Ministry of Foreign Affairs

IOB Study

Achieving universal access to sexual and reproductive health and rights

Synthesis of multilateral contribution to advancing sexual and reproductive health and rights (2006-2012)

IOB Study

Achieving universal access to sexual and reproductive health and rights

Synthesis of multilateral contribution to advancing sexual and reproductive health and rights (2006-2012)

October 2013

Preface

This report presents the findings of a desk-study of existing evaluations on the work of multilateral organisations in the field of sexual and reproductive health and rights (SRHR). It is part of a number of sub-studies of the policy evaluation of Dutch involvement in SRHR during the period 2006-2012, conducted by the Policy and Operations Evaluation Department (IOB) of the Dutch Ministry of Foreign Affairs. Other sub-studies of this policy evaluation are country impact studies in Bangladesh, Nicaragua and Mali, desk-studies of Ghana and Tanzania, and a desk-study of existing evaluations of NGOs.

In order to gain insight into the effectiveness of the support to multilateral organisations during the last seven years, existing evaluations of programmes of five organisations were reviewed: the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), the Global Fund to Fight AIDS, TB and Malaria (GFATM), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO).

After an assessment procedure, 26 evaluation reports of UNICEF, UNFPA and the GFATM were selected to be reviewed in-depth. For UNAIDS and WHO, their contribution was assessed by reviewing external evaluations and relevant policy briefs.

The study found that there is a need for more, and for better quality evaluations by the multilateral organisations. These organisations have a central role to play in advancing SRHR, and much effort has been devoted to the development of policy and guidelines, and to assist countries in health system strengthening. Some important successes were reported, such as improved community support for maternal and child health, increased uptake of services in the field of HIV/AIDS, and increased awareness about and reducing incidence of female genital mutilation. Little hard evidence has been found regarding the effectiveness of efforts to improve contraceptive use. Overall, few organisations could show tangible results for the beneficiaries.

External consultant Esther Jurgens has conducted this study and has drafted the report. IOB senior evaluator Marijke Stegeman was overall responsible for the policy evaluation of Dutch involvement in sexual and reproductive health and rights programmes.

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

Prof. dr. Ruerd Ruben
Director Policy and Operations Evaluation Department (IOB)
Ministry of Foreign Affairs, The Netherlands

Table of Contents

List of tables, figures and text boxes

Tables

Figures

Text boxes

List of acronyms and abbreviations

AIS	AIDS Indicators Surveys
ANC	Antenatal care
ART	Antiretroviral therapy
ARV	Antiretroviral drugs
ASRH	Adolescent Sexual and Reproductive Health
AYA	African Youth Alliance
BCC	Behaviour change communication
CCP	Center for Communication Programs
CCT	Conditional Cash Transfers
CPE	Country Programme Evaluation
CPR	Contraceptive prevalence rate
CRC	Convention on the Rights of the Child
DFID	Department for International Development
DHS	Demographic and health survey
DOS	Division for Oversight Services
DRC	Democratic Republic of the Congo
EDL	Essential Drugs List
EmONC	Emergency obstetric neonatal care
EQA	Evaluation quality assessments
FGM	Female genital mutilation
FP	Family planning
GAVI	GAVI alliance; former acronym of Global Alliance for Vaccins and Immunisation
GBV	Gender-based violence
GE	Gender equality
GFATM	Global Fund to Fight AIDS, TB and Malaria
GPRHCS	Global Programme to enhance Reproductive Health Commodity Security
HCT	HIV counselling and testing
HPV	Human Papilloma Virus
HRP	UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Training in Human Reproduction
IAEG	InterAgency and Expert Group
ICPD	International Conference on Population and Development
IDP	Internally displaced persons
IOB	Dutch abbreviation for Policy and Operations Evaluation Department
KMC	Kangaroo Mother Care
LMIC	Low- and middle-income countries
LPS	Life-planning skills
LSE	Life-Skills education
M&E	Monitoring and evaluation
MARP	Most at risk populations
MDG	Millennium Development Goals
MFA	Ministry of Foreign Affairs

MFMC	My Future is My Choice
MHTF	Maternal Health Thematic Fund
MMR	Marternal mortality rate
MNCH	Maternal, newborn, and child health
MoH	Ministry of Health
MSI	Marie Stopes International
MTCT	Mother to child transmission
MVA	Manual Vacuum Aspirator
NGO	Non-governmental organisations
ODA	Official Development Assistance
OF	Obstetric fistula
OVC	Orphans and vulnerable children
P&D	Population and development
PAC	Post-abortion care
PCB	Programme Coordination Board
PHC	Primary health care
PLHIV	People living with HIV
PLHWA	People living with AIDS
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of mother to child transmission
POA	Programme of Action
PPH	Post-partum haemorrhage
PrEP	Pre-exposure prophylaxis
RH	Reproductive health
RHC	Reproductive health commodities
RHCS	Reproductive Health Commodity Security
SHRH	Sexual and reproductive health and rights
SIE	Second Independent Evaluation
SMAG	Safe Motherhood Action Groups
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually transmitted infections
TERG	Technical Evaluation Reference Group
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNSG	United Nations Secretary-General
VAW	Violence against women
VIAA	Visual inspection with acetic acid
WHA	World Health Assembly
WHO	World Health Organization
YFS	Youth-Friendly Services

Executive summary

Aim and methodology

This synthesis presents the findings of a literature study into the effect of the Netherlands Ministry of Foreign Affairs' (MFA) support to multilateral organisations during the period 2006-2011 for programmes on sexual and reproductive health and rights.

The **aim of the study** was to evaluate the Dutch collaboration in sexual and reproductive health and rights (SRHR) interventions that were implemented via the multilateral channel.

Using the OECD/DAC criteria for evaluations of development interventions, the review focused on effectiveness, impact, relevance and sustainability. The evaluation questions that guided the review related to relevance, changes in legislation relating to SRHR, institutional strengthening, outcome of services, output (commodities), and also aimed to reveal the factors which influenced these aspects.[1] The study is part of a comprehensive review of the MFA's implementation of policies on SRHR.

Evaluations of programmes of five organisations were reviewed: the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), the Global Fund to Fight AIDS, TB and Malaria (GFATM), hereafter called Global Fund, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO). For three of these (UNICEF, UNFPA and the GFATM), eligible evaluations were inventoried and their quality was assessed. The 26 evaluations analysed for this review were selected by applying the following criteria: representative of the elements of the SRHR Strategy and the focus countries of the Netherlands; at least two evaluations of adolescent programmes per organisation; and published between 2006 and 2012. For the remaining two organisations (UNAIDS and WHO), their contribution was assessed by reviewing external evaluations and relevant policy briefs.

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

- Improving maternal and newborn health;
- Ensuring contraceptive choice and safety and fertility services;
- Eliminating unsafe abortion and providing post-abortion care;
- Reducing sexually transmitted infections, including HIV, and other reproductive morbidities;
- Promoting health sexuality, including adolescent health, and reducing harmful practices.

The *first chapter* places SRHR in a global context and within the Netherlands policy environment. The 1994 International Conference on Population and Development (ICPD) marked a change in the global debate, by placing individual rights at the centre of reproductive health, and advocating that sexual health be included as a separate domain, next to reproductive health. It also provoked international commitments to SRH, including Millennium Development Goals (MDGs) 5 (improve maternal health) and 6 (combat HIV/

[1] Terms of Reference, December 2011 *(in Dutch)*.

AIDS, malaria and other diseases) and the adoption of the first Global Strategy on Reproductive Health at the World Health Assembly in 2004. From the outset, the Netherlands has actively promoted sexual and reproductive rights, and financially supported interventions in this field. The selection of SRHR as one of the four priority areas of the MFA's foreign aid policy is a reflection of the Netherlands' commitment to furthering the ICPD agenda.

Chapters two to seven discuss the findings of the literature review on to what extent and how the multilateral organisations addressed the core elements of SRHR in their programmes: maternal and perinatal health (chapter 2), family planning (chapter 3), unsafe abortion (chapter 4), sexually transmitted infections (STIs), including HIV (chapter 5), reproductive rights, sexual health, gender issues and gender-based violence (chapter 6) and adolescent sexual and reproductive health (chapter 7). Each chapter starts with a situational analysis of current issues, followed by an analysis of the evidence for the support provided by the organisations. Chapter eight presents conclusions on multilateral aid in SRHR. Chapter 9 presents the overall conclusions and recommendations.

Maternal and perinatal health

Most of the evaluations pertaining to this domain relate to the work of UNFPA. With regard to the progress achieved in specific countries, the UNFPA thematic evaluation of maternal health looks at the progress specific countries have made and reports successes in community support for maternal and child health. However, it notes that there is a need to tie these efforts to national efforts to strengthen health systems. Another means of improving maternal health that can be deployed in addition to community participation is to apply simple, affordable and effective measures at the primary level. Evidence from the selected evaluations demonstrates the added value of combining community involvement and health system strengthening.

Family planning

Only one evaluation was found on interventions in the domain of family planning: it was of the UNFPA Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS). The lack of evaluations reflects the low priority given to this area, despite the high overall unmet need for family planning commodities. The 2012 London Summit on Family Planning was a turning point: it resulted in an increased sense of urgency, and in its slipstream came political and financial commitments. The GPRHCS played a key role in developing specific Reproductive Health Commodity Security. The largest share of funding of GPRHCS is still spent on contraceptives, which is not unreasonable, given that this has long been a neglected area. However, no hard evidence has so far been forthcoming on the effect of contraceptive use.

Unsafe abortion

The need to prevent abortions from being performed under unsafe conditions is obvious, as according to WHO, the proportion of maternal deaths due to unsafe abortions is high: an estimated 13%. Unsafe abortion not only severely harms women's health, but is also an economic burden to the family and society. It is estimated that the global costs health

systems incur from treating complications arising from unsafe abortion are around USD 1 billion yearly. For years the Netherlands has strongly advocated to combat unsafe abortion, highlighting our collective responsibility to ensure that abortions are performed under safe conditions. None of the multilateral organisations included in this review explicitly addresses abortion, though indirectly those working in the area of family planning eventually contribute to its prevention. A landmark was the WHO updated guidance on safe abortion, issued in 2012.

STIs, including HIV

It proved difficult to find stand-alone evaluations of multilateral support for combating STIs. Most of the evaluations included in this review are therefore of interventions in the domain of HIV/AIDS, except for one evaluation, which assessed the effect of a national programme on prevention and treatment of cervical cancer. Many of the evaluations report that one result of the interventions has been increased uptake of services. Whereas community involvement is widely encouraged in HIV/AIDS prevention, care and treatment, the UNAIDS Second Independent Evaluation (SIE) reports some mixed results in this regard. Overall, increased representation of civil society resulted in greater civic involvement in policy and strategy development and implementation of programmes and services, and representation on national policy and coordination bodies. UNAIDS' support has also played a key role in engaging with PLWHA organisations and strengthening their capacity and leadership.

Reproductive rights, sexual health, gender issues and gender-based violence

The evaluations included in this review all deal with different aspects of reproductive rights, sexual health, gender issues, and gender-based violence. None of the evaluations deals specifically with sexual health. The evaluation of UNICEF-supported interventions aiming to end female genital mutilation reported tangible results: in Senegal, for example, community mobilisation helped to increase awareness and – to some extent – reduce female genital mutilation (FGM). UNAIDS has been instrumental in highlighting HIV/AIDS as a human rights issue. An evaluation of UNFPA's work on gender equality showed mixed results, as it remains challenging to translate national policy intentions into concrete actions on the ground. On the other hand, the organisation has achieved progress: for example, towards ending gender-based violence.

Adolescent sexual and reproductive health

UNICEF calls it the 'youth bulge', the fact that 20% of the world population is between 10 and 19 years old – a percentage which is expected to rise in the future. The statistics on the health situation of young people, especially adolescent girls, illustrate the challenges ahead. Adolescent pregnancies remain high (11%), with only half of the deliveries being attended by skilled health workers. An estimated 2.2 million adolescents (aged 10 to 19) – around 60% them girls – are living with HIV. Many of them do not know they are infected. Proven interventions in the domain of enhancing the sexual and reproductive health of adolescents are those working simultaneously on promoting protection, prevention and providing 'youth-friendly services', as evidenced by the evaluations of the work of UNICEF, UNFPA and GFATM in this domain.

1

Background, aim and methodology

Each year, millions of women and children die from preventable causes. These are not mere statistics. They are people with names and faces. Their suffering is unacceptable in the 21st century. We must, therefore, do more for the newborn who succumbs to infection for want of a simple injection, and for the young boy who will never reach his full potential because of malnutrition. We must do more for the teenage girl facing an unwanted pregnancy; for the married woman who has found she is infected with the HIV virus; and for the mother who faces complications in childbirth.

United Nations Secretary-General, 2010

1.1 Sexual and reproductive health and rights: the global context

In 1994, the Programme of Action (POA) of the International Conference on Population and Development (ICPD) redefined reproductive health by putting individual rights at the centre, while at the same time stressing the importance of not losing sight of the larger social, cultural and economic contexts in which people operate. Two ground-breaking achievements of the ICPD were the shift from population control to a human rights perspective, and the inclusion of sexual health in the domain of reproductive health, noting that reproductive health should 'include sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases'.[2]

Ten years later, in 2004, the World Health Assembly (WHA) adopted the first *Global Strategy on Reproductive Health*.[3] This was a renewed commitment to the principles underlying the ICPD. In addition, the WHA urged for joint and *accelerated* action to achieve the Millennium Development Goals (MDGs). The strategy targeted five priority aspects of reproductive and sexual health: improving antenatal, delivery, post-partum and newborn care; providing high-quality services for family planning, including infertility services; eliminating unsafe abortion; combating STIs, including HIV, reproductive tract infections, cervical cancer and other gynaecological morbidities; and promoting sexual health.[4]

The importance of the 2004 Global Strategy was reaffirmed at the 2005 Millennium Summit[5], where Heads of State and Governments expressed their commitment to 'achieving universal access to reproductive health by 2015, as set out at the ICPD, and integrating this goal in strategies to attain the internationally agreed development goals, including the Millennium Development Goals (MDGs).'[6] In 2007, following a recommendation of the

[2] ICPD Programme of Action, 1994, paragraph 7.2.
[3] Also referred to in this document as the 'Global Strategy'.
[4] http://www.who.int/mediacentre/news/releases/2004/wha2/en/.
[5] High-level plenary meeting of the 60th session of the General Assembly. See: http://www.un.org/en/events/pastevents/worldsummit_2005.shtml.
[6] WHO 2011f.

United Nations Secretary-General (UNSG) to the United Nations (UN) Assembly in 2006, a new target was added to MDG 5: universal access to reproductive health. Again, this demonstrated strong commitment at the highest levels for improved sexual and reproductive health. With the inclusion of this new target, additional indicators were needed. The InterAgency and Expert Group (IAEG) on MDG indicators therefore issued a revised MDG monitoring framework in 2008, which integrated the new target (MDG Target 5B) and included four indicators for monitoring progress.[7] Meanwhile, the Global Strategy continued to serve as guidance to the monitoring process: for example, in the development of national health policies and strategic plans on SRH, and in the implementation of maternal and child health activities.[8]

In 2007, WHO published the *Strategic Approach to Strengthening Reproductive Health Policies and Programmes*.[9] The approach aims to help governments, non-governmental organisations (NGOs) and international agencies in assessing countries' RH needs and priorities, and serves as a useful tool for testing pilot and established approaches for possible scale-up of useful interventions. For example, in Brazil, such an assessment led to the formulation of a comprehensive reproductive health service model. In Zambia, a need was identified for fundamental changes in the provision of sexual and reproductive health services through a more balanced contraceptive mix. In 2010, the UNSG launched *Every Woman Every Child, the Global Strategy for Women's and Children's Health*, which called upon partners to take action to reverse decades of underinvestment, increase the efficient delivery of services, and accelerate global progress towards the child and maternal health MDGs.

1.2 Sexual and reproductive health and rights: the Dutch response

'For years, the Netherlands has been committed to promoting people's right to decide for themselves whether, when and with whom to have children, and to determine the size of their own families. And we've been successful, both in the Netherlands and in developing countries', were the words of the Secretary of State for European Affairs and International Cooperation at the July 2012 Family Planning Summit in London.[10] This explicit commitment of the MFA to SRHR (including the fight against AIDS) follows a long line of commitments to the ICPD and other international agendas, as witnessed in the various policy statements on priorities and strategies to accelerate the SRHR agenda.[11]

7 WHO 2011f.

8 See the 2010 Progress report in which data from 57 countries are complied, in: WHO, 2010d.

9 More on the approach is found in: WHO, 2007b.

10 Jointly organised by the UK Government and the Bill & Melinda Gates Foundation.

11 See: MFA (2007) Policy Brief on Development Aid (Een zaak van iedereen); MFA (2008) Choices and Opportunities. Policy Memorandum on HIV/AIDS and SRHR in foreign policy; MFA (2009) Working together towards global challenges: the Netherlands and multilateral aid; MFA (2011) Focus Letter on Development Aid; (MFA 2011a) Letter on Multilateral Development Aid (Brief inzake Multilateraal OS-beleid, in Dutch); MFA (2012) Letter to the House of Representatives/Parliament regarding the Policy on SRHR, including HIV/AIDS.

A 2007 policy review of MFA's commitment to MDGs 4, 5 and 6 and the Cairo Agenda affirmed the concordance of Dutch foreign policy with the various international treaties.[12] This conclusion came as no surprise, as the Netherlands has always been an active contributor to international processes, including the Cairo consensus (1994), the Fourth World Conference on Women (in Beijing, 1995), and the Millennium Summit (2000). Moreover, Dutch commitment went beyond international diplomacy: the Netherlands took a leading role in defending human and SR rights, and voicing concerns on sensitive topics such as abortion, and the rights of sexual minorities.

The 2011 Focus Letter specifies support to the domain of SRHR, which is one of the four spearheads of Dutch policy.[13] In July 2012, Parliament approved this approach, reaffirming the Netherlands' commitment to the millions of young people and women who are put at risk every day due to lack of information and lack of access to contraceptives and good care.[14] See text box 1 for the cornerstones of Dutch policy in SRHR.

Text box 1 *Key elements of Dutch SRHR policy*

The 2011 MFA Focus Letter on development aid mentions 'reduction in unwanted pregnancies', 'reduction in maternal mortality' and 'reduction in HIV infections' as *impact indicators*, and formulates as outcomes:

- Young people have increased knowledge of sexuality, pregnancy, and HIV, and are free and able to make choices in their sexual relationships, safe sex, and the use of contraceptives;
- Improved access to and choice of good quality family planning, male and female condoms, drugs, vaccinations and other SRHR commodities, and improved HIV prevention;
- Improved access to, and quality of public and private services in SRHR, including safe abortion and HIV/AIDS;
- Improved access to health services among *key populations*;
- Universal reproductive rights worldwide, in particular of women and youth, are brought to the attention of policy makers and the public within the focus countries[15] of the Netherlands, and are included in policies and laws.

Source: MFA (2011) Focus Letter on Development Aid

[12] The findings of the policy review on operational goals 5.4.and 5.5 were presented to Parliament on 9 November 2007.

[13] The four spearheads are: water; sexual health and rights; food security; and security and the rule of law. The letter also proposed that the number of partner countries be reduced from 33 to 15. http://www.rijksoverheid.nl/documenten-en-publicaties/kamerstukken/2011/03/18/aanbiedingsbrief-focusbrief-ontwikkelingssamenwerking.html.

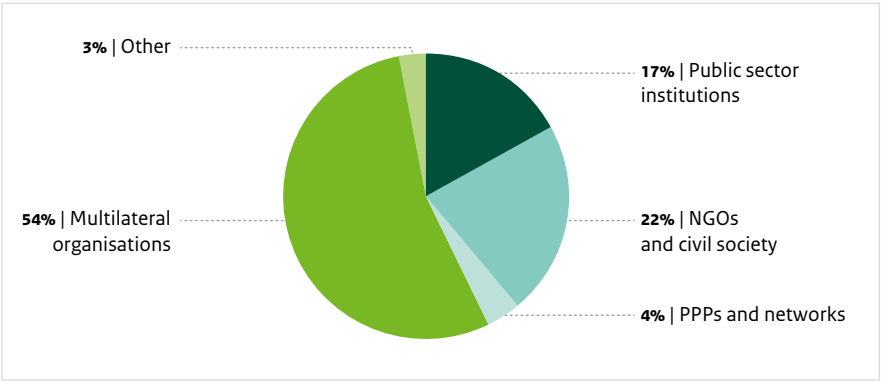
[14] http://www.minbuza.nl/en/news/2012/07/house-supports-details-of-new-development-policy.html.

[15] See MFA 2007, which defined four categories: 1) Accelerated MDG achievement: Bangladesh, Benin, Bolivia, Burkina Faso, Ethiopia, Yemen, Ghana, Kenya, Mali, Mongolia, Mozambique, Nicaragua, Rwanda, Senegal, Tanzania, Uganda, Zambia; (2) Safety and development: Afghanistan, Burundi, Colombia, Congo, Guatemala, Kosovo (SC Res.1244), Pakistan, Palestine Territories, Sudan; (3) Broad relation: Egypt, Georgia, Indonesia, Moldova, Vietnam, South Africa, Suriname; (4) Phasing out: Bosnia-Herzegovina, Eritrea, Sri Lanka, Albania, Armenia, Cape Verde, Macedonia.

With regard to multilateral cooperation, both the Focus Letter (MFA, 2011) and the Policy Brief on Multilateral Cooperation (MFA, 2009 and MFA, 2011a) outline this cooperation and the role of the UN and other multilateral organisations.[16] The use of multilateral organisations as a channel for development aid implies that the Dutch priorities outlined above will be followed, and that the underlying principles will be selectivity, added value and effectiveness. In the period 2008-2010, Dutch ODA to multilateral organisations averaged some EUR 1,100 million per year, representing 25-30% of the total ODA budget (MFA, 2011a).

Over the period 2007-2012, total MFA expenditure allocated to health and SRHR was EUR 435 million per year. Until 2009, the trend was upward, but since then, yearly expenditure has decreased. Figure 1 below presents the breakdown of total health, SRHR and HIV/AIDS expenditure in 2007-2012 per channel. The largest share (54%) was allocated to multilateral organisations. In this channel, the organisation with the largest share was UNFPA (over 33%), followed by the Global Fund (26%), UNAIDS (13%) and the GAVI Fund (9%). Less important were WHO (7%), the World Bank (4%) and UNICEF (3%).

Figure 1 *Breakdown of MFA expenditure on health, SRHR and HIV/AIDS 2007-2012, as % per channel*



UNICEF, the World Bank and UNDP are considered cornerstone organisations in the current ODA structure, because of their size, knowledge, convening power, broad commitment and coordinating role. GFATM, UNFPA and UNAIDS[17] are among the organisations[17] receiving support because of their effectiveness and because their mandate and activities are in line with Dutch policy priorities. UNFPA and UNAIDS are specifically supported because of their crucial role in SRHR and combating HIV/AIDS; however, the Focus Letter comments on the need to improve their effectiveness (MFA, 2011a). In light of the growing interest in global public goods, the Netherlands financially supports organisations that are key because they set standards and norms, have a sound knowledge base and are known for their role in negotiations. These organisations have a wider role beyond the aid channel because they function as a knowledge platform and play a role in the development of international

[16] Following the principles of avoiding fragmentation and overlapping of interventions, and aiming for harmonisation, alignment, result orientation and mutual accountability as defined in the Paris Declaration and the Accra Agenda for Action.

[17] Alongside with AsDB, AfDB, IFAD, IFC, GFATM, GAVI, UNHCR, UNOCHA and WFP (MFA, 2011a).

agreements and standards. WHO falls within this category[18] (MFA, 2011a). Dutch development aid is thus positioned within a broader context, within the global aid architecture.[19]

1.3 Aim of the review

This synthesis presents the findings of a literature review of the effect of the Netherlands Ministry of Foreign Affairs' (MFA) support to multilateral organisations during the period 2006-2011.

The **aim of the study** was to evaluate the Dutch collaboration in SRHR via the multilateral channel. The review applied the OECD/DAC criteria for evaluations of development interventions, and specifically focused on effectiveness, impact, relevance and sustainability. The study is part of a comprehensive review of MFA's policy implementation in SRHR. Support to other channels (bilateral and through NGOs) fell outside the scope of this evaluation, and have been dealt with separately.

The literature review which formed the basis for this publication is structured around the core components of sexual and reproductive health[20] as outlined in the Global Strategy on Reproductive Health (WHO, 2004a):

- Improving maternal and newborn health.
- Ensuring contraceptive choice and safety, and fertility services.
- Eliminating unsafe abortion and providing post-abortion care.
- Reducing STIs, including HIV, and other reproductive morbidities.
- Promoting health sexuality, including adolescent health and reducing harmful practices.

1.4 Methodology

Five organisations were included in the review, selected on the basis of their contributions to the domain of SRHR: the United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), the Global Fund to Fight AIDS, TB and Malaria (GFATM), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO).

The selection of evaluations was based on their thematic focus (SHRH), their quality and whether the evaluated intervention concerned a focus country of the Netherlands. In addition, the evaluation had to be of recent date, and in English or Spanish. Evaluations of

[18] Alongside with IMF, WTO, ILO, UNEP and FAO (MFA, 2011a).

[19] Based on the five principles (ownership, alignment, harmonisation, results and mutual accountability) outlined in the 2005 Paris Declaration and the 2008 Accra Agenda for Action.

[20] With the following exceptions: The category 'Sexually Transmitted Infections' includes HIV and cervical cancer, but does not elaborate on reproductive tract infections and gynaecological morbidities. The domain of adolescent SRHR is included in the review as a separate category. The category health sexuality includes: reproductive rights, gender issues and gender-based violence.

the work of UNICEF, UNFPA and the GFATM that met these criteria underwent a quality assessment and a final selection was made by applying three criteria: spread among the elements of the SRHR Strategy and the focus countries of the Netherlands[21]; at least two evaluations of adolescent programmes per organisation; and published between 2006 and 2012. The contribution of UNAIDS and WHO was assessed by reviewing external evaluations and policy briefs.

