Synthesis Evaluation of SRHR Subsidy Frameworks 2011-2015

Final Report

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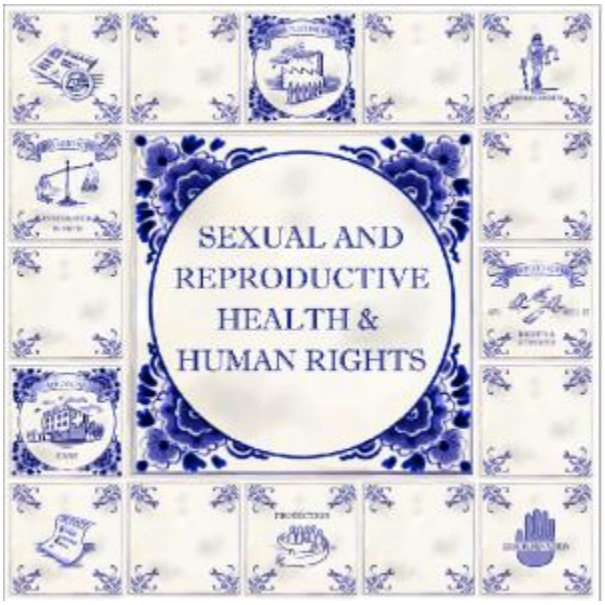

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List of Abbreviations

ANC	Antenatal care
ASK	Access Services and Knowledge
BtG	Bridging the Gap
CAHR	Community Action on Harm Reduction
CSE	Comprehensive Sex Education
CIDIN	Centre for International Development Issues Nijmegen
DAC	Development Assistance Committee
DfID	Department for International Development
E&M	Electronic and mobile
FP	Family planning
HIC	Higher income country
IAFP	Improving Access to Family Planning
ICPD	International Conference on Population and Development
IEC	Information, education and counselling
INGO	International Non-governmental organisation
IOB	Policy and Operations Evaluation Department (Dutch MFA)
IDU	Intravenous drug user
IUD	Intra-uterine device
Ipas	Global NGO aiming to end preventable deaths and disabilities from unsafe abortion
IPPF	International Planned Parenthood Federation
IT	Information technology
LGBT	Lesbians, gay, bisexual and transgender people
LMIC	Lower middle-income country
MCH	Mother and child health
MNCH	Mother, neonatal and child health
MDG	Millennium development goals
M&E	Monitoring and evaluation
MFA	Ministry of Foreign Affairs
MI+	Motivational Interviewing +
MSM	Men having sex with men
MTCT	Mother to child transmission
NGO	Non-governmental organisation
ODA	Official development assistance
OECD	Organisation for Economic Cooperation and Development
PoA	Programme of Action
PSI	Population Services International
SGBV	Sexual and gender based violence
SDG	Sustainable Development Goal
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
SSI	Semi-Structured Interview
STI	Sexually transmitted infections
SUSO	Stepping Up Stepping Out
ToC	Theory of Change
ToR	Terms of Reference

UAMC	Unite Against Child Marriage
UN	United Nations
UNICEF	United Nations Children's Fund
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

Introduction

This report is a synthesis evaluation of five SRHR Subsidy Frameworks funded by the Dutch Ministry of Foreign Affairs (MFA) between 2011-2015 (Table 1). Twenty-one SRHR programmes were implemented through these frameworks. The evaluation assesses whether these frameworks have been an effective tool to support SRHR in resource-limited settings and contribute to the four SRHR result areas (Ministry of Foreign Affairs, 2016). It seeks to facilitate important learning about the design and implementation of subsidy frameworks and programmes.

Table 1. The 5 subsidy frameworks (2011-2015)

Subsidy Framework	CHOICES AND OPPORTUNITIES FUND	KEY POPULATIONS FUND	STEP-UP FUND	SRHR FUND	CHILD MARRIAGES FUND
Period	Jan 2011 – Dec 2014	July 2011 – Dec 2015	Nov 2012 – Dec 2015	Jan 2013 – Dec 2015	July 2014 – July 2015
Budget	€40,000,000	€35,000,000	€6,000,000	€125,000,000	€5,700,000
No. of programmes funded	4	1	1	11	4

The subsidy frameworks were expected to address one or more of four Result Areas of Dutch SRHR policy:

1. Ensuring that young people know more and are thus equipped to make healthier choices about their sexuality;
2. Increasing the number of people who have access to and can use contraceptives, condoms, anti-retroviral drugs and other essential sexual and reproductive health commodities;
3. Increasing the number of people using high-quality sexual and reproductive health care services at public and private clinics; and
4. Winning more respect for the sexual and reproductive rights of groups who are currently denied these rights.

Objectives of the evaluation

The evaluation had three broad objectives:

I. To assess whether the envisaged results of the 21 programmes have been achieved, and to what extent they have contributed to the four SRHR result areas;

II. To examine a) the efficiency and effectiveness of the decision-making process that led to the policy frameworks, and b) the collaboration between the Ministry and the partner organizations and between the partner organizations and their partners in the South;

III. To assess the sustainability of the programmes.

Related to these objectives, 18 questions were formulated to guide the evaluation .

Methods

The evaluation used a rigorous, mixed-methods approach, adapted from established methodologies for the review and synthesis of evidence (Popay et al., 2006). We combined a desk study of secondary data (SRHR programme documents and academic literature) with primary data-collection through an online survey (n=164), and 31 semi-structured interviews with key stakeholders (MFA staff and staff of lead organisations, alliance partners and implementing partners). A Consensus Conference with stakeholders was held at the end of the study, where some of the key findings and recommendations were discussed.

Main findings

The main findings are presented below by objective and by question.

Objective I. Programme Results

1) Are the programme objectives relevant to the SRHR subsidy frameworks and the four result areas?

The programme objectives were relevant to the subsidy frameworks and the four result areas. Most programmes covered three or four result areas. In line with the frameworks, many of the programmes focused on sensitive SRHR issues (like abortion) and the rights of marginalized groups, including LGBTs, IDUs and sex workers.

2) To what extent have envisaged outputs and outcomes been realized?

The majority (between 71% to 89%) of the envisaged output and some outcome targets were realized, and many were surpassed. These positive results undoubtedly reflect organisations' dedication and expertise; they may also reflect conservative target setting.

Most of the output indicators surpassing targets concerned the number of people reached (with information, training, activities, commodities, advocacy strategies), especially when electronic and mobile-health strategies were used. While these are positive output results, reaching people does not necessarily mean that the programme has effects for longer term outcomes such as increased knowledge or behaviour change.

Targets not achieved were often related to institutional or structural changes, usually pertaining to Result Areas 3 (increased usage of SRH care) and 4 (more respect for SR rights). This finding is not

surprising, given that deeply embedded social structures (norms, values, power relations) change only gradually.

Several programmes provide some evidence of programmes effects on outcomes such as increased use of contraceptives or health services, or change in gender equitable attitudes, although there is uncertainty regarding whether these effects can be (only) attributed to the programmes. Methodological tools for addressing the attribution problem, such as independent evaluations or a study design that includes pre- and post-tests, control groups and tests of significance, were under-used and, when used, received limited attention in final reports.

3) Did the implemented activities lead to unexpected results and if so, which ones?

Positive unexpected results were found in a number of programmes (e.g. larger uptake of services, reaching other people than the originally intended target group, and unexpected synergies between collaborating organizations). Negative unexpected results were rarely reported. Some reports and interviews confirmed adverse effects, including risks to NGO staff. Awareness of, and responsibility for, adverse unexpected effects is an ethical stance and evaluation focus which should be encouraged whenever possible.

4) Which intervention strategies appear to have contributed to programme objectives and the four MFA result areas?

a) Which interventions and intervention strategies are reported to be effective by programmes?

Programmes implemented a large variety of interventions and intervention strategies. The following interventions and intervention strategies were most commonly used, and reports suggest that they were effective in achieving programme objectives and contributing to the four result areas:

1. Comprehensive Sexuality Education (CSE)
2. Peer involvement, including peer education
3. Use of electronic and mobile (E & M) health technologies
4.. Male involvement in SRHR
5. Training of health workers / community health workers, including through E & M Health strategies.
6. Youth Friendly Health Services and Centres
7. Linking Communities and Care
8. Promoting legal change and awareness of human rights
9. Advocacy
10. Needle and syringe (harm-reduction) programmes
11. Integrated packages / multi-level approaches

b) What, if any, is the evidence regarding the effectiveness of interventions and intervention strategies?

For most of these interventions, there is some supporting evidence of effectiveness in the academic literature. We found insufficient evidence for two interventions: youth centres and some forms of peer education. Available evidence needs to be interpreted with caution; it is often derived from studies in

high income countries, usually supports effectiveness regarding selected outcomes (e.g. behaviour change) rather than impact (e.g. HIV reduction), and effectiveness will always depend on context and the quality of implementation.

c) Were the logic and assumptions underpinning the log frames correct?

In general, interventions seem logically aligned with programme objectives and the underpinning log frames. Some of the log frames or implicit theories of change contained problematic assumptions, including for example an over-emphasis on individual decision-making power (reflected for instance in the great number of programmes focusing on changing knowledge and attitudes), or the idea that shared demographic features (e.g. age) make someone a peer.

5) Which contextual factors have affected the results or implementation positively or negatively?

Various factors related to the political, social, and operational environment affect implementation and results, in positive as well in negative ways. Factors having a negative impact include:

Political factors: government's limited commitment and restrictive legal frameworks (particularly regarding key population groups such as LGBTs, injecting drug users, sex workers and young people, and sensitive issues such as abortion and CSE.

Social factors: stigmatization of target groups; shyness and taboos around SRHR issues; poor SRHR knowledge; lack of youth-friendliness of health care and language barriers.

Operational factors: the poor functioning of the health or educational system, and electronic and electricity infrastructure; the lack of good working relationships with local actors and structures.

6) What has been adjusted within programmes during implementation?

Several of the programmes made good use of operational research and evaluations to tailor programmes to the context and needs of target groups. Dutch MFA and programme lead organisations created room for flexibility and adaptations; this facilitated the achievement of programme objectives. However, few programmes made fundamental changes in intervention approach based on reflection of underlying assumptions.

7) What are programme costs in relation to results (e.g. cost per output achieved)?

Due to the lack of sources it was impossible to determine whether programme costs are reasonable in view of the outputs achieved. In many cases, programme targets have been surpassed by 100% or more, suggesting that at the project design phase there were no realistic expectations of programme costs. Programmes over-estimated the costs of interventions and activities; they were able to do much more with the budget available than estimated at the start.

8) How do similar programmes compare in terms of outputs (or outcomes) and costs?

Comparison across even similar programmes compounds aforementioned problem, amongst others because the cost of material and human inputs can be very different in different settings.

Objective II. Decision-making & Collaboration

9) Which contextual factors affected the formulation of the five subsidy frameworks?

The subsidy frameworks were formulated in the context of Dutch and international SRHR policy. Dutch SRHR policy has been consistent for more than two decades, and is aligned with international sexual and reproductive health and rights declarations and standards. Its priorities are clearly outlined in policy documents. The MFA emphasizes the importance of focusing on sensitive SRHR issues and the rights of marginal groups, areas which other donors are less keen to be involved in.

10) Which policy actors and processes influenced the formulation of the five subsidy frameworks?

The formulation of the three larger subsidy frameworks (Choices and Opportunities Fund, Key Population Fund and SRHR Fund) was initiated and led by MFA staff in The Hague. In some cases consultation with embassy staff of implementing countries or representatives of (I)NGO's took place before the formulation of the frameworks. While consulting (I)NGO's is a good practice, there is a tension between drawing on their valuable expertise and creating a conflict of interest for the NGOs involved in the policy formulation. The MFA clearly aspired to create a level playing field, and to have a thorough process of assessment.

The two smaller subsidy frameworks (Step Up Fund and Child Marriages Fund) resulted from amendments by Members of Parliament. The Child Marriages Fund lasted one year only, leading to serious concerns amongst MFA staff and organisations regarding effectiveness and sustainability of short programmes addressing complex issues.

11) What were some of the strengths and weaknesses of subsidy frameworks formulation and and implementation processes, including application and selection procedures?

The frameworks' application and selection criteria and processes are clear. However, the process is labour-intensive for applicant organizations as well as selection committees, in particular when the frameworks were formulated in such a way that many organisations could apply (Choices and Opportunities Fund, and SRHR Fund).

Different subsidy frameworks had different rules regarding whether single organisations or alliances, national or international organisations could apply. There was no convincing rationale to use different requirements for different subsidy frameworks.

Threshold criteria can exclude organisations that potentially have an added value for the MFA and achieving the objectives of the SRHR policy, for example those which are new, or led by target groups (e.g. youth led-organisations).

There are clear disadvantages to short term subsidy frameworks, as they are inefficient for both MFA staff and NGOs. Moreover, it is impossible to make a meaningful contribution to the SRHR results areas.

12) How did partners in programmes and alliances collaborate with each other?

Overall, the collaboration in the programmes was valued positively and perceived to have an added value for the implementation of the programmes. Organisations benefited from mutual learning; collaboration brought more resources together to tackle wider and more complex issues, including stronger strategic collaboration to influence policy; and partners brought together complementary skills or positions in society, which were conducive for the attainment of results.

Overall, the structure of the alliances was clear to (most) partners, and communication was good. However, the involvement of southern partners in discussions and decision-making at various stages of the programmes (formulation, developing action plans) differed strongly between programmes and was not always considered adequate.

Working in alliances involves substantial investment in coordination and communication, and therefore transaction costs. Considerable time and effort were invested to make alliances work, especially the large alliance in the Key Populations Fund. Whether these investments are worth it seems to depend on the types of activities jointly executed (for example advocacy and strategic collaboration). Understanding of the conditions and requirements for effective collaboration in alliances is still lacking.

13) How did the MFA and the partners collaborate in the programmes and how did they value this collaboration?

Collaboration between MFA and organisations is considered positive and productive. The MFA's flexibility, including the room for adaptation within the implementation of programmes and the easy access (formal and informal) to and exchange with MFA staff are considered crucial aspects of this positive collaboration. MFA staff's trust in the expertise, knowledge and experience of the collaborating organisations was also valued.

Partner organisations value highly the MFA's support for SRHR programmes, in particular for the controversial themes and marginalized groups, which other donors are less inclined to support.

Embassy commitment to and involvement in SRHR programmes was uneven. Several embassies were supportive and could offer protection or facilitate access to governmental structures in countries when needed. However, embassies' relative autonomy meant that involvement in SRHR programmes was at the discretion of senior embassy staff.

14) In what ways has MFA played a role as knowledge broker?

The MFA does not have a clearly defined description and strategy as knowledge broker, but in practice carried out several knowledge broker activities as a 'linking agent', and 'information and knowledge manager'. These knowledge broker roles were important for the realization of programme goals, and the strengthening and expansion of SRHR policy in general.

15) How do MFA staff and programme partners view reporting?

Work plans, annual and final reports are used for the MFA's monitoring and evaluation activities and public accountability. Monitoring and evaluation activities informing the reports helped improve the quality of the programme and tailor them to the needs of target groups. The functions that the MFA attributes to the reports highlight the need for high-quality reports that give detailed insights into both 'what works' and 'what does NOT work', including unintended consequences of programme activities.

There were no formal guidelines regarding the format and contents of annual and final reports, other than quantification of programme results, partly to meet demands for accountability from parliament. Flexibility in reporting was considered an asset by many organisations, but may also have affected the quality and certainly comparability of the reports.

Objective III. Sustainability

16) What are indicators and participants' perceptions of the sustainability of their programme?

Reports, the survey and the interviews were generally positive about sustainability of activities and organizations. They indicated that: many programmes led to structural improvements in service delivery (e.g. embedding activities and services in existing health and education systems) and improvement in SRHR policy; organizations' capacity was enhanced; additional funding obtained; and alliances were continued. Nevertheless, gaps in organizational capacity were noted, especially amongst small, target-group led organisations and in particular regarding M&E.

17) What are perceived opportunities for and barriers to sustaining the results of the programmes?

Various programmes were confronted with barriers to sustaining programme activities and results:

- An (increasingly) hostile international and national climate regarding SRHR, especially for key populations and sensitive issues as abortion. This has affected programmes' ability to embed activities and services in the existing health and education system, since the required political support from different levels of government (local, regional, federal, national) could not be obtained. Some governments delayed or stopped implementation.
- High national poverty levels constitute a structural barriers to sustainability of the programmes since they affect infrastructures on which programmes depend, and limit programmes' chances to obtain governmental funding.
- Long-term and core funding from the MFA, given lack of capacity and willingness of national governments and other donors is important to promote sustainability of programmes and results.

18) What, if any, measures have been taken to ensure continuation of activities or foster sustainability of the programmes or programme results?

Several measures have been taken to ensure continuation of activities and foster sustainability, including: capacity building of the implementing partners; fostering local ownership; embedding activities in health and education systems; securing funding; building an enabling environment; and knowledge-sharing to improve visibility of programmes.

Capacity building took place through mentoring and training, supported by new IT systems, important especially for standardized M&E. E-learning and train the trainer approaches made capacity building more sustainable.

Recommendations

Programme results

To improve the achievement of programme results and strengthen the assessment thereof, we recommend that the MFA:

1) Allows enough budget and time in programmes' inception phase for the joint definition of indicators and realistic target setting, involving northern and southern partners in this process. MFA should consider developing, together with NGOs, more standardised frameworks for indicators. Moreover, some programme results (e.g. more respect for sexual and reproductive rights) require qualitative assessment.

2) Make proposals more evidence-based, by making inclusion of reviews of existing quantitative and qualitative evidence a requirement. Given the resource implications, the MFA might consider commissioning a series of mixed-method systematic reviews regarding commonly used interventions (e.g. peer education; e- and m-health).

3) Requests more information about M&E methodology and findings in reports, including process evaluation of implementation; analysis of whether more vulnerable sub-groups are reached; unintended outcomes; assessment of 'what works for whom under what circumstances' (in line with realist evaluation principles). Implications for resources and capacity need to be considered in programme proposals and budgets. In order to foster more robust M&E and operational research, greater collaboration between NGOs and knowledge institutions is recommended.

4) Builds a database of SRHR program activities and costs to improve programme budgeting and planning.

We recommend that (lead) organisations:

5) Increase critical reflection on assumptions regarding the link between outputs, outcomes and impact. The use of Theories of Change (ToC), now required in the new MFA SRHR subsidy framework, is conducive for this, as assumptions about mechanisms of effect have to be made explicit before implementation. ToCs requires the validity of assumptions to be checked *before and during* implementation, and will thus facilitate making any necessary changes.

SRHR subsidy frameworks

To improve the formulation of SRHR subsidy frameworks and selection of proposals we recommend that the MFA:

1) Continues involving (I)NGOs and embassies in the formulation of subsidy frameworks, to create frameworks attuned to the circumstances at country level, the needs of particular target groups, and priorities in specific SRHR sub-areas.

2) Avoids conflicts of interest with regard to the involvement of organisations in the preparatory phase of subsidy frameworks. The MFA could consider to conduct consultations with (I)NGOs to formulate the subsidy frameworks more formally and openly, and exclude consulted organisations.

3) Avoids SRHR frameworks and programmes of short duration (1-2 years). If programmes of short duration are unavoidable, MFA and programmes should continue to enable and encourage organisations to embed them in existing programmes.

4) Explores the possibility of adapting the MFA 'Standaard Subsidiekader Ontwikkelingssamenwerking' (2006) in such a way that it allows funding programmes of longer duration (up to 10 years).

5) Ensures that if application requirements for a subsidy framework differ from others (e.g. only Dutch or international NGOs or only alliances can apply) this is based on a clear rationale.

6) Ensures that threshold criteria do not exclude organisations which may be of strategic value for the MFA, in particular, small target-group led organisations (e.g. youth led organisations).

7) Makes the application and screening process more efficient by introducing a two stage application procedure: a concept note and then a full proposal after selection of the best applications, to avoid many organisations investing time in developing full proposals.

Collaboration

To improve collaboration among MFA/embassies and organisations we recommend that the MFA:

1) Explores mechanisms, which enable a more consistent embassy involvement in SRHR programmes across countries (including for example improved communication and training).

2) Has more regular and structured communication with all partner organisations, for example annual meetings with organisations and the MFA (including embassy staff).

3) Commissions research, in deliberation with organisations, into the conditions and criteria for efficient and effective collaboration in alliances (including alliance size, types of interventions undertaken, and organization and communication structure).

To improve collaboration among organisations we recommend that the lead organisations:

4) Involve all partner organizations, in the North and in the South, in decision-making about programme formulation, planning and the implementation of activities.

To enhance MFA's and the organisations' role as knowledge brokers, we recommend:

5) The MFA first explores/defines what the role of knowledge broker should entail, and then, if deemed desirable, further develop staff capacities to fulfill this role in a more structured way. Retaining staff who have expertise in sub-themes is important to further develop this role.

6) The MFA and organisations find ways to build (more) on each other's strengths as knowledge brokers, including making more intensive use of Share-Net, the Dutch and international knowledge platform for SRHR and HIV/AIDS.

Reporting

To improve reporting on programme processes and results and to make better use of programme reports we recommend that:

1) The MFA enables staff to invest adequate time to review reports.

2) The MFA and lead organisations develop a reporting and feedback system to ensure that feedback reaches all organisations in the North and South.

3) The MFA and lead organisations ask for more critical discussion of 'lessons learned' in reports, foster critical self-reflection among programmes, and stimulate an approach of reporting mistakes or underachievements.

Sustainability

In order to foster sustainability of organisations, activities and results, we recommend that the MFA:

1. Makes long-term investments in organisations, alliances and programmes.

2. Consider core funding for organisations, instead of or in addition to programme funding to foster continuity, organizational strengthening.

3. Increase investments in capacity building and enhancing organisational capacity (including M&E), especially for small, target-group led (e.g. youth led, sex worker led) organisations.

We recommend that organisations:

4. Pay more attention for sustainability plans, at an earlier stage in the programme

5. Make organizational capacity assessment default practice.

6. Embed activities in existing health, education and community structures, but paired with risk assessment and monitoring of quality.

1. Introduction

For the period 2011-2015, the Dutch Ministry of Foreign Affairs (MFA) established five Subsidy Frameworks to finance cooperation with Dutch and international civil society organizations in the field of Sexual and Reproductive Health and Rights (SRHR – see Box 1.1). Twenty-one programmes were funded (Table 1.1).

Table 1.1. The 5 Subsidy Frameworks (2011-2015)

Subsidy Framework	CHOICES AND OPPORTUNITIES FUND	KEY POPULATIONS FUND	STEP-UP FUND	SRHR FUND	CHILD MARRIAGES FUND
Period	Jan 2011 – Dec 2014	July 2011 – Dec 2015	Nov 2012 – Dec 2015	Jan 2013 – Dec 2015	July 2014 – July 2015
Budget	€40,000,000	€35,000,000	€6,000,000	€125,000,000	€5,700,000
No. of programmes funded	4	1	1	11	4

The 21 programmes differ in fund size and period (ranging from €1,370,219 for a period of one year to €35,000,000 for a period of five years). They were all expected to address one or more of the four Result Areas of Dutch SRHR policy:

1. Ensuring that young people know more and are thus equipped to make healthier choices about their sexuality;
2. Increasing the number of people who have access to and can use contraceptives, condoms, anti-retroviral drugs and other essential sexual and reproductive health commodities;
3. Increasing the number of people using high-quality sexual and reproductive health care services at public and private clinics; and
4. Winning more respect for the sexual and reproductive rights of groups who are currently denied these rights.

Funding for the programmes expired on 31 December 2015, except for a limited extension of the SRHR Fund to mid-2016.

This report is a synthesis evaluation of the five SRHR Subsidy Frameworks. The evaluation assesses whether these frameworks have been an effective tool to support SRHR in resource-limited settings and contribute to the four SRHR result areas (Ministry of Foreign Affairs, 2016). It seeks to facilitate important learning about the design and implementation of frameworks and programmes.

Box 1.1: Reproductive and sexual health and rights: Definitions.

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so (United Nations, 1994).

Sexual health is a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence (WHO, 2006).

Reproductive rights and sexual rights are grounded in international human rights treaties. They enable people to enjoy a mutually satisfying and safe relationship, free from coercion or violence and without fear of infection or pregnancy, and they enable them to regulate their fertility without adverse or dangerous consequences (United Nations, 1994).

1.1 Goal of evaluation and evaluation questions

The Terms of Reference specify three broad objectives (Ministry of Foreign Affairs, 2016):

1. To assess whether the envisaged results of the 21 programmes have been achieved, and to what extent they have contributed to the four SRHR result areas;
2. To examine a) the efficiency and effectiveness of the decision-making process that led to the Subsidy Frameworks, and b) the collaboration between the Ministry and the partner organizations and between the partner organizations and their partners in the South.
3. To assess the sustainability of the programmes.

Related to these objectives, 18 evaluation questions were formulated (Table 1.2)

Table 1.2 Evaluation questions & methodology

Dimension	Objective I. Results
Relevance	1. Are the programme objectives relevant to the SRHR Subsidy Frameworks and the four result areas?
Results	2. To what extent have envisaged outputs and outcomes been realized? 3. Did the implemented activities lead to unexpected results and if so, which ones?
Effectiveness of intervention strategies	4. Which intervention strategies appear to have contributed to programme objectives and the four MFA result areas? a. Which interventions and intervention strategies are reported to be effective by programmes? b. What, if any, is the evidence regarding the effectiveness of interventions and intervention strategies? c. Were the logic and assumptions underpinning the log frames correct? 5. Which contextual factors have affected the results or implementation positively or negatively? 6. What has been adjusted during implementation?
Costs	7. What are programme costs in relation to results (e.g. cost per output achieved)? 8. How do similar programmes compare in terms of outputs (or outcomes) and costs?
	Objective II. Decision-making & Collaboration
Framework formulation and decision-making	9. Which contextual factors affected the formulation of the five Subsidy Frameworks? 10. Which policy actors and processes influenced the formulation of the Frameworks? 11. What were some of the strengths and weaknesses of Subsidy Framework formulation and implementation processes, including application and selection procedures?
Collaboration	12. How did partners in programmes and alliances collaborate with each other? 13. How did the MFA and the partners collaborate in the programmes and how did they value this collaboration? 14. In what ways has MFA played a role as knowledge broker? 15. How do MFA staff and programme partners view reporting?
	Objective III. Sustainability
Sustainability	16. What are indicators and participants' perceptions of the sustainability of their programme? 17. What are perceived opportunities for and barriers to sustaining the results of the programmes? What were the broader environmental, political, economic, and socio-cultural factors that impact upon sustainability of the programmes? 18. What, if any, measures have been taken to ensure continuation of activities or foster sustainability of the programme or programme results? Have (implementing) organisations been strengthened institutionally and is their capacity enhanced? If so, how?

1.2 Methodology

This evaluation used a rigorous, mixed-methods approach, adapted from established methodologies for the review and synthesis of evidence (Popay et al., 2006). We combined a desk study of secondary data (existing SRHR programme documents and academic literature) with primary data-collection through an online survey (164 respondents) and 31 semi-structured interviews (SSIs) with key stakeholders (MFA staff and staff of lead organisations (58), alliance partners (55) and implementing partners (61) - see Box 1.2). For full details on the evaluation methodology see Annex 2; since there is a lack of detailed descriptions of evaluation methodology available in the public domain on which synthesis evaluations can build, we include an extensive description of our methodology in this report.

Box 1.2: Types of organisations

- *Lead organisation*: Organisation in charge of the entire programme
- *Alliance partner*: Organisation involved in the consortium that submitted the programme proposal
- *Implementing organisation*: Organisation involved in the implementation of the programmes.

Most Northern partners were lead or alliance partner; Southern partners were usually implementing partners.

Table 1.3 summarises which methods addressed which study objectives. Objectives set out by the ToR were supplemented by two additional themes which emerged from the desk study, and were addressed through the survey and interviews: reporting and accountability, and the 'Dutch approach' to SRHR. Reporting merited further research given the quality issues of M&E and programme reports. In addition, reports suggested that the 'Dutch approach', or the specific focus on progressive SRHR issues and human rights, led to challenges and, sometimes, problematic unintended consequences. Since these were rarely reported we collected further data on these issues.

Table 1.3 Methods used, by objective

Objective	Methods
1. Results of the programmes	Desk study of SRHR programme documents and academic literature
2. Collaboration & decision-making	Survey and SSIs with key stakeholders
3. Sustainability of programmes	Desk study of SRHR programme documents
Additional theme 1: Reporting and Accountability	Survey and SSIs with key stakeholders
Additional theme 2: 'The Dutch approach' to SRHR	Survey and SSIs with key stakeholders

1.2.1 Desk study

Documentation reviewed

Time-constraints required selection of materials to review. We reviewed programme proposals and final year reports. A total of 10 out of the 21 programmes had conducted independent evaluations; we reviewed those to which we had access.

Quality assessment

Using an appraisal tool (see Annex 3), we evaluated the quality of programme documentation to determine to what extent, and with how much confidence, documents could answer the evaluation questions.

Quality assessment highlighted various design issues. Approximately one third of all programmes did not use a baseline assessment, and in several cases, the methodological rigour of the pre- and post-assessments was poor (e.g. base-line and post-test conducted in different regions) or hard to assess due to lack of methodological detail. Few programmes included tests of significance to assess the meaning of any changes observed and only two programmes included a control-group. These issues greatly limited our ability to assess programmes' effectiveness, further affected by limitations in critical analysis, for instance regarding possible confounders (factors other than the intervention which can explain any changes observed). We partially compensate for these attribution problems by juxtaposing claimed effects of interventions with evidence from systematic reviews regarding intervention effectiveness (see chapter 4).

Synthesis

We synthesized information according to the steps for narrative synthesis outlined by Popay et al. (2006), described in detail in Annex 2. Synthesis of information *within* programmes (across countries of implementation) was followed by synthesis *across* programmes, and triangulation of data from the desk study with data from the online survey, interview study and consensus conference (see below).

1.2.2 Online Survey & Interview study

Approximately 90% of respondents from Northern organisations were either lead or consortium partners, compared to less than 10% of respondents from the South. The questionnaire, pre-tested, included statements for which respondents could indicate strength of (dis)agreement, and some open questions.

Data were analysed using quantitative statistical analysis and qualitative thematic analysis.

Interviews, lasting on average 75 minutes, were conducted by experienced qualitative researchers. Staff from implementing organisations were mainly interviewed by local researchers. Some of the questions were informed by findings from the survey, enabling us to use qualitative data to interpret the quantitative results.

Using purposive and (due to time constraints) convenience sampling we interviewed 31 respondents:

- Ten MFA staff: all (available) contact persons for the 21 programmes and staff involved in the formulation of the five Frameworks.
- 21 NGO staff, involved in five programmes (one per Framework), working for five lead organisations, four alliance partners, and 11 implementing organisations.

Interviews were recorded and transcribed verbatim, with the exception of three interviews conducted in a language other than English which were translated directly from the recording. We used thematic analysis to identify patterns in responses.

1.2.3 Consensus conference

During a half day consensus conference we presented a selection of preliminary findings and recommendations, and elicited feedback from MFA, lead and alliance partners who also formulated their own recommendations and prioritized recommendations through voting. We ensured inclusion of priority recommendations in this report, if sufficiently supported by our own analysis.

1.2.4 Limitations

We acknowledge several limitations. First, in the desk study, time constraints necessitated selection of the most important documents; proposals, final reports and independent evaluations. If information in final reports and evaluation reports raised important questions, we looked for answers in other documents (e.g. operational research reports, year reports). Nevertheless, we may have missed out on some relevant information.

Second, in the interview and survey study, there is a potential bias in the sample, which is modest in size (although not small) and based on a combination of purposive and convenience sampling. It is unknown who was contacted to fill out the survey, so we have no insight in non-response. Due to time-restraints, there was no possibility to make a list of possible respondents and contact them ourselves. There was a relatively high discontinuation rate of the ones who started the survey. Possibly, partners who were more satisfied with the programme were more likely to participate. However, there is no difference between Northern and Southern partners in terms of discontinuation rates, and all questions were filled in by more than 100 respondents, which was the target for this survey. A final source of bias in terms of sampling is that the questionnaire was in English and thus excluded non-English speakers. An opening page explaining in Spanish and French that the questionnaire would be in English, with the option to end there. No-one used this option. However, two respondents answered open questions in French; these responses were included in the analysis and did not noticeably differ from other responses. Nevertheless, the views expressed may not be representative for the entire 'population' of organizations and staff members.

Third, social desirability may also have led to bias in responses. The evaluation is based on self-report. Programme reports, survey and interview responses will all have overemphasised positive aspects and de-emphasised negative ones. Organizations rely on funding, and participants will have been keen to 'sell' their programme and alliance, even though we promised anonymity and explained that responses would not affect funding. Nevertheless, many respondents offered insightful and critical reflections, as

well as positive stories. Since closed questions in the survey may also have been coloured by social desirability, it is more interesting to compare answers to different items, or to compare different groups on the same item, than to focus simply on percentages.

Fourth, implementing organisations and international NGOs were not represented at the consensus conference. Thus, we missed their input in the fine-tuning of our analysis and recommendations. We did however make sure to pay special attention to their views and experiences in our analysis of the survey and interviews.

1.3 Outline of the evaluation report

Chapter 2 summarizes Dutch SRHR policy over the last two decades and answers the evaluation questions related to the formulation and implementation of the Frameworks (Objective II a), mainly from the perspective of MFA staff. Chapters 3 and 4 address objective I. We present analysis of programme results, and assess their relevance by linking the programme objectives to the four SRHR result areas. We also evaluate intervention strategies used and the influence of contextual factors on implementation and results. Furthermore, we discuss adaptations made to the programmes.

Chapter 5 addresses Objective III and examines the sustainability of the programmes. Chapter 6 addresses the second part of Objective II, examining the collaboration between programme partners, and between programme partners, the MFA and embassies. We also describe the role of the MFA as knowledge broker in the field of SRHR. Chapter 7 summarises key findings and recommendations for the future.

2. Dutch SRHR policy and Subsidy Frameworks

- Which contextual factors affected the formulation of the five Subsidy Frameworks?
- Which policy actors and processes influenced the formulation of the Subsidy Frameworks?
- What were some of the strengths and weaknesses of Subsidy Framework formulation and implementation processes, including application and selection procedures?

2.1 Policy contexts influencing the Subsidy Frameworks

The promotion of sexual and reproductive health and rights (SRHR), including the fight against HIV/AIDS, has been a priority in Dutch international development policy for many years. Substantial funds have been made available to this end. Dutch SRHR policy is grounded in human rights - the right of everyone, regardless of age, gender or sexual orientation, to make choices about their sexuality and reproduction, as long as this does not infringe on the rights of others (Ministry of Foreign Affairs, 2016). Both international and national policy frameworks have guided the Dutch SRHR agenda.

2.1.1. International frameworks guiding Dutch SRHR policy

Dutch SRHR policies and the five Subsidy Frameworks are guided by international agreements and policies, including the 1994 International Conference on Population and Development (ICPD) (United Nations, 1994), the WHO strategy for promoting SRHR (WHO, 1994), the Millennium Development Goals, the Sustainable Development Goals (SDGs), and UN declarations on HIV/AIDS (UN 2001, 2006).

The ICPD was a landmark conference whereby diverse views on human rights, population, SRH, gender equality and development merged into a global consensus that placed individual dignity and human rights, including the right to plan one's family, at the heart of development (United Nations, 1994). Its Programme of Action (PoA) was endorsed at the Fourth World Conference on Women in Beijing in 1995 (United Nations, 1995). Both the Cairo and Beijing PoA incorporated family planning into a broader agenda of women's empowerment and reproductive rights, emphasizing that men and women have the right to be informed of, and to have access to, safe, effective, affordable and acceptable methods of fertility regulation of their choice.

The principles and language on reproductive and sexual health agreed on at the ICPD have faced opposition, but were largely maintained at later conferences, although the Millennium Development Goals (MDGs), launched in 2000, adopted a narrower approach. Four MDGs were directly linked to SRHR: gender equality and women's empowerment (MDG 3); the reduction of child mortality (MDG 4); improvement of maternal health (MDG 5); and combating HIV/AIDS, malaria and other diseases (MDG 6). Initially, MDG 5 had only one target: a 75% reduction in maternal mortality. After much debate, a target was added in 2006 to broaden the scope to universal access to reproductive health (IOB 2013).

Several of the SDGs, which replaced the MDGs in 2015, pertain to SRHR, in particular those concerning health, education and gender equality. Targets include access to SRH services, comprehensive sexuality education and the ability to make decisions about one's own health (Galati, 2015). Compared to the MDGs, sexual and reproductive *rights* feature more prominently in the SDGs.

2.1.2 Dutch SRHR approaches influencing the Subsidy Frameworks

The most important Dutch policy documents that guided national SRHR policy before and during the period 2011-2015 are listed in Table 2.1 below. They demonstrate the centrality of human rights and gender equality, and SRHR more generally, to Dutch international development policy.

Table 2.1: Policy documents informing MFA SRHR policy development

Year	Policy document name (translated to English)	Focus / priorities for Dutch development policy
2003	'*Mutual interests, mutual benefits*'	HIV and reproductive health
2006	'*Strong people, weak states*'	HIV and reproductive health
2007	'*Our common concern*'	SRHR; gender and sexuality equality
2008	*'Choices and opportunities: HIV/AIDS and sexual and reproductive health and rights in foreign policy'*	SRHR and HIV; challenges of human rights violations and coordination of agencies in the field of SRHR
2012	'*Letter to the Parliament*' ('Kamerbrief')	The four SRHR Result Areas specified with expected outcome and impact results. Human rights and SRHR.
2013	*'Justice and respect for all'*,	Sexual and reproductive rights; equal rights for women and LGBT community.
2015	Policy letter '*A world to gain - a new agenda for aid, trade and investment*'	SRHR, human rights of women and girls, and gender equality are important priorities despite shrinking Official Development Assistance (ODA) budget. Link aid and trade, eliminate child marriages.

In 2015 *'Een nieuw beleidskader voor SRGR voor de periode 2016-2012' ('A new policy framework for the period 2016-2017'* stipulates the initiation of the SRGR Partnership Fund, that will provide funding to partnerships between Dutch organisations and local, regional and international NGOs, the private sector and knowledge institutions. The format of partnerships was already developed in the policy framework '*Samenspraak en Tegenspraak*' (2014). The Dutch MFA also drafted a *'SRHR vision document'* (White Paper) in October 2015 which aims to enhance the impact of programmes in support of the four Result Areas related to young people, commodities, services and rights. The vision document reiterates the importance of these result areas, and underlines the need to further shape the Theory of Change (ToC) for SRHR to facilitate priority setting.

