SUMMARY

Annual Action Programme 2018 Part 1 in favour of Ethiopia to be financed from the 11th European Development Fund

1. Identification

EDF allocation	11th European Development Fund (EDF)
Total cost	**EUR 30 000 000** (EU contribution)
Basic act	Council Regulation (EU) 2015/322 of 2 March 2015 on the implementation of the 11th European Development Fund

2. Country background

Ethiopia is a landlocked country and second most populous country in sub-Saharan Africa (after Nigeria), with an estimated population of 101 million. Ethiopia plays an important role as a source of stability in an unstable and conflict-afflicted region. The position of Ethiopia as a strategic partner for the EU in the Horn has been recognised by the signing of the **EU-Ethiopia Strategic Engagement** in June 2016. However, internal tensions have increased due to both lack of political and economic inclusiveness.

Since the 2005 elections, the country has witnessed a progressive erosion of political freedoms and human rights. **Political and ethnic tensions** increased since 2015, notably in the Oromia and the Amhara regions. The underlying concerns are lack of democratic space and participation, unequal distribution of wealth, and malfunctioning federal mechanisms. Under the State of Emergency (10/2016 to 08/2017) tens of thousands of people were arrested and there were increased concerns about human rights violations. In February 2018 the Prime Minister resigned and the State of Emergency was re-imposed, with continued protests and episodes of violence. The election of Prime Minister Dr Abiy Ahmed in April 2018 has however raised new hopes of political and economic reforms.

Ethiopia has made remarkable **economic progress**. Its broad-based growth averaged 10.5 % a year from 2005-2006 to 2015-2016, compared to a regional average of 5.4 %. The service sector accounts for the highest growth (15 %), agriculture for more than 8 %, and industrial development doing less than expected (10 % instead of the foreseen 11-18 %). The economy is strongly marked by agriculture, which contributes 36 % to the GDP and employs close to 70 % of the population. However, most agricultural activities are performed by small-scale and family entities marked by low productivity and output, and the sector is highly vulnerable to climate change.

Foreign direct investment has increased from less than USD 820 million in 2007-2008 to 3.2 billion in 2015-2016. However, firms are seriously constrained by administrative burden, poor logistics, lack of forex access, inadequate domestic supply of raw material inputs, and lack of suitable skills among the work force. Ethiopia remains close to the bottom of the Ease of Doing Business (161 out of 190 countries in 2016); the Global Competitiveness Index (109 out of 140 countries in 2016); the Transparency International Corruption Perceptions Index (103 of 168 countries in 2015); and the Economic Freedom Index (148 out of 178 countries in 2015).

The Government of Ethiopia's (GoE) development strategy, the **"Growth and Transformation Plan II"** (GTP II), which is complemented by the Climate Resilient Green Economy Strategy, focuses on infrastructure, industry, the participation of the private sector, a stable macroeconomic environment, good governance and access to quality social services – to be achieved in an environmentally sound manner. It stresses the willingness to make the country a leader in light manufacturing in Africa, mainly by developing **import substituting and export oriented industries**, promoting domestic private sector development and supporting human capital development. This strategy should also contribute to tackling **unemployment** which is particularly high in urban areas and a major economic and social challenge (over 2 million young people entering the job market every year). With a large informal sector as the most important source of employment for the growing population, job quality remains a concern.

Ethiopia remains a least developed country (LDC) with a per capita income of USD 660 and ranking 174/188 in the 2016 UNDP Human Development Index. Despite significant progress in child mortality, exposure to hunger and school enrolment, the country is still facing important challenges in **maternal mortality, nutrition and gender**. The population still largely dependent (85 %) on low-productive rain-fed agriculture, with a high chronic malnutrition rate (44 % stunting for under-five year olds) and a high maternal mortality rate (676 per 100 000 live births). Other challenges are the recurrent food insecurity following periods of drought and in the maintenance of productive agricultural and water supply due to the **deterioration of the environment**.

The year 2017 saw another major drought in Ethiopia. Half a million people are displaced because of the drought, and **8.3 million Ethiopians are expected to be in need of emergency assistance** –despite the Ethiopian Social Safety net (PSNP) which covers 7.9 million people. In addition to the drought, the South and South-East of the country are also affected by the conflict between Oromia and Somali Region which has flared up since September 2017. Over one million people have been displaced because of the violence. The Humanitarian appeal presented by the GoE for 2018 amounts to USD 1.6 billion for a caseload of 7.88 million persons.

Ethiopia, which currently hosts nearly 900 000 refugees, is one of the focus countries for the roll-out of the **Comprehensive Refugee Response Framework (CRRF)** as set-out in the New York Declaration on Refugees and Migrants. The Ethiopian Government has made a major policy shift in the refugee response and now seeks to increase refugee self-reliance by gradually allowing for inclusion of refugees into socio-economic structures outside camps. Revision of the Refugee Proclamation is required to implement these pledges and its adoption is still pending.

3. Summary of the Action Programme – Part 1

The Annual Action Programme (AAP) 2018 supports the Ethiopian development strategy "**Growth and Transformation Plan II**" (GTP II), which is in line with the United Nations 2030 Agenda for Sustainable Development. Priorities of GTP II include improved access to quality social services. The AAP 2018 – Part 1 will support the following sectors of cooperation identified in the National Indicative Programme (NIP): "Health" and "Civil Society and Synergetic Governance" – contributing to **Sustainable Development Goals (SDGs) 1, 2, 3 and 5**.

Action 1: Ethiopian Social Accountability Programme III (ESAP3)

Priority - Support Ethiopia's immediate stability and peace by means of dialogue and by providing technical and financial support to the political reform programme and to more inclusive governance.

ESAP3 is a multi-donor programme the objective of which is to strengthen the capacities of citizens groups, representatives and government to work together in enhancing the access and the quality of basic services in five decentralised sectors (education, health, water and sanitation, agriculture and rural roads). ESAP3 builds on the achievements of the previous phases in 223 woredas of the country (20 % of the woredas), including concrete improvements in the access and quality of services as well as the creation of a constructive dialogue between service users and service providers to assess challenges, identify priority actions and monitor their implementation.

This new phase aims at expanding the benefits of social accountability to a growing number of citizens and service users across the country by increasing the coverage from the existing 223 woredas to 500 woredas (50 % of the woredas) as well as by expanding to additional kebeles. The programme will continue to support awareness and voice of the demand for better services, by helping communities articulate their demands in line with sector standards and by facilitating a constructive dialogue with service providers. This third phase also aims at strengthening responsiveness to citizens' demands by mainstreaming social accountability approaches within government processes, including budget cycle, and by working more closely with the councils. To this aim, the programme will pursue and foster the critical facilitation role played by a set of diverse Civil Society Organisations (CSO), including resident and Ethiopian charities and societies.

The overall objective of the programme is to support and strengthen the social accountability system and mechanism for enhanced service delivery in Ethiopia by 1) Expanding the uptake of social accountability tools; 2) Supporting the strengthening and embedding of social accountability tools and approaches at federal and subnational level; 3) Ensuring effective and efficient project management, coordination and knowledge management.

ESAP3 total envelope is USD 53 000 000 and will be implemented through two funding channels. A World Bank-managed Multi-donor Trust Fund (USD 33 000 000) potentially including Austrian Development Cooperation, Irish Aid, Sweden, the Department for International Development (DfID), the United States Agency for International Development (USAID) and the EU and an International Development Association (IDA) grant (USD 20 000 000) managed by the World Bank and the Government.

Previous phases of the project have shown that ESAP can be instrumental in addressing **gender equality and inclusion of vulnerable groups** at local levels through the social accountability process and tools (e.g. quotas for women's participation in basic service assessment, capacity development of women's groups, representatives in Social Accountability Committees (SACs) to identify priorities, gender-responsive budgeting etc.) These aspects will be further reinforced by ensuring the participation of the Ministry of Women's Affairs in ESAP3 Steering Committee at federal level. The programme follows a **rights-based approach** and facilitates participation and access to decision making processes, non-discrimination and equal access, accountability and access to the rule of law, and transparency and access to information. In addition, social accountability in service delivery indirectly addresses **local governance** by providing a platform for citizens and authorities to discuss service delivery and facilitated by CSO.

Action 2: Addressing Social Determinants of Health for gender equality

Priority - Support Ethiopian people and country's social capital creation by improving the health system with specific focus on gender.

Despite Ethiopia's progress in improving access to basic health services, huge challenges remain as reflected in the still unacceptable high maternal mortality rate and high prevalence of stunting and wasting amongst children under five years old (38 % and 10 % respectively in 2016). Furthermore, the 2016 Ethiopian Demographic and Heath Survey (EDHS) indicated that unmet need for family planning is 22 % amongst women aged 15-49 years old, and 13 % of women aged 15-19 have begun childbearing (teenage pregnancy). The sector financing is heavily dependent on external resources (37 %) and significant out-of-pocket expenditure (33 %) by households, which is one of the major constraints for women's access to health services in Ethiopia.

The Action is to complement the on-going health sector budget support and other EU supported programmes with the aim to address social determinants of health for gender equality. The intervention puts women and adolescent girls at the centre and attempts to address health and gender inequalities with **focus on family planning, nutrition, water and sanitation and hygiene and harmful traditional practices as well as gender-based violence**. The overall objective is to support the Ethiopian Government to improve health and well-being of Ethiopian citizens with specific emphasis on improving health and wellbeing of women and adolescent girls and children under five years of age. The specific objective is to contribute to the improvement of social determinants affecting health outcomes in three of Ethiopia's Developing Regional States (Afar, Benishangul Gumuz and Gambela).

The Action's principal objective is directed at gender equality. It uses a **rights-based and a gender-sensitive approach**, starting from the rights to protection and care for the child, girls and women against harmful practices and gender-based violence, and the right to health and adequate nutrition, and the obligations of the public sector to ensure these rights are honoured. It will pay a special attention to the safe disposal and appropriate management of health care waste and to minimise the possible impacts on the **environment** in relation to the installation of water supply system to the health facilities.

4. Communication and visibility

The communication and visibility of the "**Ethiopian Social Accountability Programme III**" and "**Addressing Social Determinants of Health for gender equality**" projects will be undertaken by the implementing organisations as part of the contracts that will be concluded. The EU will oversee that adequate communication and visibility plans are produced and implemented.

5. Cost and financing

Ethiopian Social Accountability Programme III	EUR 10 000 000
Addressing Social Determinants of Health for gender equality	EUR 20 000 000
Total EU contribution to the measure	**EUR 30 000 000**

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This action is funded by the European Union

ANNEX 1
of the Commission Decision on the Annual Action Programme 2018 Part 1 in favour of the Federal Republic of Ethiopia to be financed from the 11th European Development Fund

Action Document for
Ethiopian Social Accountability Programme III (ESAP3)

1. Title/basic act/ CRIS number	*Ethiopian Social Accountability Programme III (ESAP3)* CRIS number: ET/FED/039-016 financed under the 11th European Development Fund (EDF)	
2. Zone benefiting from the action/location	Federal Republic of Ethiopia The action shall be carried out at the following location: country wide coverage, starting with 223 woredas (districts) and aiming at covering 500 woredas across the country by the end of the action.	
3. Programming document	National Indicative Programme (NIP) 2014-2020 for Ethiopia	
4. Sector of concentration/ thematic area	Civil society and synergetic governance	DEV. Aid: YES[1]
5. Amounts concerned	Total estimated cost: EUR 32 300 000 Total amount of EDF contribution: EUR 10 000 000 This action is jointly co-financed by, indicatively: - Ireland for an amount of EUR 5 000 000 - Austria for an amount of EUR 2 500 000 - Sweden for an amount of EUR 9 000 000 - United Kingdom for an amount of GBP 3 000 000 (approx. EUR 3 400 000) - USA for an amount of USD 3 000 000 (approx. EUR 2 400 000)	
6. Aid modality and implementation modality	Project Modality Indirect management with the World Bank	
7 a) DAC code(s)	15150 – 100 % Democratic Participation and Civil Society	

[1] Official Development Aid is administered with the promotion of the economic development and welfare of developing countries as its main objective.

b) Main Delivery Channel	44000 World Bank Group *- 44002 – International Development Association (IDA)*			
8. Markers (from CRIS DAC form)	**General policy objective**	**Not targeted**	**Significant objective**	**Main objective**
	Participation development/good governance	☐	☐	X
	Aid to environment	X	☐	☐
	Gender equality (including Women In Development)	☐	X	☐
	Trade Development	X	☐	☐
	Reproductive, Maternal, New born and child health	☐	X	☐
	RIO Convention markers	**Not targeted**	**Significant objective**	**Main objective**
	Biological diversity	X	☐	☐
	Combat desertification	X	☐	☐
	Climate change mitigation	X	☐	☐
	Climate change adaptation	X	☐	☐
9. Global Public Goods and Challenges (GPGC) thematic flagships	N/A.			
10. Sustainable Development Goals (SDGs)	Main goals: 1 "No Poverty" and 16 "Promote peaceful and inclusive societies for sustainable development" Secondary goals: 3 "Good health and well-being", 4 "Quality education" and 6 "Water and sanitation".			

SUMMARY

ESAP3 is a multi-donor programme the objective of which is to strengthen the capacities of citizen groups, representatives and government to work together in enhancing the access and the quality of basic services in five decentralised sectors (education, health, water supply and sanitation, agriculture and rural roads). ESAP3 builds on the achievements of the previous two phases and will be implemented under an overall ten-year strategy divided into two five-year funding cycles. This action document covers the first five years (2018-2022). During this period ESAP3 will extend and broaden the scope of the Ethiopian Social Accountability Programme II (ESAP2) by: 1) scaling up the application of existing social accountability tools in new woredas (districts) and in more kebeles (wards), with the objective of increasing the coverage from 223 woredas to 500 woredas; 2) including a stronger focus on institutionalisation.

The overall objective is to support and strengthen the social accountability system and mechanism for enhanced service delivery in Ethiopia. To this aim, and based on a situation analysis and on lessons learnt, the specific objectives are: 1) Expand the uptake of social accountability tools; 2) Support the strengthening and embedding of social accountability tools and approaches at federal and subnational level; 3) ensure effective and efficient project management, coordination and knowledge management.

ESAP3 total envelope is USD 53 000 000 and will be implemented through two funding channels:

1) World Bank-Managed Multi-donor Trust Fund (USD 33 000 000). The World Bank will contract with a management agency that has the responsibility for programme

implementation, including managing the grants to civil society organisations (CSOs) to act as facilitators between service users, service providers and councils at local level;
2) IDA grant (USD 20 000 000). The Government will manage IDA resources and may contract with a second management agency. The EU only contributes to the first channel (Multi-donor Trust Fund).

1 CONTEXT

1.1 Sector/Country/Regional context/Thematic area

Since 2013 Ethiopia has a total population of about 90 million and a population growth rate of 2.6 % which, according to UN estimates, will lead to a total population of 130 million in 2025. By 2050 Ethiopia is projected to be among the world's ten most populated countries. Its ethnic diversity comprises 80 nationalities and peoples who speak 83 languages.

After the fall of the Derg in 1991, Ethiopia has taken the firm path of a "developmental state", aiming at state-led and broad-based growth. This is reflected in the national development policy framework, the Growth and Transformation Plan II (2015/16-2019/20). The aim is to reach lower middle-income status by 2025 within stable macroeconomic environment while pursuing rapid industrialisation and structural transformation. To this aim, the Government of Ethiopia follows a public infrastructure investment policy coupled with a pro-poor spending policy by increasing allocation to basic services.

Ethiopia achieved high levels of economic growth and significant advances in human development and poverty reduction. Real Gross Domestic Product growth has averaged 10.5 % per year between 2003-2004 and 2015-2016. According to the World Bank Poverty Assessment for 2014, this performance helped reduce the share of the population living below poverty line from 38. 7% in 2004-2005 to 29.6 % in 2010-2011. Furthermore, Ethiopia is one of the countries that have made the fastest progress towards the Millennium Development Goals. Life expectancy rose from 52 years in 2000 to 63 years in 2011.

Despite positive trends, Ethiopia remains one of the low-income countries, with a per capita Gross National Income (GNI)[2] of USD 1 428 in 2014. It ranks 174 out of 188 countries in human development according to the 2016 Human Development report. Despite relatively low Gini coefficient of 0.3, economic growth has not been fully inclusive and millions of people remain vulnerable to shocks[3]. Consumption growth of the bottom 40 % did not match the consumption growth of the top 60 from 2005 to 2014, a period of high economic growth. Falling poverty rates across regions mask significant disparities between and within regions and woredas. Furthermore, recent social unrest that led to the State of Emergency (October 2016-August 2017) highlighted deep-rooted developmental, social and political grievances and drew attention to the growing challenge of job creation and participation. The Government recognised that some concerns raised were legitimate and that solutions should be found. Citizens' engagement and Social Accountability can be instrumental and can complement efforts in this direction.

In October 2016 the Government of Ethiopia declared a State of Emergency in the country for six months (extended to August 2017), after large scale civil unrest since November 2015, limiting the freedom of expression and gathering. The Government of Ethiopia announced after a reform process to address the grievances of the people (lack of good governance,

[2] In Purchasing Power Parity (PPP) %.
[3] ESAP III Design Document, 12 September 2017, Ministry of Finance and Economic Cooperation, World Bank.

unemployment, etc.), including a dialogue with the different stakeholders. Consultations of the civil society sector and opposition parties took place in 2017. Nevertheless, other episodes of unrest occurred late 2017 and early 2018 (despite the release of prisoners), which led to the re-imposition of the State of Emergency in February 2018, after the resignation of the Prime Minister.

Public Policy Assessment and EU Policy Framework

The 1994 Constitution of the Federal Democratic Republic of Ethiopia establishes a federal form of government with a parliamentary democratic system and an administrative structure including federal regions, zones, woredas and kebeles. Since 2003, decentralisation has been one of the key goals of the government. Accordingly, Ethiopia has opted for a decentralised model of basic service delivery largely financed by the Federal Government through the **Federal Block Grant (FBG)**. The Federal Government provides non-earmarked transfers to regional governments using a pro-poor formula approved by the parliament. Regions keep a share of the grant (approximately 40 %) and redistribute grants to woreda administrations, where services are delivered. The Block Grant covers recurrent expenditures and is subject to audits by the Office of Federal Auditor General (OFAG) and the Office of Regional Auditor General (ORAG).

