Ministry of Foreign Affairs

IOB Study

NGOs in action:

A study of activities in sexual and reproductive health and rights by Dutch NGOs

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September 2013

Preface

This report presents the findings of a desk-study of existing evaluations on the work of Dutch non-governmental organisations in the field of sexual and reproductive health and rights (SRHR). It is part of a number of sub-studies of a policy evaluation of Dutch involvement in SRHR in the period 2007-2012, conducted by the Policy and Operations Evaluation Department (IOB) of the Dutch Ministry of Foreign Affairs. Other sub-studies of this policy evaluation are country impact studies in Bangladesh, Nicaragua and Mali, desk-studies of Ghana and Tanzania, and a desk study of existing evaluations of multilateral organisations.

In order to gain insight into the results of the work of Dutch NGOs and their southern partners, organisations who had received funding from the Netherlands Ministry of Foreign Affairs in the period 2007-2012 were invited to send existing evaluation reports of their SRHR activities. After an assessment procedure, 51 evaluation reports of ten organisations were selected to be studied in-depth. The findings of this study provide a broad, albeit non-representative, overview of the role of Dutch civil society organisations in SRHR programmes.

The findings of this study provide insight into the success factors and bottlenecks of the approaches and strategies of the NGO interventions. It outlines the results of interventions in the field of improving knowledge on SRHR, increasing availability of and access to services and the results of lobby and advocacy activities. Some main findings of the study are that the NGOs have played an important role in improving knowledge on SRHR and extending services to underserved groups, including to key populations and adolescents. Policy influencing was moderately successful, with some examples of positive changes. Results at the level of improved practices and use of services were less conclusive.

IOB researcher Saskia Hesta and external consultant Muriel Visser have conducted this study and have drafted the report. IOB senior evaluator Marijke Stegeman was overall responsible for the policy evaluation. The NGOs and policy officers of the Ministry of Foreign Affairs have provided their comments and feedback on the terms of reference and the preliminary findings.

IOB would like to thank all the organisations and their southern partners for their willingness to participate in this study and to share the evaluation reports. It is hoped that the systematic analysis of this valuable body of knowledge has contributed to more insight into the role of NGOs in the field of sexual and reproductive health and rights.

The final responsibility for the content of the publication rests with IOB.

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral Treatment
BCC	Behaviour Change Communication
CAH	Citizen Action and Health
CAR	Central Asian Republics
CEPHAD	Centre for Public Health and Development
CHBC	Community Home Based Care
CHF	Catholic Health Facilities
CIC	*Conseil Interconfessional de Lutte contre le SIDA*
COREC	*Coordination de la Réponse Commune des Confessions Religieuses face au VIH et au SIDA*
CSB	Civil Society Building
CSO	Civil Society Organisation
CtCT	Called to Care Toolkit
DGIS	*Directoraat-generaal Internationale Samenwerking* (Directorate-General for International Development)
DPA	Direct Poverty Alleviation
DRC	Democratic Republic of the Congo
EHAIA	Ecumenical HIV and AIDS Initiative for Africa
FSW	Female Sex Worker(s)
GDP	Gender Development Project
GBV	Gender-based Violence
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
IATT	Inter-Agency Task Team
ICPD	International Conference on Population and Development
IDU	Intravenous Drug User(s)
IESSH	Institute for Studies in Health, Sexuality and Human Development
IOB	*Inspectie Ontwikkelingssamenwerking en Beleidsevaluatie* (Policy and Operations Evaluation Department of the Ministry of Foreign Affairs)
IF	Innovation Fund
KP	Key Populations
FC	Female Condom
FGC	Female Genital Cutting
FGM	Female Genital Mutilation
FNGO	Field Non-Governmental Organisation
FP	Family Planning
ICT	Information Communication and Technology
IEC	Information Education Communication
MDG	Millennium Development Goals
MDM	*Médecins du Monde*
M&E	Monitoring and Evaluation
MFA	Ministry of Foreign Affairs
MFP	*Medefinancieringsprogramma* (Co-financing Programme)

MFS	*Medefinancieringsstelsel* (Co-financing Mechanism)
MONHAR	Monks and Nuns HIV/AIDS and Human Rights
MSM	Men who Have Sex with Men
NGO	Non-Governmental Organisation
NHIS	National Health Insurance Scheme
NYRHP	Nomadic Youth Reproductive Health Programme
OVC	Orphans and Vulnerable Children
PBF	Performance Based Financing
PCM	Project Cycle Management
PEP	Post Exposure Prophylaxis
PLHIV	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
PNG	Papua New Guinea
RH	Reproductive Health
RHR	Reproductive Health and Rights
SHG	Self Help Groups
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
SW	Sex Worker(s)
TBA	Traditional Birth Attendants
TMF	*Thematische Medefinanciering* (Thematic Co-financing)
TVEP	Thohoyandou Victim Empowerment Trust
UAFC	Universal Access to Female Condoms
UN	United Nations
UNAIDS	United Nations Joint Programme against AIDS
USA	United States of America
USAID	United States Agency for International Development
VAC	Violence Against Children
VAW	Violence Against Women
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
WPF	World Population Foundation
WSWM	The World Starts With Me

Executive summary

This report is part of an evaluation of Dutch policy on sexual and reproductive health and rights (SRHR), including HIV/AIDS, carried out by the Policy and Operations Evaluation Department (IOB) of the Netherlands Ministry of Foreign Affairs. It is the outcome of one of a series of sub-studies in this policy evaluation and analyses the SRHR activities of Dutch non-governmental organisations (NGOs) co-financed by the Ministry of Foreign Affairs in the period 2007-2012.

For this report, IOB analysed existing methodologically sound evaluation reports of the NGOs' SRHR projects and programmes. A total of 138 evaluation reports were initially proposed for inclusion in the study. After identification on the basis of minimum criteria, the selection comprised 80 reports by ten organisations. Excluded were organisations or reports for which no evaluations existed, or whose funded activities were too broad to be included for the purpose of this study. The strengths of each of these evaluation reports were assessed using criteria relating to the validity and reliability of the evaluations. Validity focused on the clarity of the problem statement and the research questions; reliability assessed the research methods, the scope of the study, the independence, and the quality control mechanisms. Fifty-one evaluation reports met the criteria and were subjected to in-depth analysis.

The selected evaluation reports were analysed for evidence of the effectiveness of the interventions in terms of capacity building, improving knowledge, increasing access to services and influencing of policy, across four main themes: maternal and perinatal health, contraceptive choice, HIV/AIDS, and sexual and reproductive rights.

The seven main findings were:

1. *Capacity development of Southern partners played a large role in the interventions. Overall, the NGOs' assistance in this area was greatly appreciated by the partners, but the evaluations provide limited information about the strategies followed and results achieved.*

Capacity development – in particular of partner organisations, but also of other service providers – was a prominent feature across most of the interventions that were studied, and was often part of a broader approach to enhance access to prevention or to extend services. The target groups for the interventions included partner organisations (NGOs, religious institutions), other implementing organisations, government partners (health officers, teachers), community structures (e.g. local associations or informal groups), and direct beneficiaries. In some cases, capacity development focused on unusual target groups, such as hairdressers and Buddhist monks and nuns. The training of peer educators and/or community volunteers was a feature of more than one third of the evaluations. There were positive perceptions and reactions of partner organisations to the capacity development efforts by Dutch NGOs in most of the evaluation reports. However, capacity strategies were not always strongly formulated or implemented, or clearly linked to a plan for supporting the beneficiaries. In addition, from the reports it was clear that both the NGOs and their project partners faced certain challenges in implementing projects around sensitive issues, such as sexuality for adolescents.

2. *The selected NGO interventions have led to increased knowledge about SRHR, particularly among young people and in the field of HIV/AIDS prevention. Some reports provide anecdotal evidence of changes in skills, attitudes and behaviour (e.g. reduction in perceived discrimination and stigma).*

Almost all evaluations reported on efforts to improve knowledge on and awareness of SRHR, especially in the field of HIV/AIDS prevention. Many interventions were targeted at young people: 26 of the 51 evaluation reports informed about youth interventions. The most commonly used and successful strategies were to engage at community level and to involve key figures or peer groups in getting messages across. Evaluations of sexuality education programmes for young people provided evidence of improved knowledge about sexuality issues among youth, and to a lesser extent of improved skills and attitudes. Other evaluations reported that interventions had contributed to perceived decreases in stigma and discrimination for people living with HIV (PLHIV).

3. *Through the NGO interventions, services were extended to underserved populations or to those who were excluded from access to services, such as nomadic people or key populations, especially in the field of HIV/AIDS prevention and treatment.*

Results at the level of service delivery were included in 70% of the evaluation reports. Service delivery was an especially large component of interventions in the field of HIV/AIDS, where interventions focused on PLHIV, orphans and vulnerable children, adolescents, and key populations. Concrete results in service delivery were reported for treatment of women with obstetric fistulas, distribution of the female condom, improved access to anti-retroviral therapy, increased voluntary counselling and testing, treatment of Opportunistic Infections (OI), Prevention of Mother to Child Transmission (PMTCT) and Home-Based Care (HBC). A key element mentioned as increasing adolescents' access to services was the availability of youth-friendly services. Few evaluations yielded information about quality of services.

4. *Interventions had a strong focus on promoting SRHR in communities, including on sensitive issues. Little information was given about improved practices or utilisation, particularly concerning contraceptive use.*

Many interventions focused on improving awareness and acceptance of SRHR in communities, particularly on the more sensitive issues, such as PLHIV, adolescent sexuality and the prevention of harmful practices such as female genital mutilation. Overall, the evaluations report that the interventions have led to more knowledge and awareness about SRHR and better availability of SRHR services. In addition, they provide qualitative information that favourable conditions have been created for improvements in the SRHR of the target groups. Few evaluation reports link this information to the level of demand and to actual beneficiary utilisation rates. This is particularly marked in the field of contraceptive use, and especially for young people.

5. *Lobby and advocacy for policy change was moderately successful, but mostly at the community and district levels.*

While lobby and advocacy was included across a number of interventions and thematic areas, there were only a few examples of effectiveness in influencing policy. Several evaluation reports mentioned that a factor contributing to the limited effectiveness was a lack of realistic or explicit advocacy strategies. Across the thematic areas, lobbying for policy changes was most successful at the community and district levels, with certain topics, such

as adolescent reproductive health, being included in local-level plans and sometimes in budget allocations at decentralised levels.

6. *Sustainability of the interventions, where assessed, is limited.*

The evaluation reports did not base their assessments of sustainability on identical criteria, nor did all reports systematically examine sustainability across different dimensions such as funding, individual commitment, institutional commitment, context, etc. Over half of the evaluations concluded that the project's activities were unlikely to be sustainable. In some reports, training was seen as guarantee of sustainability (knowledge staying with partners or in communities). However, other reports challenge this assumption, given problems with high staff turn-over, the erosion of skills and knowledge over time, and the lack of integration with a broader organisational approach. Other limiting factors reported in the evaluations were lack of investment to enable activities to be continued, lack of cooperation or integration with government services, and the short duration of the projects in relation to the complex nature of the interventions and their context.

7. *A strong feature in the evaluations is the substantial qualitative information provided. However, robust evidence of the effectiveness of NGO projects in SRHR is scarce, especially at the level of outcomes.*

Most of the evaluation reports give detailed insight into lessons learnt, doing so by drawing from qualitative sources, such as focus group discussions and interviews. All 51 evaluation reports included collected qualitative data, and two-thirds of them also included quantitative data, most frequently at output level. The evaluations provided only limited quantified information on outcomes. The information provided in most of the selected evaluations was insufficient to enable results to be attributed to the projects or progress to be assessed. Comparisons against baseline data were conducted in one quarter of the evaluation reports, mostly on the basis of secondary data. Only in two evaluation designs a control group was used.

1

Introduction

This report is part of a policy evaluation of Dutch involvement in the field of sexual and reproductive health and rights (SRHR), carried out by the Policy and Operations Evaluation Department (IOB) of the Netherlands' Ministry of Foreign Affairs. A policy evaluation consists of several mandatory elements, including the description of the instruments applied and an analysis of the societal effects.[1] One of the instruments of the Dutch policy is the funding of non-governmental organisations (NGOs). The present study is an analysis of the effects of the work of these NGOs in the period 2007-2012 in the field of SRHR. The analysis is based on a selection of existing evaluations of projects and programmes of NGOs co-financed by the Netherlands Ministry of Foreign Affairs through the *Co-financing Mechanism* (MFS 1) and the *Schokland Fund*.[2]

1.1 Goals

The policy evaluation has two objectives:
- To account for the expenditure on SRHR by assessing the effectiveness of Dutch development cooperation support to SRHR;
- To present lessons that can be learnt, by identifying the factors which have contributed to the achievements or to the lack of results.

This study concerns the Dutch NGOs active in the field of SRHR. Specifically the study seeks to identify:
- What were the objectives and intervention strategies of the Dutch NGOs in the field of SRHR;
- What main SRHR activities were financed by the Dutch NGOs (implemented either directly or through southern partners) between 2007 and 2012;
- What is known about the achieved results (effectiveness and sustainability).

1.2 Subject and scope of this study

Subject

The promotion of SRHR has been a priority in Dutch policy for years and substantial financial resources are deployed in support of this goal. The Netherlands takes the position that SRHR relate to the right of everyone – regardless of age or gender – to make choices about their own sexuality and reproduction, as long as this does not infringe on the rights of others. This right also includes the right to access to information and services in order to make these choices and to optimise health.[3] SRHR and HIV/AIDS are closely linked. The vast

[1] Ministerie van Financiën, 2012, Regeling Periodiek Evaluatieonderzoek (RPE) 2012, Staatscourant, 11 september 2012, nr. 18352, p.14.

[2] The original Terms of Reference of this study (in Dutch) can be found on www.iob-evaluatie.nl. These ToR have been adapted after the first meeting with the NGOs.

[3] There is no internationally agreed definition of SRHR: this definition is a working definition that was developed by a Swedish NGO. The term reproductive health and rights was defined at the International Conference for Population and Development (1994). The definition about sexual rights was added during the Fourth International Conference on Women (1995).

majority of HIV infections are transmitted through sexual contact and HIV/AIDS is the leading cause of death for women of reproductive age (15-49 years). In this report SRHR is therefore taken as including HIV/AIDS. Key populations (KP) are understood to be: men who have sex with men (MSM), injecting drug users (IDUs) and sex workers (SW).[4]

This study is structured according to the core elements of the Global Strategy on Reproductive Health (WHO, 2004):

- Improving antenatal, perinatal, postpartum and newborn care;
- Providing high-quality services for family planning, including infertility services;
- Eliminating unsafe abortion[5] and providing post-abortion care;
- Reducing sexually transmitted infections, including HIV, and other reproductive morbidities;
- Promoting sexual health.

The findings in chapter 5 will be presented along the lines of these themes, with the exception of the third component regarding eliminating unsafe abortions and provision of post-abortion care, as no evaluations were included that covered specific activities in this field.[6] In this study the section 'sexual and reproductive rights' discusses results in the field of gender-based violence (GBV) and sexual violence, adolescent sexual and reproductive health and rights and female genital mutilation.

A thematic presentation has its limitations. The links between the themes may be overlooked and, in addition, in many cases the projects and programmes address various themes of WHO SRHR strategy simultaneously. An obvious example is promoting sexual and reproductive rights, which covers aspects of family planning, contraceptive choice and the prevention and treatment of sexually transmitted infections (STIs) and HIV/AIDS.

Scope

This report discusses organisations that received funding through MFS 1 (2007-2010) or the Schokland Fund (2008-2012) and that are active in the field of sexual and reproductive health and rights. The findings of this study are based on 51 evaluation reports of 10 organisations. The evaluations cover projects and programmes with an aggregated budget of around EUR 130 million. As the study is based on a selection of available project evaluations, it does not provide a comprehensive and representative overview of all SRHR activities carried out by the NGOs.

[4] These so-called 'vulnerable' or 'high-risk' groups have received attention in Dutch policy for some time, but during the UN-summit about HIV/AIDS in New York in June 2011 they were for the first time explicitly acknowledged as key populations.

[5] The WHO strategy uses the terminology elimination of unsafe abortion. In Dutch policy ICPD language is used: access to safe abortions.

[6] Abortion was, however, several times included as one of the topics of sensitisation and awareness raising activities, e.g. in the Youth Incentives programme of the Rutgers Nisso Group (report 39).

1.3 Outline of this report

This report is divided into six chapters. The *first chapter* has provided the introduction to the study. C*hapter two* describes the methodology used in this study. *Chapter three* presents the policy of the Dutch government on SRHR and provides an overview of the funding for civil society organisations in this area. Next, the NGOs and their overall involvement in SRHR are presented. *Chapter four* then provides an overview of the characteristics and methodology of the evaluation reports that were analysed in this study.

Chapter five presents the findings from the evaluation reports across the four thematic areas: maternal and perinatal health, contraceptive choice and safety, sexually transmitted infections (STI) and HIV/AIDS, and sexual and reproductive rights. Each section presents the approach of the interventions, and examines the results found in terms of improving knowledge, increasing access to and use of services, and the results of efforts to influence policy. Each section concludes with the factors that contributed to the achievement of results, as well as the key lessons learned. Chapter five also provides the overall findings on capacity development and sustainability. The final chapter of this report, *chapter six*, presents the main conclusions of the study. The report is complemented by a number of annexes that provide further information pertaining to the methodology and content of this study.

2

Overview of the methodology

2.1 Phases

This study was conducted in a number of steps, as follows:
- Identification of NGOs;
- Identification and assessment of evaluations for inclusion;
- In-depth analysis of the evaluation reports;
- Briefing of NGOs on the preliminary findings;
- Report finalisation.

2.2 Procedures

Fifteen organisations were identified at the start of the study as having received funding through MFS 1 and/or the Schokland Fund and to carry out activities in SRHR: Cordaid, Hivos, Humana, Oxfam Novib, ICCO, Prisma, AIDS Foundation East-West, AMREF Nederland, Female Cancer Foundation, Healthnet TPO, Mainline, Rutgers Nisso Groep (Youth Incentives), World Population Foundation, STOP AIDS NOW!, and Text to Change.

A brief overview and description of all organisations is found in chapter three of this report. Annex 4 provides further details on each of the organisations.

In June 2012, IOB organised an information session with the NGOs and relevant policy departments of the Netherlands Ministry of Foreign Affairs to explain the purpose of the study and outline the main steps of the process. This was followed by a questionnaire, requesting information from the NGOs on:

- Overall vision, goals, key activities, and funding;
- Specific goals, added value, focus areas, and funding of SRHR activities;
- Evaluation reports of MFS 1 or Schokland funded projects.

All NGOs returned the questionnaire, along with relevant documents and evaluation reports. This was followed by interviews, in person or by phone, with representatives of the NGOs to obtain additional information and discuss the evaluations in more detail.

In this initial stage, five organisations were excluded from analysis in this study. These were organisations for which no evaluations existed[7], or whose funded activities were too broad to be included for the purpose of this study. For example, non-SRHR specific activities or organisations that focused on broader systems strengthening or on performance-based financing (PBF).[8] However, the five organisations are included in the small overview of NGO involvement in SRHR in chapter three.

7 Text to Change.

8 For the Female Cancer Foundation, Healthnet TPO, Humana, and Mainline the evaluations did not match the (narrowly) defined selection criteria.

As a result of the initial selection process, 138 evaluation reports by ten organisations were selected for inclusion in the study.

The selected evaluation reports were subjected to a detailed assessment process. The assessment process consisted of two parts:
- A screening against minimum requirements for inclusion (see text box);
- An assessment of the strengths of the study design for the evaluations that passed the minimum criteria.

Using this process, 80 reports of 10 NGOs met the minimum requirements for inclusion, and 51 reports (64%) passed the evaluation quality criteria.

Box 1 *Minimum requirements used for inclusion of NGO evaluations in this report*

To qualify for inclusion the evaluations had to meet ***all*** of the following criteria:
- Cover at least one year in the period 2007-2011
- Include information about methodology
- Include information about results (output and/or outcomes)
- At least 25% MFS 1 or Schokland funding
- Contain specific SRHR objectives
- Written in English, Dutch, French, or Spanish

The assessment of the strengths of the evaluation design was done against criteria of validity and reliability, based on criteria developed by IOB. [9] The assessment process also drew on lessons from USAID and UNAIDS, which have developed a rigorous approach for assessing quality of evidence.[10]

Validity focused on the clarity of the problem statement and the research questions. Reliability assessed the research methods, the scope of the study, the independence, and the quality control mechanisms.[11] Points were given to each of these factors on a scale of 1 (poor) to 4 (good). The factor 'verification/triangulation' carried twice the weight. The rationale for this was that in the absence of rigorous research designs verification of data is an important indicator for reliability of the findings.

With a total of eight factors of assessment (one of which counted double), a maximum score of 36 could be obtained. Evaluations had to have a minimum score of 25 to be selected for inclusion in the study. Most evaluation reports received a score either well above or well below the 25-point threshold.

The two researchers initially both independently analysed three randomly selected evaluations, and then compared their assessment to identify differences in approach and to

[9] IOB (2011), Methodische kwaliteit van Programma-evaluaties in het Medefinancieringsstelsel-1 2007-2010.
[10] Quality Insurance Project et al., 2008; and O'Meara & Samuels, 2009.
[11] The assessment form that was used in the study can be found in Annex 5.

ensure consistency in the assessment process. The remaining evaluations were each assessed by one of the researchers. However, in the few cases where evaluations fell on the cut-off point for inclusion, the researchers consulted to decide whether exclusion or inclusion was merited.

Once the assessment process was completed, written feedback was provided to the NGOs on which evaluations were selected. A full list of these reports can be found in annex 7. Upon request, additional information was provided on the rationale for exclusion of certain evaluation reports.

The assessment of the methodology was followed by a phase during which the selected evaluations were analysed in-depth. This analysis served to find the overall defining features of the NGO interventions, their effectiveness, and the key lessons to be learned. In order to do this, each evaluation report was reviewed to identify the main themes and objectives covered, the intervention logic and pursued strategies, the results achieved (at output and outcome level), factors contributing to the achievement of results, conclusions and lessons drawn by the evaluators, and finally, the methodological issues encountered.

Preliminary findings from this analysis were presented in a feedback meeting to the participating NGOs and policy officers of the Ministry. Subsequent comments and suggestions were, where possible and relevant, taken into account in the drafting of this report. The draft report was circulated for final comments and corrections.

Chapter four provides details on the characteristics of the evaluation reports that were studied.

