

COUNTRY NOTE

Evaluation of UNFPA Support to Adolescents and Youth (2008-2015)

Ethiopia

2016

Evaluation Office

Valeria Carou Jones	Evaluation Manager
Natalie Raaber	Evaluation Analyst

Case Study Team Members

Dr. Kate Molesworth (Swiss TPH)	Team Leader
Dr. Jana Gerold (Swiss TPH)	Scientific Collaborator
Dr. Mirgissa Kaba Serbessa	National Consultant
Ms. Yeabsira Bogale	National Consultant

Evaluation Office, United Nations Population Fund

E-mail: evaluation.office@unfpa.org

For further information on the evaluation please consult the Evaluation Office webpage:

http://www.unfpa.org/evaluation

Table of Contents

LIST OF TABLES

LIST OF BOXES

LIST OF FIGURES

List of abbreviations and acronyms

AAG	Action for Adolescent Girls
A&Y	Adolescents & Youth
AIDS	Acquired Immune Deficiency Syndrome
APRO	UNFPA Asia & the Pacific Regional Office
ASRO	UNFPA Arab States Regional Office
AWP	Annual Work Plan
AYFRH	Adolescent and Youth Friendly Reproductive Health
BoYS	Bureau of Youth and Sport
CO	UNFPA Country Office
COAR	UNFPA Country Office Annual Reports
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CSA	Central Statistic Agency
CSO	Civil Society Organisation
OECD-DAC	Development Assistance Committee of the Organization for Economic Cooperation and Development
DFID	Department for International Development
DRF	Development Results Framework
EDHS	Ethiopian Demographic Health Surveys
EECARO	UNFPA Eastern Europe and Central Asia Regional Office
EQ	Evaluation Question
ESARO	UNFPA East & Southern Africa Regional Office
FfA	UNFPA Framework for Action on Adolescents and Youth
FGAE	Family Guidance Association of Ethiopia
FHI	Family Health International
FLE	Family Life Education
GTP	Growth and Transformation Plan
GTP II	Second Growth and Transformation Plan
FGD	Focus Group Discussion
FGM/C	Female Genital Mutilation/Cutting
FP	Family Planning

GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
HLI	Higher Learning Institutions
HTP	Harmful Traditional Practices
HQ	UNFPA Headquarters
ICPD	International Conference on Population and Development
INGO	International Non-Governmental Organisation
IP	Implementing Partner
IRF	Integrated results framework
JP	Joint Programs
LAC	Latin America & the Caribbean
LACRO	UNFPA Latin America & the Caribbean Regional Office
LNWB	Leave No Woman Behind
M&E	Monitoring & Evaluation
MDG	Millennium Development Goal
MH	Maternal Health
MoE	Ministry of Education
MoF	Ministry of Finance
MoH	Ministry of Health
MoWCYA	Ministry of Women, Children and Youth Affairs
MoYS	Ministry of Youth and Sports, now MoWCYA
MTR	Mid-term Review of the UNFPA Strategic Plan (2012-2013)
NGO	Non-Governmental Organisation
PASDEP I	Plan for Accelerated and Sustained Development to End Poverty
PEPFAR	United States President`s Emergency Plan for AIDS Relief
PRS	Poverty Reduction Strategy
RO	UNFPA Regional Office
SDG	Sustainable Development Goal
SGBV	Sexual and Gender-Based Violence
SP I	UNFPA Strategic Plan 2008-2011
SP II	UNFPA Strategic Plan 2014-2017
SPA	Service Provision Assessment
SRH	Sexual and Reproductive Health

SWAp	Sector-Wide Approach
ToC	Theory of Change
ToR	Terms of Reference
TGW	Technical Working Group
UN	United Nations
UNCT	United Nations Country Team
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNGA	General Assembly of the United Nations
UNICEF	United Nations Children's Fund
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
VCT	Voluntary Counselling and Testing
WCARO	UNFPA West & Central Africa Regional Office
WHO	World Health Organisation
YFHS	Youth-Friendly Health Services

Structure of the case study note

Chapter 1, the introduction, outlines the purpose and objectives of the evaluation of UNFPA support to adolescents and youth 2008-2015 and the purpose and objectives of the country case studies. The chapter also sets out the scope of this particular case study.

Chapter 2 describes the methodology of the case study. It presents the case study selection rationale (process and criteria), case study design and case study process. It elaborates on data collection and analysis methods as well as limitations.

Chapter 3 presents the country context and background information to provide a better understanding of the context in which UNFPA interventions are designed and implemented in support of adolescents and youth.

Chapter 4 presents an overview of UNFPA response in the area of adolescents and youth in the country. The overview of the response by UNFPA describes the programmatic and financial support provided over the period under evaluation.

Chapter 5 on findings contains the main analysis supported by underlying evidence structured along the evaluation criteria and associated key evaluation questions and assumptions.

Chapter 6 presents action points for UNFPA Ethiopia for the area of adolescents and youth for the current and forthcoming programme cycle.

Chapter 7 presents key issues or considerations based on the findings of the case study to inform the overall aggregate analysis for the thematic evaluation.

The annexes include key country data, the stakeholder map, the portfolio of UNFPA adolescents and youth interventions, and the list of people and documents consulted.

1 Introduction

1.1 Purpose, objectives and scope of the evaluation of UNFPA support to adolescents and youth 2008-2015

The purpose of the evaluation is to assess the performance of UNFPA in its support to adolescents and youth during the period 2008-2015, falling under UNFPA Framework for Action on Adolescents and Youth and UNFPA Strategic Plan 2008-2013 (including the midterm review). The evaluation also provides key learning to contribute to the implementation of the current UNFPA Strategy on Adolescents and Youth 2012-2020 under the current UNFPA Strategic Plan 2014-2017 and to inform the development of the next Strategic Plan 2018-2021.

The primary objectives of the evaluation are:

- To assess how the frameworks, as set out in the UNFPA Strategic Plans 2008-2013 and 2014-2017, the UNFPA Framework for Action on Adolescents and Youth (implemented in 2007) and the UNFPA Strategy on Adolescents and Youth (2012), have guided the programming and implementation of UNFPA interventions in the field of adolescents and youth
- To facilitate learning, capture good practices and generate knowledge from UNFPA experience across a range of key programmatic interventions in adolescents and youth during the 2008-2015 period, in order to inform the implementation of relevant strategic plan outcomes and future interventions in the field of adolescents and youth.

The primary users of the evaluation are UNFPA staff at all levels, UNFPA public and private sector implementing partners, civil society organisations, policy makers and donors, as well as the end beneficiaries of UNFPA support. The results of the evaluation are also expected to be of interest and importance to other stakeholders and partners working on adolescents and youth in countries where UNFPA interventions are being implemented.

The evaluation covers the period 2008-2015, which corresponds to three programmatic periods embedded in three strategic planning documents: UNFPA Strategic Plan 2008-2011, Mid-term Review of the Strategic Plan 2012-13 and UNFPA Strategic Plan 2014-2017 as well as two adolescents and youth strategies (2006 and 2012). It takes stock of the evolution of UNFPA support to adolescents and youth since the deployment of the first adolescents and youth framework (2006) and analyses changes in focus, approaches and resource allocation.

The evaluation addresses the global, regional and country levels and considers both targeted and mainstreamed interventions in all UNFPA regions of operation. Thematic areas assessed include:

- Evidence-based advocacy for development, investment and implementation
- Sexual and reproductive health education and information for adolescents and youth
- Sexual and reproductive health services for adolescents and youth
- Initiatives to reach marginalised and disadvantaged adolescents and youth, especially girls
- Youth leadership and participation in policy dialogue and programming.

Particular attention is paid to the integration of cross-cutting issues such as gender equity, culturally sensitive and human rights-based approaches in UNFPA support to adolescents and youth.

The evaluation covers interventions directly relevant to adolescents and youth financed from core and non-core resources. It does not specifically focus on support to adolescents and youth in disaster, conflict or post-crisis settings.

The evaluation covers interventions directly relevant to adolescents and youth financed from core and non-core resources.

1.2 Objectives of the country case study

The purpose of the country case study is to provide a more in-depth analysis of adolescents and youth support at country level, identifying successes and challenges, and allowing to capture best practices. Country case studies illustrate the range and modalities of UNFPA support under the adolescents and youth component within a specific country context. Case studies represent a key source of data and inform and provide input to the thematic evaluation. The country case study does not constitute a programme level evaluation.

The case study focuses on three specific areas:

- Implementation of the UNFPA results framework at country level in the area of adolescents and youth. The case study assess how well global strategic priorities as defined in the UNFPA strategy documents have been translated into strategic priorities, actions and sustainable results at country level;
- Coordination and partnerships for programming at country level. The case study assesses whether regional and country coordination and partnerships in adolescents and youth has helped to develop country technical capacity, dialogue and a policy environment for advancing adolescents and youth issues in the country; and
- Support to countries from UNFPA Regional Offices and HQ. The case study assesses UNFPA regional office (RO) support for UNFPA country offices (COs) for the implementation of the adolescents and youth component.

1.3 Scope of the Ethiopia Case Study

This country case study covers UNFPA adolescents and youth interventions in Ethiopia during the period 2008 to 2015, with a stronger emphasis on recent years due to the learning aspect of the thematic evaluation of UNFPA support to adolescents and youth. It covers UNFPA in the area of adolescents and youth with a particular emphasis on activities and partners in Addis Ababa, Amhara and Afar, where site visits were undertaken for data collection purposes.

2 Methodology

2.1 Country case study selection

Case study selection was purposeful based on a multi-indicator needs assessment including health and development indicators for all UNFPA programme countries grouped by region to provide a general overview of the status of development in the country, and specifically, the situation of adolescents and youth.

UNFPA support covers six regions of intervention, namely: West and Central Africa; East and Southern Africa; Asia and the Pacific; Arab States; Eastern Europe and Central Asia and Latin America and the Caribbean.

Table 1: Multi-indicator needs analysis (no expenditure figures included)

Indicator	Weight
Gini Coefficient, 2003-2012	10%
Proportion of population 15-24 years (%), 2010	5%
Population of 15-24, both sexes, combined, 2010, estimates thousands	5%
Adolescent birth rate (number of births per 1,000 girls 15-19 years, national	12%
HIV prevalence (%), national, 2009	12%
Contraceptive prevalence (%), national	12%
Population with at least some secondary education (% aged 25 and above), female, 2005-2012	5%
Population with at least some secondary education (% aged 25 and above), male, 2005-2012	5%
Human Development Index, 2013	12%
Gender Inequality Index, 2013	12%
Government effectiveness, 2012, rank	10%

The health and development data was combined with programme expenditure on adolescents and youth programming to provide better insight into resource allocation relative to country needs.

Table 2: Multi-indicator analysis (expenditure figures included)

Indicator	Weight
Expenditure on adolescents and youth 2012-2013 (U6 code only)	20%
Expenditure on adolescents and youth 2008-2011	20%
Gini Coefficient, 2003-2012	6%
Proportion of population 15-24 years (%), 2010	3%
Population of 15-24, both sexes, combined, 2010, estimates thousands	3%
Adolescent birth rate (number of births per 1,000 girls 15-19 years, national	7.2%
HIV prevalence (%), national, 2009	7.2%
Contraceptive prevalence (%), national	7.2%
Population with at least some secondary education (% aged 25 and above), female, 2005-2012	3%
Population with at least some secondary education (% aged 25 and above), male, 2005-2012	3%
Human Development Index, 2013	7.2%
Gender Inequality Index, 2013	7.2%
Government effectiveness, 2012, rank	6%

Additional criteria further informed the purposeful selection of country case studies, which included:

- UNFPA country quadrant classification
- Recent country programme evaluation in the country
- Identification of case study implementation risks or limitations (example Ebola, crisis situation, no Representative in country, etc.)
- Existence of joint programmes in the area of adolescents and youth in the country
- Diversity of the programme/prongs or areas of the strategy implemented in the country
- Levels of programme implementation (national – regional and municipal level)
- Scale up or intensification of support in certain areas of adolescents and youth support
- Level of government support in the area of adolescents and youth
- Delivering as one modality
- Country case studies selected for a parallel corporate thematic evaluation

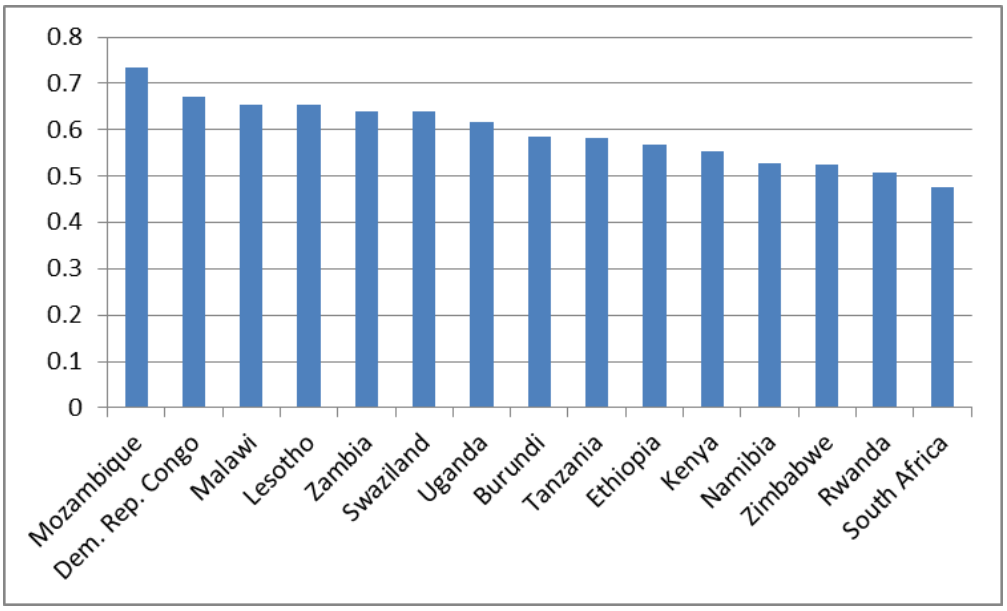
Furthermore, selected case studies should be illustrative for their respective regions as either a big country with a robust programme or a smaller country with greatest need.

Case study selection assessed need (as per selected indicators) and counter-weighted this ranking with UNFPA investment. Countries with greatest need and highest investment by UNFPA ranked highest. Qualitative

judgements were then made to select countries and regions that could offer a range of contexts, programmes and investment patterns (past versus present).

Ethiopia was selected for the Eastern and Southern Africa region. As per the needs indicator analysis (health and development indicators) in the table below, Ethiopia falls nearly in the bottom third of countries in terms of need (almost 2/3 of countries in the region have a higher need than Ethiopia).

Figure 1: Needs indicator analysis Eastern and Southern Africa region (no expenditure data)



When health and development indicators were combined with UNFPA investment data Ethiopia ranks as one of the programmes with highest investment by UNFPA (as per Figure 2) than most other countries in the region.

Figure 2: Needs indicator analysis Eastern and Southern Africa region (includes expenditure data)

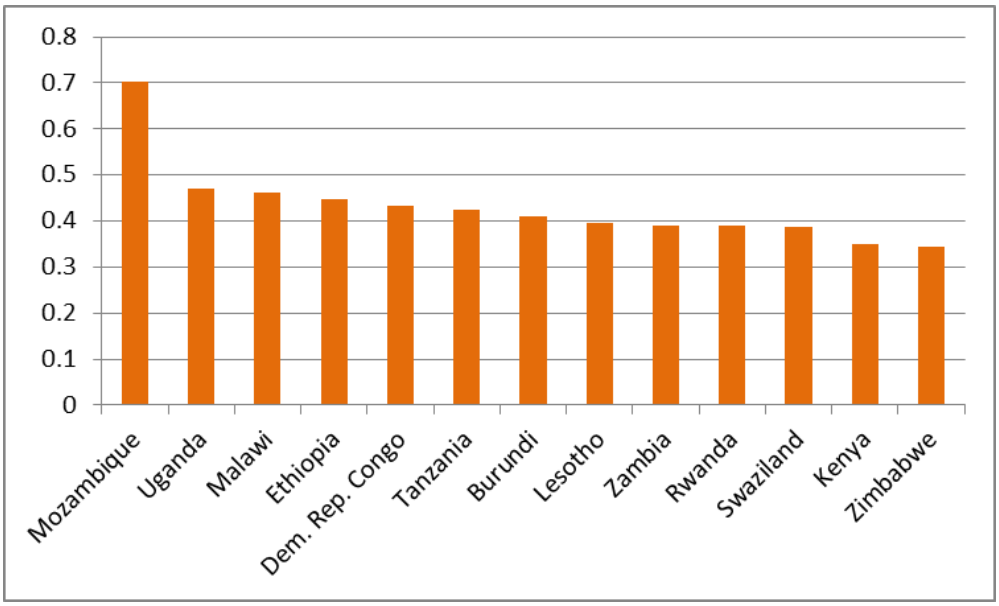


Table 3: Countries selected for case study visits

Countries selected for case study visits
Côte d'Ivoire (Western and Central Africa)
Egypt (Arab States)
Ethiopia (Eastern and Southern Africa)
Kyrgyzstan (Eastern Europe and Central Asia)
Nepal (Asia and the Pacific) – converted to desk study due to earthquake
Nicaragua (Latin America and the Caribbean)

UNFPA country quadrants - modes of engagement by setting

The country quadrant classification is a UNFPA system which groups countries on the basis of their ability to finance their own interventions and level of need. The model provides guidance for how UNFPA should engage in different country contexts (in a particular country).[1] In terms of country quadrant, Ethiopia falls within the red quadrant, meaning UNFPA support should focus on advocacy and policy dialogue/advice, knowledge management, capacity development and service delivery.

Table 4: UNFPA modes of engagement

UNFPA modes of engagement	
A/P	Advocacy and Policy Dialogue/Advice
KM	Knowledge Management
CD	Capacity Development
SD	Service Delivery

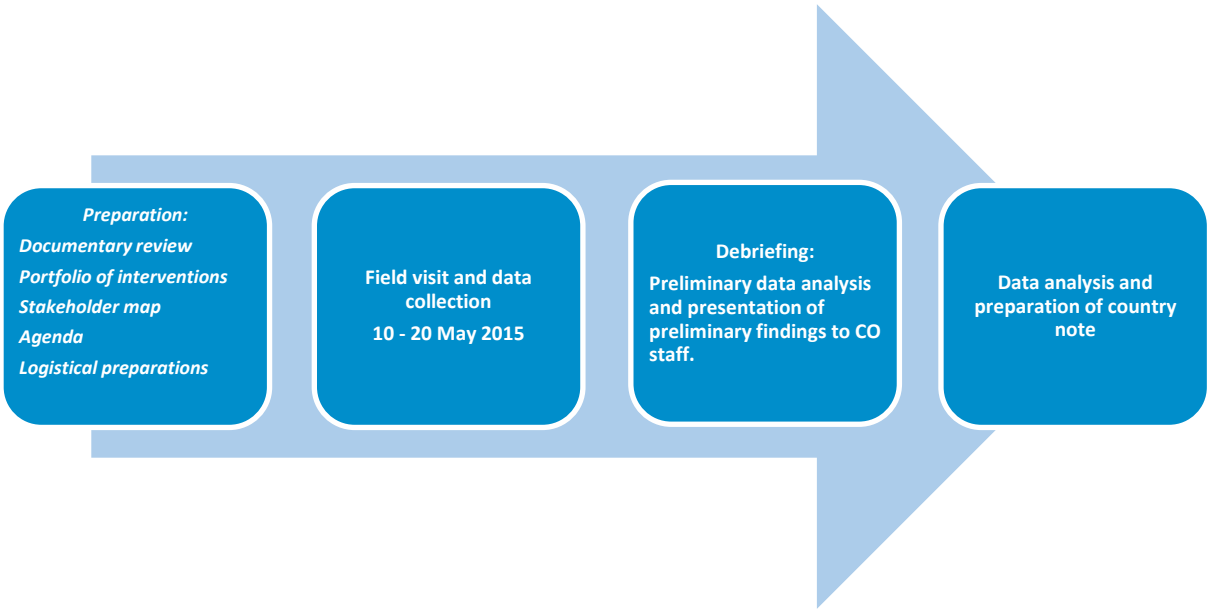
Table 5: UNFPA modes of engagement by country needs and income

Modes of engagement by country needs and income				
Ability to finance	**Level of Need**			
	Highest	High	Medium	Low
Low income countries	A/P, KM, CD, SD	A/P, KM, CD, SD	A/P, KM, CD	A/P, KM
Lower-middle income countries	A/P, KM, CD, SD	A/P, KM, CD	A/P, KM	A/P
Upper-middle income countries	A/P, KM, CD	A/P, KM	A/P	A/P
High income countries	A/P	A/P	A/P	A/P

[1] UNFPA Strategic Plan 2014-2017. For example, in countries that have the highest needs and low ability to finance their own interventions (coloured red in the matrix above), UNFPA should be prepared to offer a full package of interventions, from advocacy and policy dialogue/advice through knowledge management and capacity development to service delivery. However, in countries with low need and high ability to finance their own programmes (coloured pink in the matrix above), UNFPA should focus on advocacy and policy dialogue/advice.

2.2 Case Study Process

The case study was conducted in four stages:



1. *Preparation:* the team conducted a documentary review, including the portfolio of interventions and developed an updated stakeholder map (see Annex 2); and developed the agenda and logistical preparations in coordination with the country office.
2. *Data collection:* the team travelled to Ethiopia from the 10th to the 20th of May 2015 to conduct interviews, focus group discussions and site visits. At the outset, the evaluation team met with the UNFPA Ethiopia country office to inform staff about the purpose, objectives, scope and evaluation methodology, and to be briefed on UNFPA adolescents and youth-related activities. A discussion was also held on the country context with an assessment of how difficult it is to work on adolescents and youth issues (see Section 3.5). Following the briefing, interviews were conducted with UNFPA staff. The team subsequently divided into two sub-teams. Interviews and group discussions were conducted in Addis Ababa, Afar and Amhara.
3. *Debriefing:* Preliminary data analysis and presentation of preliminary findings at debriefing session at UNFPA Ethiopia country office (20th of May 2015); and
4. *Data analysis and preparation of the country note*: A review of preliminary findings, as well as further analysis and drafting of the country note was conducted in the subsequent weeks following the mission.

Data collection and analysis was undertaken by four evaluators, two international and two national consultants (including a youth).

2.3 Methodological framework

2.3.1 Methodological approach

The evaluation utilised a theory-based approach involving analysis of UNFPA planning documents and other strategic frameworks, which reflect the conceptual and programmatic approach taken by UNFPA, including the most important implicit assumptions underpinning the change pathways. These documents constitute the

aggregated results framework and contain the intervention logic and the strategy that have guided the goals of UNFPA support to adolescents and youth from 2008 to 2015. The theory of change of UNFPA support to adolescents and youth was reconstructed at the inception phase of the evaluation.[2] The evaluation team tested the theory of change in each country case study to assess the ways in which the UNFPA support adolescents and youth contributed to, or was likely to contribute to, change. The theory of change is reflected in the evaluation matrix[3], which presents the seven evaluation questions by evaluation criteria (relevance, effectiveness, sustainability, efficiency and added criteria of partnership, coordination and added value). It also lays out the assumptions underlying each evaluation question, the indicators associated with these assumptions, sources of information and sources and tools for data collection. The evaluation matrix for the thematic evaluation comprises three levels of analysis: national, regional and global. The country case studies address the national level of the evaluation matrix.[4] The evaluation questions and the underpinning assumptions are the same across all case studies, but indicators may vary given the specificities of each country determined by the country context and the specific UNFPA modalities of support.

The case study was inclusive, participatory, and integrated both gender equality and human rights perspectives[5]. The case study process was sensitive to gender, beliefs, culture and customs of all stakeholders. The team ensured a clear communication with stakeholders with respect to the case study's purpose, the criteria applied, and the intended use of the findings. The case study has ensured the participation of adolescents and youth as active members of the evaluation team and integrated the views and perspectives of beneficiaries. The voices of programme beneficiaries were captured by:

- Integrating adolescents and youth into the case study team (a youth leader for each field country case study)
- Conducting focus groups during country visits with beneficiaries

Evaluation questions and criteria are shown in Table 6 below.

[2] See inception report for the thematic evaluation.
[3] See inception report for the thematic evaluation.
[4] Some of the questions in the evaluation matrix contain a regional and global dimension. This is not addressed in case studies but rather in the evaluation report.
[5] In line with UNEG guidance.

