FINAL EVALUATION REPORT

Mid-term Evaluation of Ethiopian Crises to Resilience Programme

May 2024-January 2025

Authors: Centre for Evaluation and Development (C4ED)
Ethiopia team:

Dr. Mohammed Seid

Dr. Robert Poppe

Dr. Cherkos Meaza

Nolawit Teshome

Sintayehu Tilaye

Yebelay Berehan

Evaluation Coordination Committee - UNICEF Ethiopia

Dr. Mussarrat Youssuf - Evaluation Manager

Lulutani Tembo, Donor Relations Specialist

Maryamawit Solomon Assefa, UNV-Evaluation

ETHIOPIA COUNTRY OFFICE

JANUARY 2025

unicef | for every child

© United Nations Children's Fund, New York, 2025

United Nations Children's Fund

Three United Nations Plaza

New York, New York 10017

January 2025

The purpose of publishing evaluation reports produced by the UNICEF Evaluation Office is to fulfil a corporate commitment to transparency through the publication of all completed evaluations. The reports are designed to stimulate a free exchange of ideas among those interested in the topic and to assure those supporting the work of UNICEF that it rigorously examines its strategies, results, and overall effectiveness.

The contents of the report do not necessarily reflect the policies or views of UNICEF.

The text has not been edited to official publication standards and UNICEF accepts no responsibility for any error.

The designations in this publication do not imply an opinion on the legal status of any country or territory, or of its authorities, or the delimitation of frontiers.

The copyright for this report is held by the United Nations Children's Fund. Permission is required to reprint/reproduce/photocopy or in any other way to cite or quote from this report in written form. UNICEF has a formal permission policy that requires a written request to be submitted. For non-commercial uses, the permission will normally be granted free of charge. Please write to the Evaluation Office at the address below to initiate a permission request.

This report is available for download at: [Evaluation reports | UNICEF Evaluation]

Please cite the work as follows: UNICEF. 2024. *"Mid-term Evaluation of Ethiopian Crises to Resilience Programme"*. UNICEF Ethiopia, Ethiopia.

This report was commissioned by the UNICEF Ethiopia Country Office. The report was prepared and submitted by the research team of the Centre for Evaluation and Development (C4ED).

0. Acknowledgements

This report was prepared by the Research Team at the Centre for Evaluation and Development (C4ED). We appreciate the valuable contributions made by the experts from the **consortium of implementers,** who played an active role from kick-off meeting to the inception phase in reviewing our report and the tools drafted in making it to the most current version. Their insightful comments helped improve the Inception Report and provided crucial information on the various components of the EC2R programme.

The Research Team would like to acknowledge the invaluable guidance, exceptional support, and facilitation provided by Dr. Mussarrat Youssuf, Evaluation Manager, and Maryamawit Solomon, Evaluation Officer at UNICEF Ethiopia Country Office. Their direct engagement throughout the evaluation, from inception to review, including facilitating supporting letters and conducting field visits during data collection, was instrumental in the study's success. We would also like to thank Martha Kibur, Evaluation Specialist, and Ereblina Elezaj, Social Policy Manager, who were involved during the initial stages of this evaluation assignment and helped lay a strong foundation for its successful completion.

We extend our gratitude to the Child Protection Officer/Specialist, Education Specialist, Health Specialist, Nutrition Expert, Social Protection Specialist, SBC Expert GBV Specialist, and field coordinators of the implementing consortium for their unwavering support throughout our research.

Finally, we would like to express our sincere thanks to the field officers, participants in both quantitative and qualitative data collection, the field team, and, the communities, the experts from the regional bureaus of the five regional states for their cooperation and invaluable contributions to this study.

TABLE OF CONTENT

Contents

LIST OF TABLES

LIST OF FIGURES

ACRONYMS

C4ED	Centre for Evaluation and Development
CAPI	Computer-assisted Personal Interview
CRGE	Climate Resilient Green Economy
EC2R	Ethiopia Crises to Resilience
EQ	Evaluation Questions
ERCS	Ethiopian Red Cross Society
ERIC	Ethical Research Involving Children
ESSSWA	Ethiopian Society of Sociologists, Social Workers, and Anthropologists
FCDO	Foreign Commonwealth Development Office
FGD	Focused Group Discussion
GBV	Gender-based Violence
GEEW	Gender Equality and the Empowerment of Women
GoE	Government of Ethiopia
IDI	In-depth Interview
IDPs	Internally Displaced Persons
KII	Key Informant Interview
MHPSS	Mental Health and Psychosocial Support
NGO	Non-governmental Organization
PSNP	Productive Safety Net Programme
SAM	Severe Acute Malnutrition
SBC	Social and Behavior Change
SRCTs	Shock-Responsive Cash Transfers
UNCRC	United Nations Convention on the Rights of the Child
UNICEF	United Nations Children's Fund
WFP	World Food Programme
WASH	Water, Sanitation, and Hygiene

EXECUTIVE SUMMARY

I. Background and Context

Ethiopia is currently grappling with a range of severe challenges, including widespread malnutrition, health crises, disruptions in education, and the effects of natural disasters such as droughts and floods. These crises have overwhelmed national and international response systems, leading to delayed and inadequate support. Malnutrition remains a critical public health concern, with 35.7% of children under five years stunted and 9.1% wasted. The health system is further strained by conflict, internal displacement, and outbreaks of diseases like malaria and measles, particularly in regions like Tigray, Afar, and Amhara. The education sector has also been severely impacted, with over 13 million children out of school. The economic disruptions caused by conflict and natural disasters have further deepened the humanitarian crisis.

Despite these challenges, the Ethiopian government has implemented key strategies, including the Homegrown Economic Reform (HGER) and the Climate Resilient Green Economy (CRGE) strategy, to foster inclusive growth and transition the country to middle-income status. However, issues such as governance challenges, resource constraints, and external factors like conflict and climate change have limited the effectiveness of these efforts. The Ethiopia Crises to Resilience (EC2R) programme has been developed to address these multifaceted challenges, focusing on reducing vulnerabilities and enhancing resilience in the most affected and marginalised communities.

The EC2R programme, launched on January 2022 and set to run until March 31, 2025, aims to provide multi-sector humanitarian assistance to Ethiopia's most vulnerable populations. The programme focuses on enhancing disaster resilience, supporting poor households, and strengthening the humanitarian system for early risk identification and cost-effective responses. Its objectives include responding to immediate needs, strengthening systems, and promoting evidence-based decisions. It operates with the support of the UK's Foreign Commonwealth Development Office (FCDO) and involves partners such as WFP, ERCS, the British Red Cross, UNICEF, and the government of Ethiopia. It targets sectors including health, nutrition, WASH, protection, education, and social protection, prioritizing interventions where it can prevent deaths and provide lifesaving support.

II. Evaluation Purpose

This evaluation provides an objective assessment of the progress and achievements of the EC2R program, identifying key gaps, challenges, and lessons learnt. It examines the effectiveness of the intervention to highlight best practices and offers actionable recommendations to guide the remaining implementation period. The findings will inform the design of future programme phases, ensuring alignment with the evolving needs of affected populations and improving the efficiency of outcomes.

Primary users of the evaluation include implementing partners, the Ethiopian regional and national governments, and FCDO. These stakeholders will gain critical insights to enhance operational and strategic decision-making, improve programme effectiveness, and optimize

resource allocation. The findings and lessons learned will be actively disseminated to stakeholders.to maximise the impact. This collaborative learning approach will not only strengthen the programme during its current phase but also enhance the design of future humanitarian interventions, ultimately contributing to greater resilience among affected populations and more successful humanitarian efforts in Ethiopia.

III. Objectives and Scope of the Evaluation

The mid-term evaluation of the EC2R programme assesses its relevance, effectiveness, efficiency, impact, and sustainability in meeting the needs of affected populations. It examines the programme's contributions to system strengthening and evaluates accountability mechanisms. Additionally, the evaluation addresses cross-cutting issues, including climate change, gender equity, and disability inclusion, ensuring alignment with human rights and equity principles covering activities from January 2022 to June 2024, and spanning sectors like health, nutrition, education, child protection, GBV, and WASH.

IV. Evaluation Methodology

The methodology for this mid-term evaluation employed a mixed-methods approach, combining quantitative and qualitative data collection to provide a comprehensive assessment of the EC2R programme. Quantitative data were gathered through document analysis, household surveys, and facility assessments, while qualitative data is collected via Key Informant Interviews (KIIs), Focus Group Discussions (FGDs), and case studies. The evaluation spanned five regions (Tigray, Amhara, Oromia, Sidama, and Benshangul Gumuz) and incorporates a multi-stage sampling strategy to ensure a representative sample. Household surveys focused on key programme indicators such as education, health, nutrition, WASH, and child protection, while qualitative methods capture deeper insights into the lived experiences of beneficiaries and stakeholders.

The sampling approach included a proportional selection of woredas and systematic respondent sampling. Purposive and extreme case sampling was used for KIIs, FGDs, and case studies to explore specific aspects of the programme, such as success stories and stakeholder perspectives. Data was collected by multilingual teams trained to ensure quality and consistency.

Quantitative data was analysed using descriptive statistics, with results presented in graphs and tables. Qualitative data was subjected to thematic analysis using MAXQDA software to identify common themes and patterns. Triangulation of both data sets enhanced the robustness and trustworthiness of the findings. The methodology also included a thorough desk review of secondary data, such as programme reports, monitoring data, and project documents, to supplement primary data and provide a deeper understanding of programme progress and impact.

V. Findings and Conclusions

The evaluation of the EC2R programme has led to several key findings and conclusions regarding its relevance, efficiency, effectiveness, lessons learned, and cross-cutting issues. These insights provide a comprehensive understanding of the program's impact and areas for improvement.

A. **Relevance**: The EC2R programme has strongly aligned with the critical needs of vulnerable populations affected by conflict and humanitarian shocks. By targeting key

groups such as children, pregnant and lactating women, and PWDs, the programme effectively addresses immediate needs while contributing to broader humanitarian and development goals. The alignment with national policies and global humanitarian standards further underscores the program's relevance. Moreover, stakeholders, including government offices both at regional and federal levels as well as contacted beneficiaries of the components, have provided positive feedback regarding the program's focus, indicating a strong demand-driven approach.

B. **Efficiency**: The programme has successfully utilized 75% of its total budget, reflecting effective resource allocation in several key areas such as, health services and cash transfers. However, certain programme components, particularly child protection, have experienced slower progress. These inefficiencies highlight the need for more adaptive management strategies and improved monitoring mechanisms to ensure timely implementation. Furthermore, procurement and distribution processes for essential supplies could benefit from further streamlining to enhance cost-effectiveness and reduce delays.

C. **Effectiveness and Quality of the programme**: The effectiveness of the EC2R programme is reflected in its significant achievements in improving access to essential services such as water, sanitation, and hygiene (WASH), healthcare, and education. Beneficiary satisfaction levels, particularly in relation to cash transfer components, remain high, indicating the program's tangible impact on improving household resilience. However, challenges persist in ensuring the accessibility of WASH facilities for PWDs, highlighting the need for more inclusive infrastructure planning. Moreover, while cash transfers have provided immediate relief, their long-term economic impact remains uncertain, necessitating a more comprehensive approach that integrates livelihood support and financial literacy training to ensure sustainable benefits.

D. **Lessons learned**: A critical lesson from the programme is the value of fostering strong partnerships with government institutions, local actors, and community-based organizations. Such collaborations have been instrumental in enhancing programme outreach and effectiveness. Moreover, community engagement has emerged as a key determinant of programme success. Programs that invest in strengthening local institutions and enhancing the capacity of service providers are more likely to yield long-term benefits for affected populations. Utilization of innovative technologies such as solar-powered water systems and approaches such as providing timely support, improving partnerships, and empowering grassroots efforts address funding gaps and coordination issues while emphasizing scalable, collaborative solutions for long-term impact. In addition to this, the integration of flexible and adaptive programming mechanisms has proven essential in responding to evolving humanitarian needs.

VI. **Cross-cutting issues**: The EC2R programme has placed considerable emphasis on inclusivity by addressing the specific needs of women, children, and PWDs through targeted support, inclusive infrastructure, and specialized training. Moreover, the program's adoption of climate-resilient solutions, such as solar-powered water systems, represents a significant step toward integrating environmental sustainability into humanitarian efforts, although explicit climate-specific programming and awareness remain limited. Similarly, while strides have been made in improving the accessibility of services for PWDs, further efforts are needed to ensure that all interventions incorporate universal design principles. Strengthening these cross-

cutting dimensions will be crucial in enhancing the program's overall impact and ensuring that no vulnerable group is left behind.

VII. Recommendations

The following key recommendations are proposed to address the challenges identified in the midterm evaluation, enhance the effectiveness of the EC2R Programme for the remainder of its implementation period, and inform future programming:

- Strengthen Partnerships and Coordination: Deepen collaboration with government entities at all levels by establishing structured platforms for knowledge-sharing and coordination. Actively engage federal, regional, and local government offices in planning and implementation to foster joint ownership and accountability.
- Improve Health Service Delivery: Ensure the timely procurement and distribution of essential medicines in EC2R intervention woredas. Prioritize critical needs such as beds, chairs, and laboratory tools. Support minor facility improvements, including repairs to WASH infrastructure (latrines and water supply), to enhance hygiene standards. Provide hygiene kits (soap, disinfectants, gloves) and staff training to strengthen infection control measures.
- Expand Community Feedback Mechanisms: Establish structured feedback systems, including community meetings, periodic surveys, and anonymous suggestion boxes, to enhance accountability and responsiveness. These tools will help capture beneficiary insights and improve programme effectiveness based on real community needs.
- Enhance the Impact of Cash Transfers: Link cash transfer programmes to income-generating activities and skills development initiatives, focusing on vulnerable groups, including households with disabled members. Explore complementary support mechanisms such as subsidized community-based health insurance for persons with disabilities (PWDs) to ensure long-term impact.
- Ensure Funding and Intervention Flexibility: Adapt funding and implementation timelines to respond effectively to external challenges such as inflation, political instability, and humanitarian crises. Flexible resource allocation will enable timely adjustments based on evolving community needs.
- Strengthen Monitoring and Accountability: Implement robust tracking mechanisms to prevent resource misuse and ensure that humanitarian assistance reaches those most in need. Regular assessments to identify infrastructure challenges and unintended aid distribution issues, enabling timely corrective actions.
- Enhance Beneficiary Awareness and Engagement: Strengthen community engagement efforts to manage expectations and reduce aid dependency. Implement awareness campaigns to facilitate beneficiaries' transition from emergency assistance to resilience-building initiatives.
- Optimize Fund Allocation: Accelerate budget execution for underperforming components, such as Child Protection, to ensure a balanced programme impact. Strategically reallocate resources to areas demonstrating high need and impact potential.
- Ensure Sustainability of Services: Build local ownership by strengthening the capacity of community structures and service providers. Encourage government and local stakeholders to take an active role in maintaining essential services beyond the programme's duration.
- Enhance Inclusion and Support for Vulnerable Groups: Improve access to essential services for PWDs by ensuring inclusive infrastructure, accessible information, and tailored interventions. Strengthen partnerships with Disabled People's Organizations (DPOs) and integrate disability-inclusive strategies into programme planning and implementation.

1. Introduction

This Evaluation Report presents the findings and analysis from the mid-term evaluation of the EC2R Programme. It consolidates the work undertaken since the inception phase, including the collection and analysis of both quantitative and qualitative data from the project regions, as well as the review of relevant secondary data sources. The report outlines the evaluation's key findings, identifies emerging trends, and provides a summary of the programme's performance against its objectives.

The evaluation team has assessed the programme's progress, challenges, and overall impact through field visits, stakeholder interviews, and data analysis. This report also synthesises insights from these activities, offering a comprehensive view of the programme's effectiveness and providing actionable recommendations for the next phase of implementation. The findings aim to guide programme improvements, inform decision-making, and support the EC2R Programme's broader goals of building resilience in the targeted communities. The draft report was presented to all the key stakeholders including UNICEF programmes, implementing partners, donors and the regional evaluation team for validation of findings and co-creation of recommendations. This final report includes their feedback and comments.

1.1. Background and Context

Ethiopia faces a multitude of challenges, including significant malnutrition, health crises, disruptions in education, and natural disasters. Malnutrition remains a critical public health issue; for instance, in 2019, about 35.7% of children under five years of age stunted and 9.1% wasted[1]. These concurrent shocks have overwhelmed national and international response systems, leading to delayed and inadequate responses. Although there has been a decrease in these rates over the years, severe food poverty is prevalent among nearly 47% of children aged 6-23 months and other health issues[2]. The impact of these nutritional deficiencies is exacerbated during emergencies, necessitating a multifaceted approach to prevention and treatment.

Health crises in Ethiopia are compounded by conflicts, particularly in Tigray, Afar, Amhara, and Oromia regions, alongside severe droughts in other areas[3]. The 2023 Humanitarian Response Plan seeks nearly USD 4 billion to assist over 20 million people affected by these crises[4]. The health system in Ethiopia is grappling with substantial challenges, including shortages of trained medical staff, limited access to essential health services, and outbreaks of infectious diseases such as malaria and measles[5]. Internally displaced persons (IDPs) are particularly vulnerable, with many lacking access to basic health care and services.

[1] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0296451
[2] https://www.moh.gov.et/index.php/en/initiatives-4 col/Adolescent_and_Youth_Health_Program?language_content_entity=en
[3] https://www.unocha.org/publications/report/ethiopia/ethiopia-situation-report-10-june-2024
[4] https://www.unocha.org/publications/report/ethiopia/ethiopia-humanitarian-response-plan-summary-2023
[5] https://www.unocha.org/publications/report/ethiopia/ethiopia-situation-report-10-jan-2024

The education sector in Ethiopia has been severely impacted by COVID-19, conflict and climate change. Over 13 million children are out of school in Ethiopia[6]. Schools in conflict-affected regions are often damaged or lack basic teaching materials[7]. The psychological impact on children and teachers is profound, with high levels of anxiety, trauma, and violence reported[8]. Mental Health and Psychosocial Support (MHPSS) services help these communities recover and rebuild their lives[9].

Economic disruptions due to conflict have led to a breakdown in supply chains, price increases, and severe shortages of goods and services. This economic crisis has compounded the humanitarian situation in Ethiopia, which has already been strained by natural disasters such as droughts and floods. The worst drought in 40 years has left over 24 million people facing food insecurity, while flooding has displaced an additional 1.7 million people. These natural disasters have stretched Ethiopia's limited resources and exacerbated the humanitarian crisis.

The Government of Ethiopia (GoE) has been committed to reducing poverty and improving the living conditions of its people through key national policies and strategies, notably the Homegrown Economic Reform (HGER) and the Climate Resilient Green Economy (CRGE) strategy. The HGER aims to accelerate inclusive economic growth by addressing macroeconomic imbalances, fostering private-sector development, and improving the business environment[10]. Launched in 2011, the CRGE strategy seeks to improve living conditions and transition Ethiopia into a middle-income country by 2025.[11] The EC2R programme is strategically aligned with key Sustainable Development Goals (SDGs), addressing critical humanitarian and development challenges. The programme directly contributes to SDG 2 (Zero Hunger) and SDG 3 (Good Health and Well-being) by enhancing food security, reducing malnutrition, and strengthening health systems. Its efforts to restore education services and reintegrate out-of-school children can also be linked with SDG 4 (Quality Education**)**. At the same time, interventions focused on gender equality and Empowering women (GEEW) and child protection align with SDG 5 (Gender Equality). Furthermore, the programme tackles economic vulnerabilities through cash assistance and social protection mechanisms, advancing SDG 1 (No Poverty) and SDG 10 (Reduced Inequalities) by prioritising children, PLW and communities that are directly or indirectly affected by humanitarian shocks (drought and conflict). Investments in WASH infrastructure and sustainable solutions, such as solar-powered water systems, further contribute to SDG 6 (Clean Water and Sanitation) and SDG 13 (Climate Action), ensuring long-term resilience in affected regions.

At a macro level, these policies and strategies have driven economic growth and reduced monetary poverty. A few years ago, Ethiopia used to be one of the fastest-growing economies in

[6] https://www.unicef.org/ethiopia/learning-and-development
[7] https://reliefweb.int/report/ethiopia/increasing-number-children-pushed-out-education-ethiopia-due-severe-drought-conflict-and-forced-displacement
[8] https://reliefweb.int/report/ethiopia/increasing-number-children-pushed-out-education-ethiopia-due-severe-drought-conflict-and-forced-displacement
[9] https://emergency.unhcr.org/emergency-assistance/health-and-nutrition/mental-health-and-psychosocial-support-mhpss
[10] https://www.mofed.gov.et/media/filer_public/38/78/3878265a-1565-4be4-8ac9-dee9ea1f4f1a/a_homegrown_economic_reform_agenda-_a_pathway_to_prosperity_-_public_version_-_march_2020-.pdf
[11] https://gggi.org/wp-content/uploads/2017/11/2015-08-Sectoral-Climate-Resilience-Strategies-for-Ethiopia-1-Agriculture-and-Forestry-Climate-Resilience-Strategy.pdf

the Horn of Africa and the world over the last two decades, with the share of the population below the national poverty line dropping from 39 percent in 2004 to 24 percent in 2015[12]. However, the benefits of this growth have not been equally shared among the country's 100 million people. The COVID-19 pandemic, consecutive climate shocks, conflict in the northern part of the country, and shifts in the national and global economic and political landscape threaten Ethiopia's progress and path out of poverty.

As a result, the effectiveness of Ethiopia's national policies and strategies has been limited by governance challenges, resource constraints, and the complex interplay of social and economic factors. The EC2R programme addresses these multifaceted challenges, focusing on reducing vulnerabilities and enhancing resilience in the most affected and marginalised communities.

The EC2R Programme is a multi-sectoral humanitarian and development initiative aiming to address drought and conflict's impacts across five regions. The programme is designed to support vulnerable populations, including adolescent girls, children, PWDs, pregnant and lactating women, and other communities affected by humanitarian shocks. The total allocated budget for the EC2R programme is USD 49.63 million where the active implementers British Red Cross Society, Ethiopia Red Cross Society, WFP, and UNICEF have implemented interventions in about 80 woredas across five regional states of the country which are Tigray, Amhara, Oromia, Sidama, and Benshangul Gumuz.

1.2. Object of Evaluation

The EC2R programme was initiated on November 30, 2022, with a projected end date of March 31, 2025. Its core aim is to i) provide multi-sector humanitarian assistance to meet the needs of Ethiopia's most vulnerable populations; ii) support poor households so they are better able to withstand disasters and shocks; and iii) invest in the humanitarian system so it can identify risks and respond early and cost-effectively. It is a flexible multi-sector programme designed to enable implementing partners to support those in greatest need across health, nutrition, WASH, protection, humanitarian cash, emergency education, and social protection.

It operates through the support of the Foreign Commonwealth Development Office (FCDO) and collaborative efforts involving WFP, Ethiopian Red Cross Society (ERCS), British Red Cross, REACH, UNICEF, and the government of Ethiopia (GOE) at both national and regional levels. In addition, the programme supports ICRC and the Government of Ethiopia's Productive Safety Net Programme through the World Bank. The latter is outside the scope of this evaluation. The programme prioritises sectors for intervention based on areas where it can have the most significant impact on preventing deaths and providing lifesaving support, expects significant underfunding, and aligns with UK humanitarian reform priorities. Please refer to ***Annex 3*** for a summary of the EC2R components and the corresponding types of interventions under each.

1.3. Evaluation Purpose

[12] https://databankfiles.worldbank.org/public/ddpext_download/poverty/987B9C90-CB9F-4D93-AE8C-750588BF00QA/AM2020/Global_POVEQ_ETH.pdf

The primary purpose of this evaluation is to provide an objective assessment of the progress and achievements of the EC2R program, with a focus on identifying gaps, and challenges and capturing key lessons learned. By evaluating the intervention's overall achievements, the evaluation aims to highlight best practices and offer actionable recommendations that will inform decision-making for the remaining implementation period of the EC2R program and guide the design of future interventions. By assessing the program's progress, effectiveness, and sustainability, the evaluation will generate evidence-based insights to refine intervention strategies, ensuring they remain responsive to the evolving needs of affected populations and contribute to long-term impact.

The evaluation will also strengthen accountability by assessing the efficient use of resources and evaluating whether the program has achieved its objectives. The findings will enhance transparency and support stakeholders—including donors, implementing partners, and government entities—in making evidence-based programmatic improvements that align with their commitments to affected communities.

The evaluation will foster broader learning, capturing best practices, challenges, and lessons to strengthen future programming. Moreover, it will serve as an evidence base for advocacy, reinforcing the need for sustained investment in resilience-building initiatives and informing policy decisions to support vulnerable populations better.

The primary users of this evaluation include UNICEF programme sections, implementing partners, the regional and national governments of Ethiopia, and FCDO. These stakeholders will gain valuable insights into the program's performance, enabling them to make more informed operational and strategic decisions. By understanding what has worked well, identifying successes and areas for improvement, the stakeholders will be better positioned to enhance program effectiveness, optimise resource allocation, and ultimately contributing to the achievement of EC2R's objectives.

The evaluation findings and lessons learned will be actively disseminated to all relevant stakeholders to maximize their impact. Sharing these insights will not only facilitate improvements during the remaining implementation period but also ensure that future interventions can build upon the successes and challenges of this phase. By promoting a collaborative learning environment, the evaluation will contribute to strengthening the resilience of the affected populations and support the continued success of humanitarian efforts in Ethiopia..

1.4. Evaluation Objectives

The main objective of the mid-term evaluation is to assess the effectiveness and quality of the EC2R programme and its impact on systems strengthening while incorporating the perspectives of the programme's right holders (beneficiaries) on the relevance of the support and addressing cross-cutting issues. This evaluation seeks to understand how well the support meets the needs of the affected populations, ensures accountability, and assesses the overall quality and relevance of the support provided. Additionally, the evaluation will address cross-cutting issues such as climate change, gender, and disability inclusion. By doing so, the evaluation aims to provide

actionable insights that can guide future programme improvements. It will be conducted within the framework of the OECD-DAC criteria[13] and has the following specific objectives:

- To examine the relevance of the programme design and activities from the perspective of the programme's right holders (beneficiaries). Specific objectives include:
- To evaluate the quality and effectiveness of EC2R activities in achieving programme objectives, focusing on the appropriateness and dignity of support provided.
- To evaluate the programme's progress in system strengthening, including capacity building, improved governance, enhanced accountability, and fostering sustainability of services.
- To identify best practices, lessons learned, and the potential for replicating and scaling up successful interventions in the target regions.
- To assess the programme's consideration of cross-cutting issues (climate change, gender, disability) by analysing how activities address these issues and their impact on target populations and the environment. Key areas of inquiry include:
- To develop actionable recommendations for improving programme design, implementation approaches, replicating and scaling up interventions

1.5. Scope of the Evaluation

The evaluation covered the period from January 2022 to June 2024, encompassing all EC2R programme activities, including health, nutrition, education, child protection, GBV, and WASH. The evaluation considered all relevant aspects of the programme. The programme focuses on three areas: Responding to Needs (nutrition, health, WASH, protection, education, financial aid), Preserving and Strengthening Systems (humanitarian capabilities, crisis preparedness, national systems), and Use of Evidence (data-driven decisions, monitoring). Its key outputs include improved access to essential services, cash assistance, and enhanced humanitarian aid delivery, all aimed at saving lives and building long-term resilience.

Geographically, the mid-term evaluation covers the regions of Amhara, Oromia, Benishangul-Gumuz, Tigray, and Sidama. The programme is implemented in almost 80 woredas (districts); in each woreda, different types of activities (sectoral) are implemented by different partners, and woredas for the fieldwork were identified using criteria for selection.

[13] In this mid-term review, the assignment mainly focuses on the Relevance of the Programme, Quality and Effectiveness of EC2R, Efficiency of EC2R, Lessons Learnt and Cross-Cutting Issues.

2. Detailed Evaluation Methodology

This evaluation employs a mixed-methods approach, utilising both quantitative and qualitative data collection methods to achieve a comprehensive understanding of the programme's relevance, effectiveness, efficiency, lessons learned, and consideration of cross-cutting issues. Quantitative data is gathered through document analysis/desk review, and household and facility surveys. For each of the target regions' selected woredas, we consider different profiles such as gender, disability status, age, etc. The qualitative component of this study explores changes in participants' lives, the drivers of these changes, and the factors to which they attribute them. Data is collected through Key Informant Interviews (KIIs), Focus Group Discussions (FGDs), and case studies, offering insights into project implementation, expectations, and cross-cutting issues. This approach complements quantitative data, providing a comprehensive evaluation of the programme's impact, addressing supply-side limitations, and identifying solutions to challenges for informed decision-making.

