

COUNTRY NOTE

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

## Côte d'Ivoire

**2016**

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# List of Abbreviations and Acronyms

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| AWP | Annual Work Plan |
| CEC | Centres d'Ecoutes de Conseil |
| CO | UNFPA Country Office |
| COAR | UNFPA Country Office Annual Reports |
| CPAP | Country Programme Action Plan |
| CPD | Country Programme Document |
| CSO | Civil Society Organisation |
| EVP/EmP | Education à la Vie Familiale et En Matière de Population |
| FfA | UNFPA Framework for Action on Adolescents and Youth |
| FGD | Focus Group Discussion |
| FGM/C | Female Genital Mutilation/Cutting |
| FP | Family Planning |
| GBV | Gender-Based Violence |
| HIV | Human Immunodeficiency Virus |
| HQ | Headquarters |
| ICPD | International Conference on Population and Development |
| INGO | International Non-Governmental Organisation |
| IP | Implementing Partner |
| JICA | Japanese International Cooperation Agency |
| KOICA | Korean International Cooperation Agency |
| M&E | Monitoring & Evaluation |
| MDG | Millennium Development Goal |
| MH | Maternal Health |
| MoE | Ministry of Education |
| MoF | Ministry of Finance |
| MOH | Ministry of Health and HIV/AIDS |
| MSFFE | Ministry of Families, Women and Children |
| MoY | Ministry of Youth |
| MSLS | Ministère de la Santé et lutte contre le SIDA |
| MTR | Mid-term Review of the UNFPA Strategic Plan (2012-2013) |
| MdJ | Ministère de la Jeunesse |

| | |
|---|---|
| MENET | Ministère de l'Education National et de l'Enseignement Technique |
| MESAD | Mouvement pour l'Education, la Santé et le Développement |
| MESSI | Mouvement Etudiant de Sensibilisation et de lutte contre le SIDA |
| MoD | Ministère de la Défense |
| NGO | Non-Governmental Organisation |
| ONEF | Organisation Nationale pour l'Enfant et la Femme |
| ONEG | Observatoire Nationale pour l'Egalité et du Genre |
| PNSSU | Programme National de la Santé Scolaire et Universitaire |
| PRS | Poverty Reduction Strategy |
| HQ | UNFPA Headquarters |
| RO | UNFPA Regional Office |
| SSSU | Services de Santé Scolaire et Universitaire |
| SDG | Sustainable Development Goal |
| SGBV | Sexual and Gender-Based Violence |
| SP I | UNFPA Strategic Plan 2008-2011 |
| SP II | UNFPA Strategic Plan 2014-2017 |
| SWAp | Sector-Wide Approach |
| ToC | Theory of Change |
| ToR | Terms of Reference |
| UN | United Nations |
| UNAIDS | The Joint United Nations Programme on HIV/AIDS |
| UNDAF | United Nations Development Assistance Framework |
| UNDP | United Nations Development Programme |
| UNESCO | United Nations Educational, Scientific and Cultural Organisation |
| UNFPA | United Nations Population Fund |
| UNGA | General Assembly of the United Nations |
| UNICEF | United Nations Children's Fund |
| UN Women | United Nations Entity for Gender Equality and the Empowerment of Women |
| VCT | Voluntary Counselling and Testing |
| WCARO | UNFPA West & Central Africa Regional Office |
| WHO | World Health Organisation |
| ZPC | Zero Pregnancy Campaign |

# Structure of the case study note

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

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

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

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

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

**Chapter 6** presents action points for UNFPA Côte d'Ivoire for the area of adolescents and youth for the current and forthcoming programme cycle.

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

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

# 1 Introduction

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

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

The primary objectives of the evaluation are:

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

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

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

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

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

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

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

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

## 1.2 Objectives of the country case study

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

The case study focuses on three specific areas:

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

## 1.3 Scope of the Côte d'Ivoire case study

This country case study covers UNFPA adolescents and youth interventions in Côte d'Ivoire during the period 2008 to 2015, with a stronger emphasis on recent years due to the learning aspect of the global evaluation of UNFPA support to adolescents and youth. It covers UNFPA work in the area of adolescents and youth with a particular emphasis on activities and partners in Abidjan, Yamoussoukro, Toumodi, Daloa, and Bouaké, where site visits were undertaken for data collection purposes.

# 2 Methodology

## 2.1 Country case study selection

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

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

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

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

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

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

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

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

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

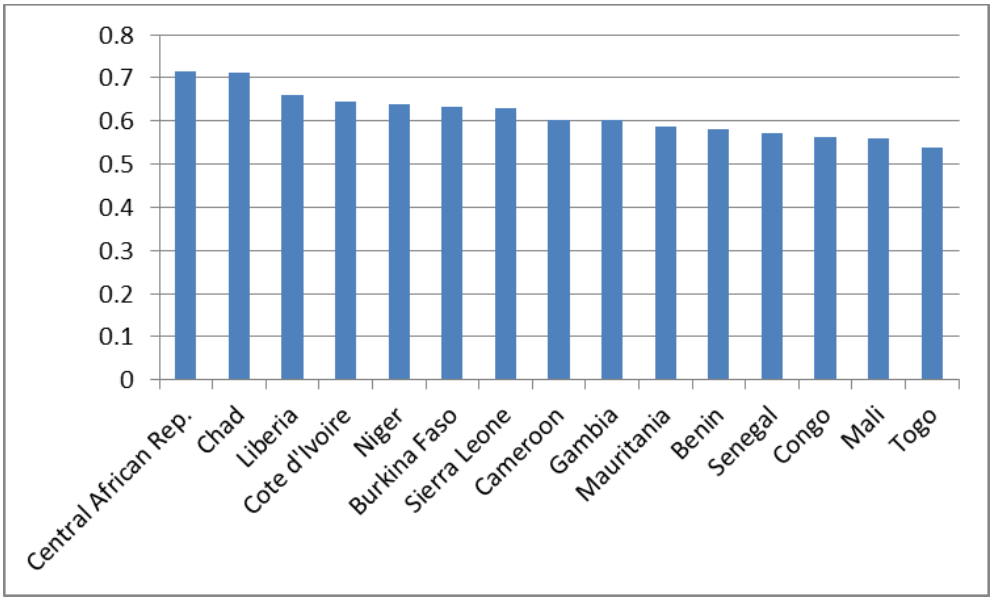
Furthermore, selected case studies should be illustrative for their respective regions as either a big country with a robust programme or a smaller country with greatest need.

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

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

Côte d'Ivoire was selected for the West and Central Africa region. As per the needs indicator analysis (health and development indicators) in the table below, the country ranked among the highest in terms of need.

Figure 1: Needs indicator analysis WCARO (no expenditure data)




When health and development indicators were combined with UNFPA investment data Côte d'Ivoire falls nearly in the middle of countries in investment by UNFPA (as per the graph below).

Figure 2: Needs indicator analysis WCARO (includes expenditure data)

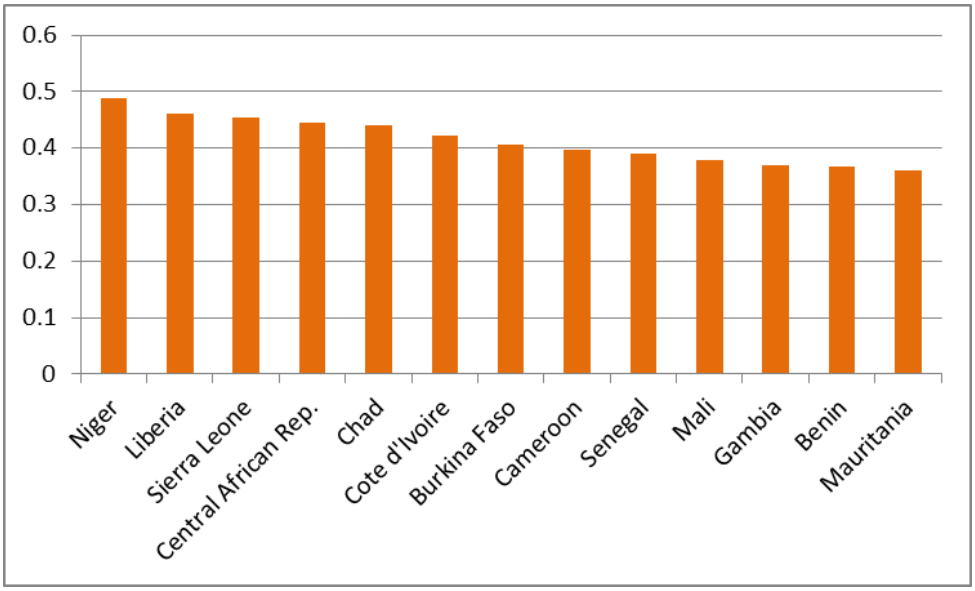



Table 3: Countries selected for case study visits

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

**UNFPA country quadrants – modes of engagement by setting**

The UNFPA country quadrant classification groups countries on the basis of their ability to finance their own interventions and on their level of need. The model provides guidance for how UNFPA should engage in different country contexts (in a particular country).[1] Côte d'Ivoire falls within the red quadrant meaning UNFPA support covers all modes of engagement: service delivery, advocacy and policy dialogue/advice, knowledge management, and capacity development.

Table 4: UNFPA modes of engagement

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

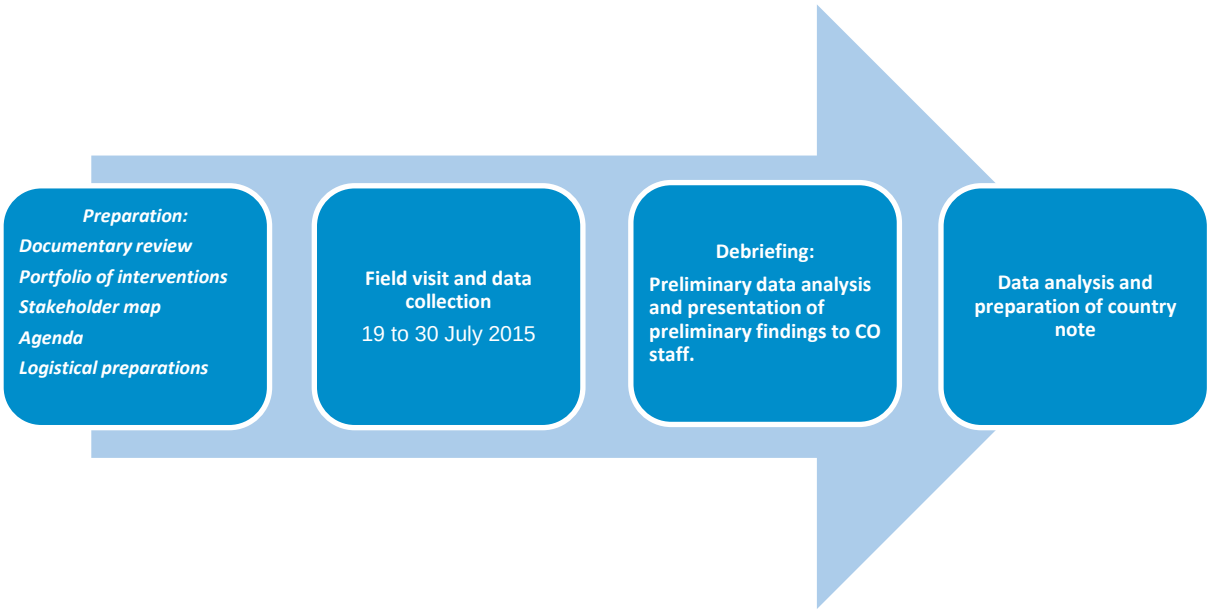
[1] UNFPA Strategic Plan 2014-2017. For example, in countries that have the highest needs and low ability to finance their own interventions (coloured red in the matrix above), UNFPA should be prepared to offer a full package of interventions, from advocacy and policy dialogue/advice through knowledge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

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

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

## 2.2 Case study process

The case study was conducted in four stages:




1. *Preparation:* the team conducted a documentary review, including the portfolio of interventions and developed an updated stakeholder map (see Annex 2); and developed the agenda and logistical preparations in coordination with the country office.

2. *Data collection:* the team travelled to Côte d'Ivoire from 19 to 30 July 2015 to conduct interviews, focus group discussions and site visits. At the start of the mission, the evaluation team met with staff at UNFPA Côte d'Ivoire to them about the purpose, objectives, scope and evaluation methodology, and to be briefed on UNFPA adolescents and youth -related activities. A discussion was also held on the country context with an assessment of how difficult it is to work on adolescents and youth issues (see Section 3.5). Following the briefing, interviews were conducted with UNFPA staff. During the first week, interviews and group discussions were conducted in Abidjan with government, UN organisations and other development

partners. At the end of the first week, the team visited other areas of the country (Daloa, Bouaké, Yamoussoukro and Toumodi).

3. *Debriefing:* Preliminary data analysis and findings were presented to the UNFPA country office (30 July 2015);
4. *Data analysis and preparation of the country note*: A review of preliminary findings, as well as further analysis and drafting of the country note was conducted in the subsequent weeks following the mission.

Data collection and analysis was undertaken by a four-person team comprised of an international team leader, an international project officer, and two national consultants including a youth.

## 2.3 Methodological Framework

### 2.3.1 Methodological approach

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

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

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

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

Evaluation questions and criteria are shown in Table 6 below.

Table 6: Evaluation questions and criteria

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

The evaluation matrix, the theory of change and methodological instruments inclusing interview guides can be found in Volume II of the main Evaluation Report.

## 2.4 Approach to data collection and analysis

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

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

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

rights language. With more than 60 indigenous languages, French is the common, national language in Côte d'Ivoire for programme communications. No materials were available in national languages.

**2. Interviews:** The evaluation team met with UNFPA staff members; representatives of the UN country team (UNCT); donors; non-governmental, government representatives; and beneficiaries including adolescents and youth leaders. Interviewees were selected purposely based on a stakeholder mapping (see Annex 2). Interviews were conducted using semi-structured in-depth methods.

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

A total of 60 stakeholders were consulted including 28 adolescents and youth beneficiaries. At the outset, stakeholders were informed about the evaluation and scope of interviewing and either written or oral consent was obtained. Interview guides are available in Volume II of the thematic evaluation.

**4. Direct observation:** Site visits were made in Abidjan, Yamoussoukro, Toumodi, Daloa, and Bouaké. Sites were visited from a selection of services and implementing partners of UNFPA support, aiming to include both rural and urban locations and mix of cultural diversity. At the sites, youth-friendly clinics and youth centres (CEC) were observed.

Table 7: Types and number of stakeholders consulted

| Types and numbers of stakeholders consulted (n=60; adolescents and youth =28) | | | | | | |
|---|---|---|---|---|---|---|
| UNFPA | UN Staff | Government Partners | Donors | International NGOs | National NGOs, CSOs, Academia | adolescents and youth Beneficiaries |
| **6** | **3** | **5** | **1** | **4** | **13** | **28** |

**Definition of categories:**
**UNFPA:** all UNFPA staff
**UN Staff:** staff from any other UN organisations
**Government Partners:** including local and central levels and service providers
**Donors:** including bilateral donors and foundations
**International NGOs:** including international NGOs and CSOs
**National NGOs, CSOs and Academia:** national NGO, CSO or academic institution including universities
**Adolescents and youth beneficiaries:** including adolescents and youth leaders, volunteers, and youth led organizations

*Methods for Data Analysis*

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

Qualitative and quantitative methods were utilized to analyse data. Evidence from data collection methods was coded and a country spread sheet was created (assisted by an evidence sorting database) allowing the

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

systematic analysis of evidence by assumption in the evaluation matrix. Content analysis was used to identify emerging common trends, themes and patterns for each evaluation question. Content analysis was also used to highlight diverging views and opposing trends. Contribution analysis was applied using the reconstructed theory of change (ToC) and its pathways to assess UNFPA contribution to changes over the period. During the field mission the theory of change was tested to understand influencing factors that contribute to changes. Alternative assumptions identified for each pathway of change.

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

*Methods to ensure reliability and validity*

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

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

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

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

**Limitations and Mitigation Strategies**

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

Table 8: Case study limitations and mitigation strategies

| Limitations and mitigation strategies | |
|---|---|
| **Limitation** | **Mitigation strategy** |
| The sexual and reproductive health programme officer could only meet briefly with the team just prior to leaving the country. | Evaluators held additional interview sessions with the adolescents and youth Programme Officer in order to collect additional sexual and reproductive health programme information. |
| The Ministry of Youth focal point did not have the time for the planned interview. | Evaluators discussed the MOY programmes with other MOY programme officers. |

# 3 Situation analysis of adolescents and youth in Côte d'Ivoire

## 3.1 Demographics

According to 2014 data, the population of Côte d'Ivoire is estimated at 22,671,331 inhabitants.[7] The population is experiencing rapid growth with an annual growth rate estimated at 2.8 per cent.[8]

The Ivoirian population is very young with 41.5 per cent being under 10 years of age, 60 per cent less than 25 and 79 per cent less than 35 years old.[9] The demographic picture is characterized by a high adolescent fertility rate at 129 per 1000 but an overall downward trend in gross fertility rates: from 7.2 children per woman in 1981 to 5 in 2012 (EDSCI, 2012). In 2012, 10 to 19 year olds accounted for 23 per cent of the total population of which 31 per cent had borne a child before age 18. Adolescents aged 15 to 19 contributed approximately 13 per cent of the national total fertility rate (EDS III CI 2012).

The geographical distribution of the population changed significantly due to the political events of 19 September 2002 which resulted in a large concentration of people moving from the Central, North, and West regions towards the South of the country.[10] Population displacement remains a significant socio-economic and political challenge.

Côte d'Ivoire continues to have a high maternal mortality rate (614 per 100,000 live births) and neonatal mortality rate (38 per 1000). The contraceptive prevalence rate among adolescents (15-19) is at 11.9 per cent.[11] Unmet family planning needs are estimated at 27 per cent among women of reproductive age. Only 15.7 per cent of young women against 24.6 per cent of young men aged 15-24 years had complete knowledge about HIV.[12]

## 3.2 Socio-economic context

Long years of political crisis have led to the deterioration of living conditions despite the implementation of various economic and financial programmes. Analysis of income profiles indicates a steady deterioration in the living conditions of all households since the 1990s.[13] The poverty rate in 2008 reached 49 per cent nationwide, with a strong predominance of rural areas (62 per cent) against urban areas (29 per cent).[14] By comparison, in 1993, these rates were respectively 32 per cent nationally, 42 per cent rural and 19 per cent urban (EDSCI, 2012).

The Human Development Index (HDI) has changed slightly from 0.43 per cent in 2010 to 0.45 per cent in 2013 ranking Côte d'Ivoire at 171st out of 187 countries in the world, according to Africa 2014 Human Development Report.

The proportion of Ivoirians living in extreme poverty is 23.3 per cent (i.e. living on less than USD 1.25 a day). The proportion considered poor by World Bank standards (i.e. living on less than USD 2 a day), rises to 46.8 per cent. In fact, the number of poor people has multiplied by a factor of ten in the space of one generation. Today one

[7] Document: Other Documents (Recensement Général de la Population et de l'Habitat 2014).
[8] Document: Other Documents (Enquête Démographique et de Santé de Côte d'Ivoire, 2012).
[9] Document: Other Documents (National Strategic Plan for Adolescents and Youth 2010-2014).
[10] Document: Other Documents (National Strategic Plan for Adolescents and Youth 2010-2014).
[11] Document: Other Documents (Enquête Démographique et de Santé de Côte d'Ivoire, 2012 (EDSCI, 2012)).
[12] Document: Partner and Relevant Thematic Documents (UNICEF 2012, Country Statistics: (http://www.unicef.org/infobycountry/Côtedivoire_statistics.html)).
[13] Document: Other Documents (Recensement Général de la Population et de l'Habitat 2014).
[14] Document: Institut National de la Statistique (INS, 2008) Enquête sur le niveau de vie.

in every two Ivoirians is poor, compared with one in ten in 1985. Côte d'Ivoire's economy is essentially agricultural. It represents an added value of 50 per cent of the gross national product and 90 per cent of all export receipts.

The share of the state budget devoted to health spending has not exceeded 5 per cent of the total budget[15]. In terms of access to health services for adolescents and youth, services are supposed to be free of charge reflecting a government decree arising from the March 2007 Ouagadougou Accord.

In terms of education, Côte d'Ivoire has a relatively high number of out-of-school youth as deduced from its net rate of secondary school attendance of 33.1 per cent for boys and only 24.6 per cent for girls.[16] However, the literacy rate among 15-24 year olds is 72.3 per cent for men and 62.7 per cent for women.[17] In 2012, 96.3 out of 100 Ivoirians had a portable telephone but only 2.4 per cent used the internet.