This structure has provided timely and predictable financing to lower levels, contributing to the increase of services and sector outcomes in the five basic services (education, health, water supply and sanitation, agriculture and rural roads). The steady increase of the allocation to the federal block grant reflects strong government commitment. Thanks to these policies access to basic services have significantly improved. A key priority now is to improve the quality and the equity of service delivery. Yet, despite the increase, the allocation to the FBG does not match economic growth and acute budget shortfalls continue to prevail at local levels (vertical imbalances). To this aim, and in line with most international lessons, the Government of Ethiopia explores ways of citizen participation in the planning, monitoring and delivery of basic services to make best use of available resources to improve the quality and the equity of services in line with local priorities.

To this aim, the Constitution **provides for people's participation in decentralised**[4] **government** through "*direct participation in the administration of their local units*" (Article 50:4). Specifically, "*State governments shall be established at state and other administrative levels that they find necessary and adequate power shall be granted to the lowest units of government to enable the people to participate directly in the administration of such units*". Based on the above, the Ethiopian Constitution provides the basis for people's empowerment and engagement with the local government. Article 43 (sub-article 2) of the Constitution explains that citizens have the right to participate in national development and, in particular, to be consulted with respect to policies and projects affecting their community. In addition, according to Article 12, "*the conduct of affairs of the government shall be transparent*"; "*Any public official or elected representative is accountable for any failure in official duties*". At lower levels, and even though in a fragmentary and non-harmonised way, the legal and regulatory frameworks also provide for some entry points for citizens participation, such as the recent directive for pre-budget discussions.

[4] Decentralisation is an outcome of the adoption of a federal system of government in Ethiopia. With the devolution of power to the regional governments, implementation of economic policies and development programmes is shifting, to a large extent, from the federal government to regional governments, with the latter deciding about priorities in implementing the national policies, in the context of Regional Strategic/Development Plans aligned with the GTP II. The regional governments and their respective woredas have been given extensive mandates with regard to local development and the delivery of basic services in their jurisdiction, under the umbrella of the regional constitution.

Although there is not one comprehensive and harmonised framework for citizens engagement and social accountability in Ethiopia, the Government has developed a series of **policies, strategies and initiatives that provide opportunities** to improve service delivery through social accountability.

- The first **Growth and Transformation Plan (GTP I) (2010-2011-2014-2015)** foresaw the establishment of a system for citizen access to information and the strengthening of public participation, following which a public participation strategy was developed.
- The **GTP II** (**2015-2016- 2020-2021)** plans to combat corruption and rent-seeking through enhanced capacity of the civil service and citizen engagement at all levels of government. Woreda and Kebele Councils are expected to enhance and consolidate public participation to ensure that the public becomes both owner and beneficiary of development outcomes and strengthen the legitimacy and oversight of federal and regional councils[5].
- In line with GTP II, sector policies include provisions for engaging with communities and organizing public mobilisation in various ways.
- Since 2006, the Government of Ethiopia has embarked on a number of citizen engagement initiatives with the aim of improving the quality of services. It included Social Accountability and Financial Transparency and Accountability initiatives under the Citizens' Engagement component of the three successive phases of the Protection and Promotion of Basic Services multi-donor programmes (PBS). The first phase of the Ethiopian Social Accountability I (ESAP I) ended in 2009 and the second phase of the Ethiopian Social Accountability Programme (ESAP II) is under implementation and will end in December 2018.

Finally, there are a number of incentives for the Ethiopian state to promote citizen engagement, particularly in the current context:

- Citizens' engagement can enable the state to further **enhance its role as provider of basic services** and build the trust of citizens while mitigating the risk of confrontational forms of citizen action.
- The government draws its legitimacy in part **by delivering development results to its citizens**.
- Limited state capacity for monitoring service delivery at local levels means that effective citizen engagement with service delivery can have significant value for improving services.
- **Enhance the effectiveness** of the decentralised form of government.

The legal and policy framework outlined above provide the anchorage for ESAP3. However, major challenges remain to implement the legal and policy frameworks, including amongst others, capacity limitations to respond to demands (resources, skills, know-how, incentives…).

The Ethiopian Social Accountability Programme, with its focus on improved service delivery, is in line and contributes to the two main objectives of **the EU Agenda for Change[6] (2011), notably: good governance and inclusive and sustainable growth for human development.**

[5] Perspective of Citizen Engagement in Ethiopia, Ministry of Finance and Economic Cooperation (MoFEC), Basic Service Delivery Joint Review and Implementation Support (JRIS) Mission 14 -16 December 2016, Ghion Hotel, Addis Ababa.

[6] Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions: Increasing the impact of EU Development Policy: an Agenda for Change, COM(2011)637 final of 13.10.2011.

Furthermore it is in line with the EU Communication (2011) on Civil Society and EU Communication on Local Authorities (2013). The Action is also in line with the new European Consensus on Development "Our World, Our Dignity, Our Future"[7] and in particular with the key themes "People - Human development and dignity", "Peace - Peaceful and inclusive societies, democracy, effective and accountable institutions, rule of law and human rights for all".

1.1.1 Stakeholder analysis

ESAP3 will support awareness, voice and responsiveness systematically by capacitating citizen representative and service providers with skills to apply Social Accountability tools with significant benefits on quantity and quality of basic services. To this aim, the programme will work with stakeholders at various levels:

At federal level, the following stakeholders will be engaged:

- **The Ministry of Finance and Economic Cooperation** (MoFEC) is the policy lead for Social Accountability and Financial Transparency and Accountability.
- **The Ethiopian Charities and Societies Agency** (ChSA) will ensure the creation of an enabling environment for Social Accountability Implementing Partners (SAIPs).
- **Sector ministries** including the Ministry of Health, the Ministry of Education, the Ministry of Water Irrigation and Electricity, the Ministry of Agriculture and the Ethiopian Roads Authority are key to internalise social accountability processes in their ways of doing business.
- **The Ministry of Women's and Children's Affairs** will ensure gender responsiveness in overall guidance.
- **The Ministry of Public Service and Human Resources Development** will also ensure coordination with the Government's governance agenda in order to encourage institutionalisation and ownership of the Social Accountability approach;
- **The Ethiopian Institute of the Ombudsman** has the mandate to ensure citizens rights and benefits provided for by law are respected by organs of the executive, rectify malpractice in government administration and to promote overall good governance. Regional branch offices have started participating in regional committees tackling the links between Social Accountability, Financial Transparency and Accountability and Grievance Redress Mechanisms.
- **CSOs and CSOs networks'** critical role as facilitators of social accountability processes and implementers has been confirmed by all assessments and will be pursued.

At regional level the ESAP3 will work with:

- **The Bureaus of Finance and Economic Development** to create an enabling environment for programme implementation, to facilitate CSOs operations and to coordinate the linkages between Financial Transparency and Accountability, Social Accountability and Grievance Redress mechanisms.
- **Sector bureaus in health, education, agriculture, Water Sanitation and Health (WaSH) and rural roads.**
- **Regional councils** will be key partners in ensuring the sustainability of Social Accountability in the country.

At local level, the programme will work with:

[7] OJ C 210 of 30.6.2017.

- **Woreda Office of Finance and Economic Development** to facilitate programme implementation by closely working with the Management Agency and the SAIP working in the woreda.
- **Sector Offices** to support community discussions and interface meetings at kebele and at facility level.
- **Woreda councils** to enhance the sustainability and institutionalisation.
- **Woreda Social Accountability Committees** including all relevant Social Accountability (SA) stakeholders.
- **Kebele Social Accountability Committee** including all relevant SA stakeholders at facility level.
- Community-Based Organisations to ensure connection to the marginalised and vulnerable groups of the community.
- **Citizens**, the main stakeholders in establishing accountable service delivery systems.

1.1.2 Priority areas for support/problem analysis

The Government of Ethiopia follows pro-poor policies that need to be implemented in a large federal setting. Over time, the Government's efforts resulted in an increased access to basic services but major challenges remain as regards the improvement of the quality and equity of service delivery across the board and with sufficient country coverage:

ESAP2 achieved positive results but with limited country coverage: ESAP2 has proven effective in facilitating a constructive dialogue between citizens and local governments with concrete positive results in service delivery. However, ESAP2 only covered a limited number of Woredas countrywide. To maximise the impact of social accountability and sustain it, there is need to further consolidate and deepen SA in existing Woredas as well as to expand the practice to new Woredas. To this aim, ESAP3 aims at expanding from the current 223 Woredas to 500 Woredas, in line with the World Bank's programme "Enhancing Shared Prosperity through Equitable Services" (ESPES) performance indicator. In addition, a number of new kebeles will be added in existing woredas to deepen the outreach. The exact combination and numbers of new kebeles in existing woredas and new woredas will be determined during the inception phase.

This requires consolidating and supporting the emergence of responsive local governments and engaged citizens to improve service delivery in existing and new woredas. Achieving this requires that individuals are equipped with the necessary information and tools to engage in the social accountability process. Yet, there is a still a substantial skills gaps in the public sector and across the board. Staff turnover remains high, officials still often do not have the skills to engage in participatory planning, budgeting and monitoring processes and communities often lack the capacities and skills to articulate their demands. Therefore, **ESAP3 will continue to complement the Government's efforts to capacity development on Social accountability**. **As part of this, it will continue to rely on the critical facilitation role of CSOs to bring all relevant stakeholders together, including service users, service providers and councils. ESAP3 will also encourage innovation at local level** such as (but not only) the establishment of a referral system whereby demands arising outside the five sectors can be channelled to appropriate bodies for appropriate response.

Based on the above, **key priorities** for the programme are to: 1) Continue to support and expand the demand for improved service delivery; 2) Strengthen the capacity of the community to formulate their demands in line with their entitlements and sector standards; 3) Reinforce the support to the supply side response to citizens' demand for improved service delivery; 4) Create space for innovation through flexible mechanism and innovation grants for high performing SAIPs and woredas.

The integration of social accountability in regular government systems and processes at various levels remains weak. ESAP2 had strong positive impacts in creating space for citizens and service providers to engage in dialogue on basic service provision by successfully promoting awareness, voice and participation. However, available assessments indicate that responsiveness by service providers is lagging behind, with the challenge of financing the Joint Action Plans being only one illustration. This is partly due to the fact integration of Social Accountability process in government systems at various levels remains limited, making the process dependent on project structures. Yet, improved service delivery can only be sustained and achieved at national level as best practices become increasingly embedded in government institutions and scaled up in more kebeles, woredas and regions. Therefore, ESAP3 will give more attention to the sustainability and institutionalisation agenda by engaging more with the supply side to internalise social accountability at various levels. Without this, the risk is to create demands that cannot be addressed and that could fuel tensions. To this aim, ESAP3 will consider supporting the capacity and responsiveness of the supply side in various ways:

- Regional specificities: the asymmetrical pace of decentralisation and the variance in the role that certain levels of administration play (e.g. zonal administrations), means that decentralisation is not uniform across regions. **ESAP3 will be flexible to tailor the Social Accountability processes to regional specificities**.
- Shortage of government budget to implement the Joint Action Plans: vertical imbalances results from the fact that, on the one hand, the growth of the FBG does not match economic growth and is not enough to cover woreda mandates, while on the other hand woredas can only raise minimal amounts of local revenues. As a result, **acute budget shortfalls continue to prevail at local levels.** In the short term, the Government of Ethiopia seeks to better link local priorities as reflected in the Joint Action Plans to the planning and budget processes, without which budget allocations at local levels will continue to be inadequate to match local priorities. To this aim it explores ways for citizens to participate in the planning, monitoring and delivery of basic services. The gap between available resources and financing needs is filled by voluntary community contributions. While this has proven effective to address service delivery gaps, there is need to limit the risk of overburdening communities, to improve the governance mechanism of community contributions as well as the coordination of the different sources of funding to basic services by assessing and adjusting the role of each funding source to ensure effectiveness and fairness. In the long term, unless adequate and sufficient public funding mechanisms are designed to fund local priorities as part of the budget, the participatory planning processes are at risk of losing their appeal, as plans cannot be turned into realities. **In the short term, ESAP3 will strengthen the link between social accountability and the policy, planning and budgeting cycles at various levels**. In the medium term, ESAP3 can be an instrumental platform to explore and test options for innovative funding mechanisms and for improved coordination between various sources of funding. ESAP3 will provide flexibility to carry out exploratory studies/initiatives as opportunities arise.

  Limited sector engagement: The lack of a single, harmonised and comprehensive national citizen engagement framework has led to different understanding, approaches and fragmentary practices on how to engage citizens. On the one hand, sector ministries included initiatives to engage with the public in their strategies. Yet, the focus has been on the organised public mobilisation and feedback mechanisms rather than on social accountability**.** There is need to bring sectors on board to expand social accountability, ensure its internalisation in their way of doing business

and to ensure that both approaches –Public mobilisation and social accountability- complement each other. **This will be done by further engaging sectors in the dialogue, strengthening the coordination between the Ministry of Finance and Economic Cooperation and the sector ministries at federal level and by promoting pilots to mainstream social accountability building on the lessons learnt from Productive Safety Net Programme (PSNP), the recent experience with the Roads sector and other experiences from abroad.**

- The links between Social Accountability and mainstream oversight bodies remain limited. A national framework would help identify the roles and responsibilities, provide the right incentives and encourage sustainability. Furthermore, while ESAP2 focused more on the links between service users and service providers, **ESAP3 will seek to strengthen the capacities to strengthen the councils.**

Based on the above, ESAP3 priorities will be to: 1) support sector engagement, including through the support to the development of a consistent national framework and pilot experiences; 2) better link the social accountability processes to the policy, planning and budget cycle; 3) train local actors and mainstream accountability bodies at local level.

While institutional arrangements have generally worked well, there is room for improvement to ensure effective and efficient coordination at various levels. While the institutional arrangements have generally worked well, there is nonetheless room for improvement. Effective project management and expansion requires improving coordination at various levels:

- At local level, improved service delivery can only be achieved when processes linking service users, service providers and relevant government departments are effectively managed by skilled independent facilitators. To this aim, it is critical that a set of diverse CSOs, including Ethiopian and Resident CSOs are eligible for programme implementation[8]. ESAP3 will ensure **continued dialogue prior and during programme implementation, indicators and capacity development for CSOs to ensure that a diverse set of CSOs can participate in the programme.**
- To maximise impact, there is need to improve the link between evidence and lessons learnt from Social Accountability, decision-making processes and dialogue at the Steering Committee and beyond. **ESAP3 will pay particular attention to knowledge management and to ways to reach out to new stakeholders.**
- During the design phase, challenges with the governance and steering mechanism and policy dialogue were jointly identified and remedial actions were agreed and integrated in ESAP3[9].

[8] This is key to ensure: i) Credibility of ESAP3 by promoting plurality and diversity of CSO and avoid favouring by design only one type of organisation (e.g. mass based organisations); ii) Smooth programme implementation: under ESAP2 there was a critical mass of Resident CSOs because they are the ones with sufficient capacities to manage fiduciary risks. Throughout the programme they have built the necessary skills in social accountability that will be key for ESAP3. Due to their weak implementation capacities, only four CSOs were Ethiopian charities. Therefore, for ESAP3 to be successful and scale up to the target of 500 woredas, the participation of Resident CSOs will be critical while at the same time gradually increasing the number of Ethiopian CSOs; iii) Programme funding: Some Development Partners (DPs) who may not be able to finance the programme without guarantees that both Resident and Ethiopian CSOs can participate in the programme.

[9] i) need to monitor the cost effectiveness and efficiency of the implementation modality (World Bank MDTF) and to improve transparency and mutual accountability at the Steering Committee; ii) need to officially reestablish a donor co-chair role alongside the World Bank to ensure that all donor views are properly reflected in the dialogue; iii) revision of the governance mechanism of the programme, including a revision of the Steering Committee Terms of Reference (ToR), donor coordination platforms and role of the Service Delivery Secretariat.

These three priorities will be financed through two funding channels: 1) a World Bank-Managed Multi Donor Trust Fund (USD 33 000 000) and; 2) an IDA Grant (USD 20 000 000).

2 RISKS AND ASSUMPTIONS

Risks	**Risk level (H/M/L)**[10]	**Mitigating measures**
Policy Risks		
National Citizens' Engagement (CE) strategy/framework not formulated which impacts the sustainability of SA.	M	- World Bank's Programme Enhancing Shared Prosperity through Equitable Services includes an indicator on the development of the national CE framework, while ESAP3 foresees flexible mechanism to support government through exploratory studies and pilots (Specific Objective 3).
Budget shortfalls at subnational level put at risk the credibility of the participatory process.	H	- ESAP3 includes indicators on Joint Action Plan financing, on better linking the Social Accountability and the budget process as well as flexible mechanism for exploratory studies and piloting.
Operational Risks		
Different levels of government commitment/ownership at various levels and in various institutions.	M	- Follow up of formal Steering Committee agreement to engage more sector ministries at federal level.
Weak coordination with sectors and other stakeholders such as councils.	M	- ESAP3 Specific Objective 2 addresses the institutionalisation agenda (links with regular government systems and with mainstream accountability bodies). - Specific indicators set for mainstreaming Social Accountability in the Productive Safety Net Programme.
Woreda and sector bureaux planning and operational weak capacities.	M	- ESAP3 foresees to involve sector ministries to facilitate mainstreaming of the ESAP approach as well as to support the supply side in close coordination with other existing programmes and initiatives.

[10] H=high, M=medium, L=low.

Operating environment for CSOs is not clarified which limits the ability to implement and expand ESAP.	H	- Pursue dialogue and monitoring of CSOs operating environment at the Steering Committee. - Agree on safeguards to include in programme design (indicators to monitor CSO participation, develop approach to capacity development for CSOs in linkage with other CSO programmes, train the ChSA on ESAP and introduction of a precondition on guarantees for all legally registered Ethiopian CSOs to be eligible for programme implementation.
CSO Capacities including high staff turnover and high costs for citizen participation and service providers engagements.	M	- ESAP3 foresees to train critical mass of individuals in relevant institutions, make operational manuals available, carry out annual surveys to monitor the costs of the SA process for different stakeholders and institutionalisation to reduce transaction costs.
The existence of two funding flows and recruitment of two Management Agencies leads to confusion, duplication, inefficiencies and fragmentation.	H	- The two Management Agencies will use the same Project Implementation Manual to contribute to one single results framework under the supervision of the Steering Committee.
Possible gap in activities and momentum between the end of ESAP2 and ESAP3 due to delays in setting up the MDTF, mobilising development partners' funds and possible change of Management Agency.	M	- Commitment of all stakeholders is strong to reduce the gap as much as possible. All partners make multi-year funding commitments. - Steering committee supervision.

