviews:** This process involved conducting interviews with a diverse group of stakeholders, identified in the stakeholder mapping refined in the design phase, who served as key informants, considering their specific rights, duties, needs, interests, concerns, and potential impact. The targeted individuals included staff from UNFPA CO, officials from various government ministries, representatives from United Nations agencies, donors to UNFPA, strategic partners, and both national and international NGOs serving as implementing partners[2]. The Evaluation team also conducted group interviews to gather crucial information on the progress towards the intended outputs and outcomes of the 9th CP. The Evaluation team prepared interview guides for these Key Informant Interviews (KIIs) across different thematic areas of programming. The selection of participants, the Evaluation team ensured that considerations of gender and diversity were included to capture as much gender and intersectional data as possible. During the interview sessions, the Evaluation team also explored gender issues and intersectional aspects to ensure that gender perspectives were adequately represented in the feedback. The related interview guide is presented in Annex 4.
ii. **Focus group discussions (FGD):** The Focus Group Discussions (FGDs) were strategically designed to collect information from primary beneficiaries of the programme, including those who had benefited from UNFPA capacity-building initiatives. The target group included government staff such as health workers, members of the statistics and planning department, and other ministry staff who directly benefited from the UNFPA 9th CP support. It also included adolescents, youth, and community-level beneficiaries like women, men, boys and girls who had participated in activities supported by the UNFPA 9th CP. Thematic discussion guides were developed, and information was gathered on the degree to which the program had achieved its intended results, as well as to identify any emerging needs or unintended outcomes. This method was employed due to its ability to rapidly and effectively collect data from many programme beneficiaries. It also provided additional insights into data obtained from other respondent categories. Purposive sampling was utilized to select participants for the FGDs, ensuring a balanced representation of respondents from all different socio-economic backgrounds. Each FGD consisted of at least 6-10 participants, ensuring balance in terms of gender, diversity, and focus area. During the sessions, the Evaluation team explored gender issues and intersectionality and ensured that gender perspectives and intersectional issues were adequately captured in the feedback. The related interview guide is presented in Annex 4.
iii. **Documentary review**: The collection of secondary data was facilitated through a comprehensive review of existing literature pertinent to the UNFPA 9th CP and other associated partners within the country. This included annual reviews, progress reports, midterm evaluation reports, Strategic Information System

[2] The Strategic partners are those implementing similar programmes as UNFPA and will be contacted for their relevance in the framework of implementation.

(SIS)/COARs reports, and administrative data. Throughout the review process, the team identified and accessed other key documents with the assistance of the UNFPA Ethiopia CO, in addition to related documents from other stakeholders to inform the CPE process. Moreover, the quantitative performance of the programme, as outlined by the Country Programme Development (CPD) Results Framework, was informed by documentary evidence found in various reports provided by the UNFPA Ethiopia CO. Documentary evidence played a significant role in this CPE, supplementing the limitations in accessing primary data.

iv. **Observations**: Following consultations with the UNFPA Ethiopia CO, the Evaluation team, contingent upon the prevailing circumstances, undertook site visits during the data collection phase to augment the evidence base for this CPE. These site visits served a dual purpose. First, during the observation of operations, the Evaluation team had the opportunity to observe the operations in their actual context, including the women, girls, boys and men in displacement in Tigray, GBV shelters, safe homes, Fistula treatment centres, Fistula survivors vocational centre. This first-hand experience provided valuable insights into the practical aspects of the programme's implementation and its impact on the ground. Second, the Evaluators engaged with participants of the programme activities. These interactions offered a platform to discuss the UNFPA activities in the specific locality and the results achieved thus far. These site visits not only enriched the data collected but also provided a more nuanced understanding of the programme's effectiveness and its impact on the beneficiaries.

Data Validation and Analysis: The data analysis was grounded on the synthesis and triangulation of information and data gathered through various methods from diverse sources. The analysis of the data was guided by the evaluation matrix. In addition to a systematic triangulation of data sources and data collection techniques, data validation from the CP implementation reports was conducted for performance on the indicators. A budget analysis was also conducted. Given that the data collected for this evaluation was predominantly qualitative, it formed the primary technique employed for data analysis. Content analysis was utilized to examine documentary evidence as well as qualitative data, using themes and concepts pertinent to the different evaluation questions, associated assumptions, and indicators in the evaluation. Contribution analysis was used to evaluate the degree to which the 9th CP contributed to anticipated results. Furthermore, descriptive statistics were employed to outline or summarize key characteristics of quantitative data obtained from secondary sources. As per the design, data analysis was an ongoing process throughout the first three evaluation phases: design, field, and reporting. The Evaluation team periodically held consultations on the key findings, providing insights into the programme's performance. Additionally, data validation will be pursued through regular exchanges with the UNFPA Staff and stakeholders.

1.3.3 Stakeholders consulted and sites visited

Sampling Design and Method: The Evaluation team used a non-probability sampling design, implying that certain members of the programme participants had a greater likelihood of being included in the response than others, based on their involvement and expertise in the programme implementation. Purposive and Convenience sampling were utilized.

1. **Purposive Sampling**: This method was instrumental in attracting individuals who provided comprehensive information on the programme evaluation topic under investigation. Purposive sampling aided the CPE in clustering evaluation regions based on the 9th CP components relevant to the region and respondents, including individuals representing a diverse range of opinions and who participated in programme implementation.
2. **Convenience Sampling**: This is another nonprobability sampling strategy that the CPE employed. The Evaluation team selected participants and cases that were easily accessible and readily available. This strategy was particularly useful for interviewing GBV survivors and caregivers given the sensitivity of the information gathered from them and needed prior planning to access them.

An analysis of UNFPA 9th CP documents and a stakeholder mapping conducted during the design phase identified and clustered the main evaluation stakeholders into the following groups:

1. **UNFPA Ethiopia CO Staff**: This included the management of the UNFPA Ethiopia Country Office (CO), technical specialists and associates in the thematic areas of programming of the 9th CP, and staff of operations and cross-cutting units in the CO.
2. **Government counterparts**: This group comprised officials from relevant line ministries and institutions.
3. **Implementing partners**: This category included staff from I/NGOs, Civil Society Organizations, Academic Institutions, and others in their respective areas of coverage.
4. **Direct beneficiaries**: These were individuals or groups who directly benefited from the programme, either through capacity building and development or service delivery support.
5. **Indirect beneficiaries**: This group included women of reproductive age, adolescents, and youth in communities targeted by the 9th CP. It also included clients of reproductive and maternal health services,

as well as family planning services; adolescents and youth participating in youth-led programmes and various activities and capacity-building workshops, among other indirect beneficiaries.

6. **Donors**: This group consisted of representatives from bilateral donor agencies funding interventions implemented by UNFPA and/or implementing projects in thematic areas of programming of UNFPA and geographic areas where UNFPA and its implementing partners operate.
7. **United Nations agencies**: This included the United Nations Resident Coordinator and representatives of relevant United Nations agencies, which coordinated programmes with UNFPA CO, including members of system-wide development and humanitarian coordination mechanisms, where possible and relevant.

Table 2: Summary of sampling frame

Component / Target Entity	Stakeholders[3]	Number of sessions held			Sites visited
		KII	FGD	Observation	
Government Agencies	Both at the Federal and Regional levels	38	-		Oromia, Sidama, Tigray, Addis Ababa, Amhara and Afar
Implementing Partner NGO/CSOs		22	-		Oromia, Sidama, Tigray, Addis Ababa, Amhara and Afar
UNFPA CO	Head of Programmes, SRHR Lead and Team, A&Y Lead and Team, GEWE Lead and Team, PD Lead and Team, Humanitarian team, M&E, Operation team, Resource Mobilization and Partnership	7	-		Addis Ababa
UNITED NATIONS Agencies	UN-RCO, WHO, WFP, UNITED NATIONS Women, UNDP, OCHA, UNICEF, UNHCR	8	-		Addis Ababa
Donors		4	-		
Beneficiaries	Women Group, Youth Group (boys and girls), GBV Survivors group and IDP groups and CP direct beneficiaries at government agencies		4		Oromia, Sidama, Tigray, Addis Ababa, Amhara and Afar
Observation sessions				4	Hamlin Fistula Centre, Tigray IDP Settlement, AWSAD safe house and Mums for Mums
Total		79	4	4	

[3] Refer to Annex 3 for a full list of the sampled stakeholders

1.3.4 Limitations and mitigations measures

Table 3: Evaluation limitations and mitigation measures

Types of Risk /Challenges	Limitation	Mitigation Measure
Remote data collection	This limited the extent to which the evaluation team could observe contextual aspects of the CP intervention implementation framework, in addition to the response bias that this comes with. Limited observation of the personal behaviours/reactions to the interview for further probe.	Triangulating the responses with extensive document reviews, in addition to increasing the number of respondents for variation. The evaluation team increased the number of IPs in similar thematic areas to exhaust the amount of data and responses.
New staff in the positions targeted	Staff turnover occurred over the evaluated period. Interviewees included new staff who had not witnessed the entirety of the CP cycle. In several cases, this implied a loss of institutional memory and limitations in data accessibility.	The Evaluation team not only interviewed the new staff for the period they had interacted with UNFPA CO, but also reached out to the previous position holders, which helped in verifying the evidence.
Overdependence on qualitative data for evidence	This had the potential for subjectivity in the data being collected, in addition to limiting the extent of extrapolating the evidence to reflect the bigger picture in the CO's performance on the 9th CP, given that the scope of the evaluation was national.	The Evaluation team ensured having varied respondents and different sources to enable verification of evidence. Additionally, the same interview guides were used and the same questions were asked with the same understanding of the reliability and validity of evidence. Additionally, the team used evidence from documented sources to validate the responses.
Outdated national quantitative data	The most current quantitative population-based data in Ethiopia was from the Ethiopian demographic and health survey (EDHS) and mini-EDHS which were conducted in 2016 and 2019 respectively, before the 9th CPD limited measurement of the 9th CP and SP outcomes	The Evaluators depended on the programme reports to gather achievements at output levels, and qualitatively assessed the extent to which the 9th CP outputs contributed to the achievement of the SP and CP outcomes. Additionally, at the time of the CPE the sources of data for measurement of the outcome level indicators had not been collected, and therefore could not be reported quantitatively.
Limited data disaggregation	There is a lack of disaggregated data by population groups limiting the assessment of differential results	The evaluators disaggregated findings by population groups, including the Youth, Adolescents, Women, GBV survivors, female sex and industrial workers, and their specific needs were identified and effectively assessed and addressed during KIIs and FGDs, fieldwork and report writing.
Security problem	This limited the team's access to the CP locations, limiting interactions with the beneficiaries. Regions like Somali could not be visited by the evaluation team.	The evaluation team in consultation with the UNFPA CO team organized remote data collection with the Ips. Additionally, the consultants utilized as much documentary review as possible to augment the remotely collected evidence for reliability.
Language barrier	In some instances, members of the evaluation team did not share a common language with the beneficiaries. For example, at the Tigray IDP settlement, beneficiaries primarily spoke Tigrinya.	The team was accompanied by local translators. The team ensured that there were more than two translators so that any variation could be corrected.

CHAPTER 2: COUNTRY CONTEXT

2.1 Development Challenges and National Strategies

2.1.1. Country Profile, Macroeconomic Imbalance, and Shocks

Ethiopia is a landlocked low-income country in the Horn of Africa with a total land area of 1,129,300 square kilometres. Between 2004–2019, state-led economic development resulted in exceptionally high growth rates of over 10 per cent, placing Ethiopia among the fastest-growing economies in the world. The country has adopted a federal structure based along ethnic lines. However, due to policy distortions, compounded by internal and external shocks, including the COVID-19 pandemic, Russia-Ukraine conflict, soaring global food and energy prices and conflicts in various parts of the country, GDP growth has been significantly constrained. The GDP growth rate in 2022 was only around 6 per cent (World Bank 2024). Though this GDP growth rate is not low when compared to other low-income countries, it will not be sufficient to achieve the country's development goals. In recent years, the country has experienced significant macro-imbalances and financing challenges, a sharp decline in external reserve buffers, foreign exchange shortages and a growing parallel market premium, and high inflation. Overall, the country faces an acute shortage of resources needed to finance development and reconstruction expenditures, to service debt, and to finance imports. Prospects for macroeconomic stability will depend on the outcome of the ongoing discussions/negotiations between the Government of Ethiopia and the International Monetary Fund.

The Ten Years Development Plan and the Home-Grown Economic Reform Agenda sought to prioritize reforms that would address macroeconomic distortions and unlock greater private sector participation and market orientation. However, implementation was slowed mainly due to the major conflict in the north and soaring global food and energy prices—that exacerbated macroeconomic vulnerabilities. Evidence also suggests that the benefits from growth have been unevenly distributed, urban areas in the country growing at a higher rate than rural areas. Therefore, inequality as measured by the Gini coefficient has increased (World Bank, 2020). The combination of climatic shocks, disease outbreaks, armed conflict, and economic shocks have also hampered poverty reduction efforts significantly and poverty rates are estimated to have stagnated at around the level observed in 2016. Despite significant reductions in poverty over the past few decades, the share of people living below the international poverty line (measured at $2.15 a day) was projected to stand at 24 per cent in 2022, lower than the 27 per cent recorded in 2015 (the most recent official poverty survey period) but declining at a much slower pace than in previous years (World Bank, 2022).

The recent economic growth has not been accompanied by expanding job opportunities, particularly for the youth. Job creation in the last two decades has been driven by the service sector mainly through informal self-employment in micro, small and medium enterprises in urban areas. The contribution of formal and modern services is limited. Industry remains an urban phenomenon too and suffered from job losses between 2013 and 2021 due to structural weaknesses which were worsened by the social and economic consequences of COVID-19 (World Bank, 2024)**.** Ethiopia's Human Development Index was 0.498 out of one in 2021. It is below the average of Sub-Saharan African countries (0.547), positioning Ethiopia in the low human development category. Due to this and other demographic factors, unemployment in Ethiopia which was around 4.5 per cent in 2013 has increased to 8 per cent according to the most recent Labour Force and Migration survey (ESS, 2021). Moreover, unemployment is more pronounced among females than males, among the youth than adults, in urban areas than in rural areas. Youth unemployment is much higher than the national unemployment level. Coupled with population growth and increased poverty and food insecurity, unemployment has a significant impact on growth and development at large.

In addition to the macroeconomic challenges, covariate shocks such as armed conflicts in various regions, COVID-19 related disruptions, desert locust outbreaks as well as climate and ecological related disasters such as drought, flood are undermining the developmental efforts and exacerbating macroeconomic fragility and aggravating the humanitarian crisis. The shocks, especially the conflict in Northern Ethiopia, have devastated the humanitarian situation in the country, the provision of basic service delivery and human development indicators, worsening the already low level of human development. The population dependent on humanitarian assistance is growing, becoming an unprecedented challenge for the country (28.6 million - HNO/HRP, 2023). The conflict in Northern Ethiopia has alone affected more than 14.8 million people in Tigray, Amhara and Afar regions and displaced more than 4.6 million people. The armed conflicts also caused multi-

sectoral infrastructure damage (estimated at more than 5 billion USD and predominantly in the health and education sectors) (HNO, 2024). The country is vulnerable to risks associated with climate change, epidemics, and pandemics that overlay risk drivers related to poverty and inequality, including gender inequality, exclusion, demographic pressures, unplanned urbanization, ecosystem degradation, displacement, weak institutions, and declining respect for human rights.

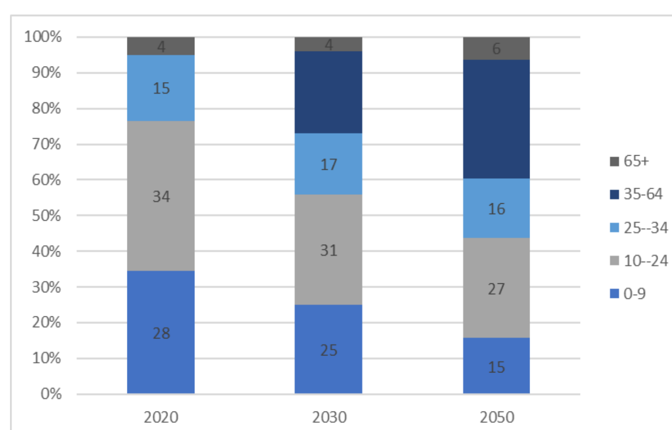
Climate shocks such as drought are magnifying the challenges to growth and development. Climate change in the coming decades could reduce the productivity of the agriculture sector, which currently employs about two-thirds of Ethiopia's workforce, including the most vulnerable groups in the population[4]. By threatening food security, climate change will also likely worsen conflict within and across regions. Higher temperatures and changes in rainfall patterns could also exacerbate the incidence of diseases such as malaria and dengue, which along with likely adverse effects of heat stress will reduce labour productivity and the prospects of human capital accumulation, both critical to sustaining growth. Climate change could also damage energy, transport, and digital infrastructure needed to support the structural transformation of the economy to industry and manufacturing.

2.1.2. Demographic and Health Trends and Challenges

With an estimated population of about 126.5 million at the beginning of 2023, Ethiopia is the second most populous nation in sub-Saharan Africa after Nigeria (World Bank, 2023). This makes Ethiopia the 11th most populous nation in the world accounting around 1.6per cent of the world population. The annual population growth rate is estimated to be around 2.6per cent which is one of the fastest growth rates in the world. Along the current path, the country's population will increase to 145.7 million by 2030 and 294 million by the end of the 21st century according to the United Nations Population Division medium-fertility scenario projections (UN, 2022). The challenge of providing adequate economic and social services for such a huge population size is understandably unimaginable. Urbanisation is increasing and around 22.1per cent of the population of Ethiopia was urban in 2023. The latest National Population and Housing Census was conducted in 2007, and the latest Demographic and Health Survey (DHS) was held in 2016, which presents a formidable challenge to get up-to-date disaggregated socio-demographic and health data.

Due to the changing demographic transition, Ethiopia's current population is characterized by a relatively large youth bulge. According to the latest Labour Force and Migration Survey, the proportion of the population aged below 15 years constituted 42.4per cent while the proportion of the youth (age 15 -29) is 26.5per cent, implying that around 70per cent of the Ethiopian population is under the age of 30 years (Ministry of Planning and Development: Ethiopian Statistics Services, 2021)**.** The population of individuals aged 15 to 29 is forecasted to increase by close to one-third by 2030[5]. As Figure 1 below demonstrates, more than 62 per cent of Ethiopia's population will be below 35 years old by 2050.

Figure 1: Projected distribution of the Ethiopian population by age group in percentage



Source: *Computed from the United Nations Population Division – 2022 Projections, Medium Variant.*

The youth bulge can be a source of economic prosperity if properly managed and harnessed but could also be a huge burden if the opportunity is missed. Conducive policies and strategies need to be put in place to

[4] HNO 2022 and 2023
[5] In 2020 an estimated 34 million people are between the ages of 15 and 29, by 2030 that number could be as high as 41 million.

reap the dividends of the demographic transition while the window of opportunity is still open. Realizing the demographic dividend requires making investments in young people enabling them to have quality education, quality health service, job opportunity, meaningful engagement in planning, decision making, and entrepreneurship among other things.

Ethiopia has reaffirmed its ICPD commitment of putting "people, planet and prosperity" at the centre of its sustainable development and leave "no one behind" (LNOB) when it adopted the 2023 Agenda for Sustainable Development Goals (SDGs). National and sectoral programmes and plans have been put in place to address the various dimensions of the population and development nexus – poverty, gender, youth, access to health and reproductive health services, family planning, and education to mention a few. For instance, the long-term national development plans have mainstreamed population issues and give due emphasis to creating a conducive environment for the fast-growing working age population to actively participate in the country's development process. The major focuses of the TYDP (2021-2030) are based on the basic principles and major components of the ICPD program of action. The components include providing care and support for the most vulnerable groups specifically children, youth, elderly persons, and people with disabilities; ensuring the provision of quality and affordable RH service and maintaining the right to access them; improving the health and well-being of citizens by reducing mortality and morbidity at all ages of the population, etc. The preparation of the TYDP was informed by the SDG need assessments. The 2022 Voluntary National Review (VNR) shows that Ethiopia has made some progress in the poverty, hunger, health, education, and gender dimensions of the SDGs through implementing a wide range of pro- poor interventions[6]. Progresses in SDG 3 and 5 are particularly relevant in the context of this evaluation. Ethiopia has made modest progress in allocating more budgetary resources to the health sector and in reducing mortality rates of both mothers and children. It has also made significant efforts to improve women empowerment and gender equality, although much remains to be done. While it has made progress in the implementation of the ICPD Programme of Action and targets in terms of policy and programme formulation, development of appropriate legal frameworks, adoption of relevant international instruments, and allocation of resources and budget, a lot remains to be done to register further achievements and address new challenges.

Ethiopia has expanded its health infrastructure and made significant gains in several health and mortality-related indicators. Significant progress has been made in reducing maternal mortality in Ethiopia, from 1,250 in 1990 to 267 per 100,000 live births by 2020 (Ministry of Health, 2023)**.** The expansion of health facilities and personnel, increased supply of life saving medicine, and the mobilization of partnerships to complement and advance the SRHR agenda are among the main contributing factors for the reduction in maternal mortality. Despite these achievements, critical maternal health indicators still remain low. For instance, skilled birth attendance remains at 62 per cent in 2023; skilled delivery reached only 68 per cent; Only 14 per cent of expected deliveries took place in functioning EmONC facilities in 2022; the rate of caesarean delivery remains low at 4.7 per cent, with high regional disparities ranging from 52 per cent in Addis Ababa to 1.2 per cent in Somali and 1.6 per cent in Afar. In addition, weak reporting and referral systems, poor quality of service delivery, inadequate health facilities due to conflict related looting and destruction are other factors that continue to challenge progress.

Programmes for adolescents and young people are also small-scale, short-lived, and fragmented, often not based on evidence due to a lack of age and sex-disaggregated data and a failure to leverage the power of young people. Only 51per cent of public health facilities provide youth friendly services. Ethiopia has made remarkable progress in controlling the HIV/AIDS pandemic over the past decade. The estimated HIV prevalence for Ethiopia for the year 2023 is estimated to be 0.87 per cent (EPHI, 2023), which is a big achievement compared to the 2.3per cent in 2002. This indicates the proportion of the population aged 15-49 years who are living with HIV. The contribution of sexual and reproductive health programs and initiatives is significant in reducing HIV transmission. While the national HIV prevalence rate of the adult population is low at about 0.8 per cent, there is wide variation by sex, age, geographic location, and population groups. For example, one-third (34 per cent) of new infections occur among women 15-29 years and a quarter of new infections occur in the age group of 0-14 years. In some urban areas, the HIV prevalence rate is very high (Gambella (3.7 per cent), Addis Ababa (3.2 per cent), Diredawa (2.7 per cent) and Harari (2.5 per cent). Suboptimal HIV case finding, especially in paediatric and adolescent age groups and in key and priority populations; testing; and service disruption due to conflicts and a high number of internally displaced people are additional challenges in this sector.

Ethiopia has also made commendable progress in the provision of family planning services. Family planning services are available in nearly all public health facilities. According to the Ministry of Health (2023) 90 per cent of health facilities offered any family planning method, and 84 per cent offered any modern family planning methods in 2022. The most widely available methods in health facilities were combined oral contraceptives and progestin-only injectables (77 per cent), implants (67 per cent), male condoms (63 per cent), and progestin-only contraceptive pills (57 per cent). There has been a dramatic increase in contraceptive prevalence rate (CPR) from 1.25 per cent in 1980, 8 per cent in 2000, to 41.4 per cent in 2016. In 1990, 94 per cent of urban and 57 per cent of rural women aged 15-49 years knew at least one type of

[6] Ministry of Planning and Development, 2022

contraceptive method. In 2016, contraceptive knowledge became nearly universal (99 per cent). Unmet contraceptive needs significantly reduced from 37 per cent in 2000 to 22.3 per cent in 2016. However, huge disparity among urban and rural communities, regions, and across socio demographic groups is a cause for concern. Adolescents residing in Afar and especially in Somali had significantly lower likelihood of exposure to family planning information than all the other regions (MOWCY, UNICEF and SRI, 2019). The Ethiopian Government has formulated the Health Sector Transformation Plan (HSTP II) that identified family planning (FP) and maternal health as one of the priority areas and realize the vision of providing UHC by 2035 through primary health care.

Fertility plays a major role in shaping the population structure of any country. The total fertility rate has declined by nearly 2-fold from 7.7 in the 1990s to 4.1 in 2022, which resulted in the country being grouped among countries with the most considerable reductions in total fertility rate. The fertility decline is a result of several achievements among which the expansion of health services, rapid improvements in education levels for women, reductions in infant and child mortality, and reductions in child marriage are the prominent ones. However, family planning in the country continues to be challenged by both the demand and supply factors, among others: inadequate provider competence and high staff turnover, limited health provider commitment and motivation, inadequate domestic financing for family planning, shortage/interruption in the supply of family planning commodities; lack of adequate youth-friendly service for Adolescents and Youth Health; and cultural and religious barriers compounded by deep-rooted misconceptions and rumours on FP. The youth in Ethiopia is one of the most affected populations with the conflict in the country.[7] The conflict is coupled with economic disintegration and social fragmentation, leaving the Ethiopian youth feeling overwhelmed and insecure about their future[8][9].

2.1.3. Gender and Social Inclusion Issues

Inclusion and empowering various sections of the society and enabling them to benefit from economic development is considered as one of the intervention areas of the TYDP (Ministry of Planning and Development, 2021). Strengthening the participation of women, children, the youth, the elderly, people with disabilities and all vulnerable groups in the county's social, economic, and cultural affairs and safeguarding their security and rights are critical areas of intervention. Ethiopia has made progress on several dimensions of gender equality and women's empowerment (GEWE). The prevalence of Female Genital Mutilation (FGM) among women aged 15-49 nationally declined from 80 per cent in 2000 to 65 per cent in 2016, with variations across age groups. EDHS 2016 indicates a significant generational reduction in child marriage, with 61.3 per cent of women aged 30-34 who were first married by 18 years old compared to 40.3 per cent of women aged 20-24 (Central Statistical Agency, 2016). The Ethiopian Government has initiated several strategies to prevent gender-based harmful practices, including the promulgation of the criminal code prohibiting FGM, the revised abortion law, the National Strategy on Harmful Traditional Practices against Women and Children and the National Costed Roadmap to End Child Marriage and FGM. However, many forms of GBV and harmful practices are still highly prevalent in Ethiopia. Restricted access to resources and limited community participation are still prevalent in many parts of Ethiopia. EDHS data (2016) show that 23 per cent of women aged 15-49 have encountered physical violence, while 10 per cent have faced sexual violence since reaching the age of 15. The report by UNICEF and Ministry of Women, Children and Youth (2019) also indicated that one in three women experienced physical, emotional or sexual violence in their lifetime, and 65 per cent of women have experienced female genital mutilation (Ministry of Women, Children and Youth, UNICEF Ethiopia and SPRI, 2019). Multiple forms of GBV, including conflict-related sexual violence (CRSV), continue to occur. Teenage pregnancy is also significantly high at 13.6 per cent, contributing to maternal death and limiting the opportunities for young girls to realize their potential.

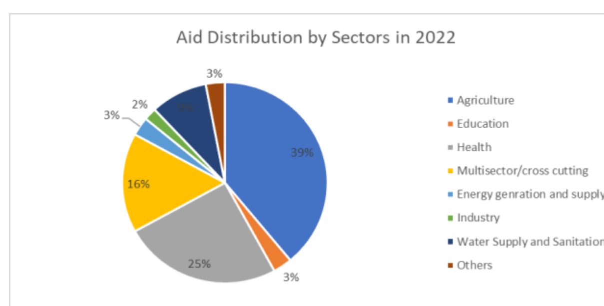
The current conflicts and resulting humanitarian crisis have aggravated the risks and increased the vulnerabilities to GBV. Other challenges include the following among others: (i) the absence of a systematic data collection system for GBV, (ii) inadequate funding for GBV, including child marriage and FGM programs, (iii) inadequate GBV coordination staff, (iv) limited grass root presence to address social and gender norms that perpetuate GBV and HP lack of capacity of local women-led organizations that have relatively better grass root presence to implement GBV prevention and response interventions and (v) vulnerabilities caused by protracted crises in the different parts of the country. The minimum age for marriage in some regions is against the federal constitution, family code, and United Nations Child Rights Convention. In Ethiopia, 65 per cent of girls are affected by FGM. Child marriage is a significant concern in the country, with 14 per cent of girls married by age 15 and 40 per cent by age 18. The Amhara region has an even higher child marriage rate at 45 per cent, exceeding the national average.

[7] interviews and document reviews
[8] UNFPA. World Population Dashboard Ethiopia. 2024. https://www.unfpa.org/data/world-population/ET. Accessed 12 July 2024.
[9] Admassu, T.W., Wolde, Y.T. & Kaba, M. Ethiopia has a long way to go meeting adolescent and youth sexual reproductive health needs. *Reprod Health* 19 (Suppl 1), 130 (2022). https://doi.org/10.1186/s12978-022-01445-3

2.2. The Role of External Assistance

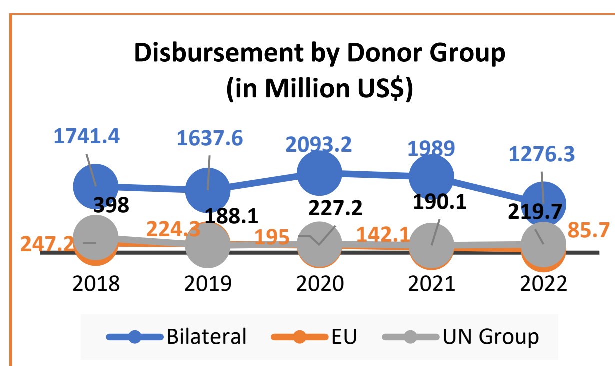
Ethiopia has a long history of receiving foreign aid. Due to recurrent droughts, fast population growth, huge and growing balance of payments deficits, and a largely stagnant economy, the importance of development assistance grew steadily over the last few decades. The net official development assistance received as per cent of GDP was 3.9 per cent in 2022. Official development assistance is expected to enhance domestic resource mobilization capacity, promote private sector financing for sustainable development of the country, improve trade performance and facilitate integration into the world economy. Given the increasing investment needs of the country, external resources remain vital to bridge the financial gap in the implementation of the country's development goals. Between 2018 and 2022, Development Partners have committed around US$20.8 billion out of which US$17.5 billion has been disbursed (Ministry of Finance, 2022). During 2021/22 fiscal year, development partners disbursed USD 3.2 billion for development projects/programs and humanitarian activities. From this amount, Multilateral and Bilateral Development Partners committed USD 2.7 billion (73.4per cent) and (26.6 per cent), respectively. Agriculture, health, and cross-cutting sectors[10] are the top three sectors receiving 38.5per cent, 24.8per cent, and 15.8per cent of total commitments, respectively.

Figure 2: Development aid disbursed in 2021/22



***Source**: Ministry of Finance, Ethiopia*

Figure 3: Disbursement by donor agency



***Source**: Ministry of Finance, Ethiopia*

Budget disbursement through government channels in the form of direct budget support or through NGOs or State actors of humanitarian activities by donor agencies shows a declining trend particularly during the last few years because of political instability and the Northern Ethiopia conflict. The disbursement by the top development partners during the last few years is presented in Figure 3 above. However, both commitments and disbursements from donors, through bilateral, multilateral, and other channels recently showed a declining trend. The internal conflict in the northern part of the country and instability in the other parts of the country, coupled with the economic impact of COVID-19, negatively impacted the disbursements of development partners. As a result, the implementation of development projects has been delayed, some contracts were cancelled, and some partners have shifted their support from programmatic and direct budget support to humanitarian and emergency assistance, which has huge implications on health and other sectors. Such declining trends in external assistance would thus make countries like Ethiopia compromise towards achieving global and regional goals. Even though the Government has committed to allocate more than two-thirds of the country's budget to pro-poor sectors such as road, education, agriculture, water and sanitation, and health, in line its commitment of boosting resilience, concerted and enhanced support from development partners is required both to continue to maintain the pro-poor expenditure and financing the recovery and reconstruction of basic services damaged during the conflict.

[10] This reflects those activities that span a range of sectors and also tend to span multiple countries. These include research and policy for instance.

CHAPTER 3: THE UNITED NATIONS AND UNFPA RESPONSE

3.1. United Nations and UNFPA strategic response

The United Nations expressed their commitment to reducing the global maternal mortality ratio to less than 70 per 100,000 live births (SDG target 3.1); ensuring universal access to SRH, including FP, information and education, and integration of reproductive health into national strategies and programmes (SDG target 3.7); achieving universal health coverage, including financial risk protection without compromising the quality of essential health care services (SDG target 3.8); ensuring equal access to both women and men aged 15 years and older to SRHR services, information and education (SDG target 5.6), legislating and enforcing policies for the promotion of GEWE (5.c); eliminating all forms of violence against women and girls in the public and private spheres (SDG target 5.2); and eliminating all harmful practices, including child, early and forced marriage and female genital mutilation (SDG target 5.2).

The Strategic Plan (2022-2025) is the second of three consecutive plans through which UNFPA will contribute to the achievement of the Sustainable Development Goals (SDGs), in particular good health and well-being (Goal 3), the achievement of gender equality and the empowerment of women and girls (Goal 5), the reduction of inequality within and among countries (Goal 10), and peace, justice and strong institutions (Goal 16). In line with the vision of the 2030 Agenda for Sustainable Development, UNFPA seeks to ensure that no one will be left behind and that the furthest behind will be reached first. Informed by the International Conference on Population and Development (ICPD) – held in Cairo in 1994, the Strategic Plan focuses on four outcome areas of sexual and reproductive health, adolescents and youth, gender equality and the empowerment of women (GEWE), and population dynamics. The ICPD placed population and development issues within a human rights-based framework, and UNFPA is committed to integrating human rights into its work globally. The Strategic Plan also responds to other global frameworks underpinning the 2030 Agenda, including the Sendai Framework for Disaster Risk Reduction 2015 – 2030 of the Third United Nations World Conference on Disaster Risk Reduction, the 2015 Paris Agreement on climate change, and the 2015 Addis Ababa Action Agenda of the Third International Conference on Financing for Development.

Building on ongoing collaboration among United Nations organizations, UNFPA contributes to strengthening inter-agency policy and programming approaches that are cross-cutting and able to address complex, multidimensional issues. As a member of the UNCT, UNFPA works with other United Nations agencies and other stakeholders' development to monitor and assess the progress achieved against the UNSDCF (2020-2023) outcomes. In humanitarian contexts, inter-agency accountabilities will be detailed through mechanisms such as the common humanitarian action plan, the consolidated appeal process, the inter-agency flash appeal and the transitional or early recovery appeal process.

3.2. UNFPA Response through Country Programmes

3.2.1. Brief description of UNFPA previous programme cycle, goals and achievements

UNFPA Ethiopia implemented its 8th CP covering the period from 1st July 2016 to 30 June 2020. The CP was designed and implemented to contribute to the United Nations Development Assistance Framework (UNDAF) 2016-2020 for Ethiopia. It was also guided by the goals and targets of the ICPD Programme of Action, SDG Agenda 2030, and UNFPA Strategic Plans. The 8th CP targeted goal was to realize the achievement of universal access to sexual and reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the International Conference on Population and Development agenda. This was to be achieved through four outcome areas covering SRHR, GEWE, Adolescent and Youth, and Population dynamics components and was further targeted for realization through six outputs. distributed across the component. Humanitarian and resilience-building interventions were integrated as cross-cutting themes across the outcome areas.

The 8th CP achievements by outcome areas included the following:

- **Outcome 1 (SRHR):** The 8th CP contributed to improved delivery of integrated SRH, BEmONC, EmONC and fistula repair services in the targeted operational woredas. Additionally, it contributed to the

strengthened capacity of healthcare workers and health systems which further contributed to ensuring improved availability and accessibility of quality SRH services.

- **Outcome 2 (Adolescent and Youth):** The 8th CP contributed to youth empowerment and engagement of youth in community education on SRHR results including HIV prevention and control, and gender; and further enabled the youth in targeted districts to access social spaces and engage in social, educational and cultural activities.
- **Outcome 3 (GEWE):** The 8th CP effectively contributed to enhanced awareness raising on gender issues and harmful social practices in the country and the need to mainstream gender in national plans. The CP further supported advocacy and awareness strategies that contributed to improved knowledge on gender inequality, GBV issues, FGM and child marriage, thereby leading to community commitments for the abandonment of FGM and ending early child marriage. The 8th CP's support effectively responded to the needs of the GBV survivors and the provision of comprehensive services in the developmental and humanitarian settings, leading to awareness raising and the establishment of protection groups, which contributed to GBV survivors getting support at the community level and access to the relevant services at the health centres, One Stop Centres and Safe Spaces.
- **Outcome 4 (Population Dynamics):** The 8th CP contributed to the improvement of data quality, production and availability through enhancement of technical capacities, techniques and strategies for the collection of population data. However, serial postponement of the census exercise is a serious issue.

3.2.2. The current UNFPA country programme and an analysis of its theory of change

Following the findings and recommendations of the 8th CPE, the 9th CP was developed in consultation with the Government of Ethiopia's relevant sector ministries, civil society organizations (CSO), academia, bilateral and multilateral development partners (including sister United Nations organizations), and the private sector. Its focus areas were drawn from the UNFPA global Strategic Plan (2022-2025), the Sustainable Development Goals (reducing maternal deaths, ensuring universal access to SRH services, eliminating all forms of violence and harmful practices against women and girls), the International Conference on Population and Development (ICPD) Programme of Action, and the Health Sector Transformation Plan (HSTP II, 2020-2025). From a policy perspective, the 9th CP is aligned with the United Nations Sustainable Development Cooperation Framework for Ethiopia (2020-2025), the Ethiopian Government's Home-Grown Economic Reform Agenda, and the 10-Year Perspective Development Plan. The overall goal of the 9th CP is ensuring universal access to SRH and reproductive rights (SRHR) and accelerating the implementation of the ICPD Programme of Action, and as a long-term plan, achieving UNFPA Transformative Results (ending preventable maternal deaths, ending unmet need for FP, ending GBV and harmful practices, and ending new HIV infection).

The CP operates centrally (from the Country Office) and regionally (through coordinating offices at regional state levels). The implementation sites of the 9th CP in 2024 are 248 Woredas in ten regions and Addis Ababa. Intervention sites and programme selection are based on national data/demand and UNFPA areas of interest. As before, during the implementation of the 9th CP, UNFPA is engaged in policy document development, national and regional humanitarian programme coordination, and technical support to the line ministries and regional health bureaus. Given the country's situation is favourable; UNFPA is committed to influence the government policy through generating population-based evidence and advocacy for integrated and comprehensive SRHR. UNFPA works towards the inclusion of SRH and GBV in the preparedness and response interventions and ensures the availability of SRH commodities and care for GBV survivors in all settings. Establishing one-stop centres, safe houses, and maternity waiting homes and ensuring their functionality are in the domain activities of the 9th CP.

The 9th CP has been implemented both directly and through implementing partners, in coordination and strategic partnership with the Government of Ethiopia line ministries and regional bureaus. Among government line ministries involved are the following: the Ministry of Health, the Ministry of Women and Social Affairs, the Ministry of Finance, the Federal Supreme Court and the Ministry of Planning and Development. There is also a long list of implementing partners from NGOs, professional associations, charity organizations and faith-based organizations. UNFPA Country Office conducts global procurement of SRH commodities, higher education capacity building, human resources for health development, national health facility and community-based surveys, and high-level national advocacies and policy assessments.[2]

During the alignment of the 9th CP with the UNFPA global strategic plan, the number of outputs was reduced from eight to six. UNFPA global Strategic Plan was taken as a guide for development of the revised 9th CP outputs as highlighted below. The primary focus of Output 1 (policy and accountability) of the global strategic plan is on integration of SRHR, as well as the prevention of and response to GBV and harmful practices, into UHC-related policies, plans, and accountability frameworks, which is addressed in different outputs of the revised 9th CP. Therefore, it was not separately addressed in the aligned 9th CP.

Strategic Plan Output 2: [Quality of care and services]

9th CP Output 1. "Effective supply chain strengthened for ensuring availability of sexual and reproductive health commodities at all service delivery points including in humanitarian settings."
The 9th CP planned to support the availability of quality-assured life-saving reproductive health drugs and FP commodities in all settings and advocate sustainable financing of reproductive health commodities. As a result, (according to the UNFPA 2022 national survey) primary service delivery points (SDP) with 'no stock-out' of any modern contraceptive method and RH kits delivery to SRH service providing health facilities in humanitarian settings will be double the baseline.

9th CP Output 2. "Comprehensive sexual and reproductive health service provision improved and uptake increased in all settings."
The 9th CP intended to support (a) guiding a multi-year plan for comprehensive SRH services within the larger framework of UHC; (b) strengthening the capacity of health facilities on maternal and perinatal death surveillance and response (MPDSR); (c) strengthening the capacity of health facilities to provide comprehensive SRH services in all settings; and (d) increasing provision of treatment for women and girls with obstetric fistula.

Strategic Plan Output 3: [Gender and social norms]

9th CP Output 3. "Strengthened capacity of government and key stakeholders on prevention, protection of GBV, and provision of services to survivors of GBV and to eliminate harmful practices in all settings."
Strengthening multi-sectoral capacity was planned to protect women and girls from GBV and provide services for GBV survivors in all settings. For this effect, supporting institutionalized engagement of multiple stakeholders (including CSO, faith-based organizations, and men and boys), national accountability mechanism in line with women and girls' rights standards, and prevention and protection of child marriage and FGM. The set targets (among others) are doubling the comprehensive SRH services and young girls (10-19 years) protected from marriage and FGM.

Strategic Plan Output 4: [Population changes and data]

9th CP Output 4. "Strengthened data systems and evidence that take into account population changes and other megatrends (including aging and climate change), in development policies and programmes, especially those related to sexual and reproductive health and reproductive rights."
Supporting evidence-based policy dialogue on population dynamics and its inter-linkages and tracking of SRH and GBV indicators in the national SDGs monitoring and evaluation framework were planned. Furthermore, strengthening the national capacity for production, analysis, use and dissemination of high-quality disaggregated population data in all settings was the 9th CP plan. As the demographic transition (youth bulging) is visible from the serial population pyramids,[21] the 9th CP has supported the development of the roadmap for the Ethiopian demographic dividend. Conducting the fourth Population and Housing census, the fifth DHS, third EmONC health facility survey, gender and vital statistics, supporting the MPDSR, and establishing a regional web-based integrated management information system (IMIS) and knowledge platforms were planned for execution during the 9th CP.

Strategic Plan Output 5: [Humanitarian action]

9th CP Output 5. "National and regional service delivery systems have strengthened capacity to provide lifesaving sexual and reproductive health and gender-based Violence information and services for populations affected by Crisis."
The 9th CP aims to mainstream SRH services, GBV prevention and management, and HIV prevention in the national and regional emergency preparedness and response. UNFPA has expressed its commitment to provide SRH commodities and related training to improve access to services for most vulnerable groups in regions affected by humanitarian emergencies. The UNFPA strategies for humanitarian response include but not limited to reaching to and delivering lifesaving SRH and GBV services for crisis-affected populations within 48 hours of the crisis by applying the objectives of minimum initial service package (MISP) for RH, supporting the transitions to comprehensive SRH and GBV services, and involving young people in decision-making and peacebuilding across the humanitarian programme cycle.

Strategic Plan Output 6: [Adolescents and youth]

9th CP Output 6. "Adolescents and youth, particularly those most vulnerable, are equipped with skills & knowledge to make informed choices about their SRH and rights within an enabling environment that promotes adolescent health and wellbeing."
The 9th CP intends to equip adolescents and youth with skills and knowledge to make informed choices about their SRHR and engage them in leadership exercises and humanitarian interventions. Supporting adolescent and youth life skills development and comprehensive sexuality education through youth-serving platforms (including youth centres) and engaging young people in policy development are among the detailed activities focusing on adolescent and youth development. The life skills development programmes as well intended to

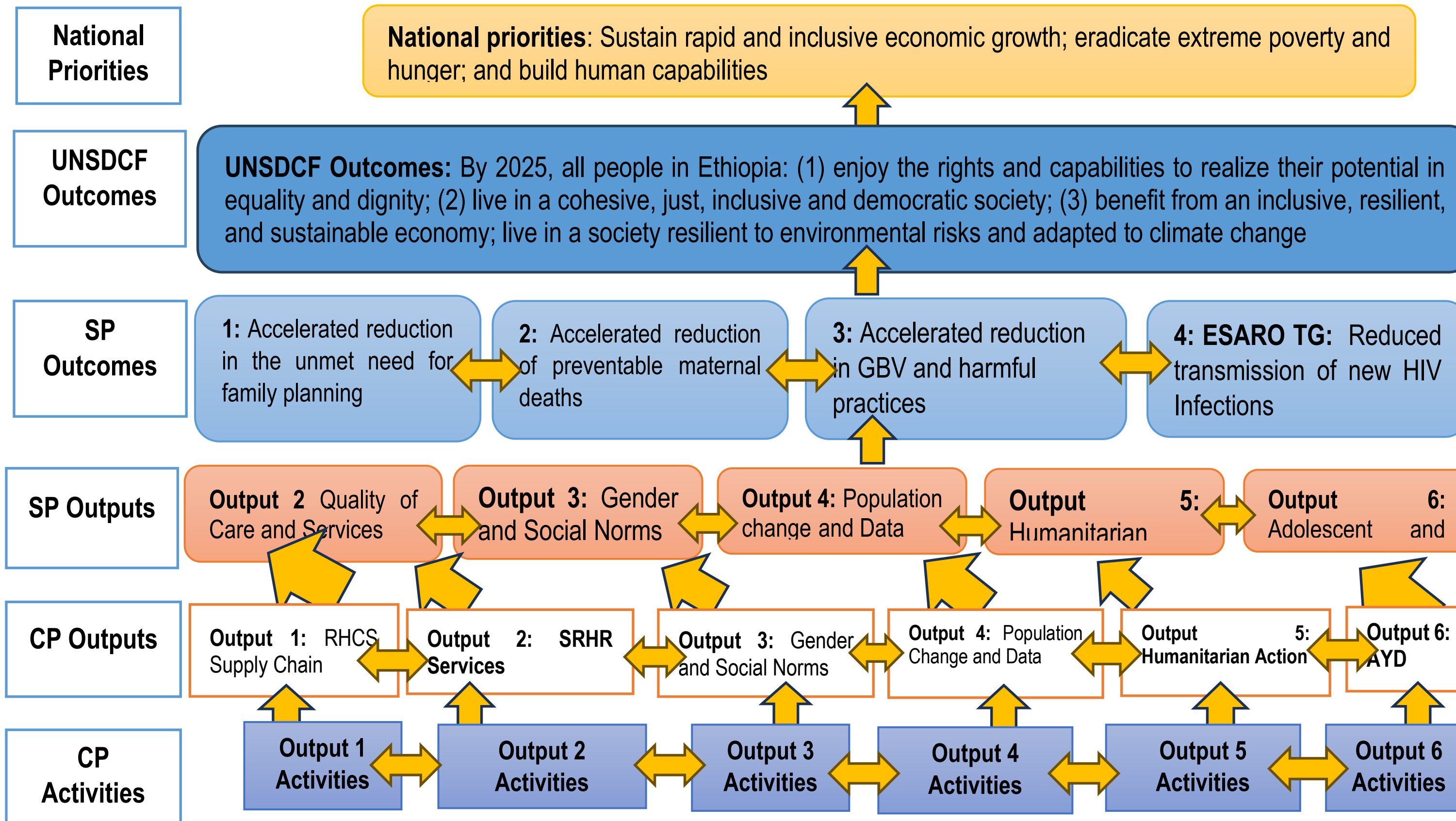
reach vulnerable adolescents and youth (marginalized, disabled displaced, and destitute). Integration of the SRHR of adolescents and youth in at least two sectors (beyond the health sector) was planned.

As at the time of the CPE, the CO continued to implement the activities of the 9th CP, with most of the interventions already implemented. Ongoing activities, such as advocacy and lifesaving services, continued at the implementation sites. The achievements and status of implementation are presented in Section 4.3.

The 9th CP Theory of Change

The Theory of Change (ToC) for the 9th CP was reconstructed during the design phase to illustrate the changes across the logic chain. This reconstruction was intended to guide the assessment of how results were derived from the implementation of the 9th CP interventions. The adequacy of the existing CP ToC (see Annex 5) was evaluated to ensure the sufficiency of the result flow across the intervention logic. Following the realignment of the CP with the new Strategic Plan 2022–2025, the revised ToC incorporated the Humanitarian Response output, which was not part of the original 9th CP. The causal links across the result pathways clarified the expected outcomes and the interactions among the interventions and outputs. The reconstructed ToC provided guidance for both the field and reporting phases and considered the assumptions and risks associated with achieving the results. The ToC was also framed within the context of the UNFPA Strategic Plan 2022–2025, incorporating modes of engagement and result accelerators. The results of the 9th CP were defined to contribute to various pathways, including the UNFPA Strategic Plan results, the UNSDCF, and National Development Plans. This alignment was informed by reporting mechanisms that included both COARs sent directly to UNFPA, and reports submitted to the Government through the UNSDCF. It may be beneficial to evaluate the pathways independently in the next program cycle. The reconstructed ToC is illustrated in Figure 4 below.

Figure 4: The reconstructed theory of change



3.2.3. The 9th Country Programme Financial Structure

The financial structure for the 9th CP is broadly categorized as: 1) Regular (Core) resources and 2) Other (Non-core or Co-financing) resources. The plan for mobilizing resources in the 9th CP was 112 million US dollars for the period starting July 2020 to June 2025. The 9th CP budget allocation was annually structured around the five output areas (including humanitarian response which was cross-cutting at the time) under the four Strategic Plan Outcomes including SRH, Adolescent and Youth, GEWE and Population dynamics. The indicative budget for the original CP is presented in Table 4 below.

During the period of review, the 9th CP was reviewed to align with the Strategic Plan output areas, changing the number of outputs from five to six, and introducing an output on Humanitarian response. The financial data from the CO for the first 4 years of the 9th CP (2020-2024) shows that the yearly budget amounts allocated had been incremental from the year 2020 up to the year 2023, with a reduction in 2024, though taking into consideration that the 2024 budget was only allocated to the extent of what had been committed at the time of the CPE. The distribution is as follows in Table 5 below.

Table 4: Proposed indicative assistance (in millions of $ by SP outcome and sources)

Strategic Plan Outcome Areas	Regular Resource	Other Resource	Total
Outcome: SRH	10.7	33.0	43.7
Outcome 2 Adolescents and youth	3.3	23.0	26.3
Outcome 3: GEWE	2.7	24.0	26.7
Outcome 4 Population dynamics	3.8	10.0	13.8
	1.5		1.5
Total	22.0	90.0	112.0

***Source**: UNFPA Ethiopia Financial Data.*

Table 5: Budget allocation per output per year of the 9th CP

9th CP Output	**9th CP Year Budget amount in USD**				
	2020	**2021**	**2022**	**2023**	**2024**
Output 1	2,040,899	1,477,753	1,171,396	3,980,310	334,683
Output 2	2,156,782	3,507,366	3,735,996	4,290,126	2,404,695
Output 3	2,737,708	5,712,465	5,102,271	4,206,346	3,347,439
Output 4	413,924	763,284	1,902,134	1,396,682	1,232,980
Output 5	3,318,425	10,201,720	19,065,005	27,071,344	14,484,256
Output 6	1,973,360	3,020,061	2,496,844	3,405,825	2,487,895
Total Budget	**12,641,098**	**24,682,649**	**33,473,646**	**44,350,633**	**24,291,948**

***Source**: UNFPA Ethiopia Financial Data as of June 2024.*

The budget expenditure across the 9th CP indicated that the budget utilization rate improved linearly from 83.3 per cent in 2020 to 92.7 per cent in 2023 which shows considerable progress in budget management. On the other hand, the budget rates in 2024 were low because while funds had been advanced to the Implementing partners for 2024, at the time of the CPE were yet to report on the 2024 expenditures. This is likely to improve when they report. The analysis of expenditure of funds by output levels during the period 2020 to 2024 shows that the funds were mostly (50 per cent) spent to achieve the Humanitarian output. The next high expenditure (17 per cent) was on GBV and Harmful Practices. This was closely followed by the expenditure on Comprehensive Sexual and Reproductive Health Rights (12 per cent). Adolescents and Youth took 9per cent, while Family Planning services took 8per cent. The lowest allocation (4 per cent) was made for PD-related activities. It should however be noted that even the humanitarian response directly supported interventions on SRH, GEWE, adolescents and youth, and population dynamics.

Table 6 presents the budget utilization by output area and year. It is also notable that almost all the FP commodities delivered to implementing partners (Ips) were in-kind donations where the money did not come to the CO. The value of the FP and related commodities delivered was USD 29,504,332.18 with CYP of 9,113,216 from July 1, 2020, to December 31, 2023.

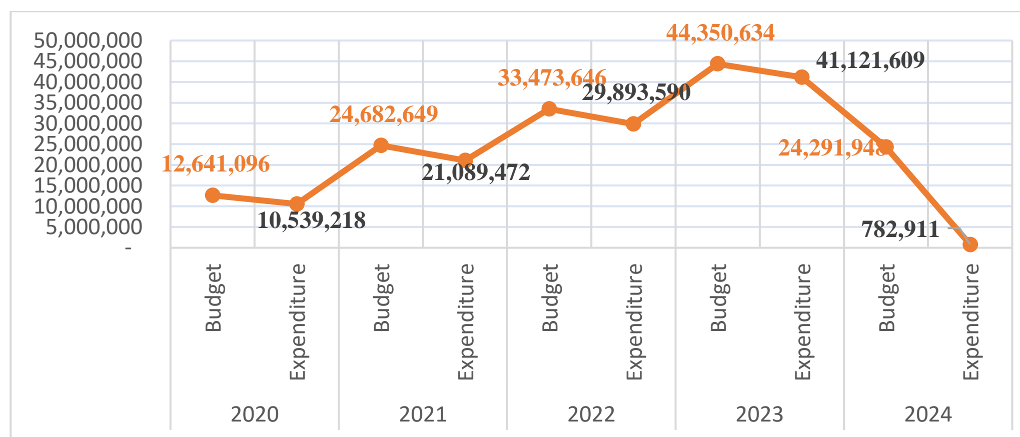
Table 6: Budget utilization rate by output and year

Output	2020			2021			2022			2023			2024		
	Budget	Expenditure	rate (per cent)	Budget	Expenditure	rate (per cent)	Budget	Expenditure.	rate (per cent)	Budget	Expenditure.	rate (per cent)	Budget	Expenditure.	rate (per cent)
1	2,040,899	1,865,776	91	1,477,753	1,448,308	98	1,171,396	1,138,089	97	3,980,310	3,829,163	96	334,683	7,460	2
2	2,156,782	1,570,067	73	3,507,366	3,222,020	92	3,735,996	3,575,198	96	4,290,126	3,693,866	86	2,404,695	336,997	14
3	2,737,708	2,290,096	84	5,712,465	5,741,398	101	5,102,271	4,956,380	97	4,206,346	4,100,619	97	3,347,439	57,420	2
4	413,924	383,545	93	763,284	724,406	95	1,902,134	1,548,626	81	1,396,682	1,284,380	92	1,232,980	48,830	4
5	3,318,425	2,951,947	89	10,201,720	7,237,203	71	19,065,005	16,479,909	86	27,071,344	25,264,333	93	14,484,256	308,489	2
6	1,973,360	1,477,787	75	3,020,061	2,716,137	90	2,496,844	2,195,389	88	3,405,825	2,949,246	87	2,487,895	23,714	1
Total			83.3			85.4			89.3			92.7			3.2

***Source**: UNFPA Ethiopia Financial Data as of June 2024.*

Figure 5 below presents a comparison between the budget allocation by year. The incremental amounts of the budget allocations by year show the CO's efforts in resource mobilization to respond to the identified needs. The CO made excellent headway largely owing to the humanitarian situation.

Figure 5: 9th CP budget and expenditure amounts by year



***Source**: UNFPA Ethiopia Financial Data as of June 2024.*

CHAPTER 4: FINDINGS

4.1 Relevance: Answer to Evaluation Question 1

EQ 1: To what extent is the country programme adapted to (i) the needs of diverse populations, including the needs and participation of vulnerable and marginalized groups; (ii) national development strategies and policies; (iii) the strategic direction and objectives of UNFPA; and (iv) priorities articulated in international frameworks and agreements, in particular the ICPD Programme of Action and the SDGs, (v) The flexibility to accommodate shifts caused by crises or major political changes.

Summary of the Findings:

The 9th CP addressed the country's development and humanitarian priorities espoused in the Ten Years Development Plan (2021-2030) and the Home-Grown Economic Reform Programme (2023-2025), and contributed to sectoral strategies, guided by the line ministries. The CP's SRH component was also integrated into the UHC policies and plans, directly contributing to addressing the national needs of marginalized and vulnerable women and girls among the target populations. The CP design and implementation was fully aligned to the UNFPA Strategic Plan 2018 – 2021 and 2022 - 2025, the UNSCDF, ICPD Programme of Action and SDGs (particularly Goals 1, 3, 5, 10, 13, 16 and 17), and were also informed by the 8th CPE results. Evidence also revealed consultation upheld in the design and implementation of the programme, especially with the government and IPs, ensuring direct contribution to the national strategies, and ownership. The 9th CP was responsive to changing national needs and environment especially during COVID-19 and the eruption of armed conflict in Tigray and other regions, where UNFPA was instrumental as part of the UNCT and HCT to contribute to the response, in addition to reprogramming to adapt to the context of the pandemic, ensuring realization of results. While there was widely reported engagement of the most vulnerable and marginalized populations during the CP implementation, there was little evidence of how the design of the CP benefited from consulting them to effectively reflect on their needs. Further, the inadequate financial capacity of the government also limits the leveraging of resources for greater results.

For details of the evidence supporting findings in section 4.1, see Evaluation Matrix, Assumptions 1.1, 1.2, 1.3, and 1.4 (Annex 1)

4.1.1 Alignment of the CP to the National Strategies and Policies, and Adaptation to the needs of diverse populations, including vulnerable and marginalized groups

Interviews with various government, UNFPA and implementing partner staff and document review revealed that the 9th CP was well adapted to address the federal and regional government priorities and population needs[11]. The 9th CP was aligned with the Government of Ethiopia's 10-year Perspective Development Plan (2021 – 2030), in addition to the Home-grown Economic Reform Development Plan, the Pathway to Prosperity 2021 – 2030, especially in contributing to SRH, adolescent and youth, and populations needs, including addressing GBV. The programme contributed to strengthening statistics and data generation systems which are key for providing evidence for development.

The thematic focus of the 9th CP was particularly contained in the strategies of the line ministries including the Ministry of Health, Ministry of Women and Social Affairs, Ministry of Planning and Development, and agencies of the ministries including thematic regional bureaus. Additionally, the 9th CP was implemented in collaboration and consultation with the various line ministries, directly contributing to their respective objectives, and making it relevant to the national needs. It is also imperative to note that the CP was implemented through the coordination of the Federal Ministry of Finance which was instrumental in the disbursement of CP resources to the line ministries and bureaus according to the approved annual work plans (AWPs) which were prepared based on the national and regional priorities and approved by the Government of Ethiopia[12]. Interviews also revealed that the 9th CPD and related interventions were developed and implemented in close consultation with the Government. Document reviews also indicated that the national and regional governments line ministries and bureaus respectively and related agencies, were UNFPA CO's implementing partners confirming the contribution of the programme to the national priorities. Interviews and document reviews also confirmed that UNFPA interventions complemented those delivered by the Government, in addition to being delivered through government institutions. Further, interviews and document reviews confirmed that the design and implementation of the 9th CP utilized experiences from the 8th CP as documented in the 8th CPE. The relevance of the 9th CP is also explained

[11] Interviews with Government of Ethiopia; UNFPA CO and IPs staff and review of COARs and CPD (including the alignment document).
[12] Interviews, COARs and AWP reviews.

under each of the components. These included SRH, GEWE, Population Dynamics, and Adolescent and Youth, which are explained in the sections that follow.

4.1.1.1 Sexual and Reproductive Health and Rights

Interviews and review of documents indicate that the development of the 9th CP SRH component interventions was in alignment with the Government of Ethiopia strategies and priorities. The strategic documents contributing to the 9th CP include the 2005 liberalized revised abortion law (that permits safe abortion for rape, incest, foetal anomaly, or maternal disability), the Health Sector Transformation Plan (HSTP) I and II (2015-2020, 2021-2025), the National obstetric fistula elimination strategies (2015-2020, 2021-2025), National reproductive health (RH) strategies (2016-2020, 2021-2025), National guidelines for family planning (2020, 3rd edition), National RH commodity security strategy (2022-2026). Regional disparity on the targeted intervention on comprehensive abortion care (CAC) area was also considered during the development and implementation of the 9th CP[13].