Table 6: Evaluation questions and criteria

EQ	Evaluation Question	Evaluation criterion
EQ 1	To what extent was support to adolescents and youth, particularly the most marginalised and vulnerable, at global, regional and country levels, aligned with UNFPA policies and strategies, partner government priorities, plans and the needs of adolescents and youth and responsive to local contexts?	Relevance
EQ 2	To what extent have human rights, gender responsive and culturally sensitive approaches been incorporated into programming in the area of adolescents and youth at global, regional and national level? To what extent has UNFPA prioritised the most marginalised and vulnerable adolescents and youth, particularly young adolescent girls in its interventions?	Relevance
EQ 3	To what extent has UNFPA contributed (or is likely to contribute) to an increase and sustainability of the availability of sexual and reproductive health education and information and integrated services (including contraceptives, HIV and gender-based violence) for adolescents and youth?	Effectiveness, sustainability
EQ 4	To what extent has UNFPA contributed to evidence-based policies and programmes that incorporate the needs and rights of adolescents and youth? To what extent has UNFPA contributed to increasing priority for adolescent girls in national development policies and programmes?	Effectiveness, sustainability
EQ 5	To what extent has UNFPA contributed to increasing adolescents and youth leadership, participation and empowerment, especially for marginalised and vulnerable adolescents and youth, particularly adolescent girls?	Effectiveness, sustainability
EQ 6	To what extent were resources (human, financial, administrative) available, optimised and utilised to achieve the expected results in relation to UNFPA support to adolescents and youth?	Efficiency
EQ 7	To what extent has UNFPA provided leadership, coordinated effectively and established partnerships to advance adolescents and youth issues at global, regional and country levels? To what extent has UNFPA promoted South-South cooperation to facilitate the exchange of knowledge and lessons learned and to develop capacities in UNFPA programme countries for advancing adolescents and youth policies and programmes?	Partnership, coordination, added value

2.4 Approach to data collection and analysis

The case study followed a mixed-methods approach, consisting of the following data collection methods:

1. Document review: A thorough document review was conducted. Key sources included relevant UNFPA corporate strategies, country programme documents, the Country Programme Action Plan (CPAP), country office annual work plans (AWPs), annual reports (COARs), financial information, mid-term reviews, evaluations and monitoring data. Further, documentation such as training manuals developed in cooperation with implementing partners, was collected from stakeholders and reviewed during the field mission.

Documents were reviewed and relevant information was entered into a grid (extraction matrix). Additional documents collected while in Ethiopia were likewise entered and reviewed. National team members reviewed programme and technical materials to screen for gender-sensitive, informal and/or formal human rights language.

2. Interviews: The evaluation team met with UNFPA staff members; representatives of the UN country team (UNCT); donors; non-governmental, government representatives; and beneficiaries including adolescents and

youth leaders. Interviewees were selected purposely based on a stakeholder mapping (see Annex 2). Interviews were conducted using semi-structured in-depth methods.

3. Focus group discussions: conducted with adolescents and youth leaders.[6]

A total of 118 stakeholders were consulted including 60 adolescents and youth beneficiaries (see Table 7 and annexes). At the outset, stakeholders were informed about the evaluation and scope of interviewing and either written or oral consent was obtained. Interview guides are available in Volume II of the thematic evaluation.

4. Direct observation: Site visits were made in Addis Ababa, Amhara, and Afar. Sites were visited from a selection of services and implementing partners of UNFPA support, aiming to include both rural and urban locations and mix of cultural diversity. At the sites, youth-friendly clinics, community consultative forums and youth group gatherings were observed.

Table 7: Types and numbers of stakeholders consulted

Types and numbers of stakeholders consulted (n=118; A&Y =60)						
UNFPA	UN Staff	Government Partners	Donors	International NGOs	National NGOs, CSOs, Academia	A&Y Beneficiaries
8	**2**	**15**	**5**	**5**	**23**	**60**
Definition of categories: **UNFPA:** all UNFPA staff **UN Staff:** staff from any other UN organisations **Government Partners:** including local and central levels and service providers **Donors:** including bilateral donors and foundations **International NGOs:** including international NGOs and CSOs **National NGOs, CSOs and Academia:** national NGO, CSO or academic institution including universities **Adolescents and youth beneficiaries:** including adolescents and youth leaders, volunteers, and youth led organizations						

Methods for Data Analysis

The evaluation matrix guided data analysis for the case study. Data was structured under each evaluation question, assumption and indicator. Findings were formulated by triangulating evidence and organised under each assumption and question.

Qualitative and quantitative methods were utilized to analyse data. Evidence from data collection methods was coded and a country spread sheet was created (assisted by an evidence sorting database) allowing the systematic analysis of evidence by assumption in the evaluation matrix. Content analysis was used to identify emerging common trends, themes and patterns for each evaluation question. Content analysis was also used to highlight diverging views and opposing trends. Contribution analysis was applied using the reconstructed theory of change (ToC) and its pathways to assess UNFPA contribution to changes over the period. During the field

[6] See Volume II of the thematic evaluation for interview guides.

mission the theory of change was tested to understand influencing factors that contribute to changes. Alternative assumptions identified for each pathway of change.

Financial data was analysed to assess patterns of expenditure by modes of operation over the evaluation period. The financial analysis is separated into two distinct periods, 2008-2013 and 2014, given the changes in reporting since introduction of the GPS system in 2014.

Methods to ensure reliability and validity

Triangulation (cross-checking) of data from different sources and across methods was utilised to ensure reliability and credibility of findings. It was applied at all levels and included:

- Cross checking of different sources of information by comparing evidence generated through different stakeholder (UNFPA country office, ministries, civil society etc.)
- Cross checking evidence from different methods of data collection (document review, interviews, group discussions, direct observation)

Triangulation by different data collection methods is referenced in footnotes by listing the method and/or stakeholder category from which the information was derived. If only one method and/or stakeholder category is listed, then no less than three stakeholders from that category have shared the same or similar opinion.

The evaluation applied internal and external validation techniques. External validation consisted of a debriefing workshop in Ethiopia at the end of the field visit in which preliminary findings and action points were shared, discussed and validated with country office staff. The revision of the first draft of this report by the country office to identify factual errors and omissions was also part of the external validation process. Internal validation took place through a review process among evaluation team members and the Evaluation Office at the analysis workshop and during the production of draft versions of this country note.

Limitations and mitigation strategies

The main limitations of the case study as well as steps taken to mitigate are presented in table 8.

Table 8: Evaluation limitations and mitigation strategies

Evaluation limitations and mitigation strategies	
Limitation	**Mitigation strategy**
Observations of youth-friendly clinics were limited by the absence of youth clients in the centres as well as a lack of peer-education sessions at the time of the mission.	Although the evaluation team was not able to observe adolescents and youth in service or peer education sessions, discussions with adolescents and youth in focus groups and individual interviews informed evaluators about their perceptions of the services and education sessions. The relatively limited possibility to observe sessions may reflect their limited availability in some settings.

3 Situation analysis of adolescents and youth in Ethiopia

3.1 Demographics

Ethiopia is the second most populous country in Africa with an estimated population of over ninety million people in 2015[7]. With a current annual growth rate of 2.1 per cent, Ethiopia's population is projected to reach 125 million people by 2025 and 188 million people by 2050[8]. The country is known to be one of the least urbanised countries in the world with 83 per cent of the population living in rural areas. However, the current trend of urbanisation indicates that the rural population will decline to 62 per cent by 2050[9].

Ethiopia is characterised by a young demographic profile with 63 per cent of the population below the age of 25 years and over 30 per cent made up of 10-24 year olds[10].

3.2 Socio-economic context

Ethiopia is located in the centre of the Horn of Africa. Its land area of 1.14 million km^2[11] shares borders with the Sudan and South Sudan to the west; Eritrea to the North and Northeast; Djibouti and Somaliland to the East; and Somalia and Kenya to the South. A mosaic of cultural diversity with over 80 distinct cultural groups, Ethiopia's religious composition comprises 62.8 per cent Christians (43.5 per cent of the Ethiopian Orthodox Church and 19.3 per cent of other denominations); 33.9 per cent Muslims, 2.6 per cent traditional faiths and 0.6 per cent[12] others.

According to the 2011 Ethiopian Demographic Health Survey, despite relative improvement in educational enrolment in recent years, 17 per cent of 10-14 year olds, 18 per cent of 15-19 year olds and 39 per cent of those aged 20-24 years had no education[13]. Evidence suggests that family disapproval, inability to afford to send children to school and early marriage of girls are major factors that hamper school attendance[14]. The Demographic Health Survey showed that 25 per cent of adolescent girls aged 12-17 and 11 per cent of orphans live with neither of their parents,[15] indicating that they may need to work to meet their basic needs.

3.3 Political situation

The Ethiopian Constitution of 1994 is a fundamental document that provides the legal basis for adolescents and youth sexual and reproductive health. This document guarantees women's right to protection from harmful customs and calls for an end to practices that oppress women or cause them physical or mental harm[16]. Related to this, the revised National Penal Code and the relatively recent Family Law took important steps in protecting

[7]Document: Central Statistical Agency (CSA). Ethiopian population projection, Addis Ababa, June 2014
[8]Document: United Nations, Department of Economic and Social Affairs, Population Division (2014). World Urbanization Prospects: The 2014 Revision, Highlights (ST/ESA/SER.A/352).
[9]Ibid
[10]Document: CSA. Population and Housing Census Report, 2007, Addis Ababa, 2007
[11]Document: Federal Democratic Republic of Ethiopia, Ministry of Foreign Affairs [http://www.mfa.gov.et/]
[12]Ibid
[13]Document: CSA, Ethiopia Demographic and Health Survey: 2011,Central Statistical Agency Addis Ababa, Ethiopia, ICF International Calverton, Maryland, USA
[14]Document: UNFPA and UNICEF, Rights-Based Approach to Adolescent and Youth Development in Ethiopia: UNFPA and UNICEF Joint Program (2007-2011) Annual Progress Report, Jan 2010
[15] Document: UNFPA and UNICEF, Rights-Based Approach to Adolescent and Youth Development in Ethiopia: UNFPA and UNICEF Joint Program (2007-2011) Annual Progress Report, Jan 2010.
[16] Document: FDRE, Constitution of the Federal Democratic Republic of Ethiopia, Addis Ababa, 1994

the sexual and reproductive health of young people[17]. The revised Penal Code of Ethiopia, in particular, sets out concrete measures to address gender-based violence (GBV) and harmful traditional practices. Furthermore, it criminalises the act of rape and abduction, female genital mutilation and renders these acts punishable by law[18]. The revised Family Law has also set a minimum age of 18 years for marriage for girls and the Penal Code sets strong punishments for under-age marriages.

A number of policies such as the National Youth Policy of 2004[19], the adolescent sexual and reproductive health strategy of 2006[20] and the Education Policy and subsequent Education Development Strategies[21] have been enacted to translate provisions that articulate the sexual and reproductive health of adolescents and youth. These policy documents highlight the following issues related to adolescents and youth in Ethiopia:

- Young people have to contend with multiple socio-cultural, employment, recreational economic and educational determinants that impact upon their health and well-being[22];
- Vulnerable and disadvantaged young people (including girls, pastoralists, those infected or affected by HIV, out of school young people, those with physical and mentally impairment, orphans etc.) did not receive adequate attention[23];
- Poor participation of girls in education is determined by an array of economic, socio-cultural, familial, personal and school–related factors. The traditional practices of early and abduction marriages maintain the high prevalence of school dropout[24];
- Both young people out of school and those in higher education institutions are highly vulnerable to HIV and need to be prioritised within specific prevention programming using approaches including life-skills, peer education, school community conversation, youth leadership development, mass-media campaigns and to have enhanced access to youth-friendly sexual and reproductive health services[25].

3.4 Key adolescent and youth development partners in Ethiopia

The Youth Policy of 2004 outlines the need to engage diverse and multi-sectoral stakeholders, including civil society organisations, communities, families and young people themselves in its implementation to better meet the needs of young people[26]. Currently, in addition to government, several local and international stakeholders are engaged in working with and for adolescents and youth. UNFPA and the United Nations Children's Fund (UNICEF) provide support to the government's implementation of sexual and reproductive health programming for adolescents and youth, while the United States' President's Emergency Plan for AIDS Relief (PEPFAR) supports health of young people through Pathfinder, Save the Children and other implementing partners. Similarly, the governments of Norway and the Netherlands support youth programmes through implementing

[17] Documents: FDRE, Criminal Code of the Federal Democratic Republic of Ethiopia, May 2005, FDRE, Federal Negarit Gazetta of the Federal Democratic Republic of Ethiopia the Revised Family Code Federal Negarit Gazetta - Extra Ordinary Issue No. 1/2000 the Revised Family Code Proclamation No. 213/2008 Addis Ababa 4thDay of July, 2008

[18] Ibid

[19] Document: MoYS, National youth policy, ministry of youth, sport and culture, Addis Ababa, 2004

[20] Document: FDRE, MOH, National Adolescent & youth RH strategy: 2006-2015, Addis Ababa, 2006

[21] FMoE, Education Sector Development Program IV (ESDP IV): 2010/2011 – 2014/2015 2003 EC – 2007 EC: Program Action Plan, August 2010.

[22] Document: Mirgissa Kaba. Adolescent and Youth Sexual Reproductive Health in Ethiopia, October 2012

[23] Documents: MoYS, National youth policy, ministry of youth, sport and culture, Addis Ababa, 2004, FDRE, MOH, National Adolescent & Youth RH strategy:2006-2015, Addis Ababa, 2006

[24] Document: NEWA, Baseline Study Report conducted in four University within the program "Enhancement of Women`s and girl`s reproductive Health in Ethiopia" 2009

[25] Document: Tagebuer et al. Risky Behaviours and predisposing Factors among Ethiopian University Students, 2011

[26] Document: MoYS, National youth policy, ministry of youth, sport and culture, Addis Ababa, 2004.

partners such as Amref, Talent Youth Association, Family Guidance Association of Ethiopia (FGAE) and Youth Network for Sustainable Development (YNSD). Furthermore, the Packard Foundation's support to adolescent sexual and reproductive health is implemented through the Consortium of Reproductive Health Associations (CoRHA) and other youth-run organisations.

At the operational level, there is a multitude of national and international organizations that are implementing adolescent sexual and reproductive health projects and programmes, either in collaboration with the health sector or alone. FGAE, Pathfinder International, IPAS, Amref, and Talent Youth Association, for example, provide sexual and reproductive health services either in their own youth centres or integrated into public health facilities.

3.5 Key challenges and opportunities for adolescent and youth programming

During the briefing session at the start of the data collection mission, UNFPA staff, together with the evaluation team, discussed the country context related to legal, policy, regulatory, cultural, economic and political barriers to advocate for and implement adolescents and youth interventions in Ethiopia. After considering each factor, UNFPA staff came to a consensus as to the difficulty of working on adolescents and youth issues in Ethiopia and provided an overall rating (see Table 9).

It was found that while there are structural - legal, and policy - barriers, they were not major impediments to advancing adolescents and youth sexual and reproductive health in the country. Youth focused policies and strategies create a conducive work environment for UNFPA, with the government giving priority to addressing adolescent and youth development. Consensus was reached that generally the context was moderately restrictive with regional variations and dynamic changes in the last five years.

Table 9: Country context assessment

Country context assessment	
Factor	**Value Scale**
Laws, policies and regulations restrict adolescents and youth access to services *Value: 1*	3 = Heavily restrictive/ limiting 2 = Moderately restrictive / limiting; positive change has occurred in last 5 years 1= Not very restrictive / limiting; open to positive change 0 = Facilitative
Social, cultural, religious norms impede adolescents and youth access to information and services related to sexual and reproductive health *Value: 2*	
Economic, political, environmental or internal (crisis in government; war/conflicts; public health crisis; other) stress factors restrict adolescents and youth programme implementation directly or indirectly *Value: 3*	
Historical or current social, economic and ethnic discrimination of specific populations limits access to marginalised or vulnerable adolescents and youth groups *Value:3*	
Social, cultural, or religious restrictions on adolescents and youth (especially girls) participation limits meaningful engagement by adolescents and youth in programmes *Value:2*	

4 UNFPA support for adolescents and youth in Ethiopia

4.1 UNFPA programmatic support for adolescents and youth

During period under investigation, UNFPA has implemented two country programmes (CPs) - i.e., the sixth CP for 2007-2011 and the seventh CP for 2012 to 2015 (extended to mid-2016). The 2007-2012 country programme mainstreamed adolescents and youth within the gender equality and reproductive health and reproductive rights components. Important lessons learnt, based on the 2013 Programme and Review Planning Workshop[27] were translated into the following AWPs, whereby more attention was given to improving demand for youth friendly health services, as well as work on HIV prevention and sexual and reproductive health education and information in schools.

Adolescents and youth received a sharper focus in the draft of the country programme document (CPD) of 2016-2020 (to be presented in the first regular session in 2016), with a newly suggested outcome area specific to adolescent and youth (outcome 2) in addition to those on sexual and reproductive health, gender equality and women`s empowerment, and population dynamics. Outcome 2 has two outputs, namely Output 3, "Capacity of adolescents and young people strengthened to make informed decisions on their sexual and reproductive health and rights" and Output 4, "Institutional capacity strengthened to provide youth-friendly sexual and reproductive health services". The main modes of engagement are capacity development and service delivery; advocacy and policy dialogue activities are not explicitly described.

For the period under evaluation, joint programmes were the main mode of programming for adolescents and youth. Annex 3 provides a more detailed summary of the predominant activities undertaken related to adolescents and youth. The following joint programmes (Joint Programmes, see Box 2 - 6) were implemented within the time frame 2008-2012, and either explicitly targeted or mainstreamed attention to adolescents and youth and/or adolescent girls.

Box 1: Berhane Hewan (Light of Eve)

Berhane Hewan (Light of Eve) funded by Nike Foundation and UN Foundation
Pilot phase from 2004-2006, second phase from 2007-2011 with the following implementing partners: MoY, BoY, BoE, BOA, Population Council. The objective of the programme was to reduce the prevalence of child marriage, create safe social spaces for adolescent girls and to provide access to sexual and reproductive health services in rural Amhara region. Its overall goal was to establish appropriate and effective mechanisms to protect girls at risk of forced early marriage and support adolescent girls who are already married. Key interventions were community conversations, female mentorship programs, support for girls to remain in school, community based economic incentives and livelihood improvements, formal and non-formal education as well as group formation, and community awareness. Cross-sectional baseline and final survey results of the pilot phase showed significant delays in marriage and increase in school enrolment among girls aged 10-14 years. From 2011 until 2015, DFID partnered with the Government of Ethiopia to scale up this programme in the East and West Gojam Zones of the Amhara Region.

[27] Document: Programme Review and Planning Workshop (PRPW) in 2013.

Box 2: Joint Programme of UNFPA and World Food Programme on "Leave no Woman Behind"

Joint Programme of UNFPA and World Food Programme on "Leave no Woman Behind" funded by MDG Achievement Fund 2009-2013

Implementing partners: MoFED, MoWCYA, BoFED, BoWCYA, Regional Bureaus of Agriculture and Rural Development, Regional Bureaus of Cooperative Promotion Agency, Regional Bureaus of Education, Regional Bureaus of Health, Regional Bureaus of Women Children & Youth Affairs. The programme was a government-led initiative with sector ministries at sub-regional level implementing different components.

The core component was social mobilisation of women's groups promoting life skills training, RH/HIV and linkage to services, and livelihood support in two regions (Amhara and Tigray). Key interventions were community-based components in adult education, livelihood interventions and reproductive health services, including HIV/AIDS programming targeting adolescent girls and women. Capacity building of government implementing partners as well as of women and adolescent beneficiaries was the central strategy of the programme, as well as micro-finance schemes.

Box 3: Joint Programme of UNFPA and UNICEF on "Rights-Based Approach to Adolescent & Youth Development"

Joint Programme of UNFPA and UNICEF on "Rights-Based Approach to Adolescent & Youth Development" funded by Government of Norway (NORAD)

First phase from 2008-2013; second phase from 2014-2017 with the following implementing partners: MoWCYA and BoWCYAs, MoH and RHBs, FHAPCO, RHAPCOS, CSOs, 13 universities. Implementation covered six regions.

The first phase was implemented through both federal and five selected regional coordinating bodies as implementing partners with an emphasis on youth-focused capacity building, youth friendly service provision, promotion of youth participation, awareness building and by addressing socio-cultural factors that encourage prevailing risky behaviours. The programme's human rights-based approach focuses on improved capacity and strengthened livelihoods of rights holders and improved capacity of duty bearers (government, non-government bodies, parents and the wider community).

The second phase focuses on a human rights-based approach to adolescent and youth in 6 regions. The Joint Programme also addresses gender inequalities such as limited participation of young women and girls, access to sexual and reproductive health/HIV services and low economic empowerment through social protection, improving access to justice, livelihood opportunities. Key strategies for the programme are capacity building, community and religious institutions engagement, sexual and reproductive health education and information, adolescent sexual and reproductive health service provision including HIV. Modes of programme implementation include youth participation at policy and programmatic level.

Box 4: Joint Programme of UNFPA and UNICEF to "Accelerate Abandonment of FGM/C"

Joint Programme of UNFPA and UNICEF to "Accelerate Abandonment of FGM/C" funded through core funding

First phase was from 2008-2013, second phase from 2014-2017 with the following implementing partners: BoWCYAs and CSOs.

Ethiopia is one of 17 countries in which the Joint Programme is being implemented. The Joint Programme is implemented through the BoWCYA as well as various faith-based (Orthodox and Muslim) organisations in Afar Region, as well as at the federal level with regard to advocacy for the adoption of the National Harmful Traditional Practices (HTPs) Strategy.

Main objectives include a human-rights based approach in engaging communities to change laws, strengthen adolescents and youth-friendly reproductive youth centres with peer-educators and health care services, and initiate youth education activities through girls clubs, youth organisations and faith based organizations, and mass media dialogue.

Box 5: Flagship Joint Programme "Gender Equality and Women's Empowerment" (GEWE)

Flagship Joint Programme "Gender Equality and Women's Empowerment" (GEWE) funded by Ethiopia One UN Fund

Duration: 2011-2015, with 249 implementing partners.

The Joint Programme is co-led by UNFPA and UN WOMEN with distinct division of labour based on their mandates and strengths. The participating agencies contribute to Joint Programme goals through four outcome areas, each led by one organisation that coordinates the contributions of all organisations. These outcomes are:

- Women have increased income for improved livelihoods (lead organisation: ILO)
- Women and girls have increased access to opportunities for education, leadership and participation in local decisions making (lead: UNICEF)
- Federal and Local government institutions have increased their capacity to implement national and international commitments on gender equality and women's empowerment (lead: UN WOMEN)
- Federal and local level institutions and communities have enhanced their capacity to promote and protect the rights of women and girls (lead: UNFPA)

UNFPA in Ethiopia has worked with a number of international and national partners over the years. According to the draft eighth CPAP, "UNFPA will execute the programme through federal and regional government structures, academia, the private sector and civil society organisations"; youth-led organisations are not explicitly mentioned. For the previous country programme, UNFPA has implemented its adolescents and youth programme in support of and together with the Ministry of Health (MoH), the Ministry of Women Children and Youth Affairs (MoWCY), the National Statistics Committee (NSC) as well as national and international NGOs, including faith-based organisations (FBOs). UNFPA has closely collaborated and coordinated with other UN organisations such as UNICEF and the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) under the respective UN Development Assistance Frameworks (UNDAF).[28]

[28] Documents: UNFPA, "Country Programme for Ethiopia," (New York2006); "Draft Country Programme Document for Ethiopia," (New York2011); "Draft - Country Programme Document for Ethiopia," (2015).

4.2 Financial support for adolescents and youth in Ethiopia

The sixth UNFPA CPD 2007-2011 envisaged assistance for Ethiopia (both regular and other resources) in the amount of USD 96.25 million, of which USD 53.05 million was budgeted for reproductive health and USD 34.20 million for population and development strategies.[29] Proposed indicative assistance for Ethiopia for the current cycle 2012-2015 (extended to mid-2016) is a total of USD 85 million, with USD 52 million budgeted for reproductive health and reproductive rights, USD 16.6 million for population and development, and USD 15.6 million set aside for gender equality.[30,31] The Country Programme Document does not indicate an amount for adolescents and youth support specifically as such a budget line was only introduced for Country Programme Documents developed under the 2014-2017 SP.