The following sections provide a detailed overview of the methodology employed during the mid-term evaluation. This includes a description of the types of data collected, both qualitative and quantitative, and the specific methods used to gather this data. Additionally, the sections outline the approaches applied for data analysis, explaining how the collected information is processed and examined to answer the key evaluation questions and assess the program's progress and impact.

2.1. Evaluation Questions

The evaluation addresses the following main questions, focusing on key aspects of the programme's relevance, effectiveness, efficiency, lessons learned, and consideration of cross-cutting issues. These questions guide the assessment of outcomes, methods, stakeholder engagement, and sustainability (*please see **Annexe 1** for the sub-evaluation questions*).

A. Relevance of the Programme
- To what extent are the programme design and activities relevant from the perspective of the Programme's right holders (beneficiaries)?

B. Quality and Effectiveness of EC2R
- How effective are the EC2R activities in achieving programme objectives?
- Is EC2R achieving stated outputs and is EC2R likely to achieve intended outcomes?

C. Efficiency of EC2R
- To what extent is the EC2R Programme efficient in achieving its objectives within the allocated timeframe and budget?
- To what extent is the EC2R Programme effective in strengthening systems, including capacity building, improved governance, enhanced accountability, and fostering the sustainability of services?

D. Lessons Learnt
- What are the best practices, lessons learned, and potential for replicating and scaling up successful interventions in the target regions?

E. Cross-Cutting Issues
- To what extent does the programme consider cross-cutting issues (climate change, gender, disability), and what is the impact of these activities on target populations and the environment?

2.2. Sampling Strategy and Data Collection Tools

2.2.1. Quantitative Component

The midterm evaluation is conducted in five Ethiopian regional states: Amhara, Benishangul-Gumuz, Oromia, Tigray, and Sidama. The study employs a cross-sectional design to gather information from project beneficiaries and stakeholders at this mid-point. The target population includes beneficiaries in the selected Woredas.

A multi-stage sampling approach ensures a representative sample. In the first stage, project-participating woredas (districts) are identified and clustered within each region. A proportional-to-size (PPS) method selects clusters based on the number of active project beneficiaries in each woreda. In the second stage, systematic sampling selects the final sample of respondents within each cluster. The sample size for the mid-term evaluation is determined using the Cochran sample size formula and is estimated to be 400 beneficiaries per component. The following table shows the detailed distribution of beneficiaries across the components.

Table 1: Sample Size for each thematic area

Thematic area	Target respondents	Disaggregation	Sample size	Final sample size
Nutrition	Caregivers or mothers of children under 5 years old	Age and gender	400	640
WASH	WASH beneficiaries	Gender	400	533
Health	Health facilities (facility survey)	No	97[13]	23
	Health beneficiaries	Gender	400	519
Emergency Education	Mothers/caregivers of pre-primary and primary school children	Gender	400	417
Humanitarian Cash Transfers	HCT cash transfer beneficiaries Child grant beneficiaries: pregnant women and mothers or caregivers of children<1 year at the time of registration	Gender and disability for HCT	400	490
Child protection and GBV	Children, Vulnerable women and girls, and PWDs reached by the program	Disability	Qualitative data	337

			supplemented by quantitative	

We selected the woredas for the survey based on an assessment of the programme's target areas, considering the thematic areas, implementing parties, and accessibility, which shows the distribution of woredas by sector, implementer, and security risk. Due to security risks and accessibility challenges, some woredas could not be surveyed, as sending data enumerator teams to these areas would raise ethical and operational concerns. Our sampling strategy focuses on clusters of intervention, with the woreda serving as the main cluster for selecting households for interviews. In addition, we include areas with other target populations, such as refugees and IDPs living in camps, in the selected woredas, with these areas determined and agreed upon in collaboration with the consortium partners.

During the inception phase, we initially planned to distribute the sample size proportionally across the different intervention components, ensuring that the sample was disaggregated by gender. This would allow us to analyse gender-specific data and understand how the programme impacts male and female beneficiaries. However, in practice, we encountered challenges in obtaining gender-disaggregated beneficiary data due to the nature of the interventions.

For instance, in the cash transfer component, most beneficiaries are internally displaced persons (IDPs), predominantly mothers. Considering this, we determined that collecting data at the household level would be more practical and effective than focusing on individual beneficiaries. This approach allows us to gather more comprehensive data on the impacts of the interventions while maintaining a gender perspective. In the findings section, we will report the proportion of male- and female-headed households, as this will offer insights into how the programme affects different household structures.

The differences between the proposed and final sample sizes can be attributed to several factors related to the data collection process and programme implementation. In components such as WASH, Health Beneficiaries, and Humanitarian Cash Transfers, the final sample sizes exceeded initial targets due to overlapping interventions in the selected woredas. Many beneficiaries participated in multiple interventions simultaneously, enabling broader data collection than originally anticipated. This overlap resulted in higher-than-proposed sample sizes in these areas. On the other hand, the health facility survey sample size was lower than planned due to limited availability of intervention sites. Despite efforts to meet the target, fewer health facilities had active programme interventions in the selected woredas, reducing the actual sample size. For the child protection and GBV component, while the initial plan relied primarily on qualitative data collection, quantitative data was also gathered by integrating it with education interventions in relevant woredas. This approach allowed for the collection of additional insights on child protection and GBV, enhancing the comprehensiveness of the evaluation. These adjustments were made to optimise resource use and provide a more holistic understanding of the program's impact.

2.2.2. Qualitative Component

C4ED used a purposive sampling approach to select participants for the KIIs, and FGDs, from each of the five regional states: Amhara, Benishangul-Gumuz, Oromia, Tigray, and Sidama. Hence, the participants were selected based on specific criteria relevant to the research questions, such as their expertise, experiences, or characteristics essential to the study. For the case studies,

beneficiaries were selected through extreme case sampling to identify and extract lessons learned from successful stories of change. Also known as deviant case sampling, this approach focuses on highly unusual manifestations of the phenomenon of interest (outliers), such as outstanding success/notable failures. For this evaluation, the case studies were used to capture success stories. It is used to illuminate both the unusual and the typical and can provide clear examples of where the programme interventions led to significant improvements. The sample frame for the sampling of the KIIs was acquired through discussions with the stakeholders, during the inception phase.

In terms of area coverage, the qualitative data collection was conducted in a selected woreda within each of the five regions. The interviews and group discussions were conducted with different stakeholders and beneficiaries. Most of the programme beneficiary research participants were adults. However, the data collection also included children who are in their late adolescence, i.e., between the ages of 15 to 18.

FGDs were conducted with five different types of direct beneficiary groups as follows.

- Set 1 (FGD 1): Five FGDs with (mixed gender) beneficiary households to explore differentiated programme activities,
- Set 2 (FGD 2): Five FGDs with (females only) parents/caregivers (especially pregnant women and mothers and caregivers of children less than 1 year at the time of registration) that receive the child grant. These FGDs with caregivers were held with females only so that the FGD participants feel more comfortable openly sharing their views and opinions.
    - One of the five FGDs was conducted with beneficiaries of maternal and early child health care services (females only) to focus on the elements of the programme related to maternal and early child health care. The sample included pregnant and breastfeeding women and mothers of children under the age of four.
- Set 3 (FGD 3): Five FGDs with parents/caregivers (mixed gender) beneficiaries any/all programme components to capture intra-household dynamics and decision-making. This FGD was also intended to help acquire different perspectives on overall services related to education, WASH, gender-based violence, and mental health and psychosocial support.
- Set 4 (FGD 4): four FGDs with IDPs, refugees, and returnees were conducted to help assess their program-related access, use and knowledge of all (but mainly humanitarian aid-specific) services.
- Set 5 (FGD 5): Five FGDs with children between the ages of 15 to 19 (in their late adolescence) to hear children's experiences regarding all/any programme components in the selected intervention woredas and provide input aligned with their preferences.

The total number of FGDs with beneficiaries was thus 24. C4ED also conducted three different case studies, using successful examples from WASH and general healthcare SRCT and child grant grievance redress mechanisms and maternal and early child healthcare services.

A total of 38 KIIs were conducted with programme staff and stakeholders, such as UNICEF, FCDO, WFP, ERCS, and Imagine1day. C4ED also conducted KIIs with various members of the community/region, such as Kebele/camp leaders, health facility managers, vaccination centre staff, school principals and/or teachers, and the GoE government stakeholders ranging from regional to community level responsible for implementing cash transfer interventions. KIIs with representatives from the Ministerial offices could not be conducted because a lot of the work

related to the programme was said to be overseen mainly by experts at the regional level and because some participants were too occupied with urgent work.

The following table presents the type of interview including KIIs, FGDs and case studies, type of respondents, location distribution and number of respondents that were interviewed during the qualitative data collection.

Table 2: Planned Vs actual qualitative data collection sample

No:	Type of tool	Sample size	
		Planned	Actual
1	KII	40	**38**
2	FGD	24	**24**
3	IDI	3	**3**
Total		**67**	**65**

2.3. Primary Data Collection and Analysis

2.3.1. Quantitative Component

The evaluation adopts a mixed-methods approach, utilising both quantitative and qualitative data to comprehensively assess the impact of the six intervention components of the EC2R program. The primary focus is on the beneficiaries of these interventions, with most of the components targeting households as the main unit of intervention. However, some components, such as the WASH (Water, Sanitation, and Hygiene) intervention, are implemented at the community and institutional levels. This multi-level approach reflects the diverse nature of the program's scope, which includes direct household assistance and broader community-wide or institutional changes.

A. Household Survey

To capture a detailed understanding of the programme's impact, a household survey is conducted with the main beneficiaries across all six components. The survey tool is specifically designed to gather data on key indicators related to each component and is structured into the following modules:

- **Demographic Information**: This section collects data on household composition, socio-economic status, and other relevant characteristics to establish an understanding of the target population.
- **Coping Mechanism**: The Livelihood Coping Strategies Index (LCSI) and Reduced Coping Strategies Index (rCSI) were used to assess how households manage challenges, particularly during and after periods of crisis. These tools help evaluate the resilience of households to humanitarian shocks.
- **Education Module**: This module collected data on the educational status of children and adults, including school attendance, barriers to education, and any support provided by the programme to enhance educational outcomes.

- **Health Module**: This section focused on health-related data, including access to health services, health behaviours, and outcomes for household members. It provides an understanding of how health interventions are being integrated into the program.
- **Nutrition Module**: The module collected information on the household's awareness and response to Severe Acute Malnutrition (SAM) and the receipt of Vitamin A supplements by children. It also examines the nutritional support provided to pregnant or lactating women, including the use of supplements and food vouchers. These questions help assess the effectiveness of nutrition interventions, the impact of food vouchers on dietary habits, and the overall understanding of health and nutrition practices within households, especially for vulnerable groups.
- **WASH Module**: Given the focus of the WASH component at both the community and institutional levels, this module gathers information on water access, sanitation facilities, hygiene practices, and the impact of these interventions at both household and community scales. In summary, the module focuses on accessibility, availability, and challenges faced by EC2R programme beneficiaries and areas for programme improvement.
- **Child Protection and Gender-Based Violence (GBV)**: This module assesses the program's role in addressing child protection issues, as well as its efforts in preventing and responding to gender-based violence. This component was primarily addressed in the qualitative analysis, but we also sought to understand the experiences of beneficiaries. We specifically asked those beneficiaries identified as potential respondents for the education component about their experiences and involvement.
- **Social Protection or Cash Transfer**: The questions in the Cash Transfer component assess beneficiaries' experiences with the program, including their satisfaction with timeliness and amount. It also examines the impact of the transfers on food security, access to healthcare, education, and income generation, as well as support for households with disabled members. These questions help evaluate the programme's effectiveness in improving beneficiaries' livelihoods.
- **Feedback Mechanism**: The questions in the Feedback Mechanism module aimed to evaluate beneficiaries' awareness and use of feedback mechanisms within the EC2R program. If beneficiaries are familiar with these mechanisms, the module explores how they learned about them, how frequently they use them, and their level of satisfaction with the process. It also examines whether beneficiaries have received responses to their feedback, the timeliness of these responses, and whether the feedback has resulted in any changes or improvements to the program.

B. Health Facility Interviews

In addition to the household survey, the midterm evaluation included health facility interviews to gather insights on the support provided to health centres, such as material resources, rehabilitation, and renovations. These interviews with health professionals across the selected regions offer valuable perspectives on the implementation of the health and nutrition components. Although the original plan called for interviews with 97 health facilities, not all selected woredas across the five regions had the required number of health centres involved in the intervention. Nonetheless, the health facility interviews remain a crucial component of the data collection process, providing a deeper understanding of institutional-level interventions and challenges (please see ***Annexe 4*** for the summary).

2.3.2. Qualitative Interview and Discussion Guides

The qualitative component of the midterm evaluation utilised FGDs with gender-segregated and mixed groups of adolescent and adult beneficiaries, IDIs with beneficiaries whose lives were significantly improved by the programme and KIIs with programme implementers and other stakeholders.

Focus Group Discussions (FGD) were used for their quality of allowing for interaction and group dynamics among participants, which can generate rich data through shared experiences and group consensus. FGDs are specifically beneficial to understanding social norms, collective attitudes, and community perceptions, and exploring gender-related barriers to accessing services. It also provides a platform for participants to express opinions and debate viewpoints, offering nuanced insights into shared beliefs or cultural practices.

On the other hand, Key Informant Interviews (KII), focused on interviewing individuals with deep knowledge or insights related to the evaluation topic allowing researchers to gather detailed information from experts or key stakeholders. KIIs are advantageous when researchers need targeted information from individuals who are well-informed about specific aspects of the programme or project implemented in the area. They provide in-depth understanding, often revealing insider perspectives or expert opinions that might not be accessible through other methods.

Case studies, which involve intensive examination of a particular instance or phenomenon within its real-life context were conducted using in-depth interviews with selected programme beneficiaries. This method allows for a holistic exploration of complexities and contextual factors surrounding each case. Case studies offer detailed, context-specific insights that can provide practical implications. The case studies were used to show the success stories of the program.

To collect data using KII, FGD, and IDIs (for case studies), the evaluation team prepared interview guides and protocols with separate questions for each category of respondents. The tools were developed based on the EQs, the programme's ToC, and contextual information collected from the client. The interview guides comprise open-ended questions supporting the collection of in-depth information about the themes of interest while leaving space open for exploring aspects not considered beforehand.

Informed consent for participation in the interviews and recordings of sessions were requested from all participants through an information letter and consent form explained by the evaluators and signed by the participant before the interview. For interviews with children, C4ED requested a signing of an assent form after having each child's parent/caregiver sign a separate consent form. The finalised tools were translated into the local language in each region. Upon receiving informed consent from participants, FGDs, KIIs, and case study interviews were recorded to capture the information revealed. Recorded files were then transcribed and translated into English. All data and material including audio recordings, transcripts, field notes, and consent forms were transferred to C4ED Ethiopia by the field researchers via a secure link. Personally identifiable information on transcripts was removed before coding and analysis.

2.3.3. Fieldwork

After the approval of the inception report and after all preparatory tasks were completed, researchers were deployed to the field to conduct surveys, FGDs, KIIs, and case study interviews.

The training for the data collection process was conducted in three key locations: Addis Ababa (covering Oromia, Sidama, and Benshangul Gumuz), Kombolcha, and Mekelle. A research team, consisting of a Quantitative Researcher, a Qualitative Researcher, and a Survey Manager/Field Coordinator, traveled to Kombolcha and Mekelle to train local field staff. After completing the training sessions, a successful pilot test was carried out to ensure that all procedures were in place and understood by the field staff.

Upon successful completion of the training and pilot testing, the field team was deployed to the designated woredas for the actual data collection. The main field team, including supervisors and enumerators, was recruited based on their previous experience in data collection and their fluency in the most widely spoken languages in each targeted region. This approach ensured that the team was well-equipped to engage effectively with local communities, ensuring the quality and accuracy of the data collected.

During the qualitative fieldwork, five teams of researchers were deployed to the study regions. C4ED had initially planned to use three teams comprising multilingual qualitative researchers so that they could conduct interviews in more than one region. However, to compensate for the delay during the inception phase, more qualitative researchers were recruited and sent to the regions simultaneously on October 14, 2024, apart from the Amhara region where data collection began later November 01, 2024. As part of the plan to utilise a gender-sensitive research approach, the research team was composed of both female and male researchers. An intensive screening and recruitment process was made to select well-experienced qualitative researchers with related academic backgrounds. The regional researchers then received a two-day training which followed a pilot and adjustment of the interview guides when necessary. The training and piloting of qualitative researchers took place in three different sessions. Two separate trainings were held simultaneously in Mekelle (with the data collection team for the Tigray region) and Addis Ababa (with the three teams to be deployed to the Oromia, Sidama and Benishangul Gumuz regions). Another training session was later held in Kombolcha town with the data collection team for the Amhara region.

The qualitative researchers and C4ED QREMs conducted a total of 64 (24 FGDs, 37 KIIs, and 3 IDIs). Almost all the interviews were held in person, the exceptions being KIIs with a few stakeholders. Within the woredas, the research teams conducted interviews like KIIs and IDIs separately and managed the FGDs together (one as a moderator and the other as a note-taker). Researchers alternated between respondent groups to maximise their exposure to different topics and viewpoints.

The consortium partners' field staff of the regions and staff of implementing organisations, including regional and woreda-level government offices supported the identification and mobilisation of selected interview respondents based on the agreed-upon selection criteria. Local guides recruited by C4ED also assisted with the identification of respondents and the organisation of interviews and group discussions.

Table 3: Quantitative and qualitative data collection sites

Region	Quantitative Survey Woredas	Qualitative Data Collection Woredas	Remark
Tigray	Nekgsge, Mekelle, Abiy Addi, and Tahtay Maichew and Enda mehoni	Mekelle and Endamehoni	Gulomekeda Woreda was not selected due to security concerns. Enda mehoni was later included since there was no health intervention in Abiy Addi.
Amhara	Debre Birhan, Legambo, Dewa chefa, Kombolcha and Dessie	Debre Birhan, Legambo, and Desie	Considering the security situation, Beyeda, Telemt, Janamora/Adiarkay and Sequota were all replaced.
Benishangul-Gumuz	Bambasi and Sherkole	*Bambasi,*	Considering the security situation: GUBA woreda was replaced by Bombasi and Maekomo was replaced by Sherkole
Oromia	Dodola, Shashemena Zuria and Liben	Shashemena Zuria	Aga Wayu, Adami Tulu, Gobo Sayo, Gimbi and Nedjo are not selected due to security concerns.
Sidama	Shebedino	Shebedino	Aleta-wondo and Shebedino were selected but there was no active health intervention in the woreda. The sample size increased to Shebedino

2.4. Data Analysis

2.4.1. Quantitative Data Analysis

The analysis of the quantitative data is conducted by the quantitative team using a comprehensive descriptive approach, which include the calculation of various statistical measures such as mean, median, standard deviation, minimum, maximum, and percentiles. The quantitative team believe these statistics provide an overall understanding of the data distribution and variability, offering valuable insights into the central tendencies and dispersion of the indicators under study. To enhance the clarity of the findings, results are presented through both graphs and tables, allowing for a visual representation of the data trends and patterns.

Throughout the analysis process, every step, from data cleaning to the final analytical models, are thoroughly documented in do-files. These files can be shared with the consortium partners if necessary, just to ensure complete transparency and replicability of the analysis. By adhering to established standards for research integrity, we have attempted to ensure that the relationship between raw data and the generated "data products" is explicit, as recommended by the OECD (2016). This process guaranteed that our methods are traceable, and the results can be independently verified by other stakeholders.

2.4.2. Qualitative Data Analysis

The qualitative research team utilised tested procedures and practices to ensure data quality. Starting from intensive training of the data collectors to provide a better understanding of the research purpose and the tool, the quality check also included field-based supervision of the data collection process, daily audio recording auditing, and monitoring of each transcription work so that it is done according to the C4ED's organisational standards and guideline.

Except for one KII (where the participant was not willing to be audio-recorded) all the FGDs, KIIs and IDIs were audio-recorded after securing informed consent from the respondents, to ensure information shared can be captured and analysed within context. Throughout the data collection period, the field researchers continuously sent audio recordings for review and gave feedback to the evaluation team mainly focusing on the ways how the interview was administered, the quality of the interviews in achieving the intended purpose, and the clarity of the recording for the transcriber.

The qualitative research team performed a series of quality checks on the delivered transcripts to ensure they respected appropriate standards. The audio length of each interview was checked against the corresponding transcript and transcripts were also thoroughly reviewed to make sure that each was unique, with no plagiarism.

C4ED used qualitative content and thematic analysis to analyse the transcripts of all recorded and transcribed FGDs, IDIs and KIIs. Qualitative content analysis provides a systematic way of extracting information and ensures openness to aspects and outcomes not considered beforehand. In addition, the thematic analysis method allowed the team to use themes that emerged from the responses of the beneficiaries, implementers and other stakeholders. Once monitored transcriptions were completed, cleaned and made ready for coding, each piece of qualitative data was coded in an iterative process using MAXQDA software, based on a coding structure developed according to the objective of the research and research questions with adjustments made based on the empirical information gathered, including the emergence of new themes and unexpected outcomes. The qualitative team at C4ED conducted an in-depth analysis to identify and categorise responses, perspectives and experiences across respondents, categorise commonalities and explore differences in perspectives, triangulate the response across different respondents of KII, IDI and FGD, and identify the overall pattern and trends of the data. While working with the coding structure and coded sequences, individual interview fragments have also been considered in relation to the full transcript, to ensure their contextual understanding. A rigorous triangulation process is conducted between the qualitative and quantitative data. This process systematically integrates the findings from both research methods, ensuring alignment with the research objectives, evaluation questions, and the project/organisation's theory of change. Triangulation aims to strengthen the reliability and validity of the findings by comparing

the results derived from each approach. The report highlights key commonalities, convergences, and discrepancies identified during this process. By employing a mixed-methods approach, the analysis provides a more comprehensive understanding, drawing on diverse evidence and perspectives to offer a balanced and thorough interpretation of the data.

2.5. Secondary Data Collection and Analysis

In the context of the assignment, reviewing secondary sources is not merely a background task but a central component of the study's approach and methodology. The desk review is a major activity conducted in the first phase of the assignment, where the evaluation team systematically reviews and analyses existing literature and data. This process is essential to summarise key findings that address the evaluation questions related to output-level indicators, providing a comprehensive understanding of the programme's progress and performance. The following documents will be reviewed as part of the desk review mainly by the quantitative team:

- **Bi-annual Report and Post Distribution Monitoring**: These reports provide essential information on the programme's progress over six months, highlighting key achievements, challenges, and adjustments. The Post Distribution Monitoring (PDM) reports offer insights into how beneficiaries perceive and utilise the aid provided, focusing on the effectiveness of the delivery process, timeliness, and satisfaction with the assistance received.
- **Monitoring Data**: This data includes quantitative and qualitative information collected during routine programme monitoring activities. It offers a detailed overview of the program's outputs, such as the number of beneficiaries reached, the amount of assistance provided, and other performance metrics. Analysing this data allows the evaluation team to assess the programme's effectiveness in meeting its goals and targets.
- **Programme Documents**: These include project proposals, work plans, implementation guidelines, and other key documents that outline the programme's objectives, strategies, and expected outcomes. Reviewing these documents helps the evaluation team understand the program's design, intended activities, and how these align with actual implementation and results.

2.6. Limitations And Mitigation Strategies

Throughout the data collection process, we encountered some challenges and risk concerns that had the potential to affect the quality, and timeliness of the data. These challenges arose from information gaps and security concerns in some regions. In response, we developed and implemented a range of mitigation strategies to address and minimise the impact of these issues. The following table highlights the key challenges and risks faced, outlines the limitations, and describes the proactive measures taken to maintain the integrity and success of the data collection process.

Table 4: Limitation encountered, and mitigation strategies applied.

#	Limitation/challenge	Mitigation strategies	Limitations or challenges?

1	**Administrative, Logistics, and Mobility-Related Risks:** Security issues arising from conflicts and drought make certain areas and households inaccessible.	1. A security assessment was conducted, and consultations were held with consortium partners to obtain security updates before staff deployment. Based on the assessment, necessary adjustments were made, such as changing the research woreda, as the situation did not permit data collection or mobility. Initially, remote interviews were planned to cover potentially inaccessible areas; however, we were advised to proceed with face-to-face data collection and followed this recommendation. 2. There were security concerns in Benshangul Gumuz and after a careful assessment: • GUBA woreda was replaced by Bombasi • Maekomo is replaced by Sherkole	Challenge
2	Limited information on implementation: A few components of EC2R were not implemented in some of the selected woredas as per the distribution of the sample size of beneficiaries, which became apparent after the field team was deployed.	After consulting with component experts, we instructed the field team to collect data only from beneficiaries where the components were implemented. The team was then relocated to other woredas where the programme was operational to ensure accurate data collection.	Limitation
3	Limited support from woreda authorities: Insufficient support at the woreda and kebele levels to give us support letters	Local authorities and UNICEF Experts were engaged, and regular communication was maintained with relevant stakeholders to ensure smooth coordination and support.	Limitation
4	**Logistical challenge**: some of the car rental service providers either hesitated to have a deal or offered us extremely higher price than the market price. This is because there were security concerns and roads weren't good enough to travel.	We tried to negotiate but prices were still unreasonable. In the first few days, we let the field team travel using public transport and continue looking for car rents. Finally, we adjusted our budget allocation for transportation and prioritised flexibility in our travel arrangements to accommodate these challenges.	Challenge
5	Unable to disaggregate data: Problems with data disaggregation using gender becausethe primary beneficiary/caretakers of the child grant programme are female	Cash transfer beneficiaries in Sidama are all women. According to the information we got from the coordinators the eligibility criteria for the cash transfer selection is being women, The same is true for those cash transfer beneficiaries in Abi Adi and Mekelle where they are IDPs, and most of the beneficiaries are found to be women.	Limitation/ challenge
6	Limitations of the sampling strategy	It is important to highlight the limitations of the sampling strategy employed due to the unavailability of a comprehensive beneficiary list. This lack of access significantly hindered our ability to draw a representative sample, potentially impacting on the reliability of our findings. Additionally, the security concerns in various woredas necessitated a reevaluation of our selected locations, requiring us to shift our focus to	Limitation

		alternative woredas based on ongoing security assessments. These adjustments not only constrained our sampling framework but also may have introduced bias, further complicating the evaluation process.	

2.7. Ethical Considerations, Safeguards and Inclusiveness

Evaluations must conform to the 2020 United Nations Evaluation Group (UNEG) Ethical Guidelines. Accordingly, the evaluation team was responsible for safeguarding and ensuring ethics at all stages of the evaluation cycle. This included but was not limited to, ensuring informed consent, protecting the privacy, confidentiality, and anonymity of participants, ensuring cultural sensitivity, respecting the autonomy of participants, ensuring fair recruitment of participants (including women and socially excluded groups), and ensuring that the evaluation results in no harm to participants or their communities. All interviewees were informed of the purpose of the interview, the voluntary nature of their participation, and their right not to answer any of the questions that they did not want to provide, and/or leave the interview at any point in time. Interviewees' verbal informed consent was documented by the evaluation team. To avoid disclosing the identity of the interviewees, all data were treated anonymously. For security reasons, quotes were assigned to categories of respondents rather than individuals. All participants in the data collection activities were provided with information on how to report concerns or ask questions.

In alignment with UNICEF's Ethical Research Involving Children (ERIC) guidelines, special attention was given to ethical considerations when engaging with children aged 15-18 in the data collection process. Informed consent was obtained from the parents or caregivers, and assent was sought from the children themselves. Moreover, FGD was translated into the local languages of the regions, ensuring that children understood the content and implications of their participation. The evaluation team took every necessary precaution to safeguard the well-being of the child participants, in line with the ethical standards set by UNICEF.

In line with the Leave No One Behind (LNOB) principle, this evaluation was designed to ensure the inclusion of the most marginalised and vulnerable groups, including adolescent girls, children, PWDs, pregnant and lactating women, and other vulnerable populations affected by the humanitarian shocks of drought and conflict. Special efforts were made to ensure that these groups were adequately represented in the data collection process and that their voices were captured in the evaluation findings. In addition, the evaluation adhered to the UN Disability Inclusion Strategy, ensuring that all aspects of the evaluation process, from data collection to analysis, were accessible to persons with disabilities. The inclusion of these diverse groups was central to the evaluation, ensuring that the findings reflect the realities and needs of those most affected by the humanitarian shock.