As mentioned above, the OECD/DAC criteria for evaluations of development interventions were applied, with a focus on effectiveness, impact, relevance and sustainability. The evaluation questions that guided the review were to ascertain effects in terms of relevance, changes in legislation in the domain of SRHR, institutional strengthening, outcome of services, output (commodities), and were also intended to identifying the factors which influenced these effects.

The search yielded 62 eligible evaluations, 26 of which met the inclusion and quality criteria.[22] Table 1 and Annex 3 give an overview of the UNAIDS and WHO documents reviewed; Annex 4 presents notes on the quality assessment of the evaluations.

[21] See MFA 2007 which defined four categories: 1) Accelerated MDG achievement: Bangladesh, Benin, Bolivia, Burkina Faso, Ethiopia, Yemen, Ghana, Kenya, Mali, Mongolia, Mozambique, Nicaragua, Rwanda, Senegal, Tanzania, Uganda, Zambia; (2) Safety and development: Afghanistan, Burundi, Colombia, Congo, Guatemala, Kosovo (SC Res. 1244), Pakistan, Palestine Territories, Sudan; (3) Broad relation: Egypt, Georgia, Indonesia, Moldova, Vietnam, South Africa, Suriname; (4) Phasing out: Bosnia-Herzegovina, Eritrea, Sri Lanka, Albania, Armenia, Cape Verde, Macedonia.

[22] Of these, 7 evaluations pertain to UNICEF (out of 10 eligible evaluations), 13 to UNFPA (out of 37 eligible), and 6 to GFATM (out of 15 eligible).

Table 1 Geographical and (in italics) thematic distribution of the 26 evaluations reviewed

Thematic area	UNICEF		GFATM
Maternal / perinatal health (N= 10)	Sudan *(Health and Nutrition Programme)*	Global *(Maternal health, thematic evaluation)* Eritrea *(Safe motherhood)* Uganda *(Obstetric fistula)* Bolivia, Mali, Pakistan, Rwanda and Tanzania *(Country Programme Evaluations)*	Ethiopia *(Health systems: health facility)*
Family planning (N=1)		Global *(Commodity security)*	
Unsafe abortions (N=0)			
STIs, including HIV (N=7)	Tanzania *(National HIV response)* Global *(AIDS campaign)* Mozambique *(NGO-Government partnership)*	Bangladesh *(Cervical cancer)*	Multi-country[25] Ethiopia *(National response to HIV)* Tajikistan *(PLHIV)* Kenya *(OVC)*
Reproductive rights, sexual health, gender issues and gender-based violence (N=3)	Senegal *(GBV)*	Global *(Gender)* Global *(Dignity kits)*	
Adolescent SRHR (N=5)	Namibia *(Life skills)* Global *(Adolescents)*	Tanzania *(Youth Alliance)*	Bangladesh *(Community readiness)* Bangladesh *(Life skills)*

Observations on the selected evaluations

Overall, the number of evaluations meeting the selection criteria was less than anticipated. Only in the case of UNFPA was the target of 10 evaluations per organisation met, as UNFPA's mandate is closely tied to improving SRHR worldwide. In the case of UNICEF, the vast majority of the evaluations in their evaluation database relate to the core business of UNICEF, which is child health and protection, which left only a limited number of evaluations to select from. Finding good quality evaluations proved difficult. This finding is

[23] The Global Fund Five-year Evaluation (Macro International Inc., 2009) was reviewed, specifically focusing on the two country case studies (both in Ethiopia).

in line with the conclusions from the Quality assessment of UNFPA decentralized CPEs (UNFPA, 2012), which notes that many evaluations do not meet the quality standards of the organisation, and that the assessments done in 2005, 2009 and 2012 show few improvements.[24]

The spread of evaluations over the core themes is uneven, in part because of a classification issue: for example, family planning being reported on in the context of a maternal health programme. On the other hand, the spread may well reflect a shift in focus of multilateral organisations.[25] No evaluations were found of programmes preventing unsafe abortions or treating abortion-related complications, including post-abortion care, most probably because the number of programmes implemented by multilateral organisations in this domain is limited. As gender is often considered as a cross-sectoral theme in the organisations' strategies and approaches (as in the country Programmes of UNFPA and UNICEF), few specific evaluations on gender issues (in SRHR) were found, except for the UNFPA in-depth study on gender equality.[26] The situation is similar for human rights reviews, except for those addressing specific violations, such as gender-based violence and female genital mutilation. The number of good quality evaluations of interventions regarding adolescents was also limited, which is surprising, as organisations are increasingly focusing on adolescent health and development.

Limitations

As the achievements and challenges with regard to multilaterals' support to improve SRHR were assessed mainly on the basis of external published and non-published evaluations, the IOB reviewer was limited to secondary material. The study covered only six years (2006-2012), with preference being given to the most recent evaluations from the period. A selection bias may have occurred because the search was limited to reports written in English or Spanish. An exception was made, so as to be able to include the UNFPA programme evaluation on Mali, which was available only in French; it was included because of IOB's particular interest in Mali, which is a focus country.

[24] In 2012, of the 34 CPEs only 3 were scored 'good', with the remaining 31 rated as 'poor' (23) or 'unsatisfactory' (8). None scored 'very good'. The 2009 EQA report stated that 'no systematic improvement in evaluation quality in the period 2007-2009 was identified, and ... 51% of evaluation reports were below expectations of quality'. The 2005 meta-evaluation assessed 66% of evaluation reports as being unsatisfactory across all criteria (UNFPA, 2012).

[25] This is similar to the observation in MFA/IOB (2009), in which the gaps in evaluation evidence were pinpointed, as not all aspects of sexual and reproductive health have attracted similar interest from researchers and policy makers. A relatively large number of studies described in that synthesis dealt with aspects of improving maternal and perinatal health, family planning and sexual and reproductive health of adolescents, whereas other areas, such as abortion, human rights and gender, received less attention.

[26] Universalia (2011).

2

Maternal and perinatal health

2.1 State of the art and evidence of improved maternal and perinatal health

'In the five minutes it takes to read this page, 3 women will lose their lives to complications of pregnancy or childbirth, 60 others will suffer debilitating injuries and infections due to the same causes, and 70 children will die, nearly 30 of them new-born babies. Countless other babies will be stillborn or suffer potentially long-term consequences of being born prematurely. The vast majority of these deaths and disabilities are preventable.' This statement from the Countdown to 2015 report[27] summarises the issues still dominating the maternal and perinatal/child health agenda. Despite recent evidence of a declining trend in maternal mortality, high maternal mortality continues to be concentrated in sub-Saharan Africa and in South Asian countries. An African woman's lifetime risk of maternal mortality is still 100 times higher than that of a woman in a developed country.

Globally, there are an estimated annual 287,000 maternal deaths (2010), and a global adult lifetime risk of maternal mortality of 1 in 180[28] (WHO, 2012c). Two recent studies of maternal mortality trends (Hogan et al., 2010 and Lozano et al., 2011)[29] show that since 1980 the global average annual number of maternal deaths has fallen by around 200,000 (Hogan, 2010). Lozano and colleagues (2011) further predict that if the current rate of decline is maintained, for *'96 countries it will take more than 20 years after 2015 to reach the MDG 5 target'* (Lozano et al., 2011). More than half of the countries in the world, including China, India and some countries in sub-Saharan Africa (such as Kenya, Swaziland, Zimbabwe and Botswana) have seen an acceleration in reduction over the past 10 years, whereas others, among them South Africa, Mexico and Brazil, have experienced a reduced rate of decline (Lozarno, et al., 2011). None of the countries in sub-Saharan Africa is expected to achieve both MDG 4 and 5 (see Table 2).

[27] WHO/UNICEF, 2012. Countdown to 2015 is a global movement to track, stimulate and support country progress towards achieving the health-related MDGs 4 and 5. The movement tracks progress in the 75 countries where more than 95% of all maternal and child deaths occur, and publishes periodic reports and country profiles on key aspects of reproductive, maternal, newborn and child health.

[28] The probability that a 15-year-old woman will eventually die from a maternal cause.

[29] According to both reviews, maternal deaths fell, and the global MMR decreased, though the 2011 study presents estimates of maternal deaths that are some 30,000 lower than the estimates given in the study one year earlier. According to Lozano, the disparity is attributable to differences in input data, data processing, and modelling strategies. In some cases the difference was as high as 35% (in the UN 2007 study the number of maternal death was 546,000 compared to 347,000 in the Lozano study). All in all, more global attention to the measurement of maternal mortality has led to a more comprehensive worldwide database on maternal mortality.

Table 2	Estimated maternal mortality ratios (ranges shown in parentheses) worldwide and in developing and developed countries.					
	Maternal mortality ratio per 100,000 live births			Maternal deaths in in numbers		
	1990	2000	2011	1990	2000	2011
Worldwide	299.3 (280.2-320.4)	299.5 (286.9-313.0)	201.8 (189.2-215.3)	409,053 (382,910-437,860)	393,830 (377,209-411,556)	273,465 (256,332-291,693)
Developing countries	335.8 (314.2-359.6)	332.2 (318.0-347.2)	224.7 (210.3-239.8)	405,605 (379,510-434,426)	390,959 (374,333-408,616)	270,772 (253,486-289,063)
Developed countries	21.7 (21.0-22.5)	20.8 (20.1-21.6)	18.0 (16.4-19.8)	3,448 (3,329-3,573)	2,872 (2,769-2,987)	2,603 (2,453-2,968)

Source: Lozano et al., 2011.

Leading causes of maternal deaths – haemorrhage, hypertensive disorders, sepsis, and abortion complications – differ starkly between the geographical regions. In Africa and Asia, haemorrhage is the leading cause of more than 30% of the maternal deaths, whereas women in Latin America and the Caribbean tend to die from hypertensive disorders before or during childbirth. HIV/AIDS causes about 6% of the deaths in Africa. Anaemia and obstructed labour each account for about a tenth of deaths in Asia, and abortion-related mortality was the highest in Latin America and the Caribbean (Khan et al., 2006). Each year an estimated 10,000 women and 200,000 infants in tropical areas of Africa with intense transmission of *Plasmodium falciparum* die as a result of malaria infection during pregnancy, with severe malaria anaemia contributing to more than half of these deaths.[30] Obstetric fistula (OF)[31] affects some 50,000 to 100,000 women worldwide each year. This hidden and often lifelong condition is directly linked to obstructed labour. It is estimated that more than 2 million young women in Asia and sub-Saharan Africa live with untreated obstetric fistula. The condition is preventable and can largely be avoided by delaying the age of first pregnancy, ceasing harmful traditional practices, and ensuring timely access to obstetric care.[32] Experiences with community support show the importance of raising awareness on the condition. Such support helps to reduce stigma and to benefit the recovery process.

[30] Information adapted from: http://www.rbm.who.int/cmc_upload/0/000/015/369/RBMInfosheet_4.htm and http://www.who.int/malaria/high_risk_groups/pregnancy/en/index.html.

[31] OF is a hole in the birth canal. Women who experience obstetric fistula suffer constant incontinence, shame, social segregation and health problems.

[32] See: http://www.who.int/features/factfiles/obstetric_fistula/en/.

High maternal, perinatal, neonatal, and child mortality are generally associated with inadequate and poor quality health services (WHO, 2010a) that have bottlenecks, such as health workforce shortages and disruptions in the supply chain (Lozano et al., 2011). Promoting skilled attendance at birth is challenging – given the low percentages of births unattended by health personnel – and may not be the only option. Current thinking on increasing access to maternal health services draws upon the 'three delays model', which recognises the different barriers women face in achieving timely and efficient care. The first two delays take place at household and community levels (delay in decision to seek care, and in reaching care), whereas the third delay addresses the health system barriers (delay in receiving adequate health care). Overcoming these delays requires interventions at all levels, including at the community and household levels, and combining facility-based interventions with those at the primary health care (PHC) level. See Table 3 below for figures on access to maternal and perinatal health services.

Table 3 Access to maternal and perinatal health services: worldwide and in the six WHO regions

WHO region	ANC coverage (at least 1 visit) in %	ANC coverage (at least 4 visits) in %	Pregnant women with HIV receiving ARVs to prevent MTCT in %	Births attended by skilled health personnel in %	Births by caesarean Section in %	Postnatal care visit within 2 days of childbirth in %
	2005-2011	2005-2011	2010	2005-2011	2005-2010	2005-2010
African Region	74	43	50	48	4	37
Region of the Americas	95	87	59	93	35	-
South-East Asia Region	76	52	13	59	9	48
European Region	-	-	79	98	22	-
Eastern Mediterranean Region	72	43	3	59	16	42
Western Pacific Region	93	-	30	91	24	-
World total	**81**	**55**	**48**	**69**	**16**	**46**

Source: World Health Statistics 2012 (WHO, 2012a). Legend: ANC = antenatal care; ARV = antiretroviral drugs; MTCT = mother-to-child transmission.

The 2008 *The Lancet* Series on Alma-Ata focused on effective maternal, newborn, and child health (MNCH) interventions in primary care settings.[33] For example, the inclusion of evidence-based interventions (such as community-based strategies with functional first-level referral facilities, and service availability at household and community level and first-level facilities) in MNCH in Pakistan and Uganda yielded a remarkable reduction in maternal and newborn deaths (up to 30% maternal deaths, and up to 40% post-neonatal deaths in children aged less than 5 years) (Bhutta et al., 2008). See Annex 5 for more studies addressing the pros and cons of delivery in PHC and additional delivery and demand-creation strategies.

More than one third of the deliveries in developing countries are not attended by skilled health personnel (2012c), so therefore a priority is access to an uterotonic for the prevention and treatment of post-partum haemorrhage (PPH). [34] In circumstances where oxytocin is not an option – it requires cold storage and health providers with the skills and equipment to provide intravenous therapy – the best available option for prevention and treatment of PPH is misoprostol.[35] Evidence on the safety and effectiveness of misoprostol as medicine for use in low-resource settings is growing, based on multi-country research and national experience, such as the community-based distribution in Bangladesh.[36] In 2012, the International Federation of Gynaecology and Obstetrics and WHO published new guidelines on community-based distribution of misoprostol for PPH prevention.[37]

[33] Although the provision of services for instrumental deliveries and caesarean sections is a key intervention for maternal survival, the review of preventive measures in the PHC strategies showed that reasonable gains can still be made for maternal health and survival in primary health care by introducing a range of preventive interventions ranging from family planning or provision of contraceptives, through care seeking, clean delivery, preventing pre-eclampsia, and providing antenatal care to address maternal risk factors, such as anaemia and pregnancy-induced hypertension (Bhutta et al., 2008).

[34] FCI/Cody and Goltz, 2012.

[35] Idem.

[36] The Mayer Hashi pilot project demonstrated high acceptability and demand: 92% of the women who had received the medicine in advance were successfully able to self-administer it. See: Engender Health/The RESPOND project (2010). Mayer Hashi Project, Preventing Postpartum Hemorrhage: Community-Based Distribution of Misoprostol in Tangail District, Bangladesh. Project Brief May 2010/ No. 2.

[37] http://www.figo.org/publications/miscellaneous_publications/Misoprostol_Recommendation_2012 and http://www.ncbi.nlm.nih.gov/pubmed/23433680.

2.2 Findings[38]

Table 4 The ten evaluations reviewed in the area of maternal and perinatal health

UNICEF	UNFPA	GFATM
Sudan *(Health and Nutrition Programme)*	Global *(Maternal health, thematic evaluation)* Eritrea *(Safe motherhood)* Uganda *(Obstetric fistula)* Bolivia, Mali, Pakistan, Rwanda and Tanzania *(Country Programme Evaluations)*	Ethiopia *(Health systems: health facility)*

Eight of the ten evaluations are for the work of UNFPA, as this is the main thematic area pertaining to the organisation's mission. The presentation of the findings therefore draws predominantly on the UNFPA support to maternal and perinatal health. Generally, UNFPA country programmes are structured around reproductive health and rights, gender equality, and population and development Despite differences in focus that reflect the needs on the ground, all eight of the UNFPA country programmes were considered to be relevant because they address high MMR. None of the UNFPA evaluations reviewed mentions efforts to reach out to vulnerable groups in particular; all the programmes seem to have targeted broader groups, such as women of reproductive age, or adolescents. Overall, looking at specific country progress, the thematic evaluation (UNFPA, 2012a) reports successful community support for maternal and child health in, among others, Burkina Faso, Laos, Ethiopia and Cambodia.

The general understanding is that each any of these efforts needs to be linked to national efforts to strengthen health systems, as was reported in Zambia, where efforts were made to integrate the 'Safe Motherhood Action Groups' into the national maternal health policy frameworks (UNFPA, 2012a). In other countries too, community approaches seem to have paid off: for example, in Burkina Faso, where UNFPA supported the establishment of *cellules villageoises de gestion des urgences obstétricales*, focusing on community support in case of emergency and raising awareness of safe motherhood. Another tangible result was the creation of Emergency Obstetric Neonatal Care (EmONC) subsidies that helped to increase facility-based deliveries by more than 27% between 2005 and 2010.

In terms of strengthening the health-care system, country case studies show that a long-term effect of technical training of health workers is achieved only when these efforts are supported or embedded in national human resource systems or plans. Even though UNFPA has provided assistance in this regard (especially in technical training in HIV/AIDS, FP, OF, and EmONC) sustained results could not be demonstrated. Prior to the establishment of the Maternal Health Thematic Fund (MHTF) in 2008, country offices supported the deployment

[38] In the case of the UNFPA Country Programme Evaluations, all findings are presented in this chapter, including those explicitly or implicitly pertaining to other domains in SRHR: for example, in the case of family planning, or gender-based violence.

and scaling-up of skilled attendance during pregnancy and childbirth, and EmONC services; however, as the evaluators conclude, 'UNFPA country offices have not yet adequately defined their roles and responsibilities for addressing health system-wide bottlenecks, including capacity gaps in line ministries, problems with staff retention, identification of barriers and addressing them, inadequate health information systems or inadequate referral systems. Unless these are addressed, these bottlenecks will decrease the chances that EmONC plans can be rolled out to their fullest potential' (UNFPA, 2012a).

In terms of policy and/or legislative adjustments, all five UNFPA country programmes have played a role in the development of relevant SRH policies and strategic plans (general or sector). Most notable were the UNFPA support to the development of a new constitution in Bolivia (in 2009), the inclusion of cervical and breast cancer in the National Equal Opportunities Plan, and efforts to place sexual violence on the national agenda. In other countries too, there is evidence of UNFPA's support to the shaping of the SRH and development agenda. Examples are UNFPA's response to gender-based violence (GBV) during the humanitarian crisis in Pakistan, which helped to place GBV on the national agenda, and in Uganda, where with support from UNFPA, obstetric fistula was included in national policy.. The Thematic Evaluation of UNFPA's support to maternal health indicates that UNFPA has a track record in anchoring this particular domain more firmly in policy frameworks.

All evaluations included in this review include findings on institutional strengthening, as in the case of Uganda, where UNFPA supported the training of surgeons and obstetricians/ gynaecologists in order to tackle the large backlog of women with obstetric fistula. In Rwanda the training involved health workers at local levels, while in Mali, UNFPA invested in technical training of health workers across the board: from community level to health workers specialising in EmONC.

Though most of the evaluations explicitly mention outcome levels, in some cases, evaluators are cautious in presenting the findings because of data collection problems, such as in the UNFPA Eritrea evaluation of the safe motherhood programme. Overall, the evaluators of that programme report an upward trend in key indicators, among them ANC, a large increase of more than 43% in access to skilled birth attendants and a similar large increase in health facility deliveries. The UNFPA obstetric fistula programme in Uganda also shows increases in access to skilled care at birth – but not through routine services. Some of the evaluations mention increases in access to services, such as in Bolivia and Mali, and also in Pakistan – where increases of up to 700% were reported in per month deliveries in health facilities. In the case of Global Fund support in Ethiopia, increased access was reported, in particular to antiretroviral treatment (ART) and STI services.

Quality of care is an underreported area: none of the evaluations included in this review mention aspects of the quality of the maternal health services delivered. This may reflect a bias in many evaluations, or an area for improvement, as quality of care is not often made a priority. The only evaluation to report on the quality effect of the intervention – in this case obstetric fistula repair in Uganda (UNFPA-supported programme) – addressed quality of care

aspects such as the availability of written consent and of post-operative nursing care protocols. However, none of the facilities reviewed in that evaluation had written pre-operative and intra-operative protocols and infection prevention measures. In the evaluation, the quality indicators are the success rate of the repairs and low rates of second or third repairs. Other data on quality were merely anecdotal.

An important aspect of the review was to assess the comparative value of a particular intervention in the case of multiple services. This proved difficult, because of variations in reporting on direct outcome, and problems in attributing the outcomes. Nonetheless it was possible to single out some promising strategies, such as the involvement of maternal health volunteers in Eritrea in the promotion of safe motherhood and in preventing obstetric fistula. However, the lesson learned is that such approaches need to be complemented by interventions that remove financial or logistical barriers to access to care.

The report on the obstetric fistula programme in Uganda is not conclusive on the best strategy to follow, given the enormous backlog of patients with OF: whether to integrate the OF strategy into the national maternal and newborn health strategy, or to continue repair services under the provision of clinical services. UNFPA support to repair camps resulted in increased access, but this may not be a sustainable approach.

Many pilot interventions are being scaled up without substantial evidence from research or assessment about their effectiveness and potential scalability. As noted in the Thematic Evaluation of UNFPA support to maternal health: 'UNFPA has not been able to gauge which contributions maternal health programmes have made to higher level maternal health outcomes and to systematically use lessons from pilot interventions for future maternal health support' (UNFPA, 2012a).

The implementation of interventions is often hindered by conflict, or natural or manmade disasters, such as reported in the UNICEF-supported programme in Sudan, and UNFPA's County Programme in Pakistan. Generally, what is conducive to programme implementation is political will and strong leadership on the part of governments and development partners in advancing maternal health. A prerequisite for adequate implementation is good relationships between the partners, including with civil society organisations. An example is the UNFPA-implemented Country Programme in Rwanda, where synergy between Rwanda's development priorities and the mutually consultative approach initiated by the MoH and supported by UNFPA resulted in significant improvements in family planning and maternal health-care outcomes over the reported years. As the Mali report (UNFPA) demonstrates, civil support – the involvement of village and religious leaders – proved to be important in the fight against female genital mutilation, but changing this reality also needs strong political commitment. In Tanzania, the collaboration with religious leaders was seen as pivotal in developing programmes and guidelines on various topics in SRH.

3

Family planning

3.1 Call for action

In 2006, John Cleland and colleagues made a plea for greater investment in family planning: "Low contraceptive practice, combined with high fertility, population growth, and unmet need for family planning makes greater investment in family planning compelling."[39] Six years later, in their contribution to the 2012 *The Lancet* series on Family Planning[40], Cleland and his colleagues again placed family planning prominently on the agenda (Cleland et al., 2012). In the article, they highlight the 'non-contraceptive' benefits of contraception use, such as improved perinatal and child survival, besides averting maternal mortality: "Contraceptive use has the potential to improve perinatal outcomes and child survival by widening the interval between successive pregnancies; in rich and poor countries the risks of prematurity and low birth weight are substantially raised by short intervals, and in developing countries, risk of death in infancy (ages <1 year) would fall by 10%, and in ages 1-4 years by 21%, if all children were spaced by a gap of 2 years" (Cleland et al., 2012). The benefits of contraceptive use are also highlighted in the *Adding It Up* report – a regularly updated report on costs and benefits of contraceptive services (Singh and Darroch, 2012).

Clearly, countries with high fertility, high unmet need for family planning, and illegal and unsafe abortion (most of which are in sub-Saharan Africa), are expected to benefit most from increased focus on family planning (FP) and on contraceptive use. However, increasing such rates will be challenging in a number of countries, especially in central and western Africa. The 2013 *The Lancet* publication on trend analysis in contraceptive prevalence and unmet need for FP (Alkema et al.) demonstrates that a low contraceptive prevalence rate (CPR) in 1990 did not consistently translate into substantial increases over time. Though the overall CPR increased from 54.8% in 1990 to 63.3% in 2010, among the countries studied there were huge differences in progress. Of the 26 countries with a CPR lower than 10% in 1990, in 16 of these, all in Africa, the absolute increase in CPR achieved by 2010 was less than 10%.[41] In central and western Africa, contraceptive prevalence still remained low: by 2010 fewer than 1 in 5 married/in-union women of reproductive age used any contraceptive method (Alkema et al., 2013). The trend in unmet need for family planning was similar: the global rate of unmet need for FP fell from 15.4% in 1990 to 12.3% in 2010.

Since the 1960s, the main responses to the high fertility and rapid population growth have been the implementation of family planning programmes, and efforts to increase levels in education and improve health (Ezeh et al., 2012). Many programmes aimed to influence demographic changes, such as the controlled experiment in family planning in Matlab, a rural district in Bangladesh. The programme included the involvement of literate female workers, who gave doorstep counselling and supplied commodities. Two years into programme's implementation, tangible successes were noted, such as a sixfold increase in contraceptive use and declining fertility levels (a fall of about 1.5 births per woman as

[39] In an article in *The Lancet* which formed part of a 2006 Series on SRHR (Cleland et al., 2006).

[40] Coinciding with the London Summit on Family Planning in July 2012, jointly organised by the UK Government and the Bill & Melinda Gates Foundation.

[41] Ethiopia, Mozambique, South Sudan, Angola, Chad, Sudan, Côte d'Ivoire, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone (Alkema et al., 2013).

compared to non-intervention sites). Furthermore, the success of the programme inspired the Government of Bangladesh to adopt the Matlab model as its national FP strategy. By the late 1990s, Bangladesh's fertility had declined to 3.4 births per woman, while in neighbouring Pakistan fertility remained at 5.0 (Ezeh et al., 2012). Evidence of strong well-organised family planning programmes paying substantial attention to information, education and communication was also found in other countries, such as Kenya, Indonesia and Iran (as described by Bongaarts in Ezeh et al., 2012).