Assumptions

Security situation will allow a smooth implementation of Social Accountability activities at local level.

ESAP3 will continue to be led at Federal level and the Government will continue to strongly support Social Accountability, follow up on decisions and agreements made at the Steering Committee and will be successful in building a common vision within government and with the Charities and Society Agency.

The recently established constructive and conducive environment between donors and with the government will continue and will allow raising and addressing issues. The State Minister will continue to be actively involved to give guidance and facilitate binding decisions.

Mutual accountability in the implementation of the programme will be strengthened and the

Development Partners co-chair alongside the World Bank will be functional as interlocutor for the government.

3 LESSONS LEARNT, COMPLEMENTARITY AND CROSS-CUTTING ISSUES

3.1 Lessons learnt

The key lesson of international experience is the importance of local context in shaping which Social accountability approaches and tools make the best fit. For instance, the choice of tools should be shaped by local context depending on what aspect needs more strengthening: demand-side voice, or the supply-side response, or both in equal measure. In Ethiopia, one of the key lessons is that while continued support to the demand side and role of Civil Society Organisations need to be prioritised, there is need to make more efforts in addressing and supporting the supply side response to ensure sustainability.

The World Bank conducted an impact evaluation based on the Randomised Control Trial (RCT) approach at woreda level for ESAP2. Preliminary results suggest that social accountability interventions vary in their effectiveness, and that the most effective interventions have the potential to significantly enhance service delivery and human development outcomes in targeted communities. A RCT or similar independent study should be repeated in ESAP3 as a complementary effort by the World Bank.

In addition, the ESAP2 Internal Assessment (2016) pointed out the following key lessons and achievements at local levels:

- The Social Accountability mechanism has transformed the way woreda institutions are conducting business and how they interact with citizens.
- Citizens and service providers both refer to the crucial role that SAIPs have played in bringing them together, in ensuring that all relevant officials are engaged and in finding consensus on binding commitments to improve service delivery.
- On the demand side, ESAP2 was able to create an engaged society that articulates its needs and understands its obligations.
- Social Accountability can help increased government responsiveness in public service delivery through behavioral change among frontline service providers such as reduced absenteeism, improved and more open.
- ESAP2 has been instrumental in improving the inclusion of vulnerable groups, leading to concrete results such as some schools offering special needs education for the first time.
- Interface meetings and Joint Action Plans were instrumental in generating a constructive dialogue between service providers and citizens that led to tangible service improvements.

3.2 Complementarity, synergy and donor coordination

3.2.1 Complementarity

Many donors contribute to delivery service through Budget Support, Performance for Results (P4R) or to Pool Funds in the five basic sectors. In this context, and in line with the lessons learnt from the World Bank's Panel Inspection Report on the Promoting Basic Services programme, social accountability acts as a safeguard and risk mitigation measure when supporting government policies. In this respect, ESAP3 will complement the EU Health budget support, the Sector Policy Support Programme Roads IV, the Productive Safety-Net Programme support and other upcoming budget support operations.

Finally, ESAP3 is already linked to the World Bank Enhancing Shared Prosperity through Equitable Services (ESPES) Programme for Results, which includes indicators on social accountability.

3.2.2 Synergies

The programme will be more proactive in liaising with other relevant governance platforms and stakeholders to identify synergies with other ongoing government initiatives and donor programmes, including civil society support programmes such as the EU Civil Society Fund 3 (CSF3). Building on the positive experience of piloting Social Accountability in the Productive Safety Net Programme, ESAP3 will seek to strengthen sector engagement and to better liaise to relevant sector working groups and platforms.

3.2.3 Donor Coordination

Coordination between donors will be done through a single governance entity: the ESAP Steering Committee, chaired by the State Minister of Finance and Economic Cooperation. It will be complemented by a Technical Working Group including government and donor counterparts and by the Transparency and Accountability Group (TAG) which is the platform for donor coordination.

In terms of funding, ESAP3 total envelope is USD 53 000 000 and will be financed through the two funding channels:

- **World Bank Multi Donor Trust Fund (USD 33** 000 000**)** including contributions from Austrian Development Cooperation, the Department for International Development (DfID), Irish Aid, Sweden, the United States Agency for International Development (USAID) and the EU. As in previous phases, the World Bank will manage the programme and procure a Management Agency to implement the relevant ESAP3 components.
- **IDA grant through the ESPES Programme for Results (USD 20 000 000)** will complement the Multi Donor Trust Fund (MDTF). The Government of Ethiopia will manage IDA resources separately but in an effort to complement and coordinate with the MDTF. The Government may recruit a second Management Agency.

Bilateral donor funding will be directly coordinated through a single World Bank Multi Donor Trust Fund. The coordination between this Trust Fund and the IDA grant will be insured as both channels contribute to the same results framework both will be managed and discussed in where all donors are present and the development of detailed operational coordination arrangements has been agreed. Governance mechanisms have been revised to improve donor coordination and ensure harmonised approaches in the dialogue with the government.

3.3 Cross-cutting issues

The programme directly addresses various cross-cutting themes: Gender equality and Governance.

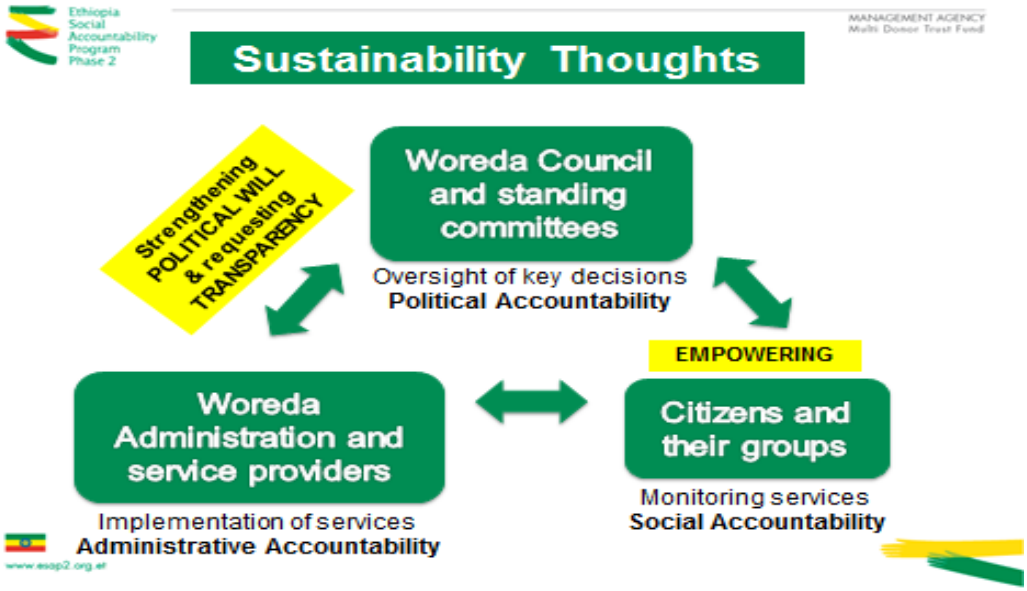
As lessons learnt show, ESAP is instrumental in **addressing gender equality and inclusion of vulnerable groups** at local levels through the social accountability process and tools (e.g. quotas for women's participation in basic service assessment, capacity development of women's groups, representatives in Social Accountability Committees (SACs) to identify priorities, Gender responsive budgeting etc.) This will be reinforced by ensuring the participation of the Ministry of Women's Affairs in ESAP3 Steering Committee at federal level.

In addition, social accountability in service delivery indirectly **addresses local governance by providing a platform for citizens and authorities to discuss service delivery** and facilitated by CSOs.

Finally, although the programme does not directly address environmental sustainability, it does not pose any direct risk on environmental sustainability as it focuses on the soft governance process. Furthermore, through the social accountability process, the community and/or the authorities can raise this issue if it is identified as a key priority in the locality. They issue can be either integrated in the Joint Action Plan if it is linked to one of the five sectors of intervention or, alternatively, ESAP3 will channel concerns to the relevant bodies through a referral mechanism to be established.

4 DESCRIPTION OF THE ACTION

ESAP objective is to strengthen the capacities of citizens' groups, representatives and government to work together in enhancing the access and the quality of basic services in five decentralised sectors (education, health, water supply and sanitation, agriculture and rural roads). The programme is implemented by 48 competitively selected CSOs called "Social Accountability Implementing Partners" (SAIPs) in 223 woredas representing all regions of Ethiopia. The programme supports these CSOs to facilitate and enhance the dialogue between citizens, woreda administration and woreda councils on the needs and concerns regarding the access and the quality of services in the five sectors. To this aim, CSO facilitate the interface between service users and service providers by, amongst others, helping local actors: establish SACs that integrate representatives of each group; identify the priority sectors for the community on which the project should focus on; choose and apply the "best fit" social accountability tools to their local context (e.g. community scorecards, citizens' report cards, participatory planning and budgeting, gender responsive budgeting and Public Expenditure Tracking Surveys etc.) Finally, the SAIPs support the SACs defining and monitoring the implementation of Joint Action Plans to address priority issues identified by the communities.



ESAP3 will be under an overall ten-year strategy divided into two five-year funding cycles. This Action Document covers the first five years of the period 2018-2022. During this period, ESAP3 will extend and broaden the scope of ESAP2 by:

- Scaling up the application of existing Social Accountability tools in new woredas and in more kebeles in existing woredas. It will also focus on the same five basic service delivery sectors with the aim of scaling up from 223 woredas to 500 woredas as set out in the Government of Ethiopia and World Bank Country Partnership Framework for 2018-2022. The pace and sequencing will be to sustain implementation in the 223 woredas but double the number of kebeles and cover five sectors and at the same time expand to an additional 227 woredas with a gradual roll out to approximately 50 woredas per year depending on the strategy proposed during the inception phase.
- Introducing new activities, including a stronger focus on strengthening the supply side systems and service delivery responses to social accountability, building increased government capacity for social accountability and institutionalise activities within government activities and pilot and test new and innovative approaches.

4.1 Objectives/results

The overall objective of the action is to **support and strengthen the social accountability system and mechanism for enhanced service delivery in Ethiopia**.

The action includes three specific objectives:

Specific Objective 1: Expand the uptake of social accountability tools

The outcomes under this specific objective are:

- Outcome 1.1: Citizens and citizen groups are aware of their entitlements and responsibilities to contribute to and demand for improved quality public services.
- Outcome 1.2: Citizens and user communities (including vulnerable and PSNP groups) in targeted woredas and sectors are empowered to participate in the planning, budgeting, implementation and monitoring of basic public services.
- Outcome 1.3: Basic public service providers in education, health, agriculture, water and sanitation and rural roads deliver improved quality of basic services, responding to citizen's prioritised needs.

Specific Objective 2: Support the Strengthening and Embedding of Social Accountability tools and Approaches at Federal and subnational levels

The outcomes under this specific objective are:

- Outcome 2.1: Government policy and strategy formulation process is informed by evidence from social accountability interventions.
- Outcome 2.2: Government accountability and oversight structures, kebele assemblies, woreda councils and regional councils in particular are strengthened to embed and sustain Social Accountability initiatives in their mandated roles and functions.
- Outcome 2.3: Local community structures and service user groups, including Social Accountability Committees, Parents-Teachers Associations, Community Based Organisations, Mass Based Organisations are strengthened to implement, scale up and sustain Social Accountability initiatives.

Specific Objective 3: Ensure effective and efficient Project Management, Coordination and Knowledge Management

The outcomes under this specific objective are:

- Outcome 3.1: the Social Accountability programme is effectively managed.

- Outcome 3.2: CSOs and other relevant actors play an effective interlocution/facilitation role between citizens and service providers to implement SA projects.
- Outcome 3.3: Improved access to and benefit from knowledge on local, regional and global social accountability practices.

This programme is relevant for the United Nations Agenda 2030 for Sustainable Development. It contributes primarily to the progressive achievement of **SDG 1 "No Poverty" and SDG 16 "Promote peaceful and inclusive societies for sustainable development"**, but also promotes progress towards SDG 3 "Good health and well-being", SDG 4 "Quality education" and SDG 6 "Water and sanitation". This does not imply a commitment by the country benefiting from this programme.

4.2 Main activities

The main activities under each specific objective are as follows:

Expand the uptake of social accountability tools	Capacity building and SA systems strengthening	Project management coordination and monitoring and evaluation
Continue and scale SA: • Community empowerment and mobilisation • Community needs identification and prioritisation processes • Interface meetings • Joint Action Plan development, implementation and monitoring Piloting of innovative approaches in selected geographic areas	• Capacity building for supply and demand side actors including Government and SAIPs capacity building • SA systems strengthening • Institutionalisation through sectors, Community-based Organisations (CBOs), councils and other citizens' representative forums and institutions at federal, regional, woreda, kebele and community levels • Links with Financial Transparency and Accountability (FTA), Grievance Redress Mechanisms (GRM), Public Finance Management, budgetary cycles and the overall decentralised governance and management systems	• Coordination of daily project activities • Monitoring and evaluation – including impact evaluation • Grants management • Learning and knowledge management

Specific objective 1 will be managed and coordinated by the Management Agency (ies) and will be jointly financed by the MDTF and IDA funds. It will include grants to Ethiopian Resident and Local CSOs to implement Social Accountability activities on the ground.

Specific objective 2 will be jointly implemented by the Management Agency and the Government. The majority of component 2 will be implemented by the Management Agency.

A smaller share, mainly focusing on capacity building in federal government agencies will be implemented by the Government of Ethiopia. The activities cover all aspects of the institutionalisation process, including hardware (equipment, training, structures etc.) and software (shifting mindsets, understanding and applying rules of engagement etc.)

Specific objective 3 will be implemented by the Management Agency and includes the coordination of daily project activities as well as the selection and capacity development of SAIPs and grants management.

4.3 Intervention logic

The theory of change of ESAP3 is based on the assumption that citizen engagement enhances government responsiveness and accountability in providing basic services. To achieve this, **the programme will support three main key changes**:

- Public service providers are willing and able to respond to citizens' demands articulated through SA by promoting the expansion and institutionalisation of SA in the basic public service sectors (enabling environment).
- Citizens' groups are willing and able to articulate their needs and priorities and hold providers to account by building SA skills and capacities amongst citizens.
- Increased ability of interlocutors to foster productive engagement and dialogue between citizens, service providers and government mediated by independent interlocutors. Particular emphasis will be put on the facilitator role that CSOs can play between the citizens and the authorities and in their potential role in deepening participatory processes and promoting social accountability. To this aim, the capacities of CSOs will also be reinforced in the implementation of projects and in their oversight role.

The three Specific Objectives of the programme, with their respective outcomes, outputs and indicators will contribute to the same Project Development Objective (cf. logframe, which will be revised and adjusted during the inception phase of ESAP3.

5 IMPLEMENTATION

5.1 Financing agreement

In order to implement this action, it is foreseen to conclude a financing agreement with the partner country.

5.2 Indicative implementation period

The indicative operational implementation period of this action, during which the activities described in section 4.2 will be carried out and the corresponding contracts and agreements implemented, is 60 months from the date entry into force of the financing agreement.

Extensions of the implementation period may be agreed by the Commission's authorising officer responsible by amending this decision and the relevant contracts and agreements; such amendments to this decision constitute non-substantial amendment in the sense of Article 9(4) of Regulation (EU) 2015/322.

5.3 Implementation of the budget support component

N/A.

5.4 Implementation modalities

Both in indirect and direct management, the Commission will ensure that the EU appropriate rules and procedures for providing financing to third parties are respected, including review

procedures, where appropriate, and compliance of the action with EU restrictive measures affecting the respective countries of operation.

5.4.1 Indirect management with an international organisation

This action may be implemented in indirect management with the World Bank. This implementation entails the management of the Multi Donor Trust Fund (MDTF) for the Ethiopian Social Accountability Programme 3. This implementation is justified because it is the only modality accepted by the Government of Ethiopia to contribute to ESAP3, on the grounds that it is a well-known, tried and tested tool for pooling Donor Partners (DP) resources. The MDTF has been instrumental to promote DP harmonisation to reduce duplication and transaction costs and joint missions.

The entrusted entity would carry out the following budget-implementation tasks: Manage the pooled financial support for ESAP, including consultancies, studies, staffing, etc. required for the efficient and effective implementation of ESAP3 as well as and responsibility for the management and administration of funds through the MDTF.

The Commission authorises that the costs incurred by the entrusted entity may be recognised as eligible as of June 2018 because preparatory activities are likely to start before the signature of Financing Agreement and allowing eligibility of expenditures will facilitate the planning process of the MDTF and of the activities carried out by the Management Agency.

5.5 Scope of geographical eligibility for procurement and grants

The geographical eligibility in terms of place of establishment for participating in procurement and grant award procedures and in terms of origin of supplies purchased as established in the basic act and set out in the relevant contractual documents apply.

The Commission’s authorising officer responsible may extend the geographical eligibility in accordance with Article 22(1)(b) of Annex IV to the ACP-EU Partnership Agreement on the basis of urgency or of unavailability of products and services in the markets of the countries concerned, or in other duly substantiated cases where the eligibility rules would make the realisation of this action impossible or exceedingly difficult.

5.6 Indicative budget

	EU contribution (in EUR)	Indicative third party contribution (in currency identified)
5.4.1 – Indirect management with the World Bank	10 000 000	- Ireland: EUR 5 000 000 - Austria: EUR 2 500 000 - Sweden: EUR 9 000 000 - UK: GBP 3 000 000 (approx. EUR 3 400 000) - USA : USD 3 000 000 (approx. EUR 2 400 000)
5.9 – Evaluation, 5.10 - Audit	0	N.A.
5.11 – Communication and visibility	0	N.A.
Total	**10 000 000**	**EUR 16 500 000** **GBP 3 000 000** **USD 3 000 000**

Since ESAP3 is a joint action implemented through the World Bank Multi-donor Trust Fund, Evaluation, Audit and Communication and visibility are included in the EUR 10 000 000 allocated to the Indirect Management with the World Bank and resources cannot be earmarked.

5.7 Organisational set-up and responsibilities

A **Steering Committee** (SC) will be chaired by the State Minister of Finance and Economic Cooperation and co-chaired by a representative of the CSOs. It consists of representatives from relevant Government Institutions, Development Partners, and Civil Society Umbrella Organisations. The Steering Committee provides overall policy guidance and oversight of programme implementation through quarterly meetings.