The evaluation follows a rights-based approach, aligning with international frameworks such as the Convention on the Rights of the Child (CRC), Core Commitments for Children in Humanitarian Action (CCC), and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). Given the programme's focus on adolescent girls, children, PWDs, pregnant and lactating women, and vulnerable populations affected by humanitarian shocks, these benchmarks ensure that principles of non-discrimination, participation, and accountability are upheld. The

evaluation assesses the extent to which the intervention promotes gender equality, child protection, and social inclusion, ensuring alignment with global rights-based standards.

In addition, the draft report was presented to all the key stakeholders including UNICEF programmes, implementing partners, donors and the regional evaluation team for validation of findings and co-creation of recommendations. This final report includes their feedback and comments.

3. Evaluation Findings

This section provides a detailed summary of the findings derived from both quantitative and qualitative data collection conducted across the five regional states within the project area as part of the mid-term evaluation assignment. The evaluation follows key criteria designed to assess the program's progress and effectiveness, offering insights into various aspects of the project's implementation. Data was collected through multiple methodologies, including structured surveys, in-depth interviews, focus group discussions, and direct field observations. These diverse approaches ensure a well-rounded analysis by combining numerical data with contextual insights from participants and stakeholders, ultimately providing a more comprehensive understanding of the program's impact.

Whenever sub-evaluations allowed for the use of multiple data sources, we made a deliberate effort to triangulate findings by integrating both quantitative and qualitative data presentations. This approach enhances the reliability and depth of the analysis, enabling us to cross-verify information from different perspectives. For instance, the health facility survey was designed to complement the household survey, ensuring that the evaluation captures both household-level experiences and institutional-level service delivery dynamics. By collecting data at both levels, we were able to assess not only how beneficiaries perceive and receive support but also how service providers experience programme implementation, challenges, and gaps. This dual-layered analysis strengthens the credibility of the findings and ensures that conclusions are drawn from a holistic evidence base, aligning with best practices in evaluation research.

3.1. Relevance of the Programme

EQ 1: To what extent are the programme design and activities relevant from the perspective of the Programme's right holders (beneficiaries)?

SEQ 1.1: How effectively did the programme consult with the beneficiaries regarding available services and support during the design phase as well throughout the implementation of the programme?
SEQ 1.2: Are the beneficiaries satisfied with the type of support they received? Is assistance having the desired effect?
SEQ 1.3: What are the advantages/strengths and disadvantages/weaknesses of several supports (e.g., in-kind (dignity kits) vs. cash transfers) from the perspectives of the right holders?

- SQE 1.4: What mechanisms are in place for beneficiaries to provide feedback and how responsive is the programme to this feedback?

SEQ 1.1: How effectively did the programme consult with the beneficiaries regarding available services and support during the design phase as well throughout the implementation of the programme?

Consultations were continuously held with stakeholders across the different programme components and implementation regions, including representatives from regional, woreda, and community-level government offices (such as education, health, water, and women's affairs), healthcare workers, school principals, teachers, IDP committee members, and beneficiaries. These consultations mainly aimed to inform stakeholders about the program's objectives, key interventions, support packages, beneficiary selection criteria, procedures, and the locations of service delivery.

> *Different organs from woreda and the region as well as representatives from health office and women and social affairs came to our kebele and conducted repeated discussions with us. The discussion created clarity that our kebele was selected for new programme that will be implemented as a pilot program. We discussed about the criteria of selection of beneficiaries. (FGD, Adult beneficiary, Shebedino)*

> *"We first heard about the ERCS intervention (in the health sector) from kebele administrators during public gatherings such as meetings. We were informed that the intervention primarily supports children and women. Similarly, information was also disseminated through churches and mosques. For instance, during the vaccination campaign." (FGD, Adult Beneficiary, Endamehoni)*

> *"The Programme was discussed with Health clinic staff, Woreda Health officers, and IDP committees on how to implement it, and common action plans were made. The ongoing activities were monitored, and adjustments were taken by consulting beneficiaries. In doing so, service corrections were made." (KII, Health programme officer, UNICEF)*

During the design of the programme, however, the participation of beneficiaries was limited. As evident in the statements of KII participants below, it is usually difficult to use a bottom-up approach in such interventions during emergencies because the timeline set for the process of developing programme proposals and securing funding doesn't usually allow for it. Some considerations need to be made when selecting intervention areas which can contribute to the lack of opportunity to participate in programme design.

> *"The concept of the bottom-up approach is only theoretical. Nobody can do that. Things usually go the other way. (and) Since we used the PSNP initiative and it is a government-led initiative, for instance, we can't just pick an area of implementation. So, what is done usually is familiarization and sensitization work…However, we use the result of the seasonal multi-agency assessment of the EDRMC (Ethiopian Disaster and Risk Management Committee) which helps to examine the severity and inform decision-making. In terms of intervention site selection, the MOH, Metrology bureau and regional GoE offices discuss and make the decision which later informs where to do nutrition component intervention and where to do the WASH component, for instance…where it is most needed." (KII, Staff, WFP CO)*

> *"Such types of programs usually adopt a top-down approach. We find ourselves positioned between the community, kebele officials, and woreda offices. Therefore, when a new programme is set to be implemented, we engage in discussions with the community. For example, we informed them about the support being provided by the ERCS for children who have not been vaccinated due to the conflict. We encouraged parents to allow their children*

to visit health centres for vaccination. The same applies to caregivers and mothers. We worked to create awareness about the program's objectives and opportunities through two mechanisms. The first has been through the established channels of the health centre, including health extension workers and volunteers, down to the 'development groups'- small farmer groups with five members, one of whom serves as a health representative. The second method is through community meetings, which usually take place in churches or kebele gatherings" (KII, Health Facility Manager, ERCS)

"There was not much engagement before the programme started…We received assistance without much discussion prior… The programme focused on delivering support rather than involving us in the decision-making process and most of us only learned about the programme when it was already underway. (FGD, IDP beneficiary, Debre Birhan)

During the implementation process, however, the programme was flexible enough to use contextual strategies if they aligned with the program's objectives. It was indicated that in some areas, school and health facility rehabilitation designs were made to consider PWDs based on the discussion made with the stakeholders. Participants mentioned that programme launching, and consultations had an important impact on the outcome as most modifications were made based on the insight given by the community members. In this consultation, things about the programme were briefed and the building design was modified to be convenient for children and PWDs. Key informants and beneficiaries emphasized that frequent power interruptions were a significant challenge in the area. As a result, the community prioritized the solarization of water pumps and healthcare facilities, proposing various organizations to intervene and address this issue. In Benishangul for instance, the community members were using fuel-based engine water pumps for their daily consumption. However, the area was very remote, and insecurities in transporting the fuel made the process challenging and doubled the cost. During the EC2R programme implementation, the community members were consulted and the solarization process was started based on their insight and prioritized needs.

In addition, decisions were also made to adjust the frequency of aid provision to prevent aid diversion. Some support service sites also had to be changed to prevent theft.

"One of the reasons why we did things differently from the protocol was to minimize the commodities that are in the hands of the beneficiaries at any given time. Because, when we gave out these huge quantities of food in an environment like this, we found out that some of these commodities were being sold by the beneficiaries. These are some examples of programmatic adjustments that we had to make based either on feedback from the beneficiaries or feedback through our monitoring processes." (KII, Programme officer, WFP)

"The head of the Woreda health office, the head of the health centre, and the IDPs committee discussed the program. Although health services initially began at the health centre, they had to be moved to a clinic due to the wastage of drugs caused by some irresponsible health workers. This decision was made after consultations with the health facility head and other stakeholders." (KII, Health facility Manager, Bambasi)

SEQ 1.2: Are the beneficiaries satisfied with the type of support they received? Is assistance having the desired effect?

Beneficiaries were asked to what extent they were satisfied with the support they received. Table 5 presents how far the beneficiaries of cash transfer components of the programme are satisfied

concerning the overall satisfaction, the extent to which the Cash Transfer supported economic activities, and so on. Overall, 47% of respondents reported being very satisfied with the cash transfer component of the EC2R programme, and 41% were satisfied. A smaller proportion (9.2%) remained neutral, and dissatisfaction was low (2.4%).

Table 5 Overall satisfaction with the cash transfer and how it affects beneficiaries.

Satisfaction with Cash Transfer	N = 487[1]
Overall Satisfaction with Cash Transfers	
Very satisfied	229 (47%)
Satisfied	201 (41%)
Neutral	45 (9.2%)
Dissatisfied	8 (1.6%)
Very dissatisfied	4 (0.8%)
Extent to Which the Cash Transfer Supported Economic Activities	
A lot	86 (18%)
Somewhat	204 (42%)
Not at all	197 (40%)
Extent the cash transfer supported HHs with children's education	
Not at all	161 (33.4%)
To some extent	175 (36.3%)
To a large extent	146 (30.3%)
Extent to Which Additional Cash Supported Household Members with Disabilities	
Not applicable (no people with disability)	308 (63%)
A lot	37 (7.6%)
Somewhat	114 (23%)
Not at all	28 (5.7%)
[1]n (%)	

In terms of economic impact, 18% of respondents reported that the cash transfers from the EC2R programme significantly supported their economic activities, 42% felt the support was moderate, and 40% stated that the transfers had no impact on their economic activities. Regarding support for household members with disabilities, 63% of respondents noted that this question did not apply to them, as their households did not include members with disabilities. Among those with disabled household members, 7.6% found the support from the cash transfer component of the EC2R programme substantial, 23% reported moderate support, and 5.7% indicated no support at all.

Complementing this, we have tried to see how the cash transfer programme affected or supported households in the education of their children. Most respondents (around 36.3%) indicated that CT helped **to some extent**, suggesting that while the financial assistance provided some relief, it was not always sufficient to fully cover educational expenses. Meanwhile, about 33.4% of households reported that **CT did not help at all** in supporting their children's education, implying that the amount was either inadequate or allocated to other pressing household needs like food and healthcare.

A relatively smaller proportion (around 29%) stated that **CT helped to a large extent**, indicating that for some families, the financial support was substantial enough to cover key educational costs, such as school fees, supplies, or transportation. Overall, the findings suggest that while CT had a **moderate impact** on education support, a significant portion of households either did not

benefit or only received partial assistance. This highlights the need to assess the adequacy of CT amounts and whether additional interventions are necessary to enhance educational support for vulnerable families.Overall, the cash transfer component of the EC2R programme has achieved high satisfaction levels in terms of beneficiaries overall rating. However, there is potential to improve its impact on economic activities and provide better support for households with disabled members. These insights are valuable for strengthening future iterations of the cash transfer component of the EC2R programme.

Qualitative interviews also revealed that beneficiaries were satisfied with the support they received, and this was common across all programme components. Similar to the quantitative finding above, beneficiaries showed appreciation, especially for the timeliness of the programme support.

> *"We are incredibly happy to have this project. It will give me a chance to have my assets. Before joining the program, I did not have anything. Now, I have two goats, and some egg laying hens…and I feed my child their eggs. But before joining the programme (specifically child grant), I was doing nothing for my children because I had no money. Nowadays, if my child needs something, I can afford it, thanks to the project." (IDI, Adult beneficiary, Shebedino)*

> *"Yes, the (HCT) support came when we needed it most. Even though we still need critical and essential support such as food items, clothing, and shelter, we are satisfied with the cash support. This was because it came at the right time and helped us in various ways as mentioned above." (FGD, Cash transfer beneficiary, Mekelle)*

In the education component of the programme, for instance, beneficiaries expressed their appreciation explaining that the intervention was successful in helping many out-of-school children to go back to school. The school improvement including rehabilitation of classrooms and playgrounds, capacity building training, and training on psychosocial and crisis-sensitive management given to teachers were very productive. In Tigray, for instance, the community mobilization efforts, such as the back-to-school campaign, had a significant impact on school enrolment and family engagement. Through the work of the Community Core Coalition (CCC), including door-to-door outreach, families were encouraged to enrol children in school, particularly those with disabilities who were previously excluded. Providing scholastic materials alleviated economic burdens on families, further encouraging participation. Schools became safe spaces for children, offering protection, peer interaction, and a sense of normalcy amidst the crisis. These efforts successfully gained community trust and addressed the immediate educational needs of vulnerable populations.

Some factors have negatively affected the level of satisfaction of programme beneficiaries. Factors such as distance of service provision centres (affecting accessibility to PWD and the elderly), misconduct of some service providers, insufficient provision of drugs (resulting in beneficiaries' suspicion of embezzlement by health workers), and inconsistency of some of the supports were mentioned during discussions.

> *"Since they are treated free of charge, they are relatively satisfied. But the problem is that the health workers providers giving the services are incompetent and undisciplined." (KII, Camp leader, Bambasi)*

"They provided us with health services and cared for us like a parent would for a child. However, our village is quite large, and we still face water shortages. There is also a shortage of fuel for the generator that pumps water to the stations. The water stations serve the entire community, from a place called 'Kophi Guta' to 'Jalo Dida.' While we cannot deny that there has been significant improvement in the availability of drinkable water, there are still many areas that need access to these water stations." (FGD, Adult beneficiary, Shashemene).

"However, we all have concerns about the adequacy of the cash support provided. It often falls short of what we truly need…The provision of financial support has been helpful. It was beneficial to me, allowing me to fulfil my basic needs like rent and food. The educational initiatives were also appreciated. (However) there are issues with the adequacy of the financial support… We need more than simply basic support to truly meet our needs. The current assistance is a good start, but it needs to be improved." (FGD, Adult beneficiary, Debre Birhan)

SEQ 1.3: What are the advantages/strengths and disadvantages/weaknesses of several supports (e.g., in-kind (dignity kits) vs. cash transfers) from the perspectives of the right holders?

Both in-kind and in-cash support is found to have advantages/strengths and disadvantages/weaknesses depending on different contextual factors. The finding indicates however that most beneficiaries prefer cash transfers over in-kind support.

According to beneficiaries and other research participants, in-kind support offers several advantages, including ensuring quality and specificity by providing standardized, high-quality products like dignity kits and medications, especially in areas with limited local availability or inflated prices. It is cost-effective, safeguarding against market fluctuations and ensuring essential goods remain accessible to beneficiaries. Additionally, it minimizes the risk of misuse by directly addressing targeted needs and promotes sustainability when backed by strong infrastructure and thorough need assessments.

"Most of the beneficiaries in this programme are affected by poverty or illnesses. If cash support is given to them, they cannot purchase anything going to the market. Therefore, cash transfer has a disadvantage compared to in-kind support." (FGD, Adult beneficiary, Shebedino)

"I prefer the in-kind support because (the items) are expensive if we were to purchase them. " (FGD, Adolescent IDP, Mekelle)

"The in-kind support in medication is more important than cash support because, if someone wants to get medication, its cost is not affordable with the existing inflation. Therefore, in this case, in-kind support is preferable even though cash is sometimes important to make instant payment for other things." (FGD, Late adolescent IDP, Bambasi)

The provision of in-kind support also has challenges including the need for robust logistics, limited flexibility for beneficiaries with diverse and immediate needs, and operational constraints, such as restricted service hours in health centers, which impact its effectiveness.

"In this health facility, we are not happy with the kind support because we are not able to receive the health service for the whole working hours during the day and there is no service at nighttime. Since we, the patients, are not getting the health services during these periods, (it would thus be better) if the support is cash-based because the beneficiaries could use the money at any time for medications and other purposes based on their needs." (FGD, Adult beneficiary, Bambasi)

As the above beneficiary and many others mentioned, cash support offers significant advantages, including flexibility that allows beneficiaries to address diverse and immediate needs while empowering them with autonomy over resource allocation. It is also reported that, compared to in-kind support, it is more time-effective, reducing logistical challenges and delays by enabling direct fund transfers. It is also evident that cash support often results in higher beneficiary satisfaction as it aligns with individual priorities and urgent demands.

"Cash support is particularly important for pregnant and breastfeeding women. It helps us ensure we have what we need during this critical time." (FGD, IDP beneficiary, Debre Birhan)

"We prefer cash support because, although it hasn't fully met our basic needs, it offers greater flexibility. As mothers, we prefer this flexibility, since in-kind support is typically for a single purpose only. With cash support, I am the decision maker on allocating it based on my specific needs and priorities. It gives me full control, allowing me to manage it more effectively. However, in-kind support only addresses one specific gap." (Adult beneficiary, Mekelle) "Cash support reduces logistical challenges and involves fewer bureaucratic hurdles as it can be directly deposited into beneficiaries' accounts from the centre." (KII, UNICEF staff, Mekelle)

However, as mentioned above, market fluctuations can diminish the value of the cash, potentially making it insufficient for essential needs. It is also vulnerable to misuse. Particularly in rural or insecure areas, it can also be vulnerable to theft.

"The cash support doesn't have any disadvantage for the beneficiaries who are living in towns but for rural beneficiaries, the cash may be snatched from beneficiaries by the gang on the road." (KII, Camp leader, Bambasi)

SEQ 1.4: What mechanisms are there in place for beneficiaries to provide feedback and how responsive the programme is to this feedback?

To assess awareness, respondents were questioned about any mechanisms available to provide feedback on the support they received. Approximately 45% acknowledged their awareness. These respondents were then asked how they became aware of the mechanism. The findings emphasise that community-based interactions, particularly staff-led engagements and community meetings, play a central role in raising awareness about feedback mechanisms. These methods have proven effective, highlighting the need to strengthen and expand them for broader outreach. As shown in the table below, the majority became aware through community meetings and programme staff.[14]

Table 6: How respondents became aware of the feedback mechanism

[14] Note that the percentages do not total 100% as this question allowed for multiple responses.

Awareness mechanisms	N = 923[1]
Aware of any mechanisms in place to provide feedback	**923 (44.9)**
Programme staff	582 (63%)
Community meetings	620 (67%)
Posters/Flyers	51 (5.5%)
Other beneficiaries	174 (19%)
Other (myself through visit)	12 (1.3%)

[1]n (%)

Respondents were also asked which mechanisms they were aware of. The majority indicated community sessions and community leaders. The table reveals that community-based feedback mechanisms are the most recognized, with 57% of respondents aware of community sessions and 53% identifying community leaders as key sources. Suggestion boxes were mentioned by 20%, while house-to-house visits and hotlines were less recognized, at 17% and 14%, respectively. A small portion (4.3%) noted other mechanisms. These findings highlight the central role of community-driven methods, particularly community sessions and leaders, in raising awareness of feedback mechanisms, suggesting the need to strengthen these channels for broader engagement.

Table 7: Feedback mechanisms respondents are aware of

Mechanisms respondents are aware of	N = 923[1]
Hotline	127 (14%)
Suggestion Box	184 (20%)
Community Sessions	524 (57%)
House to House Visits	161 (17%)
Community Leaders	488 (53%)
Other	40 (4.3%)

[1]n (%)

Out of the 923 beneficiaries who were aware of the feedback mechanisms, 47% (438 respondents) reported having used them to provide input. Regarding the frequency of use, 52% of respondents used the mechanisms occasionally, 35% used them once, and 13% used them frequently. In terms of satisfaction with the feedback mechanisms, a majority of 60% expressed satisfaction, while 24.5% reported dissatisfaction. The remaining 15% felt neutral about their experience with the mechanisms.

Though 47% of beneficiaries used the feedback mechanisms, their engagement was mostly occasional. Satisfaction with the mechanisms is generally positive, with 60% of users indicating satisfaction. However, a significant portion (24.5%) expressed dissatisfaction, indicating room for

improvement. Enhancing the mechanisms to address user concerns could help improve both usage frequency and overall satisfaction.

Table 8: Frequency of Use and Satisfaction Levels with Feedback Mechanisms

Use and satisfaction with feedback mechanisms	N = 923[1]
Used feedback mechanisms to provide input.	438 (47%)
Frequency of use of feedback mechanisms	
Once	152 (35%)
Occasionally	229 (52%)
Frequently	57 (13%)
Satisfaction with feedback mechanisms	
Very dissatisfied	33 (7.5%)
Dissatisfied	75 (17%)
Neutral	66 (15%)
Satisfied	233 (53%)
Very satisfied	31 (7.1%)
[1]n (%)	

Among the beneficiaries who used any of the feedback mechanisms, 78% reported that they had received a response. Of those who received feedback, half received it within one week, while the remaining respondents reported receiving feedback either within one week to one month or after more than a month. In terms of the quality of the responses, approximately 85% of those who received feedback felt that it adequately addressed their concerns or suggestions. Furthermore, 84% of respondents believed that their feedback contributed to changes or improvements in the programme, highlighting a positive perception of the feedback process and its impact on programme enhancement.

Most beneficiaries who used the feedback mechanisms received timely and adequate responses, with most believing their feedback led to programme improvements. This highlights the effectiveness of the feedback process in addressing concerns and driving positive change.

Table 9: Response Timeliness, and Satisfaction with Feedback Mechanisms

Response to feedback and its impact	N = 438[1]
Response to feedback provided	343 (78%)
Average time taken to receive a response to feedback	
Within a week	167 (49%)
Between 1 week and 1 month	100 (29%)
Over 1 month	76 (22%)

Response to feedback and its impact	N = 438[1]
Adequacy of response to concerns	292 (85%)
Impact of feedback on programme changes	288 (84%)

[1]n (%)

Qualitative data also corroborates that several mechanisms were established to enable beneficiaries to provide feedback on the services and programs they received. Most of the participants were also aware of the availability of feedback mechanisms.

One feedback mechanism was the use of suggestion boxes which were widely used in service centers, such as health facilities, where beneficiaries could submit written feedback. Appeal committees were established to review suggestions and act accordingly. For example, in one health centre, a committee consisting of five members (three males and two females) reviewed complaints and forwarded serious issues to a disciplinary committee.

> *"One feedback mechanism established by the ERCS is the suggestion box you see over there. We can write our concerns and insert the paper into the box. Then, it will be opened and reviewed by those concerned (a committee) to address the issues we raised." (FGD, Adult beneficiary, Endamehoni).*

Beneficiaries were also encouraged to submit feedback and complaints in person to caseworkers, facilitators, or designated focal persons. This method was often informal, as some beneficiaries noted a lack of formal platforms for structured submissions. Officials and programme implementers conducted regular field visits, often using Beneficiary Contact Monitoring (BCM) questionnaires. These visits assessed safety, security, service effectiveness, and complaints. Additionally, satisfaction assessments and checklists were used to gather beneficiary feedback during these visits.

> *"It is only if we can meet them that we can give feedback. For example, as you are here standing in front of us asking about our experience, if they did the same, we would have shared what we feel. But we did not get to meet them so we couldn't discuss with them except for that one time they came here to select representatives…" (FGD, Adult beneficiary, Shashemene)*

Like the quantitative findings, community engagements with community representatives played a major role in collecting and forwarding complaints. Implementers also stated that the programme integrated awareness activities on Protection from Sexual Exploitation and Abuse (PSEA) and Accountability to Affected Populations (AAP). Beneficiaries were encouraged to submit feedback through suggestion boxes or verbally to focal persons if they were unable to write. For interventions such as WASH, education, and CT, feedback mechanisms were often managed by the respective government offices. This included handling complaints during direct visits and community meetings.

There are many examples of cases that showed the programme's responsiveness to the feedback of the beneficiaries. Health facilities addressed frequent closures after beneficiaries raised complaints, adjusting their working hours to meet community needs. During field visits, officials identified issues such as a lack of classroom furniture and acted by facilitating its provision through the Education Bureau.

"One of the series of complaints from the beneficiaries' side was the frequent closure of the health facility for the service. Accordingly, we met the health facility staff and communicated about adjusting the working hours. Now, the problem is already addressed." (KII, UNICEF staff, Bambasi)

"The feedback that we received was about the delay of cash transfer . We are dealing with the issues with the bank and UNICEF and trying to have the cash transferred monthly, …this will be resolved soon." (KII, Woreda official, Shebedino)

"Once… there was a complaint about drug service support by the beneficiaries, and the service was terminated for some periods but later because of the complaints forwarded to the committees, the problems were solved." (FGD, Adult beneficiary, Bambasi)

Some beneficiaries also noted that there were delays or a lack of responses to their complaints, such as objections to merging health service centres in IDP camps. Others reported a lack of change despite repeated suggestions, such as requests for timely distribution of educational materials.

"Nothing has been changed. For example, we raised an idea and forwarded our suggestion regarding the timing of the supply of stationary materials and dignity kits. However, it is as it used to be… Nothing has changed based on what we have raised." (FGD, Adolescent IDP, Mekelle)

"There are no formal feedback mechanisms regarding these support systems, but we are addressing our grievances to the community representatives with the hope that they in turn will forward our complaints to their bosses. (However)…responses are not coming on time. For instance, we asked that the health centre at IDP site one not be merged with the health centre at IDP site two because of its distance to get the health service there. (FGD, Parent beneficiary, Bambasi)

In other cases, implementers also mentioned that there was a lack of understanding about the programme and its inclusion criteria which led to complaints that could not be resolved (due to the nature of the programme).

"They (beneficiaries) know (have been informed) about the criteria, but they still come to the focal person and complain. …there is also a free call and free text centre. We receive, and then technically analyze it, but most of the complaints were about non-eligibility because they didn't fulfil the criteria. But to minimize the complaints, we prepared banners including entitlement and admission criteria and posted them in the waiting and health education area to be visible to all." (KII, WFP programme officer, Mekelle)

There is also a limited awareness and understanding of complaint and feedback mechanisms (CFM) among some beneficiaries which prevented some beneficiaries from reporting issues. A few others explained that they refrained from reporting due to hopelessness about receiving a timely or meaningful response.

"Thus, there is no platform or any mechanism such as a suggestion box to provide our feedback or any criticism to the cash support or the organization itself. So, we have never provided any comment, suggestion or feedback so far." (FGD, Adult Beneficiary, Mekelle

EQ 2 (A): How effective are the EC2R activities in achieving programme objectives?

- SEQ 2.1: Do people have knowledge of key behaviours, services, and supplies?
- SEQ 2.2: Has the programme identified populations in greatest need?
- SEQ 2.3: Has the programme covered the intended population groups?
- SEQ 2.4: Has the programme covered the populations in need/vulnerable populations?
- SEQ 2.5: Has the programme reached beneficiaries on time, and was the amount of support and/or types of services received adequate?
- SEQ2.6: What are the gaps or shortcomings in the support provided that need to be addressed?

EQ 2(B): Is EC2R achieving stated outputs and is EC2R likely to achieve intended outcomes?

- SEQ2.7: To what extent did the programme achieve its **WASH, education, health, nutrition, and social protection** targets?

SEQ 2.1: Do people have knowledge of key behaviours, services, and supplies?

The table below outlines respondents' actions when someone in their household experienced diarrhoea. The majority (94%) would seek medical attention by going to the clinic, demonstrating a strong inclination toward professional healthcare in such cases. Furthermore, many reported taking proactive measures to stay hydrated, with 22% preparing a homemade sugar-salt solution, 19% drinking safe fluids, and 18% using oral rehydration solutions from pharmacies or hospitals. In contrast, only a small fraction mentioned less common responses, such as stopping eating (1.3%) or consuming starches (1.1%). A minority (3.2%) cited other actions, while 0.6% were uncertain, reflecting a limited awareness of alternative remedies. Most respondents demonstrate appropriate knowledge and awareness of how to address diarrhea, particularly through seeking medical attention and rehydration methods. The table below indicates that they demonstrate a good understanding of appropriate responses.

Table 10: Actions Taken in Response to Household Diarrhea Cases

Actions Taken in Response to Household Diarrhea Cases	N = 533[1]
Go to the clinic	502 (94%)
Drink safe fluids	102 (19%)
Use oral rehydration solution from pharmacy/hospital	95 (18%)
Make sugar-salt solution at home	116 (22%)
Stop eating	7 (1.3%)
Eating starches	6 (1.1%)
Other	17 (3.2%)
don't know	3 (0.6%)

[1]n (%)

Respondents were surveyed about their awareness of critical handwashing times. The majority recognized the importance of handwashing before preparing food (79%), eating (80%), and after using the latrine (76%). However, awareness was lower for handwashing after coughing and sneezing (2.1%), caring for animals (12%), returning from outside (16%), and before feeding children (13%). This indicates that while some key times for handwashing are recognized, there is a considerable gap in knowledge regarding other important hygiene practices. That is, the results suggest a need for targeted hygiene education on less commonly recognized handwashing moments.