2.3 Limitations

The findings presented in this report need to be seen in light of the following limitations of the study.

- The large number of evaluation reports made for a lengthy assessment process.
- While care was taken to develop a rigorous, validated, tool for assessment and to ensure inter-coder reliability, the bulk of the assessments were done by a single researcher.
- Various reports had to be excluded because of a lack of information on the evaluation methodology, although the presentation and discussion of findings appeared to indicate that the findings were sufficiently evidence-based. This entails that some evaluations, which may have had a solid research design and relevant findings, were not included in the study.
- Following the selection and assessment process 87 reports and five organisations were excluded. While the findings from this study apply to the projects and programmes that were covered by the 51 evaluations that were included, they are not representative of the full range of activities that were carried out by NGOs with MFS 1 and/or Schokland funding in the field of SRHR.

- The evaluations showed that the NGOs had engaged in a wide range of projects and programmes of varying sizes and budgets, with varying numbers of partners, and with equally wide ranging target groups, target settings, strategies, and outcomes. This has posed challenges for aggregating the findings in a meaningful way. In this report interventions are categorised under dominant themes and in the case of HIV/AIDS also by target group. However, in practice many interventions covered multiple themes and multiple target groups, and could therefore have been discussed under more than one of the sections in the report. In the interest of presentation and brevity each evaluation is only discussed under the most dominant theme of the project or programme (with a few exceptions) in this report.
- An overall judgement on the degree to which the NGOs were effective could not be provided, given that the evaluations which form the basis of this study did not provide enough solid information to allow for this kind of generalisation.

3

Dutch SRHR policy and funding for NGOs

3.1 Dutch policy on SRHR

SRHR has been a priority in Dutch development cooperation for the last two decades. The guiding framework for the Dutch policy is the implementation of the Cairo-agenda of the International Conference on Population and Development (ICPD) in 1994, the international agreements and United Nations (UN) resolutions, including international human rights agreements, and the Millennium Development Goals (MDGs) that target child mortality (no. 4), maternal mortality (no. 5) and the fight against HIV/AIDS and other serious diseases (no. 6).

In 2008, the first policy memorandum focusing specifically on SRHR was drafted: *Choices and Opportunities: HIV/AIDS and sexual and reproductive health and rights in foreign policy*. It is the first document that addressed both SRHR and HIV/AIDS. The letter to the House of Representatives presenting the spearheads of development cooperation policy (May 2011) named SRHR as one of the four spearheads of policy. The document fleshing out the above letter (May 2012) stated that Dutch efforts were focused on achieving universal access to sexual and reproductive health and rights. The letter mentioned three results that could be defined as having impact. These were not quantified.

- Fewer unwanted pregnancies;
- Fewer deaths during pregnancy and childbirth;
- Fewer cases of HIV.

The envisaged outcomes are:

- Young people are better informed about sexuality, pregnancy and HIV and are able to decide for themselves about sexual relations, safe sex and the use of contraceptives;
- Improved access to a range of high-quality contraceptives (including male and female condoms), medicines, vaccines and other medical resources for reproductive health and HIV prevention;
- Improved access to and quality of public and private sexual and reproductive health services, including safe abortion and HIV/AIDS treatment. Key populations also encounter fewer obstacles to access to health care;
- Reproductive rights for all, but in particular for women and young people, have been brought to the attention of other countries, in particular the Netherlands' partner countries, so that they can be discussed and anchored more firmly in legislation.

The letter states that the Netherlands is internationally recognised as a particularly progressive and resolute advocate of sexual and reproductive health and rights, and as having a unique added value in this field. The Netherlands' strength lies in defending human rights and raising sensitive issues. Its approach is based on its own demonstratively effective approach (very low percentage of teenage pregnancies; one of the lowest abortion rates in the world; low rate of HIV among new drug users).

The letter also looks at interfaces with foreign policy and at certain crosscutting themes, like gender and good governance, as well as at levels of intervention. The Netherlands lobbies for SRHR around the world and contributes to international organisations. At bilateral level,

the intensity of effort varies greatly according to the priority attached to working with a particular country. Efforts through private channels take the form of support for international NGOs, Dutch NGOs targeting key populations and public-private partnerships.

3.2 Funding for civil society organisations

Providing funding for civil society organisations or NGOs is one of the strategies of Dutch foreign policy. Just over 20% of the budget for sexual and reproductive health and rights is channelled through civil society organisations.[12] Civil society organisations from the Netherlands, international or local organisations in partner countries can be funded directly via various central financing programmes of the Ministry of Foreign Affairs (MFA) or through embassies. The largest portion of the budget for civil society organisations is spent through different co-funding programs of the Ministry and from the core funds of the Ministry itself.[13]

In the first years of the millennium a policy framework was put in place for financing of the so-called co-financing organisations (MFOs)[14], the *MFP-Breed 2003-2006*. According to the policy framework the programmes would 'provide a contribution to achieving the international goals of poverty reduction and sustainable development as agreed in the world conferences organised by the United Nations (UN) in the 90's and laid down in international agreements'.

In addition to the *MFP-Breed* the year 2002 also saw the establishment of the *Thematic Co-financing* (TMF) channel. In the context of the TMF subsidies could be provided to initiatives in the area of 'human development'. In 2007, *TMF* and *MFP-Breed* were integrated in the *Medefinancieringsstelsel 2007-2010* (MFS 1), which had a budget of EUR 2.1 billion.

The main aim of MFS 1 was 'sustainable poverty reduction in developing countries by strengthening civil society in the South, to contribute to improvement of living conditions and to improve the voice of the populations in development and implementation of government policies.'[15] MFS 1 comprised three main intervention strategies: direct poverty alleviation, society building (including capacity building) and policy influencing. MFS 1 allowed for funding to organisations with broad mandates and which cover multiple themes, as well as for smaller thematic and more specialised organisations that work through a theme that is a priority within the Dutch foreign policy.

In 2007, the *Schokland Fund* was established. This fund is based on the *Akkoord van Schokland*, in which private and public partners emphasised their commitment to strive towards the

[12] Piramide, internal financial data system Ministry of Foreign Affairs.

[13] Within the MFA the Directorate for Social Development, Department for Social Organisations (DSO/MO), is responsible for the management of these subsidies.

[14] Co-financing of Dutch civil society organisations started in 1965 with the current ICCO and Cordaid organisations. These were followed by Novib (1968), Hivos (1976) and in a later stage Plan Nederland (2000) and Terre des Hommes (2003).

[15] Policy framework for the *Medefinancieringsstelsel* (MFS) 2007-2010.

achievement of one or more MDGs. The *Schokland Fund* was intended to stimulate innovative initiatives from society to contribute to the MDGs. From 2008 to 2012 EUR 50 million was made available to this end.[16]

3.3 Overview of the NGO's involvement in SRHR

Fifteen organisations that received funding through MFS 1 or the Schokland Fund were initially identified for inclusion in this study because of their involvement in the field of SRHR. This comprises four large co-financing organisations under MFS 1: Cordaid, Hivos, the ICCO Alliance (i.e. ICCO and Prisma) and Oxfam Novib, and ten smaller thematic NGOs that received funding through MFS 1 or Schokland.[17] A number of these organisations work specifically in the area of SRHR, a number in the area of HIV/AIDS, and others on a combination of both. The SRHR activities of the broad MFS organisations are generally implemented through broader programmes in the areas of health, education and gender. As was mentioned in chapter two, five organisations were not selected for further analysis in this study, but a short description of their work on SRHR is provided below.

Large MFS NGOs

Cordaid (Catholic Organisation for Relief & Development Aid)

Cordaid works in a large number of countries worldwide. During the period 2007-2010 support for SRHR was provided through two programmes: the HIV/AIDS programme and the Health programme (including maternal health). Health system strengthening was one of the main strategies in the health programme; for HIV/AIDS the focus was on care for vulnerable groups (e.g. home-based care), but treatment and education were also part of the programme. Dialogue and cooperation has been sought with the Catholic Church, especially for raising awareness and prevention of HIV.

Next to its general programmes, Cordaid was also involved in a Schokland Partnership on MDG5. This partnership covered five projects, including the training of midwives in several countries, developing heat-stable Oxytocin, raising awareness and support for MDG5, and linking & learning.

Hivos

Hivos is an international development organisation guided by humanist values. Hivos' activities in the area of SRHR have their origin in three different (sub) programmes: Gender, Women & Development, HIV/AIDS, and LGBT rights & sexual diversity. Since 2007, these have all been part of the Hivos programme Civil Choices. Activities under these programmes included raising awareness, expanding access to rights, lobby and advocacy, and service provision. Key populations have been an important target group of Hivos' programmes. A large emphasis has been placed on human rights and on addressing sensitive or controversial

[16] Aidenvironment (2009) *Review Schoklandfonds. Classificatie en impact op de organisatie.*

[17] The selected evaluations do not cover all organisations. See also chapter two.

issues, such as Female Genital Mutilation (FGM), child marriage, honour killings, sexual abuse, safe abortion, rights of LGBT, etc.

ICCO Alliance (ICCO and Prisma)

The ICCO Alliance is a cooperation of six Dutch development organisations[18] which share a faith-based identity. Within the ICCO Alliance, ICCO and Prisma have been the two organisations most active in the field of SRHR, more specifically in two main areas: HIV/AIDS and Health & SRHR.[19] Main activities in these areas included capacity building for health system strengthening in order to provide basic sexual and reproductive health (SRH) services for underprivileged groups, and treatment, care and support for People Living with HIV/AIDS (PLHIV). Engaging in dialogue with religious leaders and organisations has been an important aspect of the work.

Oxfam Novib

Oxfam Novib is part of Oxfam International, which is an international confederation of 17 organisations working in more than 90 countries. The Innovation Fund (IF) was established in 2007, in order to link gender empowerment, address HIV, promote SRHR, and to ensure quality education programming in a rights-based approach. This fund supported over 80 projects in over 32 countries and included projects such as nationwide SRH programmes using computers and mobile phones, education around female genital mutilation, support of HIV positive networks and projects, edutainment, safe schools, decreasing gender-based violence, increasing SRH services and information, and empowering youth around their SRHR. Other SRH programmes included the Universal Access to Female Condoms (UAFC) Programme, established in 2008 by Oxfam Novib in partnership with MFA's Directorate General for International Development (DGIS), the World Population Foundation (WPF) and I+ Solutions, aiming to improve access to female condoms.

Smaller, thematic NGOs

AMREF Flying Doctors

AMREF is an international organisation working in Africa aiming to ensure that every African can enjoy the right to good health. AMREF believes that by focusing on the health of women and children, the health of the whole community can be improved. AMREF is concerned with skilled care of mothers before, during and after childbirth, prevention and treatment of cervical cancer, and proper management of childhood illnesses. The main areas of intervention have been maternal and child health; HIV and Tuberculosis; safe water and sanitation; malaria; and essential clinical care.

AIDS Foundation East-West (AFEW)

AFEW is a Dutch non-governmental humanitarian public health organisation working in Eastern Europe and Central Asia aiming to reduce the impact of HIV among vulnerable populations. To this end, AFEW has engaged in capacity building of service providers,

[18] Edukans, ICCO, Kerkinactie, Oikocredit, Prisma, Share People; which were participating organisations during MFS 1.

[19] The two programmes are now combined in one programme: Basic health & HIV/AIDS.

provision of treatment, care and support services, and advocacy. Main target groups have been PLHIV and key populations. Examples of activities that have been carried out are HIV prevention and support for (ex-) prisoners, promoting harm reduction, such as needle exchange and substitution therapy, but also wider SRHR activities related to HIV, such as addressing the needs of vulnerable women.

Female Cancer Foundation (FCF)[20]

FCF is a small organisation working to eradicate cervical cancer in developing countries through screening, research and education. FCF has developed a 'See & Treat' method[21] for cervical cancer treatment. Under the Female Cancer Program, FCF aimed to implement this inexpensive treatment method in poor and remote regions in Indonesia and South Africa, e.g. through outreach programmes. Activities included training and awareness-raising.

Healthnet TPO[22]

HealthNet TPO is a Dutch aid agency that works on health care in areas disrupted by war or disasters. It aims to build and restore health systems in collaboration with communities that are excluded from functioning healthcare, by combining international public health expertise with local tradition. SRHR activities have generally been part of wider efforts to strengthen health systems and primary health service delivery in fragile states. SRHR related activities were for example increasing access to (mental) health services for PLHIV or victims of sexual violence, or to improve referral mechanisms. Other activities were immunization, Voluntary Counselling and Testing (VCT), and provision of malaria nets and anti-retrovirals (ARV) for pregnant women. A very specific SRHR project of Healthnet TPO (with Schokland Funding) was targeted at reducing maternal mortality in Afghanistan, and consisted of training midwives to work in remote areas.

Humana[23]

Humana is a development organisation active in Southern Africa in the areas of education, health and rural development. During MFS 1 SRHR activities were part of a broader Child Aid programme and consisted of prevention of HIV/AIDS through the promotion of condom use and Prevention of Mother to Child Transmission (PMTCT), as well as counselling and care for PLHIV through community support groups. Humana also worked with One Sixty Mobile concepts within Schokland on a public-private partnership project in Malawi in which information about HIV/AIDS was collected and disseminated through SMS text messages.

Mainline[24]

Mainline is an organisation working both in the Netherlands and internationally (in Eastern Europe and Asia), aiming to improve the health and quality of life of substance users. SRHR

[20] The organisation was not included for analysis in this study.
[21] The See & Treat method is a single visit and cost-effective method, whereby screening is done through the VIA-method (table vinegar) and treatment of early stages of cervical cancer is done using N_2O gas.
[22] The organisation was not included for analysis in this study.
[23] The organisation was not included for analysis in this study.
[24] The organisation was not included for analysis in this study.

activities have been grounded in Mainline's efforts in harm reduction among People Using Drugs (PUD). Harm Reduction strategies have included the prevention of HIV infections during (injecting) drug use, and providing treatment, care and support for HIV positive drug users. It also included measures targeting the sexual health of PUD, such as the provision of information and the distribution of condoms. The main harm reduction project under MFS 1 was implemented in Pakistan, Nepal, Indonesia and India.

Rutgers WPF

Rutgers WPF incorporates former Rutgers Nisso Group/Youth Incentives[25] and World Population Foundation (WPF). Both organisations received MFS 1 funding and carried out similar activities in the field of SRHR, placing emphasis on increasing access to SRHR information and services for adolescents. Projects were in the field of sexuality education, youth participation, capacity building, sexual and gender-based violence and sexual diversity, among others. Projects and programmes have been grounded in research and in expertise gained in the Netherlands.

STOP AIDS NOW!

STOP AIDS NOW! (SAN) was established by five organisations: Aids Fonds, Cordaid Memisa, Hivos, ICCO and Oxfam Novib, in order to more effectively fight the AIDS epidemic. The organisation targets mainly women, young people and children such as orphans and vulnerable children (OVC). Activities have included prevention, treatment and (financial) support, for example through social cash transfers, but also addressing HIV at the work place and promoting women's rights.

Text to Change (TTC)[26]

TTC was founded in 2008 and received Schokland funding. TTC works on innovative mobile solutions for development in the areas of healthcare, education, and economic development. In the area of SRHR, the aim has been to gather information and to inform citizens on SRHR related topics, such as HIV/AIDS and family planning, through the use of mobile telephones.

Added value in SRHR

According to the Dutch government, a diverse civil society is crucial for realising sustainable and inclusive development.[27] In SRHR, the MFA considers civil society to play an important role in the debate about inequities, discrimination and taboos relating to sexual health, and to engage in policy influencing and calling governments to account. In addition, NGOs are considered crucial in reaching underserved people and to deliver services on sensitive issues, such as youth sexuality education or safe abortion. The MFA supports NGOs to engage in three main areas: service delivery, capacity building and policy influencing.[28]

[25] Youth Incentives was the international programme of Rutgers Nisso Groep.

[26] The organisation was not included for analysis in this study.

[27] Information from the internal website of the Ministry of Foreign Affairs and the *Beleidskader MFS 2007-2010*.

[28] SRHR policy note to parliament, 7 May 2012, DSO/GA-83/12, and interviews held with representatives of DSO-GA and DSO-MO of the Ministry of Foreign Affairs.

In congruence with the above view on the role of NGOs, in general the organisations stated that their added value lies in their community approaches, their dialogue with various stakeholders, the provision of service delivery and information and education on sensitive issues and/or for difficult to reach groups, as well as the implementation of innovative solutions.[29]

Annex 4 provides a more detailed overview of the organisations, their SRHR objectives, target groups and reported areas of added value.

[29] Information from interviews held with representatives of the organisations and from the questionnaires.

4

Coverage and design of the evaluations

This chapter will provide an overview of the 51 evaluation reports[30] that were reviewed. It lists the evaluated projects in terms of countries covered, percentage of the budget, coverage of the SRHR themes, result areas and target groups. Finally, this chapter provides an overview of the findings on results and evaluation methodology of the selected reports.

4.1 Coverage of the evaluation reports

Countries

The largest number of evaluations covered projects in Uganda, Malawi and South Africa (covered by respectively 7 and 6 evaluations). The first non-African country is Indonesia, which is the sixth most covered country (4 evaluations). Most of the HIV/AIDS interventions were implemented in African countries, with the exception of the interventions targeting key populations.

Table 1 provides an overview.

Table 1 Countries that are subject of selected evaluations

Countries:	Report:	Countries:	Report:	Countries:	Report:
Bangladesh	32, 39, 40	Laos	32	Somaliland	32
Bolivia	13	Malawi	28, 34, 39, 40, 42, 43	South Africa	8, 27, 30, 32, 38, 42
Burundi	8	Mali	32, 39	Tanzania	2, 8, 40
Cambodia	20	Myanmar	35	Thailand	47
Cameroun	5, 8, 37	Nicaragua	10	Uganda	6, 8, 9, 26, 32, 45, 47
DR Congo	8	Niger	31	Vietnam	21
Ecuador	12	Nigeria	32, 37	Zambia	8, 41, 42
Ethiopia	2, 8, 42	Pakistan	32	Zimbabwe	11, 17, 32, 42
Ghana	4, 7	Peru	14, 15, 22	Regional and world-wide:	
India	8, 18, 42, 44	PNG	8	Central Asia	1
Indonesia	8, 33, 46, 47	Rwanda	25, 39, 40	South America	18
Kenya	2, 29, 42, 46, 47	Senegal	19, 32	Africa (the Horn, East and Southern Africa)	16, 23, 24
		Sierra Leone	3	World-wide*	36, 42

* *World-wide = more than 4 countries covered by the evaluation or unspecified which countries.*

[30] Report 47 consists of a synthesis report and four country reports (47a, b, c, d) of the same programme.

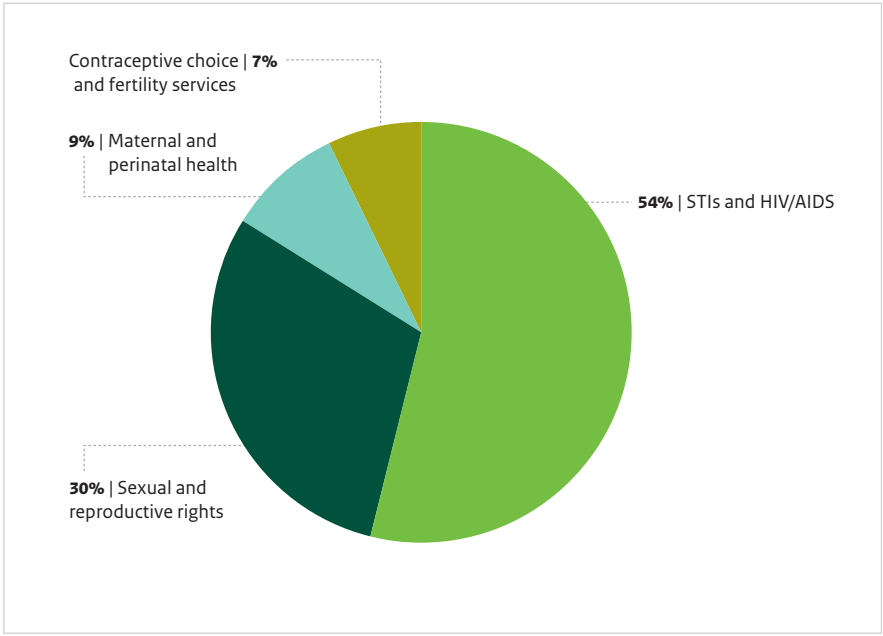
Budget

The ten included organisations spent a total amount of about EUR 311 million on SRHR activities in the period under evaluation.[31] The evaluations covered interventions with about EUR 128 million worth of funding.[32] This figure may present an overestimate of the evaluation coverage, as some projects may have also been included in the budget of other evaluated programmes in this study. In addition, a small number of the evaluated projects covered a longer period than MFS 1, and finally, other donors may also have contributed to the project's budget.

Themes

Figure 1 shows that more than half of the evaluations (54%) covered activities in the field of HIV/AIDS (37 reports), of which 31 were found to have its predominant focus in this area. It is to be noted that many of the interventions covered multiple themes. Thus, a reliable overview of the budget allocation to the various SRHR components cannot be provided. For the purpose of this report, the evaluations will be discussed according to the predominant theme addressed in the project.

Figure 1 *Themes covered by the selected evaluations*



In terms of target groups, eight evaluations targeted key populations, mostly in the field of HIV/AIDS. A total of 23 evaluations (about 50%) included interventions that targeted adolescents/young people.

[31] For MFS organisations the period 2007-2011 is taken, for Schokland 2008-2012.

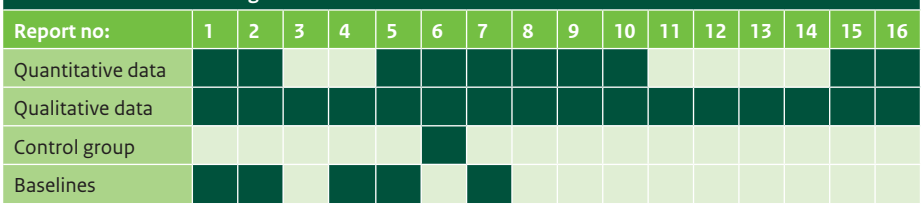
[32] Based on financial information and project reports provided by the organisations. Figures are based on rough estimates of the percentage allocated to SRHR.

4.2 Methodology of the evaluation reports

Table 2 shows that qualitative data analysis and reporting was predominant in the evaluation reports. This would often include a combination of data collected through interviews, focus groups, and observations, as well as in a number of cases simple survey instruments. Perceptions of change were most frequently based on self-reported data and not compared to objective indicators (e.g. changes in HIV prevalence).