2.1.3 The Subsidy Frameworks

The five Subsidy Frameworks embody various aspects of the international and national policy agendas discussed above (for details see Annex 5).

The Choices and Opportunities Fund (2011-2014) focused on themes and groups mentioned in the ICPD agenda that are, across many societies, facing discrimination, marginalization and vulnerability,

including youth, and key populations such as the LGBT community, sex workers, intravenous drug users (IDUs), people living with HIV/AIDS (PLWHA), prisoners, street children, and refugees. Core themes to be covered were youth and sexuality, family planning, safe abortion and harm reduction. In addition, the Framework intended to focus on fragile states (Staatscourant 2010).

The Key Populations Fund (2011-2015) focused more specifically on universal access to HIV prevention, treatment, care and support, and key populations (LGBT; sex workers; IDUs) whose stigmatization was seen as a major access barrier. The Key Populations Fund was formulated to redress the limited attention given to key populations in the Choices and Opportunities Fund, even though this Subsidy Framework did set out to include them (Staatscourant 2011).

The third Subsidy Framework, the Step Up Fund (2012-2015), focused on one of these key populations: sex workers (Kamerstukken II 2010/11). Its rationale was that in many countries the HIV epidemic is concentrated mainly amongst sex workers, who should be empowered to step out of this work (Staatscourant 2012a). This Subsidy Framework was very specific in focus, like the fifth Subsidy Framework, the Child Marriages Fund (2014-2015). The latter emphasizes that child marriage is an infringement of universal human, women's and children's rights and, as they are often enforced upon people against their will, a breach of children's autonomy (Staatscourant 2014). Both these narrow Subsidy Frameworks were initiated by parliamentarians, respectively motion van der Staaij/Ferrier and amendment Voordewind (Kamerstukken II 2010/11; Kamerstukken 2013/2014).

In the fourth Subsidy Framework, the SRHR Fund (2013-2015), the scope was broadened again. Special attention was paid to aspects that had not received adequate attention in the previous Subsidy Frameworks, namely: integration of SRHR and HIV/AIDS; adolescents and youth; and commodities and services. Programmes could apply for three sub-funds or 'counters', which differed substantially in size: integrated programmes (Counter A, 90 million Euro); one or more of the sub-themes (Counter B, 30 million Euro); and innovative activities (Counter C, 5 million Euro) (Staatscourant 2012b).

2.2 Subsidy Framework design, formulation and selection processes

2.2.1 Requirements of the Subsidy Frameworks

This section compares the requirements of the five Subsidy Frameworks. It then analyses the key policy actors involved in policy formulation, and finally the selection of programmes. The strengths and weaknesses of these processes are discussed.

The five Subsidy Frameworks differ regarding some core requirements: whether Dutch or international organizations could apply or take the lead; whether working in an alliance[1] was mandatory or not; and which target countries to focus on (Table 2.2).

Various reasons were given for the different requirements. The Choices and Opportunities Fund is the only Subsidy Framework for which only international NGOs could be lead, based on the rationale that INGO's activities could have a demonstrable added value regarding the Dutch priority themes.

[1] In Dutch the term 'samenwerkingsverbanden' is used. The programmes themselves used the term 'alliance' or 'consortium' to refer to their collaboration format. In this evaluation we refer to all of them as alliance.

Programmes had to be led by organizations which were active in places or fields of intervention where Dutch NGOs had not yet been active, or which delivered a unique 'product' or approach.

Table 2.2: Application requirements of the Subsidy Frameworks

Subsidy Framework	Eligibility for non-Dutch organisations to apply as lead organisations	Working in alliances required?	Target countries
1. Choices and Opportunities Fund (2011-14)	Only international organizations working in ODA receiving countries[2]	No	More than 1 country
2. Key Populations Fund (2011-15)	Only Dutch organizations	Yes	Minimally in 2 Dutch 'partner countries' [3]
3. Step-Up Fund (2012-15)	Only Dutch organizations	Yes	Minimally in 2 Dutch 'partner countries'
4. SRHR Fund (2013-15)	International and national organizations and research institutes	Single organization OR Alliances	Minimally 50% of requested funding for Dutch 'partner countries' Regional spread
5. Child Marriages Fund (2014-15)	Only Dutch organizations	Single organization OR alliances	Minimally 1 Dutch 'partner country' AND 1 country that belongs to the top 20 'high-prevalence child marriages'

By contrast, the Key Populations Fund, the Step-Up Fund, and the Child Marriages Fund only allowed Dutch organizations to apply as lead. For the Key Population Fund this was justified with reference to the unique Dutch approach to HIV prevention among vulnerable groups. In the Step-Up Fund and Child Marriages Fund, the requirement to work with Dutch organisations was stipulated in the amendment.

The SRHR Fund was open for applications by international and national NGOs and research institutes. This is the only Subsidy Framework that also explicitly mentioned UN organizations and the private sector as possible partners (though they could not take the lead).

The Key Population Fund and the Step-Up Fund sought to fund only one alliance in total, on the grounds that expertise about different key populations (Key Populations Fund), including sex workers (Step-Up Fund), was scattered over various organisations. The Choices and Opportunities Fund, the SRHR Fund and the Child Marriages Fund allowed both single organizations and alliances to apply for funding. The SRHR Fund considered the inclusion of a youth organization (preferably youth-led) in the partnership an advantage. For the Child Marriages Fund, the importance of intensive collaboration with local organizations was explicitly mentioned.

[2] OECD-DAC list Official Development Assistance (ODA) (www.oecd.org/dac/stats/daclist.htm)
[3] Partner countries as defined in the Tweede Kamer (2011).

2.2.2. Formulating Subsidy Frameworks – the role of different policy actors

The Subsidy Frameworks are strongly rooted in Dutch SRHR policy; in addition several key actors and factors have informed and shaped the particular foci and formulation of the Subsidy Frameworks. The information in this section is based mainly on interviews with MFA staff.

The prominent role of central government MFA staff and the Dutch approach

MFA staff took the initiative for and the lead in designing the three largest Subsidy Frameworks (Choices and Opportunities, Key Population Fund and SRHR Fund). Most had extensive experience in SRHR, either in The Hague or in embassies, and were well informed about debates and developments in Dutch and international SRHR policies, which informed their priority setting. In interviews many MFA staff referred to the distinctiveness of the 'Dutch approach' in SRHR development cooperation and emphasized that the Subsidy Frameworks and programmes should and do focus on sensitive SRHR issues and the rights of marginal groups which other donors were less keen to be involved in.

The limited influence of embassy staff

Embassy staff were occasionally, but not systematically, involved in the development of the Subsidy Frameworks, especially when embassy staff included a health or SRHR specialist. Some of the MFA interviewees commented that the Subsidy Frameworks, and the selection of programmes, too heavily influenced by The Hague and could have benefitted from more embassy staff input.

The influence of (I)NGOs

MFA priority setting was also influenced by discussions with (I)NGO staff, although they had no formal role in developing or writing up the Subsidy Frameworks. According to one MFA informant, consulting 'the field' at an early stage is important, since it enables formulation of realistic targets, but maintaining a level playing field remains a requirement.

Consulting NGOs at an early stage of policy making may result in a 'conflict of interest', in particular when the potential candidate is involved in this phase. Some respondents noted that one of the Subsidy Frameworks was written with potentially good candidates in mind. NGOs may also inform Subsidy Frameworks by directly lobbying parliamentarians, which indeed occurred for one Subsidy Framework.

NGOs appeared in general however to be consulted to a limited extent. According to survey findings:

- Only 29% of respondents (NGO staff) agreed that the MFA had involved Northern partners in Subsidy Framework formulation, and 66% could not answer this question / statement.
- Only 25% agreed that the MFA had involved Southern partners in Subsidy Framework formulation, and 64% could not answer this question / statement.

The role of parliamentary actors

Amendments by Members of Parliament drove the two smaller Subsidy Frameworks (the Step-Up Fund and the Child Marriages Fund). These amendments demanded increased attention to two target groups, 'sex workers' and 'girls' at an increased risk of early marriage. These target groups fit the four SRHR areas, but MFA staff noted a tension between the extra focus and budget for sex workers, and the solutions proposed, and rights-based SRHR policy. The amendment on sex-workers aimed to support women to 'step out of prostitution', mainly through economic empowerment. However, from a rights-

based perspective, sex workers do not necessarily have to be enabled to step out of prostitution. Rather, they should be supported to make their own choices and protect their health. MFA staff had to negotiate this tension between competing approaches when formulating the Subsidy Framework.

The Child Marriages amendment was criticized for its focus on a group already high on the Dutch SRHR agenda and covered by some programmes in existing Subsidy Frameworks. As one MFA staff member argued, there was no need for narrow, short-term (one year) child marriage programmes, since broader adolescent SRHR interventions also contribute to decreasing child marriages. Another MFA staff member however, noted that the framing of 'child marriage' is a valuable strategy which can attract attention to the field of SRHR; 'SRHR' is too vague to appeal to politicians or the public. MFA staff again negotiated these tensions by enabling NGOs to reframe broader empowerment strategies towards child marriage.

2.2.3. Selection procedures for proposals

The Subsidy Frameworks were published in the Staatscourant, the formal communication channel of the Dutch government, and widely disseminated through international and national networks, including Sharenet, the Knowledge Platform in the field of SRHR and AIDS. The tender process and assessment criteria adhere to the 'Subsidieregeling Ministerie van Buitenlandse Zaken' (Subsidy Regulations of the Ministry of Foreign Affairs) (2006) and the 'Standaardkader Ontwikkelingssamenwerking' (Standard Framework for Development Cooperation).

Proposals were assessed based on three sets of criteria:

- Threshold criteria, pertaining to for instance the aim of the organization(s), the adequacy of the organization's financial management, the salary of board members and management staff.
- Quality of the proposal
- Quality of the organization (track record).[4]

Table 2.3 shows that the number of proposals submitted to each Subsidy Framework varied and this partly explains the highly variable success rates, ranging from 14% (SRHR Fund) to 57% (Child Marriages Fund). Out of 124 applications submitted, 38 (30%) failed to meet one or more of the threshold criteria and were not considered further.

Final selection was usually made by a team of experts, generally consisting of MFA staff (including Financial staff) and external, Dutch, consultants. Programmes for the Child Marriages Fund were selected by MFA staff only. In the SRHR Fund, a health or SRHR specialist at the embassy was also consulted about proposals concerning that country and 'rotating assessment teams' were put in place, which were changing pairs or groups of people assessing the proposals, to avoid group thinking and increase calibration in judgments.

Organizations were sent detailed feedback regarding the assessment, ranking of their proposal and reasons for rejection. They could request further feedback and, according to MFA staff, for the SRHR

[4] The contents of the criteria differed by Framework. Details can be found in the previously mentioned editions of the Staatscourant.

Fund many of them did so. In the SRHR Fund, one organization objected to the decision. This objection was reviewed and rejected by a Board of Appeal at the MFA.

Table 2.3: Number of proposals submitted, rejected and accepted for Subsidy Frameworks

Subsidy Framework (budget)	# of proposals submitted	# of proposals rejected - not meet threshold criteria	# of proposals accepted (% of total submitted)	# of objections to decision
1. Choices and Opportunities Fund *€40,000,000*	27	4 (15%)	4 (15%)	0
2. Key Populations Fund 35,0000,000	2	0 (0%)	1 (50%)	0
3. Step-Up Fund €6,000,000	2	0 (0%)	1 (50%)	0
4. SRHR Fund €125,000,000	76	31 (41%)	11 (14%)	1
5. Child Marriages Fund €5,700,000	7	3 (42%)	4 (57%)	0
Total	**124**	**38 (30%)**	**21 (17%)**	**1**

Strengths and weaknesses of selection procedures

Overall, MFA interviewees were rather positive about the tender system (mostly about SRHR and Key Population Fund), which was deemed to create a 'level playing field', offering equal opportunities to organizations to develop a relevant SRHR programme. They also thought that careful assessment according to established criteria had led to a good selection of programmes. However, they all pointed to challenges, risks and weaknesses of tender and selection procedures.

First, the process is very time-consuming, both for organizations and MFA staff, especially when the call was open to many partners, as was the case with the SRHR Fund. This tender process was considered to be inefficient, but as one MFA interviewee said "it is essential to do justice to the quality of the proposals. I don't see another way to do it more efficiently". Interviewees from organizations commented on the huge time-investment of proposal writing. One interviewee noted that for one of the SFs, the application had to be translated in Dutch, which was considered a waste of time.

MFA and NGO staff made several suggestions to make this process less time-intensive and more efficient, such as selecting proposals first on the basis of concept notes, or increasing the threshold criteria, so that fewer organizations could apply. Lessons learned from this earlier round of selection procedures (in particular from the SRHR Fund) have affected requirements for proposals for the new 2016 SRGR Partnership Fund. One MFA interviewee who had worked with both systems, summed up the differences:

> *In the new partnerships we focus on two of the four result areas; only Dutch NGOs can submit proposals in close collaboration with international and local NGOs; only ToC and Track Record instead of extended project proposals with budgets; and submitting before the summer period, to avoid NGOs having to develop the proposals during the entire summer.*

Second, according to some of the MFA interviewees the inclusion of an 'innovation counter' in the SRHR Fund was in hindsight deemed an inefficient way to generate innovative interventions. This 'counter' attracted too many proposals, while the requirement of demonstrating a track record was problematic, as organizations could not be expected to show their experience with interventions that were supposed to be innovative. It was suggested that other ways should be found to generate innovative programmes.

Third, concerns were expressed that the threshold criteria might have disadvantaged small or new organizations, especially Southern or youth organisations. An internal MFA evaluation note about the SRHR tender observed that few proposals were submitted by partners from the South and reasons for that should be considered. The note also observed that the call for proposals was only disseminated in Dutch and English, not in French, which might explain the limited involvement of Francophone Africa.

2.3 Conclusions

Formulation of Subsidy Frameworks: context and procedures

Dutch SRHR policy has been consistent for more than two decades, and is aligned with international sexual and reproductive health and rights declarations and standards. Its priorities are clearly outlined in policy documents and MFA staff adhere strongly to and advocate for this rights-based approach. The evaluated Subsidy Frameworks are formulated in the context of this international and Dutch SRHR policy, with a strong emphasis on sensitive SRHR issues (like abortion) and the rights of marginal groups, which other donors were less keen to be involved in.

The MFA is constantly engaged in policy dialogue with other actors in the field (including (I)NGOs). Consultations with these organizations, including during the process of Subsidy Framework design, are not formally structured. While consulting (I)NGO's is a good practice, there is a tension between drawing on their valuable expertise and creating unfair disadvantages for other organisations.

While MFA staff play a central role in Subsidy Framework formulation, Members of Parliament, through amendments, can influence these frameworks. The amendments proposed are not necessarily (fully) in line with a reproductive rights approach, but MFA staff have pragmatically sought to negotiate the tension between the partly competing approaches. There are, however, disadvantages to short (one year) or narrowly defined Subsidy Frameworks resulting from the amendments (Child Marriages Fund and Step Up Fund). It is also difficult to achieve the aims of this type of SRHR programme in a short time period.

Selection procedures: strengths and weaknesses

Application procedures for Subsidy Frameworks are clear, but the process is labour-intensive for the organizations. The system to assess proposals is thorough, but time-consuming for MFA, especially when the Subsidy Framework is broadly defined, and thus enabling many organisations to submit a proposal (which was the case for Choices and Opportunities Fund and SRHR Fund).

Different Subsidy Frameworks had different requirements. As organisations worldwide have adopted the SRHR approach and the capacity of organisations to carry out programmes differs hugely, this

differentiation in requirements is not justified, as long as applying organisations can meet the requirements and criteria of the Subsidy Framework.

Threshold criteria, while mandatory within current MFA subsidy regulations, can exclude organisations which might have added value, for example those which are new, or led by target groups (e.g. youth-led). However, lowering the threshold criteria (if possible) will increase the number of applicants, which in turn makes the process more competitive (forNGOs) and more time and resource intensive (for MFA).

3. Programme results

- Are the programme objectives relevant to the SRHR Subsidy Frameworks and the four Result Areas?
- To what extent have envisaged outputs and outcomes been realized?
- Did the implemented activities lead to unexpected results and if so, which ones?
- What are programme costs in relation to results (e.g. cost per output achieved)? How do similar programmes compare in terms of outputs (or outcomes) and costs?

This chapter analyses the twenty-one programmes' results based on the data available from their annual and final reports. The quality and quantity of written programme documentation varied enormously; these inconsistencies presented a serious limitation to our analysis.

3.1 Relevance: Intended programme contributions to result areas

As mentioned in chapter 1, the Dutch MFA seeks to address four Result Areas. We have mapped the potential contributions of the 21 programmes to these Result Areas (Table 3.1). The five Subsidy Frameworks cover the four Result Areas well, although Area 2 is under-represented. According to one of the MFA informants, NGOs were considered to have less added value in this area, compared to some international organizations (e.g. UNFPA).

About half of the programmes cover three or four result areas. This may create synergies in activities, but there is also a risk of spreading activities too thinly. Programme objectives and interventions are in general logically aligned with the objectives of the SRHR Subsidy Frameworks. That is, they are 'on target'. However, some target groups mentioned in the Choices and Opportunities Fund have not been covered (street children); others (e.g. refugees and prisoners) have been included in only very few programmes.

3.2 Defining indicators and setting targets

Interview respondents indicated that organisations considered defining mutually exclusive indicators and establishing realistic targets difficult tasks. This process of definition was mostly led by the lead organisations. Sometimes, they asked M&E staff of the partner organisations in the countries of implementation to come up with country-specific indicators. In other programmes, the decision-making process happened without any involvement of Southern partners, perhaps due to time-constraints. In order to set realistic targets, the organisations took into account national and local statistics (if available), and their own past achievements, and budgetary constraints.

The degree of collaboration between lead, alliance, and implementing organisations in target-setting also varied. A surveyed staff member of a lead organisation indicated that, due to time-constraints in the inception phase, targets had sometimes been set hastily and without any involvement of the

Southern partners. As a consequence, targets had to be adjusted (usually downwards) during implementation to be more realistic.

Table 3.1: Intended coverage of result areas, by programme

Subsidy Framework	Programmes	Result Area				Total
		1 More knowledge & healthier choices (young people)	2 Access commodities	3 Use quality SRH services	4 Sexual & Reprod Rights	
Choices and Opportunities Fund (2011-2014)	Adolescent, Young People and Sexuality	■		■		2
	Community Action on Harm Reduction (CAHR)			■	■	2
	Global Program to Increase Women's Access to Safe Abortion	■	■	■	■	4
	Improving Access to Family Planning (IAFP)		■	■		2
Key Populations Fund (2011-2015)	Bridging the Gaps (BtG)			■	■	2
Step Up Fund (2012-2015)	Stepping Up Stepping Out II (SUSO)	■		■	■	3
SRHR Fund (2013-2015)	Access Services and Knowledge (ASK)	■	■	■	■	4
	Faith to Action Project	■	■		■	3
	Global Dialogues	■			■	2
	Keep It Real	■				1
	Link Up	■	■	■	■	4
	Making SRH Work for the Next Generation	■	■	■		3
	Men Care+	■	■	■	■	4
	MI+	■		■		2
	Netherlands HER Project	('women workers')		■	■	2/3
	SHARP		■	■	■	3
	Staying Alive!	■		■	■	3
Child Marriages Fund (2014-2015)	Suddenly Not a Child Anymore	■		■		2
	No, I Don't…	■	■		■	3
	Unite Against Child Marriage (UACM)	■		■	■	3
	That's No Way To Marry!	■		■	■	3
Total		**17**	**9**	**16**	**15**	

In addition to targets being too ambitious, there were sometimes too many. An interviewee from a lead organisation observed that this complicated both the implementation and the reporting afterwards. Overall, the challenge in setting targets, then, was to make them, in the words of an Ipas staff member, 'ambitious but not delusional'.

The relevance of some targets was questioned by a considerable number of interviewees from the organisations and MFA. Organisations criticized numerical targets for offering a 'false sense of security', and for revealing little about the impact of a programme. Furthermore, pre-setting targets can go against participatory aims. For the Bridging the Gaps (BtG) programme, pre-defined targets clashed with a programme design in which the actual desires of drug users inform programme goals and activities throughout the implementation period.

MFA staff members largely agreed with these observations, identifying the following requirements:

- Room for target adjustments during programme implementation
- 'Bottom-up' target setting with Southern partner involvement
- Indicator standardisation, because of the wide range of NGOs that use their own M&E indicators

However, MFA staff felt room for manoeuvre was restricted due to the parliament's explicit, and rather inflexible, request for progress indicators and targets.

3.3 Results: Programme outputs and some outcomes

As requested by the MFA and Dutch parliament, most reports devoted considerable space to the description of quantitative targets, and results. Reported results were mostly at *output* level (concrete activities performed as part of the intervention or programme e.g. people trained or 'reached', reports written). There were fewer reported *outcomes* (short- and medium-term effects of an intervention's outputs, mainly in terms of knowledge, attitudes and behaviour) and virtually no *impac*t results (deeper, long-term health effects e.g. maternal mortality) (OECD, 2010). Outcome and impact are inherently more difficult to measure. It was often unclear how the output results had been measured, or how reliable the reported M&E strategies were. The organisations mentioned that M&E activities were indeed often challenging, especially when dealing with taboo SRHR topics that would not be directly observable or measurable.

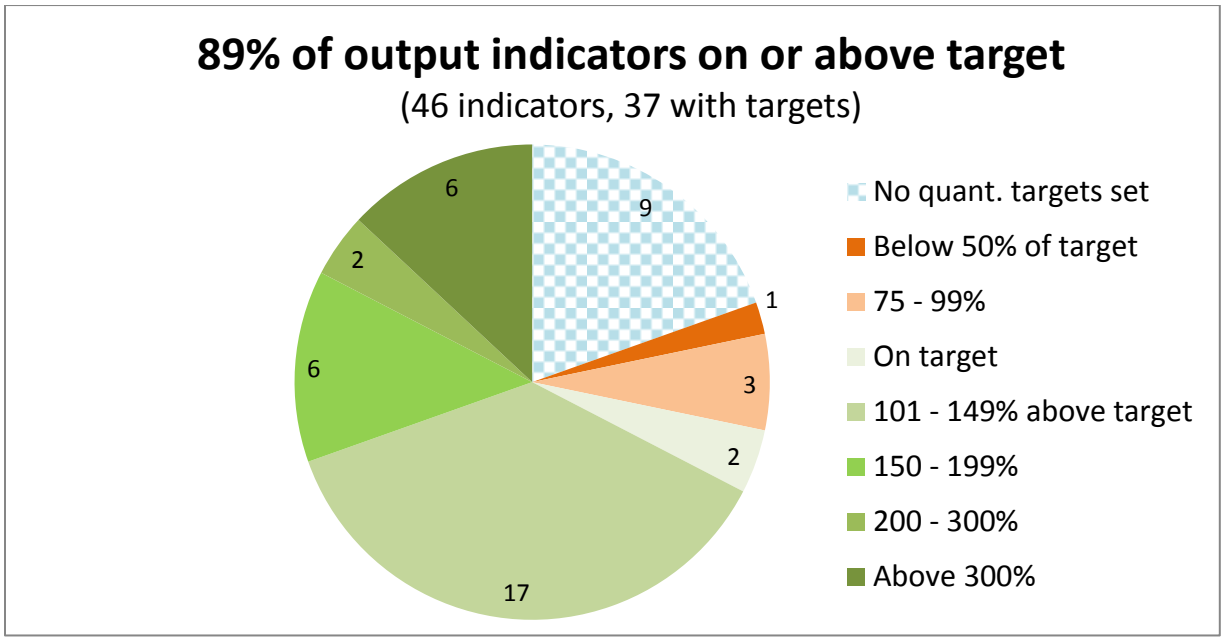
This section summarises these data, in particular comparing targets set with outputs or outcomes achieved. We also discuss their implications. The graphs below show the number of target indicators for each Subsidy Framework (i.e. all its programmes) which were exceeded or fell below target (expressed as % above or below target). The graphs are followed by an analysis of the nature of indicators that yielded consistently high or low results. For the target results of each programme see Annex 4.

3.3.1 Choices and Opportunities Fund (2011-2014)

Out of all indicators (n=46) that were used by the four programmes in the Choices and Opportunities Fund (See Figure 3.1a), nine indicators belong to the category 'no quantitative targets set'. This category

actually refers to a higher quality method for assessing results, discussed in more detail in section 3.4: indicators measured not in relation to set targets, but on the basis of pre- and post-intervention tests or through the use of a control group. Figure 3.1a shows that the Choices and Opportunities Fund programmes reached or exceeded 89% of its 37 set targets. Four indicators were below target.

Figure 3.1a: Choices and Opportunities Fund: Results against targets



Indicators scoring well above target

Figure 3.1b and Table 3.2 summarise the nature of the indicators that scored well above target, by MFA result area and then by types of indicator.

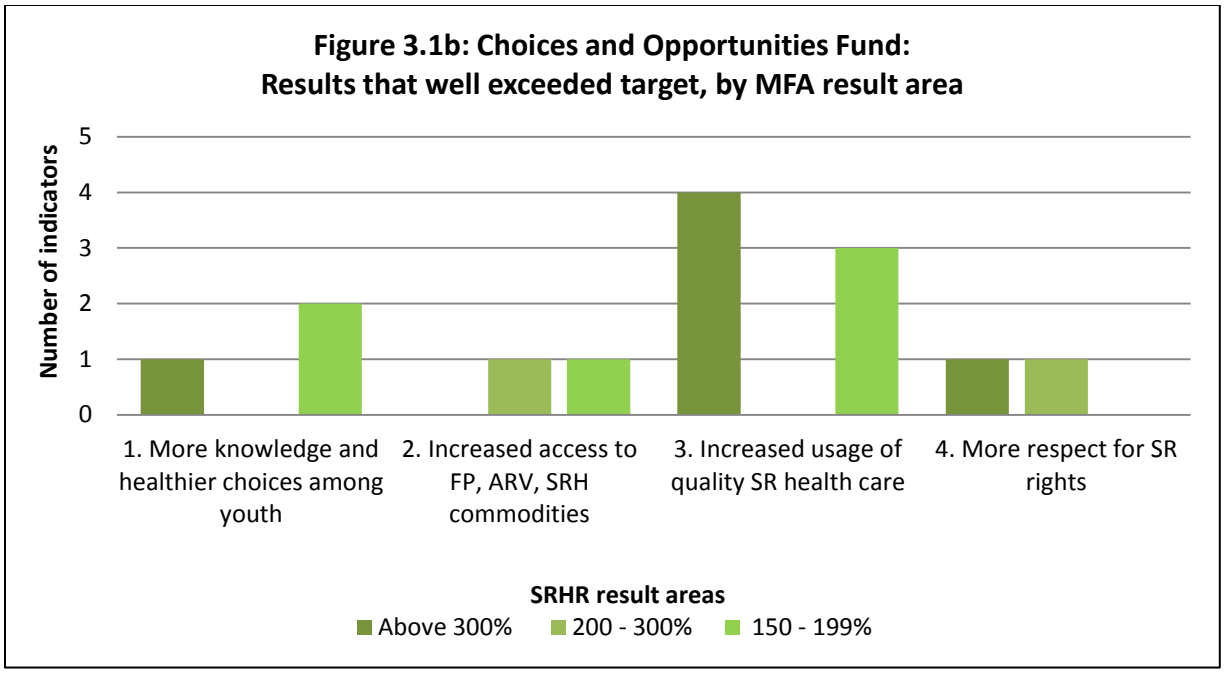


Table 3.2: Choices and Opportunities Fund: Indicators scoring well above target

CHOICES AND OPPORTUNITIES FUND					
Meta-indicator	**Output/outcome indicator**	**150-199%**	**200-300%**	**> 300%**	**TOTAL**
People receiving SRH services	- Number of people who received specific SRH care - Number of partners that provide specific SRH care - Number of SRH care treatments provided - ***Improved health seeking behaviour***	**5**		**4**	9
Advocacy/policy-related activities	- Advocacy activities - Policy documents developed - Policy dialogues		**2**		2
People trained	- Number of health care staff, teachers, facilitators, service providers, officials, organizations or community workers sensitized and / or trained	**1**			1
People reached	- Number of people reached by campaign / who have received information - Number of clicks from project website to SRHR information			**1**	1
Monitoring activities	- Partners monitoring / reporting improvement - Mid-term evaluations			**1**	1
TOTAL		6	2	6	

Bold italic = outcome result

The majority of indicators well above target are for the provision and uptake of sexual and reproductive health care (result area 3). The four indicators in this category which exceeded target by 300%+ were part of International Planned Parenthood Federation (IPPF) "Adolescents, Young People and Sexuality" programme (Fig 3.1b). In its annual and final reports, IPPF did not give concrete explanations for (over)achievements on SRH service-related targets, but mentioned strategies which might have generated success:

- focusing on *youth participation* and *youth empowerment*
- effective delivery of *youth friendly* SRHR services
- *outreach* to marginalised and rural populations

The programme's decision to set considerably higher targets in 2015 (the extension year) following its successes might reflect both the effectiveness of its work and, in retrospect, that the targets for the period 2011-2014 were set too low.

For the other categories of indicators scoring well in this Subsidy Framework (Table 3.2 below), e.g. people trained or people reached, it is not clear what these target results mean on the ground. Reaching or training (many) people does not necessarily imply change in knowledge and behaviour.

Numbers are also easily overestimated in these domains due to double-counting. For instance, Ipas reported that overachievement by more than 300% on "the number of women who attended Ipas supported interventions that promote women's knowledge, skills, social support, and ability to obtain safe abortion care" might be an overestimate due to women attending multiple events. Such acknowledgments – absent in most other programme reports – highlight that reported figures should be interpreted with caution and carefully weighed against the quality of the adopted M&E strategies.

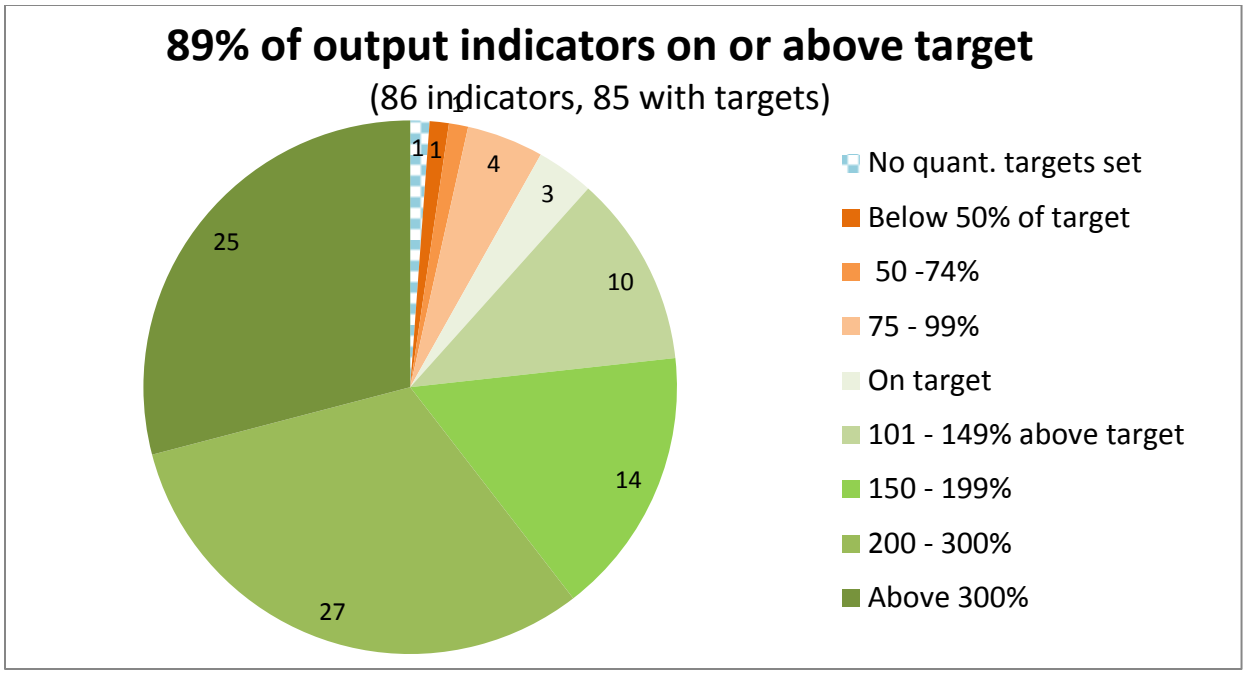
Indicators with results below 50% of the envisaged target

Only one programme, "Improving Women's Sexual and Reproductive Health and Rights" (Ipas), reported an indicator for which the results were below 50% of the target. The goal was to have the (sub-)national authorities of 13 new countries commit to contributing financially to comprehensive abortion care. This happened in six countries – which, in itself, seems a tremendous accomplishment rather than a failure. Given the difficulty of achieving this structural change, the target might just have been set unrealistically high to begin with.

3.3.2 Key Populations Fund (2011-2015)

This Subsidy Framework included one large programme, Bridging the Gaps (BtG), which reached or exceeded 89% of its 85 set targets (see figure 3.2.a). Six indicators were below target.

Figure 3.2a: Key Populations Fund: Results against targets



Indicators with results well above target

Figure 3.2b and Table 3.3 summarise the nature of the indicators that scored well above target, by MFA result area and then by types of indicator (again, mainly output indicators). According to BtG's final report, the successful delivery of almost all target outputs and outcomes could be explained by a combination of factors:

- Targets originally set too low
- Large amounts of additional co-funding obtained by several partners, particularly with regard to the objective of 'improving the human rights of key populations'. This enabled the implementation of many more activities, especially in the LGBT People Project and People who Use Drugs Project which managed to secure much more additional funding than the Sex Workers Project.

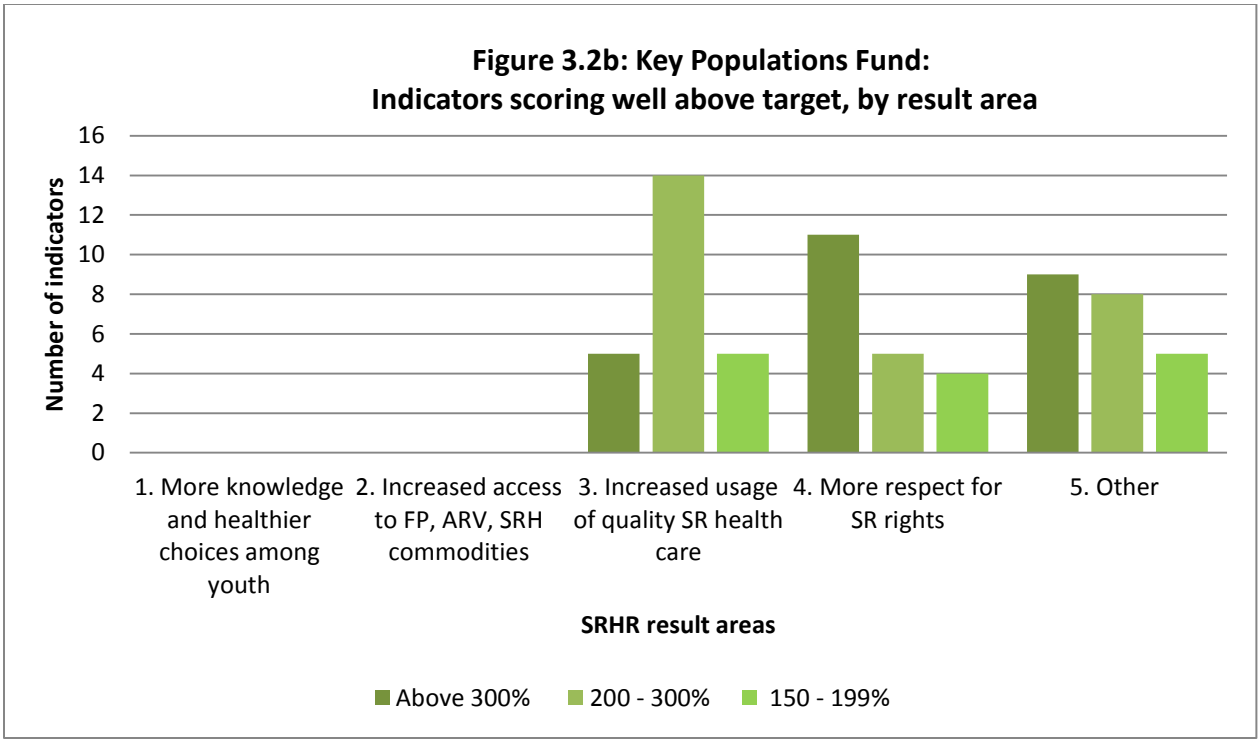


Table 3.3: Key Populations Fund: Indicators scoring well above target

KEY POPULATIONS FUND					
Meta-indicator	**Output/outcome indicator**	**150-199%**	**200-300%**	**> 300%**	**TOTAL**
Needs assessment performed	- Needs assessments - Baseline surveys - Assessment reports	**4**	**4**	**2**	10
Written documents produced	- Programme plans, guidelines - Reports, publications developed and/or published		**7**	**2**	9
Advocacy/policy -related activities	- Advocacy activities - Policy documents developed / - Policy dialogues	**3**	**2**	**4**	9
People trained & sensitised	- Number of health care staff, teachers, facilitators, service providers, officials, organizations or community workers sensitized and/or trained	**2**	**1**	**5**	8
Meetings organized	- Number of meetings organized for/by different stakeholder groups		**3**	**3**	6
Monitoring activities	- Partner monitoring - Reporting improvement - Mid-term evaluations		**4**	**1**	5
Support offered	- Resources/support given to partners, target groups and/or key actors		**2**	**3**	5

Planning activities	- Number of people and partners developing and/or implementing a strategic plan	**1**	**2**	**1**	4
People reached/contacted	- Number of people reached by campaign / Number of people who have received information - Number of clicks from project website to SRHR information	**2**	**1**		3
Media campaigns organized	- Press releases / (social) media toolkits	**1**		**1**	2
Sustainability	- ***Number of partners that can continue activities independently***			**2**	2
People receiving service	- Number of people who received specific SRH care - Number of partners that provide specific SRH care - Number of SRH treatments provided - ***improved health seeking behaviour***		**1**		1
Attitudinal change	- ***Partners experiencing a positive change in their environment towards human rights of key populations***	**1**			1
Collaboration within programme	- Number of linking and learning opportunities within the programme			**1**	1
TOTAL		14	27	25	

Bold italic = outcome result

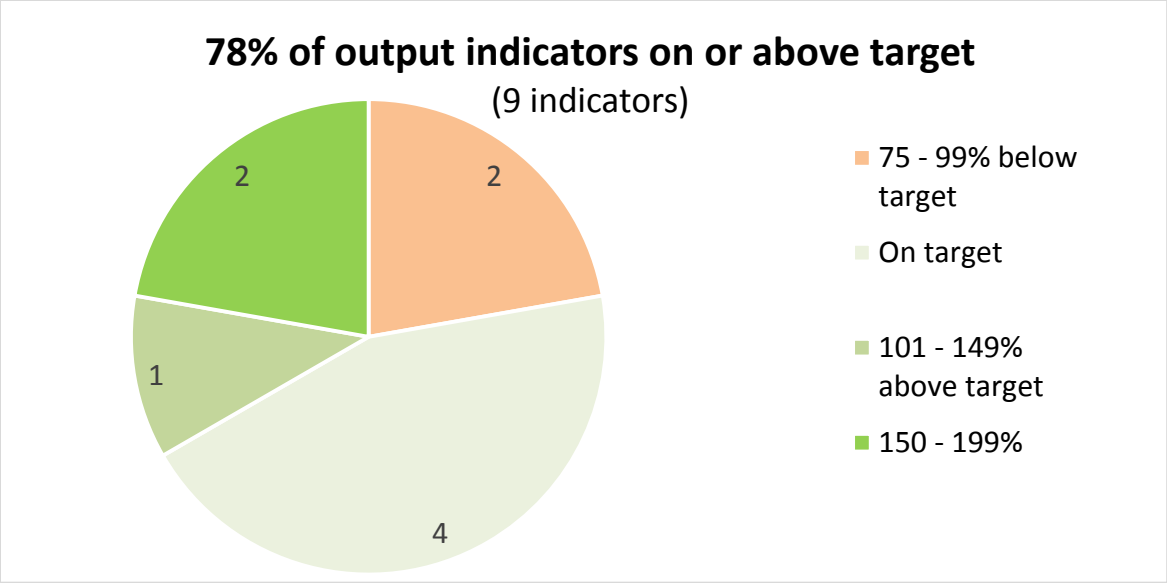
Indicators with results below 50% of the envisaged target

Only one indicator remained below 50% of the target. Instead of ten (joint) policy position papers, BtG generated only three such papers. While no specific explanations were given, the final report mentioned that, despite the underachievement of this target, there had been numerous joint contributions by global partners to ensure that key populations are meaningfully involved and represented in the formulation and implementation of global guidelines, policies, and strategies.