Table 11: Awareness of Critical Handwashing Times Among the Respondents

Respondents' Awareness of Critical Times for Handwashing	N = 533[1]
Before preparing food	423 (79%)
Before eating	426 (80%)
After using latrine	403 (76%)
After coughing and sneezing	11 (2.1%)
After taking care of pets or farm animals	65 (12%)
When returning to the house after being outside	87 (16%)
Before feeding your children	67 (13%)
Others	15 (2.8%)
do not know	1 (0.2%)

[1]n (%)

Table 12 presents findings from a survey of 533 households on water, sanitation, and hygiene (WASH) facilities, focusing on their experiences and knowledge. Most households (81%) rely on piped water for drinking, the remaining reported springs (6.9%), surface water (6.4%), or wells (4.5%) as their main sources of drinking water. Over half (55%) collect water in under 15 minutes, though 44% of the respondents explained they wait longer than 15 minutes, with 16% spending over an hour. Households with PWD[15] face challenges like inadequate infrastructure and limited access to public water points. The main reported barriers include inadequate infrastructure (3%), dependence on assistance from family (2.8%), and limited availability of accessible public water points (2.8%). Only 1.3% of such households have direct access to indoor water facilities. Water availability varies: 40% report consistent access, 43% face occasional interruptions, and 13% experience frequent disruptions.

Sanitation-wise, pit latrines with slabs are the most common (39%), followed by composting toilets (33%), but 15% of households still rely on open defecation. Fewer than 2% have advanced facilities like flush systems. Accessibility for PWD remains limited, with only 18% of households offering fully accessible toilets. *These findings highlight gaps in water access, sanitation*

[15] About 90 per cent of the respondents reported having no people with disabilities members.

infrastructure, and disability-inclusive services, emphasizing the need for targeted improvements to WASH systems.

Table 12: Availability of WASH facilities

Availability of Wash facilities	N = 533[1]
The main source of drinking water	
Piped water	431 (81%)
Water from spring	37 (6.9%)
Surface water	34 (6.4%)
Well (protected/unprotected)	24 (4.5%)
Other	5 (0.9%)
Tanker/truck	1 (0.2%)
Bottled water	1 (0.2%)
The time it takes to collect water	
Less than 15 minutes	295 (55%)
15 to 30 minutes	90 (17%)
More than 60 minutes	87 (16%)
30 to 60 minutes	61 (11%)
Water access for households with disabilities	
No PWD	479 (90%)
Difficulty accessing water due to lack of infrastructure	16 (3.0%)
Special assistance from family or community	15 (2.8%)
Accessible public water point (designed for people with disabilities)	15 (2.8%)
Direct access to water (e.g., indoor tap)	7 (1.3%)
Other	1 (0.2%)
Consistency of water availability	
Occasionally interrupted (once a week or less)	228 (43%)
Yes, available consistently	211 (40%)
No, often interrupted	69 (13%)
Frequently interrupted	25 (4.7%)
Household toilet facility type	
Pit Latrine (with a slab or covered pit)	208 (39%)
Composting toilet	174 (33%)

Availability of Wash facilities	N = 533[1]
No Facility/Open Defecation (fields, bushes, or any open space)	81 (15%)
Open Pit Latrine (no slab or covering)	60 (11%)
Ventilated improved pit latrine	6 (1.1%)
Flush to piped sewer system or septic tank	4 (0.8%)
Accessibility of toilet facilities for household members with disabilities	
Not applicable (no people with disabilities in the household)	347 (77%)
Yes, fully accessible	82 (18%)
Yes, but with limited difficulty	16 (3.5%)
No, not accessible	7 (1.5%)

[1]n (%)

SEQ 2.2: Has the programme identified populations in greatest need?

The EC2R programme was inherently humanitarian, designed specifically to address the needs of vulnerable populations affected by drought and conflict. Its core objective was to provide targeted support to those in greatest need, including pregnant and lactating women, children under five, adolescents, PWD, and the elderly. By prioritizing these groups, the programme demonstrated a clear commitment to alleviating suffering and meeting the basic needs of the most affected individuals.

The targeting process was highly collaborative, involving extensive consultation and discussions with regional government bureaus. This approach ensured that the selection of beneficiaries and intervention sites was contextually informed and aligned with local realities. Implementers credited this collaborative effort with successfully identifying populations in greatest need, affirming the programme's ability to reach those it was designed to serve.

> *"My husband doesn't have any source of income or job. So, we were suffering from different forms of problems before being selected for this program. Kebele administrators and social workers visited home to home and selected my daughter to support her in school equipment." (IDI, Adult beneficiary, Shebedino)*

Although some gaps in the capacity of local organizations to assess and identify certain vulnerable groups, such as PWDs, were noted, the programme has effectively used a structured and inclusive identification process. Overall, the EC2R programme's design and execution underscore its humanitarian focus and its dedication to addressing the needs of those most affected by crises.

SEQ 2.3: Has the programme covered the intended population groups?

Participants acknowledged that the programme, across each thematic intervention, has provided different types of services, and believed that it met the needs of the beneficiaries. Most responses indicated that the support was effective because it helped them to survive and recover, provided access to education for the students who were out of school, and increased access to clean water and health services.

"Before the project was implemented, we received orientation on the type of services to be delivered in and after a crisis to take us back to normalcy. We feel that the project (EC2R) understands the extent of the damage that the crisis caused to our health centre. As a result, a range of rehabilitation activities have been implemented." (KII, Health facility manager, Endamehoni)

Beneficiaries expressed their satisfaction and claimed that the interventions were inclusive. For instance, it was indicated that classroom and health facility rehabilitation work was done by, among other aspects, making the centres accessible to PWDs. As a result, children with physical disabilities using their wheelchairs can enter the classrooms easily while those with visual impairments were able to receive and use brail display devices.

"The programme interventions were inclusive regardless of age, gender and PWDs. All are equally benefited from the support." (KII, Camp leader, Bambasi).

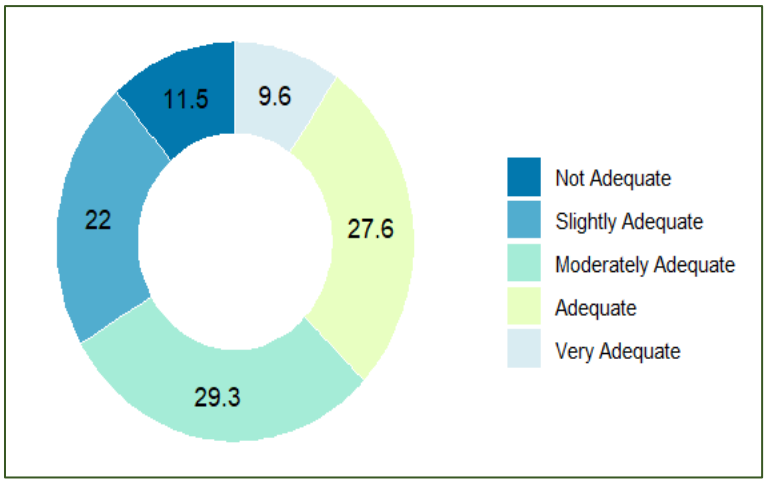
In some components of the programme, such as nutrition, beneficiary selection was said to use standardized procedures which, key informants and beneficiaries argued does not allow room to make things more inclusive. This is because, for example, if a child or a pregnant and lactating woman fulfils the MUAC admission criteria, they become part of the programme regardless of their gender or disability status. In other programme components such as health, care was provided to beneficiaries at their homes.

"A weakness that I have observed is the program's inability to include mothers with special needs. Initially, the criteria stated that only lactating mothers with children under one year old could participate. However, a mother with a child aged a year and a month who had special needs was unable to join. On the other hand, a mother with a child under one year who did not have special needs or could feed nutritious food to her child and herself was included. This approach did not seem fair in serving the community. For instance, during identification in a kebele, a mother with a medical condition approached us with her one-year-old child. Following the criteria, we had to turn her away. "(KII, HFM, Shebedino)

SEQ 2.4: Has the programme covered the populations in need/vulnerable populations?

Respondents were asked to assess how adequately they felt the programme addressed the needs of vulnerable or high-need populations. The results indicate a generally positive evaluation of the program's effectiveness in meeting these needs. A significant proportion of respondents viewed the programme as sufficiently addressing the needs, with many ratings it as either "Very Adequate" or "Adequate. These findings reveal mixed perceptions, with a majority (66.5%) viewing the EC2R programme as moderately or better, but a significant proportion (33.5%) indicating dissatisfaction. This suggests that while the programme has achieved some success, there is room for improvement to better address the needs of vulnerable populations.

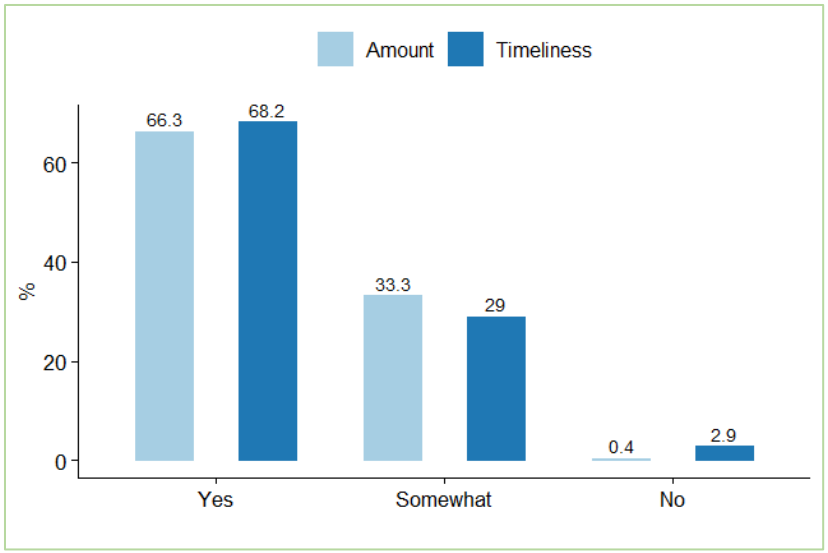
Figure 1: Program's Adequacy in Addressing the Needs of Vulnerable Populations



SEQ 2.5: Has the programme reached beneficiaries on time, and was the amount of support and/or types of services received adequate?

The survey results indicate a generally positive perception of the cash transfer component of the EC2R programme among beneficiaries, particularly regarding its timeliness and adequacy. A significant majority (68%) expressed satisfaction with the timeliness of the assistance, while 29% were somewhat satisfied, and only 2.9% were dissatisfied. Satisfaction with the amount of assistance provided by the cash transfer component was also high, with 66% fully satisfied and 33% somewhat satisfied, while dissatisfaction was minimal at 0.4%. These findings indicate that the EC2R programme has successfully delivered cash transfers to beneficiaries on time and in amounts that meet their expectations. The minimal levels of dissatisfaction suggest that the program's cash transfer component is both effective and well-received.

Figure 2: Satisfaction with the Timeliness and Amount of Assistance Provided



The qualitative component of the midterm evaluation explored the satisfaction of beneficiaries in terms of timeliness, amount, and type of support provided. The results contain varying perspectives across different contexts, thematic interventions and regions. For instance,

beneficiaries frequently responded that the support provided was timely, stressing the fact that it reached them during a time when they were highly vulnerable because of the conflict and drought.

> *"That support made it possible for me to continue my studies. The financial assistance directly contributed to my ability to afford school-related expenses, which is essential for my education…I have found the money helpful. I paid the rent and bought food for my family. This support has really improved our living conditions… Health services have also been made available, especially for pregnant women, which is crucial for their well-being." (FGD, Adolescent beneficiary, Debre Birhan)*

Beneficiaries also mentioned that the support was appropriate and adequate. However, some others had different experiences, mainly related to timeliness, discussing the issue of delays in support provision. Some others also expressed that the support was not adequate to cover their multifaceted needs and argued that the available support is too small compared to the magnitude of the problem and the number of people who require support. For instance, beneficiaries and implementers argued that even though the programme provided essential health services, it was inadequate when compared to the diversity and magnitude of the community's needs.

> *"Yes, indeed. I am very grateful for the support provided. However, the issue is that the support doesn't come at regular intervals and on time. For example, if I register in September but only receive the exercise books in December, it would be too late to be useful. There are sometimes delays in the provision of these materials. We appreciate the support, but it would be even more helpful if it arrived on time." (FGD, Adolescent beneficiary, Mekelle)*

> *"One major issue is the inconsistent food supply. The food that comes to us every month is maize, which is not sufficient for our needs. We need a more regular and varied food supply… The duration of assistance is another issue. Families receive support every month, even sometimes not in a regular way, which is challenging given the high cost of living. More frequent disbursements would help us manage our expenses better." (IDI, IDP beneficiary, Debre Birhan)*

> *"Whenever ever we visit these areas there is a lot that we hear about. I went to check the water project there, and I have seen many people being starved. That needs intervention in nutrition. With the Red Cross, our intervention is limited to WASH and Health and even that is limited to specific areas." (KII, ERCS focal person, Shashemene)*

> *There was a shortage of drugs to be provided on time and food item supports were delayed because of the security issues everywhere affecting transportation. The amount of food items given per head (15 KG) was not adequate for a month and we were worried and doing daily labour to complement this consumption gap." (FGD, Adult beneficiary, Bambasi)*

SEQ 2.6: What are the gaps or shortcomings in the support provided that need to be addressed?
The implementation of programs in conflict-affected regions had significant gaps related to accessibility, coordination, and resource limitations. Security issues in border areas, natural disasters, and damaged infrastructure disrupted transportation and monitoring of interventions, particularly in regions such as Amhara, Tigray, Oromiaand Benshangul Gumuz. Communication breakdowns and safety concerns made it difficult for implementers to verify reports or ensure aid reached intended beneficiaries. Supply chain disruptions and procurement delays further hindered the timely delivery of essential resources. Coordination gaps among stakeholders and

insufficient integration of multi-sectoral services, such as health and education, also reduced the overall effectiveness of interventions.

> *"…Pregnant women's follow-up and the children's vaccines were good… When it comes to health services for children, regular vaccines and nutritious supplements were provided. However, there were interruptions to these services making it hard to address the unique needs of this group." (FGD, Adolescent beneficiary, Bambasi)*

> *"For example, we were unable to communicate or meet with our teams in Axum and Shire, as communication channels were completely cut off. Additionally, there was a mismatch between the demand and the available resources. We often lacked the necessary resources to meet those demands." (KII, Imagine1day staff, Mekelle)*

> *"In certain instances, your pipeline, from the time you procure the food items up until you get them, takes almost six months. Because these specialized nutritious products are not produced within the country. So, you must rely on the supply chain. Sometimes the items must come from South Africa or Belgium. So, if there is any issue along the pipelines, it is completely out of our hands and it might end up affecting our work here. (KII, WFP staff, Mekelle)*

Funding-related issues, including unpredictability, short intervention periods, and budget delays, severely affected programme continuity and impact. Annual funding cycles and short-term contracts limited long-term planning, with gaps often leaving beneficiaries unsupported. Inflation and market unpredictability further strained budgets, delaying activities and reducing programme scope. Aid distribution faced accountability concerns, including mismanagement and diversion, which eroded trust among beneficiaries. Despite timely efforts to address immediate needs, the support was often inadequate to meet the scale of challenges, especially for vulnerable groups such as children and IDPs, who lacked basic services and educational materials.

> *"The programme was less effective in supporting the children with notebooks and uniforms, so parents were forced to engage in daily labour to satisfy these needs. At the same time, the health facility didn't have any laboratory, so patients were given similar drugs without the lab result, and it was not effective for them. The services provided were limited because of the large number of beneficiaries." (FGD, Adult beneficiary, Bambasi)*

Moreover, weaknesses in government structures and service delivery compounded the challenges. Many health and education facilities in conflict-affected regions were understaffed, lacked resources, or were dysfunctional, delaying the reinstatement of essential services. Poor commitment and skill gaps among service providers, as well as capacity issues with local contractors, further hindered implementation. Limited feedback mechanisms and over-expectation from beneficiaries underscored the need for stronger accountability systems, more sustainable support, and better coordination to ensure that programs could effectively meet the needs of vulnerable populations.

> *"The people overseeing the water stations need to be equipped with maintenance skills… because some of the buttons are malfunctioning; only two or three are currently working. This contributes to long waiting lines around the water station. If all the buttons were properly maintained and functional, the waiting times would be significantly shorter than they are now". (FGD, Adult beneficiary, Shashemene)*

> *"In the health facility, the health workers are not always available in the workplace… and were even strongly warned by UNICEF staff. They start late and leave early. Besides, there is*

a skill gap from the health workers' side, where they sometimes prescribe the wrong medicines… The nutritional supplement for children is good but there is not enough follow-up by UNICEF for the delivered drugs and how they are used." (FGD, Adult beneficiary, Bambasi)

"During the solarization process, there was no problem, but the problem was with the water treatment plantation. Concerning this, we made two rounds of bidding for contractors, but no one showed up for the first bidding process with the required criteria because of the lack of experience of local bidders as well as the remoteness and insecurity issues around there which are threats for contractors. Later, we had the needed discussion on the nature of the bidding criteria and had to remove the criteria that required previous experience on treatment plants just to attract new bidders and we were successful in getting one by then." (KII, UNICEF staff, Sherkole)

SEQ 2.7: To what extent did the programme achieve its WASH, education, health, nutrition, and social protection targets?

The table outlines the mid-term progress of the **EC2R humanitarian assistance program**, designed to support communities impacted by humanitarian shocks like conflict and drought. It compares planned targets with actual achievements across key sectors **Nutrition, Health, WASH, Cash Transfers, Child and GBV Protection, and Education** to evaluate the program's effectiveness and pinpoint areas for improvement.

Table 13: Planned vs achieved (progress) of selected indicators of the EC2R programme components.

Component		Planned	Achieved
Nutrition	Number of children 6-59 Months treated for SAM	1000	4910
	Number of children and pregnant and lactating women (PLW) treated for moderate acute malnutrition	42,300	3160
	Percentage of children 6-59 months with Severe Acute Malnutrition cured, defaulted and died	>75% Recovery Rate	92.59% recovery rate
		<15% Defaulter Rate	1.3% defaulter rate
		<10% Death Rate	0.08% death rate
	Moderate Acute Malnutrition (MAM) Recovery, Defaulter and Death rate	>75% Recovery Rate	95.3% of recovery
		<15% Defaulter Rate	4.3% defaulter
		<3% Death Rate	0% death
	Number of mothers/caretakers of under 2 children receive nutrition education and IYCF counselling at HF and community levels	7500	3,925
	#Of children 6-59 months receiving Vitamin A	46281	14,054
	#Of children 24-59 Months receiving deworming	32,047	8562
	#Of pregnant women receiving folic acid and Ferrous sulphate	4994	2662
	# Of adolescents' girls receiving folic acid[16]	8712	3521
Health	Mobile Health and Nutrition Team (MHNTs)/Outreach/Fixed Facilities Supported	75	75
	Medical consultations[17]	159,289	63,981
	Health workers trained	360	1,031
	Health facilities rehabilitated /refurbished	6	3 Started constructions 2 awarded to contractor and 3 in bid process
	People reached through Social behavioural communication, SBC	234,420	655,943
WASH	People accessing enough (SPHERE standard) safe water for drinking and domestic needs	10,000	10,629
	Health care facilities with safe access to, and use, of appropriate WASH services in health care facilities	1	not available

[16] Number of Women, adolescents and children receiving micronutrient deficiency preventive interventions
[17] Medical consultation includes ANC4, Penta 3, MCV1, Skill Birth Attendant

	Schools with safe access to, and use, of appropriate WASH services	2	2
	People reached hand-washing behaviour-change (SBC) programmes	183,600	191,600
	People reached through the provision of sanitation	5760	4,767
	People reached with critical WASH supplies	5,745	8,330
Social protection/ Cash transfer	Households received at least one round of Shock Responsive Cash Transfer (SRCT)	15,564 households (77,820 individuals)	17,164 households (85,865 individuals)
	Number of households receiving fresh food vouchers for prevention of wasting	2500	2300 registered
	Identification and registration of persons with disabilities completed	-	478 SRCT Amhara and 1,363 SRCT in Oromia
	Pregnant women and caregivers of children<1 received 1 bi-monthly cash transfer payment	1950	1400
	Grievance redress mechanisms (GRM) established in new woredas	-	GRM established in all SRCT target woredas
	% of payments made to core beneficiary households according to the program's performance standards for timeliness	55%	103%
Child Protection/GBV	# Survivors who have experienced GBV reached by health, social work or justice/law enforcement services	No target	970
	# health facilities supported to provide GBV services to survivors	5	5 safe spaces and 6 one stop center
	# women and girls (including with disability) accessing safe spaces	1614	1517
	#Women and girls receiving dignity kits or cash in lieu	12,518	1287
	# girls and boys (including children with disability), and caregivers provided with community-based mental health and psychosocial support	3120	13,321
	#children (girls and boys; including children with disability) provided with landmine or other explosive weapons prevention and/or survivor assistance interventions	982	13,909
	# girls and boys who have experienced (or at risk of experiencing) violence reached by health, social work or justice/law enforcement services	900	628
	# UASC (girls and boys; children with disability) provided with alternative care and/or reunified	500	462
Education	# pre-primary primary-level children to directly receive teaching-learning materials and teacher training.	6000	6006
	# Children to benefit from assistive devices.	360	Partnership signed
	# pre-primary children to indirectly benefit from improved pedagogy through teacher training and ECD kit distribution	8000	Procurement in progress
	# of teachers trained in teaching pedagogy at pre-primary and primary level	60	100

	# of schools damaged by conflict rehabilitated or # of temporary learning spaces established for conflict affected children	-	Contract signed to start rehabilitation.
	# of people reached with back to school and value of education	20,000	20000
	# of children at pre-primary and primary level received school bag and stationaries	55,000 (50% female)	55,000 procured and dispatched to the project regions
	# of children with disabilities received assistive devices	Mapping and screening of CWDs in project area	conducting mapping and screening of CWDs

Source: EC2R logical framework June 2024

The EC2R mid-term evaluation demonstrates strong achievements across several key programme areas but highlights gaps requiring focused intervention.

- The **Nutrition** sector saw significant overachievement in the treatment of Severe Acute Malnutrition (SAM), with 4,910 children treated compared to the planned 1,000. Recovery rates for both SAM and Moderate Acute Malnutrition (MAM) were well above target, at 92.59% and 95.3%, respectively, while defaulter and death rates remained impressively low. However, there were major shortfalls in treating Moderate Acute Malnutrition, reaching only 3,160 out of the targeted 42,300 children and PLW. Similarly, essential micronutrient supplementation efforts fell short Vitamin A supplementation reached only 14,054 children out of 46,281 planned, and deworming covered just 8,562 of the intended 32,047. Pregnant women receiving folic acid and iron supplementation, as well as adolescent girls receiving folic acid, also remained below target, with achievement rates around half of the planned numbers.
- In **Health**, notable achievements were recorded in workforce capacity building, with 1,031 health workers trained far exceeding the planned 360. The reach of Social and Behavioral Change Communication (SBC) efforts also expanded significantly, engaging 655,943 people against an initial target of 234,420. However, medical consultations were far below expectations, with only 63,981 conducted out of a planned 159,289, possibly due to service accessibility or reporting issues. The rehabilitation of health facilities faced delays, with only three facilities under construction and two awarded to contractors, while three remain in the bidding process, indicating procurement and execution challenges.
- The **WASH** sector generally performed well, exceeding targets in safe water provision, handwashing behavior change programs, and WASH supplies distribution. A total of 10,629 people gained access to safe drinking water, slightly surpassing the 10,000 planned. Handwashing programs reached 191,600 people, exceeding the target of 183,600. WASH supplies distribution also expanded, benefiting 8,330 people instead of the initially planned 5,745. However, sanitation services reached only 4,767 people compared to the 5,760 expected. There was also a lack of reported progress on improving WASH services in healthcare facilities, suggesting potential implementation bottlenecks.
- The **Social Protection and Cash Transfer** component performed strongly, exceeding targets in key areas. The number of households receiving Shock-Responsive Cash Transfers (SRCT) was 17,164 (benefiting 85,865 individuals), surpassing the planned 15,564 households (77,820 individuals). Furthermore, 103% of payments were made on time, exceeding the program's 55% target, highlighting strong efficiency in disbursement. Grievance redress mechanisms (GRM) were successfully established in all SRCT-targeted woredas, ensuring accountability and program transparency. Additionally, efforts to identify and register persons with disabilities made notable progress, with 478 individuals registered in Amhara and 1,363 in Oromia. However, there were gaps in fresh food voucher distribution, as only 2,300 households were registered out of a planned 2,500, and only 1,400 pregnant women and caregivers received bi-monthly cash transfers compared to the 1,950 planned.
- In **Child Protection and Gender-Based Violence (GBV) services**, significant overachievement was recorded in mental health and psychosocial support (MHPSS), reaching 13,321 children and caregivers compared to the planned 3,120. Similarly, landmine and explosive risk awareness efforts expanded beyond expectations, benefiting 13,909 individuals instead of 982. However, major gaps were noted in the distribution of dignity kits or cash in lieu, with only 1,287 recipients compared to the planned 12,518,

pointing to potential funding or supply chain issues. Protection services also fell short, with only 628 children at risk of violence receiving appropriate interventions instead of the 900 targeted. Additionally, while efforts to reunify and provide alternative care for unaccompanied and separated children (UASC) made progress, the program reached 462 children instead of the intended 500.

- The **Education** sector performed well in some areas while facing delays in others. The distribution of teaching and learning materials met its target, with 6,006 children benefiting. The back-to-school outreach campaign reached its 20,000-person target. Similarly, school bag and stationery distribution was successfully executed, with 55,000 kits procured and dispatched as planned. However, the provision of assistive devices for children with disabilities was still in progress, with procurement ongoing. Rehabilitation of conflict-damaged schools had also not been completed, though contracts had been signed to start the work. Teacher training exceeded expectations, with 100 teachers trained instead of the planned 60, contributing to improved teaching quality. Meanwhile, pre-primary children targeted for improved pedagogy were still awaiting program implementation, as procurement was still in progress.
- Finally, our review showed the following results on BSC. WFP has been implementing the EC2R programme in Meket Woreda, Amhara Region, by providing cash transfers alongside social behavior change (SBC) initiatives. The support targets food-insecure households with children aged 6-23 months and pregnant or breastfeeding women/girls (PBW/Gs), aiming to enhance dietary diversity and stimulate local markets through increased fresh food demand.
- 46,915 people were reached through Social and behavioural change communication (SBC) activities to improve demand and uptake of maternal and child health services including immunization.
- In Benishangul Gumuz, 12,080 people in IDP sites in Bambasi and Buldigilu woredas were reached with hand-washing behaviour-change programmes.

In summary, the program demonstrated strong performance in several areas, particularly in the treatment of acute malnutrition, cash transfers, mental health support, and teacher training. However, critical gaps remain, particularly in moderate acute malnutrition treatment, micronutrient supplementation, medical consultations, dignity kit distribution, and school rehabilitation. Addressing these challenges will require strengthened logistical support, supply chain improvements, and enhanced outreach efforts to ensure more equitable service delivery.

3.3. Efficiency of EC2R

EQ 3 (A): To what extent is the EC2R Programme efficient in achieving its objectives within the allocated timeframe and budget?

SEQ 3.1: Does the partnership approach lead to the efficient use of resources in achieving the EC2R Programme's objectives?

SEQ 3.2: To what extent have the planned results of the programme been achieved on time?

SEQ 3.3: Have the programme outcomes been achieved in line with the financial resources allocated to the project?

SEQ 3.4: To what extent has the programme efficiently utilised resources to address the needs of PWDs?

EQ 3 (B): To what extent is the EC2R Programme effective in strengthening systems, including capacity building, improved governance, enhanced accountability, and fostering the sustainability of services?
SEQ 3.5: To what extent has the EC2R Programme contributed to the development of skills and competencies among stakeholders?
SEQ 3.6: How has the EC2R Programme influenced the quality of governance structures and processes?
SEQ 3.7: How effective has the EC2R Programme been in ensuring the long-term sustainability of services?

SEQ 3.1: Does the partnership approach lead to the efficient use of resources in achieving the EC2R Programme's objectives?

The partnership approach in the EC2R programme significantly contributed to the efficient use of resources in achieving its objectives. UNICEF, WFP, and ERCS leveraged existing government structures and local partners to implement health, education, WASH, and nutrition interventions. By working through government offices at federal, regional, and district levels, the programme reduced costs associated with creating parallel systems, such as human resources and management expenses. Additionally, local NGOs with established community connections, such as Imagine1day and the Amhara Development Association, played key roles in facilitating access and implementation. This approach enabled resource savings and improved programme targeting while allowing the programme to respond effectively to the unique needs of vulnerable groups, including people with disabilities.