Over two thirds of the evaluation reports also included quantitative data, mostly to quantify outputs achieved. For most of the evaluation reports this consisted of reporting on numbers of beneficiaries and frequency of occurrence of certain results (either from primary data collection or secondary sources, e.g. monitoring reports). Comparisons against base-line data were conducted in less than one quarter of the evaluation reports, mostly on the basis of secondary data. A control group design was part of two out of the 47 evaluations.

Table 2 Evaluation design of the evaluations



Report no:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Quantitative data	■	■			■	■	■	■	■	■					■	■
Qualitative data	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Control group						■										
Baselines	■	■		■	■		■									

Report no:	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32
Quantitative data	■	■	■	■	■	■	■	■		■	■	■	■	■	■	
Qualitative data	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Control group																
Baselines				■									■			

Report no:	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47
Quantitative data	■	■	■		■		■	■		■		■	■		■
Qualitative data	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Control group															■
Baselines					■			■	■				■		■

As shown in table 3 below, almost all evaluations reported on the input, activities, the outputs and intermediate results (outcomes) of the interventions. Only one evaluation (report 47) had examined the net effects (impact) that could be attributed to the intervention.[33]

[33] See annex 6 for an intervention matrix of how the authors interpreted the different criteria.

Table 3 Evaluation reporting on result chain levels (input/activities, outputs and outcomes)

Report no:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Input/activities	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Outputs	■	■	■	■	■		■	■	■	■	■	■	■	■	■	■
Outcomes	■	■	■	■	■	■	■	■	■		■	■	■	■	■	■
Impact																

Report no:	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32
Input/activities	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Outputs	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■
Outcomes	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Impact																

Report no:	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47
Input/activities	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Outputs	■	■	■	■	■	■	■	■	■	■		■	■	■	■
Outcomes	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Impact															■

Activities were usually outlined in very general terms, and the reports often did not provide specifics on numbers, budget allocation and scope. In many cases, reported results, both at output and outcome level, are not related to the objectives or targets set. In addition, outcomes are not always quantified. Most evaluations did not contain the intervention logic.

Result areas

The following table provides an overview of which evaluation reports provided information on: improved knowledge, increased access to and use of services (including commodities) and changes in policy and legislation. This relates to the three main envisaged results in of the MFA SRHR policy and the intervention strategies defined in the MFS-policy framework (direct poverty alleviation, society building and policy influencing), as discussed in chapter 3.

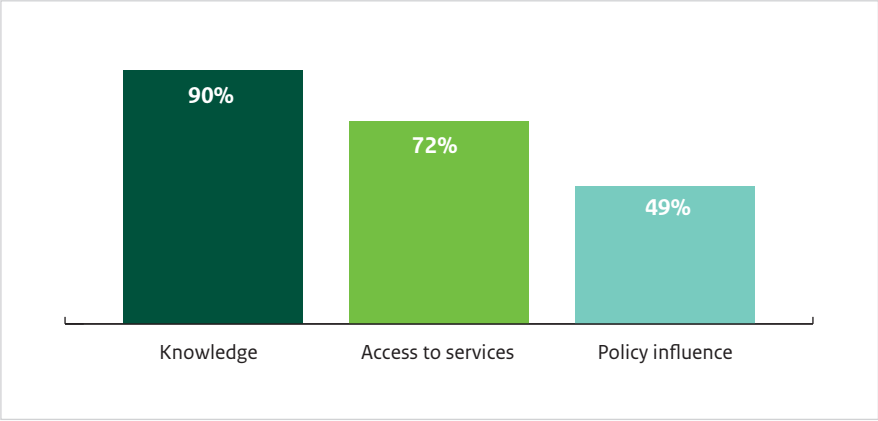
Table 4 Coverage of result areas reported on in the evaluations

Report no:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Knowledge	■	■	■	■	■	■	■	■		■	■	■	■	■	■	■
Access to services	■	■		■	■	■	■	■	■	■		■	■	■	■	
Policy influence	■	■	■	■			■	■				■	■	■	■	■

Report no:	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32
Knowledge		■	■	■	■		■	■	■	■	■	■	■	■	■	■
Access to services	■	■		■				■			■	■		■	■	■
Policy influence		■			■	■		■								■

Report no:	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47
Knowledge	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Access to services	■	■	■	■	■	■	■	■			■	■	■	■	■
Policy influence		■		■	■	■	■	■			■			■	

Figure 2 *Percentage of reports that included discussion of the three main results areas*



As can be seen from table 4 and figure 2 above, almost all evaluations reported results of efforts to improve knowledge. Most interventions covered more than one result area.

Concluding remarks on evaluation designs

Some evaluation designs were particularly strong, with a clear definition of research questions, a solid and well set out research model, demonstrated efforts at triangulation, and clear links between the data collected and the conclusions drawn. It is to be noted here that interventions with a very limited scope and budget do not require a rigorous evaluation approach. However, not all evaluation reports clearly outlined the methodology that was used for data collection (or did so in an annex to which this study did not have access). In addition, a considerable number of evaluations did not contain basic information on the intervention that was being evaluated – in terms of budgets, number of beneficiaries, strategies etc., and failed to explain what had actually been done by the interventions. In most reports, information on and the linkage between targets, input, activities, outputs and longer-term results was missing.

Availability of data was a particular problem across reports and often reflected weaknesses in M&E by the projects themselves. This made the process of understanding the findings from the evaluation more difficult. The limited number of baselines conducted was particularly striking and also limited the approach that could be taken by evaluation teams.

The involvement of the NGOs themselves and of beneficiaries in the evaluation process was a commendable feature of a number of evaluations. In addition, the evaluation studies all provide a valuable body of knowledge about the work of NGOs in the field of SRHR and important lessons that can be drawn. The next sections will describe the findings and identified lessons more in detail.

5

Findings

This chapter presents the main findings of this study. It is based on an in-depth analysis of the evaluation reports that were selected after the assessment process. The findings from the evaluation reports are presented across the four thematic components: maternal and perinatal health, contraceptive choice and safety, STIs and HIV/AIDS, and sexual and reproductive rights.

Each thematic section first summarises the main approaches pursued by the NGOs on this theme. Secondly, it describes the results the interventions have sorted in three (outcome) areas: improving knowledge, increasing access to and use of services and commodities, and influencing policy. Each thematic section then describes the main success factors and bottlenecks that were distilled from the evaluations.

The chapter is concluded by overall findings across the various evaluations on capacity building and sustainability.

5.1 Maternal and perinatal health

Five evaluations focused on interventions that worked in the area of maternal and perinatal health. An overview of these interventions can be found in the table below.

Table 5 Overview of evaluations on maternal and perinatal health

Project (report #)	Objectives and aims in maternal and perinatal health	Budget in EUR (period)	Scope	Target group
Organisational and functional support to DIMOL and the Centre for Women who are Victims of Obstetrical Fistula (report # 31)	**To reduce the number of fistula cases.** Prevention of female genital mutilation. Treatment of fistula cases. Capacity building of the NGO DIMOL to provide effective support and carry out prevention activities.	250,000 (2007-2010)	Niger	Women in reproductive age
Health Child: Improving the management of child illnesses and the health of young mothers (report # 6)	**To improve the management of child illnesses and health of young mothers.** To empower young mothers against vulnerability to sexual exploitation, the risk to HIV infection and uncontrolled pregnancies.	180,000 (2007-2010)	Uganda	Adolescent mothers < 25 yrs., children aged 0-10 years, men
Save for Health Uganda maternal and neonatal health insurance pilot project (report # 9)	**To reduce delays in seeking health care.** To increase/strengthen: access of pregnant women to healthcare services, child survival rates, quality of health care services, community participation, and health management information systems.	250,000 (2009)	Uganda	Pregnant women and new born children, as well as broader communities

Table 5 Overview of evaluations on maternal and perinatal health				
Project (report #)	**Objectives and aims in maternal and perinatal health**	**Budget in EUR (period)**	**Scope**	**Target group**
Strengthening of Health Care in East Cameroon – Phase II (REDSSEC 2) (report #5)	**To improve access to health care for underserved populations.** Improve resource management of Catholic Health Facilities (CHF), strengthen community participation, and enhance CHF capacity to provide services to PLHIV.	686,000 2007-2010	Cameroon	Communities with poor access to health services
Citizen Action and Health MDGs (CAH-MDGs) project (report # 4)	**To improve health of Ghanaians marginalised from health services.** Educate communities on MDGs, increase Government accountability, and strengthen capacity of the implementing NGOs and the Health Platform.	265,000 2007-2010	Ghana	Communities with poor access to health services

Three of the five projects focused on specific aspects of maternal and perinatal health[34], while the other interventions were broader health/RH related interventions (which included attention to maternal and perinatal health). The evaluations used solid research designs, which generally combined quantitative and qualitative research methods. The evaluation of the Health Child Project in Uganda used a control group design. In two of the evaluations progress was assessed against baselines (Cameroon and Ghana).

Approach

This section provides a brief overview of the approach and strategic choices that were made to reach the intended objectives of the interventions.

All five evaluated projects included a focus on **improving knowledge of target populations**. In addition most of the interventions also focused on enhancing **knowledge and attitudes of decision makers** (e.g. community leaders, government authorities) and of health staff.

Box 2 *Using ICT resources centres for health care awareness (Uganda)*

In Uganda, ICT resource centers were used to: provide information on health education; for computer skills development; behaviour change and networking. As a result of having the ICT resource centre, community members received health information, which was found to raise awareness on health issues in the community. The computing skills of young people were enhanced through the use of the ICT resource facility.

Source: Report 6

[34] Reports 6, 9 and 31.

Capacity development emerged as a key strategy of the interventions. In a number of cases, capacity development targeted government or other health services (e.g. services provided by religious organisations). For example, in Cameroon[35] the focus was on capacity strengthening of staff of the Catholic Health Centre (CHC) in RH and in supporting PLHIV, including pregnant or lactating mothers. The introduction of a PBF/contractual model for CHC was a key element of this strategy. In Niger[36], capacity building targeted community health agents and focused on SRHR, in the assumption that this would allow health agents to provide better obstetrical support, as well as information on family planning. In Ghana[37], the advocacy around MDGs 4, 5, and 6 was also based on capacity development of health platform members and the Field Non Governmental Organisation (FNGO), in order to equip them to embark on advocacy, engage in policy dialogue at various levels, and empower citizens to hold duty bearers to account.

The involvement of **community health workers** was another strategy common to a number of interventions. In the Uganda Child Health Programme[38] community volunteers were recruited to go from house to house and sensitise young women and men. In Cameroon, as part of the health services strengthening project, community health agents were involved in provision of antenatal care and vaccinations.

The advocacy programme around the health MDGs in Ghana[39] used an innovative combination of strategies, which centred on **community sensitisation and education** (to bring about an increase in demand for accountability). Key strategies included translation of MDGs in local languages, radio discussion programmes, participatory monitoring of the health sector in relation to MDG 4, 5, and 6, biannual roundtables, capacity building, skills training for platform members on policy analysis, advocacy and on budget processes, and production of Information Education and Communication (IEC) materials. The intervention in Uganda also used **media as a specific strategy**. Information, Communication and Technology (ICT) resource centres were used as a specific strategy for enhancing knowledge and bringing about behaviour change in Uganda (see text box 2).

Results – knowledge, attitudes, and behaviour change

Selected evaluations reported **improvements in knowledge and changes in attitudes**. This included knowledge on maternal and perinatal health, as well as knowledge of SRHR, including of family planning. Most interventions did not include a pre and post-test design that would have allowed for a quantitative measure of change in these areas.

In Ghana, the MDG advocacy project evaluation found that citizens within target communities had become more knowledgeable about their rights and responsibilities, and in certain cases had been able to demand a measure of accountability from duty bearers

35 Report: 5.
36 Report: 31.
37 Report: 4.
38 Report: 6.
39 Report: 4.

(over 5,000 persons reached). Duty bearers in the communities and districts had also become more alert to their responsibilities.

In Uganda, the Child Health project was found to have produced changes in the intervention area with higher percentages of community members having heard of family planning methods in the last three months (79% against 72%, when comparing intervention and control areas) and an increase in spousal communication on matters related to family planning (46% against 35% among couples in the control group). The strengthened efforts of the community health volunteers appear to have made the difference as source of information.

In Niger, the fistula project brought about changes in perception of parents, teachers, religious leaders and community authorities of women's dignity and rights. However, this finding was based on self-report and the information on this change was qualitative only.

Results – availability, accessibility, use and quality of services

Most of the projects had a strong accent on improving access and use of services. However, not all project evaluations quantified changes in service delivery. Quality of services in particular received little attention across the evaluations.

The project in Niger had been effective in providing access to medical care for women with fistulas. A total of 1,183 women were treated, more than double than what had been planned. Due to budgetary limitations as well as conflicts between the implementing NGO and the government health services, the project was less successful in re-integrating women in their communities. Of the 610 women who were operated in two years, 40 (7%) were reintegrated into their communities.

The Child Health project in Uganda reported positive changes in access, use and quality of services, compared to the control group. This was reflected in increases in:

- The proportion of women receiving supervised antenatal visits;
- The proportion of adolescent mothers receiving post-delivery advice;
- The use of contraceptives (98% in the intervention areas compared to 60% in the control area);
- Increase in respondents who indicate always using a FP method (26.9% versus 20%).

Positive findings were noted in this project from the involvement of men. This contributed to the above-mentioned improvement in spousal communication. The project led to an increased level of satisfaction with FP services in the intervention areas, where 46% of users against 30% in the control area are very satisfied. The partnership with the public health centres was found to have contributed strongly to this increase. The intervention group also used a larger variety of contraceptive methods than the control group, but it was unclear to what extent this could be attributed to the project.

The Ugandan health insurance scheme project established that there had been an increase by 30% in utilisation of maternal and neonatal health care services in the project area. However, the change could not directly be attributed to the intervention, as the design of

the project did not control for cofounders. Based on qualitative interviews, the evaluation also found 'moderate to strong solidarity of the scheme members to contribute towards the care of pregnant women and neonates'. It further established, however, that the level of premiums which households were willing to pay was far below the cost of services, implying that substantial subsidies would be needed in the medium term. Quality of services, however, was not found to have improved.

In Cameroon, a key focus of the project was on prevention of HIV and AIDS and support for PLHIV, including pregnant women or lactating mothers. The project resulted in an increase in the availability of Voluntary Counselling and Testing (VCT) through CHC, with all centres providing this facility at the end of the project (against a target of 87% in the project document). 64% of PLHIV were accessing treatment, compared to a target of 60%. However, the anticipated 100% integration of PLHIV in associations that provide support was not achieved. In one locality the indicator was not measured, and only 64% of the PLHIV in other locations were integrated in an association.

Results – advocacy

Advocacy was not a prominent component of the initiatives that were evaluated, with the exception of the Citizens Action and Health MDG project in Ghana. This intervention reached 7,000 people (approximately 30% more than planned), and was found to have resulted in stronger monitoring and advocacy by individuals, communities and field level NGOs. It also resulted in the integration of MDG 4, 5, and 6 into health planning in districts covered. At the outcome level, two of the districts reported that the project may have contributed to a 10 percentage point increase in coverage of the National Health Insurance Scheme (NHIS). However, the design of the project did not allow for this to be established conclusively. The evaluation of the Ugandan health insurance scheme initiative concluded that advocacy was a missing element in the design of the project and that a possible next phase would need to include 'advocacy of change in blanket abolition of user fees and devise means of networking with other civil society organisations and create change of this environment of high out of pocket expenditure'.[40]

Success factors and bottlenecks

The use of **community volunteers** was identified as a success factor in a number of the initiatives. The evaluation of the Child Health Project in Uganda found that community health volunteers were more effective in the areas where the project was in operation compared to the control areas. It further found that the combination of community health volunteers and strengthening health systems was effective in bringing about behaviour change and engaging in outreach services in the community, and thus contributing to addressing community development needs.

Community health agents were indispensable to the success of the community health project in Cameroon, where they were responsible for a variety of activities, including prevention and treatment, amongst others in the areas of pre-natal care and vaccinations.

[40] Report 9, p. 46.

Similar success with using community volunteers in combination with health workers contributed to a more judicious use of resources in the Ghanaian MDG project, effectively because their mobilisation skills were found to be stronger than that of duty bearers and because they had a competitive advantage since this was their area of expertise.

However, as noted in the Cameroon study, there is a need across these different settings to clarify the status of community volunteers. Their acknowledged invaluable role was often not formally recognised or supported by health services. Limitations of using community health workers were also noted, for example the Child Health project in Uganda found that community workers were the least preferred source of family planning as they could only provide information but not dispense services.

The **partnership with public health centres and with public health workers** emerged as an important success factor in Uganda, Cameroon and Ghana. However, in Niger, the FGM work showed that the context may not always be favourable to NGOs developing the kind of relationship with public services that is essential to such collaboration.

Community participation was a key element for success in some of the interventions. In Uganda, communities were actively involved in defining health service packages, selecting service providers and in the management of the insurance schemes. In Ghana, the MDG project was based on the premise of empowerment of communities, and their involvement in all phases of the project contributed to the success.

Main bottlenecks for the achievement of the objectives of the interventions included:

The limited focus of some interventions – e.g. the Uganda Child Health Project focused on curative services, while the evaluation noted that prevention and promotion services are cheaper and that the project should have included family planning services.

Frequent changes of staff – e.g. in the MDG project in Ghana a major challenge to continuation was the frequent replacement of the key duty bearers which meant the advocacy efforts had to be re-initiated.

Methodological challenges/inconsistent approaches – in the Ghana MDG project different advocacy approaches were used without clear reasons for these differences, and in some cases with implications for the success of interventions. In Cameroon, there were issues around the definition of PBF, which generated difficulties during implementation.

Funding – in a few cases the projects saw funding reduced midstream, for example in Cameroon where the budget was reduced by one third, which affected the support provided to the PLHIV.

5.2 Contraceptive choice

Three evaluation reports[41] – covering a range of projects (table 6) – mention specific activities in the field of ensuring contraceptive choice, more specifically the female condom (FC).[42]

Table 6 Overview of evaluations on contraceptive choice and safety

Project (report #)	Objectives and aims in contraceptive choice	Budget in EUR (period)	Scope	Target Group
Universal Access to Female Condoms (UAFC) Joint Programme (Report #37)	**To reduce STIs, including HIV and unwanted pregnancies, by making female condoms accessible, affordable and available for all.** Support research, development & manufacturing; increasing demand; ensuring a steady supply of different types of condoms; and integrating the female condom in national programmes and advocacy in Nigeria and Cameroon, and in global advocacy efforts.	12,5 million (2009-2011)	Global, Nigeria, Cameroon	Women
Thohoyandou Victim Empowerment Trust (Report #38)	**To contribute to rape prevention and end violence against women, support women who are victims of violence, and reduce the risk of HIV infections experienced by women.** Promoting the female condom as method for women to protect themselves against STIs, HIV and unwanted pregnancies.	463,180 (2008-2011)	South Africa	Victims of rape, young people
The Hunger Project (Report #34)	**To reduce vulnerability of women and girls to HIV/AIDS.** Empowering women to defend their sexual rights and improve access to and/or use of HIV and AIDS related services.	708,210 (2005-2010)	Malawi	Women and girls

The large-scale UAFC programme had a predominant focus on promoting the female condom, both globally and in two case countries. In the smaller Thohoyandou Victim Empowerment Trust (TVEP) project in South Africa and the Hunger Project in Malawi, the FC

[41] Reports: 34, 37, 38.

[42] NB: Report 38 is also included in section 5.4 of this report, regarding its activities around VAW. Report 34 contains a much wider thematic scope than FC activities, but for this report it was decided to focus on the FC activities and results.

activities were incorporated into a wider strategy to empower women and to protect them against HIV/AIDS. The selected interventions did not include other family planning or fertility services and the focus was on protection against HIV/AIDS.

Approach

The general approach of the country level interventions regarding the FC included three aspects: awareness raising, delivery of services, more specifically distribution of female condoms, and strengthening the enabling environment.

Increasing access to **service delivery** in the field of RH was part of all projects, explicitly or implicitly. At the same time, the specific approach taken to increase access to FP commodities was not always clear.

Through the UAFC programme in Nigeria and Cameroon, **social marketing** organisations were recruited to implement the FC programmes. This included distribution, national advocacy and social marketing, in collaboration with NGOs. Peer educators, such as hairdressers and barbers, were involved to reach out to customers and to sell the FC. In the Hunger Project in Malawi, so-called HIV/AIDS Animators from the community were the major source of free condom (especially FC) distribution.

Working with **multiple key-stakeholder groups**, such as religious elders, parents, civil society organisations, teachers, and government institutions, was a shared strategy. In the UAFC programme this comprised both private and public partners.

Capacity building was a common approach in all interventions. It occurred at different levels through varying activities. It consisted of efforts to **empower** the target groups to address their reproductive health needs, but also to build capacity of local leaders and communities to **influence policy** and decision-making.

Advocacy for promoting the female condom was a large component of the UAFC and TVEP interventions. For the TVEP project in South Africa this consisted of advocacy at national level, for the other project this took place at both the national level (the Netherlands, the United States of America (USA), Cameroon, Nigeria and Mozambique) and through global advocacy. For both projects, the advocacy efforts were grounded in **research**.[43] The project on universal access to the female condom was carried out by multiple NGOs and intended to gain global support for the FC through advocacy.

Results – knowledge, attitudes and behaviour

All three evaluations provided information about results in the domain of knowledge and awareness. Overall, **the reported trends were positive**.

The UAFC programme reached 2 million people in Nigeria and 750,000 in Cameroon with educational activities – 94% and 263% of the overall programme target, respectively. The

[43] Reports: 37, 38.

evaluators noted this was an impressive achievement, given the short time span and the large geographical scope. The evaluation found general acceptance of the FC, provided that initial questions and concerns about the FC were properly addressed prior to the interventions. The evaluation of the Hunger Project in Malawi also reported that community sensitisation had contributed to a general acceptance of condom use: 83% of respondents said it should be generally promoted, and 95% even said it should be promoted among youth. The evaluation even noted a preference for FC to male condoms, because it allowed women to protect themselves against HIV and to use it as a FP method – without needing the male's consent. However, negative aspects of the FC were also mentioned, specifically that some women found it uncomfortable to wear.