At the time of the 9th CP development, the maternal mortality ratio was 267 per 100,000 live births and neonatal mortality rate was 20 per 1000 live births, with the maternal deaths among adolescents and young women being high and the unmet need for contraception being high with only about 41 per cent of married women aged 15-49 years using modern methods of family planning. On the other hand, unsafe abortion contributed to 10per cent of maternal deaths, with new cases of obstetric fistula (OF) recorded annually, in addition to a recorded backlog of 37,000 cases[14]. To contribute to increased SRH service provision and building on the experiences from the implementation of the 8th CP by UNFPA, the 9th CP supported the implementation of the multi-year plan for SRH within the UHC framework, strengthening capacities of health facilities on MPDSR and provision of comprehensive SRH services including EmONC, cervical cancer prevention, HIV prevention, and STI prevention and treatment, and increased identification and treatment of obstetric fistula. UNFPA was instrumental in ensuring an effective supply chain for SRH commodities, the CP supported increased availability of quality-assured lifesaving SRH drugs and FP commodities and continued the advocacy for sustainable financing of RH commodities in the country. Additionally, UNFPA supported surveys on the availability of RH commodities and at SDPs and supported supplies and capacities of staff to ensure access and last-mile availability of RH commodities giving priorities to areas with stockouts[15]. The CP interventions addressed the very common SRH challenges as they were critically relevant in the country.

UNFPA ensured reaching hard-to-reach areas for SRH services by selecting intervention woredas with low coverage and lack of support from other development partners in the area, inclusive capacity building, contributing to the health extension programme (HEP) optimization and reactivation, and deploying mobile health teams. In the HEP package, SRH (maternal and newborn health and family planning) issues were top priorities, and health extension workers (HEW) were critically relevant to reach inaccessible communities and UNFPA continued to support the HEP. UNFPA was also strategic in addressing highly related problems of its thematic areas through the integration of SRH services with GBV services, HIV/STI prevention, and adolescent and youth development (AYD) programmes in the woredas of intervention[16].

Interviews and reviews of programme reports confirmed UNFPA contribution to the Ministry of Health's flagship priority initiative of catchment-based clinical mentorship (CBCM) which aimed to respond to the regional disparities in SRH service delivery. The primary focus of CBCM is improving Reproductive Maternal, Newborn, Child and Adolescent Health (RMNCAH) services at the PHC unit by emphasizing integrated SRH services through hospital-health centre mentorship to fill the knowledge, skills, and facility readiness gap among mentees. Through the 9th CP, UNFPA CO, in collaboration with the Ministry of Health and regional health bureaus (RHB) utilized high delivery, low family planning service utilization, and high neonatal mortality areas as criteria, including hard-to-reach, for selecting health facilities for CBCM targeting improvement of quality of SRH services PHC units at health centre levels.

Interviews revealed that UNFPA support during the 9th CP focused both the demand side by building public knowledge, breaking religious and cultural barriers, and targeting social and behavioural change strategies tackling negative perceptions on SRH services through training, community conversation, pregnant women conferences, and advocacy through mass media; and supply side by increasing access to SRH services, improving quality and affordability of SRH services, and making service delivery points user-friendly. UNFPA has been also supporting community conversations, safe-mother-hood advocacy campaigns, pregnant women forums, and maternity waiting homes (MWH), which were all government priorities to improve community demand creation and access for SRH services. Additionally, recognizing health facility survey reports showing low availability of medical commodities in PHC units, and inadequate referral facilities,

[13] Document review and interviews.
[14] Document reviews (CPD, COARs, HSTP, EDHS, 8th CPE Report), Interviews with IPS,
[15] UNFPA document reviews CPD, and COARs and Interviews with IPs, Government of Ethiopia and UNFPA CO staff.
[16] Interviews and document review

UNFPA supported the line ministries and regional bureaus in ensuring the availability of essential medicines, medical supplies, medical devices, and ambulances at the PHC units through procurement and distribution.

4.1.1.2 Gender Equality and Social Norms

Interviews with key stakeholders and reviewed documents revealed that the 9th CP's emphasis on gender equality, social norms, and women's empowerment was in line with the national agenda, including Ethiopia's Ten Years Development Plan which placed a high priority on eradicating GBV and ensuring that women live free from any form of violence, among other important objectives. Furthermore, the CP aligned with the National Costed Roadmap to End Child Marriage and FGM/C 2020–2024 which provided five strategic pillars that serve as a framework for coordinating efforts to achieve the goals of eliminating child marriage and female gentita mutilation (FGM/C). The UNFPA programme contributes to all these areas by strengthening the capacity of Government and key stakeholders on GBV prevention, protection, and supporting survivors of GBV and advocacy on ending FGM/C, Child marriage and harmful practices.

The 9th CP played a crucial role in supporting the Ministry of Education's strategy for girls' education by preventing child marriages, which negatively impacts on girls' educational attainment. Additionally, it aligned with the Ministry of Health's Gender Strategy by addressing the health complications associated with Female Genital Mutilation (FGM) in healthcare institutions and enhancing the clinical management of FGM/C health consequences by healthcare professionals. The UNFPA 9th CP on ending FGM and child marriage is highly relevant, focusing on regions with high rates such as Somali (99 per cent), Afar (95 per cent), and Oromia (76 per cent)[17]. UNFPA efforts in national advocacy, capacity building, and engaging men and boys have effectively addressed the needs of women and girls affected by FGM and child marriage[18]. Feedback from beneficiaries in FGDs indicated that the 9th CP interventions were instrumental in empowering communities to act against these harmful practices.

The 9th CP is also aligned with the needs and desires of the community. The emergence of the crises in the targeted locations of Ethiopia intensified cases of GBV and violation of rights. The key informant interview with stakeholders and observation indicated that there were limited One-stop Centres (OSC) and Safe Houses in the programme-targeted area, some of which were disrupted by the conflict, making the response mechanisms for GBV more complex. Furthermore, the interviews with government and CSO IPs staff and the FGDs with beneficiaries revealed that a significant number of GBV survivors remained untreated, which further exposed women and girls to mental health issues and hindered their productivity, ultimately exacerbating the poverty situation in the country. The 9th CP played a crucial role in contributing to addressing the needs of the community and satisfying the unfulfilled demand for GBV services through supporting the expansion of OSCs, Shelters/Safe Houses, and ensuring standardized survivor-centred service provisions. Feedback from interviews with stakeholders and FGDs with beneficiaries confirmed the 9th CP's contribution to the recovery of survivors of GBV through strengthening the OSCs, Shelters/Safe houses, providing comprehensive services that included MHPSS, legal and health, livelihood skill development, empowerment etc was remarkable.

> *"We were in critical situation and our mental well-being was in jeopardy, with many of us contemplating suicides. The psychosocial support we received significantly improved our mental health. We now regained hope, embraced life once again, and are now focused on our personal development thanks to UNFPA support"* – ***Beneficiaries during FGDs in Mekelle IDP***

4.1.1.3 Population Change and Data

Review of documents and interviews with UNFPA CO, Ministry of Planning and Development and Ethiopian Statistical Services (ESS) staff revealed that the Population dynamics and Data (PD) component of the 9th CP was fully aligned with the national policies and programmes including the Ten Years Development Plan (2021-2030) and the Home-Grown Economic Reform Programme (2023-2025). The component aimed at addressing the changing needs for data generation and utilization including digitalization and vital registration systems, and hence directly contributed and complemented the development programmes of the country.
The PD activities were based on and aligned with the National Strategy for the Development of Statistics I and II, which governs the production and use of statistical data responding to the needs and addressing the ever-changing data and statistics ecosystem of the country. Additionally, the PD component is in line with the Ethiopian Statistics Development Programme, a recent initiative focused on generating information that meets the diverse requirements of various users. Furthermore, UNFPA efforts in the component are grounded in the 1993 National Population Policy of Ethiopia (NPPE), which acknowledges the interconnectedness of population dynamics, resource management, environmental considerations, and overall development.

[17] Landinfo, Country of Origin Information Centre 2021.
[18] Document review and Interviews.

Interviews with IPs highlighted the critical role of UNFPA financial and technical support in strengthening the country's statistical systems. Ethiopia faced considerable challenges regarding data coverage, quality, and accessibility, which hampered informed policymaking. During the 9th CP, the strengthening of the statistics systems capacities in the country, including those at the regional levels, was a relevant contribution to the country's statistics system given the historical challenges that Ethiopia faced in producing reliable data necessary for policy formulation, evidence-based decision-making, and improving public service delivery.[19] UNFPA capacity-building approach was highly relevant and contributed to the transfer of skills of the national and regional statistics staff.[20] Interviews with UNFPA CO, Ministry of Planning and Development, and Ethiopian Statistical Service (ESS) staff indicated that the design of the 9th CP incorporated the needs of the government line ministries through stakeholder consultations. The PD interventions also contributed to the generation, utilization, and dissemination of relevant evidence for planning, tracking progress and formulation of policies through its capacity-building efforts.

The PD component also responded well to the changing national needs in the country including the conflicts in various parts of the country through its data support to the humanitarian interventions. The PD intervention was instrumental in supporting ESS to develop systems for the planning of the Population and Housing Census using digital methods, bearing in mind that this has been postponed severally before, but UNFPA through high-level advocacy enabled a buy-in from the national stakeholders to plan for it. Through the PD unit, UNFPA was also instrumental in the provision of disaggregated population data to other United Nations agencies for use during humanitarian responses. The IP respondents confirmed being consulted on their existing population dynamics needs to be addressed, to ensure the CP deliverables and support were consistent with and considered the needs in the country, in addition to capturing the needs of the marginalized and vulnerable populations during implementation of the programme. The planning processes involved in the design and implementation of the 9th CP reflected a strategic focus on addressing existing gaps and effectively selecting target beneficiaries for interventions.[21]

4.1.1.4. Adolescent and Youth

The 9th CP interventions were aligned and contributed to the National Adolescent and Youth Health Strategy, National Youth Policy, National Plan of Action of Persons with Disabilities (2012-2021), Rural and Urban Youth Package with a Multi-Sectoral Youth Development Strategic Plan (2006-2015), National Employment Policy and Strategy (2009), the Ethiopian Youth Development and Change Package (2013), Growth and Transformation Plan II (2015-2020), the Ten-Year Perspective Development Plan (2021-2030), the three-year Home-grown Economic Reform Plan, the third and fourth Decent Work Country Programs (2017-2020, 2021-2025)[22] . During the period of coverage, interviews indicated that UNFPA supported Ministry of Women and Social Affairs in conducting Youth Policy assessment, which guided review and development of new youth policy and strategy. Interviews with Ministry of Health, Ministry of Women and Social Affairs, IPs and UNFPA CO staff revealed that the 9th CP supported programmes that mainstreamed SRH and HIV prevention, and targeted A&Y knowledge and life skills development. Respondents from the UNFPA CO and IPs also confirmed the CP's focus on the A&Y who were most marginalized, vulnerable, disabled, and living in hard-to-reach areas. These contributed to addressing the high burden of morbidity and mortality among the A&Y from multiple factors including teenage pregnancy, unplanned pregnancy, compromised nutrition, HIV and STIs, unsafe abortion, early and child marriage, and unmet needs for FP[23]. Additionally, the development of the Youth Policy contributed to streamlining the A&Y-related interventions, including highlighting the need for meaningful participation of young people[24].

The Ethiopian young people, particularly those at risk, including female sex workers, industrial park workers, young people with disability, and those living with HIV were supported by the 9th CP. Interviews with UNFPA CO, Ministry of Women and Social Affairs, Youth/ Women-related bureau and IPs staff indicated that UNFPA prioritized population at risk and those in hard-to-reach areas with programmes. UNFPA also targeted the 30 industrial parks, each of which is estimated to have over 30,000 youth workers, with no access to SRH services. UNFPA also supported the assessment on the Integration of adolescent and youth health with community-based health insurance.

Interviews and a review of the Country Office Annual Report (COAR) revealed that the 9th CP contributed to the consolidation and strengthening of strategies and policies targeting adolescents and youth in the country. Specifically, the 9th CP supported the line ministries in developing several key strategies, including the Adolescent Health Strategy, the National Strategy on HIV Prevention, the Roadmap for HIV Prevention,

[19] Interviews and documentary reviews
[20] Interviews with IPs and CO staff
[21] ibid
[22] Interviews and document reviews
[23] EDHS, 2016
[24] Admassu, T.W., Wolde, Y.T. & Kaba, M. Ethiopia has a long way to go meeting adolescent and youth sexual reproductive health needs. *Reprod Health* 19 (Suppl 1), 130 (2022). https://doi.org/10.1186/s12978-022-01445-3

the Condom Programming Strategy, and the standardization of out-of-school comprehensive sexuality education) manuals. It also contributed to the development of strategies for female sex workers and young people with disabilities, as well as Minimum Service Packages for Industrial Park Workers and HIV-positive adolescents and youth. Despite these efforts, the implementation of these policies by the line ministries remained suboptimal.

4.1.2 Strategic Alignment to the International Frameworks

Review of documents and interviews with various stakeholders revealed that the UNFPA 9th CP was aligned to the various international frameworks and agreements that the Government of Ethiopia and UNFPA subscribe to. These included the Sustainable Development Goals (SDGs), the UNFPA Strategic Plan, and the ICPD, among other international frameworks and conventions.

The 9th CP was aligned and contributed to the achievement of the 2030 Agenda on sustainable development in Ethiopia. Particularly, the 9th CP significantly contributed to the SDG 3 on good health and wellbeing; SDG 5 on Gender equality; SDG 10 on Reduced inequalities; SDG 16 on Peace, justice and strong institutions; and SDG 17 on Partnership building for the goals. The 9th CP technically and financially supported increased access to quality SRH services through mentorship, training and deployment of healthcare workers; equipment of health facilities; demand creation, performance monitoring on unmet needs and provision of FP services; and strengthening reproductive health commodities and security contributed to SDG 3. UNFPA, through the 9th CP technical and financial support to combating GBV, eliminating harmful practices, and ensuring access to SRH services by women and girls, men and boys, and working in transforming social norms and men and boys' engagement in positive masculine, institutional and legal frameworks towards gender equality contributed to the SDG 5. On the other hand, UNFPA ensured that hard-to-reach areas, marginalized and vulnerable populations have access to a comprehensive package of SRH information and services, advocacy efforts on elimination of discrimination and promoting inclusion; and evidence generation and advocacy on demographic dividend contribute to the reduction of inequalities (SDG 10). UNFPA played a role in peacebuilding and conflict resolution, supporting legal and justice access services for the marginalized and the violated, and institutional strengthening contributed to SDG 16. Lastly, UNFPA nurtured strong partnerships and collaboration with the Government of Ethiopia, United Nations agencies, donors, communities, and local and international organizations, among others, contributing to SDG 17. The 9th CP further contributed to SDG 1 on eradication of poverty by supporting the economic empowerment of women in the women and girls friendly spaces (WGFS), and the drought-affected people to access SRH services. The CP also contributed to SDG 13 by supporting activities on adaptation to climate change and disaster risk reduction.[25].

The design and implementation of the UNFPA 9th CP was in full alignment with the UNFPA Strategic Plans (SP) 2018 – 2021, and 2022 – 2025[26]. Ethiopia's 9th CP was designed to directly contribute to the 2018 – 2021 SP outcome areas of SRHR, Adolescent and youth, GEWE and Population dynamics and utilized the related outcome and output level indicators in reporting. While the 9th CP was designed to integrate humanitarian action with a focus on climate-change related crisis, the massive humanitarian crisis due to eruption of armed conflict between the Government of Ethiopia and forces in the Tigray region in November 2020 and prolonged until November 2022 affected its operations[27]. This necessitated a review of the CP to give the humanitarian response more prominence through introducing a dedicated output area, thereby realigning the CP with the 2022 - 2025 SP. With this realignment, the CP output and outcome areas were fully aligned to the 2022 – 2025, including the reporting framework on the Quantum Plus platform contributing to the three transformative result areas[28]. Additionally, the UNFPA CO continued to utilize the SP modes of engagement, namely advocacy and policy dialogue and support; knowledge management; capacity development; service delivery; and coordination, partnership and South-South and triangular cooperation for delivery.

Towards alignment to the International Conference on Population and Development (ICPD) Programme of Action, the 9th CP aimed at contributing to stopping preventable maternal morbidity and mortality and accelerated access to FP services; ending GBV and harmful practices such as FGM and child marriage; addressing the needs of adolescents and youth; and advocating and supporting incorporation of population dynamics into development. The 9th CP also aligned itself to the ICPD by contributing to improved national population data systems to facilitate evidence-based programming and policy formulation. The 9th CP also emphasized the human-centred focus through supporting participatory approaches towards its delivery and advocated for and supported the integration of population issues into development strategies, planning and programming to achieve social justice and by extension the SDGs[29].

[25] UNFPA, donors, IPs and Government of Ethiopia staff, FGDs with beneficiaries and document review.
[26] CPD 9; UNFPA Strategic Plan 2018-2021; UNFPA Strategic Plan 2022-2025; and CPD 9th (alignment document) and interviews with UNFPA staff.
[27] UNFPA COARs, interviews with UNFPA, Government, IPs and Donor staff.
[28] UNFPA COARs, interviews with UNFPA Staff.
[29] Interviews with UNFPA, Ministry of Planning and Development and IPs staff and review of documents

Towards African Union Agenda 2063, UNFPA supported the road map for harnessing the demographic dividend through supporting the production of the country's demographic dividend using the transfer account methodology, in addition to supporting the production of the report on the progress made in response to the implementation of the Addis Ababa Declaration on Population and Development (AADPD) as well as the gaps and challenges faced by Ethiopia during the past ten years of its implementation[30].

The 9th CP outcome for Gender Equality and Social Norm was also aligned and contributed to the international commitments made by the Government of Ethiopia to end gender inequality. These commitments included the Beijing Declaration and Platform for Action, which aims to end GBV and promote gender mainstreaming, the Convention on the Elimination of Discrimination Against Women, which focuses on women's human rights and equitable participation; the London Girls Summit 2012, which aims to end female genital mutilation/cutting (FGM/C) and child marriage[31].

4.1.3 Responsiveness of the CO to the shifts caused by crisis and political changes

Interviews and review of the 9th CP-related documents confirmed the responsiveness of the UNFPA CO to the shifts caused by crisis and contextual changes. The period saw several changes in the context and UNFPA readily adapted and reprogrammed to the changing circumstances. The changes during the period of evaluation included armed conflict between the Government of Ethiopia and forces in the Tigray region and other regions, COVID-19, drought, floods, and institutional and structural changes.

At the onset of the armed conflict between the Government of Ethiopia and forces in the Tigray region, and other regions including Amhara, Afar, and Oromia, among others, the CO spearheaded the realignment of the 9th CP to incorporate a new output area on humanitarian response, which was not initially included in the CPD 9. Interviews with the UNFPA CO, United Nations agencies, IPs and Government of Ethiopia staff revealed that this provided the CO with an opportunity to reprogramme and effectively respond to the ensuing crisis through enhancing focus on addressing the needs of the populations affected by the humanitarian crisis brought about by the conflict. Additionally, there was evidence of the UNFPA CO mobilizing resources outside the core resources to finance the interventions through leading appeals for funding under the annual humanitarian response plans (HRP) which were conducted annually to gather new evidence through assessment for response on the arising needs[32], in addition to incorporating all SP modes of engagement, including service delivery, especially under SRH and GBV due to the changes in the implementation context[33]. During the humanitarian crisis, interviews revealed that the UNFPA CO also mobilized more than 30 staff through the surge model to respond to the crisis34. During the period, UNFPA also supported emerging priorities in the Afar region with deployment of more than 60 midwives where permanent staff had been displaced. The CO also provided cash to pregnant women to access maternal and child health services. In addition to supporting the region with ambulances to facilitate referral services. UNFPA was also recognized for introducing service provision on GBV and MHPSS which were not there prior to the conflict[35].

The 9th CP was also instrumental in responding to the COVID-19 pandemic where the UNFPA CO reprogrammed to adapt well and remained relevant to the changing implementation context. With mobility curtained due to the health crisis, UNFPA CO aligned its efforts by supporting the Ministry of Health and RHBs to respond in the most affected areas providing lifesaving SRHR and GBV services. Recognizing the risk involved among young people during the period, UNFPA CO supported the Consortium of Reproductive Health Associations (CORHA) to prepare a peer education manual to help them, including the adolescents and youth living with HIV, to understand and address the specific challenges that they faced. The UNFPA CO also adapted to the changes within the implementation context, including remote management through work from home for staff and conducting virtual sessions. Further, UNFPA CO also contributed to the efforts through the integration of COVID-19 infection prevention and control into its programming in addition to the reallocation of funds to respond to the effects of the pandemic[36].

Interviews with IPs also revealed that UNFPA CO was responsive in the delivery of the programme including flexibility in programme beneficiary targeting. For example, UNFPA supported the Hamlin Fistula Hospitals to treat fistula. However, during the case identification, there were arising cases of pelvic organ prolapse

[30] Ibid
[31] Document reviews and Interviews with UNFPA and MoWSA staff
[32] Interviews and review of COARs and HRP 2022, 2023, and 2024
[33] DP/FPA/CPD/ETH/9: UNFPA Country Programme Document July 2020 – June 2025, and interviews with CO staff
[34] UNFPA COARs, interviews with UNFPA, Government, IPs and Donor staff.
[35] UNFPA COARs, interviews with UNFPA, Government, IPs and Donor staff.
[36] Ibid

(POP) and while this was not initially the CP's intervention focus, UNFPA CO responded by supporting the various IPs and hospitals to continue identifying and treating the same as this was contributing to the CP's overall objective of increasing access to SRH services to women and restoring their dignity. The UNFPA CO also successfully engaged the donor in the revision[37]. UNFPA also supported climate change-related disasters like floods, and drought, among others through the provision of different services, including integration of SRHR and GBV outreach services and static facilities, and further supported coordination mechanisms to facilitate coverage with services as confirmed through interviews and document reviews. UNFPA also contributed to the emergency and disaster response in the country through supporting assessments which were instrumental in supporting evidence-based responses. Due to the changing implementation context, the increasing need for enhanced integration of the peace component in the humanitarian-development-peace nexus approach to programming, the UNFPA CO recruited an international expert on peace and security[38].

With the humanitarian crisis in Ethiopia leading to the situation being complex and protracted in the period of evaluation, UNFPA contributed to the humanitarian response through the implementation of the MISP for SRH services, which guided the humanitarian actors on the minimum actions to be taken in response to populations' SRH needs during emergencies. Additionally, UNFPA contributed to the coordination mechanisms by supporting the GBV AOR sub-cluster and the RH Working Group to ensure access to services by the affected population. During these periods, UNFPA procured and distributed Emergency Reproductive Health Kits, Dignity Kits and reproductive health supplies[39] .

While UNFPA endeavoured to respond to the changing contextual and emerging needs, UNFPA was limited by capacity due to their short-term sources of funds. There was also no flexibility in the budget for prepositioning of supplies as most of the funding was earmarked, limiting funding for preparedness activities. Additionally, the complexity of the conflict limited access to some of the affected locations for effective assessment and establishment of the needs of the populations[40].

4.2 Coherence: Answer to Evaluation Question 2

EQ2: To what extent has UNFPA Ethiopia integrated its mandate to improve SRHR and gender inequalities of the vulnerable and marginalized population through leveraging strategic partnerships with national, local and grassroots organizations (e.g. youth-led groups, people with disability and women's rights activists)?

Summary of Findings:

The design and implementation of the 9th CP incorporated a high level of coordination, partnerships and collaborative mechanisms to ensure a high level of coherence in its delivery and realization of results. With the CP's implementation being hinged on partnership, particularly with the Government and NGOs in the country, there was evidence of intended coherence in its design and implementation. Additionally, the alignment of the 9th CP contributing to the UNSDCF also contributed to its coherence in both design and implementation. Analysis of the CP documents and interviews with key informants revealed that UNFPA CO integrated its programming and nurtured strategic partnerships with national, local and grassroots organizations to improve SRHR and gender inequalities of the vulnerable and marginalized population.

For details of the evidence supporting findings in section 4.2, see Evaluation Matrix, Assumptions 2.1 and 2.2 (Annex 1).

The alignment of the 9th CP with the United Nations Sustainable Development Cooperation Framework (UNSDCF) and its contribution to the framework's outcome areas ensured coherence in planning, implementation and collaboration with different United Nations agencies. Notably, the 9th CP was fully aligned to the UNSDCF Ethiopia 2020-2025 which provided the overall United Nations support to the Federal Government of Ethiopia. Documents reviews and interviews revealed that the UNFPA mandate in Ethiopia was guided by these results in the framework, with a collective contribution to the achievement of the United Nations priorities in Ethiopia. The UNFPA programme contributed to all the UNSDCF outcome areas through all six CP output areas. Joint programmes were implemented during the 9th CPD including the Irish Aid Programme with UNICEF[41], the UNICEF and UNFPA Joint Programme on a Rights-Based Approach to Adolescent and Youth Development, the UNFPA-UNICEF Global Programme to End Child Marriage, the UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation and the Bill and Melinda Gates Foundation Programme with UNICEF and WHO[42]. Additionally, UNFPA received funding from various United Nations mechanisms to support the Country Program (CP), including the United Nations Central

[37] Interviews with UNFPA, IPs, Embassy of Canada and Government staff and COARs.
[38] Interviews with UNFPA CO, UN agencies and government staff and document reviews.
[39] Document review and Interviews with IPs and CO staff.
[40] Interviews with UNFPA CO, IPs and government staff and document reviews.
[41] Ensuring the health and well-being of women, children, and adolescents in humanitarian settings
[42] Service Delivery Innovations in Conflict-Affected Areas.

Emergency Fund and the UNAIDS Unified Budget, Results, and Accountability Framework[43]. Interviews with stakeholder indicated that these coordination mechanisms effectively brought together agencies—including government bodies, United Nations entities, international and national NGOs, and professional organizations—ensuring that synergies were leveraged, and responses were coherent.

UNFPA nurtured partnership in the implementation of the 9th CP ensuring coherence of mandate and coverage of marginalized and targeted locations. Interviews with the IPs confirmed that UNFPA programming approaches aligned with their strategic objectives. UNFPA also reported conducting assessments for the implementing partners to ensure the IPs met the requisite criteria, and this made the alignment effective ensuring that the IPs selected had mandates that matched those of the CO. One best practice in this sense was for example the partnership with a faith-based IP effectively targeted the religious leaders to tackle negative social norms in the country, in line with UNFPA objectives. UNFPA coherence with the donor's mandates were also found to fit within its implementation framework. For example, the Government of Canada's strategic objectives specifically targeted addressing issues of gender equality, targeting women and children, in addition to a focus on global health with a portion on SRH, a focus that fitted well with the mandate of UNFPA[44]. UNFPA also partnered with local women organizations for GBV prevention and response which facilitated utilization of local knowledge and experience to deliver on the mandate. There was however limited partnership and collaboration with private partners as well as the academia and local level CSOs.

The coherence of the 9th CP with government initiatives was also confirmed by government respondents both at the federal and regional level. The role played by UNFPA in the development of policies, capacity building and in-kind contributions to the implementations of mandate directly contributed to the government's strategic objectives and results. For example, the support to the government with RH commodity procurement directly contributed to the country's commodity needs thereby addressing the felt needs. The fact that UNFPA delivery is through the government's approval and based on joint work plans developed jointly, participatory and approved jointly are pointers of coherence in the framework of implementations in the country. UNFPA played a crucial role in mainstreaming its SRH thematic area into the national agenda through policies and services that directly contributed to addressing maternal and perinatal health, unintended and teenage pregnancy, HIV transmission prevention, STI screening and treatment, obstetric fistula and pelvic organ prolapse treatment, and cervical cancer prevention.

The alignment of the 9th CP with the national Ministry of Health, Ministry of Planning and Development, Ministry of Women and Social Affairs, regional bureaus and government agencies' strategic objectives also contributed to the coherence of the CP with government actions. For example, UNFPA played a leading role in combating obstetric fistula, demonstrating the Country Office's significant contribution to the government's efforts outlined in the 10-Year Transformation Plan. This contribution also aligns with the Reproductive Health Strategic Plan (2021-2025), the National Strategic Plan for the Elimination of Obstetric Fistula (2021-2025), the Obstetric Management Protocol for Health Centres and Hospitals, and the Antenatal Care (ANC) guidelines. Through these initiatives, UNFPA supported the achievement of national indicators related to obstetric fistula. Additionally, the Country Office contributed to the plan's indicators through its outputs in gender equality, social norms, adolescent and youth programming, population dynamics, and humanitarian action. Furthermore, During the 9th CP, UNFPA aligned its Adolescent and Youth (AY) thematic area with the policies and strategies of government line ministries focused on adolescents and youth, including the Ministry of Health, Ministry of Women and Social Affairs, Ministry of Planning, and the Ministry of Labor and Social Affairs. This also adhered to international standards, such as the UNESCO Comprehensive Sexuality Education Guide. Although there was age definition discrepancy between Ministry of Health/ United Nations and Ministry of Women and Social Affairs, the CPE noted that UNFPA was adaptable to support AY-focused programmes initiated by both ministries (Ministry of Health and Ministry of Women and Social Affairs) and other implementing partners, irrespective of the age range, to ensure inclusiveness and align with the respective ministries and regional youth bureaus.

Within the UNFPA CO, coherence and synergies among the different thematic areas of the 9th CP were also ensured. The PD team provided the necessary data for programme decisions and facilitated evidence generation within the other thematic areas. The 9th CP also effectively incorporated gender considerations throughout all thematic areas, in line with the UNFPA Strategy for Promoting Gender Equality and the Rights of Women and Adolescent Girls, in addition to the efforts made to mainstream gender across the 9th CP components. Furthermore, achievements were made in effectively integrating the various components of the CP, including incorporating female genital mutilation (FGM) into sexual and reproductive health (SRH), increasing female youth participation in adolescent and youth (AY) programs, and enhancing gender-based violence (GBV) protection, prevention, and response within humanitarian efforts. Gender statistics were also integrated into the population dynamics component. The CP also integrated the peace component across programmes, by the hiring of international staff for peacebuilding and security at the CO.

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[43] UNSDCF 2020 - 2025.
[44] Interviews with UNFPA CO and Canadian Embassy staff and document review.

One remarkable example of enhanced coherence was in the field of FGM/C and Child Marriage. UNFPA played a crucial role in coordinating efforts to put an end to FGM/C and Child Marriage at various levels, including national, regional, and community. This coordination ensured a unified response to FGM and prevented duplication of programmes and geographical coverage with other organizations working towards the elimination of FGM. For example, as confirmed in the annual report of joint project on ending FGM/C and child marriage, UNFPA provided technical and financial support to the National Alliance to End Child Marriage and FGM/C, led by the Ministry of Women and Social Affairs. UNFPA facilitated quarterly meetings at the national level, bringing together members from key government ministries, United Nations agencies, national and international NGOs, faith-based organizations, and research institutions. These meetings strategized and aligned interventions for the elimination of FGM, based on the priorities outlined in the National Costed Roadmap to End Child Marriage and FGM/C 2020-2024.

4.3 Effectiveness: Answer to Evaluation Question 3

EQ3: To what extent have the UNFPA Ethiopia interventions successfully delivered outputs and contributed to the achievement of the UNFPA strategic plan outcomes (ending unmet need for family planning; ending preventable maternal deaths; ending gender-based violence and harmful practices) and integrated human rights, gender perspectives, disability inclusion, and those furthest behind? Additionally, what have been the unintended consequences, both positive and negative, of these interventions?

Summary of Findings:

The 9th CP, implemented in partnership with the Government of Ethiopia, IPs, donors and CSOs, have made significant strides in advancing the UNFPA outcome results, both at national and regional levels. Most of the 9th CP output indicators were either achieved or on track.

The SRH component of the 9th CP enhanced the acceptability, accessibility, affordability and utilization of SRH services contributing to ending of preventable maternal deaths, reducing unmet need for FP and reducing HIV infections in the country. The component strengthened the government and CSO capacities in the delivery of the RH services through capacity building, policy and strategy development, coordination, strengthening RHCS supply chain mechanisms, infrastructure and medical supplies support, and deployment of skilled healthcare workers in the areas of need. Additionally, the UNFPA CO technically and financially contributed to the quality-of-care mechanisms, including supporting performance assessments, guidelines development and technical working groups. There was however low availability of SRH commodities at service delivery points (SDPs) in rural areas and primary health care (PHC) units; inadequate government capacity and policy implementation; inadequate obstetric fistula case detections and referrals systems; low FP utilization rates; inadequate CEmONC services and high rates of home delivery in Afar region. to the quality-of-care mechanisms, including supporting performance assessments, guidelines development and technical working groups. There was however low availability of SRH commodities at service delivery points (SDPs) in rural areas and PHC units; inadequate government capacity and policy implementation; inadequate obstetric fistula case detections and referrals systems; low FP utilization rates; inadequate CEmONC services and high rates of home delivery in Afar region.

Under the Gender and Social Norms component, the 9th CP significantly contributed to ending GBV and harmful practices including female genital mutilation and child, early and forced marriage through employing transformative approaches and advocacy mechanisms both at upstream and downstream levels. The component tackled gender inequality and negative social norms through the promotion of positive masculinity among men and boys; engagement of community and religious leaders; development of standard operating procedures (SOPs) and guidelines; capacity building; increased knowledge and awareness on the harmful practices; strengthening GBV coordination and service provision. Context-specific challenges like deeply rooted socio-cultural beliefs hindered some of the gains made through the CP and may take time to change.

The PD component significantly contributed to the strengthening of the country's data generation and utilization systems, and increased advocacy for integration of population data into development and policy formulation through capacity building, advocacy, coordination and south-south cooperation and partnerships. Inadequate and outdated national disaggregated data on population issues limited the extent of assessment of the 9th CP results.

The 9th CP considerably contributed to the humanitarian response in the country by strategically facilitating the implementation of an integrated SRH/GBV/STI/HIV/MHPSS targeting the affected populations; enhanced coordination of the SRH and GBV interagency working groups; strengthened capacities of the stakeholders; distribution of supplies in the IDP settlements, emergency and hard-to-reach areas in the country. The Conflict situations in Tigray, Amhara, and West Oromia also compromised humanitarian response.

The A&Y component increased access of adolescent and youth sexual and reproductive rights (ASRHR) services by the young people through training of healthcare workers on and establishment of youth-friendly services (YFS); awareness-raising mechanism; and development of national youth policy and strategy. As a gap, UNFPA support for HIV prevention is not visible or not given much credit by RHBs. All youth centres and Youth-friendly health service remained non-functional in the Tigray region even after more than one and a half years of the peace agreement. There were unintended consequences documented.

The design and implementation of 9th CP highly integrated human rights approaches in its delivery; considered gender perspectives in programming; and targeted hard-to-reach and marginalized areas with interventions, in addition to promoting inclusion in decisions. However, there was limited disaggregation of data on target groups to assess the extent of inclusion.

For details of the evidence supporting findings in section 4.3, see Evaluation Matrix, Assumptions 3.1, 3.2, 3.3, 3.4 and 3.5 (Annex 1).

4.3.1 Sexual and Reproductive Health and Rights

Introduction: The Sexual and Reproductive Health and Rights (SRHR) component of the UNFPA Ethiopia was designed to contribute to the quality of care and services by ensuring an effective supply chain strengthened for ensuring the availability of SRH commodities at all SDPs, including in humanitarian settings, and comprehensive sexual and reproductive health service provision improved, and uptake increased in all settings[45]. The component had two output areas with a total of eight indicators, and the respective achievement in each of the output level indicators are as illustrated in Annex 6[46]. Further, the component was implemented both directly by UNFPA through direct implementation and IPs respectively. The interventions in this component were identified and implemented in close consultation with the Ministry of Health, the Ministry of Finance, and Regional Health Bureaus (RHB).

Effective supply chain strengthened for ensuring availability of SRH commodities at all SDPs, including in humanitarian settings

During the evaluation period, interviews with government officials, IPs, and UNFPA Country Office (CO) staff, along with document reviews, revealed that the UNFPA CO strived to enhance the effectiveness of the supply chain to ensure the availability of SRH commodities at all SDPs, including in the humanitarian settings, through various mechanisms. The mechanisms included capacity building of the IP staff (Ministry of Health, Ethiopian pharmaceuticals supply service agency (EPSS), the Ethiopian Food and Drug Authority-FDA and health facilities); procurement of reproductive health commodities (RHC) and supporting monitoring of commodity availability and management at all levels of the supply chain systems through the last mile assurance system.

Interviews with the Government of Ethiopia and IPs staff underscored the significant contribution by UNFPA during the 9th CP in strengthening the supply chain system, ensuring the availability of RH commodities. The procurement and delivery of FP and life-saving maternal health products had far-reaching contributions especially to the Couple of Years of Protection (CYP) and the quality of FP services provided to women and girls of reproductive age. For example, the 9th CP managed to contribute to about 9.1 million CYP[47] till end of 2023 which the Ministry of Health and IPs recognized as a significant contribution in the country ensuring availability and access to the commodities to the targeted populations, especially bridging the funding gaps for SRH commodities for the country, including through co-financing arrangement[48]. Additionally, results show that UNFPA effectively coordinated with the Ministry of Health and EPSS[49] to ensure that there was timely delivery of the commodities into the service delivery point contributing to minimization of stock-outs in the country. While stock outs were experienced during the period with only 4.8 per cent of the targeted primary SDPs experiencing no-stock-outs of any modern contraceptive method, including permanent methods (on day of visit). Interviews and reviews of COARs indicated that more than 95 per cent of the primary SDPs had at least three of the methods.

Interviews with Federal Ministry of Health and RHBs indicated that UNFPA strengthened the ministry's capacity in supply chain management, through capacity building. The 9th CP supported the training of the UNFPA CO staff and Ministry of Health staff on supply chain management including on product selection, quantification, procurement, storage, distribution and reverse logistics, and leadership. Furthermore, the training of the EPSS up to international accreditation levels, the support to the Ministry of Health in the implementation of the electronic logistics management system and FP service quality standards in a total of 483 and 246 public health facilities respectively[50] contributed to a more effective supply chain system for the RHC and improved the access and quality of FP services in the country. UNFPA also contributed to the institutionalisation of Commodity Security training at the Addis Ababa University's School of Pharmacy through supporting the implementation of the Health Supply Chain Management Postgraduate Programme in the implementation of the curriculum developed its evaluation and revision with the technical and financial and technical support of UNFPA[51].

UNFPA contributed to the coordination and monitoring of the RHC supply distribution and supply chain management. The 9th CO supported the Ministry of Health to conduct monthly coordination sessions under the FP technical working groups (TWGs) where key decisions on FP, supply chain and product regulation were discussed and gaps addressed, further contributing to the provision of quality FP/RH services to the

[45] The CPD 2020 – 2025, including Alignment document
[46] COAR 2020, 2021, 2022 and 2023
[47] This is up to 2023, according to the COAR 2023.
[48] Interviews and document reviews.
[49] UNFPA supported the EPSS in conducting the price index visibility, assisting FP commodities quantification, and supporting in tracking distribution and effective stock management.
[50] Review of COARs
[51] Interviews and COAR reviews.

targeted populations. The 9th CP also supported the monitoring of the last mile availability and management of the RH commodities provided through the last mile assurance system through spot checks which contributed to the identification of gaps and informed strategies to ensure effectiveness in the supply chain system of the RHCS[52]. The 9th CP was also instrumental in conducting two health facility-based national assessments on the availability of RH commodities and services at SDPs (2020 and 2022), which provided vital information on the availability of services, with the results being discussed at the FP TWG, and key strategies determined for implementation to address the existing gaps. Trend analysis on the past 7 years dataset was also conducted and the findings disseminated to stakeholders. Availability of all the 17 essential and life-saving maternal and RH medicines at SDPs (as per the WHO guideline) was more than 70 per cent except for cefixime (51 per cent) (UNFPA SDPs Assessment, 2022). UNFPA was also a member of the FP commodities Logistics TWG and has been providing technical and financial support for the national annual forecasting and regular supply plan revision of FP commodities through Ministry of Health and EPSS by engaging all FP stakeholders.

At the time of the CPE, a 7-year Costed Implementation Plan (CIP) (2024 - 2030) for the National FP Programme had been developed with the financial and technical support of UNFPA. This served as a national guide to pool the efforts and resources of all stakeholders towards the common goal of increasing CPR to 54 per cent and reducing the unmet need for family planning to 17 per cent, through ensuring identification of priority actions around service delivery, commodity security, demand creation, and policy and enabling environment are taken into consideration. At the time of the CPE, the CIP was being disseminated in the regions.

The period of the CPE also saw the advocacy efforts by UNFPA to contribute to the sustainable financing of RH commodities yielding results where the UNFPA Supplies Partnership Programme Compact document on government's commitment to co-finance the procurement of FP/RH commodities was jointly developed, by teams from Ministry of Health and UNFPA, and signed by Ministry of Health, Ministry of Finance and UNFPA (UNFPA Ethiopia and HQ), with the implementation guidance manual under development. The launching of the Compact agreement at the 2022 World Contraception Day in the presence of government higher officials from Ministry of Health, Parliament members, UNFPA Representative and staff, and FP stakeholders was marked significant for the country to ensure sustained financing of the RH commodities for the country. The introduction of the Compact initiative and its wider familiarisation to the donor group encouraged other donors to come together and create a multi-donor compact for the procurement of FP commodities which is under implementation. There was also support for advocacy on increasing domestic resource mobilization from federal and regional governments to ensure continuity of the FP programme[53].

Through Ministry of Health and IP capacity building, utilization assessments, development of CIP, enhanced coordination and monitoring of the RHC supply distribution and supply chain management, advocacy for increased government contribution in RHC supplies and strengthened demand creation, the 9th CP significantly contributed to reducing the unmet need for FP and increased CPR among the targeted population. The CPE however identified challenges and gaps affecting effectiveness. High trained staff turnover from health facilities affected the effectiveness of the training services on quality service delivery with the UNFPA CO having to constantly repeat training to ensure continuity. There were delays in the procurement and distribution of RH commodities reported during the period. There was also weak quantification of RH commodities at the SDP affecting effectiveness of resource planning and distribution of commodities from woredas to health facilities. Further, while UNFPA ensured availability of SRH commodities, the SDP assessments conducted by the CO still showed low availability and stock-outs of essential and lifesaving RH medicines and contraceptive methods in rural and primary-level SDPs, with remarkable regional disparity. This was partly due to inefficiency of the public supply chain system in the management of health commodities as UNFPA did not operate beyond the central level in the delivery of SRH commodities. The UNFPA survey during the 9th CP has as well concluded that the main reasons for not offering life-saving RH medicines were delays of re-supplying, delays by the SDP in requesting, and non-availability of the RH medicines in the market.

Improved and increased uptake of Comprehensive SRH service provision in all settings

Interviews with Ministry of Health, IPs and RHB indicated that UNFPA immensely contributed to the comprehensive SRH service provision in the country with the CO being recognized as an instrumental pillar and contributor in SRH through supporting health facilities in the country, supporting both lifesaving interventions and provision of quality SRH services. During the period of evaluation, the 9th CP contributed to the output through guiding a multi-year plan for comprehensive SRH services within the larger framework of UHC; strengthening the capacity of health facilities on MPDSR; strengthening the capacity of health

[52] Ibid
[53] Interviews and document reviews.

facilities to provide comprehensive SRH services in all settings; and increasing provision of treatment for women and girls with OF. The CO ensured that the SRH components were delivered in an integrated manner ensuring service diversification, integration, ensuring quality, demand creation, and improving access.

Strengthening of EmONC services in the target location: during the 9th CP, UNFPA contributed to the reduction of the maternal and newborn morbidity and mortality through strengthening of the provision of EmONC services, including BEmONC and CEmONC, across the targeted health facilities in the country. Interviews with the Ministry of Health, RHBs, and IPs staff confirmed the role played by UNFPA in improving the maternal health by expanding and strengthening EmONC services which enhanced access and quality of service provided through capacity development on EmONC, obstetric haemorrhage, and mentorship training of health professionals. UNFPA also utilized the CBCM approach to strengthen the capacities of Ministry of Health's healthcare workers from hospitals mentoring staff in health facilities, including midwives, in addition to facilitating regular monitoring of the progress through conducting assessments, which also provided a basis for further support, especially when gaps were identified. Review of reports and interviews with Ministry of Health indicated that the CBCM had contributed to improve the quality of SRH service provided at the supported health facilities. To further enhance the capacity of the facilities providing EmONC services, UNFPA supported them with essential supplies and equipment.

UNFPA also contributed to strengthening of EmONC services through strengthening access to skilled birth attendance by pregnant women. This was achieved through the training and deployment of Midwives in selected hard to reach health centres. During the period of CPE, the 9th CP supported deployment of over 3,500 midwives in the targeted health facilities, including in MWH built near health facilities[54]. The MWH highly contributed to the access to skilled delivery as they enabled pregnant women to conveniently access care before safe delivery at the health facility nearby. UNFPA, additionally, strengthened the MWH with basic supplies and equipment and training of health workers on maternal health services[55]. Through this initiative, UNFPA ensured supporting the facilities with comprehensive SRH services including FP commodities, and maternal health support. UNFPA support for MSC clinical midwives was confirmed through the RHBs that it contributed to increased access to caesarean section in the target rural areas. UNFPA further contributed to EmONC through training and supporting the health extension workers at level 4 health facilities to provide basic emergency delivery, FP (counselling, IUCDs and implant), vaccination, and house-to-house for sensitization and identification of pregnant women and referring them to health facilities. This contributed to increasing access to quality health services[56]. UNFPA contributed to the continuous professional development system and e-licensing system through the administration of a computer-based competency exam for midwives in collaboration with the Ministry of Health and the Ethiopian Midwives Association[57]. UNFPA contribution to early identification and registration of pregnant women sensitising them to attend monthly pregnant women conferences at the community level, including engagement sessions with partners, kebele leaders, religious leaders and women development groups enhanced referrals for antenatal care (ANC) and access to skilled birth attendance[58].

UNFPA contributed to the increased uptake of comprehensive SRH service by supporting integration of SRH service, including FP, BEmONC, SRH/Life skill, post-abortion care, outreaches in the hard-to-reach areas, antenatal care (ANC), postnatal care (PNC), early detection of cervical cancer through awareness creation and demand generation on cervical cancer screening, prevention and management of Sexually Transmitted Infections (STIs) and HIV, and strengthening MPDSR. Interviews revealed that these, in addition to maternal health and the benefit of blood donation, were high-impact interventions that UNFPA supported the 9th CP to improve maternal health care and service utilization. UNFPA supported the training of health professionals to provide integrated services further contributing to the reduction of maternal and newborn morbidity and mortality. There were however implementation challenges on the integration of the programme interventions[59].

During the period, UNFPA, through the support of the Bill and Melinda Gates Foundation and in partnership with UNICEF and WHO, contributed to increased access to integrated SRH services using mobile health and nutrition clinics in pastoralist areas, and probably in conflict-affected and other hard to reach areas Afar, Amhara and Oromia regions. These clinics provided comprehensive and integrated SRH (including the CEmONC facility), GBV, EPI and nutrition services to the targeted population thereby contributing to access to quality services[60]. In Afar, where the blood transfusion system was not institutionalized and blood banks were nearly absent, women had to travel over 400 km to access blood. The mobile clinics provided SRH services, while ambulances facilitated referrals, contributing significantly to reducing maternal and neonatal

[54] Interviews and document review
[55] Interviews with Ministry of Health, RHB and UNFPA CO staff and COARS
[56] Interviews and document reviews
[57] Ibid
[58] review of COARs and interviews
[59] Ibid
[60] Interviews with Ministry of Health, RHB and UNFPA CO staff and COARS

mortality in the region. This was also instrumental in increasing SRH service utilization, particularly for a region with lower SRH indicators than the national average, for example, the CPR for Somali is 3.6 per cent and for Afar a is 13 per cent vs 41 per cent national; and the skilled birth attendance is 26 per cent for Somali and 31 per cent for Afar vs 50 per cent national (EDHS 2019). Furthermore, the results indicated that community-based and long-term programmes, such as the UNFPA-supported Women Extension Workers, were particularly effective in introducing SRH services to the community, thereby enhancing access to these services.

UNFPA support to the Ethiopian Public Health Institute (EPHI) for MPDSR and health commodity management information system, designed by UNFPA for EPSS) could not progress as planned. Despite decade-long implementation (including the 9th CP period), the MPDSR system captured only less than 10 per cent of expected maternal deaths and less than one per cent of the perinatal deaths in the country, mainly due to inadequate government health sector capacity to guide, and coordinate, and monitor the surveillance and response[61]. In the Tigray region, despite UNFPA not being expected to address all gaps across the region, many health facilities struggled to deliver optimal SRH services following the Pretoria peace agreement. This was largely due to shortages in medical equipment, supplies, medicines, and healthcare staff, and ongoing security issues in disputed areas to the west and north of Tigray. The absence of comprehensive national data (such as DHS and EmONC) limited the ability to quantitatively measure the availability and performance of SRH services. This underscores another challenge in the government's implementation of existing policies and programmes.

Obstetric fistula prevention, treatment and strengthening social reintegration of fistula survivors: During the period of coverage, the UNFPA CO continued to support the Ministry of Health in addressing the challenge of obstetric fistula in the country through supporting prevention, identification and management of obstetric fistula cases, working with different contributors, including health facilities across the country. Interviews and document review revealed that UNFPA ensured this through capacity building of healthcare workers and providing funds for fistula prevention, treatment and social reintegration interventions. During the period, a total of 5,979 cases were treated across the country. Additionally, while not planned for in the 9th CP, UNFPA supported treatment of POP which arose during identification of the Obstetric fistula cases[62].

> *"With the support of UNFPA and others, Hamlin fistula hospital's holistic activities are evolving. Our earlier interest was on obstetric fistula treatment at facility level. This time, we are engaged in midwives training, supporting selected health facilities to bring them to the Hamlin standard, sensitization of the community about obstetric fistula prevention, case identification, treatment, and social reintegration."* **Key informant from Hamlin fistula hospital.**

To enhance the treatment and handling of fistula in the country, UNFPA supported middle-level healthcare workers in the identification of the cases, particularly in the hard-to-reach areas, and supported the transportation of patients with identified cases to the health facilities for treatment, operated by Hamlin Fistula. UNFPA also contributed to strengthening the prevention of fistula through capacity building of health facilities to provide comprehensive SRH services and community demand creation for both prevention and treatment. This included strengthening referral systems for increased access to SRH services. UNFPA also supported the Ministry of Health on the development and implementation of obstetric fistula surveillance and response guidelines and training material, in collaboration with the RHBs, EPHI, Fistula TWG and media enhancing sensitization, case identification, access to treatment and reintegration. UNFPA also supported training obstetricians on basic fistula surgery skills, for example, Uro gynaecological training for five specialists in 2023. UNFPA also supported the observation of the International Fistula Days which advocated for strengthening identification of fistula cases for specialized treatment. Additionally, UNFPA support to the HEWs in creating awareness and obstetric fistula and POP case identification was identified as instrumental in enhancing access to services. While there were specialized treatment facilities across the country for obstetric fistula cases, interviews revealed that the operations of the facilities were suboptimal due to inadequate systems of case detection and referral system, with all the nine fistula treatment centres performing much below their capacity for nearly a decade. Limited national data on fistula is available, with delayed population and housing census.

Towards integration of fistula survivors, UNFPA collaborated with various IPs, for example, Mums for Mums in the Tigray Region, to provide psychosocial support, and vocational skills training to equip and empower survivors' socio-economically. Additionally, UNFPA supported IPs to facilitate community linkage and support reintegration, including family reunions. Interviews with UNFPA CO staff and relevant IPs indicated that the support for reintegration was instrumental in their rehabilitation. Mums for Mums ensured the reintegration of the survivors through linkage with their respective communities, including their families. Where husbands

[61] Document review and Interviews
[62] While POP was not planned for in the 9th CP, it was identified as one of the most neglected and crippling disorder of aged women in rural Ethiopia.

had abandoned their wives because of fistula, they were also taken through counselling to be able to accept the fistula survivors.

Strengthening of Policy Framework and Coordination on SRH: The 9th CP immensely contributed to the strengthening of the SRH policy framework by providing technical and financial support for the development and revision of various SRHR policies and strategies, SOPs, implementation frameworks and guidelines, in addition to supporting and contributing to inter-agency coordination mechanisms in the country. UNFPA support to the Ministry of Health, IPs and other government agencies in the development, dissemination and implementation, including training and monitoring of implementation of policies was highly regarded by the stakeholders as effective in guiding the implementation and improving the national set target and SDG goals focused on maternal and neonatal health. During the period, UNFPA supported development of MPDSR strategic plan, National Preeclampsia/Eclampsia Prevention and Management Guideline, Obstetric Fistula Surveillance and Response document Safe Abortion Care technical and procedural guideline, preconception care job aid and Training manual for ultrasound.

During the 9th CP, UNFPA contributed to strengthening coordination mechanisms through participation and/ or leading through co-chairing and technically supporting the operations of coordination mechanisms in SRH. In the period, UNFPA CO contributed to the national MPDSR, quality of care, safe motherhood, obstetric fistula TWGs, where the policy and advocacy frameworks were guided and discussed[63]. It was however noted that the government capacity and ownership of the various policy and strategy implementation was inadequate affecting accountability and sustainability. The strengthening of EmONC, access to skilled birth attendance; enhanced integration of access to SRH services, including targeting marginalized and hard-to-reach populations and areas with low SRH indicators, and strengthened MPDRS, policy and coordination significantly contributed to ending preventable maternal deaths in the targeted locations in both development and humanitarian settings.

Unintended Consequences

i. UNFPA initiated and co-signed the Supplies Partnership Compact Agreement for RH commodities with the Ministry of Finance and the Ministry of Health for the procurement of RH commodities. This initiative was identified by other donors as a good lesson and led to the signing of a multi-donor compact agreement with the Ethiopian government to boost domestic financing and improve the RH commodities availability.

ii. The house-to-house search for obstetric fistula cases enabled the identification of many women with POP. When fistula treatment centres were short of obstetric fistula cases for treatment, they also performed POP surgeries, which was not by design, but brought benefits as such cases are usually given less attention.

4.3.2. Gender and Social Norms

Introduction: The Gender and Social norm output of the 9th CP was designed to contribute to the strengthened mechanisms and capacities of actors and institutions to address discriminatory gender and social norms to advance gender equality and women's decision-making through ensuring the strengthened capacity of government and key stakeholders on prevention, protection of GBV, and prevention of services to survivors of GBV and to eliminate harmful practices in all settings[64]. The component had one output area with a total of three indicators, and the respective achievement in each of the output level indicators are as illustrated in Annex 6[65]Further, the component was implemented directly by UNFPA through direct implementation and IPs, respectively. The interventions in this component were identified and implemented in close consultation with Ministry of Women and Social Affairs, the Ministry of Finance, and the Regional Bureaus for Women and Social Affairs.

Strengthened capacity of government and key stakeholders on prevention, protection of GBV, and prevention of services to survivors of GBV and to eliminate harmful practices in all settings

Gender transformative approach: The 9th CP placed great emphasis on adopting a gender transformative approach, as recommended in the 8th CP Evaluation. To transform social, cultural, and religious norms, the prevention pillar of the gender and social norm component implemented several

[63] Interviews and review of COARs.
[64] The CPD 2020 – 2025, including Alignment document.
[65] COAR 2020, 2021, 2022 and 2023

transformative approaches. This included engaging religious leaders in gender norm dialogue, encouraging men and boys to promote positive masculinity, facilitating community discussions on restrictive norms through the Community Conversation and Social Norm Analysis and Action, airing drama and talk shows on social norms, and organizing radio listener groups. Moreover, peer-to-peer education was implemented, gender clubs were established both in and out of school, support was provided to Women Development Groups (WDG) and HEW to integrate gender education in their community services, and capacity building was offered to various stakeholders engaged in GBV prevention. These initiatives were successful in increasing community awareness and social behaviour change among the 21,875,440 community members reached on gender equality resulting in a shift in practices of gender equitable norms. Discussions with community groups revealed that the 9th CP had a positive influence on their understanding and attitudes, leading them to challenge cultural, social, and religious norms that hinder gender equality. The beneficiaries confirmed the programme's impact, empowering the community to reconsider social and cultural norms, including abandonment.

School and community-based awareness raising: According to the 9th CP annual report of 2023 as part of the school-based GBV Prevention programme, UNFPA helped 161 gender clubs in eight universities and 153 schools. These clubs played a crucial role in advocating for gender equality and eliminating gender-based violence within the school community, fostering egalitarian relationships among the younger generation. The implementation of an in-school GBV and FGM/C and Child Marriage case reporting system further enhanced the reporting of cases, leading to effective follow-up actions. Consequently, this contributed to significant prevention and cancellation of FGM/C and child marriages. The collaborative efforts between UNFPA and the Population Media Centre- Ethiopia, the use of radio to air the "*Nekakat*" and "*Unfinished Journey*" shows through the National Radio Service of Ethiopia and Fana Broadcasting Corporation respectively, were effective in reaching the underserved population with integrated information on gender, GBV, SRH FGM/C, and child marriage, leading to the promotion of social behavioural and normative changes towards gender equality.

Enhanced advocacy on the prevention of GBV and elimination of harmful practices

Religious leaders' engagement: The 9th CP effectively contributed to enhancing the norm-setters' capacity to reassess cultural, social, and religious norms. A significant achievement of UNFPA, in conjunction with UNICEF, was the assistance extended to religious scholars in delving into the theological dimensions of GBV and integrating GBV into the theological curriculum. The four dominant religious denominations in Ethiopia including Orthodox, Catholic, Protestant and Muslim integrated and passed circulars to their affiliated religious institutions to incorporate GBV in their religious preaching and religious services by the repentance fathers to prevent discriminatory practices that affect gender equality and the empowerment of women and girls. According to the Country Office Annual Report (COAR) 2023 and interviews with key informants, the CP's support on the engagement of norm setters enabled to reach a total of 650 prominent religious leaders on GBV, FGM/C and Child Marriage and were able to sensitize over 20,000 people in the religious institutions' structures against FGM, child marriage and GBV. The engagement further led to the declaration made by the religious leaders against FGM/C and child marriage, printed and circulated for wider action.

Engagement of Women of Faith: The 9th CP the role played by the women of faith in the community awareness and prevention of GBV, FGM/C and child marriage is significant. The involvement of women of faith in the programme proved to be a ground-breaking strategy in preventing GBV, FGM/C and child marriage. These women provided religious services at the household level and in the congregation religious assembly, focusing on children, youth and women, and they successfully integrated gender into regular religious services. These contributed to enhancing the positive transformation of GEWE restrictive norms within the community and the prevention of harmful practices.

Male engagement for positive masculinity: In recognition of men and boys as crucial catalysts for transforming societal norms due to their role in perpetuating GBV, the 9th CP utilized the in-school and out-of-school clubs, peer-to-peer education, and community dialogues to actively engage men and boys in discussions regarding negative masculine behaviours that perpetuate GBV. The engagement led to the men and boys endorsing positive masculinity, inspiring them to serve as role models by demonstrating attitudes and behaviours that promote gender equality. The 9th CP successfully supported the development of Men and Boys' Engagement Strategy which guided group discussions on various topics such as gender equality, healthy relationships, patriarchy, masculinity, and

> *"In the past, our actions may have harassed girls, but we were unaware due to our limited understanding. However, after participating in the men-only sessions, we have become more mindful of our behaviour. We have even begun advising others to prevent harassment..."* – **Youth beneficiary during CPE**

the division of labour based on gender roles. Interviews with IPs revealed that male engagement interventions resulted in significant transformations in masculine behaviours, promoting gender equality and empowering women and girls. The strategy of involving young men in promoting positive masculinity was also a successful approach towards ending FGM and challenging cultural norms that discriminate against uncut girls.

Ending Female Genital Mutilation /Cutting and Child Marriage

Interviews and document reviews revealed that the UNFPA 9th CP was instrumental in driving positive changes towards ending FGM/C and child marriage and achieved community declarations on abandonment of the practice of FGM/C and child marriage through supporting comprehensive and transformative strategies aimed at enhancing community awareness and promoting behavioural changes regarding the consequences of FGM/C and child marriage. These strategies included community conversations, life skills training for female and male adolescents and youth, mobilization of norm setters who played a crucial role in shaping social, cultural, and religious norms, capacity building for service providers, and the establishment of advocacy platforms and coordination mechanisms.

Through collaboration with the Inter-Religious Council of Ethiopia, a faith-based umbrella organization overseeing seven major religious groups, there has been a shift in religious practices concerning FGM/C and Child marriage. Manuals for religious leaders, rooted in theological reflection and AI Azhar materials, have been created and finalized. The teaching manuals for Christians and Muslims have been put into practice in seven regions across the country[66]. Interviews with IPs and FGD with community members revealed that the initiative not only led to an improvement in the religious leader's engagement in unlawful practices, but it also enhanced their ability to influence the community by integrating gender education into their religious services contributing to ending GBV and prevention of harmful practices through religious decrees.