About 90 per cent of financing for the response to HIV in Côte d'Ivoire is assured by international development partners based upon a common response to the national strategic plan for HIV/AIDS.[18] The United States President's Emergency Plan for AIDS relief (PEPFAR) programme is the largest contributor since 2006 and the most significant partner in the fight against HIVAIDS.[19] The Global Fund for AIDS, TB, and Malaria is the second largest source of financing. In 2010, Côte d'Ivoire benefited from a second grant under Round Nine.

## 3.3 Political and legal context

Côte d'Ivoire is emerging from a profound crisis that shook the country from 2002 to 2011. This crisis severely affected the economy and all social sectors, thus delaying important economic developments.

The tense political and security situation, resulting from the post-electoral crisis of April 2011, has gradually normalised, but in its wake has left an estimated 1.5 million people displaced.[20] Parliamentary and local (regional and municipal) elections were organized respectively in December 2011 and in April 2013, having now completed a process for re-shaping the institutions of the Republic.

Since the end of the first half of 2011, the country undertook a process of economic reconstruction and recovery with the ambition to become an economic leader of West Africa, an emerging country 2020.[21]

The Family Planning Strategic Plan of 2012-2016 noted that services, policy and programmes should reflect core principles of human rights, notably self-determination, participation, and non-discrimination. These same principles are equally reflected in the Plan Stratégique National de Lutte Contre l'Infection à VIH, le SIDA et les

[15] Document: Plan Stratégique de la Santé de la Reproduction 2010-2014.
[16] Document: Partner and Relevant Thematic Documents (UNICEF 2012, Country Statistics: http://www.unicef.org/infobycountry/Côtedivoire_statistics.html).
[17] Document: Partner and Relevant Thematic Documents (UNICEF 2012, Country Statistics: http://www.unicef.org/infobycountry/Côtedivoire_statistics.html).
[18] Document: Other Documents (Ministère de la lutte contre le SIDA : Estimation des Flux de Ressources et Depenses de Lutte Contre le SIDA (EF/REDES) Côte d'Ivoire, 2009).
[19] Document: Other Documents (Ministère de la lutte contre le SIDA : Estimation des Flux de Ressources et Depenses de Lutte Contre le SIDA (EF/REDES) Côte d'Ivoire, 2009).
[20] Document: Partner and Relevant Thematic Documents (UNHCR, UNAIDS, 2012, Rapport de la mission conjointe d'évaluation sur le VIH/sida au sein des personnes déplacées internes et de leurs communautés hôtes dans les localités de Duékoué, Guiglo, Man et Danané: Côte d'Ivoire - 25 mai au 1er Juin 2011).
[21] Document: Partner and Relevant Thematic Documents (Côte d'Ivoire, Document de stratégie pays 2013-2017, Banque Africaine de Développement, 2013).

IST, 2011-2015. An analysis of legal texts showed a lack of legal protection and support for women to fully exercise their human rights in the area of sexual and reproductive health.[22]

## 3.4 Key adolescents and youth development partners in Côte d'Ivoire

Several key actors were involved in the implementation of adolescents and youth programmes in Côte d'Ivoire. These included government structures (Ministry of Education, Ministry of Youth, Ministry of Health and HIV/AIDS, Ministry of Defense, and Ministry of Solidarity, Family, Woman and Child); numerous civil society organizations (e.g. Association Ivoirienne pour le Bien Etre de la Famille (AIBEF), Mouvement Etudiant de Sensibilisation et de lutte contre le SIDA (MESSI), Vivre Informer Fraternite (VIF), Cavoequiva, etc.); private sector; technical and financial partners (i.e. bilateral cooperation such as USAID, KfW, etc.); and multilateral partners including the United Nations system (e.g. UNAIDS, WHO, UNICEF, UNDP, UNWOMEN) and regional organisations (African Development Bank and Economic Community of West African States (ECOWAS)).

With regards to reproductive health programs, UNFPA is the main provider of contraceptive products in Côte d'Ivoire (64 per cent) followed by USAID (17.79 per cent) and KfW up to 8.90 per cent.[23]

## 3.5 Key challenges and opportunities for adolescents and youth programming

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

It was found that while there were limited structural - legal, policy and regulatory - barriers, they were not insurmountable impediments to advancing adolescents and youth sexual and reproductive health in the country. Rather the concern focused on social and cultural norms and values which restrict access to and use of modern contraceptives as well as sexual and reproductive health education and information for young people.

Another restrictive factor is the economic and political context which weakened the advancement of adolescents and youth sexual and reproductive health in the country. From 2008 until 2011, the crisis limited the possibility of UNFPA to advance the adolescents and youth agenda in a difficult emergency situation. Given these barriers, consensus was reached that the context was moderately restrictive.

Table 9: Country context assessment

| Country context assessment | |
|---|---|
| **Factor** | **Value Scale** |
| Laws, policies and regulations restrict adolescents and youth access to services<br>*Value: 1* | 3 = Heavily restrictive/ limiting |

[22] Document: Other Documents (Plan Stratégique de la Planification Familiale 2012-2014, v.3, June 2012, pg. 16).
[23] Document: Other Documents (Plan d'action national de la planification familiale de la Côte d'Ivoire 2015-2020).

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

# 4 UNFPA support for adolescents and youth in Côte d'Ivoire

## 4.1 UNFPA programmatic support to adolescents and youth

The UNFPA programme of cooperation with the government of Côte d'Ivoire (CPAP 2009-2013) was based upon the United Nations Development Assistance Framework (UNDAF) Programme of Development Assistance (2009-2013) which reflected the priorities of the national poverty reduction strategy and the Plan of Action of the Ouagadougou Peace Accord. The UNFPA programme of cooperation centred upon three core programme directions: (1) sexual and reproductive health and reproductive rights; (2) population and development; (3) gender, culture and human rights with an approach rooted in human rights, results-based management, partnership, advocacy, and political dialogue and communication.

Support to adolescents and young people was a central part of the component on sexual and reproductive health and reproductive rights. The adolescents and youth component related to Millennium Development Goals (MDGs) four, five and six and contributed to the achievement of the UNDAF outcome that "by 2013, there is improvement to the equitable access for all to basic, quality social services and protection of vulnerable groups". In order to bring both the UN and the government cycles into better alignment on national priorities, the UNDAF 2009-2013 was extended to 2014-2015. As a consequence, the UNFPA country programme was also extended to the same period.[24]

During the evaluation period (2008-2015), UNFPA Cote d'Ivoire supported interventions related to advocating for adolescents and young people's sexual and reproductive health, providing technical support to partners, and building adolescents and young people's capacities.[25]

In responding to the lessons learned from the 5th Plan of Action between UNFPA and the government of Côte d'Ivoire, the 6th Plan of Action focused on (1) strengthening institutional capacity to deliver reproductive health services; (2) integrated sexual and reproductive health services that are available and accessible to the needs of the poorest citizens; and (3) increasing the demand for and supply of quality HIV prevention services. During the evaluation period, the UNFPA country office supported three major projects for adolescents and youth: (1) the youth health project, (2) "aide-ado" initiative, and (3) zero pregnancy campaign in school.[26]

In the country programme action plan (CPAP) of 2009-2013, youth needs were specifically addressed by focusing on the creation of youth friendly services through (a) national health centres for schools and universities (Programme National de la Santé Scolaire et Universitaire—PNSSU), and (b) youth centres for study, communication, arts and cultural activities (CECAAC - commonly known as Centres d'Ecoutes de Conseil or CECs). CECs were developed to (i) organise awareness campaigns on sexual risk behaviour, (ii) make male and female condoms available and accessible to young people, (iii) implement trainings including education to family life, integration and reintegration of young people, (iv) reach out-of-school youth - especially marginalised girls and adolescents - on sexual and reproductive health, sexually transmitted infections / HIV, gender-based violence (GBV) and early pregnancy, and (v) facilitate job creation.[27]

[24] Documents: UNFPA Programming Documents (UNFPA Submission Form for Country Programme Extension, Côte d'Ivoire, Annex II extending programme from the period 2009-2013; UNFPA Extensions of country programmes in the West and Central Africa region: Note by the Executive Director, 2013, DP/FPA/2013/10).
[25] Documents: UNFPA Annual Reports (COARs 2008-2014).
[26] Documents: UNFPA Annual Reports (COARs 2008-2014).
[27] Documents: UNFPA Programming Documents (CPAPs 2009-2013).

From 2008 to 2015, UNFPA worked with a wide range of stakeholders and implementing partners including government institutions, civil society organisations and adolescents and youth associations and networks. The main partners from government institutions were the Ministry of Health and HIV/AIDS, the Ministry of Education, the Ministry of Youth, Ministry of Defence and the Ministry of Women and Families.[28] UNFPA also developed partnerships with civil society organisations such as MESSI, Ruban Rouge, and RNJCI.[29] UNFPA country office worked in collaboration with different international partners such as the World Bank, cooperation agencies (Korea International Cooperation Agency, Le Fonds Français Muskoka, Belgium), European Union, other UN organisations (UNICEF, UNDP, UNIFEM) and other partnership programmes (H4+Sida, Peace Building Fund (PBF), Emergency Relief Fund (ERF)) according to country office annual reports and UNFPA country office staff.

## 4.2 Financial support for adolescents and youth in Côte d'Ivoire

For resource allocation purposes, in 2014, UNFPA categorised programme countries into "colour quadrants" based on the combination of need and ability to finance.[30] Cote d'Ivoire is classified within the "red" quadrant, with high unmet need and low ability to finance. Within red quadrant countries, UNPFA offers a full package of interventions, engaging through advocacy and policy dialogue/advice, knowledge management, capacity development and service delivery.[31]

Based on an analysis of UNFPA Atlas financial data, including data from the Global Programming System (GPS) module,[32] Table 10 and Figure 3 compare the amount budgeted with the amount spent in support of adolescents and youth by the country office for the period 2008-14. Total expenditure amounted to around USD 3.3 million. Data indicate fluctuating annual expenditures (and implementation rates) with peaks in 2008 (USD 720,000) and 2014 (USD 1 million). Overall, adolescents and youth expenditure accounted for roughly five per cent of total country office expenditure for 2008 to 2014.[33]

Table 100: Annual budgets and expenditure in support of adolescents and youth from 2008-2014 (USD)

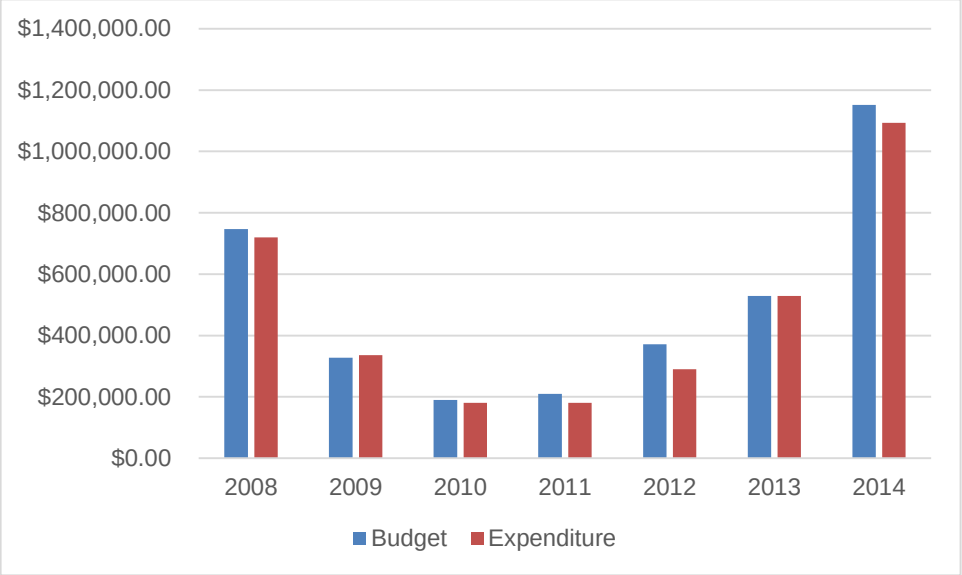
| Annual budgets and expenditure in support of adolescents and youth from 2008-2014 (USD) | | | |
|---|---|---|---|
| **Year** | **Budget** | **Expenditure** | **Execution rate** |
| 2008 | $746,874.00 | $720,255.76 | 96% |
| 2009 | $328,000.00 | $335,895.80 | 102% |
| 2010 | $190,052.59 | $180,155.72 | 95% |
| 2011 | $209,381.00 | $180,144.67 | 86% |

[28] Interviews: UNFPA Staff.
[29] Document: UNFPA Annual Reports (COAR 2012).
[30] The following indicators were used to determine need classification under the 2014-2017 SP: Proportion of births attended by skilled health personnel for the poorest quintile of the population; maternal mortality ratio; adolescent fertility rate; proportion of demand for modern contraception; HIV prevalence, 15-24 year olds; Gender Inequality Index. Document: UNFPA Strategic Plan 2014-2017, Annex 4 on Funding Arrangements.
[31] Document: UNFPA Strategic Plan, 2014 – 2017.
[32] For further information on Atlas and GPS coding/tagging as well as the methodology applied for the financial analysis please see Annex 4.
[33] Total country office (CO) expenditure from 2008-2013: USD 56,196,825 (Source: Atlas dataset generated June 10, 2014 and reflected on Slide 55 of the Côte d'Ivoire Mission Debriefing PowerPoint Presentation). Total CO expenditure for 2014 is $9,720,267.78. Total CO expenditure from 2008-2014 is $65,917,092.78. Note that 2008-2011 CO expenditure data was added to 2012-2013 CO expenditure data and 2014 CO expenditure data to arrive at an estimate of total CO expenditure for 2008-2014. However, expenditure figures from 2008-2011 are not directly comparable to figures from 2012-2013 or 2014, due to changes in UNFPA accounting procedures and coding (with the introduction of the new SP in 2012 and another in 2014). Though this is the case, estimates can still be made.

| | | | |
|---|---|---|---|
| 2012 | $371,677.51 | $290,041.63 | 78% |
| 2013 | $529,379.39 | $529,316.36 | 100% |
| 2014 | $1,151,185.86 | $1,092,767.11 | 95% |
| **Total** | **$3,526,550.35** | **$3,328,577.05** | **94%** |

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

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




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

Table 11 illustrates expenditure figures by project outcome codes in support of adolescents and youth (both regular and other resources) in Côte d'Ivoire for 2008-2014.

Table 11: Expenditure (in USD) by project outcome code /output code (in GPS) for 2008-2014

| Expenditure in USD per project outcome code (in Atlas)/output code (in GPS) for 2008-2014 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Project outcome/output codes** | **2008** | **2009** | **2010** | **2011** | **2012** | **2013** | **2014** | **Grand Total** |
| R205 | -$3,512.34 | -$3,168.84 | $0.01 | | | | | -$6,681.17 |
| R5 | $446,053.35 | | | | | | | $446,053.35 |
| U4 | | | | $31,438.84 | | | | $31,438.84 |
| U5 | | | | $1,611.03 | | | | $1,611.03 |
| U6 | $277,714.75 | $339,064.64 | $180,155.71 | $147,094.80 | $290,041.63 | $529,316.36 | | $1,763,387.89 |
| All 2014-2017 SP outputs under which adolescents and youth expenditure fell in 2014 | | | | | | | **$1,092,767.12** | **$1,092,767.12** |
| **Total** | **$720,255.76** | **$335,895.80** | **$180,155.72** | **$180,144.67** | **$290,041.63** | **$529,316.36** | **$1,092,767.12** | **$3,328,577.06** |

**R205:** Youth-Friendly RH Info/Services; **R5:** Improved access to sexual and reproductive health services and sexual and reproductive health education and information for young people (including adolescents); **U4:** Increased access to and utilization of quality HIV- and STI-prevention services especially for young people (including adolescents); **U5:** Gender equality and reproductive rights advanced particularly through advocacy and implementation of laws and policy; **U6:** Improved access to sexual and reproductive health services and sexual and reproductive health education and information for young people (including adolescents); **All SP Outputs 2014-2017 under which adolescents and youth expenditure fell in 2014**: **SP Output 1:** Increased national capacity to deliver integrated sexual and reproductive health services; **Output 4**: Increased national capacity to deliver HIV programmes that are free of stigma and discrimination; **SP Output 6**: Increased national capacity to conduct evidence-based advocacy for incorporating adolescents and youth and their human rights/needs in national laws, policies, programmes, including in humanitarian settings; **SP Output 7**: Increased national capacity to design and implement community and school based sexual and reproductive health education and information) programmes that promote human rights and gender equality;

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

For 2014, expenditures were found under outputs 1, 4, 6, 7, and 8 (see Table 10).[34]

Table 12: 2014 expenditure (in USD) by SP outputs 6-7-8

| 2014 expenditure (in USD) by SP outputs | |
|---|---|
| SP outcome 1, output 1 | $23,931.65 |
| SP outcome 1, output 4 | $54,863.19 |
| SP outcome 2, output 6 | $779,816.67 |
| SP outcome 2, output 7 | $205,905.44 |
| SP outcome 2, output 8 | $28,250.17 |
| **Total** | **$1,092,767.12** |

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

Table 13 shows that UNFPA has greatly relied on the availability of regular resources during the period of investigation (roughly 82 per cent of total adolescents and youth expenditure originated from regular resources). Other resources have been modest, with a peak in 2014 of USD 260,000 from the Reproductive Health and Commodity Security Thematic Trust Fund.

[34] In order to capture expenditure in support of adolescents and youth in 2014, the following methodology was used: 1) All expenditure that fell under SP output 6, 7, and 8 was included as expenditure in support of adolescents and youth and 2) to capture expenditure in support of adolescents and youth that is mainstreamed across other outputs, a keyword search was performed (derived from a literature review and an initial cursory analysis of data in July 2014). For more information on the methodology, please see Annex 4.

Table 12: Source of adolescents and youth expenditure from 2008-2014 in USD

| Source of adolescents and youth expenditure from 2008-2014 (USD) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Funding Source** | **2008** | **2009** | **2010** | **2011** | **2012** | **2013** | **2014** | **Total** |
| TTF - Multi Donor (TTF POOL RHCS II) | | | | | $100,034.01 | $141,519.31 | $260,281.21 | $501,834.53 |
| UNAIDS | | | | $31,438.84 | | | $22,786.91 | $54,225.75 |
| JP-UNFPA: Administrative Agent | | | | | | $23,953.57 | | $23,953.57 |
| ONUCI (United Nation Operation in Côte d'Ivoire) | $12,242.11 | | | | | | | $12,242.11 |
| Belgium | -$3,512.34 | -$3,168.84 | $0.01 | | | | | -$6,681.17 |
| Small contributions | | | | | | | $20,523.02 | $20,523.02 |
| **Total other resources (earmarked)** | $8,729.77 | -$3,168.84 | $0.01 | $31,438.84 | $100,034.01 | $165,472.88 | $303,591.14 | $606,097.81 |
| **Total regular resources (not earmarked)** | $711,525.99 | $339,064.64 | $180,155.71 | $148,705.83 | $190,007.62 | $363,843.48 | $789,175.97 | $2,722,479.24 |
| **Grand Total** | **$720,255.76** | **$335,895.80** | **$180,155.72** | **$180,144.67** | **$290,041.63** | **$529,316.36** | **$1,092,767.11** | **$3,328,577.05** |

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

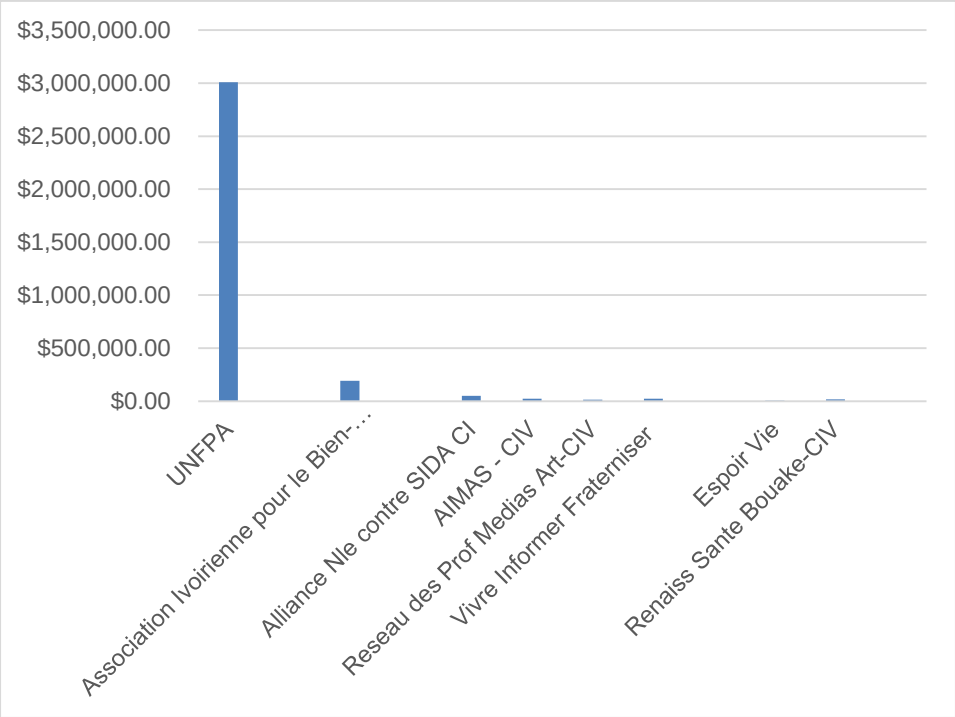
Table 14 and Figure 4 indicate annual expenditure by UNFPA and its implementing partners (IPs) between 2008 and 2014.