For the TVEP in South Africa, the fact that the implementing NGO only focused on the consequences of unsafe sex or rape (e.g. STI infections or pregnancy) was noted as a missed opportunity. The evaluation noted that a greater impact could have been brought about by also addressing – in the training and promotion materials – issues related to **empowering** women in sexual relations, addressing male patriarchal dominance, gender inequalities, or sex without consent.

Results – availability, accessibility, use and quality of services

The UAFC intervention was found to have been effective in negotiating lower prices for procurement of the female condom. It had no direct effect on accessibility for the end-users, as at this level the price was already subsidised. However, according to the evaluators, it enhanced the legitimacy and credibility of the programme in making these commodities more affordable. Women reported that the price of FC was not a problem, but they did consider it unfair that the FC is more expensive than the male condom.

The evaluation found that the availability and accessibility of FC for the general public had increased on a large scale in the intervention areas. At about two thirds of the implementation period of the project, both country programmes had reached 80% and 60% of their targets in terms of FC sold or distributed – almost 7 million FC were procured by partners of the project. Substantial investments in social marketing are considered key to this achievement.

Box 3 *Improving sales of the female condom*

After a reorientation of the strategy in 2011 the number of FC sold in Nigeria increased substantially. The revised strategy included **setting sales targets** and introducing **stipends** to make the FC a profitable product for peer educators.

Source: Report 37

The NGO carrying out the FC project in South Africa[44] developed a business case for advocacy purposes, to show that the costs incurred to society when the female condom is not available, in terms of health care costs, skills lost, ART medication, etc., outweighed the costs of producing it. However, the evaluation was not able to report on the results of this strategy.

According to the evaluation of the UAFC programme, the country programmes demonstrated that a demand can be created by guaranteeing a steady supply of commodities and by ensuring distribution through social marketing strategies. The evaluation noted a general acceptance of the FC, in a context were affordability was not a major obstacle for people. However, the evaluation could not provide information about the use of the FC. It was suggested that more time and awareness-raising would be needed to persuade people to try the FC.

The implementing agencies of the UAFC female condom programme were found to have created favourable conditions for **increasing the availability of a wider choice of female condoms** by engaging with WHO for three new types of the commodity. However, it was too early in the process to show any effects yet for the users.

Results – advocacy

All three evaluated interventions included efforts in lobby and advocacy to promote the FC. Results were mixed, but generally promising. Effects could be shown at the community and district level. At national and international level the effects were limited. Advocacy for the FC did lead to increased attention for this commodity at the international level and in the two UAFC programme countries. However, at the time of the evaluation it had not yet resulted in concrete policy changes and matching financial commitments, either from the public and the private sector. As the evaluators of the UAFC programme stated: 'it is still early for advocacy efforts to influence concrete policy changes, but the first steps have been taken'. The evaluators did note 'some changes in language' regarding FC in policy documents and statements by multilateral organisations such as WHO, UNFPA and USAID. The evaluators attributed the limited results of advocacy at the federal level to the lack of proper advocacy plans and limited joint advocacy between international and national partners. In addition, the advocacy focus was also found to have been narrow in that it did not extend to wider issues such as FP and HIV/AIDS.

In the South Africa project emphasis was placed on conducting research to parry arguments of the government against the female condom. As noted, the evaluation was unable to establish what the results of these lobby and advocacy efforts had been. The advocacy efforts of the project implementers in Malawi at local, district and national level had contributed to some positive developments, such as the establishment of a public sector marketing plan for free male and female condoms.

44 Report: 38.

Success factors and bottlenecks

All evaluation reports analysed factors behind the achievements and identified challenges. A successful and common approach applied across interventions was **involving multiple stakeholders** in the projects. For example, the UAFC programme engaged with the private sector and civil society, and the Hunger Project engaged with local church leaders. In addition, implementing **a combination of activities** in awareness raising, service delivery and strengthening of the enabling environment at the same time was mentioned as an effective and efficient strategy.[45]

Collaboration with government and **partnership with public health centres** was considered important for a steady and constant supply of the FC[46], but for the UAFC programme the involvement of the public sector was limited and there was an underutilised potential to work with family planning clinics and VCT centres.

Social marketing programmes were identified as a key strategy in promoting the female condom.[47] Financial incentives and rewards were reported as having contributed to enhancing motivation, and in this manner, to sales by sales agents in the UAFC programme. The evaluation of the project in Malawi noted that the free distribution of female condoms was not sustainable, but that purchasing them would be too expensive.

Engagement at community level was mentioned as an effective instrument to reach the envisaged target groups. An example is the UAFC programme, where hairdressers were serving as information and distribution points.

Mainstreaming gender and **involvement of men** played a crucial role in the interventions. The UAFC evaluation in this context states that 'cultural and gender dimensions seem to play a large role in accessing family planning, and condoms in general'. The extent to which these aspects were addressed varied per intervention and project area.

A number of aspects also supported effective implementation of **advocacy a**ctivities: expertise of the programme partners, a well-developed advocacy strategy, good networking and the use of appropriate communication instruments. Specific advocacy related bottlenecks in the UAFC programme included lack of sufficient time and budgets for advocacy, and limited participation of Southern partners in international advocacy.

A number of **bottlenecks** for achievement of objectives coincide with those that were also highlighted in section 5.1 on maternal and perinatal health. These include: high turnover of staff, limited monitoring and evaluation (M&E) and follow-up capacity, leading to insufficient learning and alterations to the projects, and the relatively short duration of the projects, which does not match the time it takes to achieve real changes in the field of reproductive health – most particularly to address remaining misconceptions around the female condom.

45 Report: 37.
46 Report: 34.
47 Reports: 37, 38.

5.3 HIV/AIDS

The area of STIs, including HIV and AIDS, covered the largest number of evaluations (a total of 31) after the assessment process. The majority of these evaluations examined interventions focusing primarily on HIV and AIDS (including STIs) prevention, as well as care and support. Some of the interventions concerned large multi-country initiatives (three initiatives in total), while others focused at country level (or on specific regions within countries). A number of these interventions sought to improve access to prevention, and to enhance service delivery, while others were concerned with promoting the involvement of specific categories of stakeholders in the HIV and AIDS response (e.g. church leaders), or to enhance research and advocacy. The evaluations covered countries in Latin America, Africa, Eastern Europe, and Asia.

The interventions are discussed below by population target group. Thus the remainder of the chapter will study evaluation findings concerning initiatives that focused on:

- Interventions targeted at the general population, which mostly focus on high prevalence countries;
- Interventions targeting PLHIV and OVC;
- Interventions providing access to prevention and support for specific key populations.

5.3.1 Interventions targeting the general population

The bulk of the evaluation reports concerned interventions focused on the general population and covered a range of activities from prevention to care and support/services for affected persons. A content analysis of this sub-group of studies categorised the evaluations in three main areas of focus:

a) Promoting/enhancing the involvement of religious leaders/organisations in HIV/AIDS prevention, care and support;
b) Building capacity of southern partners in HIV/AIDS prevention, care and support; and
c) Providing access to prevention and access to services, especially for young people.

a) Promoting/enhancing the involvement of religious institutions and/or leaders

Five interventions focused on promoting/enhancing the involvement of religious institutions and/or leaders in HIV and AIDS prevention care and support. Two were multi-country initiatives focusing on Sub-Saharan Africa. The other three (Cambodia, Peru and Uganda) all sought to strengthen the involvement and role of the church in reducing the spread of HIV and AIDS.

Table 7 Overview of evaluations on STIs and HIV/AIDS: projects targeting involvement of religious institutions and/or leaders

Project	Objectives and aims in STIs and HIV & AIDS	Budget in EUR (period)	Scope	Target group
Ecumenical HIV and AIDs Initiative in Africa (EHAIA) (Report #24)	Strengthen the HIV and AIDS competence of African churches and theological institutions through training and capacity development, responses to specific requests for support, and access to resources.	5.9 million (2002-2009)	Sub-Saharan Africa	Church leaders, female leaders, leaders living with HIV and persons linked to churches
Called to care Toolkit (CtCT) (Report #23)	Produce a set of ten practical action-oriented workbooks that would "*empower church leaders, congregations and their communities with knowledge, attitudes, skills and strategies they need to plan and implement effective responses to HIV*".	455,745 (2005-2011)	Sub-Saharan Africa	Church leaders PLHIV
Monks, Nuns HIV/aids and Human Rights (MONHAR) Project (Report #20)	Reduce stigma and discrimination, reduce the rate of HIV infection, improve the living conditions, promote the respect for human rights, and strengthen the Cambodian Salvation Centre organisational capacity.	343,003 (2006-2009)	Cambodia	PLHIV, OVC, families and communities
AIDS Care Education Training Project (Report #26)	Strengthen the Church to support communities to play a bigger role in reducing the spread of HIV and AIDS, mitigating the impact of HIV, and addressing drivers of the epidemic.	310,000 (2007-2010)	Uganda	Church congregations, OVC, PLHIV, men
Rosa Blanca (Report #22)	Organise religious organisations to participate in the response to HIV and AIDS, and to defend the rights of PLHIV.	240,000 (2006-2008)	Peru	Religious organisations and networks

The evaluations employed mostly qualitative designs and were based on self-report. Reports mostly lacked numerical data to illustrate changes. Attribution of the reported results to the intervention is not possible, as none of the four interventions employed a control group design.

Approach

Both multi-country interventions in Sub-Saharan Africa (EHAIA[48] and CtCT[49]) sought to enhance the involvement of the church in the HIV response through **capacity development**

[48] Report: 24.
[49] Report: 23.

of church leaders and members, including PLHIV. The EHAIA provided tailored responses through training of trainers, workshops, responses to individual requests for support, and distribution of information/resources (web based, and print). The CtCT Project, on the other hand, focused on **producing and distributing print resources that would empower church leaders**. Both interventions had a concern with **providing a clearly articulated framework** for the HIV and AIDS response, based partially on theology, and more broadly on the social, ethical, health, and practical implications of the HIV pandemic. This included addressing stigma and discrimination, and on promoting practical church based interventions that would support individuals, families and communities.

The other three interventions focused on improving **support and services for specific target groups** – in Peru for PLHIV[50], in Cambodia for PLHIV[51] and OVC, in Uganda for young people, OVC, and PLHIV[52]. A specific element of the Uganda approach was to **increase the involvement of men.** In the case of the MONHAR project in Cambodia the interventions focused on increasing the involvement of Buddhist monks and nuns, and using selected Buddhist practices such as meditation, Buddhist counselling and preaching in the psychological care for PLHIVs. In Uganda, capacity development covered 140 Christian churches of various denominations which were running at least one HIV programme (Behaviour Change Communication (BCC)/life skills, Home Based Care (HBC), or Project Cycle Management (PCM)).

Box 4 *Involving monks in PLHIV support*

In Buddhist communities monks already act as teachers and community leaders, providing mental, spiritual and social support to people with various problems. Buddhist monks are trusted, respected, influential figures who are traditionally revered.

The MONHAR project in Cambodia adopted a train-the-trainer approach, so that core trainer monks could cascade their knowledge, skills and expertise throughout the monk network.

However, the evaluation found that there was a tendency for Monks to use their own approach to helping PLHIV rather than the agreed common approach. An additional concern was that in some of the target areas the majority of the PLHIV were of other religious denominations (Christians or Muslims) and the intervention of the Buddhists was seen as being counter to their culture and beliefs.

Source: Report 20

Results – knowledge, attitudes and behaviour

The multi-country initiatives (EHAIA and CtCT) reported **higher levels of knowledge and understanding of the virus and of its routes of transmission and less misconceptions**

[50] Report: 22.
[51] Report: 20.
[52] Report: 26.

among the target group. Reported changes **breaking the silence** around HIV, **reduced level of stigma** and discrimination, greater commitment to HIV and AIDS, and a more prominent and frequent integration of these topics in church meetings and events. The EHAIA also reported **strengthened capacity and delivery of care and support**. In terms of behaviour the CtCT evaluation reported changes in intentions of community members with respect to sexual debut, remaining faithful, condom use, and uptake of VCT. No behaviour level changes were examined/reported for the EHAIA. Changes in attitudes were also reported in Cambodia intervention where the involvement of Buddhist monks and nuns was found to reduce stigma and discrimination of PLHIV. The Uganda intervention found evidence of behaviour change among adolescents, which was stronger for boys than for girls. The intervention focusing on men resulted in reduced drinking hours, men working more, more money being saved, more attention to the needs at home, increased levels of testing for HIV, and increased reported faithfulness.

Results – availability, accessibility, use and quality of services

In Cambodia, the reduction in stigma and discrimination allowed PLHIV to feel more at ease in expressing concerns in public meetings and to demand proper treatment for children at schools. As a result **children of PLHIV attended schools more regularly**. The evaluation also found that the more explicit presence of PLHIV in communities brought about changes in the way in which they were treated by staff from health clinics, which resulted in increased levels of attendance.

Results – advocacy

Two interventions reported advocacy related results. The EHAIA reported an **impact on networking**. For example, in Congo Brazzaville the interventions around training and capacity building resulted in the formation of a network of religious organisations through the *Coordination de la Réponse Commune des Confessions Religieuses face au VIH et au SIDA* (COREC). In the Democratic Republic of the Congo (DRC) a *Conseil Interconfessional de Lutte contre le SIDA* (CIC) brought together various churches. However, the evaluation did not assess what the outcomes of these networks were in terms of policy and advocacy. In a number of countries the EHAIA training also resulted in the development and implementation of workplace policies. These were reported to have impacted on church leaders' actions, and on access to holistic care and support to PLHIV. However, concrete evidence of changes as a result of these workplace policies was lacking in the evaluation report. In the Peru intervention various examples were provided of advocacy efforts with key government and other groups. The intervention reported that initial success had been made in **ensuring that rights abuses of PLHIV were prosecuted**. Specific numbers of cases were not provided in the report.

Success factors and bottlenecks

The evaluations highlighted various success factors for the two multi-country initiatives:

- **Accessibility and quality** of the materials, which facilitated adoption and use.
- The explicit use of a **theological approach** to HIV prevention, support and care. E.g. the CtCT materials highlighted that in theological terms stigmatisation and discrimination of PLHIV represents a breaking of the conventional relationship.

The CtCT evaluation highlighted a number of additional qualities, namely: **simplicity, design** (illustrations, etc.) and the workshop **format** of the different workbooks (facilitating their use).

The success factors of the MONHAR project were of a different nature given the more operational focus of the interventions. Identified strengths included the **strong teamwork** within the implementing organisation, the **strong support from government** at all levels (local, district, and from key sectors), and specific strategies that the project used, such as provision of food support and credit schemes. In Uganda **partnering with service providers** was identified as key, as well as the specific focus on men as part of the prevention strategy.

A number of **challenges** also emerged from the evaluations. For both EHAIA and CtCT the users regretted that the materials were not available in vernacular languages, which would have enhanced their relevance and use. In terms of strategies, it was found that while the EHAIA had been successful in working with individual pastors, it could have been **more strategic in engaging with groups of churches** in specific geographical areas to create a critical mass. The EHAIA initiative also faced difficulties in following up with participants after the workshops to **assess the impact of the materials** so that much of the evidence of change was anecdotal and not adequately fed back into training sessions and approaches.

The CtCT evaluation found that the demand for copies of the materials was outstripping the supply and that many participants would have liked to have **specific training** on how to most effectively use the materials in participatory/group sessions.

In Peru the **lack of a base-line assessment** of the situation in different religious organisations reduced the relevance of some interventions, and made it difficult to put in place strategies that targeted specific concerns.

Major challenges in Uganda emerged when providers scaled down services because of funding constraints. The evaluation also specifically found that while the focus on men had been effective, it had been expensive because it required specific interventions. Finally, and as is highlighted in the text box above, the use of Buddhist monks and nuns faced the challenge that in some areas most PLHIV were from other religious denominations.

b) Capacity building of southern partners in HIV/AIDS prevention

This second sub-section discusses the findings from a selection of initiatives that targeted capacity building of southern partners in the fight against HIV and AIDS. The Cordaid multi-country initiative, one of the largest included in this publication, focused on building capacity for service delivery and policy influencing among the over 100 CSOs involved in the project. In terms of the interventions that focused on specific countries, one of the projects targeted integrating gender and women's equality in programming (the Gender Development Project – GDP), and the two projects (in India and Uganda) focused on capacity development through workplace programmes.

Table 8 Overview of evaluations on STIs and HIV/AIDS: projects targeting involvement of civil society organisations				
Project	**Objectives and aims in STIs and HIV & AIDS**	**Budget in EUR (period)**	**Scope**	**Target group**
Cordaid HIV programme (Report #8)	To reduce the risk of HIV infection in 10 countries, to improve care for people living with HIV and to enhance the resilience of societies to cope with the consequences of HIV by 2010.	45 million (18.5 through MFS 1) (2005-2010)	Burundi, Cameroon, DR Congo, Ethiopia, Malawi, Tanzania, South Africa, Zambia, Uganda, India, Indonesia & PNG	Traditional target groups: youth, women/girls, community, PLHIV and non-PLHIV, OVC
Gender Development Project (GDP) (Report #46)	Promote the integration of HIV prevention, gender equality and women's right into CSP programmes.	1,500,000 (2007-2009)	Kenya and Indonesia	Local CSOs
Managing HIV and AIDS in the workplace in South Indian CSOs (Report #44)	Strengthen the capacity of partner organisations in South India to develop and implement workplace policies related to HIV and AIDS in order to create an enabling environment for prevention of HIV and for positive living of staff and communities.	1,700,000 (2008-2009)	India	Employees of CSOs
Managing HIV and AIDS in the workplace (Report #45)	Support Ugandan CSOs and partner organisation to develop and implement workplace policies and to address HIV and AIDS in the workplace.	1,700,000 (2006-2008)	Uganda	Employees of CSOs

Across the different interventions these evaluations noted difficulties in quantifying and assessing outcomes. As was the case for the previous section, no control group designs were used. Other weaknesses included the lack of (comparisons against) base-line data. In the case of the Cordaid initiative, which was exceptionally large programme, the evaluation report regretted that 'outcome indicators have not been linked to national level estimates of PLHIV in need of ART, OVCs, people most vulnerable to HIV, home-based care providers' as well as the 'lack of target setting of the outcome indicators at the beginning of the programme'.[53] Standard monitoring formats – to allow for comparison of results – were also inconsistently used. The findings below need to be seen in light of these limitations.

53 Report: 8, p. 30.

Approach

The approaches differed considerably. The intervention logic of the Cordaid multi-country Initiative[54] had a three-pronged approach, of which capacity development was one component:

- Direct Poverty Alleviation (DPA) through treatment, prevention, resilience & livelihood security;
- Civil Society Building (CSB) through training and promotion of linkages between organisations;
- Policy Influencing (PI) through capacity strengthening, lobby trajectories, and agenda setting.

The GDP project's[55] main approach was promotion of gender equality and women's rights, through community-driven transformation of participants' gender based attitudes, behaviour and norms, in the context of HIV prevention. DPA – which was a specific component of the Cordaid initiative – was a cross-cutting issue for the GDP. The project also focused on strengthening support for OVCs (e.g. to access education) and other affected groups (e.g. widows). Establishment of **support groups** was a specific strategy to promote income generation (e.g. through 'merry go round' credit schemes) and also to promote positive living for PLHIV.

The workplace interventions in Uganda[56] and in India[57] also had similar approaches. This included:

- Promoting internal mainstreaming through workplace policy development;
- Sensitisation and capacity development of staff through training, workshops, support visits;
- Linking and building of bridges with other organisations and services.

Workplace policy development was also a key strategy in the GDP, and six partner organisations developed HIV and AIDS policies that integrated gender.

Box 5 *Generating Livelihoods through 'Merry Go Round' Activities*

In Kenya the Gender Development Project included a group-based savings and investment scheme. This is a system where members in a group agree on a sum of money to be contributed at a regular interval and all the money is given to one member at a time. The money collected is then invested by recipients in income generating activities. As a result, members were involved in various activities such as chicken rearing or charcoal selling, among others.

Source: Report 46

54 Report: 8.
55 Report: 46.
56 Report: 45.
57 Report: 44.

Results – knowledge, attitudes and behaviour

The evaluations **all reported changes in knowledge and attitudes**. In the GDP knowledge of HIV and uptake of condoms increased among local CSO targeted by the intervention. This project also had an impact on attitudes towards gender-based violence, and on abilities/ skills to address this, including on beneficiaries self-esteem and capacity to initiate discussions with their sexual partners around sexual relations and sexual behavioural risks, and on the negotiation of condoms use.

Both workplace programmes in India and Uganda produced attitude changes among staff, specifically in terms of reported changes in willingness to disclose HIV status, and a more accepting attitude and declared willingness to use condoms. In the Uganda workplace programme a greater openness towards PLHIV was also noted.

The Cordaid evaluation established that large numbers of people were reached with prevention activities, 2.3 million in total (representing over 95% of the target). Qualitative accounts of knowledge gains and changes in attitudes were reported for selected country initiatives. No overall numbers were available.

Results – availability, accessibility, use and quality of services

All four interventions reported an impact on access to VCT, although in the case of the Uganda workplace initiative this appeared to be based only anecdotal evidence as no numbers were provided.

In the Cordaid Initiative, the evaluation found evidence of **increased access to services by PLHIV and OVC, as well as access to ART, treatment of Opportunistic Infections (OI), PMTCT and HBC**. Data from participating organisations reflected higher numbers of PLHIV reached. The evaluation provided selected quantitative and qualitative examples from country studies of improved access – for example, the number of persons on ART increased from 5.878 in 2006 to 19.342 in 2009, and represented 97% of the target – but could not establish overall numbers across areas of service delivery due to weak M&E systems. The evaluation also noted that in other areas of service delivery, especially for PLHIV and for provision of HBC, there was scope for further scaling up.

For the GDP project, it is reported that two of the three participating faith-based organisations began making condoms available to the communities they served, thus increasing the access to these commodities. In one case the Church took on door-to-door distribution of condoms. Both the GDP and the Cordaid Multi-Country Initiative included **elements of increasing livelihood security.** The Multi-country initiative's evaluation found that the interventions on food distribution and income generating activities had generally been weak and that there continued to be a large unmet need to increase livelihood security because most activities continue to be small-scale. The GDP initiatives in livelihood security were based on 'merry go round' activities, which provide access to credit on a rotational basis for members who participate, and were reported to be successful. The project also resulted in the enforcement of property rights for widows and support for girl's education.