For resource allocation purposes, in 2014, UNFPA categorised programme countries into "colour quadrants" based on the combination of need and ability to finance.[32] Ethiopia is classified within the "red" quadrant, with high unmet need and low ability to finance (Table 5). For red quadrant countries UNPFA offers a full package of interventions, engaging through advocacy and policy dialogue/advice, knowledge management, capacity development and service delivery.[33]

Based on an analysis of UNFPA financial data from Atlas, including the Global Programming System (GPS) module,[34] Table 10 illustrates the evaluation of expenditure on adolescents and youth under project outcome codes (regular and other resources) in Ethiopia. From 2008 to 2013, the large majority of adolescents and youth expenditure was tagged under a range of U-codes, with expenditure under U6 (the adolescents and youth specific code) being the one with the highest level of expenditure. For 2014, adolescent and youth expenditure fell under outputs 1,3, 4, 6, 7, 8, 10, 11, 14, and 15, with the majority falling under output 3 (see Table 11).[35]

[29] Document: UNFPA (2006). Country programme for Ethiopia. New York.
[30] Document: UNFPA (2015). "Draft - Country programme document for Ethiopia."
[31] For the 2012-2015 programme cycle, Ethiopia was categorized as a "red country" for resource allocation purposes.
[32] The following indicators were used to determine need classification under the 2014-2017 SP: Proportion of births attended by skilled health personnel for the poorest quintile of the population; maternal mortality ratio; adolescent fertility rate; proportion of demand for modern contraception; HIV prevalence, 15-24 year olds; Gender Inequality Index. Document: UNFPA Strategic Plan 2014-2017, Annex 4 on Funding Arrangements.
[33] Document: UNFPA Strategic Plan, 2014 – 2017.
[34] For further information on Atlas and GPS coding and tagging as well as the methodology applied for the financial analysis, please see the background note in Annex 4.
[35] In order to capture expenditure in support of A&Y in 2014, the following methodology was used: 1) All expenditure that fell under SP Output 6, 7, and 8 was included as expenditure in support of A&Y and 2) to capture expenditure in support of A&Y that is mainstreamed across other outputs, a keyword search was performed (derived from a literature review and an initial cursory analysis of data in July 2014). For more information on the methodology, please see Anne 4.

Table 10: Expenditure in USD per project outcome code (in Atlas)/output code (in GPS) 2008-2014

Expenditure in USD per project outcome code (in Atlas)/output code (in GPS) 2008-2014[36]								
Project outcome code	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**Grand Total**
G102	$374,066.69	$263,356.10	$325,391.10	$332,918.80	$0.01			$1,295,732.70
U2			$54,451.47	$168,293.08	$121,545.44	$150,976.86		$495,266.85
U3				$13,514.11				$13,514.11
U4					$44,654.62	$44,989.21		$89,643.83
U5		$0.00	$0.00	$204,717.40	$515,445.16	$203,239.30		$923,401.86
U6	$663,858.84	$2,502,896.90	$1,868,492.86	$1,960,840.65	$524,144.47	$753,447.48		$8,273,681.20
U7					$29,823.52	$28,640.59		$58,464.11
All 2014-2017 SP outputs under which adolescents and youth expenditure fell in 2014							$8,784,061.07	$8,784,061.07
Grand Total	**$1,037,925.53**	**$2,766,253.00**	**$2,248,335.43**	**$2,680,284.04**	**$1,235,613.22**	**$1,181,293.44**	**$8,784,061.07**	**$19,933,765.73**

G102: Women's Empowerment Advocacy; **U2:** Increased access to and utilisation of quality maternal and new born health services; **U3:** Increased access to and utilization of quality family planning services for individuals and couples according to reproductive intentions; **U3:** Increased access to and utilization of quality family planning services for individuals and couples according to reproductive intentions; **U4:** Increased access to and utilization of quality HIV- and STI-prevention services especially for young people (including adolescents) and other key populations at risk; **U5**: Gender equality and reproductive rights advanced particularly through advocacy and implementation of laws and policy; **U6:** Improved access to sexual and reproductive health services and sexuality education for young people (including adolescents); **U7:** Improved data availability and analysis around population dynamics, sexual and reproductive health (including family planning) and gender equality; **All SP Outputs 2014-2017 under which A&Y expenditure fell in 2014**: **SP Output 1:** Increased national capacity to deliver integrated sexual and reproductive health services; **SP Output 2:** Increased national capacity to strengthen enabling environments, increase demand for and supply of modern contraceptives and improve quality family planning services that are free of coercion, discrimination and violence; **SP Output 3:** Increased national capacity to deliver comprehensive maternal health services; **SP Output 4:** Increased national capacity to deliver HIV programmes that are free of stigma and discrimination, consistent with the UNAIDS unified budget results and accountability framework (UBRAF) commitments; **SP Output 5:** Increased national capacity to provide sexual and reproductive health services in humanitarian settings; **Output 6**: Increased national capacity to conduct evidence-based advocacy for incorporating adolescents and youth and their human rights/needs in national laws, policies, programmes, including in humanitarian settings; **SP Output 7**: Increased national capacity to design and implement community and school based comprehensive sexuality education (CSE) programmes that promote human rights and gender equality; **SP Output 8:** Increased capacity of partners to design and implement comprehensive programmes to reach marginalized adolescent girls including those at risk of child marriage; **SP Output 10:** Increased capacity to prevent gender-based violence and harmful practices and enable the delivery of multisectoral services, including in humanitarian settings; **SP Output 11:** Strengthened engagement of civil society organizations to promote reproductive rights and women's empowerment, and address discrimination, including of marginalized and vulnerable adolescents and youth (Engagement of CSOs); **SP Output 14:** Strengthened capacity for the formulation and implementation of rights-based policies (global, regional and country) that integrate evidence on population dynamics, sexual and reproductive health, HIV, and their links to sustainable development; **SP Output 15:** Strengthened national capacity for using data and evidence to monitor and evaluate national policies and programmes in the areas of population dynamics, sexual and reproductive health and reproductive rights, HIV, adolescents and youth and gender equality, including in humanitarian settings.

Table 11: 2014 Adolescents and youth expenditure (in USD) by SP output

2014 A&Y expenditure (in USD) by SP output (under the 2014-2017 Strategic Plan)	
Outcome/Output	**Expenditure**
SP Outcome 1, Output 3	$4,297,277.74
SP Outcome 4, Output 15	$1,537,103.20
SP Outcome 1, Output 1	$1,423,205.65
SP Outcome 2, Output 6	$696,611.04
SP Outcome 1, Output 4	$265,544.07
SP Outcome 3, Output 10	$162,700.29
SP Outcome 2, Output 8	$111,144.01
SP Outcome 1, Output 5	$107,676.80
SP Outcome 2, Output 7	$103,818.93
SP Outcome 1, Output 2	$50,273.31
SP Outcome 3, Output 11	$28,674.87
SP Outcome 4, Output 14	$31.16
Grand Total	**$8,784,061.07**

Source: Atlas (GPS) data.

Table 12 and figure 3 compare the amount budgeted with the amount spent in support of adolescents and youth by UNFPA Ethiopia for the period 2008-2014. The total expenditure amounted to approximately USD 20 million with the highest level of expenditure registered in 2014. Data indicates annual expenditure ranging from just over USD 1 million (2008, 2012 & 2013) to over 8 million USD in 2014 with high implementation rates for the later years. Overall, adolescents and youth expenditure accounted for roughly 18 per cent of total programme expenditure for 2008 to 2014.[37]

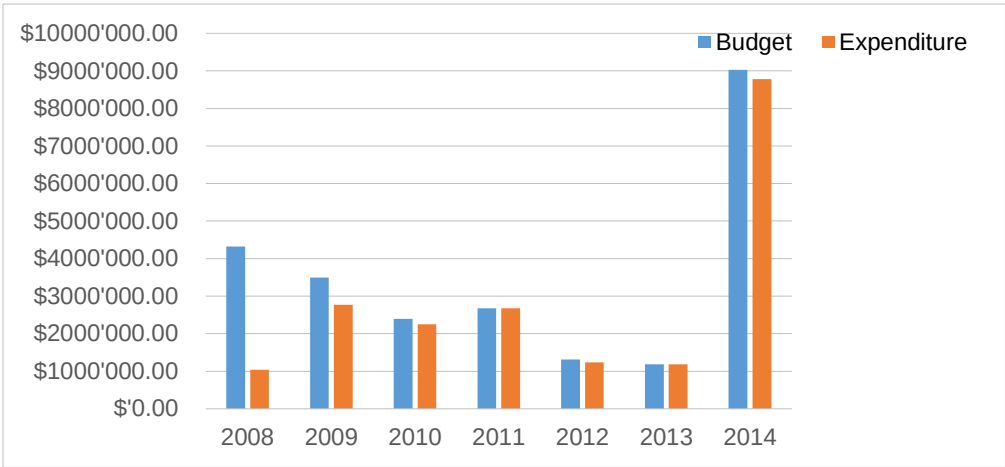
Table 12: Annual budgets and expenditure in support of adolescents and youth 2008-2014 (USD)

Annual budgets and expenditure in support of adolescents and youth 2008-2014 (USD)			
Year	**Budget**	**Expenditure**	**Execution rates**
2008	$4,319,805.00	$1,037,925.53	24.0%
2009	$3,492,735.00	$2,766,253.00	79.2%
2010	$2,393,578.04	$2,248,335.43	93.9%
2011	$2,672,017.38	$2,680,284.04	100.3%
2012	$1,309,416.82	$1,235,613.22	94.4%
2013	$1,186,838.34	$1,181,293.44	99.5%
2014	$9,028,713.91	$8,784,061.07	97.3%
Grand Total	**$24,403,104.49**	**$19,933,765.73**	**81.7%**

Source: UNFPA Evaluation Office based on Atlas (GPS) data.

[37] Total country office (CO expenditure) from 2008-2013: $89,152,010.00 (Source: Atlas dataset generated June 10, 2014). Total CO expenditure for 2014: $19,666,337.67 (Source: Atlas GPS dataset generated in September 2015). Summing the two figures, total CO expenditure for 2008-2014: $108,818,347.85. Note that 2008-2011 CO expenditure data was added to 2012-2013 CO expenditure data and 2014 CO expenditure data to arrive at an estimate of total CO expenditure for 2008-2014. However, expenditure figures from 2008-2011 are not directly comparable to figures from 2012-2013 or 2014 due to changes in UNFPA accounting procedures and coding (with the introduction of the new SP in 2012 and another in 2014). Though this is the case, estimates can still be made.

Figure 3: Adolescents and youth budget and expenditure 2008-2014



Source: UNFPA Evaluation Office based on Atlas (GPS) data.

Table 13 shows that UNFPA has very successfully mobilised other resources from a range of donors for adolescents and youth programming during the period of investigation (roughly 89 per cent of total adolescents and youth expenditure), with Norway contributing the highest amount (since 2008). For every year, the amount of other resources surpassed available regular resources.

Table 14 indicates annual expenditure by implementing partner including UNFPA and its numerous (42) governmental and non-governmental implementing partners (IPs) between 2008 and 2014. It reveals that UNFPA has directly implemented 22 per cent of resources for adolescents and youth programming and that, over the period of investigation, the Ministry of Health was its most significant implementing partner by level of expenditure, followed by the Amhara Bureau of Finance & Economic Development and the Population Council.

Table 13: Source of adolescents and youth expenditure 2008-2014 (USD)

Source of A&Y expenditure 2008-2014 (USD)								
Funding Source	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**Total**
Norway	$663,858.84	$2,502,896.90	$1,868,492.86	$1,960,840.65	$395,278.30	$584,586.16	$780,731.38	$8,756,685.09
UNFIP	$374,076.26	$263,356.10	$325,391.10	$93,784.13	$0.01			$1,056,607.60
UNDP - MPTF				$51,643.06	$438,476.77	$78,151.90	$403.94	$568,675.67
UN Women				$239,134.67		$2,383.35		$241,518.02
Joint Programme-UNFPA: Administrative Agent				$75,567.02	$70,024.06	$7,991.99	$156,087.61	$309,670.68
Republic Of Korea						$100,000.00		$100,000.00
Spain	-$9.57			$29,810.24	$506.78	$35,583.40		$65,890.85
Netherlands					$3,354.69	$5,492.61	$138,207.62	$147,054.92
Small contributions						$25,665.18	$15,560.00	$41,225.18
Gates Foundation					$12,163.76			$12,163.76
Swedish UN Association							$6,638.02	$6,638.02
OCHA							$1,000.00	$1,000.00
Sweden					$180.00		$37,959.75	$180.00
TTF – Multi Donor							$3,585,096.08	$3,585,096.08
Japan							$702,012.09	$702,012.09
United Kingdom							$28,674.87	$28,674.87
Total other resources (earmarked)	$1,037,925.53	$2,766,253.00	$2,193,883.96	$2,450,779.77	$919,984.37	$839,854.59	$5,452,371.36[38]	$15,661,052.58
Total regular resources (not earmarked)			$54,451.47	$229,504.27	$315,628.85	$341,438.85	$3,331,697.51	$4,272,720.95
Grand Total	**$1,037,925.53**	**$2,766,253.00**	**$2,248,335.43**	**$2,680,284.04**	**$1,235,613.22**	**$1,181,293.44**	**$8,784,068.87**	**$19,933,773.53**

Source: UNFPA Evaluation Office based on Atlas (GPS) data.

[38] Does not include negative amounts (i.e. the amount of $-7.80 spent by Italy)

Table 14: Expenditure by implementing agency 2008-2014 in USD

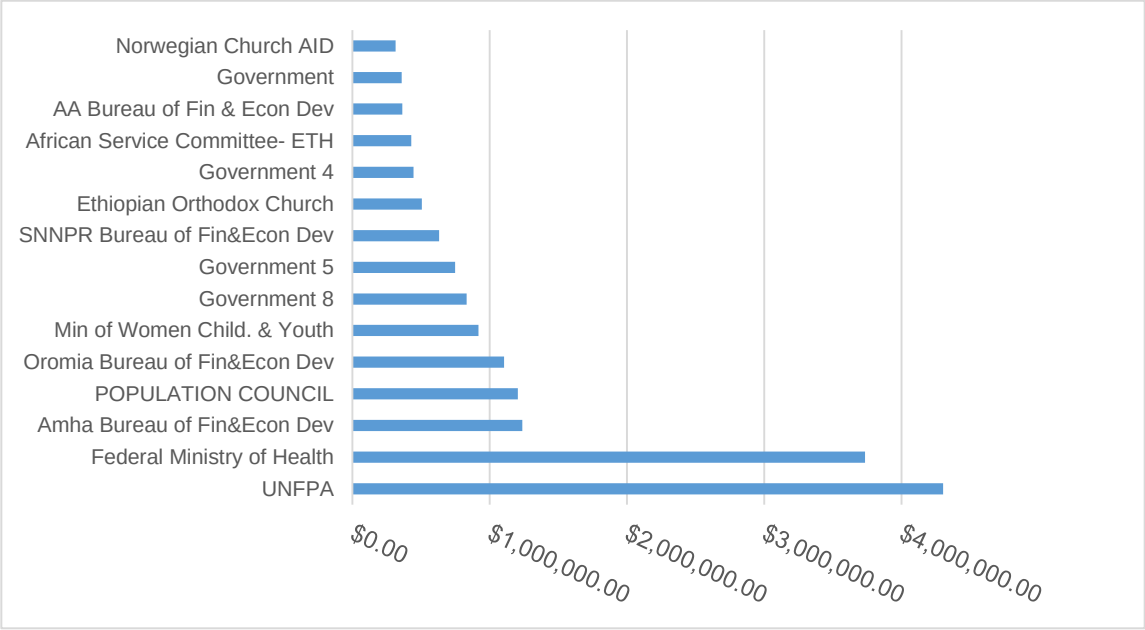
Expenditure by implementing agency 2008-2014 in USD								
Implementing Agency	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**Grand Total**
UNFPA	$717,594.88	$153,058.73	$369,439.93	$155,064.70	$184,259.57	$127,370.00	$2,596,670.02	$4,303,457.83
POPULATION COUNCIL	$135,074.10	$655,022.97	$43,117.46	$212,402.94	$159,449.26			$1,205,066.73
Amha Bureau of Fin&Econ Dev				$637,091.23	$40,919.07	$36,855.97	$523,085.17	$1,237,951.44
Min of Women Child. & Youth				$139,471.21	$484,742.75	$191,690.67	$102,364.00	$918,268.63
Government 8	-$1,471.58	$420,459.70	$408,433.57	$5,742.96				$833,164.65
Government 5	-$5,864.15	$402,880.90	$325,605.02	$25,408.86	$3.08			$748,033.71
Oromia Bureau of Fin&Econ Dev				$373,268.43	$25,367.91	$79,538.83	$626,604.21	$1,104,779.38
Ethiopian Orthodox Church	-$953.76	$105,653.61	$64,025.44	$58,709.77	$90,378.73	$142,538.29	$44,451.45	$504,803.53
Government 4	-$107.13	$342,382.54	$102,447.19	$56.48				$444,779.08
African Service Committee-ETH			$181,804.59	$248,900.05	-$1,675.60			$429,029.04
Government	$195,996.27	$109,150.86	$53,500.00					$358,647.13
Norwegian Church AID					$81,707.03	$217,928.73	$14,583.33	$314,219.09
SNNPR Bureau of Fin&Econ Dev				$96,416.96	$14,766.82	$73,700.44	$447,439.51	$632,323.73
Anti- Malaria Association		$97,105.22	$103,779.14	$83,067.70				$283,952.06
AA Bureau of Fin & Econ Dev				$219,823.09	$8,314.64	$1,422.51	$132,884.41	$362,444.65
Government 10	-$1,556.73	$120,473.01	$141,564.25	$4,269.71	$0.03			$264,750.27
African AIDS Initiative Intern			$42,413.22	$179,236.39			$39,995.19	$261,644.80
Government 18			$222,938.76	$2,754.63				$225,693.39
Afar Bureau of Fin&Econ Dev				$102,360.01	$10,278.03	$16,768.45	$47,962.64	$177,369.13
Government 9	-$308.47	$53,830.01	$101,245.22	$0.00				$154,766.76
Federal Ministry of Health				$18,863.76	$63,677.29	$66,507.26	$3,585,096.08	$3,734,144.39
Intergrated Service for AIDS S		$36,730.06	$67,151.72	$39,041.65				$142,923.43

Afar Bureau Wom Child&Youth				$69,417.15	$67,146.11			$136,563.26
German Foundation for World Po						$115,569.62		$115,569.62
Government 29		$112,723.53	$1,824.54	$0.00				$114,548.07
DKT ETHOPIA						$100,516.78		$100,516.78
Government 1	-$477.90	$73,798.17	$8,003.11	$34.45				$81,357.83
Fed HIV/AIDS Prev & Cont Off							$77,698.05	$77,698.05
Tigray Bureau of Fin&Econ Dev				$2,732.04	$2,923.81	$3,009.93	$227,321.91	$235,987.69
Org for Social Svcs AIDS-ETH							$65,055.84	$65,055.84
International Medical corps		$46,191.90					$1,000.00	$47,191.90
Government 30		$36,791.79						$36,791.79
Afar Pastoralist Development		$0.00		$6,149.87			$25,334.20	$56,818.27
Mejjejego Leko-ETH						$7,864.28	$5,088.91	$12,953.19
Government 2			$11,042.27					$11,042.27
Ethiopian Muslims Dev't Agency							$49,277.37	$49,277.37
Oromia Development Assoc-ETH						$0.00	$5,848.11	$5,848.11
Mary Joy-ETH					$3,354.69			$3,354.69
Health,Dev't & AntiMalaria Ass							$76,700.50	$76,700.50
Mother & Child Rehab. Centre						$11.68	$77,309.23	$77,320.91
Amhara Devel Assoc-ETH							$1,054.69	$1,054.69
Adama University							$4,873.47	$4,873.47
Jimma University							$6,362.78	$6,362.78
Grand Total	**$1,037,925.53**	**$2,766,253.00**	**$2,248,335.43**	**$2,680,284.04**	**$1,235,613.22**	**$1,181,293.44**	**$8,784,061.07**	**$19,933,765.73**

Source: UNFPA Evaluation Office based on Atlas (GPS) data.

Figure 4 presents the top 15 implementing agencies by adolescents and youth expenditure for the years 2008-2014.

Figure 4: Top 15 implementing agencies by adolescents and youth expenditure 2008-2014



Source: Atlas (GPS) data.

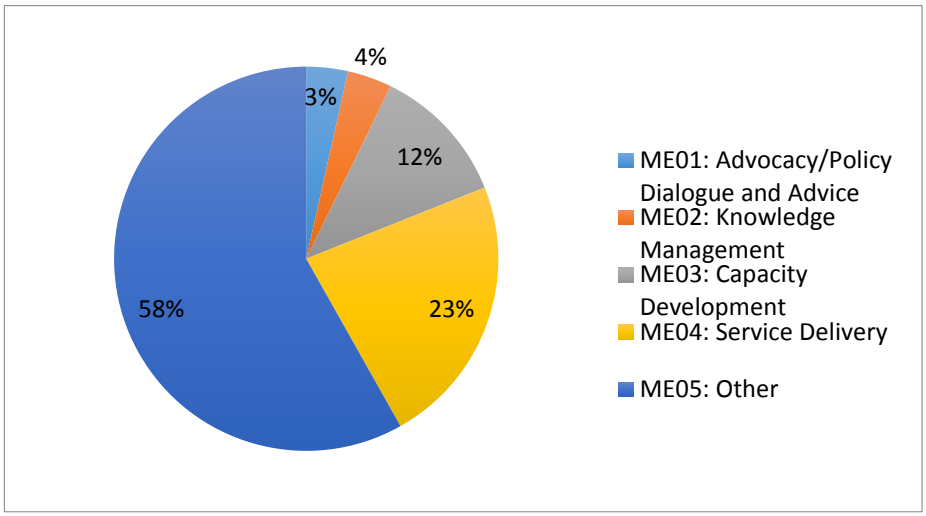
As a "red" quadrant country, priorities for Ethiopia are advocacy and policy dialogue/advice, knowledge management, capacity development, and service delivery. Table 15 captures the amount spent in 2014 under all strategic plan outputs identified as expenditure in support of adolescents and youth by mode of engagement, a category introduced in the 2014-17 strategic plan. Spending was the highest for the mode of engagement category "other" at approximately 5 million USD or 58 percent of total spending, followed by "service delivery" (2 million USD or 23 per cent of adolescents and youth spending) and "capacity development" (1 million USD or 12 per cent of adolescents and youth spending). Figure 5 illustrates percentage of adolescents and youth expenditure in 2014 by mode of engagement for Ethiopia.

Table 15: Adolescents and youth expenditure by mode of engagement for 2014 in USD

Adolescents and youth expenditure by mode of engagement for 2014 in USD	
Mode of engagement	**Expenditure**
ME05: Other	$5,109,371.19
ME04: Service delivery	$2,009,053.90
ME03: Capacity development	$1,028,109.52
ME02: Knowledge management	$329,775.85
ME01: Advocacy/policy dialogue and advice	$307,750.61
Grand Total	**$8,784,061.07**

Source: Atlas (GPS) data.

Figure 5: Adolescents and youth expenditure in 2014 by mode of engagement (USD) for Ethiopia



Source: UNFPA Evaluation Office based GPS data.

5. Findings

5.1 Relevance

EQ1. To what extent was support to adolescents and youth, particularly the most marginalised and vulnerable, aligned with UNFPA policies and strategies, partner government priorities, plans and the needs of adolescents and youth and responsive to local contexts?
Summary of findings
In terms of internal alignment, the adolescents and youth component of the country programme is generally consistent with goals and strategies outlined within the 2008-2014 UNFPA Strategic Plan, the 2006 Adolescents and Youth Framework and the 2012-2020 Adolescents and Youth Strategy. UNFPA technically and financially supported the drafting of several strategies and guidelines with relevance to adolescents and youth, for example the National Minimum Standard for Youth Friendly Services. UNFPA support corresponds to the needs of adolescents and youth as identified in plans and strategies by central and local government levels. Relevance of the UNFPA programme was favourably perceived by different stakeholders because of its focus on adolescents and youth. However, UNFPA attention to specific adolescents and youth needs such as youth leadership and participation as well as sexual and reproductive health education and information were less well recognised by stakeholders. UNFPA has been responsive to changes in government priorities, to emerging adolescents and youth needs and to contextual changes. In general, UNFPA was seen to be flexible and responsive within the framework of the UNDAF, due in large part to its ability to accommodate changing priorities/needs within a dynamic context.

5.1.1 Alignment of UNFPA support with UNFPA policies and strategies in the area of adolescents and youth[39]

Analysis of country programme documents indicates that UNFPA Ethiopia attempted to align its adolescents and youth programme with the relevant UNFPA SP of the period.[40] The country programme document (2012-mid 2016) specifically mentions adolescents and youth in the context of strategies for the provision of user-friendly health services and high quality HIV prevention services. Young people are included as an intended target under the gender component, related to female genital mutilation and sexual and reproductive health education and information and services. In the area of population and development, adolescents and youth are not specifically targeted.

[39] Evaluation assumption 1.1.

[40] For the period under evaluation two CPDs (2007 – 2011 and 2012 – 2015, extended until mid 2016) were available for analysis. There is evidence that UNFPA attempted to align its A&Y support to the strategic plans. Both these CPDs were developed prior to the release of the UNFPA SP of 2014 – 2017, the UNFPA Strategy on Adolescents and Youth, and the Midterm Review of the UNFPA Strategic Plan[40], and thus can only be considered against the UNFPA strategic plan of 2008 – 2011.