Table 13: Expenditure by implementing agency 2008-2014

| Expenditure by implementing agency 2008-2014 in USD | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Implementing agency** | **2008** | **2009** | **2010** | **2011** | **2012** | **2013** | **2014** | **Grand Total** |
| UNFPA | $720,255.76 | $335,895.80 | $176,546.49 | $131,508.62 | $248,368.39 | $389,499.45 | $1,006,480.72 | $3,008,555.23 |
| Association Ivoirienne pour le Bien-Etre familial (AIBEF) | | | | | $41,510.52 | $103,565.62 | $46,080.93 | $191,157.07 |
| Alliance Nle contre SIDA CI | | | | $48,636.04 | $162.72 | | | $48,798.76 |
| AIMAS - CIV | | | | | | $23,527.50 | | $23,527.50 |
| Reseau des Prof Medias Art-CIV | | | | | | $12,723.79 | | $12,723.79 |
| Vivre Informer Fraterniser | | | | | | | $21,793.67 | $21,793.67 |
| Espoir Vie | | | $3,609.23 | $0.01 | | | | $3,609.24 |
| Renaiss Sante Bouake-CIV | | | | | | | $18,411.79 | $18,411.79 |
| **Grand Total** | **$720,255.76** | **$335,895.80** | **$180,155.72** | **$180,144.67** | **$290,041.63** | **$529,316.36** | **$1,092,767.11** | **$3,328,577.05** |

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

Figure 4: Expenditure by implementing agency (2008-2014)




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

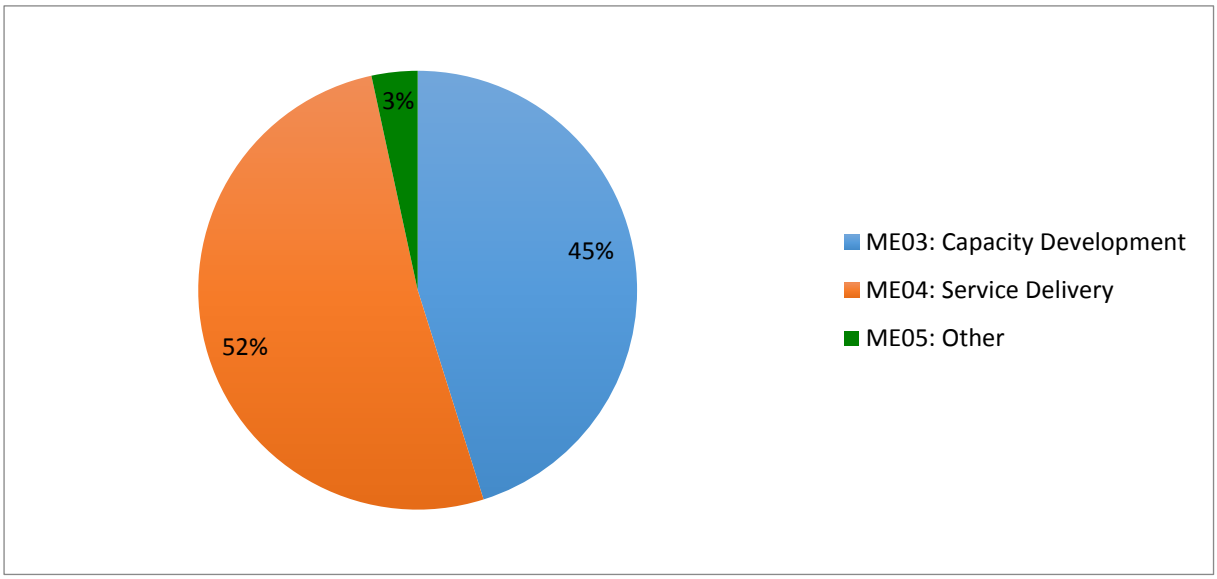
Table 15 and Figures 5 capture the amount spent in 2014 on all 2014-2017 SP outputs under which adolescents and youth expenditure fell by mode of engagement (ME). Spending was the highest for "service delivery" at approximately USD 508,000 or 52 per cent of total expenditure, followed by "capacity development" (USD 469,000 or 45 per cent). No expenditure was reported for "advocacy/policy dialogue and advice" or "knowledge management".

Table 14: Adolescents and youth expenditure by Mode of Engagement for 2014 in USD

| adolescents and youth expenditure in 2014 by Mode of Engagement (USD) | |
|---|---|
| **Mode of Engagement (MoE)** | **Expenditure** |
| ME04: Service Delivery | $562,437.39 |
| ME03: Capacity Development | $493,361.04 |
| ME05: Other | $36,968.69 |
| **Grand Total** | **$1,092,767.12** |

Source: UNFPA Evaluation Office based on GPS data.

Figure 5: Adolescents and youth spending by mode of engagement for 2014 (red quadrant)




Source: UNFPA Evaluation Office based on GPS data.

**Adolescents and youth financial resources summary**

UNFPA is a key financial supporter of sexual and reproductive health programmes in Côte d'Ivoire, including adolescents and youth programming. The irregular expenditure patterns noted between 2008 and 2014 reflect the impact of significant social and political unrest from 2009 to 2011.[35] During this time, many government ministries were effectively closed or were unavailable to imlement programme resources. As a result, overall expenditure amounts dropped significantly (i.e. 2009-2011), but then gradually increased from 2012 (USD 290,041) to 2013 (USD 529,316) and then 2014 (USD 1,013,972). Despite periods of social and political unrest, execution rates were relatively high during the evaluation period with only one notable dip in 2012 (78 per cent), returning to 99 per cent the following year.

Funding for adolescents and youth in Côte d'Ivoire, and particularly the availability of core funding, was considered low by many stakeholders (i.e. core funding dropped from a high of USD 711,525 in 2008 to a low of USD 148,705 in 2011). Independently of social and political unrest, expense data suggested an under-financing of a priority area (adolescents and youth) - and in particular, marginalised and vulnerable adolescents and youth - relative to other programme support (i.e. 65 per cent of total expenditures on contraceptive supplies). Only four per cent (USD 2,235,809) of total expenditures (core and non-core) over a five-year period (2008-2013) was spent on adolescents and youth programming. In 2014, overall adolescents and youth expenditures increased to 10 per cent of total expenditure, yet only 2.7 per cent (USD 28,287) of adolescents and youth expenditures was used to address marginalised adolescent girls.

[35] Expenditure in USD per project outcome code (in Atlas)/output code (in GPS) for 2008-2014. Source: Financial analysis of Atlas data conducted by the UNFPA Evaluation Office.

# 5 Findings

## 5.1 Relevance

**EQ1. To what extent was support to adolescents and youth, particularly the most marginalised and vulnerable, aligned with UNFPA policies and strategies, partner government priorities, plans and the needs of adolescents and youth and responsive to local contexts?**

Summary of findings

The country programme and its adolescents and youth component are generally consistent with goals and strategies outlined within the 2008-2013 UNFPA Strategic Plan, the 2006 adolescents and youth Framework and the 2012-2020 adolescents and youth strategy. Limitations were due to the post-crisis context.

UNFPA support was also aligned with national priorities and needs of adolescents and youth as evidenced by central and local government plans and strategies—as well as CSOs—and were appropriate to the epidemiological picture of adolescents and youth . Partners however felt that annual meetings to discuss programme alignment to national adolescents and youth needs (among other issues) were missed opportunities to better understand the full breadth of adolescents and youth needs, including the needs of the most vulnerable and marginalised.[36] In addition, stakeholders assessed programme activities on sexual and reproductive health education and information not well aligned to international standards.

From 2010-2011, a political crisis had effectively shut down most government service provision, including for adolescents and youth. UNFPA successfully responded to the situation by creatively re-routing earmarked funding to NGO programmes focusing on gender-based violence and human rights-based approaches to sexual and reproductive health while maintaining the coherence of the programme.

### *5.1.1 Alignment of UNFPA support with UNFPA policies and strategies in the area of adolescents and youth*

Analysis of the country programme document (CPD) for Côte d'Ivoire[37] indicates that UNFPA attempted to align its adolescents and youth programme with the relevant UNFPA Strategic Plans (SPs) of the period, although its capacity to do so was limited by the post-crisis context.[38] Under its reproductive health component, the CPD specifically mentions adolescents and youth in the context of strategies for the provision of user-friendly health services and the development of life skills.[39] Notably, although young people are included as an intended target of one outcome under the gender component - implementing

[36] Interviews: NGOs.

[37] For the period of the evaluation, only one UNFPA country programme document (CPD) from Côte d'Ivoire was available for analysis, namely that for the sixth cycle of assistance (2009 – 2013). 2008 was a transition year from the fifth cycle of assistance. For the last year of the period of evaluation, the country programme (CP) had been extended for two years in mid-2013 to align with the UNDAF and National Development Plan.

[38] Documents: UNFPA Programming Documents (CPDs 2009 – 2013).

[39] Discussed under output 2: Integrated, high-quality and comprehensive sexual and reproductive health services are available and accessible for the poorest populations, and output 3: The demand for high-quality services to prevent sexually transmitted infections and HIV is increased, particularly among women, young people, and vulnerable and at-risk groups.

job-creation mechanisms - no specific strategies to achieve this outcome are described.[40] In the area of population and development, planned support was focused on rebuilding basic capacity in the area of statistical analysis, with no discussion of adolescents and youth specifically.

In general, the CP aligns with the 2008 – 2011 UNFPA SP, specifically outcome 2.5;[41] nesting adolescents and youth concerns within other outcomes as well as the focus on services and life skills reflecting the structure of the SP. When considered against the UNFPA mid-term review of the 2008 – 2011 SP, the CP is well aligned in the area of youth services, namely with outcome 6 and outcome 7.[42] The CP is also aligned in general terms with outcome 2 of the 2014 – 2017 SP, although specific attention to sexual and reproductive health education and information (output 7), and adolescent girls (output 8) beyond the area of FGM/C is lacking.[43] Regarding UNFPA's Framework for Action on Adolescents and Youth (2007) and the UNFPA Strategy on Adolescents and Youth (2012), the country programme is most strongly aligned in the area of sexual and reproductive health services (key 3 and prong III respectively).

Data from the country office survey confirmed that UNFPA in the Côte d'Ivoire focused on youth-friendly health services in its programming. A planned desk review of how UNFPA support for sexual and reproductive health education and information and youth friendly health services had evolved in Côte d'Ivoire over the evaluation period was not possible due to an absence of development results framework data from 2008 and 2009, incomplete SIS data in 2014, and the use of multiple reporting mechanisms (DRF, SIS, COARs) and formats, which were altered several times between 2008 and 2014.[44] In addition, large amounts of important information were collected in an unstructured format, containing lengthy narratives that did not add sufficient detail to assess alignment.[45]

### *5.1.2 Alignment of UNFPA support with national (government and CSOs) priorities and needs in the area of adolescents and youth*

The document review and interviews with central government and adolescents and youth stakeholders confirmed that UNFPA support was aligned, in general, with the broad developmental priorities related to adolescents and youth of the national government as expressed through ministerial programme strategy documents (i.e. Plan Stratégique Nationale de Lutte Contre l'Infection à VIH, SIDA, et les IST 2011-2015 ; Plan Nationale de Developpement Sanitaire 2013-2015; Plan Stratégique de Suivi et Évaluation 2009-2013 du Plan d'Action du Programme de Coopération Côte d'Ivoire-UNFPA; Politique Nationale de la Jeunesse 2011-2015; Plan National de Developpement 2012-2015).[46] Specifically, the country programme action plan (CPAP) of 2009-2013 focused attention on three strategic areas: (1) rights and reproductive health, (2) population and development, and (3) gender, culture and human rights. Strategic area one focused on increasing and strengthening youth friendly sexual and reproductive health services including HIV

[40] Outcome b: job-creation mechanisms are implemented, particularly for young people, women, and communities of internally displaced people.
[41] Outcome 2.5: Access of young people to SRH, HIV and gender-based violence prevention services, and gender-sensitive life skills-based SRH education improved as part of a holistic multi-sector approach to young people's development.
[42] Outcome 6, output 15: Improved programming for essential reproductive health services to marginalised adolescents and young people. Outcome 7: Improved data availability and analysis around population dynamics, SRH (including family planning) and gender equality.
[43] Outcome 2: Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health.
[44] Documents: UNFPA Annual Reports (COARs 2008 – 2014, development results framework data 2010-2013, SIS data 2014 – indicator and narrative reports).
[45] This was especially the case with COARs and SIS narrative reports.
[46] Interviews: UNFPA Staff, Government; NGOs. Documents: Other Documents (Plan National de Developpement 2012-2015, Politique Nationale de la Jeunesse 2011-2015).

prevention; strategic area two addressed institutional strengthening on gender disaggregated data, gender disparities, and sexual and reproductive health education and information; and strategic area three addressed gender disparity/violence issues but did not target adolescents and youth programmes specifically.

The national strategy documents noted above, (except for the National Youth Strategy), tended not to prioritise adolescents and youth *per se*.[47] National strategy documents generally based their overall strategies under the umbrella frameworks of international conventions (i.e. ICPD and the Ouagadougou and Abuja agreements) and national development plans including poverty reduction strategies, but they were relatively silent on the needs of adolescents and youth specifically. The National Development Plan Overview (2012-2015) made no mention of youth except for re-integrating ex-combatants, yet it had budget categories for youth and sports (4.9 per cent), and gender, women, and children (15.7 per cent).

There was no evidence indicating that UNFPA systematically reviewed and monitored national strategic programme documents, relevant to adolescents and youth issues, against international standards (i.e. youth friendly health services or sexual and reproductive health education and information) with the intent of advocating or prioritising adolescents and youth concerns in national programme and policy documents. UNFPA did, however, hold annual needs assessment meetings with adolescents and youth stakeholders and implementing partners to discuss the development of annual workplans.[48]

Evidence suggested that UNFPA was generally in alignment with civil society adolescents and youth agendas and/or needs assessments. For example, UNFPA collaborated closely with a select number of CSOs (civil society organisations, as both stakeholders and implementing partners) on mutually focused adolescents and youth programmes addressing (a) the increase of sexual and reproductive health services, (b) gender inequality, (c) gender-based violence, (d) early child marriage, and (e) early pregnancy.[49] However, there was evidence of misalignment in the area of sexual and reproductive health education and information;[50] stakeholders felt that UNFPA support for sexual and reproductive health education and information—through the"Education à la Vie Familiale et En matière de Population" (EVP/EmP) curriculum and the Zero Pregnancy campaign–was not in agreement with CSO priorities since neither EVP/EmP nor the Zero Pregnancy campaign combined addressed the full range of issues found within international standards on sexual and reproductive health education and information.[51] (See section 5.2.2 for more details.)

UNFPA organised annual planning meetings with government ministries and other implementing partners that included a focus on adolescents and youth ,[52] but there was a perception by adolescents and youth stakeholders that UNFPA did not utilise these annual meetings well (i.e. annual planning meetings focused more on project financial reporting than on programme activities) for the ultimate purpose of better

[47] Documents: Other Documents (Plan stratégique nationale de lutte contre le SIDA /MEMPP 2011-2015; Plan Stratégique de Suivi et Évaluation 2009-2013 du Plan d'Action du Programme de Coopération Côte d'Ivoire-UNFPA Politique Nationale de la Jeunesse 2011-2015; Plan National de Developpement 2012-2015).
[48] Interviews: UNFPA Staff, NGOs, adolescents and youth Beneficiaries.
[49] Interviews: UNFPA Staff, NGOs, adolescents and youth Beneficiaries.
[50] Interviews: UN Staff, Government, NGOs.
[51] Interviews: UN Staff, NGOs. Documents: Other Documents (Education à la Vie Familiale et En matière de Population document review).
[52] Interviews: Government. Documents: AWPs 2009-2013.

understanding the full breadth of adolescents and youth needs, including the most vulnerable and marginalised.[53]

### *5.1.3 Responsiveness of UNFPA support to changing contexts while maintaining coherence of programmes[54]*

UNFPA demonstrated flexibility, timeliness and appropriateness in its response to changes in context, especially during the 2010-2011 political crisis, by adapting its funding strategy to support humanitarian efforts by NGOs when all government level activities had come to a halt. Through the "Peace Building Fund" - an initiative responding to the electoral crisis of 2010 - UNFPA directed resources towards peace-building activities during a time of wide-spread social unrest. In responding to a general increase in GBV as result of the unrest, UNFPA was able to direct support to adolescents and youth programmes directly which served as a way to draw the government's attention to adolescents and youth needs.[55] During the election crisis of 2010-2011 which paralysed the government and unleashed significant social unrest, UNFPA played a key role by re-routing earmarked funding for central government programmes towards GBV prevention, treatment and care via non-governmental partners.[56] For example, during the period of evaluation (and currently in practice), post-rape medical exams are required by law if any follow-up legal action is to be taken.[57] To respond to the situation, UNFPA worked closely with implementing partners and found ways of making rape-kit medical exams available, in both public and private clinic settings, to survivors of violence (women and girls).[58]

[53] Interviews: NGOs.

[54] Evaluation assumption1.3 of the evaluation matrix.

[55] Interviews: UNFPA Staff, UN Staff, Government, NGOs.

[56] Interviews: UNFPA Staff, UN Staff, Government.

[57] Interviews: UNFPA Staff, Government, NGOs, adolescents and youth Beneficiaries.

[58] A distinction was made between requests for rape kits by women and girls making official complaints versus requests by parents bringing their daughters for rape kit exams for unofficial, other reasons (i.e. determining paternity). Interviews: UNFPA Staff, Government, NGOs, INGO, adolescents and youth Beneficiaries.

| **EQ2. To what extent have human rights, gender responsive and culturally sensitive approaches been incorporated into programming in the area of adolescents and youth at global, regional and national level? To what extent has UNFPA prioritised the most marginalised and vulnerable adolescents and youth, particularly young adolescent girls in its interventions?** |
|---|
| Summary of findings |
| UNFPA used human-rights based language and approaches in its adolescents and youth programmes and communications. Evidence was unclear as to what extent UNFPA played a role in raising awareness, building the capacity of and supporting implementing partners to integrate specific human rights approaches in adolescents and youth interventions in education and information, health services and participation.<br><br>Gender responsive approaches addressed adolescents and youth concerns mainly through specific issues such as child marriage, adolescent pregnancy and gender-based violence (GBV). In response to the high incidence of GBV during the 2010-2011 socio-political crisis, UNFPA promoted the creation of a gender unit within the government in collaboration with other stakeholder organisations.<br><br>UNFPA demonstrated an ability to integrate culturally sensitive approaches by supporting partners to design culturally sensitive information, education and communication materials including a nation-wide school campaign to promote contraceptive use, prevent premature and unwanted pregnancies and early child marriage (called "Zero Pregnancies"). The extent of the campaign's coverage was limited, however the campaign did focus on the needs of adolescent girls aged 10-14.<br><br>UNFPA financed and supported vulnerable and marginalised young people as evidenced by studies it commissioned on HIV/AIDS in 2006 and again in 2010 carried out by UNICEF and other partners. UNFPA was a prominent convener of and focused attention on the needs of adolescent girls aged 10-14 mainly under the umbrella of the Zero Pregnancy campaign (whose age range focus is 10-19) as well as its support of GBV programmes. However, these programmes did not specifically target a sub-category of vulnerable adolescent girls, namely out-of-school youth, who represent a significant proportion of the adolescents and youth population. In general, definitions of what constituted marginalised adolescents and youth differed between stakeholder organisations highlighting a lack of strategic focus. |

### *5.1.4 Incorporation of human rights-based approaches in adolescents and youth strategies and programmes*

Nearly all informants expressed an awareness of the importance of human rights for adolescents and youth, especially young girls. Some cited the role of UNFPA in (1) promoting the importance of young girls being cognisant of their autonomy[59] and (2) promoting the participation of adolescents and youth in HIV/AIDS prevention programmes.[60] Government informants particularly praised UNFPA's role in focusing

[59] Interview: Government, adolescents and youth Beneficiaries. Documents: Other Documents (Affiche Grossesse - Campaign 'Zero Grossesse à l'Ecole' posters).
[60] Interviews: Government, NGOs.

on programme specific issues like GBV and early child marriage where UNFPA played a role in providing data and technical support on human rights based approaches.[61]

UN and national strategy documents highlighted human rights as a priority organising principle in sexual and reproductive health policy in general;[62] however it was less clear to what extent human-rights was made specific in relation to adolescents and youth. For example, the campaign "Zéro Grossesse à l'Ecole" (Zero Pregnancies in School) placed young people at the centre of its programme activities encouraging self-determination and management of their sexual and reproductive health needs and specifically sought to reduce young girl's vulnerabilities to pregnancy.[63] However, the National Strategy for Advocating about HIV/AIDS and STI's (2010-2014) only mentioned youth as "beneficiaries" with no mention of their human right to health, integrating them as advocates or developing a youth programme focus.[64] There was no evidence of UNFPA interventions that explicitly highlighted or elaborated what rights youth have with respect to information, health services and participation.