Results – advocacy

The Cordaid multi-country initiative established that **lobby activities had contributed to specific changes in policies in selected countries**. By way of illustration this included:

- Indonesia: The local CSO convinced local Government to adopt a 100% condom use regulation for all sex work in brothel areas;
- Malawi: Lobbying by the coalition of women living with HIV and other organisations resulted in the revision of the HIV bill which originally included the criminalisation of women infecting their babies and mandatory HIV testing of pregnant women and domestic workers;
- In Zambia a network organisation of OVCs in collaboration with UNICEF conducted a budget tracking exercise which resulted in more money been allocated for education of OVCs.

Across the four evaluated interventions policy influence also included workplace policies. However, it was noted that support did not always result in workplace policies that are really being implemented.[58]

Success factors and bottlenecks

Capacity development was identified as having been important to success in all four initiatives. The use **of flexible approaches** (appropriately adjusted to specific circumstances and needs), of complementary and interacting activities, and the importance of establishing linkages with other organisations (including service providers) were also identified as critical.

The evaluation of the Cordaid Initiative illustrates these findings. For example the increased networking capacity contributed to referral mechanisms and to innovative experiments that brought services closer to the people. The focus on capacity development of volunteers increased the volume of people who are able to provide support to those in need. The combination of DPA and lobby activities also allowed for the identification of key issues, which were then taken up in the advocacy work.

Weaknesses were also present. **Inefficiencies across project interventions** resulted from the fact that the programme covered a multitude of partners across different setting without coherent (85-110 partners across 9-12 countries). Limitations were also noted in the **approaches by some organisations to prevention work, which were insufficiently contextualized** and focused only on physical aspects of HIV infection and neglected the social, gender, and other dimensions. Overall the evaluation found that gender mainstreaming had received insufficient attention.

For the workplace interventions across interventions a number of common lessons emerged:

- The importance staff and PLHIV involvement in workplace policy design and implementation;
- Ensuring gender sensitivity in workplace policies;
- Planning for sustainability.

[58] Report: 8.

In the Uganda workplace intervention the establishment of a steering committee of CSOs played an important role in the successful implementation of workplace policies.

c) Providing access to prevention and care for young people

A third key area of focus under general population initiatives involved promoting prevention and access to services, particularly for young people. All five of these projects were implemented in countries with generalised epidemics in sub-Saharan Africa. Two of the projects (South Africa and Malawi) had a somewhat broader focus, including also PLHIV and the general population. One project (Senegal) focused on the general population.

Table 9 Overview of evaluations on STIs and HIV/AIDS: interventions targeting young people

Project	Objectives and aims in STIs and HIV & AIDS	Budget in EUR (period)	Scope	Target group
Developing Tools to Improve Life Skills Education for Youth Programmes (Report #41)	Contribute to the decrease of new HIV infections among youth by improving the quality of prevention efforts, in particular by increasing the quality and accessibility of life skills programmes.	864,000 (2008-2011)	Zambia	Youth (ages not defined)
Scaling up HIV and AIDS Prevention and Support (Report #29)	Reduce HIV infection among children and young people through an up-scaled life skills approach to HIV and AIDS.	360,000 (2006-2010)	Kenya	Children and young people aged 10-24
Community Action Against HIV and AIDS Programme (Report #30)	Provide high quality HIV and AIDS prevention and stigma reduction messages, counselling and testing, and care services to members of communities in municipalities.	310,000 (2007-2011)	South Africa	Children and youth, PLHIV, general population
HIV and AIDS Project (Report #28)	Contribute to the reduction of the spread of HIV to all people in a non-discriminatory manner, and to mitigate the impact of AIDS on the affected and infected.	310,000 (2007-2010)	Malawi	Young people, PLHIV, general population
Initiative Fouta (Report #19)	Sensitise communities about HIV/AIDS, support (female) artists, and strengthen the capacity of the implementing NGO.	155,000 (2005-2007)	Senegal	General population

The evaluation designs were reasonably strong, although with limitations. All evaluations used mixed data collection methods, making considerable efforts to triangulate data. Sampling was most often done by convenience means, with the exception of the Kenyan evaluation, which used a multi-stage random sampling process.

Approach

Four of the projects incorporated a life skills approach to prevention. However, the importance of the life skills component varied between the different projects. Thus in Malawi[59] and South Africa[60], **life skills was part of the prevention component which itself was part of a continuum of interventions**. For example, in Malawi the project included – in addition to life skills – access to VCT (through a mobile clinic), Community Home Based Care (CHBC), and access by OVC to social services. The two remaining projects (in Zambia and Kenya), on the other hand, focused mainly on **prevention through life skills education**. The Zambia project[61], which was implemented with eight local NGOs, was entirely research based. Through a three -year action research initiative, this project sought to enhance the relevance and uptake of life-skills materials and approaches. The **action research** encompassed four research tracks: monitoring and evaluation; strengthening systems; comprehensive life skills; and cross-cutting issues (gender, stigma and involvement of target groups). In contrast, the project in Kenya[62] was strongly slanted towards strengthening existing support systems for life skills education in Kenyan schools.

The Senegalese project[63] used an entirely different approach, namely **working with and through artists to promote theatre, dance, and singing** events in communities as a means of creating awareness and bringing about behaviour change.

Box 6 *Using theory to enhance the relevance of life skills resources in Zambia*

The life skills project in Zambia focused on:

- Documenting experience of different stakeholders
- Drawing lessons from promising practice
- Assessing the effect of project activities

The life skills manuals that were produced were based on a theoretical framework – the Theory of Planned Behaviour – which deliberately seeks to measure the effects of SRHR and HIV programmes of youth at outcome level, rather than staying at the level of outputs. The evaluation was not able, however, to see this being put in practice because considerable delays in implementing this project meant that outcome level data was not yet available.

Source: Report 41

Results – knowledge, attitudes, and behaviour

There were no recorded outputs or outcomes on knowledge and attitudes for the Zambia action research life skills project. The evaluation found that the research project had

59 Report: 28.
60 Report: 30.
61 Report: 41.
62 Report: 29.
63 Report: 19.

produced potentially important outputs in terms of guidelines – for example on monitoring and evaluation, on training and best practices – but that 'because the tools had not yet been reproduced and fully implemented'[64] the effect on policies, programmes, activities, capacity and staff skills could not be assessed.[65]

All four other evaluations, however, established an impact on knowledge and attitudes. This included knowledge on transmission (Kenya, South Africa, Malawi, Senegal), and safe sexual practices, as well as on stigma (a reduction had occurred for 90% of the youth, compared to 60% at baseline in Kenya, a reduction also took place in South Africa).

The same four projects (Kenya, Malawi, South Africa, Senegal) **also all reported impact on behaviour**. In Kenya there was a reported marked **reduction in the rate of teen pregnancy** (no figures provided). Kenya and South Africa reported a **reduction in the number of young people having sex, and increase in young people abstaining** (Kenya). The measurement of behaviour change in Malawi was complicated by the lack of base line data. In Kenya the work on improving life skills approaches with the school management boards, Ministry of Education, and CBO partners, also had broader impacts on behaviour, with youth reportedly being more disciplined, not absconding, and having better education performance.

Results – availability, accessibility, use and quality of services

Bringing about changes in access to services was part of the objectives for the Malawi and South Africa projects, and the evaluations found that this had taken place in both cases. The **strongest data on an impact on access to services came from South Africa** where the VCT reached over 13.000 previously unreached persons. The project also included **provision of HBC** for 550 individuals and support to just over 450 OVC. In the case of the OVCs the intervention was found to have had an impact on food and security, nutrition and growth, legal protection, health services, and emotional health. In Malawi, the **use of a mobile VCT clinic** provided access to populations that had previously not benefitted from HIV and AIDS related services and reached over 3000 persons.

Results – advocacy

None of the interventions had specific advocacy or policy influencing objectives.

Success factors and bottlenecks

Strategies that were common between two or more of the projects and which contributed to success included:

- A focus on **partnerships** between different organisations/entities (South Africa; Senegal; Malawi, i.e. consortia of different churches);
- **Key stakeholder involvement** – e.g. traditional/religious leaders (Malawi) and parents (Kenya);

64 Report: 41, p. 9.

65 Information provided subsequently by Stop AIDS Now! indicates that some partners have started implementing some of the tools, to take some measures to motivate voluntary life skills providers and their trainers, and to use a manual for the Strengthening Systems checklist. One organisation has also started to integrate psychosocial life skills training in all their practical life skills programmes.

- Training and working with **volunteers from communities** (Malawi, Senegal) and peer educators (Kenya);
- Promoting mechanisms for **skills transfer and capacity development** (South Africa).

5.3.2 Support for PLHIV and OVCs

A total of nine evaluations focused on improving the quality of life of PLHIV and/or OVCs. These projects covered a range of geographical and epidemic settings, the majority of which were located in high prevalence countries in Southern Africa.

Table 10 Overview of evaluations on STIs and HIV/AIDS: interventions targeting PLHIV and OVCs

Project	Objectives and aims in STIs and HIV & AIDS	Budget in EUR (period)	Scope	Target group
Professional development of CEPHAD staff through HIV/ AIDS projects (Report #21)	Contribute to the reduction of HIV and improvement of quality of life of PLHIV in Thai Binh City and Viet Tri City through support for the Centre for Public Health and Development (CEPHAD).	297,545 (2006-2008)	Vietnam	PLHIV, students, factory workers & communities
The Basic Counselling Project (Report #11)	Promote self-awareness and disclosure of HIV to significant others through training of peer counsellors.	60,000 (2005-2007)	Zimbabwe	PLHIV
HIV/AIDS Integrated Programme (Report #25)	Improve access to a continuum of high quality and sustainable HIV/ AIDS services.	315,000 (2009-2011)	Rwanda	PLHIV and OVC
E-Thembeni Project (Report #27)	Empower volunteers to support families caring for PLHIV and those affected by HIV and AIDS and to do life skills training as peer educators to youth.	395,000 (2008-2010)	South Africa	PLHIV and young people
Self-help Support Programme for PLHIV (Report #15)	Strengthen self-help groups for PLHIV, advocacy and coordination.	165,000 (2007-2009)	Peru	PLHIV
Civil Society Strengthening of the Social Cash Transfer Programme (Report #43)	Mitigate the economic and psychosocial impact of HIV & AIDS related illness and death on OVC and their caretakers through strengthening the Social Cash Transfer programme targeted at labour constrained households and implanted by the Government of Malawi.	300,000 (2010-2011)	Malawi	OVCs and caretakers

Table 10 Overview of evaluations on STIs and HIV/AIDS: interventions targeting PLHIV and OVCs

Project	Objectives and aims in STIs and HIV & AIDS	Budget in EUR (period)	Scope	Target group
Support to PLHIV, HBC, OVC, and youth prevention (Report #17)	Strengthen the capacity of extended family and communities to promote welfare of their children and reduce HIV/AID among young people.	127,000 (2005-2009)	Zimbabwe	PLHIV, OVC, young people
RedVIHDA (Report #13)	Improve the quality of life of PLHIV, reduce stigma and discrimination, and improve access to knowledge and services.	120,000 (2006-2009)	Bolivia	PLHIV
International Community of Women Living with HIV/AIDS (Report #36)	Link HIV positive women to each other, strengthen the capacity of ICW to provide support and training, to document experience, and to advocate for policy change.	300,000 (2005-2008)	Global	PLHIV (women)

All evaluations used in-depth qualitative data collection methods, with a focus on interviews, focus group discussions, and community observations. Sample sizes were generally small. Participatory methodologies were common, with feedback sessions to the participants to confirm findings. M&E was weak across the different interventions, making it difficult to present data at output and outcome level, other than perceptions of participants of change. This applied in particular to the advocacy efforts, where different organisations tend to intervene and attribution is difficult. In addition, organisations such as ICW, who have a major advocacy role, did not have indicators of expected change which made it more difficult to establish progress. This is reflected in the results discussed below. Finally, not all project evaluations systematically brought out lessons learnt which reduced the pertinence and usefulness of these evaluations for other initiatives.

Box 7 *Using Self Help Groups to support PLHIV and OVC in Rwanda*

In Rwanda SHG were found to have promoted commercial agriculture, business development, marketing, cattle husbandry, circulating leadership, handicrafts, and conflict management.

Key to success was that the SHG could refer the problems that they were unable to solve at their level to Cluster Level Associations (CLA) which integrated influential people at the community level. The combined structure of SHG and CLA provided a key social, psychological and economic role.

Source: Report 25

Approach

A common approach among five of the projects – in Zimbabwe (2 projects), Vietnam, Rwanda and Peru – was to **work through Self Help Groups (SHG) for PLHIV**.[66] The role and intervention of the SHG varied in the different intervention contexts, as follows:

- The Zimbabwe Basic Counselling Project[67] focused on **training PLHIV members of existing self-help groups** to promote self-awareness and facilitate disclosure. The assumption was that this approach would then allow these peer counsellors to support other PLHIV. In addition, the participation was assumed to be an entry point into further training in counselling which would allow PLHIV to acquire new professional skills and become gainfully employed.
- In Rwanda[68] the focus was on **establishing SHG that have a socio-economic role**. Groups of 15 to 20 members (with a homogeneous composition) received training and support to identify common problems of the members. Problems that could not be solved at the group level were referred to the higher Cluster Level Association (CLA) level, which involved community leaders. The assumption behind the strategy was that this would bring about community commitment and help addresses issues of stigma, discrimination and exclusion faced by PLHIV and OVC.
- In Vietnam[69] the SHG were **a key entry point for a multi-pronged approach** to enhance awareness and reduce stigma and discrimination, promote behaviour change, build capacity of local partners, and improve healthcare services and socio-economic conditions of PLHIV.
- The intervention of PROSA in Peru[70] targeted **organisational strengthening SHG**, to ensure the groups were led in an ethical and transparent manner.

Box 8 *Zimbabwe – block grants for OVC*

In Zimbabwe the Uzumba Orphan Care PLHIV/OVC project used block grants to encourage OVCs to go to school. The block granting concept involves making arrangements with the local school for a specific number of children to be retained in school a particular period in exchange for school resources such as text books, teaching materials, furniture or the construction of buildings.

Source: Report 17

The Vietnam and Rwanda projects focused on **improving the socio-economic conditions of PLHIV through education, training and income generating activities**. In Zimbabwe[71] the second project which targeted PLHIV/OVC project followed a similar approach focusing

66 SHG were also a feature of a number of initiatives discussed in other sections of this chapter, including the Gender Development Project in Kenya and Indonesia and the Cordaid Multi-Country Initiative (see section on capacity building).

67 Report: 11.

68 Report: 25.

69 Report: 21.

70 Report: 15.

71 Report: 17.

on financial and monetary incentives for enrolment/participation in education. The Social Cash Transfer Project in Malawi[72], on the other hand, sought to strengthen support to PLHIV by improving the management and implementation capacity of the partners involved in the existing social cash transfer scheme, and by strengthening linkages between beneficiaries and other social services. In South Africa[73] the E-Thembeni project used a dual approach to reach PLHIV with HBC and to prevent the spread of HIV among young people through a life skills education approach that was tailored to their own language and context. The ICW intervention was different in that it had a **global focus**, supporting an international network of HIV positive women. The focus of the intervention was to enhance linkages between PLHIV women, provide information and training, document experience, and lobby, advocate and campaign for change.

Results – knowledge, attitudes and behaviour

Improved knowledge and skills was reported to have been achieved through the life skills arm of the South Africa project. However, this was based on anecdotal self-reported evidence. The **knowledge and skills of peer counsellors** in the Zimbabwe project were also found to have been enhanced, and was reflected in particular in better organisation of support group meetings, although the anticipated impact on disclosure to significant others did not materialise.

Improved self-esteem was an important outcome of a number of the interventions. In Rwanda the establishment and support to SHG reportedly increased confidence, and allowed members to avoid relational problems. The TFM project in South Africa also was found to have changed the value system of the volunteers – volunteers were able to make more responsible choices, respect others and become role models. In Zimbabwe the psychosocial support to children through support clubs reportedly empowered them to identify and report cases of child abuse, and also enhanced links with community structures, including with the police's victim friendly unit. The majority of the interventions were reported to have had an impact on **reducing stigma and discrimination**.

Results – availability, accessibility, use and quality of services

A number of projects reported impact on access to services. In the South Africa E-Themebeni project this was reflected in reports by community members and beneficiaries that **HBC beneficiaries were living longer**. The establishment of **referral networks and the empowerment of families** to take care of their sick relatives were critical inputs into this, and the work of the **volunteers** was a main explanatory factor.

In Peru also, the strengthening of the SHG within the network resulted in PROSA doubling the type of services that it was able to provide, with **services for PLHIV** being offered in professional counselling, nutrition and counselling, infectology/infectious diseases, psychological counselling and group therapy. Over the two-year implementation period this resulted in a 21% increase in beneficiaries reached.

[72] Report: 43.
[73] Report: 27.

In Malawi the Social Cash Transfer project was found to have resulted in an improved **linking of beneficiaries to farm subsidies, which had a direct impact on household poverty**, with some households being considered as having graduated out of poverty. The Vietnam project evaluation reported an improvement in the **quality of examination and treatment services** through the purchasing of medical equipment, although no numbers were provided in the evaluation report.

In Zimbabwe the **support to OVC's education** reached considerable numbers of children (3426 in 2008). However, this went only some way to meeting needs – as in the area of operation up to 40% of the children were orphans, whilst interventions reached only 11%.

Results – advocacy

Advocacy targets were part of five of the interventions. The SHG approach **strengthened PLHIV positioning within the community, and gave PLHIV self-confidence** as well as a platform from which to advocate (Vietnam, Peru, Rwanda). Concrete outcomes of advocacy work were not reported. In Malawi, lobbying and advocacy were an essential component of the strategy under the assumption that this would change and/or bring about new processes, policies and approaches, and in Peru organisational strengthening sough to involve PLHIV in advocacy on key themes for PLHIV and for vulnerable populations (MSM, Transsexuals, and SW). For the global ICW network, advocacy was a major component of the work, and included advocacy for access to care, treatment and support, SRHR, and the meaningful involvement of women living with HIV and AIDS. The evaluation found that considerable efforts had been undertaken in the area of advocacy but was **unable to establish the outcomes** of this work.

Success factors and bottlenecks

In spite of the different designs of the projects, a number of common lessons emerge from the project in terms of approaches, including:

- The effectiveness of **using volunteers** (South Africa, Zimbabwe) and **peer counsellors** (Zimbabwe) when working with PLHIV which helped increase self-confidence, provided a sense of purpose, and contributed to beginning to break down stigma and discrimination.
- **Involvement of beneficiaries in priority setting and design** was a key success factor in the Rwanda and Malawi projects, in particular because it included a clear attribution of roles and responsibilities of partners, which helped structure implementation. This also highlighted the importance of internal monitoring/coordination in bringing about empowerment and ownership.
- SHG were also an important strategy, as was noted above, and found to be key ingredient to bringing about change. The Rwanda experience highlighted **the effectiveness of the SHG when combined with other levels of organisation** (i.e. clusters) so that PLHIV have recourse for problems they cannot solve.
- **Strong partnerships at community level** were important in South Africa and in Malawi, as well as with government, churches and CSOs. This was also important in Rwanda and Zimbabwe where the participation of all parties (community health workers, grassroots leaders, church leaders, police, and teachers) in the programme identification and context analysis was identified as a major contributing factor. The Vietnam experience similarly underscored the importance of involvement and empowerment of local authorities and government agencies.

The Vietnam project brought out a number of additional lessons worth noting, in particular with respect to the **role of the project management and monitoring system**, which provided key information to partners on progress and areas that required decision-making. The **frequent use of exchange visits** was also highlighted as having contributed to success, and was used to feed in to the use of mass media such as local radio and TV which has contributed to enhancing understanding about progress.

5.3.3 Providing access to prevention and support for key populations

Six evaluations discussed findings related to supporting specific key populations. As can be seen from the table below this covered a range of geographical settings and target groups. Five out of the six projects focused on SW. Sexual minorities (gays, lesbians, etc.) were targeted by half of the projects. One project in Central Asia covered prisoners, and similarly one project implemented in India and Peru targeted MSM.

Table 11 Overview of evaluations on STIs and HIV/AIDS: interventions targeting key populations

Project	Objectives and aims in STIs and HIV & AIDS	Budget in EUR (period)	Scope	Target group
HIV/AIDS Prevention in the Central Asian Republics (CAR) (Report #1)	Contribute to building a consistent and comprehensive 'continuum of care' both for highly vulnerable groups (IDU, SW, prisoners) and PLHIV that is tailored to the specific conditions in the four countries.	3.2 million (2005-2007)	Central Asia	IDU, Sex Workers, Prisoners
Fundacion Ecuatoriana Equidad (Report #12)	Improve access to prevention and services for gay, lesbian, bisexual and transsexual persons.	167,000 (2007-2010)	Ecuador	LGBT
HIV and AIDS Programme (Report #18)	Increase access to prevention, treatment and care of key affected populations (in particular PLHIV, MSM, sex workers, and transgender) and a government that assumes its responsibility for better service delivery.	6.9 million (2000-2009)	India, Peru	PLHIV, MSM, SW & transgender persons
HIV& AIDS and STI Prevention, Care and Treatment for High Risk Groups (Report #33)	Reduce social, religious, cultural, economic, legal and political barriers that make people vulnerable to STIs and HIV/AIDS.	360,000 (2007-2009)	Indonesia	Female sex workers, clients and Established Managers

Table 11 Overview of evaluations on STIs and HIV/AIDS: interventions targeting key populations

Project	Objectives and aims in STIs and HIV & AIDS	Budget in EUR (period)	Scope	Target group
HIV/AIDS Prevention and Care Programme Among Sex Workers (Report #35)	Promote HIV and AIDS awareness, condom use, health education and empowerment strategies among SWs have been promoted , and increase access to VCT and high quality care and support, including HAART.	450,000 (2006-2008)	Myanmar	Sex workers
Support to the Institute of Studies in Health, Sexuality and Human Development (IESSH) (Report #14)	Strengthen the organisational structure and institutional capacity of the IESSH to interact with its environment and to improve the relevance and effectiveness of its research endeavours.	276,000 (2007-2010)	Peru	PLHIV, LGBT, SW, and policy makers

A number of evaluations combined qualitative and quantitative techniques (e.g. CAR, Equidad). Overall, the evaluations were predominantly qualitative in nature, often employing focus group techniques, which were considered more appropriate to the sensitive nature of the target groups. A number of innovative techniques were used, for example in the Myanmar evaluation, to understand perceptions and barriers, including: actor and relationship mapping (to understand social relationships in the organisation); information and communication flow visualisations; and cause and effect diagrams. Evaluations also used documentation of local media coverage (e.g. in Indonesia) to understand how perceptions of key populations had changed, and to assess policy changes.