> *"The partnership approach has been vital in utilizing resources effectively. Organizations like UNICEF play a crucial role in coordinating support. UNICEF support has many partners under it. This collaboration has allowed for pooling resources, which in turn leads to cost savings. For instance, the implementation of cash transfers and child protection initiatives can be mentioned as joint efforts that maximized resource efficiency." (KII, Camp leader, Debre Birhan)*

> *"We have achieved a big change. For example, when the water line was prepared, we engaged physically. If this work was converted to money, it would be worth millions. This could save money... and it also helps society to consider the facility as if it is their own... Since we engaged physically to construct it, so we must take care of it as well." (IDI, Adult beneficiary, Shashemene)*

> *"There were many occasions when we utilized community labour for development activities. For example, during the construction of toilets, the community significantly reduced financial costs by doing much work themselves." (KII, HFM, Shashemene)*

Working with local and international partners also allowed for resource integration, cost-sharing, and operational efficiency. For instance, WFP initially implemented nutrition interventions in the Tigray region independently but later transitioned to collaborating with partners. This integration reduced administrative and operational costs for WFP and enhanced programme delivery. While most key informants agreed that partnerships with government structures were cost-effective due to pre-existing infrastructure, they also acknowledge that the different modalities of service delivery might require extra effort to adjust to for more efficient cooperation. Working in collaboration with local NGOs was also considered to be more effective, especially in instances where these organizations are already well established within a community. However, some KII participants expressed concerns about potential inefficiencies when multiple local NGOs involved,

citing risks of budget diversion to staffing and operations. Overall, KII participants argued that they consider the partnership approach effective in optimizing resources and achieving programme goals through cost-sharing, leveraging local expertise, and minimizing duplicative efforts.

SEQ 3.2: To what extent have the planned results of the programme been achieved on time?

Across all sectors, the program's strengths lie in areas where direct service delivery was well-coordinated, such as SAM treatment, cash transfer efficiency, mental health support, and health worker training. However, weaknesses emerge in areas that require more complex logistical arrangements, such as MAM treatment, medical service utilization, dignity kit distribution, and school rehabilitation. The stark contrast between overachievement in some areas and underperformance in others suggests the need for a more balanced resource allocation and targeted interventions to address bottlenecks. Moving forward, greater emphasis should be placed on addressing implementation barriers, strengthening supply chains, and improving coordination among service providers to ensure that all planned interventions reach their intended beneficiaries in a timely and effective manner.

SEQ 3.3: Have the programme outcomes been achieved in line with the financial resources allocated to the project?

The table outlines the budget allocation, expenditure, commitments, and total expenditure combined with commitments for the various intervention components of the EC2R program. The total allocated programme budget stands at £45,956,347, with £26,755,098 already expended and £6,634,277 committed, bringing the total utilization to £34,438,777, representing 75% of the allocated budget. Similarly, the cost recovery component, accounting for 8% of the programme budget, has utilized 75% of its allocation (£2,755,102 out of £3,676,508), making the overall utilization of the grand total budget (£49,632,855) also 75%.

Among individual components, Cross-cutting Activities and International Procurements achieved 100% utilization, indicating full efficiency in budget execution. Health and Social Policy interventions followed with high utilization rates of 90% and 92%, respectively, reflecting significant progress in these critical areas. However, components such as Child Protection and Nutrition reported lower utilization rates of 58%, indicating a relatively slower implementation compared to other components. WASH showed moderate progress at 78% utilization, while Education achieved 65% utilization.

In general, the overall budget utilization rate of 75% demonstrates steady progress in implementing the EC2R program. While certain components like Cross-cutting Activities, Health, and cash transfers are performed efficiently, areas such as Child Protection require closer attention to accelerate budget execution and programme impact. This mid-term evaluation highlights both achievements and opportunities for improvement to ensure all components meet their intended targets effectively.

Table 14: Budget Allocation, Expenditure, Commitments, and Utilization by Component

Section	Allocated budget	Expenditure	Commitments	Total expenditure + Commitment	Proportion of total budget Utilized (%)
Child Protection	4,757,052	2,568,991	169,691	2,738,682	58%
Education	5,437,896	3,361,348	200,348	3,561,696	65%
Health	7,969,495	5,479,858	1,682,521	7,162,379	90%
Nutrition	4,854,885	2,393,660	417,329	2,810,989	58%
Social Policy	9,435,208	8,594,658	67,556	8,662,215	92%
WASH	10,708,879	4,291,078	4,096,831	8,387,909	78%
Programme Effectiveness	2,792,932	65,504	-	65,504	2%
Cross-cutting Activities International Procurements	1,049,402	123,490	925,912	1,049,402	100%
Total - Programme	**45,956,347**	**26,755,098**	**6,634,277**	**34,438,777**	75%
Cost recovery @ 8%	**3,676,508**	**2,140,408**	**530,742**	**2,755,102**	75%
Grand Total	**49,632,855**	**28,895,506**	**7,165,019**	**37,193,879**	75%

SEQ 3.4: To what extent has the programme efficiently utilised resources , to address the needs of PWDs?

The programme, through its diverse components, utilized resources to address the needs of PWDs. The research indicated that PWD-targeted activities were made in education, health, WASH, and HCT-related interventions. Cash support, training for the service providers, and creating accessible service centres including health and schools were interventions targeting PWDs. Activities included ensuring WASH, health and education facilities were accessible for the physically disabled, provision of reading devices for the visually impaired. Families with PWD were provided with additional financial support while health service providers were trained in equity, inclusiveness, and disability-sensitive service provision.

> *"For instance, …in WASH programmes, the programme included gender-segregated disability-friendly institutional latrine rehabilitation/construction scheme. In health, outreach programs primarily focus on reaching and incorporating unreached segments of the community. This includes persons with disabilities. However, in phase I, there is no specific budgeting to address disability. During training, we primarily focus on including these concerns. We have had two or three programs for sensitizing disability issues including disability day celebrations." (KII, ERCS staff, Legambo)*

In terms of addressing their needs, it was revealed that even though the programme has targeted PWDs and CWDs, the level of performance in targeting and identifying was low. For instance, in the first phase of the program, from the plan of enrolling 10% of children with disabilities, the programme reached only 2 to 3% of CWDs enrolled on school. In some regions like Tigray, it has been progressing, increasing from two to six per cent. To improve the situation, it was mentioned that more budget is already requested specific to CWDs. The main gap here was attributed to the capacity gap of the local NGOs in identifying CWD, and PWD in general.

SEQ 3.5: To what extent has the EC2R Programme contributed to the development of skills and competencies among stakeholders?

Many key informants stated that the EC2R Programme has significantly contributed to enhancing the skills and competencies of diverse stakeholders through targeted capacity-building efforts. Thematic interventions highlighted the program's role in strengthening government offices at various levels and equipping local NGOs with the expertise to implement the programme effectively. This was achieved through collaborative activities, such as shared planning exercises, frequent discussions, and experience-sharing sessions, alongside specialized training designed to address specific knowledge gaps. For example, training on water management systems, concrete maintenance, and environmental sanitation empowered stakeholders, especially in the WASH sector, by fostering a sense of ownership and enhancing their operational and technical capabilities.

In the education sector, the programme provided professional development opportunities for teachers and parent-teacher unions, focusing on areas such as student-centred teaching, emergency response, and conflict-sensitive planning. These initiatives improved stakeholders' competence and accountability in delivering quality education services. In Tigray, for example, the programme empowered local decision-making through the Parent-Teacher-Student Associations (PTSAs), enabling schools to identify and prioritize their needs. Training and capacity-building initiatives strengthened school leadership and promoted inclusive education. However, challenges such as limited resources, short funding cycles, and weak government accountability created hurdles for sustainable progress. Similarly, health and nutrition interventions integrated community health facilities with the broader healthcare system. This approach, supported by training, technical assistance, and infrastructure development, helped enhance the system's capacity to implement nutrition-related interventions, strengthening healthcare delivery at the grassroots level.

> *"The Programme has made significant strides in capacity building, with detailed training provided to various stakeholders. Training was provided to health professionals and members of various committees, indicating a focused effort on skill enhancement. These trainings have had positive outcomes on system strengthening, leading to improved service delivery in the health, education, and nutrition sectors. In health, for example, the programme has strengthened the reporting system, enabling better tracking of health services and vaccination services." (KII, Camp leader, Debre Birhan)*

Partnership dynamics within the EC2R Programme also influenced capacity-building outcomes. In regions such as Tigray, constraints necessitated collaboration with NGOs instead of the government, which impacted resource allocation efficiency. While NGOs played a critical role in sustaining the program, the preference for future partnerships with government entities was emphasized due to their cost-effectiveness and established community structures. Despite these challenges, the programme demonstrated value in fostering skills, accountability, and integrated systems among stakeholders, contributing to sustainable development outcomes.

SEQ 3.6: How has the EC2R Programme influenced the quality of governance structures and processes?

The EC2R Programme is believed to have significantly contributed to improving governance structures and processes by emphasizing accountability, systematic adjustments, and capacity building. KIIs indicate that the monitoring and feedback mechanisms introduced by the programme have strengthened governance frameworks in government offices, particularly in the Tigray region. For example, the World Food Programme (WFP), shifted its TSFP from a monthly to a bi-weekly schedule, enhancing both the efficiency and accountability of health interventions. By reverting to pre-crisis community-level health screening systems, where health workers conduct screenings and partners verify results, the programme has minimized inclusion and exclusion errors while improving coordination and oversight.

UNICEF's involvement through its cash transfer initiative further demonstrates the EC2R Programme's influence on governance. Using the government's Productive Safety Net Programme (PSNP) system, UNICEF conducted rapid assessments to evaluate government capacity, community preferences, and market dynamics. These assessments revealed the need to restructure local committees to avoid misuse of resources and this was accepted by UNICEF. This approach reinforced existing governance mechanisms and introduced robust practices to mitigate inefficiencies.

> *"A rapid assessment was conducted on the government functionality structure, carrying capacity, community preference, and market dynamics. The community members suggested not to use pre-existing committee members as they are well acquainted with the misuse techniques. That was what our findings showed. However, the woreda wanted us to strengthen the existing one, but based on the community's recommendation, we didn't accept that direction." (KII, UNICEF staff, Mekelle)*

Furthermore, the EC2R Programme has utilized rigorous monitoring and evaluation practices to ensure the effectiveness of its governance interventions. UNICEF's verification of its cash transfer project, including programme visits to confirm key performance indicators, demonstrated that 71% of transactions were completed and documented. These measures highlight the programme's role in enhancing the transparency, accountability, and quality of governance structures, providing a model for improved governance in crisis-affected regions. The programme's impact on governance structures and processes will depend heavily on the government's strong commitment and ownership to ensure it drives meaningful and sustainable systemic change.

SEQ 3.7: How effective has the EC2R Programme been in ensuring the long-term sustainability of services?

Qualitative data shows that the EC2R Programme is having a notable impact on both humanitarian and developmental interventions, particularly in ensuring the long-term sustainability of services. Initially, the programme was primarily focused on addressing immediate humanitarian needs, providing lifesaving and basic services for conflict and drought-affected populations, including IDPs. This involved interventions in nutrition education, water, health, and sanitation, aimed at rehabilitating physical infrastructure and filling institutional gaps through capacity-building activities such as training workers and creating awareness within communities. These efforts are believed to have lasting impacts by not only addressing immediate needs but also building sustainable systems that would serve the community in the long run.

"The programme is proving effective in empowering beneficiaries to become self-sufficient. Currently, they are learning how to acquire resources independently and are being taught the importance of saving. For instance, they are learning skills like indoor vegetable gardening and acquiring hens and goats. Although the programme will end after two years, by encouraging saving, beneficiaries can continue to improve and sustain their livelihoods." (KII, HFM, Shebedino)

"They (ERCS) have already informed us about the maintenance responsibilities. During that meeting, they clearly stated that this water project belongs to us. From now on, we are responsible for its use, management, and sustainability, including maintenance. They suggested we collect a small fee from beneficiaries, such as 2 or 3 birrs, for maintenance and related expenses. For example, in 'Gole' Village, we charge 2 or 5 birrs. If the pipe needs maintenance, it is our responsibility to fix it." (FGD, Adult beneficiary, Shashemene)

In terms of sustainability, the EC2R Programme also focused on integrating developmental interventions into the community systems. The introduction of an accelerated education system for out-of-school children from IDPs was a prime example, reconnecting children to the education system through an approach that emphasized the importance of educational materials, not just infrastructure. Similarly, efforts to strengthen the health system, such as through bi-weekly health services in regions with collapsed health infrastructure, aimed to build the capacity of regional health bureaus and ensure sustainability in health services delivery.

An example can be the CP component of the intervention which has made a lot of improvements on the referral systems and one-stop centers. Strengthening one-stop centres, hospitals, and community coalitions was assumed to ensure the sustainability of services even after the programme phases out.

"So, while we exit, we will hand over responsibility to the government and other partners. For instance, Imagine1day may recruit a social worker, but eventually, the person will be working under the women and social affairs office." (KII, UNICEF staff, Mekelle)

Moreover, the program's focus on community-based structures and stakeholder engagement has been crucial in ensuring sustainability. By involving regional health officials, community members, and other stakeholders, EC2R promoted a sense of ownership and responsibility for the services provided. This engagement not only empowered communities but also allowed for the establishment of frameworks that supported self-reliance, such as community care coalitions that mobilized resources to maintain emergency support. The increased community awareness and voluntary financial contributions to support health services further underscored the program's contribution in setting up a sustainable system, where communities can become active participants in maintaining essential services even after the formal programme phases out. However, as many beneficiaries pointed out, there remains a lot to be done to help them achieve economic self-reliance.

"If they support both the school and health system to make it sustainable, if they help us establish an association to lend us money so that we engage in different business activities to support our economy, …to work on our own, and to be self-sufficient, sustain in economy… even if they leave us, we will be able to support ourselves and be able even to help others. We just don't want them to leave us without making these things" (FGD, Adult beneficiary, Shashemene).

"If possible, sustainable help should be put in place. For how long we will be going to stay like this? All the concerned bodies, especially the government should think over this. We need to work

and generate income. For, how long we will depend on such support? It is so sad." (FGD, IDP beneficiary, Debre Birhan)

3.4. Lessons Learnt

EQ 4: What are the best practices, lessons learned, and potential for replicating and scaling up successful interventions in the target regions?

SEQ 4.1: What were the major best practices of the programme?
SEQ 4.2: What challenges or successes have been experienced in implementing the programme?
SEQ 4.3: Are there opportunities to strengthen existing partnerships or establish new ones to enhance programme outcomes, including efforts to replicate and scale up successful interventions?

SEQ 4.1: What were the major best practices of the programme?

The programme's emphasis on system strengthening has been identified as a notable best practice. By prioritising sustainable and long-term improvements in institutional capacities and sector coordination, the programme has contributed to the establishment of a resilient foundation for service delivery. This approach aligns with global development principles, particularly those outlined in the Sustainable Development Goals (SDGs), which emphasise the strengthening of governance, financing, and equitable access to services.

"We are working with the community to be accountable for the services provided and to consider every facility as their own and protect it. It is my job to ensure the project's sustainability. We are training government organizations to make sure they have an effective partnership with us for the intervention. Also following the reshuffle in the structure of government organization, we are working with concerned bodies to make sure the intervention is sustained... By taking the opportunity, they help in facilitating the community's participation and resource mobilization for target areas they are working with, for ease and better implementation (KII, ERCS focal person, Shashemene).

Given the diverse components of the programme, which included health, nutrition, protection, and education, the involvement of specialised implementers for each component enabled efficient and effective delivery. Each implementing partner contributed expertise and contextual knowledge to their specific areas, enhancing the quality of interventions.

A significant best practice identified is localization since working with local partners who have deep-rooted connections within the community and expertise in the sector facilitated the effective delivery of services . Organizations like WFP and UNICEF leveraged local networks to maintain programme continuity, even in conflict-affected areas. Local NGOs played a vital role in addressing social and psychological challenges faced by the affected populations. Given the diverse components of the programme, which included health, nutrition, protection, and education, the involvement of specialised implementers for each component enabled efficient and effective delivery. Each implementing partner contributed expertise and contextual knowledge to their specific areas, enhancing the quality of interventions. This approach ensured that interventions

were not only effective but also culturally and contextually appropriate, highlighting the importance of localization in programme implementation.

As previously mentioned, the program's focus on system strengthening has been recognized as a significant best practice. Rehabilitation of schools, healthcare facilities, and WASH systems, coupled with capacity-building efforts, contributed to restoring essential services in conflict-affected regions. These efforts not only addressed immediate needs but also reinforced systems for future resilience. Investments in infrastructure and training laid a strong foundation for sustainable recovery and development. By prioritising sustainable and long-term improvements in institutional capacities and sector coordination, the programme has contributed to the establishment of a resilient foundation for service delivery. This approach aligns with global development principles, particularly those outlined in the Sustainable Development Goals (SDGs), which emphasise the strengthening of governance, financing, and equitable access to services. Close collaboration with government bodies and other organizations was crucial for resource efficiency and programme success, making it another best practice worth adopting. By integrating government systems and aligning interventions with national priorities, programs minimized overhead costs and avoided duplication of efforts. Examples include partnerships in education, health, and WASH programs, where coordinated efforts addressed critical needs like providing learning materials, rehabilitating infrastructure, and ensuring access to clean water.

Innovative practices, such as solar-powered water systems, addressed sustainability challenges. These systems provided consistent water access, reduced reliance on costly fuel, and promoted environmental sustainability. Other innovative approaches included the integration of education with child protection, where programs addressed trauma and psychosocial needs alongside academic development. Accelerated Learning Programs (ALP) also helped reintegrate displaced children into formal education, ensuring continuity amidst crises.

> *"Thus, the best practices that curb all these problems is solarization of the waterpower source. Solarization of the water system has several advantages. It is environmentally friendly… reducing the carbon emissions. It reduces fuel costs and helps to get a sustainable water supply. It also helps avoid threats of risks due to insecurity." (KII, UNICEF staff, Sherkole)*

Beneficiaries frequently highlighted the timely provision of support as a life-saving best practice. Cash transfers, food aid, and medical assistance were delivered to beneficiaries at critical moments, addressing immediate needs and helping families recover. The responsiveness of programs to the specific needs of conflict and drought-affected populations underscored their effectiveness and relevance in emergency contexts.

Programs created specialized safe spaces, such as Women's and Girls' Safe Spaces (WGSS) and child-friendly spaces, which offered safety, vocational training, and psychosocial support for vulnerable groups. These centres not only addressed immediate protection needs but also equipped beneficiaries with skills for long-term self-sufficiency.

Family Tracing and Reunification (FTR) programs were also instrumental in reuniting children separated from their families due to conflict. This initiative was highly praised for its ability to reconnect displaced children with their families, providing stability and emotional support. Daily reunifications demonstrated the effectiveness of a well-coordinated, collaborative effort among organizations.

"At the regional level, the program's engagement in Family Tracing and Reunification (FTR) had received high praise and recognition… In Mekelle, a significant number of children were found working as street vendors. In response, UNICEF, in collaboration with the Department of Social Affairs and other partners, conducted an assessment. As a result, 1,154 children were taken to Elshaday Center, and five partner organizations took responsibility for reuniting these children with their families. The outstanding achievement we have so far made in line with child protection has been connecting those separated with their parents." (KII, Imagine1day staff, Mekelle)

By integrating these practices, the programme has effectively addressed complex challenges in crisis settings, delivering impactful and sustainable outcomes.

SEQ 4.2: What challenges or successes have been experienced in implementing the program?

The implementation of the programme faced several challenges, which can be categorized into operational, logistical, and structural issues.

One of the main challenges was related to the cash transfer and e-payment processes, particularly account opening. Beneficiaries faced difficulties obtaining the necessary identification documents, especially in conflict-affected areas where government services were disrupted. In the case of cash transfer in Mekelle, for instance, the sudden switch from Wegagen Bank to the Commercial Bank of Ethiopia caused further complications, including complaints from beneficiaries who had already incurred costs for account openings. These issues were resolved through discussions with camp leaders and local officials, but the process added significant delays and frustration.

Additionally, interruption in programme funding posed another challenge. Contracts were often short-term, lasting six to ten months, which disrupted the continuity of support and affected the program's sustainability. Beneficiaries, particularly children and their families expressed disappointment when the programme phased out, leaving gaps in essential services like education and health care.

Transportation and accessibility were major barriers due to ongoing conflict. Implementers and beneficiaries struggled to reach target areas, with some locations requiring hours of travel on foot. This hindered resource distribution and communication, particularly in areas like Axum and Shire where communication channels were cut off. While motorbikes were later provided to ease transportation, initial delays impacted implementation timelines. Inflation and market unpredictability also disrupted procurement and rehabilitation projects for schools and health facilities. This issue, compounded by delays in cash deposits, affected beneficiaries who relied on timely financial support for critical needs, such as medical expenses.

As mentioned under EQ for effectiveness, the programme also faced limitations in its scope and coverage, as the support provided often fell short of the demand. For instance, IDP camps with thousands of residents received aid for only a small fraction of their population, creating dissatisfaction and occasional conflicts between beneficiaries and non-beneficiaries. In schools, selective support such as providing bags to only some students led to disappointment and unmet expectations.

There were also gaps in multi-sectoral coordination. Services such as child protection, health, and education were not always integrated, leading to missed opportunities for comprehensive support. Respondents suggested that the programme design should strengthen collaboration

between implementing agencies, government, and community structures to enhance effectiveness.

SEQ 4.3: Are there opportunities to strengthen existing partnerships or establish new ones to enhance programme outcomes, including efforts to replicate and scale up successful interventions?

The program's strong collaboration with government entities across federal, regional, and district levels has been a key driver of success. However, findings from qualitative data show that there is an opportunity to further strengthen these partnerships by deepening engagement and enhancing coordination. Regular coordination meetings, such as the nutrition coordination sessions, have been effective but could benefit from improved structure and participation. Expanding these meetings to include broader stakeholders, fostering shared decision-making, and ensuring timely follow-ups on action points could improve programme alignment across sectors such as health, WASH, and education.

Expanding the network of local implementing partners is another critical area of opportunity. Organizations like ERCS and Imagine1Day have demonstrated their ability to deliver context-specific solutions effectively. However, scaling up these collaborations requires addressing capacity gaps through training, mentorship programs, and resource-sharing mechanisms. Greater reliance on local NGOs not only improves cultural sensitivity but also ensures a more sustainable and cost-effective approach to programme implementation. Engaging sector-specific NGOs that specialize in child protection, gender-based violence (GBV), and social policy could fill current gaps in specialized service delivery. These partnerships could help provide holistic interventions, including medical, psychosocial, legal, and material support for vulnerable populations. Furthermore, forming alliances with the private sector could unlock additional resources, such as funding, logistics, and technology, which are essential for scaling up successful interventions.

Key informants mentioned several ways to enhance collaboration. First, establishing a robust data-sharing platform can improve transparency and coordination among implementers. A shared database for resource and beneficiary mapping would ensure efficient use of resources, prevent duplication of efforts, and promote evidence-based decision-making. Second, fostering integrated service delivery across multiple sectors of healthcare, psychosocial support, legal services, and material assistance can provide a more comprehensive response to challenges such as child protection and GBV. Encouraging implementers to jointly plan and execute activities will ensure beneficiaries receive holistic care without gaps in services. Third, increasing the involvement of community volunteers can enhance local engagement and sustainability. Developing training programs to build the capacity of these volunteers can empower them to play more significant roles in identifying and addressing community needs, thereby sustaining the gains achieved by current interventions. Finally, prioritizing localization is critical. Local structures and organizations are best positioned to understand community needs and deliver culturally appropriate solutions. Strengthening their capacity and embedding them further into programme implementation can ensure long-term sustainability and effectiveness. Several key lessons have emerged from the program’s implementation thus far resulting in replicable mechanisms for future interventions. Working through government structures has proven to be both resource-efficient and effective, ensuring that interventions align with national priorities and leverage existing systems. Engaging community-based structures and volunteers has been instrumental in mobilizing communities and accurately identifying vulnerable populations, demonstrating the importance of grassroots-level involvement. Localization has also been a significant success factor, particularly in regions affected by drought and conflict. By prioritizing partnerships with local organizations and community structures, the programme has

ensured that interventions are both culturally relevant and sustainable. Additionally, the presence of numerous organizations operating in the region provides an opportunity for resource sharing and collaborative efforts to address challenges collectively.

3.5. Cross-Cutting Issues

EQ 5: To what extent does the programme consider cross-cutting issues (climate change, gender, disability), and what is the impact of these activities on target populations and the environment?
SEQ 5.1: How effectively does the programme address the unique needs of adolescent girls and women (both pregnant and breastfeeding), children, and PWDs?
SEQ 5.2: What measures are in place to ensure that the support addresses issues associated with the impact of climate change?
SEQ 5.3: What practices help people to remain resilient during and after crises?

SEQ 5.1: How effectively does the programme address the unique needs of adolescent girls and women (both pregnant and breastfeeding), children, and PWDs?

The EC2R program, as revealed from the qualitative research, has demonstrated considerable effectiveness in addressing the unique needs of adolescent girls, pregnant and breastfeeding women (PLW), children, and persons with disabilities (PWDs), although some gaps remain. The program's gender, age, and PWD-sensitive approach is evident in its, targeted interventions, and prioritization of vulnerable groups. Households with PWDs received additional support, and infrastructural developments, such as gender-segregated WASH facilities, were designed to accommodate PWDs. Assistive devices, like wheelchairs, and brail and book reading devices were provided to enhance the inclusion of PWDs. Additionally, specialized training for health professionals was provided emphasizing equity, inclusiveness, and disability-sensitive service provision.

> "For example, if you see the water points construction, for the physically disabled there is a separate designated access point. It is convenient for them to get the supply without waiting for those who cannot stand for a longer time. They taught us and made us aware that pregnant women, lactating women, older people, and PWD to get access conveniently… they have assigned people who can manage the facility and beneficiaries to get proper access with no discrimination." (IDI, Adult beneficiary, Shashemene)

> *"Repeated discussions and counselling were held with husbands to support their wives to access cash transfers using their bank accounts. Concerning women's decision-making capacity, there are no problems from the husband's side; they allow their wives to visit the health centre to access health services or other nutritional services." (FGD, Adult beneficiary, Shebedino)*

Respondents across multiple assessments highlighted the program's commitment to inclusivity from design to implementation, noting that selection criteria when applicable, prioritized families with PWDs, elderly members, and vulnerable mothers. The provision of cash and WASH-related services specifically for PWDs underscores this attention.

> *"The criteria included families with elderly members and those with disabilities… I noticed that vulnerable people and mothers… and elderly people were prioritized in the selection process… Yes, inclusivity was a focus, which helped a lot of different families… People with*

disabilities receive special attention. However, more help is needed to ensure their livelihood." (FGD, Adult IDP beneficiary, Debre Birhan)

"One thing that makes me particularly happy about this water project is that the water stations are constructed at two levels. The first level serves vulnerable community members, such as people with disabilities, pregnant women, and the elderly, based on their physical abilities. The second level is designated for other adults. This shows how sensitive the programme is to the specific needs of our community." (FGD, Adult beneficiary, Shashemene)

Accelerated learning programs enabled out-of-school children to catch up and join appropriate grade levels, while play-based pedagogy and psycho-social support addressed the trauma many children faced. Community-based early childhood care initiatives reduced barriers by allowing children to learn closer to home. These programs not only prepared children for formal education but also fostered critical life skills.

Despite these efforts, challenges remain. Beneficiaries pointed out that community and IDP site infrastructure, such as walkways and toilets, were not fully accessible to PWD. Feedback from health facility managers across the regions and IDP site participants in Amhara identified gaps in creating accessible facilities, highlighting that while progress has been made, further improvements are necessary to fully meet the needs of PWDs.

SEQ 5.2: What measures are in place to ensure that the support addresses issues associated with the impact of climate change?

Measures addressing issues associated with the impact of climate change are present in the programme even though they are somewhat limited in scope. The program's sensitivity to climate change adaptation and mitigation is evidenced in specific activities such as the solarization of healthcare facilities and water pumps. These initiatives represent environmentally friendly approaches that not only support sustainable energy use but also enhance resilience against climate-induced challenges, such as water scarcity. Similarly, the EC2R project's water pipeline extensions indirectly address climate-related needs, as they respond to water shortages resulting from droughts, which are often linked to climate change. While these interventions are not explicitly labelled as climate-specific, they highlight an underlying acknowledgement of the interplay between environmental issues and public health.