3.3.3 Step Up Fund (2012-2015)

The Step Up Fund contained two programmes: Stepping Up Stepping Out (SUSO) II and Stepping Stones. Their reports contained many quantitative results, but initial targets were mentioned for only nine indicators (SUSO Annual Report 2015; see also CIDIN 2016). Out of the nine indicators used by the Step Up Fund, seven (78%) reached or exceeded the target (Figure 3.3a). Two indicators were below target.

Figure 3.3a: Step Up Fund: Results against targets



Indicators with results well above target

In SUSO, two indicators were well above target were:

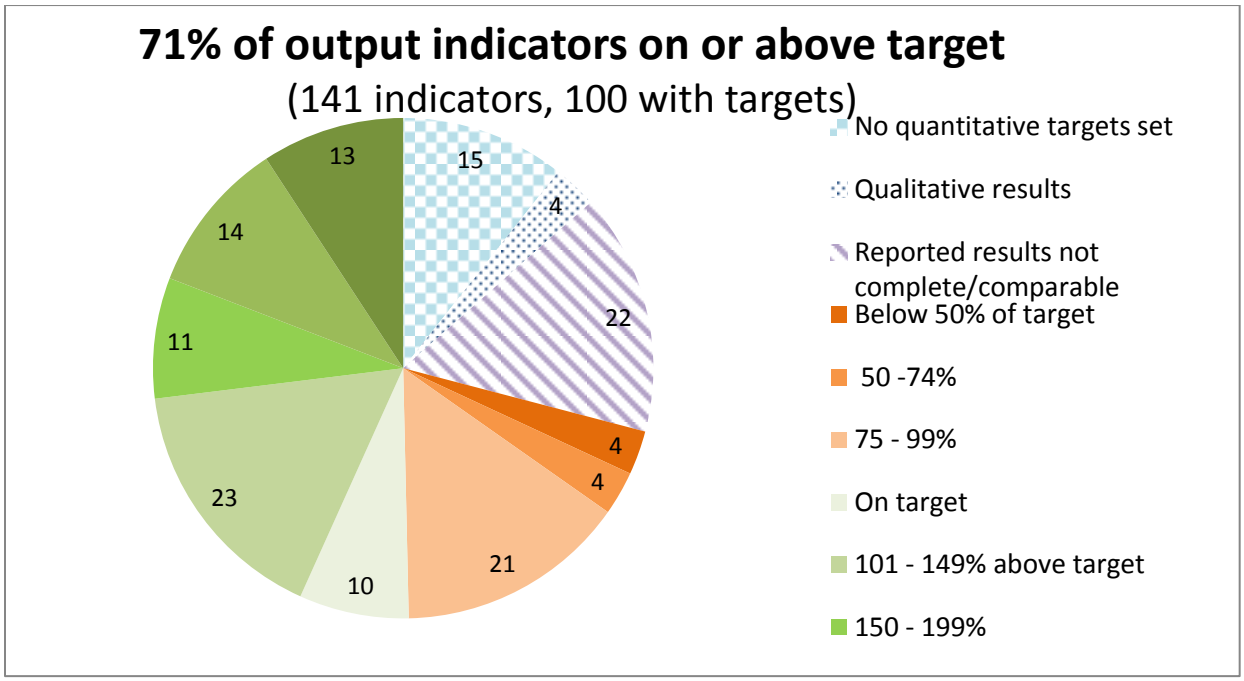
1. At least 20,000 sex workers will have taken part in initiatives that address specific needs related to their health, well-being and position in society (examples: drop-in centres, child care, social events and training for caregivers).
2. At least 20,000 sex workers will have access to sex worker friendly health care and psycho-social services.

The final report states that the results for these and other indicators had increased significantly in the last year of the programme due to an increase in numbers of partners and additional investment in organisational and technical capacity building during the initial phase of the programme. For the indicators pertaining to economic empowerment, the report notes that it took a few years of 'trial and error' before interventions aiming at economic empowerment, a relatively new issue for many partners, had been successfully implemented. These observations point to the rewards of investment, experimentation, and a need for longer-term commitments, in order for programmes to have any visible effects.

3.3.4 SRHR Fund (2013-2015)

Figure 3.4a shows that the SRHR fund programmes reached or exceeded 71% of the 100 targets for which data were relevant and available. A total of 29 (29%) of these indicators were below target. See Annex 4 for details of each programme's targets.

Figure 3.4a: SRHR Fund: Results against targets



Indicators scoring well above target

In the SRHR Fund, results for indicators pertaining to *sensitization, training*, and *information provision* are consistently high. Some programmes linked the success of these interventions to the digital channels deployed, enabling them to reach a large population. However, we should be careful to infer effects on people's attitudes and behaviour arising from people using digital media. A similar note of caution can be made with regard to the reported successes in the delivery and uptake of specific SRH care. For instance, in some cases, this meant programmes had been providing more contraceptive commodities than envisaged, yet provision does not necessarily imply the use of such commodities.

Fig 3.4b: SRHR Fund:
Indicators scoring well above target, by result area

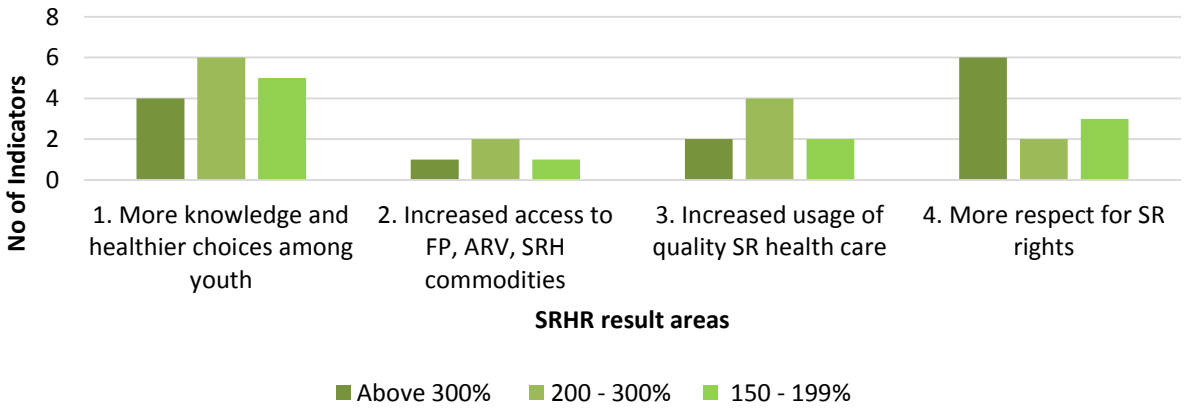


Table 3.4: SRHR Fund: Indicators scoring well above target

SRHR FUND					
Meta-indicator	**Output/outcome indicator**	**150-199%**	**200-300%**	**> 300%**	**TOTAL**
People trained	- Number of health care staff, teachers, facilitators, service providers, officials, organizations or community workers sensitized and/or trained	**2**	**6**	**7**	15
People reached/ contacted	- Number of people reached by campaign - Number of people who have received information - Number of clicks from project website to SRHR information	**4**		**5**	9
People receiving service	- Number of people who received specific SRH care - Number of partners that provide specific SRH care - Number of SRH treatments provided - ***Improved health seeking behaviour***	**3**	**2**	**1**	6
Meetings organized	- Number of meetings organized for/by different stakeholder groups		**3**		3
Media campaigns organized	- Production of films & audience of these films		**2**		2
Advocacy / policy-related activities	- Advocacy activities - Policy documents developed - Policy dialogues	**2**			2
Attitudinal change	- ***Number of men (and women) with changed views on contraceptive use***		**1**		1
TOTAL		11	14	13	

Bold italic = outcome result

Indicators with results below 50% of target

Only 4 indicators were reported to be below 50% of the envisaged target:

- Improvement of LGBT integration in participating organisations' networks (Global Dialogues)
- Number of men reached in counselling on domestic violence in clinics (MenCare+)
- Number of schools that have integrated the Comprehensive Sex Education (CSE) curriculum into their 5-year plan (Keep it Real)
- Number of agreements between the health bureau and the education bureau to ensure sustainability of CSE linkages with schools, groups and health facilities (Keep it Real)

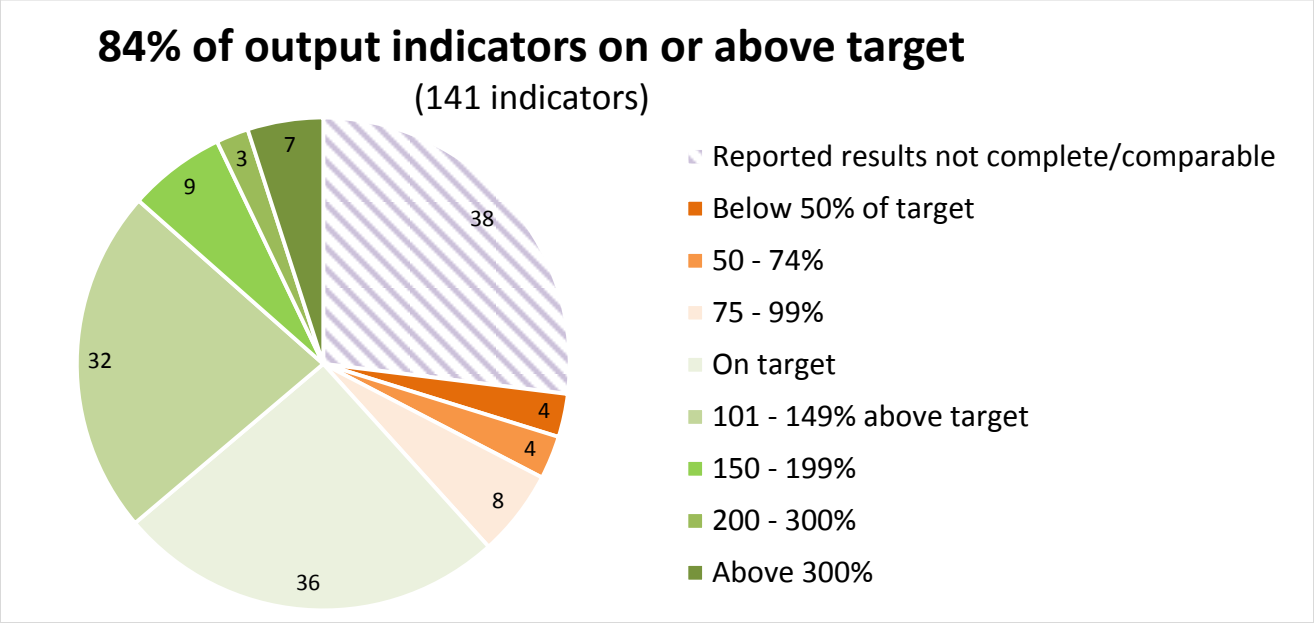
Given the sensitive and deeply institutional nature of the problems addressed here (LGBT, domestic violence, and CSE), the programmes attributed the lower achievements for these indicators mainly to contextual hindrances that prevented them from fully tackling the issues (see chapter 4).

3.3.5 Child Marriages Fund (2014-2015)

Of all indicators (n=141) that were used by the four programmes in the Child Marriages Fund, 103 indicators qualified for inclusion into our analysis, because the reported results for the remaining 38 indicators appeared to be incomplete or inconsistent. One report did not report any initial targets.

Figure 3.5a shows the Child Marriages Fund programmes reached or exceeded 84% of its targets (87 out of 103 targets); 16 indicators were below target. Annex 4 provides details for each Programme's targets.

Figure 3.5a: Child Marriage Fund: Results against targets



Indicators scoring well above target

Again, targets were exceeded mainly for indicators concerning numbers of people reached or trained – which do not necessarily reflect behavioural or attitudinal change (See Fig 3.5b and Table 3.5). Some indicators also appear to have been set low, even considering the short duration of the programmes (one year). One programme, for instance, aimed to improve the knowledge and skills of three health workers in a certain district; it managed to achieve this for 15.

Indicators with results below 50% of target

Four indicators did not achieve their targets:

- Number of schools that are more girl friendly (46%) (UAMC)
- SMS registration system to receive feedback from the patient who visited the clinic (0%) (No, I Don't …)
- 240 police officers have more knowledge about child marriage (35%) (No, I Don't …)
- 80 trainers trained in distributing life skills and SRHR information to girls and boys (46%) (That's No Way To Marry!)

Although, again, most of the reports do not provide explicit explanations for the discrepancies between the set targets and actual results, the "No, I Don't…" programme mentioned capacity and time-constraints as reasons for the lack of a fully functional SMS registration system at the end of the one-year programme. Other instances of underachievement can probably also be attributed to the short duration of the child marriages programmes.

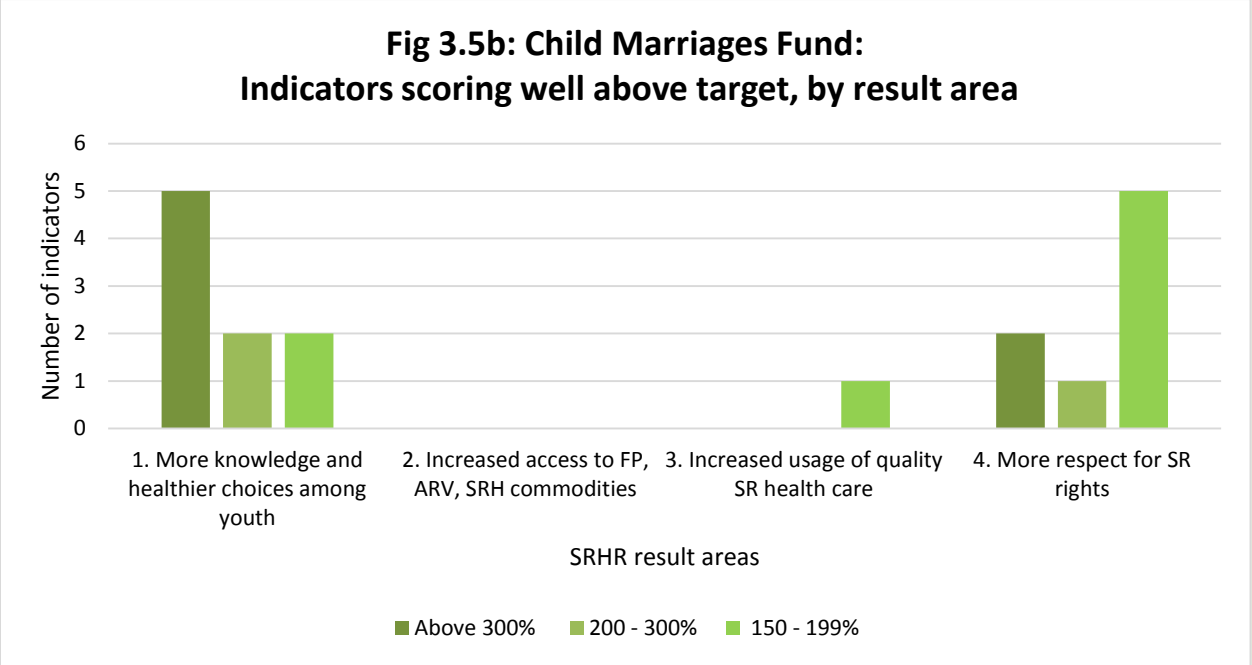


Table 3.5: Child Marriages Fund: Indicators scoring well above target

CHILD MARRIAGES FUND					
Meta-indicator	**Output/outcome indicator**	**150-199%**	**200-300%**	**> 300%**	**TOTAL**
People trained	- Number of health care staff, teachers, facilitators, service providers, officials, organizations or community workers sensitized and/or trained	**3**	**1**	**1**	5
People reached/ contacted	- Number of people reached by campaign - Number of people who have received information - Number of clicks from project website to SRHR information	**2**		**2**	4
Meetings organized	- Number of meetings organized for/by different stakeholder groups			**3**	3
Written documents produced	- Program plans, working documents, guidelines, reports, publications developed and/or published		**2**		2

Advocacy/policy-related activities	- Advocacy activities - Policy documents developed - Policy dialogues	**2**			2
People receiving service	- Number of people who received specific - SRH care / number of partners that provide specific SRH care / number of SRH treatments provided - ***improved health seeking behaviour***	**1**			1
Planning activities	- Number of people and partners developing and/or implementing a strategic plan			**1**	1
	TOTAL	8	3	7	

Bold italic = outcome result

3.4. Results: Measuring meaningful change

So far, we mainly discussed results at the level of *outputs* (concrete activities performed). We encountered several challenges in our attempt to assess *outcome* (e.g. behaviour change) and *impact* (e.g. health outcome) results. These **challenges stem mainly from the types of indicators reported in programme documentation**.

First, outcome data were less often reported and virtually none of the programmes reported on impact. Second, when programmes did report outcomes, it was hard if not impossible to assess whether a meaningful change had occurred. Although approximately 70% of the programmes conducted a baseline assessment, many pre- and post-test studies were affected by quality issues (e.g. pre- and post-test not in the same region). Lack of methodological information usually precluded quality assessment. In addition, very few pre- and post-test comparisons included tests of significance, precluding assessment of whether any observed differences were meaningful, that is, not attributable to chance. Third, only two programmes (MI+, Global Dialogues) included comparison with a control group.

Below, we discuss Men Care+ as an example of a programme which used a relatively rigorous design, including pre- and post-tests and tests of significance, providing greater insights into its potential effectiveness compared to other programmes. However, the programme did not use a control group. The two programmes which did (Global Dialogues, MI+) are not discussed here since for both practical and ethical reasons it will rarely be feasible for NGOs to use a control group. MI+ and Global Dialogues both applied through the 'innovation counter' in the SRHR Subsidy Framework. Proposing a new form of intervention made demonstration of effect particularly important. In addition, it is no coincidence that these programmes, as well as MenCare+ are amongst the few programmes which partnered with a knowledge institution (Emory University/Deloitte; Royal Tropical Institute/Amsterdam). Such partnership may be a pre-condition for measuring programme effectiveness, especially given the complexity of programme, which generally include a multitude of multi-level interventions, implemented in a range of countries and contexts.

MenCare +

MenCare+ sought to enhance SRH status of women and men by changing harmful social and cultural behaviours and norms, especially concerning masculinity, by engaging young and adult men as

caregiving partners and addressing inadequate SRH information and services. It was implemented in four countries (Brazil, Rwanda, Indonesia, and South Africa) and included six integrated and complementary interventions, addressing the MFA's four result areas (Table 3.6).

Table 3.6: MenCare + interventions by Result Area

Result Area	Interventions
1 and 2	a. SRHR/caregiving group education with young men. b. Fatherhood group education. c. Community Campaigns (MenCare).
3	d. Health sector training on engaging men/fathers in SRHR and MNCH. e. Men's (perpetrators') counselling to stop intimate partner violence.
4	f. Advocacy on engaging men in SRHR, MNCH and stopping sexual and gender based violence (SGBV), involving the health and legal sector, at district, national and international level.

Table 3.7 contains a selection of the first six indicators pertaining to outcomes and impacts, compiled from the MenCare+ 'Outcome Measurement Report'. Precise Measurements differed per country; although they addressed the same domains (e.g. gender equity attitudes) this complicates comparison.

Table 3.7: Outcome and impact results from Mencare + (SRHR Fund)

Indicators		**Brazil** men	women	**Indonesia** men & women	**Rwanda** men	women	**South Africa**
1.1.1a % of participating young men have more gender equitable attitudes	Pre-test / baseline	43.3%	22.2%	12.5%	23.96%	23.15%	*p* = between .020 and .000
	Post-test / end line	41.4%	41.7%	43.7%	28.07%	26.71%	
	Statistically signfic.	No	No	Yes	Yes	Yes	*Yes*
1.1.1b % of participating young men & women use contraceptives, including condoms at latest high-risk sex	Pre-test / baseline	50,1%	14,3%	49.4% never use condoms	Response rates for sexually active young people were too low to present meaningful results.		57.1%
	Post-test / end line	62,4%	62,4%	51.8% never use condoms			68.0%
	Statistically signfic.	**No**	**Yes**	**No**			**Yes**
1.2.1a % of participating men attend prenatal care visits	Pre-test	Sample was too small (n=26) to detect a change in men's participant in antenatal care.		93.5%	Control: 38.16% Intervent.: 34.25%		?
	Post-test			97.2%	Control: 45.01% Intervent.: 68.77%		72%
	Stat. significant				**Yes**		**?**
1.2.1b % of participating couples communicate about family planning	Pre-test	Often: 8.3%		Often: 17.2%	Control: 69.35% Intervent.: 67.78%		77.7%
	Post-test	Often: 14.6%		Often: 25.6%	Control: 54.16% Intervent.: 75.86%		81.1%
	Stat. significant	**No**		**N.A.**	**Yes**		**No (?)**
1.2.1. Extra: % of fathers participated in caregiving ONLY INDONESIA	Pre-test	Very often: Play with child: 20.4% / Talk with child: 4.3% / Help with homework: 6.4%					
	Post-test	Very often: Play with child: 38.1% /Talk with child: 15.0% / Help with homework:11.1%					
	Stat. significant	**Yes**					

The following key findings can be distilled from the table.

- Significant change in terms of ***gender equitable attitudes*** (1.1.1a) in three out of four countries; in Indonesia, Rwanda and South Africa, but not Brazil. Here however, non-significant changes in women's attitudes were observed. The programme appears to have contributed to more gender equitable attitudes but its effectiveness differs according to country or context and gender.
- In two (Brazil, South Africa) out of four countries **use of family planning (FP), including condoms during high risk sex** (1.1.1.b) increased significantly. In Brazil, findings differed again for men and women, pointing to a large increase in women's, but not men's, use of FP.
- Only in one country (Rwanda) a statistically significant change was observed in terms of **men attending prenatal are visits (1.2.1a)**. The report notes that in Indonesia no change was observed because of 'ceiling effect'; rates of male attendance were already high due to existing government MCH programmes, also complicating measuring the MenCare+ programme contribution.
- **Couples communicating about family planning (1.2.1b):** again only in Rwanda a statistically significant increase was observed, and only amongst women. Women's responses may have been affected more by social desirability. Note that communication is an imprecise concept which does not necessarily imply meaningful communication or shared-decision making.
- In Indonesia, change in terms of **fathers' participation in caregiving** was assessed and found to be significant.

Looking across all programme indicators, change was observed especially in terms of attitudes, less in terms of behaviour; less amongst men than women (changing men's SRHR attitudes and behaviours appears harder); and less in some settings (Indonesia especially) than others. Furthermore, it appears that a large proportion of participating men already had gender equitable attitudes at base-line. This points to the need to reflect on and address biases in target group participation in interventions.

Finally, it should be noted that some of the attitudinal changes observed regarding male involvement could reflect reproduction of inequitous gender-roles, e.g. the increased percentage agreeing that 'being a father is important in shaping their children's characters because parents, especially the father, are a role model for their children'. This reflects the WHO (2007) finding that male involvement strategies which are not gender transformative, but gender neutral (no attention to gender dynamics) or gender sensitive (addressing different roles and needs of men and women e.g. acknowledging men as decision-maker) risk increasing gender inequity. We discuss such adverse unintended consequences in the next section.

3.5. Positive and negative unexpected results

Few programme reports make explicit reference to unexpected results, that is, falling *beyond* the programme's scope and objectives. Below, we present analysis of those which *were* reported.

First, some programme interventions **reached people other than the ones that had been originally targeted**, thus expanding their scope. Explanations include: digital technologies allowed messages to spread rapidly throughout social networks (ASK); and those trained by the programme applied their new knowledge or skills in their personal lives, thus influencing spouses and family members (MI+).

Second, some programme interventions were **taken up with more enthusiasm** than initially anticipated. Young people in particular were more willing to act as volunteers than expected, or participate in activities such as needs assessments (SUSO/Stepping Stones). Local leaders and health workers were particularly eager to be trained and sometimes requested rollout to geographical regions that had not been targeted by the programme (MenCare+, Staying Alive!).

Third, activities sometimes led to **unanticipated outcomes**, not included in programme objectives, such as an **increase in confidence and self-esteem** of beneficiaries (SUSO/Stepping Stones). MenCAre+ reports that the issue of 'paternity leave' was put on the agenda in the Netherlands as well. It attributes this to productive partnerships, discussed in chapter 6.

Some programme activities appear to have led to **adverse effects**, mostly related to the **attitudes and behaviours of members of the target group**, for example:

- Increased fear of side effects of family planning, and their rejection by husbands (Staying Alive!)
- Programmes targeting child marriages mentioned various unforeseen effects at the local level, such as parents wanting to keep their daughters away from school out of fear that, once enrolled, it would be difficult to get these girls married (That's No Way To Marry!).

Some reports acknowledged that interventions could, **increase risks** for the target population:

- The Stepping Stones report mentions that collection of data by local partners posed a risk for these partners, because local media could accuse them of encouraging minors to sell sex.
- Economic empowerment strategies (vocational skills building) could increase some sex workers' economic vulnerability, because they could not find work in newly acquired professions (SUSO).

Sometimes, adverse effects were not explicitly mentioned but could be inferred. For instance, the UACM report mentions community concerns about the responsibility for children after dissolution of marriages, its impact on family dynamics, and that 'saving' girls from marriage may have adverse effects for the girls involved.

We could find little evidence in reports that adverse effects led to adaptations of the intervention strategies. One exception is included in the final report of Ipas. Exceptionally high uptake of long-acting reversible contraception (implants and IUDs) after abortion in Ethiopia raised concerns about undue provider influence on women's choices. Careful investigations followed (of possible contributing contextual and reporting factors), then corrective actions (with providers trained by Ipas), and working groups established (to check similar data across other Ipas countries). Such awareness and assumed responsibility for (negative) effects *beyond* the direct scope of the programme is an ethical stance that should be fostered whenever possible.

3.6 Conclusions

Our evaluation and comparison of programme results was compromised by several factors linked to **reporting systems**:

- Limited reporting of outcomes (e.g. behaviour change) or impact (e.g. improved health or rights)

- A vast number of unstandardized programme indicators
- Variation in reporting formats and quality
- Inconsistencies in reported targets and achievements
- Unexpected results, negative or positive, are rarely captured in reporting

A number of patterns can be distilled, however. First, **the targets programmes set for their indicators were much more often surpassed than not reached**. The percentage of (mainly output) targets reached and surpassed ranged from 71% (SRHR Fund) to 89% (Choices & Opportunities Fund; Key Populations Fund). A considerable number of targets (up to 28 % (Key Populations Fund) were surpassed by 300% or more. Programme partners found defining indicators and setting targets difficult, and this overachievement might be partly due to conservative target setting.

Second, **overachievement mainly happened for *output* rather than outcome indicators**. Most of the output indicators surpassed were number of people reached (with information, training, activities, commodities, advocacy strategies), especially when e- and m-health, including social media, could be used.

The implications of these output results are difficult to assess. Reaching people does not necessarily mean that the programme has any effect on their knowledge and/or behaviour afterwards, even if this is an assumption that guides a programme's log frame and intervention strategies. In their reports, organisations offer little, if any, critical reflection on their assumptions, or on the discrepancies between a programme's outputs and the intended effect on outcome/impact level.

Structural or institutional change targets were rarely or only just met. These usually related to Result Areas three (increased usage of SRH care) and four (more respect for SR rights). This finding is not surprising, given that deeply embedded social structures (norms, values, power relations) only change gradually. Moreover, the changes that are envisaged in these domains are often more qualitative in nature, and thus difficult to capture by numbers. The measurability differs per result area; progress in result area 4 (human rights) may be particularly unsuitable for a numerical assessment and representation.

A third general observation concerns **the reliability and validity of the results**. Reports include limited information about M&E and how organisations reached conclusions about programme effects. It is thus hard to assess whether the reported changes reflect actual behavioural change. Methodological tools for addressing the attribution problem – such as independent/external evaluations or a study design that includes pre- and post-tests, control group, tests of significance – were under-used and, when used, received surprisingly little attention in final reports. A few programmes did apply more rigorous M&E strategies and could demonstrate, with some confidence, some effects of interventions on attitudes and behaviour, although effectiveness differed per context and gender. This points to the importance of inclusion of sub-group analysis and realist evaluation principles (what works for whom under what circumstances), already included in a handful of programmes (e.g. ASK). However, this requires time and specialist expertise and thus has real resource implications. It seems no coincidence that several of the programmes with more rigorous evaluations collaborated with knowledge institutions, and the question is how feasible conducting in-depth evaluations is for NGOs.

4. Achieving results: Interventions, context and adaptations.

- Which interventions and intervention strategies appear to have contributed to programme objectives and the four MFA result areas?
  - Which interventions and intervention strategies are reported to be effective by programmes?
  - What, if any, is the evidence regarding the effectiveness of interventions and intervention strategies?
  - Were the logic and assumptions underpinning the log frames correct?
- Which contextual factors have affected the results or implementation positively or negatively?
- What has been adjusted during implementation?

All programmes implement a range of interventions, at multiple levels (e.g. health service, community and policy). Whilst in line with good practice (see 4.1), this makes it very difficult to identify effects of individual interventions on outcomes. Furthermore, programme evaluation methodologies prevented a rigorous assessment of the effectiveness of interventions (see chapter 3).

In interviews, respondents from organisations recognized that finding or generating evidence for their interventions (through additional operational research) is a difficult task, for which time and money are often lacking. Some larger programmes that received more funding (e.g. ASK) did allocate a substantive part of their budget to operational research, and reported extensively on its outcomes.

Even when there are challenges in generating evidence, interventions can, and should, be based on existing evidence of effectiveness as reported in the literature. Some programmes justified their interventions with explicit reference to such evidence. CAHR, for instance, based its activities among drug users explicitly on WHO guidelines. However, usually reference to the existing evidence-base was lacking in both programme proposals and reports. An MFA employee mentioned that his own request for evidence had triggered adverse reactions from some of his colleagues, about which he said:

> *I think that it is a sort of culture. […] There are people who have a wealth of experience and have been in Africa for 30 years, who say: 'I know how it works!' And then I come from the Ministry in The Hague and ask 'what kind of evidence is there?'. Yes, I can imagine that is annoying. But at the same time, I also think I do have a point, you know?*

Given the gaps in outcome evidence about effectiveness, in this chapter we analyse whether the interventions and strategies used in the programmes are reported to be effective in the wider international literature. In other words, we do a retrospective review of evidence to evaluate the programmes and claims of effectiveness. We also assess the programmes' logic and assumptions underpinning the log frames or their implicit theories of change (section 4.3). We then examine the effects of context on implementation and results, and review what kinds of adjustments programmes made during implementation. Altogether, this will help explain the results achieved.

4.1 Intervention strategies and effectiveness

We reviewed a number of important systematic reviews for a selection of interventions and intervention strategies (see Annex 2 for the methodology). We focused on those which were used more commonly and which programmes suggested were effective (usually in terms of output indicators; see Box 4.1). Fuller details regarding the evidence base (including references) are provided in Annex 7 (Evidence), which we hope will be useful to the MFA and organisations in the future. Here, we summarize our main findings.

Box 4.1. Interventions and interventions strategies deemed effective by reports.

1. Comprehensive Sex Education (CSE)
2. Peer involvement, including peer education
3. Increasing access to education, esp. for girls
4. Use of E & M Health channels
5. Male involvement in SRHR
6. Training of health workers and community health workers, including through E & M Health strategies.
7. Youth Friendly Health Services and Centres
8. Linking Communities and Care
9. Promoting legal change and awareness of human rights
10. Advocacy & community dialogue
11. Needle and syringe programmes
12. Integrated packages / multi-level approaches

We found **some supporting evidence regarding the effectiveness of the interventions used by programmes (Annex 7)**. In addition, according to the literature, integrated, combined approaches tend to be more effective than narrower, vertical approaches (Denno et al 2015; Lee-Rife et al 2012). All MFA funded programmes adhere to this principle of good practice. It does however complicate assessment of effectiveness of individual interventions (Lee-Rife et al 2012), and the heightened financial and infrastructural demands of multi-level, holistic programmes likely affect sustainability of programmes and results (Lee-Rife et al 2012).

However, programmes also include interventions which, according to a recent review of systematic reviews by Chandra-Mouli et al. (2015), are *not* sufficiently supported by evidence from studies conducted in Low and Middle Income Countries (LMICs). These include youth centres, high-level advocacy events or community meetings which inform community members about risks of harmful practices, and peer education, although evidence for the latter is more mixed (see Annex 7).

Importantly, evidence in support of interventions must be carefully interpreted:

- Evidence tends to **support effectiveness regarding certain, but not all outcomes** (e.g. needle and syringe programmes can change risk behaviours; impact on HIV and Hepatitis-C infection is limited).
- Effectiveness is **context-dependent.** Context changes the nature of the problem which interventions seek to address (e.g. teenage pregnancy in Kenya versus Bolivia), how interventions work, and for whom. For several interventions, supportive evidence was derived mainly from studies conducted in High Income Countries (HICs).
- Effectiveness of complex interventions **depends on details of intervention design and implementation**. Chandra-Mouli et al. (2015) identify three common flaws in implementation of ASRHR interventions, likely to apply to MFA programmes too:

- Interventions **do not use all elements of an interventions** which make it effective. For instance, effectiveness of CSE depends on design features in terms of content, design and delivery, e.g. a focus on skills and empowerment rather than knowledge-focused curricula (Kirby et al., 2005). We do not know whether MFA programmes met conditions necessary for effectiveness due to the lack of reports, but this seems unlikely given the difficult social environments in which programmes were implemented and the various capacity issues noted.
- Interventions are often not delivered in the right '**dosage**': regularly, consistently, and with intensity over a sustained period of time. What 'dosage' is required is generally not yet known and will differ per target group, context and starting position. It is likely that the MFA funded programmes did not deliver interventions in the right dosage given their short to medium term duration (one to four years), and since start-up problems and delays were regularly noted. Moreover, some programmes appeared to spread themselves too thinly: MI+ acknowledges for instance that in Kenya, the magnitude of the project area posed challenges in exposing all young men to trained service providers.
- Programmes tend to **exclude more vulnerable adolescents**. Dedicated outreach for specific subgroups of vulnerable adolescents (or the vulnerable in other target groups) is required but absent in most of the MFA funded programmes. Some did acknowledge differences between subgroups (e.g. LinkUp) but it appears that many programmes do not evaluate who participates and who does not.

- Absence of evidence does not mean lack of effect. Some programmes used innovative and promising interventions, such as 'narrative writing' (Global Dialogues); their effectiveness deserves further research.

In conclusion, we found evidence which supports many of the programme's chosen interventions and intervention strategies. The evidence, however, notes the conditions which are requirements for effectiveness. Limited use of process evaluations by programmes prevents analysis of these intervention details, for example whether intervention content and delivery mechanisms included all key elements to reach especially vulnerable sub-groups. More evidence is required regarding what works for whom, and under what circumstances, to ensure that interventions work and decrease inequities.

4.2 Programme logic and assumptions underpinning log frames

We also assessed programme logic and assumptions underpinning the log frames. This helped us determine how confident we can be that interventions contributed to achieving programme objectives and the MFA Result Areas.

Most interventions appeared logically aligned with programme objectives. However, we also identified a number of problematic assumptions underpinning log frames or the - usually implicit - theory of change:

- An **over-emphasis on and confidence in individuals' agency to change behaviour**, reflected for instance in the great number of behavior change interventions focused on knowledge and attitudes.

There is a relative neglect of the impact of structural conditions (such as gender relations), although perhaps because these are largely beyond the reach of NGOs. For instance, vocational skills training on its own cannot lead to economic empowerment of sex workers because the labour market and job opportunities are equally important determinants. Hence, economic empowerment strategies did not always enhance, and sometimes deteriorated, sex workers' economic position (CIDIN, 2015).