The rapid increases in contraceptive use in Rwanda and Ethiopia[42] would not have been possible without strong political will. Cornerstones in strategy to make FP a development priority were open discourse and broad commitment, alongside with strengthened health systems to deliver family planning services, and with social marketing and community involvement.[43] However, challenges remain, as 25% to 35% of married women in these countries – most of whom are the poorest people in the communities – still have a high unmet need for family planning.

The article 'Use of human rights to meet the unmet need for family planning' reports on the many barriers impeding women's contraceptive use (Cottingham et al., 2012), including lack of information and confidentiality, high fees for services, and long distance to the facility.

Studies in Bangladesh, the Philippines, Senegal, and Tanzania have shown that improvements in the quality of care according to human rights standards (including contraceptives choice, information, technically competent providers, privacy, among others) increased women's contraceptive use. Participation in the decision-making process is an essential human rights principle, besides being an effective approach, as evidence has shown. A mapping of in-country activities (WHO, 2010d) underlined the need to further investigate demand and supply dynamics, and addressed 'beyond family planning' interventions, and social factors inhibiting the use of modern contraception – such as women's low level of decision-making within the family, differences in fertility preferences between partners, religious beliefs and attitudes opposed to modern contraception, and the stigma attached to sexual activity of unmarried women.

3.2 Findings

This section draws on the evaluation of the UNFPA Global Programme to Enhance Reproductive Health (Chattoe-Brown et al., 2012), the only evaluation specifically of family planning that was included in the review.

[42] Both countries succeeded in increasing the percentage of married women using contraceptives: in Rwanda, from 13% in 2000 to 52% in 2010; and in Ethiopia, from 8% in 2000 to 29% in 2010.

[43] See the joint comment of the Prime Ministers of Rwanda and Ethiopia in *The Lancet* (2012).

Addressing the supply of contraceptives is highly relevant in many developing countries, given the high demand and negative health outcomes associated with lack of access to RH services, including contraceptives. The UNFPA Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS)[44] aims to adopt a country-specific approach to Reproductive Health Commodity Security (RHCS) by addressing both supply and demand side aspects of RHCS. [45] In general, the GPRHCS is well aligned to national policies and strategies of all the countries. It has raised the profile of commodity security and effectively placed it on the agenda for all of the countries, with the result that RHCS is increasingly being instituted in key policy and strategy documents. These are important advances, though as the evaluators of the Global Programme conclude, among the main hindrances to real progress are the inadequacy of funding, government and otherwise, for contraceptives and other RH commodities. UNFPA's emphasis on providing commodities to the state sector to be dispensed for free may even lessen the incentive for NGOs and the private sector to dispense contraceptives, as they are less likely to recoup their costs. The evaluation is critical of how the GPRHCS aligns with national aid modalities, as with the exception of Nicaragua, in most cases the GPRHCS is not included in pooled funding arrangements and poorly aligned with planning, distribution and reporting procedures.

GPRHCS's outcome is formulated as: "Increased availability, access and utilisation of RHCs for voluntary family planning, HIV/STI prevention and maternal health services in the GPRHCS focus countries." Overall, the evaluators conclude that GPRHCS has made good progress in developing and measuring some useful indicators for the Programme outputs relating to availability of family planning commodities, and uptake and availability of maternal health commodities. However, most of the output indicators measure supply (procurement, supply and distribution), rather than access and demand. Also, few output indicators deal specifically with HIV/STI prevention and maternal health services. Process in CPR was noted in a number of countries, such as in Burkina Faso, where CPR increased from 8.6% to 13.3% (DHS 2003 and MICS 2006 data), and unmet need decreased from 31.3% (2008) to 28.8% in 2010 (FMoH data); and in Ethiopia, which reported an increase from 13.9% (DHS 2005) to 31% in 2010 (MoH statistics). Only Burkina Faso could supply updated figures (supplied by MoH) for unmet need; these showing a slight decrease from 31.3% in 2008 to 28.8% in 2010.

44 The programme considers 3 streams of countries. Stream 1 countries receive medium term support for commodity supply, developing political commitment to RHCS and capacity building): Burkina Faso, Ethiopia, Haiti, Laos, Madagascar, Mali, Mongolia, Mozambique, Nicaragua, Niger, Sierra Leone. Stream 2 countries receive some support for commodities and a lesser amount for capacity building: Benin, Bolivia, Botswana, Burundi, Central Africa Republic, Chad, Congo (Brazzaville), Congo DRC (Kinshasa), Cote d'Ivoire, Djibouti, Ecuador, Eritrea, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Lesotho, Liberia, Malawi, Mauritania, Namibia, Nigeria, Papua New Guinea, São Tomé, Senegal, Sudan, Swaziland, Timor Leste, Uganda, Yemen, Zambia, Zimbabwe. Funding in Stream 3 countries (all developing countries not listed under 1 and 2), covered emergency procurement for countries with weak capacity to plan and manage their commodity procurement (including in humanitarian situations).

45 The GPRHCS defines RHCS as a state in which all individuals can obtain and use affordable, quality reproductive health commodities of their choice whenever they need them. These commodities include equipment, pharmaceuticals and supplies for obstetrics and maternal care, STIs, abortion services, and contraception.

Whereas the overall donor funding for SRH tended to increase, partly because of GPRHCS, the allocations for commodities fluctuated, as shown in Table 5 below.

Table 5 Annual expenditure on reproductive health commodities by donors, 2005-2009, in millions of USD

Donors	2005	2006	2007	2008	2009
USAID	68.8	62.8	80.9	68.9	87.5
UNFPA	82.6	74.4	63.9	89.3	81.1
PSI	28.8	30.6	24.9	14.1	17.9
BMZ/KFW	13.1	23.6	24.6	15.5	16.2
DFID	4.6	12.1	22.5	11.1	13.0
Others *	9.6	5.1	6.4	14.9	23.0
Total	**207.5**	**208.6**	**223.2**	**213.7**	**238.8**

Legend: PSI = Population Services International, BMZ/KFW = Federal Ministry for Economic Cooperation and Development and Development Bank (Germany), DFID = Department for International development (UK).
** Includes IPPF, MSI, Japan, the Netherlands.*
Source: Chattoe-Brown et al., 2012.

In order to address commodity security, one of the key standard activities of the GPRHCS was the institution of functional coordination systems related to forecasting, planning, procurement and distribution. The evaluation is not conclusive on the appropriateness of the mixed methods to the country context. It does, however, recognise that it may be useful to at least focus on long-term methods in countries where the government controls the procurement and supply chains, such as Burkina Faso, Ethiopia, Sierra Leone, Benin and Uganda, where a large proportion of GPRHCS funds has been spent on implants. This makes sense if supply chains are weak and sales of contraceptives by the private sector are minor. Short-term methods may be more suitable if alternative sources of supply (social marketing, private sector, NGOs) are in place as a safeguard in case government systems fail. In all countries reviewed, except for Nicaragua, the focus of the GRHCS programme was on contraceptives, and less on maternal health drugs or STI treatment. Only Sierra Leone, Madagascar, Mongolia, Nicaragua and Ethiopia supplied other items, though only in small volumes.

Overall, focusing on contraceptives seems a rational approach, given that contraceptive supply is usually not included in country budgets and is largely dependent on donor support. Also, given current resources, the programme's envisaged outcome (increased availability, access and use of RHCs for voluntary family planning, HIV/STI prevention and maternal health services in the GPRHCS focus countries) would be achievable only in limited areas in some of the target countries. Given that many of the countries' activities focused on improving supply chain management and providing commodities, the evaluators assumed that programme inputs were directly related to these outcomes, even though not all the results are attributable to GPRHCS. The programme aimed to move away from vertical distribution, and instead to build up integrated supply chain systems – in some cases with other implementing partners such as USAID. All the reviewed countries

were spending a significant proportion of their capacity-building funds on supply chain management. Success in this area is expected to have a positive impact on RHCS.

The funding arrangements and planning cycle of the GPRHCS are obstacles to implementation and discourage long-term planning in countries. This is due to UN accounting procedures, programme management arrangements, and uncertainty over the predictability and timing of funding. In general, there is poor alignment with countries' aid coordination systems. The timing of GPRHCS planning and funds flow does not coincide with national cycles in all countries, and separate reporting and accounting are required for the UN agencies.

4

Unsafe abortion

4.1 Beyond the statistics

An estimated 220,000 children lose their mothers each year through abortion-related deaths (Gordon et al., 2010). Of the almost 200 million pregnancies per annum in the developing countries, 40% were unintended (Sedgh et al., 2012): some 16% ended in live birth, 19% in abortion, and 5% in a miscarriage. Almost all unsafe abortions[46] take place in developing countries, and the numbers of unsafe abortions are slowly increasing. In some low- and middle-income countries, up to 50% of hospital budgets for obstetrics and gynaecology are spent treating the complications of unsafe abortion (Gordon et al., 2010). The overall rate of abortion has declined, though this trend has stalled. Women all over the world are likely to resort to an unsafe abortion when faced with an unplanned pregnancy and when safe abortion is unavailable or inaccessible. Below in text box 2 the main issues in abortion are presented.

Text box 2 *Abortion matters*

- In 1995, about 78% of all abortions took place in the developing world. This proportion has increased: in 2008 it was 86%.*
- The total number of induced abortions worldwide in 2008 was 43.8 million.**
- It is estimated that approximately 5 million women are hospitalised each year and 47,000 women die from complications of unsafe abortion.*****
- Although research indicates that the annual number of maternal deaths has declined in recent years, WHO estimates that in 2008 the proportion of maternal deaths due to unsafe abortion remained the same as in 2003: 13%.*
- The economic impact of unsafe abortion is devastating, especially for poor countries. It is estimated that the global cost to health systems for treating complications arising from unsafe abortion is USD 1 billion each year. Africa sustains 42% of the global cost.****
- Since 2003, the number of abortions has fallen by 600,000 in the developed world, but increased by 2.8 million in developing countries.*
- Serving all women in developing countries who currently have an unmet need for modern methods would prevent an additional 54 million unintended pregnancies, including 21 million unplanned births, 26 million abortions (of which 16 million would be unsafe) and 7 million miscarriages; this would also prevent 79,000 maternal deaths and 1.1 million infant deaths.**

*Source: Adapted from *Sedgh et al., 2012; **Singh and Darroch, 2012; ****WHO, 2011f; *****WHO, 2012d.*

[46] *Unsafe abortion* as defined by WHO is a procedure for termination of an unintended pregnancy done either by people lacking the necessary skills, or in an environment that does not conform to minimum medical standards, or both. Abortions done outside the boundaries of the law are likely to be unsafe even if they are done by people with medical training, because of the likelihood of unsanitary conditions, lack of post abortion care and medical back-up and delay in seeking abortion or care for complications because the abortion is clandestine. *Safe abortions* are defined as those that meet legal requirements in countries with liberal laws, or where the laws are liberally interpreted such that safe abortions are generally available and acceptable.

Abortions take place regardless of legal restrictions. However, abortion rates are generally lower in regions where the abortion laws are more liberal. In recent years, various developing countries have broadened the grounds under which abortion is legal. Evidence from South Africa illustrates that abortion mortality significantly decreased after the liberalisation of the abortion law. Similarly, in Nepal, abortion-related complications fell from 54% to 28% between 1998 and 2009. Liberalising abortion law alone is not enough to ensure the safety of abortions, however: the changes must be disseminated to providers and the public. In addition, service providers must be trained and willing to perform the procedure, and governments must commit to providing resources to ensure access to abortion services, including in remote areas. Several studies indicate the correlation between unmet need for contraception and abortion levels, which is a reason for concern, especially given that family planning services are not keeping pace with the demand.

4.2 Prevention, care and treatment of unsafe abortions

Family planning and safe post-abortion care are crucial in preventing unsafe abortions. Equally, improving abortion technologies and expanding the choice of safe and effective methods of abortion are critical in reducing the incidence of unsafe abortion.

Two randomised clinical trials[47] have established that trained nurse and auxiliary nurse-midwives can provide surgical and non-surgical medical abortion as safely as physicians. Another study, in Nepal, assessed the safety and effectiveness of the provision of medical abortion up to 9 weeks' gestation (early first trimester).[48] The studies substantiate the growing understanding that – provided permitted by law – appropriately trained midlevel health-care providers can provide safe, low- technology medical abortion services for women, independently from doctors. The findings have major implications for expanding access to safe abortion in resource-poor settings with a shortage of physicians or where physicians are overloaded (WHO, 2012f).

Medical abortion can be seen as a revolution in women's reproductive health, as it presents an alternative to surgical intervention and replaces the use of pills and herbs, often used clandestinely to provoke abortion.[49] It potentially increases access to safe and effective abortion, especially in remote areas with weak health infrastructure. There is growing evidence that its application to induce abortion is very successful and has few side effects. Access-increasing strategies include demedicalisation (as medical abortion requires less technology and can be carried out in non-clinical settings), such as 'home administration of medical abortion drugs', and 'task shifting'. These approaches encourage the use of simple and less painful procedures which can be devolved to less highly trained health workers. Marie Stopes International (MSI) has already pioneered simpler technologies for safe abortion, such as the Manual Vacuum Aspirator (MVA) for use by midlevel health workers, and, in the case of medical abortion, is promoting task shifting to trained outreach

47 Medical abortion regimen for the first trimester, comprising mifepristone and misoprostol.
48 Warriner et al., 2011.
49 This section draws on Gordon et al. (2010).

providers, pharmacists and community health workers. However, there will always be a need for back-up services to provide needed information on the procedure and complications. A positive example is Ethiopia, which placed task shifting at the centre of its increased access to safe abortion strategy: 'In order to make safe abortion services as permitted by law, accessible to all eligible women, the role of midlevel providers such as nurses and midwives should be expanded to include providing comprehensive abortion services, including uterine evacuation using MVA and medical abortion. Pre-service and in-service training for midlevel providers should respect this expanded role' (Government of Ethiopia Article 545, Section IX, 2006).

Task shifting to pharmacists (supported by Ipas) is being tried out in a number of countries. Other innovative approaches include mobilising the private sector by developing networks of trained and accredited providers, and the use of social marketing. The WHO Essential Drugs List (EDL) now includes misoprostol as an essential drug for treatment of incomplete abortions. Mifepristone may still be perceived as too politically sensitive to justify investment by pharmaceutical companies, since its sole use is in the context of medical abortion. Ultimately, the safe and effective use of affordable, high-quality medical abortion depends on ensuring that (1) health-care providers are trained; (2) referral mechanisms and monitoring systems are in place; (3) services are integrated within wider sexual and reproductive programmes; and (4) communities are educated about their reproductive health and rights.

In June 2012 a landmark was reached with the publication of the WHO updated guidelines on safe abortion (WHO, 2012b). The first edition of this global guidance on abortion-related care and policy issues was published in 2003. The updated version provides the latest evidence on clinical abortion care. It also includes information on how to establish and strengthen services, and outlines a human rights based approach to laws and policies on safe, comprehensive abortion care. The launch of the guidelines was celebrated during a 2012 World Health Assembly side-event to accelerate the attainment of MDG 5, hosted by the Netherlands' Permanent Representation in Geneva and the HRP.[50] The event allowed the Netherlands to underscore its role as a global advocate for SRHR, voicing the need to break the taboo on abortion and encouraging discussion on the implications and the high toll of unsafe abortions, such as the detrimental effects on women's health and human rights, and the negative economic implications. Overall, the Netherlands takes a pragmatic approach: abortions do take place, and they should always be performed safely.[51]

[50] http://geneva.nlmission.org/news/2012/05/the-netherlands-welcomes-new-who-guidelines-on-safe-abortion.html.

[51] Idem.

5

Sexually transmitted infections, including HIV

5.1 Key facts[52]

Sexually Transmitted Infections (STIs) are a major global cause of acute illness, infertility, long-term disability, psychological distress and death. Over 30 bacterial, viral and parasitic pathogens can be transmitted sexually, or from mother to child during pregnancy and childbirth (in the case of HIV and syphilis), and through blood products and tissue transfer.[53] Annually, close to 450 million new infections occur of *curable* STIs (syphilis, gonorrhoea, chlamydia and trichomoniasis). STIs and their complications rank in the top five disease categories for which adults seek health care. One in four untreated cases of early syphilis in pregnant women results in stillbirth; syphilis also increases the risk of neonatal and perinatal deaths, In the absence of prophylaxis, 30% to 50% of infants born to mothers with untreated gonorrhoea and up to 30% of infants born to mothers with untreated chlamydial infection will develop a serious eye infection. The sexually transmitted Human Papillomavirus (HPV) infection is closely associated with cervical cancer, which per year is diagnosed in more than 490,000 women and causes 240,000 deaths. Three quarters of all cervical cancer cases occur in developing countries where programmes for screening and treatment are seriously deficient or lacking.

One of the leading infectious killers is HIV, which has claimed more than 25 million lives over the past three decades. At the end of 2010 an estimated 34 million people were living with HIV globally, of which some 10% were children younger than 15. Half of the people living with HIV/AIDS (PLWHA) are women. In sub-Saharan Africa, 60% of PLWHA are female. In that region, the incidence of HIV infection declined by more than 25% between 2001 and 2009, including in some of the countries with the largest epidemics (Ethiopia, Nigeria, Zambia and Zimbabwe).[54] Yet in 2010 there were still 2.7 million new infections worldwide, including close to 400,000 children younger than 15 years of age. Although globally the number of newly infected people is declining, it is rising in the Middle East and North Africa. After a slow decrease in the early 2000s in Eastern Europe and Central Asia, countries in these regions report an increase in the incidence of HIV infection since 2008. The trends in AIDS-related deaths also differ, and follow a similar upward trend in the Middle East, North Africa and East Asia.

Services to provide testing, counselling and treatment have improved, with 22,400 health facilities providing ART, 130,000 providing HIV testing and counselling services, and a 72 million uptake of HIV tests (2010 data). Also, access to HIV testing and counselling for people with TB is expanding: in 2010 a total of 2.1 million people with TB were tested for HIV. In many cases, other STIs are diagnosed and treated by pharmacists, drug sellers and

52 This section draws upon: WHO, 2011i; WHO, 2011k, WHO, 2004a; WHO 2012; and WHO/UNAIDS/UNICEF, 2011.

53 STIs are caused by bacteria, viruses and parasites. Common bacterial infections: gonorrhoea or gonococcal infection; chlamydial infections; syphilis; chancroid; granuloma inguinale or donovanosis. Common viral infections: AIDS; genital herpes; genital warts and cervical cancer in women; hepatitis (chronic cases may lead to cancer of the liver); inflammation in a number of organs, including the brain, the eye, and the bowel. Parasites cause vaginal trichomoniasis; vulvovaginitis in women; inflammation of the glans penis and foreskin in men.

54 Based on national models of HIV prevalence in 22 countries in sub-Sahara Africa.

traditional healers, often ineffectively. Where there is limited access to laboratory testing – the traditional method of diagnosing STIs – WHO has recommended a syndromic approach to diagnosis and management of STIs (WHO, 2011k).

Thanks to the introduction of antiretroviral therapy (ART) 2.5 million deaths in low- and middle-income countries (LMICs) have been averted.[55] At the end of 2010, more than 6.6 million PLHIV in LMICs were receiving ART, of which between 420,000 and 460,000 were children. This represents a 16 fold increase between 2003 and 2010. At the end of 2010, ten countries achieved universal access to ART, including three countries with a generalised epidemic (Botswana, Namibia and Rwanda).[56] However, over 7 million PLHIV still have no access to treatment.

In the Countdown to 2015 report of 2011, WHO member states adopted the *Global health sector strategy on HIV/AIDS for 2011-2015*, in which four strategies are emphasised: (1) Optimise HIV prevention, diagnosis, treatment and care outcomes; (2) Leverage broader health outcomes through HIV responses; (3) Build strong and sustainable health systems; and (4) Address inequalities and advance human rights.[57] The importance of linking SRH and HIV services is widely understood, though this still remains a challenge in many circumstances. In 2009, HRP – the UNDP/UNFPA/WHO/World Bank Special Programme of research, Development and Training in Human Reproduction – in collaboration with the Global Network of People living with HIV/AIDS (GNP+), the International Community of Women living with HIV/AIDS and Young Positives developed the *Rapid assessment tool for sexual and reproductive health and HIV linkages* with which linkages and gaps can be identified, at all levels (policy, systems, services).[58] Potential opportunities for integration are still underutilised, such as Preventing Mother–to-child Transmission (PMTCT), addressing the specific SRH needs of PLWHA, better sex counselling and the promoting of condoms (including the female condom) for dual protection.[59]

The core of UNAIDS' work is to advocate for worldwide action against HIV/AIDS, and to promote partnerships among and between a wide range of actors (UN agencies, governments, civil society organisations, and regional and national networks of PLWHA).[60]

Guided by the UN declaration of Commitment on HIV/AIDS (2001), UNAIDS continues to call for the full and active participation of civil society, the business community and the private sector, media and international actors, and for the dissemination of a broad range of best

55 Globally since 1995.
56 Providing antiretroviral therapy to at least 80% of the people eligible for treatment.
57 WHO, 2011m.
58 Opportunities for linkages and integration include: maternal and perinatal health and PMTCT; prevention of STIs; condom promotion and distribution; addressing the SRHR of people living with HIV, young people and most-at-risk populations; strengthening of health commodities and systems; and operational research on SRH/HIV linkages.
59 WHO/HRP annual report 2008/2009, 2009/2010.
60 Assessment of UNAIDS is preliminary and is based on the findings compiled in the Second Independent Evaluation 2002-2008 (Poate et al., 2009).

practices.[61] Achieving a common approach to involve civil society remains a challenge with regard to defining active and meaningful involvement and systematically measuring involvement; overall, however, there appears to be increased representation of civil society in HIV/AIDS policy and strategy development and implementation of programmes and services. Positive examples are the role of PLWHA organisations in drafting legislation to protect the human and legal rights of PLWHA, and in challenging legislation that would criminalise HIV transmission, help reduce stigma and discrimination, increase treatment access and ensure critical interventions such as opioid substitution therapy. The most tangible outcome is in those countries where PLWHA representation in country-coordinating mechanisms has enabled them to access Global Fund resources.

5.2 Findings

Table 6 The eight evaluations in the area of STI, including HIV/AIDS

UNICEF	UNFPA	GFATM
Tanzania *(National HIV response)* Global *(AIDS campaign)* Mozambique *(NGO-Government partnership)*	Bangladesh *(Cervical cancer)*	Multi-country[3] Ethiopia *(National response to HIV)* Tajikistan *(PLHIV)* Kenya (OVC)

All eight evaluations demonstrated the **relevance** of the interventions in the area of STI prevention, treatment and care. The interventions were varied and included the global AIDS campaign (UNICEF), to national HIV response in Tanzania/Zanzibar (UNICEF), a programme addressing the needs of orphans and vulnerable children in Kenya (GFATM) and a cervical cancer prevention programme in Bangladesh (UNFPA). The UNICEF programme specifically claimed to redress the absence of children from the global AIDS agenda, by creating awareness that AIDS has a devastating effect not only on adults, but also on children. The GFATM programme in Tajikistan was the only programme included in the review which specifically addressed the needs among vulnerable populations (IDUs, MSM and male and female sex workers); it was particularly relevant given the nature of the epidemic, the seasonal migration of parts of the population, and the prevalence of unprotected sex in the country.

Being a national programme, the HIV/AIDS programme in Zanzibar could be expected to lead to **policy and legislative changes**. As part of the Zanzibar National HIV and AIDS Strategic Plan a number of strategies and practical plans were produced, and several studies conducted (on substance use and HIV, on impact, and on Most at Risk Populations (MARPs)). Public sector responses in the form of Workplace Programmes were initiated, and

61 www.un-ngls.org/spip.php?page=article_s&id_article=810.

62 Macro International Inc. (2009), but focusing specifically on two case studies (both in Ethiopia).

the AIDS Business Coalition was established, to stimulate private sector involvement and participation. The involvement of PLWHAs was increased and made more meaningful. One of the main successes was the formulation of a national multi-sectoral HIV strategy, preceding the formulation of the National HIV policy. The GFATM support to Orphans and Vulnerable Children (OVC) in Kenya contributed to securing approval for a costed *National Plan of Action for OVC, 2007-2010*, the establishment of the National Steering Committee on OVC, and a Parliamentary Committee on OVC. These achievements are in line with Kenyan government's emphasis on a family-centred approach, and are considered as strong elements in Kenya's OVC response.

All the programmes included in this review involved **institutional strengthening**. In some, it was the main focus of the intervention, as in the case of the cervical cancer programme in Bangladesh (UNFPA), which was initiated to strengthen government services in setting up Visual Inspection with Acetic Acid (VIAA). The UNICEF global AIDS campaign, on the other hand, slowly shifted its approach to systems strengthening during programme implementation, moving away from the earlier prioritisation of user fees. A promising example of coordinated policy development around systems strengthening – as reported in the UNICEF evaluation – was the work on children affected by HIV/AIDS[63] done by the Joint Learning Initiative on Children and HIV/AIDS (JLICA), which led to the development of a multi-level comprehensive response to children orphaned or made vulnerable by HIV/AIDS. This model is used as a benchmark for the work done by national governments and their partners to strengthen social protection systems.

In some programmes, reporting on effect at **outcome level** was relatively easy, because there was a direct relationship between upward trends in services uptake and improved and expanded service provision. This was the case for the GFATM-supported programme in Ethiopia, where access to HIV testing and ARVs strengthened HIV Counselling and Testing in health facilities and ART sites. Over three years (2005-2008), there was a 400% increase in the number of people tested for HIV, and a similarly phenomenal increase in the number of people starting ART: from 8,000 to more than 130,000. Another example is the GFATM-supported programme in Tajikistan, where no ART or PMTCT services were available before round 4 of project selection. The evaluation reported that the strengthening of service provision had resulted in good availability of antiretroviral medicines. In addition to providing direct services, the Tajikistan programme developed action plans for the integration of TB and HIV services. An example is as the Access Project in Tajikistan sponsored by the Dutch Ministry of Foreign Affairs and carried out by the AIDS Foundation East–West: this project specifically addressed the needs of key populations such as IDUs, sex workers, prisoners, communities of PLWHA and TB patients.