The sixth country programme of 2007 – 2011 is aligned with the UNFPA SP, especially in its planned support of adolescent sexual and reproductive health services (outcomes 2.4 and 2.5.[41]) It also includes attention to promoting the legal rights of women and girls and reducing harmful practices, focusing on female genital mutilation, abduction and early marriage, which demonstrate alignment with SP outcomes 3.1 and 3.2.[42] However, there is no discussion of GBV services for adolescents and youth or sexual and reproductive health education and information (both of which are also nested under outcome 2.5 of the SP.) Furthermore, work to build technical capacity of national government and implementing partners for collection and use of age-disaggregated data to inform adolescents and youth programming is weak, indicating poor alignment with SP outputs 1.2 and 1.3.[43] In contrast, the 2007 – 2011 country programme action plan results and resource framework describes a range of activities aimed at adolescents and youth, which, in addition to a strong focus on sexual and reproductive health services, includes attention to life skills education in teacher training curricula and adolescents and youth participation and leadership.[44]

Similarly, in the area of adolescents and youth programming, the subsequent (seventh) country programme of 2012 – 2015/16 contains a strong focus on sexual and reproductive health services, with increased availability of high quality HIV prevention services for young people listed as an independent output of the sexual and reproductive health component of the programme.[45] Furthermore, adolescents and youth are included as beneficiaries of other outputs, including those focused on demand creation for family planning information and services, behaviour change communication strategies, and increased availability of HIV prevention services.[46] Within the gender component, adolescent and young women are also targeted by two outputs focused on increasing capacity to claim their rights for information and services, and reduction of harmful practices and GBV, although the latter does not list any specific strategies for targeting adolescent girls.[47] Thus, both country programmes show alignment with the UNFPA SP against goals 2 and 3 (reproductive health and reproductive rights and gender equality respectively), but less so against goal 1 (population and development).

The seventh country programme also enacted the strategic impetus of "Delivering as One UN" by adopting joint programming as a key strategy for maximising impact. All joint programmes in the country portfolio address adolescents and youth, with a special focus on most vulnerable and marginalised girls aged 10-14 years.

No country programme evaluation of the sixth or seventh country programmes was conducted. However, within the frame of the current drafting of the eighth country programme, a summary report of thematic evaluations under the sixth and seventh country programmes was conducted in 2015.[48] The programmatic recommendations were translated into the draft of the eighth country programme document.[49] The draft

[41] 2.4: Demand, access to and utilisation of quality HIV and STI prevention services, especially for women, young people, and other vulnerable groups, including populations of humanitarian concern increased. 2.5: Access of young people to sexual and reproductive health, HIV and gender-sensitive life skills-based sexual and reproductive health education improved as part of a holistic multisectoral approach to young people's development

[42] 3.1: Gender equality and the human rights of women and adolescent girls, particularly their reproductive rights, integrated in national policies, development frameworks and laws. 3.2: Gender equality, reproductive rights and the empowerment of women and adolescent girls promoted through an enabling sociocultural environment that is conducive to male participation and the elimination of harmful practices.

[43] 1.2: Young people's rights and multisectoral needs incorporated into public policies, poverty reduction plans and expenditure frameworks, capitalizing on the demographic dividend. 1.3: Data on population dynamics, gender equality, young people, sexual and reproductive health and HIV / AIDS available, analysed and used at national and sub-national levels to develop and monitor policies and programme implementation.

[44] Document: UNFPA CPD, 2007 – 2011. A&Y participation and leadership is not a specific outcome of the 2008 – 2011 Strategic Plan.

[45] Output 4, sexual and reproductive health and reproductive rights component, Document: UNFPA CPD, 2007 – 2011 and UNFPA CPD 2012 - 2015

[46] Outputs 2 and 3 under the sexual and reproductive health and reproductive rights component of the programme; Document: UNFPA CPD, 2007 – 2011 and UNFPA CPD 2012 - 2015

[47] Outputs 1 and 2 under the gender component of the programme; Document: UNFPA CPD, 2007 – 2011 and UNFPA CPD 2012 - 2015

[48] Document: Evaluation documents: Summary Report of Programme Evaluations under 6th and 7th Country Programs, 2015

[49] Document: UNFPA CPD 2012 - 2015

country programme document is aligned with the current SP (2014-2017) under the adolescents and youth outcome, mainly on the output level (3 and 4), and was presented and approved by the Board in early 2016.

5.1.2 Alignment of UNFPA support with national (government and civil society organisation) priorities and needs in the area of adolescents and youth[50]

For the period under evaluation, no specific needs assessment, particularly for the most vulnerable and marginalised adolescents and youth, including adolescent girls (10-14 and 15-19 yrs.), was conducted. However, for programmes such as the Berhane Hewan (2004-2011), accurate identification for adolescents and youth needs were part of the program design and steering (see also section 5.2.4).

A situation analysis to identify priorities for the seventh country programme[51] was concluded in 2010 and was intended to be relevant until 2015.[52] The strong alignment of UNFPA support through the UNDAF and subsequently the Growth and Transformation Plan (2010-2015) indicates that UNFPA support corresponds to the needs of adolescents and youth as identified in plans and strategies by central and local government levels.[53] The Growth and Transformation Plan indicated policy direction for youth, including approaches to boost youth participation. Specifically, it aimed to increase the number of youth centres, mainstream youth development into other development programs, and strengthen youth associations and organisations.[54] Based on interviews and documentary review, the current country programme is aligned with the Growth and Transformation Plan, and also the upcoming second Growth and Transformation Plan (2015/16 - 2019/20), which UNFPA supported through capacity building of federal and regional government population experts, and in various consultative technical meetings. The second Growth and Transformation Plan II is still under review.

In 2012, UNFPA together with Pathfinder and MoH, conducted an assessment to identify opportunities and barriers for providing youth friendly sexual reproductive health services in public health facilities. The study informed the integration of youth friendly sexual and reproductive health services into general services.[55] Subsequently, UNFPA gave technical input for the implementation of the 2013 Service Provision Assessment (SPA) and for the preparation of the 2014 Mini Demographic Health Survey (DHS).[56]

Evidence indicates that UNFPA support corresponds to the needs of adolescents and youth as indicated in plans and strategies. The National Youth Policy (2004) is the main guiding document with regard to adolescents and youth. It heavily encourages youth to be active participants in society, and protects their rights and interests as stipulated in the Constitution of 1994[57]. Subsequently, strategies were produced to direct the implementation of programming for youth issues, for example, the Ten-year Multi-sectoral Youth Development Strategy (2006-2016), the National Adolescent and Youth Reproductive Health Strategy (2006-2015) and the Ethiopian National Adolescent Development and Participation Strategy (2013). UNFPA was financially and technically involved in the drafting of these strategies, in addition to the National Minimum Standards for Youth Friendly Services,

[50] Evaluation assumption 1.2.
[51] The sixth CPD was implemented through the Country Programme Action Plan (CPAP) between the Federal Democratic Republic of Ethiopia and UNFPA. The seventh CPD (2012-2015), however, has no accompanying CPAP, but is instead supported and aligned with the corresponding UNDAF Action Plan. For the purposes of aligning with the current UNDAF, the Ethiopian fiscal calendar and the government planning cycle, the seventh CPD was extended until June 2016
[52] Document: COARs.
[53] Documents: UNDAF MTR 2014, COARs; Interviews: UNFPA staff.
[54] Document: Growth and Transformation Plan.
[55] Documents: COARs. Nota bene: no online publication was found of the said study.
[56] Document: COARs.
[57] Documents: Federal Democratic Republic of Ethiopia, "National Youth Policy," ed. Sports and Culture Ministry of Youth (2004).

which are well aligned with international youth-friendly guidelines. The Strategic Plan for Intensifying the Multisectoral HIV and AIDS Response in Ethiopia (SPM II 2010/11 - 2014/2015) provides the background for adolescents and youth strategies for in- and out-of-school HIV prevention programmes, including for the joint programme of UNFPA and UNICEF named "Rights-Based Approach to Adolescent & Youth Development".

No explicit evidence was found that UNFPA support reflects an understanding of needs determined by adolescents and youth organisations and other civil society organisations.

5.1.3 Responsiveness of UNFPA support to changing contexts while maintaining coherence of programmes[58]

UNFPA has been responsive to changes in government priorities, to emerging adolescents and youth needs and to contextual changes.[59] However, CO staff stressed that major programmatic changes can only be accommodated when within the UNDAF framework,[60] (see also section 3.5 on the country context related to legal, policy, regulatory, cultural, economic and political barriers to advocating for and implementing adolescents and youth interventions in Ethiopia). Additionally, the cultural diversity of Ethiopian society presents both opportunities and challenges for development programming[61], as explained in more detail in section 5.1.6.

On an operational level, the need for corrective measures in the course of implementation is addressed through joint annual planning reviews with government agencies as well as civil society implementing partners. UNFPA was complimented by some implementing partners on their quality of responses with regard to flexibility, timeliness and appropriateness compared to other UN organisations.[62] For example, changes in programme operation were demonstrated by the Berhane Hewan programme, with highly flexible programme managers adapting to emerging adolescents and youth needs during implementation through additionally allocating and re-allocating financial support to families to compensate for the loss of the expected bride prices.[63] This economic component was initially not planned for, however proved to highly contribute to the high number of abandonment of early child marriage.

[58] Evaluation assumption 1.3 of the evaluation matrix.
[59] Interviews: UNFPA staff, Donor, NGO.
[60] Interviews: UNFPA staff.
[61] Interviews: NGO, UNFPA staff.
[62] Interviews: NGO, INGO.
[63] Interview: UNFPA staff, A&Y Beneficiaries.

EQ2. To what extent have human rights, gender responsive and culturally-sensitive approaches been incorporated into programming in the area of adolescents and youth at global, regional and national level? To what extent has UNFPA prioritized the most marginalised and vulnerable adolescents and youth, particularly young adolescent girls in its interventions?
Summary of findings
UNFPA applied human rights principles to important adolescents and youth programmes on the ground, although there is an expressed need to further build the capacity of both UNFPA staff and implementing partners in human rights-based approaches. Gender inequalities and disenfranchisement of women and girls are addressed in a multi-disciplinary manner, both through targeted programming (e.g., on early marriage and FGM) and by way of mainstreaming. UNFPA addressed cultural sensitivities in its programmatic approach through a strategic selection of implementing partners from faith-based and civil society organizations, who then adapted sexual and reproductive health and reproductive rights approaches through a faith-based lens for these mainstream congregations. The country programme is designed to prioritise adolescent girls as a marginalised and vulnerable target population and has made eminent contributions both in policy and programming. UNFPA explicitly prioritised adolescent girls through their focus on the abandonment of child marriage and harmful traditional practices. Also, the needs of out-of-school girls were among priority within Berhan Hewan, however the needs of girls aged 10-14 years were not mainstreamed within general programming.

5.1.4 Incorporation of human rights-based approaches in adolescents and youth strategies and programmes[64]

Despite the constraining county context, UNFPA engages programmatically in human rights-based approaches.

The legal framework in Ethiopia under the Charities and Societies Proclamation No. 621/2009 of Ethiopia (Civil Society Law or CSO law) enacted in early 2010, prohibits foreign organisations from engaging in activities related to human rights, children's rights, democratic governance, etc.[65] This law limits the engagement of UNFPA and its implementing partners when working on issues such as GBV, early child marriage and sexual and reproductive health education and information.[66]

Within this restrictive environment, UNFPA infuses sexual and reproductive health principles within programmes, rather than visibly engaging in rights-focused dialogue at the national policy level. For example, human rights-based approaches are evident in UNFPA support for the abandonment of FGM/C and the elimination of child marriage though the Berhane Hewan (2004-2011), Accelerate Abandonment of FGM (2008-2017) and Rights-Based Approach to Adolescent & Youth Development (2008-2013 and 2014-2017) joint programmes.[67]

[64] Evaluation assumption 2.1.
[65] Documents: National Legislative Bodies / National Authorities, " Ethiopia: Proclamation No. 621/2009 of 2009, Charities and Societies Proclamation," (2009).
[66] Document review and interviews: UNFPA staff, UN staff, Donor, INGO.
[67] Documents: Evaluation documents Erulkar et al. 2007, Muthengi et al. 2010

As its name suggests, the Joint Programme on Rights-Based Approach to Adolescent & Youth Development used a human rights-based approach to build the capacity of duty-bearers to deliver youth friendly services and to empower adolescents and youth (rights holders) to demand their rights related to HIV/AIDS, sexual and reproductive health, gender equality and sustainable livelihoods. The evaluation of the first phase of this programme found that access to education, enforcement of by-laws on harmful traditional practices (HTPs) and GBV, community education/mobilisation, peer networks, and the endorsement of community leaders were critical factors for the success of the intervention.[68]

Interviewees were critical of UNFPA and the UN, in general, for not advocating more directly on human rights related to the full implementation of sexual and reproductive health education and information (see section 5.2.2). [69]

Although UNFPA requires non-governmental implementing partners to use human rights language in their reporting and documentation, interviews highlighted that implementing partners lack knowledge about and experience with human rights-based approaches. UNFPA staff capacity to both guide and advice implementing partners on how best to implement human rights-based approaches is still a challenge.[70]

5.1.5 Incorporation of gender-responsive approaches and strategies to address gender barriers in adolescents and youth strategies and programmes[71]

Gender inequities were addressed by UNFPA in a multi-disciplinary and crosscutting manner that is integrated within all programme components. Furthermore, UNFPA has advocated for and developed the capacity of implementing partners to design interventions with the aim to identify and reduce gender barriers for adolescents and youth.

UNFPA has advocated for and designed interventions to reduce gender barriers encountered by adolescents and youth, especially for adolescent girls, through its programmes on early marriage and FGM/C. Identification of gender barriers for different age groups, however, is weak as data are not fully age-disaggregated within gender programming.[72]

The joint programme of UNFPA and the World Food Programme named “Leave no Woman Behind” (LNWB) delivered through BoWCYA in Amhara and Tigray, added value in the coordination of gender-based interventions.[73] The community conversations approach of the LNWB programme empowered women themselves to better respond to human rights violations such as child marriage and GBV in their own communities.[74] Furthermore, in response to the mid-term evaluation of the joint programme, the LNWB Community Conversation manual was revised to sharpen its focus on gender and subsequently, the final evaluation found changes in the gender division of labour in some households.[75]

Within gender programming, a national coordination mechanism was established that integrates men and boys into efforts that address sexual and reproductive health, HIV/AIDS and GBV.[76] In addition, international events

[68] Interviews: UNFPA Staff. Documents: Evaluation documents, COARs.
[69] Interviews: Donor, INGO, NGO, UNFPA staff.
[70] Interviews and documentary review.
[71] Evaluation assumption 2.2.
[72] Documents: Evaluation documents : UNFPA and UNICEF 2013 Joint Evaluation
[73] Ibid.
[74] Interviews: UNFPA staff, NGO. Documents: Evaluation documents.
[75] Documents: Evaluation documents
[76] Documents: Annual Report of ExDir 2015

were used as a platform for building capacities of implementing partners related to gender. Exchange and direct training was provided to implementing partners participating in the second MenEngage Global Symposium (India, 2014), the Global Technical Consultation on Social Services Sectors Response to Violence Against Women and Girls (Mexico City) and the annual Commission on the Status of Women session in New York. However, the international workshops attended by selected implementing partners focused on general gender issues rather than means of addressing adolescents and youth gender barriers in particular settings.[77]

5.1.6 Integration of culturally sensitive approaches in adolescents and youth interventions[78]

UNFPA has adopted culturally sensitive approaches for working with youth, communities, circumcisers and religious leaders across a range of initiatives, including to support the elimination of child marriage, FGM/C and GBV, and to roll out sexual and reproductive health education and information.

For example, the joint UNFPA - UNICEF programme to accelerate the abandonment of FGM/C (Joint Programme on FGM/C) illustrates the effectiveness of working with key opinion leaders, including circumcisers and religious leaders in Afar and Amhara. The programme employs the strategic approach of gaining the support of an initial core group of community members that have decided to abandon FGM/C. Anti-FGM/C committees are then set up at *kebele* (sub-district) and village levels to strengthen community leadership of the programme by including the local administration, clan leaders, former circumcisers, religious leaders and the *Kadi* (local judge).[79,80]

In the area of sexual and reproductive health education and information, UNFPA worked within the restrictive legal framework of the country (see section 5.1.4) and to assuage religious and cultural sensitivities. One example of a culturally sensitive approach was the creation of the “Developmental Bible”, which was piloted by UNFPA, the Population Council and the Ethiopian Orthodox Church in 2009. It addresses highly sensitive youth issues such as sexual and reproductive health and reproductive rights, female consent, child marriage, HIV voluntary testing and counselling, GBV and FGM/C through a guidance document based on interpretations and support of biblical scriptures. By framing sexual and reproductive health and reproductive rights within Christian belief systems, most sexual and reproductive health concerns of young people are integrated into daily religious teachings by the Church, to which many young people regularly attend.[81] Similarly, this approach of addressing adolescents and youth sexual and reproductive health and reproductive rights issues through a faith-based lens has been promoted by Muslim leaders as well as by faith-friendly implementing partners who work with and through religious leaders.[82]

As described above, UNFPA used highly influential cultural channels, e. g. religious leaders, to sensitively address culturally embedded practices and beliefs that impinge upon adolescents and youth sexual and reproductive health and reproductive rights. However, this approach has limited the comprehensiveness of sexual and reproductive health education and information in the country, and its alignment with UNFPA and international guidelines.[83]

---

[77] Interviews: NGO.
[78] Evaluation assumption 2.3.
[79] Document: Annual Reports, Evaluation documents: Terri Collins et al., "A Rights-Based Approach to Adolescent and Youth Development, Ethiopia: End of Programme Evaluation 2013 - Final Report," (London2013).
[80] Interviews: UNFPA staff, Government (local), NGO, A&Y Beneficiaries.
[81] Interviews: UNFPA staff, UN staff, Donors, INGOs, CSOs (including FBOs). Documents: Development Inter-Church Aid Commission of the Ethiopian Orthodox Church, Developmental Bible 2010.
[82] Interviews: UNFPA staff, UN staff, Donors, INGOs, CSOs (including FBOs).
[83] Documents: UNFPA, "Unfpa Operational Guidance for Comprehensive Sexuality Education: A Focus on Human Rights and Gender," (2014).

Cultural sensitivity has not precluded UNFPA from tackling other aspects of culture and tradition that impact negatively on the sexual and reproductive health and reproductive rights of women and girls. For example, objective six of the Joint Programme on Rights-Based Approach to Adolescent & Youth Development has the explicit goal of building the capacity of duty bearers to address the culture of silence and denial around sexual abuse[84]. Furthermore, UNFPA programming resulted in the training of health staff and police on cultural sensitivity in the management of harmful traditional practices and sexual- and gender-based violence through community intervention mechanisms. The use of cultural structures and rituals proved to be effective to communicate messages and news on these sensitive themes. For example the traditional *Dagu*[85] communication ritual and the community dialogue method was used within the forum of traditional coffee ceremonies, which encourage participation and raise the profile and importance of messages imparted.[86]

UNFPA also worked to address broader cultural taboos that prevent young people, particularly adolescent girls, from exercising their human rights, through media awareness campaigns conducted by the Joint Programme on Rights-Based Approach to Adolescent & Youth Development. This provided a channel for airing case histories, online discussions and expert opinions.

No evidence was found of UNFPA technical support to partners, including capacity building or explicit guidelines for the integration of cultural views and perspectives in the design and implementation of programmes, rather implementing partners were chosen, based on their experience working with and through religious leaders, as described above.

5.1.7 Prioritisation of interventions that identify and include adolescents and youth, particularly the most vulnerable and marginalised adolescents and youth, especially adolescent girls[87]

UNFPA has a long history of programmatic focus on vulnerable and marginalised adolescent girls. No evidence was found that UNFPA facilitated the systematic and meaningful participation of adolescent and youth in their programme design. However, UNFPA is considered a prominent convener on issues pertinent to adolescent girls and their human rights (see section 5.4.1 for more detail).

The official definition of adolescents and youth in Ethiopia embraces the age group of 10-29 years as laid out in the National Youth Policy of 2004.[88] This policy identifies specific youth groups as needing special attention: females, pastoralists, people living with HIV/AIDS, people with disabilities, victims of "social evils"[89] and orphans. These definitions guide all relevant national policy and strategy documents, such as the Youth Development Package (2006), the National Adolescent and Youth Reproductive Health Strategy (2006-2015) and accompanying guidelines and therefore also UNFPA programming (see section 5.1.2).

UNFPA did explicitly prioritise adolescent girls through their focus on the abandonment of child marriage and harmful traditional practices (see section 5.2.3). Within the UNFPA adolescents and youth programme portfolio, the needs of out-of-school girls were among the priorities of Berhan Hewan, mainly on livelihoods skill training and sexual and reproductive health education and information. One major achievement of Berhan Hewan was that the ever school attendance had increased substantially among the 10-14 years aged girls only within two

[84] Documents: Final Progress Report.
[85] Afar comprises predominantly pastoral communities that have an indigenous information exchange system called Dagu. The Dagu is an oral, interpersonal communication ritual, held in high regard by Afar people, especially as their livelihoods depend on the information they obtain from Dagu.
[86] Documents: Evaluation document.
[87] Evaluation assumption 2.4.
[88] Documents: National Youth Policy of the Federal Democratic Republic of Ethiopia, "National Youth Policy."
[89] Such as abduction, trafficking and rape.

years (2004-2006).[90] However, the needs of girls aged 10-14 years were not mainstreamed within general adolescents and youth programming.[91]

[90] Documents: Evaluation of Berhan Hewan 2007.
[91] Document: Evaluation of Rights Based Approach to A&Y 2013; Mid-Term Review

5.2 Effectiveness and Sustainability

EQ3. To what extent has UNFPA contributed (or is likely to contribute) to an increase and sustainability of the availability of sexual and reproductive health education and integrated services (including contraceptives, HIV and GBV) for adolescents and youth?
Summary of findings
UNFPA has contributed to the development of the National Adolescent and Youth Reproductive Health Strategy and quality standards for integrated adolescent and youth-friendly reproductive health services in Ethiopia. In close collaboration with UNICEF, MoWCYA and MoH, it has also supported the operationalization of youth friendly health services through the UNFPA/UNICEF Joint Rights-Based Approach to Adolescent and Youth Development. UNFPA was instrumental in building the capacity of service providers to support adolescents and youth affected by GBV and also HIV. However, the overall quality of youth friendly service delivery within the existing health system remains insufficient as it varies widely depending on the service provider. UNFPA in Ethiopia is remembered as spearheading the successful multi-sectoral programme Family Life Education of the 1990s. Since 2009 UNFPA, in collaboration with the Orthodox Church, developed the manual known as the "Developmental Bible", through which religious leaders addressed what they consider to be highly sensitive youth issues such as sexual and reproductive health and reproductive rights, female consent, child marriage, HIV VCT, SGBV and FGC. In 2015, the MoE called for consultative forums and established a technical working group on developing national standards and guidelines for sexual and reproductive health education and information, of which UNFPA is a member. However, the implementation of sexual and reproductive health education and information has been modified in Ethiopia according to legal requirements and cultural sensitivities. This adaptation to culture is well regarded by government and religious leaders, but draws criticism from international and non-governmental partners, some of whom expressed the opinion that UNFPA should be bolder in pushing for comprehensive sexual and reproductive health education and information.

5.2.1 Availability and use of quality, integrated and sustainable sexual and reproductive health services (including contraceptives, HIV & GBV) for adolescents and youth [92]

For the period under evaluation, UNFPA provided significant support for the delivery of sexual and reproductive health services for adolescents and youth, including public youth-friendly health services and private clinics (with NGOs as implementing partner). Furthermore, UNFPA supported the development of tools and guidelines to enable implementation of the National Minimal Standards for Youth-friendly Services[93], which include a minimum HIV/sexual and reproductive health intervention package, distributed to public and private health

[92] Evaluation assumption 3.1.
[93] Document: Federal Democratic Republic of Ethiopia, "Standards on Youth Friendly Reproductive Health Services: Service Delivery Guideline & Minimum Service Delivery Package on Yfrh Services," ed. Ministry of Health (2007).

facilities and higher learning institutions (HLI) to guide service providers on standards of service for young people.[94]

According to its final progress report (2007-2013)[95], the target population had more than tripled by reaching 200,000 additional young people with direct and integrated services including sexual and reproductive health/HIV information, HIV testing and counselling, training of trainers, life skills training, STI treatment, peer education and youth dialogue. From an initial 66,362 young people recorded as direct users of sexual and reproductive health services during 2009, use increased incrementally over the project period to over 600,000. However, these figures are not consistently reported in the end-of-programme evaluation.[96]

UNFPA contributed to the development of the National Adolescent and Youth Reproductive Health Strategy as well as the quality standards for youth friendly health services. The National Adolescent and Youth Reproductive Health Strategy (2006-2015) was drafted by the MoH in technical cooperation with UNFPA, USAID; YouthNet, FHI, WHO, UNICEF, Packard Foundation and The Population Council.[97] It builds on four goals: Access and quality of reproductive services, increase of awareness and knowledge about these services, multi-sectoral partnership, and inclusion of marginalized and most vulnerable young people.