- Problematic assumptions regarding **representation and selection** of target groups. Most programmes seek to involve target groups or communities or engage in peer education, which requires selection of 'representatives' of these respective groups. Reports did not acknowledge complexity of achieving adequate representation.
- More generally, programmes **assumed too easily that interventions led to behaviour change**. Programmes are generally more successful at reaching people, then changing knowledge and attitudes, and there was little evidence about behavior change. The literature confirms that interventions are generally less effective at changing behavior (see Annex 7).

Programme adaptations sometimes reflect an awareness that assumptions were unfounded; we discuss adaptations in section 4.4. First we discussed how context affected implementation and outcomes.

4.3. Contextual factors influencing implementation and results

4.3.1 Political environment

Government support was an important prerequisite for the successful implementation and uptake of programme interventions. In Ethiopia, for instance, the country's strong commitment to achieving the MDGs enabled the ASK programme to obtain positive results. In Uganda, a large campaign around e-MTCT (mother-to-child transmission) services, led by the First Lady, resulted in a notable improvement in the uptake of these services (Staying Alive!).

Government support and capacity is more likely to exist in countries with a stable political environment, and less likely in countries facing political unrest, natural disasters, conflict or post-conflict situations. Explicit government resistance affected for instance youth participation in policy development (ASK), LGBT rights (Global Dialogues, BtG) and political space for civil society in general (SUSO, Suddenly Not A Child Anymore, CAHR).

SRHR policies and laws, or the political will to revise these, are crucial enablers of programmes. For instance, a change in Uganda's policy on the initiation of ART increased access to HIV services, enabling Staying Alive! To achieve its envisaged results in this domain. Conversely, restrictive legal frameworks hindered programme goals. For example, in Indonesia unmarried couples are not allowed access to contraceptives by law, seriously limiting the provision of services to young people (ASK). A public statement by the Minister of Education forbidding sexuality education affected collaboration with schools (Global Dialogues).

In all countries, addressing the rights of key populations and those regarding safe abortions are particularly sensitive political issues, and frequently hampered by restrictive legislative frameworks. Hence, HIV organisations were less willing to engage key populations living with HIV due to potential legal consequences (BtG); people who use drugs could not access services due to their fear of

discrimination and arrest, nor obtain ID papers and employment (CAHR, BtG); minors who sell sex were, due to their illegal status, discriminated against and blocked from accessing services (SUSO); and providers did not always dare to provide safe abortion services, fearing legal risks (ASK).

Influencing policy and legal reform. For instance, Save the Children (That's no way to be married) became part of the drafting committee for state policies in child protection. IPAs set up online legal reform resources.

4.3.2 Social environment

The political environment is intertwined with the socio-cultural environment. Programmes in different countries reported remarkably similar socio-cultural barriers to implementation, affecting for instance uptake of programme interventions and creating barriers to conveying SRHR information:

- Stigmatization and marginalization of target groups, leading to fear of discrimination (e.g. ASK, MI+, SUSO) and making many target groups hard to reach.
- Shyness and embarrassment about various (taboo) SRH problems (e.g. ASK, Nee Ik Wil);
- Poor SRHR knowledge and misconceptions fueled by low educational backgrounds and low literacy rates – amongst target groups and trainers (e.g. MI+, MenCare+, No, I Don't…);
- Socio-cultural and religious attitudes and norms regarding sexuality, gender and aged-based hierarchies (e.g. Keep it Real, MenCare+, all programmes in Child Marriages Fund);
- Lack of youth-friendliness of health care providers and policy makers (ASK)
- Language barriers preventing SRHR messages from reaching the target population (Keep it Real).

4.3.3 Operational environment

Government systems and infrastructure influenced programmes' implementation and outcomes:

Health system: Interventions, especially those targeting Result Areas 2 and 3, encountered health system barriers, including frequent staff turnover requiring repetition of training activities (SHARP, MenCare+, IAFP); lack of SRHR services and commodities in health facilities (e.g. Staying Alive!, IPAS, Improving Access to Family Planning); the high costs of such services and commodities (ASK); and poor inter-personal quality of care or long waiting times. Poorly functioning health systems made it unattractive for target groups to use the commodities and services that were promoted by programmes, also because of distrust of health care information or providers (ASK, MenCare+, SUSO).

Educational system: Given the centrality of CSE, collaboration with schools was important to many projects, which depended on the functionality and flexibility of the educational system. In Uganda, for instance, strict school curricula and timetables that did not allow for the inclusion of SRHR topics, as well as generally low secondary school completion rates, precluded productive collaboration with secondary schools (Keep it Real). Responding to challenges encountered in the Indonesian educational system, the Global Dialogues programme developed a multipronged approach that did not focus primarily on schools.

Electronic infrastructure: Electronic and mobile (E&M) health strategies were key to various programmes; transmission of SRHR messages was affected by electricity supply and internet connectivity (e.g. ASK, Global Dialogues).

Transport infrastructure: Road quality, and limited availability or affordability of public transport paired with large distances influenced uptake of SRHR services and commodities (ASK, MI+, Staying Alive!), men's participation in ANC (Staying Alive!).

Collaborative structures: Good collaborative structures enhanced the effectiveness of programmes (see chapter 6). In terms of collaboration with local stakeholders, pre-existing relationships constituted social capital which facilitated implementation (CAHR, Global Dialogues, Bridging the Gaps, UACM). Some programmes (Staying Alive! and UACM) benefitted from unexpected involvement of volunteers, local leaders, and heads of districts. Challenges regarding local collaboration also reduced programme success, including:

- Local service staff motivation, busyness (Keep it Real, MenCare+) and high turnover
- Non-cooperation among local collaborators (such as volunteers, facilitators, teachers, or managers) due to lack of monetary incentives or lack of recognition of the SHRH problems to be addressed
- The clash of programme and locally embedded values and practices.

4.4 Adjustments during implementation

Many programmes carried out their needs assessments, operational research, and mid-term evaluations (e.g. MI+, ASK, Staying Alive, MenCare+, Link Up, SUSO, IPAS); suggesting readiness to adjust their approach and planned activities. In addition, a number of programmes (especially those in the Choices and Opportunities Fund) mentioned explicitly that the flexible nature of the MFA funding had enabled them to take advantage of unplanned opportunities and to swiftly respond to unexpected challenges (see chapter 6, section 6.2.1, on MFA flexibility)

Indeed, most programmes report adjustments, pertaining mostly to the following domains:

4.4.1 Targets

Some programme reports described **changes to targets** when **they appeared unrealistic** (ASK) and when the focus on achieving quantitative results was shifted to ensuring qualitative, sustainable change (Link Up). In some cases, **target countries** were changed. When programmes in the Child Marriage Fund received less funding than expected, some reduced the number of countries involved, leaving out those that scored lowest in terms of expected results (That's No Way To Marry!, Suddenly Not A Child Anymore). SHARP had to shift its focus to different regions in South Sudan due to conflict.

4.4.2 Interventions

Several interventions were **adjusted to the needs of the target group** in order to achieve better results. Especially training and IEC activities were described as having been flexible in this regard: curricula and counselling sessions for violent men were adapted to connect better to men's interests and desires (MenCare+); blended learning programmes were developed when beneficiaries felt that lengthy training

workshops kept them away from work for too long (Ipas); following evaluations, training programmes were adjusted according to the learning progress of trainees and master trainers (MI+).

In SUSO, the midterm review led to the introduction of a new training in basic financial skills, adapted to the needs and circumstances of sex workers, as this had been found to be a precondition for the success of other economic empowerment activities (e.g. saving groups, vocational workshops). In reaction to a study on client preferences, Population Services International (PSI) decided to introduce implant services rather than the initially planned IUD services (Improving Access to Family Planning). Furthermore, new initiatives were designed to enhance youth participation (e.g. PhotoVoice project, ASK).

Some programmes adapted interventions **in response to contextual circumstances** hindering implementation. Here, one can think of the organization of additional training, monitoring, mentoring, and compensation of staff in contexts of high staff turnover (Staying Alive!, SUSO); the inclusion of the private sector when programmes faced governmental or institutional opposition (Suddenly Not A Child Anymore); the creation of alternatives to digital interventions in contexts where the internet was inaccessible or unreliable (Keep It Real).

The pace and scope of some interventions were altered because of changes in a country's security situation (e.g. Staying Alive!). After a rise in violent attacks on young people selling sex in Zimbabwe, for instance, local partner organisations started to work closely with the police in investigating these cases and served as a link between the police and the local community of people who sell sex (SUSO). After the coup d'état in Mali, when mass gatherings were banned, PSI started to rely more on local community radio stations for transmitting its messages, and reallocated its budget to purchase protective equipment when faced with the Ebola outbreak in the same country (Improving Access to Family Planning). In Nepal, the fight against child marriage was replaced with an urgent focus on child protection activities after the earthquake in 2015 (Suddenly Not A Child Anymore).

4.4.3 Approach

One programme (Global Dialogues) described a substantial shift from collaborating with big organizations and with institutions such as schools to a bottom-up approach focusing on collaborations with local facilitators, CBOs, and smaller NGOs with grass-root presence. Another programme (Suddenly Not A Child Anymore) mentioned that it changed its top-down approach to dialogue and inner transformation after the local communities had shown considerable resistance (see also Annex 7, effective advocacy strategies). Such shifts imply a **substantial reconsideration of the relevant mechanisms of effect**.

4.5. Conclusions

For most programme interventions, there is some evidence in the literature which indicates they can be effective. However, evidence often pertains to HICs. Numerous contextual factors, including the quality of intervention processes, also influence effectiveness (Chandra-Mouli et al. 2015). There is a need for more context-specific evidence (at a minimum, focused on LMICs) regarding whether interventions

work, for whom, and under what circumstances (Ranking, Heard & Diaz, 2016), implementation processes (e.g. quality, frequency) and their impact on effectiveness.

Limitations in existing evidence, however, should not lead to inaction. Moreover, there needs to be room for innovation, which cannot be based on evidence. An evidence 'straight jacket' needs to be avoided.

Most interventions appeared logically aligned with programme objectives, but we identified a number of problematic assumptions underpinning log frames or implicit theories of change such as the idea that shared demographic features (e.g. age) make someone a peer. There is also an over-emphasis on individual agency; many programmes focus on changing knowledge and attitudes, yet report a multitude of contextual barriers related to the political, social, and operational environments in which the programmes have been implemented.

The **non-achievement** of envisaged results is usually attributed to these external factors (in the political, operational, or social domain), while the **achievement** of results is mainly ascribed to the programme interventions themselves. Therefore the effectiveness of the interventions, as well as the underlying assumptions about mechanisms of effect, seem rarely questioned or reconsidered. Since 2015, programmes funded by the MFA are required to use a Theory of Change. This will assist programmes in reflecting on assumptions, and addressing them.

MFA and programme leads appeared to enable and foster flexibility, and many programmes appeared to respond swiftly to problems encountered and made good use of operational research and evaluations to tailor programmes to the context and needs of target groups. Adaptations were usually small, and related to targets and interventions, rather than the programme's approach or its underlying assumptions.

5. Sustainability

- What are indicators and participants' perceptions of the sustainability of their programme?
- What are perceived opportunities for and barriers to sustaining the results of the programmes?
  - What were the broader environmental, political, economic, and socio-cultural factors that impact upon sustainability of the programmes?
- What, if any, measures have been taken to ensure continuation of activities or foster sustainability of the programme/intervention's effects?
  - Have (implementing) organisations been strengthened institutionally and is their capacity enhanced? If so, how?

This chapter reviews the sustainability of the 21 SRHR programmes, programme results and organizations. We define sustainability as an organization's or project's ability to continue to function effectively, to continue its activities and to maintain results (e.g. health benefits) (WHO, 2002). According to the literature, elements important for sustainability include capacity building, integration into available services and structures, and strong community ownership using (Shediac-Rizkallah & Bone, 1998; WHO 2002).

Section 5.1 summarises indicators and perceptions of sustainability. Section 5.2 discusses barriers and facilitators to programme sustainability. Section 5.3 examines which strategies programmes used to foster sustainability, including organizational capacity building. In section 5.4, we reflect on the MFA's role in promoting the sustainability. The conclusion summarises and sets out some broader ideas for future enhancement of sustainability.

5.1 Indicators and perceptions of capacity building and sustainability

Table 1 below summarises sustainability of programme activities and organisations. It sets out outcome and output indicators derived from programmes and the literature, and then distils key quantitative and qualitative results or reflections on sustainability achievements based on programme reports, the survey and interviews.

5.1.1 Sustainability of results: Long term changes to services, policy and people's lives

Limited evidence about programme results beyond output indicators (see chapter 3) restricted our analysis of sustainability of results in terms of outcomes and impact. Among the survey respondents (n=164), 92% were very positive about the sustainability of results, agreeing that their programme lead to lasting positive change in the SRHR situation of the target groups (See Appendix 4, Table 5, for full survey results on sustainability).

Table 5.1 shows that survey respondents were also positive about the sustainability of activities, with 81% agreeing there had been structural improvements in service delivery. Respondents from partner

organisations were even more positive about service delivery changes than those from lead organisations (see Figure 1 below). Perhaps they were in a better position to observe change, or their responses may have been coloured more by social desirability. Furthermore, 60% of respondents indicated that due to the programme, SRHR government policies have changed (Table 5.1). A smaller proportion (46%) pointed to structural integration of (sexuality) education into school curricula, suggesting that this is harder to achieve (See Table 5, Appendix 4).

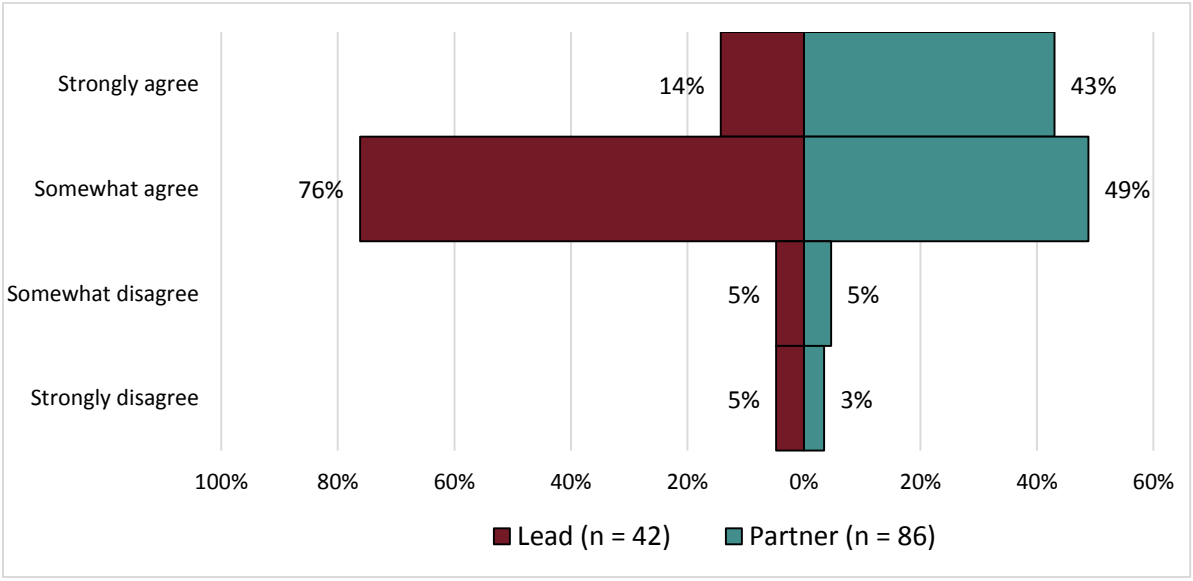
Table 5.1 Sustainability indicators and summary of sustainability performance[5]

	Outcome and output indicators	Summary of key sustainability strategies & achievements based on data available
1. Sustainability of activities: Activities can continue for the foreseeable future	1.1 Embedding of activities in existing structures and systems	Among survey respondents • 81% said that structural improvements within existing services had been achieved • 60% agreed that due to their programme, SRHR policies 'in my country' have changed Reports & Interviews: • Collaboration with government to embed activities into new or existing government structures, e.g. through legal reform (child marriage; abortion), including activities in district plans. • Sensitive SRHR activities and marginalised identities of target groups make national 'buy in' and embedding of SRHR programmes in government structures difficult if not undesirable at times.
	1.2 Local ownership, e.g. involvement of country programme staff in all project phases; stakeholders engaged in advocacy .	• Linking with small organisations led by target groups • Programmes fostering local stakeholders' ownership though training, e.g.in advocacy skills.
	1.3 Additional funding for specific activities obtained, e.g. income-generating activities performed	Among survey respondents: • A significant minority of 19% said that the programme activities were cancelled after MFA funding ended. • 91% thought continued involvement of Dutch or other international partners was, to some degree, necessary for sustaining programme results, especially those from the global South or those not working for lead organisation. Reports & Interviews: • In a few cases, implementing partners set up small businesses (fish selling, taxi service) (e.g. SUSO- Indonesia and Kenya) to sustain project(s) and reduce dependency on external funding. • Some alliance members have ***secured new funding*** for similar programmes from MFA and other governmental and non-governmental donors (DfID, USAID).
2 **Sustainability of**	2.1 Additional Funding obtained, e.g. new	Reports & Interviews: • Some alliance members have ***secured new funding*** for similar

[5] The indicators here are meta-indicators, developed on the basis of programme indicators, supplemented by indicators derived from the literature -in italics.

organizations: Organizations can continue to function independently	funding applications applied for and secured	programmes from MFA and other governmental and non-governmental donors (DfID, USAID).
	2.2 Organizational capacity increased, e.g. capacity building performed; participation in training 2.2.1 Partners able to function independently 2.2.2 Partners achieved planned programme and financial target 2.2.3 # of partners showing documented improvements in their governance, organisational development or standard of programming, e.g. involvement of country programme staff in all project phases; key documentation produced and used (e.g strategic plans, meeting reports)	Among survey respondents • 75% stated that their organisation had continued to implement activities in the SRHR field, even after MFA/Dutch partner support finished • 73% stated that their organisation still works with one or more members of the partnership from the South; 66% stated the same for Northern partners. Reports & Interviews: • In some (but a minority of) programmes capacity building was explicitly built into programme objectives and indicators. • Numerous capacity building activities performed (see 5.4). ○ **Staff training** was a prominent mode of capacity building, in key functions such as fund raising, programme development and planning, and programme implementation and management (human resources, finance,). ○ **SRHR specific training** and **collaboration skills** were also enhanced. • More emphasis on organisational capacity building needed , especially for small organisations led by target groups, including enabling the use of newly acquired skills

Figure 5.1: The programme has led to structural improvements of service delivery (by role, %)

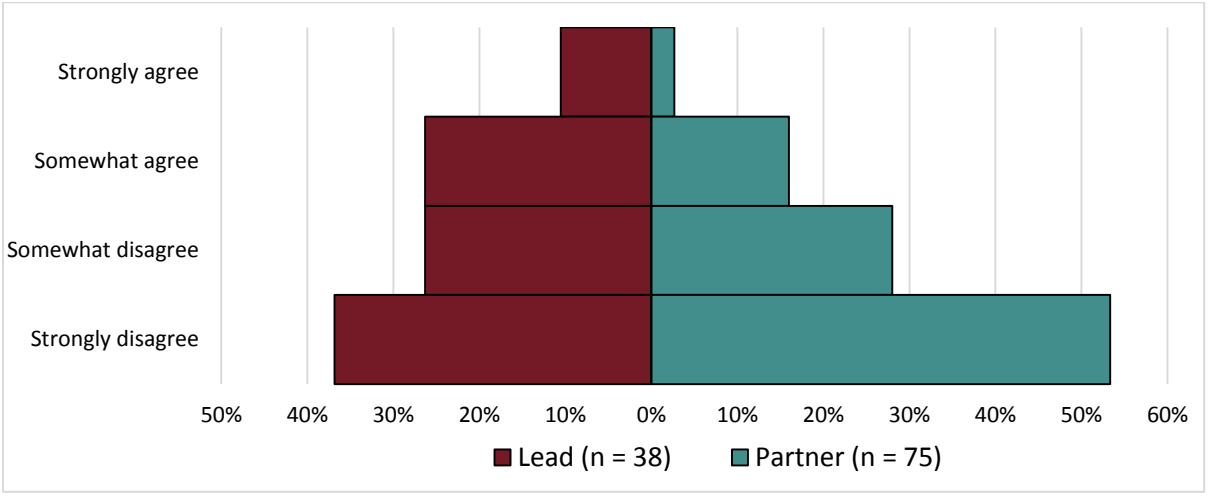


In interviews, MFA and organization staff expressed confidence that programmes had led to life-long changes for the individuals who participated. One implementing partner explained that some changes may have ripple effects, with members of target groups passing on ideas and changed attitudes to others such as relatives (husbands, children) or community-members. On the other hand, one MFA respondent acknowledged that **truly sustainable change requires structural change** (e.g. one can train professional skills but employability requires a job market), and programmes cannot be expected to achieve this.

5.1.2 Continuation of activities

A large proportion of respondents (75%) indicated that their organisation had continued to implement activities in the SRHR field after MFA funding finished (Table 5.1). This means however, that 25% of organisations were no longer active in SRHR activities, suggesting that MFA funding may have led to 'mission drift' (organizations temporarily engaging in activities because of funding). Indeed, a large minority of respondents (19%) indicated that activities were cancelled after MFA funding ended. However respondents who worked for partner organisations disagreed more strongly with the statement that activities had been cancelled (See Figure 2), perhaps because they are better informed or because of response bias by implementing partners.

Figure 5.2. Programme activities have been cancelled after Dutch Ministry funding ended (by role, %)



Some reports described how activities were continued by the government (see 5.3.3). For instance, Staying Alive! reports that fistula surgery is now offered as routine service in referral hospitals in Kenya and Uganda, that youth corners are integrated in and managed by health facilities, and that E- and M-health solutions are managed by the government or national NGOs with long term presence. Ipas mentioned how SRHR topics were embedded in national education curricula (e.g. abortion law in police curriculum, Ipas).

5.1.3 Organisational strengthening, ongoing partnerships and fundraising

In terms of organisational strengthening, programmes describe increases in organizations' **programme development and delivery skills** (e.g. M&E), **SRHR related technical expertise** (e.g. gender sensitivity,

harm reduction, human rights) and more **generic capacities** like advocacy, knowledge dissemination (e.g. Link Up, ASK), meaningful youth participation and, for youth led organizations, leadership and cooperation with 'adult organizations' (ASK). One interview respondent spoke highly of organizational strengthening of small organizations:

> *Many organisations that have started from an activist movement of two people now they are consolidated organisations. You see that key populations that were very much pressed are coming out and getting empowered and I get very emotional seeing that. It's a beautiful step forward.*

SUSO aimed to enhance staff well-being through training in stress management and communication skills for staff working with victims of trafficking or sexual violence; the report does not discuss whether this was an effective strategy. In Increasing Access to Family Planning, **business management** training for clinic managers helped to retain staff, paired with advocating with government stakeholders to maintain trained providers in the health centres for at least two years.

Furthermore, reports mention **new funding** from both MFA and other governmental and non-governmental donors (DfID, USAID), sometimes through new alliances (ASK), pointing to partners' ability to function independently.

Some programmes included explicit sustainability targets. Table 5.2 below provides an interesting example from Bridging the Gaps. Most of its indicators pertaining to organizational strengthening were met or surpassed.

Table 5.2 Sustainability targets and achievements - Bridging the Gaps.

Target and sub-target	Target	Achieved	Difference	Target and sub-target	Target	Achieved	Difference
# of local partners that defined their needs on capacity strengthening	82	270	+188	**# of partners that can continue activities independent after 5 years**	79	389	+310
# organizational development plans	86	201	+115	# proposals submitted	82	374	+292
# of partners that have technical expertise to implement activities	123	462	+339	# partners actively engaged in other funding mechanisms	41	179	+138
# people trained on technical skills	473	2.558	+2.085	# fundraising strategies developed	41	179	+138
# partners engaged in coaching curriculum	83	145	+62	# leaders supported	131	515	+384
# of partners that have developed and implemented a strategic plan	71	164	+93	**# of partners that have access to lessons learnt from other stakeholders**	911	1.385	+474

However, almost all survey respondents, especially those who worked in the global South, or who did not work for the lead organization, thought continued involvement of Dutch or other international

partners was necessary for sustaining programme results (see Table 5.1, and Table 5, Appendix 4). The survey, reports, and interviews also pointed to the need for more and earlier attention to sustainability of both activities and organizations.

A survey respondent from an implementing organisation explains:

> *There is need to invest more in building capacity of local Institutions/NGOs since they will stay when funding from the MFA ends. Since the end of our programme, my organisation has carried on with similar activities, but had it been supported well with capacity for instance on how to continuously identify resources for SRHR, it would be better prepared to continue the struggle.*

Several reports and interviews pointed to implementing partners' limitations in terms of essential skills such as financial management and M&E capacity. A few implementing partners also identified a need for IT systems to support M&E activities.

5.2 Sustainability: Barriers and facilitators

Contextual factors affecting programme results, discussed in chapter 4, will also affect sustainability. Here, we focus on the impact of broader socio-political factors, and also describe the impact of the funding landscape and the related issue of staff turnover.

5.2.1 Social and political environment

The international and national political context can affect sustainability. A positive effect was noted in Men Care+: the sustainability of male involvement interventions appeared to benefit from a growing national and international social movement of male involvement, although countered somewhat by concerns from the women's movement that male involvement programmes could reinforce male privilege and divert precious resources.

More common, however, were negative impacts of the social and political environment. In chapter 4, we discussed the prevailing conservative attitudes in countries of implementation. Some programmes and respondents noted an increasingly hostile international and national climate regarding SRHR, in particular with regard to key populations and abortion. This affected programmes' ability to embed activities and services in the existing health and education system, since the required political support from different levels of government and, presumably, implementers, could not be obtained. As a respondent from a lead organisation pointed out, government services and staff may lack the required resources, knowledge of policy and the law, or willingness. One of the implementing partners emphasized the difference between official policy change and actual commitment:

> *And now, it's not easy serving in this environment, because even the stakeholder that pretend that they are with you (…) they come up with these beautiful policies, 'Yeah MSMs [men having sex with men], they are here, we have policies, and they are there!' But, the stigma! Yes, the stigmas come, spans from NASCOP downwards. Yes, healthcare providers.*
> *I: So they are with you and not so with you...*
> *R: Not so with you, don't be (laughs) fooled. They are with you, but they are not with, they are still not with you. Yeah, they are just there because it's work.*

One lead partner explained well how embedding in existing government structures may not be feasible or desirable, since it may reduce the quality of the services:

> *How realistic it is. How would you want to integrate friendly services for key populations within a corrupt government who actually will harm even more the key populations by integrating them because they might be, make tests mandatory and open the results of the test for everyone so the question of privacy is a major risk of integrated services within the public system.*

A rights-based focus can thus be a problem for sustainability; a problem aggravated for short-term programmes with modest budgets, pertinent to the Child Marriages Fund programmes.

The BtG report notes how the increasingly conservative international and national social and political climate demonstrates the continuing need to invest in a rights-based response and the important role of the Dutch government in this policy arena, for example through sustained funding and promoting rights-based approaches in bi-lateral government meetings (see section 5.4).

5.2.2 The funding landscape

External funding

Programmes operate in resource-limited settings which restrict the infrastructures on which programmes depend, and the availability of government funding. Moreover, programmes focus on progressive, often contentious, SRHR issues that many national governments do not want to address. Withdrawal of external funding (for instance when a country obtains middle income status), would leave a gap which governments are unlikely to fill: 'Nobody would pay for something which is not considered good' (Implementing organization 1). A respondent from a lead organization explained:

> *But Kenya for instance is a very clear country where the culture says the concept of homosexuality is a western concept. 'We don't have that here'. (…) And therefore that is a major stigma and discrimination that comes from every component of society which expresses that very clearly towards key populations (…)So if you say one of the solutions to sustainability is that the government takes over, forget about it.*

When national governments do take over funding of activities and services, this is more likely based on health rather than human rights considerations. Foregrounding health reasons thus appears one important strategy to persuade governments, but may limit the scope of the activities taken up.

Several programmes noted that they work on issues which few donors other than the Dutch MFA take on. This makes Dutch funding somewhat of a mixed blessing, as a lead partner noted:

> *You have money which you would never get from anywhere else, but when the money is gone you cannot find it anywhere else. And therefore you will fall into a fall. You came from very intense support to nothing in one way or the other.*

Given programmes' dependency on external, Dutch funding, shifts in the Dutch political and economic climate can threaten sustainability; as one MFA respondent noted, over time, less money has become available for SRHR and embassies.

Long-term and core funding

All data sources highlighted the importance of long-term funding to achieve sustainability. Some survey respondents indicated that four-year programmes were not enough to promote real change. Long-term investment in 'demand creation' for SRHR programmes among many stakeholders is required because many of the SRHR programmes try to 'sell a product nobody wants' (Implementing organization 1). Obtaining local 'buy in' and commitment, and getting this solidified in concrete plans, requires time and investment in human resources, especially when programmes include controversial activities (e.g. CSE), necessitating consultation, building relationships and persuasion of many stakeholders (Keep it Real). SRHR projects might be more human resource intensive than other projects because as one respondent said, 'we are not selling sofas'.

The rights-based approach promoted by the MFA might well require a longer-term approach because of its unique commitment to deeper structural changes with respect to rights. This was acknowledged by an MFA staff member when the respondent explained how according to the 2013 IOB SRHR policy evaluation, positive results could partly be attributed to long-term policy:

> *They [IOB policy formulation] said like: only because the Netherlands has this long-term stable policy, can you make a real change ('kun je ook echt een deuk in een pakje boter slaan'). It has to do with your network, the SRHR discussions, yes, sometimes we are stubborn, and the Dutch approach does come from a long-term. I have always held this up as one of the key lessons for myself, but also externally, especially towards parliament: guys, whatever you do, don't throw away the child with the bath water, keep an eye on stability. Because it's about such complex topics, that's not something you can achieve in just a year. There are at least ten or twenty or fifty years, long-term social processes. (…) I' m enormously against those two year programmes , I don't understand why that's done, unless parliament demands it.*

Core funding for an organization, rather than programme funding, can also foster continuation and thus sustainability. As one MFA respondent explained, core funding can facilitate the delivery of complementary packages (advocacy, service delivery, youth involvement). An implementing partner suggested that core funding might mitigate the widespread problem of high staff turnover noted in several programme reports.

5.3. Sustainability strategies

5.3.1 Organizational capacity building

We have already referred to how programmes built capacity (5.1.3). Here we examine the strategies they used to achieve this and make it sustainable:

- **Inclusion of capacity building in programme objectives and indicators** (e.g. BtG, ASK, CAHR, SUSO, IPAS), and a dedicated budget line for it.
- **Development of training materials, e-learning, mentoring** (MenCAre+, Link Up, BtG), and '**train the trainer'** approaches (e.g. MI+) will make training more effective and sustainable. Important especially for youth-led organizations since youth will 'age out' of the youth movement.

- **Collaboration and working in alliances facilitates mutual learning**; see chapter 6.
- Setting up a **technical support hub** was found to be key for enhancing partners' technical skills in harm reduction for people who inject drugs in CAHR.
- **Strengthening structures for knowledge-sharing**. Individual capacity building can lead to institutional strengthening *if* staff can transfer gained knowledge into the organization or alliance. Organisational structures and hierarchies may make this difficult. A respondent of an implementing organization noted that trained 'seniors' may not pass on knowledge to 'juniors' and vice versa. The programme report of ASK notes that structures for knowledge-sharing within and across organizations may need strengthening.
- Encouraging **implementation of new interventions** to enhance organizational learning (but lack of experience and expertise may also hinder effectiveness and thus sustainability, as one lead partner noted).

Lead organisations may lack capacity and funds to build partners' capacity. One lead partner indicated that although they had seriously considered investing more in capacity building, this was seen as an unwelcome distraction from activities and delivering on the mission.

Small organisations, sometimes led by target groups such as youth-led or sex-worker-led organisations, have greater capacity building needs (all types of respondent referred to this capacity issue). One MFA respondent noted that the MFA and alliances may lower requirements for these organizations to enable them to participate (see chapter 2), and there is therefore a greater risk that they 'collapse', especially when funding discontinues (they might be almost entirely financed by a particular programme).

However, this may be an acceptable risk to take, given the benefits of involving and building capacity of small organisations and targets groups. This need for capacity building again points to longer-term funding beyond the usual three or four years. Assessing organisations' capacity and developing a capacity strengthening plan at the start of a programme is important.

5.3.2 Fostering local ownership; building stakeholders' capacity

Stakeholder involvement, fostering local ownership and participation, are strategies mentioned as key to sustainability in reports (BtG) and interviews with lead organizations and MFA staff. The BtG report mentions that it increases the chance that policies and interventions reflect the needs and priorities of communities, making them more sustainable.

Several programmes built advocacy skills of stakeholders, including young people, thus empowering them to become 'agents of change' and to contribute to policy formulation at local, district and national level (e.g., Link Up, ASK, Staying Alive!, Nee ik wil…).

Achieving real, meaningful stakeholder involvement is challenging due to entrenched power hierarchies. 'Listening to young people' may not translate into actual policy change; young people's needs may be ignored at the final stages of policy development (Link Up). MenCare+ fostered local support through 'sustainability meetings' with local leaders in Rwanda, who committed to support existing and new group activities. It is however unclear how exactly this promoted continuation of group discussions.

5.3.3 Embedding activities in structures

Embedding activities in existing structures such as the health and education system enhances sustainability. Collaboration with government is key here. Some programmes co-developed programmes with government, such as (e)training (MenCARE+), procedures and service delivery standards (BtG, SUSO), and activities being embedded into district plans (Staying Alive!).

Working with governments on sensitive SRHR issues can be difficult, as noted in 5.2.1 (political environment). Aforementioned health system challenges also point to the need to link the embedding of programme activities with strengthening health or education systems for example. District level government services can be very resource-limited. However, few programmes engaged in health system strengthening, and this is perhaps outwith the scope of NGOs.

Given the difficulties of linking with government services on some issues, collaboration with local NGOs and CBOs remains important. The Ipas report notes that it started collaboration with humanitarian NGOs working on SRH in emergencies to help them institutionalize safe abortion care. ASK notes that **embedding programme activities into the core activities of the partner organisations** fosters sustainability.

In addition to embedding activities into existing structures, organizations **developed new structures to support activities.** For instance, Staying Alive! provided support to new groups to develop a constitution and operational guidelines, and register with local government authorities. The Suddenly NO Child Anymore programme mentions the development of a national network of organisations and institutions working on child marriage.

5.3.4 Knowledge generation and sharing

Knowledge generation and sharing can increase visibility of both interventions and organizations, thus facilitating uptake of activities by other organizations, new collaborations and attracting new funding.

Key activities in this domain include:

- **Annual Reporting:** According to interviewees from partner organisations, programme reports and the MFA feedback that organisations received informed their planning, adjustment, and improvement of programme activities. Many organisations also used reports for sharing their knowledge, 'best practices', and difficulties with partner organisations (in meetings and learning events) or at international conferences. Having a written overview of past activities and achievements helped organisations in presenting themselves to potential future donors, or in ensuring the continuation of funding.
- **Operational research,** shared through academic outlets (international conferences, journals), national and international stakeholder meetings, and multi-media channels targeting professional and broader audiences (websites, twitter, you-tube, video games). For instance, in CAHR, generation of **evidence** as to what works in HIV prevention, treatment and care for PWID as a strategy to (unsuccessfully) persuade governments to enshrine the right to health for PWID and other key populations in national legislation and policies. Its website became a resource for global harm reduction stakeholders.
- Production of '**best practice guidelines'** (SUSO) or service standards (BtG).

- **Developing knowledge exchange capacity**, for instance through writing workshops (MI+).

5.4 MFA's role in sustainability

One MFA respondent suggested that the MFA is not very good at 'doing sustainability' despite frequent reference to it ('we hebben er altijd de mond vol van'). MFA staff indicated various ways in which the MFA could be more involved in promoting sustainability, for example:

- Review and comment on organizations' strategic plans
- Ensure that partnerships do not end at the same time, to protect them from threats coming from a change of government.
- Lobbying by the MFA s and international governments for SRHR and sensitive topics (e.g. abortion), promoting continuation of funding for a particular programme, organization or focus.

One lead organization noted that 'the Dutch MFA is not only a knowledge broker but also a financial and sustainability broker' and suggested that the Dutch embassy can play an important role by 'introducing to the other countries. Showing the great work we're [the local partners] doing at country level'.

However, another respondent from a lead organization doubted its effect:

> *Embassies can say, hey, this should be part of your national strategy, include it. But in countries where there is so much competition for money… I don't think it will make an awful lot of difference.*

Finally, survey respondents suggested that the MFA could devote separate funds to the sustainability of programme results. A Northern partner suggested that the MFA could:

> *Ensure a way of monitoring the impact long after the project has ended and a sustainability mechanism beyond the project. Perhaps a fund where Network members could apply to facilitate greater advocacy especially with the national governments on family planning.*

5.5. Conclusions

Evidence of sustainability

Despite the challenges of making progressive SRHR programmes sustainable, we found evidence of sustainability: capacity of organizations was built and their networks were strengthened; some activities and services were embedded in national health and education systems; and several programmes attracted more funding. However, inevitably programme reports provide little insight into programme sustainability because this requires longitudinal research.

Barriers and Facilitators to sustainability

A number of social, political and economic factors hinder sustainability. Building a conducive environment and working relationships with government stakeholders at national and sub-national

levels is essential but requires substantial time and resources, and thus adequate levels of long-term and perhaps core funding.

Given the importance of political commitment, there is a need for further analysis of strategies which can be used to build relationships with government and obtain 'buy in', especially when contentious issues are concerned. Some organisations appear to have particularly useful expertise in this area (e.g. Ipas), pointing to the benefits of sharing insights between MFA-funded programmes.

Influencing policy and legal reform are important processes to encourage, for example Save the Children (That's no way to be married) became part of the drafting committee for state policies in child protection. Ipas set up online legal reform resources. Programmes sometimes dealt with the hostile social environment by employing top down approaches, for example changing the law or introducing fines. These fear-based behaviour change approaches might not be sustainable. Adopting a multi-level approach, including multiple strategies (see chapter 4) may mitigate the problem of top down interventions and approaches.

Perhaps we should lower our expectations and requirements regarding sustainability of SRHR programmes and results. Closser (2011), speaking critically of the rhetoric of project sustainability, suggests that in an unequal world we may need to accept that sustainability requires 'continuous long-term transfers from rich to poor', and thus, donor support.