The **Technical Committee** will include Government representatives, CSO and Donor Partners representatives. It is expected to become a permanent body with terms of reference to support and feed into the Steering Committee.

The Transparency and Accountability Group (TAG) acts as the main forum for donor coordination as regards citizen engagement work. It covers Social Accountability as well as two other Promoting Basic Services subcomponents, namely Financial Transparency and Accountability and Grievance Redress Mechanisms. Coordination will be improved by a donor co-chairing with the World Bank the TAG. Furthermore, a Partnership Framework spelling out the rules of engagement has been drafted in order to improve transparency, accountability and trust.

The World Bank is responsible for the management of the Multi-Donor Trust Fund and acts as permanent Co-chair. On the one hand, together with the rotating DP Co-chair, these

responsibilities include process management tasks such as: managing the coordination and harmonisation between Development Partners, coordinating the dialogue between Development Partners and the Government, providing analytical work and advice. On the other hand, the World Bank Task Team will provide a range of services related to safeguards and fiduciary control. In this context, the World Bank is responsible for the management and administration of funds through the Multi Donor Trust Fund and for ensuring that the Management Agency complies with World Bank's procedures. It will also analyse and distribute to ESAP Development Partners the Monitoring and Evaluation reports, including quarterly progress reports etc. In line with the Steering Committee decision, the performance and cost effectiveness of the mechanism will be reviewed regularly.

Service Delivery Secretariat will play a coordination and facilitation role within and between these different structures.

The Management Agency selected for the implementation of the Multi Donor Trust Fund (MDTF) will be in charge of the operational implementation and day to day management of the three components of ESAP3. Its management role includes monitoring and evaluation, grants management, developing partnership contracts in geographical areas, and day-to-day operations management. The Management Agency will recruit a large number of CSOs which become Social Accountability Implementing Partners (SAIPs) and who work directly with communities using Social Accountability tools.

Because of the two separate funding streams (IDA and MDTF), it may be possible that two Management Agencies are recruited, following their own separate processes in line with World Bank procurement procedures. In the event that two or more separate Management Agencies are hired, they will work closely together to provide coordination and implementation support to CSOs to carry out facilitation and support implementation at the community level.

5.8 Performance monitoring and reporting

Since ESAP3 is a multi-donor programme implemented through a World Bank-managed Multi Donor Trust Fund, there will be one overall internal, technical and financial monitoring system for all donors. The system will build and improve the Monitoring and Evaluation system of ESAP2 with an emphasis on moving towards institutionalisation and system strengthening.

The day-to-day technical and financial monitoring of the implementation of this action will be a continuous process and part of the implementing partner's responsibilities. To this aim, the implementing partner shall establish a permanent internal, technical and financial monitoring system for the action and elaborate regular progress reports (not less than annual) and final reports (notably to the Ethiopian Social Accountability III Steering Committee and contributing donors). Every report shall provide an accurate account of implementation of the action, difficulties encountered, changes introduced, as well as the degree of achievement of its results (outputs and direct outcomes) as measured by corresponding indicators, using as reference the logframe matrix. The report shall be laid out in such a way as to allow monitoring of the means envisaged and employed and of the budget details for the action. The final report, narrative and financial, will cover the entire period of the action implementation.

The Commission may undertake additional project monitoring visits both through its own staff and through independent consultants recruited directly by the Commission for independent monitoring reviews (or recruited by the responsible agent contracted by the Commission for implementing such reviews).

The monitoring mechanism as agreed in the World Bank Design Document includes the following elements that will be included in a Monitoring and Evaluation schedule to be developed during the first year:

- internal operational monitoring carried out by the Management Agency to track activities and outputs.
- ad hoc/semi-annual operational joint government-donors monitoring missions and Joint Review and Implementation Support missions.
- mechanisms for Internal review of performance to supervise and assess Social Accountability Implementing Partners performance on the field.
- external quantitative impact that will be carried out in various phases, notably: i) the establishment of the baseline in Year 1 to capture the expansion of programme scope from the demand to the supply side, context evolutions and lessons learnt from the ESAP2 Randomised Control Trial evaluation; ii) a mid-term evaluation and; iii) an end line evaluation. The objective will be to measure to what extent the project achieved the desired outcomes and whether the effects measured in service delivery and citizen's engagement can be attributed to the programme[11].

5.9 Evaluation

Having regard to the multi-donor nature of the action, the World Bank will be responsible of the external and independent quantitative impact evaluation, which is included in the financial contribution.

The Commission may, during implementation, decide to undertake an evaluation for duly justified reasons either on its own decision or on the initiative of the partner.

The evaluation reports shall be shared with the partner country and other key stakeholders. The implementing partner and the Commission shall analyse the conclusions and recommendations of the evaluations and, where appropriate, in agreement with the partner country, jointly decide on the follow-up actions to be taken and any adjustments necessary, including, if indicated, the reorientation of the project.

The financing of the evaluation shall be covered by another measure constituting a financing decision.

5.10 Audit

Given the multi-donor nature of the action, Annual audits are a World Bank's responsibility. In addition, internal and external audits of the Management Agency are carried out within the scope of the multi-donor programme.

Without prejudice to the obligations applicable to contracts concluded for the implementation of this action, the Commission may, on the basis of a risk assessment, contract independent audits or expenditure verification assignments for one or several contracts or agreements.

The financing of the audit shall be covered by another measure constituting a financing decision.

[11] The specific approach and methodology will be determined by the Steering Committee, taking into account the lessons learnt from ESAP2 Randomised Control Trial evaluation that is being finalised.

5.11 Communication and visibility

Communication and visibility of the EU is a legal obligation for all external actions funded by the EU.

This action shall contain communication and visibility measures which shall be based on a specific Communication and Visibility Plan of the Action, to be elaborated at the start of implementation and supported with the budget indicated in section 5.6 above.

In terms of legal obligations on communication and visibility, the measures shall be implemented by the Commission, the partner country, contractors, grant beneficiaries and/or entrusted entities. Appropriate contractual obligations shall be included in, respectively, the financing agreement, procurement and grant contracts, and delegation agreements.

The Communication and Visibility Manual for European Union External Action shall be used to establish the Communication and Visibility Plan of the Action and the appropriate contractual obligations.

6 PRE-CONDITIONS

Guarantees should be given that all Ethiopian and Ethiopian Resident Charities and Societies as well as any other Ethiopian Civil Society Organisations legally registered can participate in programme implementation. The signature of the Financing Agreement will be subject to the pre-condition that the Steering Committee of ESAP adopts the Guiding Principles for CSO Engagement (eligibility and selection).

APPENDIX - INDICATIVE LOGFRAME MATRIX [12]

The activities, the expected outputs and all the indicators, targets and baselines included in the logframe matrix are indicative and will be updated during the inception phase of the action, no amendment being required to the financing decision. The indicative logframe matrix will evolve during the lifetime of the action: new lines will be added for including the activities as well as new columns for intermediary targets (milestones) for the output and outcome indicators whenever it is relevant for monitoring and reporting purposes.

	Results chain	Indicators	Baselines (incl. reference year)	Targets (incl. reference year)	Sources and means of verification	Assumptions
Overall objective: Impact	Support and strengthen the social accountability system and mechanism for enhanced service delivery in Ethiopia	• Percentage of citizens (men and women) reporting improved and quality public services • Percentage of participating Woredas that have aligned their budgeting and planning practices with SA processes. • The number of interface meetings held and JAPs agreed upon	TBC in inception	TBC inception	• Survey report • Mid-term and final evaluation reports • Impact assessment reports	GoE willingness to involve all segments of society in the development process
Specific objective 1: outcome	SO 1- Expand the uptake of Social Accountability tools *Outcome 1.1- Citizens and citizen groups are aware of their entitlements and responsibilities to contribute to and demand for improved quality public services*	• Percentage of citizens (men and women) aware of their service entitlements/rights in the intervention Woredas • Percentage of citizens (men and women) demanding improved and quality public services	TBD	TBD	• Survey reports • Mid-term and terminal evaluation reports	The GoE will continue to strongly support ESAP3 at various levels, including the role of a diverse set of CSOs as facilitators of the SA process

[12] Mark indicators aligned with the relevant programming document mark with '*' and indicators aligned to the EU Results Framework with '**'.

	Outcome 1.2 Citizens and user communities (including vulnerable and PSNP groups) in targeted SA woredas and sectors are empowered to participate in the planning, budgeting, implementation and monitoring of basic public services.	• Increased awareness among citizens of their co-responsibilities • User communities (disaggregated by gender) actively involved in public service planning, budgeting, implementation and monitoring • Disadvantaged and vulnerable community groups (elderly, disabled and, PSNP beneficiaries and PLWHAs) actively involved in public service planning, budgeting, implementation and monitoring • Percentage of Kebeles in participating Woredas, where annual planning and prioritisation public meetings have been held			• Survey reports • Mid-term and terminal evaluation reports • Annual & quarterly project performance reports	
	Outcome 1.3 Basic public service providers in education, health, agriculture, water and sanitation and rural roads sectors deliver improved	• Percentage of citizens and user groups that indicate satisfaction on the quality of the services provided • Proportion of vulnerable			• Survey reports • Mid-term and terminal evaluation reports • Impact assessment study reports	

	quality basic public services, responding to citizens' prioritised needs[13]	populations and PSNP beneficiaries who consider basic public services responsive to their needs and priorities				
Specific objective 2: outcome	OS2- Support the strengthening and embedding of SA tools and approaches at federal and subnational level *Outcome 2.1- Government policy and strategy formulation process is informed by evidence from SA interventions* *Outcome 2.2 -Government accountability and oversight structures; kebele assemblies, woreda councils, and regional councils in particular, are strengthened to embed and sustain SA initiatives in their mandated roles and functions*	• ESAP3 annual progress reports (APRs) feed in to GTPII annual review processes 1. • Number of Regional, Woreda and Kebele councils making use of SA tools, processes and information to undertake their mandated oversight roles and functions • Percentage of Regional, Woreda and Kebele councils that make use of SA generated evidence to make their planning and budgeting decisions • Number of Regional, Woreda and Kebele councils that provide space for SACs and other community based	TBD	TBD	• Submissions of ESAP3 APRs to GTP2 annual reviews • Survey reports • Project performance reports	The GoE is willing to internalise SA practice in its internal procedures and MoFEC is able to build buy in from other public institutions to strengthen state responsiveness

[13] This is under the assumption that the current 5 basic service sectors (education, health, agriculture, water and sanitation and rural roads) will continue to be the focal sectors for SA interventions, while there will be a mechanism in place to entertain issues coming outside these 5 sectors (please see output 4.4 in component 2).

	Outcome 2.3- Local community structures and service user groups, including SACs, PTSAs, CBOs, MBOs are strengthened to implement, scale up and sustain SA initiatives	SA structures to articulate their priorities during budget hearings and public consultations • Percentage of Regions and Woredas where vertically and horizontally aligned FTA-SA-GRM linkages are in place and functioning Proportion of local community structures and service user groups effectively working on SA in a progressively less dependent way on external technical and financial support			• Survey reports Mid-term and terminal evaluation reports	
Specific objective 3: outcome	OS3- Project Management, Coordination and Knowledge management *Outcome 3.1- The SA programme is effectively managed* *Outcome 3.2- CSOs and other relevant actors play an effective interlocution/ facilitation role between citizens and service providers to implement SA projects* *Outcome 3.3- Improved access to and*	• Execution rate: % of activities implemented according to plan • Number of CSOs and facilitators with effective interlocution capacity in place and functioning • Number of other actors (academic institutions, think tanks, private sector) with effective interlocution capacity engaged in facilitating ESAP processes • Increased partnership	TBD	TBD	• Annual, Midterm & Project performance reviews • Survey reports • Mid-term and terminal evaluation reports • Programme	

	benefit from knowledge on local, regional and global social accountability practices *Outcome 3.4-* *Evidence-based collaborative SA action research feeds national policy making and practice*	and alliance with global and regional SA forums and platforms 2. • Number of research products and inputs used by policy SA makers and practitioners			performance reports • Mid-term & final evaluation reports • Mid-term & final evaluation reports • Survey reports	
Output 1	**Output 1.1.** User community groups and citizens in all interventions areas mobilised and given awareness training on social accountability including service standards, entitlements, and information law. Gender responsiveness and inclusiveness principles are followed during mobilisation. **Output 1.2:** Citizens and community groups (including marginalised and vulnerable social groups selected on the basis of inclusiveness and gender responsiveness) trained on social accountability tools to participate in planning, budgeting, and monitoring of basic service delivery. **Output 1.3:** Citizens and Community groups (including vulnerable groups and PSNP beneficiaries selected on the basis of inclusiveness and gender responsiveness) in the intervention woredas and service sectors use social accountability tools to assess services **Output 1.4:** Citizens and community groups	Number of citizens (disaggregated by gender, vulnerable groups, PSNP beneficiaries, PLWHAs) that participated in the awareness and SA familiarisation workshops Number of citizens and citizens' groups (disaggregated by gender, vulnerable groups, PSNP beneficiaries, PLWHAs) trained in SA tools Number of citizens (including disadvantaged social groups and PSNP beneficiaries and disaggregated by men and women participants) that have actually participated in the various stages of the service assessments using SA tools Number of citizens and community groups	TBD	TBD	Annual & quarterly project performance reports Annual & quarterly project performance reports Annual & quarterly project performance reports Annual & quarterly	

	(including vulnerable and marginalised groups and PSNP beneficiaries selected on the basis of inclusiveness and gender responsiveness) trained in the application of gender analysis in the use of SA tools	(including disadvantaged social groups and PSNP beneficiaries, and disaggregated by gender) who have mainstreamed gender responsiveness in the application of SA tools in the various stages of service assessments			project performance reports	
	Output 1.5: Face to face meetings are held between citizens' groups and public service providers, facilitated by independent interlocutors, to craft and agree on service improvement plans	The number of interface meetings held and JAPs agreed upon			• Annual & quarterly performance reports • M&E reports	
	Output 1.6: Local government basic service providers are trained on SA tools and approaches	Number of basic service providers trained in SA tools 3. 4.			• Annual & quarterly project performance reports	
	Output 1.7: Basic service providers assess their own service performance using SA tools	Number of self-assessments conducted			Annual & quarterly project performance reports	
	Output 1.8 Basic service providers participate in facilitated meetings with service user communities to jointly craft and agree on Joint action Plans for service improvements	The number of interface meetings held and JAPs agreed upon			Annual & quarterly performance reports M&E reports	
	Output 1.9: SA initiated joint action plans (JAPs) feed into and are executed as part of local government service delivery plans and budget	Percent of actions identified in JAPs have been implemented JAP initiated allocation/re-allocation of resources (budget) as a measure taken to improve public			M&E reports (ESPES DLI reporting) Local government	

		services			budget and plans	
Output 2	**Output 2.1:** ESAP3 activities and results are communicated and shared with Federal level policy making bodies **Output 2.2:** Monitoring visits to ESAP3 field projects is organised for federal government stakeholders **Output 2.3:** Learning and experience sharing platforms are organised to provide policy makers research findings and insights from the ground on ESAP3 implementation **Output 2.4:** Regional, Woreda and Kebele councilors are trained on SA tools and approaches **Output 2.5:** Councils (standing committees in particular) oversee JAP execution, monitoring and follow-up **Output 2.6:**	Quarterly and annual reports submitted Number of monitoring visits made to ESAP3 projects attended by the respective federal government agencies National level experience sharing events organised bi-annually Number of Council members (disaggregated by administrative level) who participated in social accountability training sessions Number of JAP implementation, monitoring and follow up visits made by councilors (disaggregated by administrative level) Number of joint SA-FTA-GRM planning and review meetings held	TBD	TBD	Reports made available Joint monitoring reports Minutes of experience sharing conferences Annual & quarterly performance reports M&E reports Annual & quarterly performance reports Minutes of SA-FTA-GRM review	

	SA,FTA and GRM activities are well linked and coordinated	Number of joint field visits conducted to monitor implementation of activities			meetings Annual & quarterly performance reports	
	Output 2.7: Horizontal and vertical information flow mechanisms are in place and functioning to address non-ESAP sector issues coming from citizens through existing accountability institutions and processes (GRM, EIO, councils)	The number of non-basic service delivery sector issues addressed Extent of response by the concerned sector departments			Annual & quarterly performance reports Responsiveness survey reports M&E reports	
	Output 2.8: Best practices of citizen engagement through SA and FTA and GRM are identified, documented and shared with stakeholders	Number of best practices documented and disseminated through the FTA-SA-GRM communication channels. Number of SAIPs' staff who attended the regional FTA review meetings Number of PFM teams who participated in woreda level stakeholders review meetings organised by SAIPs			Best practice study reports Annual & quarterly performance reports	
	Output 2.9: User community structures suitable for implementation and scaling up of SA identified and selected **Output 2.10:** Community SA structures are	Number of user community structures selected Number of user community structures operating			Annual & quarterly performance reports M&E reports	

	established and/or revitalised and operationalised **Output 2.11:** Local community SA structures are trained on SA tools and approaches to engage service providers **Output 2.12:** Local community SA structures actively participate and engage local government and service provider institutions in the planning, budgeting, implementation and monitoring of basic public services	Number of user community structures capacitated on SA tools and approaches Number of planning, budgeting and monitoring meetings SA structures have participated in			Annual & quarterly performance reports Minutes of the planning, budgeting and monitoring meetings held	
Output 3	**Output 3.1:** Annual work plan and budget prepared and implemented timely **Output 3.2:** Programme operational guidelines, including management procurement templates developed, validated and operationalised **Output 3.3:** Grant Management Scheme is established providing grants to SAIPs as per approved procedures and directives **Output 3.4:** SAIPs are capacitated to play their SA facilitation and coordination roles and duties **Output 3.5:**	Timely submission of annual performance and financial reports Availability & functionality of SA operational guide Availability and functionality of procurement templates Grants are disbursed to eligible grantees as per set criteria and standard procedures efficiently & timely Number of SAIPs capacitated	TBD	TBD	Annual, Midterm & Project performance reviews Annual, Midterm & Project performance reviews Annual, Midterm & Project performance reviews M&E reports	

	SA knowledge exchange platforms in place and functioning **Output 3.6:** Partnership and networking with global SA forums and communities of practice established **Output 3.7:** National SA practice dissemination media channels and knowledge management portal established and functional **Output 3.8:** Action research on SA policy and practice conducted including action research on gender gaps in SA (application of SA tools; participation in SA; and responsiveness to gender priorities)	Number of experience-exchange and reflection events organised Number of partnerships and memberships accessed in global and regional SA platforms Number of local media outlets (FM), websites, newsletters and social media that make available SA information Numbers and frequency of listeners/users/subscribers Number of studies conducted			Annual and quarterly performance reports Annual and quarterly performance reports Annual and quarterly performance reports	

EN

This action is funded by the European Union

ANNEX 2

of the Commission Decision on the Annual Action Programme 2018 Part 1 in favour of the Federal Republic of Ethiopia to be financed from the 11th European Development Fund

Action Document for
Addressing Social Determinants of Health for Gender equality

INFORMATION FOR POTENTIAL GRANT APPLICANTS **WORK PROGRAMME FOR GRANTS** This document constitutes the work programme for grants in the sense of Article 110(2) of the Financial Regulation, applicable to the EDF in accordance with Article 37 of Regulation (EU) 2015/323 in the section concerning call for proposals: 5.4.1		
1. Title/basic act/ CRIS number	*Addressing Social Determinants of Health for Gender equality* CRIS No: ET/FED/040-410 financed under the 11th European Development Fund (EDF)	
2. Zone benefiting from the action/location	Federal Republic of Ethiopia The action shall be carried out in Ethiopia – both at the federal level and in three Developing Regional States (DRS): Afar, Benishangul Gumuz and Gambela.	
3. Programming document	National Indicative Programme (NIP) 2014-2020 for Ethiopia	
4. Sector of concentration/thematic area	Focal Sector: Health	DEV. Aid: YES[1]
5. Amounts concerned	Total estimated cost: EUR 20 073 684 Total amount of EDF contribution: EUR 20 000 000 This action is co-financed for the direct management part by potential beneficiary for an indicative amount of EUR 73 684.	
6. Aid modality and implementation modalities	Project Modality Direct management - grants – call for proposals, procurement of services Indirect management with the Federal Republic of Ethiopia	

[1] Official Development Aid is administered with the promotion of the economic development and welfare of developing countries as its main objective.