In other cases, problems of attribution occurred, and it proved more difficult to measure progress: an example is the UNICEF global AIDS campaign. One of the campaign's goals was to reduce the percentage of young people living with HIV by 25% globally by 2010. Trend analysis of this indicator proved to be difficult, as many countries still have insufficient data

[63] Under UNICEF's campaign priority area P4: Protect and support children affected by HIV/AIDS.

on HIV prevalence and sexual behaviour trends among young people. Similarly, in the case of the UNICEF-supported national response programme in Zanzibar, the evaluation report was able to present only some quantitative data, because not all MARPs[64] had been targeted or reached. Overall, the evaluation indicated that not all HIV and AIDS treatment and care packages were comprehensive – or, in the case of condoms, were available. Reasons include minimal involvement of civil society organisations (NGOs and faith-based and community-based organisations) and the private sector and the fact that prophylaxis was not yet routinely offered to patients.

Many prevention programmes measure and demonstrate changes in **knowledge**, as this is often one of their main aims. In Ethiopia, primary data demonstrated that the levels of women's knowledge about the HIV virus had improved, as had condom use among high-risk groups. Trend analysis showed national HIV prevalence stabilised between 2004 and 2008 and in urban areas even declined. Though knowledge of AIDS increased, the level of misconception was also fairly high. Data on more specific elements – such as knowledge of modes of prevention and higher-risk sex – showed minor improvements. The prevention programme in Zanzibar (UNICEF) appeared to have influenced the number of prevention efforts at community level, though not all MARPS were reached. The evaluators commented that the focus of campaigns seems to be on creating awareness of the existence of HIV, yet this was already high (close to 100%). Another comment was that HIV prevention efforts were not linked to substance use prevention and to income-generating activities (particularly targeting youth), with the result that they were not relevant to all drivers of the epidemic. Few evaluations addressed the **quality of care**. Some, as in the case of the GFATM programme in Tajikistan, mentioned that stigma limited high-risk groups from accessing services, and that stock shortages may have impeded the provision of quality services. The evaluators of the UNFPA Bangladesh programme assessed the screening clinics on the basis of quality indicators such as building conditions, hygiene, privacy and supply of consumables: most were rated as being good quality. Often though, as in this case, only anecdotal reports were available to illustrate quality aspects such as waiting time, the accessibility of the services at community level, client-provider interactions, and the provision of information.

In the OVC programme in Mozambique (UNICEF), one of the **conducive factors** in the implementation of the intervention was the involvement of local (i.e. community) members and community-based organisations in identifying children and families most in need, and in defining the type of assistance needed. This empowered people, and, by involving elders, enhanced inter-generational relations. The pilot approach in Tajikistan – in the UNICEF support to PLWHA programme – demonstrated the success of active outreach to high-risk groups by involving the wives of labour migrants in the detection of HIV cases. This proved more cost-effective, as HIV prevalence amongst pregnant women was very low.

[64] Prisoners, seasonal workers, persons involved in the transportation sector and employees in the tourism sector.

6

Reproductive rights, sexual health, gender issues and gender-based violence

6.1 Freedom from violence, freedom to decide

Sexual health [65]

Implicit in the working definition of sexual health[66] is the right of all people to have the knowledge and opportunity to pursue a safe and pleasurable sexual life. However, reaching this stage is highly dependent on access to comprehensive information about sexuality and to good quality health care. It requires an environment that affirms and promotes good health, and it is influenced by the risks people face and their vulnerability to adverse consequences of sexual activity.

Promoting sexual health is best done in an integrated manner, for example through the reproductive health infrastructure. Such interventions, however, need to go beyond reproductive aspects: the conditions necessary for a sexually healthy society must also be promoted. The WHO sexual health framework suggests actions such as promoting sexual health in policies and offering sexual health services without stigma or discrimination on the basis of race, ethnicity, age, lifestyle, income, marital status, sexual orientation or gender expression (WHO, 2010). HRP – the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Training in Human Reproduction – and Harvard developed an SRH tool for identifying barriers to services, and have set out indicators on sexual health that encompass both positive and negative aspects of sexual health and sexuality (WHO, 2011f).

Violence against women and gender-based violence

Violence against women (VAW) is a major public health problem, and a violation of human rights.[67] A 2005 WHO multi-country study found that 15–70% of women (aged 15-49) reported experiencing physical and/or sexual violence from an intimate partner at some point in their lives (15% in Japan and 70% in Ethiopia and Peru), with estimates in most countries ranging from 30% to 60%.[68] Population-based studies of relationship violence among young people suggest that it also affects a substantial proportion of young people, as seen in South Africa, where within the age group of 13-23, some 42% girls/young women and 38% boys/young men reported being a victim of physical dating violence. Though studies on violence (gender-based and otherwise) are increasing, overall data on the scope and impact of intimate partner violence is still limited.[69]

There are few interventions in violence prevention whose effectiveness has been scientifically proven. Though limited, the best evidence for effectiveness has been found for primary prevention school-based programmes addressing violence within dating

65 This subsection draws on information from: WHO (2010). Developing sexual health programmes.

66 '...a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health 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. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.'

67 WHO (2011n).

68 WHO (2005).

69 Garcia-Moreno and Watts (2011).

relationships, and for strategies that: combine microfinance with gender equality training; promote communication and relationship skills within communities; reduce access to, and the harmful use of alcohol; and change cultural gender norms.[70] Such programmes need to be supported by legislation and policies that protect women and girls, and that address discrimination against women and promote gender equality. It is recognised that interventions require a multi-sectoral approach in order to deal with the full spectrum of cause and consequence, such as acquiring evidence on the act of violence, and providing counselling and health and legal sector services. A good example of an integrated approach is the WHO antenatal care model, which includes a module on VAW (WHO, 2011f).

To supply a need for information on domestic VAW, information from over 24,000 women from 15 locations in 10 countries was compiled in a database (WHO, 2012f). Addressing the scope and prevention of sexual violence in conflict situations, 13 UN organisations are collaborating in the United Nations Action Against Sexual Violence in Conflict (UN Action), which focuses on sexual and other forms of GBV in post-conflict situations, as violence is usually continued or even elevated in these periods, due to breakdown in the rule of law and social disruption (WHO, 2011f).

Female genital mutilation [71]

About 140 million girls and women worldwide are currently living with the consequences of female genital mutilation (FGM), which is mostly carried out on young girls sometime between infancy and age 15.[72] In Africa, an estimated 92 million girls aged 10 years and above have undergone FGM. The procedure has no health benefits for girls and women and can cause severe bleeding and problems in urinating, and later cysts, infections and infertility, as well as complications in childbirth and increased risk of newborn deaths. The practice is mostly carried out by traditional circumcisers, though there is a trend for health-care providers to perform the procedure (in 18% of the cases). The causes of female genital mutilation include a mix of cultural, religious and social factors within families and communities. Seen from a human rights perspective, the practice reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women. FGM is nearly always carried out on minors, implying a violation of the rights of the child. Furthermore, the practice also violates the right to health, security and physical integrity of the person, the right to be free from torture, and cruel inhuman or degrading treatment, and the right to life when the procedure may result in death.[73]

[70] WHO (2011n).

[71] Unless otherwise stated, data and information in this subsection are obtained from WHO 2012h.

[72] FGM, also called 'female genital cutting', covers all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. FGM is classified into 4 major types: Clitoridectomy (the partial or total removal of the clitoris); Excision (partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora); Infibulation (narrowing of the vaginal opening through the creation of a covering seal); Other (all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterising the genital area).

[73] WHO, 2008.

Available data suggest a declining trend in almost all countries in which FGM practice is documented, though the extent of decline varies widely.[74] While regulations against FGM are currently in place in 18 of the 28 countries with known FGM prevalence in Africa, their implementation is generally low. The only systematic knowledge on the health effects of FGM is limited to a 2006 WHO study on obstetric outcomes; information is lacking on other health outcomes or risks associated with the practice.

There is a growing evidence base on effective programmes to eliminate FGM, such as community empowerment programmes involving public declarations expressing determination to stop the practice.[75] Overall, supportive legislation has increased and political will is growing.[76] In 2008, an interagency statement on the elimination of FGM that was signed by ten UN agencies (a renewal of the 1997 Joint Statement by WHO, UNICEF and UNFPA). The Statement highlights the wide recognition of the human rights and legal dimensions of the problem, and underlines the crucial role of communities in the prevention of the violation (WHO, 2008). A WHA resolution (WHA61.16, 2008) followed the statement, denouncing FGM as a violation of human rights and a barrier to the achievement of the MDGs and emphasising the need for concerted multi-sectoral action. The resolution resulted in tangible actions, including legislative advances, national plans to combat FGM, the implementation of ICE and community interventions, adaptations of clinical guidelines, national help-lines and the provision of in-service training. To address health sector responses, in 2010 WHO published the document *Global strategy to stop health-care providers from performing female genital mutilation*, in which WHO, UNICEF and UNFPA, together with other international organisations express their concern about the trend for medically trained personnel to perform FGM.[77]

HIV and human rights[78]

The evaluators in the Second Independent Evaluation concluded that UNAIDS has played a critical role in highlighting HIV and human rights. The conclusion was based on performance in terms of leadership, the highlighting of issues in human rights, the development of clear guidance, and timely action. Evidence was mixed, as the evaluation was to assess the efficacy, effectiveness and outcomes of UNAIDS across the board (including UNAIDS secretariat, co-sponsors and Programme Coordination Board (PCB), at global, regional and country levels). The evaluation pointed out that effects of UNAIDS actions in empowering key populations and supporting their meaningful participation varied widely. Though a high proportion of countries stated they had plans to address those most at risk of HIV, fewer than half had actually implemented prevention services for IDU, MSM or sex workers. Fragmentation was also apparent in efforts to address stigma and discrimination

74 WHO, 2011f.

75 Women and men in practising communities declaring their support for FGM abandonment.

76 Laws against FGM practice were adopted in 22 African countries and in 12 industrialised countries with migrant populations from FGM-practising countries. In most countries, prevalence of FGM has decreased, and an increasing number of women and men in practising communities support ending its practice.

77 WHO 2010f.

78 This sections draws on the Second Independent Evaluation (Poate et al., 2009), in particular the part on how UNAIDS has addressed key issue (chapter 8: Human rights and gender).

at country level, though in some countries UNAIDS successfully worked on those issues with justice and interior ministries. The organisation proved instrumental in establishing partnerships with groups working on human rights and PLWHA organisations to advocate and improve HIV-related laws and law enforcement.

Gender

Overall, the SIE concludes that UNAIDS global leadership on gender dimensions of the epidemic has been weak. Despite increased attention to women and girls in response to the epidemic, the evaluation noted 'there has been a lot of rhetoric, but this has not been matched by action at the country level'.[79] It appeared to be difficult to reach consensus on whether to focus specifically on girls and women, or to address the gender dynamics between women and men. A conclusion was that UNAIDS had made a moderate contribution to addressing gender inequity, partly because of the lack of coherent leadership, as well as the limited effect of a gender dimension in national HIV strategies. Despite their influence on their partner's health, most men tend to be unaware of women's sexual and reproductive issues because of their limited involvement in SRH and in promoting gender equality.

6.2 Findings

Table 7 The three evaluations on reproductive rights, sexual health, gender issues and GBV

UNICEF	UNFPA	GFATM
Senegal *(GBV)*	Global *(Gender)* Global *(Dignity kits)*	-

The findings of the three evaluations included in this review are discussed below, under three headings: FGM, Dignity kits and Gender equality.

FGM

The practice of female circumcision is widespread in Senegal, where 28% of women aged 15-49 have undergone the procedure. The large differences in the circumcision rates in the three regions (ranging from 2% in some areas to 80% in others) are largely attributable to ethnicity. The FGM abandonment intervention programmes in Senegal aimed at building the capacity of communities and increasing their awareness of the effect of traditional practices on women's health.[80] Almost all villages that benefited from the programme had made a declaration demonstrating positive changes at the community level, which in some cases had even led to steps to reduce or stop the practice. The intervention did not seem to

79 Poate et al., 2009.

80 Such as early marriage, frequent pregnancies, and circumcision.

have a large effect on increasing access to SRH services (use of health facilities for delivery, and ANC). In the intervention villages, both the attitude towards FGM and the actual practice of FGM decreased. One of the conducive factors in the FGM programme in Senegal was that prior to the programme, social groups and committees had been formed. The public declaration process contributed to the strengthening of these committees and their involvement in decision-making and monitoring. However, these committees were not sustainable: over time, most of them ceased to exist. The lack of organised follow-up and the absence of basic infrastructures in the villages prevented the new capacities in the communities from being fully used.

Dignity kits

There are over 43 million refugees and internally displaced persons (IDPs) in the world today. Dignity kits serve as a tangible reflection of UNFPA's mandate to incorporate RH and women's needs more broadly into its agenda for humanitarian aid. The kits are packages handed out to displaced women and girls, comprising basic necessities for feminine hygiene, dignity and respect in their daily lives and including culturally appropriate items that vary across countries and regions (such as headscarves in Muslim countries). They are adapted according to the needs generated by the specific type of emergency. Through the dignity kits programme, the UNFPA COs have been able to forge strong relationships with local organisations and government agencies, and have enabled UNFPA to increase the organisation's visibility in humanitarian response. Increased mobility and access to basic services were among the outcomes of the dignity kits programme: however, the effects varied depending on the context. Increased mobility was certainly one effect for Muslim women given headscarves through the programme. The evaluation was not conclusive about the extent to which additional services such as education on GBV, RH, psychosocial support and general hygiene were provided alongside with the kits. In some countries, such potential was exploited: for example, in Ecuador and Peru, where dignity kits contained pamphlets on GBV and were combined with information sessions. In Darfur, kit provision served as an opportunity to build positive relationships with communities that UNFPA could target at a later stage to address GBV. In Uruguay and Peru, kits included educational games for HIV prevention. The programme faced challenges due to a general lack of clarity on the objective of the intervention and logistical problems on the ground.

Gender equality

The large-scale evaluation of UNFPA operational goal of gender equality provides examples of UNFPA's support to gender equality at various levels, especially with regard to integration in national frameworks, such as the alignment and integration of gender equality and the human rights of adolescent girls and women into national policies and laws. The translation of these national frames into concrete actions poses challenges, however. There is little information on whether efforts to support the implementation of GE-related policies and laws have been systematic or effective. The evaluation reported tangible results in the Democratic Republic of the Congo (DRC), Rwanda, Mali, Yemen, Ghana, Sierra Leone and Tanzania in the alignment to and integration of gender equality into national policies and laws. The translation of these national frames in concrete actions, however, remains challenging. Although UNFPA makes visible efforts to support the implementation of

GE-related policies and laws, there is little information on the extent to which these efforts have been systematic or effective. Of the four outcomes for UNFPA Organisational Goal 3, the evaluation team found the least evidence of country-level activities for outcome 3: *human rights protection systems and participatory mechanisms to protect reproductive rights of adolescent girls and women, including the right to be free from violence*. On the other hand, evaluation data per country indicated that UNFPA is very well known for its work on ending gender-based violence, including raising awareness, strengthening capacities that address GBV and enhancing services for victims of GBV.

7

Adolescent sexual and reproductive health and rights

7.1 Growing up healthy[81]

'Health in adolescence[82] is the result of interactions between prenatal and early childhood development and the specific biological and social-role changes that accompany puberty, shaped by social determinants and risk and protective factors that affect the uptake of health-related behaviours.'[83] Thanks to decades of investments in early childhood health and well-being, many children have survived to adolescence. Now, almost every fourth world citizen is younger than 24 years old.[84] Adolescence is a turbulent period, during which children mature physically and psychologically, form their values and core beliefs, and develop a sense of identity and understanding of their place in the world. It is also a time of forming relationships and taking on new roles. It is seen as an important time to consolidate the promise of better child health, and translate it into lasting good health for adolescents and adults. Generally, it is also a period in which many young people begin to explore their sexuality. Behaviours often established in adolescence – such as using tobacco, alcohol and drugs, having unprotected sex and avoiding physical activity – along with conditions such as exposure to violence, account for two thirds of premature deaths and one third of the total disease burden in adults.[85] In Annex 5, key facts on adolescents are presented, highlighting the main challenges many of today's 1.2 billion adolescents are facing.

The UNICEF 2012 situational analysis of adolescents makes clear that access to sexual and reproductive health information and services is as necessary for their well-being as the existence of support systems established within the family, schools, and the community. Achieving MDG 5 is important to adolescents because 11% of births worldwide are to adolescent girls. Early childbirth curtails education and other opportunities for all adolescent girls and can be dangerous for the youngest among them. Progress towards MDG 6 is important for adolescent girls and boys, because millions of those who are becoming sexually active live in countries with a high HIV prevalence. An estimated 2.2 million adolescents (aged 10-19), around 60% of them girls, are living with HIV, and many do not know they are infected. Of these, 1.8 million live in sub-Saharan Africa. Adolescent girls who are sexually active are particularly vulnerable to HIV biologically. They are also at higher risk because they may have older sexual partners who are more likely to have been

[81] The main part of this section draws on the report of UNICEF (2012).

[82] The UN defines adolescence as the period between 10 and 19 years. The Convention of the Rights of the Child defines child as a person younger than 18 years, unless majority is attained at a younger age. The UN defines youth as people aged between 15 and 24 years. Teenager refers to people aged 13-19; a less formal defined group is young people, generally people aged 10 to 24. The 10 to 24 age range is often divided into early adolescence (10-14 years), late adolescence (15-19 years) and young adulthood (20-24 years) (Sawyer et al., 2012).

[83] Cited in an article of Susan Sawyer and colleagues, which is the first of four articles in *The Lancet* focusing on Adolescent Health. The 2012 series is a sequel to the 2007 The Lancet series on Adolescents. (Reference to footnote forms no part of the original citation.)

[84] UNICEF (2012) projects a declining population, a trend that is expected to continue through 2050. On the other hand, during this period the absolute number of adolescents is expected to rise. Falling mortality rates together with high fertility rates combine to form the basis of a large youth segment in many countries, referred to as a 'youth bulge'.

[85] UNICEF, 2012.

exposed to HIV infection; adolescent girls in such relationships often cannot negotiate the correct and consistent use of condoms with their partners. The most marginalised adolescents – those who inject drugs, those involved in sex work, and adolescent males who have sex with other males – experience great vulnerability to HIV infection in all epidemic settings.

A study into the sexual behaviour of adolescents in sub-Saharan Africa (Doyle, 2012) reported that some 10% of adolescents in the developing world – excluding China – had sex before the age of 15, with the highest rate in Latin America and the Caribbean (17% of the girls). Global averages on condom use during higher-risk sex are low. [86] In nearly all of the countries, boys were more likely to report using condoms during higher-risk sexual activity than girls. In sub-Saharan Africa, contraceptive use is low among women who are married or in union and even lower among married adolescent girls between the ages of 15 and 19. Many of these young married women may choose not to use contraception because they wish to have a child; some 25% had an unmet need for family planning. See Annex 5 for more data on the sexual behaviour of adolescents in sub-Saharan Africa, based on an analysis of patterns from DHSs and AIDS Indicators Surveys.

Whether experienced as young children or as adolescents, sexual violence has many negative outcomes for the adolescent years and beyond. Girls who have experienced sexual violence are more likely to be depressed, to engage in behaviours that put them at risk of STIs or HIV infection, and to commit suicide. They are also three times as likely to have an unplanned pregnancy and are less likely to go to school. Adolescent girls are vulnerable to violence within marriage, including sexual violence. Many factors contribute to the incidence of domestic violence. In many places, child marriage, gender-based power relations, women's low economic status and traditional practices or social norms perpetuate domestic violence – processes which are often deeply rooted and difficult to overcome. Societal attitudes that convey acceptance or justification of domestic violence may make girls and women more vulnerable to becoming victims. Available data for developing countries show that nearly 50% of girls and women aged 15–49 believe that wife-beating is justified under certain circumstances.

At the ICPD it was agreed that 'full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality' (ICPD POA paragraph 7.3). The needs of adolescents are increasingly being addressed: for example, in the school environment (by sexuality education and life-skills training, for example), and at the level of the health and legal systems, such as Youth-Friendly Services (YFS). [87] Tyler et al. (2007) note that although barriers young people face in accessing health services are recognised, little evidence is so far available on what effectively overcomes such barriers. One of the findings was that help-seeking behaviours of adolescents in developed and developing countries are similar, despite differences in social context and service provision.

[86] Referring to condom use during last sex with a non-marital, non-cohabiting partner.

[87] See also WHO 2010d, which provides an overview of programmes in adolescent sexual and reproductive health worldwide, and WHO 2012g.

Insights into risk and protective factors are given in the *The Lancet* review paper on prevention science (Catalano et al., 2012). The authors document several programmes that effectively reduced risks while simultaneously enhancing protection, such as cash transfer programmes (providing cash incentives for students to remain in school) and school-based prevention programmes. A combined approach is recommended, simultaneously engaging schools, families, and communities. According to Catalano and colleagues (2012) one of the remaining gaps is the lack of an evidence base on prevention interventions for adolescents in low- and middle-income countries. More controlled trials are needed on the effect of prevention programmes (such as peer education), which in turn would substantiate their replication and scaling-up.

Overall, at the programmatic level more attention is given to older adolescents (aged 15-19), leaving the needs of the 10 to 14 year olds slightly neglected (WHO, 2011h). There are a few exceptions. The joint publication *Seen but not heard. Preventing HIV in early adolescence* (UNAIDS, 2004) specifically recognised the needs of early adolescents. The period of early adolescence is seen as one of *maximum change* (social, psychological and physical developments), *maximum vulnerability* (exposure to risks), and *maximum opportunity* (protection monitoring by parents, caregivers, teachers). The *Opportunity in crisis* report (UNICEF, 2011) and the 2012 UNAIDS fact sheet also focused on young adolescents, highlighting interventions in HIV prevention such as combined approaches and the active seeking out of young adolescents (UNAIDS, 2012c).

7.2 Findings

Table 8 The five evaluations of adolescent SRHR programmes

UNICEF	UNFPA	GFATM
Namibia *(Life skills)*	Tanzania *(Youth Alliance)*	Bangladesh *(Community readiness)*
Global *(Adolescents)*		Bangladesh *(Life skills)*

The **relevance** of all programmes included in the review is evident: all addressed the rights and needs of adolescents and young people. As summarised in the UNICEF study on participation: "Youth represent 25 per cent of the working age population and account for 47 per cent (88 million) of the world's unemployed and… an estimated 515 million young people, nearly 45 per cent of the total, live on less than two dollars a day. In many post-crisis transition countries, over half the population is younger than 25 and many of them are teenagers. Half of the world's out-of-school population of 39 million children live in conflict-affected countries…. Globally, over 18 million children are affected by forced displacement."[88]

[88] Peebles D., et al. (2010).

The evaluation of the UNICEF Global Participation Programme found several good practices related to participation that could be scaled up or replicated. Harder to find were concrete examples that demonstrated **changes in national or international policy**. UNICEF did prove to be instrumental in integrating children and young people's participation in high-profile policy processes at the global and regional levels. This investment served to raise awareness among national governments on the need to consult with children and young people in policy processes. In the absence of an overall policy on adolescent and young people's rights, development and participation, the Convention on the Rights of the Child (CRC) guided UNICEF on these issues. The evaluators of the UNICEF Global Participation Programme, however, note some shortcomings in taking this approach. For example, there is a growing need to define specific approaches by taking into account the evolving capacities of children, as well as their age-rated vulnerabilities. The assumption that the needs of children of all ages could be covered by the same set of rights is considered to be 'age-blindness'. The review revealed a need to analyse the CRC from the point of view of adolescents' specific capacities, responsibilities, vulnerabilities and singularities. Also, the evaluation underlined the need to foster increased participation of children under 14.

The evaluation of the UNICEF-supported My Future is My Choice (MFMC) programme in Namibia – which had been running for more than 10 years – included some good examples of **policy changes at the national level**. Most notable was the establishment of the extracurricular life-skills programme at secondary and combined schools, which was officially endorsed by the Ministry of Education. The MFMC programme in Namibia also showed the effect of the intervention on **strengthening** of peer facilitators, institutional and otherwise, as the programme invested greatly in their knowledge and skills development. Peer facilitators reported important changes in their own lives, including increased knowledge on sexuality, reproduction, and HIV/AIDS, less discriminatory behaviour towards HIV-positive people, and a reduction in risky sexual behaviours. The evaluation reports a positive effect of the intervention on **increased use** of services (attendance at youth-friendly services) and some effect on SRH knowledge and behaviour.

Many of those who completed the life-skills programme reported that the important lessons learned were to treat HIV-positive people with care and respect, not to discriminate, and to avoid stigmatism. The MFMC programme aimed to ensure that youth have a sense of control and self-efficacy over their lives, their health and their future. Based upon focus group discussion data, these goals appear to have been met: among others, MFMC graduates reported increased knowledge on RH and HIV/AIDS, and adopted protective sexual practices. Before scaling-up the programme, quality measures were to be addressed, such as training and retention of peer facilitators, monitoring and evaluation, revision of the curriculum. The programmes' success is highly dependent on the skills of peer facilitators, and on the availability of a supportive, enabling school environment with clear accountability structures, and a strong functioning M&E system, but many of these were missing at the time of their review. **Impeding factors** in the UNICEF-supported MFMC Programme were the limited knowledge and skills of the facilitators, high peer facilitator turnover that compromised the programme's continuity, and the fact that the programme

reached only a small proportion of the target group. In addition, the marginalisation of the programme within the school as an add-on rather than integral component of the school curriculum compromises its effectiveness. The evaluators of the MFMC programme observed that in itself, building knowledge is not sufficient to promote and influence risk-reduction behaviour. Also, such programmes appear to be more effective when they start when children are younger, and when the activities are embedded in programmes also addressing the broader social and political context.