A majority of respondents, however, did not attribute their knowledge and understanding of adolescents and youth human rights-based approaches to UNFPA support. As such, it was not clear to what extent UNFPA played a key role in raising awareness, building the capacity and supporting partners to integrate human rights approaches in support of adolescents and youth and sexual and reproductive health.[65]

### *5.1.5 Incorporation of gender-responsive approaches and strategies to address gender barriers in adolescents and youth strategies and programmes*

Under the umbrella of gender—as a cross-cutting issue—UNFPA integrated adolescents and youth programme support through advocacy and technical assistance activities and institutional capacity building.[66] Adolescents and youth stakeholders felt, however, that while UNFPA incorporated adolescents and youth concerns in gender-responsive programming, their overall support for institutional capacity building was weak.[67]

UNFPA integrated a gendered approach in its programming and adapted its messages to challenge gender-negative norms and roles for young women and men.[68] Within the evaluation period, for example, UNFPA integrated gender transformative messages through the national campaign "Zero Pregnancies in School"[69], where a posters targeted young boys and their need to respect the life goals of young girls and take responsibility for their role in early pregnancies. In 2012, UNFPA trained a wide range of civil servant actors (police, army officers, section heads of rural development bureaus, etc.) on a human rights-based approach to better understand, prevent and address gender-based violence.[70] And, in an effort to reduce FGM/C, UNFPA supported mobile vans that were deployed in four high-risk provinces to reach out to men,

[61] Interviews: Government.
[62] Documents: UNFPA Programming Documents (CPAP 2009-2014, CPDs 2009-2013), Partner and Relevant Thematic Documents (UNDAF 2013 – 2015), Other Documents (Plan Stratégique Suivi Evaluation 2009-2013).
[63] Documents: Partner and Relevant Thematic Documents (Campagne « zéro grossesse à l'école » 2013-2015: Plan Accéléré de Réduction des Grossesses en Milieu Scolaire - Revue de la Première Année d'Exécution).
[64] Document: Other Documents (National de Stratégie de Plaidoyer en matière de lutte contre le VIH/SIDA 2010-2014).
[65] Interviews: NGOs, adolescents and youth Beneficiaries.
[66] Documents: UNFPA Annual Reports (COARs 2008-2010).
[67] Interviews: Government, adolescents and youth Beneficiaries.
[68] Documents: UNFPA Strategic Planning Documents (UNFPA Strategic Plan 2008-2011); UNFPA Programming Documents (CPAPs 2009 -2013), UNFPA Annual Reports (COAR 2012).
[69] Interviews: Government. Documents: Other Documents (Affiche Grossesse - Campaign 'Zero Grossesse à l'Ecole' posters).
[70] Interviews: UN Staff, Government. Documents: UNFPA Annual Reports (COAR 2012).

women, and community leaders about the illegality and health-associated risks of FGM/C.[71] But it was less clear, and to what degree, UNFPA support built the capacities of partners in this area (materials, training of trainers).[72] Partners, for example, expressed that, while appreciative of support on gender-focused training activities in general, technical support came sporadically and insufficiently thus decreasing their potential for efficiencies and effectiveness.[73]

Due to the increase and seriousness of GBV during the socio-political crisis of 2010-2011,[74] UNFPA and other UN organisations promoted the creation of a gender unit within the government. This unit is now called the "Unit of Gender Equality" under MSFFE (Ministry of Families, Women, and Children). [75]

### *5.1.6 Integration of culturally sensitive approaches in adolescents and youth interventions*

UNFPA demonstrated an ability to integrate culturally sensitive approaches in adolescents and youth interventions. Many NGO stakeholders mentioned the importance of culturally sensitive approaches and the need to work with local community and traditional and religious leaders.[76] Several key informants believed that the most culturally sensitive way to address socio-cultural barriers was to focus discussions of programme approaches rooted in studies and data versus attempting to challenge traditional belief systems.[77]

With support from UNFPA, the MOE demonstrated an ability to adapt its strategies and programmatic approach by integrating cultural views and perspective as a way to address a substancial increase in adolescent pregnancy. The Zero Pregnancy campaign designed culturally appropriate materials (mainly posters) with images and messages developed in consultation with young people, religious leaders, traditional leaders and CSOs that focused on positive, self-affirming statements from influential community members rather than using fear tactics (i.e. using graphic images of STI consequences).[78] For example, some posters and messages included the voices of an imam and a pastor who supported young people's sexual and reproductive health and spoke against FGM and child marriage.

### *5.1.7 Prioritisation of interventions that identify and include adolescents and youth, particularly the most vulnerable and marginalised, especially adolescent girls*

UNFPA financed and supported a study on vulnerable and marginalised young people and HIV/AIDS in 2006, which was again carried out in 2010 by UNICEF and other partners. Despite the existence of these studies, there was no evidence that data from these studies or other sources were used to develop programmes and build the capacity of implementing partners to address the needs of vulnerable or

[71]; Interviews: UNFPA Staff, Government. Documents: UNFPA Annual Reports (COAR 2012).
[72] Interviews: UNFPA Staff, NGOs, adolescents and youth Beneficiaries. Documents: Other Documents (Affiche Grossesse - Campaign 'Zero Grossesse à l'Ecole' posters).
[73] Interviews: Government, NGOs, adolescents and youth Beneficiaries.
[74] Interviews: UN Staff, Government.
75 Interviews: UNFPA Staff, Government.
[76] Interviews: NGOs, adolescents and youth Beneficiaries.
[77] Interviews: UNFPA Staff; Government, NGOs.
[78] Interviews: Government. Documents: Other Documents (Affiche Grossesse - Campaign 'Zero Grossesse à l'Ecole' posters).

marginalised adolescents and youth.[79] Aside from peer education initiatives, no evidence was found of mechanisms in place to engage vulnerable and marginalised adolescents and youth views in programme design and implementation.

In general, definitions of what constituted marginalised adolescents and youth in Côte d'Ivoire differed between stakeholder organisations.[80] UNFPA focused attention on the needs of adolescent girls aged 10-14 mainly under the umbrella of the Zero Pregnancy campaign (whose age range focus is 10-19), and its support of GBV programmes. However, these programmes did not specifically target a sub-category of vulnerable adolescent girls, namely out-of-school youth who represent a significant proportion of the adolescents and youth population.[81] Smaller scale peer education projects run by local NGOs, and financially supported by UNFPA, carried out the majority of the work in this area.[82]

[79] Interviews: UNFPA Staff, UN Staff, NGO, adolescents and youth Beneficiaries.
[80] Interviews: UNFPA Staff, NGOs, adolescents and youth Beneficiaries.
[81] Education Data and Policy Center, Cote d'Ivoire, National Education Profile 2014 Update. http://www.epdc.org/sites/default/files/documents/EPDC%20NEP_Cote%20d%20Ivoire.pdf. "In Cote d'Ivoire, 39% of children of official primary school ages are out of school...for example...approximately 34% of boys of primary school age are out of school compared to 43% of girls of the same age. «
[81] Interviews: UNFPA Staff, Government, NGO.

## 5.2 Effectiveness and Sustainability

| **EQ3. To what extent has UNFPA contributed (or is likely to contribute) to an increase and sustainability of the availability of sexual and reproductive health education and information and integrated services (including contraceptives, HIV and GBV) for adolescents and youth?** |
|---|
| Summary of findings |
| UNFPA supported the national school health programme to implement youth-friendly health services (youth friendly health services) for in-school adolescents and youth, however, the quality of services delivered did not yet meet minimal standards. Basic tenants of youth friendly health services standards were not evident including assuring confidentiality, privacy, and availability of educational materials. UNFPA contributed however to an increase in the availability of youth friendly integrated health services through the development of clinic infrastructure, providing contraceptive methods, medicines and equipment as well as national-level trainings. The existence of sexual and reproductive health services targeted specifically to in-school adolescents and youth through the youth friendly clinics system provided opportunities for young people to access modern family planning methods, HIV testing, and referrals for gender-based violence (GBV) cases.<br><br>There has been a steady increase in use of sexual and reproductive health services by adolescents and youth, especially at Services de Santé Scolaire et Universitaire (SSSUs), over the evaluation period 2008-2014, although the coverage was not national and clinics focused mostly on in-school young people. This situation points to the challenge of making integrated services available for all young people in Côte d'Ivoire. The basic infrastructure for youth friendly health services is in place, but they did not adequately implement international standards for youth friendly health services. Stakeholders and evaluators' observations noted a lack of supplies at the local level (i.e. information, education and communication materials) while central government offices appeared better resourced.<br><br>Data were inconclusive whether UNFPA-supported activities contributed to increased national ownership and sustainability as evidenced by, for example, increased central and local government budgets for integrated services during the evaluation period. It was not evident that there was a multi-sectoral sustainability plan in place for the future provision of contraceptive methods or sexual and reproductive health services for adolescents and youth.<br><br>Between 2008 and 2014, UNFPA participated in supporting the development of sexual and reproductive health education and information in Côte D'Ivoire under the leadership of local non-governmental organisations. The national sexual and reproductive health education and information curriculum in Côte d'Ivoire is not comprehensive or fully in line with international standards. UNFPA worked closely with central government partners to integrate pedagogically sound methods for introducing sexual and reproductive health education and information within a broader, family life education curriculum, but it did not advance a national, standardized sexual and reproductive health education and information curriculum, and seemed to have missed the opportunity of joining current national discussions in this area. The focus of sexual and reproductive health education and information seemed to be within schools and SSSUs, with little evidence of systematic targeting and/or reaching out-of-school young people. In |

general, there was a lack of leadership, involvement and coordination from UNFPA (and other UN organisations) on sexual and reproductive health education and information, with NGOs taking the lead in developing curricula and training materials with government and adolescents and youth leaders in 2015. Implementing partners lacked materials for training and IEC on sexual and reproductive health education and information.

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

UNFPA supported a national school health programme to implement youth friendly health servicess for in-school adolescents and youth. Delivery of services to international standards remains a major challenge. UNFPA contributed to an increase of youth-friendly health services through the development of clinic infrastructure,[83] the provision of contraceptive methods, sexual and reproductive health medicines and small equipment as well as national-level trainings for PNSSU staff (Programme National de la Santé Scolaire et Universitaire, i.e. School-based Health Services) and CECs (Centres d'Ecoutes et de Conseil - i.e. youth centres), and Aide-Ado (i.e. "adolescent helpers" or peer educators) working with these facilities. There are 163 SSSUs (Service de Santé Scolaire et Universitaire) across the country.[84] Although no evaluation on the youth friendliness of these services was ever conducted, from observation of several sites, services did not seem aligned to UNFPA youth friendly health services guidelines (e.g. convenient operating hours, privacy ensured, package of essential services, etc.) and tended to reach only in-school young people (as opposed to reaching out to out-of-school adolescents and youth who comprise the majority of marginalised and vulnerable young people). UNFPA trained clinic staff on a variety of issues including GBV, but staff for these youth friendly clinics never received specific training on how to provide youth friendly services.

In Côte d'Ivoire, WHO took the normative lead in developing guidelines and protocols for youth friendly health services. UNFPA had a supportive role (i.e. organising clinical trainings) in line with UN country coordination.[85] Central government-funded youth friendly clinics or consultation rooms within hospitals visited by the evaluators (SSSUs, n=3) did not appear to fulfil the UNFPA criteria of youth friendly health services.[86]

Between 2008 and 2014, none of the service providers from CECs or SSSUs had been trained in delivering youth friendly services as defined by UNFPA standards.[87] Discussions with key informants confirmed that UNFPA supported trainings focused on family planning, as well as on GBV and the special needs of victims/survivors of violence and how and where to refer these young people. While many central and local government and beneficiary partners had received some training funded wholly or in part by

[83] Document: UNFPA Annual Reports (COAR 2008).
[84] http://www.gouv.ci/_actualite-article.php?recordID=5036. *Sante Scolaire et Universitaire: Dr. Goudou-Coffie lance la visite Medicale Systematique*. 3 November 2014.
[85] Interviews: UNFPA Staff, UN Staff. Documents: Partner and Relevant Thematic Documents (UNDAF 2009-2013).
[86] Direct observation: SSSUs: Yamoussoukro, Daloa; District Health referral station (Daloa).
[87] Interviews: UNFPA Staff, Government.

UNFPA,[88] key informants expressed concern that there was no post-training follow-up in the form of resources (i.e. medical/FP supplies) and/or supervision. Trainings appeared to be singular events without being part of a larger package of sustainable programme/professional development on adolescents and youth concerns as a way to build the capacity of staff and adolescents and youth peer educators.

Aside from the availability of contraceptive methods, the SSSUs and CECs visited were under-resourced with limited service delivery.[89] The consultation rooms and waiting areas of the SSSUs observed appeared poorly maintained and equipped, often devoid of information, and lacking confidential structures to ensure privacy (i.e. two separate doors for entry and exit).[90] The initial design of the SSSU services was intended for in-school young people, although a transition to opening up these services to all young people is currently under discussion at the government level.[91] Services were meant to be free (guaranteed by government decree in 2008), however some key informants expressed that SSSU services were not entirely free.[92] In visited SSSUs, posters in waiting rooms communicated a consultation fee for the purchase of materials such as latex gloves, masks and thermometers, totalling anywhere from USD 4-6 - a sum significant enough to possibly discourage adolescents and youth from visiting SSSU clinics.[93]

Educational materials for young people were not available at the time of the visits. Peer educators were affiliated with some of the SSSUs and CECs through UNFPA funding[94], however, peer educators did not cover all SSSUs and received limited support in the form of information (pamphlets, posters, flyers) and/or on-going training from project staff.[95] Several respondents mentioned a lack of motivation for youth engagement because CECs had no budgets or other resources to conduct activities.[96] Peer educators operated in the absence of any communications tools (i.e. pamphlets, flyers, TVs, i-pads/smartphones, internet, etc.) or other support to organise adolescents and youth -focused events.[97]

Although no evaluation has been conducted on youth friendly health services *per se*, and despite no evidence of specific advocacy efforts to increase youth friendly health services, other documents reviewed revealed that between 2008 and 2014, there was a steady increase in young people's use of sexual and reproductive health services, especially at SSSU's.[98] The Zero Pregnancy campaign aimed to reduce socio-cultural and gender barriers to service access by showcasing positive examples of secondary school male and female adolescents and youth using modern contraception.

Finally, it was unclear whether UNFPA-supported activities had contributed to increased national ownership and sustainability as evidenced by, for example, increased central and local government budgets for these services during the evaluation period. It was not evident that there was a multi-sectoral sustainability plan in place for the future provision of contraceptive methods or sexual and reproductive health services for adolescents and youth.

[88] Interviews: UNFPA Staff, Government, adolescents and youth Beneficiaries. Source: Financial analysis of Atlas data conducted by the UNFPA Evaluation Office.
[89] Direct observation: SSSUs: Yamoussoukro, Daloa; District Health referral station (Daloa).
[90] Direct observation.
[91] Interviews: UNFPA Staff, Government, adolescents and youth Beneficiaries.
[92] Interviews: UNFPA Staff, Government, adolescents and youth Beneficiaries.
[93] Interviews: UNFPA Staff, Government, adolescents and youth Beneficiaries. Direct observation.
[94] Interviews: UNFPA Staff, Government, NGO.
[95] Interviews: UNFPA Staff, Government, adolescents and youth Beneficiaries.
[96] Interviews: Government, adolescents and youth Beneficiaries.
[97] Interviews: adolescents and youth Beneficiaries. Direct Observation.
[98] Interviews: Government, NGO. Document: UNFPA Annual Reports (COARs 2013-2014).

Box 1: Revision of the theory of change pathway for services

| Activities (Modes of Engagement) to Output 1[99] |
|---|
| The evaluation theory of change holds that all modes of engagement (activities) should be used to achieve **Output 1**: Strengthened national capacity to make comprehensive adolescents and youth sexual and reproductive health services available, including HIV and GBV care and treatment. In Côte d'Ivoire, this element of the ToC pathway held true, with all modes of engagement used, although each to varying degrees. |
| **Output 1 to Outcome A**[100] |
| Between Output 1 and Outcome A, **Hypothesis a** (key socio-cultural, legal and gender barriers are overcome) was shown to be valid by this case study as a fundamental assumption to be addressed for increased availability and use of integrated sexual and reproductive health services for adolescents and youth . Indeed, in Côte d'Ivoire, UNFPA-supported youth friendly health services are reportedly not used to full capacity, due to on-going socio-cultural, gender, financial, and other barriers to their access.<br><br>The importance of **Hypothesis b** (service providers and teachers are effective at reaching adolescents and youth victims / survivors of violence) was also valid in Côte d'Ivoire, where services are only partially integrated; cross-referring from education programmes to sexual and reproductive health services is not clearly evident and the degree to which gender-based violence is addressed by teachers in sexual and reproductive health education and information is unclear, thus limiting the reach of UNFPA support to adolescents and youth survivors of violence. As such, the hypothesis is too narrowly focused to reflect the importance of linkages between sexual and reproductive health education and information initiatives and health services for adolescents and youth.<br><br>Testing of **Hypotheses e** (national ownership increases and sustains resources for integrated sexual and reproductive health services, information and education, including GBV and HIV) was limited in Côte d'Ivoire by the fact that full national ownership of youth-friendly health services is yet to be realised. Nonetheless, it is clear that the quality and comprehensiveness of government-funded services are constrained by very limited resources.<br><br>This particular case study furthermore demonstrates the importance of adhering to international standards in order to deliver quality and integrated services (**new hypothesis**). Similarly, evidence from Côte d'Ivoire highlights the need for the collection and use of accurate, age-disaggregated data related to adolescents and youth health issues, including the use and quality of health services (**new hypothesis**). |

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

### *5.2.2 Availability and sustainability of sexual and reproductive health education and information for adolescents and youth [101]*

Between 2008 and 2014, UNFPA participated in supporting revisions of a family life education curriculum and related policies under the leadership of the Ministry of Education. The national family life education curriculum (Education à la Vie Familiale et En Matière de Population - EVP/EmP), adapted to primary and secondary schools, seeks to integrate sexual and reproductive health and family life education through core subjects such as art, language and mathematics courses.[102] In 2013, as a part of the Zero Pregnancy campaign, UNFPA worked with the Ministry of Education to develop sexual and reproductive health thematic sheets (*fiches pédagogiques*) focused on communication with adolescents and youth as well as their parents on pregnancy prevention including themes related to human rights, gender equality, gender-based violence (GBV) and reproductive health.[103] A review of these thematic sheets affirmed that although the material is in line with international standards, and are a valuable complement to the EVP/EmP curriculum, it is not comprehensive enough to be termed a standalone sexual and reproductive health education and information curriculum.[104] At the time of this evaluation (July 2015), the Ministry of Education and some adolescents and youth stakeholder groups were in the process of finalising a newer and more comprehensive curriculum to better align to the newest international standards on sexual and reproductive health education and information - a process in which UNFPA was not perceived as having played a role.[105]