"Our happiness knows no bounds. Especially as women, we bear the primary responsibility for water usage. Before the ERCS water project, we truly suffered. However, now we experience great relief. For instance, during pregnancy and labour, our children can bring us water without worry or difficulty. Yet, if you ask me whether our water problem is fully solved, my answer is 'No.' There is still a shortage of drinkable water in different parts of our Kebele. Our Kebele is very large, and people still travel from far away to fetch water for household use. Mothers and children still travel for 1 to 2 hours to get water. If there's any way to provide them with water services like we have received, I wish for that." (FGD, Adult beneficiary, Shashemene)

However, direct climate change-specific programming appears to be minimal. As noted, most beneficiaries were conflict-affected individuals, including IDPs, and the primary focus was on addressing the immediate needs created by displacement and conflict. Nonetheless, climate-related challenges such as drought-induced migration, water scarcity, and associated health and

livelihood issues are indirectly addressed through broader public health and WASH interventions. For example, solar-powered systems for water access and potential discussions around climate-friendly electric ambulances were mentioned during interviews with key informants illustrating attempts to incorporate sustainable solutions.

Despite these efforts, gaps in awareness and direct engagement on climate change remain evident. Beneficiaries reported limited or no training, awareness sessions, or direct interventions aimed at climate adaptation or mitigation. Many participants highlighted that climate-related issues were not part of the discussions or services they received. This lack of direct focus on climate change adaptation and coping strategies could hinder long-term resilience among affected populations, particularly those already struggling with displacement and livelihood disruptions. Strengthening awareness and integrating explicit climate-related measures could enhance the program's effectiveness in addressing the broader impacts of climate change, considering especially that the impact of climate change is a primary concern for many intervention areas.

> *"In our community's context, there is no significant conflict that can cause internal displacement. The Common problem which occurred repeatedly in our community is natural conditions particularly climate change and associated economic instability" (FGD, Adult beneficiary, Shebedino).*

SEQ 5.3: What practices help people to remain resilient during and after crises?

To assess the resilience of beneficiaries, this evaluation employs the Reduced Consumption Strategies Index (RCSI), a widely recognized measure of food insecurity. The RCSI quantifies the extent to which households rely on negative coping strategies to address food shortages. A higher RCSI score reflects greater reliance on these strategies, indicating heightened food insecurity. Conversely, a lower score denotes reduced use of such strategies, signifying improved food security.

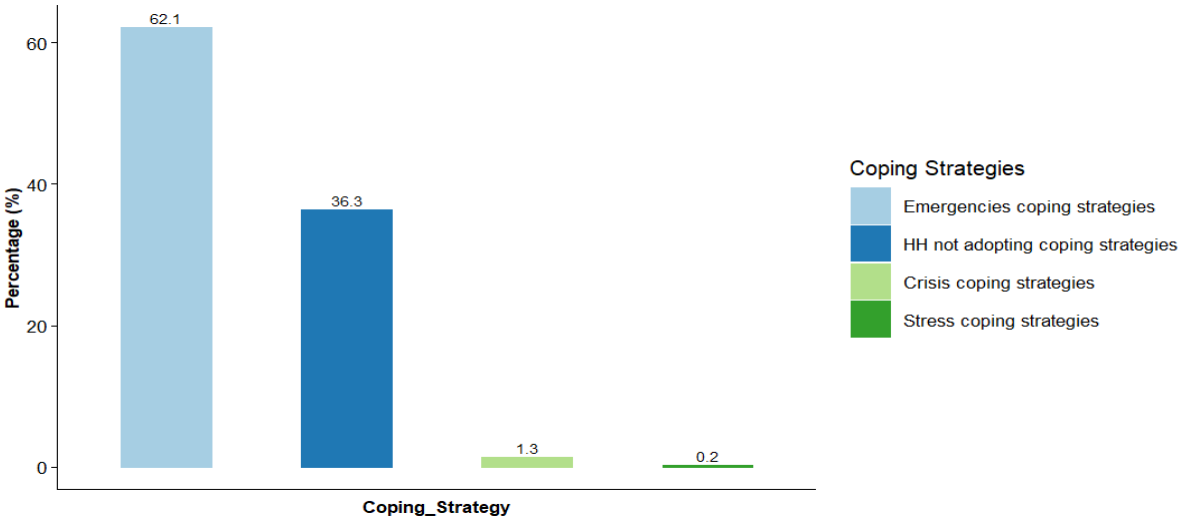
The RCSI has a maximum score of 56, which represents the daily use of all five coping strategies over the preceding seven days. In this evaluation, the mean RCSI score is 14.4, suggesting that households rely on negative coping strategies to a moderate extent, highlighting ongoing but not extreme levels of food insecurity.

Livelihood Coping Strategies Index[18] (LCSI) was also used to evaluate how households manage economic stress and food insecurity. The findings, as indicated in the figure below, reveal that a significant proportion of households (62.1%) are relying on emergency coping strategies, which typically indicate severe economic distress. These strategies, such as selling essential household

[18] **Emergency Coping Strategies** (Most severe, last resort) eg.: Selling productive assets (e.g., land, livestock used for breeding), Taking children out of school to work, engaging in illegal or high-risk activities for income, Migration of entire households due to inability to cope
Crisis Coping Strategies (Medium severity, affecting livelihoods). Eg: Selling non-productive assets (e.g., household furniture, jewelry), Reducing essential non-food expenses (e.g., health, education), Taking on high-interest debt or borrowing money to afford necessities, changing dietary habits significantly (e.g., relying only on cheaper food options)
Stress Coping Strategies (Short-term, but with long-term consequences). Eg: Selling small livestock or assets that are easier to replace, reducing food consumption (e.g., skipping meals, eating smaller portions), Relying on support from extended family or community members, taking on moderate debt or loans to meet basic needs
Households Not Adopting Coping Strategies: These households are not engaging in any of the above strategies, or are financially stable and resilient

assets, suggest that these households have exhausted less severe options and are struggling to maintain basic needs. This high reliance on emergency measures highlights their heightened vulnerability to shocks and a limited ability to recover from crises, underscoring the need for targeted interventions to improve resilience and economic stability.

Figure 3: Coping Strategies in response to shocks



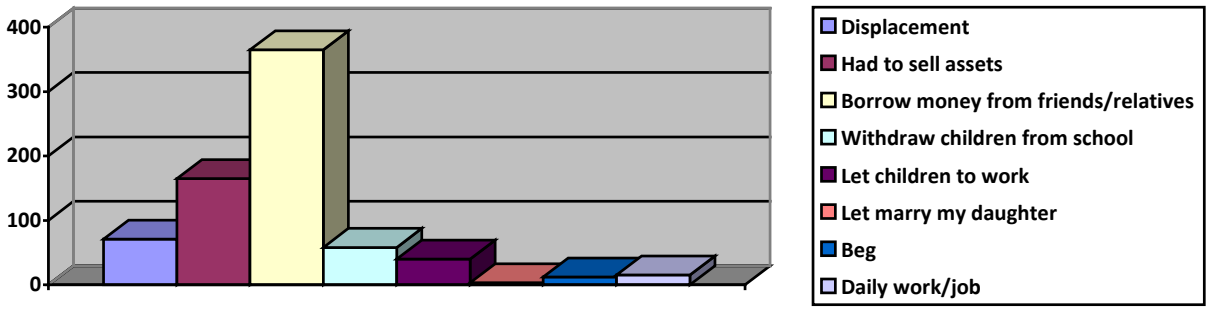
Qualitative interview participants shared that before the program, their resilience relied heavily on community support and resource-sharing. Families and neighbours pooled resources, bartered items for essentials, or engaged in subsistence farming, which was often insufficient. Some individuals turned to daily manual labour to earn a modest income for survival.

After the program, significant changes were observed in the coping strategies of beneficiaries. Some IDPs used cash transfers to start small-scale entrepreneurial activities, such as selling vegetables within the camp. However, saving for emergencies remains a challenge due to limited financial resources, despite encouragement from programme committees.

For persons with disabilities, barriers to resilience were more pronounced, with no distinct coping mechanisms identified beyond community support and additional cash assistance from UNICEF. The program's inclusive practices ensured equal access to resources, though participants emphasized the need for further targeted efforts to address the unique challenges faced by persons with disabilities. Overall, the programme improved resilience strategies but highlighted the need for more comprehensive support to meet diverse needs effectively.

Complementing this, we have asked beneficiaries what would have happened to them hadn't they received cash transfer from the program. We asked them to make an educated guess (what they imagine and where they expect themselves to be if they weren't beneficiaries) because they can't be seen in that situation. The chart illustrates the potential consequences that beneficiaries anticipated if they hadn't received the program's support. These include displacement, selling assets, borrowing money, withdrawing children from school, forcing children into labor, early marriage, begging, and engaging in daily labor. This data underscores the critical role of the cash transfer programme in preventing these adverse outcomes and highlights the vulnerability of the beneficiary households.

Figure 4: Coping Strategies in response to shocks hadn't been a suport


400
300
200
100
0
Displacement
Had to sell assets
Borrow money from friends/relatives
Withdraw children from school
Let children to work
Let marry my daughter
Beg
Daily work/job

4. Evaluation Conclusions

The EC2R programme can be seen as an overall successful programme that generally met the output targets set at the starting phase. Substantial progress has been made in improving access to WASH, education, and health services in the targeted regions and institutions. Evidence suggests that the programme is contributing to advancing child protection, gender-based violence (GBV) prevention, social protection through humanitarian cash transfers, and capacity-building within health and education systems. However, there is room for improvement in systems strengthening, and challenges remain in ensuring WASH accessibility for PWD and advancing gender equality.

The evaluation's strengths include a diverse and strong data collection technique that combines qualitative and quantitative methods, allowing for a thorough study of programme effects. The evaluation also benefited from significant consultation with a wide range of stakeholders, including beneficiaries, government representatives, and implementing partners, resulting in a comprehensive understanding of the program's impact and problems. Furthermore, the utilization of mixed-methods research aids in triangulating findings, increasing the dependability of the conclusions. However, limitations must be recognized to provide a more transparent and impartial judgment. Due to the ongoing war in Amhara and some woredas, primarily in Benshangul-Gumuz, we were obliged to reschedule our data collection because their remote locations made it difficult to capture the full spectrum of beneficiary experiences, potentially resulting in gaps in representation. Addressing these constraints in future evaluations is crucial to achieving even more precise and actionable insights.

We have drawn the following conclusions from the findings of the report.

- The programme has set up ways to consult with beneficiaries regarding available services and support during the design and throughout the implementation of the programme. These consultations contributed to the programme's success by enabling it to align with the priorities of the beneficiaries.
- **Beneficiary Satisfaction and Programme Impact: As it is discussed in the previous section, the finding showed that** beneficiaries expressed high levels of satisfaction with the cash transfer component of the EC2R programme in terms of the timeliness and amount, which has provided critical support for vulnerable households. However, the long-term economic impact of these transfers remains moderate. Many households, particularly those with disabled members, continue to face significant challenges that require tailored interventions. These vulnerable groups often struggle to access essential services, underscoring the need for inclusive strategies that address their unique needs. In line with this, findings suggest that while cash transfers had a **moderate impact** on education support, a significant portion of households either did not benefit or only received partial assistance. We can therefore conclude that the moderate impacts of the support highlight the need to assess the adequacy of cash transfer amounts and whether additional interventions are necessary to enhance educational support for vulnerable families.
- The finding that most beneficiaries prefer cash transfers over in-kind support suggests a need to prioritize flexible assistance models that align with beneficiary preferences and enhance programme efficiency. While both modalities have contextual advantages and

limitations, cash transfers offer greater autonomy, allowing households to address their most pressing needs. However, in contexts where markets are unstable or supply chains are weak, in-kind support may still be necessary. The evaluation concludes that a hybrid approach, combining both forms of support based on contextual assessments, would optimize impact and sustainability

- The evaluation finding shows that the programme has made progress in addressing the needs of vulnerable and high-need populations, with many respondents perceiving it as meeting these needs effectively. While the program's efforts are acknowledged positively by the majority, a notable portion of respondents expressed dissatisfaction, Therefore, the dissatisfaction highlights areas where the program's support could be enhanced to ensure that the needs of all vulnerable populations are adequately addressed.
- **Resilience and Coping Strategies:** A significant proportion of households reported relying on emergency coping strategies, reflecting persistent vulnerabilities. This reliance highlights the need for strengthened resilience programs that reduce economic and social risks for beneficiaries. We therefore concluded that without such interventions, households may remain trapped in cycles of vulnerability, unable to achieve long-term stability and independence.
- **WASH interventions complement Health, Nutrition, and Education:** The WASH interventions under the programme have played a crucial role in complementing Health, Nutrition, and Education outcomes by ensuring access to safe and reliable water supply and sanitation services in health and education institutions. Improved water availability and hygiene facilities in schools have contributed to better learning environments and improving student well-being. In health facilities, access to clean water and improved sanitation has strengthened infection prevention and control, enhancing the quality of maternal and child healthcare services. Similarly, in Nutrition, safe water and proper sanitation have been essential in preventing waterborne diseases and malnutrition, particularly among young children and vulnerable populations. These integrated efforts highlight the program's holistic approach to improving overall community well-being.
- **Service Delivery and Health Facility:** The evaluation demonstrates progress in improving health facility readiness, with many facilities reporting sufficient medical supplies and equipment, reflecting the program's impact on resource availability. However, some facilities continue to experience shortages in essential medications and basic infrastructure, which affect their ability to provide quality care and respond effectively to community health needs. Cleanliness and hygiene standards were generally satisfactory in most facilities, but there are still notable gaps that require targeted efforts to improve maintenance and hygiene practices. Addressing these issues is essential to enhance the quality of healthcare services, strengthen community trust, and ensure that facilities can meet the demands of the populations they serve.
- During their ANC (Antenatal Care) visits, Pregnant and Lactating Women (PLW) utilize key services such as health check-ups, ultrasounds, blood tests, nutritional counselling, and immunizations. This reflects their proper engagement with available healthcare services and indicates a good level of awareness and knowledge about essential maternal care, which is critical for ensuring maternal and child health during pregnancy. The use of these services by PLW highlights their proactive approach to maternal health, ensuring better outcomes for themselves and their babies.

- **Community Feedback Mechanisms:** The evaluation highlights the importance of community feedback systems in ensuring that health facilities remain responsive to the needs of their beneficiaries. Encouragingly, more than four-fifths of the health facilities have implemented mechanisms to collect community input, and community meetings. These systems enable facilities to address community concerns and improve service delivery. However, the remaining health facilities lack such mechanisms, limiting their ability to engage with and respond to the populations they serve. Expanding these systems is crucial for fostering accountability and ensuring that health services align with community needs.
- **Inclusiveness of the components:** Households with PWD face challenges like inadequate infrastructure and limited access to public water points. The main reported barriers include inadequate infrastructure, dependence on assistance from family, and limited availability of accessible public water points.
- The programme has made substantial contributions to the development of skills and competencies among stakeholders, enhancing their ability to effectively implement and manage various interventions. Through targeted capacity-building initiatives, such as training sessions on water management systems, concrete maintenance, and environmental sanitation, the programme empowered local NGOs and government offices, particularly in the WASH sector, to strengthen operational and technical capabilities. In education and health, professional development opportunities for teachers, parent-teacher unions, and community health facilities enabled stakeholders to deliver quality services more effectively.

- Regarding the quality of governance structures and processes, the EC2R Programme played a crucial role in enhancing accountability and coordination. By introducing systematic monitoring, bi-weekly health screenings, and feedback mechanisms, the programme improved governance frameworks in conflict-affected regions such as Tigray. UNICEF's involvement and rapid assessments led to the restructuring of local committees and the strengthening of existing governance mechanisms.
- In ensuring long-term sustainability, the EC2R Programme demonstrated effectiveness by integrating developmental interventions with community systems. Through accelerated education systems for out-of-school children and bi-weekly health services, the programme aimed to build sustainable systems that would continue to serve communities beyond its duration. The emphasis on community engagement and ownership allowed stakeholders to take responsibility for the services provided, with structures like community care coalitions and voluntary financial contributions helping to maintain essential services. Although there are ongoing challenges, such as achieving economic self-reliance, the program's focus on empowering communities through capacity-building and sustainability frameworks laid the groundwork for continued support even after the programme phases out.
- The programme emphasizes several best practices, including system strengthening through sustainable improvements in institutional capacities and sector coordination, localization, restoring of essential services in conflict-affected regions, using innovative solutions like solar-powered water systems, creation of specialized safe spaces for vulnerable groups and reuniting separated children with their families. These best practices allowed the programme to effectively address complex challenges in crisis settings, delivering impactful and sustainable outcomes.

- The partnership approach in the EC2R programme significantly contributed to efficient resource use. It utilized existing government structures and local partners to implement the different intervention components. By working through government offices at federal, regional, and district levels, the programme minimized costs related to creating parallel systems, such as human resources and management expenses.
- **Fund allocation and utilisation across various components:** the overall budget utilization rate of 75% demonstrates steady progress in implementing the EC2R program. While certain components like Cross-cutting Activities, Health, and cash transfers are performed efficiently, areas such as Child Protection require closer attention to accelerate budget execution and programme impact. This calls both achievements and opportunities for improvement to ensure all components meet their intended targets effectively. Complementing this, in our review we found it challenging to do cost analysis which is how costs compare to similar interventions or standards, the most efficient way to get expected results. We limited our analysis only to budget utilization per component.
- The program's successful collaboration with government entities at federal, regional, and district levels has driven success. Strengthening these partnerships can be achieved through deeper engagement, better coordination and scaling up which requires addressing capacity gaps with training, mentorship programs, and resource-sharing mechanisms.
- The programme addresses climate change impacts through initiatives like solar-powered healthcare facilities, water pumps, and pipeline extensions, which indirectly enhance resilience to climate challenges like water scarcity. While these efforts reflect an awareness of environmental issues, direct climate-specific interventions are minimal, as the primary focus remains on conflict-affected populations and immediate needs.
- The programme is deemed effective in addressing the unique needs of adolescent girls, pregnant and breastfeeding women, children, and PWDs, although some gaps remain.

5. Recommendations

To address key program challenges identified in this evaluation and further enhance the EC2R program's relevance, efficiency, effectiveness, sustainability, and impact, the following recommendations are made for the remaining period of the programme:

To address key programme challenges identified in this evaluation study and further enhance the EC2R programme's relevance, efficiency, effectiveness, sustainability, and impact, the following general recommendations are proposed for the remaining programme period:

1. **Strengthen Partnership Approach:** Deepen collaboration with government entities at all levels to optimise resource use, improve coordination, and scale up successful interventions. Actively involve governments and strategic partners in programme planning and implementation to promote joint ownership, collaboration, and transparency. To achieve this:

    - Enhance collaboration and knowledge exchange through regular webinars and meetings with all partners and government stakeholders.
    - Establish a multi-stakeholder task force comprising key government entities, strategic partners, and programme staff to strengthen coordination.
    - Ensure that federal and regional offices actively co-lead initiatives rather than merely providing support.
    - Collaborate with local women's organisations and advocacy groups to ensure the voices of women and marginalised groups are heard.
    - Organise regular joint field visits to effectively monitor and assess the implementation of interventions.

2. **Address Gaps in Health Service Delivery:** Improving healthcare service delivery and ensuring quality care requires the following:

    - Equip health facilities with the necessary medications, infrastructure, and maintenance to provide quality care.
    - Enhance hygiene and cleanliness standards to build trust and better meet community health needs.
    - Strengthen supply chain management to prevent shortages of medical supplies and equipment.
    - Establish a robust procurement and distribution system to ensure consistent access to critical medications such as Amoxicillin, Zinc, and ORS.
    - Provide basic infrastructure (e.g., beds, chairs, and laboratory equipment) to enhance service readiness.
    - Conduct regular monitoring and stock assessments to identify and address supply gaps promptly.

3. **Expand Community Feedback Mechanisms:** Enhancing accountability and responsiveness requires incorporating structured community feedback systems into all programme components:

    - Establish community feedback mechanisms in all programme-supported facilities within the next six months by introducing structured monthly community meetings and biannual surveys to gather beneficiary input.
    - Ensure every facility has a suggestion box to collect anonymous feedback, with a designated staff member responsible for reviewing and addressing suggestions monthly.

- Develop a standardised process for collecting, analysing, and responding to community feedback, ensuring actionable recommendations are incorporated into programme improvements.

4. **Enhance the Impact of Cash Transfers:** To maximise the long-term benefits of cash transfer programmes:

   - Link cash transfers to income-generating activities and skills development initiatives to promote economic resilience.
   - Provide targeted support to vulnerable groups, including households with disabled members, to ensure tailored assistance improves access to essential services.
   - Allocate a portion of the budget to community-based health insurance premiums as in-kind support, enabling persons with disabilities (PWDs) and other vulnerable groups to access year-round healthcare services at local health centres.
   - Ensure remaining cash assistance is strategically used to support income-generating activities or cover medical expenses when essential medicines are unavailable.
   - Establish a monitoring system to track the long-term impact of cash transfers and adjust strategies based on beneficiary needs.

5. **Ensure Flexibility in Funding and Intervention Periods:** Successful programme implementation depends on adaptability to changing conditions:

   - Align funding and intervention timelines with beneficiary needs and external factors such as economic conditions, political stability, and humanitarian crises.
   - Reallocate resources efficiently in response to inflation, currency fluctuations, or sudden policy shifts.
   - Incorporate contingency plans to allow for extensions or adjustments based on evolving needs and ground realities.
   - Regularly monitor and assess funding requirements to ensure timely adjustments and programme sustainability.

6. **Strengthen Monitoring to Track Progress and Challenges:** Resource efficiency and programme effectiveness can be enhanced through stronger monitoring mechanisms:

   - Improve monitoring systems to track progress and address challenges in resource use and programme outcomes.
   - Implement timely measures to prevent and respond to resource misuse.
   - Conduct continuous accessibility analyses to ensure humanitarian assistance reaches the intended beneficiaries.
   - Enhance oversight of critical infrastructure, such as water points, to prevent disruptions caused by theft or damage.
   - Ensure fair distribution of cash transfers, addressing cases where beneficiaries are pressured to share funds with others.

7. **Increase Awareness Among Beneficiaries About the Intervention**: Strengthen engagement with beneficiaries and improve awareness-raising efforts to prevent unrealistic expectations and dependency on aid. This will support the transition from life-saving assistance to resilience-building initiatives. Key actions include:

   - Provide training sessions on financial literacy, income generation, and sustainable livelihoods to reduce aid dependence.
   - Organise awareness sessions for beneficiaries on the programme's scope and how they can benefit.

8. **Optimise Fund Allocation:** Ensure the timely and efficient use of allocated funds for underperforming programme areas, such as Child Protection, to maximise programme impact and equitably reach all target groups. Key actions include:

    - Accelerating budget execution for underperforming components to ensure funds are utilised effectively within the designated timeframe.
    - Conducting rapid assessments to identify bottlenecks in fund utilisation and implementing targeted strategies to address them.
    - Holding regular review meetings to assess budget performance, track expenditure progress, and make necessary reallocations for optimal impact.
    - Promoting joint cross-sectoral planning whenever feasible, such as engaging health institutions for Health and WASH outputs and collaborating with schools for WASH and Education interventions to enhance efficiency and resource sharing.

9. **Ensure Sustainability of Services:** Foster community ownership and strengthen partnerships to ensure the sustainability of essential services beyond the programme's duration. To achieve this:

    - Strengthen partnerships by leveraging successful models and integrating joint monitoring mechanisms for long-term sustainability.
    - Build community ownership through capacity-building initiatives that empower local stakeholders.
    - Ensure local stakeholders are adequately equipped and empowered to sustain essential services beyond the programme's duration.
    - Facilitate knowledge sharing and collaboration among stakeholders to align efforts and maintain momentum post-programme.
    - Encourage participatory approaches that involve community members in decision-making and programme planning to instil a sense of shared responsibility and accountability.

10. **Enhance Inclusive Strategies and Tailored Support for Vulnerable Groups**Strengthen inclusive strategies to ensure that persons with disabilities (PWDs) have access to essential services and infrastructure. Additionally, develop tailored interventions to address the specific needs of households with disabled members:

    - Conduct thorough disability needs assessments early in the intervention.
    - Develop clear disability indicators for monitoring and accountability.
    - Partner with Disabled People's Organisations (DPOs) to improve programme design.
    - Apply universal design principles consistently.
    - Ensure programme information is accessible (e.g., braille, sign language, visual aids).
    - Strengthen feedback systems to enable PWDs to actively shape the programme's direction.