The UNFPA-supported integrated programme of the African Youth Alliance (AYA) in Tanzania (UNFPA-supported) achieved most of the desired **outcomes**, especially among female youth, whose knowledge and self-efficacy increased. The evaluation found a weak positive effect of the intervention on abstinence among males. In terms of behaviour change, the strongest change was regarding the use of condoms and contraception; there was little visible effect on delay of sexual debut, abstinence, or partner reduction, except for a slight positive impact among girls. The AYA programme strategy in Tanzania focused on implementing and scaling-up a defined set of integrated and comprehensive Adolescent Sexual and Reproductive Health (ASRH) interventions by using existing local institutions. The positive outcome of the intervention underlines the need to take a multi-layered approach that implements strategies including advocacy, capacity building, behaviour change communication, life-planning skills (LPS), and integration of ASRH with livelihood skills training. This approach was unique in attempting to implement these components simultaneously while building capacity and fostering coordination among established partners to scale-up ASRH services.

The **outcome** of a package of interventions under the GFATM-supported programme among male youth in Bangladesh was tested by comparing two models: one was Life-Skills Education (LSE) with provision of condoms, and the other LSE only. To do so, male youth from two locations where these models had been implemented were surveyed and compared with male youth from non-intervention locations. Overall, LSE appeared to have positive effects on youth knowledge of SRH issues such as STIs, HIV, safe sex, contraceptive methods (including condom use for its dual role [contraception and protection] and efficacy), health risks of teenage pregnancy and parents' role in determining the sex of the child. During the intervention period, knowledge of these issues increased significantly in experimental sites, compared to the control sites. The other GFATM programme in Bangladesh, which addressed community involvement around HIV prevention, yielded results: there was considerable increase in awareness on the HIV/AIDS epidemic, the vulnerability of Bangladeshi youth, and routes of transmission. The intervention focused on including community and religious leaders, but also other groups such as businessmen and union members. Evidence of enhanced community readiness – i.e. measures in the community to prevent the epidemic taking hold in the community – was harder to find, as none of the subgroups had begun to prepare or plan prevention measures within their communities.

8

Multilateral aid in SRHR

MFA's support to the multilateral organisations is based on number of criteria, such as the size and convening power of UNICEF, and the crucial role played by UNFPA and UNAIDS in SRHR and HIV/AIDS (MFA, 2011a). Tables 9-11 summarise the performance of UNICEF, UNFPA and GFATM on the key elements in Dutch SRHR policy[89], as derived from the literature review and the findings from the evaluations, complemented with findings from the DFID's review of their multilateral aid.[90]

Table 9 Performance of UNICEF on the key elements in Dutch SRHR policy

Adolescent SRHR[91]	Performance of UNICEF in this domain is strong, though not specifically addressing SRH issues. The work of the organisation reaches beyond health, and focuses on participation and life-skills development. There is evidence of an increased focus on needs of very young adolescents, though this is an area for improvement.
Access to FP, SRHR commodities and HIV prevention	Access to FP and SRHR commodities is not a key area for UNICEF, though in some countries UNICEF supports HIV prevention programmes (for example PMTCT).
Access to SRHR services, including safe abortion and HIV/AIDs	UNICEF is strong in positioning the needs of children within the HIV/AIDS response. The organisation has never provided support for abortion, and continues its long-standing policy of not supporting abortion as a method of family planning. However, the organisation has endorsed documents (such as the UN International Guidelines on HIV/AIDS and Human Rights UNAIDS, 2006b) in which legalisation of abortion is called for.
Access to health services among key populations	Overall strong poverty focus and a critical role in the delivery of the MDGs (DFID, 2011). Some focus strategies addressing the needs of vulnerable children.
RR of women and youth on the agenda and included in laws and policies	UNICEF is making progress on gender, as concluded in the DFID review: 'Good progress on gender, including its significant advocacy role for girls' education and promoting sex-disaggregated data.'
Other (DFID, 2011)[92]	Good value for money. Taking positive steps to improve cost control, and has reduced its administration to programme cost ratio. UNICEF works well with partner governments and other development partners and has a strong emphasis on building the capacity of local partners. However, its approach to collaborating with other UN organisations is inconsistent, as is its approach to working with civil society in humanitarian situations.

89 As stated in the 2011 MFA Focus Letter on development aid.

90 DFID (2011).

91 Young people have increased knowledge of sexuality, pregnancy, and HIV, and are free and able to make choices in their sexual relationships, safe sex, and the use of contraceptives.

92 Including: value for money, contribution to UK development objectives, organisational strengths and capacity for positive change.

Table 10 Performance of UNFPA on the key elements in Dutch SRHR policy	
Adolescent SRHR	ASRHR is a core element in the work of UNFPA, reaching out to young people through its four-pillar multi-sectoral strategy.
Access to FP, SRHR commodities and HIV prevention	Improving access to FP/SRH commodities is a key area of UNFPA. The organisation has a good track record on procurement (and considers value for money principles) (DFID, 2011). On the other hand, administration costs are high and UNFPA does not systematically report on prices achieved, nor does it track procurement savings (DFID, 2011).
Access to SRHR services, including safe abortion and HIV/AIDs	Strong performance in the area of accessing SRH services, as much of the organisation's work is intended to increase access. FP services are seen as an element in the prevention of unsafe abortion, and UNFPA also support services for women suffering from complications of unsafe abortions.
Access to health services among key populations	Targeting key populations is not a specific focus of the organisation, though attention is paid to certain groups, such as women of reproductive age and adolescent girls, as well as to the rights of minorities.
RR of women and youth on the agenda and included in laws and policies	Strong presence of UNFPA in the domain of establishing policies and legislation pertaining to SRHR.
Other (DFID, 2011)	UNFPA continues to play a critical role in advancing MDG 5 and related MDGs through global level advocacy and delivery. Its work on SRHR is unique, especially around family planning and population issues. The organisation reports comprehensively on the achievements regarding its global objectives, but mainly in terms of activities. UNFPA has a wide range of policies on gender, and management is held to account, though at times the evidence of impact is unclear. Overall, the evaluation culture and global results chains are weak. Accountability to partner governments is strong, but transparency is weak.

Table 11 Performance of GFATM in relation to the key elements in Dutch SRHR policy	
Adolescent SRHR	This is not a specific area of GFATM, though adolescent programmes are being implemented.
Access to FP, SRHR commodities and HIV prevention	Critical in the delivery of MDG 6, as it is the leading organisation disbursing funds to programmes on AIDS, TB and malaria. Finances a range of high impact interventions in perinatal health and childhood, with an important impact on MDGs 4 and 5 (DFID, 2011).
Access to SRHR services, including safe abortion and HIV/AIDs	No specific presence in the area of safe abortion, though strong pursuit of increasing access to services (SRH and HIV/AIDS), including FP.
Access to health services among key populations	No specific focus on key populations, but given the wide scope of interventions supported, it is likely that vulnerable populations are reached. This will probably increase, with the inclusion of civil society organisations in its grant portfolio.
RR of women and youth on the agenda and included in laws and policies	GFATM thoroughly assesses the gender relevance of all proposals, but the quality of the proposals in terms of addressing gender issues has been poor (DFID, 2011).
Other (DFID, 2011)	Beneficiary spokesmen are reasonably well embedded in all layers of governance. The Fund places a heavy burden on countries and partners because, despite its focus on a country-led approach, its own systems and requirements are often burdensome. The interval between grant approval and disbursement is too long. There is scope to simplify processes and improve efficiency and effectiveness, but the Fund must ensure it can deploy its resources on the ground more quickly.

UNAIDS is charged with delivering an effective response to the global HIV/AIDs pandemic, and as such has contributed significantly to facilitate progress on combating HIV/AIDS worldwide. DFID's review is critical about UNAIDS' delivery in country, as this is limited by the inconsistency of its key coordination role and lack of accountability by co-sponsor agencies for the team performance. DFID's literature review confirmed UNAIDS's key role in defining guidelines and standards; its performance in partnering is considered to be strong. The review recommends strengthening collaboration with others, beyond the co-sponsors. It is critical of the high administrative costs, as well as of UNAIDS' strategy and implementation plans, and its results framework, pointing out that lack of clarity and authority results in insufficient leadership at the country level. In terms of the present review, however, it can be concluded that there is a strong strategic fit for meeting MDG 6 and the Dutch priority on combating HIV/AIDS, given its coordinating role.

WHO is a specialised agency with authority for directing and coordinating work on international health, including) SRHR, in particularly for adolescents. Core of the work is the production of guidelines and standards and assisting countries in addressing public health issues. The literature and the DFID reviews conclude that WHO is an important player in terms of global leadership and convening power on the development of humanitarian health matters. Presence at country level is less visible, as is its guidance for working in fragile contexts (DFID, 2011). Though WHO is taking steps to improve its work on gender equality, progress has been slow. The organisation works well with partner governments, though its use of participatory approaches and harmonisation with the UN system is not strong (DFID, 2011).

Overall, the DFID review confirmed that the multilateral system is a critical complement to what the UK government can do alone. Together, the multilateral organisations mobilise large-scale funding, bring specialist expertise, support innovation, play pivotal leadership roles with other donors, have the mandates and legitimacy to help to deal with conflict situations, and provide a platform for action in every country in the world. Multilateral organisations such as UNICEF, the GAVI Alliance and the GFATM, which save poor people's lives and increase their life chances, are assessed as offering very good value for money for UK aid.. The review also found that the system is complex and fragmented, with overlapping mandates and coordination problems. There was not enough evidence of multilaterals consistently delivering results on the ground, particularly in fragile states. Too many organisations lack a clear strategic direction and systems to get the right staff in place at the right time and ensure that management and staff are focused on achieving results and are held to account for this. Most multilaterals do not pay sufficient attention to driving down costs or achieving value for money. Neither do most multilaterals concentrate enough on gender issues. Furthermore, there is still much room for the multilaterals as a group to improve their transparency and accountability. Poorly functioning partnership between multilateral organisations is undermining the effectiveness of the system (DFID, 2011).[93]

[93] Of the 43 organisations, 9 were deemed to offer very good value for money, 16 to offer good value for money, 9 to offer adequate value for money, and 9 to offer poor value for money for UK aid. See DFID 2011 for the results by organisation.

9

Conclusions

Nine conclusions can be drawn from this review.

1. ***There is a need for more evaluations, and for better quality evaluations***, as shown by the relatively low number of quality evaluations of multilateral organisations actively involved in SRHR and, as illustrated by the UNFPA assessment of country programme evaluations, the fact that quality standards are often not met. The uneven spread over the five core themes revealed that programmes tend to neglect family planning, abortion, and gender issues.

2. ***More attention should be given to measuring effect before interventions are scaled up, and to controlled trials*** that assess long-term outcomes or compare the efficacy of prevention and other implementation strategies in SRHR.

3. ***The review underlines the central role of multilateral organisations*** in advancing SRHR. These organisations complement the support for SRHR given by MFA via other channels. The review of the effect of the multilateral organisations' work demonstrated their added value in this field, despite wide variety in their scope, mandate, and ways of operating. A shortcoming is that few evaluations report on results at the beneficiary level. Main observations: **UNICEF** is valued for its coordinating role and broad commitment in domains that reach beyond SRHR. The organisation has potential to address the rights and needs of a relatively neglected group, the early adolescents, as well as those of children affected by the HIV/AIDS pandemic. **UNFPA**, **UNAIDS** and **GFATM** score positively because of their close alignment with international and Dutch priorities in SRHR, though some areas are relatively neglected (most notably family planning, unsafe abortions and sexual health). **UNFPA** is valued for advocacy and its track record in translating evidence-based approaches into practice. **WHO** continues to play an essential role in setting standards and norms, in developing international agreements, and also for its support for gathering and documenting evidence on the efficacy of approaches. Overall, multilateral organisations – some more than others – are valued for supporting and collaborating with civil society. However, such efforts should be strengthened and accelerated. Although multilateral organisations are committed to the Paris Declaration and the Accra Agenda for action, evidence on the ground indicates there is considerable scope for reducing bureaucracy and improving harmonisation, transparency, accountability, and the reporting of results.

4. ***In order to improve maternal and perinatal health, primary health-care approaches must be revised and strengthened.*** The majority of the evaluations pertaining to this domain relate to the work of UNFPA. With regard to the progress of specific countries, the **UNFPA** thematic evaluation of maternal health reports successes for community support to maternal and child health but notes that there is a need to tie these efforts to national efforts to strengthen health systems. In addition to community participation, another strategy to improve maternal health is to implement simple, affordable and effective measures at the primary level.

5. ***Family planning needs more support and sustained commitment.*** Political will and financial commitment are urgently needed in order to address the high unmet family planning needs of millions of couples worldwide. Progress has been reported on several levels. At national level, for example, national strategies have been introduced to improve commodity security in RH. However, more interventions are needed to accelerate access to effective birth control and reduce the high unmet need. Only one evaluation dealt with family planning interventions: the evaluation of **UNFPA's** Global Programme to Enhance Reproductive Health Commodity Security. An issue of concern was highlighted in the evaluation was that as contraceptives are often not included in country budgets, donors tend to be relied on to provide RH commodities. As well as highlighting the need to provide RH commodities, the evaluation had also noted that the provision of RH commodities should be accompanied by investment in building capacity.

6. ***Legalisation of abortion*** should continue to be a policy priority for the Netherlands and, in countries where abortion is illegal, should be a topic in the policy dialogue. Given the high abortion rate and unmet need for family planning, plus the need to support legalisation, it is necessary to support the implementation of innovative strategies to increase access to safe abortion. This has been demonstrated by the positive experiences with the introduction of medical abortion and implementation of task shifting. A landmark was the **WHO** updated guidance on safe abortion, issued in 2012.

7. ***In the light of the remaining challenges in HIV/AIDs prevention and treatment, continued support is needed to address various issues***: access to services for vulnerable populations; preventive measures (especially for young girls); increasing access to ARVs; and meeting the needs of chronic AIDs patients, and the SRH needs of PLWHA. All three multilateral organisations reviewed (**UNICEF**, **UNFPA** and **GFATM**) are active in the domain of HIV/AIDS, though their focus and scope differ. As such, they provide support to achieving MDG 6. Given the high levels of STIs (for example, the high incidence of cervical cancer), there is an urgent need for prevention programmes and better access to information. Some of the multilateral organisations included in the review have imparted knowledge and implemented programmes addressing this issue. Examples of such interventions are the investments in strategy development and support to improved screening and treatment programmes, such as VIAA. With a few exceptions, overall, little attention has been given to key populations.

8. ***In order to achieve gender equality, a multi-layered approach is required.*** The evaluations referring to gender equality note that although included in national plans, concrete actions to achieve gender equity and equality are often overlooked or poorly understood by key stakeholders, including the multilateral organisations reviewed in this study (**UNICEF** and **UNFPA**). Although the promotion of gender equality has been integrated in many development programmes, the challenge lies in ensuring that 'paper' commitments to addressing inequalities result in tangible outcomes. VAW and also gender-based violence are increasingly receiving attention, especially when a multi-sectoral approach is taken, because the scope of these problems is becoming

more visible and their underlying dynamics are better understood. Successes have been reported in the implementation of school-based prevention programmes, and in combined microfinance and gender equality training.

9. ***More focus is needed on protection and prevention programmes in adolescent SRHR, and existing focus must be improved.*** Evidence from the evaluations of the work of **UNICEF**, **UNFPA** and **GFATM** suggests the importance of starting early with investing in building the life skills of young people. It also suggests it is not enough merely to build skills and improve knowledge. Access to 'youth-friendly' SRH services is essential in order to address the crucial needs of young people. There is evidence that it is effective to increase the positive role of safe and supportive environments (family, school, community) in guiding young people in their physical and psychological growth. As demonstrated in the evaluations, lessons need to be learned from the effect of the many life-skills programmes that are being implemented. Tying such programmes to youth-friendly SRH services is key, as it has been confirmed that such programmes increase SRH knowledge and – to some extent – improve behaviour. However, life-skills education alone is not enough to change sexual behaviour: SRH services must also be available. Furthermore, it is increasingly being understood how support systems within the family, the school and the community can be crucial in helping young people to weigh up the risks. Finally, the needs of young adolescents aged 10 to 14 are increasingly being brought to the fore.

Bibliography

Abbott L, et al. (2011). *Evaluation of UNFPA's Provision of Dignity Kits in Humanitarian and Post-Crisis Settings*. New York: United Nations Population Fund.

Alkema L, Kantorova V, Menozzi C, Biddlecom A (2013). National, regional, and global rates and trends in contraceptive prevalence and unmet need for family planning between 1990 and 2015: a systematic and comprehensive analysis. *The Lancet*. Published Online March 12, 2013. http://dx.doi.org/10.1016/S0140-6736(12)62204-1.

Arowolo O, Dungumaro E, Mosha A, Urrio T, Nangawe E (2010). *The Evaluation of the UNFPA6th Country Programme of Assistance to the Government of the United Republic of Tanzania*.

Basu P, Majid M (2008). *Cervical Cancer Screening Program of Bangladesh: Evaluation & Formulation of Quality Assurance Standards & Guidelines*.

Bearinger L, Sieving R, Ferguson J, Sharma V (2007). Global perspectives on the sexual and reproductive health of adolescents: patterns, prevention, and potential. *The Lancet*; 369: 1220-1231. [This is the second in the 2007 The Lancet Series of six papers on Adolescent Health].

Bhutta A, Ali S, Cousens S, Ali T, Haider B, Rizvi A, Okong P, Bhutta S, Black R (2008). Interventions to address maternal, newborn, and child survival: what difference can integrated primary health care strategies make? *The Lancet* 2008; 372: 972-989 [This is the sixth in a 2008 The Lancet Series of eight papers on Alma-Ata: rebirth and revision].

Blum W, Bastos F, Kabiru C, Le L (2012). Adolescent health in the 21st century. *The Lancet*: DOI:10.1016/S0140- 6736(12)60407-3. [Comment in the 2012 The Lancet series on Adolescent Health].

Bongaarts J, Cleland J, Townsend J, Bertrand J, Gupta M (2012). *Family Planning Programs For the 21st Century Rationale and design*. New York: The Population Council.

Butcher K, Dickinson C (2010). *Evaluation of the Joint UNDP/ World Bank/ UNAIDS programme on mainstreaming AIDS into national development plans and processes*. London: HLSP.

Cappa C, Wardlaw T, Langevin-Falcon C, Diers J (2012). Progress for children: a report card on adolescents. *The Lancet;*
http://dx.doi.org/10.1016/S0140-6736(12)60531-5. [Comment in the 2012 The Lancet Series on Adolescent Health].

Carr B, Gates French M, Mitchell A, Shah R (2012). Giving women the power to plan their families. *The Lancet*;
http://dx.doi.org/10.1016/S0140-6736(12)60905-2. [Comment in the 2012 The Lancet Series on Adolescent Health].

Catalano R, Fagan A, Gavin L, Greenberg M, Irwin Jr C, Ross D, Shek D (2012). Worldwide application of prevention science in adolescent health. *The Lancet*; 379: 1653-1664. [This is the third in the 2012 The Lancet Series of four papers on Adolescent Health].

Center for Global Development/UNAIDS (2009). *Preparing for the future. Report of the UNAIDS Leadership Transition Working Group.*

Centre for Sustainable development/Institute for Policy Analysis and Research (2012). *End Line Evaluation UNFPA Rwanda 6th Country Programme.*

Chambel A, Carou Jones V/UNFPA (2011). *Evaluación del programa de país: Bolivia 2008-2011.*New York: United Nations Population Fund.

Chandan U, Cambanis E, Bhana A, Boyce G, Makoae M, Mukoma W and Phakati S. (2008). *Evaluation of My Future is My Choice (MFMC) peer education life skills programme in Namibia: Identifying strengths, weaknesses, and areas of improvement*. Windhoek: UNICEF Namibia.

Chattoe-Brown A, Weil O, Braddock M (2012). *UNFPA Global Programme to Enhance Reproductive Health. Commodity Security Mid-Term Review. Final draft (version 2)*. London: HLSP.

Cleland J, Conde-Agudelo A, Peterson H, Ross J, Tsui A (2012). Contraception and health. *The Lancet;* 380 (9837): 149-156. [This is the second in the 2012 The Lancet Series of five papers on Family Planning].

Cottingham J, Germain A, Hunt P (2012). Use of human rights to meet the unmet need for family planning. *The Lancet;* 380:172-180. [This is the fifth in the 2012 The Lancet Series of five papers on Family Planning].

Creanga A, Iliyasu Z, Arinaitwe L (2008). *An evaluation of the United Nations Population Fund/ Uganda's obstetric fistula program.*

CSID/University of Aberdeen, Ipact, IPR/Rwanda (2012) *UNFPA Rwanda 6th Country Programme. End of Line Evaluation.*

DFID (2011). *Multilateral Aid Review. Ensuring maximum value for money for UK aid through multilateral organisations.*

Dickinson C, Martínez J, Whitaker D, Pearson M (2007). *The Global Fund operating in a SWAp through a common fund: issues and lessons from Mozambique. Policy brief.* London: HLSP Institute

Doyle A, Mavdzenge S, Plummer M, Ross D (2012). The sexual behavior of adolescents in Sub-Saharan Africa: patterns and trends from national surveys. *Tropical Medicine and International Health;* 17(7): 797-807.

Ethiopian Health and Nutrition Research Institute (2008). *Five-year evaluation of Global Fund Health Impact Evaluation: Health Facility Report*. Addis Ababa: FMoH and EHNRI.

Ethiopian Health and Nutrition Research Institute (2008). *Impact Evaluation of Ethiopia's National Response to HIV/AIDS, Tuberculosis and Malaria*. Addis Ababa: FMoH and EHNRI.

Ezeh A, Bongaarts J, Mberu B (2012). Global population trends and policy options. *The Lancet*; 380: 142-148. [This is the first in the 2012 The Lancet Series of five papers on Family Planning].

FCI/Cody A and Goltz S (2012). POLICY BRIEF Scaling Up Misoprostol for Postpartum Hemorrhage: Moving from Evidence to Action. Family Care International: New York.

GFATM (undated). *The Global Fund Strategy 2012-2016: investing for impact*. Geneva: The Global Fund to Fight AIDS, Tuberculosis and Malaria.

Global HIV Prevention Working Group (2010). *Global HIV Prevention Progress Report Card 2010*.

Global HIV/AIDS Initiatives Network (undated). *Coordinating Funding for HIV/AIDS. A Study of Global Initiatives and Their Effects on National and Sub-National Coordination in Seven Countries. Briefing paper.*

Gordon P, Boler T, Burgin J and Brett T. (2010) *What women want: meeting the global demand for medical abortion*). London: Marie Stopes International 2010.

Gore F, Bloem P, Patton G, Ferguson F, Joseph V, Coffey C, Sawyer S, Mathers C (2011). Global burden of disease in young people aged 10–24 years: a systematic analysis. *The Lancet*; DOI:10.1016/S0140- 6736(11)60512-6.

GoZ/ZAC (2007). *Taking Stock: Joint Review of the National HIV Response in Zanzibar 2004 to 2007.*

Guttmacher Institute (2006). *Meeting the Sexual and Reproductive Health Needs Of People Living with HIV.* New York: The Guttmacher Institute.

Guttmacher Institute/IPPF (2010). *Facts on the Sexual and Reproductive Health of Adolescent Women in the Developing World.* New York: The Guttmacher Institute.

Habumuremyi P and Zenawi M (2012). Making family planning a national development priority; *The Lancet*; http://dx.doi.org/10.1016/S0140-6736(12)60904-0. [This is a comment in the 2012 The Lancet Series on Family Planning].

Hanefeld J, Musheke M (2009). What impact do Global Health Initiatives have on human resources for antiretroviral treatment roll-out? A qualitative policy analysis of implementation processes in Zambia. *Human Resources for Health 2009*, 7:8.

Hogan M, Foreman J, Naghavi M, Ahn S, Wang M, Makela S, Lopez A, Lozano R, Murray C (2010). Maternal mortality for 181 countries, 1980–2008: a systematic analysis of progress towards Millennium Development Goal 5. *The Lancet;* 375: 1609-1623.

Hongyi XU, Bayoumi A (2009). *Evaluation of Unicef – Government of Sudan 2002-2006 Country Health And Nutrition Programme.*

Horton R, Peterson H (2010). The rebirth of family planning. *The Lancet*. http://dx.doi.org/10.1016/S0140-6736(12)61026-5.

ICDDR, B (2007). *An Assessment of Community Readiness for HIV/AIDS Prevention Interventions in Rural Bangladesh. Prevention of HIV/AIDS among Young People in Bangladesh*.

IEG/WB (2012). *The Global Fund to Fight AIDS, Tuberculosis and Malaria, and the World Bank's Engagement with the Global Fund — Volume 1: Main Report*. Washington: Independent Evaluation Group, The World Bank Group.

ILO (2010). *Recommendation concerning HIV and AIDS and the World of Work (no. 200)*. Geneva: International Labour Office.

International HIV/AIDS Alliance (2009). *Report on access to Global Fund resources by HIV/AIDS Key Populations in Latin America and the Caribbean*. Hove: International HIV/AIDS Alliance Secretariat.

ITAD, LSHTM, KIT (2001). *Inception Report for: The Five-Year Evaluation of UNAIDS.*

JSI (2007). *Evaluation of the African Youth Alliance program in Tanzania: Impact on Sexual and Reproductive Health Behavior among Young People.* Rosslyn: JSI Research & Training Institute, Inc.

Kalavakonda V, Groos N, Karasi J (2007). *Mid-term evaluation of the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM) 5th Round Project on Health Systems Strengthening: Assuring Access to Quality Care: The Missing Link to Combat AIDS, Tuberculosis and Malaria in Rwanda*. Washington DC: World Bank Group.