UNFPA's capacity-building and material support to university-level as well as community level adolescents and youth sexual and reproductive health service provision has been mixed in terms of service quality and sustainability. Some HLI sexual and reproductive health clinics were excellent and provided quality services to standard according to the UNFPA-YFS checklist, where it was evident that UNFPA's initial support had acted as a springboard for the broadening and strengthening of sexual and reproductive health and related social services.[98] Yet the majority of UNPFA-supported youth friendly health services in Ethiopia are embedded into the existing health system where, although labelled as "youth-friendly", evidence suggests they are weak in terms of sustainability due to high staff turn-over, poor supplies and quality of service provision.[99]

There is evidence that UNFPA supported partners to address sexual and reproductive health services for adolescents and youth multi-sectorally and were mainstreamed into other services and contributed to the establishment of policy and structures to strengthen adolescents and youth sexual and reproductive health services more generally. For example, UNFPA developed a 24-month work plan and mobilised co-financing from different partners, including the Joint Programme on Rights-Based Approach to Adolescent & Youth Development, to provide resources to implement the youth sector development plan and the youth package.[100]

In the area of GBV, UNFPA supported four safe houses for girls and women who have experienced sexual and gender-based violence. The project fully integrated police, medical and social services with safe placement of girls and women escaping abuse and harm and provided services to 1,286 GBV survivors, including children and adolescents girls.[101]

Box 6: Revision of the theory of change pathway for services

Modes of Engagement to Output 1[102]

[94] Documents: COARs, Federal Democratic Republic of Ethiopia, "Tools (Planning, Implementing, and Monitoring) for Adolescent and Youth Friendly Reproductive Health (Ayfrh) Service Standards in Ethiopia," ed. Ministry of Health (2010).
[95] Documents: UNICEF and UNFPA, "Rights-Based Approach to Adolescent and Youth Development in Ethiopia: Unicef and Unfpa Joint Programme (2007 – September 2013) - Final Progress Report," (2013).
[102] Modes of Engagement: 1: Capacity development including technical assistance and training; 2: Service delivery, commodity security, behavior change communication, health systems strengthening; 3: Advocacy and policy dialogue / advice; 4: Knowledge development and management, design and

The evaluation Theory of Change (ToC), holds that all modes of engagement (activities) should be used to achieve **Output 1**: Strengthened national capacity to make comprehensive adolescents and youth sexual and reproductive health services available, including HIV and GBV care and treatment. In Ethiopia, this element of the ToC pathway held true, with all modes of engagement used, albeit to varying degrees. Within Mode of Engagement 5, there was no indication of the use of South-South or triangular collaboration.

Output 1 to Outcome A[103]

Between Output 1 and Outcome A, **Hypothesis a** (key socio-cultural, legal and gender barriers are overcome) was shown to be valid by this case study as a fundamental for increased availability and use of integrated sexual and reproductive health services for adolescents and youth. The importance of **Hypothesis b** (service providers and teachers are effective at reaching adolescents and youth victims / survivors of violence) was demonstrated in Ethiopia, where cross-referral from education programmes to sexual and reproductive health services is not clearly evident and the degree to which gender-based violence is addressed by teachers in sexual and reproductive health education and information is unclear, thus limiting the reach of UNFPA support to adolescents and youth survivors of violence. As such, the hypothesis appears too narrowly focussed to reflect the importance of linkages between sexual and reproductive health education and information initiatives and health services for adolescents and youth. Testing of **Hypotheses e** (national ownership increases and sustains resources for integrated sexual and reproductive health services, education and information, including GBV and HIV) was constrained in Ethiopia by the fact that full national ownership of youth-friendly health services is yet to be achieved. Nonetheless, it is clear that the quality and comprehensiveness of government-supplied services are constrained by high staff turn-over and poor supplies. This is, at least in part, due to a lack of political will and ownership on the prioritisation of adolescents and youth services (**new hypothesis**), and demonstrates the need for an emphasis on quality of services (not reflected in Outcome A in the original ToC). This particular case study furthermore demonstrates the importance of adhering to international standards in order to deliver quality and integrated services (**new hypothesis**).

5.2.2 Availability and sustainability of sexual and reproductive health education and information for adolescents and youth[104]

dissemination of guidance and tools; 5: Facilitation of partnerships and coordination, including multi-sectoral, South-South and triangular collaboration; 6: Mainstreaming of A&Y issues within other programmatic areas. Output 1: Strengthened national capacity to make comprehensive A&Y sexual and reproductive health services available, including HIV and GBV care and treatment.

[97] Document: Ministry of Health, "National Adolescent and Youth Reproductive Health Strategy," (Federal Democratic Republic of Ethiopia, 2006).

[98] Interviews: NGOs; Government (service providers), Documents: Evaluation documents. Direct observation in in Addis Ababa, Afar, and Amhara Region.

[99] Interviews: Government (local and service providers), Donors, A&Y Beneficiaries. Direct observation.

[100] Documents: COARs.

[101] Interviews: Government (local and service providers), NGOs. Documents: COARs. Direct observation.

[102] Modes of Engagement: 1: Capacity development including technical assistance and training; 2: Service delivery, commodity security, behavior change communication, health systems strengthening; 3: Advocacy and policy dialogue / advice; 4: Knowledge development and management, design and dissemination of guidance and tools; 5: Facilitation of partnerships and coordination, including multi-sectoral, South-South and triangular collaboration; 6: Mainstreaming of A&Y issues within other programmatic areas. Output 1: Strengthened national capacity to make comprehensive A&Y sexual and reproductive health services available, including HIV and GBV care and treatment.

[103] Outcome A: Increased availability and use of integrated sexual and reproductive health services by adolescents and youth.

[104] Evaluation assumption 3.2.

While sexual and reproductive health education and information is gaining acceptance globally, certain aspects of its content sensitive issues in Ethiopia. It is worth noting that UNFPA has been actively engaged in Ethiopia on sexual and reproductive health education and information, spearheading the multi-sectoral programme of Family Life Education (FLE) since the 1990s.[105]

Within the Joint Programme on Rights-Based Approach to Adolescent & Youth Development, UNFPA has promoted sexual and reproductive health education and information through peer education sessions to both in-school and out of school adolescents and youth, as well as integrating certain aspects of sexual and reproductive health education and information into school curricula. But this promotion has not been in full accordance with UNFPA definitions and guiding principles on sexual and reproductive health education and information due to restrictive legal frameworks within Ethiopia (see section 5.1.4).[106] At present, sexual and reproductive health education and information cannot be considered to exist in Ethiopia, as the current FLE excludes a number of critical elements. For example, in comparison with the UNFPA international definition of sexual and reproductive health education and information[107], FLE does not comprehensively "… equip children and young people [both in and out of school] with the knowledge, skills, attitudes and values that will enable them to develop a positive view of their sexuality". Recently however, in 2015, the MoE called for consultative forums and established a technical working group (TWG) in order to developing national standards and guidelines for sexual and reproductive health education and information, in which UNFPA participates.

In spite of the restrictive legal context, many international partner organisations and some non-governmental implementing partners were highly critical of UNFPA's lack of bold leadership and advocacy to make sexual and reproductive health education and information more comprehensive in Ethiopia.[108] On the contrary, the culturally sensitive and non-confrontational mode in which UNFPA has approached sexual and reproductive health education and information is well regarded by government and religious leaders, particularly for its direct engagement of religious and community leaders.[109]

Young people themselves commented that peer-to-peer education supported by UNFPA enabled and empowered them to adequately seek and receive appropriate information from non-restricted sources. This reportedly improved their awareness of youth-friendly services, which in turn increased their use of services. Those interviewed highly appreciated the same-sex peer approach as effective in establishing approachable sources of information within school, higher education and community settings.[110]

Box 7: Revision of the Theory of Change pathway for sexual and reproductive health education and information

Revision of the Theory of Change pathway for sexual and reproductive health education and information
Modes of Engagement to Output 2[111]

[105] Interviews: Donors, NGOs.
[106] Documents: UNFPA, "Unfpa Operational Guidance for Comprehensive Sexuality Education: A Focus on Human Rights and Gender."
[107] Document: UNFPA, "Unfpa Operational Guidance for Comprehensive Sexuality Education: A Focus on Human Rights and Gender."
[108] Interviews: Donors, INGO, NGO.
[109] Interviews: UNFPA staff, INGO, NGOs.
[110] Interviews: A&Y Beneficiaries.
[111] Modes of Engagement: 1: Capacity development including technical assistance and training; 2: Service delivery, commodity security, behavior change communication, health systems strengthening; 3: Advocacy and policy dialogue / advice; 4: Knowledge development and management, design and dissemination of guidance and tools; 5: Facilitation of partnerships and coordination, including multi-sectoral, South-South and triangular collaboration; 6: Mainstreaming of A&Y issues within other programmatic areas. Output 2: Increased national capacity to design and implement community and school-based sexual and reproductive health education and information that promotes human rights and gender equality.

The evaluation theory of change (ToC), holds that all modes of engagement (activities) should be used to achieve **Output 2**: Increased national capacity to design and implement community and school-based sexual and reproductive health education and information that promotes human rights and gender equality. In this case study, this held generally true, yet there was no indication of mainstreaming of adolescents and youth issues into other programmatic areas to increase national capacity for sexual and reproductive health education and information (Mode of Engagement 6) or of South-South or triangular collaboration (Mode of Engagement 5).

Output 2 to Outcome B[112]

Hypothesis a (key socio-cultural, legal and gender barriers are overcome) and **Hypothesis c** (sexual and reproductive health education and information is comprehensive and follows internationally agreed standards) proved valid for achieving increased availability of sexual and reproductive health education and information (**Outcome B**). In Ethiopia, the curriculum is not aligned with international standards. Similarly, despite the importance of **Hypothesis b** (service providers and teachers are effective at reaching adolescents and youth victims / survivors of violence) the degree to which gender-based violence is addressed by teachers within the existing sexual and reproductive health education and information was unclear. Cross-referral from education programmes to sexual and reproductive health or other services was not clearly evident, presenting a missed opportunity for increased reach and effectiveness of UNFPA support to adolescents and youth. As such, the hypothesis appears too narrowly focussed to reflect the importance of linkages between sexual and reproductive health education and information initiatives and health services. In Ethiopia, there was no evidence that UNFPA support addresses **Hypothesis d** (education and information reach out-of-school adolescents and youth). National ownership in Ethiopia on sexual and reproductive health education and information is very strong, however there was no clear evidence that this has resulted in increased, sustainable resources for adolescents and youth sexual and reproductive health services, education or information, but for the case of sexual and reproductive health education and information, strong national ownership even seems to be inhibiting the agenda (**Hypothesis e**) Therefore the hypothesis does not hold true. This would depend on government commitment and political will for increased funding, and prioritisation of adolescents and youth issues (**modified Hypothesis e**). There was no indication that UNFPA engages with parents in Ethiopia as presented in **Hypothesis f** (parents, schools and community leaders engage in adolescents and youth sexual and reproductive health education and information). Rather, broad community engagement would be required to ensure the wider needs of adolescents and youth are addressed (**modified Hypothesis f**). In addition, as was the case with UNFPA support for services, the ToC pathway for education does not recognise the importance of collection, disaggregation and dissemination of data on sexual and reproductive health education and information activities and adolescents and youth issues more generally, in order to design enabling policies, programmes and strategies for adolescents and youth (suggested **new hypotheses**).

[112] Outcome B: Increased availability of sexual and reproductive health education and information and information.

EQ4. To what extent has UNFPA contributed to evidence-based policies and programmes that incorporate the needs and rights of adolescents and youth? To what extent has UNFPA contributed to increasing priority for adolescent girls in national development policies and programmes?
Summary of findings
In Ethiopia, UNFPA has long placed specific emphasis on large-scale programming for adolescent girls aged 10 to 14 years, particularly targeting child marriage and FGM/C, with important results on the ground and at the policy level, with the Ethiopian government committed to further action aimed at eradicating child marriage and FGM/C by 2025. UNFPA has strengthened national capacities of government and partners for the collection, analysis, and use of adolescents and youth data to influence the development of policies and multi-sector programmes and investments that incorporate the needs of adolescents and youth. In an environment where multiple stakeholders contribute to the development of evidence-based policies and programs, UNFPA has supported numerous studies on adolescents and youth disaggregated data and particularly on adolescent girls also within joint programming. Recent age-disaggregated data of adolescents and youth indicators however were funded by the Packard Foundation, culminating in publications that the UNFPA and others active in the field of adolescents and youth found to be important sources for planning.

5.2.3 Priority given to adolescent girls in national development policies and programmes[113]

Since 2004, vulnerable and marginalised girls, especially those aged 10-14 years, are a strategic focus of UNFPA Ethiopia. At the end of the Berhane Hewan programme in 2011, girls aged 10 to 14 were one tenth as likely to be married and three times as likely to still be in school, compared to the baseline. Furthermore, married girls who took part in the programme interventions were three times more likely to use family planning than the control group.[114] Since 2011, the British Department for International Development (DFID) has partnered with the government to scale up this successful programme.

UNFPA-supported participation of adolescent girls in programs had increased the priority given to their needs and human rights in national laws, policy, strategies and programs. Since 2011, UNFPA technically and financially supported the work of the National Alliance to End Child Marriage under the lead of the MoWCYA and is currently the first rotational vice-chair.[115] UNFPA supported the development of the National Strategy and Action Plan on Harmful Traditional Practices against Women and Children in Ethiopia (2013) and as a result of multi-stakeholder lobbying at the Girl Summit in London in 2014, the Ethiopian government committed to further action aimed at eradicating child marriage and FGM/C by 2025.[116] The Deputy Prime Minister reflected this well by firmly endorsing Ethiopia's position on FGM/C stating that "child marriage compromises the development of girls and is an infringement of their rights".[117] In line with these efforts, the African Union launched its first campaign to End Child Marriage in Africa in 2014. The two-year campaign was launched in partnership with UN

[113] Evaluation assumption 4.1.
[114] Documents: Evaluation documents, COARs.
[115] Documents: COARs.
[116] Interviews: UNFPA staff, Government (central), NGOs. Documents: National Strategy and Action Plan on Harmful Traditional Practices against Women and Children in Ethiopia (2013), COARs.
[117] Documents: Ethiopia UNFPA, http://countryoffice.unfpa.org/ethiopia/2014/05/30/9868/campaign_to_end_child_marriage_in_africa_launched/ .

organisations, CSOs and national governments to accelerate change across the continent by encouraging governments to address child marriage and harmful traditional practices.

The prioritisation of marginalised and vulnerable girls was further advanced by the Joint Programme of UNFPA and UNICEF to "Accelerate Abandonment of FGM/C (2008-2017). The Joint Programme facilitated parliamentary hearings on FGM/C and supported capacity building within the justice system for judges, prosecutors, lawyers and magistrates, as well as local leaders. Within legal instruments relevant to FGM/C such as the African Charter on Human and People's Rights, the Joint Programme focused on law enforcement via national coordination bodies. One example is the National Strategy on Harmful Traditional Practices, which was launched by the MoWCYA in 2013, with a two-year action plan to prevent and respond to GBV including FGM/C. Subsequently, 40 justices from the police and courts who attended FGM/C and child marriage consultations are now being held accountable for the implementation of the law. In 2013, 13 individuals who violated the national law against FGM/C were prosecuted in court. Through the support of UNFPA, 958 child marriages were cancelled, 42 planned polygamy cases and 44 attempted abductions were averted.[118]

Finally, UNFPA's Action for Adolescent Girls (AAG) initiative addressing health, social and economic asset building was rolled out in Ethiopia from 2014, and aims to reach 80,000 unmarried girls aged 10-14, and married girls 10-19, by 2017. This programme is being implemented in 12 countries, and builds on previous and continuing programmes on child marriage and FGM/C, however does not specifically reference to South-South learning in its programme document.[119] It has the goal of protecting adolescent girls` rights, with a view to delaying marriage and childbearing and empowering the most marginalised girls.[120]

Box 8: Revision of the Theory of Change pathway for prioritisation of adolescent girls

Modes of Engagement to Output 3[121]
The evaluation Theory of Change (ToC), suggests that four **modes of engagement** (capacity development, advocacy and policy dialogue / advice, knowledge development and management, and mainstreaming of adolescents and youth issues)[122] should be used to achieve **Output 3**: Increased capacity of partners to design and implement comprehensive programmes that reach marginalised adolescent girls, particularly those at risk of child marriage and adolescent pregnancy.
Output 3 to Outcome C[123]
In Ethiopia, the capacity of partners to design and implement comprehensive programmes for marginalised girls was significantly increased (**Output 3**), with the result that the pathway from Output 3 to **Outcome C** (increased priority on adolescent girls in national development policies and programmes) was successfully tested within this case study. There is clear evidence from the rigorously evaluated Berhane Hewan programme, that data/evidence influences policies and programs (**Hypothesis i**). However, there was no

[118] Documents: COARs, evaluation documents. Collins et. Al 2013.
[119] Documents: UNFPA's Action for Adolescent Girls. Building the Health, Social and Economic Assets of Adolescent Girls, Especially Those at Risk of Child Marriage," programme document (2014).
[120] Documents: Programme documents, COARs.
[121] Output 3: Increased capacity of partners to design and implement comprehensive programmes that reach marginalised adolescent girls, particularly those at risk of child marriage and adolescent pregnancy.
[122] More precisely, these are Mode of Engagement (MoE) 1: Capacity development including technical assistance and training; MoE 3: Advocacy and policy dialogue / advice; MoE 4: Knowledge development and management, design and dissemination of guidance and tools; and MoE 6: Mainstreaming of A&Y issues within other programmatic areas.
[123] Outcome C: Increased priority on adolescent girls in national development policies and programmes.

indication that UNFPA adolescent girls participated in programs design as beneficiaries (**Hypothesis j)**. Furthermore, that increased investment for adolescents and youth that proportionally target young adolescents and marginalized adolescents and youth (**Hypothesis g**) did partially hold true in this pathway, as donor support for joint programming seems to build on existing success (e.g. of Berhane Hewan). There was no indication that UNFPA engages with parents in Ethiopia as presented in **Hypothesis f** (parents, schools and community leaders engage in adolescents and youth sexual and reproductive health education and information. Rather, it appears that broad community engagement, beyond the area of sexual and reproductive health education and information (**modified Hypothesis f**), would be required to overcome socio-cultural, legal and gender barriers (**Hypothesis a**) to ensure the needs of adolescent girls are addressed – as was noted to be the case with sexual and reproductive health education and information and services.

5.2.4 Collection, analysis and use of disaggregated adolescents and youth data[124]

Evidence was found that UNFPA has strengthened national capacities of government and partners for the collection, analysis, and use of adolescents and youth data to influence the development of policies and multi-sector programmes and investments that incorporate the needs of adolescents and youth, particularly adolescent girls.

Within the Berhane Hewan programme, numerous surveys were funded by UNFPA and conducted by the Population Council. Also for the Joint Programme of UNFPA and UNICEF on "Rights-Based Approach to Adolescent & Youth Development", the Population Council conducted a baseline among 10 000 boys and girls.[125] These studies provided disaggregated data by age (12-24 years), marital status, school status, religion and residence.[126] Furthermore, it must be highlighted, that Berhane Hewan was one of the first rigorously evaluated interventions to have demonstrated a delay in marriage in sub-Saharan Africa and is showcased as an illustrative example of programming to create an enabling environment for adolescent sexual and reproductive health at the community level. It was recently referenced in the "Journal of Adolescent Health" in January 2015.[127]

UNFPA financially supported the Ethiopian Demographic Health Surveys (EDHS) in 2011, the mini DHS in 2014, and an in-depth analysis on FP indicators among adolescents and youth and young women in 2013. Analyses of adolescents and youth indicators however were not supported by UNFPA but funded, in fact, by Packard Foundation[128], culminating in publications that UNFPA and others active in the field of adolescents and youth found to be important sources for planning:

1. Atlas of Youth Reproductive Health (2011)
2. Level and Trends in Unmet Need for Family Planning among Adolescents and Young Women in Ethiopia (2000, 2005, 2011)
3. Trends in Key Demographic and Health Indicators for Young Adults (2000, 2005, 2011)
4. Policy brief on Young People and the Demographic Dividend (2014)

[124] Evaluation assumption 4.2.
[125] Documents: Evaluation 2013.
[126] Documents: Surveys.
[127] Documents: J. Svanemyr et al., "Creating an Enabling Environment for Adolescent Sexual and Reproductive Health: A Framework and Promising Approaches," *J Adolesc Health* 56, no. 1S (2015).
[128] Interviews: UNFPA staff, INGO. Documents: COARs.

Box 9: Revision of the Theory of Change pathway for evidence-based advocacy and data

Revision of the Theory of Change pathway for evidence-based advocacy and data
Modes of Engagement to Output 4[129]
Four Modes of Engagement (activities) should be used to achieve **Output 4**: Strengthened national capacity for production, analysis and use of adolescents and youth data.
Output 4 to Outcome D[130]
In this case study, this ToC pathway generally held true. The government in Ethiopia as well as other stakeholders have recognised the value of data related to adolescents and youth (**Hypothesis h**[131]) as a tool for developing effective evidence-based policies and programmes (**Outcome D**). However, evidence highlighted that data / evidence on adolescents and youth was not generated through the support of UNFPA to the government **Hypothesis i.**[132] There was no evidence that strengthened national capacity for adolescents and youth data resulted in increased investment for adolescents and youth that proportionally targets young or marginalised adolescents and youth (suggesting the removal of **Hypothesis g**[133] from the pathway).

[129] Output 4: Strengthened national capacity for production, analysis and use of A&Y data for evidence-based laws, policies and programmes that integrated the needs and rights of A&Y.
[130] Outcome D: Evidence-based policies and programmes incorporate the needs of adolescents and youth.
[131] Hypothesis h: Governments support the collection, disaggregation and dissemination of data related to A&Y.
[132] Hypothesis i: Data/evidence influences policies, programmes and priorities.
[133] Hypothesis g: Increased investments for A&Y that proportionally target young adolescents and marginalised A&Y.

EQ5. To what extent has UNFPA contributed to increasing adolescents and youth leadership, participation and empowerment, especially for marginalised and vulnerable adolescents and youth, particularly adolescent girls?
Summary of findings
Within the Joint Programme on Rights-Based Approach to Adolescent & Youth Development, UNFPA's support of peer-to-peer information exchange and learning on sexual and reproductive health and reproductive rights enabled older and more experienced youth to support and lead younger peers. The dialogue and community conversation skills of adolescents and youth were developed through a training of trainers or cascade approach by training young "master-trainers" who then, in turn, built the capacity of a cadre of grass-roots level trainers and community conversation facilitators. UNFPA supported the participation of youth leaders, student peer-educators and pastoralists at a range of conferences. However, there is a lack of evidence of follow-up or capitalisation on these visits. No evidence was found that representatives of youth organizations and marginalised adolescent girls were involved in planning, implementation, monitoring and evaluation of local, national, regional and global policies and programmes.

5.2.5 Capacities of youth advocates and of adolescents and youth organisations, networks, and institutional structures that promote leadership and participation of adolescents and youth[134]

UNFPA conducted a range of activities in Ethiopia to develop the capacity of youth advocates and organisations.

One example is the Joint Programme on Rights-Based Approach to Adolescent & Youth Development, which specifically engages with adolescents and youth to build their capacity for participation and leadership. The programme focuses on young peoples' active participation and aims to support youth and adolescents sexual and reproductive health. From 2009 to 2013, 213,534 adolescent and young people were reached under output one of the programme: 186,037 participated in youth dialogue and community conversation, 14,615 were trained as facilitators, 3,696 participated in cascading training (i.e. training of trainers, TOT) and 9,186 received refresher trainings and acted as information sources and change agents among their peers. Sustainability and scale up of cascade training for young people on adolescents and youth sexual and reproductive health was evident in the multiplying effect reported for 2009: the pool of 468 youth trainers created by UNFPA trained a further 1,802 youth facilitators, who were then able to facilitate youth dialogue, peer education and community conversations on issues related to GBV, HIV/AIDS, and adolescent and youth sexual and reproductive health. As a result, 40,000 adolescents and youth were reached by the programme across 782 sites that year.[135] However, the end of programme evaluation identified challenges, including a lack of information on the quality and content of workshops and dialogue on youth development and sexual and reproductive health.[136]

Secondly, UNFPA supported the participation of adolescents and youth in sexual and reproductive health at international conferences and in national and regional meetings. These fora included the National Symposium of Family Planning held in Bahir Dar in 2012, which had a whole day dedicated to youth; the March 2012 ICPD

[134] Evaluation assumption 5.1.
[135] Documents: COARs.
[136] Documents: Evaluation documents: Collins et al. 2013.