The development of thematic sheets in 2013 demonstrated progress towards sexual and reproductive health education and information in line with international standards. However, there was still a considerable discrepancy between what adolescents and youth stakeholders and UNFPA thought constituted "comprehensiveness." Evidence stemming from the curriculum itself, teaching materials and interviews with adolescents and youth stakeholders actively involved in sexual and reproductive health education and information, portrayed a national curriculum that was not comprehensive. However, it should be noted that in 2015, UNESCO published a global review of sexual and reproductive health education and information curricula in which Côte d'Ivoire was classified as having met international standards based upon the Sexuality Education Review and Assessment Tool (SERAT).[106] Given the combination of education curricula available (i.e. EVP/EmP and the new lesson plans for the Zero Pregnancy campaign) it is not clear, from the UNESCO report, which curricula were assessed.[107]

In general, there was a lack of leadership and coordination from UNFPA and other UN organisations on sexual and reproductive health education and information, with NGOs taking the lead in developing sexual and reproductive health education and information curriculum and training materials with government and other adolescents and youth leaders in 2015.[108] There was no unified or coordinated UN input to sexual and reproductive health education and information especially with respect to the 10-14 year old

[101] Evaluation assumption 3.2.
[102] Interviews: UNFPA Staff, Government. Documents: EVP/EmP curriculum.
[103] Interviews: UNFPA Staff, Government. Documents: Partner and Relevant Thematic Documents (EVP/EmP "fiches pédagogique").
[104] Evaluators compared the EVP/EmP curriculum with CSE standards.
[105] Interviews: UNFPA Staff, INGO, adolescents and youth Beneficiaries. Document: Partner and Relevant Thematic Documents (Draft curriculum 2015).
[106] Document: Partner and Relevant Thematic Documents (Emerging Evidence, Lessons and Practice in Comprehensive Sexuality Education: A Global Review, UNESCO, 2015).
[107] Document: Partner and Relevant Thematic Documents (EVP/EmP "fiches pédagogique").
[108] Interviews: UNFPA Staff, NGO/INGO, adolescents and youth Beneficiaries. Direct observation.

age group which is often an area of programme overlap between UN organisations.[109] There was some confusion about what sexual and reproductive health education and information entailed in relation to updated international standards and curriculum and whether the EVP/EmP curriculum adequately addressed it.[110]

The focus of sexual and reproductive health education and information was primarily in schools with some evidence of targeting and reaching out-of-school young people through mobile outreach, an innovative call centre (organised by region through the Ministry of Education) and a SMS service – where young people can ask questions and receive sexual and reproductive health and HIV information.[111] In general, school-based programmes seemed to focus more on sexual and reproductive health and pregnancy prevention while out-of-school education efforts focused on HIV prevention.[112] Another key approach is through peer educators and sexual and reproductive health and HIV prevention activities carried-out through Centres d'Ecoutes et de Conseil (CEC). These youth centres (13 nationally in 2008) were initially funded by UNFPA and supported with multiple trainings on sexual and reproductive health education and information and HIV/AIDS. CECs experienced significant capacity strengthening support in the years 2008-2010, showing government uptake in terms of commitments of USD 130,000 in 2010 by the Ministry of Youth. However, CECs appear to have lost all funding from 2011-2014; evaluators saw no materials available and no IEC sessions with young people during their visits.[113]

The 'Zero pregnancy' campaign followed a broader outlook on sexual and reproductive health education and information through its mass messages and thematic sheets to address communication between adolescents and youth and parents. UNFPA engaged with parents and religious leaders during the development of the campaign messages and used their pictures and voices in campaign posters.[114]

Many stakeholders confirmed that sexual and reproductive health information, education and communication (IEC) materials were, indeed, very scarce, including within programmes funded by UNFPA.[115] During observation visits, there was no evidence of training and IEC materials made available by UNFPA at the local level, even for the 'Zero pregnancy' in-schools campaign.[116] Materials such as posters seemed to have remained mainly at the Ministry level.[117] Despite this lack of materials, a review of the Zero Pregnancy Campaign in 2014 demonstrated a 20.5 per cent decrease (n=4,035) in pregnancies among in-school girls from its baseline in 2012-2013 (n=5,076).[118]

The Zero Pregnancy Campaign review also demonstrated an increased use of contraceptives and HIV testing in 97 out of 105 CSSUs.[119] Knowledge about HIV transmission continued to increase incrementally

[109] Interviews: UNFPA Staff, UN Staff, Government.
[110] Interviews: UNFPA Staff, Government.
[111] Interview: UNFPA staff, Government.
[112] Comparative review of EVP/EmP curriculum; Fiches Pédagogiques; and UBW/UBRAF figures on HIV-focused capacity building activities. Documents: Partner and Relevant Thematic Documents (EVP/EmP "fiches pédagogique", EVP/EmP curriculum, UBW/UBRAF figures on HIV-focused capacity building activities.
[113] Interviews: UNFPA Staff, Government, NGO, adolescents and youth Beneficiaries. Documents: UNFPA Annual Reports (COARs 2008-2014).
[114] Interviews: UNFPA Staff, Government, adolescents and youth Beneficiaries. Documents: Other Documents (Affiche Grossesse - Campaign 'Zero Grossesse à l'Ecole' posters). Direct Observation: Site visit to call centre for campaign.
[115] Interviews: UN Staff, NGO, adolescents and youth Beneficiaries.
[116] Interviews: NGO, adolescents and youth Beneficiaries.
[117] Interviews: NGO, adolescents and youth beneficiaries.
[118] Documents: Evaluations, Reviews, and Assessments (Campagne « zéro grossesse à l'école » 2013-2015: Plan Accéléré de Réduction des Grossesses en Milieu Scolaire - Revue de la Première Année d'Exécution, 2014).
[119] Documents: Evaluations, Reviews, and Assessments (Campagne « zéro grossesse à l'école » 2013-2015: Plan Accéléré de Réduction des Grossesses en Milieu Scolaire - Revue de la Première Année d'Exécution, 2014).

during the period of evaluation.[120] There is clear evidence that UNFPA addressed GBV multi-sectorally as well as mainstreaming it into such areas as clinical provider trainings, the Zero Pregnancy campaign, and support to IPs.

There was no evidence to suggest that UNFPA applied a multi-sector mainstreaming lens to address sexual and reproductive health education and information. Despite this, although the Zero Pregnancy Campaign is foremostly a campaign and not a sexual and reproductive health education and information programme – it does comprise many elements of sexual and reproductive health education and information standards especially around gender equality and empowerment of adolescent girls. UNFPA contributed towards an increase in national ownership and sustainability of sexual and reproductive health education and information, through its key role in shifting the national discussion on sexual and reproductive health education and information in 2011 with the introduction of the EVP/EmP curriculum and later through the Zero Pregnancy Campaign. However, there is insufficient evidence to conclude that UNFPA has supported the institutionalisation of a *comprehensive* sexual and reproductive health education and information curriculum, based on most recent international standards.

Box 2: Revision of theory of change pathway for sexual and reproductive health education and information

| Modes of Engagement to Output 2[121] |
| --- |
| The evaluation Theory of Change (ToC), which was reconstructed from the ToC developed by UNFPA for the current Strategic Plan (2014 – 2017), holds that all Modes of Engagement (activities) should be used to achieve **Output 2**: Increased national capacity to design and implement community and school-based sexual and reproductive health education and information that promotes human rights and gender equality.<br>The Côte d'Ivoire case study was able to only marginally test this hypothesis given that UNFPA was not promoting a fully comprehensive sexual and reproductive health education and information curriculum according to international standards but rather a less-than-comprehensive family life education curriculum |
| **Output 2 to Outcome B[122]** |
| Testing of **Hypothesis a** (key socio-cultural, legal and gender barriers are overcome) and **Hypothesis c** (sexual and reproductive health education and information is comprehensive and follows internationally agreed standards) in this case study proved valid for achieving increased availability of sexual and reproductive health education and information (**Outcome B**). In Côte d'Ivoire, although the national sexual and reproductive health education and information curriculum has some alignment with international standards, teachers and administrators may avoid sensitive components for socio-cultural |

[120] Documents: Other Documents (Enquête Démographique et de Santé de Côte d'Ivoire, 2012) compared against EDS-MICS 2005 (https://dhsprogram.com/pubs/pdf/AIS5/AIS5.pdf).

[121] Modes of Engagement: 1:Capacity development including technical assistance and training; 2: Service delivery, commodity security, behavior change communication, health systems strengthening; 3: Advocacy and policy dialogue / advice; 4: Knowledge development and management, design and dissemination of guidance and tools; 5: Facilitation of partnerships and coordination, including multi-sectoral, South-South and triangular collaboration; 6: Mainstreaming of adolescents and youth issues within other programmatic areas. Output 2: Increased national capacity to design and implement community and school-based comprehensive sexual and reproductive health education and information that promotes human rights and gender equality.

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

reasons. Similarly, despite the importance of **Hypothesis b** (service providers and teachers are effective at reaching adolescents and youth victims / survivors of violence) the degree to which gender-based violence is addressed by teachers within the national curriculum was unclear and cross-referral of students to youth friendly health services was not fully evident in Côte d'Ivoire, presenting a missed opportunity for increased reach and effectiveness of UNFPA support to adolescents and youth. A stronger emphasis on linking in-school adolescents and youth to services would help increase demand for youth friendly health services. In Côte d'Ivoire, there was some evidence that UNFPA support addressed **Hypothesis d** (information and education reach out-of-school adolescents and youth). The hypothesis remains relevant given the vulnerable status of this sub-population group of adolescents and youth.

There seemed to be a large degree of national ownership of the EVPEmP (Education à la Vie Familiale et En matière de Population) programme, although there was no clear evidence that this has resulted in increased or sustained resources for adolescents and youth sexual and reproductive health services (**Hypothesis e**).

There was clear evidence of parents, schools and community leaders engaging in adolescents and youth sexual and reproductive health issues, as beneficiaries of outreach activities, (**Hypothesis f**, parents, schools and community leaders engage in adolescents and youth sexual and reproductive health education and information).

In addition, as was the case with UNFPA support for services, the ToC pathway for sexual and reproductive health education and information does not reflect the importance of collection, disaggregation and dissemination of data on sexual and reproductive health education and information activities, and adolescents and youth issues more generally, in order to design enabling policies, programmes and strategies for adolescents and youth (suggested **new hypotheses**).

| **EQ4. To what extent has UNFPA contributed to evidence-based policies and programmes that incorporate the needs and rights of adolescents and youth? To what extent has UNFPA contributed to increasing priority for adolescent girls in national development policies and programmes?** |
|---|
| Summary of findings |
| Contributions to evidence-based policies and programmes focused mainly on the prevention of early pregnancies among in-school adolescents as well as addressing child marriage, GBV, and FGM/C.<br><br>UNFPA contributed to developing a knowledge base for an increased prioritization on marginalised adolescents by building stakeholder and partner capacity for the analysis and use of disaggregated monitoring data. However, there was a large gap in availability of age-disaggregated information at the national level both in terms of monitoring and survey data, including adolescents and youth needs and facility assessments. Evidence showed that districts did not report age disaggregated data from health facilities.<br><br>In general, the category of adolescent girls 10-14 lacked a clear operational (i.e. programmatic) definition in Côte d'Ivoire. Policy prioritisation of adolescent girls did not translate into a matched resource allocation for programme implementation. |

### *5.2.3 Priority given to adolescent girls in national development policies and programmes*

Adolescent girls were prioritized in policy documents and programmatic discussions at the central government level and UNFPA as expressed through annual workplans, the country programme action plan (CPAP) 2009-2013 and United Nations Development Assistance Framework (UNDAF) 2009-2013 documents. As of 2013, UNFPA worked with the Ministère de la Promotion de la Femme, de la Famille et de la Protection de l'Enfant (MSFFE) through the Direction de l'Egalité et de la Promotion du Genre (DEPG) to support a national strategy to combat early child marriage.[123] The national Zero Pregnancy Campaign demonstrated evidence-based programming to address the needs of and participation by adolescent girls. Stakeholders often cited the Zero Pregnancy Campaign as an example of where a programme was created directly as a result of having analysed age-disaggregated data: irrefutable data demonstrated a dramatic increase in teenage pregnancy precipitating this national response. The Zero Pregnancy Campaign also included participation by parents and communities.

Prioritisation of adolescent girls was not adequatedly reflected at the level of resource allocation,[124] especially in the areas of advocacy and policy dialogue. Aside from school-based programming there was a lack of focus in national programmes targeting the needs of adolescent girls. There was evidence that UNFPA developed the capacity of partners to analyse Ivoirian laws, policies and barriers affecting adolescents and youth and their rights in line with international standards. For example, one government

[123] Document: Rapport progress Annuel 2013, SRAJ, 52B.

[124] Interviews: Government. Documents: UNFPA Strategic Planning Documents (Plan d'Action du Programme de Pays entre le Gouvernement de Côte d'Ivoire et le Fonds des Nations Unies pour la Population 2009-2013); Partner and Relevant Thematic Documents (UNDAF 2009 – 2013), Other Documents (Plan National de Developpement 2012-2015).

agency, Observatoire de l'équité et du Genre (ONEG), monitors Ivoirian laws related to gender-based violence (GBV), child marriage and female genital mutilation / cutting (FGM/C), and advocates for changes.

Despite a general consensus on the need to prioritize adolescent girls in policy and programmes, and to make progress on using age-disaggregated information, the category of young adolescent girls (10-14) seemed to lack a clear operational distinction and definition. At the national level, the prioritisation of adolescent girls focused mainly on in-school female adolescents. Among government and other partners, there appeared to be a general lack of definition and consensus that the 10-14 age group for "adolescent girls" represented a social grouping distinct from the conceptual understanding of a girl child or a young adult in her late teens early twenties.[125]

Box 3: Revision of theory of change pathway for prioritisation of adolescent girls

| Modes of Engagement to Output 3[126] |
| --- |
| The evaluation theory of change suggests that four modes of engagement (capacity development, advocacy and policy dialogue / advice, knowledge development and management, and mainstreaming of adolescents and youth issues)[127] should be used to achieve **Output 3**: Increased capacity of partners to design and implement comprehensive programmes that reach marginalised adolescent girls, particularly those at risk of child marriage and adolescent pregnancy. In Côte d'Ivoire, the pathway holds true: UNFPA has engaged in capacity building and policy dialogue, with the result that partners have the capacity to design and implement comprehensive programmes that reach marginalised adolescent girls, particularly those at risk of child marriage and adolescent pregnancy. |
| **Output 3 to Outcome C[128]** |
| In Côte d'Ivoire, the capacity of partners to design and implement comprehensive programmes for marginalised girls (**Output 3**), did not necessarily result in the realisation of **Outcome C** (increased priority on adolescent girls in national development policies and programmes). **Hypothesis f** (parents, schools and community leaders engage in adolescents and youth sexual and reproductive health education and information) could not be fully tested due to the absence of a national sexual and reproductive health education and information curriculum; however, as an example, through the Zero Pregnancy Campaign there was clear engagement by parents and community leaders thus contributing towards **Output 3**. **Hypotheses i and j[129]** held true while **hypothesis g** did not hold true if budget expenditures for young adolescents and marginalised youth are a proxy for proportionate "investments". |

[125] Interviews: Government, NGOs. Document: Other Documents (Politique Nationale de la Jeunesse 2011-2015).
[126] Output 3: Increased capacity of partners to design and implement comprehensive programmes that reach marginalised adolescent girls, particularly those at risk of child marriage and adolescent pregnancy.
[127] More precisely, these are Mode of Engagement (MoE) 1: Capacity development including technical assistance and training; MoE 3: Advocacy and policy dialogue / advice; MoE 4: Knowledge development and management, design and dissemination of guidance and tools; and MoE 6: Mainstreaming of adolescents and youth issues within other programmatic areas.
[128] Outcome C: Increased priority on adolescent girls in national development policies and programmes.
[129] Hypothesis g: Increased investments for adolescents and youth that proportionally target young adolescents and marginalised adolescent and youth. Hypothesis j: Adolescent girls participate in programmes as beneficiaries. Hypothesis i: Data / evidence influences policies, programmes and priorities.

### *5.2.4 Collection, analysis and use of disaggregated adolescents and youth data[130]*

UNFPA contributed through training towards building the capacity of partners in the collection, analysis and use of disaggregated data, and promoted the understanding that age-disaggregated information was vital to the development of evidence-based national strategies and programmes for adolescents and youth.[131] However, despite these efforts, there is an information gap in age-disaggregated data, particularly adolescent girls aged 10-14,[132] due to a lack of prioritisation at the central government level to enforce age-disaggregated reporting as well as a large gap in the availability of age-disaggregated information in routine monitoring. Monitoring data from government facilities, including for youth friendly health services, were reported at an aggregated level (by district) with no reference to age groups.[133]

In terms of survey data – including data looking into adolescents and youth needs and service assessments – there was a general lack of prioritising age-disaggregated data at the national and local level. Age categories used for reporting on adolescents and youth were inconsistent between organisations (implementing and non-partners), with no common government led framework. [134]

UNFPA utilised partnerships and mainstreamed the engagement and participation of adolescent girls as evidenced by the Zero Pregnancy Campaign (ZPC).[135] In terms of using data for advocacy, the ZPC was a good example of how the government took action because age-disaggregated evidence demonstrated a high number of pregnancies in schools using Ministry of Education statistics (approximately 5,000 pregnancies/year).[136] The campaign was often cited as a clear example where UNFPA worked with the Ministry of Education to use data that would ensure adolescent girls' needs were prioritised.[137] UNFPA also trained Ministry of Education staff to use age-disaggregated data to design programme outreach and communications materials targeted to the needs of different audiences.[138]

[130] Evaluation assumption 4.2.
[131] Interviews: UNFPA Staff, Government. Document: UNFPA Programming Documents (AWP 2012).
[132] Interviews: UNFPA Staff, Government. Direct observation.
[133] Interviews: UNFPA Staff, Government, adolescents and youth Beneficiaries. Direct observation.
[134] For example, the Parliament des Jeunes uses 10-17 years, interviewed adolescents and youth leaders talked about 15-24 or 14-24, and the Government uses 15-45.
[135] Interviews: Government, adolescents and youth Beneficiaries.
[136] Interviews: UNFPA Staff, Government, NGO.
[137] Interviews: UNFPA Staff, Government, NGO.
[138] Interviews: UNFPA Staff, Government.

Box 4: Revision of theory of change pathway for evidence-based advocacy and data

| Modes of Engagement to Output 4[139] |
| --- |
| According to the evaluation theory of change four modes of engagement (activity level) should be used to achieve **Output 4**: Strengthened national capacity for production, analysis and use of adolescents and youth data. In Côte d'Ivoire, this pathway did partially hold. UNFPA strengthened national capacity for the production, analysis and use of adolescents and youth data by providing technical assistance (**Mode of Engagement 1**), including for knowledge development and management (**Mode of Engagement 4**). In addition, data was used for advocacy purposes around child marriage and GBV (**Mode of Engagement 3**). It was unclear the extent to which adolescents and youth issues were mainstreamed within other programmatic areas **(Mode of Engagement 6).** |
| **Output 4 to Outcome D[140]** |
| In this case study, this ToC pathway generally held true. The government in Côte d'Ivoire has recognised the value of data related to adolescents and youth (**Hypothesis h[141]**) as a tool for developing effective evidence-based policies and programmes (**Outcome D**). The pathway for **Hypothesis i** generally held true within UNFPA to influence policies, programmes and priorities, however the pipeline age-disaggregated information from clinic to national statistics was poor, suggesting the need to modify **Hypothesis i**[142] to highlight the importance of the routine collection of age-disaggregated information. There was no evidence that strengthened national capacity for the production, analysis and use of adolescents and youth data resulted in increased investment for adolescents and youth that proportionally targets young or marginalised adolescents and youth (suggesting the removal of **Hypothesis g[143]** from the pathway). |

[139] Output 4: Strengthened national capacity for production, analysis and use of adolescents and youth data for evidence-based laws, policies and programmes that integrated the needs and rights of adolescent and youth.
[140] Outcome D: Evidence-based policies and programmes incorporate the needs of adolescents and youth.
[141] Hypothesis h: Governments support the collection, disaggregation and dissemination of data related to adolescent and youth.
[142] Hypothesis i: Data/evidence influences policies, programmes and priorities.
[143] Hypothesis g: Increased investments for adolescents and youth that proportionally target young adolescents and marginalised adolescent and youth.