<table>
<tr><td>7 a) DAC code(s)</td><td colspan="4">Main DAC code: 120 - HEALTH
Sub-code 12240: Basic nutrition
Sub-code 12261: Health education
Main DAC code: 130 - POPULATION POLICIES/ PROGRAMMES AND REPRODUCTIVE HEALTH
Sub-code 13020: Reproductive health care
Main DAC code: 140 – WATER AND SANITATION
Sub-code 14031: Basic drinking water supply
Sub-code 14032: Basic Sanitation
Main DAC code: 151 GOVERNMENT AND CIVIL SOCIETY, general
Sub-code: 15170 Women’s equality organisations and institutions
Sub-code 15180 Ending violence against women and girls</td></tr>
<tr><td>b) Main Delivery Channel</td><td colspan="4">N/A.</td></tr>
<tr><td rowspan="6">8. Markers (from CRIS DAC form)</td><td>General policy objective</td><td>Not targeted</td><td>Significant objective</td><td>Main objective</td></tr>
<tr><td>Participation development/good governance</td><td>X</td><td>☐</td><td>☐</td></tr>
<tr><td>Aid to environment</td><td>X</td><td>☐</td><td>☐</td></tr>
<tr><td>Gender equality (including Women In Development)</td><td>☐</td><td>☐</td><td>X</td></tr>
<tr><td>Trade Development</td><td>X</td><td>☐</td><td>☐</td></tr>
<tr><td>Reproductive, Maternal, New born and child health</td><td>☐</td><td>☐</td><td>X</td></tr>
<tr><td rowspan="5"></td><td>RIO Convention markers</td><td>Not targeted</td><td>Significant objective</td><td>Main objective</td></tr>
<tr><td>Biological diversity</td><td>X</td><td>☐</td><td>☐</td></tr>
<tr><td>Combat desertification</td><td>X</td><td>☐</td><td>☐</td></tr>
<tr><td>Climate change mitigation</td><td>X</td><td>☐</td><td>☐</td></tr>
<tr><td>Climate change adaptation</td><td>X</td><td>☐</td><td>☐</td></tr>
<tr><td>9. Global Public Goods and Challenges (GPGC) thematic flagships</td><td colspan="4">None</td></tr>
<tr><td>10. Sustainable</td><td colspan="4">SDG 2 - End hunger, achieve food security and improved nutrition and</td></tr>
</table>

Development Goals (SDGs)	promote sustainable agriculture SDG 3 - Ensure healthy lives and promote well-being for all at all ages SDG 5 - Achieve gender equality and empower all women and girls SDG 6 - Ensure Access to Water and Sanitation

Acronyms

CEFM	Child, Early and Forced Marriage
CPR	Contraceptive Prevalence Rate
CSA	Central Statistics Agency
EDHS	Demographic and Health Survey
DRS	Developing Regional State
EPHI	Ethiopian Public Health Institute
FGM/C	Female Genital Mutilation/Cutting
FP	Family Planning
GBV	Gender Based Violence
GoE	Government of Ethiopia
GTP	Growth and Transformation Plan
HC	Health Centre
HMIS	Health Management Information System
HP	Health Post
HSTP	Health Sector Transformation Plan
HTPs	Harmful Traditional Practices
MNCH	Maternal, Neonatal and Child Health
MoFEC	Ministry of Finance and Economic Cooperation
MoH	Ministry of Health
MoWCA	Ministry of Women & Children Affairs
MTEF	Medium Term Expenditure Framework
NNPII	National Nutrition Programme 2016-2020
OWNP	One Wash National Programme
PBS	Promotion of Basic Service
PFM	Public Finance Management
RHB	Regional Health Bureau
SDG	Sustainable Development Goals
SARA	Service Availability and Readiness Assessment
SRHR	Sexual Reproductive Health and Rights
WaSH	Water and Sanitation & Hygiene
WHA	World Health Association

SUMMARY

The health sector in Ethiopia has achieved encouraging results in the last 20 years, as confirmed by UN estimates and country level surveys: the under-five child mortality rate (U5MR) has dropped from 204 per 1 000 live births in 1990 to 67 per 1 000 in 2016 and the maternal mortality ratio has decreased from 871 deaths per 100 000 live births in 2000 to 412 deaths per 100 000 live births in 2016[2].

Despite Ethiopia's progress in improving access to basic health services and achieving most of the health Millenium Development Goals (MDGs), serious challenges remain as reflected in the still high maternal mortality rate and in the high prevalence of stunting and wasting amongst children under five (38 % and 10 % respectively), as indicated in the Ethiopia Demographic and Health Survey (EDHS) 2016 report. Furthermore, the report indicates that 22 % of women aged 15-49 years are faced with unmet needs for family planning, and 13 % of women aged 15-19 years have begun childbearing (teenage pregnancy). There exists huge disparity across regions in terms of health outcome with the four Developing Regional States (DRS) and/or pastoral areas facing the greatest difficulties. For instance teenage pregnancy rate is highest in Afar at 23 %. Efforts also need to be reinforced to improve the readiness of health facilities to provide quality services. The sector financing is heavily dependent on external resources (37 %) and significant out-of-pocket expenditure (33 %)[3] by households, which is one of the major constraints for women's access to health services in Ethiopia.

The Action targets women and adolescent girls and complements the on-going health sector budget support and other EU supported programmes with the aim to address social determinants of health for gender equality. It focuses on family planning, nutrition, water, sanitation and hygiene (WaSH), and harmful traditional practices (HTPs). Specifically, it aims at improving access to and quality of integrated nutrition and family planning services, prevention and support for harmful traditional practices and gender-based violence (GBV) victims and improving WaSH in health facilities. The Action is expected to achieve four interrelated results in three Developing Regional States[4]: (1) Improve access and quality of sexual reproductive health and rights (SRHR) services with special emphasis on Family Planning (FP) services and specific SRHR) services for HTP and GBV victims; (2) Improved access and quality of integrated nutrition services for adolescent girls, pregnant and lactating women and children under 5 years of age; (3) Improved functionality and readiness of health facility to provide quality services with special emphasis on improving WaSH; and (4) Prevention of GBV and HTPs – promotion for change of social norms and mind-sets, attitudes and beliefs, and improved access to and use of support services for GBV victims/survivors.

1. CONTEXT

1.1 Country and sector context

Ethiopia is the second most populous country in Africa with an estimated population of 93 million (Central Statistics Agency projection 2013), and growing rapidly at an average annual rate of 2.6 %. The majority of the population (80 %) lives in rural areas. It is a low income country with a per capita income of USD 550 in 2014 – up from USD 377 in 2009-2010, ranking 174 out of 188 countries at the Human Development Index (2016). According to official government data, the country had an average Gross Domestic Product (GDP) growth of 11 % for the period 2004-2005 to 2011-2012 and according to the 2014 World Bank Poverty Assessment, this performance has helped reduce the share of the population living below poverty line from 38.7 % in 2004-2005 to 29.6 % in 2010-2011.

[2] Ethiopian Demographic & Health Survey (EDHS, 2016).
[3] National Health Account (NHA, 2013-2014)
[4] Ethiopia's DRS include Afar, Somali, Gambela and Benishangul Gumuz. As defined in the HSTP, these regions need special support aiming at addressing the challenges of inequality and further improve health status of the pastoral population. The proposed Action is thus focusing on the three of the DRS (Afar, Gambela and B/Gumuz) as similar activities are being supported from the RESET initiative in Somali region.

In line with the objective of poverty eradication and bringing about social development, the country has invested in both physical and human capital formation to address the challenges related to improving access to basic services. In the **Health sector**, improving quality and addressing inequity are among the major challenges highlighted in the HSTP. Despite the country's investment in expanding access to health facilities, the latest Service Availability and Readiness Assessment (SARA, 2016) report indicates that availability of basic amenities and supplies necessary to provide services within the health facilities is quite low. For instance, health facilities access to water supply and connection to power source is as low as 30 % and 23 %respectively. Challenges to improve the quality of health care in Ethiopia also relate to financial and human resources constraints, particularly at the lower decentralised service delivery levels. The limited access to essential basic services and supplies is impacting on health outcomes. For example, according to 2016 EDHS, Skilled Birth Attendance (SBA) and ante natal care (+4 visits) are only at 28 % and 32 % respectively. With regards to inequity, the national figures hide stark inequalities across regions, rural and urban areas, wealth groups and educational status of mothers. The Health Sector Transformation Plan (HSTP) acknowledges that the Developing Regional States (Afar, Somali, Gambela and Benishangul Gumuz) have the lowest health and nutrition indicators and need special support to address pertaining challenges of inequality and further improve health and nutritional status of the pastoral population. Similarly the prevalence of HTP and GBV in the DRS is amongst the highest in Ethiopia (please refer to section 1.1.3 for further details).

The National Gender Strategy, the Health Sector gender mainstreaming manual (published in 2013), and the National Strategy and Action Plan on Harmful Traditional Practices against Women and Children in Ethiopia, published in June 2013, all highlight the government recognition of and planned efforts to address gender inequalities and reduce HTPs through mainstreaming gender across all line ministries, agencies and private institutions, and within all programmes and plans. The Ministry of Women and Children Affairs (MoWCA) is responsible for coordinating gender-mainstreaming efforts, ensuring that policies, programmes and budgets reflect the need of both women and men, and to coordinate efforts to address GBV and HTPs. Policy dialogue on gender equality and women empowerment is coordinated by the Government – Donors Assistant Group (DAG) Gender Technical Working Group which is chaired by MoWCA.

A key objective of the National Nutrition Programme (NNP II, 2016-2020) is the reduction of stunting (chronic undernutrition) to 26 % by 2020 which is more ambitious than the World Health Assembly (WHA)/SDG nutrition target of reducing stunting by 40 % by 2025. Ethiopia has, in the last 20 years, reduced the prevalence of stunting in children under five years of age from 67 % to 38.4 % (EEDHS 2016) which has been a major contributing factor to Ethiopia's good performance in reducing child mortality. However, in 2016 an estimated 5.7 million children in Ethiopia were still stunted which is the 7th highest number of stunted children in the world. The situation varies significantly across the country with some of the DRSs showing the highest stunting prevalence rates; stunting rates in Afar (41.1 %) and Benishangul Gumuz (42.7 %) are higher than the national average (38.4 %) while the rates are lower in Gambella (23.5 %). Wasting rates are also very high in DRSs with 17.7 % in Afar, 11.5 % in Benishangul Gumuz and 14 % in Gambella. Children can be stunted and wasted at the same time. Having both deficits greatly elevate risk of mortality. Consequently additional efforts are required by the government and partners to secure the level of stunting reduction required to reach these targets.

A situation analysis commissioned by the EU found that poor water supply and sanitation were risks for child stunting[5]. These linkages have recently been disputed[6], but more information is needed.

[5] A situation analysis of the nutrition sector in Ethiopia 2015: https://eeas.europa.eu/sites/eeas/files/ethiopia_nutrition_situation_analysis_july_2015.pdf

[6] Luby, Stephen P et al. Effects of water quality, sanitation, handwashing and nutritional interventions on diarrhoea and child growth in rural Bangladesh: a cluster randomised controlled trial, The Lancet Global Health, Volume 6 , Issue 3, e302 - e315, 2018

There are some efforts to link WaSH and nutrition interventions in Ethiopia. The Seqota Declaration and other projects are a first attempt to nutrition sensitive WaSH.

Ethiopia is host to the second largest refugee population in Africa, with over 901 235 registered refugees and asylum seekers (408 494 in Gambela, 253 861 in Somali, 62 565 in Benishangul Gumuz and 37 188 in Afar)[7]. The Government of Ethiopia, in collaboration with the United Nations High Commissioner for Refugees (UNHCR) and other humanitarian organisations, and/or donor agencies, has been working on a range of initiatives to address the socio-economic needs of refugees and host communities. As the intervention of the proposed Action targets the DRSs where the majority of the refugees is residing, efforts will be made to work with UNHCR and the European Commission's Directorate-General for European Civil Protection and Humanitarian Aid Operations (DG ECHO) in exploring the links and maximise the potential spill over effects of interventions in addressing issues related to refugee communities.

1.1.1 Public policy assessment and EU policy framework

The Government of Ethiopia has the experience and capacity to define long and medium-term sector development programmes/plans and is currently implementing the 2nd Growth and Transformation Plan (GTP II, 2015-2016 – 2019-2020). At sectoral level, the Ministry of Health (MoH) has developed a strategic document entitled "**Ethiopia's path towards universal health coverage through primary health care**" that guides health sector investment, directions and priorities for the coming 20 years. It projects the health sector development on Ethiopia's economic development targets 2025-2035 and the expected demographic and epidemiologic transition. On the basis of this framework and the GTP II, the Ministry has also developed and is implementing its **Health Sector Transformation Plan** (HSTP, 2015-2016 – 2019-2020).

The HSTP emphasises the need to transform the sector so as to provide **universal access to quality health services** and proposes strategies to improve the quality of health services and address inequalities, which are two key challenges in the sector. The plan also gives due attention to **addressing the social determinants of health**, including nutrition, WaSH and socio-cultural issues related to family planning and harmful traditional practices and GBV. The HSTP recognises that high disparity exists in the uptake and coverage of high impact interventions amongst geographic, ethnic, income and gender dimensions. The HSTP further emphasises the need to improve the readiness of health facilities to provide quality services (with a concern on access to WaSH and electricity) as this was found often to be inconsistent in availability and quality, and unreliable.

In **nutrition**, which is a multi-sectoral domain that dramatically influences health outcomes, Ethiopia has demonstrated a strong political commitment by launching the multi-sectoral National Nutrition Strategy (NNS) in 2008 and being one of the first countries to commit to the Scaling Up Nutrition (SUN) movement in 2010. The NNS in Ethiopia is now operationalised through the multi-sectoral National Nutrition Programme II (NNP II) 2016-2020 with 13 signatory ministries. The Ethiopian government is committed to the reduction of stunting to 26 % by 2020 and wasting to 4.9 % and in 2015 also signed the Seqota Declaration, which commits the government to ending stunting for children under-two by 2030. Uniquely, the EU in Ethiopia has joined forces with other Member States to initiate a joint strategy on nutrition in support of the Government of Ethiopia's National Nutrition Programme. This EU+ group has been engaged with the Government to ensure that key social and agricultural flagship programmes are nutrition sensitive. As part of a Joint Action Framework, the EU+ group has also put a focus on the nutrition-WaSH linkages that require further evidence and action to which this programme shall contribute. The EU also supports the MoH to establish a Nutrition Information Analysis Platform called the National Information Platform on Nutrition (NIPN). The Action is also taking into consideration the priorities identified by the European

[7] UNHCR R report (January 2018).

Commission's Communication on Enhancing Maternal and Child Nutrition[8] and the Action Plan on Nutrition[9].

The country has also developed the "National Strategy and Action Plan on **Harmful Traditional Practices** against Women and Children" based on three pillars: prevention, protection and provision of rehabilitation services. At the Girls' Summit in London in 2014, Ethiopia announced that it commits to achieving the total elimination of Female Genital Mutilation/Cutting (FGM/C) and child, early and forced marriage (CEFM) by 2025 through a strategic, multi-sectorial approach covering improved multi-sectoral coordination, improved monitoring with strong accountability mechanisms for effective law enforcement, while increasing financial resources to eliminate FGM/C and CEFM. The GTP II also highlights the government's commitment to eliminating violence against women and children and HTP through ensuring women and child rights and wellbeing as cross-cutting issues with clear targets regarding HTP, FGM/C as well as regarding maternal mortality ratio and child mortality rate through promoting family planning services, ante and post-natal care services, delivery by skilled personnel, improving child feeding and caring practices, and improving coverage and quality of health care. The EU works within the framework of the Gender Action Plan II 2016-2020 that renewed and expanded the EU commitment toward Gender Equality and Women's Empowerment (GEWE)[10].

Ethiopia's past track record is also positive as regards the ability to implement health policy/strategies, to align donors and to achieve results such as: i) implementation of consecutive five-year Health Sector Development Programmes since 1996; ii) promoting International Health Partnership (IHP) principles ("one plan, one budget, one report"); iii) donor alignment around the Sustainable Development Goals (SDGs) Performance Fund; and iv) successful implementation of policies/strategies down to the community level through the Health Extension Programme (HEP) and the Health Development Army (HDA).