Beyond 2014 meeting in Accra; the 2013 International Conference on Family Planning; the 2014 Adolescents Sexual Reproduction, Health and Rights and HIV in Africa Symposium in Lusaka; and the 2014 World Congress of Global Partnership for Young Women and the Global Partnership for Women in South Korea. However, some implementing partners and NGOs, particularly young members, expressed frustration at the lack of tangible outcomes and follow-through from conference and consultation attendance by youth representatives.[137]

No evidence was found that UNFPA supported representatives of youth organizations in planning, implementation, monitoring and evaluation of local, national, regional and global policies and programmes. Similarly, no evidence was found to confirm that increased support by UNFPA to strengthen civil society participation and youth mobilization resulted in greater priority given to sexual and reproductive health by adolescents and youth and their organizations and groups.

In Ethiopia, adolescents and youth leadership within the sexual and reproductive health arena is complicated by a number of issues, including the diversity of youth groups, which have their own thematic and political agendas; they lack accountability and have limited interest and capacity in sexual and reproductive health. Within the evaluation period, adolescents and youth engagement and leadership in programming and implementation were ad hoc.[138] Adolescents and youth CSOs did not have plans shared with them, nor were criteria made clear on which youth organisations were entitled to participate in which fora.[139]

No evidence was found that adolescent and youth, particularly the most vulnerable and marginalised, especially girls, were systematically and meaningfully involved in programme design or implementation during the period under evaluation. Observation during field visits of programme beneficiaries of Berhane Hewan suggested that the great potential of girls as active agents of change was not fully explored. Their engagement was mainly institutionalised in community transformative dialogues; however, girls were not systematically part of programme design, monitoring, implementation nor dissemination.[140]

Box 10: Revision of the Theory of Change pathway for adolescents and youth leadership and participation

[137] Interviews: Donors, NGOs, A&Y Beneficiaries.
[138] Interviews: UNFPA staff, A&Y Beneficiaries.
[139] Interviews: UNFPA staff; A&Y Beneficiaries.
[140] Interviews: A&Y Beneficiaries, Teachers and Community Representatives. Documents: Evaluation documents. Erkulkar et al. 2007 Direct observation during field visit to Amhara, previously Berhan Herwan.

Modes of Engagement to Output 5[141]

The evaluation Theory of Change (ToC) holds that all Modes of Engagement other than service delivery[142] should be employed to achieve **Output 5**: Strengthened adolescents and youth organisations, networks and institutional structures.

Output 5 to Outcome E[143]

Testing of this pathway highlights that **Outcome E** (increased adolescents and youth participation and leadership) does not reflect a logical effect of **Output 5** (strengthened adolescents and youth organisations, networks and institutional structures). Rather, Outcome E should be revised to capture the idea that meaningful adolescents and youth participation can ensure that adolescents and youth needs and priorities are reflected in sexual and reproductive health policies and programmes.

In Ethiopia, UNFPA-supported strengthening of adolescents and youth organisations and networks has not facilitated full civil society participation and youth mobilisation – nor is the breadth and scope of UNFPA support for adolescents and youth participation and leadership clear. This suggests the need for revision of **Hypothesis l**[144] to reflect the more logical and specific goal of the integration of adolescents and youth voices in formal decision-making processes – something that has not been realised in Ethiopia. While it is difficult to assess the degree to which UNFPA support has helped adolescents and youth organisations to prioritise sexual and reproductive health in Ethiopia, no evidence was established that engaging in sexual and reproductive health is a priority for adolescents and youth focused organizations and groups (**Hypothesis k**).[145] Furthermore, the Ethiopia case study highlights that marginalised and vulnerable young people, including adolescent girls, were not clearly included in UNFPA-supported activities to increase adolescents and youth participation. **Hypothesis j**[146] should therefore be included in this pathway, but modified to include adolescent girls as active agents for change, rather than passive beneficiaries of programming, in accordance with UNFPA principles.

[141] Output 5: Strengthened A&Y organisations, networks and institutional structures.
[142] Modes of Engagement (MoE) 1: Capacity development including technical assistance and training; MoE 3: Advocacy and policy dialogue / advice; MoE 4: Knowledge development and management, design and dissemination of guidance and tools; MoEMinistry of Education 5: Facilitation of partnerships and coordination, including multi-sectoral, South-South and triangular collaboration; MoE 6: Mainstreaming of A&Y issues within other programmatic areas.
[143] Outcome E: Increased adolescent and youth leadership and participation.
[144] Hypothesis l: Full civil society participation and youth mobilisation is facilitated.
[145] Hypothesis k: Engaging in sexual and reproductive health is a priority for A&Y-focused organisations and groups.
[146] Hypothesis j: Adolescent girls participate in programmes as beneficiaries.

5.3 Efficiency

EQ6: To what extent were resources (human, financial, administrative) adequate and utilised to achieve the expected results in relation to UNFPA support to adolescents and youth?
Summary of findings
Since 2008, the priority and commitment on adolescents and youth programming increased. Around 11 per cent of the adolescents and youth expenditures came from core funding, and around 89 per cent from earmarked funds. In total, the adolescents and youth expenditure accounted for 13 per cent of the total CO expenditure. Responsibility for managing adolescents and youth programming is taken care of by two to three technically competent NPOs, with the involvement of other colleagues as needed. Despite the recruitment of UNFPA monitoring experts at the national and sub-national levels, the availability and quality of adolescents and youth programming data remains a challenge - inter alia because of weak monitoring capacities of the implementing partners. Technical support was received from and knowledge exchange facilitated by both UNFPA HQ and the RO for the multi-country initiatives on FGM/C and child marriage; support was also given for adolescents and youth programming under the current strategic plan. More guidance on South-South cooperation, human rights-based approaches, sexual and reproductive health education and information, and meaningful participation and leadership of adolescents and youth would be appreciated by the country office.

5.3.1 Allocation and distribution of human and financial resources to support adolescents and youth programmes[147]

UNFPA very successfully mobilised other resources from a range of donors for adolescents and youth programming during the period of investigation (roughly 89 per cent of total adolescents and youth expenditure). However, the timely distribution of resources to implementing partners (implementing partners) was not always guaranteed.

Overall, adolescents and youth expenditure of approximately USD 20 million for the period 2008-2014 amounted to 18 per cent of total country office expenditure. Atlas data show increased commitment to adolescents and youth programming between 2009 and 2011, largely thanks to mobilised earmarked contributions from Norway. Regular resources only made up 11 per cent of the adolescents and youth expenditures. Total expenditure in support of adolescents and youth dramatically increased to USD 8.75 million in 2014, due to an influx of earmarked resources.

Within the 2008-2014 timeframe, UNFPA Ethiopia experienced the fifth largest budget cut globally.[148] However, this budget cut was not perceived to hinder adolescents and youth programming.[149] Since 2008, UNFPA has very successfully mobilised other resources for adolescents and youth programming (roughly 89 per cent of total adolescents and youth expenditure) from a range of donors. Atlas data on adolescents and youth showed that

[147] Evaluation assumption 6.1.
[148] Interviews: UNFPA staff.
[149] Interviews: UNFPA staff.

core funds (regular, non-earmarked resources) steadily increased from 0 per cent in 2008 and 2009 to USD 54,451 in 2010 and USD 341,438 in 2013 and over USD 3.3 million in 2014. Earmarked funds for adolescents and youth similarly peaked in 2014 at almost USD 5.5 million. The budget cut however had a major impact on other programmatic areas within the country programme.[150]

Since 2010, the use of funds has been optimised as evidenced by steadily increasing implementation rates (from 24 per cent in 2008, to 93.9 per cent in 2010, and 94.4 per cent in 2012). The overall implementation rate averaged 81.7 per cent for 2008 – 2014. Delays in fund transfers to implementing partners hindered smooth implementation of programming in some cases,[151] although other performance issues may, in part, also explain challenges faced by implementing partners in implementation. Resources to implement adolescents and youth programmes were administered through the national execution (NEX) modality.

In line with the new business model of the SP 2014-2017, Ethiopia is classified as a "red" country, meaning it is a country with high needs and low ability to finance interventions. The expenditure for 2014 shows that the highest expenditure per mode of engagement was the "other" mode of engagement category (USD 5.11 million), followed by service delivery (USD 2.0 million), capacity development (USD 1.03 million), knowledge management (USD 0.33 million) and advocacy / policy dialogue and advice (USD 0.31 million, see Table 17 in Section 4.2).

UNFPA has put in place skilled human resources at all levels (including officers in all regions they work in in Ethiopia) to facilitate programming and implementation of adolescents and youth interventions. The UNFPA team in Ethiopia is composed of a national programme officer (NPO) for adolescent and youth reproductive health, another in charge of the joint programming of the NORAD funded programme (programme coordinator), and another for gender, mainly working within the field of adolescents and youth. In practice, however, the adolescents and youth planning and implementation can involve other colleagues, depending on the intervention. The NPO for adolescent and youth reproductive health has a social and political science background, has been in the position for the past 2 years and has received formal training on adolescents and youth sexual and reproductive health.[152]

The Joint Programme on Rights-Based Approach to Adolescent & Youth Development supports staff positions for programme coordinators and drivers within the country office and at the regional level.[153] Overall the staff percentage paid by the joint programme declined from 9 staff positions in 2009 to 3.5 staff positions in 2014. Regional programme coordinators were reported to improve implementation at regional level through close supervision and coordination, and to strengthen visibility of UNFPA among implementing partners and UN organisations.[154]

Table 16: Country office (CO) staff positions paid by joint programmes[155]

Country office (CO) staff positions paid by joint programmes					
2009	**2010**	**2011**	**2012**	**2013**	**2014**
3 staff at CO = 100%	3 staff at CO = 100%	3 staff at CO = 100%	2 staff at CO = 80%	2 staff at CO = 80%	1 staff at CO = 50%

[150] Interviews: UNFPA staff. Documents: Atlas data
[151] Interviews: NGOs.
[152] Interviews: UNFPA staff.
[153] Documents: Joint programme documentation.
[154] Interviews: UNFPA staff. Documents: COARs.
[155] Interviews: UNFPA staff.

6 staff at regional level = 100%	7 staff at regional level = 100%	7 staff at regional level = 70%	7 staff at regional level = 80%	7 staff at regional level = 80%	6 staff at regional level = 50%

5.3.2 Systems (including monitoring and evaluation) to gather data, evidence and lessons learned[156]

Since 2008 UNFPA has strengthened its monitoring system. This process has been led by technical experts at the national level, and since 2012 sub-national programme officers have been based in each of the six regions (Addis Ababa, SNNPR; Amhara, Tigray, Afar, Oromia), where the country programme is implemented. These sub national staff regularly visit field sites to monitor programme implementation and results, and to interact with the respective implementing partners. However, from interviews with UNFPA CO staff it became clear that problems exist with the general quality of monitoring data provided by implementing partners.[157] For example, they lack reliable adolescents and youth data, especially in the disaggregation by age.[158] Therefore, in 2014, UNFPA decided to support implementing partners on the preparation of the AWPs and to ensure close follow-up by the regional and national programme coordinators. Nonetheless, challenges in monitoring and evaluation remain due to limited funding and high turnover of M&E staff at IP level.[159]

Evidence from interviews and annual reports indicate that efficiency in programme implementation at the sub-national level within Ethiopia increased over the evaluation period due to UNFPA efforts to build the capacity of implementing partners in using results-based management frameworks within Joint Programmes.[160] Since 2014, the training of implementing partners has been mainstreamed within programmatic areas of the UNFPA portfolio. The valued experience of rigorous monitoring and results-based management within the Joint Programmes was transferred to the regular country programme.[161]

Also, in the area of internal reporting, comparison of CO evaluation survey data with SIS data from 2014 suggests that the SIS inadequately captured the status of sexual and reproductive health education and information and sexual and reproductive health services for adolescents and youth in Ethiopia, as well as UNFPA's support in these areas[162]. In addition, SIS data on the national capacity to analyse and use disaggregated data on adolescents and youth contrasted with the lack of attention to age-disaggregated data in the country programme documents.[163]

For the Joint Programme on Rights-Based Approach to Adolescent & Youth Development, the Norwegian Embassy carried out monitoring field visits. Suggested programmatic changes were discussed at the steering committee, and operational changes were accommodated and executed at the respective programme implementation level.[164]

In addition, within the gender programme, UNFPA held bi-annual meetings with all relevant stakeholders and implementing partners to regularly monitor progress. The experiences shared informed programme planning at UNFPA, and implementing partners highly appreciated this forum for exchange and mutual learning. The same implementing partners would appreciate the same format of exchange for adolescents and youth focused

[156] Evaluation assumption 6.2.
[157] Interviews: UNFPA staff. Documents: COARs.
[158] Interviews: UNFPA staff; Documents: COARs.
[159] Interviews: UNFPA staff. Documents: COARs.
[160] Interviews: UNFPA staff. Documents: COARs.
[161] Interviews: UNFPA staff. Documents: COARs.
[162] Documents: Evaluation survey data, SIS data 2014. The indicators relevant to education and services were not reported on in the SIS in 2014.
[163] SIS indicator 13.3a.
[164] Interviews: UNFPA staff. Documents: Evaluation documents: Yusuf 2015.

interventions.[165]

External end-of-programme evaluations were the primary means of evaluating adolescents and youth programmes. Examples include:

- Evaluation of Berhane Hewan: A Pilot Program to Promote Education & Delay Marriage in Rural Ethiopia (2007)[166];
- A Rights-Based Approach to Adolescent and Youth Development, End of Programme Evaluation (2013);
- Joint Evaluation of UNFPA-UNICEF Joint Program on Female Genital Mutilation/Cutting: Accelerating Change 2008-2012;
- Evaluation of Violence Against Women (2012);
- Final Evaluation 2013 Africa Gender Thematic Window, Ethiopia. UN Joint Program on Leave no Woman Behind (2013).

Interviews with UNFPA staff presented contradictory messages on the use of evaluation findings. Some reported using these findings extensively, for example within the framework of Joint Programmes, and others expressed the opinion that UNFPA is not rigorous enough in generating and using this information. No documentary evidence was found that evaluation findings were used for steering programming at regional level within the country. Some UNFPA staff stated that they prefer to use the EDHS and other national surveys such as the census extensively for programming, not only because they are considered to provide robust data for adolescents and youth programming, but also because of alignment purposes with implementing partners.[167]

No evidence was found for the systematic collection and use by UNFPA of good practices and success models to inform the design and replication of similar interventions in other settings. Some good practices might have been shared on an ad hoc basis within UNFPA; however no systematic process was identified. Only the Berhane Hewan serves as a programmatic example, where data was collected, analysed, used and disseminated rigorously to improve the adolescents and youth intervention (see section 5.2.4). Many of these programmatic success stories are featured in booklets and brochures developed by HQ.[168]

3.3 Advice, guidance and training to UNFPA country offices by HQ and RO for adolescents and youth interventions[169]

During the evaluation period, UNFPA received technical support for the multi-country initiatives on FGM/C and child marriage from the regional office (RO) and HQ. HQ provided guidance on implementation of the SP and training to facilitate workflow.[170] No specific interaction between the RO and the country office in Ethiopia was mentioned related to adolescents and youth programming.[171] However, UNFPA staff in Ethiopia identified areas where they would benefit from more guidance and support, namely human rights based approaches to programming, meaningful participation and leadership of adolescents and youth, sexual and reproductive health education and information, and utilisation of new technologies for service delivery. In addition, systematic approaches towards exchange of best practices and South-South cooperation were identified as areas of training

[165] Interviews: UNFPA staff, NGOs.
[166] Documents: Evaluation documents.
[167] Interviews: UNFPA staff.
[168] Documents: Other documents.
[169] Evaluation assumption 6.3.
[170] Interviews: UNFPA staff.
[171] Interviews: UNFPA staff.

needed for UNFPA staff in Ethiopia.[172]

[172] Interviews: UNFPA staff.

5.4 Partnership, Coordination, Comparative Advantage

EQ7: To what extent has UNFPA provided leadership, coordinated effectively and established partnerships to advance adolescents and youth issues at global, regional and country levels? To what extent has UNFPA promoted South-South cooperation to facilitate the exchange of knowledge and lessons learned and to develop capacities in UNFPA program countries for advancing adolescents and youth policies and programmes?
Summary of findings
The extent and strength of UNFPA leadership and visibility has varied over time despite it being an instrumental leader in certain specific aspects of the political advancement of adolescents and youth sexual and reproductive health and reproductive rights during the period. The UNFPA CO is credited with having facilitated important programmatic partnerships and collaborated in Joint Programmes in support of adolescents and youth sexual and reproductive health. However, the country office's ability to lead on the national adolescents and youth agenda, especially with regard to policy development, has not been optimal. Implementing partners and donors stated furthermore that UNFPA does not adequately demonstrate and disseminate its programme results to strongly position itself as a leader of adolescents and youth sexual and reproductive health and reproductive rights approaches and thereby misses opportunities to optimize and broaden donor support. UNFPA country office has supported a range of South-South exchanges in the area of adolescents and youth, including experience-sharing exchanges at various fora and support for student peer-educators to participate in regional meetings on adolescents and youth sexual and reproductive health and reproductive rights. Despite an investment in South-South cooperation, there is a scarcity of documentation related to follow-up of or capitalisation on these exchanges, and no apparent mechanism to guide this engagement within the field of adolescents and youth.

5.4.1 Technical and political leadership for advancing the global, regional and national adolescents and youth agendas[173]

UNFPA is actively shaping the national adolescents and youth agenda, but is less acknowledged by stakeholders as the leading agency within the field.

The MoWCYA has the mandate to coordinate and oversee national adolescents and youth development, which UNFPA supports as a member of the Steering Committee on National Child Marriage, and by convening an advocacy workshop on adolescents and youth Development and informing the Plan for Accelerated and Sustained Development to End Poverty (PASDEP I) on adolescents and youth sexual and reproductive health.[174] UNFPA is regarded by international agencies/donors, implementing partners and the MoWCYA to have been instrumental in bringing different stakeholders and donors together for the consultative meetings for the Growth and Transformation Plan II, where the empowerment of youth and women forms one of seven strategic

[173] Evaluation assumption 7.1.
[174] Documents: Ministry of Finance and Economic Development, "Ethiopia: Building on Progress. A Plan for Accelerated and Sustained Development to End Poverty (Pasdep) (2005/06-2009/10). Volume I: Main Text " (2006).

pillars.[175]

UNFPA was present in a number of important adolescents and youth-related national policy processes, but it did not necessarily take a leading role.[176] For example, in 2014, the MoWCYA published the Ethiopian Adolescent and Youth Status Report, the overall purpose of which was to assess the situation of adolescents and youth development in Ethiopia related to the implementation of the National Youth Policy since 2004, and the Growth and Transformation Plan since 2009. MoWCYchaired the TWG for the report, with the Packard Foundation, Pathfinder International and two consultants as members. UNICEF, rather than UNFPA, was mentioned as the key partner in the field of adolescents and youth.[177] This can be considered a missed opportunity for greater visibility and to advance the adolescents and youth agenda.

Similarly, also in 2014, a regional consultation with around 700 people from youth associations, government offices, non-governmental organisations, religious forums, and communities was held with the aim of informing national policies, especially the youth focus in the preparation of the Growth and Transformation Plan II. The findings were intended to lay the foundation for a national multi-sector coordinating body on adolescents and youth development in the country. The consultation was organised by the respective regional states' BoWCYA and BoYS, with the financial support of the Packard Foundation and the technical support of Pathfinder International. UNPFA was member of the core planning team and present at the conference, where the findings were shared and discussed with high-level dignitaries and key development partners in the field of adolescents and youth; however, UNFPA did not take a leadership role.

In 2015, UNFPA was a member of the TWG convened by the MoH for the crafting and development of the new National AYRH Strategy[178], which is to take the adolescents and youth framework into its next phase. This is an example that UNFPA actively participates in national task forces related to adolescents and youth strategic priority setting, programming and funding.

UNFPA's technical leadership has been visible in supporting the development of national plans such as the Health Sector Development Plan to include adolescents and youth sexual and reproductive health and reproductive rights[179], and UNFPA is regarded by donors and implementing partners to have been highly involved in initiating new approaches to adolescents and youth programming, such as the various Joint Programmes.[180] However, discussion with youth leaders, implementing partners and other international agencies/donors revealed a shared perspective that UNFPA's leadership was not focused on adolescents and youth sexual and reproductive health and reproductive rights to the extent that they would expect or wish.[181] Furthermore, implementing partners and donors stated that UNFPA does not adequately demonstrate and disseminate its programme results to strongly position itself as a leader of adolescents and youth sexual and reproductive health and reproductive rights, and has thereby missed opportunities to optimise and broaden donor support.[182]

[175] Interviews: UN staff, Government (central), Donor.
[176] Interviews: UN Staff, Donor. Document: Shelley Megquier and Kate Belohlav, "Ethipia`S Key: Young People and the Demographic Dividend," news release, 2014.
[177] Document: Children and Youth Affairs Ministry of Women, "Ethiopia Adolescent and Youth Status Report, 2014," (Addis Ababa, Ethiopia 2014).
[178] Interviews: UNFPA staff. Document: Ministry of Health, Invitation Letter for technical support (2015).
[179] Interviews: UN staff. Documents: Federal Ministry of Health, Planning and Programming Department, 2005. Health Sector Strategic Plan (HSDP III) IV 2005/6– 2009/10, Federal Democratic Republic of Ethiopia Ministry of Health 2010. Health Sector Development Programme IV 2010/11 – 2014/15.
[180] Interviews: Government (central), Donor, NGO.
[181] Interviews: Donor, INGO, NGO, A&Y Beneficiaries.
[182] Interviews: Donor, INGO.

5.4.2 Coordination, multi-sectoral partnerships and South-South collaboration to promote and utilise synergies at country level[183]

UNFPA in Ethiopia is credited with having facilitated important programmatic partnerships and collaborations in support of adolescents and youth. For example, the Joint Programme on adolescents and youth is engaged with multi-sectoral partnerships at different levels. As well as quarterly TWG meetings at federal level, 30 other meetings were convened at the smallest administrative unit (*woreda* level) and taskforces were also established in all six programming regions.

UNFPA has built strong collaborative partnerships with religious and clan leaders, for instance within the Joint Programme of UNFPA and UNICEF to "Accelerate Abandonment of FGM/C and across ministries. For example, UNFPA is co-chairing with the Ministry of Women and Children Affairs the National Alliance against child marriage and FGM. In addition, UNFPA is one of the key partners to engage in the multi-sectoral response against HIV and AIDS. Partners, such as donors do not always correctly perceive this. They felt that UNFPA has not engaged with a full range of ministries at central level, beyond the health sector, to establish more effective synergies for adolescents and youth sexual and reproductive health and reproductive rights and form the basis for broader donor interest and support.[184] Financial data seems to support the claim that UNFPA is not facilitating financially in substantive multi-sectoral partnership as most funds go to Ministry of Health.[185]

Evidence was found that UNFPA has managed and facilitated fundraising, leveraging and synergies among donors to support A&y interventions through joint programming. However no evidence was found that UNFPA successfully leveraged funds among government and other national partners to advance the national adolescents and youth agenda.

UNFPA has supported a range of South-South exchanges in the area of adolescents and youth. For example, among implementing partners, it facilitated experience-and knowledge sharing exchanges in fora such as the International Conference on AIDS and STIs in Africa (ICASA) in South Africa. Furthermore, the Afar Pastoralist Development Association engaged with other countries in the acceleration of the abandonment of FGC at the 2013 International Conference on Female Genital Mutilation/Cutting in Rome, which was organized by Organized by the Government of Italy, UNFPA and UNICEF.[186]

In spite of these South-South exchange investments, there is a scarcity of documentation related to follow-up of or capitalisation on these exchanges, and no apparent mechanism to guide south-south cooperation within the field of adolescents and youth. This said, South-South cooperation, where countries exchange programmatic experiences seems not to be exploited in the original sense.[187]

With regard to partnerships among UN agencies, the Joint Programme on adolescents and youth was evaluated as a strong example of the UN "Delivering as One". In working together, UNFPA and UNICEF "successfully demonstrated many features of human rights-based programming such as working with locally owned processes, combining top-down and bottom-up approaches to create synergy, and focusing on marginalised and disadvantaged groups".[188] The Joint Programme GEWE was also evaluated as a promising strategy for addressing one critical development issue or problem by a number of UN organisations, and the establishment of cross-

[183] Evaluation assumption 7.2.
[184] Interviews: Donor.
[185] Interviews: INGO, NGO. Documents: Atlas data.
[186] Interviews: UNFPA staff, NGO, A&Y Beneficiaries.
[187] UNFPA, "The Unfpa Stategic Plan, 20014-2017," (2013).
[188] Document: Evaluation documents.

institutional TWGs as a good way of ensuring participation across a large number of organisations.[189] However, no evaluative evidence was found that the Joint Programmes maximised the effectiveness of the UN country team, reduced transaction costs for Governments, donors or the UN, or strengthened the cooperation between UN organisations and donors.[190]

[189] Document: Evaluation documents.