Table 15: Mapping of recommendation and target implementers

No.	Recommendation (s)	Action required	Implementer or target user	Priority
1	Strengthen Partnership Approach	1. Host regular webinars and/or meetings involving all partners and government stakeholders to ensure continuous knowledge exchange	Implementers and the Government (Ministries, Regional Bureaus involved in each component)	M
		2. Establish a task force with representatives from key government entities (regional and federal), strategic partners, and programme staff	Government (Ministries, Regional Bureaus involved in each component)	
		3. Involve federal and regional offices in co-leading initiatives, not just supporting them	Implementers (WFP, ERCS, the British Red Cross, UNICEF)	
		4. Collaborate with local women's organizations and advocacy groups to ensure that the voices of women and marginalized groups are heard	Implementers and Government (Ministries, Regional Bureaus involved in each component)	
		5. Organize regular joint field visits to monitor the implementation of interventions.	Implementers and Government (Ministries, Regional Bureaus involved in each component)	
2	Address Gaps in Health Service Delivery	1. Ensure timely procurement and distribution of basic medicines in EC2R intervention woredas	UNICEF/RCS	M
		2. Prioritize critical needs e.g., beds, chairs, laboratory tools	UNICEF/RCS, Ministry of Health, Regional Health Bureaus	
		3. Support minor facility improvements, such as repairs to WASH infrastructure (latrines, water supply), to improve hygiene standards.	UNICEF/RCS, Ministry of Health, Regional Health Bureaus	
		4. Enhance hygiene and infection control measures through the provision of hygiene kits (soap, disinfectants, gloves) and staff training on proper hygiene practices	UNICEF/RCS	
		5. Train Voluntary health leader who works closely with health extension workers	UNICEF/RCS	
3	Expand Community Feedback Mechanisms	1. Establish community feedback systems like meetings and suggestion boxes.	Implementers (WFP, ERCS, the British Red Cross, UNICEF)	H

		2. Follow up the comments regularly and give feedback	Implementers (WFP, ERCS, the British Red Cross, UNICEF)	
		3. Scale up best practices in CFM from any of the components or woreda to others	Implementers and Government	
4	Enhance the Impact of Cash Transfers	1. Link cash transfers to income-generating activities	UNICEF and Ministry of Women and Social Affairs	H
		2. Link cash transfers to skills development, with a focus on vulnerable groups.	UNICEF Ministry of Women and Social Affairs	
5	Flexibility in Funding and Intervention	1. Establish a reserve fund or contingency budget to address unexpected shocks (e.g., inflation, political instability, supply chain disruptions). 2. Conduct regular reviews of macroeconomic trends, security conditions, and policy shifts to anticipate necessary adjustments.	Donors, WFP, UNICEF, RCS	M
		3. Allow for budget reallocations between programme components based on emerging priorities		
6	Stronger Monitoring to Track Progress	1. Real-time tracking of resources, ensuring transparency in the allocation, usage, and expenditure of funds.	Red Cross, WFP, UNICEF	H
		2. Create and promote anonymous reporting mechanisms to report any observed misuse of resources.	Red Cross, WFP, UNICEF	
7	Strengthen Awareness about the program	1. Provide training sessions on financial literacy, income generation, and sustainable livelihoods to reduce aid dependence	Implementers and Ministry of Women and Social Affairs	L
		2. Organize awareness sessions for beneficiaries on programme scope, and how they can benefit	Implementors and Regional Bureaus of each sector	
8	Optimize Fund Allocation	1. Accelerate budget execution for underperforming components.	Implementors and Funder	M
		2. Conduct a **rapid assessment** to identify bottlenecks in fund utilization	Implementors	
		3. Hold regular review meetings to assess budget performance and make necessary reallocations.	Funder and Implementors	
		4. Joint cross-sectoral planning whenever feasible. For instance: health institutions for Health and WASH outputs as well as schools for WASH and Education outputs interventions	Implementors	
9	Sustainability of Services	1. Strengthen partnerships leveraging successful models, and integrating joint monitoring for long-term sustainability	Implementers and Regional Bureaus	H
		2. Building community ownership through capacity-building initiatives,	Regional Bureaus	
		3. Ensuring local stakeholders are empowered to sustain essential services beyond the program's duration	Regional Bureaus	

10	Enhance Inclusive Strategies and tailor support to Vulnerable Groups	1. Conduct thorough disability needs assessments early.	Red Cross, UNICEF, Ministry of Women and Social Affairs	H
		2. Develop clear disability indicators for monitoring and accountability.	Health, Local DPOs	
		3. Make programme information truly accessible (e.g., braille, sign language, visual aids).	Implementers, Ministry of Women and Social Affairs, Ministry of Health	
		4. Partner with Disabled People's Organizations (DPOs) for better programme design.	Implementers, Ministry of Women and Social Affairs	
		5. Apply universal design principles consistently.	Implementers and the Government (Ministries, Regional Bureaus involved in each component)	
		6. Strengthen feedback systems so PWDs can shape the program's direction	Implementers, Ministry of Women and Social Affairs	

H = High, M = Medium, and L = Low

RCS: Red Cross Society

Regional Bureau = Bureau of Social Affairs, Health, Education, Energy

Implementers = UNICEF, Red Cross Society, WFP

ANNEXE 1: EVALUATION MATRIX

OECD DAC Criteria	EQ	No	SEQ	Indicator	Data Source	Data Analysis
Relevance	To what extent are the programme design and activities relevant from the perspective of the Programme's right holders (beneficiaries)?	1.1	How effectively did the programme consult with the beneficiaries regarding available services and support during the design phase as well throughout the implementation of the programme?	Number of consultation sessions held with beneficiaries	Desk review Key informant Interview	Qualitative content and Thematic analysis
				Changes made to the programme design and implementation based on beneficiary feedback	Desk review Key informant Interview	Qualitative content and Thematic analysis
		1.2	Are the beneficiaries satisfied with the type of support they received? Is the assistance having the desired effect?	level of satisfaction of beneficiaries with the type of support received	Desk review Beneficiary Survey Key informant Interviews, FGDs	Descriptive analysis Qualitative content and Thematic analysis
				Percentage of beneficiaries reporting that the assistance had the desired effect.	Desk review Beneficiary Survey	Descriptive analysis
		1.3	What are the advantages/strengths and disadvantages/weaknesses of different types of support (e.g., in-kind (dignity kits) vs. cash transfers) from the	% of beneficiaries satisfied with in-kind support (dignity kits) vs. cash transfers.	Desk review Beneficiary Survey	Descriptive analysis
				Perceived Advantages of in-kind (dignity kits)	Desk review Beneficiary Survey, KIIS FGDs,	Descriptive analysis Qualitative content and Thematic analysis

OECD DAC Criteria	EQ	No	SEQ	Indicator	Data Source	Data Analysis
			perspectives of the right holders?	Perceived Advantages of Cash Transfers	Desk review Beneficiary Survey, KIIs FGDs,	Descriptive analysis Qualitative content and Thematic analysis
		1.4	What mechanisms are in place for beneficiaries to provide feedback and how responsive is the programme to this feedback?	Awareness of and use of available feedback and complaint system.	Desk review FGDs, Key Informant Interview	Qualitative content and Thematic analysis
				% of beneficiaries using feedback and complaint mechanisms	Desk review Beneficiary Survey	Descriptive statistics
				The number of feedback closed.	Desk review	Descriptive statistics
				The average time taken to respond to beneficiary feedback.	Beneficiary Survey	Descriptive statistics
				Programme changes were implemented because of beneficiary feedback.	Desk review KIIs and FGDs	Qualitative content and Thematic analysis
Effective-ness	2. How effective are the EC2R activities in achieving programme objectives?	2.1	Has the programme identified populations in greatest need	criteria used to assess vulnerability and need.	KIIs Desk Review	Qualitative content and Thematic analysis
		2.2	Has the programme covered the intended population groups	The proportion of intended population groups reached by the programme.	KIIs Desk review	Qualitative content and Thematic analysis

OECD DAC Criteria	EQ	No	SEQ	Indicator	Data Source	Data Analysis
		2.3	Has the programme covered the populations in need/vulnerable populations?	Percentage of vulnerable or high-need populations covered by the programme.	KIIs Desk review	Qualitative content and Thematic analysis
		2.4.	Has the programme reached beneficiaries on time, and was the amount of support and/or types of services received adequate?	Beneficiary satisfaction with the timeliness of the support provided	KIIs, IDIs and FGDs Beneficiary survey	Qualitative content and Thematic analysis
				Beneficiary satisfaction with the amount of support provided	KIIs, IDIs and FGDs Beneficiary survey	Qualitative content and Thematic analysis
		2.5	What are the gaps or shortcomings in the support provided that need to be addressed?	List of areas of improvement in programme delivery	KIIs, IDIs and FGDs	Qualitative content and Thematic analysis
	3. Is EC2R achieving stated outputs and is EC2R likely to achieve intended outcomes?	3.1	To what extent did the programme achieve its WASH targets?	Level of achievement of the WASH target	Desk Review: Programme Documents (Proposal, Logframe, Annual Reports; Monitoring Reports)	Quantitative descriptive analysis comparing the set targets with actual achievements
		3.2	To what extent did the programme achieve its Health targets?	Level of achievement of Health target	Desk Review: Programme Documents (Proposal, Logframe, Annual Reports; Monitoring Reports)	Quantitative descriptive analysis comparing the set targets with actual achievements

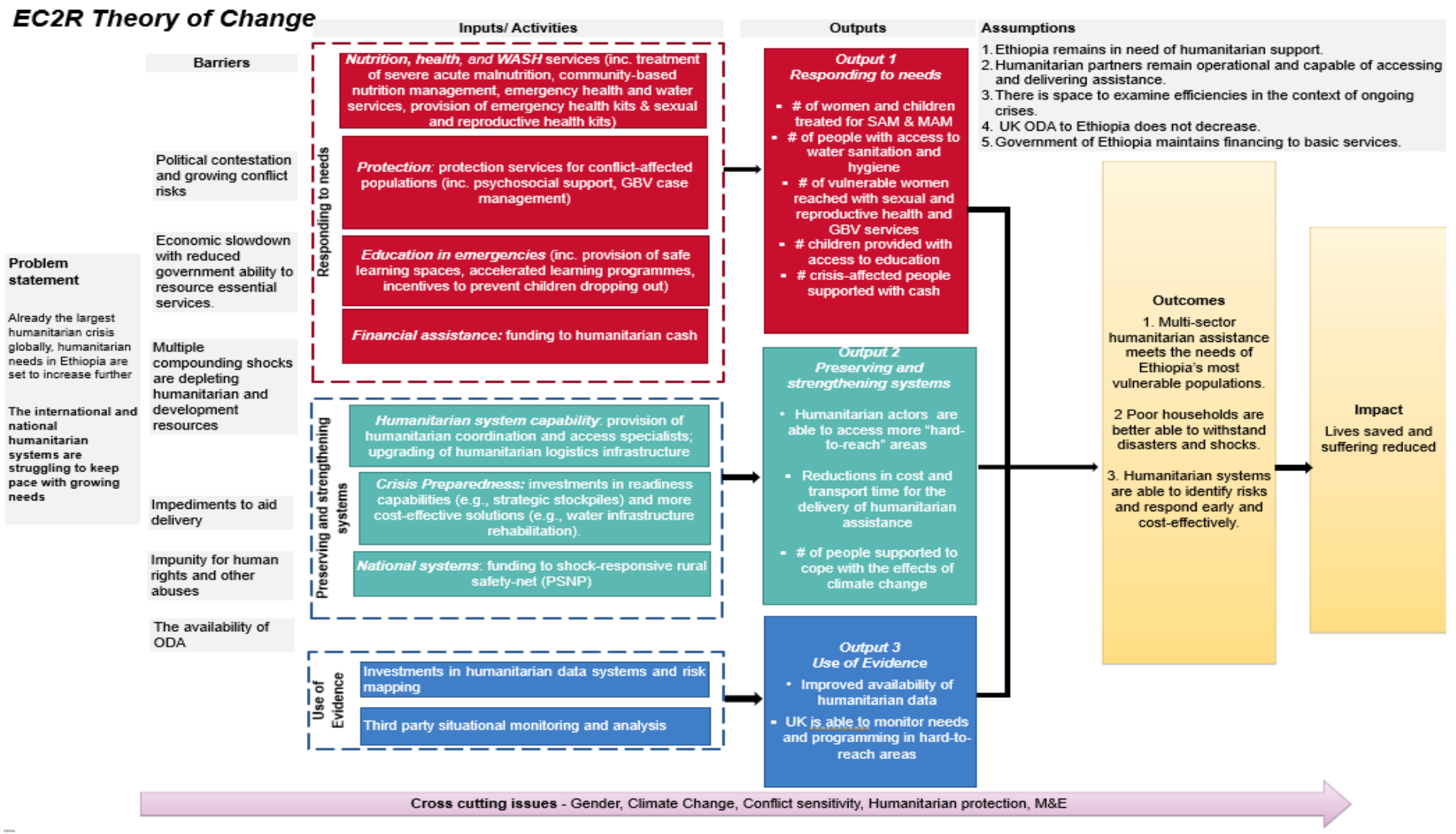
OECD DAC Criteria	EQ	No	SEQ	Indicator	Data Source	Data Analysis
		3.3	To what extent did the programme achieve its education targets?	Level of achievement of Education target	Desk Review: Programme Documents (Proposal, Logframe, Annual Reports; Monitoring Reports)	Quantitative descriptive analysis comparing the set targets with actual achievements
		3.4	To what extent did the programme achieve its nutrition targets?	Level of achievement of nutrition target	Desk Review: Programme Documents (Proposal, Logframe, Annual Reports; Monitoring Reports)	Quantitative descriptive analysis comparing the set targets with actual achievements
		3.5	To what extent did the programme achieve its social protection targets?	level of achievement of social protection target	Desk Review: Programme Documents (Proposal, Logframe, Annual Reports; Monitoring Reports)	Quantitative descriptive analysis comparing the set targets with actual achievements
Efficiency	4. To what extent is the EC2R Programme efficient in achieving its objectives within the allocated timeframe and budget	4.1	To what extent have the planned results of the programme been achieved on time?	Actual time taken to complete the programme compared to the planned time	Desk Review: Programme Documents (Proposal, Logframe, Annual Reports; Monitoring Reports)	Quantitative descriptive analysis comparing the planned time with actual achievements
		4.2	Have the outcomes of the programme been achieved in line with the financial resources allocated to the project?	The ratio between the level of achievement of ECR2 objectives and % of planned budget used	Desk Review: Programme Documents (Proposal, Logframe, Annual Reports; Monitoring Reports)	Quantitative descriptive analysis comparing the planned budget with actual spending
		4.3	To what extent has the programme efficiently utilized resources to address the needs of PWDs?	Cost-related challenges in programme accessibility to PWD	Desk review Key informant Interview	Qualitative content and Thematic analysis

OECD DAC Criteria	EQ	No	SEQ	Indicator	Data Source	Data Analysis
				Budget allocation process to ensure accessibility to PWD		
	5. To what extent is the EC2R Programme effective in strengthening systems, including capacity building, improved governance, enhanced accountability, and fostering the sustainability of services?	5.1	To what extent has the EC2R Programme contributed to the development of skills and competencies among stakeholders?	Number of capacity building sessions conducted	Desk review Key informant Interview	Qualitative content and Thematic analysis
		5.2	How has the EC2R Programme influenced the quality of governance structures and processes?	Changes in governance structure.	Desk review Key informant Interview	Qualitative content and Thematic analysis
		5.3	How effective has the EC2R Programme been in ensuring the long-term sustainability of services?	Resource allocation for sustainability	Desk review Key informant Interview	Qualitative content and Thematic analysis
Lesson learned	6. What are the best practices, lessons learned, and potential for replicating and scaling up successful interventions in the target regions?	6.1	What were the major best practices of the program	List of best practices	Desk review Key informant Interview	Qualitative content and Thematic analysis
		6.2	What challenges or successes have been experienced in implementing the program?	Identified challenges success	Desk review Key informant Interview	Qualitative content and Thematic analysis

OECD DAC Criteria	EQ	No	SEQ	Indicator	Data Source	Data Analysis
		6.3	Are there opportunities to strengthen existing partnerships or establish new ones to enhance programme outcomes, including efforts to replicate and scale up successful interventions??	Potential areas for improved collaboration Possibilities for new partnerships	Desk review Key informant Interview	Qualitative content and Thematic analysis
Cross-Cutting Issue	7. To what extent does the programme consider cross-cutting issues (climate change, gender, disability), and what is the impact of these activities on target populations and the environment?	7.1	How effectively does the programme address the unique needs of adolescent girls and women (both pregnant and breastfeeding), children, and PWDs?	% of adolescent girls and young women participating in the program	Beneficiary Survey	Quantitative descriptive analysis
				% of PWDs participating in the program	Beneficiary Survey	Quantitative descriptive analysis
				Experiences of adolescent girls, women and PWD on how well the programme addresses their unique needs	FGDs	Qualitative content and Thematic analysis
		7.2	What measures are in place to ensure that the support addresses issues associated with the impact of climate change?	climate change adaptation and mitigation activities integrated into the programme	FGD KIIs	Qualitative content and Thematic analysis
				Reduction in the vulnerability of target populations	FGD KIIs	Qualitative content and Thematic analysis

OECD DAC Criteria	EQ	No	SEQ	Indicator	Data Source	Data Analysis
				to climate-related disasters		
		7.3	What practices help people to remain resilient during and after crises?	# of coping mechanisms adopted by participants	Beneficiary Survey	Quantitative descriptive analysis
				% of participants reporting improved resilience strategies	Beneficiary Survey	Quantitative descriptive analysis
				Types and effectiveness of coping strategies used before and after the programme	KIIs and FGDs	Qualitative content and Thematic analysis

ANNEXE 2: THEORY OF CHANGE



ANNEXE 3: SUMMARY OF THE EC2R COMPONENTS AND THE CORRESPONDING TYPES OF INTERVENTIONS

Health: The programme aims to reduce morbidity and mortality among vulnerable populations in targeted regions by enhancing existing health systems through capacity-building, the provision of medical equipment, and essential drugs. The project will also support early detection and timely response to health emergencies with capacity-building and prepositioning of emergency supplies. Capital investments, such as Solar Direct Drive Refrigerators, vehicles for MHNTs, and health facility rehabilitation, will contribute to system sustainability.

Nutrition: The nutrition component of the EC2R programme focuses on preventing and treating childhood wasting by enhancing essential nutrition services and implementing nutrition-sensitive interventions. This includes providing food vouchers to moderately malnourished children, pregnant, and lactating women. Preventive services will offer vitamin A supplements for children and iron-folic acid supplements for pregnant women and adolescent girls. Health facilities will receive lifesaving nutrition commodities, and health workers will be trained in treating severe acute malnutrition (SAM). The project will support livelihood activities such as distributing seeds, fruit seedlings, farm tools, and small livestock and aiding smallholder farmers in producing fruits, vegetables, and animal-source foods.

Education: The education programme of the EC2R project is divided into three key outputs: 1) Developing foundational learning skills for disadvantaged children at pre-primary and primary levels, especially those affected by humanitarian crises; 2) mainstreaming out-of-school children, including children with disabilities, by running back-to-school campaigns, engaging communities, and rehabilitating classrooms; and 3) enhancing the capacity of school management and woreda education offices, improving school planning, and developing a comprehensive school database system disaggregated by gender, age, and disability status.

Child Protection and Gender-Based Violence (GBV): Children are particularly vulnerable during crises, facing risks such as separation from families, exploitation, and violence. Crises can increase the risk of GBV, including sexual violence, exploitation, and domestic abuse. Immediate needs and rights will be addressed while building sustainable community-based protection systems. A comprehensive approach will be taken, integrating child protection into sectors like education, WASH, nutrition, health, and communication to prevent and respond effectively to child protection risks. The programme will strengthen the capacity of health facilities, including One-Stop Centers and Mobile Health and Nutrition Teams, to provide comprehensive healthcare and mental health support to survivors of gender-based violence. This will be achieved through training, equipment provision, and capacity building.

Water, Sanitation, and Hygiene (WASH): Access to clean water, sanitation, and hygiene is critical for preventing disease outbreaks and maintaining public health. Key strategies will focus on improving access to safe water through a combination of approaches. This includes drilling new water sources in affected areas, rehabilitating existing water systems by repairing hand pumps, providing essential spare parts, and extending water pipelines to increase coverage. Additionally, solar power will be utilised to operate non-functional water systems. In situations where alternative water sources are unavailable, emergency water trucking will be implemented to supply immediate needs for both internally displaced persons (IDPs) and affected communities. To ensure safe water

consumption, households will be provided with water treatment chemicals and training on proper usage.

Social Protection-Humanitarian Cash Transfers: The programme implements Shock-Responsive Cash Transfers (SRCTs) with a focus on cash-plus care for vulnerable populations in conflict- and climate-affected areas, focusing primarily on Internally Displaced Populations (IDPs). In addition to the lifesaving one-off or two rounds of SRCTs, beneficiary households are provided also with one-time top-up cash transfers for women of reproductive age and persons with disabilities. Additionally, the programme funds a nutrition-sensitive child grant for households with pregnant women and children under 1 year in Amhara and Sidama that are severely affected by drought and prone to poor nutritional outcomes. This pilot is part of the broader strategy of the programme to enhance holistic social protection, by using development cash transfers as a gateway to linkages with other essential services. The lessons from the pilot will also inform the next phase of the PSNP design, specifically the Temporary Direct Support (TDS) component which targets pregnant and lactating women engaged in the public works component.

ANNEXE 4: TERMS OF REFERENCE

1. Background

Children and women throughout Ethiopia remain at high risk for protection concerns and other harms stemming from armed conflict and violence, climate shocks and stressors, multiple disease outbreaks, new refugee influxes and large-scale population displacements. About twenty million people require humanitarian assistance, including about 15 million children and women and more than 4 million displaced people. (https://www.unicef.org/appeals/ethiopia)

UNICEF continues its timely, principled, child-centred humanitarian assistance in Ethiopia on a 'no-regrets' basis. Multiple and integrated streams of work are carried out in close partnership with the Government and with local and international humanitarian actors. The people who are hardest to reach, those who are in the most vulnerable households, displaced persons and new refugee populations are priorities for humanitarian assistance.

Critical life-saving assistance are at the heart of UNICEF's response, while measures for community resilience building are interwoven into services to help break the cycle of shocks and stressors that have eroded household capacities to cope.

Immediate life-saving assistance includes treatment of children with severe forms of malnutrition; providing access to critical health-care services for pregnant and lactating women; provision of safe spaces for children and women, including mental health and psychosocial support; water trucking during sudden-onset crises; rapid deployment of social workers for case management of survivors of violence and abuse, including gender-based violence; as well as provision of shock-responsive humanitarian cash transfers to address the urgent needs of those newly displaced and other extremely vulnerable households.

Additionally, UNICEF promotes capacity building of health workers to enhance the prevention, early detection and treatment of children who are wasted. The organization provides support for drilling new boreholes to enable sustainable sources of safe water and to help stem water-borne diseases in places where incidence is highest. UNICEF implements the 'Bete' programme with integrated child protection and education approaches and further connect humanitarian cash transfers to the government safety net programme for food-insecure households.

Disability- and gender-sensitive programming is a priority. Partnership approaches ensure all assistance is equitable and inclusive through capacity strengthening of partners. Zero tolerance of sexual exploitation and abuse is central to all partnership agreements; the capacity of all staff is strengthened to ensure the protection of children and women.

Scaling up local partnerships, particularly in hard-to-reach locations, drives results. At the same time, UNICEF consistently engages communities in planning and decision-making processes and through feedback mechanisms. Throughout the programme cycle, community feedback is sought to hold UNICEF and partners accountable and to make sure that information, supplies and services reflect the needs of communities. Behavioural insights on community resilience help to identify and design programmes on social and behavioural drivers of life-saving practices and use of services. Conflict-sensitive, 'do no harm' programming guides all interventions, and together with local capacity building strengthens communities' resilience to future shocks and stressors. (adapted from UNICEF's strategy, https://www.unicef.org/appeals/ethiopia#download)

2. Object of the review

The Ethiopia Crises to Resilience (EC2R) programme commenced on November 30, 2022, with an anticipated conclusion on December 31, 2025. Its primary objective is to mitigate the adverse effects of conflict and drought on Ethiopia's most impoverished

communities. Expected outcomes upon its culmination include firstly the fulfillment of multi-sectoral humanitarian aid to meet the needs of the nation's most vulnerable demographics; secondly, the enhancement of resilience among impoverished households to withstand various calamities; and thirdly, the optimization of humanitarian systems for early risk detection and cost-effective responses. Targeting internally displaced persons and returnees in conflict-affected regions such as Amhara, Oromia, Benishangul-Gumuz, and Tigray, alongside pregnant and lactating women, and young children in Amhara and Sidama, the programme operates through a partnership with FCDO, UNICEF, WFP, Ethiopian Red Cross Society (ERCS), REACH, and GOE at both federal and regional levels. Its focus areas include child protection, education, health, nutrition, as well as the provision of humanitarian and developmental cash transfers and WASH initiatives.

This research serves dual objectives: Firstly, it aims to review the project's progress at the output level across various focus areas. Secondly, it seeks to scrutinize the circumstances, obstacles, and strengths including maturity of partnership related to achieving the project's three primary outcomes:

1. Ensuring multi-sector humanitarian assistance adequately addresses the needs of Ethiopia's most vulnerable populations.
2. Enhancing the resilience of impoverished households to withstand disasters and shocks.
3. Strengthening humanitarian systems to proactively identify risks and mount early, cost-effective responses.

Furthermore, the review endeavors to furnish actionable recommendations for implementing corrective measures where necessary.

3. Rationale for the Evidence Generation Activity/Justification

The mid-term review of the EC2R programme intends to learn on how the programme partnership has been conducive to the achievement of / contribution to the program's outcomes, by focusing on and giving voice to the rights holders, including children, with the aim to inform the implementation of the program. X

The review aims at looking into availability of services, their quality, their use, and on the users' satisfaction. For example, aims at looking into utilization of health services and at health seeking behaviors, nutritional support and practices in accessing services, hygiene promotion practices, access to child protection and GBV services, etc; into eventual barriers to optimal practices and gaps in service provision, and on what effect the EC2R programme delivery is having on desired behavioral changes (most probably a reflection on how EC2R is reasonably contributing to changes and/or likely to do so by the end of the program). The review intends also look into the availability, quality and use of feedback mechanisms – in the spirit of Accountability to Affected Population – looking at hearing both from rights holders and duty bearers.

1. This evidence generation piece intends to assess the results of the programme at the output level for each of the programme interventions in child protection, education, health, nutrition, as well as the provision of humanitarian and developmental cash transfers and WASH initiatives. In addition, it examines if each of the interventions are on the right track in achieving the outcomes and identify any challenges to enable the partners to take corrective actions, including how the programme partnership is contributing and likely to contribute to expected outcomes.
2. Gathering insights on knowledge, attitudes, and behaviors regarding priority actions is essential. Based on these findings, interventions will be adjusted or reinforced to ensure effectiveness and alignment with desired outcomes.

3. At the midpoint of the program, it becomes essential to engage in this learning endeavors aimed at refining and enriching the subsequent phase of the program's lifecycle. Such learning serves to inform strategic decisions and implementation processes, thereby optimizing outcomes for the remainder of the program's duration. By dedicating resources to this endeavor, the programme can adapt, evolve, and address any emerging challenges or opportunities, ensuring its continued effectiveness and relevance in achieving its objectives. This proactive approach underscores a commitment to ongoing improvement and the fulfillment of the program's overarching goals and aspirations.

4. Owners of the review and use of the findings

The review steering committee comprises experts from FCDO, UNICEF, WFP, ERCS, REACH, and GOE, representing federal and regional levels, ensuring comprehensive expertise and collaboration in guiding the learning endeavors. Review findings will primarily enhance the program's design and implementation for its remaining duration and guide the development of similar future programs, emphasizing the practical application and long-term impact of the research outcomes**.**

The TOR will be shared with all members of the steering committee of the review listed above.

5. Scope of the Review Activity

The review covers 5 regions which includes Amhara, Oromia, Benishangul-Gumuz, Tigray and Sidama. The learning encompasses all intervention sectors outlined in the programme document. the temporal scope is from the beginning of the programme to the moment of the inception phase.

The programme is implemented in almost 80 woredas (districts); in each woreda, different types of activities (sectorial) are implemented by different partners - woredas for the fieldwork will have to be identified and, in order to do so, criteria for selection will have to be agreed during the inception phase.

6. Review questions

The learning focus will be on 1) the current status and likelihood of achievement of the programme outputs and outcomes, and 2) how the partnerships is conducive (or not).

The review seeks to answer the following questions:

1. **Programme outcomes review:**

   The programme aims to enhance both service demand and supply, though strategies vary across sectors for effectiveness. On the demand side, it focuses on transforming community knowledge, experience, attitudes, intentions, and practices. Meanwhile, on the supply side, it addresses constraints in the provision and quality of basic services. Though lacking uniformity in approach, the programme endeavors to foster change holistically, engaging communities to shift their perceptions and behaviors while simultaneously tackling systemic barriers to service delivery. Through this comprehensive approach, it strives to bridge gaps between service users and providers, fostering a more inclusive and efficient service ecosystem.

What changes have occurred in participants' knowledge, experience, attitudes, intentions, behaviors/practice and eventually resilience and adaptation to climate change as a result of the program? Specifically:

a. Do people have knowledge of key behaviors, services, and supplies? (Knowledge and experience)
b. What is people's experience with service providers/supplies?

c. Do people know and avail feedback and complaint system?
d. What are the parents' attitudes towards sending their children to school, family's attitudes towards cash transfers, parents, and youth intentions to practice recommended behaviors?
e. Do people practice the key behaviors? Do people use feedback and complaint mechanisms? What practices help people to remain resilient during and after crises?
f. What platforms exist in the community? Which platforms are trustworthy? What are sources of information on WASH, health, nutrition, protection, cash transfer etc.?
g. Are the status of output indicators and milestones on track as per the programme targets for each of the interventions?

2. **Programme outputs review:**
   a. How efficiently has the programme utilized its resources (financial and time)?

3. **Collaboration and Partnerships:**
   a. To what extent have partnerships with other organizations or stakeholders contributed to the program's effectiveness?
   b. What challenges or successes have been experienced in collaborating with partners?
   c. Are there opportunities to strengthen existing partnerships or establish new ones to enhance programme outcomes?

7. Methods

Both quantitative and qualitative methods are proposed to be used to answer the review questions. Detailed research methods including matrix that includes information on how each of the ~~research~~ questions will be answered, what methods will be used, and sources of information and limitations should be clearly indicated in the proposal.

Quantitative Methods include:

- Surveys and Questionnaires: household and facility surveys are proposed to be undertaken. Propose enough samples to get representation for each of the regions and different profiling various such as gender, disability status and age etc.
- Statistical Analysis: the researchers should propose the specific statistical analysis methods that will be used to answer each of the questions using the quantitative data.

A note on the sampling: as mentioned above, the programme is implemented in almost 80 woredas (districts), according to needs, resources available, presence/absence of other partners. The units of programme implementation, and the intensity of activity in each, thus, are quite diverse. The sampling will involve different layers - woreda (district) - kebele (village) - individual. The sampling criteria will have to be agreed in the inception phase; it would be useful if the bidder could elaborate on some proposal.X

About XXXX households are expected to be surveyed, in the five regions. The data collected through the household survey have to be adequately complemented by qualitative data collected at the level of households, service providers and other stakeholders at federal/national, woreda and kebele level.

Qualitative Methods:

- Interviews: In-depth interviews with partners/stakeholders (including government/s, donors, implementing partners, UNICEF) and community leaders.

- Focus Groups: facilitated group discussions to understand perspectives, opinions, and experiences related to a programme or intervention. The specific focus groups will be identified during the inception phase in the presence of all stakeholders.
- Observation: Observing activities, behaviors, and interactions in natural settings for the priority behaviors of the intervention as required.
- Document Analysis: Reviewing documents such as reports, records, and programme materials.

Case Studies: focusing on good examples of programme interventions.

Collaborative Approach: Action research involves collaboration between researchers and stakeholders to identify problems, develop solutions, implement interventions, and evaluate outcomes in real-world settings.