Organisational capacity building

In some (but a minority of) programmes capacity building was explicitly built into programme objectives and indicators. Staff training was a prominent mode of capacity building, but this needs to be supplemented by individuals' ability to use and pass on newly acquired skills within embedded organisational structures and hierarchies. Training can be made more sustainable through train the trainer approaches or e-learning.

There are good reasons for partnering with small organisations, especially those led by target groups. However, they have greater capacity building needs (e.g. financial management, M&E).

The perception that organizational capacity building is at odds with the organization's or programme's mission seems to point to the need for longer-term approaches; it would seem that organisational capacity building is at most a short term, but not a long term, distraction.

The MFA should encourage programme partners to explore lessons from other organisations about how to make capacity building at different levels of the organization effective and relatively low cost. One respondent for example said they had received support for financial management and proposal development, but that this was not provided in a way that (recognizably) enhanced capacity.

Funding for sustainability

Core and longer-term funding for organisations, instead of or in addition to programme funding, may foster continuity, organizational strengthening and should be considered more often. Although securing national government funding promotes sustainability, the politically sensitive nature of many of the SRHR programmes strongly reduces the likelihood that governments take over. The focus on rights-based progressive SRHR policy and programmes may necessitate ongoing external (Dutch) funding.

6. Collaboration

- How did partners in programmes and alliances collaborate with each other?
- How did the MFA, embassies and the partners collaborate in the programmes?
- How did the MFA and programme staff experience and value this collaboration?
- In what ways has MFA played a role as knowledge broker?

All programmes involved collaboration between organisations of the South and North. This chapter examines the value of collaboration in the programmes (north-north, south-south and north-south), and the way the organizational structure, communication and decision-making in the programmes was perceived by the various actors. It also examines collaboration between the MFA, embassies and partner organizations. Finally, it discusses the role of the MFA as a knowledge broker.

6.1 Collaboration within alliances and programmes

6.1.1 The value of collaboration

Some organisations collaborated in alliances due to MFA funding requirements, which initially made it feel imposed, like an 'arranged marriage'. As one of the alliance partners said: "We had to do this, because the ministry wanted us to do it". Several interview and survey respondents expressed a similar view, but said that with time they came to appreciate the (added) value of working together. Below we thematically discuss the value placed on collaboration.

Mutual learning

In interviews and the survey many positive comments were made regarding mutual learning. According to a northern survey respondent: *"Whatever level of capacity an organization may have, there is always a lesson to learn through working in partnership"*. The survey data show that:

- 67% felt that their organisation had learned a lot from partners in the North
- Even more, 80%, had learned from Southern partners.
- Amongst lead partners, many more (87%) felt their organization had learned from southern partners, compared to northern partners (55%).

We identified several sub-themes pertaining to mutual learning from all the data.

First, within programmes, north-north, north-south and south-south **exchanges in methods or tools** enhanced effectiveness and partners' confidence in their work. Some alliance partners brought organizations in the south together and encouraged them to learn from each other's experiences and "best practices". Such horizontal exchange opportunities were valued by southern organisations.

Second, respondents underlined the importance of **learning from "people on the ground"** to inform decision making. As a northern alliance partner said, it is not enough to get information through reports and yearly visits, "it's important to listen to what the local people have to talk about or have to say". This was mentioned regarding north-south *and* south-south collaboration, for example when

organisations of and for different key populations worked together, or when faith-based organisations collaborated with secular organisations.

Third, **learning from and respecting each other's views** was important because many of the programmes handle sensitive issues, and had to develop a joint approach. For instance, in SUSO, alliance partners had different views on the position of child sex workers. As one of the alliance partners said: "For me, they [the minors] are victims of sexual commercial exploitation", which is "related to other issues like trafficking people (…) therefore we cannot speak about defense of sex work", from a rights-based perspective, which was the approach of the other partner.

Discussing different viewpoints and agreeing to disagree enabled organisations to cooperate in a constructive way, without fully losing their own vision. Cooperation, as a survey respondent phrased "allows one to know and respect other ways of thinking" (Northern partner, survey).

Some organisations used the Values Clarification Tool to discuss sensitive issues in a culturally sensitive and respectful way, obtain a compromise and enable activities to move forward. This tool stimulates people to clarify for themselves and each other their values with regard to a sensitive issue. Its aim is *not* that everybody shares the same view; it is not about converting others but about stimulating people to take a position. As one lead partner said:

> *Now, what we've learned over the years is that values clarification does not convert anyone. So, if you're opposed to abortion to start off with, we're not going to make you favorable towards abortion. But if you're borderline or if you are not quite sure how you feel about it or you're not really convinced that this is a topic that your organization should take up, it helps move people along.*

Widening the resource pool, and scope and effectiveness of interventions

Collaboration could lead to various strategic advantages. It enabled coverage of more regions or SRHR "result areas" (by dividing the regions or result areas among partners). However these collaborative arrangements could also lead to coordination problems and loss of synergies across projects (see below).

Addressing SRHR issues often requires a **multi-sectoral, multi-agency approach** involving different sorts of interventions, at different levels, for example education, sexual health services, and policy influencing (see chapter 4). Such holistic approaches may be hard to achieve by single organisations. Several interviewees were convinced that it takes alliances to work on SRHR in challenging settings and achieve change, as the tasks were too big to do it alone. In the words of one implementing partner:

> *The good thing of this collaboration was that we also realized we were not alone in implementing this program. (…) We need other organizations to achieve [name organisation's] vision and missions that are to improve young people's SRHR.*

A respondent from a lead organization said:

> *And [working together] gives power! Empower each other, yes. Because your voice gets stronger, you learn from each other so your capacity gets stronger as well. You feel that you are not alone.*

Collaboration enables **complex SRHR problems to be addressed more effectively**. For instance, when a programme required data on abortion in humanitarian settings, local partners had the capacity to be actually present and collect data, whilst the lead organisation added technical capacity and knowledge to steer the data gathering and interpretation. In Bridging the Gaps, bringing together key populations (drug users, sex workers, LGBT) that were not used to collaborating formed the cornerstone of the programme. This not only lead to positive synergies for greater reach and effectiveness, but also to the experience of empowerment. In this programme, one implementing partner focusing on drug users and harm reduction, could make use of alliance partner organisations for other key populations (sex workers and LGBT) to reach out to drug users belonging to these groups.

> *The collaboration makes us stronger, because you see for example our members [who] were using drugs, we'd refer them now to the reach-out centre, which is also funded by the Dutch.*

Survey results show that 73% of respondents agreed that their programme would not have achieved as much if it had been implemented by individual organisations. None of the people who worked for organisations in the South disagreed with this statement. 80% of the respondents thought it was a good idea that the MFA stimulated alliances (while most of the others did not have an opinion about that) (See Table 3, Appendix 4).

In the interviews, organisation staff were asked to react to the survey finding about the efficiency of working in alliances. Interviewees of all three types of organisation commented that they would not have been able do the work on their own.

> *Our collaboration makes me fly high. Because as I said earlier, we can't work alone. Yeah. We can't work alone. We have to collaborate with other organisations (…) to ensure that we reach our goal (…) at the end of the day. (Implementing partner)*

Advocacy and influencing policy and legislation was one area where respondents considered strategic collaboration important. Building multi-sectoral coalitions between people and organizations who might not have worked together previously is for instance key to Ipas' objective of increasing access to save abortions, where legislative change is a key strategy. In Malawi, for example, the programme works with "medical doctors and hospitals, human rights organisations and feminists, traditional chiefs, and the media, to reach the political will for a legal change".

Strategic collaboration took place within countries as well as internationally. National alliances enabled local perspectives and needs to be better addressed. National governing boards and the appointment of an independent country coordinator for programmes were good governance mechanisms to manage these alliances. Joining forces in such national alliances increased the possibility to achieve the jointly defined strategic goals.

6.1.2 Coordination problems and collaboration efficiency

Building collaborative networks between diverse groups is not always easy (Vries, de et al. 2015). In BtG, organisations of different key populations were initially not always willing to work together or stigmatized each other. Collaboration became complex because many were strongly "identity based groups", and some perceived collaboration between their organisations as imposed by the donor.

Relationship and trust building among these organizations required time, and continuation of the programme and these relationships was considered crucial to fully exploit the added value of collaboration.

Local organizations joining forces to cover more regions or SRHR Results Areas in the same country did not always create the desired added value due to coordination complexities. One of the implementing partners described how in their programme, partners did not fully stick to what they agreed in terms of coverage of Result Areas, and different elements of the programme were implemented in different regions. Hence, there were "difficulties to develop synergies".

Other interviewees also referred to coordination problems at "ground level" and mentioned how northern organisations in one alliance worked apart from each other, each in their own district or country. This is perhaps an efficient organizational structure, but it may reduce the potential to achieve a cumulative effect.

Coordination between different MFA funded programmes in one country could also be improved to increase complementarity and effectiveness. One MFA interviewee recalled observations made at a field visit:

> *(…) There were four projects in complete different geographic areas of the country. (…) One more directed on services, the other on education and the other on delivering commodities. In such a way the complementarity is not reached at all, because if you do one thing in one area, and the other in another area, then you do not have any connection between the two.*

Another MFA interviewee remarked that southern partners will not be inclined to critique such lack of coordination, since they depend on the funding. It was noted that it might be helpful to give embassies a stronger programme coordinating role within countries.

Nearly one third of survey respondents (31%) said that the **transaction costs of working with partners**, a requirement of the MFA, reduced the efficiency of some of their organisation's activities (Table 3, Items 19-21, Annex 8). A total of 14% of Northern respondents also disagreed with the statement that their programme activities would not have achieved as much if they had worked alone, and consensus conference participants also emphasized the need to examine the 'cost-effectiveness' of alliances.

Interviewees expressed several reservations regarding alliances. Compared to working independently, collaboration in an alliance requires more communication, investing time and effort in getting to know each other and establishing proper coordination mechanisms, even if "at the end it does improve the quality of the work" (alliance partner).

Some said that they would rather receive the money directly so that they could spend more on activities or their own organisational capacity. An MFA respondent described similar concerns he had heard from a Southern partner who thought it would be more efficient to get funds directly instead of through a Northern partner.

> *They said, like: 'Why is the lead partner here? Why are they here at all? Can't we do business directly? We can manage this all ourselves. Always those NGOs as intermediaries. This would*

suffice.' I found this interesting. He thought, he thought this was just another organisation as go-between, which costs more money.

Some of the lead partners had fewer doubts about the efficiency of joint working, but some distinguished between areas where joint working is efficient – for example in lobbying and advocacy - and where not. One of them added that in the beginning partners might have preferred to receive their own budget and work alone, and it could take up to 2 years until they saw the added value of working together.

6.1.3 Organisational structure, communication and decision-making

Organisational structure

Survey results show that overall the respondents were positive about the organisational structure of the alliance and programme in which they participated (Table 2 in Annex 8, questions 4-7). In the interviews and open survey questions strong aspects of alliances included the clarity of the *governance structure of the alliance, and clear definitions of roles for all partners*.

Several factors explaining good governance were mentioned by some respondents: *strong leadership and procedural integrity* were considered important, and the fact that there was *little bureaucracy.* Others appreciated the *high level of commitment of each partner.*

A significant minority of survey respondents did, however, raise concerns about the clarity of structure and roles for their alliance:

- 26% disagreed that the organizational structure of the partnership was clear;
- 11% felt that each partner organization did not have clear roles or responsibilities

Communication and building trust

Communication between partners was evaluated positively by survey respondents. In response to open questions, several respondents commented that *communication was open, with short and clear communication lines.* This was considered important for easily sharing expertise, ideas, and best practices. As one of the Southern partners put it:

> *It made it possible for partners in the South to work closely together and complement one another's expertise, building consensus more easily in terms of decision making.*

Communication structures enabled *regular, well-managed meetings* at country level and also with Northern partners, which were considered important. **Communication style** was also appreciated. Openness and respect were two of the key words used in the survey and interviews. One respondent mentioned that it was important that they felt able to share less positive experiences as well: *"Opportunities to put on the table weaknesses, in order to discuss how to improve, and also lessons learned".*

Responses also pointed to **scope for improving communication among alliance partners**. Critical comments concerned the high number and complexity of communication lines. Moreover, the survey findings showed that 50% agreed there had been preventable misunderstandings, as well as strong

differences of opinion or priorities. However, 64% agreed that there were proper strategies in place to resolve such conflicts (Table 4 in Annex 8 – questions 25-27)).

A high proportion of survey respondents (45%) also agreed there should have been more opportunities to discuss courses of action within programmes, especially for partners in the South (Table 2 in Appendix 4, questions 8-9).

In the interviews with organization representatives we asked for their reactions to these findings about the need for more opportunities for discussion. The reactions were very mixed. Some said this did not apply to their programme, others that more discussion was needed. A few other interviewees, mainly from Southern organization, suggested that limited discussions may result from "fear of donors, because they give you money" (it should be noted that the lead party was sometimes referred to as "donor").

Some argued that such discussions were important for building a **trusting relationship** for equal partners, and that local partners always explicitly expressed their appreciation of such dialogue. Many respondents referred to this **trust building as fundamental to the well-functioning of collaborations**, and pointed to the time and efforts invested in getting to know each other and to build trust in the early stages of the alliance.

Involvement in decision-making

Collaboration has implications for an organisation's autonomy in decision-making about a programme's activities. The survey data indicate that a substantial minority of respondents (42%) felt partners in the South lacked a voice in the early agenda setting stage of the programme, which was dominated by Northern partners. Once the programme was running, however, the great majority of respondents (90%) from both the South and North perceived (sufficient) space to define the content and form of interventions and influence programme implementation (Table 4 in Annex 8, questions 28-29).

The interviews found a similar experience of limited early involvement in decision-making, when the programme's direction and main objectives were being decided, but then more voice in decisions during later implementation phases. Some Southern and Northern partners stated that more involvement of Southern partners in the programme development phase was required. This was considered important for both programme effectiveness and because it created a sense of ownership.

Several Southern respondents said they enjoyed joint decision-making as part of the collaboration processes while others said they were pleased with the relative autonomy which they had within the alliance decision-making structure. A Southern alliance partner respondent, for example, underlined the freedom they had to define their own course of action:

> *They don't actually enforce you to do activities. They don't put pressure on you to do something that they want.(…) It's us, it's us who come with something and then we let them know what we want to do and then they tell us 'if it's fine'. (…) I love it. Because you know when we do that, we are able to do what our members really need, you know?... So I think that kind of relationship has been perfect*.

Flexibility in decision-making was valued: some interviewees underlined the importance of being able to adapt the programme without consulting the lead partner about every detail. Respondents of lead

organisations agreed that partner organisations should be able to maintain their autonomy with regard to the contents of their own programmes, but that joint agreements have to be made about overarching and long-term alliance issues which affect all partners.

Some respondents and interviewees did, however, raise some dissatisfaction with their involvement in decision-making:

> *I felt our opinions didn't matter so much since it seems we were just mere recipients / implementing players with limited say in formulating important decisions, particularly when defining scope and resources to allocate.* (Southern partner – survey)

Some Southern interviewees also emphasized that there should be an egalitarian dialogue between partners; Southern organisations should adhere to their principles, and seek to come to an agreement with their donor. As one of them phrased it:

> *I sit down, we talk, we laugh. I agree to disagree. If we cannot agree then I don't need your money: If you cannot agree with me then why would I take the money that is going to make me hectic? No.*

6.2 Collaboration between organisations, the Dutch MFA and embassies

The MFA wants to be more than just a funding agency in the field of SRHR (Ministry of Foreign Affairs, 2016, p. 2). Its stated ambitions are also to be a linking agency between grassroots and international levels, and to be a knowledge broker and bridge builder between SRHR policy actors. In this section we examine how staff of MFA, embassies and (lead) partner organizations experience their mutual collaboration; we also examine the role of the MFA as knowledge broker.

6.2.1. Collaboration between MFA and partner organisations

In interviews, MFA staff and lead and alliance partners were quite positive about their collaboration. Several related themes emerged from the interviewees.

Trust and mutual appreciation

78% of survey respondents agreed that the 'rights-based approach' of the MFA is important for improving SRHR in countries where the programmes were implemented (see Table 3, Annex 8, question 15). Lead and partner organisations were very positive about MFA support for SRHR, particularly because MFA is one of the few donors willing to support and finance controversial themes and marginalized groups, such as abortion, IDUs, sex workers and LGBT.

Some of the interviewees explicitly applauded the MFA for taking this outspoken and much-needed position, sometimes referred to as **the "Dutch approach", a source of much needed support which is hard to find elsewhere**. Along with the financial support, the MFA's ideological and moral support to these issues and groups was appreciated as well, for instance for organizations working on abortion, where people are often "telling you that what you are doing is wrong and bad and stigmatized". While most comments about the 'Dutch approach' were positive, critical remarks were sometimes made because in some contexts this approach was considered to be "too pushy".

In return, MFA staff were positive about lead partner organisations and their networks**.** MFA staff **trusted their partners**, noting their expertise, knowledge and experience. The organisations were described as: "professional organisations, regarding proposal and reporting systems, well-functioning (…) a well-oiled machine", and "as very knowledgeable and recognized worldwide as such", and "creative in handling sensitive issues".

Strategic collaboration: facilitating advocacy

Many examples of strong advocacy and lobbying partnerships were provided and reflect complementarity of expertise and reciprocity between the MFA and the organisations involved in the programmes. As a Ministry, the MFA is uniquely placed within partnerships to facilitate policy dialogue and advocacy for changes at local, national or international levels. Therefore, **advocacy is a major area in which the MFA can make an impact**. MFA staff, by using their position as state representatives, can 'open-doors' or amplify the voices of NGOs at the level of policy-making, for example advocating for sensitive issues such as abortion care among Ministries of Health.

A lead organisation interviewee referred to another example of how the Dutch MFA enabled them to be involved in policy making at international levels. In the preparatory phases for global UN meetings, her organisation was requested to provide input to the Dutch delegation participating in UN bodies and meetings. Through the MFA, the NGO got access to these early phases:

> *So you know, we don't have access to those phases as an NGO, but we do through them. (…) And they invite us to do so, it's not we're pushing our views on them, they ask for our advice.*

Some of the interviewees also underlined the importance of the Dutch MFA having an ambassador for SRHR and AIDS, who can actually be invited to speak at international meetings and draw attention to politically sensitive issues. As one non-Dutch interviewee of a lead organisation said:

> *The idea of having an ambassador for sexual and reproductive health and rights is like nirvana for us.*

In the survey, partners also mentioned that they would appreciate *more* support for advocacy, especially in challenging environments. This could mean helping to develop messages, and also to lobby directly with governments.

Flexibility

Lead and alliance organizations **valued the great flexibility or room for manoeuvre offered by the MFA** within Subsidy Frameworks that many other donors do not offer. This flexibility was experienced in different ways: it allowed space for organisations at country level to decide on how the money was actually used, based on local needs assessments; it also allowed them to adapt plans along the way and to react to unexpected development or crisis situations; and, to some extent, adapt the budget. Having this freedom, which is related to not being monitored on every small detail, was very much appreciated by partners.

MFA staff also emphasized the importance of this flexibility for programmes to function effectively. They did not want to be involved in "micro-management", preferring to monitor "outcomes and results, rather than activities", as one of them phrased it. **Feedback meetings following annual reporting**

enabled discussions about adaptations to plans, which the MFA expected and allowed for. As one MFA employee said:

> *You cannot have a budget or a plan for five years and then entirely hold on to that. For example, we agreed this in 2011 for 2014. That's impossible and you need to be flexible. But it is important to have sufficient trust in the implementing organisations.*

MFA staff also tried to give flexibility to organisations to manage their own activities, trusting them to do that:

> *A thing that we struggle with regularly is attempting to monitor the programmes that are being done on the level of results and outcomes. This means, we should not focus on the level of activities and tell partners what to do. You need to have confidence that these organisations know what they are doing.*

Working in this way, however, must be based on trust, which can only be built over time. MFA staff acknowledge there is tension between not wanting to control and check everything (because you trust that they make the right choices) versus still wanting to be sure that the money is well spent (as you do have the role as a donor as well).

Communication between the MFA and lead organisations

Some lead organization representatives said that ***direct access to MFA staff and being able to communicate in an informal way was an asset in the collaboration***. This facilitated the above mentioned programme flexibility, and also discussions about problems, future plans and international and national developments in their particular field. One of the lead persons spoke about contacts with MFA staff in terms of being "transparent with good dialogue"; others valued the way MFA staff were present or involved in the organization of meetings or conferences and that they encouraged mutual exchange between programmes covering the same theme.

Reporting systems provided a particular mechanism for dialogue. Annual reports were normally assessed by the MFA contact person in charge of the programme, and discussed in a meeting between MFA and the lead organization. Most MFA staff and the lead organisations deemed annual reporting meetings – focusing not on numbers but on actual problems and proposed solutions or future directions – more informative than the written Annual reports. During these meetings, other stakeholders involved felt that sufficient space was given to the organisations to openly discuss their problems and adjust their strategies and activities accordingly. Some believed this freedom and flexibility towards NGOs to be a typically Dutch attribute.

Having an expert staff member at MFA in charge of a particular theme (which is the case for child marriages), and who oversees all the MFA funded programmes in this theme or field, was considered a huge asset in terms of communication and exchange of experiences, strategies and methods. It also facilitated the provision of hands-on collaboration and technical support, ranging from being a 'sparring' partner to helping develop a Theory of Change (ToC) for a programme, or being involved in setting targets and monitoring progress.

Some interviewees did, however, indicate **the need for more regular and structured contact** with MFA staff which could contribute to a more cohesive and coordinated working relationship. As one lead partner said: "we have good relationships, but one would want to develop them a bit more".

More direct communications with *all* partners would also be appreciated. For example, annual meetings of partners with MFA staff were suggested. Also, the MFA could be more visible in the field at ground level.

Most interviewees mentioned that MFA staff were too busy and had a high staff turnover, which was considered problematic for continuity. MFA staff also recognized this as a major problem.

6.2.2. Collaboration with the embassies

Embassies within countries can play important roles for programmes such as linking people and organisations, sharing information and enabling local advocacy and lobbying. However about a third of the respondents were not able to react to the statements about embassies, or did not agree that embassies were important for their work: 39% said that that they did not play an important role in the implementation of the programme, and only 50% said that embassies were important for advocacy and diplomacy (Table 3, Annex 8, questions 16 and 17).

Several key factors influenced whether and how embassies became involved in SRHR programmes: whether the embassy had an SRHR programme or not; the presence of an enthusiastic ambassador for SRHR issues, or another SRHR 'policy champion'; or the presence of an SRHR or health expert. The presence of an SRHR specialist in the countries of implementation could also enable improved MFA monitoring and evaluation processes. The specialist could provide contextual information and a complementary point of view alongside annual reports, which would help MFA staff in The Hague to properly assess the information presented in the reports.

A system of rotating staff was not seen as helpful in building working relationship with embassy staff. As one of the lead partners mentioned:

> *It [working with Dutch embassies] has been pretty hit and miss. We would really love their help but I think the structure of the way that they are organized makes it challenging and also because of the heavy rotation of staff - you know they come in and out of embassies - makes it challenging as well. But I think that's something that I hope they can look at and think about how internally they might be able to organize and work more closely with some of their key partners in pushing it [sensitive issues] forward.*

As embassies have the autonomy to define their own thematic priorities, and not necessarily identify SRHR and HIV/AIDS as a core theme, they might limit their engagement in such programmes. This autonomy from The Hague had several implications for embassy involvement in programmes. Several MFA staff, while acknowledging the autonomy embassies have, felt there should be more communication, understanding and collaboration between MFA staff and the embassies. This could lead to better cooperation, which is badly needed. As one of them, currently working at an embassy, emphasised:

It is remarkable that programmes are being done in this country with MFA support, but the embassy is not involved, while there could be a role for them in the programmes. Sometimes there is and sometimes there isn't, but it now depends completely on the ambassador, a manager, or an individual staff member.

One of the partner organisation interviewees expressed discontent with embassies' limited involvement, arguing that embassies should be more involved not because of the personal interests or commitments at local level, but because the Dutch government is investing a lot of money:

You know there is a misconnection, there is a misconnection between the principle that the government is dedicating [XX] million to such a project, but the embassies do not feel the ownership of that. Even if they are not considered partners, they are representatives of the government, the government giving this money.. Is the minimum expectation that they will have in one way or the other a certain level of ownership at country level? Absent! And if they did, it was because they had a good heart. Because it was a good and committed ambassador because they thought the thing was relevant, but not as a consequence of the principle of where this money comes from, the government, and therefore I am a government representative and therefore this is partly my ownership.

Embassies still play an important background role however, notably in terms of their links to key government actors and support for advocacy, and their presence for moral support or even protection at difficult times. A few interviewees referred to the supporting role embassies played when people of their programme were being threatened (this referred to key populations). The embassies offered a safe haven, or facilitated the organisation of meetings with these groups. Being connected with the Dutch Embassy and having their support gave a sense of protection and encouragement.

Respondents also noted that since the new MFA partnerships in 2016, embassy involvement had increased, both in terms of moral support, but also to increase partners' advocacy and lobbying potential with their own government. Embassies also play a role as knowledge broker – being linking agents, information managers and facilitating lobbying and advocacy, discussed in the next section.

6.2.3 The Role of MFA as knowledge broker

Is the MFA a knowledge broker?

The MFA aspires to be a knowledge broker (Ministry of Foreign Affairs 2016). Glegg and Hoens (2016, p. 115) describe knowledge brokering in the health domain as:

'A strategy to support collaborations and partnerships within and across clinical, research, and policy worlds to improve the generation and use of research knowledge. Knowledge brokers function in multiple roles to facilitate the use of evidence by leveraging the power of these partnerships.'

They distinguish several brokerage roles: information manager, linking agent, capacity builder, facilitator, and 'evaluator' of available information.

In the survey, 23% did not agree that the MFA played a knowledge broker role, and 35% did not know about this role of the MFA (Table 3, Annex 8, item 18).

MFA staff held different views about their role as knowledge brokers. Some felt the MFA did not have a comparative advantage with knowledge sharing, had dwindling technical expertise, and so were not convinced it should play this role:

> *I see our role increasingly as simply one of the regular partners in a network. Therefore, I don't think this should be a special role for us. […] That can be expected from Oxfam Novib or Rutgers. They have 15 times as much knowledge as we have, let them do it.*

Lead and alliance partners pointed to various knowledge broker roles that MFA staff played, but also noted their limitations in developing this role, especially because MFA staff were too busy and changed positions quickly. Partners also questioned the MFA comparative advantage in this area: "they rather need us [NGOs] to collect knowledge instead of the other way round" (Alliance partner)

Although MFA staff recognized their limits as knowledge brokers, all partners who were interviewed also gave examples of the MFA performing roles as knowledge broker, which we discuss below, based on the interviews and the online survey.

Linking agent

The MFA brought partners into contact with each other to enable knowledge sharing. The MFA has a wide network of organisations operating at different levels within government and civil society arenas which can be brought together purposefully. One programme interviewee was extremely positive about the efforts MFA staff had made to stimulate meetings for knowledge exchanges among (Dutch) partners working in the same field, and also at an international level:

> [*Name MFA staff] was talking in London with Girls not Brides and with UNICEF [United Nations Children's Fund], and she nicely linked everything to each other. This was really great! The added value of this was enormous. Still it is.*

Factors enabling MFA staff to play a role as linking agent included: personal and long-term engagement of the staff member in a particular theme, an ability to focus on a sub-theme of expertise, and the possession of a good network.

Information and knowledge manager

MFA staff members were all able to give examples of sharing information. A first task that they see for themselves is to facilitate the dissemination of experiences from successful programmes. Reporting systems provided one mechanism for this learning and sharing. MFA staff stated that they gained more knowledge about achievements, possibilities, and challenges in the field through Annual Reports and reporting meetings. This knowledge could subsequently be used in communications with embassies or parliament, in international negotiations, during knowledge sharing events or conferences, and in the formulation of future policies. One MFA staff member, however, thought reports remained underutilized, and claimed 'we are not really a learning organisation'.

Partner organizations fully acknowledged the importance of the MFA's knowledge sharing task, which could also operate from the ground upwards:

Well, what I really like to do, is translate local knowledge to international policies or share it with [UN bodies], where they also do not know everything that is going on at the local level, so they can do something with this knowledge at that level as well. (MFA)

MFA staff can also alert alliances to the work of others because of their work at international level and the contacts and reports they see. This sharing increases partners' knowledge and stops them duplicating others' work. One alliance partner also mentioned the added value of information sharing to enable *better coordination of activities at country level* in the south. To illustrate this she pointed to 'mini-conferences' in Southern countries organised on the initiative of the Dutch MFA, which aimed to bring stakeholders working in the same field together.

6.3 Conclusion

Overall, organisations from the Global North and South valued working in collaborative MFA programmes. They benefited from mutual learning, including from grassroots organisations 'on the ground'. Collaboration brought *more resources together to tackle wider and more complex issues*, including stronger *strategic collaboration* to influence policy. Partners bring to their programme different and complementary skills or positions in society, such as service delivery, project design, policy influence and, importantly, access to 'hard to reach' target groups.

Alliances incur coordination problems and transaction costs, and a minority of respondents expressed a preference for the MFA to allocate funding more directly to their specific organization and service delivery activities rather than spending it on intermediaries and coordination activities.

Overall the structure of the alliances was clear to partners, and communications were good

However, in particular Southern partners expressed the need to have more voice in early decision-making processes about a programme's formulation, agenda or content and more opportunities were desired for partners to be able to talk through and discuss courses of action within their programmes, especially for partners in the South.

Lead and other partners applauded the "Dutch Approach" to SRHR. The MFA offers much-needed support for SRHR programmes which is hard to find elsewhere. Partners also complemented the MFA's flexibility, the room for manoeuvre they were given within grant frameworks and the fact that they could have easy and informal access to MFA staff.

Embassy commitment and involvement in SRHR programmes was uneven. Some were supportive and most could offer protection or important access to higher levels in country when needed. Embassy's relative autonomy, however, meant involvement was at the discretion of senior embassy staff.

While, the MFA does not have a clearly defined description and strategy as knowledge broker, in practice MFA staff carries out quite a number of knowledge broker related activities and has potential to do more in this area.

Including target groups in decision-making processes within the programme, such as youth, was considered essential by several respondents.

7. Key Findings and Recommendations

7.1 Main findings

7.1.1 Subsidy frameworks: formulation and selection criteria

The subsidy frameworks were formulated in the context of Dutch and international SRHR policy. Dutch SRHR policy has been consistent for more than two decades, and is aligned with international sexual and reproductive health and rights declarations and standards, which on their turn are influenced by developments and changing needs in the field of SRHR and HIV/AIDS. Its priorities are clearly outlined in policy documents. The MFA emphasizes the importance of focusing on sensitive SRHR issues and the rights of marginal groups, areas which other donors are less keen to be involved in.

The formulation of the three larger Subsidy Frameworks (Choices and Opportunities Fund, Key Population Fund and SRHR Fund) was initiated and led by MFA staff in The Hague. In some cases consultation with embassy staff of implementing countries or representatives of (I)NGO's took place before the formulation of the frameworks. While consulting (I)NGO's is a good practice, there is a tension between drawing on their valuable expertise and creating a conflict of interest for the NGOs involved in the policy formulation. The MFA clearly aspired to create a level playing field, and to have a thorough process of assessment.

The two smaller Subsidy Frameworks (Step Up Fund and Child Marriages Fund) resulted from amendments by Members of Parliament. The Child Marriages Fund lasted one year only, leading to serious concerns amongst MFA staff and organisations regarding effectiveness and sustainability of short programmes addressing complex issues.

The frameworks' **application and selection criteria and processes** are clear. However, the process is labour intensive for applicant organizations as well as selection committees, in particular when the frameworks were formulated in such a way that many organisations could apply (Choices and Opportunities Fund, and SRHR Fund).

Different Subsidy Frameworks had different rules regarding whether single organisations or alliances, national or international organisations could apply. The Choices and Opportunities Fund is the only framework that was open only to international INGOs (given their added value). For the other frameworks, only Dutch organizations were eligible to apply as lead organizations. This decision was justified with reference to the unique Dutch approach to HIV prevention among vulnerable groups (Key Populations Fund); to sex work (Step-UP Fund) and child marriage (Child Marriage). For the latter two Subsidy Frameworks this requirement resulted directly from the amendments. There was no convincing rationale to use different requirements for different Subsidy Frameworks.

Threshold criteria can exclude newer and smaller organisations, for example those led by target populations in the global South (e.g. youth led-organisations), that can potentially add value for the MFA and achieve the objectives of the SRHR policy.

There are clear disadvantages to short term Subsidy Frameworks, as they are inefficient for both MFA staff and NGOs. Moreover, it is impossible in only one or two years to make a meaningful contribution to the SRHR results areas.

The selection of proposals is done by a team of experts consisting of MFA staff, (in most cases) external consultants (only Dutch); in some cases health or SRHR experts at embassies were consulted as well. The fact that only Dutch consultants were involved may result in selection bias towards well-known Dutch organisations, and making it more difficult for newcomers in the field to apply successfully.

7.1.2 Relevance of programme objectives and achievement of targets

The programme objectives were relevant to the Subsidy Frameworks and the four Result Areas. Most programmes covered three or four result areas and each was implemented in many (up to 15). In line with the Subsidy Frameworks, many of the programmes focused on sensitive SRHR issues (like abortion) and the rights of marginalized groups, including LGBTs, IDUs and sex workers.

The majority (between 71% to 89%) of the envisaged output and some outcome targets were realized, and many were surpassed. These positive results undoubtedly reflect organisations' dedication and expertise; they may also reflect conservative target setting.

Most of the output indicators surpassing targets concerned the number of people reached (with information, training, activities, commodities, advocacy strategies), especially when electronic and mobile-health strategies were used. While these are positive output results, reaching people does not necessarily mean that the programme has effects for longer term outcomes such as increased knowledge or behaviour change.

Targets not achieved were often related to institutional or structural changes, usually pertaining to Result Areas 3 (increased usage of SRH care) and 4 (more respect for SR rights). This finding is not surprising, given that deeply embedded social structures (norms, values, power relations) change only gradually. Progress in Result Area four (with its focus on rights) might be particularly unsuitable for a numerical assessment and representation.

Several programmes provide some evidence of programmes effects on outcomes such as increased use of contraceptives or health services, or change in gender equitable attitudes, although there is uncertainty regarding whether these effects can be (only) attributed to the programmes. Methodological tools for addressing the attribution problem, such as independent evaluations or a study design that includes pre- and post-tests, control groups and tests of significance, were under-used and, when used, received limited attention in final reports.

The process of defining indicators and setting targets was mostly led by the lead organisations; sometimes it happened without any involvement of Southern partners. A considerable number of interviewees (organisations and MFA) were doubtful / skeptical about the role of targets. Such doubts were strengthened by our finding that many indicators obtained results vastly above targets set.

Positive unexpected results were found in a number of programmes (e.g. reaching other people than the originally intended target group, and unexpected synergies between collaborating organizations). **Negative unexpected results were rarely reported**. Some reports and interviews confirmed adverse

effects, including risks to NGO staff. Awareness of, and responsibility for, adverse unexpected effects is an ethical stance and evaluation focus which should be encouraged whenever possible.

7.1.3 Achieving programme results: Interventions, contexts and adaptations

Programmes implemented a large variety of interventions and intervention strategies. The following interventions and intervention strategies were most commonly used, and reports suggest that they were effective in achieving programme objectives and contributing to the four result areas:

1. Comprehensive Sexuality Education (CSE)
2. Peer involvement, including peer education
3. Use of electronic and mobile (E & M) health technologies
4. Male involvement in SRHR
5. Training of health workers / community health workers, including through E & M Health strategies.
6. Youth Friendly Health Services and Centres
7. Linking Communities and Care
8. Promoting legal change and awareness of human rights
9. Advocacy & Community dialogue
10. Needle and syringe (harm-reduction) programmes
11. Integrated packages / multi-level approaches

For most of these interventions, there is some supporting evidence of effectiveness in the academic literature. We found insufficient evidence for two interventions: youth centres and some forms of peer education. Available evidence needs to be interpreted with caution; it is often derived from studies in high income countries, usually supports effectiveness regarding selected outcomes (e.g. behaviour change) rather than impact (e.g. HIV reduction), and effectiveness will always depend on context and the quality of implementation. Quality of implementation is sometimes hard to achieve due to the challenging circumstances and collaboration with relatively small and inexperienced target-group led organisations.

In general, interventions seem logically aligned with programme objectives and the underpinning log frames. Some of the log frames or implicit theories of change contained problematic assumptions, including for example an over-emphasis on individual decision-making power (reflected for instance in the great number of programmes focusing on changing knowledge and attitudes), or the idea that shared demographic features (e.g. age) make someone a peer.

Various factors related to the political, social, and operational environment affect implementation and results in positive as well in negative ways**.** Factors having a negative impact include:

Political factors: government's limited commitment and restrictive legal frameworks, particularly regarding key population groups such as LGBTs, injecting drug users, sex workers and young people, and sensitive issues such as abortion and CSE.

Social factors: stigmatization of target groups; shyness and taboos around SRHR issues; poor SRHR knowledge; lack of youth-friendliness of health care services and language barriers.

Operational factors: the poor functioning of the health or educational system, and electronic and electricity infrastructure; the lack of good working relationships with local actors and structures.

Several of the programmes made good use of operational research and evaluations to tailor programmes to the context and needs of target groups. Dutch MFA and programme lead organisations created room for flexibility and adaptations; this facilitated the achievement of programme objectives. However, few programmes made fundamental changes in intervention approach derived from reflections on underlying assumptions.

7.1.4 Programme Costs

Due to the lack of sources it was impossible to determine whether programme costs are reasonable in view of the outputs achieved. In many cases, programme targets have been surpassed by 100% or more, suggesting that at the project design phase there were no realistic expectations of programme costs. Programmes over-estimated the costs of interventions and activities; they were able to do much more with the budget available than estimated at the start. Comparison across even similar programmes compounds aforementioned problem, amongst others because the cost of material and human inputs can be very different in different settings.

7.1.5 Sustainability

Reports, survey and interview respondents were generally positive about sustainability of activities and organizations. They indicated that: many programmes led to structural improvements in service delivery (e.g. embedding activities and services in existing health and education systems) and improvement in SRHR policy; organizations' capacity was enhanced; additional funding obtained; and alliances were continued. Nevertheless, gaps in organizational capacity were noted, especially amongst small, target-group-led organisations and in particular regarding M&E. It was also recognized that activities were cancelled after MFA funding ended. Some implementing partners identified the need for more capacity building , especially in M&E, and more and earlier attention for sustainability.