[190] Documents: United Nations Country Team, "Development Assistance Framework in Ethiopia 2007 - 2011," (United Nations, 2006); "Ethiopia United Nations Development Assistance Framework: 2012 to 2015," (2011); "United Nations Development Assistance Frameworks Ethiopia 2012-2015," (2011); "United Nations Development Assistance Framework Action Plan. Ethopia 2012-2015," (2011).

6. Action-oriented Suggestions for UNFPA in Ethiopia

1. Show greater leadership for adolescents and youth sexual and reproductive health and reproductive rights

UNFPA should strongly invest in the dissemination of its programme results as a way to position itself as a leader in the area of adolescents and youth sexual and reproductive health and reproductive rights, and thereby optimise opportunities to broaden the base of donor support for this important thematic area. In taking a clearer adolescents and youth leadership role, UNFPA can more effectively advance multi-partner approaches to youth-friendly service provision emphasizing established international standards of service quality. UNFPA's expertise and mandate in adolescents and youth should be more explicitly expressed to implementing partners and donors as well as within the UNCT.

2. Broaden human rights based approaches to programming

Although Ethiopia's legal context makes it difficult for UNFPA to explicitly advocate for human rights-based approaches to sexual and reproductive health, there are multiple indirect ways in which UNFPA could more boldly advocate for the sexual and reproductive health and reproductive rights of adolescents and youth. For example, as a global leader in adolescent sexual and reproductive health, UNFPA could convene—or support others to convene—meetings and stimulate data development on "sensitive" sexual and reproductive health thematic areas giving space to subjects that are generally kept out of public discourse. Skills and capacities to translate human rights-based approaches into programming – beyond focusing on the roles of duty bearers - need to be strengthened, within UNFPA and among its implementing partners.

3. Advance quality age- and sex-disaggregated adolescents and youth data gathering, analyses and dissemination

With its programmatic emphasis and expertise on adolescents and youth in general and adolescent girls aged 10-14 in particular, UNFPA is well positioned to take a more strategic as well as systematic stance on data collection, disaggregation, analyses and specifically innovative dissemination for both, programming and advocacy.

4. Engage in bold dialogue with government partners for sexual and reproductive health education and information

UNFPA should use its position to engage high-level dialogue towards establishing comprehensive sexual and reproductive health education and information in Ethiopia. UNFPA should take advantage of its unique mandate to more inclusively address the needs and rights of all young people.

5. Better use of lessons learned locally, not only internationally

UNFPA should more systematically collect cases of good practice and results in country and use these lessons learned as a way to inform future programme design. While Ethiopian success stories are featured within booklets and brochures developed by HQ, they are not equally shared within Ethiopia itself. Regular updates on programmatic achievements should be presented through social media or other more innovative means of reaching a wider audience within Ethiopia.

6. Institutionalise exchange among implementing partners working in the field of adolescents and youth

UNFPA holds biannual meetings with all relevant stakeholders and implementing partners to monitor progress within the gender component of the country programme. The experiences shared not only inform programme planning on behalf of UNFPA, but serve as a forum to exchange ideas among the implementing partners. This learning platform should be institutionalised to foster communication and sharing of best practices for adolescents and youth-focused interventions as well.

7. Broaden the scope of agents of change towards more inclusive adolescents and youth programming

The current draft of the eighth country programme document has a strategic programmatic emphasis on girls aged 10-14 years and an outcome dedicated to adolescents and youth. This emphasis needs to translate into the systematic and meaningful engagement of adolescents and youth leaders and organisations as active change agents for policy development, programme design, monitoring, and implementation. UNFPA should also include boys in its focus on adolescents to more holistically respond to the sexual and reproductive health and reproductive rights needs of this age group.

Change agents should also be broadened to include other vulnerable young people such as those living with HIV and those affected by AIDS.

8. Sustain UNFPA investment in youth leadership through South-South exchange

So far, youth leadership has been supported programmatically through limited South-South exchanges. However, these exchanges have had weak and un-sustained effect due to the lack of reporting, sharing and follow-on planning. Mechanisms and/or processes should be developed for youth leaders to report, share and plan actions based on what they have learned and the connections they have made through South-South exchanges. In this way, UNFPA's investments might strengthen youth networks, advocacy and ownership of planning and action on sexual and reproductive health and reproductive rights. These investments should be monitored and evaluated to determine their efficacy in developing adolescents and youth leaders and the range of influence of adolescents and youth voices.

7. Key Considerations for the Evaluation of UNFPA Support to Adolescents and Youth

CONSIDERATION 1: Bolder approach to dialogue with government partners on sensitive issues

The integration of cultural views presents both challenges and opportunities. While it is essential to be culturally sensitive to achieve results, UNFPA must also advocate for and support the advancement of sexual and reproductive health education and information which faces opposition from traditional attitudes, values and beliefs. UNFPA should use its mandate to advocate for the sexual and reproductive health and reproductive rights of all young people at the highest government levels. This would also help create an enabling environment for other key aspects of the Fund's mandate, including sexual and reproductive health education and information and youth friendly health services.

CONSIDERATION 2: Learn from and expand faith leaders' support of adolescents and youth sexual and reproductive health

The strong implementing partnership with the Ethiopian Orthodox Church has illustrated that faith leaders and faith-based groups can open another avenue in the path towards adolescents and youth to understand their sexual and reproductive health needs. UNFPA should appropriately adapt this model in order to engage with faith leaders of other religions to provide materials that link young people of faith with positive sexual and reproductive health practices. However, special attention must be paid to ensure that core messages and principles are not diluted.

CONSIDERATION 3: UNFPA should show innovation for adolescents and youth data and evidence

Due to its programmatic emphasis and expertise on adolescents and youth in general and adolescent girls in particular, UNFPA should position itself to more strategically promote adolescents and youth data generation and use. Approaches could include greater attention to adolescents and youth indicators in surveys and censuses, and increased emphasis on innovative dissemination using new media channels for e.g. of best practices, successful models, and lessons learned.

CONSIDERATION 4: Capitalise on and sustain investments in adolescents and youth leadership

Support of youth leaders engaging in international conference participation currently has no apparent systematic reporting, planning, or follow-up. Mechanisms need to be developed for youth leaders to report and disseminate their learnings, and to support them to take action on what they have learned and connections they have made at conferences. In this way, these investments in young people would work to strengthen youth networks, as well as adolescent and youth advocacy and ownership of planning and action on sexual and reproductive health and reproductive rights.

CONSIDERATION 5: Strengthen the visibility of UNFPA within joint programming

Joint programmes for adolescents and youth in Ethiopia have demonstrated vast potential for programme success and, especially for leveraging earmarked funds. However, UNFPA must develop strategies to ensure it maintains its leadership and visibility in a field with multiple agencies with overlapping mandates.

CONSIDERATION 6: More strategic engagement on general adolescents and youth policy development

Considering that marginalised and vulnerable girls have been a strategic focus of UNFPA`s work since 2004, UNFPA has been successful in its advocacy and policy engagement with regard to child marriage and abandonment of FGM/C. Yet, UNFPA should be equally strategic and play a leadership role in engaging in policy related to the broader adolescents and youth sexual and reproductive health agenda in the country.

8. Annexes

Annex 1: Key country data Ethiopia

Country | Ethiopia	
Geographical location	• Ethiopia is located in the centre of the Horn of Africa. It shares borders with the Sudan and South Sudan to the west; Eritrea to the north and north-east; Djibouti and Somaliland to the east; Somalia and Kenya to the south. [1]
Land area	• 1.14 million km² [1]
Terrain	• High plateau with central mountain range divided by Great Rift Valley. [2]
People	
Population	• The population according to the 2007 Census was 73,918,505. 2012 projections are 91,728,800.[5]
Population growth rate (average annual)	• 2.3% (2012-2030) [5]
Urban population	• Approximately 17.2% of the population is estimated to live in urban areas. Annual urban population growth rate is 4.4%. (1990-2012) [5]
Net migration rate	• -60,001 (2012) [4]
Age structure	• 46% fall within the 1-14 age range; 51% between 15 and 64; and 3% are over 65. [1]
Median age	• 16.1 (2011) [3]
Religion	• Christians make up 62.8% of the population (43.5% follow the Ethiopian Orthodox Church and 19.3 other denominations); Muslims 33.9%; traditional faiths 2.6%; and others 0.6%. [1]
Government & Politics	
Government	• Ethiopia is a multi-party federal democracy with legislative authority resting with the government headed by an executive prime minister and the elected House of Representatives (547 members) and the House of Federation (110 members). The Prime Minister is chosen by the party in power following multi-party democratic national and federal state elections which are held every five years. Parties can be registered at either the national or the federal state level. The President is elected by the members of the House of People's Representatives. **President**: Dr. Mulatu Teshome **Prime Minister**: Hailemariam Desalegn **Speaker of the House of People's Representatives**: Abadula Gemeda. [1]
Key political events	• Two years long war between Eritrea and Ethiopia although the actual fighting was confined to three relatively short campaigns, in May-June 1998, February-June 1999 and May-June 2000. These, however, left and led to at least 60,000 casualties, as well as the expulsion of tens of thousands of Eritreans from Ethiopia (the majority of whom had voted for an independent Eritrea in the referendum of 1993) and at least as many Ethiopians from Eritrea. [1]
Seats held by women in national parliament	• 25.5 (2013) [6]
Economy	
Income Group (The World Bank List)	• Low Income Group (2012) [4]
Main industries	• Coffee, Livestock Products. Live animals and Meat, Oil Seeds and Pulses, Fruits, Vegetables and Flowers, Textile Fabrics and Garments, Natural Gum, Tea & Mineral Products. [7]
GPD per capita PPP USD	• 1140 (2012) [5]
GPD growth rate (at constant 2005 prices (annual %))	• 3.2% (2012) [5]
Social Indicators	

Human Development Index (HDI) and rank	• Value 0.396, Rank, 173 (2012) [9]
Poverty headcount ratio (at national poverty lines (% of population))	• 29.6% (2010) [4]
Unemployment, total (% of total labor force)	• 5.4% (2012) [4]
Ratio of youth unemployment rate to adult unemployment rate, both sexes (Age 15-24)	• 8.0 (2010-2014) [4]
Unemployment, youth total (% of total labor force ages 15-24)	• 8.0 (2013) [4]
Life expectancy at birth, both sexes (years)	• 63 (2012) [5]
Under 5 mortality (per 1,000 live births)	• 64 (2013) [4]
Maternal mortality (deaths of women per 100,000 live births)	• 676 (2011) [3]
Fertility rate total (live births per women)	• 4.6 (2012) [5]
Death rate, crude (per 1,000 people)	• 8 (2010-2014) [4]
Physicians density	• 0.0 (2010) per 1000. [4]
Health expenditure (% of GDP)	• 5.1% (2013) [4]
Births attended by skilled health personnel, %	• 23 (2013) [4]
Abortion rate women aged 15-49	• 23/1000 women, 2008-(Age 15-44) [10]
Contraceptive prevalence rate (age 15-49)	• 29% (2011) [3]
Unmet need for contraception (% of married women ages 15-49) (year/%)	• 25.3% (2011) [3]
Prevalence of HIV, total (% of population ages 15-49)	• 1.5% (2011) [3]
Prevalence of HIV, both sexes (% ages 15-24)	• 0.4% (2012) [5]
Gender inequality index (GII) and rank	• 0.547 Rank 121 [8]
Gender-based-violence (% women aged 15-49)	• Insufficient Information
Female Genital Mutilation/Cutting (FGM/C)	• Prevalence Women: 91.1%, Prevalence Daughters: 16.5% Attitudes, Support for the Practices: 54% (2002-2012) [5]
Adult literacy rate	• 39% (2008-2012) [5]
Individuals using the internet	• 1.5 (2012) [6]
Youth and Adolescents	
Population aged 10-19, Thousands 2012	• 22,993.3 [5]
Population aged 10-19, Proportion of total population (%) 2012	• 25.1 [5]
Adolescent birth rate	• 79% (2006-2010) [5]
Births by age 18 (%)	• 22.2 (2008-2012) [5]

Adolescents currently married/ in union (%)	• Female 19.1% • Male 2.2% (2002-2012) [5]
Contraceptive prevalence, among girls aged 15-19 (year/%)	• 29 (2011) Women Aged 15-49 [3]
Unmet need for contraception	• 26 (2011) [4]
Adolescent fertility rate (births per 1,000 women ages 15-19)	• 79 (2011) [3]
Teenage childbearing (15-19 years)	• 12 (2011) [4]
Justification of wife-beating among adolescents (%)	• Female: 64.1% • Male: 51% (2002-2012) [5]
Comprehensive knowledge of HIV among adolescents (%)	• Female: 24% • Male: 31.8% (2008-2012) [5]
Lower secondary school gross enrolment ratio	• 46.9 (2008-2012) [5]
Upper secondary school gross enrolment ratio	• 17.3 (2008-2012) [5]
Use of mass media among adolescents (%)	• Female: 38.4% • Male: 42.3% (2002-2012) [5]
A&Y laws and polices	
Insurance coverage (and free coverage) for sexual and reproductive health services for adolescents and youth	Not existing
Consent restriction for sexual and reproductive health services based on age or marital status	tba
Any restrictions on legal abortion	Since 2004. abortion is legal in Ethiopia in cases of rape, incest or fetal impairment. In addition, a woman can legally terminate a pregnancy if her life or her child's life is in danger, or if continuing the pregnancy or giving birth endangers her life. A woman may also terminate a pregnancy if she is unable to bring up the child, owing to her status as a minor or to a physical or mental infirmity (https://www.guttmacher.org/pubs/FB-UP-Ethiopia.pdf)
GBV criminal code or statuary requirements (eg requires medical confirmation of violation)	tba
Marital age	Age 18 for both male and female (http://www.popcouncil.org/uploads/pdfs/briefingsheets/ETHIOPIA.pdf)
FGM restrictions	tba
Mandatory school drop out if pregnant	tba
National law or policy covering adolescent sexual and reproductive health and youth participation in governance	tba
Health policies covering adolescent sexual and reproductive health service integration	tba
National strategy for adolescents and youth	tba

development, health, education, etc.	
Other relevant laws, polices or regulations facilitating or restricting adolescents and youth sexual and reproductive health and participation	tba
Millennium Development Goals (MDGs) Progress by Goals	
1 Eradicate Extreme Poverty and Hunger	On track to achieve. [11]
2 Achieve Universal Primary Education	On track to achieve with additional effort. [11]
3 Promote Gender Equality and Empower Women	On track to achieve with additional effort. [11]
4 Reduce Child mortality	On track to achieve. [11]
5 Improve Maternal Health	Off track to achieve. [11]
6 Combat HIV/AIDS, Malaria and other Diseases	Target more than achieved. [11]
7 Ensure Environmental Sustainability	On track to achieve. [11]
8 Develop a Global Partnership for Development	On track to achieve. [11]

References of the key country data

1. Federal Democratic Republic of Ethiopia, Ministry of Foreign Affairs []
2. World Fact Book, CIA Fact Sheet: [https://www.cia.gov/library/publications/the-world-factbook/geos/et.html]
3. Ethiopian Demographic Health Survey (EDHS) 2011: [www.unicef.org/ethiopia/ET_2011_EDHS.pdf]
4. World DataBank: Explore. Create. Share: Development Data [http://databank.worldbank.org/data/home.aspx]
5. UNICEF Statistics: Ethiopia [http://www.unicef.org/infobycountry/ethiopia_statistics.html]
6. UN Data: Country Profile Ethiopia: [http://data.un.org/CountryProfile.aspx?crname=Ethiopia]
7. Institute for the Promotion of Ethiopian Exporters: Exported Ethiopian Products [http://www.ethiopianexporters.com/products.html]
8. UNDP Human Development Reports [http://hdr.undp.org/en/content/table-4-gender-inequality-index]
9. UNDP Human Development Report: The Rise of the South, Human Progress in a Diverse World [http://hdr.undp.org/sites/default/files/Country-Profiles/ETH.pdf]
10. Guttmacher Institute: International Perspectives on Sexual and Reproductive Health, Volume 36 Number 1 March 2010 [http://www.guttmacher.org/pubs/journals/3601610.html]
11. Assessing Progress Towards the Millennium Development Goals: Ethiopia MDGs Report, 2012: [www.uneca.org/sites/default/files/publications/mdgreport2012_eng.pdf]

Annex 2: Stakeholder mapping Ethiopia

Stakeholder Group	Type of Organisation	Main Level of Operation	Where (if regional)	Main Institutional Capacities				URL
				Technical Expert Group	Knowledge Sharing & Dissemination	Policy Analysis and Dialogue	Producing Research Evidence	
Population Council	INGO	global					x	http://www.popcouncil.org/about
Amha Bureau of Fin&Econ Dev	Government		Amhara	x		x		
Min of Women Child. & Youth	Government	national		x		x		
Government 8	Government							
Government 5	Government							
Oromia Bureau of Fin&Econ Dev	Government		Oromia	x		x		
Ethiopian Orthodox Church	FBO	national		x	x			http://www.ethiopianorthodox.org/english/indexenglish.html
Government 4	Government							
African Service Committee- ETH	INGO	global		x	x			http://www.africanservices.org/
Government	Government							
Norwegian Church AID	INGO	global		x	x	x		https://www.kirkensnodhjelp.no/en/
SNNPR Bureau of Fin&Econ Dev	Government							
Anti- Malaria Association	CSO	global		x				http://cnhde.ei.columbia.edu/ngos/org06.html
AA Bureau of Fin & Econ Dev	Government			x				
Government 10	Government							
African AIDS Initiative Intern	INGO	global		x				http://www.africanaidsinitiative.org/
Government 18	Government							

Afar Bureau of Fin&Econ Dev	Government		Afar					
Government 9	Government							
Federal Ministry of Health	Government	national						
Pathfinder International	INGO	global		x				http://www.pathfind.org/our-work/where-we-work/ethiopia/
Afar Bureau Wom Child&Youth	Government		Afar					
German Foundation for World Po	INGO	global		x	x			http://www.dsw.org/home.html
Government 29	Government							
DKT ETHOPIA	INGO	global		x		x		http://www.dktinternational.org/
Government 1	Government							
Fed HIV/AIDS Prev & Cont Off	Government			x		x		
Tigray Bureau of Fin&Econ Dev	Government		Tigray					
Org for Social Svcs AIDS-ETH	INGO			x				http://www.aidsalliance.org/about/where-we-work/44-organisation-for-social-services-for-aids-ossa
International Medical corps	INGO			x				https://internationalmedicalcorps.org/
Government 30	Government							
Afar Pastoralist Development	NGO		Afar	x				http://www.apdaethiopia.org/Apda.html
Mejjejego Leko-ETH								
Government 2	Government							
Ethiopian Muslims Dev't Agency	FBO	national		x		x		http://emrda.org/
Oromia Development Assoc-ETH	NGO		Oromia	x		x		http://www.wmoda.org/index.php/en/
Mary Joy-ETH	NGO	national		x		X		http://maryjoy-ethiopia.org/

Health,Dev't & AntiMalaria Ass	NGO	National						
Mother & Child Rehab. Centre	NGO	National	Addis Ababa	x				http://www.mcrc-addisababa.org/home
UNAIDS	UN Fund/Program	global		X	X	X	X	http://www.unaids.org/en/regionscountries/countries/kyrgyzstan
UNDP	UN Fund/Program	global		X	X	X	X	http://www.undp.org/
UNICEF	UN Fund/Program	global		X	X	X	X	http://www.unicef.org/
UN Women	UN Fund/ Programme	global		X	X	X	X	http://www.unwomen.org/en
UNAIDS	UN Fund/ Programme	global		X	X	X	X	http://www.unaids.org/en/?gclid=CMeFwriviMkCFda4Gwod-uABBQ
UNDP	UN Fund/ Programme	global		X	X	X	X	http://www.undp.org/
UNESCO	UN Fund/Programme	global		X	X	X	X	http://en.unesco.org/
UNICEF	UN Fund/Programme	global		X	X	X	X	http://www.unicef.org/
UNIFEM	UN Fund/ Programme	global		X	X	X	X	http://www.unwomen.org/en
UN Women	UN Fund/ Programme	global		X	X	X	X	http://www.unwomen.org/en
WHO	UN Fund/Programme	global		X	X	X	X	www.who.org
Gates Foundation		global						http://www.gatesfoundation.org/
Norad/Embassy	Government							http://www.norad.no/en/front/
Dutch	Government							https://www.government.nl/topics/development-cooperation

Annex 3: Portfolio of UNFPA adolescents and youth interventions in Ethiopia (2008-2014)

Implementing agency	Funding source	Beneficiaries	Geographical location
ETH5G102: Child marriage project			
AA Bureau of Fin & Econ Dev	UN Women	young adolescent girls, general communities (parents, teachers etc.), community leader, local government bodies,	
Amha Bureau of Fin&Econ Dev	UN Women		
	UNFIP		
Government	UNFIP		
Government 18	UNFIP		
Government 25	UNFIP		
Government 29	UNFIP		
Government 30	UNFIP		
POPULATION COUNCIL	UN Women		
	UNFIP		
UNFPA	Spain		
	UN Women		
	UNFIP		
ETH6G102: Women's empowerment advocacy			
Min of Women Child. & Youth	UNDP-MPTF	womens groups	
	CO Programme Delivery		
ETH6G103: Resource planning for gender			
Min of Women Child. & Youth	CO Programme Delivery		
ETH6G21A: Leave No Women Behind (MDG - S)			
Amha Bureau of Fin&Econ Dev	Spain		
Min of Women Child. & Youth	Spain		
ETH6R201: Comprehensive reproductive health			
AA Bureau of Fin & Econ Dev	CO Programme Delivery	service provider	

Amha Bureau of Fin&Econ Dev	CO Programme Delivery		
Government 10	CO Programme Delivery		
Government 8	CO Programme Delivery		
SNNPR Bureau of Fin&Econ Dev	CO Programme Delivery		
Tigray Bureau of Fin&Econ Dev	CO Programme Delivery		
ETH6R207: Capacity to manage integrated Reproductive Health			
Federal Ministry of Health	CO Programme Delivery	health manager, service providers	
Government 10	CO Programme Delivery		
ETH6R209: Scaling-up for HIV prevention			
AA Bureau of Fin & Econ Dev	CO Programme Delivery	adolescent and youth in general, service provider, university students	
Afar Bureau of Fin&Econ Dev	CO Programme Delivery		
Amha Bureau of Fin&Econ Dev	CO Programme Delivery		
Government 10	CO Programme Delivery		
Government 2	CO Programme Delivery		
Government 4	CO Programme Delivery		
Government 5	CO Programme Delivery		
Government 8	CO Programme Delivery		
Government 9	CO Programme Delivery		
Oromia Bureau of Fin&Econ Dev	CO Programme Delivery		
SNNPR Bureau of Fin&Econ Dev	CO Programme Delivery		
ETH6R301: Awareness about sexual and reproductive health/RR/Gender			
Min of Women Child. & Youth	CO Programme Delivery		
ETH6R51D: A Right Based approach to Adolescent and Youth Development			
AA Bureau of Fin & Econ Dev	Norway	adolescent and youth in genera, in and out of school youth, health providers, youth groups, university students, media	6 regions, 30 woredas
Afar Bureau of Fin&Econ Dev	Norway		
African AIDS Initiative Intern	Norway		

African Service Committee- ETH	Norway		
Amha Bureau of Fin&Econ Dev	Norway		
Anti- Malaria Association	Norway		
Ethiopian Orthodox Church	Norway		
Government	Norway		
Government 1	Norway		
Government 10	Norway		
Government 18	Norway		
Government 4	Norway		
Government 5	Norway		
Government 8	Norway		
Government 9	Norway		
	CO Programme Delivery		
Intergrated Service for AIDS S	Norway		
International Medical corps	Norway		
Oromia Bureau of Fin&Econ Dev	Norway		
POPULATION COUNCIL	Norway		
SNNPR Bureau of Fin&Econ Dev	Norway		
UNFPA	Norway		
ETH7U203: High-quality information and services			
AA Bureau of Fin & Econ Dev	CO Programme Delivery	adolescents and youth sexual and reproductive health service provider	
Afar Bureau of Fin&Econ Dev	CO Programme Delivery		
Amha Bureau of Fin&Econ Dev	CO Programme Delivery		
Federal Ministry of Health	CO Programme Delivery		
Oromia Bureau of Fin&Econ Dev	CO Programme Delivery		
SNNPR Bureau of Fin&Econ Dev	CO Programme Delivery		

Tigray Bureau of Fin&Econ Dev	CO Programme Delivery		
UNFPA	CO Programme Delivery		
	Sweden		
ETH7U404: Increased availability of high-quality HIV Prevention Services			
AA Bureau of Fin & Econ Dev	Norway	adolescents and youth sexual and reproductive health service provider	
	CO Programme Delivery		
Afar Bureau of Fin&Econ Dev	Norway		
Amha Bureau of Fin&Econ Dev	Norway		
Oromia Bureau of Fin&Econ Dev	Norway		
	CO Programme Delivery		
SNNPR Bureau of Fin&Econ Dev	Norway		
	CO Programme Delivery		
UNFPA	CO Programme Delivery		
ETH7U509: Community response to Harmful Traditional Practices and Gender Based Violence			
Afar Bureau of Fin&Econ Dev	Joint Programme POOL FGM/C	vulnerable and marginalized girls, peer-educators, girls clubs	
Amha Bureau of Fin&Econ Dev	CO Programme Delivery		
Mary Joy-ETH	Netherlands		
Mejjejego Leko-ETH	Netherlands		
	UN Women		
Min of Women Child. & Youth	Spain		
	UNDP-MPTF		
Mother & Child Rehab. Centre	Netherlands		
Oromia Development Assoc-ETH	Netherlands		
ETH7U510: Institutional response to Harmful Traditional Practices			
Mary Joy-ETH	Netherlands	judges, police, FBOs, peer-educators	
Min of Women Child. & Youth	CO Programme Delivery		

	UNDP-MPTF		
UNFPA	CO Programme Delivery		
	Small Contributions		
ETH7U608: sexual and reproductive health rights to information and Services			
DKT ETHOPIA	CO Programme Delivery	adolescent and youth clubs,	
	Republic of Korea		
Ethiopian Orthodox Church	Norway		
	CO Programme Delivery		
Federal Ministry of Health	Norway		
German Foundation for World Po	Norway		
Min of Women Child. & Youth	CO Programme Delivery		
Norwegian Church AID	Norway		
Population Council	Norway		
UNFPA	Gates Foundation		
	Norway		
	CO Programme Delivery		
ETH7U706: Enhanced capacity of selected of selected National Institutions			
Min of Women Child. & Youth	UNDP-MPTF		
GHR6U513: Strengthened national capacity for addressing GBV			
Afar Bureau Wom Child&Youth	Joint Programme POOL FGM/C		
GRP6G21A: Advocacy on Women & girls Reproductive Right, male involvement & elimination of harmful practices			
UNFPA	Joint Programme POOL FGM/C		
GRP6G42A: Global awareness on gender-based violence impact			
Afar Pastoralist Development	Joint Programme POOL FGM/C		
Afar Bureau Wom Child&Youth	Joint Programme POOL FGM/C		
UNFPA	Joint Programme POOL FGM/C		

Annex 4: List of documents consulted

African Health Observatory and WHO, Ethiopia: Health statistics profile 2010.