Remarkable achievements were made in the prevention and response to FGM/C and Child Marriage. A significant number of 1,764 communities publicly declared their opposition to these harmful practices, leading to the cancellation of numerous instances of FGM and Child Marriage. Notably, by 2023, a total of 7,750 arranged child marriages and 5,550 cases of FGM were successfully prevented in Amhara, Sidama, Gambella, Afar, and Oromia regions. This success can be attributed to the strong collaboration of UNFPA CO with grassroots structures such as Women Development Groups, HEWs and Anti-Harmful Transitional Practices, who diligently monitored and reported cases of harmful practices.

The UNFPA joint programmes with UNICEF on ending FGM/C and Child marriage effectively advocated for the use of human rights-based approaches to combat FGM/C and Child Marriage. This was accomplished by empowering girls through leveraging on various movements and organizations led by women and feminists. One of the major accomplishments in promoting girls' agency and empowerment was the creation of Girls Power, a National Out-of-School Girls Empowerment manual and implementation guideline, as well as the establishment of adolescent girls' clubs and platforms. As a result, 55,179 girls were empowered to assert their rights and say no to any forms of violation against women and girls, because they participated in continuous life skills development sessions. According to the 2023 annual report of the joint programme (UNFPA and UNICEF) on end FGM/C and child marriage the implementation of the Interactive Voice Response mobile application proved to be a ground-breaking method that empowered girls through providing a platform that not only provided girls with the chance to self-evaluate their comprehension of FGM/C and child marriage, but it has also enhanced their access to digital technologies. The overall completion rate stood at 64 per cent, while the endline quiz results indicated a remarkable 92.5 per cent accuracy, showing an improved knowledge of girls regarding FGM/C and child marriage. Nevertheless, the completion rate highlights the need for further efforts to enhance girls' access to technology, as it is currently reported to be limited.

The utilization of various media platforms, such as the production and broadcast of a national television series called "Yegna" featuring teenagers discussing real-life issues related to girls' rights violations, in addition to the radio programme "Nekakat" which consisted of 156 episodes, and "Unfinished Journey" comprising of 49 episodes focusing on educating about the harmful effects of FGM/C and child marriage, has proven to be an effective strategy in reaching a wider audience with information aimed at promoting behavioural change. These approaches significantly enhanced community awareness regarding the repercussions of FGM and Child Marriage, with a notable 94.3 per cent improvement as highlighted in the Social Behaviours Change midline assessment for Ethiopia 2023. Despite the advocacy efforts in the prevention of GBV, FGM/C, and child marriage, the GEWE's restrictive cultural, social, and religious norms persisted as they remain deeply rooted, posing a challenge to the gains made and the ongoing efforts to accelerate the reduction of the GBV and harmful practices.

[66] Interviews and review of programme annual report 2022 and 2023.

The integration of gender in the other 9th CP thematic areas resulted in empowerment of young women. For example, incorporating gender training into the youth training manual significantly contributed to the increase of participation of young women, leading to the achievement of female youth leadership. In Hawassa and Sidama, there were four youth clubs exclusively for females in Tula and twelve in Tabor. Additionally, the participation and leadership of young women in mixed-gender youth clubs were 50 per cent, showing empowerment. This had a ripple effect, allowing female youth to be considered for employment in formal government institutions. The 9th CP recognized that women's economic dependence is a risk factor for GBV, as it diminishes their agency and empowerment, therefore it supported the survivors financially and business skills training. The economic support programme for vulnerable women is currently limited, despite the significant changes in the lives of the survivors.

> *"The small financial aid and business skills training have been a turning point in my life. I now feel empowered to protect myself from violence. Women need their own income to become independent and challenge violence against them."* – **Survivor during CPE**

Strengthened policy and legal frameworks on GBV, child marriage and FGM/C: UNFPA CO played a significant role in advancing upstream advocacy and coordination efforts to bolster the country's initiatives in speeding up advancements in gender equality and combating GBV. In collaboration with the United Nations agencies, Ministry of Women and Social Affairs, and women’s rights organizations, UNFPA contributed to the high-level policy dialogue and advocacy on essential services for survivors of GBV which raised commitments of decision makers for coordinated support for prevention and response to GBV UNFPA was also instrumental in the development of the GEWE policy, which places a strong focus on preventing and responding to GBV, as well as the creation of a national costed road map aimed at eradicating FGM/C and Child Marriage[67]. Further, the advocacy mechanisms through the support of the joint UNICEF and UNFPA Global Programme in Ending Child Marriage contributed to ending child marriage and adherence to child marriage laws at national and regional levels and integration into strategies and national development plans[68].

The advocacy mechanisms further led to the reviewing and reshaping of the laws that perpetuated the harmful practices, particularly at the regional level. For example, interviews in Oromia and Sidama regions revealed that the 9th CP advocacy with key national and community level stakeholders successfully contributed to the transformation of customary laws integrating prevention of GBV and harmful traditional practices in the customary law systems, where in Sidama region the prevention of FGM and Child Marriage is incorporated into the Sidama customary law, which consists of three hierarchical structures: *Song* (senior clan leaders who initially discuss any community issues), *Waree* (the community mobilization wing), and *Sera* (those responsible for implementing community action plans)[69]. These contributed to the accelerated reduction of GBV and harmful practices among the targeted communities in Ethiopia. Despite the progress made in the policy and legal frameworks, the enforcement of national laws and policies on gender equality remains a challenge, particularly weaknesses in the implementation and monitoring by the Government of Ethiopia.

Strengthened GBV Response

The 9th CP played a significant role in enhancing survival centre GBV services. The confluence of crises, such as the COVID-19 global pandemic and the prolonged armed conflict in northern Ethiopia spanning two and a half years, notably exacerbated the GBV situation in the country. This led to further fragmentation of service provisions, complicating the GBV response services. In response, the UNFPA efforts in expanding service provision infrastructures, including the establishment of one-stop centres, safe houses, and capacity building for service providers to implement standard operating procedures and enhance access to legal services, were key accomplishments during the implementation of the 9th CP.

The 9th CP successfully contributed to the strengthening of the GBV response through supporting a total 164 service points consisting of 10 safe houses, 33 One Stop Centres and 133 Women & Girls Friendly Spaces (WGFS), as of December 2023. The service points were supported through capacity building the staff and equipment with facilities to deliver a wide range of services GBV services including psychosocial counselling, healthcare, legal support, life skills training, and livelihood development skills training. UNFPA managed to provide standard and comprehensive services to a total of 82,055 survivors as of December 2023 at the One Stop Centre and Safe Houses, achieving 59.6 per cent of the CP target. Interviews with the beneficiary-GBV survivors confirmed the significance of the support in greatly enhancing their mental well-being, psychosocial status and recovery. Additionally, the livelihood support helped them gain economic independence and reduced their reliance on men, which is a critical risk factor for GBV. As a result, these GBV survivors have become empowered and were actively advocating for their rights and the rights of other women at the time of the CPE. However, due to the severity and complexity of the cases, some survivors

[67] Interviews and reviews of COARs 2022 and 2023.
[68] Evaluation of the Global Programme in Ending Child Marriage.
[69] Interviews and document reviews.

had to stay at the safe houses for a longer duration than initially anticipated. This posed a critical challenge in meeting the set targets and necessitated additional funding commitments. Interviews with the government, IPs and WGFS beneficiaries indicated that the WGFS were also instrumental in enhancing the empowerment of women and girls by creating safe spaces where they openly discussed and consulted on issues affecting them. The review of documents and interviews with IPs indicated that the WGFS were instrumental for women and girls in boosting their self-esteem, their negotiation abilities, and their understanding of GBV, in addition to increasing their awareness of rights through training and peer-to-peer support, helping them prevent rights violations and assert their rights, hence fostering their empowerment. Interviews with Government of Ethiopia and IPs indicated that the manual designed to empower young girls, along with the in-person sessions and mobile phone sessions utilizing Interactive Voice Response technology, also proved to be a successful approach in empowering female youth, enhancing their skills and knowledge in areas of GBV, FGM/C and child marriage prevention.

The UNFPA assistance in standardizing the GBV service provision through the support in the development and implementation of related Standard Operating Procedures (SOP) for GBV service provision, as well as their support in capacity building for safe house and One Stop Centre employees on GBV case management and treatment, had a positive impact on the delivery of survivor-centred services. The majority of the visited One-Stop Centres and Safe Houses met the national protocol for GBV services, ensuring confidentiality, comprehensive service provision includes Psychosocial health, legal and livelihood skills development, and effective case management. Interviews and FGDs also confirmed the effectiveness of the service delivery points in contributing to the coordination of partners to ensure that the affected women and girls received the right service and support through the right referral pathways.

A total of 301,278 women and girls impacted by crises and vulnerable received dignity kits, which together with the provision of menstrual hygiene support, played a crucial role in promoting girls' education. Interviews and FGDs with the targeted groups shed light on how this support not only dignified them but also enabled the girls to continue their education. The integration of gender perspectives into the health components helped to break down barriers to service utilisation, increasing awareness among men and boys regarding women's health issues. As a result, there was evidence of men actively advocating for the end of fistula and supporting women's rights to family planning.

A review of the 2023 COAR and interviews with IPs reported that UNFPA enhanced access to legal services for violated women and girls through the promotion of free legal assistance and the provision of training on legal matters. The partnership and collaboration of UNFPA with the Ethiopian Women’s Lawyers Association ensured effectiveness in gender-responsive law enforcement by providing capacity-building training for law enforcement bodies. This enabled the women and girls’ survivors to break gender barriers that previously impeded their access to legal services. The 2023 COAR shows a total of 36,839 individuals received free legal aid services. UNFPA also contributed to strengthening access to GBV services through the support of the national GBV hotline services, which offered information on GBV and guidance on GBV case referrals. Interviews revealed that the hotline was effectively promoted, with a significant number of users seeking GBV information and referral advice.

Unintended Consequences

i. **Women Leadership and Formal Employment:** The inclusion of gender integration in various aspects of the programme, such as service provisions, capacity-building activities, and women's economic empowerment, created opportunities for women to assume leadership roles and secure employment. The evaluation participants observed that the involvement of young individuals in the adolescent and youth programme also led to employment opportunities within government institutions, with some even being appointed to leadership positions. This has served as a source of inspiration for employers and local government authorities. The evaluation results showed that the changes brought about by UNFPA-supported youth clubs and centres, other youth clubs and centres included female youth in leadership positions, thus promoting gender in youth leadership.

ii. **Repercussion of rewarding positive deviances:** The programme was implemented to incentivize both uncut girls and their mothers as part of a strategy to promote the eradication of FGM. However, despite these strategies successfully motivated the community, leading to a rise in the number of uncut new-born babies, interviews with Ministry of Women and Social Affairs and regional bureaus revealed that many individuals have reported to their office to claim the reward but expressed intentions to proceed with the circumcision if the reward was not implemented. Mechanisms that can verify whether the changes observed are a result of genuine behavioural changes rather than changes driven solely by the rewards are not in place at this point, which has the potential to result in unintended negative repercussions regarding the resurgence of FGM.

4.3.3. Population Change and Data

Introduction: The Population Dynamics (PD) output of the 9th CP was specifically designed to enhance data systems and generate evidence that reflects population dynamics and megatrends—such as ageing and climate change. This focus is crucial for informing development policies and programmes, particularly those concerning sexual and reproductive health and reproductive rights[70]. The component had one output area with a total of five indicators, and the respective achievement in each of the output level indicators, which serve as critical metrics for evaluating the effectiveness and impact of the interventions implemented under this component and are illustrated in Annex 7[71]. Implementation of this component took place through a dual approach: UNFPA directly seconded technical staff to provide necessary assistance and Government IPs. The implementation process was characterized by close consultation with key stakeholders, including the Ministry of Planning and Development, the Ministry of Finance, the Ethiopian Statistical Services (ESS), and various line Regional Bureaus.

Strengthened data systems and evidence that take into account population changes and other megatrends (including ageing and climate change), in development policies and programmes, especially those related to sexual and reproductive health and reproductive rights.

The PD component contributed to strengthening the capacities of the government agencies to generate and utilize data for evidence-based decision-making, monitoring the progress of policies and programme formulation as well as for assessing progress on ICPD and SDG-related indicators and interventions in humanitarian response. UNFPA support to the ESS for the preparation of the population and housing census as well as the DHS surveys and civil registration and vital statistics (CRVS) were important to ensure improved quality, timeliness and utilisation of data. Additionally, the 9th CP enhanced advocacy on the integration of population dynamics into development, considering the changing population patterns within Ethiopia.

Enhanced advocacy and strengthened national capacity to conduct the National Population and Housing Census: Recognizing the over 17 years of delayed implementation of the Census in Ethiopia, UNFPA, in collaboration with the United Nations Resident Coordinator Office (UNRCO) and its Secretariat at the African Union enhanced advocacy with the Government of Ethiopia on the need for Census, getting the approval for it, with the Prime Minister's Office leading the coordination. At the time of the CPE, a task force to coordinate the Census, incorporating membership from various ministries had been established and functioning. This was a success given the several failed attempts to conduct a Census in the country[72].

Towards the preparation for the Census, the 9th CP contributed technically and financially to the ESS to undertake the 4th round of Census. Interviews with IPs, CO staff and United Nations agencies underscored the critical and catalytic role played by the CO given its mandate in enhancing capacities in generation of data and utilization for informed decision-making in development. Interviews and document reviews revealed that UNFPA contributed to strengthening the capacity of the ESS through training, development of guidelines, equipping the concerned units, and south-south cooperation, in addition to hiring international experts. Interviews with UNFPA CO staff also confirmed that the government is eager to adopt digital technologies, such as satellite imagery and statistical estimation techniques (hybrid census) and has instructed the ESS to build its capacity in preparation for a future census. According to the document review, the capacity of 68 staff of ESS was strengthened by supporting their participation in training workshops on various subjects related to census undertaking involving data capturing, transfer and data processing, small area estimation, Geographic Information System (GIS)/Cartography, as well as data analysis and dissemination[73]. Additionally, interviews with ESS and CO staff confirmed that UNFPA supported the ESS by procuring various ICT materials to refurbish the Central Statistical Agency data centre and support the data transfer including servers, solar power banks, printers, computers, etc. Through this support, the ESS was able to prepare digital maps, including digitizing enumeration areas which can be utilized for other surveys in the country, and could easily be modified in case of any changes in the boundaries.

UNFPA also supported the introduction of digital technologies for data collection in remote and conflict areas using statistical modelling for estimating populations in hard-to-reach areas, particularly given the prevailing conflict-context in Ethiopia. In addition, taking into consideration the administrative boundary changes that had occurred after the previous census mapping, the technical capacity of 13 experts of the ESS trained in

70 The CPD 2020 – 2025, including Alignment document
71 COAR 2020, 2021, 2022, and 2023
72 Interviews and document reviews.
73 UNFPA Annual Report 2023.

small area estimation techniques and use of mobile technology to produce dis-aggregated/granular data on development indicators at lower administrative levels[74]. The trained field staff were able to conduct the EA updating and synchronize with the available geo-referenced database. The CO played a pivotal role in facilitating and supporting knowledge and experience-sharing visits to South Sudan. These visits were designed to provide insights into the implementation of a technology-assisted census and the estimation of population figures through a hybrid census approach and enhance understanding of how advanced technologies can be integrated into census processes. The ESS management has also visited Ghana to get experience in digital services, according to the document review and interviews. The ESS experts were able to use the digital technology without the support of others.

Increased CRVS capacity for enhanced generation of data for decision-making: The 9th CP technically and financially contributed to enhancing the capacity of ESS, Ministry of Health and Immigration and Citizenship Services (ICS), in improving CRVS systems, including collection, analysis, and reporting[75]. UNFPA hired and deployed a consultant who strengthened the ESS to produce the annual vital statistics data. Similarly, according to the 9th CP progress report 2021 and confirmed by the interviews, the capacity of 240 civil registration officers and data processing staff working at the ICS (50) and ESS (190), was enhanced in vital statistics data management. 13 experts (ten from ESS, two from ICS, one from Ministry of Health) were also trained in report writing skills which enabled them to produce the vital statistics report. The 9th CP support enabled ESS to organize users' consultation forums to identify data needs from vital statistics for inclusion in future data analysis and report preparations and follow-up and monitoring visits to branch offices to support data capturing and verification officers on how to address challenges if encountered during data verification and capturing. Additionally, the CP strengthened the CRVS function by equipping the ESS with 15 desktops, 3 shelves, 18 laptops and 1 server enhancing data management. UNFPA also supported capacity-building training and participation of technical and managerial staff in international conferences. Using this support from the UNFPA, the ESS was able to produce four Annual Vital Registration reports, including data at Kebele levels[76].

While the UNFPA support during the period of coverage was significant, there was low coverage of the civil registration limiting the use of the Vital Statistics reports for planning, and monitoring of SDG indicators as the statistics focused only on vital events and did not pay attention to other demographic and socio-economic indicators. The reports did not also capture deaths outside of institutions or those without birth and death certificates. In addition, delay in the transfer of civil registration data from regional ICS to ESS branch offices due to paper-based, non-automated civil registration processes negatively impacted the timely preparation of vital statistics reports[77].

Advanced evidence-based decisions through established Integrated Management Information Systems (IMIS)

Interviews with stakeholders indicated that the UNFPA support for the establishment of the Integrated Management Information System (IMIS) enabled users, both at national and regional levels, to generate data that meet their specific needs and conduct basic statistical analysis and prepared customized tables, calculate indicators, and generate thematic maps at any administrative level. During the 9th CP, ESS was able to develop functional IMIS in ten regions. The support of the CO included material support, technical skill training and experience sharing visits to different regions. The regional IMIS system is linked to the ESS database so that users can access data from the ESS and use it for their purpose. The respondents from the supported regional bureaus related to population cited the significant contribution of IMIS in generating and accessing data, including administrative data for planning and decision-making. For example, the Sidama region was able to compile and upload more than 625 socio economic indicators and is in the process of launching it, but the use of these indicators for regional planning is yet to be demonstrated. Similarly in the Amhara region the system was successfully installed in 2019 and region and sector specific data for the period 2013 to 2022 have been uploaded so that the data can be used for planning development interventions. This support also enabled researchers, planning officers and sector bureaus to easily access disaggregated data online for their respective purpose. UNFPA also facilitated capacity building, through the deployment of a technical expert on IMIS, to seven sector bureau officers per region on the system enhancing their capacity to use the data for their planning activities. Updating the data using current information and implementation of the plan to cascade the system to lower levels of administration were not possible due to the prevailing conflict in some of the supported regions.

While the efforts of the CO to establish IMIS in the various regions were highly significant, the functionality of some of the systems was a concern. For example, the system in Afar has not been properly installed and

[74] UNFPA Annual Report 2023, UNFPA quarterly report 2023.
[75] UNFPA Annual report 2023.
[76] Capacity building was also provided to 120 staff working for ICS.
[77] Interviews and document review.

became operational due to changes in the administrative structure of the region. Staff turnover was also a major issue. Those who were trained on the system were often transferred to other higher political positions and hence, the number of trained staff was significantly reduced. In addition, limited technical skills and knowledge for identifying relevant sector-specific indicators for integrating into the IMIS in some regions also require close follow-up. Furthermore, while some regions are capable of operating and maintaining the system in the absence of UNFA support, some regions still require follow-up support. The advocacy efforts in some of the regions are also inadequate resulting in low level of utilization of the system.

The Ethiopian Demographic and Health Survey (EDHS): To avail up-to-date disaggregated population data, UNFPA supported ESS in conducting the Ethiopian Demographic and Health Surveys (EDHS) and was at an advanced stage of implementation of the 5th round. IPs interviewed both at the national and regional levels emphasized the critical role of the UNFPA in supporting the planned survey as it will help to bridge the gaps and inadequacy of data for planning and programming. According to interviews with IPs, UNFPA is a well-recognized entity by the government in population data generation. Considerable efforts had been made by the CO for the inclusion of new GBV indicators (Fistula and FGM) in the forthcoming EDH Survey in addition to the already existing SRH-related indicators. The inclusion of these UNFPA mandate area indicators in the upcoming EDH survey is an important milestone, according to the interview with stakeholders, particularly in the monitoring of the SP and CP outcome level indicators which were not possible during the CPE due to the unavailability of data. The UNFPA CO was represented in both the TWG and the Steering Committees on the EDHS. At the time of the evaluation, the revision and translation of the survey questionnaire had been completed and the training of the field workers had already started.

Support for Seasonal Assessment of Risks: UNFPA Ethiopia also provided financial support for the seasonal assessments and risk profiling vulnerability analysis and risk reduction interventions undertaken by the Ethiopian Disaster Risk Management Commission which was instrumental in the humanitarian response planning and preparedness. The seasonal assessment was conducted by the Ethiopian Disaster Risk Management Commission and humanitarian partners and produced every year for the *Meher* and *Beg*[78] seasons, particularly identifying regions and districts that were vulnerable to natural calamities and preposition prevention and emergency preparedness and strengthening early warning and early action mechanisms.

Advocacy and Policy Dialogue: UNFPA supported several advocacy and policy initiatives in collaboration with the main implementing partner, Ministry of Planning and Development. These initiatives accelerated the demographic transition in the country, supporting the revision of the Population Policy of Ethiopia, and the follow-up to the ICPD/AADPD Commitments, among others. Interviews with the Government of Ethiopia and CO staff indicated that the 9th CP provided technical support to Ministry of Planning and Development during the preparation of the assessment report on the implementation of the AADPD+10 ensuring that the commitments of Ethiopia were achieved in the framework of the realisation of the three transformative results of UNFPA. UNFPA also provided support to the Ministry for the preparation and revising the Information, Communication, Education- Behavioural Change and Advocacy strategy, a module that targeted the integration of population into development plans and programmes. UNFPA provided financial support for the Consortium of Reproductive Health Association (CORHA) for the revision and update of the manual and provided three rounds of training to regional stakeholders.

The 9th CP also supported the integration of population dynamics into development planning through enhanced advocacy during the annual World Population Days, collaborating with Ministry of Planning and Development and engaging with different stakeholders. UNFPA and Ministry of Planning and Development utilized this to also popularise the State of the World Population (SWP), as part of the advocacy to integrate population dynamics in the development planning. The participants in these events were drawn from government line ministries and civil society organizations, development partners, United Nations agencies and other stakeholders. The CO provided technical and financial support for this event, which was used as a high-level forum for raising awareness on population and development issues and in putting the ICPD agenda in the limelight.

UNFPA support for the revision of the NPPE: During the 9th CP, the CO also supported financially and contributed to the preparatory work for the revision of the 1993 Population Policy of Ethiopia. It supported the participation of four experts from the Population and Development Affairs Unit of Ministry of Planning and Development and one staff from the UNFPA in a capacity-building workshop on population policy formulation and population programme management in Nairobi, Kenya[79]. UNFPA also financed the production of three policy briefs (on Demographic dividend, age at first marriage and regional disparities in fertility levels)[80][81][82] to be used as background papers on the state of the population dynamics and inform

[78] *Meher* and *Belg* are long (covering June to September) and short (covering February to May) rainy seasons in Ethiopia.
[79] UNFPA Annual Report 2023 and interview with IPs.
[80] Raising Age at first marriage as a factor contributing to the reduction of fertility in Ethiopia.
[81] Pathways to Accelerate the process of harnessing the demographic dividend in Ethiopia.
[82] Redressing regional disparities in fertility levels in Ethiopia.

the advocacy and policy dialogues on the population and development nexus in the country. UNFPA has also supported the production of three other studies focusing on youth migration, the unemployment problem and the demographic dividend[83][84][85], which will be used as inputs for evidence-based information for the revision of the Policy.

Support to prepare a Demographic Dividend Roadmap: To maximize the benefits of the demographic dividend linked to Ethiopia's youth bulge, the 9th CP has played a crucial role in supporting the development of the Demographic Dividend roadmap for Ethiopia. The document review and key informant interviews confirmed that an agreement was signed with the University of Cape Town with the support of the CO to prepare the roadmap using the National Transfer Accounts methodology, which provides an accounting framework of economic flows from one age group to another. The CO also facilitated a two-day training workshop for 22 experts from various governmental and non-governmental organizations on the National Transfer Accounts methodology. This initiative reflects UNFPA commitment to leverage the potential of the demographic dividend through a strong partnership with the Ministry and other stakeholders, positioning itself among the key United Nations agencies focused on youth and women. However, due to unavailability of disaggregated data on the huge informal economic activities the development of the roadmap had not progressed as planned. To overcome this challenge the ESS was requested to organize a rapid assessment survey that will provide data for the preparation of the roadmap.

Overall, the added value in terms of UNFPA through the 9th CP was widely confirmed by interviews with IPs, and document reviews. Despite these achievements there are some areas that warrant further considerations. These included inadequate attention paid to population matters at federal and regional levels and within the UNFPA. The PD component received the least financial resource allocation within UNFPA and the regional offices of UNFPA do not have PD-related activities. The CO's programmatic interventions on some of the mega trends like urbanization, ageing and migration has not been adequate. While the CO interventions are well aligned with national priorities and made significant progress in building technical capacities within the IPs, the lack of up-to-date disaggregated data on population-related issues makes monitoring progress on SDGs and other development indicators difficult. There was also little evidence of dissemination and wider utilization of the data generated, and insecurity was also cited inhibiting collection of reliable data.

Unintended Consequences

Two unintended positive consequences were captured in the PD Intervention.

i. The support of the UNFPA for ESS to enhance its technological capacity created a multiplier effect within the organization to digitalize all other services. This positive externality had not been planned by the CO but stimulated the ESS to modernize and digitalize its services.
ii. The ESS planned to undertake a standalone GBV survey but was unable to implement it due to lack of capacity and experience and preparedness in conducting such kinds of surveys and due to other more urgent priorities. This situation led to the establishment of a dedicated unit that deals with Social and Inclusive Statistics within ESS. According to the key informants from ESS, there is now a plan to establish a dedicated unit within the organization that will be able to produce all kinds of disability statistics.

4.3.4 Humanitarian Action

Introduction: The humanitarian action component of the UNFPA 9th CP was designed to ensure the strengthening of the capacities of national and regional service delivery systems to provide lifesaving SRH and GBV information for populations affected by crises in the country. The output targeted to reach six indicators and the respective achievement in each of the output level indicators are as illustrated in Annex 7[86]. Further, the component was implemented both directly by UNFPA through direct implementation and in partnership with IPs respectively. The interventions in this component were identified and implemented in close consultation with the respective line ministries, both at the national and regional levels, in addition to coordination and collaboration with the various stakeholders in the implementation context.

[83] Youth Migration: Policy Options for Development in Ethiopia.
[84] Harnessing the Demographic Dividend in High and Low Fertility Regions of Ethiopia.
[85] Unemployment and Development in Ethiopia.
[86] COAR

Strengthened capacity of national and regional service delivery systems to provide lifesaving SRH and GBV information and services for populations affected by Crisis

A review of documents and interviews with various stakeholders highlighted the vital contribution that UNFPA made in Ethiopia's humanitarian response providing integrated lifesaving support and services on SRH, GBV, and MHPSS through different mechanisms in the country.[87] The 9th CP was originally developed with a development focus, only integrating humanitarian response, particularly at the policy level, but due to the contextual changes, UNFPA shifted from development to humanitarian to address the crisis based on its comparative advantage i.e. SRH and GBV in an emergency context. The response covered conflict-affected areas in the country, mainly including Tigray, Afar, Somali, Oromia, and Amhara, among other regions, in addition to working at the federal level with line ministries for policy support and coordination mechanisms to ensure delivery of quality and standardised services. While the interventions were context-specific, UNFPA ensured an integrated approach, enhancing efficiency in the delivery of services, in addition to the development-oriented interventions being implemented in parallel, further contributing to the humanitarian response[88]. Under the leadership of a senior Humanitarian Programme Coordinator, UNFPA actively enhanced the coordination and delivery of integrated SRH and GBV services, including contributing to the coordination of inter-agency working groups, strengthened capacities of the national and regional stakeholders and the United Nations agencies on humanitarian response, conducted outreaches and distributed supplies in the IDP settlements, emergency and hard-to-reach areas in the country[89].

Interviews and reviews of COARs revealed that UNFPA facilitated training and implementation of MISP for SRH and GBV in emergency-affected woredas in different regions in the country, targeting and reaching 526 frontline health service providers, SRH programme coordinators and managers, SRH TWG members and humanitarian actors. To ensure targeted support, UNFPA supported the conduct of a readiness assessment to provide MISP for SRH in Crisis Situations. UNFPA gave prominence to integrating SRH and GBV in emergencies through using the MISP curriculum and training of health service providers and managers on the same, in addition to supporting the MISP focal points at national and regional levels ensuring quality assurance. This training facilitated the implementation of key lifesaving SRH and GBV interventions to multiple emergency-affected regions in the country. Interviews with the government line ministries' staff further revealed that the training also contributed to changing their mindset on emergency response enhancing further delivery and support of the humanitarian response, particularly contributing to the coordination.

Lifesaving Emergency obstetric care and service delivery: The 9th CP supported quality preventive as well as life-saving services for the management of complications of pregnancy and childbirth across the emergency-affected locations in the country. These included strengthening the reproductive maternal, newborn, and child health (BEmONC and CEmONC) service delivery through supporting equipping a cumulative of 554 health facilities with emergency obstetric care (EMOC) equipment and supplies. UNFPA ensured functional EMOC health facilities for maternity care in the country, supporting full packages including commodities, equipment, fully functioning theatre and capacitated staff throughout support[90]. Interviews revealed that the 9th CP's support for deploying trained midwives—through partnerships with the Ethiopian Midwives Association (EMwA) and Marie Stopes Ethiopia (MSIE)—significantly increased the number of pregnant women visiting health facilities for skilled deliveries. This was especially evident in areas where existing health facilities had been damaged due to conflict and healthcare workers had fled. Additionally, the 9th CP also supported the deployment of mobile health teams, volunteers, and HEWs, collectively providing lifesaving SRH and GBV services to 1,050,942 people affected by the emergency. UNFPA also ensured that communities were sensitised on the available MNCH services in their communities to create demand and access to skilled health service delivery to the marginalised communities. This contribution ensured continuity of service provision in health facilities and IDP settlements facilitating increased access to quality and timely lifesaving SRH services including ANC, delivery, PNC, FP, CAC, clinical management of rape (CMR), C-section, safe blood transfusion, and STI treatment[91].

UNFPA targeted areas with poor access to health services and areas affected by humanitarian crises with routine integrated supplementary outreach and mobile health teams (MHT) clinic interventions with all the reproductive maternal, newborn, and child health services. The services included BEmONC, incorporating EPHS, family planning and community sensitization, including prepositioning of RH kits in 18 hospitals and

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[87] The humanitarian response was mainly implemented through donor funding support from the Danish Government, Irish Aid, Canada, Japan, KOICA, Bill and Melinda Gates Foundation, World Bank and others, with complementary support for the agency's resources.
[88] Interviews and document reviews.
[89] Document Review and Interviews with Government of Ethiopia, IPs and UNFPA CO Staff.
[90] Document reviews and Interviews with IP and CO staff.
[91] Document reviews and Interviews with IP and CO staff.

health centres which were fully damaged or looted during the crisis. The outreaches and MHT clinics targeted highly populated areas with little access to healthcare services. The MHTs implemented jointly with UNICEF, integrating GBV, SRH and nutrition screening facilitated access to integrated humanitarian services. Interviews and document reviews indicated that the outreaches and MHT clinics made a lot of difference in the locations targeted as they also made referrals to facilities with CEmONC services (for BEmONC outreaches) in the localities, with UNFPA facilitating transportation costs, including supporting with five ambulances and related costs. UNFPA also responded to the emergency needs of those affected by drought and Elnino in Ethiopia through integrated SRH and GBV outreach services. UNFPA also conducted outreaches in the IDP settlements with no access to health services enhancing access to integrated quality SRHR, GBV, MHPSS, and HIV and cervical cancer services in the target humanitarian locations by the affected populations, particularly women and girls. In addition to the health services, UNFPA ensured targeting the vulnerable populations with emergency kits, including the distribution of dignity kits to vulnerable women and girls in the IDP settlement and the hard-to-reach areas.

COVID-19 Response: During the period of coverage, UNFPA greatly contributed to the prevention and response to the impacts of the COVID-19 pandemic in the country through advocacy mechanisms the National COVID-19 Response Plan integrated SRHR and GBV priorities. This approach facilitated the continuity of related services through a coordinated strategy for resource mobilization, especially within the UNCT and HCT, and the effective use of emergency funds to address the crisis. Further, UNFPA was instrumental in strengthening the capacities of various actors for effective preventative, responsive and promotive programmes to prevent and respond to violence, abuse, exploitation, neglect, and family separation; and further strengthening of prevention, mitigation, and response services for violence, including GBV, and increase awareness and help-seeking behaviours. UNFPA also contributed to the continuity of SRH and GBV services by supporting the supply of health facilities and staff with personal protective equipment as part of the rapid scale-up of services due to the pandemic. The support also helped with the protection of the health workers who were providing these services to the population.

Strengthening humanitarian-development-peace nexus programming: The 9th CP was instrumental in strengthening the humanitarian-development-peace (HDP) nexus programming aimed at ensuring lasting and coordinated results in response to the humanitarian crisis in Ethiopia. Notably, UNFPA contributed to building capacities of the government agencies and the national counterparts on humanitarian preparedness and resilience. UNFPA also enhanced preparedness, early warning and response mechanisms within the IDPs and vulnerable populations. Most recently, in 2024, UNFPA Ethiopia also hired an international expert on Peace and security to further strengthen the integration of peace in the HDP nexus programming. The expert contributed to strengthening the integration of peace in the CP and was supporting the United Nations Development Programme (UNDP) (through UNRCO) in the integration of the Disarmament, Demobilization, and Reintegration programme.[92] Additionally, UNFPA enhanced its HDP nexus programming through integrated efforts, which involved reassigning staff initially focused on humanitarian work to contribute to the HDP approach. Interviews with Country Office (CO) staff during the evaluation period indicated that strengthening the HDP nexus was a key focus within the CO and was reflected in the proposals submitted to donors. However, it was too early to fully assess the progress of these efforts, as the implementation context remained fluid in the conflict-affected regions. Interviews with IPs also indicated that UNFPA highly contributed to the HDP through the financial and technical support for the development of SOPs, guidelines, policies and manuals, in addition to conducting training on different response aspects, including MISP[93]. UNFPA also increased the potential for triggering early warning or early action by strengthening the capacity of the ESS in the use of satellite imagery enabling data collection in inaccessible areas[94].

GBV Prevention and Response in the Humanitarian Setting: UNFPA strengthened access to integrated lifesaving GBV response and prevention during the 9th CP in all seven regions affected by humanitarian crises and natural disasters through supporting 8 shelters, 10 safe houses and 33 OSCs which were equipped to provide standard and comprehensive services for survivors of gender-based violence, reaching 187,857 women and girls, including sexual and gender-based violence survivors. The GBV lifesaving services included comprehensive GBV case management, CMR services, emergency referrals, psychosocial first aid, PSS, awareness information sessions, community mobilization interventions, skill development activities, behaviour change and GBV prevention interventions integrated with Prevention of Sexual Exploitation and Abuse (PSEA). UNFPA also supported the operation of the WGFS with more women and girls being informed on GBV prevention.

Strengthening Coordination of humanitarian response: UNFPA significantly contributed to the strengthening of multisectoral coordination and referrals mechanism among the SRH and GBV key actors

[92] Interviews with ESS and UNFPA CO staff and review of COARs.
[93] During the period under evaluation, UNFPA contributed to systems strengthening through the revision of the GBV Policy, Revised guidelines on training, Data and information management, supporting service delivery Planning and implementing strategies through HRP, M&E training and Participation in the Contingency planning.
[94] Interviews with ESS and UNFPA CO staff.

through chairing, co-chairing, financing of meetings and participating in the coordination structures across the country to enhance service delivery in the humanitarian framework. During the period, UNFPA supported the delivery of GBV prevention and response by leading the GBV area of responsibility (AOR) in collaboration with the Ministry of Women and Social Affairs and the line regional bureaus. Interviews and document review showed that the coordination efforts spearheaded through the GBV AOR were instrumental in leveraging resources and partnerships for coverage (elimination of overlaps) and service delivery, enabled harmonization of key messages, especially for advocacy on GBV response and prevention, in addition to using it to strengthen capacities of different actors on GBV response and prevention. The platform was also instrumental in coordinating the development and implementation of SOPs, guidelines and policies. Additionally, it was useful and effective for strengthening referral mechanisms for GBV survivor support. Interviews with the national and international NGOs reported benefiting from the UNFPA-facilitated capacity-building sessions through the GBV AOR leadership as it leveraged for stakeholders' coordination and joint effort. As at the time of the CPE the GBV sub-cluster had a membership of 72 organizations comprising INGOs, NGOs, UN, donors and national entities, with active coordination mechanisms in nine regions (Afar, Amhara, Benishangul Gumuz, Gambella, Oromia, Somali, Sidama, and Tigray) distributed in 17 locations at zonal and district levels, which strengthened area-based coordination mechanisms, enhancing humanitarian responses in the affected areas[95].

During the period, UNFPA also co-led the national SRH TWG with EPHI with the participation of more than 22 United Nations agencies, both international and local NGOs, professional associations and government stakeholders, in addition to co-leading the regional SRH TWG in Tigray, Amhara and Afar regions in collaboration with the RHBs. Like the GBV AoR, UNFPA coordination efforts ensured systematic reach to needy people and leveraging of resources and met frequently to share and strategize on how to share activities, in addition to eliminating overlap.

Facilitating factors: During this period, the UNFPA CO implemented effective strategies in their humanitarian response. These included the following:[96][97]

- **Strong government relationship:** The CO developed a strong relationship with the Government of Ethiopia, earning enough confidence to be entrusted with implementing the World Bank-supported programme in Tigray.
- **Leadership and convening power:** The CO's role in co-chairing the SRH sub-cluster and the GBV AOR demonstrated its convening power and leadership in coordinating responses.
- **Donor engagement and accountability:** By facilitating donor missions to the field, the CO showcased its work, enhancing accountability and providing evidence for its impact. The CO's approach included documenting experiences and communicating evidence, focusing on the most at-risk groups, and reaching marginalized and hard-to-access areas.
- **Stakeholder engagement:** The CO's leadership and active engagement with the Government, donors, and within the UNCT and HCT helped build trust and confidence among stakeholders.
- **Surge capacity:** The deployment of over 30 additional staff through the surge model enabled the CO to respond rapidly to the humanitarian crisis.
- **Scenario planning:** Effective scenario planning by the CO facilitated the accurate determination of humanitarian needs and guided the response efforts.

Even though UNFPA was instrumental in supporting and contributing to the humanitarian response in the country there were challenges that hampered delivery. This was however corrected by having a coordinator who had experience with the UNFPA business model, and this facilitated processes effectively. Interviews also showed that UNFPA CO leadership experienced challenges with changes in the senior CO leadership with a total of six transitions in the role of the Country Representatives during the 9th CP. This was reported to hamper engagements with stakeholders during the period, including affecting credibility with donors. The office was stable with the leadership contributing a lot to the UNFPA mandate. The humanitarian response was also affected by high government staff turnover, particularly after capacity building, affecting response continuity. Implementation of policies and guidelines also had limitations with limited capacities and accountability of stakeholders, particularly Government. Furthermore, Ethiopia has a relevant number of refugees, but the 9th CP did not prioritize them. Additionally, inadequate access to the conflict-affected areas limited effective identification of needs and response.

Unintended Consequences

i. **Humanitarian capacity building of local IPs:** During this period, UNFPA engaged MSIE as an implementing partner for the humanitarian response—a field in which the organization had not

[95] Interviews with IPs, UN and UNFPA CO staff and a review of Documents.
[96] Interviews with Government of Ethiopia, CO and donor staff.
[97] UNFPA COARs, interviews with UNFPA, Government, IPs and Donor staff.

previously worked on, only been involved in development-oriented work. However, due to the experience gained through the partnership with UNFPA, MSIE was in the process of establishing an emergency department. This development was driven by UNFPA support, which included training and providing essential guiding response documents such as the MISP.

4.3.5 Adolescent and Youth Development

Introduction: The adolescent and youth component of the UNFPA 9th CP was designed to ensure adolescents and youth, particularly those most vulnerable, are equipped with skills & knowledge to make informed choices about their SRHR within an enabling environment that promotes adolescent health and wellbeing. The output targeted to reach five indicators and the respective achievement in each of the output level indicators are illustrated in Annex 7[98]. Further, the component was implemented both directly by UNFPA through direct implementation and in partnership with IPs respectively. The interventions in this component were identified and implemented in close consultation with the respective line ministries, both at the national and regional levels.

A&Y, particularly those most vulnerable, are equipped with skills & knowledge to make informed choices about their SRHR within an enabling environment that promotes adolescent health and wellbeing

Interviews with government agencies and IPs recognized UNFPA support in adolescent and youth knowledge and skills development through onsite training and developing online platforms and digital learning materials. SRH and HIV-related services provision in health facilities - including public health facilities, those run by NGOs such as Family Guidance Association of Ethiopia, industry parks, and youth centres-, peacebuilding efforts - through integration in SRH services - and support for institutional strengthening were reported as critically important. The holistic approach of UNFPA - from education, health and wellbeing, inter-facility linkage, and different skills development to startup for livelihoods - was described as highly strategic for AY and the country's sustainable economic development with peace and security.

Youth-Friendly Services and Youth Centres: The 9th CP contributed to increased access to comprehensive adolescent and youth-related services, including adolescent sexual and reproductive health (ASRH) services provided by skilled health staff trained with support from UNFPA, through supporting adolescent and youth-friendly services (AYFS) establishment and strengthening in public health centres, the Family Guidance Association of Ethiopia, youth centres, and industry parks in the targeted regions. Interviews and document reviews established that there were both isolated AYFS corners and those integrated in the health facilities (including private facilities), enhancing access and addressing different needs of the A&Y. Interviews and reports indicated that UNFPA supported the facilities with medical equipment and office furniture, trained healthcare providers and RH commodity supplies, including STI drugs. Reviews of CP reports revealed that UNFPA supported a total of 198 Youth Friendly Service outlets equipped with the necessary equipment and supplies to increase access to quality integrated SRH services. Additionally, the 9th CP also contributed to strengthening the quality-of-service delivery by capacitating a total of 1,071 health professionals on adolescent and youth health, HIV prevention and SRH. These enabled the young people to receive comprehensive SRH services, including the following: contraception and FP; condom promotion and provision; HIV counselling, testing and treatment; STI screening, management, and follow-up; cervical cancer screening; GBV; PSS; referral services from the facilities, and increased awareness and demand creation for ASRH and YFS. UNFPA also ensured the corners were fully equipped to provide services, including abortion care and maternity waiting areas.

UNFPA also supported school youth clubs and provided dignity kits; in addition to supporting young women working in industry parks to receive family planning service, antenatal care, HIV testing, STI treatment, safe abortion service, psychosocial support, and screening for cervical cancer risk. It is imperative to note that UNFPA, during the 9th CP, contributed to addressing the unique vulnerabilities of the industrial park workers who were mostly female below 25 years of age and access SRHR-related services through supporting the development of Minimum Service Package, facilitation of signing of a memorandum of understanding (MoU) involving the Ministry of Health, RHB, Industrial Park Managers, and the Industrial Parks Development Corporation. This MoU allowed transfer of ownership of the health facilities in the parks to the RHB ensuring access to integrated and quality SRH and GBV services by the workers[99].

[98] Review of COARs.
[99] Review of COARs.

Utilization and sustainability of YFS services were however challenged by multiple factors, including armed and civil conflicts (to the extent of total service disruption in Tigray and many parts of Amhara, Oromia, and Afar), stigma, time of service availability, and lack of all services in the same facility as per the National Minimum Service Package and Standards. The A&Y was afraid of stigma to visit clinics during working hours and opening only during working hours has limited their utilization of the services. The evaluation also established that the so-called "best performing" AYFS have been providing only HIV testing and counselling, clinical STI screening, contraception provision, condom promotion and provision, implying the huge service gap in the AYFS providing facilities. Whether to have an isolated AYFS or an integrated one in the existing health facility also influenced their access by the A&Y, but their preference was not clear to the health service administrators. Interviews indicated that several youths preferred to get the health service during weekends and at night, as these periods minimized possible stigma, and those working in industries could have free time to get the service. In Afar region, the utilization of the YFS and youth centres was a challenge as the services were integrated and due to deeply rooted cultural issues the A&Y could not access the services conveniently with interviews reporting discrimination of A&Y seeking the services. Additionally, the GBV cases were also not reported due to dignity, religious and culture-related issues. There were also gaps in reaching the out-of-school youth as they were not permanent in their respective places of residence.

> *"When I go to that room, people will be sure that I am going to receive a contraceptive method or condom. They may also think that I am pregnant, requesting abortion. Then after, people start talking about me and even they may tell my parents that I am pregnant or living with HIV. You see, how we can easily be stigmatized and discriminated against? If all the services are provided in youth centres where we can as well go to the clinic for any health problem, we will not be afraid of stigmatization."* - **Focus group discussant from Bahir Dar.**

At the youth centres, the youth also accessed recreational services low-cost livelihood development opportunities, job opportunities and linkages, capacity building, and business development services, including substance abuse management, among other support. For example, according to the FGD sessions with the beneficiaries the life skills training on self-expression, awareness and demand creation on SRH and GBV, coping up with challenges, preventing unintended pregnancy and STI/HIV; escaping risks of violence prevention, gambling, and substance use, were reported useful for the young people increase their knowledge and skills. The result was instrumental in enabling the young people to receive access to different services, including contraception, HIV testing and counselling, STI screening and treatment, safe abortion, integrated sexual and gender-based violence services, mental health, psychological support and financial support to enrol in the community-based health insurance schemes, allowing them access to free primary health care services, including SRH. Additionally, feedback was that the young people were able to effectively deal with their life challenges, including making guided choices and well-being.

> *"We benefit a lot from the youth centre; more than 80 per cent of youth in our sub-city benefited from this centre; our confidence is built with training and exchanging experience; some of us were addicted to different substances, but now we are free and role model for many of our brothers and sisters who are still dependent on it. Some of us and many others got jobs after the free business development skills training; we did not know about grant writing before, but now we are getting grants by ourselves. We will do our best to make this centre more fruitful."* - **FGD at Bahir Dar Youth Centre**

There was confirmed adoption of the UNFPA approaches in targeting and empowering the youth through the youth centres. For example, in the Sidama region, the Youth Bureau capacity built the youth on different aspects, including strengthening youth platforms and establishing peer education forums at the youth centres in Tabor and Tula sub-cities where UNFPA provided support. The youth centres thereafter established vibrant youth clubs (the majority being girls' clubs) that enabled the production of many youth leaders (especially female youth leaders) and entrepreneurs. Despite more than half of the 3,000 youth centres reportedly being non-functional nationally in 2020 and completely shut down centres in the Tigray region, the 9th CP support through the youth centres in Amhara and Hawassa regions showed the untapped potential of youth centres for youth development, probably the experience from Bahir Dar and Hawassa to be shared with other regions.

Strengthening the prevention of new HIV infections among young populations and key populations

UNFPA responded to the efforts of ensuring the reduction of new infections which were found to be higher among the young people. This was in alignment with the East and Southern regional transformative results area on HIV prevention. Through the 9th CP, UNFPA contributed to enhancing HIV programming among young people and key populations through the integration of SRH, HIV and GBV services enhancing their access through various strategies, including the development of policies, and strategies and conducting advocacy with the same. Integration of HIV interventions enhanced coverage and ensured that no one was left behind and young people were incorporated in the programme. UNFPA supported the Ministry of Health

on the prevention of new HIV infections through targeting marginalized communities, and inclusivity of the programme through advocacy and policy strengthening. Interviews indicated that through UNFPA leadership and advocacy, there was ensured mainstreaming of adolescent and youth interventions in the HIV policy.

During the 9th CP, UNFPA facilitated the population at risk, like the sex workers and young people living with disabilities to access integrated SRH, HIV and GBV services through training and distribution of commodities/ kits. The capacity building enabled the professionals to provide friendly SRHR services and/or link them to other health facilities. To ensure safeguarding and dignity enhancement for female sex workers, UNFPA established drop-in centres[100]. UNFPA financial support to adolescent and youth with disability to access SRH services was instrumental in building their capacity through training and produce relevant materials, including knowledge development, preventing STI/HIV and GBV, making informed choices, breaking attitudinal information barriers, ensuring equal access to SRH and GBV services, mainstreaming adolescent and youth with disability with the HEP, and supporting the production of information education communication and behaviour change communication materials (brail, sign language, and audio). The UNFPA material and financial support to organizations of persons with disability was also significant in systematically mapping and identifying major SRH and GBV-related problems and possible solutions. Based on the identified gaps, training and advocacy programmes were conducted. Additionally, public health facility modifications have been also done to enhance service availability and accessibility to young people with disabilities.

Exemplary supports of UNFPA to adolescent SRH were the "Smart Start" (delaying pregnancy after marriage through informed family planning decisions) and "Her Space" (mentoring 11-14 years adolescent girls' healthy transition to adulthood). "Smart start" was launched by PSI (as adolescent 360) in Ethiopia in 2016 to combat teenage pregnancy among married girls between 15 and 19 years of age. During the current CP, UNFPA contributed a lot to the "smart start" project scale up by availing contraceptive methods and providing finance to regions for advocacy and integration into the existing government's health structure. To ensure meaningful and inclusive youth engagement in the health sector lifecycle, from designing a policy/programme to implementation, monitoring, and evaluation, UNFPA supported Ministry of Health in the development of A&Y health strategy, adolescent and youth engagement guideline implementation, which are important policy documents for partners and programmers at the federal and regional levels. Ministry of Health and regional health bureaus have taken a bold step for the establishment of regional youth councils and including youth as board members of health centres and primary hospitals.

During the peak of COVID-19 (2021), UNFPA supported the launching of adolescent and youth health and life skills literacy technology known by the name "Yenetab" mobile application, which was developed by the Consortium of Reproductive Health Association (CORHA) and endorsed by Ministry of Health to address adolescent and youth SRH. This was appreciated as it was responding to the CP innovation plan as accelerators, but utilization was not as planned and CORHA is currently working to increase the reach. In the same year, another mobile application (named "Minch") development for adolescent and youth with disability was supported by UNFPA in collaboration with other partners, as an alternative toll-free source of information and networking for SRH. The primary focus of both "Yenetab" and "Minch" mobile applications was on SRHR, GBV, HIV and related matters.

UNFPA as well supported the DKT project that aimed at increasing female sex workers' knowledge and skill development by using a standard out of school comprehensive sexuality education guideline, condoms and contraceptive use, HIV and other STI screening, and linkage with health facilities for additional health services. As a result, use of the services was reported as increased. However, despite the female sex workers' higher risk of developing cervical cancer (due to high prevalence of human papilloma virus and other STI) precancerous cervical lesion screening was not included in the project activities. Furthermore, the project did not include supporting the sex workers to change their lifestyle from risky to relatively safe jobs.

Integration of youth participation in peacebuilding: During the period of the CPE, UNFPA enhanced the role of young people in the peace building, recognizing the potential and vulnerability they have in the conflict situation in Ethiopia. Apart from co-leading the newly established Youth Peace and Security Technical Working Group (YPS TWG) within the UNCT, UNFPA supported training of more than 30 representatives of the youth associations on youth engagement for peace development and humanitarian response targeting increased engagement of youth associations in humanitarian response and conflict resolutions. Additionally, UNFPA supported the Ministry of Women and Social Affairs to develop the National Plan for YPS (Youth Peace and Security), and this led to the formation of YPSR TWG to facilitate coordination of the efforts. While it was too early at the time of the CPE to establish the results of these efforts, interviews and reviews of reports highlighted the need for enhanced engagement of the youth in peace processes which was limited during the period.

[100] Interviews and document reviews.

The following limitations and challenges were witnessed in this area:

- The government structure dealing with youth issues was several times disbanded, which was a challenge for UNFPA AY programmes. New regions were taking long to organize themselves and get engaged in development programmes, including the 9th CP.
- Earlier UNFPA supported the establishment of some of the YFS and youth centres in Tigray region, but there was no functional YFS or youth centre in Tigray region at the time of our evaluation (as the regional health bureau and youth bureau reported). Prior to the eruption of the conflict, all YFS and 91 youth centres were fully functional.
- Lack of public health facilities in industrial parks and availability of limited type and costly nature of SRH services in privately owned clinics are real gaps, regional health bureaus in Sidama and Amhara regions have already noted. Even then, out of more than 30 operational industry parks[101] in the country, only two established referral linkage with higher health facilities.
- Inadequate resource allocation and delays in disbursement were reported as a major bottleneck for the expansion of AYD and related activities. UNFPA has limited capacity to support basic services that need to be introduced as per the national minimum service package in YFS of its target areas.
- Community youth engagement in the development of the new youth policy was a gap; the new youth policy drafting consultants invited youth bureaus for consultative workshops but did not invite youth from the community.
- Except for condom distribution through EPSS and supporting the integrated HIV testing in youth-friendly health service, UNFPA-supported HIV prevention activities were not visible in all sampled regions; regional health bureaus maternal and child health and HIV prevention directors reported that they did not have HIV prevention programmes with UNFPA.
- Lack of disaggregated youth data was a challenge to measure overall 9th CP performance outputs given that the CP was highly integrated.

Unintended consequences:

i. **Expansion of Youth Empowerment Initiatives:** Building from the positive results of UNFPA support to the youth centres in two Hawassa sub-cities; many of the youth in the region have been establishing youth clubs and requesting capacity-building training for leadership and employment. The regional state had as well benchmarked the experience of the youth clubs in the two sub-cities and budgeted for similar undertakings in other youth centres in the region. Members of the youth clubs in the two sub-cities spearheaded the establishment and took the leadership of the Regional Youth Network, by mobilizing 40 youth clubs in the region.

ii. **Peacebuilding and Conflict Resolution through SRH and Youth Skills Development:** The earlier planned interventions through KOICA-UNFPA support for AY in Guji-Gedeo zones - where the inter-communal conflict was protracted and caused severe damage and a large population displacement- contributed to peacebuilding. Specifically, the community conversation on SRH service utilization and youth skills development interventions opened room for a dialogue between adults and youth, which was instrumental in ensuring conflict resolutions.

4.3.6 Integration of human rights, gender perspectives, disability inclusion, and those furthest behind

The 9th CP effectively incorporated gender considerations throughout all thematic areas, in line with the UNFPA Strategy for Promoting Gender Equality and the Rights of Women and Adolescent Girls. This strategy emphasizes Agency, Choice and Access, focusing on gender-responsive SRH, reducing GBV, promoting gender and rights-based opportunities and services for adolescents and youth, as well as gender-responsive population data and research to advance human rights and gender equality as critical pathways for gender transformation[102].

Aligned with the gender strategy framework, the 9th CP strived to embed gender perspectives in SRH, adolescent and youth issues, population dynamics, and humanitarian response to achieve gender-responsive programme outcomes. The development of capacity-building manuals and tools ensured the integration of gender aspects, with the CO Gender Unit offering expert support in reviewing and providing input on gender integration in the production of capacity-building materials across various components[103]. The incorporation of FGM into the SRH programme, which involved creating a registration system for pregnant women at health centres and connecting them with HEWs for ongoing support and follow-up to prevent FGM of the newborn female, was an impressive integration that interviews, and document reviews indicated led to a greater community engagement in the preventing planned FGM. Additionally, the inclusion

[101] Ethiopian Investment Commission Guide 2023.
[102] Document review.
[103] Interviews with UNFPA CO, IPs and document review.

of gender aspects in the youth training manual is a noteworthy accomplishment in the integration of gender in the Adolescent and Youth components. This achievement resulted in increased participation of young females, both as members and in leadership positions, in youth clubs, as observed in the Amhara and Sidama regions.

Gender integration proved to be effective in the humanitarian response sector, particularly in the areas of protection and GBV prevention and response within humanitarian settings. This was crucial in meeting the UNFPA mandate of preventing GBV in both development and humanitarian contexts responding to crises-induced GBV. However, current gender integration efforts primarily focus on protection and GBV issues without fully addressing the broader gender-related barriers that prevent women from participating in key decision-making processes within humanitarian response frameworks. Although the 9th CP made efforts to align gender mainstreaming with gender mainstreaming with the UNFPA gender strategy document, there is a lack of consistent gender analysis as a prerequisite for gender mainstreaming. The limited practice was evident in specific donor-supported projects, which needed to be more consistent to inform the programme implementation and the mainstreaming strategy.

The 9th CP duly recognized the importance of intersectionality and the principle of leaving no one behind. The programme specifically prioritized women who experienced various forms of discrimination, such as adolescent and young girls, women with disabilities, women and girls in conflict settings, rural women, and girls of all ages. These groups were identified by the IPs as the primary beneficiaries of the programme.

Furthermore, the 9th CP emphasized regions where GBV, FGM/C, and child marriage were highly prevalent, to address the violations of human rights of women and girls. The intervention actively advocated for human rights by prioritizing the empowerment and engagement of those whose rights were violated. The review of programme documents indicated that the programme intervention tackled both the demand and supply aspects that promoted a human rights approach in programming by encouraging individuals to seek services and enhancing the capabilities of service providers. Additionally, interviews also indicated that the 9th CP's engagement of various stakeholder groups toward the advancement of gender equality and reproductive rights within the context of implementation, advocacy and support for the development of the GEWE and FGM policies enhanced the integration of gender and human rights. Additionally, the targeting of the women with obstetric fistula also restored their dignity and enhanced their rights to access RH service[104].

Interviews and FGD with beneficiaries indicated that the programme successfully ensured access to services for individuals who faced various forms of discrimination due to their social and health status, as well as distance barriers. A notable achievement in this regard was the CP's efforts in the prevention of GBV and FGM/C and Child Marriage through media engagement, which promoted inclusivity by incorporating sign language and audio-visual aids for individuals with hearing and vision impairments. Additionally, the program's partnership with the Ethiopian Disability Association contributed to facilitating an inclusive approach for people with disabilities, and evaluation findings have shown their active participation in the programme. According to the interviews with IPs, one significant accomplishment in this area was that women with disabilities who survived GBV were able to access services, with 84 individuals benefiting from these services in the Amhara region.

UNFPA focus on integrated RH needs and rights of the most vulnerable, including people with disabilities, marginalized women and girls, among others is also evidence of a human rights perspective. In addition, UNFPA supported the selection of locations with needs through the availability of data contributing to the HNO and HRP, with locations lacking service delivery being targeted through the mobile health teams indicating the intention to reach those most in need. Nonetheless, the entire orientation of the UNFPA CP supports the realization of rights to RH including safe motherhood, cancer care, family planning, HIV prevention, for adolescents, around GBV, and for the empowerment of women, ensuring that no one is left behind[105]. The programme's approach of collaborating with WDG and HEW was instrumental in reaching women and girls residing in remote areas that lack access to SRH and GBV information and services. By training HEWs in delivering SRH services, they were equipped to assist women in extremely remote areas with safe deliveries and referrals to the nearest healthcare facility in case of complications upholding the rights of the affected populations to service and ensuring LNOB.

The 9th CP also supported the implementation of strategies that addressed marginalization and discrimination based on social and harmful practices in the country, including the needs of people living with disabilities. UNFPA made deliberate efforts through partnerships with stakeholders to reach the hard-to-reach locations, in addition to supporting inclusion and participation of adolescents, youth, IDPs, vulnerable women and girls in access to services, dialogues and education sessions aimed at changing discriminatory gender norms, especially the abandonment of FGM and participation in discourses on implementing their reproductive rights. There was also support for training IPs on gender issues, the establishment of women and girls' safe spaces, and early child marriage awareness[106]. Key vulnerable populations were targeted

[104] Interviews and document reviews.
[105] Document review and interviews.
[106] Interviews with IPs and UNFPA CO staff and document review

during the 9th CP, exhibiting a focus on enhancing human rights approaches. During the period of consideration, the people living with disability (PWDs) benefited from the interventions of the CP[107]. UNFPA also supported ESS to include a module to give a profile on the prevalence of disability in the EDHS. Further, UNFPA used advocacy mechanisms through social media platforms to amplify the voices of the youth and the need for youth inclusion in the peace process, while considering young women and people with disabilities in the decision-making process. However, there was no dedicated project targeting PWDs, and none of the programme reports included data on the number of PWDs supported. While programme reports did contain sex and age-disaggregated data on beneficiaries, the reporting tools (COARs) did not provide options for further disaggregation by disability status or other social factors, except when specified as a component indicator.

4.4 Efficiency: Answer to Evaluation Question 4

EQ4: To what extent has UNFPA Ethiopia efficiently utilized its human, financial and administrative resources, while adhering to appropriate guidelines and procedures, to deliver the intended outputs and pursue the achievement of the UNFPA strategic plan outcomes?

Summary of Findings:

Overall, UNFPA CO made good use of its resources during the 9th CP to ensure the results were achieved in an efficient manner. UNFPA CO made good use of its financial and human resources. The programme was managed from the Country Office headquarters in Addis Ababa with regional offices which were useful in facilitating follow-ups with regional partners and enhancing relationships. UNFPA CO had internal controls on finance, procurement and administration functions, ensuring compliance. The CO had a robust M&E facilitating the implementation of quality CP interventions and facilitating accountability. However, the staff was spread thin coordinating wider coverage, in addition to inadequate focus on learning, knowledge management and disaggregation of data, especially on the most marginalized populations.