Approach

A range of approaches was used by the projects. The majority of the projects had in common a focus on capacity development, on promoting of networking between local organisations, and on improving service delivery.

In the CAR[74] the focus was on developing a **client management system, which would ensure appropriate, long-term, quality care**. Specific strategies in the context included knowledge and skills transfer to local government and NGOs, and developing and sharing best practices. In Ecuador[75] EQUIDAD sought to ensure service delivery to gay men, through provision of communication and information, capacity development and advocacy. **Service delivery**, based on a rights based model, was also central to the HIVOS HIV/AIDS programme in India and Peru[76]. In Indonesia[77] the HIV/AIDS and STI prevention for high risk groups also included

74 Report: 1.
75 Report: 12.
76 Report: 18.
77 Report: 33.

networking between local organisations and service delivery to female SW and their clients as key strategies. The Médecins du Monde (MDM) project for HIV/AIDS prevention and care for SW in Yangon (Myanmar)[78] on the other hand, focused only on service delivery.

Networking was a consistent approach across the different initiatives that was put in place variously to enhance visibility of key populations (the case of Equidad), to increase access to services by the target groups (for SW in Indonesia), to widen the level of debate (HIVOS in India and Peru).

Organisational strengthening was one dimension of capacity development that was common to a number of the initiatives. In the case of the Peruvian Institute of Studies in Health, Sexuality and Human Development (IESSDH) this focused on strengthening decision making, improving financial management and capacity to generate resources, and enhancing planning, monitoring and evaluation processes. It was also a prominent part of the approach for the projects supporting the gay organisation Equidad (Ecuador) and in the support to local HIVOS partners in India and Peru.

Some approaches were unique and stood out. The Central Asian Republics (CAR) project included prominent attention to the development and implementation of a **health promotion curriculum for prison settings**. The HIVOS project focused on empowerment of key populations to claim their rights and increase self-esteem. Part of this approach was to get healthcare providers themselves to acknowledge their own discriminative attitudes and to change their behaviour accordingly.

Results – knowledge, attitudes, and behaviour

Changes in knowledge and attitudes occurred across the different initiatives, for example in the HIVOS Project targeting key populations (MSM, SW and transgender persons) this was the case for health care providers and for police stations. In addition, key populations themselves had an increased understanding of their rights and increased self-esteem and self-confidence. In India and Peru, the evaluation of the HIVOS intervention found reduced levels of fear and discrimination as a result of higher levels of knowledge and changed attitudes among family members and communities.

Results – availability, accessibility, use and quality of services

Most interventions had **strong data supporting increased access to services**. The CAR intervention experienced an almost twenty fold increase in the number of services provide over three years (from 985 in the first year, to 16,093 in year three). This intervention was also particularly interesting because the evaluation found that the **client management approach had made it possible to break down the vertical nature of health systems** in Central Asia. In Ecuador, the **increase in the number of gay men seeking support** was so great that the number of days in which services are provided was increased from two to five days, with an average of six persons assisted per day (as compared to one person per day prior to the intervention). Similarly in Indonesia there was a **marked increase in the number of SW and clients having VCT and getting care, support and treatment**. In India and Peru HIVOS partners were able to monitor

[78] Report: 35.

availability of ARVs and ART and take actions when key population access was denied. The evaluation noted that their action did not extend to issues around addressing the quality of care.

Results – advocacy

Notable examples of policy influencing were recorded in a number of evaluations.

- In India and Peru the intervention by the HIVOS project contributed to **revisions in the laws** to fight stigma and discrimination.
- In Peru the Fundacion Equidad was found to have had a big impact though its **mobilisation of other organisations and groups** to participate in the discussion on the new constitution, which as a result, now includes sanctions for discrimination based on sexual orientation or gender identity. The constitution was also adopted to include recognition of same sex relationships. Equidad also contributed to putting issues of human rights and attention to LGBT on the agenda, as well as access to treatment, and the development of counselling guidelines and norms for treating LGBT populations.
- The IESSDEH produced **various important studies** which were given prominent attention in forums for discussion and decision-making. However, the evaluation could not establish what the specific contribution of these studies had been to the advancement of the agenda on protection and human rights.
- In the CAR the **prison component of the project was adopted by Ministries of Justice** in Kyrgyzstan and Tajikistan and officially endorsed. It was subsequently used as a model for training and management in prisons.

Success factors and bottlenecks

Key lessons learnt included:

- The importance of having **high quality training** programs as this enhances the reputation of organisations and supports advocacy and networking functions because of increased credibility;
- The relevance of **linking medical services to soft-services** (counselling, etc., e.g. Yangon);
- Using **peer educators** (e.g. Female Sex Workers (FSW) to liaise with other FSW in Myanmar and in Yangon);
- Building interventions on **lessons learnt** from elsewhere;
- Making the **empowerment** of key populations a key objective, and using a **rights-based approach** to achieve this (HIVOS India and Peru);
- The use of a Theory of Change to deal with stigma and discrimination and access to services, and ensuring that this includes prominent attention to structural bottlenecks that hamper access and quality of services (HIVOS India and Peru).

There were challenges in a number of the projects in terms of the approaches used. In Indonesia the SW project was found to have **lacked gender sensitive prevention strategies** so that the condoms promotion strategies had focused on FSW and not on their clients when women can generally not force their clients to use condoms. MDM's interventions in Myanmar were **insufficiently clear on the target groups**, which resulted in prevention teams distributing IEC materials for FSW in an unsystematic and unplanned fashion to the general public, creating ambiguity and uncertainty. The project was also found **not to be**

sufficiently tailored to the economic realities and working practices of SW, or to the fact that SW sell sex as part of a 'complex, mixed and diverse livelihood portfolio'. Challenges were also noted in terms of **reaching targets groups** in other initiatives, e.g. in the CAR the programme was highly successful but was found to have reached mainly older clients.

Other challenges common to different projects included **motivation and turn-over of staff** (Myanmar, CAR), the **lack of an exit or sustainability strategy** (Indonesia, Equidad in Ecuador, MDM in Myanmar, HIVOS in India and Peru) often related to dependence on external funding, weak monitoring and evaluation systems, and in some cases continued issues around organisational management and capacity in spite of efforts made to improve this (e.g. in the case of Equidad). There were also a number of contexts in which stigmatising attitudes towards key populations continued to be present.

5.4 Sexual and reproductive rights

This chapter will discuss three specific areas of sexual and reproductive rights, namely: violence against women (VAW), adolescent sexual and reproductive health and rights, and female genital mutilation.

5.4.1 Violence against women

Three project evaluations focused on addressing violence against women. The Nicaragua project sought to empower women and adolescents to exercise their rights, and especially their reproductive and sexual rights, free from violence. The second project aimed to reduce the social acceptance of violence against women and children in various regions of Africa, and the third project was aimed at providing services to women who had experienced violence, such as rape, in South Africa.

Table 12 Overview of evaluations in sexual and reproductive rights: violence against women

Project	Objectives and aims in sexual and reproductive rights Violence against women	Budget in EUR (period)	Scope	Target group
Colectivo de mujeres "8 de marzo" (Report #10)	Promote citizen participation of women, youth and adolescents of both sexes to defend their human rights, with an emphasis on sexual and reproductive rights.	100,000 (2006-2009)	Nicaragua	Women, youth & adolescents, women victims of violence
Raising Voices: VAW program and Violence against Children program (Report #16)	Reduce social acceptance of VAW (and children); foster a discourse; advocacy to influence practice and policy to prevent VAW and Violence Against Children (VAC).	360,000 (2008-2011)	Africa (the Horn, East en Southern Africa), Uganda	Women and children
Thohoyandou Victim Empower-ment Trust (Report #38)	Contribute to preventing rape, ending VAW, dealing with the effects of VAW, and reducing the risk of HIV infections experienced by women.	463,180 (2008-2011)	South Africa	Victims of rape, young people

Approach

All projects included **awareness raising and empowerment** and **advocacy** to influence government policies. Two projects also included **service delivery** for women who had experienced violence. Media campaigns were widely used by the NGOs in informing the public about gender and violence issues.

In two projects the NGO set up (shelter) centres to **provide care** for victims[79] of violence. For example, the project in Nicaragua[80] ran one centre in each of the three project areas that provided both prevention and care services. The prevention work involved awareness raising, education and training, and the use of media to educate the general public about GBV and other issues. Care and counselling was offered to women who had experienced violence. The South Africa[81] project set up their trauma centres adjacent to rural government hospitals **to refer** women when necessary. Both projects took a **comprehensive approach**, including providing legal, medical, and psychological assistance. In addition, the project implementers in South Africa also campaigned for increasing availability of the **female condom** as a means to prevent consequences of rape, such as STIs or unwanted pregnancies.[82]

The evaluation of the Raising Voices Project in the Africa region and Uganda[83] consisted of two pillars: one on preventing VAW and the other on preventing violence against children (VAC). The NGO promoted **public discourse** about the topic, **developed and tested methodologies and tools** to address issues of violence, **built capacity** of partners to use these tools, and engaged in **advocacy** work. For VAW this included international organisations, donor agencies and opinion leaders, for VAC advocacy remained limited to Uganda. A GBV prevention network was set up together with other civil society organisations.

Results – knowledge, attitudes, and behaviour

Overall, the evaluations found that knowledge and awareness about VAW and VAC improved, but little concrete data was provided. Information was based on perceptions from interviews and FGD with the intervention groups. There were no control groups or baseline data available.

The South Africa project – which broadcasted a weekly radio programme – led to increased awareness about issues such as women's rights, domestic violence as a crime and HIV/AIDS prevention. However, the evaluation of the project noted that the NGO needed to move beyond technical and legal aspects to address underlying reasons for non-consensual sex and rape, such as the patriarchal system.

79 The term 'victim' is contested, as it places too much emphasis on a weak position. See report 38 or text box.
80 Report: 10.
81 Report: 38.
82 This project is therefore also discussed in section 5.2 of this report.
83 Report: 16.

The evaluation of the Raising Voices project noted that the materials used reached especially those partners that were already part of the GBV prevention network, with much lower access and use for those with no prior involvement. Nevertheless, of the survey respondents, 68% reported 'a strong influence on personal beliefs about VAW' and 48% felt it had influenced their 'behaviour in interpersonal relationships'.

Results – availability, accessibility, use and quality of services

Both the South Africa and the Nicaragua evaluations highlighted that the project centres were **the only comprehensive services available** to women. It was considered unique to have centres that offered a comprehensive package of services for women who had experienced rape, sexual abuse or domestic violence (see text box). According to the evaluation of the South Africa project, **'many women' avoided HIV infection** by receiving immediate testing and Post Exposure Prophylaxis (PEP) medication at the NGO's centre. The evaluation further established that the provision of (legal) assistance had led to more women wanting to file a case.

Box 9 *Do's and don'ts in addressing violence against women*

The term 'victim' portrays a patronising, rather than empowering position. *Source: report 38*

'The language of power – rather than gender, rights or violence – has helped remove 'violence against women' away from being solely a woman's issue, where it is often marginalised.' *Source: report 16*

Raising Voices 'encourages the thinking that violence is everyone's problem and everyone's responsibility.' *Source: Report 16*

Results – advocacy

Concrete results of advocacy on policy were scarce in the evaluations. Some anecdotal evidence was provided that the work of the various NGOs led to **increased government participation and interest**.

The evaluation of the Nicaragua project noted that the comprehensive approach contributed to tackling aspects of awareness raising, care, training and support. It also found that women leadership in communities had enabled them to better **defend their rights** at the local and national level. This is not further substantiated. At the local level some **collaboration** was established with government agencies, e.g. the police, the ministry of health and local courts. The South Africa project also attracted attention from government and this has led to the **establishment of a government care centre**. A large number of respondents in the evaluation of the Raising Voices project reported that the organisation had been very effective in influencing policies, without providing concrete examples. The evaluation noted the **lack of an explicit advocacy strategy** and an imbalanced focus on improving **quality** of methodologies and discourses as opposed to meeting the demand of organisations.

Success factors and bottlenecks

Key success factors included:

- **Mobilising communities and engaging men**, and especially adolescents – for example, the Raising Voices project noted that **the approach to mobilise the family, community and social structures** had had a substantial impact on partner's programming;
- **Using media for awareness raising** – e.g. television was most often identified by respondents as being a very effective instrument in media campaigns in the Raising Voices Project;
- **Clustering prevention, care and advocacy in a comprehensive approach** to tackle VAW – to offer women a package of social, medical and legal counselling and the possibility to file cases;
- **Collaboration with and sensitisation of government institutions** – e.g. police and prosecutors;
- **Involving schools** in addressing VAW – e.g. the project in the Africa region designed toolkits for schools. In the South Africa project this was considered a missed opportunity by the evaluators.

The evaluation of the South Africa project concluded that more effort should have been put in empowering women and men to voice their needs and demands.

5.4.2 Adolescent sexual and reproductive rights

The evaluation reports of six programmes that addressed SRHR rights of young people were selected.

Table 13 Overview of evaluations in sexual and reproductive rights: interventions targeting adolescents

Project	Objectives and aims in sexual and reproductive rights Adolescent Sexual and Reproductive Health & Rights	Budget in EUR (period)	Scope	Target group
Adolescent Reproductive Health Project (Report #7)	Facilitate the development and implementation of an integrated adolescent health programme at community level which integrates issues of adolescent reproductive health into primary health care activities.	250,000 (2007-2009)	Ghana	Adolescents and youth aged 10-24
Innovation Fund (Report #32)	Design and implement innovative activities, projects and programmes that link education, gender and HIV/AIDS, sexuality awareness and prevention in a programmatic 'triangle' approach.	26 million (2007-2010)	32 countries world-wide	Children and adolescents

Table 13 Overview of evaluations in sexual and reproductive rights: interventions targeting adolescents				
Project	**Objectives and aims in sexual and reproductive rights Adolescent Sexual and Reproductive Health & Rights**	**Budget in EUR (period)**	**Scope**	**Target group**
Nomadic Youth reproductive Health Programme (NYRHP) (Report #2)	Increase knowledge and improve practices among nomadic youth, strengthen health services to provide youth friendly services, increase support for adolescent sexual and reproductive health and rights at community and district level.	8 million (2007-2010)	Regional, Kenya, Ethiopia, Tanzania	Nomadic youth aged 10-24
Youth Incentives (Reports #39, 40)	Improve the sexual and reproductive health of young people in developing countries.	4.6 million (2005-2008 & 2009-2010)	Bangla-desh, Rwanda, Malawi, Tanzania/ Mali[83]	Young people, orphans, key populations, labourers
The World Starts With Me (WSWM) (Report #47, a, b, c, d)	Increase access to sexuality education to address the SRHR needs of young people; to empower young people to obtain knowledge; to develop appropriate attitudes; and learn healthy and responsible behaviour and life skills.	4 million (2002-2009)	Uganda, Kenya, Thailand, Indonesia	Youth aged 12-21
Promoting the Rights and Dignity of Children (Report #3)	Train policymakers to lobby their peers from other districts to join in advocating for a change in national policy on banning child FGM.	63,000 (2008-2009)	Sierra Leone	Children, esp. girls under 18

The selection included two country projects (Ghana and Sierra Leone) and four large-scale programmes with a budget of several million euros. The common denominator of the projects was to improve the SRH and/or rights of young people. Two evaluations were selected that included specific efforts to address FGM – a regional intervention on SRH of nomadic youth in three countries: Kenya, Ethiopia and Tanzania and a project on rights and dignity of children in Sierra Leone, with a particular focus on preventing harmful traditional practices such as FGM.

[84] Tanzania was replaced by Mali in the course of the project period due to poor performance of the implementing partner.

Box 10 *Four Large-scale programmes*

The triangle approach – Innovation Fund (IF)
Innovative activities intended to link quality education, gender justice, and HIV/AIDS prevention & sexuality/SRHR. For example, a few NGOs introduced SMS answering services, staffed by young people, with the back-up of experts for consultation.

The RAP-rule approach – Youth Incentives (YI)
A *Rights*-based approach, *Acceptance* of young people's sexuality, *Participation* of youth in policy-making and programmes on sexuality. This so-called 'Dutch Approach' promotes a youth policy, guided by active citizenship and self-reliance of young people. The programme included attention to sensitive issues like abortion, and produced a brochure on this topic which received much interest among partners. Example of an innovative feature from Mali: a telephone hotline.

Sexuality education programme – The World Starts With Me (WSWM)
Programme in the framework of the UNESCO technical guidance on sexuality education and experiences with the Dutch programme '*Lang Leve de Liefde*'. The education programme consists of 14 lessons, focusing on knowledge, skills and attitudes of young people.

Nomadic Youth Reproductive Health Programme (NYRHP)
A regional programme to improve sexual and reproductive health for the nomadic youths aged 10-24. Each project had defined country-specific objectives in the field of prevention, services provision and enabling environment at the community and district level. The regional component aimed to define determinants for SRH of nomadic communities in Eastern Africa in order to develop a regional NYRH model.

Approach

The six evaluated interventions differed in scope and objectives, but overall covered the following:

- **Community level raising awareness** and acceptance of young people's rights and sexuality,
- (**Sexuality**) **education and transferring knowledge** to young people,
- **Capacity building of southern partners**, including government, to implement youth friendly health services (e.g. teachers, youth organisations, and government health workers),
- **Lobby and advocacy to integrate SRHR issues of adolescents** at policy level (e.g. changes in school curricula), including participation of youth in decision-making.

All programmes shared an emphasis on conveying messages about **SRH and rights *of* and *for* young people**. This entailed providing youth with the information and services they need, and improving acceptance by the environment of young people's sexuality. Linkages were made to **gender** issues, prevention of **HIV/AIDS** and **unwanted pregnancies**.

Education of youth about SRHR across the interventions took place through **adolescent clubs and through formal and informal education in and out of schools**. The most elaborate programmes were the large-scale programmes of the Innovation Fund[85], Youth Incentives[86], The World Starts With Me (WSWM)[87], and the Nomadic Youth Reproductive Health Programme (NYRHP)[88] (see box), which were based on a rights-based approach, including the right of young people to make decisions regarding their own sexuality. **An emphasis was placed on educational activities**. Service delivery – for example youth friendly SRHR services – was also included in some projects.

The FGM projects specifically focused on **awareness raising** and advocacy work to strengthen the **enabling environment** for addressing FGM[89]. The most extensive work was done in the NYRHP. For example, in Kenya, religious elders, leaders, Traditional Birth Attendants (TBA)/circumcisers, parents, CSOs, health workers, community workers, teachers, etc. were included in the sensitisation sessions. In nomadic groups this was complemented with specific youth peer-educators. The project also included a **regional component**. This aimed at research, developing a regional model for serving the RH of young nomadic communities in Eastern Africa, and networking and learning for evidence-based advocacy.

Results – knowledge, attitudes, and behaviour

The interventions all had had **a positive effect on improving knowledge** among youth about SRH issues. A few of the evaluations sought, and were able, to show any effects of the interventions beyond the level of knowledge.[90] Examples of positive results are:

- The Innovation Fund 'contributed significantly to quantitatively and qualitatively improved provision of basic information to young people, girls and boys, about HIV transmission and other STIs, prevention methods, changes during puberty, basic hygiene as well as social and legal issues around early marriage and (prevention of) abuse and VAW'.
- The Youth Incentives programme led to the development of 'a basic understanding of sexual development and implications of unsafe sexual intercourse'.
- The WSWM project increased knowledge about STIs and preventing pregnancies in Uganda. Young people also showed a more positive attitude to the right to decide about their own SRH and a more positive attitude to using a condom. In addition, the programme led to an increased belief in ability to delay first sexual intercourse, future use of condoms and dealing with force. For the other countries results were mixed and less prominent.

85 Report: 32.
86 Reports: 39 and 40.
87 Report: 47.
88 Report: 2.
89 In report 2 the term 'female genital cutting (FGC)' is used.
90 Reports 39 and 47. For example, evaluation 47 sought to systematically report on changes in attitudes and behaviour of youth. With baseline and end line questionnaires for the intervention and control groups the evaluators have measured knowledge, attitudes, 'self-efficacy' and intentions of youth in sexual and reproductive issues. Some questions also measured reported sexual behaviour and health seeking behaviour. Report 39 provides mostly anecdotal evidence for changes in attitudes and (health-seeking) behaviour.

- In the NYRHP 'remarkable progress was made towards abandonment of Female Genital Cutting (FGC)'. Interviewed youth from the three countries who had attended awareness sessions consistently reported increased knowledge on FP, and of the disadvantages of early marriage and early pregnancy. Some evidence was provided of an increased dedication among community members to denounce FGC. In Kenya a large number of community awareness campaigns took place (more than 44) on FGC and GBV – 175 girls and 281 parents publicly denounced FGC and 147 girls underwent **alternative rites of passage**, which was more than the envisaged 20% of girls and elders rejecting the practice in 2010 (10% in 2007).

Across programmes there was an improved capacity of young people to exercise their SRHR within their local contexts. In the WSWM this was evident in the reduction of stigma of young people living with HIV and the stigma associated with condom use.[91] A similar effect was found among the target groups of the YI programme (staff of partner organisations, health staff and young people).[92]

Results – availability, accessibility, use and quality of services

All evaluation reports mention an **increased access to services** by young people. This entails both access to information as well as health services (such as testing and counselling for HIV/AIDS) and access to condoms. For example, in the WSWM in 2009, 8,500 young people received counselling from youth-friendly services. The NYRHP also resulted in an **increase in uptake of FP services** (condoms and other FP methods) in Tanzania and Ethiopia, and even a steep increase in Kenya. In addition, interviewed youth reported that they had access to condoms in high school, although this could not be further verified by the evaluation. The targeted increase in improving **quality of youth friendly services** was not achieved but evaluators mentioned that satisfaction was already high at baseline.[93] The YI evaluation noted that the interventions were effective in incorporating 'the right of access to health care'. This was found to be most effective when there was a strong referral link between counselling for young people and providing access to service delivery.

Results – advocacy

Several projects aimed at **increasing participation and involvement of adolescents**. Results are varied. Positive examples are given for increased youth participation in activities and implementation. For example, in Ghana, youth participated in meetings of adolescent health clubs and in advocacy activities. In other programmes they were involved in implementing activities through the member associations and participation in the evaluations of the various programmes. In addition, young people reported that they had learned to articulate their needs within their peer groups and communities. It is mentioned that 'their participation was not only allowed, but actively promoted'[94]. Less progress is

[91] Report: 47.
[92] Reports: 39, 40.
[93] Report: 2.
[94] Report: 39.

noted for youth involvement in actual programme design, which is considered a missed opportunity in responding to adolescent sexual health needs.[95]

Not all projects engaged in advocacy efforts. For the four where this was the case, the results of lobby and advocacy efforts were mixed.