Ambelu, W., et al., Ethiopia Young Adult & Gender Survey: Afar Region. 2010.

Arawolo, O.O., Country Case Study: Ethiopia - Country case study prepared for the Center for Global Development Working Group on UNFPA's Leadership Transition. 2010.

Central Statistical Agency Ethiopia and ICF International, Ethiopia Demographic and Health Survey 2011.

Collins, T., et al., A Rights-Based Approach to Adolescent and Youth Development, Ethiopia: End of Programme Evaluation 2013.

Degefa, T., Harnessing Demographic Dividend in Ethiopia: Assessment of the Opportunities and Challenges. 2014.

Erulkar, A.S., et al., Ethiopia Young Adult Survey: A Study in Seven Regions. 2010.

Erulkar, A.S. and E. Muthengi, Evaluation of Berhane Hewan: A Pilot Program to Promote Education & Delay Marriage in Rural Ethiopia. 2007.

Ethiopian Exporters Institute. Exported Ethiopian Products: http://www.ethiopianexporters.com/.

Etta, F.E., Y. Endeshaw, and A.K. Wold, Ethiopia Joint Flagship Programme on Gender Equality and Women`s Empowerment (Joint Programme GEWE). End-Evaluation of Phase 1. 2013.

Executive Board of UNFPA. UNFPA Ethiopia Extension of Country Prgrammes. 2015.

Federal Democratic Republic of Ethiopia, National Youth Policy, 2004.

Federal Democratic Republic of Ethiopia, Standards on Youth Friendly Reproductive Health Services: Service Delivery Guideline & Minimum Service Delivery Package on YFRH Services, 2007.

Federal Democratic Republic of Ethiopia, Growth and Transformation Plan (Growth and Transformation Plan): 2010/11-2014/15. 2010.

Federal Democratic Republic of Ethiopia, Tools (Planning, Implementing, and Monitoring) for Adolescent and Youth Friendly Reproductive Health (AYFRH) Service Standards in Ethiopia. 2010.

Federal Democratic Republic of Ethiopia Ministry of Foreign Affairs. http://www.mfa.gov.et/.

Federal Democratic Republic of Ethiopia Ministry of Health, National Adolescent and Youth Reproductive Health Strategy. 2006.

Federal Democratic Republic of Ethiopia Ministry of Health, Health Sector Development Programme 2010-2015. 2010.

Feder Government of the Democratic Republic of Ethiopia, Constitution of the Federal Democratic Republic of Ethiopia. 1994.

Feder Government of the Democratic Republic of Ethiopia, Criminal Code of the Federal Democratic Republic of Ethiopia. 2005.

Feder Government of the Democratic Republic of Ethiopia, Federal Negarit Gazetta of the Federal Democratic Republic of Ethiopia the Revised Family Code Federal Negarit Gazetta - Extra Ordinary Issue No. 1/2000 the Revised Family Code Proclamation No. 213/2008. 2008.

Federal Ministry of Education Ethiopia, Education Sector Development Program IV (ESDP IV): 2010/2011 – 2014/2015 2003 EC – 2007 EC: Program Action Plan, 2010.

Federal Ministry of Health Planning and Programming Department, Health Sector Strategic Plan 2005-2010. 2005.

Ferede, A. and A. Erulkar, Adolescent girls in urban Ethiopia: Vulnerability & opportunity. 2009.

Ferede, A., et al., Ethiopia Young Adult & Gender Survey: Amhara Region. 2010.

Gebreselassi, T. and P. Govindasamy, Level and Trends in Unmet Need for Family Planning among Adolescents and Young Women in Ethiopia. 2013.

Girma, W., et al., Ethiopia Young Adult & Gender Survey: Southern Nations, Nationalities and People`s Region. 2010.

ICF International, Trends in Key Demographic and Health Indicators for Young Adults. Data from the 2000, 2005, and 2011 Ethiopia Demographic and Health Surveys. 2012.

ICF International, Atlas of Youth Reproductive health: Data from the 2011 Ethiopian Demographic and Health Survey. 2012.

ICF International, Trends in Demographic and Reproductive Health Indicators in Ethiopia. 2013.

Jensen, J. and K. Helmore, Voices of Change. 2014 Annual Report of the UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change. 2014.

Kaba, M., Desk Review on Adolescent and Youth Sexual Reproductive Health in Ethiopia. 2012.

Kabuchu, H., Ethiopia Gender Joint Programme MTE Final Draft Report, REGION: Africa, Country: Ethiopia. Window: Gender Equality & Women's Empowerment. Leave No Woman Behind (LNWB). 2010.

Kabuchu, H. and MDG Achievement Fund, Final Evaluation 2013: Africa: Gender Thematic Window - Ethiopia - UN Joint Programme on Leave No Woman Behind (LNWB). 2013.

Megquier, S. and K. Belohlav, Ethiopia's Key: Young People and the Demographic Dividend, 2014.

Merso, F., Women & Girls and HIV/AIDS in Ethiopia. NN: Addis Ababa.

Ministry of Finance and Economic Development, Ethiopia: Building on Progress. A Plan for Accelerated and Sustained Development to End Poverty (PASDEP) (2005/06-2009/10). Volume I. 2006.

Ministry of Women, C.a.Y.A., Summary Report of the Regional Consultative Meetings "Integrated Multi-Sectoral Response for Sustainable Youth Development". 2014.

Ministry of Women, C.a.Y.A., Ethiopia Adolescent and Youth Status Report, 2014. 2014: Addis Ababa, Ethiopia.

Muthengi Karei, E. and A.S. Erulkar, Building Programs to Address Child Marriage: The Berhane Hewan Experience in Ethiopia. 2010.

National Legislative Bodies / National Authorities, Ethiopia: Proclamation No. 621/2009 of 2009, Charities and Societies Proclamation. 2009.

NEWA, Baseline Study Report conducted in four University within the program "Enhancement of Women`s and girl`s reproductive Health in Ethiopia. 2009.

NN, Summary Report of the Regional Consultative Meetings: "Integrated Multi-Sectoral Response for Sustainable Youth Development". 2014.

Singh, S., et al., The Estimated Incidence of Induced Abortion In Ethiopia, 2008. International Perspectives on Sexual and Reproductive Health, 2010. 36(1): p. 16-25.

Tagebuer, D., Risky Behaviors and predisposing Factors among Ethiopian University Students. 2011.

The World Bank Group. World Data Bank: Explore. Create. Share: Development Data 25.05.2015]; Available from: http://databank.worldbank.org/data/home.aspx.

UNDP. Human Development Reports: Gender Inequality Index. http://hdr.undp.org/en/content/table-4-gender-inequality-index.

UNDP, National Human Development Report 2014 Ethiopia. Accelerating Inclusive Growth for Sustainable Human Development in Ethiopia. 2015.

UNFPA, Country Programme for Ethiopia. 2006.

UNFPA, Country Programme Action Plan between the Government of the Federal Democratic of Ethiopia and the United Nations Population Fund 2007-2011. 2006.

UNFPA, Strategic plan, 2008-2011: Accelerating progress and national ownership of the ICPD Programme of Action. 2007.

UNFPA, Strategic Plan 2008-2011: Indicators, Baselines and Targets. 2007.

UNFPA, Strategic Plan 2008-2011 - Development Results Framework. 2007.

UNFPA, Strategic Plan 2008-2011 - Management Results Framework. 2007.

UNFPA, Strategic Plan 2008-2011: Development and Management Results Frameworks Indicators, Baselines and Targets 2008.

UNFPA, Ethiopia Country Office Annual Report. 2008.

UNFPA, Ethiopia Country Office Annual Work Plan. 2008.

UNFPA, Ethiopia Country Office Annual Report. 2009.

UNFPA, Ethiopia Country Office Annual Work Plan. 2009.

UNFPA, Ethiopia Country Office Annual Report. 2010.

UNFPA, Ethiopia Country Office Annual Work Plan. 2010.

UNFPA, Ethiopia Country Office Annual Report. 2011.

UNFPA, Ethiopia Country Office Annual Work Plan. 2011.

UNFPA, Ethiopia Country Programme Performance Summary. 2011.

UNFPA, Draft country Programme Document for Ethiopia. 2011.

UNFPA, Midterm review of the UNFPA strategic plan, 2008-2013. 2011.

UNFPA, Ethiopia Country Office Annual Report. 2012.

UNFPA, Ethiopia Country Office Annual Work Plan. 2012.

UNFPA, Ethiopia Country Office Annual Report. 2013.

UNFPA, Ethiopia Country Office Annual Work Plan. 2013.

UNFPA, UNFPA Strategy on Adolescents and Youth. Towards realizing the full potential of adolescents and youth. 2013.

UNFPA, Report of UNFPA Ethiopia Programme Review and Planning Workshop. 2013.

UNFPA, UNFPA Strategy on Adolescents and Youth. Towards realizing the full potential of adolescents and youth. 2013.

UNFPA, ICPD Beyond 2014: Linkages with the strategic framework. 2013.

UNFPA, Ethiopia Country Office Annual Report. 2014.

UNFPA, Ethiopia Country Office Annual Work Plan. 2014.

UNFPA. Proceedings of the Town Hall Meeting & Campaign to End Child Marriage: May 28 - 29, 2014

UNFPA, UFFPA profile design. 2014.

UNFPA, Proceedings of UNFPA Ethiopia Country Office Programme Review and Planning Workshop. 2014.

UNFPA, UNFPA`s Action for Adolescent Girls. Building the health, social and economic assets of adolescent girls, especially those at risk of child marriage, in Programme document. 2014.

UNFPA, The UNFPA Strategic Plan, 2014-2017. 2014.

UNFPA, The UNFPA Strategic Plan, 2014-2017: Annex 1 - Integrated results framework. 2014.

UNFPA, The UNFPA Strategic Plan, 2014-2017: Annex 2 - Outcome theories of change. 2014.

UNFPA, The UNFPA Strategic Plan, 2014-2017: Annex 3 - Business model. 2014.

UNFPA, The UNFPA Strategic Plan, 2014-2017: Annex 4 - Funding arrangements. 2014.

UNFPA, The UNFPA Strategic Plan, 2014-2017: Annex 5 - Alignment of the Strategic Plan with QCPR 2014.

UNFPA, Extension of country Programmes, in DP/FPA/2015/14. 2015.

UNFPA, Country Programme Document. 2016.

UNFPA and UNICEF, UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change. Annual Report 2012. 2012.

UNFPA and UNICEF, Joint Evaluation: UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change (2008 - 2012) - Final Report (Volume II) - Evaluation Report. 2013.

UNFPA and UNICEF, 2013 UNFPA-UNICE Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change. Summary Report of Phase 1, 2008-2013. 2013.

UNFPA and UNICEF, 2014 Annual Report of the UNFPA_UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change 2014.

UNFPA Evaluation Office and UNICEF Evaluation Office, Joint Evaluation: UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change 2008-2012 (Volume I). 2013.

UNICEF. Ethiopia: Statistics. 2013. http://www.unicef.org/infobycountry/ethiopia_statistics.html.

UNICEF and UNFPA, Monitoring & Evaluation Framework. UNICEF & UNFPA Joint Program Rights-based Approach to Adolescent & Youth Development & HIV Prevention. 2011.

UNICEF and UNFPA, Rights-Based Approach to Adolescent and Youth Development in Ethiopia: UNICEF and UNFPA Joint Programme (2007 – September 2013) - Final Progress Report. 2013.

UNICEF and UNFPA, Funding Proposal to the Norwegian Government: Joint Programme on Rights-Based Approach to Adolescent & Youth Development in Ethiopia: Phase II (2014 –2017). 2013.

United Nations, Ethiopia: Health profile. 2014.

United Nations Country Team, Development Assistance Framework in Ethiopia 2007 - 2011. 2006.

United Nations Country Team, Ethiopia United Nations Development Assistance Framework 2012 to 2015. 2011.

United Nations Country Team, United Nations Development Assistance Framework Action Plan. Ethiopia 2012-2015. 2011.

United Nations Economic Commission for Africa, et al., MDG Report 2014: Assessing Progress in Africa toward the Millennium Development Goals. Analysis of the Common African Position on the post-2015 Development Agenda. 2014.

United Nations Statistics Division. Country Profile Ethiopia. http://data.un.org/CountryProfile.aspx?crname=Ethiopia.

Universalia, UNDAF Ethiopia Mid-Term Review (MTR). Final Report Volume 1. 2014.

WHO, Ethiopia: WHO statistical profile 2012. 2015.

World Fact Book. CIA Fact Sheet. https://www.cia.gov/library/publications/the-world-factbook/geos/et.html.

Yusuf, Y., Report on the Mid Term Review of UNFPA`s CPAP (2007-2011): RH, HIV Prevention and Humanitarian Components. 2009.

Yusuf, Y., Summary Report of Program Evaluations under Sixth and Seventh Country Programs. 2015.

Annex 5: List of people consulted

Definition of Categories:

UNFPA: all UNFPA staff
UN Staff: staff from any other UN organisations including the World Health Organisation & World Bank
Government Partners: including local and central levels and service providers
Donors: including bilateral donors and foundations
International NGOs: including international NGOs and CSOs
National NGOs, CSOs and Academia: any national NGO, CSO or academic institution including universities
A&Y Beneficiaries: including A&Y leaders, volunteers, and youth led organizations, eRoundtable participants

UNFPA				
#	**First Name**	**Family Name**	**Sex**	**Position |Name of Organisation**
1	Dursit	Abdishekur	m	Program Coordinator, A&Y Development Program | UNFPA
2	Addisu	Chane	m	Regional Programme Coordinator | UNFPA, Regional Office
3	Sabine	Beckmann	f	Program Coordinator, SRH & HIV and AIDS | UNFPA
4	Tsehay	Gette	f	National Program Officer Gender | UNFPA
5	Bethelhem	Kebede	f	National Program Officer Gender & Human Rights | UNFPA
6	Behanu	Legesse	m	Assistant Resident Representative | UNFPA
7	Meron	Negussi	f	Program Specialist Adolescent and Youth Development | UNFPA
8	Faustin	Yao	m	Representative | UNFPA
UN Staff				
#	**First Name**	**Family Name**	**Sex**	**Position |Name of Organisation**
9	Girma	Alemayeha	m	National Program Officer | UNESCO
10	Wondwossen	Temiess	m	Adolescents & HIV Program Specialist | UNICEF
Government Partners				
#	**First Name**	**Family Name**	**Sex**	**Position |Name of Organisation**
11	Mengist	Alamirew	m	Zonal government

12	Anteneh	Ale	m	Woreda Government
13	Mohammad	Ali	m	Child Protection Officer | Woreda Office Afar
14	Simegn	Amogne	f	Zonal government
15	Yeshiwas	Demilew	m	Zonal government
16	Nazartetu	Desalegn	f	Finance Officer | HIV AIDS Prevention and Control Office (HAPCO) Region
17	Kefele	Fanta	m	Kebele administrator
18	Yemane	Gesesew	m	Commander | Federal Police
19	Zahra	Humed	f	Head of the Bureau | Women Children & Youth Affairs Bureau Afar Region
20	Meskele	Lara Lencha	m	Director General | Pharmaceuticals Fund and Supply Agency
21	Temeta	Mengistu	m	Joint Programme Focal Person | HIV AIDS Prevention and Control Office (HAPCO) Region
22	Yayo	Mohammad	m	HIV/AIDS UNDAF Coordinator | HIV AIDS Prevention and Control Office (HAPCO) Afar
23	Haileleul	Siyoum	m	Directorate Director | Ministry of Women, Children and Youth Affairs -(MoWCY)
24	Aster	Teshome	f	EMwA President/A&Y focal person | Ministry of Health (MoH)
25	Tsigerada	Zendu	f	Vice-President | Ethiopian Youth Federation

Donors

#	First Name	Family Name	Sex	Position |Name of Organisation
26	Teshome	Admassu	m	Program Associate | Packard Foundation
27	Tsige	Alemayehu	f	Program Officer | Royal Norwegian Embassy
28	Yemeserach	Belayneh	f	Country Advisor | Packard Foundation
29	Havard	Hoksnes	m	Head of Development Cooperation | Royal Norwegian Embassy
30	Bouwe-Jan	Smeding	m	First Secretary Health | Kingdom of the Netherlands

International NGOs

#	First Name	Family Name	Sex	Position |Name of Organisation
31	Addisalem	Befekadu	f	Program Coordinator | Norwegian Church Aid (NCA)
32	Kidist	Belaynek	f	Program Manager | Norwegian Church Aid (NCA)
33	Annabel	Erulkar	f	Country Director | Population Council
34	Elleni	Gebreamlak	f	President | Africa AIDS Initiavitve (AAI)
35	Molalika	Seman	m	Program Director | Africa AIDS Initiavitve (AAI)

National NGOs, CSOs, Academia				
#	First Name	Family Name	Sex	Position |Name of Organisation
36	Samson	Bekele	m	Department Head- HIV Prevention & Control Unit | Ethiopian Orthodox Tewahdo Church
37	Valerie	Browning	f	Program Coordinator | Afar Pastoralists Development Association (APDA)
38	Endalkachew	Chane	m	Accountant | Organization for Social Services for AIDS (OSSA)
39	Dereise	Demeke	m	Editor | Pro Pride
40	Dawit	Desalegn	m	Program Director | Ethiopian Society for Obestetricians & Gynecologists
41	Abdulkadir	Eado	m	Finance & Admin Head | Organization for Social Services for AIDS (OSSA)
42	Tefera	Haile	m	Program Coordinator | Family Guidance Association of Ethiopia (FGAE)
43	Nuredin	Jemech	m	Program Director | Ethiopian Muslim Development Organization (EMDA)
44	Desta	Kebede	m	Programm Director | Family Guidance Association of Ethiopia (FGAE)
45	Selamawit	Kifle	m	General Manager | Ethiopian Society for Obestetricians & Gynecologists
46	Alemayehu	Kisi	m	Anti HIV/AIDS and RH Club President | Africa AIDS Initiative
47	Henok	Melesse	m	Managing Director | Save Your Generation Ethiopia (SYGE)
48	Genet	Mengistu	f	Director General | Family Guidance Association of Ethiopia (FGAE)
49	Trehas	Mezgebe	f	Executive Director | Mujejeguwa Loka, Womens Development Association
50	Ephrem	Mohammad	m	Managing Director | Talent Youth Association (TaYA)
51	Maria	Murit	f	Executive Director | Association for Womens Sancutray and Development
52	Samuel	Said	m	Journalist | Pro Pride
53	Yemisirach	Seifu	f	Program Manager | Talent Youth Association (TaYA)
54	Bekele	Senbete	m	Executive Director | Organization for Social Services for AIDS (OSSA)
55	Tiruedl	Shitaye	f	Chair Person of AAU Girls Club | Africa AIDS Initiative
56	Meti	Terefe	f	Programme Coordinator | Association for Womens Sancutray and Development
57	Elisabeth	Tesfaye	f	Women's Association Secretary | Semera University
58	Ibrahim	Yusuf	m	Program Manager | Organization for Social Services for AIDS (OSSA)
A&Y Beneficiaries				
#	First Name	Family Name	Sex	Position |Name of Organisation
59	Azenek	Abat	f	Student

60	Amina	Abdu	f	Peer Educator
61	Fatuma	Abdu	f	Peer Educator
62	Aisa	Abi	f	Peer Educator
63	Momina	Abreham	f	Peer Educator
64	Minale	Ademe	m	Priest
65	Rokiya	Ahmed	f	Peer Educator
66	Fatuma	Ahmed	f	Peer Educator
67	Fatuma	Ahmed	f	Peer Educator
68	Bidiga	Ali	f	Peer Educator
69	Aynete	Amele	f	Farmer
70	Endugday	Asefa	f	Farmer
71	Yeromnesh	Asfaw	f	Gender Club Secretary | Semera University
72	Gojam	Atinkugn	f	Student
73	Mekdes	Awubel	f	Student
74	Teshamush	Ayele	f	Student
75	Fatuma	Ayifrah	f	Peer Educator
76	Amalye	Aynalem	f	Farmer
77	Melese	Berasu	m	Temari-net Club Chair | Semera University
78	Hilina	Berhanu	f	Peer Educator | Africa AIDS Initiative
79	Minwuyelet	Biresaw	m	schoold director
80	Kibiru	Bogale	m	Peer Educator | Semera University
81	Fatuma	Bore	f	Peer Educator
82	Getachew	Gedeno	m	Peer Educator | Semera University
83	Kasaye	Genete	f	Farmer
84	Kidist	Getachew	f	Peer Educator | Africa AIDS Initiative
85	Belay	Getnet	m	Peer Educator | Africa AIDS Initiative
86	Banchamlak	Gudu	f	Student
87	Nebat	Hadgu	f	Peer Educator | Africa AIDS Initiative
88	Mekasha	Hailu	m	Peer Educator | Africa AIDS Initiative
89	Fatuma	Hammad	f	Peer Educator

90	Asia	Hammad	f	Peer Educator
91	Amina	Hebano	f	Peer Educator
92	Bidiga	Hussien	f	Peer Educator
93	Kulsuma	Idhis	f	Peer Educator
94	Hawi	Iga	f	Peer Educator
95	Zahara	Kadish	f	Peer Educator
96	Hunelign	Ketema	m	Peer Educator | Africa AIDS Initiative
97	Meseret	Meke	f	Student
98	Hawu	Mohammad	f	Peer Educator
99	Merima	Mohammad	f	Peer Educator
100	Kulsuma	Mohammad	f	Peer Educator
101	Lubaba	Mohammad	f	Peer Educator
102	Tigist	Mulugeta	f	Women's Association President | Semera University
103	Amina	Mustafa	f	Peer Educator
104	Amina	Nuru	f	Peer Educator
105	Degu	Sewnegn	m	Priest
106	Wubager	Shale	f	Student
107	Aklile	Solomon	f	Peer Educator | Africa AIDS Initiative
108	Hilina	Stiphanos	f	Peer Educator | Africa AIDS Initiative
109	Shasehe	Tedesse	f	Student
110	Meke	Tefera	m	Farmer
111	Zebib	Teklay	f	Peer Educator | Semera University
112	Bithoegn	Tesfahun	m	Farmer
113	Senait	Tsegaye	f	Peer Educator | Semera University
114	Hasena	Umer	f	Peer Educator
115	Hasena	Usman	f	Peer Educator
116	Atitegeb	Wole	f	Farmer
117	Indris	Yasin	m	Peer Educator | Africa AIDS Initiative
118	Tsedelu	Yirsa	m	Anti HIV/AIDS Vice Chair | Semera University