For details of the evidence supporting findings in section 4.4 see Evaluation Matrix, Assumptions 4.1, 4.2, 4.3, and 4.4 (Annex 1)

4.4.1. Human Resource and Technical Assistance

The human resources and technical assistance provided during the 9th Country Programme significantly enhanced the program's efficiency in achieving its targeted results. The creation of regional offices and the strategic assignment of staff to government implementing partners ensured that expertise was applied where it was most needed. The program benefited from the appropriate skill sets and effective teamwork among staff, as well as the careful selection of strategic partnerships. Integration and enhancement of technical guidelines, tools, and manuals improved overall execution. Additionally, internal capacity building and rigorous monitoring and evaluation practices further contributed to the program's increased efficiency and successful outcomes.

The field-presence of UNFPA with sub-offices in the regions across the country played a vital role in ensuring the successful implementation of the CP through providing support and oversight of programme activities and stakeholders at the regional and district levels, serving as a bridge between UNFPA CO, regional and district governments, and the programme targeted groups. According to the interviews with the implementing partners, the existence of UNFPA sub- offices facilitated exchange of information between UNFPA and other regional-level line bureaus. Additionally, the staff from the sub-offices represented UNFPA in various working groups at the district and regional levels. Furthermore, according to the interviews with government IPs the deployment of UNFPA staff to government IPs greatly contributed to the coordination and integration of UNFPA thematic components into existing government programmes in the targeted regions.

UNFPA recruited national and local staff with national and local understanding that facilitated the efficiency of the CP delivery. Particularly, the recruitment of local staff at the sub-regional offices facilitated an understanding of local dynamics and enhanced effective relationships with the local structures including local government enhancing the delivery of context-sensitive services. Additionally, interviews with IPs confirmed that the assignment of local GBV case management specialists at the regional level greatly contributed to the improvement of the technical capacity and support for IPs.

The successful implementation of the 9th CP was also attributed to the presence of skilled staff and effective teamwork that regularly provided expert support for IPs as evidenced by feedback from interviews with them on the technical support they received from UNFPA. Each of the 9th CP thematic areas was supported by program analysis/specialists and experts who provided necessary assistance for the CP implementation facilitating its efficiency. Interviews with IPs confirmed that both the UNFPA programme and operations teams were effective in providing them with the necessary technical and operational support, which was well-planned and tailored, enabling them to implement quality and comply with the necessary delivery

[107] interviews and document review

requirements. The assignment of focal points for the IPs particularly enabled and facilitated efficient engagement and delivery of the programme through guided support and follow-ups. The UNFPA CO significantly enhanced the capacity of the staff in their areas of technical focus during the 9th CP through organizing capacity building and exposure visits contributing to the quality of deliverables Additionally, the hiring of consultants for in-country provision of services facilitated the transfer of technical skills, with a specific focus on enhancing institutional capacity. Interviews with the UNFPA CO staff revealed that this support by consultants also improved the CO's team capacity enabling them to provide the required technical support for IPs facilitating efficiency.

The program's efficiency was significantly boosted by the strategic selection of implementing partners. This careful selection ensured strong buy-in from the Government and communities, supported alignment with government strategies, and improved coverage of marginalized and vulnerable populations, thereby enhancing overall program delivery. International NGOs brought valuable technical expertise and contributed to operational costs, including shared staff expenses, further supporting the effective implementation of the 9th CP.

The programme integration approach also improved the CP's efficiency, with staff being able to provide a wide range of services with the existing staff size. For example, the integrated SRH programme offered a variety of services that also included GBV, MPSS, STI/HIV management, and Cancer screening, among others, with the Gender and humanitarian team being able to provide an array of interventions, enhancing the coverage of the CP interventions. Moreover, the development of technical guidelines, tools and manuals enabled quality service delivery and cascading of the skills which significantly facilitated the 9th CP efficiency reaching the wider section of the community.

While UNFPA effectively utilized human resources and technical assistance for the 9th Country Programme (CP), challenges emerged regarding the limited number of CO staff as compared to the wide geographic focus and large number of implementing partners (IPs). Interviews with IPs, United Nations agencies, the Government of Ethiopia, and CO staff revealed that UNFPA staff were sometimes overstretched, struggling to provide the necessary support. The varying capacity levels of IPs, with some requiring consistent technical assistance from UNFPA, highlighted the need for adequate staffing levels. Additionally, the CO staff noted that certain thematic areas, such as Gender-Based Violence (GBV) and gender, required intensive technical support. However, the representation of GBV specialists was limited, with some regions lacking these experts, which created challenges for UNFPA in fulfilling its mandate. The Population Dynamics team also faced constraints, with only one fixed-term staff member, supported by an international consultant covering for a long-term sick leave, and two National Programme Officers, which limited operational capacity. Additionally, UNFPA presence in the regions and districts appeared spread too thin with resources being limited for optimum results and efficiency.

4.4.2. Financial and Administrative Efficiency

UNFPA put in place mechanisms to ensure compliance and quality assurance ensuring organizational efficiency. UNFPA utilized both national and direct execution modalities to deliver the programme. To ensure compliance within the office, the CO ensured that the staff had of all the procedures, in addition to continuously updated SOPs to customize processes in finance, procurement, logistics and HR. Interviews and documents review showed that UNFPA had a clear and robust system for ensuring checks and balances, and to ensure that all IPs were accountable for deliverables promptly. Interviews and document reviews revealed that UNFPA had a well-established system of developing, reviewing and approving AWPs, on which the 9th CP was operationalized. The AWPs guided the respective IPs' financial and programmatic commitments on which accountability was expected through programmatic and financial reports, providing feedback on completeness, quality and absorption or utilization rates of the funds. The UNFPA Country Office assigned focal points, referred to as fund managers, to each implementing partner (IP). These managers played a crucial role in supporting and monitoring the IPs throughout the management and delivery of the AWP. Their proactive follow-ups on deadlines and action points were instrumental in ensuring the efficient implementation of the 9th Country Programme (CP). A standard Fund Authorization and Certificate of Expenditures form, reflecting the activity lines of the Work Plan, was used by IPs to request funds. The CO followed the quarterly schedule for the release of funds to the partners and was based upon the submission of quality and complete progress reports of the ending quarter and funds requests for the following quarter.

Interviews with IPs and UNFPA CO staff and document reviews revealed that UNFPA conducted audits and spot checks with recommendations used to support the IPs on the implementation processes of the 9th CP. Further, the CO implemented micro-assessments and IPs' risk assessments to determine the capacity and the risk rating of the IPs, which also determined the cash transfer modalities, where those with low risk are given funds to spend while those with high risks have direct payments to the suppliers made on their behalf to ensure reduced risks in handling cash. Further, the reimbursement modality was also employed where the IPs' expenditures were authorized for payment for spending and funds reimbursed to them based on the approval. All these ensure efficiency and compliance with the UNFPA procedures. Interviews with IPs

confirmed that UNFPA CO was very supportive in providing them with support, capacity building including training and provision of guidelines to ensure that they complied. Based on the global Harmonized Approach to Cash Transfers Agreement, UNFPA utilized the UNDP's Quantum system for the disbursement of funds to the IPs and reporting. During the period under review, UNDP changed the system to the Quantum Plus system and while this aimed to improve efficiency, it affected the delivery processes by the IPs as some delays were experienced due to the inadequacy of experience. However, the IPs reported improvement in the fund management and AWP process due to the introduction of the Quantum Plus system. IPs also reported flexibility with UNFPA support ensuring that budgets were effectively utilized, including on repurposing funds and ensuring effectiveness in the achievement of results.

Some IPs reported delays in disbursement of funds. The interviews revealed that there were challenges emanating from both UNFPA and the partners' sides. On the partner side, the delays were mainly due to the unavailability of the signatories, or the time taken to approve the AWP. On the UNFPA side, this was reported to be due to the unavailability of funds, despite having agreed on the AWP implementation. UNFPA acknowledged challenges in disbursement to IPs, but highlighted the efforts and progress made compared to 2020-2021, leading to shorter delays. These efforts included a strengthened regional presence for improved advance request liquidation and work plans signing with a dedicated person following up the matters; a revamped enterprise application system with modules; and several training for staff and IPs since 2023. The mismatch in the UNFPA budgeting calendar (January to December) and that of the Government (July to June) also affected the planning and disbursement processes.

Interviews and document reviews provided evidence that UNFPA implemented efficient procurement and logistics mechanisms to enhance the delivery of its programs. The CO generated semi-annual and annual procurement plans, which were instrumental in facilitating effective planning and timely replenishment of program materials to ensure that resources were allocated appropriately and available when needed. UNFPA utilized both in-country and external procurement sources. For external procurement, the CO relied on a centralized office in Copenhagen. Daily procurement of program supplies was managed by the UNFPA CO in collaboration with the Supply Management Unit and the relevant thematic units. To mitigate delays in procurement, the CO prepared procurement plans in consultation with the programme units to ensure compliance with standard guidelines and policies. By drafting annual and quarterly procurement plans, the respective units were able to initiate the procurement process based on their specific work plans and requirements, thus ensuring thorough reviews and approvals of procurement proposals.

Despite these efficient mechanisms, there were some challenges, particularly with international procurement processes, affected by geopolitical issues such as the wars in Gaza and Ukraine. These situations hindered the timely delivery of essential items. Additionally, the COVID-19 pandemic exacerbated logistics challenges, particularly during the global shutdown between 2020 and 2021 when the movement of goods was significantly restricted. In response to these challenges, UNFPA adapted by strategically planning procurement earlier, allowing for contingencies and minimizing the impact of possible delays on program delivery. Overall, UNFPA procurement and logistics mechanisms exemplified a commitment to efficiency and effectiveness in program delivery, even when confronted with significant global challenges.

4.4.3. Monitoring and Evaluation

Interviews with IPs and UNFPA CO staff and reviews of the annual plans and reports revealed that the CO put in place a robust monitoring and evaluation (M&E) system for the 9th CP, facilitating planning, collection of data, progress monitoring, and reporting. The CPE established that UNFPA CO had in place different interdependent functions that, together, facilitated the capturing of the performance of the CP ensuring accountability to the various stakeholders of the UNFPA CO. From the analysis of records and interviews with the UNFPA CO, United Nations Agency and donors' staff, the UNFPA CO M&E system was based on the CP's results and resources framework, the UNSDCF and the donors' frameworks. UNFPA CO implemented all the main planned activities including, planning (both annual and quarterly), monitoring activities, midterm review and the CPE.

The UNFPA CO M&E Unit spearheaded the functions and ensured the 9th CP was delivered in a timely, quality and efficient manner. Interviews and document reviews indicated that the M&E processes for the 9th CP were effectively implemented across the programme cycle. Document review and interviews with CO staff revealed that the unit utilized the planning processes to develop the results and resources framework, which effectively facilitated the alignment of the CP with the national priorities, the UNSDCF, and UNFPA SP, with resources and targeted stakeholders clearly allocated and identified. The period saw changes in the CPD implementation context and SP, necessitating a realignment that saw the RRF being aligned to incorporate a humanitarian action output[108] with specific indicators that were not contained in the original CPD. This confirmed the UNFPA CO's responsiveness to changes in the implementation framework. UNFPA CO conducted both annual and quarterly planning including setting targets based on the RRF for the 9th CP,

[108] The realignment was done for the period 2022 – 2025.

facilitating follow-up on its progress and performance on the indicators[109]. UNFPA also held biannual and annual review sessions for the IPs, including government stakeholders, with the participation of all the relevant CO staff, facilitating experience sharing and enabling the teams to address arising challenges, in addition to planning for the following annual programme cycle[110].

UNFPA used a global web-based SIS for annual reporting and quality monitoring, enabling the UNFPA CO to plan, monitor, and report. This system was integrated with the regional, and headquarters offices for real-time status of the 9th CP by output area and its contribution to the SP. The CO has however transitioned to the Quantum Plus system, in alignment with the global requirement which has integrated programme and operation management functions. This was reported through interviews with the CO to be highly efficient as it enabled them to easily track progress, in addition to aligning with the UNFPA SP. The CO employed different mechanisms to assess the CP's performance and capture feedback, in addition to ensuring compliance with the accountability mechanisms in place.

The UNFPA CO conducted monitoring activities planned to inform the progress of the programme, including the management of reporting processes periodically. Interviews reported that the monitoring processes for the humanitarian response output had different information needs, and the M&E Unit put in place a data and information management mechanism requiring IPs to report on. This was particularly influenced by the crisis and the required weekly service data collection mechanism informing implementation processes. This was however eventually changed to monthly service data reporting. At the time of the CPE, the M&E team had designed a PowerBI dashboard integrating development and humanitarian data, particularly facilitating the nexus approach. Additionally, the IPs also submit the Workplan progress report to assess progress made on the implementation processes and facilitate monitoring of the results being achieved by the IPs. The M&E team confirmed training the IPs and programme staff on the reporting processes, ensuring capacity strengthening and harmonization of processes.

Interviews revealed that while the UNFPA CO had staff dedicated to conducting the function, including the field monitoring visits, the programme component staff also had an active role in monitoring of 9th CP component activities. The field monitoring activities enabled feedback provision to the IPs, and support supervision to the IPs, including capacity building them in areas of weakness. Interviews with the CO staff also revealed that UNFPA incorporated accountability to affected populations through conducting surveys, including post-distribution monitoring to measure the satisfaction of the beneficiaries, especially those in the humanitarian setting to assess the effectiveness of programme delivery[111].

Interviews with the IPs across the programme areas confirmed being clear on the reporting system and that it also served their interest in improving their understanding of their performance. They reported that they still had challenges in utilizing the Quantum Plus system but acknowledged the support they received from the UNFPA team enabling them to report on their AWPs. The quality of the narrative of the CP annual reports was mixed. Some parts of the reports did not sufficiently report at the UNFPA output level, but mostly remained at activity level, lacking a description of the resulting changes from the interventions. The M&E team was however on course to strengthen the focus on results-based reporting through training[112]. There was also feedback that the government's oversight role in the implementation context was limited due to the limited human resources, technical and financial capacities to undertake the same, and the conflict context.

While there was evidence of monitoring and evaluation (M&E) information being used for reporting and assessing implementing partner (IP) performance, tracking progress against CP targets, and evaluating partner capacities for effectiveness, there was insufficient documentation of learning and dissemination. Additionally, there were gaps in knowledge management and the disaggregation of program data, including data on inclusion and key populations. For example, from the analysis of deliverables by the IPs, which had technical quality issues and challenges, the CO hired two staff with technical skills and communication and assigned them to the WGSS. Interview feedback confirmed that the hired staff were able to capacity-build the staff at the WGSS improving the quality of their deliverables. While interviews revealed that there was limited capturing of learning points in the reports, there were reviews done by the programme teams with the IPs and targets set based on experiences and payments to IPs being based on performance.

During the 9th CP, the M&E Unit experienced growth in terms of size, from two staff at the beginning to eight at the time of the CPE, when it was led by an international M&E Specialist and supported by seven other team members performing different roles, including two Humanitarian Data Analyst and GBV AoR Information Manager, enhancing the efficient delivery on the M&E functions. While the context of implementation had challenges, especially with access to the conflict-affected programme areas, interviews with the M&E and Programme teams indicated that UNFPA was able to assign different team members to

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[109] Interviews with CO and IP staff and Annual Planning 2020- 2024.
[110] Interviews with IPs and CO staff.
[111] Interviews with CO and IP staff and document reviews.
[112] Interviews with CO staff.

deliver on their mandates and provide feedback on the performance of the project. The newly established Power BI dashboard was also reported to be effective in providing real-time information on the programme's performance[113]. There was also confirmed support from the ESARO M&E Advisor based in South Africa.[114].

4.5. Sustainability: Answer to Evaluation Question 5

EQ 5: To what extent has UNFPA Ethiopia contributed to strengthening Ethiopian institutional capacities and development (in system and human resources) and to what extent have partners (rights holders, Government, NGO, development partners, etc) been engaged to ensure sustainability?

Summary of Findings:

The 9th CP promoted government ownership. It enhanced policy and strategy frameworks, through UNFPA technical and financial support. The integration of SRHR/HIV/GBV into policy, planning and services was successfully achieved, through strengthened Ministry of Health support and implementation across various health facilities. It also increased stakeholders' capacity, including that of midwives, frontline workers, HEWs, and community volunteers, as well as the Government's ability to generate relevant population data. It improved the capacity of the health system by equipping health facilities.
Despite these advancements, sustainability was hindered by inadequate budget allocations, limited commitment, and inadequate government capacity in policy implementation and monitoring, and staff turnover.

For details of the evidence supporting findings in section 4.5, see Evaluation Matrix, Assumptions 5.1 and 5.2 (Annex 1)

4.5.1. Strengthening of National Ownership and Policy Framework

UNFPA contributed to strengthening the national ownership of the 9th CP interventions through different means. The majority of the UNFPA 9th CP interventions were implemented in close partnership with the Government and target operation of government systems. For example, both the Federal government and regional bureaus were IPs of UNFPA through the Ministry of Finance and the related regional bureaus. The Annual Work Plans were developed in close cooperation with government partners and were included in the national budget which also facilitated government financial contributions. UNFPA endeavoured to ensure that the interventions were implemented within the government framework of service delivery and based on guiding policy frameworks which assured sustainability of the CP results.

By aligning the 9th CP with the Government's key priorities, UNFPA promoted the integration and prioritization of CP components within government initiatives. This approach enhanced ownership and support from government line ministries and regional bureaus, thereby contributing to long-term sustainability. UNFPA also influenced government policy decision-making through advocacy efforts. For example, during the period UNFPA and UNICEF partnered to deliver mobile health and nutrition clinics which were not in the government policy. At the time of the CPE, the Ministry of Health had developed a national guideline for mobile health clinics, which was reported to be effective, thereby integrating the approach into service delivery mechanisms in the hard-to-reach locations in the country. The revision of the Ministry of Health Essential Health Service Package to include maternal and newborn health, family planning, and CAC services in the UHC cost free package also confirmed institutionalization of SRH service delivery. The cost-free ambulance transport for labouring mothers and construction of MWHs with the government budget also confirms ownership and contribution by the Government in financing SRH interventions.

While most of the 9th CP interventions were humanitarian response, UNFPA was successful in promoting national ownership around SRHR in different ways, particularly building on achievements in previous programme cycles. UNFPA provided financial and technical support for the development of several policies, guidelines and strategies, and promoted SRHR/HIV/GBV integration at policy, planning and programming levels as stated in section 4.3. For example, under the SRH component, UNFPA, supported the Ministry of Health to revise the national health policy (endorsed by the Cabinet in 2024), developed HSTP II, RH strategy, obstetric fistula elimination strategy, MPDSR strategy, and triple elimination of mother-to-child transmission of HIV, HBV, and syphilis strategy, which all have prioritized SRH issues for action, indicating that Government has unwavering commitment to improve the SRH indicators through impactful actions[115]. Interviews indicated that the country would not have realized the benefits of service integration—an

[113] Interviews and review of documents
[114] Ibid
[115] Interviews and review of COARs 2021, 2022 and 2023.

approach increasingly acknowledged by the Ministry of Health, the Ministry of Women and Social Affairs, and their respective service providers as integral to health system strengthening—without UNFPA leadership and support. Interviews with the federal line ministries confirmed that this programme implementation approach will be sustained as the benefits provided increased service access. Despite ownership by the government institutions, there is still needed to support their enforcement, monitoring and institutionalization.

Towards institutionalization of sustainable health financing, UNFPA and other partners established a co-financing mechanism with the Government of Ethiopia for SRH commodities, the Compact Agreement. The initiative was acknowledged by both UNFPA CO and government staff as crucial for ensuring the continuity of SRH services. Ethiopia is the first among low-income countries to implement this innovative health financing scheme. With UNFPA regular resources for SRH services progressively declining, against the yearly increasing population by more than 3 million, this initiative was praised to bridge the funding gap. While this was a step in the right direction, interviews revealed that tracking the contribution of the Government in the purchase of SRH commodities was a challenge. Further, there were signs indicating institutionalization of UNFPA-supported results. For example, the support for ESS on digitization led to the establishment of a GIS department with a focus on ensuring continuity of the acquired technical services despite the support by UNFPA coming to an end. Additionally, with UNFPA support, the country had a georeferenced database and digital maps that were produced and updated by ESS's through use of their own capacity. The support on IMIS yielded results, especially with confirmation of the regional bureaus using the administrative data inputted into the system. There were however some bureaus, such as the one in the Afar region where the system was not in use due to inadequate space.

The partnership approach employed by UNFPA during the 9th CP, where UNFPA engaged the support of local IPs to implement the CP interventions also created a sense of ownership, specially building on local knowledge and understanding of the local context and needs. The IPs also confirmed that they were, in most cases, consulted in the design and this facilitated their ownership of the programme interventions. For example, the Gender IPs exhibited ownership of the WGFS, OSCs and Shelters/ safe houses interventions as the scope resonated with mandate and would continue to look for funding opportunities to continue delivering GBV, life skills and livelihood services to the local community, even if UNFPA funding ended. The local NGOs were using innovative resource mobilization approaches, including seeking support private institutions and individuals to complement the support provided by UNFPA[116]. IPs designed the activities supported by UNFPA in line with their organization's strategic focus; further embedding ownership and assuring continued appeal to the local stakeholders even after the conclusion of the contract with UNFPA. Furthermore, UNFPA collaborated with community members, particularly the youth, to address peace-related issues, and these efforts are expected to continue. For instance, in Sidama and Amhara, youth supported by UNFPA took ownership of the 9th CP's initiatives and leveraged the related results to influence regional decisions, encouraging greater support for youth initiatives. Interviews also highlighted that communities actively supported UNFPA activities by engaging in and contributing to the various interventions.

The attachment of GBV survivors' safe houses and women and girls' friendly spaces with women's associations who have structures at village level and volunteer membership was a promising practice of ownership and sustainability of the services. The attachment of One Stop Centre in public health facilities and continued capacity building for health professionals on GBV case management sustained the provision of direct services to GBV survivors. As a limitation, respondents expressed their concern that the UNFPA support was mostly project-based and short-term, hindering the long-term sustainability of the observed positive change. UNFPA dependence on government policy and structure enhanced ownership but sometimes hindered progress due to the Government's limited capacity and commitment to execute the planned activities or due to administrative structure change. A notable limitation to sustainability is that, despite the significant focus of SRH and GBV issues on adolescents and youth (ages 10-35), the investment in young people has been disproportionately low relative to their needs. This underfunding has constrained the expansion of programs and their potential for long-term impact on AYD. According to CO staff, greater resources would have enhanced their ability to engage in youth leadership initiatives, build the capacity of youth centres, and implement innovative approaches for AYD.

4.5.2 Capacity Building and Institutional Strengthening

The 9th CP integrated capacity development as one of key modes of engagement. Interviews with stakeholders indicated that the 9th CP facilitated sustainability through investing in capacity building initiatives. Throughout the programming for integrated SRHR, HIV and GBV, UNFPA built the capacity of the

[116] Interviews and review of COARs 2021, 2022 and 2023.

public health system and supported implementing partners who could complement Government of Ethiopia services. Extensive national capacity development had also taken place regarding condom programming, including development of a condom strategy. UNFPA contributed to the training of nurses and midwives through supporting their accreditation, further facilitating professionalization, including licensing practitioners. UNFPA also contributed to the delivery of midwifery education through supporting implementation of the curriculum. Capacity development of GBV, and SRH frontline workers, including community level HEWs ensured quality service provision. Another area where UNFPA made major contributions was strengthening health facilities capacity in the rural areas and ensuring sustainability through the refresher training to clinical midwives at Master of Science level to perform caesarean sections. With one month refresher training, the trained midwives were able to perform more than 1,000 caesarean sections confirming transferred skills[117].

UNFPA also utilized South-South Cooperation to strengthen the capacities of the targeted staff from the IPs, with the government IPs confirming learning from the processes.[118] One notable experience during the period was the facilitated visit to South Sudan to learn about utilization of mobile data collection and remote data collection, especially for those who are on the move like the pastoralists or IDPs[119]. Interviews with ESS, Ministry of Planning and Development, and UNFPA CO staff confirmed that there were improved skills in data generation through UNFPA support in data analysis, use of Computer Assisted Personal Interviewing (CAPI), GIS, report writing and training, skills that will continue to be within the institutions supported as the support was institutionalized. This knowledge and skills gained are likely to enhance sustainability of the 9th CP areas of focus. UNFPA also hired a consultant to support the ESS on the design and use of CAPI and this facilitated on-job-training which encouraged hands-on learning through practical experience[120]. Integration of the SRH indicators into the EDHS tools will enable continued collection of data on the indicators beyond the 9th CP. Additionally, the support of ESS in the digitalization of the enumeration areas was already being used to conduct other surveys.

UNFPA nurtured partnerships with local CSOs and this contributed to the strengthening of their capacities. Through these partnerships, UNFPA was able to provide sustainable support to the CSOs' staff, mainly in terms of capacity building and training that aimed at providing them with the necessary expertise and skills to be able to respond to people's needs in different areas and sectors including SRH, AY and GBV. For example, an interview with local IPs in Tigray and Amhara reported that UNFPA support helped their staff to gain the necessary knowledge to be able to manage the system of referrals, psychosocial support, and case management in addition to the application of tools and guidelines, enabling them delivering effectively in their responsibilities, especially in planning, reporting and technical aspects.

UNFPA also facilitated the transfer of skills through the engagement of international experts who worked closely with national experts at the ESS to deliver in their technical areas of focus. This facilitated skill transfers from the international experts to the national experts who will remain in the country to provide the support to deliver on similar skills. However, the sustainability of results depends, for instance, on the sufficient deployment of trained staff and their retention in the post. The IPs reported that staff turnover tended to be high, jeopardizing long-term gains from the training that took place. The Government's capacity and commitment to take up the role in making financial resources available and retaining experts can also unwind the gains made.

As the support of UNFPA to the government system aimed to demonstrate good practice and handover to the Government of Ethiopia for sustainability (transferring the initiative from project to programme), projects such as "Her Space" and "Smart Start" in Oromia region and youth clubs in Sidama region were found to be good examples for UNFPA AY component. "Her Space" and "Smart Start" have been already budgeted and included as regular programmes by Oromia Regional State. In the Sidama region, several youth centres have started getting government budget and technical support after the UNFPA supported youth centres demonstrated good results in terms of AY. UNFPA also supported development of various strategies, SOPs and a centralised management information system to collect data on GBV cases; and to guide the implementation process for various aspects of the CP thematic areas. The RMNCAH was developed, which will continue to guide the delivery of the RH services to the populations. The development of SOPs in various thematic areas, including CMR, Case management, GBV, PSEA, among others will continue to guide the quality standards for the delivery of services. It is however worth noting that there is low commitment of the government on the utilization of the developed strategies.

As inaccessibility, unavailability, and poor quality of SRH services were contributing factors for the occurrence of obstetric fistula and high maternal and neonatal deaths, UNFPA prioritized PHC units' capacity building with human resource and health facility setup, which is in line with the global strategic plan. In practical terms, UNFPA supported the human resource capacity building efforts of the Government through

[117] Interviews and document reviews.
[118] Other South-South Cooperation to Madagascar, China etc.
[119] Ibid.
[120] Document review and interviews with IP and CO staff.

pre-service education (midwifery instructors capacity development, skill labs establishment) and in-service off-site and on-site training (including BEmONC and CEmONC training and CBCM). These actions were taken based on the national licensure exam results that have shown a decline from 60 per cent to 46 per cent pass results, demonstrating the graduates' incompetency.

The community mobilization platforms were probably the most impactful for the sustainability and productivity of the SRH programmes. The primary focus of UNFPA on SRH service demand creation and increased utilization in the communities, which have somehow resulted in community capacity building, is expected to increase the health care seeking behaviours and its continuity.

4.6. Coordination: Answer to Evaluation Question 6

EQ 6: To what extent does UNFPA Ethiopia provide leadership in the GBV sub-cluster and the SRH working group for the effective and timely delivery of service, and how has it contributed to the effective coordination mechanisms of the UNCT and HCT?

Summary of Findings:

UNFPA played a key role in the Ethiopian UNCT and HCT coordination mechanisms, driven by its triple mandate of coordination, accountability, and capacity building. The agency significantly contributed to the implementation of the UNSDCF and supported reporting on the results groups. UNFPA effectively engaged in collaborative efforts within the UNCT and HCT through joint programmes, and coordination through patriating and co-chairing of subclusters like GBV AoR, PSEA Network, SRH sub-cluster and TWG and the YPS TWG. There were however weaknesses in the coordination mechanisms within UNCT with the agencies appearing to be competing, difficult to highlight mandates. The overfocus on humanitarian response also hampered coordination at the UNCT.

For details of the evidence supporting findings in section 4.6, see Evaluation Matrix, Assumption 6.1 (Annex 1)

Interviews with the United Nations agencies, including the UNRCO revealed that UNFPA utilized its comparative advantage and contributed to the coordination mechanisms within the UNCT and HCT contributing to the synergies among the United Nations agencies in the delivery of programmes and minimizing duplication. UNFPA 9th CP was implemented to contribute to the UNSCDF 2020 – 2025[121], supporting the priorities and the targeted results of the National Development Priorities in the Ten-Year Perspective Development Plan, Africa Agenda 2063 and the Sustainable Development Goals and Targets. Additionally, UNFPA contributed to different coordination clusters, forums, technical working groups and task forces in the country contributing to the development and humanitarian response. UNFPA was recognized by the United Nations agencies as a key actor as part of the UNCT and HCT, contributing to the country's national development and humanitarian response agenda. It was underscored that UNFPA played a role in facilitating coordination within the UNCT and HCT[122]. While the 9th CP was aligned with and contributed to the UNSDCF, concerns arose regarding overambitious targets in the UNSDCF, particularly at the outcome levels, which made performance tracking challenging in addition to reprogramming to humanitarian interventions.

Interviews with the United Nations agencies' staff and document reviews confirmed that UNFPA continued to lead the GBV sub-cluster of the Protection Cluster providing leadership at national and regional levels. UNFPA played a crucial role in co-chairing the GBV AOR alongside Ministry of Women and Social Affairs, providing essential leadership in the GBV sub-cluster. Feedback from evaluation participants confirmed that UNFPA actively contributed to the coordination of the GBV AOR, bringing together diverse stakeholders to respond to GBV. This enabled the achievement of GBV resource leverage and synergy among the GBV prevention and response actors, minimizing duplication of efforts in the humanitarian response. UNFPA was also coordinated with the Office for the Coordination of Humanitarian Affairs (OCHA) in the management of the pooled humanitarian Central Emergency Response Fund, where they mobilized more than USD 10 million for humanitarian response ensuring services to the affected were provided, especially through the CSOs. UNFPA further facilitated coordination by co-chairing the SRH TWG, with the Ministry of Health enhancing standardization of SRH approaches supporting Ministry of Health's quality of care. UNFPA also participated and supported HCT in conducting multisectoral assessments that contributed to identifying and prioritization of needs of the population[123]. Interviews with the United Nations agencies also revealed that UNFPA actively participated in the programme management team where the deputy representative attended regularly. Additionally, interviews with United Nations staff also indicated that the UNFPA Country Representative always stepped in as RCO.

[121] UNFPA contributed to all the three outcome areas of the UNSDCF 2020 – 2025.
[122] UNSDCF 2020 – 2025 Ethiopia, UNFPA CPD 9, COARs, and interviews with UN agencies and CO staff.
[123] Interviews with UN agencies and CO staff.

UNFPA also played a role in the UNCT by co-chairing the United Nations Data and Statistics Working Group in which several United Nations agencies were also represented. The focus of this Group was the coordination of data and statistics interventions within the United Nations system in the country thereby supporting the Government in data availability and utilization. This Working Group under the leadership of the UNRCO was instrumental in advocating with the Government of Ethiopia for the conduct of the 4th Ethiopian Census, which had been postponed severally, particularly during the conflict period. At the time of the CPE, there was a task force established on the same to discuss the progress. According to the interview with the CO staff, the Technical Working Group had been active for the last year holding meetings every month to brainstorm on issues related to data and statistics. At the time of the evaluation, UNFPA was a member of a newly established platform, Partners' Group, as part of the United Nations system to support the production of vital statistics through coordination. The CO was also a member of the newly formed platform called Partners' Group within the United Nations system to support the production of vital statistics through coordination of the CRVS. This was a new platform, and results were yet to be observed at the time of the CPE.

Under the UNCT, UNFPA also led the coordination of the United Nations agencies on A&Y issues, being the Chair of the Youth Action Group. The CO also contributed the services of the Peace and Security expert in supporting the UNCT and HCT to strengthen the HDP Nexus programming approach. Further, UNFPA co-chairs the newly established YPS TWG alongside the International Organization for Migration (IOM), RCO, and UNDP to enhance the role of young people in the peacebuilding process through tailored technical support. During the period, UNFPA also supported UNDP in organizing a leadership forum, and Youth Peace and security[124]. In the roadmap towards the development of the Ethiopia UNSDCF 2025 – 2030, the CO played a key role in leading gender equality and aligning the UNSDCF to the basic normative LNOB from a human rights perspective. During the Common Country Analysis, UNFPA participated in the inter-agency team and contributed to the Health and Gender sections of the assessment, in addition to the PD.

During the period of evaluation, there was evidence that UNFPA implemented joint programmes and collaborated with various United Nations agencies ensuring the leveraging of resources for enhanced use of comparative advantage. Interviews and document reviews revealed that UNFPA and UNICEF collaborated to jointly implement their global partnership on FGM and Ending Child Marriage programmes where both agencies utilized their comparative advantage to deliver the programmes. UNFPA led the FGM programme while UNICEF led the Ending Child Marriage programme harnessing synergies and effectively coordinating to eliminate duplication and overlapping. UNFPA and UNICEF also collaborated and mobilized resources in-country from the Irish Aid up to 2023. The two agencies at the Ethiopia Country Office also benefited from a Joint Programme Coordination Team at Headquarters and Regional Offices receiving strategic guidance and quality assurance to promote resource efficiency and prevent redundant efforts[125]. With the coordination of this programme with the Ministry of Women and Social Affairs, there were challenges in adapting and using the reporting platforms where the requirements from UNFPA were different from that of UNICEF. Interviews revealed that there were efforts put in place by the two agencies to orient Ministry of Women and Social Affairs on the reporting process.

Under the health and nutrition sector, UNFPA also implemented a joint project with both WHO and UNICEF funded by the Bill and Melinda Gates Foundation. This was a pilot project implemented to test and refine the model for mobile health and nutrition teams (MHNTs) in the climate-related shocks and conflict-affected populations in Afar, Oromia and Amhara regions. The planning processes involved both agencies. While UNFPA contributed to the provision of integration SRH and GBV services and UNICEF provided integrated nutrition and child health services. There was confirmed collaboration where both UNICEF and UNFPA-supported clinics provided each other's services ensuring comprehensive delivery to the affected populations. For example, UNFPA deployed midwives in all the UNFPA and UNICEF-supported clinics. UNFPA also jointly implemented with UNICEF a programme on rights-based approach on adolescent and youth development funded by the University of Norway targeting the most-at-risk groups including female sex workers, youth and those working in industrial parks and youth with disabilities in 15 hotspot areas.

UNFPA also collaborated with different United Nations agencies to ensure strengthened referrals and access to services. For example, UNFPA collaborated with the World Food Programme (WFP) and FAO to refer vulnerable and marginalized women and girls engaging in negative coping mechanisms to be prioritized for food and livelihood support respectively. This effectively contributed to addressing vulnerabilities within the affected populations and restoring their dignity. UNFPA further collaborated with WFP as the pipeline manager and utilized the logistics clusters for transportation of commodities. Additionally, the evaluation established that UNFPA worked with WFP to integrate FP and GBV into their programming where UNFPA trained WFP staff on the same. This UNFPA effectively utilizing its comparative advantage to support other United Nations agencies. UNFPA also worked with the United Nations Office for Project Services (UNOPS) to establish service points through World Bank funding. Additionally, UNFPA worked with UNOPS to recruit short term GBV staff for deployment in monitoring through OCHA funding in the SNNP and Oromia regions.

[124] Interviews with Un agencies and review of COAR 2023.
[125] Interviews with UNICEF and UNFPA CO staff and COARs.

UNFPA was part of the Protection Cluster, led by the United Nations High Commissioner for Refugees (UNHCR), where they coordinated efforts on the refugee and returnee service program. UNFPA also utilized the UNHCR offices to host its staff through a memorandum of understanding to deliver GBV and SRH interventions to the refugees and returnees. Additionally, UNFPA and IOM collaborated on supporting returnees and migrants, with UNFPA supporting IOM through supplies and IOM facilitating distribution. Both agencies also collaborated to ensure that there were integrated GBV tools to track data on cases[126]. Interviews however revealed that UNFPA was not strong in refugee programming as refugees were not included in the SRH services it provides. Feedback from the evaluation respondents, particularly from the United Nations agencies, indicated that UNFPA effectively co-chaired the PSEA Network with UN Women. In this arrangement, the agencies collaborated to ensure the UN agencies were trained and sensitized and reporting mechanisms clarified on PSEA. Additionally, UNFPA was instrumental in strengthening national and local level capacities including supporting awareness creation and information sharing. During the period of review, UNFPA also supported the position of the PSEA Coordinator, seconded to the UNRC's office. The victim support was however weak and ensuring that the people on the ground knew what was right and wrong on PSEA[127].

> *'Here in Amhara, UNICEF and UNFPA operate in the same woredas, but different kebeles. They have a joint work plan, and if you go to UNICEF Clinics, you will find UNFPA-related services of SRH and GBV. You will also get the same happening in the UNFPA clinics…. UNFPA uses guidelines developed by UNICEF, and UNICEF does the same with UNFPA-developed guidelines. UNFPA will strengthen the capacity of stakeholders on health services, UNICEF would support legal providers, ensuring complementarity'* – **Interviews with the Amhara RHB.**

UNFPA, UNICEF and UN Women also collaborated under the National Alliance for Ending Child Marriage and FGM (2020 – 2024). Notably, they shared resources to conduct advocacy mechanisms, particularly during the international days. UNFPA, UNICEF and UN Women also collaborated on ending child marriage and GBV advocacy and response, and jointly supported technically and financially the Ministry of Women and Social Affairs to develop SOP for shelters and OSC for essential services, in addition to the SOP for GBV prevention and response services. UNFPA supported technically and financially, while UN Women contributed technically. Additionally, UNFPA and UN Women supported the Government on the GEWE Policy, with UN Women supporting both financially and technically, while UNFPA contributed technically as part of the TWG established to develop the same. The two agencies further supported the Ministry of Women and Social Affairs in developing a national sex offender registry. The CPE findings however showed that there was no clarity in the roles played by UNFPA, UN Women and UNFPA in the implementation of the OSC and shelters creating an impression that they were competing.

While the above findings confirm UNFPA active role in contributing to the coordination mechanisms within UNCT, the CO was found not to be actively engaged in the Gender Thematic Group led by UN Women, despite being a member of the group and the relatedness of its mandate. Additionally, there was weaknesses in the mainstreaming of gender equality which was not well coordinated among the United Nations agencies, with further need to strengthen collaboration and advocacy with the relevant government stakeholders and the senior management within UNCT to ensure cross-cutting functions are implemented, including scorecard on the gender equality assessment[128].

4.7 Coverage: Answer to Evaluation Question 7

EQ 7: To what extent does UNFPA Ethiopia's humanitarian response reach the most vulnerable and marginalized groups including women, adolescents and youth with lifesaving SRH and GBV interventions in humanitarian settings?

Summary of Findings:

UNFPA contributed to ensuring reach of the affected geographical areas and the affected most vulnerable populations through partnership with the local and international NGOs and facilitating coordination mechanisms within the response framework. The CP mainly focused and concentrated activities in areas identified to be most in need, hard to reach areas and marginalized populations, particularly areas without functional healthcare services utilizing a human-right programming approach ensuring no one is left behind. UNFPA additionally supported the identification of the needy areas through data capture. Conflict situation and COVID hampered access to some population limiting the extent of demographic and geographic coverage.

[126] Interviews with IOM, UNRCO and UNFPA staff.
[127] Interviews with UNRCO, UN Women, UNICEF and UNFPA staff.
[128] Interviews with UN agencies staff.

For details of the evidence supporting findings in section 4.7, see Evaluation Matrix, Assumption 7.1 (Annex 1)

UNFPA 9th CP utilized its comparative advantage to enhance access to various lifesaving SRH and GBV services and information by the vulnerable and marginalized groups including women, adolescents and youth among the crisis affected locations. The period of evaluation had a humanitarian crisis due to the armed conflicts across the country, mainly in Tigray region, with effects in Afar, Oromia, Somali and Amhara regions; drought and floods; COVID-19, among others. UNFPA ensured reaching affected populations and geographical coverage through partnerships; capacity building; supporting evidence-based programming through needs identification; strategy, guideline, and SOP development; supporting coordination; provision of RH supplies and health facility support; and use of mass media and community engagement. Review of programme documents and interviews with IPs and CO staff revealed that UNFPA was particularly intentional in targeting the marginalized and discriminated populations in hard to reach and crisis-affected locations, based on the LNOB principle.

UNFPA contributed to the access of integrated SRH and GBV services by the vulnerable populations during the period of review through several strategies. Capacity building of the humanitarian actors, including both Government and IPs, contributed to enhancing coverage and quality of services delivered. UNFPA built the capacity of stakeholders on MISP and emergency preparedness, provided support to MWHs, OSC, safe houses, deployment of midwives in the crisis-affected locations; provided support to the development of response guidelines and equipped health facilities, including strengthening referrals effectively contributed to enhanced access to quality lifesaving SRH and GBV services targeting vulnerable women, adolescent girls and young people in the affected locations which were hard to reach during the crisis[129].

During the period of evaluation, UNFPA contributed to the identification of needs and response on SRH and GBV for women, adolescent girls and young people through supporting different mechanisms. Feedback from IPs and government stakeholders reported the flexibility by UNFPA enabling adaptation to changing situations, reprogramming and contextualizing response to suit the situation including putting a response plan which enabled provision of targeted services and resources allocated based on identified populations and geographical locations with needs. Additionally, UNFPA contributed to the evidence-based response to the needs through supporting assessment and surveys to determine the needs of the drought and flood-affected populations and locations and effectively ensured provision of integrated SRH and GBV services. The data collected also enabled other stakeholders, including the Government, to respond in other areas of response based on the gaps established[130].

Through collaboration and partnership with the Government of Ethiopia (including the regional bureaus of health and women and social affairs), UNICEF, WHO and IPs, UNFPA ensured access to integrated lifesaving SRH and GBV services through provision of integrated mobile health and nutrition and outreach services across the country in the affected areas. The mobile health and nutrition clinics were particularly equipped and targeted the hard-to-reach locations and marginalized. For example, in Afar region, the clinics targeted areas not covered by HEP, the marginalized communities and those affected by shocks and cultural beliefs[131]

'*Initially, the Government was not having a buy-in for the mobile health clinics since this was a new concept in the country. With its effectiveness in the delivery of the integrated SRH and GBV services, including distribution of FP commodities and dignity kits to the affected and underserved populations, and with the advocacy and support of UNFPA, the Ministry of Health is spearheading implementation of the National Guideline on Mobile Health'* **– Interview with Regional Bureau of Health and UNFPA**

UNFPA Ethiopia CO actively engaged, as part of the HCT, in the advocacy and support of prioritization and allocation of resources based on vulnerability and those at risk like IDPs, pregnant women, children, girls, people living with disabilities and the elderly to access services in the HRP[132]. UNFPA effectively collaborated and coordinated with WHO and UNICEF to ensure that underserved locations were reached, and resources allocated. Evidence indicated that there was engagement and consultations with the affected populations in prioritizing those in need[133].

Recognizing the marginalization and the gaps that existed at the time of the crisis, with most service points not tailored to serve young people, UNFPA in collaboration with the regional bureaus of health, youth affairs, women and social affairs, adapted and supported selected youth centres and health facilities to provide YFS based on specific needs of young people, including clinical SRH and GBV services like STIs testing, counselling and treatment, HIV testing and referrals, PSS and FP services, and other recreational services. UNFPA also supported the training of healthcare workers to provide services with the specific needs of young people. Interviews and document reviews revealed that these efforts were instrumental in reaching out to young people, who were initially not able to access SRHR and GBV services because there were no friendly

[129] Document review and interviews with UNFPA CO, IPs and government staff.
[130] Reviews of COAR, interviews with UNFPA CO, IP and government staff.
[131] Interviews revealed that some women in Afar never trusted the health facilities for services, and therefore would miss on the maternal care risking the lives of those pregnant.
[132] Document reviews – HRP 2022, 2023, 2024, COARs and Interviews with UNFPA CO, IPs and government staff.
[133] Interviews with Government, IPs, UN agencies and UNFPA CO staff and Document reviews.

services. The trained service providers also used the centres and facilities to sensitize the young on key aspects, including prevention of GBV and positive masculinity.

The cash assistance support by UNFPA for fistula cases[134] covering transportation and medical expenses to those vulnerable women in the hard-to-reach areas enabled them to access advanced medical care in specialized facilities, and this included care for other services like STIs and HIV care, as reported through COARs and interviews with IPs, government and UNFPA staff. This further enabled vulnerable communities to access services. In Afar and Tigray regions for example, UNFPA cash support for emergency referrals enabled the vulnerable women to access SRH services in the targeted SDPs. The UNFPA CO's equipment and support to MWHs and deployment of midwives and lifesaving commodities enabled marginalized and vulnerable pregnant women to access services. Additionally, UNFPA support of ambulances facilitated referrals and access to CEmONC by the underserved populations. During COVID-19 pandemic, UNFPA mobilization of emergency resources facilitated capacity building of the government and other actors, in addition to supporting health facilities, particularly ANC clinics, with personal protective equipment to ensure continuity of response and coverage of vulnerable populations and those in the hard-to-reach areas. The training on MISP planning and preparedness ensured services were provided in a standardized manner[135].

Even though UNFPA CO endeavoured to respond and ensure that the most vulnerable and marginalized populations particularly women and young people were reached, the dynamism in the context, access issues, inadequacy of data on the number of people affected and inadequacy of resources, limited the extent to which the response could be provided. Interviews and document review indicated that UNFPA CO collaborated with different stakeholders to ensure leveraging of resources and capacities to reach the affected population. The UNFPA CO's advocacy for humanitarian response and resource mobilization, through its leadership in coordination mechanisms, was reported by stakeholders as crucial for ensuring coverage of key populations, including people with disabilities and sex workers, as well as addressing various geographical locations during the coverage period. For example, during the COVID-19 pandemic, UNFPA provided tailored health services to over 450 young people with disabilities and 850 sex workers, specifically addressing their unique vulnerabilities. Additionally, the three pilot censuses conducted in 2021 included Washington Group questions on disability in their questionnaires to better capture and address the needs of PWDs.

UNFPA also enhanced coverage of gender issues through being deliberate on the mainstreaming of gender into its humanitarian response programming in the 9th CP. Interviews and document reviews revealed UNFPA support to women and adolescent girls and young people and the prevention of GBV through training and advocacy mechanisms. UNFPA also supported the Ministry of Women and Social Affairs in the development and utilization of gender mainstreaming guidelines during the conflict and COVID-19 pandemic. These ensured that women and adolescent girls' needs were taken into consideration and responded to. While UNFPA endeavoured to ensure that there was coverage of key populations with the humanitarian response, there were still reported gaps in the coordination mechanisms, especially with the government line ministries to ensure the marginalized groups were targeted and reached with services. This limited the extent of impact the CP could realize. There was also a need to reassess the level of targeting of the people living with disability in the context of the war, which had potential of increasing disabilities[136].

4.8 Connectedness: Answer to Evaluation Question 8

EQ 8: To what extent has UNFPA Ethiopia contributed to enhancing the capacities and systems of implementing partners and communities to ensure their preparedness and resilience in humanitarian settings, including humanitarian-development-peace nexus?

Summary of Findings:

The 9th CP contributed to strengthening the capacities of the actors, in addition to supporting the development of strategies, SOPs, manuals, guidelines and policies to guide implementation; initiated youth participation in peacebuilding processes; supporting coordination and promoting integration of programmes handover of health facilities to Government and national ownership of interventions and results. The 9th CP was instrumental in strengthening the HDP nexus programming aimed at ensuring lasting and coordinated results in response to the humanitarian crisis in Ethiopia. Despite visible efforts, the level of integration of peace activities in the programme activities was, however, still limited at the time of the CPE.

For details of the evidence supporting findings in section 4.8, see Evaluation Matrix, Assumption 8.1 (Annex 1)

[134] UNFPA supported women with fistula cases with between 6000 – 7000 ETB per person to cater for their transport and accommodation during treatment.
[135] Interviews with Government, IPs, UN agencies and UNFPA CO staff and Document reviews.
[136] Interviews with the Government line ministries, UNFPA CO and Donor organization.

During the period of evaluation, interviews and document review revealed that UNFPA CO made substantial strides in enhancing the capacities and systems of partners and communities to contribute to longer-term results. UNFPA contributed to this by strengthening the capacities of the actors, developing strategies, guidelines and policies to guide implementation, integration of peace activities into youth interventions, coordination and promoting integration of programmes, national ownership of interventions and results, and enhancing integration of HDP during the period. There was also evidence of developing a roadmap towards meaningful and inclusive participation of young people in peacebuilding and governance and was engaged in the integration of the peace component in disarmament, demobilization, and reintegration. While the implementation of this was hampered by COVID-19 pandemic and conflict, it is hoped that empowering the youth provides a chance to advance peace and socio-economic transformation.

While the initial 9th CP had integrated humanitarian response, particularly on emergency and climate change-related disasters, the emergence of the armed conflicts in the country necessitated strengthening of the HDP Nexus programme approach to ensure integration of peace into the CP activities. Interviews with the IPs and UNFPA CO staff and document reviews revealed that UNFPA CO made deliberate efforts the integrate peace in all the programme activities that the CO was designing, strengthening the UNFPA CO's focus on nexus programming. The level of integration of peace activities in the programme activities was, however, limited at the time of the CPE, particularly the engagement of the youth in peacebuilding activities. Interviews further revealed that given the conflict context of implementation, the UNFPA peace and security expert had made strides towards the integration of peace into the disarmament, demobilization, and reintegration of the Tigray People's Liberation Front in Tigray[137]. During the period, UNFPA implemented the Adolescent-Youth and Family Planning project which integrated the HDP-nexus approach as this had youth discussing peace and security.

During the period under review, UNFPA endeavoured to strengthen the localisation agenda by enhancing the capacities of local NGOs and the government on various humanitarian response and service delivery modalities. For example, in the period, most of the UNFPA CO humanitarian response IPs were from the local NGOs, and UNFPA capitalised on building its capacities in several response areas in its comparative advantage. Additionally, UNFPA support to the government on the development of policies, guidelines, and SOP, among other national guiding documents will go a long way in enhancing preparedness, resilience and longer-term results in case of any emergency response. The development of the National SRH guidelines, National SOPs for GBV services deliveries, development of training materials in the development

Interviews with UNFPA CO, Ministry of Women and Social Affairs and Ministry of Health staff revealed that the training on emergency preparedness and training in MISP by UNFPA was instrumental in supporting the frontline workers (healthcare workers, NGO staff, and WGFS facilitators) to respond to humanitarian situations in the targeted regions. Results showed that the MISP training enhanced coordination and facilitated preparedness and development of response management. UNFPA also ensured that the programme staff also had the necessary competence to provide services. To ensure continued provision of training, UNFPA supported the training of Pooled Master Trainers, and these were instrumental in ensuring the transfer of skills and rollout of MISP for SRH in the woredas. There was confirmation of the training being cascaded at the woreda levels by EPHI and the NGO IPs with reports that the training also contributed to changing the mindset of the government on humanitarian response.

Additionally, the training was decentralized to make it easy for response mechanisms up to the Woreda levels. While the programme was effective in facilitating training and technical support, the availability of commodities was affected by bureaucratic procurement processes for commodities, slow attitudinal change towards emergency response and inadequate adoption of policy changes by the authorities[138]. It is however believed that the strengthened capacity will sustainably enhance resilience due to the transferred skills, overall knowledge, awareness competencies and systems that have been established as part of humanitarian assistance which will be available for future engagement in Ethiopia.

UNFPA CO sought to strengthen resilience at all levels: the system level by enhancing the capacity of health facilities to provide SRH and GBV services; and the community level through youth-led community initiatives to build back better, enhance social cohesion and foster inter-generational dialogue to include young people more in decision-making. This also helped the government to cope with the humanitarian programme. Further, UNFPA worked with Government agencies both at the federal and regional levels and integrated SRH and GBV services in the service package. For instance, UNFPA supported EPHI to provide leadership in the humanitarian response by training different entities on MISP.

UNFPA also contributed to the establishment and strengthening of the Youth Peace and Security Technical Working Group (YPS TWG) through co-chairing and providing tailored technical support in collaboration with IOM, RCO, and UNDP. The initiation of the YPS Action Plan development process by the Ministry of Women

[137] Interviews with Government, IPs, UN agencies and UNFPA CO staff and Document reviews.
[138] Interviews with Government, IPs, UN agencies and UNFPA CO staff and Document reviews.

and Social Affairs was a sign that the focus on peace will be enhanced to ensure longer-term results[139]. UNFPA support to the generation of data for decision-making facilitated response to the various humanitarian responses and development within the country. Interviews with various stakeholders revealed that UNFPA through leading the GBV AoR capacity-built stakeholders on GBV and facilitated mainstreaming of Gender in the HRP, enhancing the consciousness of the stakeholders on the importance of the same. Interviews and document reviews further revealed that UNFPA supported the ESS to establish geo-referenced boundaries which will be used in sampling across the country, further facilitating identification of development needs for prioritization.

Interviews and document reviews revealed that UNFPA supported the development of knowledge materials, especially targeting behaviour change themes on peace, GBV, family planning, women's empowerment, and COVID-19, among others. These will contribute to enhancing knowledge transfer. However, behaviour change takes time and the extent to which such changes occurred during the period of review could not be established. There was also evidence of UNFPA handing over of MWHs and health facilities to the government. For example, in Tigray and Afar, UNFPA handed over health facilities and MWHs to be operated by the regional government's RHBs with the initially deployed midwives being reassigned elsewhere. Evidence was also confirmed by MSIE and EMwA where their capacities were built in emergency response and were influenced to introduce a department with this focus.

4.9 Lessons Learnt

I. **Resource Mobilization Through Strategic Engagement:** UNFPA CO's proactive engagement in various Government, UN, and Donor platforms significantly contributed to acquiring substantial resources for financing the 9th CP interventions. By generating evidence, advocating for SRH and GBV issues in humanitarian settings, and soliciting, preparing, and submitting numerous proposals, the CO successfully secured significant funding.

II. **Co-Financing Initiative and Domestic Resource Mobilization:** The introduction of the co-financing initiative and advocacy for domestic resource mobilization played a crucial role in enabling the government to secure additional resources from the public treasury and donors. This approach ensured the continuous availability FP/RH commodities.

III. **Effective Partnerships with Local Organizations:** Collaborating with local organizations, such as the Ethiopian Midwifery Association and women-led organizations like the Amhara Women Association, proved effective in mobilizing and deploying service providers, such as midwives. These partnerships facilitated prompt deployment and provision of group support services for girls and women at risk of GBV.

IV. **Prepositioning Supplies for Timely Emergency Response:** Prepositioning essential supplies, such as dignity kits and emergency RH kits, enabled timely support for vulnerable girls and women at the onset of emergencies, ensuring prompt assistance when needed most.

V. **Financial and Technical Synergies Through Strategic Partnerships:** Achieving greater financial and technical synergies at national and programming levels is feasible through strategic partnerships with government and other stakeholders. Effective joint initiation of program design and planning from the outset of interventions enhances overall impact.

VI. **Capacity Building for Sustainability:** Investing in the capacity building of IPs lays the foundation for sustainability and enhances program efficiency. Continued technical assistance and financial resources are necessary to maintain and improve these capacities.

VII. **Extended Stay in Safe Houses for GBV Survivors:** The program's framework initially set a standard three-month stay for GBV survivors in safe houses, but the complexity of cases often required stays of six months or longer. This discrepancy stretched the allocated resources and impacted the planned targets.

VIII. **Context-Specific Prevention Strategies for Gender-Based Violence:** Variations in social norms and gender barriers across different locations highlight the need for context-specific prevention strategies. For example, practices such as FGM vary by region, requiring tailored gender analysis to inform effective prevention and response strategies.

IX. **Addressing Gender Norms and Positive Deviations:** Implementing a gender-transformative approach encouraged communities to re-examine and challenge restrictive norms, resulting in increased reporting of GBV cases. However, this shift also exposed new challenges, such as discrimination against survivors and backlash against positive deviations from traditional norms. The program needs to develop strategies to address these issues and mitigate unintended consequences. The CPE revealed that conflict-induced GBV survivors face significant stigma, with derogatory labels and increased instances of internal displacement as survivors attempt to escape discrimination. The program must develop strategies to address these challenges and support survivors in coping with the stigma and displacement.

[139] Interviews with IPs, MoWSA and CO staff.

CHAPTER 5: CONCLUSIONS

5.1 Strategic Level

Conclusion 1: The 9th CP strategically aligned to the national and international development priorities, addressed the needs of vulnerable and marginalized populations, and was responsive to contextual changes. There is however room for more strategic capacity strengthening to enhance effectiveness and sustainability.

Origin: EQ 1 Relevance, EQ 3 Effectiveness, EQ 5 Sustainability, EQ7 Coverage.

Associated Recommendation: 1

The 9th CP design and implementation fully aligned and contributed to the national and international development objectives and priorities. The CP was fully aligned to the UNFPA global Strategic Plans 2018 – 2021, and 2022 – 2025 and UNSDCF, the SDG and the ICPD, significantly contributing to their achievements at the country level. The CP was highly adapted to the country's development and humanitarian needs, including those of the most vulnerable and marginalized populations, particularly in the hard-to-reach and conflict-affected populations. There was evidence of the design and implementation of the programme in a consultative manner, particularly with the government. However, it was not explicit in the CP design how the most vulnerable populations were consulted at the design stage, unlike during the implementation period where they were engaged. The CP was responsive to changing national needs and environment, especially during the COVID-19 pandemic, conflict and disasters. UNFPA strategically strengthened capacities and advocacy at upstream and downstream levels, including developing strategies, policies, SOPs and guidelines. There is however room for more strategic capacity strengthening particularly with the government structures and local CSOs to enhance the sustainability of policies and related implementation. Additionally, there was insufficient commitment of the government towards the implementation and monitoring of policies and strategies hampering results' effectiveness.

Conclusion 2: UNFPA Ethiopia strategically integrated its mandate and nurtured partnerships with key national and international stakeholders, including facilitating coordination within the UNCT, HCT and other relevant coordination mechanisms to improve the delivery of SRHR and GEWE interventions in Ethiopia. However, some coordination and partnership gaps remained.

Origin: EQ 2 Coherence, EQ 6 Coordination Associated Recommendation: 2

The CO effectively ensured the integration of the 9th CP's interventions to contribute to the policies and strategies to meet the needs of the affected populations. It established and capitalised on partnerships and collaborations with national, local and international organizations for resource mobilization and leveraging of resources for enhanced coverage and consolidation of the UNFPA support to the arising needs in the country. The CO actively participated in the functioning of the UNCT and HCT coordination mechanisms and implemented joint programmes with UNICEF and WHO, in addition to collaborating with other United Nations agencies along its areas of comparative advantage, particularly in A&Y, GBV, population dynamics, Gender and SRHR for enhanced delivery of the interventions. The CO effectively co-chaired the Gender thematic group, PSEA Network, SRH TWG and GBV AoR subclusters. There were however coordination gaps among the United Nations agencies, in addition to inadequate coordination, particularly on joint approaches in the engagement of government and donors. There were also opportunities for stronger partnerships, collaboration and integrated programming at both national and regional levels to improve synergies and strategies enhancing access to services by vulnerable and marginalised populations. There were also weaknesses in the integration of mandate, collaboration and partnership with private organizations, and the academia for enhanced leveraging of resources and sustainability.

Conclusion 3: The UNFPA CO considerably utilized its resources in compliance with strong internal systems for efficient achievement of the 9th CP results. However, disbursement delays and challenges in data disaggregation and knowledge management persisted. There were also limited resources compared to the wide programme coverage.

Origin: EQ 4: Efficiency Associated Recommendation: 3 and 4

The UNFPA implemented strategic approaches to ensure efficient delivery of the 9th CP. The office organizational structure ensured local presence and effectiveness in the coordination and monitoring of programme activities. The presence of skilled staff, the provision of technical assistance and the strengthened adherence to the internal controls facilitated efficiency in the delivery of the 9th CP

interventions. Additionally, UNFPA had a robust M&E system in place with adequate staff facilitating the implementation of the programme performance tracking and quality functions. There were, however, reported delays in the disbursement of funds to the IPs and Government by UNFPA, affecting the timely and quality implementation of the 9th CP interventions. This was partly due to the mismatch in planning months for the government (July – June) and UNFPA (January – December) affecting budgeting cycles at UNFPA. The was also limited staff capacity by size in some of the programme and operation units, in addition to the CO having a wider coverage compared to the resources available limiting follow-ups and engagement with stakeholders. There was also inadequate integration of learning and knowledge management and disaggregation of programme data hampering the evidence for UNFPA programming.