Kelly K, Birdsall K, Tshose P, Banati P, Low-Beer D (2006). *Community Perspectives on Systems Effects of HIV/AIDS Funding in South Africa*. Braamfontein, Johannesburg: Centre for AIDS Development, Research and Evaluation.

Khan KS, Wojdyla D, Say L, Gülmezoglu M, Van Look P (2006). WHO analysis of causes of maternal death: a systematic review. *The Lancet*; 367(9516):1066-1074.

Kleinert S (2007). Adolescent health: an opportunity not to be missed. *The Lancet*. DOI:10.1016/S0140- 6736(07)60374-2. [Comment in the 2007 The Lancet Series on Adolescent Health].

The Lancet (2012). Putting adolescents at the centre of health and development. *The Lancet*. DOI:10.1016/S0140- 6736(12)60536-4. [Editorial in the 2012 The Lancet Series on Adolescent Health].

Lozano R, Wang H, Foreman K, Rajaratnam J, Naghavi M, Marcus J, Dwyer-Lindgren L, Lofgren K, Phillips D, Atkinson C, Lopez A, Murray C (2011). Progress towards Millennium Development Goals 4 and 5 on maternal and child mortality: an updated systematic analysis. *The Lancet; 378:* 1139-1165.

Lougue H/Government of Mali/UNFPA (2011). *Rapport de l'**é**valuation finale du 6ième programme de coop**é**ration Mali-UNFPA 2008-2012.*

Macro International Inc. (2009). *Global Fund Five-Year Evaluation: Study Area 3: The Impact of Collective Efforts on the Reduction of the Disease Burden of AIDS, Tuberculosis, and Malaria. Final Report*. Calverton: Macro International Inc.

Macro International Inc. (2010). *Long-term evaluation of the Tostan programme in Senegal: Kolda, Thiès and Fatick regions*. Calverton: Macro International Inc.

MAG/ETC/GOGA/HERA XXI (2011). *Clients' and providers' perspectives on Ceasarean sections: An operational study into the high Ceasarean Section rate in Georgia*.

Maximizing Positive Synergies Academic Consortium (2009) *Interactions between Global Health Initiatives and Health Systems: Evidence from Countries* (Georgia, Peru, China, Ukraine, Zambia).

Meirik O, My Huong N, Piaggio G, Bergel E, Hertzen H (2012). Complications of first-trimester abortion by vacuum aspiration after cervical preparation with and without misoprostol: a multicentrerandomised trial. *The Lancet*; 379: 1817-1824.

MFA (2007). *Policy Brief on Development Aid (Een zaak van iedereen, in Dutch)*. The Hague: Ministry of Foreign Affairs.

MFA (2008). *Choices and Opportunities. Policy Memorandum on HIV/AIDS and SRHR in foreign policy.* The Hague: Ministry of Foreign Affairs.

MFA (2009). *Working together towards global challenges: the Netherlands and multilateral aid*. The Hague: Ministry of Foreign Affairs.

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

MFA (2011a). *Letter on the Multilateral Development Aid* (Brief inzake Multilateraal OS-beleid, in Dutch). The Hague: Ministry of Foreign Affairs.

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

MFA/IOB (2009). *Synthesis of impact evaluations in sexual and reproductive health and rights. Evidence from developing countries*. The Hague: Ministry of Foreign Affairs.

MFA/IOB (2009a). *Evaluation policy and guidelines for evaluations*. The Hague: Ministry of Foreign Affairs.

MolzanTuran J/Eritrean MoH/UNFPA (2007). *Final report on the pilot community mobilization / education project for promotion of safe motherhood and prevention of obstetric fistula in Eritrea*.

Nasreen M, Islam S, Chwodhurry W, Eder B (2011). *Final report. Evaluation of the 7th country programme UNFPA Bangladesh*.

O'Neill B, Liddle B, Jiang L, Smith K, Pachauri S, Dalton M, Fuchs R (2012). Demographic change and carbon dioxide emissions. *The Lancet*; 380: 157-164. http://dx.doi.org/10.1016/S0140-6736(12)60958-1. [This is the third in the 2012 The Lancet Series of five papers on Family Planning 3].

ONUSIDA (2004). *Support to Mainstreaming AIDS in Development. UNAIDS Secretariat Strategy Note and Action Framework 2004-2005.*

Osotimehin B/UNFPA (2012). Family planning save lives, yet investments falter. *The Lancet*. http://dx.doi.org/10.1016/S0140-6736(12)60906-4.

Patton G, Coffey C, Cappa C, Currie D, Riley L, Gore F, Degenhardt L, Richardson D, Astone N, Sangowawa A, Mokdad A, Ferguson J (2012). Health of the world's adolescents: a synthesis of internationally comparable data. *The Lancet*; 379: 1665-1675. [This is the fourth in the 2012 The Lancet series of four papers on Adolescent Health].

Peebles D, Brydon R, Gervais R, Peebles W, Sachdeva N, Tezare K (2010). *Final Report: Evaluation of UNICEF's Programme and Work in Relation to Adolescents and the Participation of Children and Young People*. Ontario: Kartini international Consulting Inc.

Pfleiderer, R and O. Kantai (2010). *Orphans and Vulnerable Children (OVC) Programming in Global Fund HIV/AIDS Grants in Kenya*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

Poate D, Balogun P, Attawell K (2009). *UNAIDS Second Independent Evaluation 2002-2008. Final Report*. Geneva: Joint United Nations Programme on HIV/AIDS; available at: www.unaids.org/en/media/unaids/contentassets/dataimport/pub/basedocument/2009/20091002_sie_final_report_en.pdf.

Population Council (2007). *Improving Access to Life Skills based Sexual and Reproductive Health Education and Condom Services for Male Youth. Prevention of HIV/AIDS among Young People in Bangladesh*. Ney York: Population Council.

Resnick M, Bowes (2007). Us and them: worldwide health issues for adolescents. *The Lancet*. DOI:10.1016/S0140- 6736(07)60372-9 [Comment in the 2007 The Lancet series on Adolescent Health].

Resnick M, Catalano R, Sawyer S, Viner R, Patton G (2012). Seizing the opportunities of adolescent health. T*he Lancet*. DOI:10.1016/S0140- 6736(12)60472-3. [Comment in the 2012 The Lancet Series on Adolescent Health].

Ringheim K, Colombini M (2010). *Evaluation of the WHO training initiative transforming health systems: gender and rights in reproductive health 1997-2007.* Geneva: World Health Organization.

Rosato M, Laverack G, Howard Grabman L, Tripathy P, Nair N, Mwansambo C, Azad K, Morrison J, Bhutta Z, Perry H, Rifkin S, Costello A (2008). Community participation: lessons for maternal, newborn, and child health. *The Lancet;* 372: 962-971. [This is the fifth in a 2008 The Lancet Series of eight papers on Alma-Ata: rebirth and revision].

Saifuddin A, Qingfeng Li, Li Liu, Amy O Tsui (2012). Maternal deaths averted by contraceptive use: an analysis of 172 countries. *The Lancet*; 380: 111-125.

Sawyer S, Afifi R, Bearinger L, Blakemore S-J, Dick B, Ezeh A, Patton G (2012). Adolescence: a foundation for future health. *The Lancet*; 379: 1630-1640. [This is the first in a 2012 The Lancet Series of four papers on Adolescent Health].

Sawyer S, Drew S, Yeo M, Britto M (2007). Adolescents with a chronic condition: challenges living, challenges treating. *The Lancet*; 369: 1481-1489. [This is the fifth in the 2007 The Lancet Series of six papers on Adolescent Health].

Schlangen R, Jones A (2010). *Unite for children, Unite against AIDS. Campaign evaluation. Evaluation report.* New York: United Nations Children's Fund.

Sedgh G, Susheela Singh S, Shah I, Åhman E, Henshaw S, Bankole A (2012). Induced abortion: incidence and trends worldwide from 1995 to 2008. *The Lancet*; DOI:10.1016/ S0140- 6736(11)61786-8.

Singh S, Darroch J, Ashford L, Vlassoff M (2009). *Adding It Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health.* New York: The Guttmacher Institute and United Nations Population Fund.

Singh S, Darroch J (2012). *Adding It Up: The Costs and Benefits of Contraceptive Services. Estimates for 2012.* New York: The Guttmacher Institute and United Nations Population Fund.

Souza, J. et al./WHOMCS Research Group (undated). *The world health organization multicountry survey on maternal and newborn health: study protocol.*

Thaver I, Qureshi, H, Mahmood N, Kamal Z (2011) *Evaluation of the Evaluation Of United Nations Population Fund (UNFPA) Seventh Country Programme 2004-12 (Pakistan). Final Report.*

Toumbourou J, Stockwell T, Neighbors C, Marlatt G, Sturge J, Rehm J (2007). Interventions to reduce harm associated with adolescent substance use. *The Lancet*; 369: 1391-1401. [This is the fourth in the 2007 The Lancet Series of six papers on Adolescent Health].

Tuominen M, Roden H, Herminio K (2010). *Mozambique: Assessment of UNICEF NGO-Government Partnership Programme.* New York: United Nations Children's Fund.

Tylee A, Haller D, Graham T, Churchill R, Sanci L (2007). Youth-friendly primary-care services: how are we doing and what more needs to be done? *The Lancet*; 369: 1565-1573. [This is the sixth in the The Lancet 2007 Series of six papers on Adolescent Health].

UN Department of Peacekeeping Operations (2004). *HIV testing policy for uniformed peacekeepers*. New York: United Nations.

UN Office on Drugs and Crime/WHO/UNAIDS (2006). *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings A Framework for an Effective National Response*. Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS (1997). The female condom and AIDS: UNAIDS point of view. UNAIDS Best practice collection. Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS (2003) *UNAIDS Global Reference Group on HIV/AIDS and Human Rights. How Should Guidance for National Policies Be Framed? Issue Paper.* Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS (2004). *Making condoms work for HIV prevention: cutting-edge perspectives*. Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS (2005). *UNAIDS Intensifying HIV prevention: a UNAIDS policy position paper.* Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS (2006). *HIV and sex between men. Policy brief.* Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS (2006a). *Strengthening Health Systems to improve HIV/AIDS programs in the Europe and Eurasia Region using Global Fund resources*. Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS (2006b). *International Guidelines on HIV/AIDS and Human Rights*. Consolidated Version. Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS (2007). *The Greater Involvement of People Living with HIV (GIPA). Policy brief.* Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS (2008). *UNAIDS Legal and Regulatory Self-Assessment Tool for Male Circumcision in Sub-Saharan Africa*. Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS (2009). *Comprehensive External Evaluation of the National AIDS Response in Ukraine: Consolidated Report*. Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS (2009a). *Operational plan for UNAIDS Action Framework: addressing women, girls, gender equality and HIV.* Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS (2009b, update from 2004). *Condoms and HIV prevention. Position paper.* Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS (2010). *State of the AIDS response in 2010. The AIDS response special section. Outlook*. Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS (2011). *Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping their Mothers Alive 2011-2015.*Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS (2011a). *Ten Targets: 2011 United Nations General Assembly Political Declaration on HIV/AIDS: Targets and elimination commitments.* Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS (2011b). *The report of the UNAIDS Advisory Group on HIV and Sex Work.* Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS (2011c). *UNAIDS Guidance for Partnerships with Civil Society, including PLHIV & Key Populations. UNAIDS Guidance Document.* Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS (2012). *AIDS Dependency Crisis Sourcing African Solutions. Issues brief.* Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS (2012a). *Letter to Partners.* Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS (2012b). *Promising practices in community engagement for elimination of new HIV infections among children by 2015 and keeping their mothers alive.* Geneva: UN Joint Programme on HIV/AIDS.

UNAIDS (2012c). *Adolescents, young people and HIV.* Fact sheet. Geneva: UN Joint Programme on HIV/AIDS.

UNAIDS (2012d). *Women, girls, gender equality and HIV.* Fact sheet. Geneva: UN Joint Programme on HIV/AIDS.

UNAIDS (2012e). *Info graph on young women and HIV/AIDS.* Geneva: UN Joint Programme on HIV/AIDS.

UNAIDS/ILO/IOM (2008). *HIV and International Labour Migration. Policy brief.* Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS/UNDP (2005). *Mainstreaming AIDS in development instruments and processes at the national level: a review of experiences.* Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS/UNDP (2008). *Criminalization of HIV Transmission. Policy brief.* Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS/UNFPA/WHO (2009). *Condoms and HIV prevention. Position statement.* Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS/UNHCR (2006). *HIV and Refugees. Policy brief.* Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS/UNITAR (2005). *Evaluation of the UNAIDS/UNITAR. AIDS Competence Programme.* Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS/WFP/WHO (2008). *HIV, food security and nutrition. Policy brief.* Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS/WHO (2004). *UNAIDS/WHO Policy Statement on HIV Testing.* Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS/WHO/OHCHR (2005). *Disability and HIV. Policy brief.* Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS/WHO/OHCHR (2009). *Disability and HIV. Policy brief.* Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS/WHO/UNDP (2011). *Using TRIPS flexibilities to improve access to HIV treatment. Policy brief.* Geneva: Joint United Nations Programme on HIV/AIDS.

UNEG (2005). *Standards for Evaluation in the UN System. Foundation Document.* New York: United Nations Evaluation Group.

UNFPA (2010). *Sexual and Reproductive Health for All. Reducing poverty, advancing development and protecting human rights.* New York: United Nations Population Fund.

UNFPA/Evaluation Branch/Division for Oversight Services (2012). *Quality assessment of UNFPA decentralised country programme evaluations.* New York: United Nations Population Fund.

UNFPA/Evaluation Branch/Division for Oversight Services (2012a).*Thematic Evaluation. UNFPA support to maternal health 2000-2011.*Final report + VOLUME 2 Annexes. New York: United Nations Population Fund.

UNHCR/WHO/UNAIDS (2009). *Policy Statement on HIV Testing and Counseling in Health Facilities for Refugees, Internally Displaced Persons and other Persons of Concern to UNHCR.* Geneva: United Nations High Commissioner for Refugees.

UNICEF (2005). *Guide to monitoring and evaluation of the national response for children orphaned and made vulnerable by HIV/AIDS.* New York: United Nations Children's Fund.

UNICEF (2007). *UNICEF evaluation policy.* New York: United Nations Children's Fund.

UNICEF (2010). *Global Evaluation Reports Oversight System.* New York: United Nations Children's Fund.

UNICEF (2010a). *UNICEF-Adapted UNEG Evaluation Reports Standards.* New York: United Nations Children's Fund.

UNICEF (2010b). *UNICEF-Adapted UNEG Quality Checklist for Evaluation Terms of Reference.* New York: United Nations Children's Fund.

UNICEF (2011). *Opportunity in Crisis: Preventing HIV from early adolescence to young adulthood.* New York: United Nations Children's Fund.

UNICEF (2012). *Progress for Children. A report card on adolescents.* New York: United Nations Children's Fund.

United Nations (2011). *Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS. Resolution 65/277 adopted by the GA Sixty-fifth session, July 2011*. New York: United Nations.

Universalia (2010). *Mid Term Evaluation of UNFPA Strategic Plan Organizational Goal 3 – Gender Equality. Final Evaluation Report*.

Universalia (2011). *Mid Term Evaluation of UNFPA Strategic Plan Organizational Goal 3 – Gender Equality. Phase II. Final Evaluation Report*.

UNMP (2006). *Public Choices, Private Decisions: Sexual and reproductive health and the Millennium Development Goals*. New York: Millennium Development Project.

UNSG (2010). *Global Strategy for Women's and Children's Health.* New York: United Nations.

Van Rompaey S, Dodarbekov M, Madjitova T (2010). *Final Evaluation Report: Objective 3 of the Round 4 GFATM HIV grant addressing provision of treatment, care and support to people living with HIV/AIDS (PLHIV) United Nations Development Programme (UNDP) Tajikistan*.

Viner R, Ozer E, Denny S, Marmot M, Resnick M, Fatusi A, Currie C (2012). Adolescence and the social determinants of health. *The Lancet*; 379: 1641-1652. [This is the second in the 2012 The Lancet Series of X papers on Adolescent Health].

Wall S, Lee A, Carlo W, Goldenberg R, Niermeyer S, Darmstadt G, Keenan W, Bhutta Zulfiqar A., Perlman J, Lawn J (2010). Reducing Intrapartum-Related Neonatal Deaths in Low- and Middle-Income Countries — What Works? *Semin Perinatol* 34:395-407.

Warriner I and Shah I, eds. (2006). *Preventing Unsafe Abortion and its Consequences: Priorities for Research and Action*, New York: Guttmacher Institute, 2006.

Warriner I, Wang D, My Huong NT, Thapa K, Tamang A, Shah I, Baird D, Meirik O. (2011). Can midlevel health-care providers administer early medical abortion as safely and effectively as doctors? A randomised controlled equivalence trial in Nepal. *The Lancet*; Volume 377, Issue 9772, Pages 1155 - 1161, 2 April 2011.

WHO (2002). *Integrating gender perspectives in the work of WHO: WHO gender policy.* Geneva: World Health Organization.

WHO (2003). *HIV and infant feeding: framework for priority action*. Geneva: World Health Organization.

WHO (2004). *Evidence for action on HIV/AIDS and injecting drug use. Policy brief: reduction of HIV transmission in prisons*. Geneva: World Health Organization.

WHO (2004a). *Reproductive Health Strategy to accelerate progress towards the attainment of international development goals and targets (WHO's first global strategy on reproductive health, adopted by the 57th WHA May 2004)*. Geneva: World Health Organization.

WHO (2005). *Multi-country study on women's health and domestic violence against women*. Geneva: World Health Organization.

WHO (2007). *Monitoring and Evaluation of Maternal and Newborn Health and Services at the District Level. Technical Consultation Meeting Report 5-8 December 2006*.Geneva: World Health Organization.

WHO (2007a). *Standards for Maternal and Neonatal Care*. Geneva: World Health Organization.

WHO (2007b). *The WHO Strategic Approach to Strengthening Sexual and Reproductive Health Policies and Programmes*. Geneva: World Health Organization.

WHO (2007c). *Introducing WHO's sexual and reproductive health guidelines and tools into national programmes. Principles and processes of adaptation and implementation*. Geneva: World Health Organization.

WHO (2007d). *Report of the Female Condom Technical Review Committee.* Geneva: World Health Organization.

WHO (2007e). *Global strategy for the prevention and control of sexually transmitted infections: 2006-2015: breaking the chain of transmission.* Geneva: World Health Organization.

WHO (2008). *Eliminating female genital mutilation: an interagency statement UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNIFEM, WHO.* Geneva: World Health Organization.

WHO (2008a). *External evaluation 2003-2007 of the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP)*. Geneva: World Health Organization.

WHO (2008b). *Improving the safety and effectiveness of contraception in China: a case-study in promotion and planning of family planning*. Geneva: World Health Organization.

WHO (2008c). *Mid-level health-care providers are a safe alternative to doctors for first-trimester abortions in developing countries*. Geneva: World Health Organization.

WHO (2009). *Maternal and Child Health in Namibia. 2nd Edition*. Geneva: World Health Organization

WHO (2009a). *Monitoring Emergency Obstetric Care: a handbook*. Geneva: World Health Organization.

WHO (2010). *Developing Sexual Health Programmes. A Framework for Action*. Geneva: World Health Organization.

WHO (2010a). *Packages of Interventions for Family Planning, Safe Abortion care, Maternal, Newborn and Child Health.* Geneva: World Health Organization.

WHO (2010b). *WHO's Strategic Vision in Sexual and Reproductive Health and Rights Business Plan 2010-2015.* Geneva: World Health Organization.

WHO (2010c). *Working with Individuals, Families and Communities to Improve Maternal and Newborn Health*. Geneva: World Health Organization.

WHO (2010d). *Joint country support. Accelerated implementation of maternal and newborn continuum of care as part of improving RH. Mapping of in-country activities WHO/UNICEF/WB.* Geneva: World Health Organization.

WHO (2010e). *Caesarean section without medical indication increases risk of short-term adverse outcomes for mothers.* Geneva: World Health Organization.

WHO (2010f). *Global strategy to stop health-care providers from performing female genital mutilation. UNAIDS, UNDO, UNFOA, UNHCR, UNICEF, UNIFEM, FIGO, ICN, IOM, MMWIA, WCPT, WMA. WHO*. Geneva: World Health Organization.

WHO (2011). *Global HIV/AIDS response: epidemic update and health sector progress towards universal access: progress report 2011*. Geneva: World Health Organization.

WHO (2011a). *Accelerating Universal Access to Reproductive Health: Ethiopia Case Study.* Geneva: World Health Organization.

WHO (2011b). *Accelerating Universal Access to Reproductive Health: Malawi Case Study.*Geneva: World Health Organization

WHO (2011c). *Accelerating Universal Access to Reproductive Health: Nepal Case Study.* Geneva: World Health Organization.

WHO (2011d). *Accelerating Universal Access to Reproductive Health: Rwanda Case Study.* Geneva: World Health Organization.

WHO (2011e). *An update on WHO's work on Female Genital Mutilation (FGM). Progress report*. Geneva: World Health Organization.

WHO (2011f). *HRP Biennial Technical Report 2009-2010.*Geneva: World Health Organization

WHO (2011g). *Kesho Bora Study. Preventing mother-to-child transmission of HIV during breastfeeding. Policy brief.* Geneva: World Health Organization

WHO (2011h). *The sexual and reproductive health of young adolescents in developing countries: Reviewing the evidence, identifying research gaps, and moving the agenda. Report of a WHO technical consultation, Geneva, 4-5 November 2010*. Geneva: World Health Organization.

WHO (2011i). *Universal Access to Reproductive Health. Accelerated Actions to Enhance Progress on Millennium Development Goal 5 Through Advancing Target 5B.*Geneva: World Health Organization.

WHO (2011j). *Fact sheet on HIV/AIDS. Fact sheet N°360 November 2011.* Geneva: World Health Organization.

WHO (2011k). *Fact sheet on sexually transmitted infections. Fact sheet N°110. August 2011.* Geneva: World Health Organization.

WHO (2011l). *WHO/UNAIDS/UNICEF Report on global HIV/AIDS response (2011)*. Geneva: World Health Organization.

WHO (2011m). *Global health sector strategy on HIV/AIDS 2011-2015.* Geneva: World Health Organization .

WHO (2011n). *Fact sheet on violence against women. Intimate partner and sexual violence against women. Fact sheet N°239 Updated September 2011*. Geneva: World Health Organization.

WHO (2011o). *Human rights and gender equality in health sector strategies: how to assess policy coherence.* Geneva: World Health Organization.

WHO (2011p). *Global health sector strategy on HIV/AIDS 2011-2015.* Geneva: World Health Organization.

WHO (2011q). *Evaluating the quality of care for severe pregnancy complications: the WHO near-miss approach for maternal health.* Geneva: World Health Organization

WHO (2011r). *Gender mainstreaming in WHO: what is next? Report of the Midterm Review of the WHO gender strategy*. Geneva: World Health Organization.

WHO (2012). *Global incidence and prevalence of selected curable sexually transmitted infections – 2008.* Geneva: World Health Organization.

WHO (2012a). *World Health Statistics 2012.* World Health Organization, Geneva.

WHO (2012b). *Safe abortion: technical and policy guidance for health systems. Second edition*. Geneva: World Health Organization.

WHO (2012c). *Trends in maternal mortality: 1990 to 2010. WHO, UNICEF, UNFPA and The World Bank estimates.* Geneva: World Health Organization

WHO (2012d). *Safe and unsafe induced abortion. Global and regional levels in 2008 and trends during 1995-2008*. Geneva: World Health Organization.

WHO (2012e). *Every woman, every child: from commitments to action: the first report of the independent Expert Review Group (iERG) on Information and Accountability for Women's and Children's Health.* Geneva: World Health Organization.

WHO (2012f). *HRP at 40: what they say. A history of scientific achievement to advance sexual and reproductive health*. Geneva: World Health Organization.

WHO (2012g). *Making health services adolescent friendly: developing national quality standards for adolescent friendly health services*. Geneva: World Health Organization

WHO (2012h). *Fact sheet on female genital mutilation. Fact sheet N°241 February 2012.* Online available: http://www.who.int/mediacentre/factsheets/fs241/en/.

WHO (undated). *WHO-UNFPA Strategic Partnership Programme*. Geneva: World Health Organization.

WHO/UNODC/UNAIDS (2004). *Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention: position paper.* Geneva: World Health Organization.

WHO/UNAIDS (2004). *Ensuring equitable access to antiretroviral treatment for women. WHO/UNAIDS Policy Statement*. Geneva: World Health Organization.

WHO/UNAIDS/ UN Office on Drugs and Crime (2005). *Evidence for action on HIV/AIDS and injecting drug use. POLICY BRIEF: antiretroviral therapy and injecting drug users*. Geneva: World Health Organization.

WHO/UNAIDS/UNICEF (2009). *Towards Universal Access. Scaling up priority HIV/AIDS interventions in the health sector. Progress Report 2009*. Geneva: World Health Organization.

WHO/UNFPA (2009). *Mental health aspects of women's reproductive health. A global review of the literature*. Geneva: World Health Organization.

WHO/UNODC/UNAIDS (2009). *WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users*. Geneva: World Health Organization.

WHO/UNFPA/IPPF/UNAIDS (2005). *Sexual and Reproductive Health & HIV/AIDS. A Framework for Priority Linkages*. Geneva: World Health Organization.

WHO/UNFPA/IPPF/UNAIDS (2009). *Sexual & Reproductive Health and HIV Linkages: Evidence Review and Recommendations*. Geneva: World Health Organization.

WHO/UNFPA/UNICEF/WB (2010). *Joint country support. Accelerated implementation of maternal and newborn continuum of care as part of improving reproductive health. Mapping of in-country activities*. Geneva: World Health Organization.

WHO/UNAIDS/UNFPA/FHI (2010). *Male Latex Condom: Specification, Prequalification and Guidelines for Procurement*. Geneva: World Health Organization, UNAIDS, UNFPA and Family Health International.