Strong leadership and coordination mechanisms for multi-sectoral issues exist at federal level but the capacities at lower levels are variable and both the MoH's and Ministry of Women and Children Affairs roles in coordinating multi-sectoral, inter-ministerial and inter-governmental actions need to be reinforced. Human resource challenges include limitations in technical and managerial capacity and skills mix at various levels, as well as retention issues with high turnover of staff. Data quality and data availability to inform evidence-based planning is another important challenge.

The country has managed to coordinate investment in the WaSH sector through the establishment of **One WaSH National Programme** (OWNP, 2014 – 2020). The OWNP is a sector-wide approach to water, sanitation and hygiene that brings together four ministries (Ministry of Water, Irrigation and Energy (MoWIE), Ministry of Education (MoE), Ministry of Health (MoH), and Ministry of Finance and Economic Cooperation (MoFEC)) and consolidates planning, budgeting and reporting in an effort to modernise delivery of water and sanitation services. Donors, including Civil Society Organisations (CSOs), are expected to align their targets, plans and activities with the programme and strengthen coordination in planning, implementation, monitoring and reporting of all WaSH activities amongst stakeholders at different levels.

Taking into account the national policy frameworks as well as the priorities deriving from the new **European Consensus on Development**[11], the EU+ Joint Cooperation Strategy, and the Council Conclusions on the Gender Action Plan 2016-2020, the Action which is a multi-sectoral intervention focusing on addressing gender inequalities and HTPs, selected SRHR services including Family planning, Nutrition, and WaSH is in line with the priorities defined in the 11th EDF NIP (2014-2020).

1.1.2 Stakeholder analysis

[8] Communication from the Commission to the European Parliament and the Council "Enhancing Maternal and Child Nutrition in External Assistance: an EU Policy Framework", COM(2013) 141 final of 12.3.2013.

[9] Commission SWD(2014) 234 final of 3.7.2014.

[10] Gender Equality and Women's Empowerment: Transforming the Lives of Girls and Women through EU External Relations 2016-2020. Joint Staff Working Document, SWD(2015)182 final of 21.9.2015.

[11] OJ C 210 of 30.6.2017.

The Ministry of Health (MoH) and Regional Health Bureaus are responsible for policy formulation and technical support, while **Woreda Health Offices** manage and supervise service provision at district level. In addition, the MoH has oversight over five agencies which are directly accountable to MoH[12]. Service providers at various levels are also key stakeholders; including at health facility - and community level (incl. health extension workers). Over 93 % of health facilities have governing bodies but only 52 % of hospital - and 49 % of health centre governing boards meet regularly[13]. Human resource challenges seriously hamper progress in the DRSs and strengthening their managerial and technical capacity is an integral part of the proposed action.

Central Statistical Agency (CSA) and **Ethiopian Public Health Institute** (EPHI) are responsible for monitoring and evaluation of the health policy. CSA is responsible for generating national statistical data related to socio-economic trends (including the EEDHS). EPHI undertakes research and conducts surveillance for the early identification and detection of public health risks. Reliable data are and will be crucial to inform evidence based planning for the proposed action.

The Ministry of Finance and Economic Cooperation (MoFEC) exercises oversight and coordination. It has the responsibility for supporting financial flows from the federal to the decentralised levels and for ensuring that public financial management systems work smoothly. Service providers are accountable to local governments for producing results and, in their turn, local governments are accountable to the regional and federal government for delivering basic services and reaching service delivery GTP targets. Yet, in line with GTP II, horizontal coordination among relevant sectors and agencies needs further reinforcement.

The Ministry of Women and Children Affairs (MoWCA) is responsible for coordinating and monitoring gender-mainstreaming efforts, including efforts to address GBV and HTPs. In most regions and woredas (districts) the capacity of MoWCA is limited to take on this role. MoWCA has received support from various development partners in the past (including Finland, UNICEF, and the EU) and more recently from UNFPA to address gender-based violence and HTP in selected woredas working through the Women Development Army and religious and community leaders, and with relevant Ministries (including MoH, Ministry of Education). However, concerted efforts are required to influence behaviour change at grass roots level and reduce GBV and HTPs.

The Ministry of Education (MoE) plays an important role in creating awareness and understanding on the potential impact of HTPs/GBV through strengthening in-school SRH/R and other youth clubs. There have been efforts to incorporate HTPs/FGM related topics in the relevant education curriculum which in effect enable to change set norms and behaviours at least among the younger generation. The MoE is also a key player in the implementation of recently launched School Health Programme (SHP) of the Ministry of Health. This flagship programme focuses on equipping students with the necessary knowledge of health, hygiene and nutrition. It targets providing the health packages in the school health care centres by trained workers. The Action proposes similar interventions and a possible support to the SHP for which the role of MoH is key and further analysis will be done with due consideration of the selected regions' peculiar contexts.

The **National Nutrition Coordination Body** (NNCB) chaired by the State Minister of Ministry of Health together with the National Nutrition Technical Committee (NNTC) (chaired by the Director of Maternal and Child Health Nutrition Directorate) as well as Regional Nutrition Coordination bodies (chaired by regional administrators), constitute the mechanism for leadership, policy decisions and coordination of the National Nutrition Programme II (NNPII).

[12] i) HIV/AIDS Prevention & Control Office (HAPCO) ; ii) Food, Medicine and Health Care Administration and Control Authority (FMHACA) ; iii) Pharmaceutical Fund and Supply Agency; iv) Ethiopian Public Health Institute (EPHI) ; v) Health Insurance Agency (HIA).

[13] HSTP (2016-2020), page 44.

The **One WaSH National Programme (OWNP) and related coordination structures -** The Action will be aligned to the OWNP and utilise and strengthen existing coordination structures and maintenance services especially at woreda level and at regional level in the targeted DRSs.

Civil Society Organisations are important complementary players in service delivery and improving governance of the health sector such as i) Consortia/umbrella organisations that facilitate participation in health strategy development, (ii) Women organisations that can use their knowledge and experience in governance and awareness raising on GBVs and HTPs but also on the importance of nutrition and WaSH, and on interacting with local authorities and iii) community based organisations – including the Women Development Army, that participate in village decision making, accountability and planning. The CSOs/NGOs are expected to take an active role in the implementation of this Action.

Traditional, Religious and Political Leader at different levels are champions of change and community gate-keepers. They play a crucial role in promoting social norm change and mind-set change and to influence behaviour change. Their active engagement in the proposed Action will be crucial.

The ultimate stakeholders and beneficiaries of the Action are adolescent girls, pregnant and lactating women and children < 5 years of age, and HTP and GBV victims/survivors and people at risk of HTP and GBV.

1.1.3 Priority areas for support/problem analysis

Four key priority areas for support have been identified with the aim of addressing the social determinants of health for gender equality:

1) Improve access and quality of SRHR services with emphasis on increasing demand for and uptake of comprehensive family planning services, and identification, treatment and referral of victims of GBV and HTPs;
2) Improve access and quality of integrated nutrition services as well as dietary diversity and nutritional outcomes for adolescent girls, pregnant and lactating women and children < 5 years of age;
3) Improve functionality and readiness of health facility to provide quality services with special emphasis on improving WaSH and linkages between WaSH and nutrition; and
4) Prevention of GBV and HTPs - change of social norms and mind-sets, attitudes and beliefs, and improve access to and use of support services for GBV victims/survivors.

As referred to earlier, Ethiopia has four Developing Regional States; Afar, Somali, Gambela and Benishangul Gumuz. The HSTP has emphasised that these regions need special support aiming at addressing the challenges of inequality and social determinants of health. The proposed Action is targeting its interventions in three of the DRSs (Afar, Gambela and Benishangul Gumuz) as similar activities are being supported in the Somali region from the EU funded RESET (Resilience Approach and Investment) Initiative as well as through DG ECHO supported programmes for migrants and displaced population groups. While some actions will benefit the region as a whole, others will be targeted at the most vulnerable communities.

Improve access and quality of SRHR services with special emphasis on FP services and specific SRHR services for HTP and GBV victims

The causes of maternal death in Ethiopia are multivariate and complex. In addition to inadequate health facilities and services, high frequency of births, early marriage and pregnancy, nutritional prohibitions for pregnant women, FGM/C are multiplying the exposure of Ethiopian women and girls to high risk of sickness and death. According to EDHS (2016) 13 %of women of age 15-19 began childbearing, which is more common in the DRS (23 % in Afar, 19 % in Somali and 16 % in Gambella) and has a higher risk of undesirable health outcomes for mother and infant such as

obstructed labour, obstetric fistula, depression, and stillbirths. About 34 % of childbirths among young women aged 15-19 years was unintended. Furthermore, the 2016 EDHS indicated that the highest unmet need for family planning was among the adolescent age group (15-19 years). This indicates that there is limited access to appropriate and context specific reproductive health services that meet the diverse need of adolescents. Furthermore, this high unmet need in adolescents is due to low health seeking behaviour for family planning in this age group due to the strong social norms around child-bearing soon after marriage and on the other hand, young married women are also not able to access contraceptive options when they want it. A survey from the United Nations Population Fund (UNFPA) also showed that adolescents are seeking more friendliness of providers in health services (UNFPA 2010). Evidences also showed that inadequate information on family planning services (use and efficiency of contraceptives) as well as risks related to FGM and other harmful traditional practices is a key challenge calling for concerted efforts of the government and its development partners. In addition, projections for Ethiopia show that the population is reaching 125 million by 2025 and then doubling to 200 million by 2050-2055. Despite the downward trend in terms of number of children per woman at national level (from 5.5 in 2000 to 4.6 in 2016), the population will dramatically increase in the coming years. This high rate of population growth requires effective long-term planning of health and nutrition services to ensure universal coverage while the quality of services is not compromised.

Furthermore, gender mainstreaming and prevention of GBV and HTP have been highlighted as key strategies for achieving improved health outcomes; this covers among other areas ensuring women and men benefit equally from health programmes as well as prevention, early identification and treatment of HTP and GBV victims, and timely referral for support services as required.

The Action is consequently expected to cover capacity building of health staff in youth friendly service provision, and identification, treatment and referral of HTP and GBV victims and related supportive supervision.

Improve access and quality of integrated nutrition services

Another key determinant of health outcomes in Ethiopia is **poor nutritional status of adolescent girls, pregnant and lactating women, and children under 5 years of age.** Successive EDHS reports show improving trends in reducing the prevalence of stunting in children under 5 years of age (see data presented earlier) but Ethiopia will fall short of its own commitment to reduce stunting amongst < 5 children to 26 % by 2025 and 0 % for children under 2 years of age by 2030 without concerted efforts to address undernutrition. The EEDHS 2011 revealed that the proportion of non-pregnant adolescent girls aged 15-19 years with acute malnutrition/thinness (Body Mass Index - BMI <18.5) was 36 % and boys with the same age was 66 %. Adolescents (age 15-19) are more likely to be thin (36 %) than older women (21-29 % in 20-49 year olds).

EDHS data (2016) further reveal that only 58 % of infants under six months are exclusively breastfed (as recommended by the World Health Organisation (WHO)) and only 76 % of children 18-23 months old are still receiving breastmilk while WHO recommends continuing breastfeeding for at least two years, and only 7 % of children 6-23 months were being fed the minimum acceptable diet according to their age. More than half of children 6-59 months (56 %) suffered from anaemia and about one-fourth of women age 15-49 are anaemic.

Furthermore, data reveal regional disparity in stunting rates with very high prevalence rates in some DRSs, calling for geographic specific interventions with due consideration of gender in the context of these regions including addressing cultural and religious food restriction and within household differences in diet/food consumption. Adolescent girls are particularly affected by food taboos and dietary restrictions.

To respond to urgent need to address malnutrition considering its large impact on child and maternal morbidity and mortality, the action will cover nutrition specific and selected nutrition-sensitive

interventions[14]. Increasing coverage and quality of nutrition specific interventions will be the primary target of the Action (covering interventions that address the immediate causes of malnutrition such as exclusive breastfeeding, adequate complementary feeding, importance of diet diversification, and prevention and early identification and treatment of infectious diseases). The project will further promote selected nutrition sensitive approaches especially related to health and WaSH. It is envisaged that communities in the proximity of health centres and health posts will benefit from improved access to water (see below).

Family planning interventions will be strongly linked to nutritional interventions targeted separately to adolescents (15-19 years old) and pregnant and lactating women. Family planning activities for adolescents will be designed with and for the target group, making them accessible and available to that particular target group and activities will all include nutritional assessment and counselling.

Improve functionality and readiness of health facility

The functionality and readiness of health facilities to provide quality services is a top priority of the HSTP calling for the collaboration of different sectors. Ensuring adequate **quantity and quality of water supply to the population, and connecting health facilities with adequate and permanent water supply sources** are key actions included in the HSTP. According to the 2016 EDHS, a significant proportion (43 %) of the population does not have access to improved water source and 28 % practice open defecation. Furthermore, the Service Availability and Readiness Assessment (SARA) report (2016) indicated that about 70 % and 77 % of health facilities have no access to improved water supply and electricity (sustainable source of power) respectively. The same report also indicated that about 69 % of health facilities have a latrine on premises that is accessible for general outpatient client use. However, 60 % of health posts have no client latrine on premises. Furthermore, the SARA report (2016) revealed that the mean availability of standard precaution for infection items (including safe disposal of infectious waste, disinfectant, etc.) in all health facilities is at 41 %. This lack of WaSH services compromises the ability to provide high quality and safe basic, routine services, such as safe child delivery and the prevention and control of infections for neonates and their mothers. Opportunities will be explored to maximise the number of beneficiaries in neighbouring communities with improved water system established for health facilities. Moreover, the action will support supervision and on the job coaching to ensure adherence to basic hygiene standards at the health facility level including waste management as well as integration of hygiene promotion messaging within the routine basic service delivery package.

Prevention of Gender-Based Violence (GBV) and Harmful Traditional Practices (HTPs), and improve access to and use of support services for GBV victims/survivors

Gender inequality and related **Gender-Based Violence, and HTPs** are other key determinants of women's and girls' health and wellbeing**.** The EDHS 2016 revealed that more than one-third of ever married women had experienced physical, sexual or emotional violence. There is wide variation when disaggregating data by wealth, education, geographic location and age. HTP/FGM is widely practised in Ethiopia; 65 % of women 15-49 years in Ethiopia are circumcised, but the age at which FGM is performed and severity of mutilation vary widely by region and cultural/ethnic group (with the highest in Somali – 98 % and Afar – 91 %), while FGM is less prevalent amongst women with higher education and those in the highest wealth quintile. Child marriage is recognised as a special form of Sexual and Gender-Based Violence (SGBV). In Ethiopia, about 13 % of women aged 15-19 began childbearing. Teenage pregnancy could be either the result of or a risk factor for SGBV.

A large fraction of SGBV incidences are never reported and therefore never addressed. Access to support– either through informal support networks or through formal support services – will empower victims of SGBV and change them from victims into survivors – restoring their self-esteem. Formal support services could include SRHR services and medical care, psycho-social counselling (para)legal

[14] Nutrition-sensitive interventions address the basic and underlying causes of malnutrition such as poverty, food insecurity; appropriate caring and parenting practices, women's empowerment and social status.

assistance and advice, police support with forensic evidence collection and investigation, and access to justice. Support may further include referrals to child protection services and temporary shelters, and access to social cash transfers and economic empowerment opportunities.

Globally, it is recognised that more investments, interventions and resources are required to prevent SGBV[15]. It is also recognised that prevention needs to focus on social norm change – and not (only) on changing individual attitudes and behaviour[16]. This is a very complex and time-consuming process, but this is the only way for sustainable change to prevent SGBV and HTPs.

Regional and woreda level multi-sectoral HTPs task forces have been established while various programmes have supported the establishment of community committees to address GBV and HTPs. However, the task forces and committees need ongoing support to sustainably build their capacity.

Similarly, various community sensitisation and advocacy activities have been conducted in Ethiopia but more investments are needed to ensure a lasting change in mind-set and behaviour. Furthermore, **access to and use of support services** to GBV victims/survivors (and prosecution of perpetrators) is limited although lessons learnt from various initiatives will form an excellent starting point to further develop these services, including telephone hotlines, and safe houses and rehabilitation centres run by MoWCA and NGOs/CBOs supported through income generating activities.

The proposed Action under this output will concentrate on 1) community based awareness raising on HTP and GBV to promote change on norm sets and behaviour; 2) raising knowledge of health staff to identify, support and refer GBV and HTP victims (as part of priority area 1); and 3) strengthening support services for GBV victims through a multi-sectoral coordinated approach in which MoWCA and existing coordination structures will play a key role.

2. RISKS AND ASSUMPTIONS

Risks	Risk level (H/M/L)[17]	Mitigating measures
Weak coordination mechanism in addressing the Social Determinants of Health at different levels	M	Further strengthening the collaboration among the different stakeholders and existing coordination mechanisms on gender mainstreaming, nutrition, and WaSH; build synergy and complementarity with MoH's School Health Programme (SHP) which is aimed at addressing nutrition, WaSH and sexual reproductive health of adolescents targeting schools as a venue.
Limited capacity of local authorities in DRSs	M	Technical Assistance will be recruited to support MoH/Regional Bureaus to develop grant proposals and operational and financial management of the Grants. The technical assistance (TA) should assess major capacity gaps in the DRSs and work closely with MoH and others to further strengthen existing capacity building initiatives.
Limited appetite or readiness in the DRS communities to change HTPs affecting women's	H	Close involvement of local/Community-based Organisations and opinion leaders in the actions, involvement of whole communities including men and boys, religious leaders etc. Coordination with other actions of similar nature e.g. those of UNFPA/UNICEF global programmes on child marriage and

[15] Conclusions of the 57th Session of the Commission on the Status of Women (CSW) placed a strong focus on prevention - See more at: http://www.unwomen.org/en/what-we-do/ending-violence-against-women/prevention#sthash.62myijyb.dpuf

[16] Manual on social norms and change - UNICEF/UNFPA (2016).