Conclusion 4: The 9th CP significantly contributed to the strengthening of the humanitarian response capacities in the country. However, inadequate identification of affected populations due to conflict and unpredictable context limited the extent of targeting humanitarian interventions to the most vulnerable groups. Despite evident efforts to strengthen the HDP nexus, the peace component was not fully integrated yet.

Origin: EQ1 Relevance, EQ3 Effectiveness, EQ7 Coverage, EQ8 Connectedness

Associated Recommendation: 5

UNFPA effectively responded to the crisis, mobilizing resources, including human and financial. In particular, UNFPA contributed through financing the development of a response strategic plan, provision of evidence-based information for quick response, coordination and complementarity, training and integrated support services in the disaster and conflict-affected locations and IDP settlements improving their access to quality SRH and GBV services for example, the deployment of midwives in the conflict-affected locations enabled continuity of SRH services disrupted by conflict. Establishment of GBV and SRH service provision of services enabled access to integrated SRH and GBV services. Supported evidence-based programming through HRP and built the capacity of stakeholders on SRH and GBV access. However, the volatility of the context of the operation affected the response with some places being inaccessible limiting the identification of needs. While there were considerable efforts by the CO to strengthen the HDP nexus approach, there is room to further strengthen resilience at the community level and the degree of integration of the peace at the time of the CPE, particularly on the engagement of the youth in peacebuilding initiatives was limited.

5.2 Programmatic Level

Sexual and Reproductive Health

Conclusion 5: UNFPA contributed to strengthening access to SRH and utilisation of the services and ensured quality service delivery through strengthened individual and institutional capacities. In addition, the CP ensured integration of the SRHR, cervical cancer, HIV and GBV service provision, contributing to improved transformative results in the country. There was however inadequate integration of evidence-based programming and challenges on programme integration implementation, distribution of RH commodities, OF case identification and access and provision of CEmONC.

Origin: EQ1 Relevance, EQ3 Effectiveness   Associated Recommendation: 6

The 9th CP contributed to improved access to integrated SRH, FP, OF and GBV service delivery to the targeted populations. It supported the government in building capacities, development of policies, strategies, response plans and strengthening evidence. It strengthened government structures to provide mentorships in facilities and enhance of skills of staff. Advocacy for quality of care was however inadequately done during the period and there was inadequate targeting of key populations with services. Current monitoring and supervision systems for appropriate evidence-based programming are insufficient for ensuring adequate accountability and effective delivery. Furthermore, there is inadequate integration of programs at the field level, which negatively impacts the enhancement of desired results.

Gender

Conclusion 6: The 9th CP made significant progress in promoting gender equality and combatting negative social norms. However, challenges remain due to the deeply rooted social norms, and inadequacy of data on GBV, policy and law enforcement, hindering UNFPA effectiveness in fulfilling its mandate.

Origin: EQ3 Effectiveness   Associated Recommendation: 7

During the 9th CP, UNFPA enhanced community-level engagement to identify rightsholders and duty bearers to combat negative social norms on positive masculinity to address issues like GBV, FGM/C, and child marriage, among other harmful practices. UNFPA through the IPs intensified gender transformative approaches with various rightsholders and duty bearers, particularly religious leaders and community members leading to declarations conducted denouncing FGM/C and child marriage. Deeply rooted social norms affect the level of change, with a slow pace of change requiring time. The inadequacy of data and weak policy uptake are hampering the response.

Conclusion 7: The 9th CP was highly effective in providing GBV response services to survivors in humanitarian settings and in hard-to-reach areas and effectively supported capacity building of government and CSO IPs for GBV prevention and response. Engagement of men and boys was not systematic nor well developed within the humanitarian settings, with inherently weak referral pathways and inadequate reporting of cases.

Origin: EQ3 Effectiveness Associated Recommendation: 7

UNFPA, through the 9th CP, effectively contributed to strengthening GBV prevention and response through different mechanisms, including supporting the establishment of OSC and WGFS, the development of capacities of different actors, with emphasis on survivor-centred approach, as well as in developing and rolling out service delivery SOPs and guidelines, distribution of dignity kits, as well as, coordination and partnerships through the GBV AOR, in addition to engagement of various stakeholders. UNFPA contributed to the gender and GBV service delivery mechanisms as well as response mechanisms through awareness raising. There was inadequate engagement of men and boys in the IDP settlements, with weak referral pathways particularly access to justice and the livelihood support to the survivors. Inadequate reporting on GBV cases due to low awareness and fear of reprisal by the perpetuation. Weak implementation capacities were also cited as a gap.

Population Changes and Data

Conclusion 8: The 9th CP contributed to strengthening the capacity of the country's data systems. Institutionalization of data generation by the government and use is still weak. Further, there was inadequate use of data for evidence-based programming, in addition to sub-optimal human and financial resource allocation.

Origin: EQ3 Effectiveness Associated Recommendation: 8

The UNFPA CO's support to ESS was highly regarded as it contributed to the strengthening of the institution's capacity for data generation. Notable was the strengthened digitalization of the enumeration areas. The South-South Cooperation's support of satellite imagery data collection for the Ethiopian context was instrumental in strengthening the institutional capacity for data collection in high-risk areas using satellites. Further, supporting the establishment and strengthening of the CRVS Unit was useful in availing current data. There was confirmed use of the IMIS established in the ten regions. There was however inadequate evidence-based programming, in addition to overstretched staff in the unit limiting the adequacy of support.

Conclusion 9: UNFPA advocacy for the implementation of the population and housing census and for the review of the population policy were key achievements during the 9th CP. There was however inadequate investment in the Population and Development Unit with Ministry of Planning and Development.

Origin: EQ3 Effectiveness Associated Recommendation: 8

UNFPA advocacy mechanisms for the implementation of the population and housing census were very strategic since census data is critical for mapping demographic disparities and socio-economic inequalities and for national and regional development planning and tracking progress towards the country's development indicators, including SDGs. UNFPA was instrumental in supporting the advocacy for the revision of the National Population Policy leading to its initiation and will go a long way in incorporating the emerging issues into development planning. UNFPA also supported the development of the demographic dividend roadmap. There were progress reports on AADPD+10 and ICPD commitment progress. However, there was inadequate capacity for both financial and human resources at the Ministry of Planning and Development limiting the level of engagement.

Adolescent and Youth

Conclusion 10: The 9th CP programmes have mainstreamed SRH and HIV prevention, and targeted AY knowledge and life skills development. Some have demonstrated replicable performance. The participation and contribution of the youth in peacebuilding and local governance, as well as youth employability, were however limited.

Origin: EQ3 Effectiveness Associated Recommendation: 9

The 9th CP was instrumental in contributing to the establishment and strengthening of youth centres, and the development of policies and strategies for the youth. AY knowledge and life skills development were enhanced, including critical thinking, communication, leadership and teamwork, employability, and entrepreneurship. Additionally, it contributed to the capacity strengthening of healthcare workers and enhanced advocacy mechanisms for access to ASRH services by the target populations. The IPs and other stakeholders were key in enhancing demand creation for the services. There were however weaknesses in the provision of the AYSRH services within the health facilities.

Conclusion 11: Many UNFPA-supported adolescent and youth development activities are increasingly being incorporated into government agendas. However, inadequacy in identification of adolescent and youth needs, limited funding and changing context limited results achievement.

Origin: EQ3 Effectiveness Associated Recommendation: 9

The UNFPA-supported AYFS effectively met the needs of the young people in the targeted regions. Many of UNFPA supported AYD activities are becoming government agenda (youth clubs in Sidama, "Smart start" and "Her space" in Oromia), aiming at empowering youth, ensuring AY health, and creating resilient and productive young people. Inadequate financial allocation to the youth functions limited regional bureaus from replication of best practices. There was also no policy backup for some of the AYSRH components (like sexual health and wellbeing, comprehensive sexuality education) limiting ownership by government sectors. Additionally, the advocacy and targeting of the SRH rights and needs of populations at risk is limited in the 9th CP.

CHAPTER 6: RECOMMENDATIONS

Introduction: This chapter presents the details of the recommendations logically derived from the findings and conclusions and co-created through the engagement with the CPE ERG, composed of key stakeholders, during the CPE recommendation workshop. The workshop was also attended by UNFPA CO staff who further contributed to the refining of the recommendations based on an initial draft by the evaluation consultants. Two types of recommendations are presented: strategic and programmatic. Each set of recommendations is prioritized based on their importance, urgency, and potential impact.

Recommendation 1: Strengthen strategic partnerships and national capacity for enhanced advocacy on policy and strategy implementation and monitoring.

The UNFPA CO should make deliberate efforts to strengthen partnerships and advocacy for the implementation of the policies and strategies, enhancing the achievement of the UNFPA mandate in the country. The role and capacity of the government and local CSOs in implementing and monitoring the policies and strategies should be clear and strengthened to enhance the effectiveness and sustainability of the 10th CP.

Type: Strategic Recommendation — Priority: High

Rationale: The CPE results showed that the 9th CP support to the government yielded different strategies and policies which were useful in guiding the implementation in the UNFPA areas of mandate. Advocacy for implementation and monitoring of the policies and strategies will enhance accountability for the national stakeholders. Strengthened strategic partnerships and engagement with the government and local CSOs will enhance commitment and ownership of the programme, further enhancing accountability and sustainability in the delivery of the UNFPA-supported mandate in the country. Strategic partnerships provide opportunities for the mobilization and leveraging of resources for enhanced coverage of the existing and arising development and humanitarian needs of the targeted populations.

Based on Conclusion: 1 — Addressed to: Country Office

Operational Implications:

- Enhance accountability by the government and national stakeholders for the achievement and sustainability of the UNFPA mandate in the country through capacity building and engagement for increased domestic funding.
- Champion high-level advocacy through partnerships within the UN, donors, among other key stakeholders in the country, including local CSOs to address the existing development and humanitarian needs.
- Support policy and strategy implementation and monitoring through the development of costed implementation plans for strategies and strengthening of the TWG engagement.
- Advocate for engagement of rights holders through up and downstream advocacy.

Recommendation 2: Strengthen coordination within the UNCT/HCT and other inter-agency coordination mechanisms, government, local CSO and donors and explore opportunities for integration of mandate.

The CO should continue building and further strengthen partnerships with United Nations agencies, Government of Ethiopia, CSOs, Private sectors and academia, among others, in its areas of mandate. It should maintain a proactive role in facilitating UNCT/HCT coordination utilising its comparative advantage and increasingly explore opportunities for collaboration and joint programming and advocacy initiatives.

Type: Strategic Recommendation — Priority: Medium

Rationale: UNFPA utilized both comparative advantage and partnerships to engage with the relevant stakeholders in the country to advance its mandate in the country. The UNFPA CO should build on its coordination gains within the UNCT and HCT during the 9th CP and strengthen partnerships and collaboration within the related United Nations agencies in the spirit of Delivering as One through joint approaches to resource mobilization and advocacy initiatives for enhanced complementarity in response and elimination of overlaps. UNFPA should further strengthen coordination with IPs, government counterparts, related United Nations agencies, academic institutions, Private sectors, CSOs, other stakeholders and donors for increased leveraging of resources and harmonized and improved development and humanitarian outcomes.

Based on Conclusion: 2 — Addressed to Country Office

Operational Implication:

- Explore expanded partnerships for resource mobilization through private sector, academia, and south-south partnerships, among others.
- the Resource Mobilization and Partnership Unit should enhance its efforts in highlighting and sharing the consolidated results of UNFPA work in Ethiopia. By documenting and disseminating these results effectively, the unit can engage stakeholders more effectively, leading to improved partnership opportunities and increased resource mobilization.
- Utilize comparative advantages to enhance evidence-based integrated programming for accountability.
- Advocate for strengthened collaboration within the United Nations agencies to mainstream and transform gender approaches.
- Enhance strong partnerships and networks within the UNCT and HCT for joint programming, resource mobilization and high-level advocacy.
- Increase engagement of local NGOs, women and youth-led organizations and government for enhanced localisation.

Recommendation 3: Enhance operational efficiency.

The UNFPA CO should strategically reassess its geographical presence in the country and align it to its resource (financial, human and administrative) capacity for maximisation of results. There is also a need for more concerted efforts to improve the planning and funding disbursement mechanisms with the IPs and the government for increased efficiency in the delivery of results. Additionally, the CO should strategically continue to reinforce programme integration.

Type: Strategic Recommendation — Priority: High-Medium

Rationale: The continued strengthening of operational efficiency improves the maximisation of results achieved by the CO through the CP implementation. Focusing on strategies to address the challenges that result in delays in the disbursement of funds and reporting as experienced by the government and CSO partners will increase their programmatic quality and accountability. With the increased adoption of programme integration across the CO, there is a need to reassess its geographical presence and institutional and resource capacity guided by its strategic positioning for effective delivery of its mandate in the country.

Based on Conclusion: 3 — Addressed to: Country Office

Operational Implication:

- Support the IPs and government partners through training on financial and programmatic compliance and accountability and ensure early planning and collaboration for AWP financing to the elimination of delays in approvals, implementation and disbursement.
- Assess the CO institutional capacity and geographical presence to identify and address existing gaps, particularly resource capacity and consolidation of mandate programmatic and operational efficiency.
- Enhance the use of technology in procurement and human resources management for enhanced efficiency.

Recommendation 4: Improve knowledge management and M&E for increased evidence-based decision-making.

The CO should strengthen its knowledge management function for enhanced learning across the organization. The CO should ensure that the M&E data tools capture disaggregated data according to the beneficiary groups targeted by the CP, in addition to enhancing advocacy for increased focus on results.

Type: Strategic Recommendation — Priority: Medium

Rationale: Systematic integration of knowledge management mechanisms enhances the generation, storing and sharing of evidence across the CO. This will further facilitate enhanced quality improvement, innovation and advocacy for resource mobilization and capacity building. Strengthened disaggregation of program data by target groups enhances the principle of LNOB, as it allows for the establishment and analysis of evidence-based targeting, which can inform programmatic decisions. Advocacy and support for increased visibility and focus on results will enhance accountability for the results achieved.

Based on Conclusion: 3 — Addressed to: CO and ESARO

Operational Implication:

- Increase results-based management, visibility for UNFPA focus in the country and disaggregation of data based on target groups for accountability and results.
- Promote systematic learning and cooperation between different programme components/thematic areas and their integration, as well as capacity building for standardization of approaches across programmes and IPs.
- Integrate knowledge management through enhanced documentation and widen dissemination of lessons learnt and best practices.

Recommendation 5: Reinforce Resilience building and HDP Nexus Programming

The CO should ensure increased focus on resilience building to enable the crisis-affected populations to adapt and recover from the effects of the conflict and disasters. It should strengthen the integration of HDP nexus approach for longer-term results among the affected population and increase integration of the peace component and the engagement of the youth in the peacebuilding activities.

Type: Programmatic Recommendation — Priority: High

Rationale: The CO already initiated efforts to strengthen the humanitarian-development-peace nexus in Ethiopia. There is a further need to build the resilience capacities of the actors and the affected populations to reduce the effects of shocks emanating from perennial natural and man-made calamities. Early warning and integration of peacebuilding and conflict resolution interventions will contribute to addressing humanitarian preparedness and reduce suffering during humanitarian situations. Strategic integration of the peace component and increased participation and involvement of the young people in peacebuilding will increase their contribution to reducing the effects of conflict and strengthening HDP.

Based on Conclusion: 4 — Addressed to: Country Office

Operational Implication:

- Strengthen resilience programming to bridge the humanitarian-development-peace nexus, strengthen the integration and advocate for funding for peace to enhance the HDP nexus approach.
- Promote strengthening the capacities of local and national actors to identify and deal with associated risks, vulnerabilities and their underlying causes, with particular focus on strengthening early warning and peacebuilding systems.
- Enhance capacity building of actors, especially in enhancing coordination between development and humanitarian, data collection and analysis to support the resilience programme shift for effective delivery.
- Advocate for mapping and identification of the most vulnerable populations in the conflict-affected locations for effective response.
- Advocate for increased resource allocation for coverage of the areas of mandate in the humanitarian context, including peace.

Recommendation 6: Strengthen evidence-based programming and integration of SRH, FP, HIV, Cervical Cancer and GBV at the implementation level.

Advance evidence generation in the SRH programming for increased evidence-based decisions in the formulation and execution of interventions. Increase delivery of integrated SRH programming (SRH, FP, HIV, Cervical Cancer and GBV) at the field implementation level for enhanced results and efficiency.

Type: Programmatic Recommendation — Priority: High

Rationale: UNFPA successfully integrated all services (SRH, FP, HIV, AYFS, Cervical Cancer and GBV) in alignment with Strategic Plan outputs and ensured strategic alignment providing the framework for increased effectiveness and efficiency in the delivery of the CP across the targeted locations through enhanced service access. Increased evidence generation will enhance accountability and ensure evidence-based improvement. Additionally, strengthening the integration of the programme components will improve the efficiency and effectiveness of the CP.

Based on Conclusion: 5 — Addressed to: Regional Office and Country Office

Operational Implication:

- Advance implementation of integrated SRHR, including Obstetric fistula, MPDSR, HIV, Cervical cancer, GBV, and AYFS programming at the facility level for enhanced efficiency and effectiveness in programming.
- Advocate establishment and increase demand for mini blood banks in the Afar region to facilitate a

reduction in maternal mortality ration due to haemorrhage at childbirth.
- Enhance campaigns for proper obstetric fistula identification and strengthen referrals for identified cases.
- Advocate for equipment of some of the existing ambulances in the conflict-affected and hard-to-reach locations for enhanced referral mechanisms.
- Strengthen the government and local stakeholders' technical capacity on the implementation and management of the FP/RHCS supply chain strategy to ensure effectiveness and sustainability. Enhance evidence-based distribution.
- Promote research on inclusion for increased targeting of the most at-risk groups.

Recommendation 7: Advance gender transformative approaches targeting social behaviour change and strengthen the policy and legal frameworks for improved gender equality and elimination of harmful practices.

The CO should continue advancing the advocacy mechanisms against negative social gender norms with increased engagement of religious leaders and groups, traditional leaders, and promotion of positive masculinity through male engagement. It should increase engagement and advocacy on strengthening gender-related policy and legal systems and implementation.

Type: Programmatic Recommendation Priority: High

Rationale: The evaluation established that the 9th CP's support for transformative approaches, especially the engagement of religious leaders, community members and male engagement targeting positive masculinity yielded positive results within the implementation constraints, including the establishment of laws outlawing child marriage and FGM/C. Increasing the scope will ensure the transformation of the social norms and attitudes exacerbating harmful practices. Advocacy for the development and implementation of gender-related policies and laws will strengthen mechanisms for the prevention of GBV, and the elimination of child marriage and FGM/C in the targeted locations

Based on Conclusions: 6 and 7 Addressed to: Country Office

Operational Implication:

- Target advocacy at community levels reaching out to the custodians of the norms and accelerating the awareness creation to eliminate GBV, Child protection and FGM/C.
- Increase engagement of men and boys in promoting positive masculinity for support for increased access to GBV/SRH services.
- Strengthen enforcement and monitoring of gender-related policies and legal frameworks through advocacy targeting duty bearers, including the government to increase the elimination of harmful behaviours.
- Strengthening evidence-based GBV prevention and response through increasing engagement of duty-bearers and supporting the government to implement policies and legal frameworks.
- Strengthen advocacy strategies to enhance women's leadership and participation through targeting women-led organizations and existing structures.
- Advocate for stronger partnerships, collaboration and coordination among stakeholders for leveraging resources for enhanced response and coverage, including strengthening women's economic empowerment.
- Increase utilization of GBV data for response and strengthen referral systems for GBV survivors.

Recommendation 8: Strengthen the Statistics System and advocacy for the integration of population dynamics into development planning, management and humanitarian responses.

The CO should continue strengthening the capacity of the government's statistics system including enhanced generation of evidence for formulation of programmes and development monitoring, including SDG performance. The CO should also enhance advocacy for the integration of population dynamics into the formulation of development programmes for informed decision-making through policy reviews and implementation.

Type: Programmatic Recommendation Priority: High

Rationale: Ethiopia lacks up-to-date data on population-related issues (census data in particular) making it difficult to monitor the various development frameworks that the country has subscribed to including Agenda 2063, and SDGs, among others. The existing Population Policy was developed in 1993. With changes in the country's population structures, the review of the Population Policy will facilitate the integration of population dynamics into development decisions. Strengthening the capacity of the government's statistical systems will improve the quality of evidence generated for informed decision-making.

Based on Conclusion: 8 and 9 Addressed to: Country Office

Operational Implication:

- Advocacy for the generation and use of data to increase evidence-based development and humanitarian response to address data needs or gaps in the country.
- Strengthen institutionalisation of evidence generation, dissemination and utilisation capacity for sustainability.
- Strategically intensify partnerships and collaborations for leveraging resources and advocacy for the completion of Census implementation and the integration of population dynamics into development planning and management.
- Improve availability of disaggregated data and integration of population dynamics into policy formulation.
- Leverage utilisation of digital innovations for evidence generation in hard-to-reach and marginalised locations and conflict-affected locations to facilitate evidence-based targeting.
- Prioritize strengthening of CRVS, particularly increasing the coverage and digitization of civil registration generation for enhanced use of CRVS data for planning and monitoring demographic and socio-economic indicators.

Recommendation 9: Strengthen consolidation of youth programming and coordination in the country while at the same time continuing to build the capacity of the youth on leadership, and ability to influence policy and strategies.

The CO should invest in developing a costed-national implementation plan for the national youth strategy and policy to enhance the consolidation and coordination of A&Y programming in the country. It should also continue building the capacity of the youth on leadership, and ability to meaningfully influence policy and strategies based on their needs.

Type: Programmatic Recommendation Priority: High

Rationale: The evaluation established that the A&Y interventions cut across different ministries limiting the extent of consolidation of performance in the implementation of the interventions. The development of a national youth strategy costed-implementation plan will enhance coordination of targeting of A&Y activities, leverage resources and consolidation of results on youth programming through monitoring mechanisms. Increased targeting of youth activities will further improve the engagement and participation of young people on issues affecting them including policy influence and strategy development and strengthen their access to AYSRH services and information.

Based on Conclusion: 10 and 11 Addressed to: Country Office

Operational Implication:

- Support the development of a costed-implement plan for the national youth strategy and policy to guide A&Y programming in the country. Support Ministry of Women and Social Affairs’ capacity for coordination of youth issues.
- Strengthen partnerships for advocacy for increased youth participation and civic engagement through targeted support for youth-led and youth-focused organizations. Increase focus on building the capacity of A&Y networks for their meaningful engagement and participation on national and regional decision-making platforms.
- Advocate for the enhanced role of youth in peace and security for sustainable development.
- Target strengthening economic empowerment of the out-of-school youth through skills development and partnerships, including enhanced engagement of the youth in innovation and use of technology.
- Support the minimum service package implementation in A&Y safe spaces (youth-friendly health service, youth centres, industry parks, schools) for increased access to services and to exercise their AYSRH rights.

ANNEX

Annex 1: Evaluation Matrix

Evaluation Question 1: To what extent is the country programme adapted to: (i) the needs of diverse populations, including the needs and participation of vulnerable and marginalized groups ; (ii) national development strategies and policies; (iii) the strategic direction and objectives of UNFPA; and (iv) priorities articulated in international frameworks and agreements, in particular the ICPD Programme of Action and the SDGs, (v) the flexibility to accommodate shifts caused by crises or major political changes **Evaluation Criteria:** [Relevance]	
Assumptions for verification 1.1: The 9th CP is adapted to the needs and priorities of the diverse populations targeted, including the participation of the vulnerable populations	**Indicators:** • The extent of 9th CP interventions in the thematic areas of programming were adapted to the needs, demands and priorities of the population, in particular, the most vulnerable, disadvantaged, marginalized and excluded population groups • Evidence of the needs assessment conducted in the 9th CP thematic areas, including identification of the needs of the vulnerable populations • Evidence of systematic use of findings from needs assessments in project planning and design and the selection of target groups for the 9th CP-supported interventions in the various thematic areas of focus by the interventions. • Appreciation of the 9th CP interventions' relevance and appropriateness by the target population • Extent to which the targeted populations, including vulnerable and marginalized groups, such as people with disabilities, were consulted in relation to project design and interventions throughout the project • Evidence of consultation of the vulnerable and marginalized population in the design and implementation of the 9th CP • Evidence of utilization of lessons learnt from the 8th CP in the design and implementation of the 9th CP
Data collected	Sources of information
● Midwives were deployed to provide skilled birth attendance services in conflict-affected area, particularly where the existing health facilities had been looted, vandalized and staff displaced	• Interviews with Ethiopian Midwives Association, Marie Stopes International and Regional Health Bureau of (RHB) in Amhara, Tigray and Afar, COARs
● The 9th CP targeted people in marginalized populations and locations – hard-to-reach areas, key populations, including female sex workers, industrial workers	● Interviews with RHBs, NCA and Catholic priests
● UNFPA addressed the SRH needs of people with disability and included an assessment of their issues in the planned EDHS	● COARs, Interviews with CO and IP staff
● There were consultations of the IDPs on the services the 9th CP supported during implementation.	● FGDs with Women and Girls, and men and boys in the IDPs

• UNFPA supported Ministry of Women and Social Affairs to conduct a Youth Policy assessment, which guided the review and development of new youth policy and strategy. This assessment was useful in the identification of areas of gaps that needed to be addressed by the new policy. The CP supported the integration of SRH and HIV prevention targeting adolescents and youth in the most marginalized, vulnerable, disabled, and living in hard-to-reach areas.	• Interviews with Ministry of Health, Ministry of Women and Social Affairs, IPs and UNFPA CO staff
• The design of the CPD considered the felt needs of the affected populations, including SRH needs for the hard-to-reach populations, Adolescent and youth services, and GBV survivor needs, among other interventions focus.	• Interviews with IPs, Ministry of Finance, Ministry of Health, Ministry of Women and Social Affairs, and UNFPA CO staff and CPD review
• UNFPA utilized experiences in the previous CP and based on the achievements of the previous CP, implemented the 9th CP	• CPD review, Interviews with the CO's staff
• The design of the 9th CP Gender and Social components considered the felt needs of the targeted group ensuring delivery of comprehensive services for FGM/C, Child Marriage and GBV prevention and response	• CDP review, Interview with targeted groups, Interview with IPs
• UNFPA targeted the hard-to-reach areas and marginalized populations with SRH services by selecting intervention woredas with low coverage and lack of support from other development partners in the areas. Additionally, the CO deployed mobile health and nutrition clinics targeting vulnerable populations affected by drought and other climatic changes with integrated SRHR services ensuring increased access to skilled maternal and GBV services by marginalized populations.	• Interviews with IPs, Ministry of Finance, Ministry of Health, Ministry of Women and Social Affairs, and UNFPA CO staff and CPD review
Assumptions for verification 1.2: The 9th CP is aligned and contributed to the National development strategies and policies	**Indicators:** • Evidence of the appropriateness of the design and implementation approach achieving the intended results • The extent to which UNFPA-supported interventions have appropriately taken into account the priorities of the Governments of Ethiopia, and line ministries and institutions • Choice of beneficiaries for UNFPA-supported interventions are consistent with national priorities in the project workplans • Extent to which the strategies, policies, agendas, plans, and priorities in regard to the project interventions have been discussed and agreed upon with a wide array of national and subnational stakeholders
Data collected	Sources of information

• The 9th CP supported the Ministry of Women and Social Affairs review and development of the Youth Strategy, Youth Participation strategy, and Youth volunteerism strategy	• Review of COAR; Interviews with Ministry of Women and Social Affairs, IPs and CO staff
• The 9th CP supported the Government of Ethiopia's RH commodity needs. UNFPA instrumentally ensured an effective supply chain for SRH commodities by supporting increased availability of quality-assured lifesaving SRH drugs and FP commodities and continued the advocacy for sustainable financing of RH commodities in the country. Additionally, UNFPA supported surveys on the availability of RH commodities and at service delivery points (SDPs) and supported supplies and capacities of staff to ensure access and last-mile availability of RH commodities giving priorities to areas with stockouts	• Interviews with Ministry of Health, EPSS, CO and CO staff; and reviews of reports
• The 9th CP interventions were implemented with the support of the Government of Ethiopia , particularly the delivery of SRH and GBV services in the government facilities, mostly delivered by government staff.	• Interview with regional bureaus and line ministries
• The 9th CP gender and social norm component is perfectly aligned and contributed to the national policy on ending GBV, FGM/C and Child Marriage and sectors (education and health) gender strategies.	• Interview with government and CSO implementing partiers, CO Staff and targeted documents
• UNFPA supported the development of a Demographic Dividend Roadmap to harness the dividend from utilizing the huge young population of the country.	• Interview with Ministry of Planning and Development and UNFPA staffs and 2023 COAR
• UNFPA also supported the development of an integration manual to integrate population dynamics into development plans.	• Reviews of COARs, and Interviews with Ministry of Planning and Development and CORHA
• Revision of the National Population Policy of Ethiopia: The NPPE, issued in 1993 to balance population growth and economic development, set specific objectives to be achieved by 2015 and has contributed to improvements in demographic trends over the past three decades. However, Ethiopia faces new challenges and opportunities related to population growth, changing age structures, rapid urbanization and migration. The new demographic challenges are compounded by growing environmental pressures, including the urgent threat of climate change, which have necessitated a revision of the policy. In response to these developments, the 9th Country Program (CP) provided technical and financial support to the Ministry of Planning and Development (Ministry of Planning and Development) for the revision of the NPPE.	• Interview with Ministry of Planning and Development staff, review of 2022 and 2023 COARs and interview with UNFPA CO

• **Support for the Preparation of a Demographic Dividend Roadmap**: Ethiopia has a predominantly young population, with over 70per cent under the age of 30. This youth bulge presents an opportunity for economic and social development, but if not effectively harnessed, it could lead to social crises and instability. To capitalize on the demographic dividend, adequate and well-planned interventions are necessary. Recognizing this need, UNFPA assisted the Ethiopian government in developing a demographic dividend roadmap utilizing the National Transfer Accounts methodology, which provides an accounting framework for economic flows between age groups. Additionally, the organization facilitated a training workshop for experts from various governmental and non-governmental organizations on the National Transfer Accounts methodology to enhance understanding and implementation of these strategies.	• Interview with Ministry of Planning and Development and UNFPA staffs and 2023 COAR
Assumptions for verification 1.3: The 9th CP is aligned to the strategic directions and objectives of UNFPA (2018 – 2021; and 2022 – 2025), SDGs, and ICPD priorities	**Indicators:** • Extent to which the planned interventions are in line with the UNFPA Strategic Plans 2018 – 2021; 2022 - 2025 • Extent to which the interventions implemented are in line with the SDGs and ICPD • The expected results, targets and implementation strategies outlined in the CPD and the AWPs are in line with the priorities, results and targets of the United Nations Sustainable Development Framework (UNSDCF) for Ethiopia.
Data collected	**Sources of information**
● The 9th CP was aligned to the SP 2018 – 2021; and 2022 – 2025 (The results frameworks were aligned and structured to contribute to the strategic plans directly). The CP alignment document incorporated six output areas from the SP 2022 – 2025, ensuring direct contribution into the SP.	• Review of the Alignment document, COAR (SIS) and interviews with CO staff
● There was confirmation of UNFPA CO reporting on UNSDCF. UNFPA contributed to all the results areas of the UNSDCF for Ethiopia through reporting and coordinating the SRH and GBV AoR components in the delivery of the Cooperation Framework results. It was however reported that the results areas for the UNSDCF was affected by the emergence of the crisis with most agencies reprogramming to respond to the crisis.	● Interviews with UNRCO, UNICEF, WHO, CO staff and review of reports
● 9th CP contributed directly to the reporting on SDGs for the country. UNFPA contributed to the support of the Ministry of Planning and	● Reviews of documents – COARs and CPD, and Interviews with Ministry of Planning and Development, ESS and CO staff

Development in developing the VNR report on monitoring the status of implementation of the SDGs in Ethiopia, which contributed to establishing progress. Challenges of outdated data in the country affected the effectiveness of the collection of the data for reporting	
● **Production of ICPD Commitment Status Report**: Ethiopia is one of the countries committed to implementing the Addis Ababa Declaration on Population and Development (AADPD), which is customized to the context of Africa from the Program of Action of the International Conference on Population and Development (ICPD). The fundamental principles of the AADPD are: (a) the right to development, including human rights and human development, (b) maintaining peace and security to empower and increase the capacity of citizens in playing significant and strategic roles in development; and (c) ensuring justice, equality and human dignity and rights for achieving inclusive and sustainable development. These principles and commitments have the prime objective of addressing the interrelationship between population and sustainable development by paying due attention to specific population groups such as women, youth, adolescent girls, and other marginalized groups to ensure that no one is left behind. UNFPA supported the production of the AADPD +10 national review report, which highlights the progress made in response to the implementation of the AADPD as well as the gaps and challenges faced by Ethiopia during the past ten years of its implementation.	● COAR 2023, Interviews with Ministry of Planning and Development and UNFPA CO staff
Assumptions for verification 1.4: The 9th CP has the flexibility to accommodate shifts caused by crises or major political changes	**Indicators:** • Evidence of capacity and flexibility in programming approaches to respond to emerging needs • Evidence of changes in programme design or interventions reflecting context and influencing factors i.e. change in population needs and government priorities • Evidence of financial capacity to respond to arising needs • Evidence of repeated needs assessments conducted by UNFPA and/or implementing partners, identifying the varied needs of diverse groups and lessons learned during programming period • Extent to which the response was adapted to emerging needs, demands and national priorities during the period of implementation
Data collected	Sources of information

• The 9th CP effectively contributed to the COVID-19 pandemic through reprogramming to adapt and remain relevant to the changing context of implementation. The CO supported the Ministry of Health and the RHBs to respond in the most affected areas providing lifesaving SRHR and GBV services due to the restricted movement at the time. Additionally, they supported the young people during the period by partnering with the Consortium of Reproductive Health Associations (CORHA) to write a peer education manual to help the adolescent and youth, including adolescents and youth living with HIV, to understand and address the specific challenges that they faced during the period. • The CO also adapted to remote management as a mode of working for staff and IP engagement. Further, the CO integrated COVID-19 infection prevention and control into its programming in addition to reallocation of funds to respond to the effects of the pandemic.	• Review COAR and interviews with the line ministries and IPs
• The CO realigned the 9th CP at the onset of the armed conflict leading to the humanitarian situation in Tigray, Amhara, Afar, Oromia, regions, to incorporate a new output area on humanitarian response, which was not initially included in the original 9th CPD. This enabled the CO to reprogramme and effectively respond to the arising of the affected populations • UNFPA also mobilized resources outside the core resources to finance the interventions through leading appeals for funding under the annual humanitarian response plans (HRP) which were conducted to gather new evidence through assessment for response on the arising needs.	• Interviews with the regional bureaus, Ministry of Health, IPs and UNFPA CO staff; review of COARs, HRP 2022, 2023, and 2024, and the realignment document
• UNFPA hired more than 30 dedicated staff through the surge mechanisms to support the response to the humanitarian action in the affected areas. These were effectively deployed in the affected locations and enabled the vulnerable populations to access integrated SRH and GBV services	• Review of the staff organogram, COARs, Interviews with IP, CO and Ministry of Health, Ministry of Women and Social Affairs staff and Regional bureaus
• The emergence of the crises in the targeted locations of Ethiopia intensified cases of GBV and violation of rights. The key informant interview with stakeholders and observation indicated that there were limited OSC and Safe Houses in the programme-targeted area, some of which were disrupted by the conflict, making the response mechanisms for GBV more complex	• Reviews of COARs and Interviews with Ministry of Women and Social Affairs, UNFPA Sub-Office, regional bureaus and CO staff

• UNFPA CO restructured the programme to ensure reprogramming to integrate contextual changes, including using different mechanisms to deliver SRH commodities e.g. using the logistics cluster to deliver RH commodities to the conflict-affected areas.	• Review of COARs, and HRP and interviews with CO and Government of Ethiopia staff

Evaluation Question 2 To what extent has UNFPA Ethiopia integrated its mandate to improve SRHR and gender inequalities of the vulnerable and marginalized population through leveraging strategic partnerships with national, local and grassroot organizations (e.g. youth-led groups, people with disability and women's rights activists)? **Evaluation Criteria:** [*Coherence*]	
Assumptions for verification 2.1: UNFPA Ethiopia effectively integrated its mandate to improve SRHR and gender inequalities of the vulnerable and marginalized population through leveraging strategic partnerships with national, local and grassroot organizations (e.g. youth-led groups, people with disability and women's rights activists)	**Indicators:** • Evidence of UNFPA Ethiopia and/or IPs playing a leading / Participatory role in the SRHR/GBV-related coordination mechanisms, including working groups in Ethiopia • Evidence of the collaborative efforts with local organizations in the targeted thematic interventions areas and degree of success • Evidence of collaboration between the SRHR and GBV stakeholders in planning, activities, and decision-making. • Existence of mechanisms to share data, information, and resources across sectors. • Advocacy efforts to mainstream SRHR and GBV themes into local policies and programme
Data collected	Sources of information
• UNFPA strategically partnered with various organizations and population groups to facilitate the implementation and delivery of the CP services. UNFPA programme was implemented through partnerships with both local and international NGOs in the targeted areas. UNFPA also partnered and collaborated with the community members to engage and address the various needs of the communities like advocacy against FGM/C and Child Marriage. UNFPA programming approaches were confirmed to have aligned with their respective strategic objectives and needs. The IP assessment by UNFPA to identify IPs for implementation of the UNFPA also nurtured strategic partnerships with donors and the government line minorities to access funding and to facilitate implementation of the CP respectively, and these were instrumental in advancing the delivery of the programme to the targeted communities.	• Interviews with IPs, Ministry of Health, Ministry of Women and Social Affairs and CO staff, and reviews of Annual Work Plans
• UNFPA support in the development of policies, capacity building and in-kind contributions to the implementations of the mandate of the government directly contributed to strategic objectives and results. For example, the support to the government with RH commodity procurement directly contributed to the country's commodity needs thereby addressing the felt needs.	• Interviews with Ministry of Health, EPSS, IPs staff and reviews of COARs

• UNFPA co-chaired and supported technical working groups with Ministry of Health and Ministry of Women and Social Affairs.	• Interviews with Ministry of Health, Ministry of Women and Social Affairs, EPSS, IPs staff and reviews of COARs
• The contribution of UNFPA in the coordination mechanisms brought together several agencies, including the government, UN, International and national NGOs, and professional organizations, among others ensuring the leveraging of synergies among themselves and coordinating response in a harmonized manner.	• Interviews with UNFPA CO, United Nations agencies, Ministry of Health, Ministry of Women and Social Affairs, and IPs staff and reviews of COARs
• There was integrated programming approach across the government line ministries supported by UNFPA – for example, Ministry of Women and Social Affairs and Ministry of Health collaborated on the clinical management guideline development and training, supported by UNFPA.	• Interviews with Ministry of Women and Social Affairs, Ministry of Health, IPs and CO staff and review of UNFPA reports
• UNFPA supported local NGOs with capacity while partnering with them to deliver 9th CP interventions.	• Interviews with local NGOs (Mums for Mums, Maedot, AWSAD, EWELA, APDA among others) and CO staff
• Some of the Youth activities like Youth centres were implemented in the premises of the government – e.g. in Amhara.	• Interviews with Regional bureau of youth, Observation. Reviews of COAR
• UNFPA established partnership with gender machineries, (Ministry of Women and Social Affairs, BoWSA) women's right, feminist and women's association effectively integrating its mandate on preventing and responding to GBV.	• Interview with Government IPs, CSOs and CO staff, and review of the AWPs and COARs
Assumptions for verification 2.2: UNFPA Ethiopia effectively integrated its mandate internally to improve SRHR and gender inequalities of the vulnerable and marginalized population	Indicators: ● Evidence of interventions aimed at addressing interconnected SRHR and GBV risks at the SRHR-GBV interface. ● Evidence that synergies have been actively sought in the design, implementation and M&E of the SRHR and GBV interventions and those of other stakeholders ● Evidence that integrated and interoperable information and knowledge management as well as monitoring systems were created ● Existence of mechanisms to share data, information, and resources across sectors.
Data collected	Sources of information
• UNFPA CO had staff collaborate across the thematic areas and responsibility regardless of the thematic areas. For example, programme fund managers spanned across the thematic areas while managing IPs and were expected to supervise and support them	• Interviews with IPs, Operation and programme staff
• While the Peace and Security expert supported to integration peace and security in the programme, he was attached to the adolescent and youth team, also supported the CO in the integration of the peace programming across the CP components	• Interviews with CO staff and review of COARs

• The CO had staff reassigned across humanitarian and development sectors for an integrated programme	• Interviews with CO staff and review of organogram
• The Gender and Social Norms section has provided technical support for the 9th CP thematic area for integration of gender across guided by the UNFPA gender strategy document. Efforts were made in SRH, PD and Humanitarian Response	• CO Staff interview and review of 9th CP documents, COARs
Evaluation Question 3: To what extent have the UNFPA Ethiopia interventions successfully delivered outputs and contributed to the achievement of the UNFPA strategic plan outcomes (ending unmet need for family planning; ending preventable maternal deaths; ending gender-based violence and harmful practices) and integrated human rights, gender perspectives, disability inclusion, and those furthest behind? Additionally, what have been the unintended consequences, both positive and negative, of these interventions? **Evaluation Criteria:** [*Effectiveness*]	
Assumptions for verification 3.1: UNFPA Ethiopia interventions successfully delivered the SRH, AY, and GEWE outputs and contributed to the achievement of the UNFPA strategic plan outcomes of ending unmet need for family planning and ending preventable maternal deaths; and ending gender-based violence and harmful practices respectively	**Indicators:** • Degree of completion of SRH, AY, and GEWE-related outputs planned in the M&E Framework against indicators • Evidence that completed SRH, AY, and GEWE outputs contributed to planned outcomes • Extent to which the SRH, AY, and GEWE interventions were completed on a timely basis
Data collected	Sources of information
• UNFPA CO made achievements in the targets as stated in the CPD's RRF and reported on them. As at the time of the CPE, several output indicators had been achieved, surpassed or likely to be achieved.	• Reviews of COARS and interviews with M&E staff
• UNFPA CO contributed to the Unmet FP needs by creating demand for FP, procuring and distributing of the RH commodities into the service points	• Interviews with Ministry of Health, CO staff and EPSS staff and reviews of COAR
• The CP contributed to the strengthening of EmONC services in the target location: during by enhancing access and provision of BEmONC and CEmONC, across the targeted health facilities in the country. UNFPA supported the expansion and strengthening of EmONC services for enhanced access and quality of service provided through capacity development on EmONC, obstetric haemorrhage, and mentorship training of health professionals. UNFPA also utilized the CBCM approach to strengthen the capacities of Ministry of Health's healthcare workers from hospitals mentoring staff in health facilities, including midwives, in addition to facilitating regular monitoring of the progress. UNFPA also supported them with essential supplies and equipment.	• Interviews with the Ministry of Health, RHBs, and IPs staff and Review of reports

• UNFPA contributed to ending preventable maternal deaths through strengthening EmONC services, including supporting the establishment of Maternity Waiting Homes near health facilities, particularly where service access is limited	• Interviews with Ministry of Health, IPs and CO staff and reviews of COAR
• UNFPA CO immensely supported the Ministry of Health in obstetric fistula prevention, treatment and strengthening social reintegration of fistula survivors through capacity building of healthcare workers and providing funds for fistula prevention, treatment and social reintegration interventions. During the period, a total of 5,979 cases were treated across the country as at the end of 2023.	• Interviews with Ministry of Health, IPs and CO staff and reviews of COAR
• UNFPA contributed to the increased uptake of comprehensive SRH service through supporting integration of SRH service, including FP, BEmONC, SRH/Life skill, post-abortion care, outreaches in the hard-to-reach areas, antenatal care (ANC), postnatal care (PNC), early detection of cervical cancer through facilitating awareness creation and demand generation on cervical cancer screening, prevention and management of Sexually Transmitted Infections (STIs) and HIV, and strengthening Maternal, and Perinatal Death Surveillance and Response (MPDSR),.	• Interviews with Ministry of Health, IPs and CO staff and reviews of COAR
• The 9th CP successfully delivered the gender and social norm outputs and contributed to the efforts of ending GBV and harmful practices (FGM/C and Child marriage) through the engagement of IPs. For example, UNFPA partnered with NCA to target the religious groups and communities for abandonment of FGM/C and Child marriage, targeted school and out-of-school clubs to raise awareness, partnered with Population Media Council for mass public awareness raising, capacitated the Alliance for Anti-FGM/C and Child Marriage.	• Interviews with IP, CO staff, review of CAORs of the 9th CP, interview and FGD with targeted groups
• UNFPA strengthened GBV service provision by expanding one-stop centres, safe houses, and women and girls' safe spaces (WGFS). They also improved service providers' technical skills through training and the development and implementation of standard operating procedures (SOPs) and guidelines. This comprehensive approach significantly enhanced the capacity of GBV service providers, and evaluation participants confirmed that survivors are receiving standard, comprehensive services.	• Interview with CSO, GBV survivors government Ips, observation as WGFS, OSC and Safe Houses •

• UNFPA strengthened the ministry's capacity in supply chain management, through capacity building and supporting Ministry of Health in the implementation of the electronic logistics management system and FP service quality standards to a more effective supply chain system for the RHC and improved the access and quality of FP services in the country. • UNFPA also contributed to the institutionalisation of Commodity Security training at the Addis Ababa University's School of Pharmacy by supporting the implementation of the Health Supply Chain Management Postgraduate Programme in the implementation of the curriculum developed, its evaluation and revision with the technical and financial and technical support of UNFPA	• Interviews with Federal Ministry of Health and RHBs, EPSS and CO staff
• UNFPA has contributed to enhancing the GBV Response service coverages establishing new service outlets and standardizing the services. For example, partnered with women's associations and women's right organizations implementing safe houses and WGFS, strengthened one-stop centres in the health facilities etc, and designed and implemented SOPs, and guidelines for service standardization.	• Interviews with IP and CO staff, interview and FGD with the targeted groups observation of the service outlets, feedback on the implementation of the SOP
• UNFPA supported training and deployment of midwives to underserved areas	• Reviews of COAR, and interviews with IPs, Ministry of Health and CO staff
• UNFPA supported the establishment of youth-friendly spaces enabling adolescents and youth to access quality SRH and life skills services.	• Observation, Interviews with IPs, Regional bureaus supporting the Adolescent and Youth
• Activities of the original CPD were reprogrammed to address the arising humanitarian needs	• Review of the alignment document and COAR, Interviews with IP and CO staff
• The 9th CP supported the Ministry of Health in the development of, a 7-year Costed Implementation Plan (CIP) (2024 - 2030) for the National FP Programme to serve as a national guide to pool the efforts and resources of all stakeholders towards the common goal of increasing CPR to 54per cent and reducing the unmet need for family planning to 17per cent, through ensuring identification of priority actions around service delivery, commodity security, demand creation, and policy and enabling environment are taken into consideration.	• Review of COARs, interviews with Ministry of Health, IPs and CO staff
• UNFPA supported the development of various implementation guidance strategies like SOPs for One Stop Centres. For example, UNFPA CO supported the Ministry of Health development and implementation of the RH Strategic Plan (2021-2025), the National Strategic Plan for the Elimination of Obstetric Fistula (2021-2025), and the Obstetric Management Protocol for Health Centres and Hospitals, ANC guideline and Confidentiality Enquiry guideline.	• Reviews of COARs, and Interviews with Ministry of Health and CO staff

• The GBV programme targeted IDP settlements with GBV services	• Review of COARs, Interviews with IPs, Ministry of Women and Social Affairs and CO staff
• UNFPA led the GBV AOR and coordinated the programme ensuring that the survivors had access to GBV services.	• Interviews with IPs, regional bureaus and CO staff, the view of COARs
• UNFPA supported the distribution of dignity kits to crisis-affected populations	• Interviews with IPs, Ministry of Health and CO staff
Assumptions for verification 3.2: UNFPA Ethiopia interventions successfully delivered PD outputs and contributed to the achievement of the UNFPA Strategic Plan outcomes (ending unmet need for family planning; ending preventable maternal deaths; ending gender-based violence and harmful practices)	**Indicators:** • Degree of completion of PD-related outputs planned in the M&E Framework against indicators • Evidence that completed PD outputs contributed to planned outcomes • The extent to which the PD interventions were completed on a timely basis
Data collected	Sources of information
• UNFPA provided support for ESS to improve its capacity in utilizing digital technologies (hybrid census) for undertaking census in hard-to-reach areas.	• Document review, Interview with ESS staff and CO staff.
• UNFPA successfully advocated the government to review the Population policy	• Interviews with ESS, Ministry of Planning and Development and CO staff, and M&E staff
• UNFPA supported the South-South cooperation by arranging experience-sharing visits to other countries to support the government's plan for the Population and Housing census.	• Interviews with ESS, Ministry of Planning and Development and CO staff and document review (COARs)
• UNFPA supported the capacity development of reports on CRVS	• Interviews with ESS, and CO staff; and reviews of COARs
• Supporting Advocacy and Dialogue Events on Population and Development: Promoting the inclusion of population dynamics in development planning and programming is a crucial intervention for achieving the strategic outcomes of UNFPA. With technical support from the CO, Ministry of Planning and Development organized several advocacy platforms centred around population and development issues. Throughout the program cycle of the 9th Country Programme (CP), various awareness-raising and advocacy events were held, including the commemoration of World Population Day and discussions on the State of the World Population (SWP) report. These events, attended by numerous stakeholders, served as valuable opportunities to popularize the population agenda and underscore its importance in development planning and programming. By fostering dialogue and collaboration among diverse actors, these initiatives aim to enhance understanding and engagement with population dynamics in the context of sustainable development. • UNFPA also successfully advocated to the government to review the Population policy • The preparation of the demographic dividend roadmap has also begun with the support of the CO.	• Interviews with ESS, Ministry of Planning and Development and CO staff, and document review

• Fifth Round Demographic and Health Survey (EDHS): DHS are essential data sources that provide valuable insights into various demographic and health-related indicators crucial for informing programming and policymaking. To date, Ethiopia has successfully conducted four rounds of DHS, each contributing vital information for national and local development initiatives. • As Ethiopia prepares to undertake the fifth round of the DHS, the support from the UNFPA has been instrumental. UNFPA has provided both technical and financial assistance to the ESS to ensure the successful implementation of this survey. Notably, significant efforts have been made by the CO to enhance the survey's relevance by incorporating new indicators related to Gender-Based Violence (GBV), specifically focusing on issues such as obstetric fistula and female genital mutilation (FGM). These additions complement the existing indicators related to sexual and reproductive health (SRH) and reflect a commitment to addressing critical health and social issues affecting women and girls in Ethiopia. • The inclusion of these new GBV indicators is particularly important, as they will help to generate data that can guide targeted interventions and policy responses aimed at reducing these harmful practices and improving the overall health and wellbeing of women in the country. By leveraging the findings from the upcoming DHS, stakeholders can make informed decisions that support sustainable development, promote gender equality, and enhance the effectiveness of health programs in Ethiopia.	• Interviews with ESS, Ministry of Planning and Development and CO staff, and document review

• Support for Population and Housing Censuses: Population and Housing census is crucial as these censuses serve as the primary source of data on demographic trends and population dynamics. They enable countries to collect, process, and disseminate detailed statistics on various aspects of the population, including its composition, characteristics, spatial distribution, and household organization. However, conducting a census is a complex and costly endeavor, requiring extensive manpower and resources, which is why most countries only carry out these exercises every ten years. Over time, the value of census data decreases as it becomes outdated, reducing its utility for policymakers, especially towards the end of a census cycle. • In Ethiopia, the last population and housing census was conducted in 2007, and there have since been multiple initiatives to conduct the fourth census. The UNFPA has played a significant role by providing substantial financial, technical, and material support to the Ethiopian Statistical Service (ESS) to facilitate this undertaking. UNFPA contributions included organizing training workshops on critical topics related to census execution, such as data capturing, transfer, processing, GIS/cartography, data analysis, and dissemination. • The fund also assisted in developing operational guidelines and equipping the ESS with essential tools, including servers, solar power banks, printers, and computers. • Moreover, UNFPA promoted south-south cooperation by arranging experience-sharing visits to other countries to support the government's plan for the census and hiring international experts to enhance local capacities. • These efforts introduced and provided new digital technologies for data collection, especially in remote and conflict-affected areas, enabling statistical modelling (hybrid census) to estimate populations in hard-to-reach regions. Given the current context in Ethiopia, these innovations are invaluable for accurately capturing and understanding demographic changes, thereby informing effective policymaking and development strategies. Nevertheless, the census was again postponed.	• Interview with ESS staffs, CO Staffs, and review of COARs, 2021, 2022, 2023

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• Establishment of Integrated Management Information System (IMIS): UNFPA has been instrumental in supporting regional governments in establishing a web-based Integrated Management Information System (IMIS). This system serves as an open-access data platform that consolidates statistical databases from various surveys and censuses conducted by the ESS and other government institutions. The IMIS facilitates users' direct access to diverse data sources, allowing them to create customized tables, calculate indicators, and generate thematic maps across different administrative levels. • Through the support of the 9th CP, it was possible to successfully develop a functional IMIS in ten regions. UNFPA support encompassed material provisions, technical skill training, and experience-sharing visits to enhance the capacity of professionals involved. Furthermore, the regional IMIS system is integrated with the ESS database, enabling users to access and utilize comprehensive data from the ESS for their specific needs, thereby promoting informed decision-making and effective evidence-based programming.	• Interview with CO staff, document review (COARs), interviews with regional Implementing partners.