The Innovation Fund produced results in a number of countries where the initiatives 'contributed to starting **changes in school curricula and government policies**, better preparing boys and girls for safe sex and sexuality in adolescence and adulthood. Some programmes showed promising results in changing attitudes, understanding and assertiveness about young people's sexuality, rights, opportunities and scope of taking responsibilities in their own hands.' Positive contributions of the NGO efforts in changing curricula were noted, even though attribution is difficult. Meanwhile, sustainability of these lobbying efforts was a concern.

The Youth Incentives programme was credited with having been very successful by **involving different stakeholders.** Advocacy at the national level had not received adequate attention and no concrete results could be reported of the outcomes of advocacy efforts.

In the NYRHP, lobby and advocacy efforts towards broader RH issues resulted in the inclusion of (nomadic) reproductive health in district plans and inclusions of budget allocations. This was highlighted as a big achievement by the evaluators. The project was also successful in gaining awareness and support for a ban on FGM at **community level** from a number of different stakeholders. Results in influencing district or higher levels regarding FGM were, however, mixed. In Tanzania, the project led some village governments to formulate by-laws to prevent FGM. As a result of joint advocacy work by NGOs, a budget line for RH was introduced at district level in this country, which included activities against FGM. In Kenya, there was little evidence that the project was successful in advocating against FGM beyond the community level. In Ethiopia, the NGO became a member of the FGM network to advocate against FGC. The network's research studies were published by two reputable magazines. Beneficial to the project in Ethiopia was that during the project's implementation a law against FGM was enacted, which was enforced by the government in 2008. Most stakeholders acknowledged that the project positively contributed to the government policy and to changes in FGC practices, mainly because of its engagement with influential people in the community.

The Child Rights project in Sierra Leone[96] achieved only limited and partial support from one type of actor, the district authorities, and did not manage to gain support from other important influencing actors, such as the so-called 'soweis' (traditional circumcisers).

95 Reports: 32 and 39. The evaluators of report 32 note this as a disappointing result, given the principles of the programme.

96 Report: 3.

Success factors and bottlenecks

A number of success factors were highlighted across the different evaluations:

- **Awareness raising activities, increasing health service delivery, and improved advocacy capacity** of communities, emerged as key to increased uptake among youth in the NYRHP.
- **Combining education with the provision of (free) services** was found to contribute to the promotion of rights. The effectiveness of these interventions depended on the intensity and frequency of the interventions and on the atmosphere in which they are organised. Community mobilization and the identification of teachers as a vital link in adolescent health were also important.
- **Using peer educators was found to be very effective**, as young people receive information about sexuality more easily from people of their own age.
- **Sensitisation, professional training and resources for staff and service access** and improvement (for example youth friendly corners in Bangladesh) need to be combined and focus on ensuring that sexuality is recognized as part of young people's lives. Working on the acceptance of youth sexuality was found to be critical to the success of SRHR programmes that targets youth. It was highlighted that addressing young people's sexual health issues from the lens of positive sexuality, rather than that of disease and death is an important aspect.[97]

Box 11 *Bottlenecks in addressing FGM*

Introducing FGC in the RH **curriculum** in schools was achieved in schools but it continued to be a sensitive issue that faced **resistance from parents** affecting the extent to which it was addressed in schools.

In Ethiopia, anecdotal evidence was provided that FGC went **underground** since it became illegal, or that people **only partially abandoned FGC** and changed to other forms of circumcision.

In Kenya, in contrast with Ethiopia and Tanzania, **the government** was not very active in enforcing laws against female genital cutting.
Source: report 2

In Sierra Leone, 'the **lack of political will** to undertake anything against FGM is seen as a major obstacle to the work of NGOs.'
Source: report 3, p.5

A major problem was that for 'soweis' (traditional circumcisers) a ban on FGM deprives them of **their main source of income**, **empowerment and influence** in their chiefdom.
Source: report 3

97 Report: 39.

A number of lessons were specific to efforts at addressing FGM. Both evaluations stipulated on the one hand the **necessary role of the government** in banning FGM, and on the other hand the importance of **gaining support from various key figures in the community** through sensitisation sessions. In the Child Rights evaluation, the importance of addressing **alternative means of livelihoods for traditional circumcisers** was specifically highlighted. Despite the different country contexts, the evaluators of the NYRHP found that generally, in tackling FGM, the NGO's **three pronged approach** of using local leaders in advocacy, involving local government officials to prevent continuation of the practice and raising awareness among various stakeholders, worked very well. The evaluation further noted that the field staff in the three country **projects learned from each other's experiences** regarding FGM and SRH for young people more generally and that this was an important added value of the multi-country regional approach.

Challenges were mainly related to the sensitive nature of this topic:

- Across some projects **the more sensitive issues, such as sexual violence or abortion received less attention** (Innovation Fund, Youth Incentives) in the content of messages by Southern partners. For the Innovation Fund it was found that **few projects included demonstration of condom usage, open discussions of sexuality**, including sexual pleasure and masturbation, etc. The YI evaluation found that teachers and peer educators found it difficult to communicate openly and positively about sexuality and sexual relations. The YI evaluation, however, noted that despite the often hostile context, a creditable beginning was made to put sensitive issues of youth sexuality on the agenda.
- Other examples are the **incomplete implementation of curricula in schools**, with exercises regarding skills-building and self-efficacy being skipped (the WSWM), or where boys and men were not targeted and trained (the Innovation Fund), or respondents did not come to understand the interface between substance abuse, HIV/AIDS and unwanted pregnancies (Ghana). The (perceived) reactions of communities and parents were also an inhibiting factor, as well as the conditions in many schools with overcrowded classrooms, a heavy curriculum, and few resources.
- The evaluation of the Innovation Fund also found that **gender inequalities were often not sufficiently addressed** in the design of approaches, and that there had been missed opportunities because of an inadequate understanding of, and attention for, the role of boys and men in the gender power equation.
- The evaluation of the first phase of the Youth Incentives programme highlighted **difficulties with strategies being too broad to address** specific problems of the target groups and tools not always suiting the realities of the South (i.e. being generally too sophisticated and too elaborate). This issue was subsequently addressed in the implementation of the second phase of this initiative (2009-2010).

5.5 Overall findings on Capacity Development

Capacity development covered a wide range of topics and beneficiaries. This made it difficult to extrapolate or generalise the findings across evaluation reports and thematic areas, as capacity development often served different purposes, target groups, and was implemented in a variety of ways. In general, capacity development – in particular of partner organisations, but also of other service providers – was a prominent feature across most of the interventions that were studied, often as part of a broader approach to enhance access to prevention or to extend services. Capacity development covered a wide range of areas from technical skills in domains such as planning, monitoring, budgeting, research, and advocacy to more specialist skills in health care service delivery. A key feature was that approaches often not just involved improving knowledge and skills but also attitude and behaviour change (e.g. with respect to stigma and discrimination).

Target groups across interventions included partner organisations (NGOs, religious institutions), other implementing organisations, government partners (health officers, teachers, other decision makers or planners), community structures (community leaders, local associations or informal groups e.g. community SHG), community volunteers, and direct beneficiaries. In some cases, capacity development focused on unusual target groups such as such as hairdressers and Buddhist monks and nuns.[98] The training of peer educators and/or community volunteers was a feature of more than one third of the evaluations. Positive perceptions and reactions of partner organisations to the capacity development efforts by Dutch NGOs were found in most evaluation reports.

Most of the evaluations documented the nature of the capacity building efforts and examined evidence of the link between capacity development and outputs and outcomes of the projects. The level of detail that could be provided on the capacity development activities and their outcomes and impact varied considerably, as some projects had not kept detailed records, or established a baseline on knowledge and skills that could be used to assess the changes that took place through the capacity building interventions.

Numerous examples were provided in the evaluation reports of capacity development efforts – which were often very much appreciated by beneficiaries – of which just a few can be highlighted here. In some cases capacity development efforts were successful, in other less so, with varying reason being cited. For example, the evaluation of the multi-country NYRHP established that project staff in the three countries had benefitted from capacity building activities through the regional component of the project, and that beneficiaries reported positive outcomes in terms of skills and activities from the capacity building efforts in research, gender mainstreaming and advocacy. Results of capacity building on the advocacy component remained limited, however. The reasons given were that the plans were either too ambitious, or the momentum for advocacy activities was wrong. Results on M&E skills were also limited.[99] The South African E-Thembeni programme[100] focused on capacity building and

[98] Report: 37 and report 20, respectively.
[99] Report: 2.
[100] Report: 27.

partnerships as the main avenue for sustainability and was found to have successfully increased the skills and knowledge at individual (volunteer) level, and at the level of organisations. The final sustainability outcome was hampered by the lack of an explicit longer-term sustainability plan. In the HIV/AIDS Integrated Programme in Rwanda[101] the evaluation commented on the lack of clear benefits of 'all the trainings, activities, etc. for HIV/AIDS affected/infected target groups ... (and) for sustainable economic development for its members'.

The evaluation of the Cordaid project, also in the area of HIV and AIDS[102], on the other hand, which spanned over ten countries, found various successful examples of capacity development and was, in a number of cases, able to explicitly trace how capacity development had impacted on the implementation of project activities. In fact, the evaluation established that across the three focus areas of the Cordaid initiative, the capacity development arm had been the most successful, in particular in strengthening monitoring and evaluation, training of community workers, and influencing HIV policies. Selected examples to illustrate this include:

- In Bandung, Indonesia, a partner organisation received technical support on quality management and this was found to have led to improved testing procedures and increased capacity to treat opportunistic Infections.
- In Zambia, two local organisations received support on provision of HBC which resulted in increased capacity for policy influencing and which contributed to HBC being included in the Zambian Strategic Plan on HIV.
- In Ethiopia, selected partners reported that training on gender mainstreaming, data base management, project management and income generation activities contributed to shifting the project focus from HIV prevention, to the creation and promotion of livelihood security for PLHIV, OVCs and other vulnerable groups and to have reinforced the importance of poverty alleviation and livelihood security.

Other successful examples of capacity development were in evidence across the different thematic areas, in some cases with spin off effects to unforeseen areas. The HIV/AIDS Prevention project among key populations in the CAR[103] established training resource centres which were found to have a significant impact on stakeholder understanding of harm reduction and client management. The resource centres were subsequently integrated into AIDS Centres and in this manner also contributed to networking among organisations. In Kyrgyzstan 70% of the prison staff had been trained at the end of this three-year project.

Organisational strengthening was also a common theme across the different thematic areas, and in particular in the areas of STI and HIV/AIDS, and in the support to PLHIV and key population groups. Workplace interventions were in this context used to create capacity and were credited with having contributed to organisational strengthening.[104] In the case of India this included building systems and structures and enhancing the capacity to address general

[101] Report: 25.
[102] Report: 8.
[103] Report: 1.
[104] Reports: 24, 44 and 45.

health issues. In the GDP project in Kenya and Indonesia[105] workplace policies were also developed, and this, in combination with capacity development and training (at CSO and beneficiary levels) was identified as having been critical in the enhanced capacity and understanding of HIV and AIDS and gender issues and in the capacity of beneficiaries to address GBV in families.

A number of challenges to capacity development emerged from the analysis of the reports:

- The **intervention logic or capacity development plan** was sometimes missing in the design and implementation of the interventions, leading evaluations to question the rationale and coherence *for approaches*. In this context the Cordaid evaluation noted that 'a wide range of capacity building approaches are used ... the kind of support provided seems to depend on the partner organisation needs on the one hand and the Cordaid Project Coordinator on the other hand and is often left to individual interpretations. In the absence of a comprehensive framework and understanding of how capacity development efforts link to achieving results, the activities will be incoherent'.[106]
- Capacity development was not always followed by **support to implementation**. This is highlighted by the example of the multi-country Raising Voices project evaluation[107]. The evaluation concluded that the NGO's work in preventing violence against women and children has been 'extraordinary', especially in developing methodologies. The project also developed two comprehensive tool sets: The SASA! Activist Kit, a multi-media tool to guide activists in making the link between VAW and HIV/AIDS, and The Good School Toolkit, for school staff, students and community members to assist them in creating violence-free schools. The tools provide a link between concepts and practice. However, the evaluation was critical of the results of capacity building to implement the tools, as organisations were clearly not aware of how to use the tools effectively.
- Various evaluations highlighted **in-adequate adaptation of content** to the local needs, or the use of modalities and languages[108] that were not completely appropriate/adequately adjusted to the target group.
- **The short duration of the projects**. For example, in the Zambia Action Research project[109], the evaluation found that the participating organisations and staff reported feeling more empowered as a result of their involvement in this action research project, which allowed them to critically reflect on and interact with the experience of others and the existing body of knowledge on life skills. However, because the project was unfinished, the longer-term capacity development outcome on users of the tools that were developed through the action project could not be assessed. In some cases – such as the YI programme and the WSWM – the type of change envisioned presumes long term change processes, in particular for behaviour change interventions.
- In some cases capacity building **focused on individuals**, without explicit strategies/activities at organisational or institutional level, making it difficult for the individuals who were trained to put in practice what they had learnt.[110]

[105] Report: 46.
[106] Report: 8.
[107] Report: 16.
[108] Reports: 23 and 24.
[109] Report: 41.
[110] Report: 20.

5.6 Overall findings on Sustainability

The OECD/DAC evaluation guidelines specify that sustainability is concerned with 'measuring whether the benefits of an activity are likely to continue after donor funding has been withdrawn', and that 'projects need to be environmentally as well as financially sustainable'.[111] The guidance highlights that this should include attention to:

- Whether benefits of a programme or project (are likely to) continue after donor funding ceases;
- The factors that influenced the achievement or non-achievement of sustainability of the programme or project.

Over one quarter of the interventions that were included in this study – across the different thematic areas – did not include attention to sustainability in the project design. This was the case, for example, for the support to IESSDH in Peru[112], the AIDS Care Education Training Project in Uganda[113], the Community action Against HIV and AIDS Programme in South Africa[114], and the Gender Development Project in Kenya and Indonesia[115]. Selected evaluation reports highlighted this as a weakness in project design and implementation and made recommendations to address this.

The study of reports showed that across evaluations, assessments of sustainability were not based on identical criteria and that not all reports systematically examined sustainability across different dimensions such as funding, individual commitment, institutional commitment, context, etc. For some reports, training was seen as guarantee of sustainability (knowledge staying with partners or at community level). Other reports challenged this assumption, given high staff turn-over, erosion of skills and knowledge over time, and the lack of integration with a broader organisational approach.

A small number of evaluations concluded that sustainability would likely be achieved. For example, the evaluation of the prevention of female genital mutilation initiative in Niger[116] found that certain elements of the country projects would likely be sustained. The rationale for this conclusion was that local commitment for continuing activities was high. In other cases, evaluations found evidence/examples of local projects/organisations continuing the activities with their own funding or funding from other donors, for example: in the case of DIMOL in Niger[117] which had alternative sources of funding; Equidad in Ecuador which was generating resources through training on capacity development; and the AEE HIV/AIDS integrated programme in Rwanda which was running a guest house. The cooperation of

[111] http://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm accessed 21 May 2013.
[112] Report: 14.
[113] Report: 26.
[114] Report: 30.
[115] Report: 46.
[116] Report: 31.
[117] Report: 31.

NGOs with government and the integration of activities into formal planning processes was frequently cited as a factor that would likely enhance sustainability of the intervention.

However, over half of the evaluations offered less optimistic assessments of sustainability. For example, in the area of maternal and perinatal health, the strengthening of health services project in Cameroon[118] was found to be at risk of not being sustainable due to lack of financing. And in the area of STIs and HIV/AIDS, particular concerns were identified with the GDP[119] having been developed as a stand-alone initiative, and its activities having been only marginally included in the work plans of the organisations that were involved.

In some cases, sustainability issues were related to the levels of investment that would be required to continue activities that were experimented on a pilot scale For example, the evaluation of the health insurance schemes that were piloted in Uganda[120] would require substantial medium term investments to make up for the difference between what communities were willing to pay and the real costs of services. The evaluation of the AFEW HIV/AIDS prevention intervention in the CAR similarly noted threats to sustainability given the high costs of the model and recommended that a cheaper model should be explored and rolled out if a second phase of the project was forthcoming.

In some countries the operational context was a limiting factor, which had implications for the implementation of interventions. In Niger, the NGO DIMOL had difficulties operating and developing a sustainable model because of tensions with government services. In Myanmar, the evaluation concluded that the work by Médecins du Monde[121] on HIV/AIDS prevention among sex workers in Yangon would not be sustained beyond the intervention by Médecins du Monde because of the difficult political context in the country, the sensitivity of the type of interventions, and the climate under which NGOs operate.

A further threat to sustainability was the relatively short duration of the projects, compared to the nature and complexity of what these were trying to achieve.[122] A number of evaluations noted that the change processes required more time to produce results – for example in the area of advocacy at a political level, or in the area of behaviour change for individuals and communities. Short duration of the interventions also meant that the focus of projects was on implementation, with insufficient time for proper diagnosis of issues, for lesson learning and for exploring coherent/comprehensive approaches to sustainability. For example, the female condom supply project evaluation[123] noted that external funding would continue to be needed as the commodity had not yet been integrated into the market or the public health system. The evaluators found that the three-year was too short a period to have achieved integration in the public and private sector, although some foundations towards this goal were laid.[124]

[118] Report: 5.
[119] Report: 46.
[120] Report: 9.
[121] Report: 35.
[122] See for example reports: 9, 19, and 35.
[123] Report: 37.
[124] Report: 37.

6

Conclusions

This final chapter brings together the conclusions from this study with respect to the relevance, results (effectiveness), strategies, and sustainability of the NGOs' projects and programmes, as derived from the 51 evaluation reports. It also summarises the conclusions of this study with respect to the evaluations themselves and the extent to which these provide insight into the work done by the Dutch NGOs and their Southern partners.

The evaluations covered a wide range of SRHR topics, across different geographical settings. Not all aspects of the work supported by the Dutch NGOs in the field of SRHR from 2007 to 2012 have been evaluated, and, as explained in the chapter on methodology, not all of the existing evaluations were included in this study. The conclusions in this chapter therefore relate solely to the 51 evaluations that were studied.

Taken together, the reports show that NGO interventions were **relevant** to the policy priorities of the Netherlands MFA and to the priorities of the countries and target groups concerned. Interventions covered important policy themes for the Netherlands, with a strong focus on STIs and HIV/AIDS, followed by sexual and reproductive rights. The NGOs shared a rights-based approach in targeting underserved populations. Distinctive were the NGOs' efforts in reaching adolescents and, to a lesser extent, key populations. While projects were broadly coherent with policy priorities of the Netherlands MFA, certain specific aspects – which are also laid down in global commitments – were not consistently included in project design, or did not receive sufficient attention in implementation. One noteworthy area in this respect in some of the evaluated interventions is gender. Relevance for the countries concerned was in particular sought through close collaboration with southern partners: in a considerable number of cases this was a characteristic of project design and implementation. A number of interventions also made considerable efforts to include beneficiaries in all aspects of the project cycle. This was often extended to specific efforts to involve southern partners and beneficiaries in the project evaluations – an area of good practice that emerges from this study.

A strong feature of most evaluation reports is that they provide elaborate insight into lessons learnt from qualitative information collected, for example, from focus group discussions and interviews. All 51 reports presented qualitative data; two thirds of the evaluation reports also included quantitative data, most frequently at output level. The evaluations provided only limited quantified information at the level of outcomes. Most of the selected evaluations did not present the results in such a way that they could be attributed to the projects or be used to assess progress made. Comparisons against baseline data were conducted in one quarter of the evaluation reports, mostly on the basis of secondary data. In two evaluations a control group design was used. IOB was not able to examine or assess the cost and cost-effectiveness of interventions, as only a few projects provided information about these aspects.

At output level, information was provided about target groups reached, type and scope of priorities addressed, and geographical areas covered. However, the evaluation reports did not always inform about the specific numbers of beneficiaries, approaches, and results, which points to shortcomings in the projects' data collection and monitoring and

evaluation systems. Neither were results consistently related to what was planned in the project design: this makes it difficult to draw conclusions about effectiveness.

At **outcome** level, the study sought to establish to what extent the evaluation reports provided insights into results in four key areas: changes in knowledge; access to and use of services; policy influencing; and capacity building.

Across interventions the evaluations documented changes in **knowledge** – in particular in the areas related to maternal and perinatal health, sexual and reproductive rights, FP, HIV and AIDS and changes in attitudes towards particular practices (such as FGM or use of condoms) and towards certain groups (e.g. PLHIV, MSM, IDUs). The evaluation reports provide insights into approaches used and changes that took place, such as more positive **attitudes** towards condom use and reducing levels of stigma and discrimination. They revealed that particularly useful approaches in this respect were life-skills training and the involvement of peer educators and community workers. In some cases, these changes in knowledge were not intended to bring about behaviour change in the short term, but they were found to contribute to empowerment of target groups, enabling them to make better/more well-informed decisions in the future. Where changes in practices were envisioned, most evaluations provided only a limited analysis of and insight into longer-term **behaviour** indicators, such as contraceptive use or an increase in supervised deliveries. Weaknesses in project design were identified as having an impact on the extent to which such lessons can be drawn.[125] In the case of adolescent SRHR in particular, most projects were unable to show how the increased level of knowledge and changed attitudes had impacted on sexual health and practices. It should be acknowledged, however, that such longer-term behaviour change is difficult to ascertain (particularly given the relatively short duration of many interventions), and is often also very difficult to measure, particularly in certain target groups.

Many interventions were reported to be successful in extending **services** to hard to reach or marginalised populations or to people excluded from access to services, such as nomadic populations, but also MSM, IDU, SW and PLHIV. A key element mentioned for success among adolescents was the availability of youth-friendly services. Few projects specifically assessed quality of service delivery. In a number of cases, increased uptake of condoms, counselling and anti-retroviral therapy was reported. Some NGO projects helped to increase the income of PLHIV households. It may be assumed that the efforts in service delivery overall have contributed to prevent and address problems in maternal and perinatal health, family planning, HIV/AIDS and sexual rights, and to provide treatment for health issues such as obstetric fistulas, and improve the general well-being of targeted populations.