Box 5: Zero Pregnancy in Schools Campaign

**Best practice example: Zero Pregnancy in Schools Campaign**

In the 2012-2013 school year, the Ministry of Education (MENET)—in collaboration with and support from UNFPA—documented a substantial increase in teenage pregnancies among in-school adolescents with as many as 25 per cent occurring among the 10-14 age group. In response, MENET, took action by developing a comprehensive, multi-faceted national campaign to combat teenage pregnancies among unmarried adolescents.

The Zero Pregnancy Campaign (Zero Grossesses à l'Ecole) is an education and outreach programme, primarily in schools, based upon the rights of young people to have access to sexual and reproductive health education and information and services. The Campaign combines school-based sexual and reproductive health education and information with innovative, positive media messages focused on young girls' rights to and ambitions for education, access to services and valuing self-autonomy. Young people were actively involved in the development of its communications materials development and its national hotline is staffed by young people.

Within the first year of programme implementation (2013-2014), the number of pregnancies recorded by MENET in schools fell to 4,035—a 20.5 per cent reduction.

| **EQ5. To what extent has UNFPA contributed to increasing adolescents and youth leadership, participation and empowerment, especially for marginalised and vulnerable adolescents and youth, particularly adolescent girls?** |
|---|
| Summary of findings |
| UNFPA provided support to develop the capacities of youth advocates to strengthen adolescents and youth organisations and networks. Support was mainly expressed through sponsorship of adolescents and youth participation in local, regional, and international meetings who, in turn, brought new concepts on sexual and reproductive health and human rights into national strategy and programme dialogues. However, this support was oftentimes disconnected from the efforts of other development partners and not utilised to its fullest potential for lack of a broader strategic plan of on-going engagement and follow-up support. Adolescents and youth were engaged more as beneficiaries to strengthen activities rather than fully engaged as potential programme developers, policy shapers, and adolescents and youth programme evaluators. And given the use of social media by adolescents and youth, opportunities were missed to create adolescents and youth platforms to advance sexual and reproductive health issues. |

### *5.2.5 Capacities of youth advocates and of adolescents and youth organisations, networks, and institutional structures that promote leadership and participation of adolescents and youth* [144]

UNFPA sponsored a number of youth advocates to attend national, regional, and international meetings to express their views about and learn from youth-focused public policies.[145] This participation contributed towards building the individual capacities of youth advocates and, by extension, adolescents and youth - led organisations. Participation in these international and regional meetings also made valuable contributions towards prioritizing adolescents and youth sexual and reproductive health issues within national strategy documents.[146] However, this participation did not maximise youth leadership *per se* due to a lack of follow-up through a national coordinating mechanism that could ensure sustainable participation and it was not clear whether UNFPA support for youth participation included training youth in programme planning and/or monitoring and evaluation.[147]

While youth-focused national forums were in place (i.e. the National Youth Council (Conseil National de la Jeunesse and the National Youth Network (Reseau National de la Jeunesse)), there seemed to be a lack of national coordination and transparency between these and other youth forums.

Interviews revealed that there was a gap in understanding on how to ensure meaningful participation of young people in decision making processes.[148] It appeared that government ministries, INGOs and UN organisations each had their own network of adolescents and/or youth without a coordinated interaction or learning platform between them. [149] It is worth noting that UNFPA sponsored mostly youth leaders as compared to adolescents.[150] UNFPA also supported youth engagement by sponsoring participation in

[144] Evaluation assumption 5.1.
[145] Interviews: UNFPA Staff, adolescents and youth Beneficiaries. Documents: UNFPA Annual Reports (COARs 2008-2014).
[146] Documents: UNFPA Annual Reports (COARs 2008-2010).
[147] Interviews: UNFPA Staff, NGO.
[148] Interviews: UNFPA Staff, NGOs.
[149] Interviews: UNFPA Staff, UN Staff, Government, NGO.
[150] Interviews: UNFPA Staff, UN Staff, NGO.

thematic groups at the national level and in peer education at local levels.[151] Overall, these networks, thematic groups and organisations lacked funding to ensure continuity of activities. Finally, evaluators found no evidence of social media platforms specifically designed to address youth needs and to encourage greater adolescents and youth participation.

There was also a lack of coherence in the capacity building on sexual and reproductive health and human rights of young people. Discrete training programmes that targeted adolescents and youth leaders appeared "one-off" and disconnected in the absence of follow-up support or long-term, sustainable programme activities within which to foster inputs to adolescents and youth capacities (i.e. Aide-Ados received training on sexual and reproductive health and HIV prevention but did not have any supervisory support or IEC materials to work with).[152] There also seemed to be a lack of sufficiently resourced technical capacity-building of youth organisations and networks. Key informants thought that most training focused on reporting and financial aspects instead of adolescents and youth sexual and reproductive health and human rights issues.[153] For instance, none of the youth-led organisations/networks supported by UNFPA had been trained on how to refer youth to sexual and reproductive health services.

Exceptionally, the Ministry of Education's primary and secondary school campaign "Zero Pregnancy" - in large part sponsored by UNFPA - actively involved young people in the development of communications materials and in a national hotline staffed by young people.[154] Still, key informants understood young people's participation as being limited to programme implementation - such as peer educators - and viewed the design of programmes as the responsibility of senior "experts".[155] Community-level programmes, implemented by a number of organisations, fully integrated adolescents and youth in their outreach activities using such innovative methods as employing adolescents and youth to map the geography of sexual violence and drug dealing in order to (1) avoid those locations, and (2) know where to target programme attention.[156]

Box 6: Best practice example: Covaequiva

| **Best practice example: Covaequiva** |
| --- |
| Covaequiva is a non-governmental organisation focusing their support on the most vulnerable and marginalised children (mostly girls) of Abidjan. Serving the poorest of the poor, Covaequiva takes in abandoned, lost or orphaned children and works to re-integrate them back to their families when feasible and realistic. Covaequiva works in poor communities plagued by drug dealing and sexual violence. Through information collected by young people themselves, Covaequiva developed a community map to identify and show where sexual violence and/or drug-related activity occur in order to help young people avoid these places. |

Box 7: Revision of theory of change pathway for adolescents and youth leadership and participation

| Modes of Engagement to Output 5[157] |
| --- |

The theory of change holds that all modes of engagement except service delivery[158] should be employed to achieve **Output 5**: Strengthened adolescents and youth organisations, networks and institutional structures. In Côte d'Ivoire, UNFPA activities clearly focused on capacity development for youth networks (**Mode of Engagement 1**), advocacy and policy dialogue (**Mode of Engagement 3**), knowledge development and management (**Mode of Engagement 4**), and the facilitation of partnerships including South-South collaboration (**Mode of Engagement 5**). The mainstreaming of adolescents and youth leadership and participation issues within other programmatic areas (**Mode of Engagement 6**) was less evident. UNFPA support strengthened adolescents and youth organisations and networks, but has not resulted in institutionalised mechanisms for adolescents and youth participation (**Output 5**).

**Output 5 to Outcome E[159]**

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

In Côte d'Ivoire, UNFPA-supported strengthening of adolescents and youth organisations and networks has not facilitated full civil society participation and youth mobilisation – nor is the breadth and scope of UNFPA support for adolescents and youth participation and leadership clear. This suggests the need for a revision of **Hypothesis i**[160] to reflect the more logical and specific goal of the integration of adolescents and youth voices into formal decision-making processes – something that has not been realised in Côte d'Ivoire. It was not possible to assess the degree to which UNFPA support caused adolescents and youth organisations to prioritise sexual and reproductive health (**Hypothesis k**).[161] The Côte d'Ivoire case study highlighted that adolescent girls clearly participated in programmes as both beneficiaries and change agents for activities to increase adolescents and youth participation. **Hypothesis j**[162] should therefore be included in this pathway, but modified to include adolescent girls as active change agents, rather than passive beneficiaries of programming, in accordance with UNFPA principles.

[151] Interviews: UNFPA Staff, NGO.
[152] Interviews: UNFPA Staff, UN Staff, Government, NGO.
[153] Interviews: UNFPA Staff, NGO, adolescents and youth Beneficiaries.
[154] Interviews: Government. Documents: Other Documents (Affiche Grossesse - Campaign 'Zero Grossesse à l'Ecole' posters).
[155] Interviews: UNFPA Staff, Government.
[156] Interviews: NGO, adolescents and youth Beneficiaries.
[157] Output 5: Strengthened adolescents and youth organisations, networks and institutional structures.
[158] Modes of Engagement (MoE) 1: Capacity development including technical assistance and training; MoE 3: Advocacy and policy dialogue / advice; MoE 4: Knowledge development and management, design and dissemination of guidance and tools; MoE 5: Facilitation of partnerships and coordination, including multi-sectoral, South-South and triangular collaboration; MoE 6: Mainstreaming of adolescents and youth issues within other programmatic areas.
[159] Outcome E: Increased adolescents and youth leadership and participation.
[160] Hypothesis l: Full civil society participation and youth mobilisation is facilitated.
[161] Hypothesis k: Engaging in SRH is a priority for adolescent and youth-focused organisations and groups.
[162] Hypothesis j: Adolescent girls participate in programmes as beneficiaries.

## 5.3 Efficiency

| EQ6: To what extent were resources (human, financial, administrative) adequate and utilised to achieve the expected results in relation to UNFPA support to adolescents and youth? |
|---|
| Summary of findings |
| Increased priority for adolescents and youth programming under the UNFPA strategic plan has not been matched with sufficient financial resources in Côte d'Ivoire; only a small proportion of the budget was allocated to adolescents and youth activities (five per cent of total country programme expenditures 2008-2014). Despite periods of social and political unrest, implementation rates were generally high. UNFPA financial procedures created challenges for adolescents and youth implementing partners due to rules and regulations that implied delays and abbreviated disbursement schedules.<br><br>Although adolescents and youth staff is in place, the UNFPA youth specialist has multiple competing areas of responsibility, and staff expertise in the area of policy and advocacy is less apparent.<br><br>Adequate systems appeared to be in place to collect, analyse, and evaluate good practices and successful models although evaluators did not observe their systematic use other than data found in routine reporting mechanisms (such as country office annual reports). |

### *5.3.1 Allocation and distribution of human and financial resources to support adolescents and youth programmes[163]*

UNFPA was viewed to be a key financial supporter of sexual and reproductive health programmes in Côte d'Ivoire, including adolescents and youth programming.[164] The overall expenditure patterns for Côte d'Ivoire, between 2008 and 2014, reflect the impact of significant social and political unrest during the period of 2009 to 2011.[165] In 2008, a total adolescents and youth expenditure of USD 720,256 was noted, after which it plummeted by more than half in 2009 (USD 335,895) and even further in 2010 and 2011 (to approximately USD 180,000). This drop in overall expenditure was due to the fact that from 2009-2011, many government ministries were effectively closed or unable to implement programme resources. However, overall adolescents and youth expenditure showed a gradual increase from 2012 (USD 290,041) to 2013 (USD 529,316) and 2014 (USD 1,092767).

Funding for adolescents and youth in Côte d'Ivoire, and particularly the availability of core funding was considered low by many stakeholders (i.e. core funding dropped from USD 711,525 in 2008 to a low of USD 148,705 in 2011). The low levels of adolescents and youth funding from 2009 to 2013 can be explained by the effect of social and political unrest during this period. With a gradual return to stability, adolescents and youth expenditures increased (to USD 529,316 in 2013 and USD 1,092,767 in 2014). However, independent of social and political unrest, expenditure data suggested an under-financing of a priority

[163] Evaluation assumption 6.1.
[164] Interviews: Government, NGO.
[165] Expenditure in USD per Project Outcome code (in Atlas)/Output Code (in GPS) for 2008-2014. Source: Financial analysis of Atlas data conducted by the UNFPA Evaluation Office.

area (adolescents and youth and in particular, marginalised and vulnerable adolescents and youth), relative to other programme support (i.e. 65 per cent of total expenditures on contraceptive supplies). Only five per cent (USD 3.3 million) of total expenditure (core and non-core) over the evaluation period was spent on adolescents and youth programming.[166] In 2014, however, overall adolescents and youth expenditures increased to 10 per cent and expenditure on marginalised adolescent girls was only 2.7 per cent (USD 28,287) of all adolescents and youth expenditures.[167]

Despite periods of social and political unrest, implementation rates were high in 2008 (96 per cent) and 2009 (102 per cent), gradually decreased through to 2012 (78 per cent), and returned to 100 per cent in 2013. Key informants noted that financial resources were often insufficient to cover pre-approved activities outlined and budgeted for in annual work plans affecting the ability of implementers to reach their intended targets.[168] Furthermore, UNFPA financial processes were considered time-consuming and cumbersome.[169] Funding recipients noted that the practice of disbursing funds only within a six-month period (January to July) against a year-long work plan created important implementation challenges (i.e. the six month cut-off meant that implementers could not implement activities, as planned, because the money only became available in the second semester) and most likely contributed to the steady decrease in utilisation rates.[170] Data were insufficient to understand whether under-utilisation (i.e. 78 per cent in 2012) was, in part, a function of abbreviated work-plan funding noted above and/or a result of the distribution system itself (i.e. whether project activities were funded directly by UNFPA (direct execution) or through national execution modalities (NEX)). Key informants seemed to believe that administrative hurdles would be fewer under the NEX- execution modality.[171]

From 2009-2012, UNFPA channelled resources temporarily through non-governmental organisations. There was unanimous consensus among all stakeholders that this funding strategy was highly effective in keeping key activities operational during a difficult period of social and political unrest.[172]

In terms of staffing for adolescents and youth programming, the level of institutional support in terms of in-service trainings on adolescents and youth specific themes - especially on policy and advocacy - appeared insufficient. There was no evidence of long-term staff professional development considering the institution's evolving demands for competencies in policy and advocacy,[173] and no evidence of further human resource investment (i.e. certificate/university courses, or adolescents and youth policy and advocacy webinars for health professionals) other than the sharing of policy updates with country office staff.

[166] Source: Financial analysis of Atlas data conducted by the UNFPA Evaluation Office.
[167] Document: UNFPA Relevant Thematic Documents (UNFPA Côte d'Ivoire website: http://www.unfpa.org/transparency-portal/unfpa-Côte-divoire).
[168] Interviews: Government, NGOs.
[169] Interviews: Government, NGO, adolescents and youth Beneficiaries.
[170] Interviews: Government, NGOs, adolescents and youth Beneficiaries.
[171] In 2014, UNFPA conducted a feasibility study for a new reimbursement system using mobile technology through the telecommunications company Orange. The intent was to reduce transaction costs and improve the speed of payments. The system was adopted in 2015 to cover all costs associated with trainings (i.e. per diems, transport, meals, etc.). Interviews: Government, UNFPA Staff, NGO
[172] Interviews: Government, UNFPA Staff, NGO, adolescents and youth Beneficiaries.
[173] Interview: UNFPA Staff.

### *5.3.2 Systems (including monitoring and evaluation) to gather data, evidence and lessons learned at all levels on multi-sector, innovative, successful, replicable models/programmes to support the design and implementation of UNFPA interventions in the area of adolescents and youth [174]*

Evidence showed that UNFPA had systems in place that allow for access to substantive information sharing from monitoring and reporting, however the systems were not focused on collecting and analysing specific adolescents and youth programme outcomes.[175] For example, in 2008 UNFPA reported results-oriented programme monitoring with coverage up to 75 per cent of programme activities.[176] In subsequent years (2009-2010) UNFPA reported on time-bound targets specific to adolescents and youth programming with the express purpose of sharing results for programme planning purposes. UNFPA had access to numerous national surveys, thematic evaluations (i.e. HIV/AIDS), and financing information and systems with the potential to analyse these data for programme development purposes.

There were instances, however, where systems were inadequately or rather, inefficiently used to share data that could benefit strategic programme areas. For example, survey data confirmed that while the country programme focused on youth-friendly health services, significantly more work had been done in the area of sexual and reproductive health education and information than was captured in either the CPD or 2014 SIS data.

There were clear instances where UNFPA collected, analysed and used data to inform and improve adolescents and youth interventions. UNFPA worked closely with the MOE, using timely information, to identify a precipitous increase in adolescent pregnancies in 2009-2010. These findings, and their analysis, resulted in the development of the successful Zero Pregnancy in Schools Campaign. It was less clear, however, whether UNFPA used data and good practices from thematic programming (i.e. gender-based violence, female genital mutilation, and child marriage) to inform/revise adolescents and youth strategic approaches and/or adolescents and youth policy and advocacy activities.

### *5.3.3 Advice, guidance and training to UNFPA country offices by HQ and RO for adolescents and youth interventions[177]*

Headquarters and the regional office provided policy updates and guidance on various adolescents and youth themes. The evaluation found no evidence to suggest that UNFPA Côte d'Ivoire staff, and in particular the adolescents and youth NPO, received in-depth guidance and support to incorporate evolving trends and practices on human rights, gender responsive and culturally sensitive approaches into adolescents and youth programming, or training on youth friendly health services, sexual and reproductive health education and information and adolescents and youth participation.[178]

[174] Evaluation assumption 6.2.
[175] Documents: UNFPA Annual Reports (COARs 2008-2014).
[176] Document: UNFPA Annual Reports (COAR 2008).
[177] Evaluation assumption 6.3.
[178] Interview: UNFPA Staff.

## 5.4 Partnership, Coordination, Comparative Advantage

| **EQ7: To what extent has UNFPA provided leadership, coordinated effectively and established partnerships to advance adolescents and youth issues at global, regional and country levels? To what extent has UNFPA promoted South-South cooperation to facilitate the exchange of knowledge and lessons learned and to develop capacities in UNFPA programme countries for advancing adolescents and youth policies and programmes?** |
|---|
| Summary of findings |
| UNFPA provided technical and political leadership to advance adolescents and youth agendas in Côte d'Ivoire. However, even though UNFPA has long-term relationships with various government ministries, stakeholders had differing views about the extent to which UNFPA leadership directly influenced national politics, especially in sexual and reproductive health education and information, where NGOs seemed to take the lead in national conversations without significant input from UNFPA.<br><br>Although UNFPA was seen as a convener on issues pertinent to adolescents and youth , and established partnerships among a wide variety of stakeholders, coordination and communication was often carried-out by project partners resulting in a lack of visibility for UNFPA at the national level, and consequently missing opportunities to advance the adolescents and youth agenda.<br><br>There was an absence of a national platform on adolescents and youth to address sexual and reproductive health issues and a lack of coordination and communication among adolescents and youth stakeholder organisations. UNFPA used project specific collaborations with the government to widen the debate on a broader set of adolescents and youth issues.<br><br>While UNFPA supported Ivoirian youth to participate in regional and international sexual and reproductive health forums, there was little evidence of a synergistic use of south-south collaboration as a modality for advancing adolescents and youth policies and programmes. |

### *5.4.1 Technical and political leadership for advancing the global, regional and national adolescents and youth agendas*

Partner and stakeholder perspectives regarding UNFPA technical and political leadership on the development of national adolescents and youth policy and programmes varied greatly depending on the subject matter, but in general, the convening power of UNFPA was seen to be both important and necessary for advancing various adolescents and youth agendas.[179] For example, in 2009, UNFPA paid special attention to include adolescent and young people in the development of priority action matrices for the Poverty Reduction Strategy Document (PRSD).[180] UNFPA provided technical and financial support to the process of validating the National Youth Policy, and UNFPA facilitated the inclusion of youth concerns into national strategic documents such as the PRSD, the National Development Plan (NDP) 2012-

[179] Interviews: UN Staff, Government, NGOs, adolescents and youth Beneficiaries.
[180] Document: UNFPA Annual Reports (COAR 2010).

2015 and the National Strategic Plan against AIDS. Finally, during the period 2008-2014, UNFPA was a prominent convener on issues pertinent to adolescents and youth through support for national thematic groups working on GBV, FGM, Family Planning and early pregnancy and early marriage.[181]

By facilitating multi-sectoral partnerships among a wide range of stakeholders and implementing partners (including government institutions, civil society organizations and adolescents and youth associations and networks), UNFPA shared its priorities through agreements on common aims, objectives and approaches.[182]

Nationally, all stakeholders gave credit to UNFPA for prioritising adolescents and youth programmes. UNFPA was equally acknowledged for facilitating and supporting national campaigns against early pregnancy and child marriage by promoting the human rights of adolescent girls.