[17] H=high, M=medium, L=low.

health		FGM.
High turnover of staff/Lack of skilled human resources	M	Technical and managerial capacity building is part and parcel of the programme. Specific emphasis will be placed on providing ongoing support to staff through supportive supervision to ensure knowledge and skills gained through classroom and on the job training will be implemented as part of motivational support.
Public health emergency diverting attention of health staff to providing treatment and care to patients	M	With improvements taking place in delivery of integrated community case management (ICCM) services to all health posts as part of therapeutic services, treatment and surveillance, it is anticipated that disease outbreaks will be quickly brought under control to ensure smooth continuation of project implementation. Therefore, this risk can partly be mitigated but could cause delays in implementation and incomplete accomplishment of targets.
Adolescents might not use health services particularly for family planning	M	Design health and nutrition services with participation of adolescents and create awareness in the community on the importance of adolescent nutrition and the danger of social taboos around food and sexuality.
Assumptions		
The programme assumed that there will be good cooperation and enabling environment for CSO/NGO to jointly implement the programme with the local authorities. It is also assumed that the dialogue as well as the elaborate monitoring and review arrangements between the Government of Ethiopia and Development Partners in the health and nutrition sector will continue, which will facilitate the synergies between activities financed by the MoH, from the SDG Performance Fund and those supported directly by Development Partners.		

3. LESSONS LEARNT, COMPLEMENTARITY AND CROSS-CUTTING ISSUES

3.1 Lessons learnt

The Action is informed by and built on lessons learnt from existing interventions supported by the Government of Ethiopia and Development Partners. The main lessons include the following:

Sexual Reproductive Health and Rights (SRHR) services with special emphasis on FP services

- Working in partnership with Government line Ministries (as co-implementing partners) is effective and efficient in terms of resource use and strengthening the health system across the continuum of care and ensuring sustainability of project activities beyond the programme;
- The need for capacity building and strengthening of institutions to promote efficient and quality service delivery, including MoH staff technical and managerial training at various levels;
- Experiences from EU financed Save the Children project (in Afar) indicated that strengthening adolescent and youth friendly health service (AYFS) units within the health centres has improved quality of SRH/family planning services in project intervention woredas.

Improve access and quality of integrated nutrition services

- The need to empower families and communities with the knowledge and resources necessary to ensure optimal nutrition and growth for their adolescent girls, pregnant and lactation women and children under five years old;
- The need to scale up the delivery of a package of evidence-based nutrition specific and key sensitive interventions focusing on the first 1 000 days of life;
- The importance to specifically target 15-19 year olds with nutrition interventions for their own nutrition and health as well as for the next generation;
- The need to deliver integrated messages on behavioural change, women's empowerment and dietary diversity to improve dietary intake and nutritional outcomes;
- The need for a multi-sectoral approach and better coordination among nutrition specific and nutrition sensitive interventions enhancing the coordinating role of the Ministry of Health with other ministries such as Ministry of Agriculture and Natural Resources or Ministry of Water at all levels;
- The impact of poor water and sanitation on stunting, which led to limited response in policies and programmes.

Improve functionality and readiness of health facility

- Regional governments' suggestion and Development Partners' experiences showed that due to scattered nature of population settlement and deep level of underground water source in the DRS, deep-wells (with pipe extension) are considered effective and have the potential to serve both the community and health facilities.

Prevention, Behaviour-Change, Social Norm and Mind-Set Change

- More attention and funds need to be committed to the prevention of SGBV and HTPs, especially as changing behaviour and social norms is a complex and lengthy process;
- Effective GBV and HTP prevention programmes are based on strong multi-sectoral coordination;
- Partnering with and closely collaborating with traditional, religious and political leaders as agents of change are essential;
- Existing community and government structures can be used to strengthen prevention as well as identification and referral of GBV and HTP victims;
- Good relationships between local authorities at community and woreda level and programme implementers (including CSO) are key for successful programme implementation;
- Awareness raising and dialogue on GBV and HTPs using community conversation (CC) and stepping stone trainings found to be effective; and enable the community to engage in the process of developing their own byelaws and procedures in addressing GBV and HSTPs;
- The support for government anti-HTP/FGM taskforce enables effective dialogue among actors and ensures accountability for a shared responsibility in addressing HTP/FGM at different levels of the governance structure;
- Making family planning services available and accessible to adolescents (15-19 years).

3.2 Complementarity, synergy and donor coordination

Donor Coordination

Ethiopia has effectively harmonised support from its Development Partners in the health sector and was the first country to sign the International Health Partnership (IHP+) Compact. The Health, Population and Nutrition (HPN) Forum was established by the Development Assistant Group (DAG). The HPN Forum comprises multilateral and bilateral partners and the Consortium of Christian Relief and Development Association (CCRDA) and Consortium of Reproductive Health Association (CORHA) representing NGO/CSO. The HPN has the responsibility of supporting activities in different technical and thematic areas and feed into policy discussions between the Government and the development partners in supporting implementation and monitoring of the health sector programme as part of the overall national Growth and Transformation Plan (GTP-II). The HPN works towards improved aid coordination, harmonisation and alignment, promote national ownership in line with the Paris Declaration and Accra Agenda for Action.

With regards to nutrition, the multi-sectoral National Nutrition Coordination Body (NNCB) together with the National Nutrition Technical Committee (NNTC) constitutes the mechanism for leadership, policy decisions and coordination of the NNP II. In addition, donors are also meeting at the Nutrition Development Partners Forum (NDPF), which is a working group under the Health Population and Nutrition (HPN) Forum, since the health sector in Ethiopia is mandated to coordinate nutrition among all sectors through the NNP.

The One WaSH National Programme (OWNPOne) is also a multi-sectoral dialogue platform that brings four relevant ministries (MoWIE, MoE, MoH and MoFEC) with the aim to consolidate planning, budgeting and reporting in an effort to modernise the delivery of water and sanitation services. This national programme is supported by WaSH steering committees at regional, woreda, and town level which provide advocacy and guidance for the implementation of the OWNP. Considering the limited focus of OWNP on nutrition, it will be important to create awareness on nutrition sensitive WaSH within the relevant institutions and strengthen nutrition governance at local level to ensure collaboration of health and WaSH sector on nutrition and that nutrition also becomes a focus in WaSH committees. This Action will build on existing attempts of linking WaSH and nutrition such as the activities of the Sekota Declaration.

Complementarities

The proposed programme complements and builds on recognised best practices, lesson learnt and gaps from other programmes, such as:

1) **Health Sector Budget Support:** The proposed Action will complement existing EU financed health Sector Budget Support (SBS) (EUR 115 000 000, 2016-2018) for which addressing geographic inequalities is one of the priorities for policy dialogue. The Budget Support operation has identified disbursement trigger indicators relevant to the proposed Action including (i) reducing the difference between the national median and bottom 10 % woredas percentage of deliveries assisted by SBA; (ii) proportion of health centres with access to adequate water supply; (iii) availability of Maternal and Child Health (MCH) essential lifesaving drugs at health centres. The health SBS is expected to continue with a further allocation of EUR 55 000 000 for future programming (2019-2020).
2) **The EU-UNICEF Maternal Health Initiative** – Enhancing Safe Delivery in Ethiopia (ESDE): The ESDE project (EUR 40 000 000, 2014-2017) is one of the major Development Partners' (DPs) support for Maternal Newborn and Child Health activities in Ethiopia. The project has been implemented through a tripartite partnership of the EU, UNICEF and the Federal Ministry of Health (MoH).
3) **EU+ Joint Programming on Nutrition**: the EU Delegation and 14 Member States, plus Norway (EU+), have been collaborating closely since early 2014 on a Joint Programming approach to nutrition. The aim is to ensure a coherent and cohesive response to address the problem of undernutrition in Ethiopia, and to mainstream nutrition in relevant programmes of the EU+ group.

4) **Integrated nutrition services multi-sectoral interventions to improve nutrition security and strengthen resilience** (EUR 10 000 000, 2014– 2018) implemented by UNICEF and the Food and Agriculture Organisation of the United Nations (FAO). The programme focuses on measures to combat hunger and malnutrition – especially for mothers and children – addressing both nutrition specific and sensitive interventions following the concept of applying a nutrition lens to resilience programming.

5) Similarly, the Action is envisaged to complement and build upon the lessons learnt of the **Productive Safety Net Programme** (PSNP4, 2015 – 2020) to which the EU is contributing EUR 50 000 000, and the **Agriculture Growth Programme** (AGPII, 2016-2020) to which the EU has committed EUR 45 000 000. Both programmes focus on mainstreaming nutrition and supporting interventions which link humanitarian and development interventions from a resilience perspective, and enhancing nutrition governance and accountability. The EU has successfully lobbied for inclusion of an indicator on dietary diversity in the AGPII project design; monitoring dietary diversity of pregnant women and children < 5 is one of the performance indicators for the proposed Action.

6) Complementarities and synergy will also be built with the **Resilience in Ethiopia (RESET) programme (Phase I and II, EUR 70M)** which aims at building resilience to drought, food insecurity and other shocks and expanding coping capacities of the most vulnerable populations in drought-prone and food insecure areas. RESET is based on four cornerstones for building resilience, including improving the provision of basic services (Health, WaSH, Nutrition, family planning); support to livelihoods (agricultural and off farm); Safety Nets; and Disaster Risk Reduction.

7) **EU Global Health initiatives –** Ethiopia is beneficiary country in some of EU-HQ financed global initiatives including (i) UNFPA-UNICEF Joint Programme on the Abandonment of Female Genital Mutilation/Cutting: Accelerating Change (EU contribution EUR 6 000 000, 2016-2018); (ii) UNFPA-UNICEF Global Programme to accelerate action to end child marriage (EU contribution EUR 6 000 000); (iii) UNFPA Supplies global programme (EU contribution EUR 20 000 000, 2016-2017). The Action will build upon the experiences and lessons learnt of these programmes.

3.3 Cross-cutting issues

The Action's principal objective is directed at gender equality. It uses a rights-based and a gender-sensitive approach, starting from the rights to protection and care for the child, girls and women against HTP and GBV, and the right to health and adequate nutrition, and the obligations of the public sector to ensure these rights are honoured.

The Action is in line with the Government's strategy for gender mainstreaming in the health sector and other line ministries, agencies and private institutions, and the national strategy and action plan on HTPs against women and children in Ethiopia. The Action is further aligned with the EU's Gender Action Plan 2016-2020 specifically objective 7: "Girls and women free from all forms of violence against them (Elimination of violence against Women and Girls - VAWG) both in the public and in the private sphere". Special attention will be provided where required in order to reach vulnerable marginalised groups.

The Action specifically aims to support Government initiatives that reach out to vulnerable population groups with essential prevention and promotion messages for HTP and GBV through further strengthening the Health Extension Programme (HEP) and Women Health Development Army (HDA). It further aims at empowering women and adolescent girls by improving access to age appropriate health and information services with emphasis on comprehensive FP services to address unmet needs and empower women and girls to decide when and how many children to have.

Persons with disabilities are not specifically targeted by this project but are implicitly part of the main target group of women and girls. Furthermore, the special needs of disabled person will be considered in the Action which will contribute to improving access to gender and disability sensitive WaSH package in health facilities.

Environment and climate change: the most important issue related to the programme concerns the safe and appropriate management of health care waste, including the disposal of expired medicines and to the standard construction/installation of water supply facilities. The Ministry of Health has developed guidelines for health care waste management, which are incorporated into training programmes for health care workers.

4 DESCRIPTION OF THE ACTION

4.1 Objectives/results

This programme is relevant for the United Nations 2030 Agenda for Sustainable Development. It contributes primarily to the progressive achievement of SDG 2: End hunger, achieve food security and improved nutrition and promote sustainable agriculture, SDG 3: Ensure healthy lives and promote well-being for all at all ages and SDG 5: Achieve gender equality and empower all women and girls.

The **overall objective** is to support the Government of Ethiopia to **improve health and nutrition of Ethiopian citizens** with specific emphasis on improving health and nutrition of women and adolescent girls and children under five years of age. As such, it aims at contributing to the efforts of the Government of Ethiopia to reduce poverty and engage in inclusive growth through improved health and nutrition outcomes.

The specific objective is to contribute to **the improvement of social determinants affecting health outcomes in three of Ethiopia's Developing Regional States** (Afar, Benishangul Gumuz and Gambela).

The support to the sector through this Action will provide a significant contribution towards achieving the HSTP targets. The indicators and targets to be achieved (as defined in the logframe) are aligned with the HSTP/GTP II and the progress towards the set targets will be attributable to the combined efforts by Government and development partners.

The action puts women and adolescents in the centre of the intervention and attempts to change social norms and behaviour to reduce and prevent HTPs and GBV, to identify, treat and refer victims of HTP and GBV, improve family planning uptake, improve delivery of integrated nutrition services and address nutrition needs of pregnant and lactating women and children< 5 years, and improve health facility preparedness/readiness with respect WaSH in the three DRS. It is expected to achieve four interrelated results:

1) Improved access and quality of SRHR services with emphasis on increased demand for and uptake of comprehensive family planning services; and identification, treatment and referral of victims of GBV and HTPs;
2) Improved access and quality of integrated nutrition services as well as dietary diversity for adolescent girls, pregnant and lactating women and children < 5 years of age;
3) Improved functionality and readiness of health facility to provide quality services with special emphasis on improving WaSH and ensuring linkages with nutrition interventions; and
4) Prevention of GBV and HTPs – promotion for change of social norms and mind-sets, attitudes and beliefs, and improved access to and use of support services for GBV victims/survivors.

4.2 Main activities

The activities are to support the three selected DRSs (Afar, Benishangul Gumuz and Gambela) to devise and promote context specific interventions in addressing harmful traditional practices and GBV

(including early marriage, FGM, etc.), and increase access to and use of family planning methods and approaches as well as support services to victims of GBV and HTPs.

Result area 1 – main activities

- Sexual reproductive health/family planning is of course also a man's concern, and hence separate gender appropriate communication strategies on family planning, birth spacing, FGM will be considered for women and men. Particular attention will also be given to behavioural change communication interventions to promote the idea that men and women share equal responsibility for family planning. The Action will include a capacity/capability assessment and development of roadmap indicating steps to building the capacity of health staff in 1) comprehensive FP services, 2) youth friendly service provision, and 3) identification, treatment and referral of HTP and GBV victim and related supportive supervision and 4) age-appropriate nutrition assessment and counselling of adolescents and pregnant and lactating women. Furthermore, in-service training of health workers (midwives, nurses) will be provided as required to ensure women with a scar of a sewed (closed) vagina (through FGM) will receive the support and care required prior to and during delivery. Other activities could include: Sensitisation, training and mentorship of providers of support services to SGBV survivors;
- Psycho-social support for SGBV survivors – addressing mental health;
- Strengthening the referral system between different service providers through introduction/use of simple, practical and standardised tools if/as required;
- Support access to justice, and link between traditional and local courts.

Result area 2 – main activities

With regards to ***nutrition***, the focus will be on strengthening DRS' initiatives in improving access to and quality of nutrition specific actions fully integrated within routine health service provision, particularly family planning and with a focus on adolescent girls, pregnant and lactating mothers and children < 5 years of age. The basis of the response will be the Comprehensive and Integrated Nutrition Services (CINuS) package currently being developed by the MoH. This approach aims to provide all nutrition services as a package: Components of CINuS include: nutrition screening, growth monitoring and promotion, Vitamin A supplementation, de-worming of children 2-5 years, promotion of optimal infant and young child feeding practices, promotion of optimal maternal nutrition, promotion on the utilisation of micronutrient interventions, management of acute malnutrition, strengthening the follow up and referral linkages, linkage with nutrition sensitive interventions.

Amongst the key activities of the Action will be the strengthening of capacity of Health Extension Workers and supportive supervision. Limited additional equipment might be required to ensure they can perform their role. However, more importantly will be to empower the women, carers and communities with the knowledge to prevent malnutrition through Behaviour Change Communication (BCC), one-to-one age-appropriate counselling by health extension workers and referral to higher level of care when required. Furthermore, BCC will also include hygiene promotion (see result area 3) to prevent infections. In-service training of other health staff in the delivery of integrated nutrition package and supportive supervision is also anticipated based on an initial capacity assessment (see result area 1).

The Action will ensure strong linkages with the WaSH component through awareness raising at policy as well as community level and capacity building of involved actors (e.g. in WaSH committees).

Result area 3 – main activities

Health facilities readiness and access to water supply is a key component for improving the quality of maternal and neonatal health services and attention will be given to increase the number of health centres with access to sustainable water supply (with priority for HC without water supply in their

delivery rooms), safe and appropriate medical waste disposal mechanisms, and promotion of sanitation and hygiene practices. Furthermore, opportunities will be explored to maximise number of beneficiaries in neighbouring communities from improved water system established for health facilities. The Action will also support supportive supervision and on the job coaching to ensure adherence to basic hygiene standards at the health facility level as well as integration of hygiene promotion messaging within the routine basic service delivery package. Furthermore, training in basic maintenance of the water supply and waste management facilities will be provided if/as required.

Result area 4 – main activities

Gender-based Violence and HTPs are key determinant of women's and girls' health and wellbeing. As the issues cover a wide range of challenges, activities to consider could include:

- Advocacy through community outreach, BCC and use of champions of change to increase awareness on HTP and GBV to change norm sets and behaviour;
- Training of extension workers in recognition of symptoms of SGBV and HTPs;
- Partnering with traditional, religious and political leaders on SGBV prevention – working towards social norm change;
- Comprehensive Sexuality Education for in and out of school adolescents and youth through teachers and peer educators;
- Strengthening support services and referral systems for GBV victims through a multi-sectoral coordinated approach in which MoWCA's existing coordination structures will play a key role;
- Support lower level justice offices in facilitating the development and enforcing of community byelaws to be implemented in line with the Constitution and Regional/Federal laws;
- Technical Assistance and capacity building to strengthen government's institutional capacity and policy framework in the context of SGBV prevention and access to support services;
- Strengthening of telephone hot line, and safe houses and/or rehabilitation centres (to be) run by MoWCA and NGOs/CBOs supported through income generating activities.

4.3 Intervention logic

Leading principles underpinning design and implementation of the Action are:

- Use of a multi-sectoral, comprehensive and inclusive approach
- Country ownership and government leadership
- Systems strengthening and use of and roll-out of existing tools and materials
- Evidence driven whilst addressing local needs using a bottom-up approach
- Focus on results and sustainability from the start

The programme aims to remain flexible throughout its implementation – using a rights-based approach, responding to specific needs of the population in the target areas as well as responding to concrete demands from government in the prevention and response to HTP and GBV and improving coverage of comprehensive FP services and nutrition specific and selected nutrition sensitive interventions. During programme implementation, equal access to disadvantaged groups, including people with disabilities, needs to be ensured and clearly demonstrated. The focus will be on practical and cost-effective solutions and a robust monitoring to ensure the Action will remain evidence-based.