WHO/LSHTM (2010). *Preventing intimate partner and sexual violence against women: taking action and generating evidence.* Geneva: World Health Organization

WHO/UNAIDS/UNICEF (2011). *Report on global HIV/AIDS response.* Geneva: World Health Organization.

WHO/RHR and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP), Knowledge for Health Project (2011). *Family Planning: A Global Handbook for Providers. 2011 update (2011)*. Baltimore and Geneva: CCP and WHO

WHO/UNICEF (2012). *Countdown to 2015 Maternal, Newborn & Child Survival. Building a Future for Women and Children. The 2012 Report*. Geneva. Geneva: World Health Organization

Websites

Below an overview of the websites consulted for this review between January and November 2012.

http://www.who.int/mediacentre/news/releases/2004/wha2/en/
http://www.un.org/
http://www.unicef.org/evaldatabase/
http://web2.unfpa.org/public/about/oversight/evaluations/home.unfpa
http://www.theglobalfund.org/
http://www.unaids.org/en/resources/
http://www.who.int/
http://www.rbm.who.int/cmc_upload/0/000/015/369/RBMInfosheet_4.htm
http://www.who.int/malaria/high_risk_groups/pregnancy/en/index.html
http://mip-consortium.org/
http://www.who.int/reproductivehealth/topics/best_practices/globalsurvey/en/
http://www.who.int/reproductivehealth/topics/unsafe_abortion/hrpwork/en/index.html
http://www.who.int/reproductivehealth/topics/maternal_perinatal/nearmiss/en/
http://www.who.int/mediacentre/news/releases/2004/wha2/en/
http://www.minbuza.nl/en/news/2012/07/house-supports-details-of-new-development-policy.html
http://www.un-ngls.org/spip.php?page=article_s&id_article=810
http://www.who.int/mediacentre/factsheets/fs239/en/
http://www.who.int/mediacentre/factsheets/fs241/en/
http://geneva.nlmission.org/news/2012/05/the-netherlands-welcomes-new-who-guidelines-on-safe-abortion.html
http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/basedocument/2009/20091002_sie_final_report_en.pdf

Annexes

Annex 1 About IOB

Objectives

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

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

Organisation and quality assurance

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

Programming of evaluations

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

Approach and methodology

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

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

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

Annex 2 Terms of Reference (in Dutch)

Terms of reference literatuurstudie van evaluaties van het Global Fund, UNFPA, UNICEF, UNAIDS en WHO. December 2012.

1 Aanleiding

In de evaluatieprogrammering staat voor 2013 een beleidsdoorlichting gepland van de operationele doelstelling 'seksuele en reproductieve gezondheid en rechten voor iedereen'. Deze heeft betrekking op alle kanalen van uitvoering. De evaluatie van de steun aan internationale organisaties en publiek-private partnerschappen vindt plaats op basis van secundair materiaal, aangevuld door interviews.

2 Achtergrond

SRGR-strategie

SRGR omvat de volgende elementen (WHO, 2004), die in de literatuurstudie alle onderwerp van studie zullen zijn.

1 de bevordering van antenatale, perinatale en postpartum zorg, met inbegrip van zorg voor de pasgeborene;
2 het voorzien in kwalitatief goede dienstverlening op het gebied van *family planning*;
3 het uitbannen van onveilige abortussen;
4 de bestrijding van seksueel overdraagbare ziekten, met inbegrip van hiv/aids;
5 de bevordering van seksuele rechten. Hieronder valt onder meer de vrije keuze voor seksuele relaties, de bestrijding van aan sekse gerelateerd geweld (*gender based violence*) en het tegengaan van verminking van vrouwelijke geslachtsorganen (FGM) en bescherming van de rechten van seksuele minderheden.

SRGR van adolescenten en jongvolwassenen wordt in de WHO-strategie niet als apart element vermeld, maar krijgt in de literatuurstudie wel specifieke aandacht.

Nederlands beleid

De uitvoering van de Cairo-agenda van de International Conference on Population and Development (ICPD) in 1994, internationale verdragen en VN-resoluties en de millenniumdoelen inzake kindersterfte (nr. 4), moedersterfte (nr. 5) en de bestrijding van hiv/aids en andere ernstige ziekten (nr. 6) vormen het internationale referentiekader voor het Nederlandse beleid.

De focusbrief ontwikkelingssamenwerking (mei 2011) stelt dat SRGR één van de vier speerpunten van het beleid is. In een nadere uitwerking van de focusbrief (mei 2011) staat dat de Nederlandse inspanningen zijn gericht op het realiseren van universele toegang tot seksuele en reproductieve gezondheid en rechten. De brief benoemt 3 impactindicatoren:

- Minder ongewenste zwangerschappen;
- Minder sterfte ten gevolge van zwangerschap en geboorte;
- Minder HIV infecties.

De brief benoemt 5 outcomes:
- Jongeren hebben betere kennis over seksualiteit, zwangerschap en HIV en kunnen zelf keuzes maken bij het aangaan van seksuele relaties, veilig vrijen en het gebruik van anticonceptie;
- De toegang tot en keuze uit kwalitatief goede anticonceptie, mannen- en vrouwencondooms, medicijnen, vaccins en andere medische middelen voor reproductieve gezondheid en HIV preventie is verbeterd;
- De kwaliteit van en de toegang tot publieke en private dienstverlening voor seksuele en reproductieve gezondheid inclusief veilige abortus en HIV/Aids is verbeterd;
- *Key populations* ondervinden minder belemmering in hun toegang tot gezondheidszorg;
- Reproductieve rechten van allen, maar in het bijzonder van vrouwen en jongeren zijn wereldwijd en in partnerlanden onder de aandacht gebracht en bespreekbaar gemaakt en meer verankerd in beleid en wet- en regelgeving.

3 Doel van de studie en onderzoeksvragen

Het doel van deze literatuurstudie is inzicht te krijgen in de samenwerking op het gebied van SRGR via het multilaterale kanaal en via publiek-private partnerschappen (PPP).

De hoofdvragen van het onderzoek zijn:
- Wat zijn de effecten van SRGR-programma's, uitgevoerd door internationale organisaties en PPP's?
  - Wat waren de outputs (beschikbaarheid van commodities; trainingen)?
  - Wat was de relevantie van het programma in termen van aanpassing aan de meest urgente problematiek?
  - Wat waren de resultaten in termen van nationale beleidsaanpassingen/legislatieve aanpassingen?
  - Wat zijn de resultaten op outcome niveau (toename toegang tot en gebruik van SRGR-dienstverlening)?
    - In hoeverre is de toegang tot preventie en dienstverlening toegenomen? In hoeverre heeft de toename betrekking op adolescenten en *key populations*?
    - In hoeverre is de kennis over SRGR toegenomen? In hoeverre heeft deze toename betrekking op adolescenten en *key populations*?
    - Wat waren de resultaten in termen van kwaliteit van de dienstverlening?
    - Wanneer een evaluatie betrekking heeft op verschillende vormen van dienstverlening: welke vorm van dienstverlening heeft tot de grootste toename in gebruik geleid?
  - Wat waren de resultaten in termen van institutionele versterking van overheid en private organisaties?
- Welke factoren zijn van invloed geweest op het al dan niet bereiken van deze effecten?

Gezien de diversiteit van de organisaties zullen niet alle vragen relevant zijn voor iedere organisatie. UNAIDS en de WHO zijn bijvoorbeeld uitvoerder noch financier van uitvoerende programma's. De vraagstelling beperkt zich bij deze twee organisaties dan tot 'aanpassing aan de meest urgente problematiek' en relevantie in termen van beleidsfocus.

4 Afbakening en aanpak van de literatuurstudie

De periode van onderzoek beslaat 2006-2011. Het onderzoek omvat alle elementen van de SRGR-strategie. Het onderzoek omvat afgeronde evaluaties van WHO, UNAIDS, UNFPA, UNICEF en het Global Fund.

4.1 UNFPA, UNICEF en het Global Fund

Voor iedere organisatie wordt een inventarisatie van evaluaties gemaakt. Per organisatie worden minimaal tien evaluaties geselecteerd. De selectiecriteria zijn: spreiding over onderwerpen van de SRGR-strategie; spreiding over zo veel mogelijk (ex)partnerlanden; en, indien beschikbaar, per organisatie minimaal twee evaluaties m.b.t. adolescenten.
De evaluaties worden eerst beoordeeld op validiteit, betrouwbaarheid en bruikbaarheid. Hierbij wordt gebruik gemaakt van het stramien dat van toepassing is op 'MFS-organisaties'. Van de kwalitatief goed beoordeelde evaluaties wordt een samenvatting gemaakt waarin de vragen, voor zover relevant, worden beantwoord. De als niet-bruikbaar gekwalificeerde evaluaties worden geschrapt. Wanneer er van de tien evaluaties minder dan zeven niet kwalificeren, wordt in overleg met IOB een aantal evaluaties vervangen. Het streven is dat de vervangende evaluatie betrekking heeft op hetzelfde onderwerp en dezelfde organisaties.

4.2 UNAIDS en WHO

De beschikbare overkoepelende evaluaties worden samengevat. Daarbij wordt vooral in kaart gebracht in hoeverre deze organisaties zich hebben gericht op de meest relevante problematiek en op '*key populations*'.

5 Product

De literatuurstudie resulteert in Engelstalig rapport dat thematisch is gestructureerd op basis van de vijf elementen van de SRGR-strategie. Een eerste concept wordt met IOB besproken en op basis van het commentaar aangepast.

6 Organisatie

Het IOB –onderzoeksteam voor de beleidsdoorlichting bestaat uit Marijke Stegeman (inspecteur) en Saskia Hesta (onderzoeksmedewerker). De literatuurstudie waarop deze ToR betrekking heeft wordt uitgevoerd door een consultant die middels een onderhandse gunning wordt gecontracteerd.

De literatuurstudie wordt, na publicatie van de beleidsdoorlichting, op de website geplaatst. De studie wordt gebruikt voor het eindrapport van de beleidsdoorlichting. De consultant krijgt inzage in het eindrapport van de beleidsdoorlichting en kan suggesties doen voor wijziging, indien van mening dat de inhoud van de literatuurstudie niet goed is weergegeven.

7 Tijdpad

De literatuurstudie vangt aan na ondertekening van het contract (oktober 2011). De werkzaamheden kunnen gespreid worden uitgevoerd. Het conceptrapport wordt uiterlijk medio juli 2012 aangeleverd.

Annex 3 Methodological issues

Key words used in the search strategy included: evaluation, monitoring, progress report, research, studies, and policies; (core themes) sexual health; maternal health; reproductive health; maternal mortality; antenatal, postnatal, prenatal, perinatal care; female genital mutilation; gender-based violence; domestic violence; HIV; AIDS; STI, STD; abortion; sexual rights; reproductive rights; contraceptives; family planning; adolescent health; access to sexual and reproductive health care services; sexuality education; reproductive health commodities; UNICEF, UNFPA, GFATM, UNAIDS, WHO.

Evaluation databases

All organizations included in the study have an online evaluation database. The websites of UNICEF and UNFPA are easily accessible and comprehensive. The UNICEF database [94] contains abstracts and access to the full text reports of evaluations, studies and surveys that are in compliance with the UNICEF Evaluation Policy (UNICEF, 2007) and the UNICEF Evaluation Report Standards (UNICEF, 2010a). Reports from 2000 onwards are available in this database and can be sorted by country (82 subcategories: 80 countries, inter-regional and intra-regional), by region (10 subcategories: 8 regions, global and multiregional), by theme (48 themes, of which 17 directly pertaining to sexual reproductive health), or by date (2000 and onwards).

The UNFPA database [95] contains all evaluation reports conducted by or for UNFPA, available to the broad public. The database is regularly updated with reports from Country Offices, Regional Offices or Headquarters Units. Reports are searchable by thematic keyword, by UNFPA mandate area, by country, language, year of the report.

The website of the GFATM provides access to the central Global Fund Library for all documents, publications, policies, guidelines etc. Publications, progress and annual reports can be found on this section. The Independent Evaluation Library page [96] makes evaluations of the Fund available, and includes *external studies* led by a wide range of different stakeholders, but also studies and descriptive *papers produced internally* by the Global Fund. These documents address diverse aspects of the different *mechanisms* and *processes* of the Global Fund. The documents included are classified according to four broad subject-headings: Evaluation Framework, Integrated Evaluations of GFATM, Global Fund Specific Evaluations, Information and Position Papers.

The UNAIDS database[97] provides access to resources, including policies, UNAIDS corporate publications and documents. Though there is no separate page for evaluations, the website offers access to progress, and other UNAIDS reports. The archive dates back to documents from 1997 and onwards.

94 http://www.unicef.org/evaldatabase/.
95 http://web2.unfpa.org/public/about/oversight/evaluations/home.unfpa.
96 http://www.theglobalfund.org/en/documents/integratedevaluations/
97 http://www.unaids.org/en/resources/.

The website of WHO[98] does not offer a separate page for (external) evaluations, though provides access to numerous publications on health topics (studies, guidelines, tools, position papers, policy briefs and so on).

Overview selected evaluations

Table 12 The 26 selected studies (thematic area/organisation)			
Thematic area	**UNICEF**	**UNFPA**	**GFATM**
Maternal / perinatal health	1	8	1
Family planning	-	1	-
Unsafe abortions	-	-	-
STIs, including HIV	3	1	3
Reproductive rights, sexual health, gender issues and GBV	1	2	-
Adolescent SRHR	2	1	2
TOTAL	**7**	**13**	**6**

Table 13 The eligible and selected evaluations, for three organisations						
Thematic area	**UNICEF**		**UNFPA**		**GFATM**	
	Eligible	Selected	Eligible	Selected	Eligible	Selected
Maternal / perinatal health	1	1	23	8	1	1
Family planning	-	-	1	1	-	-
Unsafe abortions	-	-	-	-	-	-
STIs, including HIV	4	3	1	1	11	3
RR, SH, gender issues and GBV	3	1	9	2	-	-
Adolescent SRHR	2	2	3	1	3	2
TOTAL	**10**	**7**	**37**	**13**	**15**	**6**

The table below presents an overview of the *main* documents, consulted for this review, pertaining to policy and technical documents, strategies and guidelines as developed/ coordinated by UNAIDS and WHO.

98 http://www.who.int/.

Table 14 Overview of UNAIDS and WHO studies, reports, policy documents	
Maternal / perinatal health	**UNAIDS** • (2003) HIV and infant feeding • (2008) HIV, Food security and nutrition • (2010) Global plan to eliminate new HIV infections among children by 2015 and keeping their mothers alive • (2011) Promising practices in community engagement for elimination of new HIV infections among children by 2015 and keeping their mothers alive **WHO** • (2007) Standards for Maternal and Neonatal care • (2007) Malaria In Pregnancy. Guidelines for Measuring key M&E Indicators • (2009) Maternal and Child Health in Namibia • (2010) Caesarean section without medical indication increase risk of short-term adverse outcomes for women • (2010) Working with Individuals, Families and Communities to Improve Maternal and Newborn Health • (2011) Kesho Bora Study. Preventing mother-to-child transmission of HIV during breastfeeding • (2012) Countdown to 2015. Maternal, Newborn& Child Survival. • (2012) Trends in Maternal Mortality: 1990 to 2010 • (2012) Every Women, Every Child: from commitment to action
Family planning	**WHO** • (2011) Family planning. A global handbook for providers (update from 2007)
Unsafe abortions	**WHO** • (2012) Safe and unsafe induced abortion. Global and regional levels in 2008, and trends during 1995-2008 • (2012) Safe abortion: technical and policy guidelines for health systems
STIs, including HIV	**UNAIDS** • (2004) Ensuring equitable access to ART for women • (2004) HIV testing policy for uniformed peacekeepers • (2004) Reduction of HIV transmission in prisons • (2004) Policy statement on HIV testing • (2004) Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention • (2005) Intensifying HIV prevention • (2005) Antiretroviral therapy and injecting drug users • (2006) HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings • (2009) Making condoms work for HIV prevention (update 2004 paper) • (2011) Using TRIPS flexibilities to improve access to HIV treatment **WHO** • (2009) Sexual and Reproductive Health and HIV. Linkages: evidence review and recommendations • (2011) Global health sector strategy on HIV/AIDS 2011-2015 • (2011) Global HIV/AIDS response. Epidemic update and health sector progress towards Universal Access. Progress Report 2011 • (2011) Reproductive choices and family planning for people living with HIV: counselling tool • (2012) Global incidence and prevalence of selected curable transmitted infections – 2008

Table 14 Overview of UNAIDS and WHO studies, reports, policy documents

Reproductive rights, sexual health, gender issues and GBV	**UNAIDS** • (2003) UNAIDS Reference Group on HIV/AIDS and Human Rights • (2004) Ensuring equitable access to antiretroviral treatment for women • (2005) Sexual and Reproductive Health & HIV/AIDS: A framework for priority linkages • (2006) HIV and sex between men • (2006) Meeting the SRH needs of people living with HIV • (2007) HIV and Refugees • (2007) Greater involvement of People Living with HIV (GIPA) • (2008) Criminalization of HIV Transmission • (2008) HIV and International Labour Migration • (2008) UNAIDS Legal and Regulatory Self-Assessment Tool for Male Circumcision in Sub-Saharan Africa • (2009) Policy statement on HIV testing and counseling in Health Facilities fro refugees, Internally Displaced Persons and other Persons of concern to UNHCR • (2009) WHO, UNODC, UNAIDS Technical Guide for countries to set targets fro HIV prevention, treatment and care for IDUs • (2011) The report of the UNAIDS Advisory Group on HIV and Sex Work • (2011) UNAIDS guidance for partnerships with civil society, including people living with HIV and key populations **WHO** • (2002) Integrating gender perspectives in the work of WHO: WHO gender policy • (2005) Addressing violence against women and achieving the MDGs • (2005) WHO Multi-country Study on Women's Health and Domestic Violence against Women • (2008) Eliminating Female Genital Mutilation. An Interagency Statement • (2009) Evaluation of the WHO training initiative Transforming health systems: gender and rights in RH 1997-2007 • (2010) Developing sexual health programmes. A framework for action • (2011) Developing sexual health programmes • (2011) Human Rights and Gender Equality in Health Sector Strategies. How to assess policy coherence • (2011) An update on WHO's work on FGM • (2011) Gender mainstreaming in WHO: what is next? Report of the midterm review of WHO gender strategy
Adolescent SRHR	**UNAIDS** • (2009) Operational plan for UNAIDS framework: Addressing women, girls, gender equality and HIV **WHO** • (2011) The sexual and reproductive health of young adolescents in developing countries: reviewing the evidence, identifying research gaps and moving the agenda

[99] Country studies in: DRC, Ethiopia, Swaziland, Kazakhstan, Ukraine, Iran, India, Indonesia, Vietnam, Peru, Haiti.

Table 14 Overview of UNAIDS and WHO studies, reports, policy documents

Other	**UNAIDS** • (2001) The Five-Year Evaluation of UNAIDS • (2002) Preventing the transmission of HIV among drug abusers • (2004) Support to mainstreaming AIDS in development • (2005) Disability and HIV • (2005) Mainstreaming AIDS in development instruments and process at the national level • (2009) Disability and HIV • (2009) UNAIDS. Preparation for the future • (2009) Towards universal access: scaling up priority HIV/AIDS interventions in the health sector. Progress Report 2009 • (2010) Global HIV Prevention Progress Report Card 2010 • (2009) Second Independent Evaluation[99] • (2009) Comprehensive External Evaluation of the National AIDS response in the Ukraine • (2010) Evaluation of the Joint UNDP/WB/UNAIDS programme on mainstreaming AIDS into national development plans and processes • (2011) Political declaration on HIV and AIDS: Intensify Our Efforts to Eliminate HIV and AIDS • (2012) AIDS dependency crisis, sourcing African solutions **WHO** • (2004) Strategy Reproductive Health • (2007) Research issues in SRH for LMICs • (2007) Introducing WHO's SRH guidelines and tools into national programmes • (2007) M&E of Maternal and Newborn Health and Services at the District Level • (2007) The WHO Strategic Approach to strengthening SRH policies and programmes • (2007) Global strategy for the prevention and control of sexually transmitted infections: 2006-2015. Breaking the chain of infection • (2008) External evaluation 2003-2007 HRP • (2009) Achieving MDG 5: target 5A and 5B on reducing maternal mortality and achieving universal access to RH (briefing note) • (2009) Sexual and Reproductive Health. Mid-term Strategic Plan 2010-2015 and Programme Budget 2010-2015 • (2009) Mental health aspects of women's reproductive health • (2009) Biennial Report of HRP 2008-2009 • (2010) Global Strategy for Women's and Children's Health • (2010) Joint country support. Accelerated implementation of maternal and newborn continuum of care as part of improving RH. Mapping of in-country activities • (2010) Packages of Interventions for Planning, Safe Abortion Care, Maternal Guidelines on abortion care • (2010) Reproductive health strategy to accelerate progress towards the attainment of international development goals and targets • (2010) WHO's strategic vision in Sexual and Reproductive Health and Rights. Business Plan 2010-2015 • (2011) Universal access to RH. Accelerated actions to enhance progress on MDG 5 through advancing Target 5B • (2011) Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people • (2011) Guidelines for intensified tuberculosis case-finding and isoniazid preventive therapy for people living with HIV in resource-constrained settings • (2011) HRP Biennial Technical Report 2009-2010 • (2012) Guidance on couples HIV testing and counselling – including antiretroviral therapy for treatment and prevention in serodiscordant couples • (2012) Guidance on oral pre-exposure prophylaxis (PrEP) for serodiscordant couples, men and transgender women who have sex with men at high risk of HIV • (2012) WHO policy on collaborative TB/HIV activities: guidelines for national programmes and other stakeholders

Annex 4 Quality assessment

The selection of eligible evaluations included a two-step quality check. First eligible evaluations were assessed drawing from the organizations' internal quality assurance processes:

- The Evaluation Quality Assessments (EQAs) conducted by the Division for Oversight Services (DOS) of the Evaluation Branch of UNFPA. For the majority of the UNFPA evaluations included in this review such a report was available. In addition, information from the 2012 'Quality assessment of UNFPA decentralised country programme evaluation' was used, in particular the evaluation of the countries included in the current review.
- UNICEF developed the 'UNICEF Evaluation Report Standards' for internal assessment of evaluations and studies. These Standards are used by the UNICEF Evaluation Office to assess evaluations, valuation of the study by external resource persons. The Standards are drawn from, and are complementary to, key references on standards in evaluation design and process increasingly adopted in the international evaluation community.
- In case of GFATM, the Technical Evaluation Reference Group (TERG) is responsible for providing independent advice, assessment and oversight for the Fund's work on Monitoring and Evaluation. No specific information is given on the (internal) quality assessment Standards and/or procedures for evaluations.

Also, each evaluation included in the review was subject to a quality assessment conducted by the evaluator. For this a quality assessment tool (evaluation scorecard) was developed based on the criteria following the *Evaluation policy and guidelines for evaluations* (IOB/MFA, 2009a). See Table 15 for the evaluation scorecard, and Table 16 for an overview of the scores per evaluation.

Table 15	Evaluation score card
1	**Validity**
1.1	Statement of the problem
1.1.1	*Clarity of the problem statement and elaboration of the research questions*
1.1.2	*Definition of the evaluation criteria*
1.2	Object of evaluation
1.2.1	*Definition, demarcation of the object of evaluation*
1.2.2	*Positioning of the object of evaluation in the policy and institutional context*
1.3	Policy theory
1.3.1	*Reconstruction of intervention logic and levels of results*
1.3.2	*Operationalization / indicators*
1.4	Analysis
1.4.1	*Sources of data, collection and processing of data*
1.4.2.	*Justification of conclusions based on findings*
2	**Reliability**
2.1	Research methods
2.1.1	*Specification and justification of the research methods*
2.1.2	*Verification of results / Triangulation*
2.2	Scope
2.2.1	*Representativeness of the sample, selection of case study*
2.2.2	*Acknowledgement of limitations*
2.3	Independence
2.3.1	*Of data sources*
2.3.2	*Of researchers / evaluators*
2.4	Conduct of the research and quality control
2.4.1	*Justification of the conduct of the research*
2.4.2	*Quality control via internal or external supervision*
3	**Feasibility**
3.1	Presentation
3.1.1	*Clarity of the objectives*
3.1.2	*Accessibility of the results*
3.2	Linkages
3.2.1	*Conclusions in line with research questions*
3.2.2	*Feasibility of lessons learned, recommendations*

Table 16 Scores per organisation	
Organization, country, thematic focus, authors, year)	**Score 1 = below 2 = average 3 = fair 4 = good**
UNICEF Sudan (H&N), *Hongyi XU and Bayoumi A (2009)*	2.95
UNICEF Tanzania (National HIV response), *GoZ/ZAC (2007)*	2.90
UNICEF Global (AIDS Campaign), *Schlangen R and Jones A (2010)*	2.55
UNICEF Mozambique (NGO-Government partnership), *Tuominen M et al. (2010)*	2.30
UNICEF Senegal (GBV), *Macro International Inc. (2010)*	2.25
UNICEF Namibia (Life skills), *Chandan et al (2008)*	2.70
UNICEF Global (Adolescents), *Peebles D, et al (2010)*	2.90
UNFPA Eritrea (Safe motherhood), *MolzanTuran J (2007)*	2.55
UNFPA Uganda (Obstetric fistula), *Creanga A, et al (2008)*	3.60
UNFPA Bolivia (CPE), *Chambel A, et al (2011)*	3.50
UNFPA Mali (CPE), *Lougue H (2011)*	3.50
UNFPA Pakistan (CPE), *Thaver I (2011)*	3.35
UNFPA Rwanda (CPE), *Centre for Sustainable Development (2012)*	3.75
UNFPA Tanzania (CPE), *Arowolo O, et al (2010)*	3.50
UNFPA Global (Commodity security), *Chatttoe-Brown A, et al (2012)*	3.00
UNFPA Bangladesh (Cervical cancer), *Basu P, et al (2008)*	2.00
UNFPA Global (Gender), *Universalia (2010)*	2.70
UNFPA Global (Dignity kits), *UNFPA/Abbott L, et al (2011)*	3.35
UNFPA Global (Maternal Health), *UNFPA (2012)*	3.75
UNFPA Tanzania (Youth Alliance), *JSI (2007)*	3.80
GFATM Ethiopia (HSS), *EHNRI (2008)*	2.65
GFATM Ethiopia (National response to HIV), *EHNRI, (2008a)*	3.00
GFATM Tajikistan (PLHIV), *Van Rompaey S, et al (2010)*	2.25
GFATM Kenya (OVC), *Pfleiderer R, et al (2010)*	2.55
GFATM Bangladesh (Community readiness), *ICDDR,B (2007)*	2.70
GFATM Bangladesh (Life skills/male youth), *Population Council (2007)*	2.90
Average	2.96

Annex 5 Interventions and strategies for delivery in PHC

Table 17 Interventions and strategies for delivery in PHC

	Recommended for inclusion in various settings	Relevant effect estimate
Low-dose aspirin in pregnancy	Expanded antenatal package (for at risk women)	17% reduction in risk of proteinuric pre-eclampsia; reduced fetal and neonatal deaths; and reduced risk of birth <37 weeks.
Calcium supplementation during pregnancy	Expanded antenatal package (universal in populations with low calcium intake)	Reduced risk of high blood pressure as well as pre-eclampsia; routine calcium supplementation in pregnancy with low baseline dietary calcium intake is associated with reduced maternal death or serious morbidity.
Referral for skilled care including oxytocic use and active management of third stage of labour for prevention of PPH; caesarean as indicated	Universal in first-level facilities	Prophylactic oxytocin showed benefits or reduced blood loss compared with no uterotonics; active vsexpectant management of labour reduces the risk of severe PPH; benefit of emergency referral and caesarean for obstructed labour and maternal complications well established with evidence that provision and strengthening of emergency obstetric care services can increase use; oral or sublingual misoprostol compared with placebo was effective in reducing severe PPH and blood transfusion; however, compared with conventional injectable uterotonics, oral misoprostol was associated with higher risk of severe PPH.
Antibiotics for preterm, premature rupture of membranes	Universal in first-level facilities	Significant reduction in chorioamnionitis; reduction in the numbers of preterm births within the next 7 days and markers of neonatal morbidity, such as infection.
Continuity of care between trained traditional birth attendants, midwives and doctors	Universal	Reduced likelihood of hospitalisation antenatally for complications and reduced risk of apgar score <7 at 1 min.
Magnesium sulphate for pre-eclampsia	Universal in first-level referral facilities	41% reduction in the risk of maternal death after eclampsia with use of magnesium sulfate compared with diazepam, and fewer infants with apgar scores <7 at 5 min.
Training traditional birth attendants for basic newborn care and referrals to health system	Situational	Reduction in number of stillbirths, perinatal death rate and neonatal mortality. Maternal referral rates were significantly higher with reduced rates of post-partum haemorrhage.