Evidence suggested, however, that UNFPA missed opportunities to use its convening power to advance adolescents and youth agendas on certain issues. NGOs seemed to advance, for example, a national dialogue about the development of a sexual and reproductive health education and information curriculum based on international standards.[183]

There were some overlapping priorities in target population and programme focus between UNICEF and UNFPA in the area of young adolescent girls and boys (10-14), which also falls under the "children" category of UNICEF programmes.[184]

No evidence was found to suggest that UNFPA had integrated new adolescents and youth concepts and frameworks such as international consensus agreement language addressing the broader recognition of the human rights of young people necessary to "enable them to deal in a positive and responsible way with their sexuality".[185] Nevertheless, in general, UNFPA was recognised as the lead UN organisation in adolescents and youth sexual and reproductive health programme development and implementation.[186]

### *5.4.2 Coordination, multi-sectoral partnerships and South-South collaboration to promote and utilise synergies at country level[187]*

UNFPA worked in close collaboration with international partners such as the World Bank, Cooperation agencies (Korea International Cooperation Agency (KOICA), Le Fonds Français Muskoka, Belgium), the European Union, UN organisations (UNICEF, UNDP, UNIFEM) and other partnership programmes (H4+Sida, PBF, ERF).[188]

UNFPA was perceived as a key partner for support to adolescents and youth programmes.[189] Documentary and stakeholder input noted numerous examples of how UNFPA mobilized resources and promoted synergies among government, partners, donors and others to support adolescents and youth

[181] Interviews: Government, NGO.
[182] Documents: UNFPA Programming Documents (AWP 2012, AWP 2014), UNFPA Annual Reports (COARs 2008-2014).
[183] Interviews: UN Staff, NGOs, adolescents and youth Beneficiaries.
[184] Interviews: UN Staff, adolescents and youth Beneficiaries.
[185] Document: UNFPA CPD 2012.
[186] Interviews: UN Staff, Government, adolescents and youth Beneficiaries.
[187] Evaluation assumption 7.2.
[188] Interviews: UN Staff, NGOs, adolescents and youth Beneficiaries.
[189] Interviews: UN Staff, Government, adolescents and youth Beneficiaries.

interventions.[190] UNFPA also promoted donor coordination and interaction amongst partners to support adolescents and youth issues, especially in HIV/AIDS.

There were two national level youth networks (i.e. Conseil National de la Jeunesse and the Réseau National de la Jeunesse) noted during this same period that worked with government to include adolescents and youth issues into national strategies and programmes.[191]

Despite support for these activities, and the acknowledgement of UNFPA as a prominent convener on issues pertinent to adolescents and youth, key informants felt there was an absence of a genuine national convener or platform on adolescents and youth that could coordinate all inputs into policy and programme development on the full range of sexual and reproductive health issues. As noted in section 5.4.1, sexual and reproductive health education and information was an example of a lack of a coherent division of labour for the advancement of adolescents and youth issues.

In terms of cross-sector coordination, adolescents and youth stakeholder organisations (i.e NGOs, multilateral/bilateral technical partners) had little knowledge of the activities of other organisations,[192] including activities of UNFPA. Key informants had the perception that it was too difficult to create and/or maintain new inter-ministerial or cross-cutting national working groups on adolescents and youth specifically - as opposed to national thematic groups on gender-based violence or female genital mutilation / cutting - in the post-conflict period (i.e. after 2011).[193] In fact, most adolescents and youth national technical working groups seemed to show very low activity levels.[194] In view of these national coordination challenges, UNFPA seemed to focus its attention towards organising and coordinating adolescents and youth actors around programme-specific interest areas (i.e. the Zero Pregnancy campaign) as a way to advance adolescents and youth issues.[195]

From 2008-2010, UNFPA sponsored a number of adolescents and youth to attend various local (Abidjan), regional (Accra, ouagadougou, Dakar, Addis-abeba, ) and international (New-York, Baku, Bali) meetings with the express purpose of influencing better coordination, exchanging ideas, and promoting South-South collaboration to advance adolescents and youth agendas both in Côte d'Ivoire and abroad.[196] In spite of this support, little evidence was found to suggest that this investment in the exchange of ideas (i.e. South-South collaboration) resulted in more effective policies and programmes in adolescents and youth.[197] Furthermore, while this participation enhanced learning within some adolescents and youth organisations, participants expressed disillusionment at the lack of systematic follow-up and support; they felt opportunities were missed to share their learning (and those from others) within wider national policy discussions.[198]

[190] Interviews: Government, NGO. Documents: UNFPA Annual Reports (COARs 2008-2014).
[191] Documents: UNFPA Annual Reports (COARs 2008-2010).
[192] Interviews: UNFPA Staff, adolescents and youth Beneficiaries.
[193] Interviews: UNFPA Staff, UN Staff, NGO.
[194] Interviews: NGOs.
[195] Interviews: UNFPA Staff, Government.
[196] Documents: UNFPA Annual Reports (COARs 2008-2010).
[197] Interviews: UNFPA Staff, NGOs.
[198] Interviews: NGOs, adolescents and youth Beneficiaries.

# 6 Action-oriented suggestions for UNFPA in Côte d'Ivoire

**1. Genuine Youth Engagement**

UNFPA should explore opportunities for support to adolescents and youth to play a more substantive role in shaping national policies that affect their lives. For example, UNFPA should promote a fully independent, national youth advisory council—comprised of a majority of youth (i.e. under 35 years old) and including adolescents (10-19 years old)—with policy making authority. Adolescents and youth membership should be constituency-based and time-limited including a good governance practice of rotational representation. To maximise efficiencies, this council could be embedded in a national adolescents and youth platform that would include all stakeholders working in the area of adolescents and youth in Côte d'Ivoire—from UN organisations, government, national and international non-governmental organisations, faith-based organisations, etc. This platform could improve communication about what new strategies and data are available and improve coordination among adolescents and youth stakeholders on key issues such as youth-friendly health services and sexual and reproductive health education and information. With high-level approval, the youth advisory council could be tasked with (1) participating in and reviewing national strategic plans, (2) reviewing and making public commentary on any national level adolescents and youth programmes (government and non-government), and (3) providing evaluation expertise/input to national adolescents and youth programmes.

**2. Promote sexual and reproductive health education and information in alignment with international standards**

Findings from Evaluation Question 3 point to the need to promote sexual and reproductive health education and information in alignment with international standards. The current curriculum known as EVP/EmP (Education à la Vie Familiale et En Matière de Population) is not equivalent to sexual and reproductive health education and information. From the evaluation of the EVP/EmP curriculum, it would be hard to deduce that young Ivoirians are getting comprehensive information about their sexual and reproductive lives. Although it is commendable that UNFPA has worked with the Ministry of Education, for example, to introduce pedagogical "teaching sheets" on sexual and reproductive health subjects, this is not a sufficient substitute for a comprehensive curriculum based upon UN standards for sexual and reproductive health education and information. Given the current context in Côte d'Ivoire, there is a strong opportunity, in collaboration with the government and other development partners, to promote a comprehensive, national, sexual and reproductive health education and information curriculum. UNFPA could act on this opportunity by working with national adolescents and youth stakeholders to implement a sexual and reproductive health education and information curriculum based on the minimum standards as noted in UNFPA's Operational Guidance for sexual and reproductive health education and information (2014). This process should examine the challenges and successes of the EVP/EmP and find ways to integrate this knowledge into the implementation of a more comprehensive and updated curriculum, in and out of schools.

### 3. Age-Disaggregated Data for Better Targeted Planning and Programming

Findings from Evaluation Question 4 show that UNFPA should support the production of age-disaggregated demographic data as well as a clearer socio-cultural understanding of adolescence and youth as distinct from childhood. In relation to age-disaggregated data collection and use there are various understandings and definitions about age groups, especially for adolescents and youth that limit the ability of government and others to monitor, plan and programme more effectively.

UNFPA gives much thought and effort to address this outstanding problem but its efforts are constrained at the national level by working across multiple ministries, each having its own special challenges in decentralising dissagregated data collection methods. UNFPA might consider a "deep dive" on age disaggregated data in order to better understand where the major bottlenecks/challenges lie and how best to address them. This type of study would explore and chart exactly where the data collection gaps exist, starting from a basic SSSU clinic or Centres d'Ecoutes et de Conseil (CEC) visit to national demographic surveys. Once the data bottlenecks are identified, UNFPA could work with relevant ministries to design a long-term solution to rectify the situation with cross UN organisation support – especially to gather data on the 10-14 age group. Furthermore, with the national gap in data on adolescents and youth, UNFPA could consider conducting regular needs assessments with young people, as well as service delivery evaluations to ensure that quality of care and information is monitored. This could support a better understanding of the national and local contexts as well as increase service use.

Of equal importance would be the development of a clearer socio-cultural understanding of the concept of adolescence.

Finally, it is important to define who are "the most vulnerable and marginalised" among the broader category of adolescents and youth with the goal of focusing limited resources for adolescents and youth activities on those most in need.

## 4. Social networking and telecommunications

In the area of adolescents and youth participation, UNFPA could make better use of and be more innovative with social networking and telecommunications. While poverty most certainly limits access to social media, young Ivoirians are nonetheless connected and communicating and UNFPA does not seem to be tapping into this modality of innovation and integrating social media into programme implementation. Social media could be easily harnessed for the greater involvement of adolescents and youth through minimally trained and resourced adolescents and youth advocates. Through social media, and the engagement of the telecommunications private sector, young people could find ways to identify where sexual and reproductive health services are poor or lacking, thus improving their ability to participate and advocate for their own sexual and reproductive health needs. Social media could be used to create e-based "safe spaces" to discuss a wide range of sexual and reproductive health issues. UNFPA should stimulate and encourage the development of these e-based spaces for young people and look for examples for the purpose of sharing best case examples.

UNFPA should map the social media terrain in Côte d'Ivoire and understand where new possibilities of engagement lie. Using social media would provide an additional avenue through which better, age-disaggregated data may be collected or, at the very least, provide new opportunities for understanding the 10-14 age group. Equally important, social media could provide an avenue of confidentiality or even anonymous information-sharing particularly for marginalised and most vulnerable youth to address issues around sexual and reproductive health. UNFPA should conduct an assessment of the benefits of investing in social media for an increase in youth outreach and use of youth-focused services. This analysis should include, *inter alia*, an examination of UNFPA staff competencies in managing e-based platforms and social media sites.

# 7 Considerations for the evaluation of UNFPA support to adolescents and youth

**CONSIDERATION 1: Advancing genuine youth engagement**

While UNFPA sponsored adolescents and youth peer educators to join national thematic groups (e.g. gender-based violence and female genital mutilation), adolescents and youth were only marginally engaged to define national adolescents and youth policies and programmes. Young people were seen as potential programme implementers and beneficiaries, but not policy shapers. The thematic groups involving adolescents and youth appeared "one-off" and disconnected from a sustainable sexual and reproductive health national strategy for adolescents and youth by adolescents and youth. UNFPA could be instrumental in taking youth engagement one step further by emphasising the central importance of youth engagement as active leaders in the development of policy and programmes rather than being only beneficiaries.

The demographic dividend and its anticipated benefits provide a policy framework wherein UNFPA could promote the development of national youth advisory councils that would have, as a principal goal, bringing youth voices to national policy and programme development. Genuinely involving youth in policy and programme formation would address adolescents and youth needs in a more comprehensive manner. These councils don't need to be state entities per se or attached to any one ministry, but they could provide an invaluable service, a youthful moral compass, in contributing towards national strategy development goals that actually reflect youth-related concerns; advise on programme development ideas across numerous social issues; and provide input and counsel and evaluation on youth-focused programmes.

# Annexes

## Annex 1: Key country data

| Country \| Côte d'Ivoire | |
|---|---|
| Geographical location | • Côte d'Ivoire is located in West Africa between latitude 4.30 and 10.30 north. It shares borders with the Liberia and Guinea to the west; Mali and Burkina Faso to the north and; Ghana to the east; Atlantic Ocean to the south. [1] |
| Land area | • 3322 462 km$^2$ [1] |
| Terrain | • Plain in the south; plateau in the central and north and mountain in the west. The highest point in "Mont Nimba" with 1753 meters [1] |
| **People** | |
| Population | • 22,671,331 (2014) [2] |
| Population growth rate (average annual) | • 2.6% (2014) [2] |
| Urban population | • 49.7% of the population live in urban (2014) [2] |
| Net migration | • 50,000 (2012) [3] |
| Age structure | • 44% fall within the 1-14 age range; 50% between 15 and 64; and 6% are over 60. [1] |
| Median age | • 16.1 (2011) [3] |
| Religion | • Muslims (38%), Catholic Christian (22%), Protestantism (5,5%), Traditional religions(17%) and others (17%) [2] |
| **Government & Politics** | |
| Government | President: Alassane OUATTARA<br>Prime Minister: Daniel Kablan DUNCAN<br>President Assemblée Nationale: Guillaume SORO. [] |
| Key political events | La Côte d'Ivoire sort d'une crise aiguë qui l'a secouée pendant près d'une décennie. Cette crise a affecté durement l'économie et tous les secteurs sociaux. [2] |
| Seats held by women in national parliament | • 9.4% (2014) [5] |
| **Economy** | |
| Income Group (The World Bank List) | • Low Income Group (2014) [3] |
| Main industries | L'économie ivoirienne repose principalement sur l'agriculture qui est basée essentiellement sur le binôme Café-Cacao. La Côte d'Ivoire est 1er producteur mondial de cacao (41% de la production mondiale) et 3e producteur mondial de café. La Côte d'Ivoire produit également le coton, le palmier à huile, l'ananas, la banane, l'anacarde. L'agriculture contribue à 22 % du PIB et constitue la source de revenus des deux tiers des ménages. Elle procure environ 75 % des recettes d'exportation non pétrolière et occupe 46 % de la population active. Le pays développe également des cultures vivrières, notamment le riz, la banane plantain, le manioc, l'igname, le maïs, qui contribuent pour plus de 17 % au PIB. Il produit le gaz et le pétrole qui contribuent pour environ 6 % au PIB. [1] |
| GPD per capita PPP USD | • 1230 (2012) [5] |
| GPD growth rate (at constant 2005 prices (annual %)) | • 8.6% (2012) [5] |
| **Social Indicators** | |
| Human Development Index (HDI) and rank | • Value 0.452, Rank, 171 (2010) [6] |

| | |
|---|---|
| Poverty headcount ratio (at national poverty lines (% of population)) | • 42.7 (2008) [3] |
| Unemployment, total (% of total labor force) | • 4.0% (2010-2014) [3] |
| Ratio of youth unemployment rate to adult unemployment rate, both sexes (Age 15-24) | • Insufficient information |
| Unemployment, youth total (% of total labor force ages 15-24) | • 5.7 (2010-2014) [3] |
| Life expectancy at birth, both sexes (years) | • 53.1 (2011) [1] |
| Under 5 mortality (per 1,000 live births) | • 43 (2012) [1] |
| Maternal mortality (deaths of women per 100,000 live births) | • 614 (2011) [1] |
| Fertility rate total (live births per women) | • 4.9 (2012) [4] |
| Death rate, crude (per 1,000 people) | • 14.4 (2012) [4] |
| Physicians density | • 6 (2010) per 1000. [8] |
| Health expenditure (% of GDP) | • 5.7% (2013) [8] |
| Births attended by skilled health personnel, % | • 59 (2012) [3] |
| Contraceptive prevalence rate (age 15-49) | • 13.9% (2012) [1] |
| Unmet need for contraception (% of married women ages 15-49) (year/%) | • 27% (2011) [1] |
| Prevalence of HIV, total (% of population ages 15-49) | • 3.7% (2011) [1] |
| Prevalence of HIV, both sexes (% ages 15-24) | • 1.3% (2012) [1] |
| Gender inequality index (GII) and rank | • 0.645 Rank 143 [6] |
| Gender-based-violence (% women aged 15-49) | • Insufficient information |
| Female Genital Mutilation/Cutting (FGM/C) | • Prevalence Women: 38%,<br>Under 5 girls: 53% [1] |
| Adult literacy rate | • 72.5% (2008-2012) [4] |
| Individuals using the internet | • 2.4 (2012) [5] |
| **Youth and Adolescents** | |
| Population aged 10-19, Thousands 2012 | • 4 591 500 [4] |
| Population aged 10-19, Proportion of total population (%) 2012 | • 23.1 [4] |
| Adolescent birth rate | • 128 (2006-2010) [3] |
| Births by age 18 (%) | • 31.1 (2008-2012) [4] |
| Adolescents currently married/ in union (%) | • Female 20.7%<br>• Male 0.8% (2002-2012) [4] |
| Contraceptive prevalence, among girls aged 15-19 (year/%) | • 11.9 (2011) Modern methods [1] |
| Unmet need for contraception | • 27 (2011) [1] |

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|---|---|
| Adolescent fertility rate (births per 1,000 women ages 15-19) | • 126 (2013) [3] |
| Teenage childbearing (15-19 years) | • 129 births for 1000 adolescents (2011) [1] |
| Justification of wife-beating among adolescents (%) | • Female47.9%<br>• Male: 42% (2002-2012) [4] |
| Comprehensive knowledge of HIV among adolescents (%) | • Female: 15.7%<br>• Male: 24.6% (2008-2012, aged 15-24) [4] |
| Lower secondary school gross enrolment ratio | • Insufficient information [4] |
| Upper secondary school gross enrolment ratio | • Insufficient information [4] |
| Use of mass media among adolescents (%) | • Female: 62.2%<br>• Male: 72.5% (2002-2012) [4] |
| **Millennium Development Goals (MDGs) Progress by Goals** | |
| 1 Eradicate Extreme Poverty and Hunger | • Prévalence de l'insuffisance pondérale parmi les enfants de moins de cinq ans : 14.9 [1] |
| 2 Achieve Universal Primary Education | • Taux net de fréquentation scolaire au niveau primaire : 68,1<br>• Taux d'alphabétisation dans la population des 15-24 ans : 55,3 [1] |
| 3 Promote Gender Equality and Empower Women | • Ratio filles/garçons dans l'enseignement primaire : 0,9<br>• Ratio filles/garçons dans l'enseignement secondaire : 0,7 [1] |
| 4 Reduce Child mortality | • Taux de mortalité infanto-juvénile : 108 ‰<br>• Taux de mortalité infantile : 68‰<br>• Pourcentage d'enfants d'un an vaccinés contre la rougeole : 64,5% [1] |
| 5 Improve Maternal Health | • Pourcentage de naissances dont l'accouchement a été assisté par un prestataire de santé formé : 59,4 % [1] |
| 6 Combat HIV/AIDS, Malaria and other Diseases | • Prévalence du VIH dans la population des 15-24 ans : 1,3 %<br>• Utilisation du condom au cours des derniers rapports sexuels à risques : 48,7 %<br>• Proportion de la population de 15-24 ans ayant une connaissance « approfondie » du VIH/sida : 23,1 %<br>• Ratio du pourcentage d'orphelins qui fréquentent l'école au pourcentage des non orphelins de 10-14 ans qui fréquentent l'école : O, 66<br>• Pourcentage d'enfants de moins de cinq ans dormant sous une moustiquaire imprégnée d'insecticide (MII) : 37,2 %<br>• Pourcentage d'enfants de moins de cinq ans dont la fièvre a été traitée avec des antipaludéens appropriés : 17,5 % [1] |
| 7 Ensure Environmental Sustainability | • Proportion de la population utilisant une source d'eau améliorée : 78,4 %<br>• Proportion de la population utilisant des installations sanitaires améliorées : 21,9 % [1] |
| **Adolescents and youth laws and policies** | |
| Insurance coverage ( and free coverage) for sexual and reproductive health services for adolescents and youth | • National Policy allows for free coverage of sexual and reproductive health services for adolescents and youth |
| Consent restriction for sexual and reproductive health services based on age or marital status | • No Access to contraception for adolescent unders 15 years old.<br>• Access not restricted based upon marital status. |
| GBV criminal code or statuary requirements (e.g. requires medical confirmation of violation) | • Résolution 1325 du Conseil deSécurité, la Politique Nationale sur l'Égalité des chances, l'Équité et le Genre en Côte d'Ivoire<br>• Medical confirmation of rape required.<br>• National Strategy Against Gender-Based Violence (SNLVBG) |

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| Marital age | • Article 1, Civil Code, 1983 Law No 83-800: Men before twenty years, women before 18 years cannot enter into marriage |
| FGM restrictions | • A national law was adopted in 1998, prohibiting FGM/C and punishing it (law 98/757, 23.12.1998). |
| Mandatory school drop out if pregnant | • No. Government decrees that adolescent girls may return to school after having given birth. |
| National law or policy covering adolescentsexual and reproductive health and youth participation in governance | • National Youth Policy, 2011-2015 |
| Health policies covering adolescent sexual and reproductive health service integration | • Politique Nationale de la Santé de la Reproduction et Planification Familiale (2ème édition) de Septembre 2008<br>• Document de Politique de la Santé Scolaire et Universitaire (PNSSU) |
| National strategy for adolescents and youth development, health, education, etc. | • National Youth Policy, 2011-2015 |