Though there are not specific indicators requiring data collection from children, this review might be an opportunity to give voice to the youngest rights holders the programme intends to serve, the children. Children-appropriate qualitative methods should be developed/adapted and used for this review, in order to hear from children's experiences and preferences .X

Ideally, integrating quantitative and qualitative data offers a thorough programme review Qualitative analysis delves into understanding the motives behind people's behaviors related to priority actions, informing interventions for better child outcomes. It also investigates supply-side constraints faced by stakeholders, suggesting remedies for bottlenecks. Integrating both facets enhances the depth and breadth of programme review, facilitating informed decision-making and targeted improvements.

Output data are available from the biannual report to the donor and from other monitoring exercises like Post Distribution Monitoring. Moreover, a mapping of the programme intervention areas, per sectorial interventions/activities, is available, and it (might have to be completed by the review team and) is expected to be used for sampling. Available secondary data are expected to be analyzed during the review, with the primary data collection focusing on outcome-level indicators – with the aim to hear about rights holders experiences and preferences; about their knowledge, attitudes, behaviors, practices.

At the same time, the review team needs to be capable of reviewing the partnership dynamics, learn strengths and weaknesses and strengthen the way forward for the rest of the programme - for doing this, evidence will have to be triangulated, and the quantitative data analysis has to be complemented by observation, interview to key informants, etc.X

Prior to proceeding with data collection, researchers bear the responsibility of subjecting their research protocols to ethical review. This essential step ensures adherence to ethical standards and safeguards the well-being and rights of participants. Ethical review involves scrutiny of the proposed methods, potential risks to participants, and measures to mitigate these risks. It also review the ethical considerations surrounding informed consent, confidentiality, and data handling. By undergoing rigorous ethical review, researchers demonstrate their commitment to upholding ethical principles and maintaining integrity in the conduct of research, ultimately fostering trust and credibility in the scientific community.

ANNEXE 5: Case Studies

Case 1: Tsega, a breastfeeding mother, Sidama, Shebedino, (Cash transfer and Health component)

In the heart of Shebedino Woreda, a 35-year-old mother of three has experienced a transformation through her involvement in the EC2R program. As a breastfeeding mother, she was selected for this initiative, which provides direct cash transfers to women, along with counseling and agricultural training, to help families recover from crises and build resilience.

For years, her family struggled to make ends meet. As their livelihood depended on agriculture, they were vulnerable to climate change, the rising costs of seeds and fertilizer. They often faced food shortages, and meeting their children's nutritional needs was an uphill battle. But when the EC2R programme began, the cash transfers allowed her to buy hens, seeds, and fertilizer, enhancing the productivity of her small farm of crops such as maize, coffee, and enset. These efforts intern improved her family's diet.

> *"This cash transfer programme helped my family to afford food for all family members including milk and eggs for my little baby. Before this programme, my family was suffering from a shortage of food for our daily consumption…Currently, you can see our farm filled with different types of food items. We planted Enset, maize, coffee, cabbage, avocado, and other food items. There is no empty space on our farm, it is all covered with food items. Our lives are now filled with joy and hope. I want to thank our government and supporting organizations for providing us with these basic life-changing support. "*

The program's unique approach of directly depositing funds into the mothers' bank accounts, stood out to her. This empowerment allowed her to prioritize her family's needs, unlike previous support models centered around the husband. In collaboration with her husband, Tsega used the funds wisely, ensuring they were invested in agricultural productivity and nutrition. The integrated health services and nutrition counselling further amplified the program's impact, helping her make informed decisions for her family's well-being.

Despite its successes, the programme also exhibited some gaps. Tsega noted that while it effectively addressed the needs of pregnant and breastfeeding women, EC2R fell short in reaching people with disabilities, who remain highly vulnerable in her community. Additionally, delays in cash disbursement caused unnecessary challenges, highlighting the need for more consistent and timely payments.

Her story underscores the transformative power of programs like EC2R. Through cash transfers, counselling, and agricultural support, her family is now more resilient and hopeful for the future.

Case 2: Ahmed, a male beneficiary, Shashemene, Oromia (Health and WASH components)

Imagine living in a small village in Oromia, where access to water was once a constant struggle. Every day, women, including the elderly and children would walk long distances to fetch water from rivers, water that often carried diseases. For years, this was the reality of many, with the

routine stealing time, energy, and health from the community. Then, the Red Cross stepped in, and things began to change.

At first, it wasn't just about the water. The Red Cross gathered the community, asking what they needed most and how they could help. Together, they worked to install water points in easily accessible areas. Ahmed was part of the process. He and his neighbors helped dig trenches for the water lines. This, he explains, gave them a sense of pride and ownership. Once those water points were ready for use, life became easier. Ahmed's wife no longer had to spend hours walking to fetch water. They were able to get clean water, so close to home, and at an affordable price, only 2 birr for 20 liters. The waterborne diseases that once plagued the community, began to fade away.

The programme also helped create awareness about hygiene, water usage, and ways to adapt to climate change. In the health component, the community has received support in laboratory equipment and drugs. The programme also made sure that PWDs had separate, convenient access points to the water.

> *"They taught us and made us aware that pregnant women, lactating women, older people, and PWD should get access conveniently…they have assigned people who can manage the facility and beneficiaries to get proper access with no discrimination."*

But challenges remain. The water system depends on fuel to run, and the rising cost of fuel is making it harder for the community to keep it going. The community has taken this issue to Red Cross and the local administration, suggesting switching to electricity, which would be more sustainable.

Case 3: Female IDP beneficiary, Tigray, Mekele (Cash transfer component)

Selam's journey, like that of many displaced individuals, is a testament to resilience and transformation amidst adversity. Before the conflict uprooted her life, she thrived in her home, earning a stable income from trade and the rental of her multi-story building. However, the conflict stripped her of everything, forcing her to endure hunger, displacement, and immense suffering.

The intervention programme became a turning point. Selam and others received trainings in handicrafts. At one point, she made a handicraft she managed to sell in an auction. This income enabled Selam and her association, Hiyab, to venture into liquid soap production. The association, which they fittingly named "Hiyab" (meaning "gift"), grew to include 23 members.

The programme provided them with more than economic tools, it brought psychological healing. With guidance from counselors and trainers. Selam found relief from the anxiety and trauma of displacement. Simple activities, like making crafts or learning new skills, helped her focus on rebuilding her life rather than dwelling on her losses.

> *"As I mentioned before, it's better not to talk about the past. However, other than that, I can say that I've experienced significant change through training, education, and in many other ways. If you ask me why, it's because I didn't just sit at home and constantly occupy my mind with other things. Whether it's making a sweater or working on something else, I don't stay idle; I work, sell, and use that income to feed my children. Even making soap has proven to be very useful."*

Even though their business was facing challenges due to the remoteness of their shop's location, they have been in talks to be relocated and receive additional funds for their business. However, there was a plan to return IDPs back to their homes and this was calling for Selam and her association to revise their plans on how to proceed.

ANNEXE 6: SUPPLEMENTARY TABLES AND CHARTS

Table 15: How cash transfer, water supply and toilet facilities are considered in households with PWDs

Extent to the cash transfer helped household members with a disability	Freq.	Per cent
A lot	37	20.67
Somewhat	114	63.69
Not at all	28	15.64
How do people with disabilities in the household access water supply service		
Difficult accessing water supply	16	30.19
Assistance from family	15	28.30
Direct access to water, indoor	7	13.21
Accessible, designed for pwds	15	28.30
How toilet facilities are accessible to people with disabilities		
Yes, fully accessible	82	78.10
Yes, but with some difficulty	16	15.24
No, not accessible	7	6.67

Note: The table highlights how cash transfers, water supply, and toilet facilities support households with PWDs. Regarding cash transfers, 20.67% of households reported significant help, while the majority (63.69%) noted moderate benefits and 15.64% felt no assistance at all. For water supply, accessibility remains mixed: 30.19% of PWDs face difficulties, 28.30% rely on family assistance, and only 13.21% have direct indoor access. Encouragingly, 28.30% reported water systems as accessible and designed for PWDs. Toilet facilities show more positive outcomes, with 78.10% being fully accessible, though 15.24% of households reported some difficulties, and 6.67% found them inaccessible. While the programs demonstrate progress in supporting PWDs, challenges persist in ensuring fully inclusive access to essential services.

Table 16: PLW experience with using ANC services during their pregnancy time.

During the pregnancy, did the pregnant woman receive any antenatal care (ANC) service	Freq.	Per cent
Yes	360	97.56
No	9	2.44
Did you have a prenatal check-up before the 16th week of your pregnancy?		
Yes	340	94.71
No	19	5.29
Did you have a prenatal check-up between the 24th and 28th week of your pregnancy?		
Yes	341	95.52
No	16	4.48
Did you have a prenatal check-up between the 30th and 32nd week of your pregnancy?		
Yes	327	91.60
No	30	8.40

Did you have a prenatal check-up between the 36th and 38th week of your pregnancy?		
Yes	327	91.60
No	30	8.40

Note: During their ANC (Antenatal Care) visits, Pregnant and Lactating Women (PLW) utilize key services such as health check-ups, ultrasounds, blood tests, nutritional counselling, and immunizations. This reflects their proper engagement with available healthcare services and indicates a good level of awareness and knowledge about essential maternal care, which is critical for ensuring maternal and child health during pregnancy. The use of these services by PLW highlights their proactive approach to maternal health, ensuring better outcomes for themselves and their babies.

Table 17: PLW and children under 2 who received food vouchers and the type of food voucher.

Type of food voucher	freq	Mean
Cereals and grains	89	.218
Fruits and vegetables	25	.061
Dairy products	30	.073
Protein sources (meat, fish, legumes)	**354**	**.866**
Cooking oil	2	.005

The table outlines the types of food vouchers distributed to beneficiaries and their respective frequencies and means. Protein sources (meat, fish, legumes) are the most frequently mentioned, with about 87 per cent. This indicates that protein sources are the dominant type of food support provided to beneficiaries, while other categories like dairy, fruits, and cooking oil are less commonly provided. The EC2R programme supported pregnant and lactating women (PLW) and children with protein-enriched foods to address malnutrition. RUTF (Ready-to-Use Therapeutic Food) was provided to treat severe acute malnutrition or restore health in children suffering from severe malnutrition. For moderate malnutrition, the programme distributed RUSF (Ready-to-Use Supplementary Food).

Table 18: Gender of household heads across the regions

Gender of household head	Regions					
	Tigray	Amhara	Oromia	Sidama	Benshangul Gumuz	Total
Male	445	274	198	135	206	1258
	48.63	67.99	73.33	73.77	71.03	61.04
Female	470	129	72	48	84	803
	51.37	32.01	26.67	26.23	28.97	38.96
Total	915	403	270	183	290	2061

The first row has *frequencies,* and the second row has *column percentages.*

Table 19: Educational status of household head

Educational Status of the Household	Regions					
	Tigray	Amhara	Oromia	Sidama	Benshangul Gumuz	Total
other	3	10	1	0	4	18
	0.33	2.48	0.37	0.00	1.38	0.87
None	190	165	72	12	107	546
	20.77	40.94	26.67	6.56	36.90	26.49
Primary School	298	129	116	129	117	789
	32.57	32.01	42.96	70.49	40.34	38.28
Secondary School	279	82	59	31	29	480
	30.49	20.35	21.85	16.94	10.00	23.29
Diploma	58	6	13	10	10	97
	6.34	1.49	4.81	5.46	3.45	4.71
Higher Education	87	11	9	1	23	131
	9.51	2.73	3.33	0.55	7.93	6.36
Total	915	403	270	183	290	2061

The first row has *frequencies,* and the second row has *column percentages.*

Table 20: Age categories of household heads across regional states

age category	Regions					
	Tigray	Amhara	Oromia	Sidama	Benshangul Gumuz	Total
Young hh Head	255	48	35	65	23	426
	27.90	11.91	12.96	35.52	8.04	20.72
Early Adulthood	354	147	84	90	67	742
	38.73	36.48	31.11	49.18	23.43	36.09
Middle Adulthood	175	105	75	24	71	450
	19.15	26.05	27.78	13.11	24.83	21.89
Late Adulthood	71	42	38	3	50	204
	7.77	10.42	14.07	1.64	17.48	9.92
Senior Household Head	59	61	38	1	75	234
	6.46	15.14	14.07	0.55	26.22	11.38

Total	914	403	270	183	286	2056

The first row has *frequencies,* and the second row has *column percentages.*

Table 21: Health Facilities information summary

Does the facility have adequate medical supplies and equipment?	Freq.	Per cent
Yes	17	73.91
No	6	26.09
How many health workers are currently employed at the facility?		
Less than 5	9	39.13
5 to 10	2	8.70
More than ten	12	52.17
On average, how many patients does the facility serve per day?		
Less than fifty	12	52.17
Fifty to One hundred	5	21.74
More than one hundred	6	26.09
How would you rate the cleanliness of the facility?		
Poor	1	4.35
Fair	6	26.09
Good	13	56.52
Excellent	3	13.04
Is there a system in place for collecting community feedback?		
Yes	19	82.61
No	4	17.39

The health facility interviews provide key insights into service readiness and challenges. While 73.91% of facilities reported adequate medical supplies, 26.09% faced shortages. Workforce availability varies, with 52.17% having more than ten health workers and 39.13% operating with fewer than five. Patient load is low, as 52.17% serve less than 50 patients daily, though 26.09% accommodate over one hundred. Cleanliness ratings were mostly positive, with 56.52% describing it as "Good" and 13.04% as "Excellent," while 26.09% rated it "Fair" and 4.35% "Poor." Additionally, 82.61% of facilities have systems for collecting community feedback, but 17.39% do not.

Among the respondents who reported that health centres do not have adequate medical supplies, several critical shortages and challenges were identified. These included essential medicines such as *Amoxicillin*, *Zinc*, *Gentamicin*, *ORS (Oral Rehydration Solution)*, and *Syrup Paracetamol*. In addition to medicine shortages, issues with equipment and infrastructure were highlighted, including the lack of a *CBC machine*, *BP apparatus*, and inadequate laboratory facilities. Respondents also noted shortages of basic furniture, such as *beds, chairs, and tables*. The reported shortages of essential medicines, medical equipment, and basic infrastructure emphasize the urgent need for improved resource allocation and supply chain management to strengthen health facility capacity.

ANNEXE 7: Selected comments from respondents/beneficiaries during the Survey (quantitative)Table

22: Selected comments from the household survey, not phrased.

Selected comments from the household survey
Currently muak measurement is bellow 12.4 but didn't get any supplementary food (Plumby nut).
I appreciate the programs activity so please strongly continue.
Inaccessibility of drug/medicine nearby their kebele is the very concern of the respondent
Medanit yelem = No medicine
Other need of water pamp
Red cross did great thing for the community
She have disable child 6 years old
She need support if it is possible because she has 3 children the same age
She was Not Attend the ANC at pregnant time because of the Confilect of Tigay the Service provider are Closed
Shortage of Medications in Health Center
Shortage of water
Some Times shortage of Immunaizashin and mam Suplment Mathers and children
Thanks for the programme because it starts up to grade 8
The cash aid should be continue.
The cash payment programme should be consider all vulnerable bodies.
The cash payment should be consider the current inflation rate.
The cash transfer programme should be continue until the IDPs rerun to their place of origin.
The HEP Staff Was technically problem they can not measure no time
The pipe or water point is not functioning
The price of water per unit is not affordable
The programme has some problems: lack of teachers, lack of teachers commitment and Shortage of education equipments.
The respondent is complaining on the price of water per unit as the fuel price is getting higher from time to time
The respondent raised his concern related with cost of piped water as the water pump needs fuel to distribute water for the beneficiary. The price of water per unit is increased due to the fact that the price of fuel got high across the country recently
The transformer is stolen so the piped water is doesn't functional properly.
The water pipe made by the wash is not serviced due to failer
The water pipe that was built by wash is not serviceable due to a malfunction
There is no any exercise books supply at the IDP site.
There is no enough educational materials and teachers

There is no one at the time of delivery because of the war and she delivered by the traditional birth at health center.
There is not enough fafafor mam
Water is not clean
Water not available at this time
Water point is not functioning
We are not getting adequate drug supply; we are forced to buy medicne/drugs from private pharmacy which we cannot afford to buy
We need addtional food for mother
We need extra educational materials support.
We were pushed by local leaders to distribute the received money forcefully for other households after I got the cash.

ANNEXE 8: SELECTED WOREDAS WITH COMPONENTS IN EACH REGION

Region	Woreda	Sector (Section)	Partner
BGumuz	Shekole	WASH	UNICEF
	Bambasi	Education	UNICEF
Oromia	Dodola	Health, WASH	Red Cross
	Shashemene Zuria	Health, WASH	Red Cross
	Adami Tulu	Health, WASH	Red Cross
Sidama	Shebe Dino	Health, Cash transfers, Child Protection	UNICEF
Tigray	Mekelle	Health, Cash transfers, Education, CP/GBV	UNICEF
	Abi Adi	Health, Cash transfers	UNICEF
	Maychew	Nutrition, CP/GBV (Town)	UNICEF, WFP
	Neksge	Nutrition, WASH	Red Cross
Amhara	D/Birhan City	CT, CP; WASH	UNICEF
	Legambo*	WASH; Health	Red Cross
	Dessie town	WASH	UNICEF
	Dewa Cheffa	Health; Nutrition	UNICEF
	Kombolcha	WASH	UNICEF
	Kutaber	Nutrition, WASH	WFP

ANEXE 9: ETHICAL CLEARANCE

unicef | for every child

Research Ethics Approval

23 September 2024

Mohammed Seid Hussen, Ph.D.
Robert Poppe, Ph.D.
Center for Evaluation and Development (C4ED)
Addis Ababa, Ethiopia

RE: Ethics Review Board findings for: *Mid-term Evaluation of Ethiopian Crises to Resilience Programme* (HML IRB Review 972ETHI24)

Dear Drs Hussen & Poppe,

Protocols for the protection of human subjects in the above study were assessed through a research ethics review by HML Institutional Review Board (IRB) on 10 – 23 September 2024. This study's human subjects' protection protocols, as stated in the materials submitted, received **ethics review approval.**

You and your project staff remain responsible for ensuring compliance with HML IRB's determinations. Those responsibilities include, but are not limited to:

- ensuring prompt reporting to HML IRB of proposed changes in this study's design, risks, consent, or other human protection protocols and providing copies of any revised materials;
- conducting the research activity in accordance with the terms of the IRB approval until any proposed changes have been reviewed and approved by the IRB, except when necessary to mitigate hazards to subjects;
- promptly reporting any unanticipated problems involving risks to subjects or others in the course of this study;
- notifying HML IRB when your study is completed.

HML IRB is authorized by the United States Department of Health and Human Services, Office of Human Research Protections (IRB #1211, IORG #850, FWA #1102).

Sincerely,

D. Michael Anderson, Ph.D., MPH
Chair & Human Subjects Protections Director, HML IRB

cc: Mussarrat Youssuf, Maryamawit Solomon Assefa, Cherkos Meaza, Nolawit Teshome, Yebelay Berehan, Sintayehu Tilaye Melesse, Penelope Lantz, JD

Health Media Lab, Inc.
1101 Connecticut Avenue, NW Suite 450
Washington, DC 20036 USA
+1.202.246.8504
unicef@hmlirb.com www.hmlirb.com

ANNEXE 10: CONSENT FORMS

I. CONSENT FORM FOR QUANTITATIVE DATA COLLECTION

Good morning/afternoon/evening,

My name is [enumerator name]. I am part of a research team conducting a study on the *Mid-term evaluation of the Ethiopian Crises to Resilience Programme in* Ethiopia. We would like to ask your household questions about your experience of being the beneficiaries of any one or many of the Ethiopia Crises to Resilience (EC2R) Programme components. We expect that the survey will take approximately 30 to 40 minutes.

If you choose to take the survey, you are free to refuse to answer any of the questions that may make you uncomfortable, and you also have the option to end the interview at any time. The information I collect will be kept strictly confidential and not shared with anyone outside the research team. Your name and any other identifying information will be accessible only to the researchers and will never appear in any report that might be published.

If you have any further questions about this research or the survey, you can contact either:

[redacted] the Research Manager, using his mobile number: +25196742[redacted] Email: [redacted]@c4ed.org or

[redacted], the Survey Manager, using his mobile number: +25193245[redacted]

Email: [redacted]@c4ed.org

If you think I have answered all your doubts and questions about this study and have received a satisfactory answer, please sign if you agree to participate. Your participation in this study is completely voluntary. We would be very grateful if you participated.

II. CONSENT FORMS FOR QUALITATIVE DATA COLLECTION

Informed assent form for Focus Group Discussions (FGDs) with child respondents (15 to 18 years old)

Information Letter

Title of Project: _____ **Date: _____**

Facilitators: _____ **Location: _____**

Hello and welcome to our session! Thank you for taking the time to join us today.

My name is *[facilitator's name]* and assisting me is *[second facilitator's name, if applicable].* We are part of a team working for the Centre for Evaluation and Development (C4ED), a non-profit research institution with offices in Addis Ababa and in Germany.

We are here today to discuss and learn about your experience with the implementation of UNICEF's EC2R program. [Use words or descriptions that is locally used to describe the project]. We will ask you questions about your life experiences, your concerns, and your hopes and wishes for the future. You can also tell us anything else that you think is important.

Please feel free to share your point of view openly with us, even if it is different from what others have said. There are no right or wrong answers. This also means that we allow others to share their opinions without interrupting or correcting them. We also ask you to keep the information that is shared within the group in confidence.

We anticipate that our discussion today will take about one and a half hours. Your participation in this study is completely voluntary. You can refuse to answer any question that you don't want to answer, and you can leave the discussion at any time without any problem, even if it has already begun.

With your permission, we would like to audio record this discussion. The audio recording with solely for the purpose of this study and will never be used to identify you.

Please note that the information you provide will be treated confidentially and will remain anonymous. We will not use your name and the information you give will never be connected to you. When we prepare reports of this study, we will assign a number code in place of your names and will not use your names or any other information that could identify you.

We thank you very much for your participation. Please feel free to ask any questions you may have about the study.

- If you have questions that you would like to discuss after our interview, including how your data will be used, you can contact:

Ms [redacted]*. Tel. 094918*[redacted] */* [redacted]@c4ed.org

Qualitative Research Manager at the Centre for Evaluation and Development (C4ED) If you wish to raise any concerns about the interview or the researcher who took part in it, you can do so directly via this e-mail address: complaints@c4ed.org

- If after this interview you feel you would need support and would like to talk to someone else about what we discussed, you can contact: [*local counsellor or support person*]

Informed assent form for Focus Group Discussions (FGDs) with <u>child respondents</u> (15 to 18 years old)

Assent Form

I have read (or someone has read for me) and understood the information presented in the information letter about the focus group discussion being facilitated by the Centre for Evaluation and Development (C4ED). I have had the opportunity to ask the facilitator(s) questions related to this discussion, to receive satisfactory answers to my questions and any additional details I wanted. I am aware that I may withdraw from the session without consequence at any time by informing the facilitator(s) of this decision.

I agree with my own free will to participate in this session and to keep in confidence information that could identify specific participants and/or information they provide.

By including my signature or thumbprint below, I understand what is expected of me to take part in the study, I agree to participate, and I understand that I may withdraw at any time:

Name: _____

Signature: _____/Thumbprint: _____

Date: _____ Age: _____

Informed consent form for parents/guardians of child respondents (under 18 years old) of Focus Groups Discussions

Information Letter

Title of Project: _____ Date: _____

Researcher(s): _____ Location: _____

Hello! We are part of a team working for the Centre for Evaluation and Development (C4ED), a non-profit research institution with offices in Addis Ababa and in Germany. Your child has been selected to participate in a discussion about the implementation of the EC2R program. [Use words or descriptions that is locally used to describe the project] concerning the life of adolescent girls and boys in this community for a study we are conducting for UNICEF. Through this discussion, we hope to learn more about adolescents' life experiences, needs, concerns, wishes, and views about their present and their future.

Your child's participation in this discussion is entirely voluntary. If s/he chooses to participate, s/he is free to refuse to answer any questions, as s/he wishes. S/he can also end the discussion at any time, even if we have already begun, without any penalty.

Our discussion will take about one and a half hours.

With your permission, we would like to audio record this discussion. Only our research team will know what your child tells us today. We will not directly share this information with anyone outside of the research team. Your child's information will be kept anonymised. This means that we will only report in general terms what we learned from this discussion, and nobody will be able to identify a specific child or household in the discussion.

Please note that your child is not being compensated for their time. In appreciation of your child's time given to this discussion, we are providing some refreshments for the children to have during our discussion.

We thank you for your support to this project.

Please feel free to ask any questions you may have about the study.

- If you have questions that you would like to discuss after the session, including how your child's data will be used, you can contact:

Ms [redacted]*. Tel. 094918*[redacted] */* [redacted]@c4ed.org

Qualitative Research Manager at the Centre for Evaluation and Development (C4ED)

- If you wish to raise any concerns about the discussion or the researcher(s) who took part in it, you can do so directly via this e-mail address: complaints@c4ed.org
- If after this session you or your child would need support and would like to talk to someone else about what we discussed, you can contact: [*local counsellor or support person*]

Informed consent form for parents/guardians of child respondents (under 18 years old) of Focus Groups Discussions

Consent Form

Title of Project: _____ Date: _____

Facilitator(s): _____ Location: _____

I have read (or _____ has read to me) and understood the information presented in the information letter about the focus group discussion being facilitated by the Centre for Evaluation and Development (C4ED). I have had the opportunity to ask the facilitator(s) questions related to this discussion, to receive satisfactory answers to my questions and any additional details I wanted. I am aware that my child and/or I may withdraw from the discussion without penalty at any time by advising the facilitator(s) of this decision.

With full knowledge of all the foregoing, I agree of my own free will to allow my child to participate in this discussion and to keep in confidence information that could identify specific participants and/or information they provide.

By adding my signature or thumbprint to this consent form, I am indicating that I have understood the purpose of my child's involvement in this discussion and that my child and/or I may withdraw at any time.

_____

Name

_____

Signature

_____

Date

Informed consent form for all <u>adult respondents</u>

Information Letter

Title of Project: _____ Date: _____

Facilitators: _____ Location: _____

Hello and welcome to our session! Thank you for taking the time to join us today to talk about your experience with UNICEF's EC2R program. [Use words or descriptions that are locally used to describe the project]. My name is *[facilitator's name]* and assisting me is *[second facilitator's name, if applicable].* We are part of a team working for the Centre for Evaluation and Development (C4ED), a non-profit research institution with offices in Addis Ababa and in Germany, and we hope to learn about your experiences with the project in your community and your views on this topic.

Please feel free to share your point of view openly with us, even if it is different from what others have said. There are no right or wrong answers. This also means that we allow others to share their opinions without interrupting or correcting them. We also ask you to keep the information that is shared within the group in confidence. Please do not share outside the group any information that could potentially identify a participant and his or her comments.

We anticipate that our discussion today will take about one and a half hours.

Your participation in this session is entirely voluntary. If you choose to participate, you are free to refuse to answer any questions, as you wish. You can also choose to leave the discussion at any time, even if we have already begun, without any penalty.

With your permission, we would like to audio record this discussion. The information provide will be treated confidentially and will remain anonymous. When we prepare reports of this study, we will assign a numerical code in place of your names and will not use your names or any other information that could identify you.

We thank you very much for your participation.

Please feel free to ask any questions you may have about the study.

- If you have questions that you would like to discuss after the session, including how your data will be used, you can contact:

Ms [redacted]. Tel. 094918[redacted] / [redacted]@c4ed.org

Qualitative Research Manager at the Centre for Evaluation and Development (C4ED)

- If you wish to raise any concerns about the discussion or the researcher(s) who took part in it, you can do so directly via this e-mail address: complaints@c4ed.org

Informed consent form for all adult respondents

Consent Form

Title of Project: _____ Date: _____

Facilitators: _____ Location: _____

have read (or someone has read to me) and understood the information presented in the information letter about the focus group discussion being facilitated by the Centre for Evaluation and Development (C4ED). I have had the opportunity to ask the interviewer/facilitator(s) questions related to this discussion, to receive satisfactory answers to my questions and any additional details I wanted. I am aware that I may withdraw from the session without penalty at any time by advising the interviewer/facilitator(s) of this decision.

With full knowledge of all the foregoing, I agree of my own free will to participate in this session and to keep in confidence information that could identify specific participants and/or information they provide.

By adding my signature or thumb print to this consent form, I indicate that I have understood the purpose of my involvement in this study, that I may withdraw at any time and (for FGD participants only: that I will not share outside the group any information that could potentially identify a participant and his or her comments.)

_____

Name

_____

Signature

_____

Date

Centre for Evaluation and Development

C4ED

O7, 3
68161 Mannheim, Germany

Email: info@c4ed.org

www.c4ed.org