Although **advocacy** was a feature in several interventions and thematic areas, only a few examples were given of its effectiveness in influencing policy. Evaluations highlighted that strategies and plans for advocacy were frequently not explicit and that time frames for

[125] Assessment of changes at the longer-term, such as reducing HIV incidence, or reducing the number of teenage pregnancies lies beyond the scope of these projects.

achieving realistic advocacy results were often overly optimistic, resulting in the projects ending without having achieved the advocacy targets. Across the thematic areas, lobbying for policy changes was most successful at the community and district levels, with certain topics being included in local-level plans, and in some cases being reflected in budget allocations at decentralised levels. Among the most tangible outcomes of advocacy efforts on policy were the interventions that targeted/worked with key populations, where success was achieved on a number of fronts such as revisions in the law to fight stigma and discrimination in India and Peru, and the adoption and endorsement of a model for training and management in prisons by Ministries of Justice in Kyrgyzstan and Tajikistan.

Many interventions had a prominent focus on **capacity development** of southern partners. This focus was much appreciated by the partners, and the interventions have therefore provided a basis that should enable the activities to continue beyond the duration of the projects. However, the details provided on capacity development activities varied considerably, as some projects did not keep records or did not establish a baseline on knowledge and skills that could be used to assess subsequent changes. Capacity strategies were not always explicitly formulated or implemented, or clearly linked to a plan for supporting the beneficiaries. In addition, the NGOs and their project partners also faced some challenges in implementing projects around sensitive issues, such as sexuality for adolescents.

A consistent and strong feature of the evaluation reports was that their evaluation of the pursued **strategies** included both the success factors and the bottlenecks. This testifies to an important positive element of the NGO evaluations, namely the efforts made across themes and settings to learn lessons from practice. At a general level, strategies that worked well included:

- Community sensitisation and involvement of multiple key stakeholders;
- Applying a comprehensive approach, in particular linking prevention to services and care and support;
- Capacity building of partners, focusing on skills and 'how to', particularly when coupled with support for implementation;
- Collaboration with existing government structures and services;
- Working with and through peer educators;
- Using self-help groups and community structures, and involving community volunteers;
- Using innovative means to reach groups and/or get across messages.

On the flip side, the study also highlights common weaknesses, mostly pertaining to technical issues:

- Lack of specificity in intervention strategies, especially in advocacy and capacity development strategies;
- Limited use of research and theory in the design and implementation of interventions;
- Shortcomings in the M&E systems and skills within interventions;
- Relatively short duration of interventions, many of which have complex goals that require time to produce results.

Many of the other lessons are specific to thematic areas and have been presented in the preceding chapters.

The focus on the capacity development of southern partners was a significant input into working towards **sustainability** of organisations, interventions and approaches. Important in this respect is the fact that capacity development was a prominent feature of most interventions. Nonetheless, project design could have explicitly included sustainability strategies from the start. The fact that on the whole the evaluations' conclusions about sustainability were either cautious or pessimistic (i.e. few evaluations concluded that it was likely that sustainability would achieved) underscores that this is an area that needs more prominence in future interventions. The discussion of sustainability in the evaluation reports itself also showed shortcomings. Criteria for assessing sustainability were either narrow (examining only a particular aspect of sustainability), or not made explicit in the reports.

From the large and diverse number of NGOs and interventions examined in this study it can be concluded that the organisations' work in the field of SRHR was relevant, particularly their efforts in addressing the needs of adolescents and key populations. Regarding effectiveness, the present study has found that the NGO interventions have improved the beneficiaries' knowledge about SRHR, and have led to increases in service delivery. There are examples where advocacy efforts have been successful at the district and local levels. Most of the evaluation reports provided insufficient detail to enable the results to be unequivocally attributed to the projects. In addition, the evaluations could not provide substantiated effectiveness of the NGO interventions at the level of utilisation.

Annexes

Annex 1 List of consulted documents

Aidenvironment (2009). *Study Schoklandfonds. Classificatie en impact op de organisatie*. Aidenvironment: Amsterdam.

Cornelissen, W., Nieuwhof, A., Schulpen, L. (2008). *Juist gemeten? Evaluatie van het beoordelingstraject Medefinancieringsstelsel 2007-2010*. SEOR: Rotterdam.

IOB (2011). *Methodische kwaliteit van Programma-evaluaties in het Medefinancieringsstelsel-1 2007-2010*. Ministry of Foreign Affairs: The Hague.

IOB (2011). Leren van NGOs: *Studie van de basic education activiteiten van zes Nederlandse NGOs*. Ministry of Foreign Affairs: The Hague.

MFA (2006). *Beleidskader Medefinancieringsstelsel (MFS) 2007-2010*. Ministry of Foreign Affairs: The Hague.

MFA (2008). *Choices and opportunities: HIV/AIDS and sexual and reproductive health and rights in foreign policy*. Ministry of Foreign Affairs: The Hague.

MFA (2011). *Focus letter on Development Aid*. Ministry of Foreign Affairs: The Hague.

MFA (2012). *Letter to the House of Representatives regarding the Policy on SRHR, including HIV/AIDS*. Ministry of Foreign Affairs: The Hague.

Ministry of Finance (2006). *Regeling Periodiek Evaluatieonderzoek en Beleidsinformatie (RPE) 2006*, Staatscourant, 28 April 2006, nr. 83. Ministry of Finance: The Hague.

O'Meara & Samuels (2008). *Quality of published evidence on the impact of education on HIV and AIDS*. UNAIDS Inter-Agency Task Team (IATT): Paris.

USAID (2008). Quality Assurance Project the United States Agency for International Development. USAID: Washington.

WHO (2004). *Reproductive Health Strategy to accelerate progress towards the attainment of international development goals and targets* (adopted by the 57th WHA May 2004). World Health Organization: Geneva.

Annex 2 List of consulted organisations and persons

Civil society organisations

AIDS Foundation East-West
Anke van Dam

AMREF Nederland
Cobi Mars
Noortje van Langen
Veerle Ver Loren van Themaat

Cordaid
Geertje van Mensvoort
Rens Rutten

Female Cancer Foundation
Carlien Marree

Healthnet TPO
Ada van der Linde
Saskia Nijhof
Willem van de Put

Hivos
Karel Chambille
Teyo van der Schoot
Artien Utrecht

Humana
Marianne Löwik

ICCO
Dieneke de Groot
Willeke Kempkes

Prisma
Arno Louws
Anke Plange – van Well

Oxfam Novib
Yvonne Es
Lincie Kusters
Marjolijn Verhoog
Lindy van Vliet

Mainline
Machteld Busz
Karen Kraan
Janine Wildschut

Rutgers WPF
Henk Rolink
Ruth van Zorge

STOP AIDS NOW!
Jael van der Heijden

Text to Change
Hajo van Beijma
Lisa Harteveld

Ministry of Foreign Affairs

DSO-GA
Monique Kamphuis
Lily Talapessy
Daisy Walburg

DSO-MO
Loes Lammerts
Marijke Roes

DSO-OO
Chris de Nie

Annex 3 About IOB

Objectives

The remit of the Policy and Operations Evaluation Department (IOB) is to increase insight into the implementation and effects of Dutch foreign policy. IOB meets the need for the independent evaluation of policy and operations in all the policy fields of the Homogenous Budget for International Cooperation (HGIS). IOB also advises on the planning and implementation of evaluations that are the responsibility of policy departments of the Ministry of Foreign Affairs and embassies of the Kingdom of the Netherlands.

Its evaluations enable the Minister of Foreign Affairs and the Minister for Development Cooperation to account to parliament for policy and the allocation of resources. In addition, the evaluations aim to derive lessons for the future. To this end, efforts are made to incorporate the findings of evaluations of the Ministry of Foreign Affairs' policy cycle. Evaluation reports are used to provide targeted feedback, with a view to improving the formulation and implementation of policy. Insight into the outcomes of implemented policies allows policymakers to devise measures that are more effective and focused.

Organisation and quality assurance

IOB has a staff of experienced evaluators and its own budget. When carrying out evaluations it calls on assistance from external experts with specialised knowledge of the topic under investigation. To monitor the quality of its evaluations IOB sets up a reference group for each evaluation, which includes not only external experts but also interested parties from within the ministry and other stakeholders. In addition, an Advisory Panel of four independent experts provides feedback and advice on the usefulness and use made of evaluations. The panel's reports are made publicly available and also address topics requested by the ministry or selected by the panel.

Programming of evaluations

IOB consults with the policy departments to draw up a ministry-wide evaluation programme. This rolling multi-annual programme is adjusted annually and included in the Explanatory Memorandum to the ministry's budget. IOB bears final responsibility for the programming of evaluations in development cooperation and advises on the programming of foreign policy evaluations. The themes for evaluation are arrived at in response to requests from parliament and from the ministry, or are selected because they are issues of societal concern. IOB actively coordinates its evaluation programming with that of other donors and development organisations.

Approach and methodology

Initially IOB's activities took the form of separate project evaluations for the Minister for Development Cooperation. Since 1985, evaluations have become more comprehensive, covering sectors, themes and countries. Moreover, since then, IOB's reports have been submitted to parliament, thus entering the public domain. The review of foreign policy and a reorganisation of the Ministry of Foreign Affairs in 1996 resulted in IOB's remit being extended to cover the entire foreign policy of the Dutch government. In recent years it has

extended its partnerships with similar departments in other countries, for instance through joint evaluations and evaluative activities undertaken under the auspices of the OECD-DAC Network on Development Evaluation.

IOB has continuously expanded its methodological repertoire. More emphasis is now given to robust impact evaluations implemented through an approach in which both quantitative and qualitative methods are applied. IOB also undertakes policy reviews as a type of evaluation. Finally, it conducts systematic reviews of available evaluative and research material relating to priority policy areas.

Annex 4 Overview of NGOs

Name of NGO	Overall area of operation	SRHR related objectives	Areas of reported added value	Sub-themes	SRHR Component						Primary Target Group			
					Maternal & perinatal	Family planning	Abortion	STI/HIV	S & R rights	Youth	Key pops	Women	Men
AMREF Flying Doctors	Healthcare for disadvantaged groups and poverty alleviation.	Increase: • Contraceptive use; • Access to sexuality education; • Acceptance of different sexual orientations.	• Community health approach; • Linkages with public health and government system; • Present in a complex context (nomadic areas).	• FGM.	x	x	x	x	x	x	x	x	x
AIDS Foundation East West (AFEW)	HIV/AIDS in Eastern Europe and Central Asia.	Prevention of HIV, universal access to treatment, care and support; advocacy.	• IEC regarding safer sex; • Distribution of condoms; • Referral networks for SRHR; • Prevention of (sexual) violence against women.	• Provision of direct services to key populations; • Few other organisations working in the region; • Harm reduction approach.				x	x		X		
Cordaid	Promoting sustainable better future for excluded groups by fighting poverty and exclusion.	Contribute to better health for women and children through health system strengthening.	• SRHR and Faith Based Organisations (FBO); • SRHR and Results based financing (RBF); • SRHR and human resources for health.	• Maternal health; • Care for PLHIV.	x	x		x	x	x		x	x
Female Cancer Foundation	Prevention of cervical cancer in developing countries.	Prevention of cervical cancer by screening, research and education.	• Only Dutch NGO focusing on prevention of cervical cancer in developing countries; • Raising awareness of cervical cancer prevention and reproductive health issues; • Use of a cost-effective 'See & Treat' method.	• Awareness cervical cancer; • HPV-screening.	x			x	x			x	

Name of NGO	Overall area of operation	SRHR related objectives	Areas of reported added value	Sub-themes	SRHR Component					Primary Target Group			
					Maternal & perinatal	Family planning	Abortion	STI/HIV	S & R rights	Youth	Key pops	Women	Men
Health Net TPO	Health systems strengthening communities in fragile states.	Culturally sensitive and effective interventions Access to SRHR and HIV/AIDS services for PLHIV, and victims of GBV. Training of providers of care.	• SRGR programming in (post-conflict) fragile states; • Access to health care in difficult areas.	Community/health staff training. Support to PLHIV. VCT centres and outreach services. Support to victims of sexual violence. PBF.	x	x	x	x	x	x		x	x
Hivos	Sustainable development through access to resources, markets, information, knowledge and political power.	Capacity development and critical voice. Cultural change for acceptance and tolerance of sexual diversity. Legislation for non-discrimination Knowledge.	• Focus on sensitive and controversial issues (e.g. violence against women, GBV, LGBT rights, sexual diversity and wider social human rights); • Focus on human rights, dignity, respect, cultural & social identify; • Civil society building.	Gender based violence. Sexual rights. Women's rights.				x	x	x	x	x	x
Humana	Promoting durable development e.g. through education, health and rural development.	Prevention of HIV. Counselling. Organisation of support groups of and for PLHIV.	• Door to door campaigns, SMS tool; • Face to face information; • Conducting home tests.	PMTCT. Condom use . HIV and AIDS campaigns. Access to care. Support groups.	x	x		x	x	x		x	x

Name of NGO	Overall area of operation	SRHR related objectives	Areas of reported added value	Sub-themes	SRHR Component					Primary Target Group			
					Maternal & perinatal	Family planning	Abortion	STI/HIV	S & R rights	Youth	Key pops	Women	Men
ICCO Alliance (ICCO and Prisma)	Sustainable economic development, democratisation and peace building, access to basic facilities.	HIV prevention, equipping communities to deal with HIV, and strengthening of quality basic healthcare, with a focus on RH.	• Dialogue with and between religious leaders and organisations; • Making debatable sensitive issues (homosexuality, gender, VAW etc.) within churches; • Capacity building of southern partners.	Basic SRH services for underprivileged groups. Destigmatisation. Treatment, care, support PLHIV. Prevention HIV/ AIDS. Sexuality education and awareness raising in this area.	x	x		x		x		x	x
Oxfam Novib	Promoting a world without poverty through empowerment, accountability and gender justice.	Reduce impunity/ social acceptance of violence against women. SRHR empowerment. Access to services. Reduce HIV/AIDS susceptibility.	• Individual behaviour change around sexuality and gender inequality; • Breaking through collective gender and cultural norms; • Leadership and empowerment of women's organisations and PLHIV groups to demand SRHR; • Universal access to female condoms.	• Addressing fistula; • Sexuality education for youth in schools; • Access to female condom; • Lobby and advocacy; • Workplace programs.	x	x	x	x	x	x	x	x	x
Rutgers WP (formerly Rutgers Nisso Groep/Youth incentives and World Population Foundation)	Sexual and reproductive rights.	Increase awareness of SRHR among young people. Improve conditions for young people to exercise SRHR. Reduce resistance to youth sexuality issues. Increase youth participation. Lesson learning.	• Acceptance of young people's sexuality; • Comprehensive sexuality education; • Positive approach to prevention and risks; • Addressing sensitive issues (e.g. sexual diversity, safe abortion, sexual and GB violence, etc.); • Expertise; both in NL and internationally; • Research; • Lobby & advocacy.	• Sexual diversity; • Sexual & GB violence; • Sexual relationships; • Youth participa-tion.		x	x	x	x	x			

Name of NGO	Overall area of operation	SRHR related objectives	Areas of reported added value	Sub-themes	SRHR Component					Primary Target Group			
					Maternal & perinatal	Family planning	Abortion	STI/HIV	S & R rights	Youth	Key pops	Women	Men
Mainline	Improving the health and quality of life of substance users.	Prevent and reduce health damage and sexual risks (under influence) of (injecting) drug use (harm reduction).	• Harm reduction; • Civil society building; • South-South knowledge exchange.	Harm reduction. Continuum of care (treatment, care, support) for HIV positive drug users.				x	x		x		
STOP AIDS NOW!	HIV/AIDS.	Communication and campaigning. Fundraising. Lobby and advocacy. Policy & innovative partnerships.	• HIV/AIDS in the workplace; • Integrating gender, HIV and human rights; • OVC affected by HIV and AIDS; • HIV prevention and SRHR for young people.	Workplace policies. Stigma reduction. Community responses to HIV/AIDS. Integrating gender, HIV/AIDS and HR.	x	x		x	x	x	x	x	x
Text to Change	Empowering citizens to take health and wellbeing into own hands through dissemination of data on development issues through mobile technology.	Use of mobile technology to: Inform about SRHR. Gather data. Increase knowledge and promote behaviour change.	• Information distribution on SRHR via mobile technology; • Creating innovative solutions to addressing SRHR topics; • Partnerships with public and private entities.	Mobile technology for health communication.	x	x		x		x		x	x

Annex 5 Assessment form

Quality Assessment of the Evaluation Reports in the NGO study on SRHR

CHARACTERISTICS OF THE EVALUATION REPORTS	
Name of the NGO	
Title and year of report	
Author(s)	
Type of evaluation	
Period under review	
Evaluation of 1 partner/multiple partners/network	
Country/countries and/or region(s)	
Budget of the evaluated project/programme	

ASSESSMENT AGAINST MINIMUM CRITERIA		
	Yes	No
Implemented in the period 2007-2011		
Information on results (output/outcome/impact), not just process		
SRHR more than 70% of the programme budget		
MFS1/Schokland more than 25% of the programme budget		

CONCLUSION: COMPLIANCE WITH MINIMUM CRITERIA?

1. VALIDITY	Score	
1.1 Clarity of the problem statement		
1.2 Operationalisation of the problem statement into research questions		
2. RELIABILITY	**Score**	
2.1 Research methods		
2.1.1 Specification and rationale for research methods		
2.1.2. Verification of data and triangulation		x 2
2.2 Scope		
2.2.1 Representativeness of the sample or case study selection		
2.3 Independence		
2.3.1 Of the source material (from the beneficiaries)		
2.3.2 Of the evaluators		
2.4 Conduct of the evaluation and the quality control		
2.4.1 Quality control via internal or external guidance		
TOTAL SCORE (VALIDITY AND RELIABILITY	**0.0**	**0.0**
Minimum: 22.5 points = average 2.5		

	yes	no	possibly
FINAL ASSESSMENT: MEETS CRITERIA TO GO THROUGH TO ANALYSIS?			
Observations			

ASSESSMENT (Score: 1=poor, 2=moderate, 3=sufficient, 4=good)

Annex 6 Intervention matrix

<table>
<tr><th>Input and activities</th><th colspan="2">Intended results</th><th>Impact
The (net) effects of the intervention that can be attributed to the intervention</th></tr>
<tr><td rowspan="3">Financial and technical resources; trainings, capacity building, developing curricula, organizing sensitization sessions, providing education, condom distribution, lobby/ advocacy, etc.</td><td><u>Outputs</u>
Direct results stemming from the activities of the project</td><td><u>Outcomes</u>
Intermediate results; benefits or changes in the situation for beneficiaries</td><td rowspan="2"></td></tr>
<tr><td>Examples:

Number of people trained; Increased availability of services: such as facilities set up, education provided, condoms distributed, etc.</td><td>Examples:

Improved access to commodities, such as AIDS-related drugs, contraceptive methods and life-saving drugs that ensure good sexual health.

Increased use of and improved quality of public and private sexual and reproductive health services.

More respect for sexual and reproductive rights of groups who are denied these rights.

Changes in policy documents/legislation and implementation (e.g. budget allocation; prosecution of cases of HR abuses).

Increased capacity is also considered an outcome.</td></tr>
<tr><td colspan="3"><u>Note</u>: Production of outputs is a necessary requirement for achieving the outcomes. Therefore, increased availability of services is considered an output (through the set-up of facilities, production of condoms, education materials, etc.). It is linked to increasing access to services, which is considered an outcome as it is related to people's behaviour, such as seeking health services and using contraceptives.

<u>Note</u>: Achieving longer-term societal results, such as decreased mortality and morbidity and decreased teenage pregnancies fall outside the scope of (most) NGO interventions.</td></tr>
</table>

Annex 7 List of included evaluation reports

Report #	NGO	Title
1	**AFEW**	Aids Foundation East-West (AFEW). HIV/AIDS prevention in the CAR. HIV Client Management Project in Central Asia. Final evaluation. TMF Project Number 10540.
2	**AMREF**	End-term evaluation of the Nomadic Youth Reproductive Health Programme 2007-2010. Traditions in a changing environment. Final report.
3	**Cordaid**	Evaluation of the AMNet Project On Promoting the Rights and Dignity of Children in the Port Loko and the Kambia District, in Northern Sierra Leone.
4	Cordaid	Citizen's Action and Health MDGs project.
5	Cordaid	Redynamisation des Soins de Santé à l'Est du Cameroun Phase II. Rapport de la mission d'évaluation finale.
6	Cordaid	Evaluation report: HEALTH CHILD: Improving the Management of Child Illnesses and Health of Young Mothers.
7	Cordaid	An evaluation of adolescent reproductive health and traditional medicine practice projects implemented by ACDEP and its partners in selected districts of northern Ghana.
8	Cordaid	Cordaid HIV programme 8 evaluation. Final evaluation report.
9	Cordaid	Final report on the end of phase one External evaluation of the Save for Health Uganda maternal and neonatal health insurance pilot project.
10	**Hivos**	EVALUACIÓN EXTERNA DE: COLECTIVO DE MUJERES "8 DE MARZO", MANAGUA. COLECTIVO DE MUJERES "ITZA", MANAGUA. ASOCIACION DE MUJERES CONTRA LA VIOLENCIA. "OYANKA", JALAPA. Febrero a Mayo 2009.
11	Hivos	HIVOS. EVALUATION REPORT OF CONTACT's BASIC COUNSELLING PROJECT.
12	Hivos	FUNDACION ECUATORIANA EQUIDAD - HIVOS - SCHORER. Apoyo de Hivos y Schorer a la Fundación Ecuatoriana Equidad. Informe de Evaluación 2007 – 2010.
13	Hivos	EVALUACIÓN EXTERNA. REDVIHDA, Santa Cruz de la Sierra, Bolivia.
14	Hivos	Evaluación institutional del Instituto de Estudios en Salud, Sexualidad y Desarrollo Humano.
15	Hivos	Evaluación Externa del Programa de Soporte a la Auto ayuda de personas seropositivas.
16	Hivos	Inspiring Activism and challenging power. Raising Voices' eight-year study.
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This report presents the findings of a desk-study of the work of Dutch non-governmental organisations (NGOs) in the field of sexual and reproductive health and rights (SRHR).
It is part of a number of sub-studies of a policy evaluation of Dutch involvement in SRHR, conducted by the Policy and Operations Evaluation Department (IOB) of the Dutch Ministry of Foreign Affairs.

The contribution of NGOs was assessed by an analysis of evaluations of NGOs that are financed through the co-financing system (MFS-I), complemented by interviews.
The study provides insight into the results, the success factors and bottlenecks of the NGO interventions in improving knowledge, increasing access to services and influencing policy on sexual and reproductive health and rights.

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