• Civic Registration and Vital Statistics (CRVS): UNFPA has played a crucial role in enhancing the production of vital statistics in Ethiopia by providing both financial and technical support to the Ethiopian Statistical Service (ESS). These vital statistics encompass essential information regarding births, deaths, marriages, and divorces, serving as a foundation for monitoring civil registration coverage and improving the overall quality of data. The initiative to produce vital statistics is established through collaborative planning between the ESS and UNFPA, with the data collection process initiated at the Kebele level. • Training sessions were conducted for data collection officers to ensure accurate and effective data capture. To enhance the quality of information, institutionalized coordination and consultation mechanisms have been put in place among various stakeholders in civil registration, including legal and administrative officers, the ESS, Immigration and Citizenship Services (ICS), and regional health bureaus. • Additionally, UNFPA supported the organization of workshops and meetings to facilitate ongoing engagement and capacity building among these stakeholders, further strengthening the data quality and the overall civil registration system in Ethiopia.	• Interviews with ESS, and CO staff; and reviews of COARs
Assumptions for verification 3.3: UNFPA Ethiopia interventions successfully delivered Humanitarian output and contributed to the achievement of the UNFPA strategic plan outcomes (ending unmet need for family planning; ending preventable maternal deaths; ending gender-based violence and harmful practices) in the humanitarian settings	Indicators: • The speed and timeliness of response (response capacity) • Adequacy of the response (quality of the response) • Evidence of changes in programme design or interventions reflecting context and influencing factors i.e. change in population needs and government priorities.
Data collected	Sources of information
• UNFPA strengthened access to integrated lifesaving SRHR and GBV response and prevention during the 9th CP in all seven regions affected by humanitarian crises and natural disasters contributing to the UNFPA Strategic Plan outcomes in the humanitarian settings	• Interviews with IPs, Government of Ethiopia, United Nations Agencies and UNFPA CO staff; and review of COARs
• UNFPA facilitated GBV coordination mechanisms through leading the GBV AOR in the conflict affected areas and ensured delivery of services to the affected populations	• Interviews with IPs, Government of Ethiopia, United Nations Agencies, and UNFPA CO staff; and review of COARs
• UNFPA prepositioned RH kits in targeted hospitals and enhanced the speed of response to the affected populations	• Interviews with IPs, Government of Ethiopia and UNFPA CO staff; and review of COARs
• The conflict situation made some locations inaccessible limiting reach to the affected with services. UNFPA CO however ensured coordination with different local IPs with local understanding of the context, in addition to working closely with the regional bureaus	• Interviews with IPs, Government of Ethiopia and UNFPA CO staff; and review of COARs

Assumptions for verification 3.4: UNFPA Ethiopia integrated human rights-based approaches, gender perspectives, and disability inclusion, and ensured those furthest behind were targeted	Indicators: • Extent to which a gender-responsive and human rights-based approach was integrated in situation assessment and analysis, planning and design, implementation and M&E of UNFPA-supported interventions in the 9th CP thematic areas of programming • Evidence of increased incorporation of a gender-responsive and human rights-based approach in Government policies, strategies and plans at federal and state levels during the period of the 9th CP • Evidence of inclusive and participatory mechanisms to systematically seek input from target populations in the design, implementation and monitoring of UNFPA-supported interventions in the 9th CP thematic areas of programming • Presence of accountability mechanisms for populations affected by humanitarian crisis, such as complaints mechanisms to report sexual exploitation and abuse by UNFPA staff and/or implementing partners
Data collected	Sources of information
• UNFPA led the GBV AOR and SRH subclusters to enhance coordination of the humanitarian response in the various affected locations	• Interviews with CO, IPs, Regional Bureaus for Health, Youth and Women and Social affairs staff
• UNFPA programmes restored and preserved the dignity of those who were served. For example, UNFPA supported case identification and treatment of obstetric fistula leading to the restoration to their normal state	• Interviews with Hamlin Fistula Ethiopia, Mums for Mums, CO, Ministry of Health and RHBs staff; and reviews of COARs
• UNFPA supported programmes reaching those with disability, female sex workers, and refugees with SRH service	• Interviews with IPs, CO, Ministry of Health and RHBs staff; and reviews of COARs
• The 9th CP targeted the most marginalized and hard-to-reach women and girls including rural women and girls, those living with disability, women and girls in humanitarian settings etc. For example, 80 women with disability benefited from the safe house in Amhara Region	• Interview with CSO, IPs, FGD and KII with targeted communities, review of the 9th CP documents including annual and monitoring reports.
Assumptions for verification 3.5: The UNFPA Ethiopia 9th CP has yielded positive or negative unintended consequences during implementation of the interventions and had mechanisms to mitigate against negative consequences	Indicators: • Evidence that unintended results were understood and captured is available and understood by UNFPA and its partners • Evidence that UNFPA and its partners have mechanisms to mitigate undesirable outcomes
Data collected	Sources of information

• Because of UNFPA partnership of Marie Stopes International in Ethiopia to respond on humanitarian interventions, the experience has made Marie Stopes to establish an emergency department	• Interviews with Marie Stopes and CO staff
• The 9th CP has documented the positive unintended outcomes of women's leadership and employment. The inclusion of gender integration in various aspects of the program, such as service provisions, capacity building activities, and women's economic empowerment, has created opportunities for women to assume leadership roles and secure employment.	• Interview with government IP, CSO and Youth
• Repercussion of rewarding positive deviances: The program was implemented to incentivize both uncut girls and their mothers as part of a strategy to promote the eradication of FGM. However, consultations with government stakeholders have revealed that many individuals have reported to their office to claim the reward but have expressed intentions to proceed with the circumcision if the reward is not implemented. This has the potential to result in unintended negative repercussions regarding the resurgence of FGM	• Interview with government IPs

Evaluation Question 4: To what extent has UNFPA Ethiopia efficiently utilized its human, financial and administrative resources, while adhering to appropriate guidelines and procedures, to deliver the intended outputs and pursue the achievement of the UNFPA Strategic Plan outcomes? Evaluation Criteria: [*Efficiency*]	
Assumptions for verification 4.1: Implementing partners received UNFPA financial and technical support as planned and in a timely manner, and UNFPA was able to mobilize appropriate resources in a timely manner to support the implementation of the Country Programme.	**Indicators:** ● Evidence that implementing partners received the planned resources to the foreseen level in AWPs ● Evidence that implementing partners received resources in a timely manner ● Evidence of coordination and complementarity among the programme components of UNFPA ● Evidence of progress towards the delivery of multi-year, predictable, core funding to implementing partners ● Percentage of annual funding requirements met
Data collected	Sources of information
• The recruitment of national and local staff with national and local understanding that facilitated the efficiency of the CP delivery, with a better understanding of the local dynamics. enhanced effective relationships with the local structures including local government enhancing the delivery of context-sensitive services. Additionally, interviews with IPs confirmed that the assignment of local GBV case management specialists at the regional level greatly contributed to the improvement of the technical capacity and support for IPs. • The successful implementation of the 9th CP was attributed to the presence of skilled individuals and effective teamwork that regularly provided expert support for IPs as evidenced by feedback from interviews with them on the technical support they received from UNFPA.	• Interviews with IPs, line ministries and CO staff; and reviews of COARs
• UNFPA CO received funding to support the interventions of the 9th CP and were allocated annually. For example, the budget allocations for the years 2020, 2021, 2022, 2023 and 2024 were USD 12,641,096, 24,682,649, 33,473,646, 44,350,634, and 24,291,948 respectively.	• Review of the budget and expenditure documents from the finance unit; and interviews with operations staff
• The fund managers coordinated with the operation staff on the AWP implementation. The CO had programme fund managers for respective grants and coordinated with IPs for the delivery of the programme interventions. This ensured efficiency in coordination and follow-up in the implementation of the respective grants and AWPs.	• Interviews with CO programme, M&E, Resource Mobilization and Partnership units and operation staff

• There were delays in disbursement of funds from UNFPA	• Interviews with regional bureaus, IPs and line ministries
Assumptions for verification 4.2: The UNFPA main and sub-offices were appropriately staffed (the right number of people with the right competencies and skills in the right positions) and located to support programme implementation	Indicators: • Evidence that UNFPA personnel (all types of contracts) have adequate expertise and experience to deliver development and humanitarian assistance • Evidence that CO staffing structure is appropriate for timely and effective implementation, including in humanitarian settings • Extent to which existing human resource management policies, rules and procedures enable the timely and effective implementation, including in humanitarian settings
Data collected	Sources of information
• The 9th CP stakeholders confirmed the appropriateness of the UNFPA technical assistance and support	• Interviews with Ministry of Health, Ministry of Women and Social Affairs, Regional Bureaus
• The presence of UNFPA sub-regional offices was vital for coordination and support to the regional stakeholders including ensuring the successful implementation of the CP by the IPs. The sub-office teams also enable oversight and support supervision for the implementation of the programme activities and stakeholders at the regional and district levels, the team also facilitates the exchange of information between UNFPA and other regional-level line bureaus in addition to representing UNFPA in various working groups at the district and regional levels	• Interviews with Regional bureaus, and IPs and UNFPA Regional office staff
• UNFPA had an organogram with staff assigned to the respective programme and operation units. The organogram effectively organized by functional units enhanced efficiency in the coordination of functions across the CO. There were however understaffing in other programme units limiting the extent of delivery by staff.	• Review of the staff structure in the organogram and interviews
• UNFPA had a human resource policy in place stipulating various guidelines on the recruitment of new staff including guidelines on the code of conduct and procedures in the behaviours and management processes.	• Interviews with CO staff and review of documents

Assumptions for verification 4.3: Programme strategic approaches, administrative, procurement and financial procedures led to the efficient achievement of programme outputs and outcomes.	Indicators: • The planned inputs and resources were received by IPs as agreed upon with partners. • Budget utilization rates per year • Quality technical assistance to build capacity was available to the level planned • Evidence that technical assistance increased capacity among implementing partners • Evidence that efforts were made to identify inefficiencies in the 9th CP thematic area of programming and to correct them • Evidence that qualified implementing partners with adequate capacity were selected for implementation of interventions in the 9th CP thematic areas of programming • The extent to which administrative, procurement and financial policies, rules and procedures were appropriate for timely and effective implementation, including in humanitarian settings • Number of days/weeks for the procurement and distribution of dignity kits and reproductive health kits to crisis-affected populations in hard-to-reach areas
Data collected	Sources of information
• UNFPA had internal controls to guide on the financial and administration (procurement and logistics) that guided the operations with both staff and IPs	• Interviews with operation and programme teams, Government of Ethiopia line ministries and IPs staff
• The CO implemented efficient procurement and logistics mechanisms to enhance the delivery of its programmes through planning and development of guidelines for implementation facilitating effective planning and timely replenishment of programme materials to ensure that resources were allocated appropriately and available when needed.	• Interviews with IPs and CO staff
• The programme integration approach also improved the CP's efficiency, with staff being able to provide a wide range of services with the existing staff size. For example, the integrated SRH programme offered a variety of services that also included GBV, MPSS, STI/HIV management, and Cancer screening, among others, with the Gender and humanitarian team being able to provide an array of interventions, enhancing the coverage of the CP interventions. There were however implementation weaknesses in the programme integration approach.	• Interviews with IPs and CO staff

• Efficiency of UNFPA Financial Support to IPs: The CO achieved excellent success in resource mobilization for the 9th CP from other resources, that complemented the regular resources largely owing to the humanitarian situations the country was confronted with during the 9th CP. • The implementation of the 9th is operationalized through AWPs, which are collaboratively developed with clear activities, expected results, and detailed budgets that adhere to agreed guidelines. This transparent budgeting and planning process fosters accountability and effective resource allocation, enabling UNFPA to better align its initiatives with pressing needs. • UNFPA has established a robust system for ensuring checks and balances, which holds implementing partners (IPs) accountable for their deliverables promptly. The CO's structured approach includes an annual and semi-annual cycle for developing, reviewing, and approving work plans at all levels. This system also encompasses a thorough review and approval process for each implementing partner's financial and program reports, ensuring feedback on completeness, quality of reporting, and the absorption or utilization rates of funds. • AWPs are crafted under each thematic area and coordinated effectively between thematic teams and UNFPA operations staff to prevent duplication and ensure the efficient use of resources. The use of a standardized Fund Authorization and Certificate of Expenditures (FACE) form allows IPs to request advance funds in connection with the specific activities outlined in their work plans, streamlining the funding process. • However, despite the CO's commitment to improving service delivery through adequate human and infrastructural resources, several IPs reported delays in fund disbursement as a significant challenge. The CO has acknowledged these issues and indicated that improvements have been made recently to address this challenge.	• Interviews with IPs, line ministries, regional bureaus, and reviews of COARs • Review of the budget and expenditure documents from the finance unit • Interviews with CO programme, M&E, Resource Mobilization and Partnership units and operation unit

Assumptions for verification 4.4: The M&E system was efficient and effective in producing timely and disaggregated data to track progress at output and outcome levels and guiding future implementation	Indicators: • Proportion of output indicators for which data has been systematically collected and comprehensive, timely and accurate data that is disaggregated at least by sex and age is available • Proportion of outcome indicators for which data has been systematically collected and comprehensive, timely and accurate data that is disaggregated at least by sex and age is available • Quality of the indicator in the M&E framework of the Country Programme • Extent to which monitoring responsibilities are clearly assigned to UNFPA CO staff • Extent to which the M&E system contributes to developing local capacity for data collection in all the 9th CP thematic areas of programming • Extent to which implementing partners are able to provide required data for M&E • Proportion of output and outcome indicators for which baseline data is available • Assumptions and risks were identified and updated in response to changes in the national context and data on assumptions and risks regularly collected • Evidence that monitoring data is used to adapt programming and make course corrections in the 9th CP thematic areas of programming
Data collected	Sources of information
• All the M&E processes for the 9th CP were effectively implemented across the programme cycle. The CO utilized the planning processes to develop the results and resources framework, which effectively facilitated the alignment of the CP with the national priorities, the UNSDCF and UNFPA SP, with resources and targeted stakeholders clearly allocated and identified. The period saw the changes in the CPD implementation context and SP, necessitating a realignment which saw the RRF being aligned to incorporate a humanitarian action output with specific indicators which were not contained in the original CPD. All the indicators had baseline values and annual targets, in addition to the CP level target. This confirmed the UNFPA CO's responsiveness to changes in the implementation framework. UNFPA CO conducted both annual and quarterly planning including setting targets based on the RRF for the 9th CP, facilitating follow-up on its progress and performance on the indicators.	• Review of the RRF in the CPD and alignment document and interviews with CO staff

• The IPs across the programme areas confirmed being clear on the reporting system and that it also served their interest in improving their understanding of their performance. While they reported challenges with the Quantum Plus system, they acknowledged the support they received from the UNFPA team enabling them to report on their AWPs. Analysis and review of the annual reports revealed that the quality of the narrative report was mixed with both result and activity level achievements limiting the extent of 9th CP contribution to outcomes.	• Interviews with IPs, and CO staff and review of documents, including COARs, IP reports and AWPs
• UNFPA facilitated biannual and annual review sessions for the IPs, including government stakeholders, with the participation of all the relevant CO staff, facilitating experience sharing and enabling the teams to address arising challenges, in addition to planning for the following annual programme cycle	• Interviews with IPs, and CO staff and review of documents, including COARs, IP reports and AWPs
• The IPs areas confirmed being clear on the reporting system and that it also served their interest in improving their understanding of their performance. They, however, reported that reported that they still had challenges in utilizing the Quantum Plus system, but acknowledged the support they received from the UNFPA team as effective for them to report on their deliverables	• Interviews with IPs, and CO staff and review of documents, including COARs, IP reports and AWPs

Evaluation Question 5: To what extent has UNFPA Ethiopia contributed to strengthening Ethiopian institutional capacities and development (in system and human resources) and to what extent have partners (rights holders, government, NGO, development partners, etc) been engaged to ensure sustainability? **Evaluation Criteria:** [*Sustainability*]	
Assumptions for verification 5.1: UNFPA Ethiopia contributed to strengthening Ethiopian institutional capacities and development (in system and human resources) to ensure sustainability	**Indicators:** • Extent to which UNFPA has taken any mitigating steps to strengthen areas with gaps hindering sustainability • Evidence of the development of exit strategies in the 9th CP thematic areas of programming to hand over UNFPA-supported interventions to Government and/or implementing partners at national and sub-national levels • Evidence for enhanced capacity of the Government and implementing partners at national and sub-national levels to implement interventions in the 9th CP thematic areas of programming without the technical support of UNFPA • Evidence of policy and institutional development and strengthening •
Data collected	**Sources of information**
• UNFPA promoted the integration and prioritization of the CP components into that of the government enhancing ownership and support by the government line ministries and regional bureaus ensuring long-term sustainability. UNFPA also influenced government policy decision-making through advocacy efforts. For example, during the period UNFPA and UNICEF partnered to deliver mobile health and nutrition clinics which was not in the government policy and was newly introduced in the context. This approach enabled the government (Ministry of Health) to develop a national guideline for mobile health clinics, which was reported to be effective, thereby integrating the approach into the service delivery mechanism in the hard-to-reach locations in the country. The revision of the Ministry of Health Essential Health Service Package to include maternal and newborn health, family planning, and CAC services in the UHC cost-free package also confirms the institutionalization of SRH service delivery. The cost-free ambulance transport for labouring mothers and construction of MWHs by the government budget also confirm ownership and contribution by the government in financing SRH interventions. •	• Reviews of documents including COAR; Interviews with CO, Ministry of Health, IP and EPSS staff

• UNFPA supported the government in assessment of the use of contraceptives in health facilities, and Last Mile Assessments and shared the results in SRH TWG chaired by the Ministry of Health and actions taken on how to strengthen the gaps	• Reviews of documents including COAR; Interviews with CO, Ministry of Health, IP and EPSS staff
• UNFPA supported the Ministry of Health in the development of strategies and policies. For example, UNFPA Financial and technically supported Ministry of Health to develop a 7-year (2024 - 2030) Costed Implementation Plan for the National Family Planning Programme (FP-CIP)	• Interviews with Ministry of Health and CO staff, and review of COAR 2022 and 2023
• UNFPA strengthened the capacity of Ministry of Planning and Development to enable it to integrate the population agenda in policy formulation and planning through technical and financial support. Ministry of Planning and Development was able to initiate the revision of the Population Policy and began the preparation of the Demographic Dividend roadmap.	• Interviews with Ministry of Planning and Development and CO staff, COAR review
• UNFPA supported the ESS to build its capacity to use digital technologies to undertake surveys in conflict areas and hard-to-reach sites. The ESS's capacity to undertake hybrid census was strengthened.	• Interviews with ESS and CO staff and review of COARs, 2022, and 2023.
• UNFPA advocated for the Government of Ethiopia to sign a government commitment of sustainable domestic financing of RH commodities	• Interviews with Bill and Melinda Gates Foundation, Ministry of Health, EPSS, CO and WHO staff
• UNFPA was successful in promoting national ownership around SRHR through building on achievements in previous programme cycles to develop several policies, guidelines and strategies, and promoted SRHR/HIV/GBV integration at policy, planning and programming levels. For example, under the SRH component, UNFPA supported the Ministry of Health to revise the national health policy (endorsed by the Cabinet in 2024), developed HSTP II, RH strategy, obstetric fistula elimination strategy, MPDSR strategy, and triple elimination of mother-to-child transmission of HIV, HBV, and syphilis strategy, which all have prioritized SRH issues for action, indicating that government has unwavering commitment to improve the SRH indicators through impactful actions	• Interviews with line ministries and agencies like EPSS for health; Ministry of Women and Social Affairs for GBV, Ministry of Planning and Development, ESS, among other, and COAR
• UNFPA supported CBCM which was done by trained staff from hospitals	• Interviews withMinistry of Health, RHBs and reviews of COARS 2020, 2021, 2022, and 2023.
• UNFPA has enhanced the technical capacity of safe houses, WGFS and One Stop Centres through professional training, guidelines, SOPs etc.	• Government IPs, CSO

Assumptions for verification 5.2: UNFPA Ethiopia ensured engagement of partners (rights holders, government, NGO, development partners, etc) to ensure sustainability	**Indicators:** • Extent of ownership of each project by implementing partners • Evidence of partnerships with local institutions like academia, among others, to enhance implementation of the supported interventions. • Evidence of training of the beneficiaries to create demand for the 9th CP-supported services • Evidence of the UNFPA CO collaborating with the partners in the design and implementation of 9th CP activities • Evidence of government allocating resources to the 9th CP thematic activities e.g. government allocation of resources for RH commodities • Evidence of localization and capacity building to undertake UNFPA-supported interventions • Evidence of linkages and partnerships strengthened • Evidence of technical assistance to the national and subnational level of governments • The extent to which programmes in the 9th CP thematic areas of programming were developed and implemented in a participatory multi-stakeholder process to promote ownership
Data collected	Sources of information
• Through partnerships with local CSOs and institutions, UNFPA contributed to the strengthening of their capacities. Through these partnerships, UNFPA strengthened both institutional capacities by training the staff on various technical skills, and equipping the CSOs with equipment and guidelines. These enabled them to acquire the necessary expertise and skills to be able to respond to people’s needs in different areas and sectors including SRH, AY and GBV.	• Interviews with Ministry of Health, Local IPs like PDA, AWSAD and CO staff • Reviews of AWPs and COAR

• UNFPA strengthened the national capacity on various programme-thematic areas including development of guidelines, SOP, and Strategies. UNFPA also supported the government on technical skills support through deployment of consultants into the offices facilitating inhouse capacity enabling them to learn and strengthen their institutions and to transfer skills in their day-to-day operations. Additionally, UNFPA contributed to the training of nurses and midwives through supporting their accreditation, further facilitating professionalization, including licensing practitioners. UNFPA also contributed to the delivery of midwifery education through supporting implementation of the curriculum. Capacity development of GBV, and SRH frontline workers, including community-level HEWs ensured quality service provision. Another area where UNFPA made major contributions was strengthening health facilities capacity in the rural areas and ensuring sustainability through the refresher training for clinical midwives at Master of Science level to perform caesarean sections enabling them to conduct caesarean sections in various facilities. UNFPA also worked with women-led NGOs to target women empowerment activities. • The 9th CP support for integrated service SRH and GBV were mostly implemented in government premises – for example, Health facilities where SRH and OSC services were delivered were owned by the Government of Ethiopia	• Interviews with Ministry of Health, Ministry of Women and Social Affairs, EPSS, ESS, Ministry of Planning and Development, RBBs
• UNFPA 9th CP interventions were implemented in collaboration with the government and the Government of Ethiopia had workplans with UNFPA to implement the 9th CP interventions	• Interviews with Ministry of Finance, Ministry of Health, Ministry of Women and Social Affairs, EPSS, ESS, Ministry of Planning and Development, and RHBs

• Through South-South Cooperation, UNFPA contributed to strengthening the capacities of the targeted staff from the IPs, with the government IPs confirming learning from the processes. For example, the South-South visit by the ESS and Ministry of Planning and Development, related government agencies and staff, enhanced their capacity on utilization of mobile data collection and remote data collection, especially for those who are on the move like the pastoralists or IDPs. Additionally, the UNFPA support to ESS on data analysis, use of CAPI, GIS, report writing and training, skills that will continue to be within the institutions supported as the support was institutionalized. This knowledge and skills gained are likely to enhance sustainability of the 9th CP areas of focus. UNFPA also hired a consultant to support the ESS on the design and use of CAPI and this facilitated training which encouraged hands-on learning through practical experience. Integration of the SRH indicators into the EDHS tools will enable continued collection of data on the indicators beyond the 9th CP. Additionally, the support of ESS in the digitalization of the enumeration areas was already being used to conduct other surveys.	• Interviews with ESS, Ministry of Planning and Development, UNFPA CO staff
• There was a confirmed handover of project interventions such as “Her Space” and “Smart Start” in Oromia region and youth clubs in the Sidama region were handed over to the regional government, with the regional governments allocating resources to fund them through budgets and included as regular programmes by Oromia Regional State; while in Sidama, the regional government supported youth centres enhancing access to services to the youth without the financial support of UNFPA. UNFPA supported the development of various strategies, SOPs and a centralised management information system to collect data on GBV cases; and to guide the implementation process for various aspects of the CP thematic areas.	• Interviews with IPs, CO, Ministry of Health and Ministry of Women and Social Affairs, and Sidama and Oromia regional bureaus staff, and review of UNFPA reports
• Various stakeholders, including government agencies, development partners, and rights holders, have been involved in addressing GBV, FGM, and child marriage. GBV referral mechanisms have engaged diverse actors responsible for GBV response, while alliances focused on ending FGM/C and child marriage have included government bodies, partners, and rights holders. This broad engagement and capacity-building efforts have significantly contributed to the sustainability of the initiatives.	• Interviews with Ministry of Women and Social Affairs, IPs, and CO staff and review of COARs
• There were weak capacities among the stakeholders on the implementation of strategies and guidelines	• Interviews and review of COARSs

Evaluation Question 6: To what extent does UNFPA Ethiopia provide leadership in the GBV sub-cluster and the SRH working group for the effective and timely delivery of service, and how has it contributed to the effective coordination mechanisms of the UNCT and HCT? Evaluation Criteria: [Coordination]	
Assumptions for verification 6.1: UNFPA Ethiopia effectively led or supported system-wide development coordination mechanisms within UNCT to reinforce programme implementation and achieve better results by preventing overlap and duplication and promoting synergies.	**Indicators:** ● Extent to which UNFPA participates in the UNCT/HCT or relevant pillar working groups ● Evidence of UNFPA playing a leading role in SRH and GBV thematic working groups of the UNCT/HCT relevant to the UNFPA mandate ● Evidence of UNFPA actively contributing and taking initiative in UNCT/HCT meetings ● Extent to which UNFPA applied the Delivering as One (DAO) approach in its interventions ● Evidence of UNFPA CO being part of joint programmes with other United Nations agencies in related thematic focus ● Evidence that synergies have been actively sought in the design, implementation and monitoring and evaluation of the UNFPA Country Programme and programmes and interventions of other UNCT members ● Extent to which the comparative advantages and technical expertise of UNFPA in the 9th CP thematic areas of programming added value to the UNCT support for sustainable development
Data collected	Sources of information
• UNFPA co-chaired sub-clusters and TWGs within UNCT and HCT - Youth Peace and Security TWG, PSEA Network, GBV AOR, SRH sub-cluster, Data and Statistics. For example, Data and Statistics working Group coordinated data and statistics interventions within the United Nations system in the country and thereby supported the government in data availability and utilization. This Working Group under the leadership of the UNRCO was also instrumental in successfully advocating with the Government of Ethiopia for the conduct of the 4th Ethiopian Population and Housing Census, which had been postponed severally, particularly during the conflict periods every month to brainstorm on issues related to data and statistics. The CO was also a member of the newly-formed platform called Partners' Group within the United Nations system to support the production of vital statistics through coordination of the CRVS.	• Interviews with UNRCO, UNOCHA, WHO, UNICEF, UN Women and CO staff

• UNFPA co-chaired UNSDCF results groups related to SRH, GBV, AY and Population dynamics	• Interviews with UNRCO, UNOCHA, WHO, UNICEF, UNWomen and CO staff
• UNFPA participated in the coordination meetings within the UNCT and HCT, in addition to the UNFPA Country Representative standing in at times for the UNRCO, a role that the CO delivered diligently.	• Interviews with UNRCO, UNOCHA, WHO, UNICEF, UNHCR and CO staff and review of COAR
• UNFPA implemented joint programmes and collaborated with various United Nations agencies ensuring leveraging of resources for enhanced use of comparative advantage. UNFPA and UNICEF collaborated to jointly implement their global partnership on FGM and Ending Child Marriage programmes where both agencies utilized their comparative advantage to deliver the programmes. UNFPA led the FGM programme while UNICEF led the Ending Child Marriage programme harnessing synergies and effectively coordinating to eliminate duplication and overlapping. UNFPA and UNICEF also collaborated and mobilized resources in-country from the Irish Aid up to 2023. Under the health and nutrition sector, UNFPA also implemented a joint project with both WHO and UNICEF funded by the Bill and Melinda Gates Foundation targeting the climate-related shocks and conflict-affected populations in Afar, Oromia and Amhara regions. While UNFPA contributed in the provision of integration SRH and GBV services and UNICEF provided integrated nutrition and child health services. There was confirmed collaboration where both UNICEF and UNFPA-supported clinics provided each other's services ensuring comprehensive delivery to the affected populations. For example, UNFPA deployed midwives in all the UNFPA and UNICEF-supported clinics. UNFPA also jointly implemented with UNICEF a programme on a rights-based approach to adolescent and youth development funded by the University of Norway targeting the most at-risk groups including female sex workers, youth and those working in industrial parks, and youth with disabilities. • UNFPA also implemented joint programmes with UNICEF and WHO to target the vulnerable populations, among others.	• Interviews with WHO, UNICEF, UNWomen, UNHCR and UNRCO staff

• There were also enhanced synergies within the UNCT with UNFPA contributing based on its comparative advantage. For example, towards the roadmap to the development of the Ethiopia UNSDCF 2025 – 2030, UNFPA played a key role in leading the gender equality alignment of the UNSDCF to the basic normative LNOB from a human rights perspective. Further, during the Common Country Analysis, UNFPA participated in the inter-agency team and contributed to the Health and Gender sections of the assessment, in addition to leading the population dynamics.	• Interviews with WHO, UNICEF, UNWomen, UNOCHA and UNRCO staff
• UNFPA engagement in the Gender Thematic Group led by UNWomen was however found to be inactive despite being a member of the group and the relatedness of its mandate. Additionally, there were weaknesses in the mainstreaming of gender equality which was not well coordinated among the United Nations agencies, with further need to strengthen collaboration and lobby the relevant government stakeholders and the senior management within UNCT to ensure cross-cutting functions are implemented, including scorecard on the gender equality assessment.	• Interviews with UNICEF, UNWomen, and UNHCR staff

Evaluation Question 7: To what extent does UNFPA Ethiopia's humanitarian response reach the most vulnerable and marginalized groups including women, adolescents and youth with lifesaving SRH and GBV interventions in humanitarian settings? **Evaluation Criteria:** [*Coverage*]	
Assumptions for verification 7.1: UNFPA Ethiopia's humanitarian response reached the most vulnerable and marginalized groups including women, adolescents and youth with lifesaving SRH and GBV interventions geographically and demographically in the humanitarian settings	**Indicators:** ● Evidence that affected communities are mapped demographically and geographically, and targeted with 9th CP interventions ● Evidence of needs assessment conducted by UNFPA and/or implementing partners, identifying the varied needs of vulnerable populations in various geographical areas in the country prior to the programming of the 9th CP interventions in the targeted locations ● Evidence of systematic use of findings from needs assessments in programme planning and design and the selection of target groups for UNFPA-supported interventions in the four thematic areas of programming in line with identified needs (as detailed in the needs assessments) as well as priorities in the CPD ● Evidence of UNFPA 9th CP interventions being in the HRP ● The extent to which the planned interventions in the 9th CP thematic areas of programming were targeted at the most at risk groups in a prioritized manner. ● The extent to which the actual interventions implemented on the ground met the needs of the most at-risk groups. ● The extentmuc to which the most at risk groups were consulted in relation to programme design and activities throughout the programme
Data collected	Sources of information

• UNFPA contributed to the identification of needs and response on SRH and GBV for women, adolescent girls and young people through supporting HNO, the development of a humanitarian response plan which enabled the provision of targeted services and resources allocated based on identified populations and geographical locations with needs. Additionally, UNFPA supported evidence-based response to the needs through assessment and surveys to determine the needs of the drought and flood-affected populations and locations and effectively ensured the provision of integrated SRH and GBV services. The data collected also enabled other stakeholders, including the government, to respond in other areas of response based on the gaps established. • UNFPA supported the development of humanitarian response frameworks, targeting the most at-risk groups with SRH, and GBV services	• Review of HRPs 2021, 2022, 2023 and 2024. Review of COARs and Interview with CO, regional bureau and IP staff • as identified through the Interviews with UNFPA CO, government, and IPs staff
• During the humanitarian crisis and COVID-19 pandemic, UNFPA supported the equipment and support to MWHs and the deployment of midwives and lifesaving commodities enabled marginalized and vulnerable pregnant women to access services. For example, UNFPA targeted locations without health facilities for deployment of midwives in the conflict-affected areas in Tigray and Afar regions Further, UNFPA supported referral mechanisms through supporting ambulance services enhancing access to CEmONC by the underserved populations. During COVID-19 pandemic, UNFPA mobilization of emergency resources facilitated capacity building of the government and other actors, in addition to supporting health facilities, particularly ANC clinics, with PPEs to ensure continuity of response and coverage of vulnerable populations and those in the hard-to-reach areas. The training on MISP planning and preparedness ensured services were provided in a standardized manner.	• Interviews with EMwA, Marie Stopes Ethiopia, WHO, UNICEF, Tigray and Afar RHBs and UNFPA CO staff
• UNFPA supported access to integrated SRH and GBV services among the IDPs through supporting coordination of the GBV AoR and SRH sub-clusters in the affected areas	• Reviews of COARs 2021, 2022, and 2023 • Interviews with Afar, Amhara and Tigray Regional Health and Women and Social Affairs bureaus

• “Because of this displacement situation, boys are traumatised. We did not have anywhere to go to. Most agencies here only think of women and children and men and boys are left out. We appreciate UNFPA as when we came here, they supported this shelter and got us support. …They have even taught us about gender and gender roles. Before, we did not respect women, but now we appreciate them, even helping them in the house with household chores”.	• FGD session with men and boys in Tigray IDP beneficiaries in a shelter established for men and boys
• UNFPA supported the establishment of women and girls’ safe spaces (WGFS) in IDP settlements and provided them with counselling and SRH services at the sites	• Observations, FGDs with women and girls in the WGFS, and Interviews with Food for Hunger, AWSAD and APDA, regional bureaus in Tigray, Amhara and Afar staff
• UNFPA provided mobile health and nutrition team clinics services targeting the pastoralist communities who were nomads and were not accessible to static services	• Interview with UNICEF, CO, IPs, Canadian Embassy, Afar RHB staff and review of COARs
• UNFPA targeted female industrial parks and female sex workers with integrated SRH services. UNFPA facilitated the signing of an MoU between the industrial park managers, RHB and DSW (UNFPA IP) on the management of the health facilities in the parks to enable the female workers to access to SRH services	• Interviews with RHB and CO staff, review of COARs

<table>
<tr><td colspan="2">Evaluation Question 8: To what extent has UNFPA Ethiopia contributed to enhancing the capacities and systems of implementing partners and communities to ensure their preparedness and resilience in humanitarian settings, including the humanitarian-development-peace nexus?
Evaluation Criteria: [Connectedness]</td></tr>
<tr><td>Assumptions for verification 8.1: UNFPA Ethiopia contributed to enhancing the capacities and systems of implementing partners and communities to ensure their preparedness and resilience in humanitarian settings, and contributed to bridging the development-humanitarian nexus</td><td>Indicators:
• Evidence of the existence of an exit strategy from the humanitarian settings with timelines, allocation of responsibility
• Evidence of details of a handover process from UNFPA to the government departments and/or development agencies
• Evidence of allocation or plan for resource allocation post-response
• Evidence of the existence of a transition strategy from humanitarian action to development, which specifies timelines, allocation of budget and roles and responsibilities
• The extent to which the capacity of individuals, in particular women, adolescents and youth, has been increased to reduce vulnerability to and adapt to humanitarian crises, as well as transform livelihoods to successfully cope with humanitarian crisis
• The extent to which the capacity of communities to prepare for, mitigate the impact of, and recover from the humanitarian crisis has been enhanced
• The extent to which the preparedness of the health and social protection systems at national and sub-national levels and the capacity to deliver services in the mandate areas of UNFPA has been increased
• The extent to which UNFPA humanitarian assistance was linked specifically to peacebuilding initiatives</td></tr>
<tr><td>Data collected</td><td>Sources of information</td></tr>
</table>

• UNFPA contributed to the localization agenda in the humanitarian response by partnering with local organization and the government on various humanitarian response and service delivery modalities. For example, most of the UNFPA CO humanitarian response IPs were from the local NGOs, and UNFPA capitalized on building their capacities on several response areas in its comparative advantage. Additionally, UNFPA supported the government in the development of policies, guidelines, SOP, among other national guiding documents, inclufing emergency preparedness, enhancing longer term results in case of any emergency response. The development of the National SRH guidelines, National SOPs for GBV services deliveries, development of training materials in the development • UNFPA enhanced emergency preparedness and service delivery in humanitarian settings through capacity-building government agencies and CSO IPs on MISP. The straining was confirmed to have been instrumental in supporting the frontline workers to effectively respond to humanitarian situations in the targeted regions. Further, MISP training enhanced coordination and facilitated preparedness and development of response management. UNFPA also ensured that the programme staff also had the necessary competence to provide services. To ensure continued provision of training, UNFPA supported the training of Pooled Master Trainers, and these were instrumental in ensuring the transfer of skills and rollout of MISP for SRH in the woredas. There was confirmation of the training being cascaded at the woreda levels by EPHI and the NGO IPs with reports that the training also contributed to changing the mindset of the government on humanitarian response.	• COAR 2021, 2022 and Interviews with Ministry of Women and Social Affairs, Ministry of Health RHBs, Afar Disaster Risk Management Commission, National Disaster Risk Reduction Commision, IPs and CO staff
• The CP facilitated the integration of peace in the humanitarian response interventions aiming to strengthen the HDP nexus approach. The UNFPA CO made deliberate efforts in the integration of peace in all the programme activities that the CO was designing, strengthening the UNFPA CO's focus on nexus programming. The level of integration of peace activities in the programme activities were however limited at the time of the CPE with the conflict context of implementation being a challenge. UNFPA peace and security expert contribution towards the integration of peace into the Disarmament, Demobilization, and Reintegration of the Tigray People's Liberation Front (TPLF) in Tigray aims to ensure a lasting peaceful situation in the country.	• Interviews with the UNRCO, UNFPA sub-offices and CO staff and document reviews

• UNFPA handed over the MWHs and health facilities to the RHBs after the deployment of midwives and equipment and operation of different health facilities during the conflict. For example, in Tigray and Afar, UNFPA handed over health facilities and MWHs to the respective RHBs with the initially deployed midwives being reassigned. MSIE and EMwA reported their capacities being built in emergency response, and were influenced to introduce a department with this focus on emergency response. These will ensure that they will be able to respond in future in case of any emergency.	• Interviews with RHBs (Tigray and Afar), IPs, UNFPA CO and Ministry of Health

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Annex 3: List of persons met and their organizational affiliations/institutions

	Surname	Name	Sex	Representation
				Implementing Partners
1.	Abdallah	Hussein	M	Bureau of Health - Afar Region
2.	Abdulkadir	Mohamed	M	Bureau of Health - Afar Region
3.	Abe	Tirowork	M	Bureau of Population Amhara Region
4.	Abraha	Mandela	M	Action for Social Development and Environmental Protection Organization)
5.	Abraha	Atakelti	M	Maedot
6.	Abubeker	Sada	F	Bureau of Population Afar Region
7.	Adamte	Senayit	F	Amhara Women's Association (AWA)
8.	Ahmed	Mohamed	M	APDA
9.	Alemu	Fekadu Mazengia	M	Ethiopian Midwives Association

10.	Alemu	Beza	F	NCA
11.	Ali	Jemal	M	Afar BoWSA
12.	Ali	Mahie	M	Disaster Risk Management Commission
13.	Ali Ahemed	Hussen	M	Afar UNFPA Regional Office
14.	Amaje	Hailu	M	Bureau of Population Sidama Region
15.	Amare	Alemat	F	Tigray BoWSA
16.	Amsalu	Abraham	M	Amhara Public Health Institute
17.	Andersson	Ase	F	SIDA
18.	Ankarso	Hailu	M	NCA
19.	Asefa	Tigist	F	Population Media Centre Ethiopia
20.	Ashenafi	Asefa	M	IMC
21.	Asmelash	Ashenafi	M	Mums for Mums
22.	Aweke	Huluasyesh	F	Amhara Women's Association (AWA)
23.	Awoke	Waleligne	M	Amhara BoWSA
24.	Ayele	Serkalem	F	Amhara BoWSA
25.	Bekele	Efrates	M	Marie Stopes International
26.	Bekele	Abebe	M	Oromia Health Bureau
27.	Berhanu	Abrham	M	NCA
28.	Berhanu	Ephrem	M	Talent Youth Association
29.	Bezabi	Betelhem	F	COHRA
30.	Brhane	Getu	M	Amhara Women's Association (AWA)
31.	Browning	Valeria	F	APDA
32.	Chanyalews	Melsew	M	Amhara Bureau of Health
33.	Chemeda	Abera	M	Oromia Regional Bureau Finance
34.	Dagnew	Tiguaded	F	Amhara BEFD- UN Programme Finance Officer
35.	Dawar	Muhammad	M	DKT Ethiopia
36.	De	Susna	F	Bill and Melinda Gates Foundation
37.	Debalkew	Mintamir	F	Mums for Mums
38.	Demiru	Yesinehe	M	Hamelin Fistula Hospital
39.	Dost	Maliha	F	Canadian Embassy
40.	Ebrahem	Usman	M	OWSA

41.	Eshete	Abebaw	M	Ministry of Planning and Development
42.	Eshete	Hailegnaw	M	Population Media Centre Ethiopia
43.	Eshetu	Firhiwot	F	NCA
44.	Esmael	Ausman	M	Oromia BoWSA
45.	Feyessa	Ashenafi	M	Ministry of Women and Social Affairs
46.	Gebregiorgis	Ashenafi	M	Action for Social Development and Environmental Protection Organization)
47.	Gebregiorgis	Tigist	F	DKT Ethiopia
48.	Gebrekirstos	Gebrehiwot	M	Tigray Regional Bureau of Health
49.	Gebremedhin	Tadess	M	Tigray Regional Bureau of Health, UNFPA focal person
50.	Gebremeghin	Negasi	M	Tigray Youth Bureau
51.	Gebremeghin	Yemane	M	Tigray Youth Bureau
52.	Gemchu	Tilahun	M	Afar UNFPA Regional Office
53.	Getachew	Tibebu	M	World Vision International
54.	Getahun	Adugna	M	Amhara Bureau of Finance and Economic Development -UN Program Coordinator
55.	Getahun	Alemayehu	M	Amhara Bureau of Youth and Sports, UNFPA focal person
56.	Getahun	Yonas	M	Ministry of Finance
57.	Getahun	Tsegaye	M	NCA
58.	H/gebriel	Kassahun	M	Bureau of Finance and Economic Development Sidama Region
59.	Habetegebrel	Kassahun	M	Sidama BOFED- UNFPA focal point
60.	Habte	Anteneh	M	Ethiopian Statistics Services
61.	Hamecha	Emala	M	Sidama RHB
62.	Hunduma	Alemayehu	M	Ministry of Health
63.	Hussein	Awol	M	Oromia Health Bureau
64.	Indris	Abdu	M	Afar BoWSA
65.	Kassahua	Lensse	F	Association for Women's Sanctuary and Development
66.	Kelili	Elilita	F	IMC
67.	Kiros	Ershan	F	Tigray BoWSA
68.	Lehone	Negash	M	Hamelin Fistula Hospital
69.	Lewoye	Asnake	M	Amhara BoWSA
70.	Melkamu	Lelise	F	Oromia Health Bureau

71.	Merssa	Hanna	F	Mums for Mums
72.	Mihrete	Tenaw	M	Amhara Bureau of Youth and Sports
73.	Milkit	Sosina	F	DKT Ethiopia
74.	Minir	Maria	F	Association for Women's Sanctuary and Development
75.	Mohamed	Umer	M	Afar Regional Youth Bureau
76.	Mohamed	Deresa	M	Bureau of Health - Afar Region
77.	Mohammed	Umer	M	Afar Bureau of Youth
78.	Mola	Tilahun	M	Hamelin Fistula Hospital
79.	Monahor	Maria	F	SIDA
80.	Muhammed	Deressa	M	Bureau of Finance and Economic Development Afar Region
81.	Mulu	Gonder	F	Mums for Mums
82.	Negash	Abebe	M	Amhara Bureau of Finance and Economic Development - UN Programme Finance Officer
83.	Negash	Mesafint	M	Amhara Women's Association (AWA)
84.	NIgusie	Solomon	M	Ethiopian Pharmaceutical Supply Service
85.	Paulos	Sebesebe	M	NCA
86.	Petros	Kidus	M	NCA
87.	Regasa	Ephrem	M	Oromia Health Bureau
88.	Sakume	Serkalem	M	Oromia Women Social Affairs (OWSA)
89.	Seyoum	Abraham	M	Sidama RHB
90.	Shiferaw	Million	M	NCA
91.	Shume	Endale	M	Bureau of Finance and Economic Development Afar Region
92.	Shumi	Demisu	M	Disaster Risk Reduction Commission
93.	Simon	Getahun	M	Ethiopian Centre for Disability and Development
94.	Siyum	Abreham	M	Sidama BoWSA
95.	Supa	Tarike	M	Oromia BoWSA
96.	Supa	Tarik	M	OWSA
97.	Taddess	Seleshi	M	Ministry of Women and Social Affairs
98.	Tadesse	Alemu	F	Marie Stopes International
99.	Tefera	Meles	M	Amhara BoWSA-UNFPA Focal
100.	Tekelu	Meheret	F	Tigray BoWSA

101.	Tekleyes	Hailay	M	Maedot
102.	Teklu	Hailemariam	M	Ethiopian Statistics Services
103.	Tesfa	Selome	F	Bureau of Population Amhara Region
104.	Tesfaye	Letay	F	Tigray Women's Association
105.	Teshome	Elias	M	NCA
106.	Tsedal	Endalkachew	M	Ministry of Health
107.	Tufa	Kebede	M	Oromia BoWSA- UNFPA focal
108.	Tufa	Kebede	M	OWSA
109.	Wakgari	Lijalen	M	Oromia Regional Bureau Finance
110.	Waleligne	Tarkekegne	F	Amhara Women's Association (AWA)- UNFPA Programme Coordinator
111.	Worku	Yohannes	M	IMC
112.	Yalew	Kasaye	F	Amhara BoWSA
		UNFPA Staff		
113.	Adonri	Osaretin	M	UNFPA CO
114.	Afzal	Mohamend	M	UNFPA CO
115.	Ahmed	Hussein Ali	M	UNFPA Afar Regional Office
116.	Alemu	Tesfu	M	UNFPA Tigray Regional Office
117.	Ali	Mahbub	M	UNFPA CO
118.	Ashraf	Farzana	F	UNFPA CO
119.	Assefa	Beyeberu	M	UNFPA CO
120.	Ayenekulu	Metsehate	F	UNFPA CO
121.	Berhanu	Gezu	F	UNFPA CO
122.	Berhe	Aster	F	UNFPA CO
123.	Bogale	Alemayehu	M	UNFPA CO
124.	Castori	Gaia	F	UNFPA CO
125.	Debalkie	Fanuel	M	UNFPA CO
126.	Degefa	Terefe	M	UNFPA CO
127.	Degefaboshera	Terefe	M	UNFPA CO
128.	Ekpon	Theophilus	M	UNFPA CO
129.	Fenta	Moges	M	UNFPA CO
130.	G/Tsadik	Alemayehu	M	UNFPA CO
131.	Gamechu	Tilahun	M	UNFPA Afar Regional Office

132.	Geber	Senayit	F	UNFPA Tigray Regional Office
133.	Geberhiwot	Tesfalidet	M	UNFPA Tigray Regional Office
134.	Gebretsadik	Alemayehu	M	UNFPA CO
135.	Gebru	Ferehiwot Kassahun	F	UNFPA CO
136.	Gette	Tsehay	F	UNFPA CO
137.	Hailu	Gezahegne	M	UNFPA CO
138.	Kebede Tekleyes	Tinos	F	UNFPA CO
139.	Mekuria Mamo	Netsanet	F	UNFPA CO
140.	Mesfin	Rediet	F	UNFPA CO
141.	Nonogaki	Akiyo	M	UNFPA CO
142.	Okara Wanyama	James	M	UNFPA CO
143.	Oluyomi	Taiwo	M	UNFPA CO
144.	Park	Faith Jiyeong	F	UNFPA CO
145.	Rabary	Onja	M	UNFPA CO
146.	Shefrif	Abdulahi	M	UNFPA Tigray Regional Office
147.	Solomon	Bethlehem	M	UNFPA CO
148.	Tamrat	Edna	F	UNFPA CO
149.	Tasew	Awoke	M	UNFPA CO
150.	Teferi	Meseret	F	UNFPA CO
151.	Tesfaye	Anteneh	M	UNFPA CO
152.	Worku	Fikru	M	UNFPA CO
			United Nations Agencies	
153.	Ahmed	Haithar	M	UNICEF
154.	Ali	Seid	M	United Nations Women
155.	Anwar	Sidra	F	UNHCR
156.	Berhanu	Naol	M	UNHCR
157.	Elisabeth	Hanna	F	United Nations RCO
158.	Lusigi	Millicent	F	UNHCR
159.	Sam	Niangrah Raymond	M	UNHCR
160.	Strangio	William	M	OCHA
161.	Workineh	Haimanot	F	WHO

162.	Worku Belete	Tigist	F	UNICEF – SRH
			BENEFICIARIES	
163.	Gidey	Haben	M	Boys and Men Group – Tigray
164.	Gedif	Abrham	M	Bahir Dar Youth Centre
165.	Ashenafi	Amare	M	Bahir Dar Youth Centre
166.	Tefera	Banchayehu	F	Bahir Dar Youth Centre
167.	Masresha	Endalew	M	Bahir Dar Youth Centre
168.	Abebaw	Esuyawukal	M	Bahir Dar Youth Centre
169.	Nigusie	Habtam	F	Bahir Dar Youth Centre
170.	Melese	Kasahun	M	Bahir Dar Youth Centre
171.	Sinte	Melsew	M	Bahir Dar Youth Centre
172.	Wubet	Sifelg	F	Bahir Dar Youth Centre
173.	Temesgen	Silesh	M	Bahir Dar Youth Centre
174.	Asfaw	Taye	M	Bahir Dar Youth Centre
175.	Rezene	Amanuel	M	Boys and Men Group – Tigray
176.	Desta	Awra	M	Boys and Men Group – Tigray
177.	Hagose	Birhan	M	Boys and Men Group – Tigray
178.	TekleBirhan	Birhane	M	Boys and Men Group – Tigray
179.	Gbere Manta	Degen	M	Boys and Men Group – Tigray
180.	Gezie	Girmay	M	Boys and Men Group – Tigray
181.	Fikadu	Kibrom	M	Boys and Men Group – Tigray
182.	Tsegay	Kihesen	M	Boys and Men Group – Tigray
183.	Rezene	Muez	M	Boys and Men Group – Tigray
184.	Mekonen	Welde	M	Boys and Men Group – Tigray
185.	Germaye	Aleme	F	WGFS- Participant
186.	Geberemedihen	Alemetsehaye	F	WGFS- Participant
187.	Germaye	Azeb	F	WGFS- Participant
188.	Hagos	Leteberehan	F	WGFS- Participant
189.	Abreha	Mulashu	F	WGFS- Participant
190.	Asefa	Tsege	F	WGFS- Participant
191.	Kidanemariyam	Tsege	F	WGFS- Participant
192.	Gedeye	Selamawit	F	WGFS- Participant

Annex 4: Data collection tools

Tool-1: Key Informant Interview Guide for UNFPA Staff and United Nations Agencies

Introduction:

a. Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current programme cycle with the view of proposing recommendations for the next CP cycle.
b. Assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis.
c. Write the names of all the Participants and their roles in the organization.

1. Rationale for the CP and Interventions undertaken

- How did you decide to undertake this work, what were the indications that it would be effective and would reach the target population?
- Who was consulted regarding the design? To what extent were they consulted?
- What other actors have been involved, how does this activity contribute to that of others?

2. Relevance

- How is the [SRHR; Gender and social norms; Population change and data; Humanitarian action and Adolescents and youth] component of the CP aligned to the a) national needs and priorities in Ethiopia such as articulated in the national and sectoral policies b) Partners and beneficiaries needs? c) UNFPA Strategic Priorities and strategic plan? d) International frameworks, policies and strategies on [SRHR, Maternal Health/Family Planning, GBV and Humanitarian response] and human rights? (probe for the needs first)

- What aspects of the national and sectoral policies do you consider are covered in the 9th CP?
- Were the objectives and strategies of the Country Programme M&E Framework discussed and agreed with national partners? [Probe]
- How did you identify the needs prior to the programming of the [SRHR; Gender and social norms; Population changes and data; Humanitarian action and Adolescents and youth] components?
- Who was consulted regarding the design? What other actors have been involved, how does this activity contribute to that of others?
- In your view, does UNFPA have the right strategic partnerships? Mutual benefit, critical to achieving shared vision.
- Were there any [SRHR; Gender and social norms; Population changes and data; Humanitarian action and Adolescents and youth] needs or priorities of the implementing partners that the country program did not address adequately or at all? If yes, what were these needs and priorities.
  Probe: Focus on vulnerability, intersectionality, gender, disability and human rights as appropriate

3. Effectiveness

- What are the indications that the approach is working or making progress toward goals established for the CP (e.g. anecdotes which provide illustrations of positive, negative or unintended effects, or quantitative and qualitative evidence)?
- Overall, what are the achievements of the 9th CP in respect of the [SRHR; Gender and social norms; Population changes and data; Humanitarian action and Adolescents and youth] component area? Probe for evidence.
- How have the outputs been utilized?
- What are the barriers/challenges to increasing demand and access to services, and how are they being addressed?
- What factors have facilitated effective implementation of the 9th CP? Which ones hindered?
- What do you consider to be the best practices from the 9th CP? And what are the learning from the 9th CP?

- To what extent did internal communication strategies on various CP components facilitate improved outcomes of the other components in terms of funding, personnel, administrative arrangements, time and other inputs contributed to, or hindered achievement of results.
- Were there any changes in national needs and global priorities during the implementation period? How did UNFPA CO respond to these changes?
- To what extent has UNFPA responded to [SRHR; Gender and social norms; Population changes and data; Humanitarian action and Adolescents and youth] emerging issues during calamities? What were the factors that facilitated UNFPA response to such emerging issues? What were the factors that hindered the UNFPA response to such SRHR or GEWE emerging issues?
  Note: Remember to ask for documents if not already shared

4. Efficiency

- How many staff are in your unit? Qualified with appropriate skills?
- Do you think your staff strength and capacity are enough for the 9th CP implementation and achievement of results?
- How timely did you receive resources for implementing this programme?
- How timely were resources for interventions disbursed to implementing partners? Were the resources sufficient for implementing partners to complete activities?
- Describe UNFPA CO administrative and financial procedures in the 9th CP?
- Do you think UNFPA CO administration and financial procedures are appropriate for the 9th CP implementation? [Probe]
- Were there any delays? If yes, why? And how did you solve the problem?
- Are there occasions when the budget was not enough, or you overspent?
- How appropriate was the programme approach, partner and stakeholder engagement for CP implementation and achievement of results?
- Have the programme finances been audited?
- To what extent were the activities managed in a manner to ensure delivery of high-quality outputs and best value for money?
- Any additional funding from the Government and other partners?
- How robust and adequate is the M&E System in place to enable measurement of the CP performance during implementation? How are M&E results used to support the CP management?

5. Sustainability

- What mechanisms is UNFPA putting in place to ensure that the results of the CP are sustained beyond the programme cycle?
- How is partner capacity building integrated into the UNFPA mode of engagement with partners?
- How have national partners utilized capacity developed through UNFPA support?
- How are national partners involved in UNFPA programming?
- To what extent are the benefits likely to go beyond the programme completion?
- Are the strategies, plans, protocols and practices developed within the programme anchored on IPs institutional arrangements?
- Do you believe that there is political will and national ownership behind the CP interventions, and is this changing? Have programmes been integrated in institutional government plans?
- How has UNFPA addressed changes in knowledge and perceptions of the target beneficiaries based on various aspects of the programme?

6. UNCT/HCT Coordination and Mandate

- Is there any Inter-Agency Technical Working Group on this 9th CP, involving other United Nations Country and humanitarian coordination Team?
- What role has UNFPA played in the UNCT/HCT joint programs? Any specific contributions? Any lessons learned?
- What are the UNCT/HCT coordination structures and mechanisms in place?
- How active, relevant and effective is UNFPA in the UNCT/HCT?

- What is the role of UNFPA CO in the United Nations Country Team coordination structures and mechanisms in Ethiopia? What partnerships exist? Any specific contributions to the achievement of results?
- What are the special strengths of UNFPA when compared to other United Nations agencies and development / humanitarian partners?
- How do implementing and national partners perceive UNFPA?
- Is UNFPA collaborating with other United Nations Agencies in implementation of interventions? Which United Nations Agencies and in which interventions? What are the roles of UNFPA and other United Nations Agencies? How has this contributed to the achievement of UNFPA results?
- How and to what extent are UNFPA priorities and mandate reflected in the UNSDCF.

7. Coverage

- How does UNFPA CP respond to humanitarian needs in Ethiopia? In which locations? Who were the target groups?
- How does UNFPA programme identify those at risk or vulnerable? How is the intersectional approach in the program?
- To what extent does UNFPA programme target the vulnerable and those in displacement in Ethiopia?
- To what extent has UNFPA responded to the [SRHR; Gender and social norms; Population changes and data; Humanitarian action and Adolescents and youth] on the humanitarian and emerging needs in the during calamities?
- What were the factors that facilitated UNFPA response to such adolescent and youth humanitarian and emerging issues?
- What were the factors that hindered the UNFPA response to such humanitarian and emerging issues?
- To what extent does the UNFPA CP interventions address the needs of populations at risk and vulnerable?
- Budget allocation for humanitarian programme interventions

8. Connectedness

- To what extent has UNFPA built the capacities of local partners during the current CP? What are the indications that the capacity building efforts are working? (Specifically in humanitarian settings)
- How has UNFPA built partnerships with local organizations or institutions in the areas of SRHR in Ethiopia? (Specifically in humanitarian settings)
- How adequate have the resources allocated to addressing emergency response been to ensure recovery and resilience.
- How has UNFPA ensured that long-term plans are put in place to address the existing SRHR or GEWE needs
- Have the facilities supported by UNFPA to respond to emergency been handed over to the local government or local communities?
- Other feedback on the implementation of the H-D-P nexus

9. Learnings

- What are the key learnings from the program?
- What do you recommend for the next program focus?

Tool-2: Key Informant / Group Interviews: Government / IPs

Introduction:

d. Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current programme cycle with the view of proposing recommendations for the next CP cycle.
e. Assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis.

f. Write the names of all the Participants and their roles in the organization.

1. Rationale of the Partnership and activities engaged in

- How did you decide to undertake this work, what were the indications that it would be effective and would reach the target populations (SRHR, Youth and adolescent or GEWE needs)?
- Have you conducted a problem analysis, needs assessment? Who was consulted regarding the design?
- What other actors have been involved, how does this activity contribute to that of others?

2. Relevance

- To what extent is the [SRHR; Gender and social norms; Population changes and data; Humanitarian action and Adolescents and youth] component of the 9th CP aligned to the a) national needs and priorities in Ethiopia such as those articulated in the national and sectoral policies; b) International frameworks, policies and strategies on gender equality and human rights?
- What aspects of the national and sectoral policies do you consider are covered in the 9th CP?
- How were the needs of vulnerable groups (i.e. youth, girls, women, young mothers, marginalized) addressed during the programming or planning process for your UNFPA project activities?
- What criteria did you use in the selection of target groups in the field of [SRHR, Maternal Health/Family Planning, GBV and Humanitarian response]? [Probe if the identified needs of these target groups included in the criteria]?
- Were there any [SRHR; Gender and social norms; Population changes and data; Humanitarian action and Adolescents and youth] needs or priorities of the implementing partners that the CP did not address adequately or at all? If yes, what were these needs and Priorities.
- How does the CP intervention interface/merge with your institutional programmatic objectives and strategies?
- How were the needs of your institution identified prior to the programming of the [SRHR, or GEWE]?
- Do you see the work of UNFPA and its implementing partners as supporting the right interventions to address [SRHR; Gender and social norms; Population changes and data; Humanitarian action and Adolescents and youth] needs, harmful practices and discrimination against women and girls?

Probe: Focus on vulnerability, intersectionality, gender, disability and human rights as appropriate

3. Effectiveness

- Looking at the implementation so far, to what extent have the planned 9th CP outputs/targets been achieved? Were the intended beneficiaries reached? Probe
- What are the indications that the approach is working or making progress toward goals established to be achieved in 2021?
- How did UNFPA provide support for challenges in the implementation of interventions to address outputs and outcomes.
- To what extent did the support address the needs of the target groups i.e. women of reproductive age, survivors of GBV, adolescents and youth, boys and men and other marginalized groups?
- What factors have facilitated effective implementation of the 9th CP? What factors hindered/affected successful implementation of the programme?
- What else should be done to make the programmes more effective?
- Has there been evidence of expected or unexpected results from work on [SRHR, Maternal Health/Family Planning, GBV and Humanitarian response] that has been supported by UNFPA?
- How timely was the disbursement of UNFPA funds to the IPs? Probe for any challenges.
- How many times did you experience a humanitarian crisis or a political change during the 9th CP? How did UNFPA support in each of the instances? Probe for the services or support provided.
- To what extent has UNFPA responded to [SRHR, Maternal Health/Family Planning, GBV and Humanitarian response] emerging issues during calamities? What were the factors that facilitated UNFPA response to such [SRHR, Maternal Health/Family Planning, GBV and Humanitarian response] emerging issues? What were the factors that hindered the UNFPA response to such SRHR and GBV emerging issues?
- How did UNFPA ensure programme integration of gender and a human-rights approach, including people with disabilities?

- To what extent did UNFPA support use of disaggregated demographic and socio-economic data for evidence-based planning and development.

Probe: Focus on vulnerability, intersectionality, gender, disability and human rights as appropriate

4. Sustainability

- What measures are in place for programme continuity in the absence of continued UNFPA support? [Probe e.g. re output/outcome areas integrated in institutional/government policies and plans/budget allocations]. In which areas do you need support to continue your own?
- To what extent have your capacities been strengthened in the areas of support by UNFPA?
- How have you utilized capacity developed through UNFPA support?
- How is capacity building integrated into UNFPA mode of engagement with its partners?
- Do you have other sources of technical and financial support? [Probe]
- What is the likelihood of sustained benefits (e.g. through capacity building, improved M&E and other systems, population data availability, etc. with or without continued UNFPA support)? [Probe]
- How has UNFPA ensured effective partnership in the country to facilitate strong sectoral networks in the country? Probe how they have participated.
- Is your organization/agency a member of any national or local coordination mechanism (including bilateral dialogues) where UNFPA shares technical expertise either as a member or as a leader? [Probe: What are these coordination mechanisms?

5. Efficiency

- How appropriately and adequately are the available resources (funding and resources) used to carry out activities for the achievement of the outputs?
- How timely did you receive resources for implementing this programme? Were there delays? If yes, why and how did you solve the problem?
- To what extent were the activities managed in a manner to ensure delivery of high-quality outputs and best value for money?
- Any additional funding from the Government or other partners for the programmes funded by UNFPA?
- Do you think UNFPA CO administration and financial procedures are appropriate for 9th CP implementation?
- How about the programme approach, partner and stakeholder engagement, was it appropriate for implementation and achievement of results?
- How did UNFPA support capacity development for implementers of interventions?
- What implementation challenges were encountered?
- Were agreed outputs delivered?
- Was the programme approach, partner and stakeholder engagement appropriate for results delivery?
- Which partnerships were more strategic in bringing about results and value-for money?
- Were institutions adequately equipped to deliver on results-based management/ M& E for the CP?

6. Coordination

- How is the UNFPA programme coordinated? What role does UNFPA play and what role do you play in coordination?
- Is there any Inter-Agency Technical Working Group on this 9th CP, involving other United Nations Country Team?
- Can you say how well the activities are coordinated, overlapping and how is this handled?
- Is UNFPA playing an active coordination or leadership role around SRHR, Maternal Health/Family Planning, GBV and Humanitarian response in the country?
- What are the special strengths of UNFPA when compared to other United Nations agencies and development partners?
- How do implementing and national partners perceive UNFPA?
- What partnerships exist? Any specific contributions to the achievement of results? Any challenges?
    - Added Value

- What unique strategies/interventions in [SRHR; Gender and social norms; Population changes and data; Humanitarian action and Adolescents and youth] of UNFPA add value to the work of other development partners, especially the United Nations system? Please give examples.
- What strategic partnerships at the National level and /or local level has UNFPA supported that produced results and are worth replicating and institutionalizing?
- What specific technical contribution has UNFPA made to the country's development agenda?

7. Learnings

- What are the key learnings from the program?
- What do you recommend for the next program focus?

Tool-3: Key Informant Interview/ Focus group discussion Guide for CP Beneficiaries

Introduction and Consent:

a. Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current program cycle with the view of proposing recommendations for the next CP cycle.
b. Assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis.
c. Ask for consents.
d. Capture every participant's name.

Probe: Focus on vulnerability, intersectionality, gender, disability and human rights as appropriate

I (We) would like to know the type of support you received from (UNFPA implementing partner)

1. Relevance

- What are the needs and priorities in your community in terms of the development agenda with regards to CP component [SRHR; Gender and social norms; Population changes and data; Humanitarian action and Adolescents and youth]?
- How important is the work supported by (UNFPA implementing partner) to these needs and priorities at the local, provincial and national levels?
- Does the (UNFPA implementing partner)'s work address the needs in [SRHR; Gender and social norms; Population changes and data; Humanitarian action and Adolescents and youth]?
- How has (UNFPA implementing partner) consulted you in the identification of your local needs in [SRHR; Gender and social norms; Population changes and data; Humanitarian action and Adolescents and youth]?
- How has (UNFPA implementing partner) integrated support for the marginalized, gender and other human rights?

2. Effectiveness

- To what extent has (UNFPA Implementing Partner) support reached the intended beneficiaries? Probe for vulnerable groups in the locality.
- Are different beneficiaries appreciating the benefits of the UNFPA interventions? For example,
- What are the specific indicators of success in your programme?
- How are gender relations and human rights being influenced by the activities undertaken by the programme?
- What do you think has worked best? What has not worked well?
- What factors contributed to the effectiveness or otherwise?
- What else should be done to make the programmes more effective?

3. Sustainability

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

- How does the UNFPA CO/ (Implementing partner) ensure ownership and durability of its programmes?

4. Learnings

- What are the key learnings from the program?
- What do you recommend for the next program focus?

Tool-4: Interview Guide for UNFPA Donors and Strategic Partners

Introduction:

a. Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current program cycle with the view of proposing recommendations for the next CP cycle.
b. Assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis.
c. Capture every participant's name.

Probe: Focus on vulnerability, intersectionality, gender, disability and human rights as appropriate

1. Rationale for the Strategic Relationship

- What is the strategic involvement of [Donor/ partner] in Ethiopia?
- What specific needs is your institution addressing in the country?
- Which specific areas did your institution support the Ethiopia 9th CP (Donor)?

2. Relevance

- How is UNFPA CP contributing to addressing the same strategy that your institution is involved in the country?
- How relevant is UNFPA programming in addressing the country needs in the areas of [SRHR; Gender and social norms; Population changes and data; Humanitarian action and Adolescents and youth]?? [Probe for specific approaches]
- What is UNFPA comparative advantage in the country?
- To what extent would you say UNFPA is addressing the national needs and priorities in Ethiopia?

3. Effectiveness

- What has been realized in the country because of UNFPA CP since 2020 to present? [Results achieved compared to plans – Probe for capacities developed]
- What has worked well and what has not worked well?
- Are there gaps in UNFPA approaches? How would they be improved?

4. Efficiency and Sustainability

- M&E systems in place, ensuring.
    - Timely reporting
    - Use of data to inform decision-making.
- Capacities in place
- Effectiveness of partnership approaches

5. Coordination

- How active, relevant and effective is UNFPA in the coordination mechanisms in the country?
- How does UNFPA contribute to the coordination within the country? Probe for specific responsibilities.
- Where there are areas of potential overlap with other United Nations mandates, how is this resolved? e.g. re gender, disability, human-rights based programming, response in humanitarian situations as well as main focal areas of SRHR, Maternal Health/Family Planning, GBV and Humanitarian response.
- What are UNFPA CO strengths, weaknesses/ limitations, and opportunities to improve its programming in the country?