Various programmes were confronted with barriers to sustaining programme activities and results*:*

- An (increasingly) hostile international and national climate regarding SRHR, especially for key populations and sensitive issues such as abortion. This has affected programmes' ability to embed activities and services in existing health and education systems, since the required political support from different levels of government (local, regional, federal, national) could not be obtained. Some governments delayed or stopped implementations.
- High national poverty levels constitute a structural barrier to sustainability of the programmes since they affect infrastructures on which programmes depend, and limit programmes' chances to obtain governmental funding.
- Long-term and core funding from the MFA is important to promote the sustainability of SRHR organisations, programmes and results, because of national governments and other donors' lack of willingness or capacity to find such activities.

Several measures have been taken to ensure continuation of activities and foster sustainability, including: capacity building of the implementing partners; fostering local ownership; embedding activities in health and education systems; securing funding; building an enabling environment; and knowledge-sharing to improve visibility of programmes.

Capacity building took place through mentoring and training, supported by new IT systems, important especially for standardized M&E. E-learning and train the trainer approaches made capacity building more sustainable.

The greater capacity building needs of small, target-group led organisations (e.g. youth-led, sex worker led) need consideration and will require more resources and time. In addition, enhancing individuals' skills may not translate into organizational learning without adequate structures and processes in place.

Several programmes, alliances or members of alliances secured new funding. Some developed income generation activities to sustain the programme, organization or (youth)participation. Funding was also secured through involving the private sector.

Building an enabling environment is crucial for the programmes to sustain, in particular given the hostile political and social environment towards some SRHR activities in several countries. Strategies to do so include situational assessments, power/stakeholder analysis, and collaboration with embassies, ministries and other governments. Also, promoting local ownership, identifying champions in country who have the expertise and willingness to continue a project and its activities or continue with advocacy help change the environment and are thus instrumental for sustainability.

Interview and survey respondents suggested various ways in which the MFA could be more involved in promoting sustainability, for example: review and comment on organizations' sustainability plan; promote continuation of funding for a particular programme (if evidence shows it is effective); lobby to national and international governments for SRHR in general and for sensitive topics in particular, such as abortion; and monitor impact long after the project has ended.

7.1.6 Collaboration

Overall, the collaboration in the programmes was valued positively and perceived to have an added value for the implementation of the programmes. Organisations benefited from mutual learning; collaboration brought more resources together to tackle wider and more complex issues, including stronger strategic collaboration to influence policy; and partners brought together complementary skills or positions in society, which were conducive for the attainment of results.

Overall, the structure of the alliances was clear to (most) partners, and communication was good. However, the involvement of southern partners in discussions and decision-making at various stages of the programmes (formulation, developing action plans) differed strongly between programmes and was not always considered adequate.

Working in alliances involves substantial investment in coordination and communication, and therefore transaction costs. Considerable time and effort were invested to make alliances work, especially the large alliance in the Key Populations Fund. Whether these investments are worth it seems to depend on the types of activities jointly executed (for example advocacy and strategic collaboration). Understanding of the conditions and requirements for effective collaboration in alliances is still lacking.

Collaboration between MFA and organisations is considered positive and productive. The MFA's flexibility, including the room for adaptation within the implementation of programmes and the easy

access (formal and informal) to and exchange with MFA staff are considered crucial aspects of this positive collaboration. MFA staff's trust in the expertise, knowledge and experience of the collaborating organisations was also valued. MFA staff were often considered too busy and had a high staff turnover, which was considered problematic for continuity and so collaborative working. A few minor improvements in MFA-partner collaborative relationships were indicated.

Partner organisations value highly the MFA's support for SRHR programmes, in particular for the controversial SRHR themes and marginalized groups, which other donors are less inclined to support.

Embassy commitment to and involvement in SRHR programmes was uneven. Several embassies were supportive and could offer protection or facilitate access to governmental structures in countries when needed. However, embassies' relative autonomy meant that involvement in SRHR programmes was at the discretion of senior embassy staff.

The MFA does not have a clearly defined description and strategy as knowledge broker, but in practice carried out several knowledge broker activities as a 'linking agent', and 'information and knowledge manager'. These knowledge broker roles were important for the realization of programme goals, and the strengthening and expansion of SRHR policy in general.

7.2 Recommendations

7.2.1 Programme results

To improve the achievement of programme results and strengthen evaluation of results, we recommend that the MFA does the following:

1) Allow enough budget and time in programmes' inception phase for the joint definition of indicators and realistic target setting, involving Northern, and notably Southern partners, in this process. MFA should consider developing, together with NGOs, more standardised frameworks for indicators. Moreover, some programme results (e.g. more respect for sexual and reproductive rights) require qualitative assessment.

2) Make proposals more evidence-based, by making inclusion of reviews of existing quantitative and qualitative evidence a requirement. Public health interventions implemented in the Netherlands are expected to be evidence-based; similar expectations should apply to programmes implemented in the partner countries. Given the resource implications, the MFA might consider commissioning a series of mixed-method systematic reviews regarding commonly used interventions (e.g peer education; e- and m-health). (For a start, see also Annex 7).

3) Continue to allow and develop innovative intervention strategies which are not (yet) based on evidence, under the condition that process and outcome evaluations by external evaluation team are done.

4) Give higher priority to monitoring and evaluation of programme results, including outcome and cost measures, and evaluation of implementation processes. Request more information about M&E methodology as well as findings in reports, including analysis of whether more vulnerable sub-groups are reached; unintended outcomes; and assessment of 'what works for whom under what

circumstances' (in line with realist evaluation principles). Implications for resources and capacity need to be considered in programme proposals and budgets. In order to foster more robust M&E and operational research, greater collaboration between NGOs and knowledge institutions is recommended.

5) Build a database of SRHR programme activities and costs to improve programme budgeting and planning.

6) Consider limiting the number of countries of implementation and regions, as this may decrease complexity of the programmes, making them easier to implement, run, monitor and evaluate, which may positively affect effectiveness, sustainability and accountability.

We recommend that (lead) organisations:

7) Increase critical reflection on assumptions regarding the link between outputs, outcomes and impact. The use of Theories of Change, now required for the more recent MFA SRHR Subsidy Framework, is conducive for this, as assumptions about mechanisms of effect have to be made explicit before implementation. The validity of assumptions can be checked *before* implementation, and then *during* implementation to facilitate making any necessary changes.

7.2.2 SRHR Subsidy Frameworks

To improve the formulation of SRHR Subsidy Frameworks and selection of proposals we recommend that the MFA does the following:

1) Continue involving (I)NGOs and embassies in the formulation of Subsidy Frameworks, to create frameworks attuned to the circumstances at country level, the needs of particular target groups, and priorities in specific SRHR sub-areas.

2) Avoid conflicts of interest with regard to the involvement of organisations in the preparatory phase of Subsidy Frameworks. The MFA might consider conducting consultations with (I)NGOs to formulate the Subsidy Frameworks more formally and openly, and excluding organisations who were consulted in the preparatory phase.

3) Avoid SRHR frameworks and programmes of short duration (1-2 years). If programmes of short duration are unavoidable, MFA and programmes should continue to enable and encourage organisations to embed them in existing programmes.

4) Explore the possibility of adapting the MFA 'Standaard Subsidiekader Ontwikkelingssamenwerking' (2006) in such a way that it allows funding programmes of longer duration (up to 10 years).

5) Ensure that if application requirements for a Subsidy Framework differ from others (e.g. only international NGOs or alliances can apply) this is based on a clear rationale.

6) Ensure that threshold criteria do not exclude organisations which may be innovative or of strategic value for the MFA, in particular, small target-group led (youth-led etc) organisations.

7) Make the application and screening process more efficient by introducing a two stage application procedure: a concept note and then a full proposal after selection of the best applications, to avoid many organisations investing time in developing full proposals.

8) Include non-Dutch experts as external consultants in the selection procedures to avoid selection bias towards well-known Dutch organisations.

7.2.3 Collaboration

To improve collaboration among MFA/embassies and organisations we recommend that the MFA does the following:

1) Explore mechanisms which enable a more consistent embassy involvement in SRHR programmes across countries (including for example improved communication and training).
2) Have more regular and structured communication with all partner organisations, for example annual meetings with organisations and the MFA (including embassy staff), which could contribute to more cohesive and coordinated learning working relationships.
3) Commission research, in deliberation with organisations, into the conditions and criteria for efficient and effective collaboration in alliances (including alliance size, types of interventions undertaken, and organization and communication structure).

To improve collaboration among organisations we recommend that the lead organisations:

4) Involve all partner organizations, in the North and in the South, in decision-making about programme formulation, planning and the implementation of activities.

To enhance MFA's and the organisations' role as knowledge brokers, we recommend:

5) The MFA first explores/defines what the role of knowledge broker should entail, and then, if deemed desirable, further develop staff capacities to fulfill this role in a more structured way. Retaining staff who have expertise in sub-themes is important to further develop this role.
6) The MFA and organisations find ways to build (more) on each other's strengths as knowledge brokers, including making more use of Share-Net, the Dutch and international knowledge platform for SRHR and HIV/AIDS.

7.2.4 Reporting

To improve reporting on programme processes and results and to make better use of programme reports we recommend that the MFA does the following:

1) Give higher priority to monitoring and evaluation of programme results, including outcome and cost measures, and evaluation of implementation processes (see point 4 under Programme Results).
2) The MFA enables staff to invest adequate time to review reports.
3) The MFA and lead organisations develop a reporting and feedback system to ensure that feedback reaches all organisations in the North and South.
4) The MFA and lead organisations ask for more critical discussion of 'lessons learned' in reports, foster critical self-reflection among programmes, and stimulate an approach of reporting mistakes or underachievements.

7.2.5 Sustainability

In order to foster sustainability of organisations, activities and results we recommend that the MFA does the following:

1) Makes longer-term investments in organisations, alliances and programmes.
2) Consider core funding for organisations, instead of or in addition to programme funding to foster continuity and organizational strengthening.
3) Increase investments in capacity building and enhancing organizational capacity (including M&E), especially for small, target-group led (e.g. youth-led, sex worker-led) organisations.

We recommend that organisations:

4) Pay more attention to sustainability plans, at an earlier stage in the programme.
5) Make organizational capacity assessment default practice.
6) Embed activities in existing health, education and community structures, but paired with risk assessment and monitoring of quality.

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Annex 1. Programme descriptors

SRHR Subsidy Frameworks	Name of the programme	Content
Child Marriage Fund[3]	By awarding grants to alliances of Dutch civil society organisations, the Netherlands aims to contribute to the following strategies: • Strengthening the position of girls (*empowerment*) by providing and teaching them with knowledge and skills that are of importance in their daily lives; • Improving access to the formal school system for girls; • Changing harmful social, traditional and religious norms through involvement with local communities; • Improving the socioeconomic position of underprivileged girls and their families; • Development and application of laws and policies that combat child marriage; and, • Improving access to SRH-services for married and unmarried girls.	
	Unite against child marriage	'Unite Against Child Marriage' is an additional programme component and upscaling of the current programmes of the SRHR Alliance and Edukans that aims at the prevention of forced marriages and child brides. Target group is (underprivileged) girls aged six to eighteen in India and Malawi. The Unite Against Child Marriage programme works on the following strategies: empowerment of girls, access to formal education for girls, involvement of local communities, development and implementation of legislation and policy aimed at prevention of child marriages, improvement of access to SRHR-services.
	Nee, ik wil...	The "Nee, ik wil…" programme is intensification and upscaling of certain interventions in Zambia and Mozambique that form part of the regional 18+ programme. The overall objective of the 18+ programme is to contribute to ending child marriages in Southern Africa, especially in Zambia and Mozambique, through: empowerment of girls, establishment of a social movement, creation of a supporting legal and policy framework and increased access to SRHR information and services.
	Ineens geen kind meer	The "Ineens geen kind meer" programme aims to reduce the number of child marriages in Bangladesh, Nepal and Pakistan. This programme focuses especially on the empowerment of girls, especially vulnerable and young girls aged zero to eighteen, on the mobilisation of the community in which girls grow up. The corresponding strategies are: strengthening the position of girls, improving access to the formal school system for girls, improving access to SRH- services for married and unmarried girls and women, improving the socioeconomic position for girls and their families, changing harmful social, traditional and religious norms in collaboration with local communities, and application of laws and policies that combat child
	Zó zijn we niet getrouwd	The "Zó zijn we niet getrouwd" programme is a continuation of running programmes (including My Rights My Voice) and concentrates in Mali, Niger, Bangladesh, Pakistan, India and Afghanistan. The programme contributes to the following strategies: strengthening the position of girls by development of their knowledge and skills in SRHR, improving access and attendance to the formal school system for girls, mobilisation of the local communities to change harmful social, traditional and religious norms and uses, improving the socioeconomic position of vulnerable girls and their families, development and implementation of laws and policy that combat child marriage, and improving the access of married and

Choices and Opportunities Fund	By awarding grants to international NGOs, the Netherlands aims to achieve the following objectives: • Increasing international support for, and helping to implement, Dutch priority themes relating to SRHR and HIV/aids; • Encouraging an integrated approach to SRHR and HIV/AIDS in policy, programming and implementation; • Widening access to prevention and health facilities for women, young people and marginalised groups; and • Empowering women, young people and marginalised groups.	
	Adolescents, Young People and Sexuality	The Adolescents, Young People and Sexuality programme aims to increase support to empower adolescents and young people, particularly through increasing access to youth-friendly services, enhancing sexuality education, and advocacy on issues affecting adolescent sexual and reproductive health. The programme works towards the following objectives: 1) To strengthen commitment to and support for the SRHR and needs of adolescents/ young people; 2) To promote the participation of adolescents/young people in governance and in the identification, development and management of programmes that affect them; 3) To increase access to comprehensive, youth-friendly, gender-sensitive sexuality education; 4) To increase access to a broad
	Community Action on Harm Reduction	The CAHR programme seeks to address HIV risk and vulnerability, and that promotes change at the personal, community, structural and health service levels. The programme works towards the following objectives: 1) Access to HIV prevention, treatment and care, sexual and reproductive health and other services for injecting drug users is improved in China, India, Indonesia, Kenya and Malaysia; 2) The capacity of civil society and government stakeholders to deliver harm reduction and other health services to injecting drug users and their partners is increased in China, India, Indonesia, Kenya and Malaysia; 3) The human rights of injecting drug users and their partners are promoted and human rights protections are increased in China, India, Indonesia, Kenya and Malaysia, and advanced in global institutions; and, 4)
	Global Programme to Increase Women's Access to Safe Abortion	This programme aims to enhance the ability and rights of women, including young women, to obtain comprehensive abortion care and prevent unwanted pregnancy. This programme has three outputs: 1) Comprehensive abortion care, including contraception, integrated into organised health systems and utilised by women; 2) Women have the knowledge, skills, social support and sources of care in their communities to make and act upon their reproductive decisions; and, 3) The policy, legislation and rights environment
	Improving Access to Family Planning	The programme aims to significantly scale up and expand delivery of high quality family planning products and services over four years to address unmet need in a sustainable and targeted manner. The programme focuses on the following results: 1) Increased availability among women of reproductive age (WRA) and underserved and marginalized populations to high quality, affordable, available family planning products and services; 2) Increased ability and motivation to use sexual and reproductive health products and services; 3) Increased integration of HIV and sexually transmitted infection (STI) products, services, and communication messages with family planning among WRA and underserved and marginalized

Step-Up Fund	By awarding a grant to an alliance of Dutch civil society organisations, the Netherlands aims to achieve the following objectives: • Improvement of individual human rights, security and emancipation of sex workers, so that they are able to make independent decisions, including stepping out; • Increase in access to care and relief of sex workers; • Improvement of signalling and reporting to authorities about minors in the sex industry; victims of human trafficking and other forms of sexual exploitation • Involvement of sex workers in the formulation and implementation of programmes that may benefit them; • Strengthening the position in civil society of organisations that support, guide or represent sex workers, with the purpose of increasing the independence of these organisations and bring about a lasting change; • Increase the international support for the position and rights of sex workers through lobby and advocacy towards governments and international fora; and • Increasing the coherence of different approaches of Dutch civil society organisations that have expertise and experience in this field of work, through exchange and collaboration.	
	Stepping Up Stepping Out II	The Stepping Up, Stepping Out (SUSO) II programme aims to use economic empowerment as an intervention strategy for HIV prevention and to build the capacity of civil society organizations working on these issues. The work programme relates to four objectives: A. Improving the capability of sex workers to make informed choices in relation to their own lives, health and career development. B. Supporting sex workers to acquire skills and opportunities that lead to increased access to income sources or new career opportunities C. Strengthening the sustainable capacity of organizations led by/supportive of sex workers to improve the social and economic position of sex workers, nationally and internationally D. Effectively addressing issues related to sexual violence and exploitation within sex
Key Populations Fund	By awarding a grant to an alliance of Dutch civil society organisations, the Netherlands aims to achieve the following objective: • Increase access to health facilities including HIV prevention for key populations and their sexual partners, including attention for prisoners, youth, street children, disabled people and people that live with HIV under the key populations; • Strengthen the position in civil society of organisations that consist of key populations or that represent the key populations with the purpose of increasing the independence of these organisations and bring about a lasting change; • Increase the international support for the rights of key populations through lobby and advocacy towards governments and international fora; and • Stimulate a mutual coherent approach to the diverse key populations through collaboration between Dutch civil society organisations that have expertise in this field of work.	
	Bridging the Gaps	The Programme links three key populations through combining four programmes into one comprehensive approach: 1. Female, male, and transgender sex work programme 2. People using drugs programme (with specific focus on injecting drug use) 3. Lesbian, Gay, Bi-sexual Transgender people, including men who have sex with men

SRHR Fund	The SRHR Fund consists of three categories of programmes: A. Integrated programmes, implemented in several countries, which cover at least two of the four result areas. All programmes explicitly consider the needs and interests of young people. B. Programmes relating to specific SRHR subthemes, namely a. Improving the quality, and increasing the capacity of, professional care during pregnancy, childbirth and maternity, as well as family planning and abortion; b. Improving comprehensive sexuality education through the formal education system and other means using traditional and/or modern channels such as social media and m- and e-learning; c. Addressing gender and sociocultural aspects of SRHR, with particular focus on the role of boys and men; and, d. Improving capacity and coordination for prevention and treatment of lasting injury following pregnancy and childbirth, especially fistulas. C. Programmes that implement innovative SRHR ideas that fall under the four result areas, which have not yet been assessed in terms of feasibility and/or impact.	
	Link Up	By 'linking up'; the programme aims to make a significant contribution to the integration of vital SRHR interventions and generate important evidence to aid the broader SRHR/HIV integration movement. Link Up has been designed to provide young people with age appropriate information and services to ensure comprehensive sexuality education and targeted commodities and services in generalized epidemics in Burundi, Ethiopia, Uganda, and concentrated epidemics in Bangladesh, Burma
	Making sexual and reproductive health work for the next generation	An innovative combination interventions which links Performance Based Financing initiatives with supply chain management, entrepreneurial approaches (Pharmacy in the Box) and changes in social cultural barriers through involvement of men, local leaders and Faith Based Health institutions. An estimated 2 million women will have access to family planning and 1, 8 million young will be reached by services targeting youth
	Access, Services and Knowledge (ASK)	The programme aims to improve the SRHR of young people (10-24 years) by increasing young people's SRHR Access, Services and Knowledge. The programme has a youth centred approach , aiming to ensure a minimum package of youth friendly services, direct access to information as well as comprehensive sexuality education and an enabling environment
	Men Care	The central objective of the MenCare Programme is to address harmful social and cultural norms and behaviours that negatively impact SRHR and MCH outcomes, by engaging young and adult men as caregiving partners. This programme will influence the SRH status of women and men positively, specifically by addressing prevailing norms of masculinity and inadequate SRH information and services.
	Staying Alive!	The goal of Staying Alive! is to reduce maternal mortality and morbidity (specifically fistula incidence) by improving the quality of direct and indirect maternal care, timely identification and referral of complications, and availability of the right skills, supplies and capacities. AMREF will do this by for instance providing training for health workers, stocking clinics, community engagement and strengthening

	SHARP	SHARP is a multifaceted intervention to reduce maternal mortality and improving accessibility of reproductive health care in three states of South Sudan. The programme has four pillars: Improving access to and utilization of Emergency Obstetric and New-born Care services; empowering communities to claim and exercise ownership over services; building professional capacity to meet unmet needs and expectations, at all levels; operational research to generate context appropriate knowledge.
	Keep it Real	Keep it Real is a Comprehensive Sexuality Education programme for in school and out of school youth in rural as well as urban areas in Ethiopia and Uganda. They will aim to reach a large group of very young adolescents and youth in different settings and educating young people to make sure that they are equipped to make healthier choices about their sexuality.
	Global Dialogues	The goal of Global Dialogues is to bring different youths, including marginalized youth, together on SRHR

		an explicit focus on addressing sexual diversity. The main medium that will be used is film, both through local as well as global competitions youth will get the chance to let their voices be heard and foster a 'global'
	Exploring new ways of improving sexual health and wellbeing of young males in Bangladesh and Kenya through a motivational intervention approach	For this proposal a Motivational Intervention (MI+) approach has been developed that focuses on young male sexual and reproductive health roles and responsibilities. The client-centred MI+ programme aims to change the way in which health professionals and peer educators engage with young MSM in Bangladesh and young male in Kenya; and introduce a genuinely new dimension to the provider-client and peer educator/peer interaction, eliciting and strengthening clients' motivation for change.
	Netherlands HERproject	HER (Health Enables Returns) project, or, is an initiative that catalyses partnerships between the private sector and local NGOs to ensure delivering of SRHR education to low-income women workers in Bangladesh and Kenya, driving changes in attitude to make better choices, access to critical resources, uptake of those services, and confidence to act on and improve their SRHR.. In Ethiopia, Ghana, Rwanda and Uganda, BSR will implement research to confirm the specific needs of women working in a variety of export oriented sectors to eventually expand the HERproject to at least two of these countries.
	Faith to Action project	The central objective of this programme is to increase faith organizations' (FOs) commitment to and provision of SRHR information to young people, access to commodities, services and respects of rights. This will be achieved by establishing a global interfaith advocacy network which is coordinated as an effective platform for dialogue and advocacy on SRHR, and by increasing FOs participation and engagement in policy

Annex 2. Methodology

2.1 Introduction

This evaluation adopted a mixed-method approach, combining a desk study of secondary data (SRHR programme documents and academic literature) with primary data-collection through an online survey and semi-structured interviews (SSIs) with key stakeholders: MFA staff and staff of lead, alliance and implementing organisations from the North and the South (see text box 1.1). Since we found that there was a lack of detailed descriptions of evaluation methodology available in the public domain on which synthesis evaluations can build, we include an extensive description of our methodology in this report.

Box 1.1 Types of organisations

- *Lead organisation*: organisation in charge of the entire programme
- *Alliance partner*: organisation involved in the consortium that submitted the programme proposal
- *Implementing organisation*: organisation involved in the implementation of the programmes

Most Northern partners were lead or alliance partner; Southern partners were usually implementing partners.

Table 1.1 summarises which methods addressed which study objectives. Note that the objectives set out by the ToR were supplemented by objectives which emerged from the desk study.

Table 1.1

Objective	Methods
1. Results of the programmes	Desk study of SRHR programme documents and academic literature
2. Collaboration & decision-making	Survey and SSIs with key stakeholders
3. Sustainability of programmes	Desk study of SRHR programme documents and academic literature
Additional theme 1 Reporting and Accountability	Survey and SSIs with key stakeholders
Additional theme 2: 'The Dutch approach' to SRHR	Survey and SSIs with key stakeholders

Ethical clearance was granted for the survey and interview study by the Ethics Committee of the Amsterdam Institute for Social Science Research at the University of Amsterdam. The study did not raise major ethical issues, but we set out the modest risks and how we addressed them in section 1.7.

2.2. Approach: Narrative synthesis

We adopted a narrative synthesis approach, which was developed to provide an explicit, auditable process for the synthesis of diverse bodies of evidence concerning effectiveness and implementation of interventions (Popay et al., 2006). Our intention was to use principles of realist synthesis (Pawson et al., 2004), which asks not merely *whether* a programme works but examines *what* works, *for whom* (which target groups), *why* (mechanism of effect) and under *which circumstances* (context). A realist lens is thus useful for generating context-specific insights into SRHR programmes. However, the complexity and heterogeneity of the programmes and data limitations restricted use of this approach. We did, however, pay particular attention to the impact of context on implementation and programme results, and reviewed whether programmes themselves pay attention to how context affects both outcomes and mechanisms of effects (see chapter 4).

2.3 Inception phase

In the inception phase we developed a work plan, evaluation matrix (adapted from the ToR), and conducted a rapid methodological review of existing synthesis evaluations. We could not locate synthesis evaluations which were sufficiently similar in terms of complexity, objectives (e.g. going beyond impact) and data limitations (e.g. reliant mainly on programme reports). We were, however able to incorporate components of other evaluations such as the MFS II evaluation (Gunning, van der Gaag, Rongen 2015); the Kaleidos (2015) evaluation of the Unite for body rights-SRHR Alliance; and the UNFPA (2013) evaluation of UNFPA Support to Family Planning 2008-2013.

2.4 Desk study

2.4.1 Documentation reviewed

In order to learn lessons regarding what appears to work and why, as well as to assess programme relevance and impact of context on implementation (objective 1), we reviewed programme proposals and final programme reports, including quantitative data on outputs and outcomes, qualitative data and narratives reporting and explaining main results, lessons learned, adaptations and challenges. Approximately two thirds of the reports also included baseline measurements and – more frequently – selected findings of operational research. We also reviewed independent evaluations, conducted for ten of the 21 programmes.

2.4.2 Quality assessment

We developed an appraisal tool (see Annex 3) to evaluate the quality of programme documentation in order to assess to what extent, and with how much confidence, documents could answer the evaluation questions. The tool was based on the IOB evaluation assessment tool and focused on the following features:

- Internal quality control (e.g. independent evaluation and accountants' report)
- Methodological rigour (e.g. was a baseline or control group used? Were indicators specific; measurable, attainable, relevant, time-bound (SMART)?)
- Critical analysis (e.g. acknowledgement of attribution problems).

Each programme was reviewed by two reviewers. Programmes that conducted relatively high quality evaluations and produced good quality reports made a larger contribution to the synthesis because they provided richer and more robust insights.

Quality assessment highlighted various design issues. Approximately one third of all programmes did not use a baseline assessment, and in several cases, the methodological rigour of the pre- and post-assessments was poor (e.g. base-line and post-test conducted in different regions; indicators not comparable, errors in denominator used) or hard to assess due to lack of methodological detail. Few programmes included tests of significance to assess the meaning of any changes observed and only two programmes included a control-group. These issues greatly limited our ability to assess programmes' effectiveness, further affected by limitations in critical analysis, for instance regarding possible confounders (factors other than the intervention which can explain any changes observed). We partially compensate for these attribution problems by juxtaposing claimed effects of interventions with evidence from systematic reviews regarding intervention effectiveness (see chapter 4).

2.4.3 Data extraction

We developed a coding system, based on the evaluation matrix, to capture relevant data, including codes such as 'unintended outcomes' or 'collaboration'. Using the qualitative data analysis programme Atlas.ti, we jointly coded and discussed one report. This detailed analysis helped us to determine our focus and adapt the coding tree, but was time-consuming; we thus shifted to manual coding. Per programme, the lead reviewer transferred relevant information into an evaluation form, or 'case-based matrix' (Pope et al. 2007), which included all evaluation questions. The form was then discussed with a second reviewer.

Quantitative data on outputs and outcomes (few programmes used indicators at the level of impact/health effects)[6] were entered into an Excel table, organized according to SRHR result area, policy-framework and programme. We calculated differences in expected and actual results, recording direction (i.e. below or above target) and size of difference. When programmes used more rigorous base-line assessments, we described the direction of results in terms of "positive change", "no change", or "negative change".

2.4.4 Synthesis

The synthesis steps that we used followed the steps for narrative synthesis developed by Popay et al. (2006), summarized in Table 1.2.

[6] Output: Concrete activities performed by programmes (e.g. training). Outcome: Effects on target groups, wider communities, or systems in terms of behaviours or provision of services. Impact: Effect in terms of health (e.g. maternal mortality, pregnancy)

Table 2.2 Steps for narrative synthesis (adapted from Popay et al. 2006)

Steps in synthesis	Objective
1. Preliminary synthesis within programmes.	1. Organize data per evaluation question, in order to describe patterns **within** programmes (across sub-programmes/countries of implementation) in terms of: a) Results (direction and size of effects, unexpected outcomes) b) Mechanism of effect/ToC. c) Implementation (facilitators and barriers) d) Collaboration e) Sustainability (facilitators and barriers)
2. Preliminary synthesis across programmes within Subsidy Frameworks.	2. Describe patterns **across** programmes in terms of: a) Results (direction and size of effects, unexpected outcomes) b) Mechanism of effect/ToC. c) Implementation (facilitators and barriers) d) Collaboration e) Sustainability (facilitators and barriers)
3. **Synthesis <u>across Subsidy Frameworks</u>**	3. Describe patterns **across Subsidy Frameworks** (see above)
4. Triangulation: Desk study and primary data (interviews, survey).	4. Contribute to the interpretation of the desk study's findings by triangulating findings from the desk study (programme reports, literature review) with findings of the interviews, survey. 5. Provide fuller answers to evaluation questions, in particular those pertaining to objective 2 (decision-making and collaboration) and 3 (sustainability). 6. Answer questions raised by the desk study concerning reporting and 'the Dutch
5. **Consensus conference**	7. Elicit feedback on findings and suggestions regarding recommendations from key stakeholders.

Step 1. Within programme synthesis of findings.

Programmes were often implemented in six countries or more, and five programmes involved 15 or more countries (see Annex 6). We therefore first identified patterns within programmes, such as factors affecting outcomes across countries of implementation. For instance, in SUSO, we found that in both Indonesia and its Latin-American countries of implementation, economic empowerment through training in vocational skills had variable and sometimes negative effects due to lack of job opportunities.

Step 2. Across programme synthesis per Subsidy Framework.

We synthesized the quantitative data regarding outputs and, where available outcomes (objective I) across programmes by using a form of 'vote counting' (see Pope et al. 2006); we calculated percentages of indicators achieving more or less than the target set (see Section 3.2) to capture the proportion of indicators which point to 'success' across programmes. We also examined patterns in terms of which kind of indicators tend to be achieved to a greater or lesser extent than expected. We developed meta-indicators inductively, by clustering, per result area, similar indicators under one more abstract meta-

indicator. To synthesize qualitative data, we used thematic analysis to identify recurrent themes. For instance, the social and political context affected implementation and attainment of results across programmes and Subsidy Frameworks.

Step 3: Synthesis across Subsidy Frameworks
We compared and contrasted findings across Subsidy Frameworks

Step 4. **Triangulation**
Where possible, we triangulated primary research findings (surveys and interviews) with findings of the desk study. In addition,since reports contained limited evidence regarding outcomes and impact, we triangulated reports with a focused review of the peer-reviewed literature (See 1.5) regarding effectiveness of a selected number of interventions and intervention strategies. This allowed us to assess the plausibility of the attribution of outcomes and any (potential) impact to specific programmes.

Step 5. Consensus conference
We organized a half day consensus conference with key stakeholders from the MFA, lead and alliance partners where we elicited feedback on a selection of preliminary findings and recommendations (mainly concerning reporting, sustainability and collaboration), and invited participants to formulate their own recommendations. In addition, participants prioritized recommendations through voting. We ensured inclusion of priority recommendations in this report, if sufficiently supported by our own analysis.

2.5 Focused literature review

Given aforementioned design and quality issues, triangulation with other data sources was crucial to assess the plausibility of the attribution of the outcomes and any (potential) impact to specific programmes. We conducted a preliminary review of the peer-reviewed literature (systematic reviews) on the effectiveness of a selected number of interventions that were commonly used such as comprehensive sexuality education, e- and m-health. We started all literature searches with Google Scholar, using the interventions, “developing countries” or “low income countries”, and “review” as search terms. If what we found was too limited, we used other databases (Cochrane Library, PsycInfo, Embase, International African Bibliography Online, and Sociological Abstracts). We searched for recent reviews (post 2007), but also included older reviews that seemed highly relevant, and used snowballing to follow up of relevant references. Judgement of the strength of the evidence, relied on the review’s or our own assessment. If we found only few studies, with no uniform findings, the strength was considered low. If we identified more studies, or few studies but with relatively consistent results, the strength was considered medium. If studies had conducted meta-analyses, or we identified many studies with largely consistent findings, the strength of the evidence was considered high. Due to time limitations, we may have missed some essential publications, and thus findings from the review are provisional.

2.6 Online Survey

Following the desk study, we conducted an online survey. Here, we describe its objectives, design and methods.

2.6. 1 Design & Objectives

Using a descriptive cross-sectional design, the survey addressed objectives 2 (collaboration & decision-making) and 3 (sustainability) and two additional themes emerging from the desk study. Specifically, we sought to document the experiences and opinions of staff regarding:

1. Collaboration between programme partners (North-North, South-South and North-South collaborations) and between partners and the MFA.
2. Opportunities and challenges for sustaining the results of the programmes.
3. Issues related to reporting and accountability
4. The 'Dutch approach'

Reporting merited further research given the quality issues in reports and M&E which we could observe and were sometimes reported by programmes. In addition, reports suggested that the 'Dutch approach', or the specific focus on progressive SRHR issues and human rights, created particular challenges including undesirable unintended consequences. Since reports included limited information on challenges and adverse effects we wanted to collected further data on these issues.

2.6.2 Sampling and recruitment

We aimed to recruit at least 100 staff members of the organisations that were involved in the programmes, including staff members from both lead, alliance and implementing organisations, from both North and South.

Programme coordinators were requested to forward an invitation to participate in the study to all partners, with the request to ask both coordinators and other staff who had been involved in the programme (e.g. managers, field workers, researchers) to complete the online questionnaire. A reminder was sent out. Invitations and questionnaire were in English (see limitations), although initially with a cover letter in French and Spanish.

2.6.3 Measures

The measures for this study were self-developed, based on an operationalisation of the research aims and questions, and on a previous evaluation of the ASK programme by Kaleidos Research (2016). The questionnaire included both open questions and closed statements regarding the four study objectives (see 2.6.1). For the statements, respondents could choose out of a set of responses: 'strongly agree', 'somewhat agree', 'somewhat disagree', 'strongly disagree', 'don't know or not applicable'. The full questionnaire is included in the separate survey report.

The questionnaire was pretested among professionals, working for northern and southern NGOs, and not involved in the partnerships we were investigating.

2.6.4 Analysis

The data were analysed using SPSS 21. For the closed questions, descriptive analyses and inter-group comparisons were conducted, using X^2 tests for nominal variables. Northern and Southern participants were compared, as well as lead and other partners, using tests of significance (see survey report for details).

The qualitative responses to the open questions were coded manually through an iterative process of clustering codes, interpreting their meaning and relations to each other, and writing down results.

2.6.5 Description of the sample

A total of 190 respondents filled in at least the background information; 24% did not finish the questionnaire, resulting in a total of 164 respondent who completed the survey. Those who dropped out were equally likely to be from an implementing partner in the South as from another (type of) organisation.

The ASK programme (43 respondents) and Bridging the Gap (22 respondents) provided most respondents for the study. Other programmes of which at least 10 people responded included Link Up (16), Making SRH Work For The Next Generation (16), Keep It Real (12), Men Care+ (12), Unite Against Child Marriage (11), and SHARP (10).

In total, 58 respondents were from lead partners, 55 work for alliance partners and 61 respondents were from implementing partners in the South. With regard to job function, 40 indicated that they were director / manager, and 54 were project managers. Furthermore, there were 31 programme officers, 20 technical advisors, and 10 researchers.

See Table 1 in the full survey report (separate supplement) for an overview of the most relevant sample characteristics. Approximately 90% of the respondents from Northern organisations were either lead or consortium partner, this was true for less than 10% of the respondents from the South. The majority of participants from the North were women, while most from the South were men. More than 40% of southern respondents were directors or managers.

2.7 Interview study

2.7.1 Design & Objectives

This descriptive study used qualitative semi-structured interviews (SSIs). Objectives were the same as for the survey; to gain insight into views and experiences regarding collaboration, sustainability, reporting and accountability, and the 'Dutch approach' (see 2.5.1). There was one additional objective: to gain insight into (decision-making) processes used to formulate the policy frameworks and select programmes.

Some of the interview-questions were based on preliminary results of the survey, enabling us to use qualitative data to interpret the quantitative results.

2.7.2 Participants, sampling and recruitment

Sampling

Using purposive and (due to time constraints) convenience sampling we interviewed 31 respondents:

- Ten MFA staff: all (available) contact persons for the 21 programmes and staff involved in the formulation of the five subsidy policy frameworks.
- 21 NGO staff, involved in five programmes (one per Subsidy Framework), working for five lead organisations, four alliance partners, and 11 implementing organisations.

We used a step-wise sampling procedure.

First, we selected five **programmes**, one per Subsidy Framework. For the three Frameworks containing more than one programme (SRHR fund, Choices & Opportunities; Child Marriages Fund), programmes were purposively sampled, using the following criteria:

a) Programmes address a variety of themes related to the 'Dutch approach'

b) Programmes reflect the diversity in funding size

c) Specific challenges reported.

Table 2.3 (below) portrays the selection process. For reasons of anonymity we cannot provide details of our selection.

Recruitment

An email introducing the study was sent out to the lead organisations and all selected alliance and implementing organisations. We asked them to provide names of staff members (of different gender and in different functions) that have played an important role in the programme, on the basis of which we selected a potential interviewee. All interviewees approached agreed to be interviewed.

Interview procedure

Most interviews lasted approximately 75 minutes. They were conducted face-to-face or via Skype, depending on participants' location, preference and feasibility. Ten of the interviews with implementing partners were conducted by local or locally based researchers, fully briefed on the project aims, purpose of the interviews, and ethical issues (see ethics).

MFA staff were interviewed by two researchers, to ensure that all issues were explored in full and achieve agreement on the approach.

Table 2.3 Selection of programmes, organisations and staff.