The Action will support provision of technical and managerial assistance to strengthen government's institutional capacity and multi-sectoral coordination (which may include clarifying roles, responsibilities and mandates of the different stakeholders), including strengthening referral mechanisms between different service providers.

Preferably, the programme will support existing structures and outreach approaches such as HDA, health extension workers and HTP task force and community committees. The design of the Action also takes into account that the identified priority areas (from the problem analysis) require further reinforcing multi-sectoral coordination mechanisms across the decentralised levels.

The intervention logic is built on the activities identified above contributing to the achievements/results in reducing prevalence of HTP through behavioural change communications/education and increased access and use of context specific family planning methods and approaches; increased access to and quality of basic health and nutrition services; improved dietary diversity for adolescent girls, pregnant and lactating women and children under five years of age; and improved WaSH facilities in health facilities. The full package of support envisaged under this Action is expected to contribute to improving social determinants affecting health outcome of the population in the three selected DRSs ultimately contributing to the overall objective of improved health and well-being of their citizens and reducing gender inequality.

An important separate component relates to Operational Research/Knowledge Management to define the baseline and conduct a comprehensive research on key barriers/challenges and analyse strategic interventions in addressing social determinants affecting health and gender equality with the aim to inform policy dialogue and scale up interventions in other areas. This research is further expected to also inform the design and implementation of the second phase Health Budget Support. It is envisaged that this research will be conducted through contracting a professional research institute or university with specialised experience in analysing multi-sectoral interventions.

5. IMPLEMENTATION

5.1 Financing agreement

In order to implement this action, it is foreseen to conclude a financing agreement with the partner country.

5.2 Indicative implementation period

The indicative operational implementation period of this action, during which the activities described in section 4.2 will be carried out and the corresponding contracts and agreements implemented, is 60 months from the date of entry into force of the financing agreement.

Extensions of the implementation period may be agreed by the Commission's authorising officer responsible by amending this decision and the relevant contracts and agreements; such amendments to this decision constitute non-substantial amendment in the sense of Article 9(4) of Regulation (EU) 2015/322.

5.3 Implementation of the budget support component

N/A.

5.4 Implementation modalities

Both indirect and direct management, the Commission will ensure that the EU appropriate rules and procedures for providing financing to third parties are respected, including review procedures, where appropriate, and compliance of the action with EU restrictive measures affecting the respective countries of operation.

5.4.1. Grants: call for proposals: Operational research/Knowledge Management (direct management)

(a) Objectives of the grants, fields of intervention, priorities of the year and expected results

The main objective of the operational research/Knowledge Management is to define the baseline and conduct a comprehensive research on key barriers/challenges and analyse strategic interventions in addressing social determinants affecting health and gender equality with the aim to inform policy dialogue and scale up interventions in selected areas. The research is also expected to inform the design and implementation of the 2nd phase of the Health Budget Support.

(b) Eligibility conditions

The Grant is envisaged to be implemented through contracting a professional research institute or university with specialised experience in analysing multi-sectoral interventions that include integrated nutrition services, comprehensive family planning and SRHR services for HTP and GBV victims, and institutional WaSH related activities. Attention will also be given to identifying research institutions and/or universities with solid experience in analysing complex socio-cultural issues relevant to GBV and HTPs - change of social norms and mind-sets, attitudes and beliefs, etc.

Subject to information to be published in the call for proposals, the indicative amount of the EU contribution per grant is EUR 1 400 000 and the grant may be awarded to a sole beneficiary or to consortia of beneficiaries (coordinator and co-beneficiaries). The indicative duration of the grant (its implementation period) is 48 months.

(c) Essential selection and award criteria

The essential selection criteria are financial and operational capacity of the applicant. The essential award criteria are relevance of the proposed action to the objectives of the call; design, feasibility, and cost-effectiveness of the action.

(d) Maximum rate of co-financing

The maximum possible rate of co-financing for grants under this call is 95 %.

If full funding is essential for the action to be carried out, the maximum possible rate of co-financing may be increased up to 100 %. The essentiality of full funding will be justified by the Commission's authorising officer responsible in the award decision, in respect of the principles of equal treatment and sound financial management.

(e) Indicative timing to launch the call

The indicative time to launch the call is the fourth trimester of 2018.

5.4.2 Procurement (direct management)

Subject in generic terms, if possible	Type (works, supplies, services)	Indicative number of contracts	Indicative trimester of launch of the procedure
Technical assistance	Services	1	4th trimester 2018

As highlighted in the risk assessment, the capacity of DRS is relatively weak and there is a need to have a Technical Assistance to support Regional Bureaus on operational and financial management aspects of the Action. The main purpose of the Technical Assistance is to support the Ministry of Health to establish and manage the Regional Grants. Specifically, the Technical Assistance will be tasked to undertake the following activities:

- Provide on the job trainings on grant contract management (such as EDF compatible procurement rules and procedures) to relevant staff of all the grant holders;
- Support the RHB in the launching and management of activities with the relevant Bureaus as co-implementing partners of the Action;
- Provide technical assistance for each RHB and their implementing partners (including BoWCA and BoWI) to develop a consolidated regional grant proposal and submit to the Contracting Authority;
- Consolidate bi-annual reports of the three Grants and present at the Project Steering Committee meeting with details on the challenges and action points for decision making;
- Work and collaborate with the operational research/knowledge management grantee in conducting the baseline survey and further analysis and impact evaluation of the Action's interventions;

- In order to effectively implement the project and provide the required services, the TA is expected to deploy three experts at Regional level and one expert (with solid experience on EU procedures) at the Ministry of Health.

5.4.3 Indirect management with the partner country

A part of this action with the objective of improving social determinants affecting health outcomes in Ethiopia's Developing Regional States may be implemented in indirect management with Ethiopia according to the following modalities:

The partner country (Ministry of Health) will act as the contracting authority for the procurement and grant procedures. The Commission will control ex-ante all the procurement and grant procedures.

Payments are executed by the Commission.

The partner country shall apply the Commission's rules on procurement and grants. These rules will be laid down in the financing agreement concluded with the partner country.

5.5 Scope of geographical eligibility for procurement and grants

The geographical eligibility in terms of place of establishment for participating in procurement and grant award procedures and in terms of origin of supplies purchased as established in the basic act and set out in the relevant contractual documents shall apply.

The Commission's authorising officer responsible may extend the geographical eligibility in accordance with Article 22(1)(b) of Annex IV to the ACP-EU Partnership Agreement on the basis of urgency or of unavailability of products and services in the markets of the countries concerned, or in other duly substantiated cases where the eligibility rules would make the realisation of this action impossible or exceedingly difficult.

5.6 Indicative budget

	EU contribution (in EUR)	**Indicative third party contribution (in EUR)**
5.4.1 Call for proposals: Operational research/ Knowledge Management (direct management)	1 400 000	73 684
5.4.2 Procurement (direct management)	3 000 000	0
5.4.3 Indirect management with the partner country	14 300 000	0
5.9 Evaluation, 5.10 Audit	250 000	N.A.
5.11 Communication and visibility	50 000	N.A.
Contingencies	1 000 000	N.A.
Total	**20 000 000**	**73 684**

5.7 Organisational set-up and responsibilities

The interventions on Social Determinants of Health involve diverse stakeholders and require a multi-sectoral approach where different partners - working in close coordination - implement identified activities together with the local authorities (as co-applicants) in a defined geographic area. On the basis of the prevalence of issues discussed in the problem analysis (section 1.1.3), about 3-4 woredas (districts) will be targeted from each of the three selected DRS(Afar, Benishangul Gumuz and Gambella).

The Action involves various actors and its implementation requires strong coordination mechanism. The RHB, as lead applicant, is expected to coordinate the implementation of the Action. The RHB will be responsible for the financial and technical reporting and overall management and coordination. Cross DRS sharing of plans, progress, challenges and lessons learnt will be an integral part of the Action. The Regions are expected to develop and ensure a very strong coordination mechanism and partnership with the local authorities at Zone, Woreda (district), kebele (ward) levels. All proposed interventions in those selected DRS are jointly identified, appraised and validated by partners in close coordination with the local authorities to make sure that they are aligned with their respective woreda/zonal development plans.

The Federal Ministry of Health (MoH) will act as Contracting Authority will be responsible in coordinating the implementation process and ensures alignment to the relevant policy and strategies.

The Federal level Project Steering committee will be established for oversight and overall coordination and monitoring of the Action's implementation process. The Steering Committee will meet at least once a year to discuss strategic issues and provide direction in addressing programme implementation challenges. High level management of institutions involved in the Action will comprise the steering committee; including Ministry of Finance and Economic Cooperation/NAO, MoH, and EU Delegation. The steering committee will be chaired by Ministry of Finance and Economic Cooperation/NAO.

5.8 Performance monitoring and reporting

The performance of the programme will be closely monitored by the Steering Committee through reviewing biannual progress reports. Implementing partners will present a summary of project implementation progress and the committee discuss at strategic level and provide direction in addressing key challenges. The steering committee shall also conduct project visits and discuss implementation issues at field level.

The day-to-day technical and financial monitoring of the implementation of the three programmes (one per DRS) resulting from the grants will be a continuous process and part of the lead-implementing partner's responsibilities. To this end, the implementing partner shall establish a robust technical and financial monitoring system for the action and elaborate regular progress reports and final reports. The annual and final reports shall provide an accurate account of implementation of the action, difficulties encountered, changes introduced, as well as the degree of achievement of its results (outputs and direct outcomes) as measured by corresponding indicators, using as reference the logframe matrix. The report shall be laid out in such a way as to allow monitoring of the means envisaged and employed and of the budget details for the action. The final report, narrative and financial, will cover the entire period of the action implementation.

The Commission may undertake project monitoring visits both through its own staff and through independent consultants recruited directly by the Commission for independent monitoring reviews (or recruited by the responsible agent contracted by the Commission for implementing such reviews).

5.9 Evaluation

Having regard to the nature of the action, a final evaluation will be carried out for this action or its components via independent consultants contracted by the Commission.

It will be carried out for accountability and learning purposes at various levels (including for policy revision), taking into account in particular the fact it is an action that will be implemented at regional level by the Regional Health Bureaus, with a multi-sectoral approach requiring strong coordination mechanisms to reach the expected results.

The Commission shall inform the implementing partner at least 30 days in advance of the dates foreseen for the evaluation missions. The implementing partner shall collaborate efficiently and effectively with the evaluation experts, and inter alia provide them with all necessary information and documentation, as well as access to the project premises and activities.

The evaluation reports shall be shared with the partner country and other key stakeholders. The implementing partner and the Commission shall analyse the conclusions and recommendations of the evaluations and, where appropriate, in agreement with the partner country, jointly decide on the follow-up actions to be taken and any adjustments necessary, including, if indicated, the reorientation of the project.

Indicatively, one contract for evaluation services shall be concluded under a framework contract at the end of project implementation.

5.10 Audit

Without prejudice to the obligations applicable to contracts concluded for the implementation of this action, the Commission may, on the basis of a risk assessment, contract independent audits or expenditure verification assignments for one or several contracts or agreements.

Indicatively, one contract for audit services shall be concluded under a framework contract at the end of project implementation.

5.11 Communication and visibility

Communication and visibility of the EU is a legal obligation for all external actions funded by the EU.

This action shall contain communication and visibility measures which shall be based on a specific Communication and Visibility Plan of the Action, to be elaborated at the start of implementation and supported with the budget indicated in section 5.6 above.

In terms of legal obligations on communication and visibility, the measures shall be implemented by the Commission, the partner country, contractors, grant beneficiaries and/or entrusted entities. Appropriate contractual obligations shall be included in, respectively, the financing agreement, procurement and grant contracts, and delegation agreements.

The Communication and Visibility Manual for European Union External Action shall be used to establish the Communication and Visibility Plan and the appropriate contractual obligations.

6. PRE-CONDITIONS

N/A.

APPENDIX 1 - INDICATIVE LOGFRAME MATRIX [18]

The activities, expected outputs and all the indicators, targets and baselines included in the logframe matrix are indicative and may be updated during the implementation of the action without an amendment to the financing decision. The indicative logframe matrix will evolve during the lifetime of the action: new lines will be added for listing the activities as well as new columns for intermediary targets (milestones) when it is relevant and for reporting purpose on the achievement of results as measured by indicators.

	Intervention logic	Indicators	Baselines (reference year)	Targets (reference year)	Sources & means of verification	Assumptions
Overall objective: Impacts	to contribute to improved health and nutrition of women, adolescent girls and children under 5 years of age	Under 5 Mortality Rate (U5MR) per 1,000 live births(*)	67 (2016)	30 (2020)	EDHS report	Improving health and nutrition of Ethiopian citizens continues as priority/pillars of both the GTP and EU-Ethiopia development cooperation during the 11th EDF programming
		Stunting prevalence in children aged less than 5 years (*)	38 National (2016) [41 Afar; 24 Gambela; 43 Ben-Gum]	26 National (2020) [28 Afar; 16 Gambela; 29 Ben-Gum]	EDHS report	
		Wasting prevalence in children under 5 years	9.9 National (2016) 17.7 Afar, 14.1 Gambela, 11.5 Ben-Gum	4.9% national (2020 NNPII)	EDHS report	
		Thinness in adolescents (15-19y)	29 National (2016)	TBD	EDHS report	
		Prevalence of domestic violence against women (emotional or, physical, or sexual violence)	35 National (2016) [22 Afar; 36 Gambela; 33 Ben-Gum]	TBD	EDHS report	
		Percentage of women age 15-49 who are circumcised (disaggregated by age 15-19 and 20-49)	65 National (2016) [91 Afar; 33 Gambela; 63 Ben-Gum]	TBD	EDHS report	
		Percentage of women age 15-19 who have begun childbearing (teenage pregnancy)	13 National (2016) [23 Afar; 16 Gambela; 14 Ben-Gum]	3 National (2020) [5 Afar; 4 Gambela; 3 Ben-Gum]	EDHS report	
		Prevalence of anaemia in women age 15-49 years (disaggregated by age 15-19 and 20-49)	23 National (2016) [43 Afar; 26 Gambela; 19 Ben-Gum]	12 National (2020) [22 Afar; 14 Gambela; 10 Ben-Gum]	EDHS report	
Specific	to improve the social determinants affecting health and	Contraceptive Prevalence Rate (CPR) among married women age 15-49 (disaggregated by adolescents/ age groups) (*) (**)	36 National (2016) [12 Afar; 35 Gambela; 29 Ben-Gum]	55 National (2020) [18 Afar; 54 Gambela; 44 Ben-Gum]	EDHS report	Continued commitment of GoE in

[18] Mark indicators aligned with the relevant programming document mark with '*' and indicators aligned to the EU Results Framework with '**'.

	gender inequalities in Ethiopia's Developing Regional States (DRS) with a focus on HTPs, GBV, family planning and nutrition	Percentage of sexually active unmarried women age 15-49 with unmet need for family planning (disaggregated by adolescents/ age groups)	26 National (2016)	TBD	EDHS report	addressing HTPs and promotion of gender equality and equity
		Proportion of exclusive breastfeeding in the first six months (disaggregated by sex, age)		TBD		
		Minimum Dietary Diversity for Women of Reproductive Age 15-49 (disaggregated by age 15-19 and 20-49) (disaggregated by adolescents/other age groups)	20 National (2015) [9 Afar; 30 Gambela; 18 Ben-Gum]	TBD	NNP review/ assessment	
		Minimum Acceptable Diet for children age 6-23 months (disaggregated by sex and age group when possible)	7.7 National (2015) [1.9 Afar; 12.1 Gambela; 16.7 B/Gum	TBD	NNP review/ assessment	
		% of pregnant women (at health facility or through outreach) supplemented with folic acid and iron folate	19 (2015)	100 (2020)	HMIS/routine admin report	
		Proportion of children aged 6-59 months who received vitamin A supplementation (*)	58 (2016) [23 Afar; 46 Gambela; 73 Ben-Gum	95 (2020)	HMIS/admin report	
Outputs	**Output 1** - Improved access and quality of SRHR services with emphasis on increased demand for and uptake of FP services and identification, treatment and referral of victims of GBV and HTPs	# of clients visiting for FP services over the past year (disaggregated by age, sex and disability)		TBD		
		% of service delivery points that have at least 3 modern FP methods at the time of the visit/assessment		TBD		
		% of service delivery points with at least 1 trained staff (knowledgeable) in the early identification, support and referral of victims of HTPs/GBVs		TBD		
		# of GBVs victims identified and referred for support services		TBD		
	Output 2 - Improved access and quality of integrated nutrition services and knowledge on	% of health facilities which benefited from WaSH improvements (result area 4) with a demonstration plot for BCC on dietary diversity				
		Percentage of carers aware of importance of dietary diversity for children 6-59 months of age				

	importance of dietary diversity for adolescent girls, pregnant and lactating women and children < 5 years of age	% of health facilities routinely delivering the full integrated nutrition intervention package				
	Output 3 - Improved functionality and readiness of health facility to provide quality services with special emphasis on improving WaSH	Proportion of health facilities with access to improved water supply	30 National [27 Afar; 35 Gambela; 21 Ben-Gum]	TBD	SARA report	
		% of health facilities practicing safe final disposal of infectious waste	58 National [27 Afar; 61 Gambela; 56 Ben-Gum]	TBD		
		Proportion of health facilities with gender and disability sensitive complete WaSH package	TBD	60 (2020)	MoH special survey	
	Output 4 —Change for social norms and mind-sets, attitudes and beliefs promoted with respect to GBV and HTPs, and improved access to and use of support services for GBV victims/ survivors.	♯ of SGBV and HTPs coordination meetings conducted (disaggregated by administrative level)		TBD		
		♯ of traditional, religious, and political leaders sensitised on SGBV and HTP		TBD		
		♯ of people reached through community mobilisation on SGBV and HTPs (disaggregated by age and sex)		TBD		
		# of telephone hotline calls/month		TBD		
		# of SGBV survivors having received at least 1 support service (disaggregated by age, sex and disability)		TBD		
	Output 5 —Increased capacity/ownership by the 3 developing regions	% of the activities implemented in the region action plan (of the grant)		TBD		

***NB**: the targets for indicators disaggregated by regions are taken proportionally from the targets set at national level (as defined in the HSTP/GTP). Baseline data and/or targets which are not disaggregated by regions and gender (indicated as TBD) will be further defined (by the baseline survey to be conducted) during the implementation of the programme.*