6. Learnings

- What are the key learnings from the program?
- What do you recommend for the next program focus?

Tool-5: Observation checklist

5.1 GBV Survivors Shelters

1. Is the shelter infrastructure being to the standards set out in the GBV service standard and operating procedure?
2. Are the spaces available for accommodation adequate and clean?
3. Is there extra activity performing areas for the GBV survivors within the shelter?
4. Is the psychosocial service provision to the standard? Is it maintaining confidentiality?
5. How is the confidentiality of GBV survivors' personal information and case management records kept?
6. How are the skills and behaviours of the service provider and customer handling?

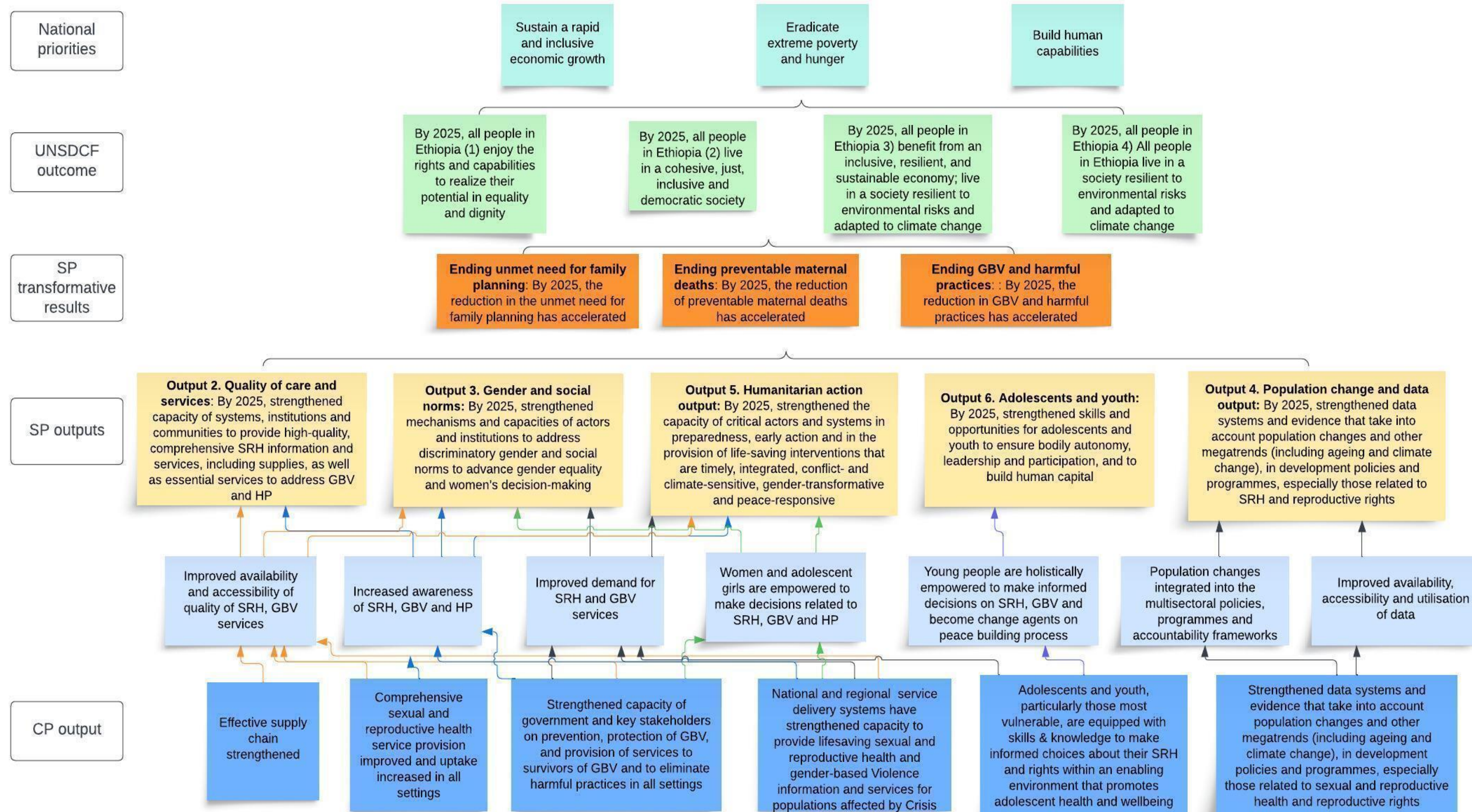
5.2 One Stop GBV service centres

1. Are all the services (health, legal and physical) being easily available in the centre?
2. How is the quality of the service provision?
3. Are all the required facilities (equipment, medicine and spaces) being available?
4. How are the skills and behaviours of the service provider and customer handling?

5.3 Health service infrastructures (midwives' sections, fistula treatment sections)

1. How are the infrastructures for delivery and fistula treatment provision? Cleans, availability of adequate equipment.
2. How is the quality of the service provision?
3. Are all the required facilities (equipment, medicine and spaces) available?
4. How are the skills and behaviors of the service provider and customer handling

Annex 5: Existing 9th CP ToC



Annex 6: 9th CP Performance as of December 2023

Output Indicators	Baseline 2020	Targets 2025	Progress against Targets	Comments
Output 1: Effective supply chain strengthened for ensuring availability of SRH commodities at all SDPs, including in humanitarian settings.				
Percent of primary service delivery points with 'no stock-out' of any modern contraceptive method (on day of visit)	8.4per cent	10.5per cent	4.8per cent	Target not achieved. There was low availability of SRH commodities at SDPs in rural areas and PHC units, probably due to an inefficient government logistic system, and inaccessibility of some of the areas.
Government commitment / contribution for co-financing of RH products procurement implemented as per the signed Compact	0per cent	3per cent	0.75per cent	Target not achieved, but there is considerable progress made by the government since the Compact Agreement was signed in 2023. There was however a significant delay in the procurement of SRH commodities by EPSS, but also no evidence by Ministry of Health that the commodities were procured.
Couple Years of Protection Provided by the contraceptive donated to implementing partners	2,126,500	12,676,914	9,097,126	Target not reached, but the achievement (71.8per cent) in three years is a bit higher than the expected average (20per cent per year) and the target is likely to be achieved in the remaining CP period.
Multi-year Costed Implementation Plan (CIP) developed for the National Family Planning Programme	NO	Yes	Yes	Target achieved: The set target is already achieved. At the time of the evaluation, the CIP was being dissemination at the regional level in preparation for implementation not yet started
Output 2: Comprehensive sexual and reproductive health service provision improved and uptake increased in all settings				
Availability of costed multiyear plan for integrated SRH services within the larger framework of universal health care	No	Yes	Yes	Target achieved: The set target is already achieved. The CIP was being disseminated at the time of the CPE.
Number of public health facilities strengthened to report, review and respond on maternal deaths system	165	313	317	Target surpassed.
Number of health facilities providing comprehensive SRH services	0	212	212	Target achieved, and is likely to be surpassed in the remaining period.
Number of women and girls who received obstetric fistula treatment with UNFPA support	4,927	6623	6,243	The performance is close (94.3per cent) to the 2025 target, which seems likely to be achieved in the remaining CP period. over achievable in two years.

Output 3: Strengthened capacity of government and key stakeholders on prevention, protection of GBV, and prevention of services to survivors of GBV and to eliminate harmful practices in all settings				
Output Indicators	Baseline (2020)	Targets 2025	Progress against Targets Until Dec 2023	Comments
Number of survivors of gender-based violence who received quality comprehensive services as per the National Protocol in non-crises settings.	34,425	137,600	82,055	This is at 59.63per cent. 1. The implementation of GBV SOP and capacity building on GBV case management have led to the provision of comprehensive survival-centred services. 2. The target was not fully met as the complexity and severity of cases prolonged GBV survivors staying at the safe house beyond the expected 3 months.
Number of young girls (10-19 years) who received—UNFPA-supported prevention and/ or protection services and care related to child marriage.	58,200	153,340	354,787	The target surpassed realizing 231.37per cent The WGFS, in and out of school and the engagement of Health Extension Workers (HEW), Women Development Groups (WDG), Anti -Harmful Transitional Practices effectively improved the referral pathways
Number of young girls (aged 10-19 years) and women who received UNFPA- supported prevention and/or protection services and care related to female genital mutilation (FGM)	401,400	750,000	1,135,382	The target is surpassed reaching 151.38 per cent The integration of FGM in the SRH programme have increased the effectiveness. The WGFS, in and out of school and the engagement of HEW, WDG, Anti - Harmful Transitional Practices effectively improved the referral pathways.

Output 4: Strengthened data systems and evidence that take into account population changes and other megatrends (including ageing and climate change), in development policies and programmes, especially those related to sexual and reproductive health and reproductive rights.				
Evidence-based policy dialogue on population dynamics and its interlinkages	No	Yes	Yes	The target achieved. The SWP was published and disseminated every year. The World Population Day celebrated each year. Three policy briefs were prepared as background papers for the revision of the NPPE
Indicators on sexual and reproductive health and rights and GBV tracked in national SDGs monitoring and evaluation frameworks	No	Yes	Yes	The preparation of the 5th EDHS is well advanced. The 5th EDHS captures new aspects of the SRH and GBV indicators such as Fistula and FGM modules.
Number of reports produced and disseminated based on 4th Population and Housing Census, 5th Demographic and Health Survey, Gender and Vital Statistics	0	10	3 (CVRS)	Target not achieved. The census was postponed
Number of reports generated using mapping to illustrate	0	4	8	Target surpassed.

vulnerability to climate and humanitarian crises				
Number of functional regional web based integrated management information system and knowledge platforms	5	11	9	Target not achieved. The 9th CP supported the establishment of MIS system 10 regions and was used by some of the regions for generating their data for decision-making.

Output 5: National and regional service delivery systems have strengthened capacity to provide lifesaving sexual and reproductive health and gender-based Violence information and services for populations affected by Crisis				
Number of service providers trained on various components of the Minimum Initial Service Package (MISP).	*200*	*1000*	526	Target not reached: These included frontline health service providers, SRH programme coordinators and managers, SRH TWG members and humanitarian actors, and were instrumental in delivering the humanitarian services on SRH to the emergency affected populations in different regions in the country
Number of crises affected population reached with lifesaving SRH services	*150,000*	*1,200,000*	1,050,942	Target not reached: However, given that this is the first year of measurement, the target is likely to be reached. The services included lifesaving SRH and GBV services provision through deployed midwives, mobile health teams, volunteers, HEWs. Additionally, the UNFPA CO also provided lifesaving IARH kits and medical supplies and equipment to enhance quality and timely (ANC, Delivery, PNC, FP, CAC, CMR, C-section, safe blood transfusion, STI treatment and other) services provision.
Number of women and girls at risk of GBV reached with GBV services	*100,000*	*400,000*	187,857	Target not reached: The women and girls at risk of GBV received psychosocial and GBV case management services from the various service points. The beneficiary number were low mostly due to non-reporting of the cases by the survivors for fear and sensitivity of the cases, while some areas in the regions were not accessible due to insecurity. UNFPA, together with the IPs and stakeholders continued to sensitize the communities and trained service providers to ensure access to the services by the affected.
Number of crises affected girls and women of the reproductive age group who received female dignity kits, messages on the availability of GBV response services and GBV risk mitigation mechanisms.	*25,412*	*350,000*	214,577	Target not achieved. These included beneficiaries from Tigray, Amhara, Oromia, Somali, Afar, SNNP and Benishangul Gumuz regions. Demonstration was done on the proper use of the kit contents by female social workers. Community members were also sensitized on the available GBV services. Post distribution assessment was conducted in selected distribution sites among women and girls and the findings were used to customize the kits contents.
Functional UNFPA led GBV and SRH inter-agency humanitarian	Yes	Yes	Yes	UNFPA ensured functional SRH and GBV inter-agency humanitarian coordination mechanisms at the national, regional Zone

coordination mechanisms at the national and regional levels.				and Woreda levels through the engagement of multiple stakeholders, including civil society and faith-based organizations, to enhance access to lifesaving SRH services, and contribute to GBV prevention and response. UNFPA supported 66 inter-agency GBV and SRH coordination bodies at the federal and regional levels.
Number of health facilities providing SRH services to emergency affected populations equipped with emergency reproductive health kits	88	170 (Cumulative)	452	The facilities were also equipped with IARH kits, medical supplies and equipment's including PPEs to ensure the continuum of SRH and GBV services and conflict affected health facilities restoration and system strengthening

Output 6: Adolescents and youth, particularly those most vulnerable, are equipped with skills & knowledge to make informed choices about their SRHR within an enabling environment that promotes adolescent health and wellbeing'				
Number of young people reached with life skills education to empower them to build their health, social and economic assets and meaningfully participate in decision making and peace building processes at all levels	253,000	510,000	515,045	Target surpassed. The technology-powered apps and tools such as *Yenetab* and *Minch* were used to reach more adolescents and youth
Number of most vulnerable young people reached with integrated HIV prevention interventions	20,000	50,000	30,470	This indicator was introduced after the alignment, which has contributed to the low performance (60.9per cent). Otherwise, the evaluation showed that HIV prevention activities are included in almost all adolescent and youth mobilizing platforms, including youth centres, youth-friendly health services, community conversations, advocacy
Number of youth-serving platforms that have operationalized out-of-school comprehensive sexuality education in accordance with international standards	65	300	206	The achievement (68.7per cent) is encouraging while there is no policy and ministry backup for comprehensive sexuality education.
Number of functional mechanisms availed for the participation of young people in policy dialogue, peace building and programming in all settings	20	50	65	Target surpassed. Peace-building efforts were successful in some areas. In some regions, young people's participation (including youth policy revision) was limited to the office level.
Number of regions where at least two sectors (beyond the health sector) have strategies that integrate SRHR of youth in all settings	2	9	10	Target surpassed.

Annex 7: CPE Terms of Reference

Terms of Reference

United Nations Population Fund (UNFPA) Ethiopia 9th Country Programme
(July 2020 to June 2025)

Country Programme Evaluation

March 2024

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Acronyms

CCA	Common country assessment/analysis
CO	Country office
CPD	Country programme document
CPE	Country programme evaluation
DSA	Daily subsistence allowance
ESARO	East and Southern Africa Regional Office
EQA	Evaluation quality assessment
EQAA	Evaluation quality assurance and assessment
ERG	Evaluation reference group
GBV	Gender-based violence
[HCT	Humanitarian Country Team
[HRP	Humanitarian Response Plan
ICPD	International Conference on Population and Development
M&E	Monitoring and evaluation
SDGs	Sustainable Development Goals
SRHR	Sexual and reproductive health and reproductive rights
ToR	Terms of reference
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNSDCF	United Nations Sustainable Development Cooperation Framework

1. Introduction

The United Nations Population Fund (UNFPA) is the lead United Nations agency for delivering a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled. The strategic goal of UNFPA is to "achieve universal access to sexual and reproductive health, realize reproductive rights, and accelerate progress on the implementation of the Programme of Action of the International Conference on Population and Development (ICPD)."[140] In pursuit of this goal, UNFPA works towards three transformative and people-centered results: (i) end preventable maternal deaths; (ii) end unmet need for family planning; and (iii) end gender-based violence (GBV) and all harmful practices, including female genital mutilation and child, early and forced marriage. These transformative results contribute to the achievement of all the 17 Sustainable Development Goals (SDGs), but directly contribute to the following: (a) ensure healthy lives and promote well-being for all at ages (Goal 3); (b) achieve gender equality and empower all women and girls (Goal 5); (c) reduce inequality within and among countries (Goal 10); take urgent action to combat climate change and its impacts (Goal 13); promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels (Goal 16); and strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development (Goal 17). In line with the vision of the 2030 Agenda for Sustainable Development, UNFPA seeks to ensure increasing focus on "leaving no one behind" and emphasizing "reaching those furthest behind first".

UNFPA has been operating in Ethiopia since 1973. The support that the UNFPA Ethiopia Country Office (CO) provides to the Government of Ethiopia under the framework of the 9th Country Programme (CP) (2020-2025) builds on national development needs and priorities articulated in:

the 10-year Development Plan of Ethiopia, 2021-2030
the United Nations Common Country Analysis/Assessment (CCA), June 2020
the United Nations Sustainable Development Cooperation Framework (UNSCDF), formerly known as the United Nations Development Assistance Framework (UNDAF)

The 2024 UNFPA Evaluation Policy encourages CO to carry out CPEs every programme cycle, and as a minimum every two cycles."[141] The country programme evaluation (CPE) will provide an independent assessment of the performance of the UNFPA 9th country programme (2020-2025) in Ethiopia, and offer an analysis of various facilitating and constraining factors influencing programme delivery and the achievement of intended results. The CPE will also draw conclusions and provide a set of actionable recommendations for the next programme cycle.

The evaluation will be implemented in line with the UNFPA Evaluation Handbook. The Handbook provides practical guidance for managing and conducting CPEs to ensure the production of quality evaluations in line with the United Nations Evaluation Group (UNEG) norms and standards and

[140] UNFPA Strategic Plan 2022-2025The document is available at: https://www.unfpa.org/strategic-plan-2022
[141] UNFPA Evaluation Policy 2024, p. 25. The document is available at

international good practice for evaluation.[142] It offers step-by-step guidance to prepare methodologically robust evaluations and sets out the roles and responsibilities of key stakeholders at all stages of the evaluation process. The Handbook includes links to a number of tools, resources and templates that provide practical guidance on specific activities and tasks that the evaluators and the CPE Manager perform during the different evaluation phases. The evaluators, the CPE Manager, CO staff and other engaged stakeholders are required to follow the full guidance of the Handbook throughout the evaluation (as specified at different stages).

The main audience and primary intended users of the evaluation are: (i) The UNFPA Ethiopia CO; (ii) the Government of Ethiopia; (iii) implementing partners of the UNFPA Ethiopia CO; (iv) rights-holders involved in UNFPA interventions and the organizations that represent them (in particular women, adolescents and youth); (v) the United Nations Country Team (UNCT); (vi) East and Southern Africa Regional Office (ESARO); and (vii) donors. The evaluation results will also be of interest to a wider group of stakeholders, including: (i) UNFPA headquarters divisions, branches and offices; (ii) the UNFPA Executive Board; (iii) academia; and (iv) local civil society organizations and international NGOs. The evaluation results will be disseminated as appropriate, using traditional and digital channels of communication.

The evaluation will be managed by the CPE Manager under the oversight of the Deputy Representative within the UNFPA Ethiopia CO in close consultation with the Government of Ethiopia Ministry of Finance that coordinates the country programme, with guidance and support from the regional monitoring and evaluation (M&E) adviser at the ESARO, and in consultation with the evaluation reference group (ERG) throughout the evaluation process. A team of independent external evaluators will conduct the evaluation and prepare an evaluation report in conformity with these terms of reference and the detailed guidance in the Handbook.

2. Country Context

Ethiopia is Africa's second most populous country, with an estimated population of 126.5 million in 2023; mostly young people, 24 years old or younger, constitute 58.4% of the population. While 81.8% of the population is still rural, the urbanization rate is increasing and is now at 16%. However, the country is challenged by the absence of up-to-date gender disaggregated socio-demographic and health data. The last National Population and Housing Census was conducted in 2007.

Ethiopia is currently grappling with heightened political tensions and conflict, particularly in the Amhara region, where clashes continue, with no clear political resolution yet in sight. In Tigray, the Cessation of Hostilities Agreement (COHA) is being held. However, key provisions of the agreement have not yet been fully implemented. Economic challenges and incomplete Disarmament, Demobilization, and Reintegration (DDR) appear to contribute to rising criminality across the country but more so in Tigray.

The protracted conflicts and instability in neighboring Somalia and South Sudan and the political turmoil in Sudan continue to impact Ethiopia's stability. Recently, Ethiopia's interests regarding access to the Red Sea have heightened tensions with Eritrea and Somalia. Ethiopia's economy continues to be under stress, with inflation remaining high. Meanwhile, prospects for macroeconomic stability

[142] UNEG, Norms and Standards for Evaluation (2016). The document is available at https://www.unevaluation.org/document/detail/1914

appear better with progress on debt service suspension with official bilateral creditors. However, the war in northern Ethiopia has greatly affected the country's macroeconomic performance and contributed to a decline in GDP growth, the expansion of the fiscal deficit, and a considerable increase in the price of food items.

Additionally, disasters and the impacts of climate and ecological changes continue to overburden humanitarian systems and undermine development gains in Ethiopia. The country is vulnerable to risks associated with climate change, epidemics, and pandemics that overlay risk drivers related to poverty and inequality, including gender inequality, exclusion, demographic pressures, unplanned urbanization, ecosystem degradation, displacement, weak institutions, and declining respect for human rights. These risks coalesce to unleash cascading impacts, causing loss of life and livelihoods and dramatic socio-economic and environmental damages. The northern war alone affected 14.8 million people (Tigray, Amhara and Afar regions) and displaced more than 4.6 million people.

Over the past three decades, significant progress has been made in reducing *maternal mortality* in Ethiopia, from 1,250 in 1990 to 267 per 100,000 live births by 2020[1,] accounting for a whopping 79% reduction. This reduction has been facilitated by the expansion and equipping of health facilities, including maternity waiting homes, ramping up the number of health providers, including the deployment of midwives in conflict-affected areas, ensuring a consistent supply of life-saving maternal health medicines and, equally importantly, mobilizing various partnership to complement efforts and advance the SRHR agenda. However, Ethiopia is still among the top ten countries with the highest maternal deaths. Critical maternal health indicators remain generally worrying. Skilled birth attendance remains at 75% in 2022; only 14% of expected deliveries took place in functioning emergency obstetric and neonatal care (EMONC) facilities, and the rate of cesarean delivery remains low at 5.4%, with high regional disparities ranging from 52% in Addis Ababa to 1.2% in Somali and 1.6% in Afar regions. This situation of maternal health is challenged by weak notification of maternal deaths, capturing only 10% of expected maternal deaths and less than 1% of perinatal deaths; poor quality of EmONC services; low provider to population density (1.4), far from the WHO set recommended target of 4.45; weak referral systems; poorly equipped, desolate and inaccessible health facilities following looting and destruction during recent conflicts in the country, among others. Moreover, programs for adolescents and young people are small-scale, short-lived, and fragmented, often not based on evidence due to a lack of age and sex-disaggregated data and a failure to leverage the power of young people. The national HIV prevalence declined from 2.3% in 2002 to 0.8% in 2021, a shift primarily credited to the association between HIV transmission and initiatives in sexual and reproductive health programs.

The country has experienced commendable progress in *family planning*, with a dramatic increase in contraceptive prevalence rate (CPR) from 1.25% in 1980, 8% in 2000, to 41.4% in 2019. The Total Fertility Rate (TFR) has declined by more than 2-fold from 7.7 in the 1990s to 3.8 in 2020[2,] which resulted in the country being grouped among countries with the most considerable reductions in TFR for 2010-2019[4]. By 1990, 94% of urban and 57% of rural women aged 15-49 years knew at least one type of contraceptive method. In 2016, contraceptive knowledge became nearly universal (99%). Unmet contraceptive needs significantly reduced from 37% in 2000 to 22.3% in 2016[5]. Despite the significant progress in CPR, there is a considerable variation among urban and rural communities, different regions, and across socio-demographic statuses. However, FP in the country continues to be challenged by both the demand and supply factors, among others: inadequate provider competence and high staff turnover, limited health provider commitment and motivation, inadequate domestic financing for family planning, shortage/interruption in the supply of family planning commodities; lack

of adequate youth-friendly service for Adolescents and Youth Health; and cultural and religious barriers compounded by deep-rooted misconceptions and rumors on FP.

Progress, though minimal, has been registered in the areas *of gender-based violence and all harmful practices against women and girls*. The prevalence of Female Genital Mutilation (FGM) among women aged 15-49 nationally declined from 80% in 2000 to 65% in 2016, with variations across age groups. EDHS 2016 indicates a significant generational reduction in child marriage, with 61.3% of women aged 30-34 who were first married by 18 years old compared to 40.3% of women aged 20-24. Teenage pregnancy is significantly high at 13.6%, contributing to maternal death and limiting the opportunities for young girls to realize their potential. However, many forms of GBV and harmful practices are still highly prevalent in Ethiopia. Estimates show that nearly half of Ethiopian women experience GBV in their lifetime[6]. Multiple forms of GBV, including conflict-related sexual violence (CRSV), continue to occur. As per the 2016 EDHS findings, 23% of women aged 15-49 have encountered physical violence, while 10% have faced sexual violence since reaching the age of 15[2]. More than one-third (37%) of Ethiopian women, nearly 1 in 3 women, experience physical/sexual intimate violence or non-partner sexual assault in their lifetime. The current escalation of the humanitarian crises in the country since 2021 has heightened risks and increased vulnerabilities to GBV. In the draft Humanitarian Needs Overview 2024, 7.15 people need GBV services. Other challenges include, among others, the absence of a systematic data collection system for GBV; inadequate funding for GBV, including child marriage and FGM programs; inadequate GBV AOR coordination staff; Limited grass root presence to address social and gender norms that perpetuate GBV and HP; lack of capacity of local women-led organizations that have relatively better grass root presence to implement GBV prevention and response interventions and vulnerabilities caused by protracted crises in the different parts of the country.

3. UNFPA Country Programme

UNFPA has been working with the Government of Ethiopia since 1973 towards enhancing sexual and reproductive health and reproductive rights (SRHR), advancing gender equality, realizing rights and choices for young people, and strengthening the generation and use of population data for development. UNFPA is currently implementing the 9th country programme in Ethiopia.

The 9th country programme (2020-2025) is aligned to the priorities of the Government of Ethiopia as outlined in the ten-year Perspective Development Plan (2021-2030) and the three-year Home-grown Economic Reform Plan, the UNSDCF (2020-2025), and the UNFPA Strategic Plan 2022-2025. In 2022, the UNFPA Ethiopia CO undertook the process of aligning the 9th country programme to the UNFPA Strategic Plan 2022-2025. The country programme was developed in consultation with the Government, civil society, bilateral and multilateral development partners, including United Nations organizations, the private sector and academia.

The UNFPA Ethiopia CO delivers its country programme through the following modes of engagement: (i) advocacy and policy dialogue, (ii) capacity development, (iii) knowledge management, (iv) partnerships and coordination, and (v) service delivery. The **overall goal** of the UNFPA Ethiopia 9th country programme (2020-2025) is **universal access to sexual and reproductive health and reproductive rights and accelerate the implementation of the ICPD Programme of Action,** as articulated in the UNFPA Strategic Plan 2022-2025. The country programme contributes to the following **outcomes** of the UNFPA Strategic Plan 2022-2025:

Outcome 1: By 2025, the reduction in the unmet need for family planning has accelerated

Outcome 2: By 2025, the reduction of preventable maternal deaths has accelerated

Outcome 3: By 2025, the reduction in gender-based violence and harmful practices has accelerated

The UNFPA Ethiopia 9th country programme (2020-2025) has 5 thematic areas of programming with 6 corresponding interconnected country programme (CP) outputs that contribute to the outcomes in the Strategic Plan 2022-2025. These SP outputs are (ii) quality of care and services; (iii) gender and social norms; (iv) population change and data; (v) humanitarian action; and (vi) adolescents and youth. All the outputs contribute to the achievement of the Strategic Plan 2022-2025 outcomes, UNSDCF outcomes and national priorities; they have a multidimensional, 'many-to-many' relationship with these outcomes.

SP Output 2: [Quality of care and services]
CP Output 1. Effective supply chain strengthened for ensuring availability of sexual and reproductive health commodities at all service delivery points including in humanitarian settings.
The programme has been supporting: (a) increased availability of quality-assured lifesaving reproductive health drugs and family planning commodities; and (b) advocate sustainable financing of reproductive health commodities.

CP Output 2. Comprehensive sexual and reproductive health service provision improved and uptake increased in all settings.
The programme has been supporting: (a) guiding a multi-year plan for comprehensive sexual and reproductive health services within the larger framework of universal health coverage; (b) strengthening the capacity of health facilities on maternal and perinatal death surveillance and response; (c) strengthening the capacity of health facilities to provide comprehensive sexual and reproductive health services in all settings; and (d) increasing provision of treatment for women and girls with obstetric fistula.

SP Output 3: [Gender and social norms]
CP Output 3. Strengthened capacity of government and key stakeholders on prevention, protection of GBV, and provision of services to survivors of GBV and to eliminate harmful practices in all settings.
Multi sectoral capacity strengthened to prevent and protect from gender-based violence, and provide services for survivors in all settings. The programme has been supporting: (a) Institutionalized engagement of multiple stakeholders, including civil society, faith-based organizations, and men and boys, to prevent and address gender-based violence; (b) provision of comprehensive sexual and reproductive health services, including for gender-based violence survivors, per the National Protocol; and (c) national accountability mechanism in line with human rights standards towards the protection of human rights of women and girls; (d) prevention and protection services and care related to child marriage and female genital mutilation.

SP Output 4: [Population change and data]
CP Output 4 Strengthened data systems and evidence that take into account population changes and other megatrends (including aging and climate change), in development policies and programmes, especially those related to sexual and reproductive health and reproductive rights.

Population dynamics integrated into national development policy-making, planning and programme formulation. The programme has been supporting: (a) evidence-based policy dialogue on population dynamics and its interlinkages; and (b) tracking of sexual and reproductive health and gender-based violence indicators in the national Sustainable Development Goals monitoring and evaluation framework.

Strengthened national capacity for production, analysis, use and dissemination of high-quality disaggregated population data in all settings. The programme has been supporting: (a) the fourth Population and Housing Census, Demographic Health Survey, gender and vital statistics; (b) application of new methodologies for vulnerability and rapid assessments, risk profiling, resilience and durable solutions; and (c) web-based integrated management information system and knowledge platforms.

SP Output 5: [Humanitarian action]

CP Output 5. National and regional service delivery systems have strengthened capacity to provide lifesaving sexual and reproductive health and gender-based Violence information and services for populations affected by Crisis.

UNFPA aims to mainstream reproductive health, GBV and maternity care in emergency preparedness and response. UNFPA's humanitarian work is in maternity and reproductive health services, GBV prevention and management, and HIV prevention. UNFPA has been taking the lead in providing commodities and related training to improve access to services for most vulnerable groups in regions affected by humanitarian emergencies. For the system-wide support, in the protection cluster, UNFPA is the lead for the GBV Area of Responsibility (AOR). In the health cluster, UNFPA leads the SRH Working Group.

The strategies for humanitarian response are the following:

- Delivering substantially expanded availability of lifesaving SRH and GBV services for crisis-affected populations;
- Significantly reducing risks to and mitigating the impact of crises on existing SRH, GBV, and other UNFPA mandate-areas of service and systems;
- Addressing SRH and GBV humanitarian needs quickly with a focus on those furthest behind;
- Facilitating transitions to resilient systems delivering quality comprehensive SRH and GBV services where emergencies have occurred or risks are high;
- Involving young people in decision-making for preparedness and during the humanitarian programme cycle;
- Delivering services to young people in crises-affected regions of the country and engaging them meaningfully in peacebuilding;
- Strengthening national population data systems to provide disaggregated data for risk assessment, baselines, and needs assessments during emergencies as well as post-disaster needs assessments;
- Ensure sexual and reproductive health and gender-based violence services, including mental health and psychosocial support (MHPSS), and protection from sexual exploitation and abuse (PSEA); and
- Support sustaining peace, including by directly contributing to SDG 16 on promoting peaceful and inclusive societies for sustainable development.

SP Output 6: [Adolescents and youth]
CP Output 6. Adolescents and youth, particularly those most vulnerable, are equipped with skills & knowledge to make informed choices about their SRH and rights within an enabling environment that promotes adolescent health and wellbeing.

Adolescents and youth, in particular those vulnerable, are equipped with skills and knowledge to make informed choices about their sexual and reproductive health and rights, exercise leadership and participate in development and humanitarian interventions. The programme has been supporting: (a) implementation of life skills programmes for marginalized girls and boys, including the disabled, in schools and out of school; (b) operationalization of out-of-school comprehensive sexuality education through youth serving platforms in accordance with international standards.

Enabling environment created for most vulnerable adolescents and youth to access sexual and reproductive health information and services in all settings. The programme has been supporting: (a) institutionalized participation of young people in policy dialogue and programming; and (b) integration of the sexual and reproductive health and rights of youth in at least two sectors (beyond the health sector).

The UNFPA Ethiopia CO also engages in activities of the UNCT, with the objective to ensure inter-agency coordination and the efficient and effective delivery of tangible results in support of the national development agenda and the SDGs. Beyond the UNCT, the UNFPA Ethiopia CO participates in the Humanitarian Country Team (HCT) to ensure that inter-agency humanitarian action is well-coordinated, timely, principled and effective, to alleviate human suffering and protect the lives, livelihoods and dignity of people affected by humanitarian crisis.

The central tenet of the CPE is the country programme **theory of change** and the analysis of its logic and internal coherence. The theory of change describes how and why the set of activities planned under the country programme are expected to contribute to a sequence of results that culminates in the strategic goal of UNFPA is presented in Annex A. The theory of change will be an essential building block of the evaluation methodology. The country programme theory of change explains how the activities undertaken contribute to a chain of results that lead to the intended or observed outcomes. At the design phase, the evaluators will perform an in-depth analysis of the country programme theory of change and its intervention logic. This will help them refine the evaluation questions (see preliminary questions in section 5.2), identify key indicators for the evaluation, plan data collection (and identify potential gaps in available data), and provide a structure for data collection, analysis and reporting. The evaluators' review of the theory of change (its validity and comprehensiveness) is also crucial with a view to informing the preparation of the next country programme's theory of change.

The UNFPA Ethiopia 9th country programme (2020-2025) is based on the following results framework presented below:

Ethiopia/UNFPA 9th Country Programme (2020-2025) Results Framework

The "Programme Intervention Areas" are categorized into the following three categories:

(1) activities that were initially planned and implemented;

(2) **in bold:** activities that were not initially planned, yet were implemented
(for example, activities in response to a (new) humanitarian emergency); and

(3) *in italics*: activities that were initially planned but were not implemented (the Nota Bene under the table should be adjusted/deleted accordingly).

<table>
<tr><td colspan="3">National Priorities: Sustain a rapid and inclusive economic growth; eradicate extreme poverty and hunger; and build human capabilities</td></tr>
<tr><td colspan="3">UNSDCF Outcomes: By 2025, all people in Ethiopia: (1) enjoy the rights and capabilities to realize their potential in equality and dignity; (2) live in a cohesive, just, inclusive and democratic society; (3) benefit from an inclusive, resilient, and sustainable economy; live in a society resilient to environmental risks and adapted to climate change.</td></tr>
<tr><td colspan="3">Related UNFPA Strategic Plan Outcome(s): 1: By 2025, the reduction in the unmet need for family planning has accelerated; 2: By 2025, the reduction of preventable maternal deaths has accelerated; 3: By 2025, the reduction in gender-based violence and harmful practices has accelerated</td></tr>
<tr>
<td>UNFPA Ethiopia 9th Country Programme Output:

Effective supply chain strengthened for ensuring availability of sexual and reproductive health commodities at all service delivery points including in humanitarian settings</td>
<td>UNFPA Ethiopia 9th Country Programme Output:

Comprehensive sexual and reproductive health service provision improved and uptake increased in all settings</td>
<td>UNFPA Ethiopia 9th Country Programme Output:

Strengthened capacity of government and key stakeholders on prevention, protection of GBV, and provision of services to survivors of GBV and to eliminate harmful practices in all settings</td>
</tr>
<tr>
<td>UNFPA Ethiopia 9th Country Programme Intervention Areas:

● Increase availability of quality-assured reproductive health and family planning commodities.
    ○ Capacitate the supply chain and regulatory systems for the delivery of quality reproductive health/family planning commodities to service delivery points.</td>
<td>UNFPA Ethiopia 9th Country Programme Intervention Areas:

● Guide a multi-year plan for comprehensive sexual and reproductive health services within the larger framework of universal health coverage.
● Strengthen the capacity of health facilities on maternal and perinatal death surveillance and response.
    ○ Maternity waiting homes</td>
<td>UNFPA Ethiopia 9th Country Programme Intervention Areas:

● Deliver institutionalized engagement of multiple stakeholders, including government, civil society, women led and faith-based organizations, media, and men and boys, to prevent and address gender-based violence.
● Provide comprehensive sexual and reproductive health services, including for gender-based violence survivors, per the National Protocol. National accountability mechanism in line with</td>
</tr>
</table>

○ Generate evidence on the availability of FP/MH commodities and services at service delivery points. ○ Implement last mile assurance (LMA) system to ensure the last mile availability and management of reproductive health/family planning commodities along the supply chain system. ● Advocate for sustainable financing of reproductive health commodities through domestic resource mobilization. ● Capacitate the health system to expand access for the provision of quality FP services.	● Strengthen the capacity of health facilities to provide comprehensive sexual and reproductive health services in all settings. ● Provide treatment for women and girls with obstetric fistula. ● **Screen and treat cervical cancer.**	human rights standards towards the protection of human rights of women and girls. ● Provide prevention and protection services and care related to child marriage and female genital mutilation. ● **Incorporate a peace component in the prevention package of GBV (newly introduced during the alignment).**
UNFPA Ethiopia 9th Country Programme Output: **Strengthened data systems and evidence that take into account population changes and other megatrends (including ageing and climate change), in development policies and programmes, especially those related to sexual and reproductive health and reproductive rights**	**UNFPA Ethiopia 9th Country Programme Output*:** **National and regional service delivery systems have strengthened capacity to provide lifesaving sexual and reproductive health and gender-based Violence information and services for populations affected by Crisis**	**UNFPA Ethiopia 9th Country Programme Output:** **Adolescents and youth, particularly those most vulnerable, are equipped with skills & knowledge to make informed choices about their SRH and rights within an enabling environment that promotes adolescent health and wellbeing**
UNFPA Ethiopia 9th Country Programme Intervention Areas: ● Organize evidence-based policy dialogue on population dynamics and its interlinkages. ● Track sexual and reproductive health and gender-based violence indicators in the national Sustainable Development Goals monitoring and evaluation framework. ● **Develop Ethiopia's demographic dividend roadmap.** ● **Revise the Ethiopian population policy.** ● **Update the integration module on population issues into development plans, policies, and strategies.**	**UNFPA Ethiopia 9th Country Programme Intervention Areas:** ● Implement the Minimum Initial Service Package (MISP) for SRH - a set of lifesaving services during emergencies. ○ Train service providers on various components of the MISP. ● Reach crises affected populations with lifesaving SRH services. ○ Provide SRH services to emergency affected populations equipped with emergency reproductive health kits at health facilities.	**UNFPA Ethiopia 9th Country Programme Intervention Areas:** ● Implement life skills programmes for the most at risk and vulnerable young people including young persons with disability including in humanitarian context. ● Operationalize out-of-school comprehensive sexuality education through youth serving platforms in accordance with international standards. ● Provide integrated HIV/AIDS Services and Strategic Document Development. ● Institutionalize participation of young people in policy dialogue and programming.

• **Update the IEC/BCC and advocacy strategy on population and development of Ethiopia.** • Support the *fourth Population and Housing Census,* Demographic Heath Survey, gender and vital statistics. • Support the application of new methodologies for vulnerability and rapid assessments, risk profiling, resilience and durable solutions. • Support web-based integrated management information system and knowledge platforms.	• Strengthen the capacity of health offices and facilities to build a strong health system that is resilient to shocks and capable of responding to the SRHR and GBV needs. • **Coordinate functional UNFPA-led GBV** and SRH **inter-agency humanitarian coordination mechanisms at the national and regional levels.** • **Ensure a robust implementation of Sexual Exploitation and Abuse (SEA) reporting and response mechanisms across all levels in affected regions.** **GBV services reaching women and girls at risk of GBV** • Promote, coordinate and provide integrated lifesaving GBV services following the survivor-centered approach and the Inter-Agency Minimum Standards for GBV prevention and response in emergencies. • Offer integrated SRH-GBV services such as GBV case management, mental health and psychosocial support (MHPSS), clinical management of rape, family planning and counselling, treatment of sexually transmitted infections and emergency referrals to GBV survivors and vulnerable women and girls (Selected Women and Girls' Friendly Spaces, One-Stop Centers, and government service entry points). • Implement GBV risk mitigation and prevention activities. • Implement life-skill and **context-based livelihood and self-reliance (Conditional Cash Transfer)** programmes. • Support social cohesion and community mobilization.	• Integrate of the sexual and reproductive health and rights of youth in at least two sectors (beyond the health sector). • **Integrate Youth Peace and Security interventions to position youth as positive peace change agents.** • Support the **Ministry of Women and Social Affairs on the development and implementation of the National Action Plan on Youth Peace and Security.**

*The humanitarian output was newly added to the updated Country Programme in 2023 aligned with the UNFPA Global Strategic Plan 2022-2025.

4. Evaluation Purpose, Objectives and Scope

4.1. Purpose

The CPE will serve the following four main purposes, as outlined in the 2024 UNFPA Evaluation Policy: (i) oversight and demonstrate accountability to stakeholders on performance in achieving development results and on invested resources; (ii) support evidence-based decision-making to inform development, humanitarian response and peace-responsive programming; and (iii) aggregating and sharing good practices and credible evaluative evidence to support organizational learning on how to achieve the best results; and (iv) empower community, national and regional stakeholders.

4.2. Objectives

The **objectives** of this CPE are:

i. To provide the UNFPA Ethiopia CO, national stakeholders and rights-holders, the UNFPA ESARO, UNFPA Headquarters as well as a wider audience with an independent assessment of the UNFPA Ethiopia 9th country programme (2020-2025).
ii. To broaden the evidence base to inform the design of the next programme cycle.

The **specific objectives** of this CPE are:

i. To provide an independent assessment of the relevance, coherence, effectiveness, efficiency and sustainability of UNFPA support.
ii. To provide an assessment of the geographic and demographic coverage of UNFPA humanitarian assistance and the ability of UNFPA to connect immediate, life-saving support with long-term development objectives.
iii. To provide an assessment of the role played by the UNFPA Ethiopia CO in the coordination mechanisms of the UNCT, with a view to enhancing the United Nations collective contribution to national development results. In addition, to provide an assessment of the role of the UNFPA Ethiopia CO in the coordination mechanisms of the HCT, with a view to improving humanitarian response and ensuring contribution to longer-term recovery.
iv. To draw key conclusions from past and current cooperation and provide a set of clear, forward-looking and actionable recommendations for the next programme cycle.

4.3. Scope

Geographic Scope

The evaluation will cover the following regions where UNFPA implemented interventions in Ethiopia: Afar, Amhara, Gambella, Central and Southern, Sidama, Oromia, Benishangul-Gumuz, Somali and Tigray.
Given the current humanitarian situation in Ethiopia, a scoping exercise should be conducted during the design phase to assist in examining accessibility and data availability.

Thematic Scope

The evaluation will cover the following thematic areas of the 9th CP: (i) policy and accountability; (ii) quality of care and services; (iii) gender and social norms; (iv) population change and data; (v) humanitarian action; and (vi) adolescents and youth. In addition, the evaluation will cover cross-cutting issues, such as adherence to the humanitarian principles; human rights; gender equality; disability

inclusion; etc., and transversal functions, such as coordination; monitoring and evaluation (M&E); innovation; resource mobilization; strategic partnerships, etc.

Temporal Scope

The evaluation will cover interventions planned and/or implemented within the time period of the current CP: 2020-2025.

5. Evaluation Criteria and Preliminary Evaluation Questions

5.1. Evaluation Criteria

In accordance with the methodology for CPEs outlined in section 6, the evaluation will examine the following five OECD/DAC evaluation criteria: relevance, coherence, effectiveness, efficiency and sustainability.[143] It will also use the evaluation criterion of coordination to assess the extent to which the UNFPA Ethiopia CO harmonized interventions with other actors, promoted synergy and avoided duplication under the framework of the UNCT and the HCT. Furthermore, the evaluation will use the humanitarian-specific evaluation criteria of coverage and connectedness to investigate: (i) to what extent UNFPA has been able to provide life-saving services to affected populations that are hard-to-reach; and (ii) to work across humanitarian- development-peace nexus and contribute to building resilience.

Criterion	Definition
Relevance	The extent to which the intervention objectives and design respond to rights-holders, country, and partner/institution needs, policies, and priorities, and continue to do so if circumstances change.
Coherence	The compatibility of the intervention with other interventions in the country, sector or institution. The search for coherence applies to other interventions under different thematic areas of the UNFPA mandate which the CO implements (e.g., linkages between SRHR and GBV programming) and to UNFPA projects and projects implemented by other UN agencies, INGOs and development partners in the country.
Effectiveness	The extent to which the intervention achieved, or is expected to achieve, its objectives and results, including any differential results across groups.
Efficiency	The extent to which the intervention delivers, or is likely to deliver, results in an economic and timely way. Could the same results have been achieved with fewer financial or technical resources, for instance?
Sustainability	The extent to which the net rights-holders of the intervention continue, or are likely to continue (even if, or when, the intervention ends).
Coverage	The extent to which major population groups facing life-threatening conditions were reached by humanitarian action. Evaluators need to assess the extent of inclusion bias – that is, the inclusion of those in the groups receiving support who

[143] The full set of OECD/DAC evaluation criteria, their adapted definitions and principles of use are available at: https://www.oecd.org/dac/evaluation/revised-evaluation-criteria-dec-2019.pdf. They also include impact, but this is beyond the scope of the CPE.

	should not have been (disaggregated by sex, socio-economic grouping and ethnicity); as well as the extent of exclusion bias, that is, exclusion of groups who should have been covered but were not (disaggregated by sex, socio-economic grouping and ethnicity).
Connectedness	The extent to which activities of a short-term emergency nature are carried out in a context that takes longer-term and interconnected problems into account, which is a nexus approach, and that also indicates the complementarity of UNFPA with other partner interventions.

5.2. Preliminary Evaluation Questions

The evaluation of the country programme will provide answers to the evaluation questions (related to the above criteria), which determine the thematic scope of the CPE.

The evaluation of the country programme will provide answers to the evaluation questions (related to the above-mentioned criteria). At the design phase, the evaluators are expected to refine and develop a final set of evaluation questions, in consultation with the CPE Manager at the UNFPA Ethiopia CO and the ERG. In particular, they will ensure that each evaluation question is accompanied by a number of "assumptions for verification". Thus, for each evaluation question, and based upon their understanding of the theory of change (the different pathways in the results chain and the theory's internal logic), the evaluators are expected to formulate assumptions that, in fact, constitute the hypotheses they will be testing through data collection and analysis in order to formulate their responses to the evaluation questions. As they document the assumptions, the evaluators will be able to explain why and the extent to which the interventions did (or did not) lead towards the expected outcomes, identify what are the critical elements to success, and pinpoint other external factors that have influenced the programme and contributed to change.

Relevance

1. To what extent is the UNFPA Ethiopia's country programme adapted to: (I) The needs and priorities of the diverse populations; (II) National development strategies and policies; (III) The strategic directions and objectives of UNFPA; (IV) The priorities of the ICPD; (V) The flexibility to accommodate shifts caused by crises or major political changes; VI. The participation of vulnerable groups; and (VII) The humanitarian-development-peace nexus programming.

Coherence

2. To what extent has UNFPA Ethiopia integrated its mandate to improve SRHR and gender inequalities of the vulnerable and marginalized population through leveraging strategic partnerships with national, local and grassroot organizations (e.g. youth-led groups, people with disability and women's rights activists)?

Effectiveness

3. To what extent have the UNFPA Ethiopia interventions successfully delivered outputs and contributed to the achievement of the UNFPA strategic plan outcomes (ending unmet need for family planning; ending preventable maternal deaths; ending gender-based violence and harmful practices) and integrated human rights, gender perspectives, disability inclusion, and those

furthest behind? Additionally, what have been the unintended consequences, both positive and negative, of these interventions?

Efficiency

4. To what extent has UNFPA Ethiopia efficiently utilized its human, financial and administrative resources, while adhering to appropriate guidelines and procedures, to deliver the intended outputs and pursue the achievement of the UNFPA strategic plan outcomes?

Sustainability

5. To what extent has UNFPA Ethiopia contributed to strengthening Ethiopian institutional capacities and development (in system and human resources) and to what extent have partners (rights holders, government, NGO, development partners, etc) been engaged to ensure sustainability?

Coordination

6. To what extent does UNFPA Ethiopia provide leadership in the GBV sub-cluster and the SRH working group for the effective and timely delivery of service, and how has it contributed to the effective coordination mechanisms of the UNCT and HCT?

Coverage

7. To what extent does UNFPA Ethiopia's humanitarian response reach the most vulnerable and marginalized groups including women, adolescents and youth with lifesaving SRH and GBV interventions in humanitarian settings?

Connectedness

8. To what extent has UNFPA Ethiopia contributed to enhancing the capacities and systems of implementing partners and communities to ensure their preparedness and resilience in humanitarian settings?

The final evaluation questions and the evaluation matrix will be presented in the design report.

6. Approach and Methodology

6.1. Evaluation Approach

Theory-based approach

The CPE will adopt a theory-based approach that relies on an explicit theory of change, which depicts how the interventions supported by the UNFPA Ethiopia CO are expected to contribute to a series of results (outputs and outcomes) that contribute to the overall goal of UNFPA. The theory of change also identifies the causal links between the results, as well as critical assumptions and contextual factors that support or hinder the achievement of desired changes. A theory-based approach is fundamental for generating insights about what works, what does not and why. It focuses on the analysis of causal links between changes at different levels of the results chain that the theory of change describes, by exploring how the assumptions behind these causal links and contextual factors affect the achievement of intended results.

The theory of change will play a central role throughout the evaluation process, from the design and data collection to the analysis and identification of findings, as well as the articulation of conclusions and recommendations. The evaluation team will be required to verify the theory of change underpinning the

UNFPA Ethiopia 9th country programme (2020-2025) (see Annex A) and use this theory of change to determine whether changes at output and outcome levels occurred (or not) and whether assumptions about change hold true. The analysis of the theory of change will serve as the basis for the evaluators to assess how relevant, coherent, effective, efficient and sustainable was the support provided by the UNFPA Ethiopia CO during the period of the 9th country programme. Where applicable, the humanitarian context needs to be considered in analyzing the theory of change.

As part of the theory-based approach, the evaluators shall use a contribution analysis to explore whether evidence to support key assumptions exists, examine if evidence on observed results confirms the chain of expected results in the theory of change, and seek out evidence on the influence that other factors may have had in achieving desired results. This will enable the evaluation team to make a reasonable case about the difference that the UNFPA Ethiopia 9th country programme (2020-2025) made.

Participatory approach
The CPE will be based on an inclusive, transparent and participatory approach, involving a broad range of partners and stakeholders at national and sub-national level. The UNFPA Ethiopia CO will develop an initial stakeholder map to identify stakeholders who have been involved in the preparation and implementation of the country programme, and those partners who do not work directly with UNFPA, yet play a key role in a relevant outcome or thematic area in the national context. These stakeholders include government representatives, civil society organizations, implementing partners, the private sector, academia, other United Nations organizations, donors and, most importantly, rights-holders (notably women, adolescents and youth). They can provide information and data that the evaluators should use to assess the contribution of UNFPA support to changes in each thematic area of the country programme. Particular attention will be paid to ensuring the participation of women, adolescents and young people, especially those from vulnerable and marginalized groups (e.g., young people and women with disabilities, etc.).

The CPE Manager in the UNFPA Ethiopia CO has established an ERG composed of key stakeholders of the country programme, including: governmental and non-governmental counterparts at national level, including organizations, donors, the regional M&E adviser in UNFPA ESARO. The ERG will provide inputs at different stages in the evaluation process.

Mixed-method approach
The evaluation will primarily use qualitative methods for data collection, including document review, interviews, group discussions and observations during field visits, where appropriate. The qualitative data will be complemented with quantitative data to minimize bias and strengthen the validity of findings. Quantitative data will be compiled through desk review of documents, websites and online databases to obtain relevant financial data and data on key indicators that measure change at output and outcome levels. The use of innovative and context-adapted evaluation tools (including ICT) is highly encouraged.

These complementary approaches described above will be used to ensure that the evaluation: (i) responds to the information needs of users and the intended use of the evaluation results; (ii) upholds human rights and principles throughout the evaluation process, including through participation and consultation of key stakeholders (rights holders and duty bearers); and (iii) provides credible information about the benefits for duty bearers and rights-holders (women, adolescents and youth) of UNFPA support through triangulation of collected data.

6.2. Methodology
The evaluation team shall develop the evaluation methodology in line with the evaluation approach and guidance provided here and in the UNFPA Evaluation Handbook. This will help the evaluators develop a

methodology that meets good quality standards for evaluation at UNFPA and the professional evaluation standards of UNEG. It is essential that, once contracted by the UNFPA Ethiopia CO, the evaluators acquire a solid knowledge of the Handbook and the required methodology of UNFPA, and of the evaluation quality assurance and assessment process, including the assessment grid.

The CPE will be conducted in accordance with the UNEG *Norms and Standards for Evaluation,*[144] *Ethical Guidelines for Evaluation,*[145] *Code of Conduct for Evaluation in the UN System*[146]*, and Guidance on Integrating Human Rights and Gender Equality in Evaluations.*[147] When contracted by the UNFPA Ethiopia CO, the evaluators will be requested to sign the UNEG *Code of Conduct*[148] prior to starting their work.

The methodology that the evaluation team will develop builds the foundation for providing valid and evidence-based answers to the evaluation questions and for offering a robust and credible assessment of UNFPA support in Ethiopia. The methodological design of the evaluation shall include in particular: (i) a theory of change; (ii) a strategy for collecting and analyzing data; (iii) specifically designed tools for data collection and analysis; (iv) an evaluation matrix; and (v) a detailed evaluation work plan and agenda for the field phase.

The evaluation team is required to follow all the guidance in the Handbook throughout the whole evaluation process, including using the templates and links provided. Notably, these include the templates for the evaluation matrix and the stakeholder agenda. They must also follow the editorial guidance in drafting the design and final evaluation reports and ensure that the evaluation report meets the requirements of the evaluation and assessment (EQA) grid.

The evaluation matrix

The evaluation matrix is the centerpiece of the methodological design of the evaluation. The matrix contains the core elements of the evaluation. It outlines (i) *what will be evaluated:* evaluation questions for all evaluation criteria and key assumptions to be examined; and (ii) *how it will be evaluated*: data collection methods and tools and sources of information for each evaluation question and associated key assumptions. By linking each evaluation question (and associated assumptions) with the specific data sources and data collection methods required to answer the question, the evaluation matrix plays a crucial role before, during and after data collection. The design and use of the evaluation matrix is described in Chapter 2, section 2.2.2.2 of the Handbook.

- In the design phase, the evaluators should use the evaluation matrix to develop a detailed agenda for data collection and analysis and to prepare the structure of interviews, group discussions and site visits. At the design phase, the evaluation team must enter, in the matrix, the data and information resulting from their desk (documentary review) in a clear and orderly manner.
- During the field phase, the evaluation matrix serves as a working document to ensure that the data and information are systematically collected (for each evaluation question) and are presented in an organized manner. Throughout the field phase, the evaluators must enter, in the matrix, all data and information collected. The CPE Manager will ensure that the matrix is placed in a Google drive and will check the evaluation matrix on a daily basis to ensure that data and information is properly compiled. S/he will alert the evaluation team in the event of gaps that

[144] Document available at: http://www.unevaluation.org/document/detail/1914.
[145] Document available at: http://www.unevaluation.org/document/detail/102.
[146] Document available at: http://www.unevaluation.org/document/detail/100.
[147] Document available at: http://www.unevaluation.org/document/detail/980.
[148] UNEG Code of conduct: http://www.unevaluation.org/document/detail/100.

require additional data collection or if the data/information entered in the matrix is insufficiently clear/precise.

- In the reporting phase, the evaluators should use the data and information presented in the evaluation matrix to build their analysis (or findings) for each evaluation question. The fully completed matrix is an indispensable annex to the report and the CPE Manager will verify that sufficient evidence has been collected to answer all evaluation questions in a credible manner.

As the evaluation matrix plays a crucial role at all stages of the evaluation process, it will require particular attention from both the evaluation team and the CPE Manager. The evaluation matrix will be drafted in the design phase and must be included in the design report. The completed evaluation matrix will be annexed to the final evaluation report to enable users of the evaluation report to access the supporting evidence for the answers to the evaluation questions. Confidentiality of respondents must be assured in how their feedback is presented in the evaluation matrix.

Finalization of the evaluation questions and related assumptions
Based on the preliminary questions presented in the present terms of reference (section 5.2) and the theory of change underlying the country programme (see Annex A), the evaluators are required to refine the evaluation questions. In their final form, the questions should reflect the evaluation criteria (section 5.1) and clearly define the key areas of inquiry of the CPE. The final evaluation questions will structure the evaluation matrix and shall be presented in the design report.

The evaluation questions must be complemented by a set of critical assumptions that capture key aspects of how and why change is expected to occur, based on the theory of change of the country programme. This will allow the evaluators to assess whether the preconditions for the achievement of outputs and the contribution of UNFPA to higher-level results, in particular at outcome level, are met. The data collection for each of the evaluation questions and related assumptions will be guided by clearly formulated quantitative and qualitative indicators, which need to be specified in the evaluation matrix.

Sampling strategy
The UNFPA Ethiopia CO will provide an initial overview of the interventions supported by UNFPA, the locations where these interventions have taken place, and the stakeholders involved in these interventions. As part of this process, the UNFPA Ethiopia CO has produced an initial stakeholder map to identify the range of stakeholders that are directly or indirectly involved in the implementation or affected by the implementation of the CP (see Annex B).

Building on the initial stakeholder map and based on information gathered through document review and discussions with CO staff, the evaluators will develop the final stakeholder map. From this final stakeholder map, the evaluation team will select a sample of stakeholders at national and sub-national level who will be consulted through interviews and/or group discussions during the data collection phase. These stakeholders must be selected through clearly defined criteria and the sampling approach outlined in the design report (for guidance on how to select a sample of stakeholders see Handbook, section 2.3). In the design report, the evaluators should also make explicit which groups of stakeholders were not included and why. The evaluators should aim to select a sample of stakeholders that is as representative as possible, recognizing that it will not be possible to obtain a statistically representative sample.

The evaluation team shall also select a sample of sites that will be visited for data collection and provide the rationale for the selection of the sites in the design report. The UNFPA Ethiopia CO will provide the

evaluators with necessary information to access the selected locations, including logistical requirements and security risks, if applicable. The sample of sites selected for visits should reflect the variety of interventions supported by UNFPA, both in terms of thematic focus and context.

The final sample of stakeholders and sites will be determined in consultation with the CPE Manager, based on the review of the design report.

Data collection

The evaluation will consider primary and secondary sources of information. For detailed guidance on the different data collection methods typically employed in CPEs, see Handbook, section 2.2.3.1

Primary data will be collected through semi-structured interviews with a wide range of key informants at national and sub-national levels, as well as group discussions with service providers and rights-holders (notably women, adolescents and youth) and direct observation during visits to selected sites.

Secondary data will be collected through extensive document review**,** primarily focusing on the resources highlighted in section 14 of these terms of reference. The evaluation team will ensure that data collected is disaggregated by sex, age, location and other relevant dimensions, such as disability status, to the extent possible.

The evaluation team is expected to dedicate a total of 3-4 weeks for data collection in the field. The data collection tools that the evaluation team will develop, which may include protocols for semi-structured interviews and group discussions, checklists for direct observation at sites visited (see template for observation during on-site visits) or a protocol for document review, shall be presented in the design report.

Data analysis

The evaluation matrix will be the major framework for analyzing data. The evaluators must enter the qualitative and quantitative data in the evaluation matrix for each evaluation question and each assumption. Once the evaluation matrix is completed, the evaluators should identify common themes and patterns that will help to answer the evaluation questions. The evaluators shall also identify aspects that should be further explored and for which complementary data should be collected, to fully answer all the evaluation questions and thus cover the whole scope of the evaluation (see Handbook, Chapter 4).

Validation mechanisms

All findings of the evaluation need to be firmly grounded in evidence. The evaluation team will use a variety of mechanisms to ensure the validity of collected data and information as highlighted in the Handbook (and see section 7 below). Data validation is a continuous process throughout the different evaluation phases, and the proposed validation mechanisms will be presented in the design report. In particular, there must be systematic triangulation of data sources and data collection methods, internal evaluation team meetings to corroborate and analyze data, and regular exchanges with the CPE Manager. A debriefing meeting with the CO and the ERG takes place at the end of the field phase, when the evaluation team present the emerging findings of the evaluation.

Use of Artificial Intelligence (AI) in CPEs

AI technologies cannot be used in the management and conduct of the CPE unless a prior written agreement is obtained from the CPE manager. Upon this prior agreement, the consultant is obligated to

disclose the utilization of AI tools in evaluation and commits to upholding ethical standards and accuracy in the application of AI tools.