Steps	Sub-steps, criteria and outcomes of the selection process
Step 1. Select programme	**Step 1 a. Include variety of themes related to the 'Dutch approach'** We selected programmes working on: child marriage; CSE, youth, male involvement; IV drug users, LGBT, sex workers.
	Step 1 b. Include diversity in funding size. We included two large, two middle-range and one small programme, in terms of funding.
	Step 1 c. Include programmes which report particular challenges, e.g. contextual barriers and reporting issues.
Step 2. Select limited number of countries of implementation.	**Step 2. Select limited number of countries of implementation.** Objectives: • Facilitate within-country comparison. • Limit the number of local interviewers required (who would have to be instructed and guided by the senior researchers). Selection criteria: a. One African and one Asian country per programme b. Challenges regarding the 'Dutch approach' encountered c. Countries where two or three programmes were implemented d. Availability of qualified researchers who are part of the evaluation team's professional networks (for quality control purposes). We selected four countries: Ethiopia, Kenya, Pakistan and Indonesia.
Step 3. Select organisations.	**Step 3 a. Select lead and alliance organisations** Selection criteria: • Include all five of the lead organisations. • Include one alliance partner per programme, unless the programme did not have an alliance partner. • For one alliance partner, we interviewed a member of staff at both the Dutch and Latin–American office. For one small (in terms of funding and duration) programme we did not interview the alliance partner due to time constraints. We selected interviewed a total of four alliance partners.
	Step 3 b. Select implementing organization. Objectives: • Include a variety of organisations, in terms of size and focus. • Include two organisations per programme, one per country. Selection criteria: a. Reported issues e.g. regarding collaboration, reporting, the 'Dutch approach'. b. Organizations based in the capital (limit travel time, better quality skype). c. If multiple organisations were suitable and similar, we randomly selected one. d. We failed to establish contact with three organizations in three countries. We selected a total of 11 implementing organisations

Step 4. **Select staff**	**Step 4. Select staff** Objectives: • Include staff with good insight into the programme. Selection criteria: • Significant involvement in the programme. Organisations were asked to suggest relevant interview respondents. • One member of staff per organization, unless organizations advised to interview another member of staff as well. In total, we conducted interviews with 21 NGO staff: five members of staff working for lead organisations, four working for alliance organisations and 12 members of staff working for 11 implementing organisations .

2.7.3 Analysis

Interviews were recorded and transcribed verbatim, with the exception of a three interviews conducted in a language other than English; which were translated directly from the recording.

We used thematic analysis to identify patterns in responses, comparing answers of different types of respondents, and juxtaposed interview findings with findings from the desk study and survey. We used Atlas.ti to code transcripts using broad codes (.e.g 'collaboration'); further analysis was conducted manually. Analysis was shared and discussed in team meetings.

2.8 Ethical Considerations: Survey and Interview study

Ethical clearance was granted for the survey and interview study by the Ethics Committee of the Amsterdam Institute for Social Science Research at the University of Amsterdam.

The survey and interview study did not raise major ethical issues. We collected data on professional conduct and experiences, not on sensitive personal issues. Nevertheless, there were some modest risks. Since respondents could report practices at odds with 'good practice' or national ideologies, findings could damage relationships between organizations, the MFA, and national governments. To mitigate these risks, findings were anonymised- we do not mentioned personal names or organisational names when reporting survey or interview findings. Furthermore, we carefully explain our findings and strive to paint a fair and balanced picture of all parties involved and the structural constraints they face. In addition, we ensured confidential, safe data storage. Notes, recordings and transcripts were stored on a password protected, secure space in the Cloud (OwnCloud), with a back-up on the UvA Q-drive accessible only to the UvA research team.

Participation in the questionnaire was conditional on completion of an informed consent form (see Annex 2) which asked participants to indicate that they saw and understood the information, and that they agreed to participate in the study. For the interviews, we obtained oral informed consent. Interview participants were explained that we are independent university researchers, albeit funded for this project by the MFA, that data will be anonymized and treated as confidential an d that participation

was voluntary. We asked for permission to record, explaining that the recorder could be switched off at any time, and that if we want to use quotes which appear sensitive we will check the respondent's permission. No respondent declined recording, although on a few occasions they asked not to be quoted on a particular issue. Respondents of implementing organisations were explained that responses would not affect their chances to obtain future funding.

Transcribers of the interviews were asked to sign a confidentiality form.

2.9 Limitations

We acknowledge several limitations. First, in the desk study, time constraints necessitated selection of the most important documents; proposals, final reports and independent evaluations. If information in final reports and evaluation reports raised important questions, we looked for answers in other documents (e.g. operational research reports, year reports). Nevertheless, we acknowledge that documentation not reviewed will have contained some information which we could not include in our analysis.

Second, in the interview and survey study, there is a potential bias in the sample, which is modest in size (although not small) and based on a combination of purposive and convenience sampling. It is unknown who was contacted to fill out the survey, so we have no insight in non-response. Due to time-restraints, there was no possibility to make a list of possible respondents and contact them ourselves. There was a relatively high discontinuation rate. Possibly, partners who were more satisfied with the programme were more likely to participate. However, there is no difference between Northern and Southern partners in terms of discontinuation rates, and all questions were filled in by more than 100 respondents, which was the target for this survey. A final source of bias is that the questionnaire was in English and thus excluded non-English speakers. An opening page explaining in Spanish and French that the questionnaire would be in English, with the option to end there. No-one used this option. However, two respondents answered open questions in French; these responses were included in the analysis and did not noticeably differ from other responses. Nevertheless, the views expressed may not be representative for the entire 'population' of organizations and staff members.

Third, social desirability may also have led to bias in responses. Programme reports, survey and interview responses will all have overemphasised positive aspects and de-emphasised negative ones. Organizations rely on funding, and participants will have been keen to 'sell' their programme and alliance, even though we promised anonymity and explained that responses would not affect funding. Nevertheless, many respondents offered insightful and critical reflections, as well as positive stories. Since closed questions in the survey may also have been coloured by social desirability, it is more interesting to compare answers to different items, or to compare different groups on the same item, than to focus simply on percentages.

Fourth, implementing organisations and international NGOs were not represented at the consensus conference. Thus, we missed their input in the fine-tuning of our analysis and recommendations. We made sure to pay special attention to their views and experiences in our analysis of the survey and interviews.

Annex 3. Quality Assessment Form

Quality assessment: Evaluation methodology & reporting

Name subsidy framework:		Name assessor:
Criterion	**Scale 0/0.5/1**	**Comments** If score 0, note whether due to absence of info or poor quality. - = comment negative + = comment positive
1. Independent evaluation carried out (no or unknown/yes, but not used in meaningful way in reporting/ yes) **Key criterion: Multiply score x 3**		
2. Quality of indicators (poor/mixed/good- meeting at least three of criteria below) Indicators are SMART: a. Specific (i.e. clear and unambiguous) b. Measurable (i.e. based on accessible data) c. Attainable d. Relevant, valid (i.e. corresponding to programme objectives; measuring what it intends to measure) & reliable (i.e. consistently used across years, if not, changes explained) e. Time-bound		
3. Quality of methods of data-collection & analysis (poor- inappropriate or no information/ fair- meeting two of the criteria below /good- meeting three or more criteria) a. Methods of data-collection and analysis specified & justified b. Strategies used for selection sources, cases or information to minimize selection bias (e.g. by random sampling) c. Sources used appropriate, e.g. independent or unbiased, able to answer the evaluation questions d. Critical reflection on data collection or analysis e. No indication that quality of data-collection or analysis was poor		
4. Evidence re. M&E capacity building and/or monitoring of quality M&E (no/some/yes, extensive)		
5. Independent accountants report (no/yes)		
6. Methodology facilitates assessment/attribution of causality		

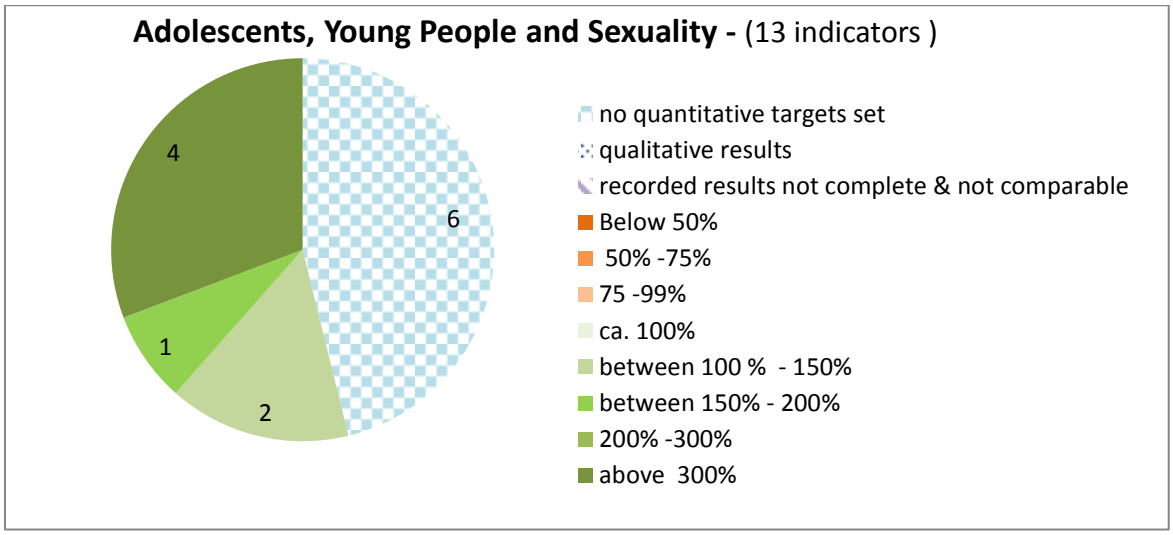
(probability or plausibility): (No/ To some extent [at least 2 of criteria below met] / Yes [criteria a & b are met, possibly others]) a. Control group used b. Before-after comparison, i.e. base-line c. *A*lternative causal hypotheses discussed (i.e. the possibility that the variable of interest is affected by other factors d. Influence of contextual factors on the effects of the intervention explained e. Intervention logic/ToC logical and convincing given common sense & evidence f. Attempts made to verify causal chain verified step by step. **Important criterion: Multiply score x 2**		
7. **Findings convincing (e.g., no contradictions or highly unlikely numbers reported; no evidence of uncritical analysis, exaggerated claims, claims not based on evidence)** (no/fair/yes)		
8. Critical analysis/reflection on limitations and lessons learned; lessons learned specific, realistic, convincing and contextualized (no, or hardly/yes, but not always convincing or relevant/yes and mostly convincing)		
Total score ***Max= 10*** ***8-12: Good*** ***3-7: Fair/medium*** ***1-2: Poor***		

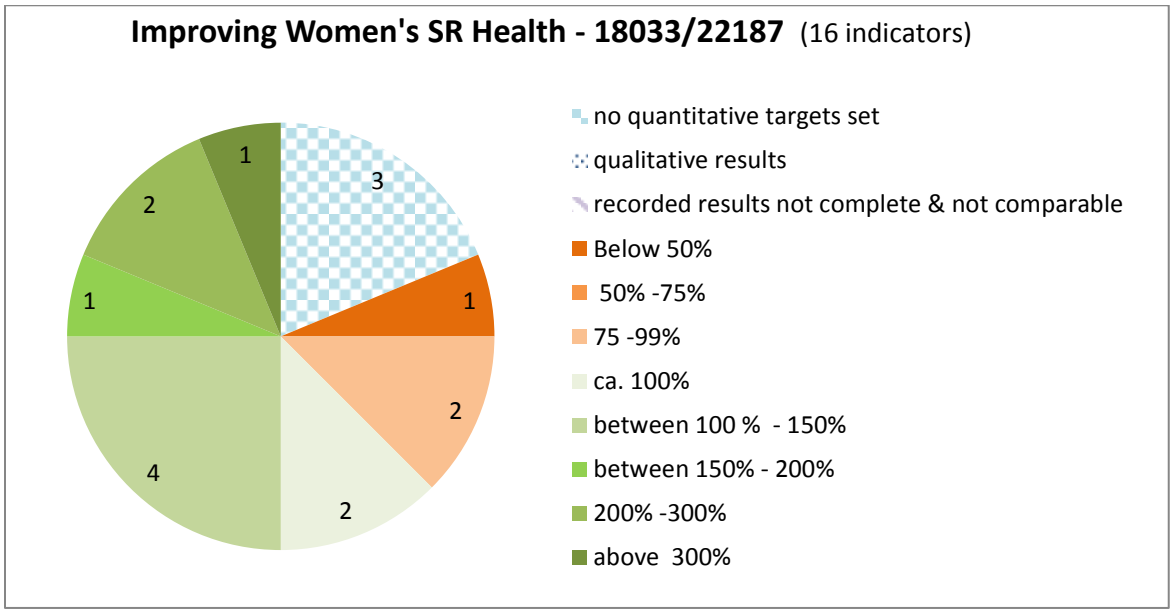
Annex 4: Programme specific results

This annex contains further details about programme target attainment (or not) from Chapter 3. It contains each programmes' targets which were not achieved, reached or exceeded.

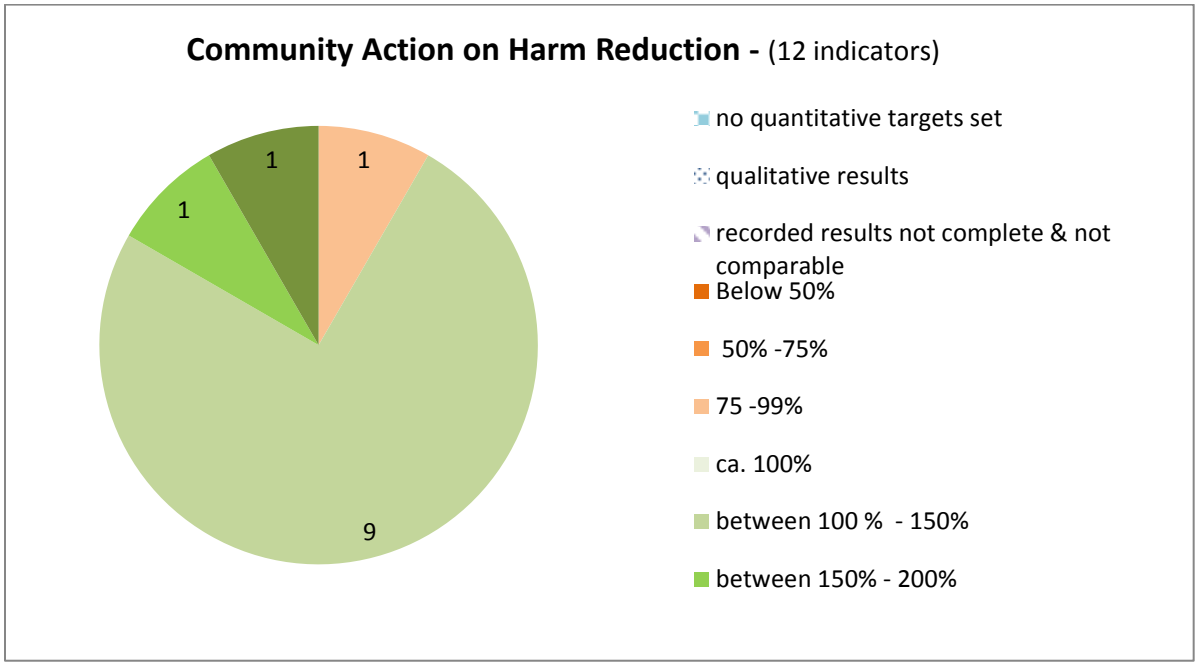
Choices and Opportunities Fund

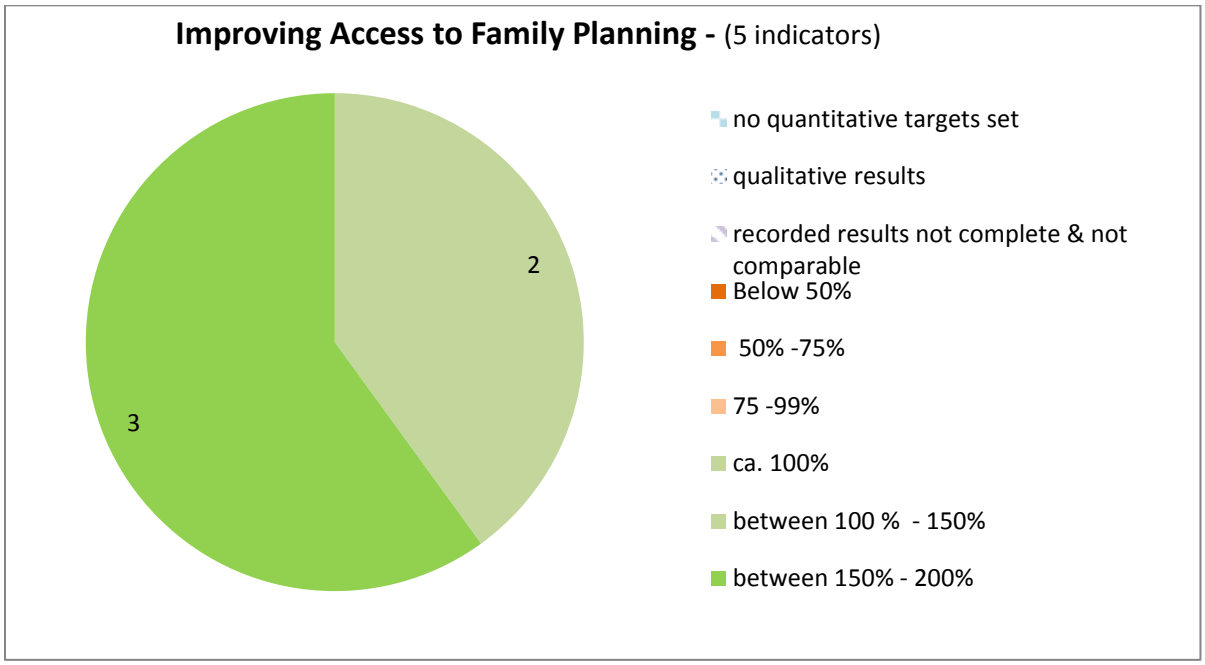
Figure 3.1: Choices and Opportunities Fund: Results against targets for each programme





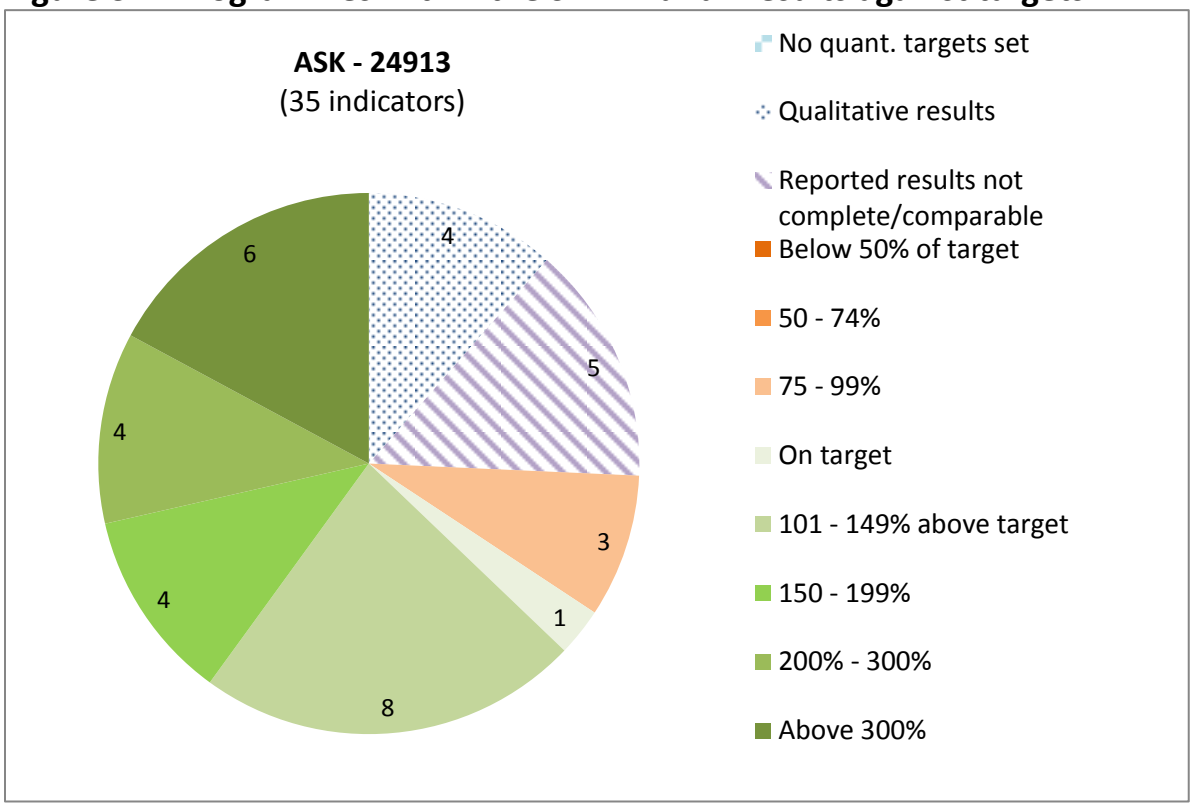
Choices and Opportunities Fund (continued)

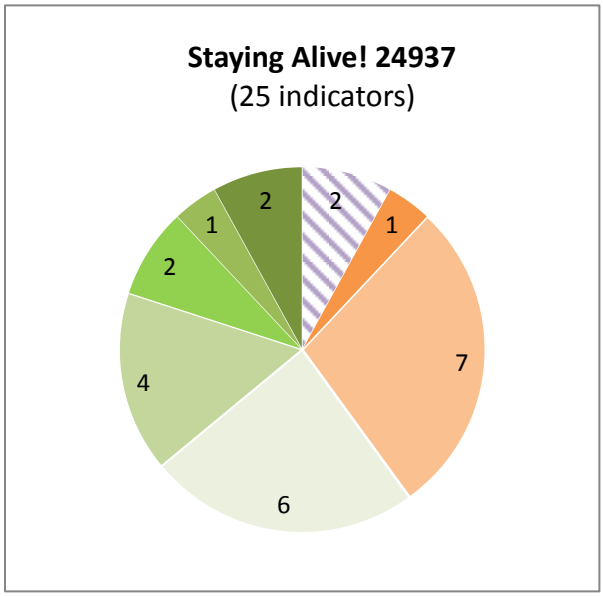


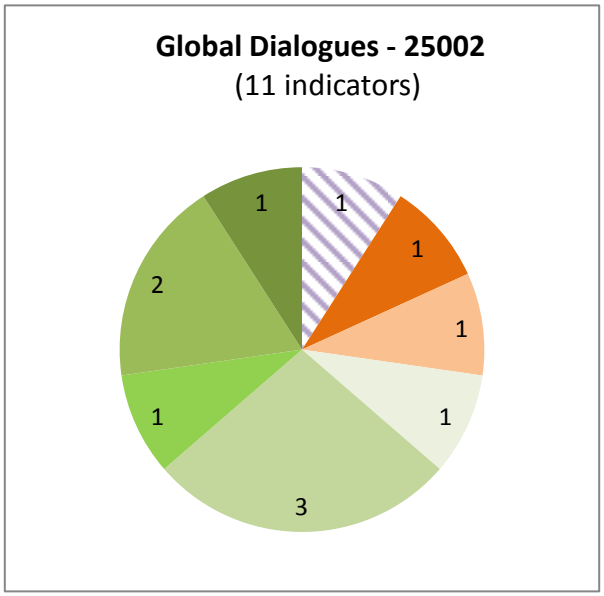


SRHR Fund

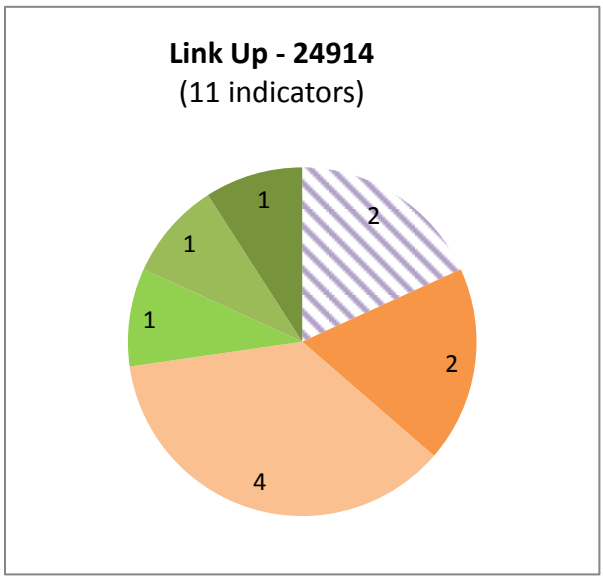
Figure 3.2: Programmes within the SRHR Fund: Results against targets

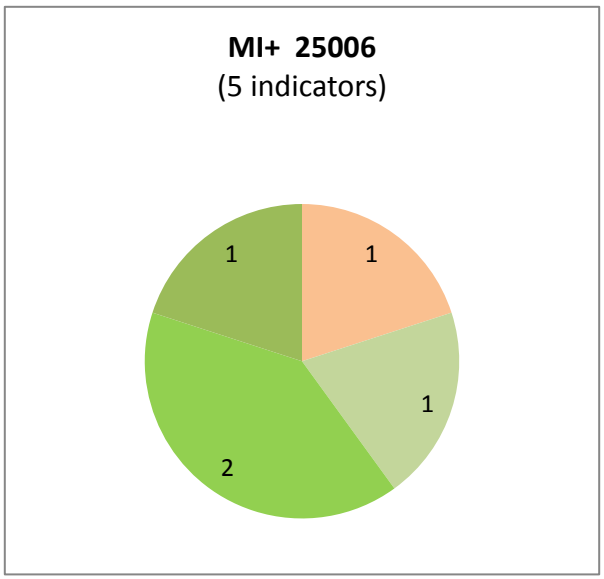


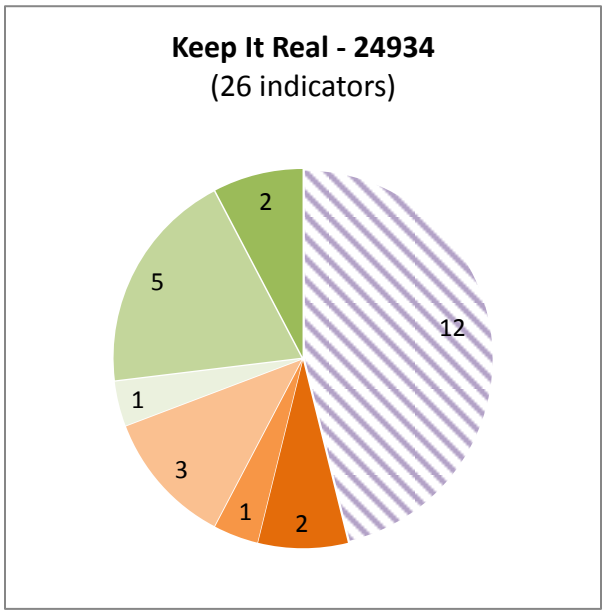


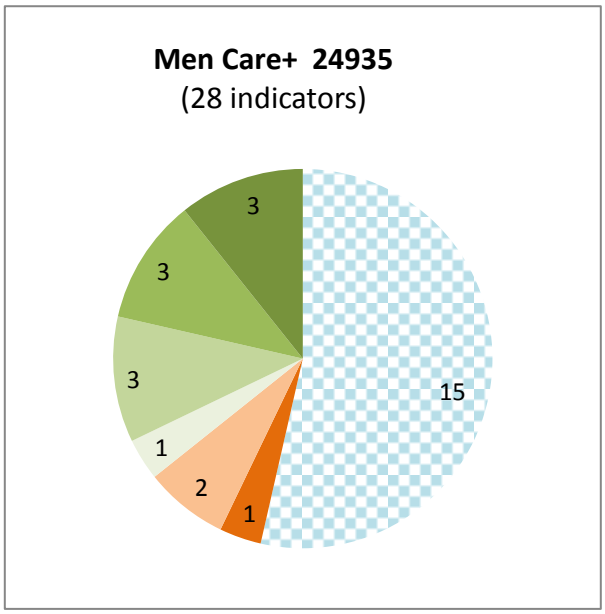


SRHR Fund- continued

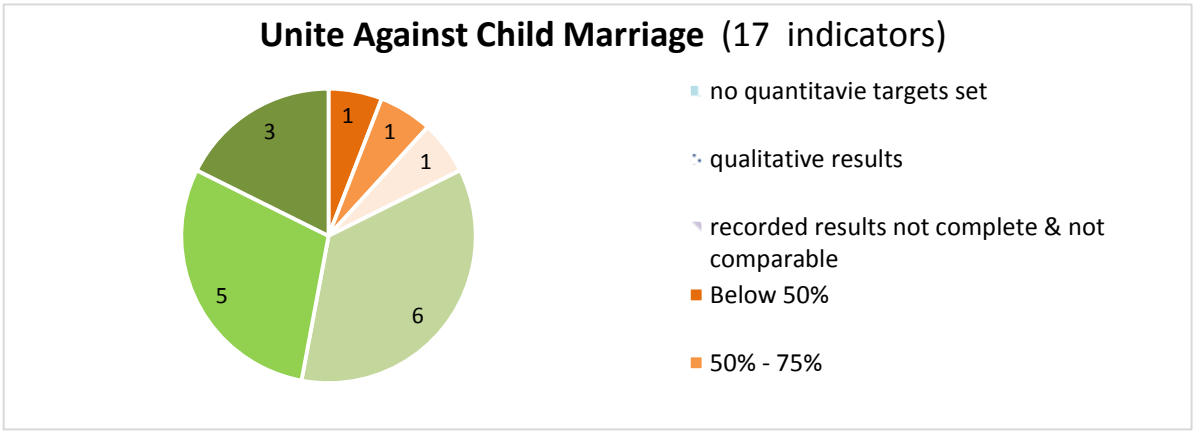


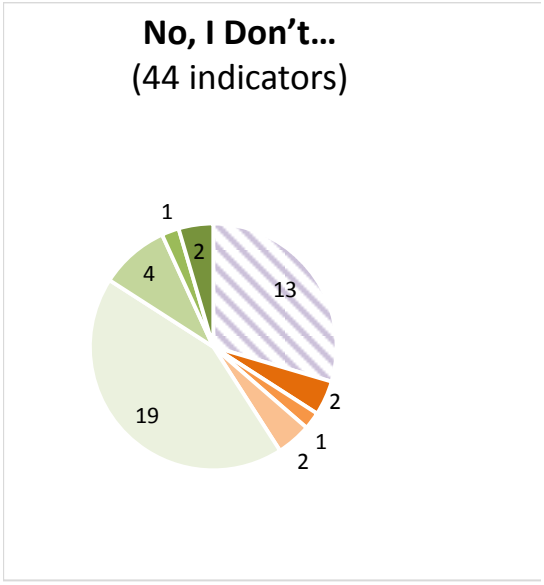


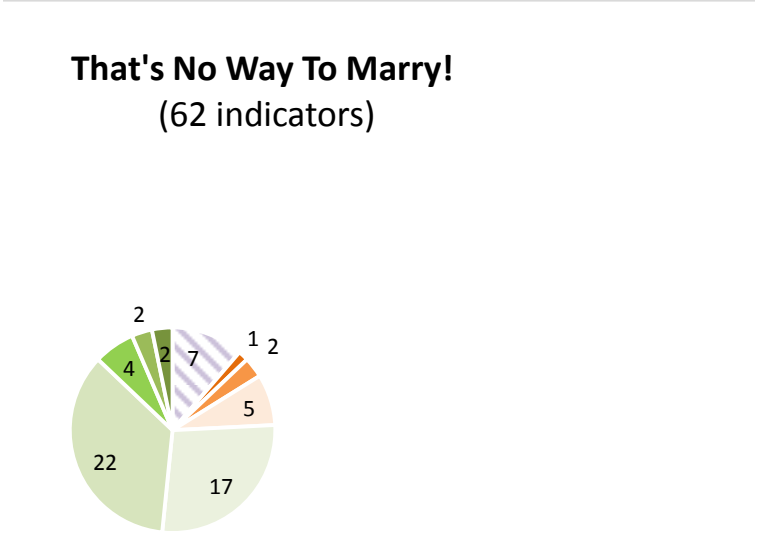




Child Marriages Fund







Annex 5. Overview of subsidy frameworks

Subsidy frameworks	Specific Rationale of Fund Focus	Fund open to whom? Argument	Alliances mandatory? Argument & Criteria for collaboration	Target countries
1. Choices and Opportunities Fund (2011 – 2014)	Ref. to policy document 'Keuzes & Kansen', Cairo agenda; UN declaration HIV/aids (2006) Central perspectives: Human Rights and prevention Focus on issues from Cairo agenda which require attention and are under threat, including youth, key populations, prisoners, refugees, and fragile states. Issues: adolescents; family planning, safe abortion, harm reduction	ONLY international NGOs whose activities' have a demonstrable added value regarding the Dutch priority teams Organization active in places or in fields where Dutch NGOs have (not) yet been (able) to be active or delivers a unique 'product' or a unique approach	No	OECD-DAC countries (ODA) More than 1 country
2. Key Populations Fund (2011 – 2015)	UN 'Universal access to HIV prevention, treatment, care and support' (2001, 2006, 2011) Ref to 'Keuze & Kansen' + 3 'beleidsbrieven' 2010/11 Motie Hachchie 2010/11 37 Stigma major issue Rights of key populations central:	Dutch NGOs ONLY Unique Dutch approach in HIV prevention among 'vulnerable' groups	Yes As expertise about various categories of key populations is scattered over various organization; and overlap in categories (eg sex workers / IUDs) Preference to fund only one alliance	Minimal in 2 partner countries (Focusbrief 18 maart 2011)

	LGBT, sex workers IUDs, HIV+, youth, prisoners, street children, people with handicap & their sexual partners		Indicate what is added value of alliance Assessment Criteria collaboration: • Contribution each member; • Capacity each member • Division of money • Decision-making • Responsibilities • M&E / Fulfillment of obligations	
3. Step-Up Fund (2012 – 2015)	3 'beleidsbrieven' 2010/11 Kamerbrief 7 mei 2012 Sex workers (concentrated HIV epidemic) Follow-up of BuZA program (2009-2011) by SOA AIDS NL & ICCO: Step up (+ emancipation) essential for Step out → International Conference 25 April 2013: lessons learned Motie van der Staaij/Ferrier (kamerstukken 2010/11)	Only Dutch organizations with expertise in this field (track record)	Yes Expertise of Dutch 'added value' is scattered over more than one organization Preference to fund only one alliance Use specific expertise of organizations Assessment Criteria collaboration (see above)	Minimal in 2 partner countries (Focusbrief 18 maart 2011)
4. SRHR Fund (2013 – 2015)	Cairo Keuzes en Kansen 3 'beleidsbrieven' 2010/11 MDGs 5 and 6	Inter(national) NGOs and research institutes – together with UN And private sector (laatste twee kunnen enkel meedoen)	Single organization OR Alliances (max 1 proposal per Loket) In case of alliance,	Minimally 50% of requested funding for selected country

	Focus on aspects that did not receive attention in previous SFs: • Integrated SRH/AIDS approach • Adolescents & youth • Commodities and services (Loketten A: integrated programs; B: sub-themes and C: innovative activities		involvement of youth organization (preferably youth-led) , if relevant, is an advantage.	partners (15) (spread of regions)
5. Child Marriages Fund (2014 – 2015).	Universal Declaration of Human Rights; CEDAW; Children Rights → violation human rights, violation autonomy. UN Human Rights Commisison (2013); Rapport High Level Panel about post-2015 Agenda Beleidsnota: wat de wereld verdient (2012/13) Amendment Voordewind (13 nov 2013)	Only Dutch organizations – Upscaling of 'running' programs (either geographically, involving other target groups; intensifying interventions; additional activities); only for 1 year. Using the strength of Dutch organizations in this field	Dutch organizations or alliances They have to collaborate intensively with local organizations Maximally 3 proposals to be funded (because of efficiency considerations)	At least: 1 Dutch partner country And 1 country that belongs to the top 20 high-prevalence child marriages

Annex 6. Overview countries of implementation

		Choices and Opportunities Fund				Key Pop. Fund	Step-Up Fund	SRHR Fund									
		AYPS €12.500.000	CAHR €11.250.000	IPAS GPASS €12.500.000	IAFP €12.500.000	BtG €35.000.000	SUSO €6.000.000	LU €30.694.876	MSRHFTNG €29.644.452	ASK €29.660.670	MC+ €8.677.554	SA €6.602.657	SHARP €8.289.181	KiR €6.430.606	GD €1.297.792	ENW… €1.253.706	HER €1.237.732
Africa	Benin				X												
	Botswana					X	X										
	Burkina Faso																
	Burundi *							X	X								
	Cote d'Ivoire *	X															
	Dem. Rep. Congo *								X								
	Ethiopia *	X		X			X	X		X				X			X ®
	Ghana			X						X							X ®
	Kenya *	X	X	X ®		X	X			X		X			X	x	X
	Mali**				X							X					
	Malawi *			X	X												
	Mozambique			X ®													
	Niger *																
	Nigeria *			X													
	Rwanda *								X		X						X ®
	Senegal	X								X							
	Sierra Leone *			X													
	Somaliland *				X												
	South Africa					X	X				X						
	South Sudan *												X				
	Tanzania	X		X ®													
	Togo *	X			X												
	Uganda *			X ®		X	X	X		X		X		X			X ®
	Zambia	X		X	X												
	Zimbabwe *				X	X	X										
Asia	Bangladesh *			X				X								X	X
	Cambodia *																X
	China		X														X
	India	X	X	X													X
	Indonesia		X			X				X	X				X		X
	Malaysia		X														
	Myanmar *		X	X			X	X									X
	Nepal *	X		X		X											
	Pakistan *	X		X		X				X							X
	Phillipines	X															X
	Thailand	X															
	Vietnam	X				X											X
Middle East	Afghanistan *																
	Egypt	X					X										X
	Lebanon						X										
	Morocco						X										
	Tunisia						X										
Eastern Europe	Albania	X															
	Bosnia*	X															
	Georgia *					X											
	Kyrgystan *					X											
	Tajikistan					X											
	Ukraine					X											
Latin America	Bolivia			X			X										
	Brazil					X	X				X						
	Colombia						X										
	Costa Rica					X											
	Dominican Republic	X					X										
	Ecuador					X											
	El Salvador			X													
	Guatemala	X		X											X		
	Guyana	X															
	Haiti *																X
	Honduras						X										
	Mexico			X													
	Nicaragua			X													
	Paraguay						X										
	Peru						X										

* Indicated as a 'fragile state' in OECD (2012). *Fragile states 2013: Resource flows and trends in a shifting world*. (Cited in IBO (2013). *Naar een nieuwe definitie van ontwikkelingssamenwerking. Beschouwingen over ODA*.)