## Annex 2: Stakeholder mapping

| Stakeholder Group | Type of Organization | Main Level of Operation | Where (if regional) | Main Institutional Capacities | | | | URL |
|---|---|---|---|---|---|---|---|---|
| | | | | Technical Expert Group | Knowledge Sharing & Dissemination | Policy Analysis and Dialogue | Producing Research Evidence | |
| Association Ivoirienne pour le Bien-Etre Familial (AIBEF) | NGO | National IPPF Affiliate | Côte d'Ivoire | x | x | x | | http://www.plannedparenthood.org/nyc/international-programs-15143.htm |
| AIMAS | NGO | National | Côte d'Ivoire | | | | | |
| Alliance Nie contre le SIDA | Network | National | Côte d'Ivoire | | | | | |
| Banque Africaine pour le Développement (BAD) | Donor/Bank | Regional | Africa | | x | x | x | |
| Belgium Cooperation | Bilateral Donor | Global | Africa | | | | | |
| Cavoequiva | NGO | National | Côte d'Ivoire | | | | | |
| Centre d'Ecoute et de Conseil | | | | | | | | |
| DSW (Deutsche Stiftung Weltbevölkerung) | NGO | global | | | x | x | | http://www.dsw.org/about-dsw.html |
| ESPOIR Vie | NGO | National | Côte d'Ivoire | | | | | |

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|---|---|---|---|---|---|---|---|---|
| Etudes et Recherche de Financements (ERF) | Business | National | Côte d'Ivoire | | | | | |
| KfW ( Kreditanstalt für Wiederaufbau—German government development bank) | Development Bank | International | Regional | | | | | |
| H4 + Sida | International Partnership | | | | | | | http://www.everywomaneverychild.org/images/H4Sida_Intermediary_report_2013-May_2014.pdf |
| International HIV/AIDS Alliance | Network / Federation | global | | x | | x | | http://www.aidsalliance.org/ |
| Japanese International Cooperation Agency (JICA) | Bilateral Donor | | | | | | | |
| Johns Hopkins Center for Communication Programs (Jhpiego) | NGO | global | global | x | x | x | x | http://www.jhpiego.org/ |
| Korea International Cooperation Agency (KOICA) | Bialteral Donor | Global | Regional | | | | | http://www.koica.go.kr/english/koica/overseas_offices/1208903_3500.html |
| Mary Stopes International | NGO | global | global | x | | | | http://www.mariestopes.org./ |
| Ministère de la Santé et de la Lutte contre le SIDA (MSLS) | Government | National | Côte d'Ivoire | x | x | x | x | |
| Ministère de la Jeunesse | Government | National | Côte d'Ivoire | x | x | x | | |

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|---|---|---|---|---|---|---|---|---|
| Ministère de l'Education national et de l'Enseignement Technique (MENET) | Government | National | Côte d'Ivoire | x | x | x | x | |
| Ministère auprès du Président de la République chargé de la défense | Government | National | Côte d'Ivoire | | | | | |
| Ministère de la Solidarité de la Femme, de la Famille et de l'Enfant<br>Département : (ONEG) | Government | National | Côte d'Ivoire | x | x | x | x | |
| Ministère de la Défense | Government | National | Côte d'Ivoire | | x | | | |
| Mouvement pour l'Education, la Santé et le Développement (MESAD) | NGO | national | Côte d'Ivoire | | | | | https://www.facebook.com/pages/MESAD/199170931801 |
| Mouvement Etudiant de Sensibilisation et de lutte contre le SIDA (MESSI) | NGO | national | Côte d'Ivoire | | | | | |
| MUSKOKA Initiative | International Bilateral Initiative | Regional | Regional | | | | | |
| Organisation Nationale pour l'enfant et la femme (ONEF) | Government | National | Côte d'Ivoire | | | | | |
| Population Council | Research Organization | global | | x | | | x | http://www.popcouncil.org/research |

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|---|---|---|---|---|---|---|---|---|
| Population Services International | NGO | global | | x | | x | | http://www.psi.org/ |
| Programme National de la Santé Scolaire et Universitaire (PNSSSU) | Government | National | Côte d'Ivoire | | | | | |
| Réseau des Organisations des Jeunes Leaders pour l'atteinte des OMD, Section Côte d'Ivoire (RONALJU-OMD) | Network | National | Côte d'Ivoire | | | | | |
| Réseau des Professionnels Medias Art-CIV | Network | National | Côte d'Ivoire | | | | | |
| Réseau National de la Jeunesse (RNJ-CI) | Network | National | Côte d'Ivoire | | | | | http://unterm.un.org/dgaacs/unterm.nsf/8fa942046ff7601c85256983007ca4d8/419f4fec9274809e85257ca60048be7e?OpenDocument |
| Renaissance Santé Bouaké (RSB-CIV) | NGO | National | Côte d'Ivoire | | | | | http://rencontresolidays.solidairesdumonde.org/archive/2010/06/11/rsb-renaissance-sante-bouake.html |
| Ruban Rouge | NGO | National | Côte d'Ivoire | | | | | |
| Save the Children (US) | NGO | global | global | x | | x | | http://www.savethechildren.org/ |

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|---|---|---|---|---|---|---|---|---|
| Search for Common Ground (SFCG) | INGO | International | Côte d'Ivoire | | | | | https://www.sfcg.org/about-us/ |
| Spanish Cooperation (bilateral) | | | | | | | | |
| UNESCO | United Nations | Global | Global | | | | | https://www.unesco.org |
| UNICEF | United Nations | Global | Global | | | | | https://www.unicef.org |
| UNDP | United Nations | Global | Global | | | | | https://www.undp.org |
| UNAIDS | United Nations | Global | Global | | | | | https://www.unaids.org |
| WHO | United Nations | Global | Global | | | | | https://www.who.int |
| UN Women | United Nations | Global | Global | | | | | |
| Vivre Informer Fraterniser (VIF) | NGO | National | Côte d'Ivoire | | | | | Vifdaloa@yahoo.fr |
| YEKANGOWA (Scouts) | NGO | National | Côte d'Ivoire | | | | | https://www.facebook.com/1610814669207853/photos/a.1610817365874250.1073741825.1610814669207853/1640126432943343/?type=3&theater |

## Annex 3: Portfolio of UNFPA adolescents and youth Interventions in Côte d'Ivoire 2008-2014

| Implementing Agency | Funding Source | Other Implementing Agencies/Partners | Beneficiaries | Geographical Location |
|---|---|---|---|---|
| **CIV5R205**<br>***Promotion SRAJ et prévention*** | | | | |
| UNFPA | CO Programme Deliveray | Direction de la Protection de la Jeunesse (DPJ) | | Abidjan, National |
| Ministère de la Jeunesse | CO Programme Delivery | | | |
| **CIV5R500**<br>***Rehabilitation Centre Materiel*** | | | | |
| UNFPA | UN Operation in Côte d'Ivoire (ONUCI) | | | |
| Ministère auprès du President de la Republique chargé de la defense | CO Programme Delivery | Direction de Santé des Armées | Prevention du VIH chez les hommes en uniformes (forces de securité set defense) | Abidjan |
| **CIV5R51B**<br>**Appui aux CECAAC** | | | | |
| UNFPA | CO Programme Deliveray | | | Dabakala, Daloa |
| **CIV6G16A**<br>**APPUI GENRE ET DEVELOPPEMENT** | | | | |
| UNFPA | CO Programme Deliveray | | | |

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|---|---|---|---|---|
| Ministère de la Solidarité de la Femme, de la Famille et de l'Enfant | CO Programme Delivery | Observatoire Nationale de l'Egalité du Genre (ONEG) | | Abidjan |
| | | Direction Nationale des IFEF | | Abidjan |
| Renaissance Santé Bouaké (RSB-CIV) | CO Programme Delivery | | Activités Generatrices de revenues pour les jeunes filles, femmes | Yamoussoukro, Toumodi, Bouaké |
| **CIV6R52B<br>SSRAJ / CECAAC JEUNES** | | | | |
| Ministère de la Jeunesse | CO Programme Delivery | Direction de la Protection de la Jeunesse (DPJ) | SR des Adolescents et des Jeunes au niveau national | Abidjan, National |
| | | Direction de la Vie Associative et du Volontariat (DVAVE) | Reseaux et Organisation de jeunesse au niveau national | Abidjan, |
| | | Secretariat Permanent du Conseil National de la Jeunesse (CNJ) | Reseaux et Organisation de jeunesse au niveau national | Abidjan, |
| Ministère l'Education Nationale et de l'Enseignement Technique (MENET) | CO Programme Delivery | Direction de la Pedagogie et de la Formation Continue (DPFC) | Education Sexuelle Complete, Eleves et Enseignats | Abidjan, National |
| | | Direction de la Mutualité et des Œuvres Sociales en Milieu Scolaire (DMOSS) | Eleves et Enseignants | Abidjan, National |
| | | Direction de la Vie Scolaire (DVS) | Eleves et enseignants des Clubs Scolaires | Abidjan |
| Ministère de la Santé et de la lutte contre le Sida (MSLS) | CO Programme Delivery | Programme Nationale des Services de Santé scolaire et Universitaire (PNSSU) | Santé des Eeves | Abidjan, National |

| | | | | |
|---|---|---|---|---|
| | | Programme Nationale de Santé des Mères et des Enfants (PNSME) | Santé de la Reproduction, population generale | Abidjan |
| Association Ivoirienne pour le Bien-Etre Familial (AIBEF - CIV) et ses Sous-beneficiaires (MESSI, CAVOEQUIVA) | CO Programme Delivery | | integration SR/ PF/VIH chez les adolescents et jeunes | Abidjan, National |
| Renaissance Santé Bouaké (RSB-CIV) | CO Programme Delivery | | Jeunes vulnerables | Yamoussoukro, Toumodi, Bouaké |
| Vivre Informer Fraterniser (VIF) | CO Programme Delivery | | Jeunes vulnerables | Daloa |
| Resaeu National de la Jeunesse (RNJ-CI) | CO Programme Delivery | | Reseaux et Organisation de jeunesse | Daloa |
| Reseau des Organisations des Jeunes Leaders pour l'atteinte des OMD, Section Côte d'Ivoire (ROJALNU-OMD) | CO Programme Delivery | | | Abidjan |
| AIMAS - CIV | CO Programme Delivery | | | Abidjan |
| Alliance Nle contre SIDA CI | CO Programme Delivery | | | |
| ESPOIR VIE | CO Programme Delivery | | | |
| Reseau des Prof Medias Art-CIV | CO Programme Delivery | | Journalistes et professionnels des medias | Abidjan |
| UNFPA | JP-UNFPA: Administrative Agent | | | |
| | PROGRAMMES4 | | | |

| | | | | |
|---|---|---|---|---|
| | TTF - Multi Donor | | | |
| **GRP6R42A**<br>***CD to scale-up HIV prevention*** | | | | |
| UNFPA | UNAIDS | | | Abidjan |
| CAVOEQUIVA à travers Association Ivoirienne pour le Bien-Etre Familial (AIBEF - CIV) | CO Programme Delivery | | Jeunes filles vulnerables d'Adjamé | Abidjan, |
| **IVC03P02**<br>***SSR-AJ/IST/VIH*** | | | | |
| UNFPA | Belgium | | | |
| Ministère de la Jeunesse | CO Programme Delivery | Direction de la Protection de la Jeunesse (DPJ) | SR des Adolescents et des Jeunes au niveau national | Abidjan,13 Centres d'Ecoute à l'interieur du pays |

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## Annex 5: List of people consulted

**Definition of Categories:**

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

| **UNFPA** | | | | |
|---|---|---|---|---|
| **#** | **First Name** | **Family Name** | **Sex** | **Position \|Name of Organisation** |
| 1 | Pauline | Abou-Kone Nankan | f | National Program Officer Maternal Health \| UNFPA |
| 2 | Saidou | Kabore | m | Deputy Director \| UNFPA |
| 3 | Yao | Konan | m | National Program Officer adolescents and youth \| UNFPA |
| 4 | Pauline | Kouye Meogbeu | f | National Program Officer Gender \| UNFPA |
| 5 | Lahissi | Saaiku Adjao | m | National Program Officer Partnerships and Resource mobilisation \| UNFPA |
| 6 | Edouard | Talnan | m | National Program Officer M&E \| UNFPA |
| **UN Staff** | | | | |
| **#** | **First Name** | **Family Name** | **Sex** | **Position \|Name of Organisation** |
| 7 | Marie Catherine | Barouan | f | HIV and TB advisor \| WHO |
| 8 | Jean | Konan Kouamé | m | HIV specialist \| UNICEF |
| 9 | Isabelle | Kouare | f | Conseiller Droits et Genre \| UNAIDS |
| **Government Partners** | | | | |

| # | First Name | Family Name | Sex | Position \|Name of Organisation |
|---|---|---|---|---|
| 10 | Kouassi Yeboua | Ban | m | Chargé d'études \| MOE Direction de la Mutualité des œuvres Scolaires et Scolaires (DMOSS) |
| 11 | Monique Angele Epse Blibolo | Bolou | f | Chef de service \| MOY Direction de la Promotion des Jeunes (DPJ) |
| 12 | Fofana Yaya Fanta | Kaba | f | Secrétaire Exécutif \| MOFamiliy Observatoire Nationale de l'Egalité et du Genre (ONEG) |
| 13 | Moussokoro Epse Toure | Kone | f | Responsable cellule Femme et enfant \| MOD Defense |
| 14 | Laura Marie Paula | Ourega | f | DC \| MOH Programme National de la Santé Scolaire et Universitaire (PNSSU) |
| **Donors** | | | | |
| **#** | **First Name** | **Family Name** | **Sex** | **Position \|Name of Organisation** |
| 15 | Awa | Kamara | f | M/E Officer \| African Development Bank, Programme d'Appui Institutionnel Multisectoriel à la Sortie de Crise (PAIMSC) |
| **International NGOs** | | | | |
| **#** | **First Name** | **Family Name** | **Sex** | **Position \|Name of Organisation** |
| 16 | Lambert | Doua | m | Chargé de Programmes \| HIV/AIDS Alliance CI |
| 17 | Yao | Mathurin | m | Programme Director \| PSI |
| 18 | Blaise | N'Dri | m | Technical Health Advisor (interim) \| Save the Children |
| 19 | Kiyali | Ouattara | m | Programme Director \| Jhpiego |
| **National NGOs, CSOs, Academia** | | | | |
| **#** | **First Name** | **Family Name** | **Sex** | **Position \|Name of Organisation** |
| 20 | Rosalie | Atta | f | President/Founder \| Yekan N'Gowa (NGO) |
| 21 | Aime Felicite Epse Kabran | Boga | f | CSR/PF Daloa \| District Health Office |
| 22 | Koffi Simon Pierre | Brou | m | President \| Réseau des Organisations de Jeunesse des Nations Unies pour l'Atteinte des OMD (ROJALNU/OMD/CI) |
| 23 | N'Dri Louise | Koffi | f | Executive Director \| CEC Toumodi (youth centre under MoY) Centre d'Ecoute et de Conseil Toumodi |

| | | | | |
|---|---|---|---|---|
| 24 | Olivier | Kouamé | m | Head doctor of youth friendly health services \| SSSU Yamassoukrou (health service) Service de Santé Scolaire et Univeritaire |
| 25 | Soiba Mariam | Ouattara | f | Directrice Exécutive \| CAVOEQUIVA |
| 26 | Mireille Ange | Takijtchie | f | Administrative and Financial Manager \| Mouvement Estudiantin pour la Sensibilisation sur le Sida (MESSI) |
| 27 | Stéphane | Tia Yaké | m | Vice president \| Réseau National de la Jeunesse de Côte d'Ivoire (RNJCI) |
| 28 | Dorothée | Toualy | f | Executive Director \| RSB (NGO - Yamassoukrou) Renaissance-Santé Bouaké) |
| 29 | Clibigayo Beatrice | Toure | f | Consultant/Ex DE \| Vivre, Informer et Fraterniser (VIF) |
| 30 | Ndri Aristide Roland | Yao | m | Medecin Chef Adjoint \| Service de Santé Scolaire et Universitaire (SSSU Daloa) |
| 31 | Nathalie | Yao N'Dry | f | Programme Director \| Association Ivoirienne pour le Bien Etre Familiale (AIBEF) |
| 32 | Kouame | Yoboue Olivier | m | Head doctor of youth friendly health services \| SSSU Toumodi (health service) Service de Santé Scolaire et Univeritaire |

**Adolescents and youth beneficiaries**

| # | First Name | Family Name | Sex | Position \| Name of Organisation |
|---|---|---|---|---|
| 33 | Marie Claire | Babe | f | Peer educator \| Renaissance-Santé Bouaké (RSB) |
| 34 | Zenab Gnoh | Coulibaly | f | Peer educator \| Vivre, Informer et Fraterniser ( VIF) |
| 35 | Marie Michelle | Diomande | f | Peer educator \| Mouvement Estudiantin pour la Sensibilisation sur le Sida (MESSI) |
| 36 | Tia Oliver | Diomande | m | Peer educator \| Mouvement Estudiantin pour la Sensibilisation sur le Sida (MESSI) |
| 37 | Amenan Amelia | Djenzou | f | Peer educator \| Mouvement Estudiantin pour la Sensibilisation sur le Sida (MESSI) |
| 38 | Francois | Ebi Kouamé | m | Peer educator \| Centre d'Ecoute et de Conseil Toumodi (CEC) |
| 39 | Carole Stephanie | Gonpou | f | Peer educator \| Renaissance-Santé Bouaké (RSB) |
| 40 | Victoire Julie | Gor Lou | f | Peer educator \| Renaissance-Santé Bouaké (RSB) |
| 41 | Rebecca | Groguhe | f | Peer educator \| Vivre, Informer et Fraterniser ( VIF) |
| 42 | Kouakou Jean | Kasset | m | Peer educator \| Mouvement Estudiantin pour la Sensibilisation sur le Sida (MESSI) |
| 43 | Aimée Estelle | Keunan Kpeyo | f | Peer educator \| Mouvement Estudiantin pour la Sensibilisation sur le Sida (MESSI) |
| 44 | Brou Marina | Koffi | f | Peer educator \| Vivre, Informer et Fraterniser ( VIF) |
| 45 | Helene | Koffi Akouassy | f | Peer educator \| Mouvement Estudiantin pour la Sensibilisation sur le Sida (MESSI) |
| 46 | Epiphanie Ange | Koffi Amenan | f | Peer educator \| Mouvement Estudiantin pour la Sensibilisation sur le Sida (MESSI) |

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|---|---|---|---|---|
| 47 | Colette | Koffi N'Goran | f | Peer educator \| Mouvement Estudiantin pour la Sensibilisation sur le Sida (MESSI) |
| 48 | Ismael | Kone Dogneri | m | Peer educator \| Renaissance-Santé Bouaké (RSB) |
| 49 | Abraham | Koné Yacouba | m | Peer educator \| Renaissance-Santé Bouaké (RSB) |
| 50 | Koisi Gustave Zephirin | Kouadio | m | Peer educator \| Mouvement Estudiantin pour la Sensibilisation sur le Sida (MESSI) |
| 51 | Affoue Elodie | Kouame | f | Peer educator \| Vivre, Informer et Fraterniser ( VIF) |
| 52 | Martial Serge | Kouamé Koudio | m | Peer educator \| Mouvement Estudiantin pour la Sensibilisation sur le Sida (MESSI) |
| 53 | Yanick | M'Bra Konakou | m | Peer educator \| Mouvement Estudiantin pour la Sensibilisation sur le Sida (MESSI) |
| 54 | Wilfried | N'Goran Kouadio | m | Peer educator \| Renaissance-Santé Bouaké (RSB) |
| 55 | Jean Michel | N'Guessan Brou | m | Peer educator \| Renaissance-Santé Bouaké (RSB) |
| 56 | Yves Tanguy | Ouattara Krotcha | m | Peer educator \| Centre d'Ecoute et de Conseil Toumodi (CEC) |
| 57 | Larissa | Poli | f | Peer educator \| Renaissance-Santé Bouaké (RSB) |
| 58 | Karidja | Sakanogo | f | Peer educator \| Vivre, Informer et Fraterniser ( VIF) |
| 59 | Massiata | Sakanogo | f | Peer educator \| Vivre, Informer et Fraterniser ( VIF) |
| 60 | Boudie Enock Christian | Tietche | m | Peer educator \| Mouvement Estudiantin pour la Sensibilisation sur le Sida (MESSI) |