- **Prior approval for utilization of AI tools:** The use of AI tools must be explicitly agreed upon and approved in writing by the CPE manager
- **Declaration of the utilization of AI tools:** If the use of AI tools in evaluation is agreed upon with the CPE manager, the consultant must be transparent and declare the use of AI tools in evaluation work and other work-related tasks, specifying the nature of AI usage. The AI tools utilized in work-related tasks must include only those tools that are vetted by EO
- **Verification of accuracy**: The consultant commits to diligently checking the accuracy of AI-generated results and assumes full responsibility for its reliability and validity
- **Ethical and responsible use**: The consultant is obligated to uphold ethical principles in the use of AI in work-related tasks, as well as relevant regulations that govern the use of AI in the UN system. This includes the Digital and Technology Network Guidance on the Use of Generative AI Tools in the UN System, Principles for the Ethical Use of Artificial Intelligence in the United Nations System, and UNFPA Information Security Policy. The consultant commits to employing AI tools that adhere to principles of non-discrimination, fairness, transparency, and accountability. The consultant will adopt an approach that aligns with the principle of 'leaving no one behind', ensuring that AI tool usage avoids exclusion or disadvantage to any group.

7. Evaluation Process

The CPE process can be broken down into five different phases that include different stages and lead to different deliverables: preparation phase; design phase; field phase; reporting phase; and phase of dissemination and facilitation of use. The CPE Manager and the evaluation team leader must undertake quality assurance of each deliverable at each phase and step of the process, with a view to ensuring the production of a credible, useful and timely evaluation.

7.1. Preparation Phase

(Handbook, Chapter 1)

The CPE Manager at the UNFPA Ethiopia CO leads the preparation phase of the CPE. This includes:

- CPE launch and orientation meeting for CO staff
- Evaluation questions workshop
- Establishing the evaluation reference group
- Drafting the terms of reference
- Assembling and maintaining background information
- Mapping the CPE stakeholders
- Recruiting the evaluation team.

The full tasks of the preparation phase and responsible entities are detailed in Chapter 1 of the Handbook.

7.2. Design Phase

(Handbook, Chapter 2)

The design phase sets the overall framework for the CPE. This phase includes:

- Induction meeting with the evaluation team
- Orientation meeting with the CO staff

- Desk review by the evaluation team and preliminary interviews, mainly with CO staff
- Developing the evaluation approach i.e., critical analysis of the theory of change suing contribution analysis, refining the preliminary evaluation questions and developing the assumptions for verification, developing the evaluation matrix, methods for data collection, and sampling method
- Stakeholder sampling and site selection
- Developing the field work agenda
- Developing the initial communications plan
- Drafting the design report version 1
- Quality assurance of design report version 1
- ERG meeting to present the design report
- Drafting the design report version 2
- Quality assurance of design report version 2

At the end of the design phase, the evaluation team will develop a **final design report** that presents a robust, practical and feasible evaluation approach, detailed methodology and work plan. The evaluation team will develop the design report in consultation with the CPE Manager and the ERG and submit it to the regional M&E adviser in UNFPA ESARO for review.

The detailed activities of the design phase with guidance on how they should be undertaken are provided in the Handbook, Chapter 2.

7.3. Field Phase

(Handbook, Chapter 3)
The evaluation team will collect the data and information required to answer the evaluation questions in the field phase. Towards the end of the field phase, the evaluation team will conduct a preliminary analysis of the data to identify emerging findings that will be presented to the CO and the ERG. The field phase should allow the evaluators sufficient time to collect valid and reliable data to cover the thematic scope of the CPE. A period of 3-4 weeks for data collection is planned for this evaluation. However, the CPE Manager will determine the optimal duration of data collection, in consultation with the evaluation team during the design phase.

The field phase includes:

- Preparing all logistical and practical arrangements for data collection
- Launching the field phase
- Collecting primary data at national and sub-national level
- Supplementing with secondary data
- Collecting photographic material
- Filling in the evaluation matrix
- Conducting a data analysis workshop
- Debriefing meeting and consolidating feedback for the debrief

At the end of the field phase, the evaluation team will hold a **debriefing meeting with the CO and the ERG** to present the initial analysis and emerging findings from the data collection in a PowerPoint presentation. The meeting will serve as a mechanism for the validation of collected data and information and the exchange of views between the evaluators and important stakeholders. It will enable the evaluation team to refine the findings, which is necessary so they can then formulate their conclusions and begin to develop credible and relevant recommendations. Should the debriefing meeting find that there are gaps in the

data gathered, the CPE Manager and the CO will assist the evaluation team to set up further interviews or to identify further documents as required.

The detailed activities of the field phase with guidance on how they should be undertaken are provided in the Handbook, Chapter 3.

7.4. Reporting Phase

(Handbook, Chapter 4)

In the reporting phase, the CPE Manager and the evaluation team will have a further meeting to agree next steps and deadlines, review the required evaluation report structure, and reflect on the requirements of the EQA grid. The team follows up on any further interviews or documents to review. The team leader finalizes the distribution of tasks for the team with deadlines for their completion, one important aspect of which is consolidating the evaluation matrix to meet quality standards. The reporting phase includes:

- Brainstorming on feedback from the ERG and CO debrief meeting
- Additional data collection if required
- Consolidating the evaluation matrix
- Drafting the findings and conclusions
- Identifying tentative recommendations using the recommendations worksheet
- Drafting CPE report version 1
  - We expect to have a draft report/ high level findings by June and July to use for the next country programme development process
- Quality assurance of CPE report version 1 and recommendations worksheet by the CPE Manager and RO M&E Adviser
- ERG meeting on CPE report version 1
- Recommendations workshop with ERG to finalize recommendations
- Revision of CPE report version 1
- Drafting CPE version 2
- Quality assurance of CPE report version 2 by the CPE Manager and RO M&E Adviser
- Final CPE report

The Handbook, Chapter 4, provides comprehensive details of the process that must be followed throughout the reporting phase, including details of all quality assurance steps and requirements for an acceptable report.

The evaluation report is considered final once it is formally approved by the CPE Manager in the UNFPA Ethiopia CO.

At the end of the reporting phase, the CPE Manager and the regional M&E Adviser will jointly prepare an internal EQA of the final evaluation report. The Independent Evaluation Office will subsequently conduct the final EQA of the report, which will be made publicly available.

7.5. Dissemination and Facilitation of Use Phase

(Handbook, Chapter 5)

This phase focuses on strategically communicating the CPE results to targeted audiences (short term) and facilitating the use of the CPE to inform decision-making and learning for programme and policy improvement (long term). It serves as a bridge between generating evaluation results, and the practical steps needed to ensure CPE leads to meaningful programme adaptation. While this phase is specifically about dissemination and facilitating the use of the CPE results, its foundation rests upon the preceding phases. This phase is largely the responsibility of the CPE manager, CO communications officer and other CO staff. However, key responsibilities of the evaluation team in this phase include:

- Taking photographs during primary data collection and during the evaluation process
- Adhering to the editorial guidelines of the United Nations and the UNFPA Evaluation Office to ensure high editorial standards
- Contribute to the finalization of the communications plan

The detailed guidance on the dissemination and facilitation of use phase is provided in the Handbook, Chapter 5.

8. Expected Deliverables

The evaluation team is expected to produce the following deliverables:

- **Design report.** The design report should translate the requirements of the ToR into a practical and feasible evaluation approach, methodology and work plan. In addition to presenting the methodology, the design report provides information on the country situation and the UN and UNFPA response. The Handbook section 2.4 provides the required structure of the design report and guidance on how to draft it.
- **PowerPoint presentation of the design report.** The PowerPoint presentation will be delivered at an ERG meeting to present the contents of the design report and the agenda for the field phase. Based on the comments and feedback of the ERG, the CPE Manager and the regional M&E adviser, the evaluation team will develop the final version of the design report.
- **PowerPoint presentation for debriefing meeting with the CO and the ERG.** The presentation provides an overview of key emerging findings of the evaluation at the end of the field phase. It will serve as the basis for the exchange of views between the evaluation team, UNFPA Ethiopia CO staff (incl. senior management) and the members of the ERG who will thus have the opportunity to provide complementary information and/or rectify the inaccurate interpretation of data and information collected.
- **Draft evaluation report.** The draft evaluation report will present the findings and conclusions, based on the evidence that data collection yielded. It will undergo review by the CPE Manager, the CO, the ERG and the regional M&E adviser, and the evaluation team will undertake revisions accordingly.
    - We expect to have a draft report/ high level findings by June and July to use for the next country programme development process.
- **Drafting of tentative recommendations using the Recommendation Worksheet for** review by the ERG (see Handbook section 4.3).
- **Final evaluation report.** The final evaluation report *(maximum 70 pages, excluding annexes)* will present the findings and conclusions, as well as a set of practical and actionable recommendations

to inform the next programme cycle. The Handbook section 4.5 provides the structure and guidance on developing the report. The set of annexes must be complete and must include the evaluation matrix containing all supporting evidence (data and information and their source).

- **PowerPoint presentation of the evaluation results.** The presentation will provide a clear overview of the key findings, conclusions and recommendations to be used for the dissemination of the final evaluation report.

Based on these deliverables, the CPE Manager, in collaboration with the communication officer in the UNFPA Ethiopia CO will develop an:

- **Evaluation brief.** The evaluation brief will consist of a short and concise document that provides an overview of the key evaluation results in an easily understandable and visually appealing manner, to promote their use among decision-makers and other stakeholders. The structure, content and layout of the evaluation brief should be similar to the briefs that the UNFPA Independent Evaluation Office produces for centralized evaluations.

All the deliverables will be developed in English.

9. Quality Assurance and Assessment

The UNFPA Evaluation Quality Assurance and Assessment (EQAA) system aims to ensure the production of good quality evaluations at central and decentralized levels through two processes: quality assurance and quality assessment. Quality assurance occurs throughout the evaluation process, starting with the ToR of the evaluation and ending with the final evaluation report. Quality assessment takes place following the completion of the evaluation process and is limited to the final evaluation report to assess compliance with a certain number of criteria. The quality assessment will be conducted by the UNFPA Independent Evaluation Office (IEO).

The EQAA of this CPE will be undertaken in accordance with the guidance and tools that the IEO has developed (see https://www.unfpa.org/admin-resource/evaluation-quality-assurance-and-assessment-tools-and-guidance). An essential component of the EQAA system is the EQA grid, which defines a set of criteria against which the draft and final evaluation reports are assessed to ensure clarity of reporting, methodological robustness, rigor of the analysis, credibility of findings, impartiality of conclusions and usefulness of recommendations.

The CPE Manager is primarily responsible for quality assurance of the deliverables of the evaluation in each phase of the evaluation process. However, the evaluation team leader also plays an important role in undertaking quality assurance, as elaborated in the Handbook. The evaluation team leader must ensure that all members of the evaluation team provide high-quality contributions (both form and substance) and, in particular, that the draft and final evaluation reports comply with the quality assessment criteria outlined in the EQA grid[149] before submission to the CPE Manager for review.

Using the EQA grid, the EQAA process for this CPE will be multi-layered and will involve: (i) the evaluation team leader (and each evaluation team member); (ii) the CPE Manager in the UNFPA Ethiopia CO, (iii) the

[149] The evaluators are invited to look at good quality CPE reports that can be found in the UNFPA evaluation database, which is available at: https://www.unfpa.org/evaluation/database. These reports must be read in conjunction with their EQAs (also available in the database) in order to gain a clear idea of the quality standards that UNFPA expects the evaluation team to meet.

regional M&E adviser in UNFPA ESARO, and (iv) the UNFPA Independent Evaluation Office, whose roles and responsibilities are outlined in section 11.

10. Indicative Timeframe and Work Plan

The table below indicates the main activities that will be undertaken throughout the evaluation process, as well as their estimated duration for the submission of corresponding deliverables. The involvement of the evaluation team starts with the design phase and ends after the reporting phase. The Handbook contains full details on all the CPE activities and must be used by the evaluators throughout the evaluation process.

Tentative timelines for main tasks and deliverables in the design, field and reporting phases of the CPE[150]

Main tasks	Responsible entity	Deliverables	Estimated duration
Design Phase			
Induction meeting with the evaluation team	CPE Manager and evaluation team		2-3 weeks
Orientation meeting with CO staff	CO Representative, CPE Manager, CO staff and RO M&E Adviser		
Desk review and preliminary interviews, mainly with CO staff	Evaluation team		
Developing the evaluation approach	Evaluation team		
Stakeholder sampling and site selection	Evaluation team, CPE Manager	**Stakeholder map**	
Developing the field work agenda	Evaluation team, CPE Manager	**Field work agenda**	
Developing the initial communications plan	CPE Manager and CO communications officer	*Communication plan (see Evaluation Handbook, Chapter 5)*	
Drafting the design report version 1	Evaluation team	**Design report- version 1**	
Quality assurance of design report version 1	CPE Manager and RO M&E Adviser		
ERG meeting to present the design report	Evaluation team, CPE manager	**PowerPoint presentation on design report version 1**	
Drafting the design report version 2	Evaluation team	**Design report - version 2**	

[150] For full information on all tasks and responsible entities, see the relevant chapters of the Handbook

Quality assurance of design report version 2	CPE Manager and RO M&E Adviser		
Final design report	Evaluation Team	**Final design report** (see Evaluation Handbook, section 2.4.4)	
Fieldwork phase			
Preparing all logistical and practical arrangements for data collection	CPE Manager		3-4 weeks
Collecting primary data at national and sub-national level	Evaluation team		
Supplementing with secondary data	Evaluation team		
Collecting photographic material	Evaluation team	**Photos** *(see Evaluation Handbook, Section 3.2.5)*	
Filling in the evaluation matrix	Evaluation team	**Evaluation matrix**	
Conducting a data analysis workshop	Evaluation team		
Debriefing meeting with CO and ERG	Evaluation team and CPE manager	**PowerPoint presentation**	
Preparing all logistical and practical arrangements for data collection	CPE Manager		
Phase 4: Reporting			
Consolidating the evaluation matrix	Evaluation team	**Evaluation matrix**	Approximately 12 weeks
Drafting CPE report version 1	Evaluation team	**Evaluation report - version 1**	
Quality assurance of CPE report version 1	CPE Manager and RO M&E Adviser		
ERG meeting on CPE report version 1	Evaluation team and CPE Manager	**PowerPoint presentation**	
Recommendations workshop	Evaluation team, CPE manager, ERG members	**Recommendations worksheet**	
Drafting CPE version 2	Evaluation team	**Evaluation report - version 2**	
Quality assurance of CPE report version 2	CPE Manager and RO M&E Adviser		
Final CPE report	Evaluation team	**Final CPE report** *(see Evaluation Handbook, section 4.5)* **with powerpoint presentation** and **audit trail**	

Consolidating the evaluation matrix	Evaluation team	**Evaluation matrix**	
Drafting CPE report version 1	Evaluation team	**Evaluation report - version 1**	
Quality assurance of CPE report version 1	CPE Manager and RO M&E Adviser		
ERG meeting on CPE report version 1	Evaluation team and CPE Manager	**PowerPoint presentation**	
Recommendations workshop	Evaluation team, CPE manager, ERG members	**Recommendations worksheet**	

Nota Bene: Column "Deliverables": In italics: The deliverables are the responsibility of the CO/CPE Manager; **in bold:** The deliverables are the responsibility of the evaluation team.

11. Management of the Evaluation

The **CPE Manager** under the oversight of the deputy representative, in the UNFPA Ethiopia CO, in close consultation with the Ministry of Finance that coordinates the country programme will be responsible for the management of the evaluation and supervision of the evaluation team in line with the UNFPA Evaluation Handbook. The CPE Manager will oversee the entire process of the evaluation, from the preparation to the dissemination of the evaluation results and facilitation of use. S/he will also coordinate the exchanges between the evaluation team and the ERG. It is the responsibility of the CPE Manager to ensure the quality, independence and impartiality of the evaluation in line with the UNEG norms and standards and ethical guidelines for evaluation. The full roles and responsibilities of the CPE Manager are provided in the Handbook for each phase of the CPE.

At all stages of the evaluation process, the CPE Manager will require support from staff of the UNFPA Ethiopia CO. In particular, the **country office staff** contribute to the preparation of the ToR and all its annexes, assist the evaluators to understand the country programme and its strengths and limitations, and assist with all logistics for the CPE. They also provide inputs to the management response and contribute to the dissemination of evaluation results. CPE Manager

The progress of the evaluation will be followed closely by the **evaluation reference group (ERG)**, which is composed of relevant UNFPA staff from the Ethiopia CO, ESARO, representatives of the national Government of Ethiopia, implementing partners, as well as other relevant key stakeholders (see Handbook, section 1.4). The ERG serves as a body to ensure the relevance, quality and credibility of the evaluation. It provides inputs on key milestones in the evaluation process, facilitates the evaluation team's access to sources of information and key informants and undertakes quality assurance of the evaluation deliverables from a technical perspective. The Handbook provides details of the roles and responsibilities of the ERG at different phases of the CPE.

The **regional M&E adviser** in UNFPA ESARO will provide guidance and backstopping support to the CPE Manager at all stages of the evaluation process. In particular, the regional M&E plays a crucial role in the evaluation quality assurance and assessment (EQAA) of the CPE. This includes quality assurance of the ToR, consultant recruitment and both the design and final evaluation reports. S/he also assists with dissemination and use of the evaluation results. The roles and responsibilities of the regional M&E adviser at all phases of the CPE are indicated in the Handbook in the respective chapters.

The UNFPA **Independent Evaluation Office (IEO)** commissions an independent EQA of the final evaluation report. The IEO also publishes the final evaluation report, independent EQA and management response in the UNFPA evaluation database.

12. Composition of the Evaluation Team

The evaluation will be conducted by a team of independent, external evaluators, consisting of: (i) an evaluation team leader with overall responsibility for carrying out the evaluation exercise, and (ii) team members who will provide technical expertise in thematic areas relevant to the UNFPA mandate (SRHR; adolescents and youth; gender equality and women's empowerment; population dynamics; and humanitarian action), including expertise on conducting humanitarian evaluations. In addition to her/his primary responsibility for the design of the evaluation methodology and the coordination of the evaluation team throughout the CPE process, the team leader will perform the role of technical expert for one of the thematic areas of the 9th UNFPA country programme in Ethiopia.

The evaluation team leader will be recruited internationally (incl. in the region or sub-region), while the evaluation team members will be recruited locally to ensure adequate knowledge of the country context. Finally, the evaluation team should have the requisite level of knowledge to conduct human rights- and gender-responsive evaluations and all evaluators should be able to work in a multidisciplinary team and in a multicultural environment.

12.1. Roles and Responsibilities of the Evaluation Team

Evaluation team leader

The evaluation team leader will hold the overall responsibility for the design and implementation of the evaluation. S/he will be responsible for the production and timely submission of all expected deliverables in line with the ToR. S/he will lead and coordinate the work of the evaluation team and ensure the quality of all evaluation deliverables at all stages of the process. The CPE Manager will provide methodological guidance to the evaluation team in developing the design report, in particular, but not limited to, defining the evaluation approach, methodology and work plan, as well as the agenda for the field phase. S/he will lead the drafting and presentation of the design report and the draft and final evaluation report, and play a leading role in meetings with the ERG and the CO. The team leader will also be responsible for communication with the CPE Manager. Beyond her/his responsibilities as team leader, the evaluation team leader will serve as technical expert for one of the thematic areas of the country programme described below.

Evaluation team member: SRHR and Adolescents/Youth expert

The SRHR/AY expert will provide expertise on integrated sexual and reproductive health services, HIV and other sexually transmitted infections, maternal health, and family planning. S/he will contribute to the methodological design of the evaluation and take part in the data collection and analysis work, with overall responsibility of contributions to the evaluation deliverables in her/his thematic area of expertise.
When it comes to adolescents and youth, s/he will provide expertise on youth friendly SRHR services, comprehensive sexuality education, adolescent pregnancy, SRHR of young women and adolescent girls, access to contraceptives for young women and adolescent girls and youth leadership and participation as well as peace and security. S/he will provide substantive inputs throughout the evaluation process by contributing to the development of the evaluation methodology, evaluation work plan and agenda for the

field phase, participating in meetings with the CPE Manager, UNFPA Ethiopia CO staff and the ERG. S/he will undertake a document review and conduct interviews and group discussions with stakeholders, as agreed with the evaluation team leader.

Evaluation team member: Gender and social norms expert
The gender and social norms expert will provide expertise on the human rights of women and girls, especially sexual and reproductive rights, the empowerment of women and girls, engagement of men and boys, as well as GBV and harmful practices, such as female genital mutilation, child, early and forced marriage. S/he will contribute to the methodological design of the evaluation and take part in the data collection and analysis work, with overall responsibility of contributions to the evaluation deliverables in her/his thematic area of expertise. S/he will provide substantive inputs throughout the evaluation process by contributing to the development of the evaluation methodology, evaluation work plan and agenda for the field phase, participating in meetings with the CPE Manager, UNFPA Ethiopia CO staff and the ERG. S/he will undertake a document review and conduct interviews and group discussions with stakeholders, as agreed with the evaluation team leader.

Evaluation team member: Population dynamics expert
The population dynamics expert will provide expertise on population and development issues, such as census, ageing, migration, the demographic dividend, and national statistical systems. S/he will contribute to the methodological design of the evaluation and take part in the data collection and analysis work, with overall responsibility of contributions to the evaluation deliverables in her/his thematic area of expertise. S/he will provide substantive inputs throughout the evaluation process by contributing to the development of the evaluation methodology, evaluation work plan and agenda for the field phase, participating in meetings with the CPE Manager, UNFPA Ethiopia CO staff and the ERG. S/he will undertake a document review and conduct interviews and group discussions with stakeholders, as agreed with the evaluation team leader.

Evaluation team member: Humanitarian expert/ Subject-matter specialist on humanitarian issues
The Humanitarian expert/ Subject-matter specialist on humanitarian issues will contribute to the CPEs that include a humanitarian component. S/he will participate and contribute to all the phases of the CPE and support the evaluation team leader and members in developing the evaluation methodology, matrix and questions, data collection and any other required effort. The role of this profile is primarily to provide expertise on evaluating humanitarian actions, integrating global guidance and standards for evaluating humanitarian action in the CPE process, and highlighting possible challenges (and solutions) to evaluating complex humanitarian responses. S/he should be knowledgeable about evaluations as well as humanitarian sector reform and architecture.

The modalities for the participation of the evaluation team members in the evaluation process, their responsibilities during data collection and analysis, as well as the nature of their respective contributions to the drafting of the design report and the draft and final evaluation report will be agreed with the evaluation team leader. These tasks will be performed under her/his supervision.

12.2. Qualifications and Experience of the Evaluation Team

Team leader
The competencies, skills and experience of the evaluation team leader should include:

- A minimum of Master's degree in public health, social sciences, demography or population studies, statistics, development studies or a related field.

- 10 years of experience in conducting or managing evaluations in the field of international development and humanitarian assistance.
- Extensive experience in leading complex evaluations commissioned by United Nations organizations and/or other international organizations and NGOs.
- **Demonstrated expertise in one of the thematic areas of the country programme covered by the evaluation (see expert profiles below).**
- In-depth knowledge of theory-based evaluation approaches and ability to apply both qualitative and quantitative data collection methods and to uphold high quality standards for evaluation as defined by UNFPA and UNEG.
- Good knowledge of humanitarian strategies, policies, frameworks and international humanitarian law and humanitarian principles, as well as the international humanitarian architecture and coordination mechanisms].
- Ability to ensure ethics and integrity of the evaluation process, including confidentiality and the principle of do no harm.
- Ability to consistently integrate human rights and gender perspectives in all phases of the evaluation process.
- Excellent management and leadership skills to coordinate the work of the evaluation team, and strong ability to share technical evaluation skills and knowledge.
- Experience working with a multidisciplinary team of experts.
- Excellent ability to analyze and synthesize large volumes of data and information from diverse sources.
- Excellent interpersonal and communication skills (written and spoken).
- Work experience in/good knowledge of the region and the national development context of Ethiopia.
- Fluent in written and spoken English.

SRHR and Adolescents/Youth expert

The competencies, skills and experience of the SRHR expert should include:

- A minimum of Master's degree in public health, medicine, health economics and financing, epidemiology, biostatistics, social sciences or a related field.
- 5-7 years of experience in conducting evaluations, reviews, assessments, research studies or M&E work in the field of international development and/or humanitarian assistance.
- Substantive knowledge of SRHR, including HIV and other sexually transmitted infections, maternal health, and family planning.
- Good knowledge of humanitarian strategies, policies, frameworks and international humanitarian law and humanitarian principles, as well as the international humanitarian architecture and coordination mechanisms
- Ability to ensure ethics and integrity of the evaluation process, including confidentiality and the principle of do no harm.
- Ability to consistently integrate human rights and gender perspectives in all phases of the evaluation process.
- Solid knowledge of evaluation approaches and methodology and demonstrated ability to apply both qualitative and quantitative data collection methods.
- Excellent analytical and problem-solving skills.
- Experience working with a multidisciplinary team of experts.
- Excellent interpersonal and communication skills (written and spoken).

- Work experience in/good knowledge of the national development context of Ethiopia.
- Familiarity with UNFPA or other United Nations organizations' mandates and activities will be an advantage.
- Fluent in written and spoken English and Amharic.

Gender and social norms expert

The competencies, skills and experience of the gender and social norms expert should include:

- A minimum of Master's degree in women/gender studies, human rights law, social sciences, development studies or a related field.
- 5-7 years of experience in conducting evaluations, reviews, assessments, research studies or M&E work in the field of international development and/or humanitarian assistance.
- Substantive knowledge on gender equality and the empowerment of women and girls, GBV and other harmful practices, such as female genital mutilation, early, child and forced marriage, and issues surrounding masculinity, gender relationships and sexuality.
- Good knowledge of humanitarian strategies, policies, frameworks and international humanitarian law and humanitarian principles, as well as the international humanitarian architecture and coordination mechanisms.
- Ability to ensure ethics and integrity of the evaluation process, including confidentiality and the principle of do no harm.
- Ability to consistently integrate human rights and gender perspectives in all phases of the evaluation process.
- Solid knowledge of evaluation approaches and methodology and demonstrated ability to apply both qualitative and quantitative data collection methods.
- Excellent analytical and problem-solving skills.
- Experience working with a multidisciplinary team of experts.
- Excellent interpersonal and communication skills (written and spoken).
- Work experience in/good knowledge of the national development context of Ethiopia.
- Familiarity with UNFPA or other United Nations organizations' mandates and activities will be an advantage.
- Fluent in written and spoken English and Amharic.

Population dynamics expert

The competencies, skills and experience of the population dynamics expert should include:

- A minimum of Master's degree in demography or population studies, statistics, social sciences, development studies or a related field.
- 5-7 years of experience in conducting evaluations, reviews, assessments, research studies or M&E work in the field of international development and/or humanitarian assistance.
- Substantive knowledge on the generation, analysis, dissemination and use of housing census and population data for development, population dynamics, migration and national statistics systems.
- Good knowledge of humanitarian strategies, policies, frameworks and international humanitarian law and humanitarian principles, as well as the international humanitarian architecture and coordination mechanisms.
- Ability to ensure ethics and integrity of the evaluation process, including confidentiality and the principle of do no harm.
- Ability to consistently integrate human rights and gender perspectives in all phases of the evaluation process.

- Solid knowledge of evaluation approaches and methodology and demonstrated ability to apply both qualitative and quantitative data collection methods.
- Excellent analytical and problem-solving skills.
- Experience working with a multidisciplinary team of experts.
- Excellent interpersonal and communication skills (written and spoken).
- Work experience in/good knowledge of the national development context of Ethiopia.
- Familiarity with UNFPA or other United Nations organizations' mandates and activities will be an advantage.
- Fluent in written and spoken English and Amharic.

Humanitarian expert

The competencies, skills and experience of the population dynamics expert should include:

- A minimum of Master's degree in public health, social sciences, demography or population studies, statistics, development studies or a related field.
- 5-7 years of experience in conducting evaluations, reviews, assessments, research studies or M&E work in the field of humanitarian assistance.
- Substantive knowledge of humanitarian strategies, programmes, policies, frameworks and international humanitarian law and humanitarian principles, as well as the international humanitarian architecture and coordination mechanisms.
- Ability to ensure ethics and integrity of the evaluation process, including confidentiality and the principle of do no harm.
- Ability to consistently integrate human rights and gender perspectives in all phases of the evaluation process.
- Solid knowledge of evaluation approaches and methodology and demonstrated ability to apply both qualitative and quantitative data collection methods.
- Excellent analytical and problem-solving skills.
- Experience working with a multidisciplinary team of experts.
- Excellent interpersonal and communication skills (written and spoken).
- Work experience in/good knowledge of the national development context of Ethiopia.
- Familiarity with UNFPA or other United Nations organizations' mandates and activities will be an advantage.
- Fluent in written and spoken English.

13. Budget and Payment Modalities

The evaluators will receive a daily fee according to the UNFPA consultancy scale based on qualifications and experience.

The payment of fees will be based on the submission of deliverables, as follows:

Upon approval of the design report	20%
Upon submission of a draft final evaluation report of satisfactory quality	40%

Upon approval of the final evaluation report and the PowerPoint presentation of the evaluation results	40%

In addition to the daily fees, the evaluators will receive a daily subsistence allowance (DSA) in accordance with the UNFPA Duty Travel Policy, using applicable United Nations DSA rates for the place of mission. Travel costs will be settled separately from the consultancy fees.

The provisional allocation of workdays among the evaluation team will be the following:

	Team leader	**Thematic experts**
Design phase	*15*	*10*
Field phase	*23*	*21*
Reporting phase	*25*	*16*
Dissemination and facilitation of use phase	*2*	*1*
TOTAL (days)	*65*	*48*

Please note the numbers of days in the table are indicative. The final distribution of the volume of work and corresponding number of days for each consultant will be proposed by the evaluation team in the design report and will be subject to the approval of the CPE Manager.

14. Bibliography and Resources

The following documents will be made available to the evaluation team upon recruitment:

UNFPA documents

1. UNFPA Strategic Plan (2018-2021) (incl. annexes) https://www.unfpa.org/strategic-plan-2018-2021
2. UNFPA Strategic Plan (2022-2025) (incl. annexes) https://www.unfpa.org/unfpa-strategic-plan-2022-2025-dpfpa20218
3. UNFPA Evaluation Policy (2024) https://www.unfpa.org/admin-resource/unfpa-evaluation-policy-2024
4. *UNFPA Evaluation Handbook*
5. Relevant centralized evaluations conducted by the UNFPA Independent Evaluation Office - available at: https://www.unfpa.org/evaluation

Ethiopia national strategies, policies and action plans

6. National Development Plan
7. United Nations Sustainable Development Cooperation Framework (UNSDCF)
8. Relevant national strategies and policies for each thematic area of the country programme

UNFPA Ethiopia CO programming documents

9. Government of Ethiopia/UNFPA 9th Country Programme Document (2020-2025)
10. United Nations Common Country Analysis/Assessment (CCA)
11. Situation analysis for the Government of Ethiopia/UNFPA 9th Country Programme (2020-2025)
12. CO annual work plans
13. Joint programme documents
14. UNFPA Ethiopia 50 Years Report: 50 Years of Ensuring Rights and Choices for All in Ethiopia
15. Mid-term review
16. Programme evaluation reports (early child marriage joint programme with UNICEF)
17. Reports on core and non-core resources
18. CO resource mobilization strategy
19. Humanitarian Sitreps

UNFPA Ethiopia CO M&E documents

20. Government of Ethiopia/UNFPA 9th Country Programme M&E Plan (2020-2025)
21. CO Country Programme biannual and annual reports
22. CO annual results plans and reports (SIS/MyResults)
23. CO quarterly monitoring reports (SIS/MyResults)
24. Previous evaluation of the Government of Ethiopia/UNFPA 9th Country Programme (2020-2025), available at: https://web2.unfpa.org/public/about/oversight/evaluations/

Other documents

25. Implementing partner annual work plans and quarterly progress reports
26. Implementing partner assessments
27. Audit reports and spot check reports (NEX HACT aduit; Last mile assurance assessment)
28. Meeting agendas and minutes of joint United Nations working groups
29. Donor reports of projects of the UNFPA Ethiopia CO

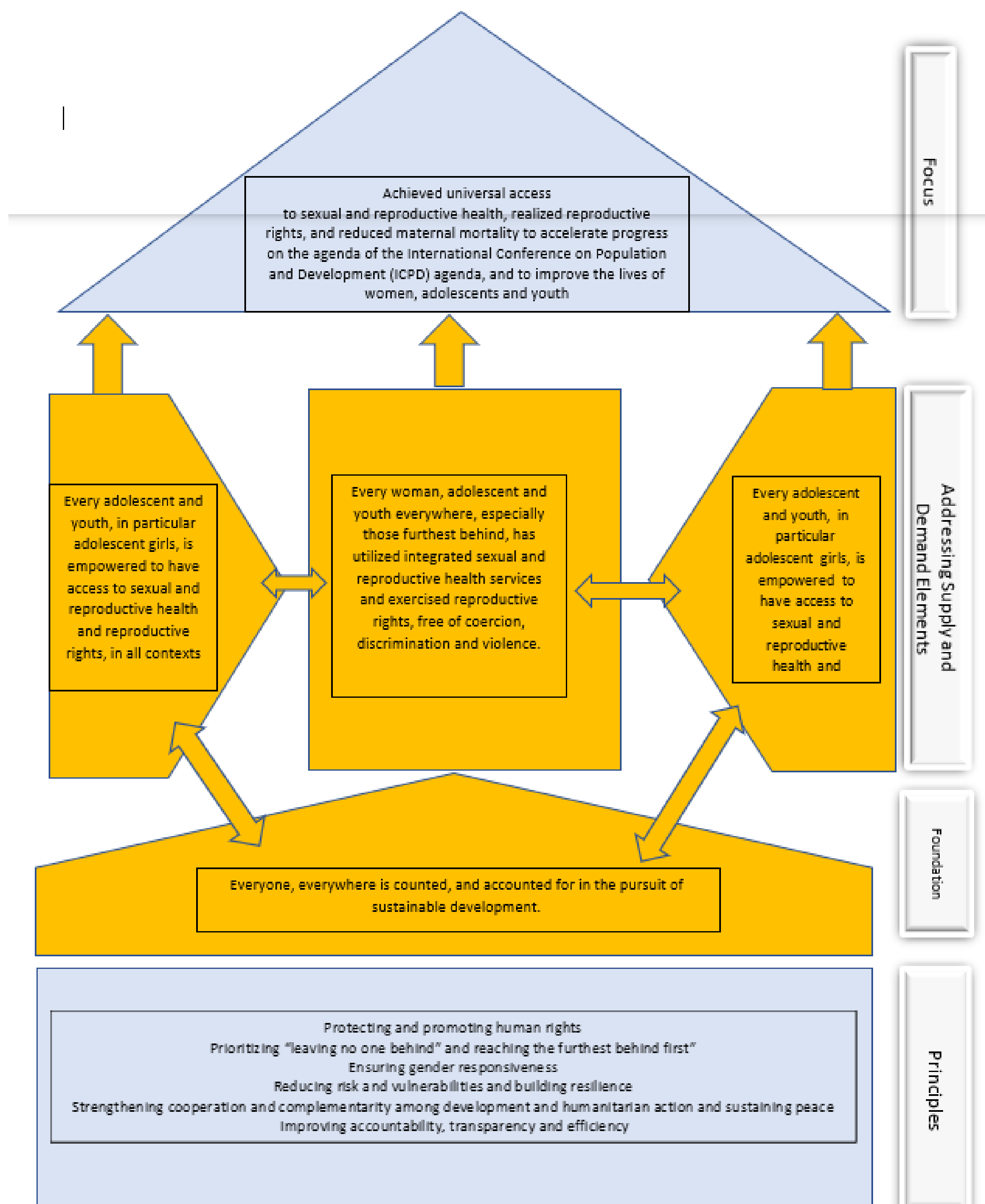
30. HRP- Humanitarian Response Plan and related reports https://response.reliefweb.int/
31. Evaluations conducted by other UN agencies
32. IAHE- Inter-Agency Humanitarian evaluations https://interagencystandingcommittee.org/inter-agency-humanitarian-evaluations
33. UNEG Norms and Standards on Evaluation - Ethics
34. UNEG Guidance on the Integration of Humanitarian Principles in the Evaluation of Humanitarian Action

15. Annexes

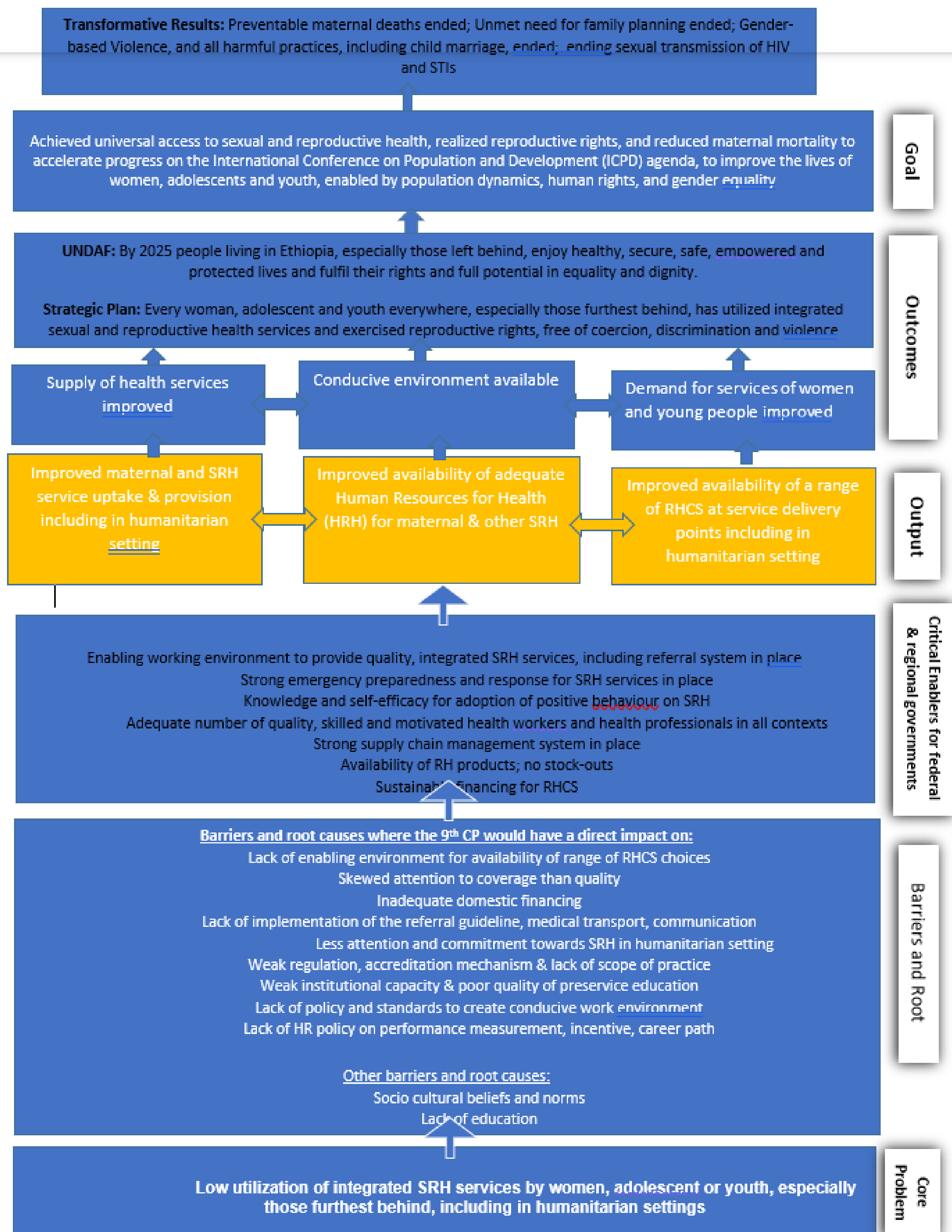
A. Theory of Change (TOC)

- Original TOC developed before the 9th Country Programme in 2019
    - 1 consolidated + 1 for each outcome (4 outcomes total)

Consolidated TOC - (2020-2025)

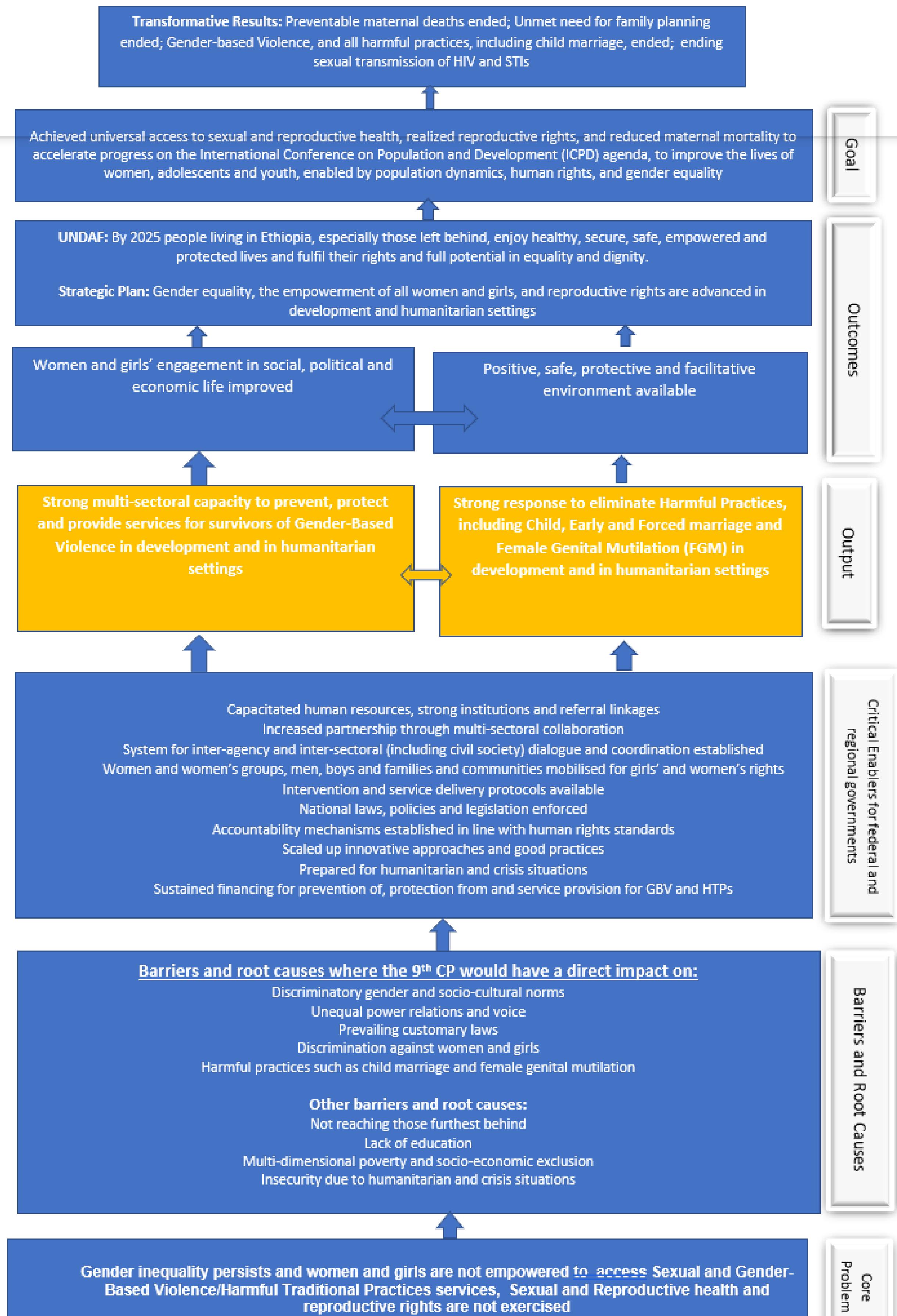


OUTCOME 1
THEORY OF CHANGE

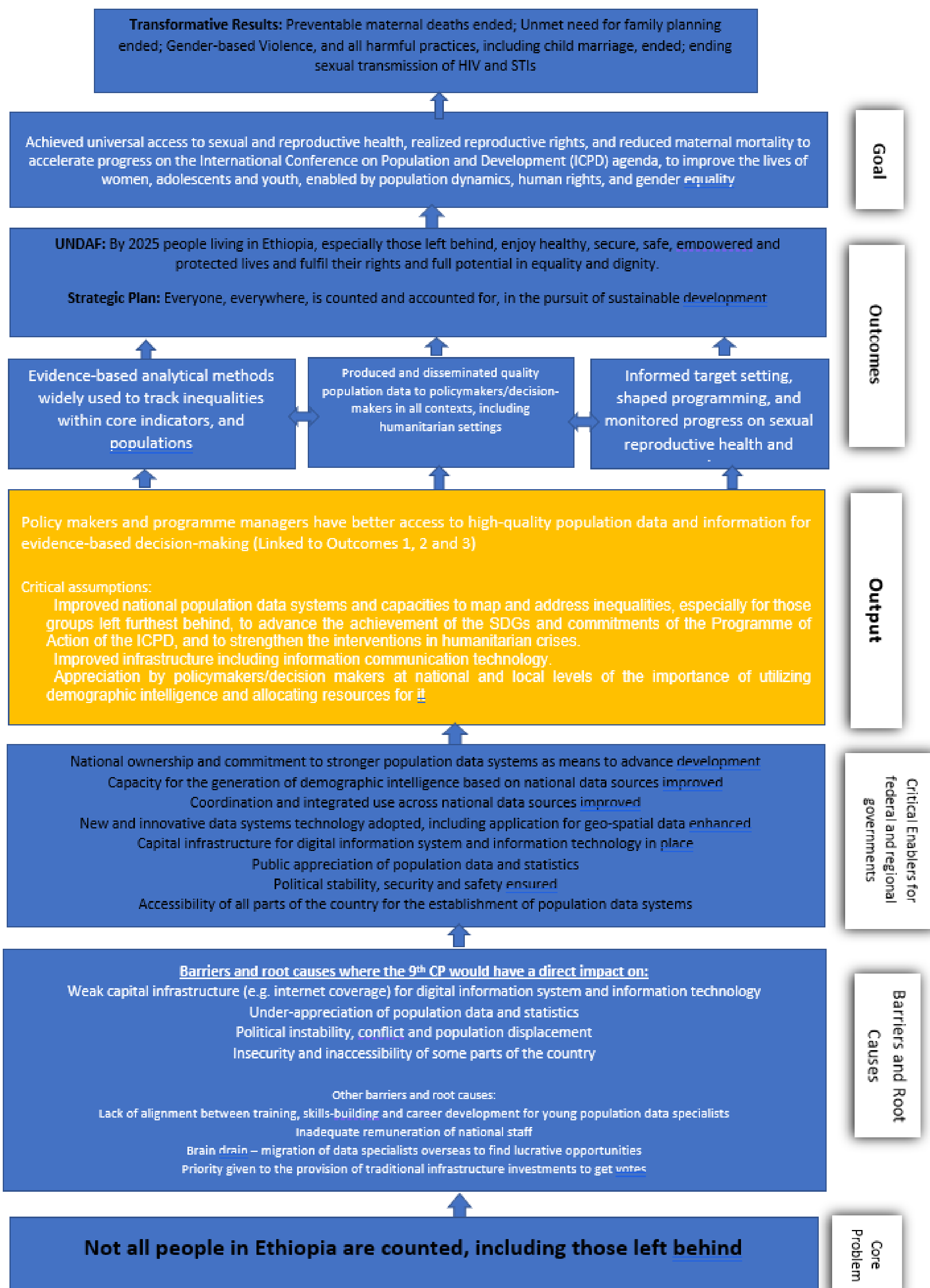


OUTCOME 2
THEORY OF CHANGE

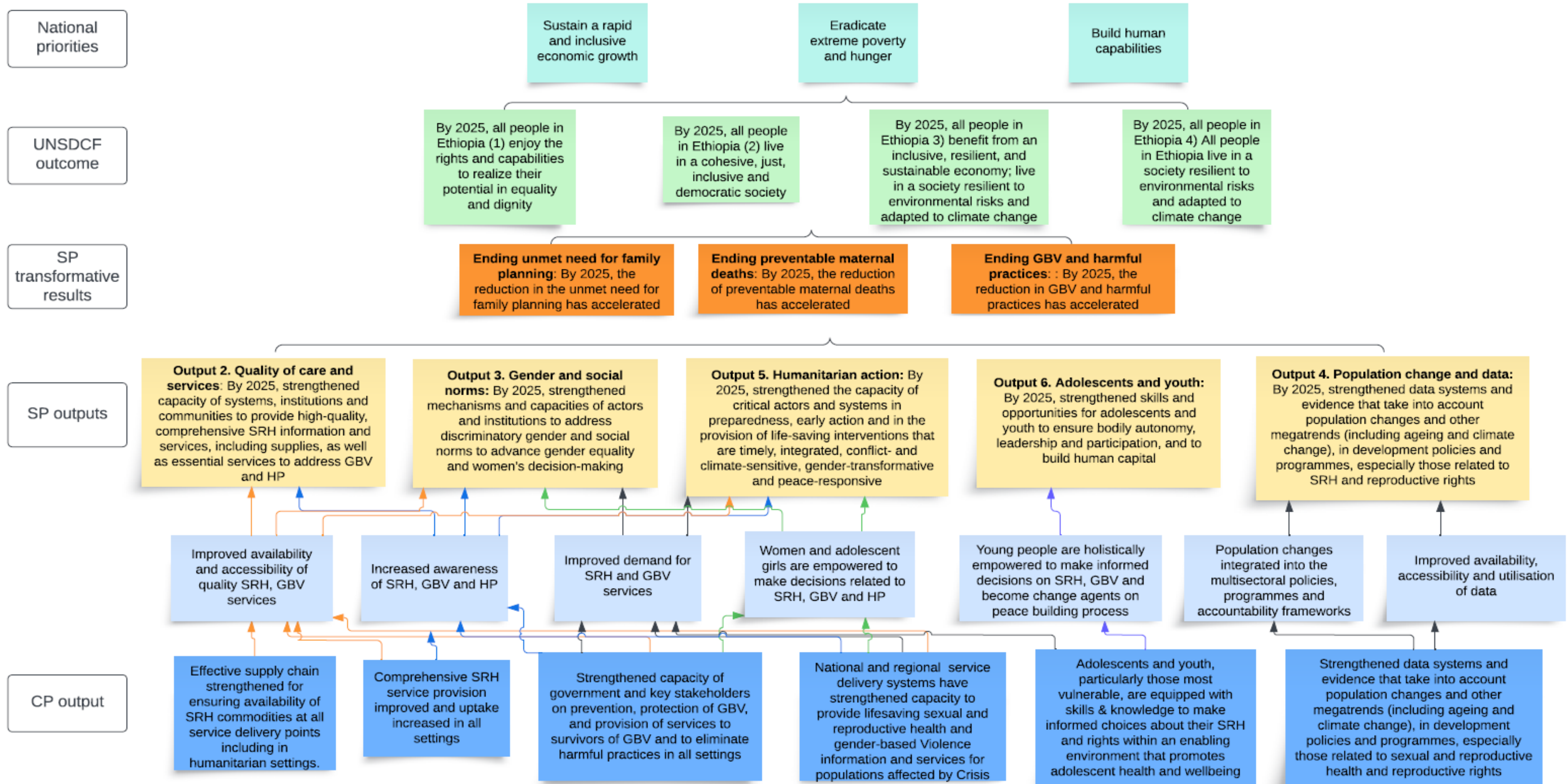
OUTCOME 3
THEORY OF CHANGE



OUTCOME 4
THEORY OF CHANGE



- Reconstructed TOC aligned with the global Strategic Plan



Reconstructed Theory of Change (TOC) Narrative

UNFPA Ethiopia's theory of change (figure available on the last page) was reconstructed to align with the UNFPA Global Strategic Plan (2022-2025), prompted by the realignment of the Country Programme Document (CPD). Effective January 2023, the revised CPD now includes a standalone humanitarian output, previously integrated across various outputs in the original CPD. Furthermore, this adjustment was also driven by the need to comply with the latest guidance from the Evaluation Office (EO) on Country Programme Evaluation (CPE), necessitating a revision of the theory of change to reflect this alignment.

The light reconstruction exercise was based primarily on existing documentation—such as the United Nations Sustainable Development Cooperation Framework (UNSDCF), the CPD, and the UNFPA Global Strategic Plan in order to minimize bias and ensure a robust validation process. This process involved initial drafting from the M&E unit, validation from the programme team leads followed by approval from the Senior Management Team.

The underlying assumptions of the theory of change are the existing demand, supply, and the enabling environment. It is also important to consider the political and security risks, beyond the control of UNFPA. In addition, UNFPA has identified the following six accelerators to scale up the achievement of the six outputs and, ultimately, the progress toward the three transformative results: (1) Human rights-based and gender transformative approaches (2) Innovation and digitalization (3) Partnership, South-South and triangular cooperation, and financing; (4) Data and evidence; (5) “Leaving no one behind” and “reaching the furthest left behind first”; (6) Resilience and adaptation, and complementarity among development, humanitarian and peace-responsive efforts. Overall, the following six pathways were identified.

CP output 1: Supply chain system strengthened

For the first CP output, UNFPA believes strengthening the supply chain will lead to improved availability of family planning and lifesaving maternal health commodities required for the provision of quality Sexual and Reproductive Health (SRH) services.

This further contributes to the following SP outputs:

- *Output 2.* quality of care and services (strengthened capacity of systems, institutions and communities to provide high-quality, comprehensive SRH information and services, including supplies, as well as essential services to address GBV and FP);
- *Output 3*. gender and social norms (strengthened capacity of systems, institutions and strengthened mechanisms and capacities of actors and institutions to address discriminatory gender and social norms to advance gender equality and women’s decision-making);
- *Output 5*. humanitarian action (strengthened the capacity of critical actors and systems in preparedness, early action and in the provision of life-saving interventions that are timely, integrated, conflict- and climate-sensitive, gender-transformative and peace-responsive).

CP output 2. Comprehensive SRH

For the second CP output, UNFPA believes that improving comprehensive SRH services and increasing their uptake in all settings will further result in the following intermediate outputs:

improved availability and accessibility of quality SRH and GBV services in addition to increasing awareness of SRH and GBV.

As a result, these will further lead to three SP outputs:

- *Output 2*. quality of care and services (strengthened capacity of systems, institutions and communities to provide high-quality, comprehensive SRH information and services, including supplies, as well as essential services to address GBV);
- *Output* 3. gender and social norms (strengthened capacity of systems, institutions and strengthened mechanisms and capacities of actors and institutions to address discriminatory gender and social norms to advance gender equality and women's decision-making);
- *Output 5*. humanitarian action (strengthened the capacity of critical actors and systems in preparedness, early action and in the provision of life-saving interventions that are timely, integrated, conflict- and climate-sensitive, gender-transformative and peace-responsive).

CP output 3. Gender

The third CP output on strengthening the capacity of the government and key stakeholders to prevent and protect against GBV, provide comprehensive and standard services to survivors of GBV, and eliminate harmful practices (early, and forced marriage and FGM) will lead to the following intermediate outputs: improved availability and accessibility of quality GBV services; increased awareness of GBV HP and SRH; improved demand for GBV and SRH services; women and adolescent girls are empowered to make decisions related to SRH, GBV and HP.

These will then result in the following three SP outputs:

- *Output 2*. quality of care and services (strengthened capacity of systems, institutions and communities to provide high-quality, comprehensive SRH information and services, including supplies, as well as essential services to address GBV and HP);
- *Output* 3. gender and social norms (strengthened capacity of systems, institutions and strengthened mechanisms and capacities of actors and institutions to address discriminatory gender and social norms to advance gender equality and women's decision-making);
- *Output* 5. humanitarian action (strengthened the capacity of critical actors and systems in preparedness, early action and in the provision of life-saving interventions that are timely, integrated, conflict- and climate-sensitive, gender-transformative and peace-responsive).

CP output 4. Population dynamics

The fourth CP output aims to strengthen data systems and evidence that consider population changes and other megatrends, such as aging and climate change, in development policies and programmes, particularly those related to SRH. This will lead to two intermediate outputs: the integration of population changes into multi-sectoral policies, programmes, and accountability frameworks, and the improvement in the availability, accessibility, and utilization of data.

These two intermediate outputs will then contribute to the achievement of SP output:

- *Output 4*. Population change and data: by 2025, strengthened data systems and evidence that incorporate population changes and other megatrends into development policies and programmes, with a specific focus on SRH and reproductive rights.

CP output 5. Humanitarian

The fifth CP output focuses on strengthening the capacity of national and regional service delivery systems to provide essential SRH and GBV information and services to populations affected by crises.

These CP outputs will result in the following four intermediate outputs: improved availability and accessibility of quality SRH and GBV services; increased awareness and improved demand for SRH and GBV services; women and adolescent girls are empowered to make decisions related to SRH and GBV.

These will then result in the following three SP outputs:

- *Output 2*. quality of care and services (strengthened capacity of systems, institutions and communities to provide high-quality, comprehensive SRH information and services, including supplies, as well as essential services to address GBV and HP);
- *Output 3*. gender and social norms (strengthened capacity of systems, institutions and strengthened mechanisms and capacities of actors and institutions to address discriminatory gender and social norms to advance gender equality and women's decision-making);
- *Output 5*. humanitarian action (strengthened the capacity of critical actors and systems in preparedness, early action and in the provision of life-saving interventions that are timely, integrated, conflict- and climate-sensitive, gender-transformative and peace-responsive).

CP output 6. Adolescents and youth

The sixth CP output focuses on equipping adolescents and youth, especially the most vulnerable, with the necessary skills and knowledge to make informed choices about their SRH and rights including HIV and AIDS. This is to be achieved within an enabling environment that promotes adolescent health and wellbeing. As a result, young people will be holistically empowered to make informed decisions regarding SRH and GBV, and they will also become change agents in the peace-building process (intermediate output). This will further result in strategic plan *output 6*. adolescents and youth (by 2025, strengthened skills and opportunities for adolescents and youth to ensure bodily autonomy, leadership and participation, and to build human capital).

The UNFPA SP (2022-2025) outputs along with output 6 on adolescents and youth will collectively contribute to achieving the SP transformative results (2022-2025). In addition to the three transformative results, there is a fourth transformative result on HIV and AIDS which is specific to the ESARO Region. As a result, the Ethiopia Country Office is working on addressing HIV and AIDS in collaboration with the government and other stakeholders. These results, in turn, will lead to the accomplishment of the UNSDCF outcomes (2020-2025), which will then further advance Ethiopia's national priorities (2021-2030).

Conclusion

The UNFPA SP (2022-2025) outputs will collectively contribute to achieving the SP transformative results (2022-2025). These results, in turn, will lead to the accomplishment of the UNSDCF outcomes (2020-2025), which will then further advance Ethiopia's national priorities noted in the Ten Years Development Plan (2021-2030).

Annex B: Tentative time frame and workplan

During the Design phase, the evaluation team leader, in collaboration with the evaluation manager will finalize the present tentative work plan and respective duration of each evaluation phase.

Evaluation Phases and Tasks	April				May				June				July				August				September				October			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Design phase																												
Induction meeting with the evaluation team				X																								
Orientation meeting with CO staff				X																								
Desk review and preliminary interviews, mainly with CO staff				X																								
Developing the initial communications plan				X																								
Drafting the design report version 1				X																								
Quality assurance of design report version 1				X																								
ERG meeting to present the design report					X																							
Drafting the design report version 2					X																							

Quality assurance of design report version 2					X																							
Submission of final design report to CPE manager					X																							
Update of communication plan (based on final stakeholder map and evaluation work plan presented in the approved design report)					X																							
Fieldwork phase																												
Inception meeting for data collection with CO staff						X																						
Individual meetings of evaluators with relevant programme officers at CO						X																						
Data collection (document review, site visits, interviews, group discussions, etc.)							X	X																				
Conducting a data analysis workshop									X																			
Debriefing meeting with CO staff and ERG									X																			
Update of communication plan (as required)									X																			
Reporting phase																												
Preparation of CPE report version 1 and recommendations worksheet										X	X																	
Quality assurance of CPE report version 1 and recommendations worksheet												X																

ERG meeting on CPE report version 1													X															
Recommendations workshop														X	X													
Revision of CPE report version 1																X												
Drafting CPE version 2																	X											
Quality assurance of CPE report version 2																		X										
Submission of final evaluation report to EO																			X									
Development of independent EQA of final evaluation report																				X								
Update of communication plan (as required)																				X								
Dissemination and facilitation of use phase																												
Preparation of management response and submission to PSD																					X							
Finalization of communication plan for implementation																						X						
Development of PowerPoint presentation of key evaluation results																							X					
Development of evaluation brief																								X				
Publication of final evaluation report, independent EQA and management response in UNFPA evaluation database																									X			
Publication of final evaluation																										X		

report, evaluation brief and management response on CO website																												
Dissemination of evaluation report and evaluation brief to stakeholders																											X	

*We expect to have a draft report/ high level findings by June and July to use for the next country programme development process

United Nations Population Fund

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