** Not indicated as a 'fragile state' in OECD (2012), but possibly in a vulnerable situation

Annex 7. Evidence-base interventions

This supplement aims to provide provisional information for the MFA and organisations about the effectiveness of SRHR interventions which are commonly used, and often reported to be effective (usually based on achievement of outputs) in the programmes of the Subsidy Frameworks 2011-2015.

Interventions needs to draw on existing evidence of effectiveness, but few programmes made explicit reference to evidence in their proposals or reports to justify their interventions. Partner organisations recognized that finding or generating evidence for their interventions (through additional operational research) is a difficult task, for which time and money are often lacking.

Given the difficulties in gathering evidence about effectiveness, we reviewed the international literature. Full systematic reviews of all interventions and intervention strategies were not possible given time limitations, but we could review important systematic reviews and make judgements with some confidence about the effectiveness of types of intervention. We present a preliminary review which should be expanded, but can inform development of future SRHR programme proposals. It provides insights not only in the effectiveness of interventions but also demonstrates the multitude of context and intervention related features on which effectiveness depends.

1. Comprehensive Sexuality Education (CSE), in and out of school (result area 1) [7]

CSE was implemented by a number of programmes (e.g. LINKUP, ASK, Keep it Real), which invested much time and effort to overcome barriers to CSE commonly prevalent in conservative environments. Aims and strategies included *building young people's communication and negotiation skills*, enabling young people and others to make and enact on decisions, and *training teachers in sexuality* education.

Evidence-base

- A meta-analysis of 33 studies of school -based sex education in LMICs concluded that this is an effective HIV-related risk reduction strategy (Fonner et al., 2014). CSE resulted in improved HIV knowledge; self-efficacy related to using sex or condom use; condom use; reduction in sex partners and initiation of sex. No individual study in the meta-analysis found that school-based sex education increased risky sexual behavior.
- Systematic reviews of studies in HICs and LMICs identified various process and content features which enhance effectiveness of sex education:
    - Incorporation of community-based components (Fonner et al., 2014).
    - Involving healthcare staff, parents, teachers and community members in intervention development (Fonner et al., 2014).
    - Adapting international curricula (Fonner et al., 2014).
    - Skills-based rather than knowledge-based programmes (IOB, 2009; Kirby et al. 2005).

[7] Strategies can be allocated to various result areas; listed are those to which they pertain most clearly.

- Empowerment approach emphasizing gender and rights (Haberland et al. 2005).

- A recent review of systematic reviews reports that curriculum content and delivery of CSE tends to be weak, and that CSE is one of a number of often used ASRH interventions which 'tend to flounder because implementation requirements are not met' (Chandra-Mouli, Lane & Wong, 2015).
- Teacher training can positively affect teacher attitudes toward sexuality education and participatory techniques. However, evidence that it also affects student behavior is more limited, possibly because other design factors 'trump' teacher training (James-Traore et al., 2004).

Conclusions

- There appears to be fairly firm evidence that CSE can reduce sexual risk behaviours and thus risk of HIV (and other STIs).
- However, effectiveness depends on various design features concerning content, design and delivery.
- CSE delivered in the MFA programmes may well not include aspects which promote its effectiveness given that social and political resistance to CSE programmes and teacher reluctance were commonly reported (see section 4.3).
- Thus, effectiveness of CSE programmes deserves further examination. Adequate investment in design, training and delivery is crucial; process evaluations should be conducted and reported on to facilitate assessment of effectiveness.

2. Peer involvement, including peer education (result areas 1, 3)

Programmes suggested that peer involvement is important especially when working with young people and key populations, given possible reluctance to openly discuss SRH issues with non-peers (e.g. adults). In some programmes, representatives selected from young or key populations (ideally by their own communities) acted as interlocutors and built trust between marginalised communities and health providers (and other community gatekeepers).

The 'Bridging the Gaps' (BtG) programme, for instance, suggests that the involvement of sex workers as peers in the provision of services to sex workers and truck drivers made the services more acceptable and accessible. Peer involvement in training programmes for, and mobilization of, MSM communities led to better targeted activities for issues concerning MSM, and increased funding for such activities. Several programmes suggest that peer involvement led to increased ability of target groups to take and enact decisions regarding SRH, on the basis of observed increases in knowledge of SRHR and services, service uptake, and increased sense of ownership (ASK, Link Up).

Evidence-base

- In the domain of ASRH, peer-led sexuality education is a common and much supported strategy to involve young people, but several reviews point to limited evidence regarding its impact on behavior (condom use; abstinence) and biological outcomes (e.g. STI incidence), access to SRH services, or social norms around adolescent SRH (Chandra-Mouli et al 2015; Kim & Free, 2008; Parkin & McKegany 2000).

- Evidence suggests that young people prefer receiving information from others e.g. health professionals (Michielsen et al., 2012; Price & Knibbs 2009).
- Nevertheless, some reviews do find that peer education is effective. A review of 13 HIC and LIC studies on peer-led adolescent sexuality education, found effects on knowledge, attitudes and intention (Kim & Free, 2008). A review of 24 peer-led youth interventions in LMICs with regard to HIV risk found effects on both knowledge *and* condom use (Maticka-Tyndale & Barnett, 2010).
- Looking at a broader range of peers -including e.g. sex workers, drug users and truck drivers, a meta-analysis of 30 studies on peer education interventions in HIV prevention in LMICs found moderate effects on behavioural outcomes (IDU equipment sharing and condom use), but not biological outcomes (STI infections) (Medley et al. 2009)
- Peer involvement and education is oftentimes underpinned by flawed assumptions and simplistic conceptualisations of 'peer' and 'participation' (Price and Knibbs 2009).
- Peers need to carefully selected, going beyond surface similarities such as age, and peer involvement may be more meaningful in the design rather than implementation phase and if if integrated in holistic interventions (Michielsen et al., 2012).

Conclusions

- The effect of involving peers on behaviour (e.g. condom use), and especially health is uncertain and may depend on the target group and 'type' of peers involved (e.g. young people, MSM, sex workers).
- Nevertheless, peer education may contribute to broader changes such as reduced taboos on sexual practices or stigmatization of target groups (Michielsen et al., 2012).
- Programmes should predominantly give peers the role of referral and sensitization, rather than main advisor and counsellor; avoid simplistic selection processes (e.g. based purely on age); and ensure quality of training of peer educators (Michielsen et al., 2012).
- Ideological belief in youth involvement and peer education should not bar critical scrutiny of its effectiveness and assumptions.

3. Increasing access to education, especially for girls (result areas 1, 4)

Interventions used to increase girls' access to education included making the physical infrastructure more girl-friendly, training teachers in gender sensitive didactics, and sensitizing communities and parents on the importance of education. However, the report of the child marriage programme UACM observes that in Malawi, girls seek marriage to get financial support in order to stay in school. Thus, promoting education without removing financial barriers may not stop child marriage.

Evidence summary

- There is some, but contradictory evidence that education, and financial incentives to increase access to education (e.g. cash transfers conditional on school enrolment; school uniforms), reduce child marriage rates (Lee-Rife et al., 2012).

- Increasing access to education is a 'vertical' intervention, with good potential for scaling up since they are politically popular and of interest to large-scale actors (op cit.).
- However, greater effectiveness is reported for 'horizontal' programmes which employ multiple strategies to address child marriage and related objectives (e.g. reduce teenage pregnancy), often focused on empowering girls by equipping them with knowledge, skills and resources (op cit.; see also 11. Integrated packages).

4. E & M Health Channels (Result areas 1, 3)

Programmes used specifically designed mobile apps (Link Up) and social media (Global Dialogues) to distribute (tailored) health messages, training content, and news updates. Such E& M health channels were identified as very effective by the programmes in providing information to a large number of (especially young) people, and more than initially targeted.

Drawbacks were also mentioned. First, digital channels exclude people, often those in rural areas, who cannot access the internet through computers or phones. Some (ASK, SUSO) programmes created alternative channels, such as SMS (text) messages and toll-free helplines. Second, several programmes acknowledged that, although these information channels may increase the knowledge of a wide group of people, we cannot assume that it also results in attitudinal or behavioural change.

Evidence summary

- Interactive digital interventions (mostly from the USA) for young people appear to have a moderate effect on SRHR knowledge, a small effect on self-efficacy, some effect on behaviour, but not on intention or biological outcomes (Bailey et al., 2015).
- A review of USA and some LMIC studies of the effects of social media (mainly Facebook), either as stand-alone intervention or in support of broader sexual health promotion, found that 14 of the 51 publications (27%) reported a behavior change effect regarding sexual health (Gabarron & Wynn, 2016). However only three studies involved randomization, problematizing attribution of effect.
- A review of five studies (4 in USA, 1 in Cambodia), found that m-Health interventions improved self-reported continuation of contraception, but not adherence (Smith et al., 2015).

Conclusions

- There is some evidence for the effectiveness of e- and m-health interventions, mostly derived from studies conducted in HICs.
- E- and m-health interventions differ greatly in terms of platform used, target group, intended outcomes. Assessing general effectiveness is problematic.
- Nevertheless, since there is some positive evidence and use of mobile phone technologies is increasing rapidly in LMICs, e- and m-health appear promising strategies.
- Programmes implementing e- and m-health technology need to pay special attention to *equity* (the poor will have reduced access), and *confidentiality*: young people and women in particular are more likely to be sharing a phone with another family member.

5. Male involvement (result areas 1, 2, 3)

Some programmes promoted the involvement of men in various aspects of SRHR (That's No Way To Marry; IATF). Male involvement was promoted through male community leaders (IATF); 'Husband Schools' which engaged men in dialogue (e.g. over FP method support; IATF); husband peer educators, who then sensitized other men (IATF); and by-laws making it mandatory for men to accompany their partner for ANC, delivery, PNC and E-MTCT services (Staying Alive!).

In some programmes, a key rationale for male involvement was that men are key decision-makers (IATF; Staying Alive). They thus relied on existing gender norms. Others focused on gender role transformation. Male involvement was the core focus and objective of MenCare+. Based on the WHO (2007) review of male involvement programmes, its aim was to engage young and adult men as caregiving partners in order to change gender/masculinity norms which affect SRHR and MNCH outcomes. Strategies included broad advocacy campaigns and individual and group counselling sessions (see also 3.4).

Evidence summary

- A WHO (2007) review of 58 intervention studies regarding the effectiveness of male involvement programmes found that 29% of the programmes were effective in that they led to change in attitudes and behaviours pertaining to sexual, reproductive, maternal, newborn and child health; fatherhood; use of violence against women and other men. An additional 38% was identified as 'promising'.
- Another WHO review (Kwankam et al. 2013) of studies regarding the effectiveness of male involvement interventions in HIV and reproductive health services identified benefits to women, their children and men themselves including increased uptake of and adherence to PMTCT and safe infant feeding, reduced infant HIV acquisition and mortality, increased notification of partners exposed to HIV, higher individual and couples HTC uptake, increased condom use and reduced seroconversion in discordant couples, increased uptake of modern contraception.
- Gender transformative programmes (promoting more gender-equitable relationships) were more effective than programmes which were gender sensitive (recognizing the specific needs and realities of men based on the social construction of gender roles) or gender neutral (distinguishing little between the needs of men and women) (WHO, 2007).
- Integrated programmes, including community outreach and mass-media campaigns, combining group sessions with individual counselling, led to more sustained behavioural and attitudinal change (WHO, 2007).
- Kwankam et al. (2013) emphasize the importance of respecting the choice of a woman to seek health services for herself without a male involvement, particularly if she fear negative outcomes.
- Programmes which focus on changing men's behaviour regarding a single issue such as family planning, without also promoting greater gender equity, risk enhancing male involvement in gender-inequitable ways (WHO, 2007).
- **P**rogrammes should adopt a relational perspective, integrating efforts to engage men and boys with efforts to empower women and girls (WHO, 2007).

Conclusions

- Since the ICPD (UN, 1994), the need to involve men in SRHR has been widely recognized.
- Transformative approaches (and peer-led), fostering critical reflection on masculinities appear more effective than gender neutral approaches or those addressing (male and female) gender needs.
- Not all MFA funded programmes involve men; those which do, do not always adopt a gender transformative approach (eg IATF).
- These programmes risk enhancing gender inequity and making male involvement into an additional barrier to girls or women's empowerment.

6. Training of health workers and community health workers, including through E & M health strategies (result areas 3 and 4)

Many programmes sought to increase quality of SRHR and maternity services by training (community) health workers (e.g. AMREF, SHARP). In BTG, training healthcare workers on the special needs of key populations and young people was reported as an essential strategy for increasing service quality and accessibility for these groups. Such training led to more conducive client-provider relationships, and decreased judgmental attitudes and expressions; these were key drivers in increasing uptake of services by LGBT people.

Programmes provided training on site or through E&M-health training programmes. E- and M-health strategies were also instrumental in provision of post-training support and performance monitoring, which contributed to further quality improvement (IPAS).
Staff-turnover greatly affected the effectiveness of training (e.g. SHARP), although when health workers move, they take their skills with them.

Evidence-base

- A review of studies of e-learning in medical education in middle and some low income settings indicates that e-learning and blended learning (combining face-to-face with computer-assisted learning) may be more effective in improving knowledge and skills of medical students than traditional education (Frehywot et al., 2013).
- E- and blended learning can have positive impact on staff retainment (Frehywot et al., 2013).
- A review of e-learning as refresher training for health care professionals in HICs found this to be at least as effective as face-to-face learning in terms of improving knowledge. However, there is little evidence regarding its impact on clinician behaviour or patient outcomes (Sinclair et al., 2016).
- Low bandwidth and power failures are common obstacles and e-learning requires human and infrastructural resources not always present in LMICs (Frehywot et al., 2013).
- Evidence suggests that training of CHWs improves motivation, job satisfaction and performance , although Few studies tested which approach worked best or how these were best implemented (Kok et al., 2015).

- With regard to supervision, high-quality supervision that focuses on supportive approaches, community monitoring, and/or quality assurance/problem solving may be most effective (Hill et al., 2014).
- CHW training packages with defined competencies and methods for assessing competencies and supervision are considered best practices, but there is little or no research on effectiveness (Tran et al., 2014)

Evidence summary

- Use and training of CHWs is an important strategy to increase access to SRHR services in LMICs.
- Greater attention should be paid to the quality of services provided by CHWs, and the quality of CHW training and supervision.
- E- learning is an increasingly common and important strategy to train (community) health workers, but should be carefully designed to ensure quality and sustainability.
- Cross-institutional collaboration in design and delivery of e-learning is relatively simple, and can enhance quality of training.
- Tailoring e-learning to country-specific economic, cultural and educational realities is important.

7. Youth-friendly health services and centres (result areas 2, 3)

In addition to training providers, establishment of 'youth corners', youth centres and the employment of young service providers were strategies to make services more youth friendly (and so aiming to enhance quality and uptake) (ASK, PSI, IPAS).

Evidence-base

- A review of systematic reviews of ASRH interventions (Chandra-Mouli, Lane, & Wong 2015) reports that offering youth friendly services can increase service use *if* a number of conditions are met regarding infrastructure, training of providers, community support, outreach.
- Achieving quality youth friendly services may require adequate supportive supervision (op cit.)
- *Youth centres* appear *not* cost-effective in terms of increasing use of SRH services or changing behaviour (op cit.). In addition, they tend to attract a small proportion of youth, often older, male and living nearby (Zuurmond et al., 2012)
- Youth centres may however provide other social benefits e.g. development of vocational skills (Chandra-Mouli, Lane, & Wong 2015) .

Conclusions

- Designing youth friendly services in such a way that all conditions for effectiveness are met is challenging and resource intensive; it is unknown whether all MFA programmes were able to meet the requirements.
- Youth centres do not seem the best choice for programmes wanting to increase use of SRH services or changing behavior.

8. Linking communities and care (result areas 2, 3)

Linking communities to care and commodities, e.g. mobile clinics, or provision of information through community outreach, was commonly described as an effective approach, for instance to reach under-served populations (PSI). Many programmes used creative methods and edutainment strategies, such as music, dance, football matches, role play, or story-telling workshops to this end (ASK, SUSO).

Various programmes established better links / relationships between the target populations and service providers, which increased referrals and visits to health services. In one of the programmes (Link Up), the creation of links between communities and facilities was central to its aim to improve accessibility and quality of SRH services for young people living with HIV. In BtG, the collaboration between sex worker-led organizations, service providers and the government appeared to make services more accessible to sex workers.

A few programmes (e.g. IATF; IPAS), involved the private sector (e.g. through social franchising) to increase access to commodities, especially Family Planning.

Evidence-base

- The literature reports mixed results regarding using referral systems linked to schools, with some studies finding that they have added value to demand generation interventions in communities (re. use of commodities and SRH related behaviour), others not (Denno et al 2015)
- In terms of *private sector strategies* to increase access to and uptake of SRH services in LMICs , a systematic review of such strategies found that evidence is weak due to flaws in study designs (lack of control groups, randomization, examination of long-term effects. However, five RCTs demonstrated that contraceptive use could be increased through supporting private providers (Peters, Mirchandani & Hansen, 2004).
- A review by Madhavan & Bishai (2010) found strong evidence that franchising can increase uptake of FP services, and moderate evidence of increased utilisation by the poor and improved quality of care.
- A study of the impact of franchised FP clinics in Pakistan established a shift from use of condoms to female sterilization (Hennink & Clements, 2005). This raises important concerns about informed consent and female autonomy in decision making.
- Importantly, the same study in Pakistan noted that franchised FP clinics did not attract more poor people despite being located in poor urban communities and offering services at subsidized rates (Hennink &Clements, 2005).

Conclusions

- Evidence suggests that involvement of the private sector, in particular through franchising, can increase access to SRH commodities, in particular FP.

- Given the fraught history of forced family planning, programmes and MFA need to pay more attention to unintended side-effects in terms of equity and violations of women's informed choice.

9. Promoting legal change and awareness of human rights (result area 4)

In order to promote and uphold human rights, by various programmes lobbied for decriminalization (e.g. of homosexuality, or abortion), and provided human rights training for stakeholders including teachers, health professionals, police and judicial officers to raise awareness of what counts as violations of human rights and existing spaces within the law to provide certain services (e.g. abortion). Documenting and reporting human rights violations (facilitated e.g. through helplines) are other strategies employed by programmes. In addition, after community advocacy (see below), some programmes led to formulation of by-laws (e.g. prohibiting child marriage).

Evidence-base

- Evidence suggests that legal change (e.g. regarding child marriage) may lead to change if linked to a holistic, multiple level, system approach involving other interventions e.g. increasing access to education, addressing sociocultural norms (Lee-Rife et al 2012.; Chandra-Mouli et al 2015)**.**
- On its own, legal change may drive practices underground, with adverse effects (op cit.)**.**

Conclusions

- Programmes were following what the literature deems good practice: advocating for legal or policy change and embedding these activities in a collection of multi-level approaches.
- The introduction of by-laws deserves more critical reflection due to potential inequitable effects.

10. Advocacy and community dialogue (all result areas)

Programmes engaged in advocacy through community-based workshops, using edutainment and various media (e.g. comic books on consequences of child marriage). Advocacy strategies reported to be particularly promising included training of local champions, and working through locally recognized institutions (e.g. CBOs) and community members with the required social capital such as older women/ paternal aunts and religious leaders. The latter are particularly important given the possible tension between SRHR and religion: involving faith leaders and faith based organizations was a central strategy to increase access to FP in the programme Faith to Action.

Furthermore, several programmes found that collaborative dialogue was an effective advocacy strategy. Ipas changed mass-edutainment to dialogue-based interpersonal communication, with community intermediaries positioning themselves as facilitators rather than educators. The independent evaluation report of SHARP (Kortmannn, 2017, p. 7) implemented in South Sudan Such notes that a dialogue approach appears to work even in conflict settings. The community dialogue approach, involving intergenerational communication and participatory learning, including participatory rural appraisal visualisation techniques, was perceived as one of the strongest pillars in SHARP, with a 'clear added value to facility based reproductive health services.' There is an interesting parallel here with another

collaborative approach: motivational Interviewing. Motivational interviewing (MI) is a client-centred approach which seeks to foster behaviour change by eliciting clients' motivation and empowering them to formulate their own solutions, rather than experts providing instructions and advice (Miller & Rollnick, 1991). Through motivational interviewing, the programme MI+ successfully change attitudes and some behaviours (e.g. uptake SRH services, condom use) amongst MSM.

Two other strategies which were key to Ipas' advocacy for access to safe abortion are providing media training to increase quality of media reporting and reduce bias, and monitoring the opposition (in the case of Ipas to abortion), developing a response and training others in it.

Evidence-base

- According to Chandra-Mouli et al.'s (2015) review, high-profile meetings informing community members about risks of harmful practices are not effective in achieving behaviour change. Instead, ongoing dialogue which facilitates community members' and leaders' critical examination of traditions and identification of barriers and solutions is required.
- Evidence indicates that the collaborative, patient-centred approach of motivational interviewing supports adoption of health behaviours and adherence to treatment (Miller& Rollnick, 1991), although there is virtually no evidence regarding its application in LMICs.
- One study did find that MI reduced risk behaviours amongst MSM in Thailand (Rongkavilit et al., 2013). The client-centered collaborative, non-judgmental style of MI also appeared to have a positive effect on mental health, important given the association between mental health, sexual risk behaviours (Blashill et al., 2012) and ART adherence (Du Bois & McKirnan, 2012).
- MI involves a complex mix of skills that take considerable time to learn. Fidelity to MI principles and quality of MI is important for its effectiveness in terms of behavour change (Gaume et al. 2010).

Conclusions

- Monitoring the opposition and developing a response appears useful for advocacy regarding other SRHR areas too e.g. LGBT rights.
- Evidence suggests that advocacy and counselling approaches which focus on dialogue, empowerment , eliciting motivations and solutions may be more effective than top-down education.

11. Needle and syringe programmes (NSPs) (result areas 3, 4)

One of several strategies in BtG (Key Populations) and central to CAHR (choices & Opportunities fund).

Evidence-base

- The WHO (2012) includes NSPs in its best practice guidelines for harm reduction strategies
- Evidence reviews find 'compelling' evidence (WHO 2004) that NSPs reduce risk behaviours (Palamateer et al., 2010).
- Evidence regarding reduced HIV and especially Hep C infection is mixed. The WHO (2004) and a meta-analysis of studies on NSPs (Aspinall et al., 2014) find that NSPs are effective in reducing HIV infection amongst IDUs, but Palamateer et al. (2010) found limited evidence for this.

- There is consensus that NSP on its own does not lead to sufficient levels of behaviour change to reduce HIV and especially Hep C infections (Palamateer et al., 2010; WHO 2004).
- Combining behaviour change interventions is crucial (WHO 2004).

Conclusions

- There is evidence regarding effectiveness of NSPs, depending on the outcome being assessed: NSPs reduce injecting risk behaviours more than that they affect HIV and in particular Hep C infections.
- Strength of evidence is affected by design issues: Most studies were based on observational design (ethical issues prevent RCTs) and studies assess self-reported risk behaviours.
- Most studies of NSPs were conducted in HICs; generalizability of findings to LMICs is uncertain.

12. Integrated packages, multi-level approaches (all result areas)

Integrated packages which combine multiple interventions are considered crucial to increase the accessibility, quality and uptake of SRH services. All programmes used such holistic approaches. In CAHR, for instance, an integrated approach for people who use drugs included targeted information, education and communication (IEC), mobile harm reduction services, needle and syringe programmes, opiate substitution treatment services, condom programmes, rehabilitation centres, a referral system with voucher coupons, sustainable livelihood interventions, family support, and legal support (Bridging the Gaps, CAHR).

Evidence-base

- Multi-sector and multi-level approaches, addressing the legal environment, community norms and individuals' empowerment are supported by evidence from systematic reviews on child marriage and ASRHR interventions (Lee-Rife et al., 2012; Chandra-Mouli et al., 2015) and MNCH interventions (Bhutta et al., 2012).
- A systematic review (Denno et al (2015) found that interventions which combine supply-side interventions (training health workers, facility improvements) and demand generation via the education sector or mass media appear to have greatest impact on the uptake of ASRH services.

Conclusions

- All MFA programmes adhere to the good practice principle of offering integrated packages and multi-level approaches
- Such approaches complicate M&E and assessing effectiveness

Annex 8. Results tables from online questionnaire survey

A total of 164 respondent took part, from lead partners (66), alliance partners (59), and implementing partners in the South (55). Approximately 90% of the respondents from Northern organisations were either lead or consortium partners, compared to less than 10% of the respondents from the South.

Table 1. Sample characteristics by region (North versus South)

	North **n = 135**	**South** **n = 55**
Gender (%)*		
- Female	63.7	27.3
- Male	35.6	70.9
- Other	0.7	1.8
Age (m, sd)	40.3 (9.9)	39.3 (8.7)
Role organisation (%)**		
- Lead partner*	47.4	3.6
- Consortium partner*	43.7	5.5
- Implementing partner*	10.4	100.0
Role respondent (%)**		
- Project manager	32.6	29.1
- Director / manager*	15.6	41.8
- Other	20.0	16.4
- Programme officer*	21.5	9.1
- Technical advisor	13.3	5.5
- Researcher*	9.6	0.0
- Advocacy officer	2.2	0.0
- Finance and administration	2.2	0.0
- Service delivery	0.7	0.0

* Significant difference between respondents from Northern and Southern regions, $p < .05$.

** Percentages add up to more than 100%, because more than 1 option could be selected.

Table 2. Opinion about statements on governance and structure by region and role of the organisation

		Region		Role		*TOTAL*
		North	South	Lead	Partners	
		n = 108	n = 40	n = 54	n = 94	*n = 148*
1. The mission and objectives of the programme were jointly developed by all partners	agree	76.9	76.6	77.6	76.4	*76.8*
	disagree	10.3	6.4	10.3	8.5	*9.1*
	don't know*	12.8	17,0	12.1	15.1	*14.0*
2. The objectives of the partnership were not entirely in line with the mission and objectives of my organisation	agree	17.2	6.5	8.8	17.1	*14.2*
	disagree	77.6	87.0	84.2	78.1	*80.2*
	don't know	5.2	6.5	7.0	4.8	*5.6*
3. The programme was built on the basis of local needs	agree	92.2	95.7	98.2	90.5	*93.2*
	disagree	6.0	4.3	1.8	7.6	*5.6*
	don't know	1.7	0.0	0.0	1.9	*1.2*
4. The organisational structure of the partnership was not sufficiently clear	Agree	27.6	21.7	19.3	29.5	*25.9*
	disagree	69.0	67.4	77.2	63.8	*68.5*
	don't know	3.4	10.936	6.7	3.5	*5.6*
5. In hindsight, some partners that were involved had insufficient added value for the programme	agree	33.9	34.8	36.8	32.7	*34.2*
	disagree	53.9	45.7	54.4	50.0	*51.6*
	don't know	12.2	19.6	8.8	17.3	*14.3*
6. Each partner organisation had clear roles and responsibilities	agree	82.6	91.3	89.5	82.7	*85.1*
	disagree	13.9	2.2	7.0	12.5	*10.6*
	don't know	3.5	6.5	3.5	4.8	*4.3*
7. All partners invested enough time and resources in the partnership	agree	80.0	87.0	87.7	78.8	*82.0*
	disagree	11.3	4.3	5.3	11.5	*9.3*
	don't know	8.7	8.7	7.0	9.6	*8.7*
8. There should have been more opportunities to discuss the course of action within the programme with partners in the North	agree	40.9	56.5	43.9	46.2	*45.3*
	disagree	27.0	21.7	28.1	24.0	*25.5*
	don't know	32.2	21.7	28.1	29.8	*29.2*
9. There should have been more opportunities to discuss the course of action within the programme with partners in the South	agree	58.3	69.6	57.9	63.5	*61.5*
	disagree	20.0	17.4	22.8	17.3	*19.3*
	don't know	21.7	13.0	19.3	19.2	*19.3*
10. The distribution of funds was reasonable, according to each organisation's commitments	agree	81.7	76.1	86.0	76.9	*80.1*
	disagree	11.3	13.0	5.3	15.4	*11.8*
	don't know	7.0	10.9	8.8	7.7	*8.1*

† Significant difference with other groups, p < .05

*** 'Don't know' and 'not applicable' have been combined**

Table 3. Agreement with statements on the role of the Dutch Ministry of Foreign Affairs (MFA) by region and role of the organisation

		Region		Role		*TOTAL*
		North	South	Lead	Partners	
		n = 108	n = 43	n = 55	n = 96	*n = 151*
11. The application procedure for funding was clear*	agree	53.0		58.2	49.0	*53.8*
	disagree	1.0		1.8	0.0	*1.0*
	don't know**	46.0		40.0	51.0	*45.2*
12. Feedback from the MFA on the proposal and progress reports was useful*	agree	52.0		60.0	44.9	*52.9*
	disagree	6.0		9.1	2.0	*5.8*
	don't know	42.0		30.9†	53.1†	*41.3*
13. The Dutch MFA involved organisations from the North in developing the SRHR policy framework in which my organisation participated	agree	25.9	34.9	21.8	32.3	*28.5*
	disagree	5.6	7.0	12.7†	2.1†	*6.0*
	don't know	68.5	58.1	65.5	65.6	*65.6*
14. The Dutch MFA involved organisations from the South in developing the SRHR policy framework in which my organisation participated	agree	20.4	34.9	18.2	28.1	*24.5*
	disagree	11.1	11.6	18.2	7.3	*11.3*
	don't know	68.5	53.5	64.6	63.6	*64.2*
15. The 'rights-based approach' as adhered to by the Dutch MFA is important to improve the SRHR in countries where the programme is implemented	agree	80.0	77.1	80.6	72.1	*78.1*
	disagree	5.5	1.0	2.8	2.3	*2.6*
	don't know	14.5	21.9	16.7	25.6	*19.2*
16. Dutch Embassies or Consulates did not play an important role in the implementation of the programme	agree	42.6	30.2	47.3	34.4	*39.1*
	disagree	30.6	37.2	34.5	31.3	*32.5*
	don't know	26.9	32.6	18.2	34.4	*28.5*
17. The involvement of Dutch Embassies or Consulates was important for advocacy and diplomacy	agree	48.1	53.5	54.5	46.9	*49.7*
	disagree	19.4	7.0	21.8	12.5	*15.9*
	don't know	32.4	39.5	23.6	40.6	*34.4*
18. The Dutch MFA functioned as a 'knowledge broker' (i.e. sharing insights in the field of SRHR and motivating partners to do so)	agree	44.4	37.2	43.6	41.7	*42.4*
	disagree	25.0	16.3	29.1	18.8	*22.5*
	don't know	30.6	46.5	27.3	39.6	*35.1*
19. The programme would not have achieved as much if the activities were implemented by individual partners rather than by a partnership	agree	73.1	71.4	74.5	71.6	*72.7*
	disagree	13.9†	0.0†	14.5	7.4	*10.0*
	don't know	13.0†	28.6†	10.9	21.1	*17.3*
20. Some activities would have been more efficient if we could have done these on our own, without our partners	agree	33.3	25.6	38.2	27.1	*31.1*
	disagree	51.9	46.5	49.1	51.0	*50.3*
	don't know	14.8	27.9	12.7	21.9	*18.5*
21. It was a good idea that the MFA stimulated working together in a partnership	agree	84.3	67.4	83.6	77.1	*79.5*
	disagree	1.9	2.3	1.8	2.1	*2.0*
	don't know	13.9	30.2	14.5	20.8	*18.5*

† Significant difference with other groups, p < .05

*** The first two items were only presented to the lead and consortium partners**

**** 'Don't know' and 'not applicable' have been combined**

Table 4. Agreement with statements on cooperation with partner organisations by region and role of the organisation

		Region		Role		*TOTAL*
		North	South	Lead	Partners	
		n = 107	n = 42	n = 54	n = 95	*n = 149*
22. The lead partner allowed enough room for partners from the South to influence decision-making on aims, target groups, and activities of the programme	agree	67.3	81.0	77.8	67.4	*71.1*
	disagree	11.2	7.1	3.7	13.7	*10.1*
	don't know	21.5	11.9	18.9	18.5	*18.8*
23. The lead partner allowed enough room for other Northern partners to influence decision-making on aims, target groups, and activities of the programme	agree	67.3†	45.2†	66.7	57.9	*61.1*
	disagree	1.9	4.8	1.9	3.2	2.7
	don't know	30.8†	50.0†	31.5	38.9	*36.2*
24. My organisation had sufficient autonomy with regard to the implementation of plans	agree	85.0	90.5	81.5	89.5	*86.6*
	disagree	8.4	4.8	5.6	8.4	*7.4*
	don't know	6.5	4.8	13.0†	2.1†	*6.0*
25. There have been misunderstandings between partners that could have been prevented by better communication and agreements	agree	55.1	35.7	63.0†	42.1†	*49.7*
	disagree	31.8	40.5	25.9	38.9	*34.2*
	don't know	13.1	23.8	11.1	18.9	*16.1*
26. Sometimes partner organisations had strong differences of priority or opinion about key decisions to be made	agree	52.3	38.1	53.7	45.3	*48.3*
	disagree	38.3	45.2	40.7	40.0	*40.3*
	don't know	9.3	16.7	5.6	14.7	*11.4*
27. There were strategies in place to resolve these differences or conflicts	agree	68.2	54.8	79.6†	55.8†	*64.4*
	disagree	15.9	9.5	13.0	14.7	*14.1*
	don't know	15.9†	35.7†	7.4†	29.5†	*21.5*
28. Sometimes the agenda of the alliance was too much determined by organisations from the North	agree	43.9	35.7	42.6	41.1	*41.6*
	disagree	29.0	28.6	33.3	26.3	*28.9*
	don't know	27.1	35.7	24.1	32.6	*29.5*
29. There was enough room for the ideas and priorities of my organisation with regard to content or form of interventions that were implemented in this programme	agree	88.8	90.5	87.0	90.5	*89.3*
	disagree	7.5	4.8	5.6	7.4	*6.7*
	don't know	3.7	4.8	7.4	2.1	*4.0*
30. My organisation learned a lot from our partners from the North	agree	64.5	73.8	55.6	73.7	*67.1*
	disagree	11.2	11.9	13.0	10.5	*11.4*
	don't know	24.3	14.3	31.5	15.8	*21.5*
31. My organisation learned a lot from our partners in the South	agree	81.3	76.2	87.0	75.8	*79.9*
	disagree	0.9†	9.5†	0.0	5.3	*3.4*
	don't know	17.8	14.3	13.0	18.9	*16.8*
32. The lead partners or other partners of the North were not always handling sensitive issues in an appropriate way, given the context	agree	24.3	23.8	29.6	21.1	24.2
	disagree	46.7	50.0	37.0	53.7	47.7
	don't know	29.0	26.2	33.3	25.3	28.2
33. Too much energy was focused on accountability and reporting progress	agree	39.3	47.6	35.2	45.3	41.6
	disagree	52.3	47.6	53.7	49.5	51.0
	don't know	8.4	4.8	11.1	5.3	7.4
34. Monitoring and evaluation activities helped improve the quality of the programme	agree	82.2	90.5	85.2	84.2	*84.6*
	disagree	14.0	4.8	9.3	12.6	*11.4*
	don't know	3.7	4.8	5.6	3.2	*4.0*

† Significant difference with other groups, p < .05 *** 'Don't know' and 'not applicable' have been combined**

Table 5. Agreement with statements on sustainability by region and role of the organisation

		Region		Role		*TOTAL*
		North	South	Lead	Partners	
		n = 103	n = 42	n = 51	n = 94	*n = 151*
35. The programme has had a lasting positive effect on the SRHR situation of the target group(s)	agree	91.3	92.9	92.2	91.5	*91.7*
	disagree	3.9	4.8	2.0	5.3	*4.1*
	don't know	4.9	2.4	5.9	3.2	*4.1*
36. SRHR policies have improved in my country because of the programme	agree	54.4†	75.6†	58.8	61.3	*60.4*
	disagree	6.8	12.2	9.7	5.9	*8.3*
	don't know	38.8†	12.2†	29.0	35.3	*31.3*
37. The programme has led to structural improvements of service delivery	Agree	76.7	92.7	74.5	84.9	*81.3*
	disagree	8.7	4.9	7.8	7.5	*7.6*
	don't know	14.6	2.4	17.6	7.5	*11.1*
38. Because of the programme, (sexuality) education has been structurally integrated in school curricula or service provision	agree	48.5	40.5	47.1	45.7	*46.2*
	disagree	19.4†	40.5†	21.6	27.7	*25.5*
	don't know	32.0	19.0	31.4	26.6	*28.3*
39. My organisation has continued to implement activities in this field, even after financial support from Dutch partners/the Ministry of Foreign Affairs has ended	agree	69.9	85.7	70.6	76.6	*74.5*
	disagree	5.8	4.8	5.9	5.3	*5.5*
	don't know	24.3	9.5	23.5	18.1	*20.0*
40. Programme activities have been cancelled after Dutch Ministry funding has ended	agree	22.3	11.9	27.5	14.9	*19.3*
	disagree	51.5†	76.2†	47.1	64.9	*58.6*
	don't know	26.2	11.9	25.5	20.2	*22.1*
41. My organisation still works with one or more members of the partnership from the North	agree	67.0	64.3	62.7	68.1	*66.2*
	disagree	7.1	4.9	3.9	6.4	*5.5*
	don't know	28.2	28.6	33.3	25.5	*28.3*
42. My organisation still works with one or more members of the partnership from the South	agree	72.8	73.8	74.5	72.3	*73.1*
	disagree	3.9	4.8	3.9	4.3	*4.1*
	don't know	23.3	21.4	21.6	23.4	*22.8*
43. Continued involvement of Dutch/international partners is necessary for sustaining programme results	agree	90.3	92.9	86.3	93.6	*91.0*
	disagree	4.8	6.8	9.8	4.3	*6.2*
	don't know	2.4	2.9	3.9	2.1	*2.8*

† Significant difference with other groups, p < .05

*** 'Don't know' and 'not applicable' have been combined**