Table 17 Interventions and strategies for delivery in PHC

	Recommended for inclusion in various settings	Relevant effect estimate
Maternal mental-health interventions	Universal	Evidence of maternal empowerment and use of reproductive health services; improved maternal mental-health outcomes including reduced rates of post-partum depression and child development in infancy.
Antenatal steroids for those at risk of preterm births	Universal in first-level facilities	Overall reduction in neonatal mortality and reduced systemic infections in the first 48 h of life and reduced risk of respiratory distress syndrome.
Kangaroo Mother Care (KMC)	Situational	In South Africa, 78 hospitals participating in the KMC programme and with monitoring reported reduction in neonatal mortality versus historical controls or those with no KMC; KMC was associated with reduced risks of nosocomial infection at 41 weeks corrected gestational age, severe illnesses, lower respiratory tract disease at 6 months follow-up, not exclusively breastfeeding at discharge.
Community Treatment of infections (including antibiotics for pneumonia and sepsis)	Situational	Treatment of neonatal pneumonia by community health workers was associated with reduction in all causes of mortality of 27% (18-35%) and pneumonia-specific mortality by 42% (22-57%); 50% reduction in neonatal deaths reported with domiciliary use of antibiotics in one community trial and 76% reduction in infection-related mortality.
Possible basic neonatal resuscitation strategies for health facilities and in community settings	Situational	A large-scale facility-based intervention with resuscitation training indicated that the incidence of mild birth asphyxia decreased by 60%, from 14% in the observation year (1995 to 1996) to 6% in the intervention years; case fatality in neonates with severe asphyxia decreased by 47.5%, from 39% to 20% and asphyxia-specific mortality rate by 65%, from 11% to 4%; similar benefits were seen in Macedonia with neonatal resuscitation training in health system settings; a systematic review showed slightly better survival rates at follow-up with the use of air versus 100% oxygen for resuscitation; domiciliary neonatal resuscitation by community health workers reduced the asphyxia-specific mortality rate by 67%.
Insecticide-treated bednets	Situational	Reduction in all-cause child mortality.
IPTi and IPT	Situational	During the first year of life, intermittent sulfadoxine-pyrimethamine treatment reduced the incidence of clinical malaria by 22.2% and the hospitalisation by 19%; IPTi reduced the incidences of malaria and severe anaemia by 22.5% and 23.6%, respectively.

Table 17 Interventions and strategies for delivery in PHC

	Recommended for inclusion in various settings	Relevant effect estimate
Prevention and treatment of severe acute malnutrition in affected children	Situational	Facility-based management indicates reduction in mortality by at least 55%; observational data suggest that survival rates are probably higher in community settings and that community-based management strategies are more acceptable to families.
Continued care and rehabilitation of undernourished children	Situational	Follow-up of children after treatment for severe acute malnutrition; some evidence from intervention studies of benefit of combined stimulation and nutrition rehabilitation.
Early child development interventions	Universal	Although large-scale community-based trials are lacking, there is strong evidence that early childhood development interventions have significant benefit.
Road traffic injury or accident prevention strategies	Universal	Maybe potentially important but the evidence of the efficacy of preventive strategies (including legislation and community education) is weak with very few data from developing countries; some studies with historical controls suggest 17-26% reduction in injuries.

RR=relative risk. SGA=small for gestational age. PPH=post-partum haemorrhage. IPT=intermittent preventive treatment for malaria. IPTi=IPT in infants. Source: adapted from Bhutta A, et al. (2008).

Table 18 Additional delivery and demand-creation strategies

	Target populations and interventions	Impact estimates
Mass-media strategies (including print and electronic media)	Communities and populations; promotion of key MNCH behaviours and uptake of interventions.	Almost all of the studies in this systematic review concluded that mass media were effective; the direction of effect was also consistent across studies towards the expected change.
Social marketing strategies and health promotion, including health days and special campaigns	Social marketing to complement mass-media strategies for several interventions including health-service schemes and use of contraceptives, especially in reproductive health.	The effectiveness of social marketing strategies has varied between various programmes; in particular, impact has been demonstrated on behaviours, such as smoking and alcohol consumption rates, but more objective data is needed; meta-analysis of 93 studies found that in disease prevention messages, gain-framed appeals that emphasise the advantages of compliance with the communicator's recommendation are more persuasive than loss-framed appeals that emphasise the disadvantages of non-compliance.
Strategies to reduce user fees	Investigation of the effects of user fees on care use, and the effect of fee reduction.	Although some studies suggest that introduction of user fees was not associated with reduced service use, reduction or elimination of user fees coupled with strategies for ensuring quality increases use of services.
Conditional Cash Transfers (CCTs)	A range of CCT projects, including Colombia, Mexico, and Nicaragua.	Reduced stunting rates in PROGRESA (Mexico); an increase of 16% in mean growth rate per year corresponding to 1 cm increase in height per year; reduced prevalence of stunting by 10% in 12-36 months age group and overall decline in stunting from 41.9% to 37.1% over 2 years.
Microcredit or voucher schemes	Microcredit programmes and voucher schemes to improve maternal health.	In a cross-sectional study from Kerala, India, early joiners of a microcredit programme in India, known as self-help groups, were less likely to report emotional stress and poor life satisfaction compared with non-members.
Community mobilisation through support groups	Community support groups providing support for care seeking and linkages with the health system.	The overall effect of community support groups on MNCH-related behaviours and newborn mortality seems positive; comparable trends are also evident on reduction in perinatal mortality.

Source: adapted from Bhutta A, et al. (2008).

Annex 6 Adolescent SRH

Text Box 3 *Key facts on adolescents*[100]

- Close to 20% (1.2 billion) of the world population is between 10 and 19 years old. More than half of them live in Asia. In absolute numbers, India is home to more adolescents – around 243 million – than any other country; followed by China (200 million). The largest proportion of adolescents however is found in sub-Saharan Africa where 23% of the population is between 10 and 19 years old. In industrialized countries adolescents make up 12% of the population, compared to 19% in developing countries.
- Some 71 million children of lower secondary school age are not in school, and 127 million youth between the ages of 15 and 24 are illiterate, the vast majority of them in South Asia and sub-Saharan Africa. Rates of secondary school enrolment, literacy and employment in most regions are lower among girls and young women than among boys and young men.
- Nearly one in every four adolescent girls aged 15-19 in the developing world (excluding China) is currently married or in union. In South Asia, nearly one in every three adolescent girls aged 15-19 is married or in union, compared to 1 in 14 in Central and Eastern Europe and the Commonwealth of Independent States (CEE/CIS).
- Yearly 1.4 million adolescents die from road traffic injuries, complications of childbirth, suicide, violence, AIDS and other causes. Causes of adolescent death vary by region, and mortality patterns are associated with sex. In Latin America, injuries (including homicide) are the leading cause of death among adolescent boys; in Africa, complications of pregnancy and childbirth are the leading cause among adolescent girls aged 15-19.
- Despite the decline in the overall birth rate in the developing world, adolescent birth rates remain high. Globally, each year around 16 million girls aged 15-19 give birth, accounting for around 11% of all births. Approximately 95% of adolescent births occur in low- and middle-income countries. At 123 births per 1,000 sub-Saharan Africa today has the highest adolescent birth rate, and this has shown almost no decline since 1990. Bangladesh, India and Nigeria alone account for one in every three of the world's adolescent births. Countries of Latin America and the Caribbean and sub-Saharan Africa have the highest proportion of adolescent births with 1 in 5 babies being born to an adolescent mother.
- The youngest mothers are the most likely to experience complications and die of pregnancy-related causes. Girls 15-19 years old account for around 14% of all maternal deaths (50,000) annually.[101]
- Around 75% of adolescent mothers in developing countries receive antenatal care, a level similar to that of all women aged 15-49 in those countries. Only about half of adolescent mothers (53%) deliver with the assistance of skilled health personnel, quite similar to the proportion of all mothers delivering with the assistance of skilled health personnel (54%). China excluding, these figures reflect the low coverage of basic health services in developing countries.

[100] All information and data in this box is adapted from: UNICEF (2012). *Progress for Children. A report card on Adolescents.*

[101] The UNICEF 'Global Card' does not provide figures on unintended pregnancies and abortion. Data from *Facts on the SRH of Adolescent Women in the Developing World* (Guttmacher, 2010): 2.7 million unintended pregnancies among 15 to 19 year old in South Central and Southeast Asia; 2.2 million in SSA; 1.2 million in LAC. Adolescents (15 to 19 year old) account for 14% of all unsafe abortions that occur in the developing world. In Sub-Saharan Africa, the proportion is 25%.

- More than one third of girls aged 15-19 (in 21 out of 41 countries with data) are anaemic. Anaemia, most commonly iron-deficiency anaemia, increases the maternal risk of haemorrhage and sepsis during childbirth. It is a severe public health problem in 16 countries; the largest number of cases being found in India, where more than half of girls aged 15-19 are anaemic. In Africa, anaemia prevalence is highest in Mali, where more than two thirds of girls aged 15-19 are anaemic.
- An estimated 2.2 million adolescents (aged 10-19), around 60% of them girls, are living with HIV, and many do not know they are infected. Of these 1.8 million live in sub-Saharan Africa. Overall, the levels of correct knowledge about HIV among older adolescents aged 15-19 remains low, with fewer girls having correct knowledge than boys. Many adolescents aged 15-19 know where HIV testing is offered; yet they are unlikely to take advantage of these services.
- Among adolescents 15-19 years old in the developing world (excluding China), a higher percentage of girls (11%) than boys (5%) had sex before the age of 15. This pattern is seen in all regions with available data. In Latin America and the Caribbean, 17% of girls had sex before the age of 15. Early sex can result in early childbearing, and it increases the risk of HIV infection. In Eastern and Southern Africa, one of the greatest risk factors for 10-14-year-olds, both boys and girls, is unsafe sex, which sets this region apart from the others in terms of key risk factors for this younger age group. Unsafe sex is the most common risk factor for 15-24-year-olds in this region, but the risk for females is nearly double that for males.
- Global averages of condom use remain low. In only three countries with an adult HIV prevalence above 5% – Lesotho, where adult HIV prevalence is 23.6%, Namibia (13.1%) and Swaziland (25.9%) – the level of condom use at the last high-risk sex encounter is 60% or more for both adolescent boys and adolescent girls aged 15-19. One quarter of the young married women have an unmet need for family planning[102].
- Large proportions of adolescent girls aged 15-19 have experienced sexual violence, and domestic violence is common among adolescent girls who are in relationships. Approximately 150 million girls and 73 million boys under age 18 experienced sexual violence and exploitation in 2002 (most recent data available). Intimate partner violence, the most common form of violence against women in developing countries, occurs frequently in adolescent relationships. A 2005 WHO study on women's health and domestic violence found that adolescent girls aged 15-19 were more likely than older women (aged 45-49) to have experienced partner violence. In surveys in the DRC, 70% of adolescent girls aged 15-19 who had ever been married reported having experienced violence at the hands of a current or former partner or spouse. Because of reporting bias, this may be an underestimation of the true size of the problem in this and other countries. Adolescents with disabilities are at increased risk of violence and sexual abuse.

[102] Facts on the SRH of Adolescent Women in the Developing World (Guttmacher, 2010) suggests that 15% of unmarried adolescent women in Sub- Saharan Africa that are sexually active want to prevent pregnancy, as are 11% of those in Latin America and the Caribbean (LAC). About half of all sexually active adolescent women in these two regions who want to prevent pregnancy are unmarried. A bit more than half (54%) of the married adolescents in LAC who do not want a pregnancy are using a modern contraceptive method, as compared to 32% in South Central and Southeast Asia, and 21% in Sub-Saharan Africa.

Table 19 The sexual behaviour of African adolescents

	High		Low	
	Male	Female	Male	Female
Sex before age of 15	Mozambique (27%) Kenya (22%)	Niger (26%) Mali (24%)	Ethiopia (2%) Ghana (4%)	Rwanda (5%) Zimbabwe (5%)
Marriage before age of 15	-	Niger (28%)	-	Rwanda (0.2%)
Sexual activity of never-married adolescents in the past year	Mozambique (55%)	Liberia (60%)	Ethiopia (4%) Rwanda (5%)	Niger (0.8%)
Multiple sexual partners in the past year (15-19 year)	Ivory Coast (32%)	Liberia (12%)	Ethiopia (4%)	Ethiopia, Niger (0.4%)
Partner 10 or more years older in the past year	-	Zimbabwe (13%)	-	Ethiopia, Niger (0.1%)
Condom use at last sex	Namibia (81%)	Namibia (67%)	Madagascar (8%)	Madagascar (5%)
Pregnancy	-	Niger (39%)	-	Rwanda (4%)
HIV test in the past year	Kenya (23%)	Lesotho (49%)	Ghana (0%)	Niger (0.9%)
Adult support for condom education for 12-14 year-olds	Namibia (84%, both sexes)		Nigeria (47%, both sexes)	

Adapted from: Doyle A, 2012.

Evaluation reports of the Policy and Operations Evaluation Department (IOB) published 2008-2013

Evaluation reports published before 2008 can be found on the IOB website: www.government.nl/foreign-policy-evaluations.

IOB no.	Year	Title evaluation report	ISBN
385	2013	Economic diplomacy in practice: An evaluation of Dutch economic diplomacy in Latin America	978-90-5328-446-9
384	2013	Achieving universal access to sexual and reproductive health and rights: Synthesis of multilateral contribution to advancing sexual and reproductive health and rights (2006-2012)	978-90-5328-445-2
383	2013	NGOs in action: A study of activities in sexual and reproductive health and rights by Dutch NGOs	978-90-5328-444-5
382	2013	Op zoek naar nieuwe verhoudingen. Evaluatie van het Nederlandse buitenlandbeleid in Latijns-Amerika	978-90-5328-443-8
381	2013	Balancing Ideals with Practice: Policy evaluation of Dutch involvement in sexual and reproductive health and rights 2007-2012	978-90-5328-442-1
380	2013	Linking Relief and Development: More than old solutions for old problems?	978-90-5328-441-4
379	2013	Investeren in stabiliteit. Het Nederlandse fragiele statenbeleid doorgelicht	978-90-5328-440-7
378	2013	Public private partnerships in developing countries. Systematic literature review	978-90-5328-439-1
377	2013	Corporate Social Responsibility: the role of public policy. A systematic literature review of the effects of government supported interventions on the corporate social responsibility (CSR) behaviour of enterprises in development countries	978-90-5328-438-4
376	2013	Renewable Energy: Access and Impact. A systematic literature review of the impact on livelihoods of interventions providing access to renewable energy in developing countries	978-90-5328-437-7
375	2013	The Netherlands and the European Development Fund – Principles and practices. Evaluation of Dutch involvement in EU development cooperation (1998-2012)	978-90-5328-436-0
374	2013	Working with the World Bank. Evaluation of Dutch World Bank policies and funding 2000-2011	978-90-5328-435-3
373	2013	Evaluation of Dutch support to human rights projects. (2008-2011)	978-90-5328-433-9

372	2013	Relations, résultats et rendement. Évaluation de la coopération au sein de l'Union Benelux du point de vue des Pays-Bas	978-90-5328-434-6
372	2012	Relaties, resultaten en rendement. Evaluatie van de Benelux Unie-samenwerking vanuit Nederlands perspectief	978-90-5328-431-5
371	2012	Convirtiendo un derecho en práctica. Evaluación de impacto del programa del cáncer cérvico-uterino del Centro de Mujeres Ixchen en Nicaragua (2005-2009)	978-90-5328-432-2
371	2012	Turning a right into practice. Impact evaluation of the Ixchen Centre for Women cervical cancer programme in Nicaragua (2005-2009)	978-90-5328-429-2
370	2012	Equity, accountability and effectiveness in decentralisation policies in Bolivia	978-90-5328-428-5
369	2012	Budgetsupport: Conditional results – Policy review (2000-2011)	978-90-5328-427-8
369	2012	Begrotingssteun: Resultaten onder voorwaarden – Doorlichting van een instrument (2000-2011)	978-90-5328-426-1
368	2012	Civil Society, Aid, and Development: A Cross-Country Analysis	979-90-5328-425-4
367	2012	Energievoorzieningszekerheid en Buitenlandbeleid – Beleidsdoorlichting 2006-2010	979-90-5328-424-7
366	2012	Drinking water and Sanitation – Policy review of the Dutch Development Cooperation 1990-2011	978-90-5328-423-0
366	2012	Drinkwater en sanitaire voorzieningen – Beleidsdoorlichting van het OS-beleid 1990-2011	978-90-5328-422-3
365	2012	Tactische diplomatie voor een Strategisch Concept – De Nederlandse inzet voor het NAVO Strategisch Concept 2010	978-90-5328-421-6
364	2012	Effectiviteit van Economische Diplomatie: Methoden en Resultaten van onderzoek.	978-90-5328-420-9
363	2011	Improving food security: A systematic review of the impact of interventions in agricultural production, value chains, market regulation, and land security	978-90-5328-419-3
362	2011	Methodische kwaliteit van Programma-evaluaties in het Medefinancieringsstelsel-I 2007-2010	978-90-5328-418-6
361	2011	Evaluatie van de Twinningfaciliteit Suriname-Nederland	978-90-5328-417-9
360	2011	More than Water: Impact evaluation of drinking water supply and sanitation interventions in rural Mozambique	978-90-5328-414-8
359	2011	Regionaal en geïntegreerd beleid? Evaluatie van het Nederlandse beleid met betrekking tot de Westelijke Balkan 2004-2008	978-90-5328-416-2
358	2011	Assisting Earthquake victims: Evaluation of Dutch Cooperating aid agencies (SHO) Support to Haiti in 2010	978-90-5328-413-1
357	2011	Le risque d'effets éphémères: Évaluation d'impact des programmes d'approvisionnement en eau potable et d'assainissement au Bénin	978-90-5328-415-5

357	2011	The risk of vanishing effects: Impact Evaluation of drinking water supply and sanitation programmes in rural Benin	978-90-5328-412-4
356	2011	Between High Expectations and Reality: An evaluation of budget support in Zambia	978-90-5328-411-7
355	2011	Lessons Learnt: Synthesis of literature on the impact and effectiveness of investments in education	978-90-5328-410-0
354	2011	Leren van NGOs: Studie van de basic education activiteiten van zes Nederlandse NGOs	978-90-5328-409-4
353	2011	Education matters: Policy review of the Dutch contribution to basic education 1999–2009	978-90-5328-408-7
352	2011	Unfinished business: making a difference in basic education. An evaluation of the impact of education policies in Zambia and the role of budget support.	978-90-5328-407-0
351	2011	Confianza sin confines: Contribución holandesa a la educación básica en Bolivia (2000-2009)	978-90-5328-406-3
350	2011	Unconditional Trust: Dutch support to basic education in Bolivia (2000-2009)	978-90-5328-405-6
349	2011	The two-pronged approach Evaluation of Netherlands Support to Primary Education in Bangladesh, 1999-2009	978-90-5328-404-9
348	2011	Schoon schip. En dan? Evaluatie van de schuldverlichting aan de Democratische Republiek Congo 2003-2010 (Verkorte samenvatting)	978-90-5328-403-2
347	2011	Table rase – et après? Evaluation de l'Allègement de la Dette en République Démocratique du Congo 2003-2010	978-90-5328-402-5
346	2011	Vijf Jaar Top van Warschau. De Nederlandse inzet voor versterking van de Raad van Europa	978-90-5328-401-8
345	2011	Wederzijdse belangen – wederzijdse voordelen. Evaluatie van de Schuldverlichtingsovereenkomst van 2005 tussen de Club van Parijs en Nigeria. (Verkorte Versie)	978-90-5328-398-1
344	2011	Intérêts communs – avantages communs. Evaluation de l'accord de 2005 relatif à l 'allègement de la dette entre le Club de Paris et le Nigéria. (Version Abrégée)	978-90-5328-399-8
343	2011	Wederzijdse belangen – wederzijdse voordelen. Evaluatie van de schuldverlichtingsovereenkomst van 2005 tussen de Club van Parijs en Nigeria. (Samenvatting)	978-90-5328-397-4
342	2011	Intérêts communs – avantages communs. Evaluation de l'accord de 2005 relatif à l'allègement de la dette entre le Club de Paris et le Nigéria. (Sommaire)	978-90-5328-395-0
341	2011	Mutual Interests – mutual benefits. Evaluation of the 2005 debt relief agreement between the Paris Club and Nigeria. (Summary report)	978-90-5328-394-3
340	2011	Mutual Interests – mutual benefits. Evaluation of the 2005 debt relief agreement between the Paris Club and Nigeria. (Main report)	978-90-5328-393-6
338	2011	Consulaire Dienstverlening Doorgelicht 2007-2010	978-90-5328-400-1

337	2011	Evaluación de las actividades de las organizaciones holandesas de cofinanciamiento activas en Nicaragua	
336	2011	Facilitating Resourcefulness. Synthesis report of the Evaluation of Dutch support to Capacity Development	978-90-5328-392-9
335	2011	Evaluation of Dutch support to Capacity Development. The case of the Netherlands Commission for Environmental Assessment (NCEA)	978-90-5328-391-2
-	2011	Aiding the Peace. A Multi-Donor Evaluation of Support to Conflict Prevention and Peacebuilding Activities in Southern Sudan 2005 - 2010	978-90-5328-389-9
333	2011	Evaluación de la cooperación holandesa con Nicaragua 2005-2008	978-90-5328-390-5
332	2011	Evaluation of Dutch support to Capacity Development. The case of PSO	978-90-5328-388-2
331	2011	Evaluation of Dutch support to Capacity Development. The case of the Netherlands Institute for Multiparty Democracy (NIMD)	978-90-5328-387-5
330	2010	Evaluatie van de activiteiten van de medefinancieringsorganisaties in Nicaragua	978-90-5328-386-8
329	2010	Evaluation of General Budget Support to Nicaragua 2005-2008	978-90-5328-385-1
328	2010	Evaluatie van de Nederlandse hulp aan Nicaragua 2005-2008	978-90-5328-384-4
327	2010	Drinking water supply and sanitation programme supported by the Netherlands in Fayoum Governorate, Arab Republic of Egypt, 1990-2009	978-90-5328-381-3
326	2009	Evaluatie van de Atlantische Commissie (2006-2009)	978-90-5328-380-6
325	2009	Beleidsdoorlichting van het Nederlandse exportcontrole- en wapenexportbeleid	978-90-5328-379-0
-	2009	Evaluatiebeleid en richtlijnen voor evaluaties	-
-	2009	Evaluation policy and guidelines for evaluations	-
324	2009	Investing in Infrastructure	978-90-5328-378-3
-	2009	Synthesis of impact evaluations in sexual and reproductive health and rights	978-90-5328-376-9
323	2009	Preparing the ground for a safer world	978-90-5328-377-6
322	2009	Draagvlakonderzoek. Evalueerbaarheid en resultaten	978-90-5328-375-2
321	2009	Maatgesneden Monitoring 'Het verhaal achter de cijfers'	978-90-5328-374-5
320	2008	Het tropisch regenwoud in het OS-beleid 1999-2005	978-90-5328-373-8
319	2008	Meer dan een dak. Evaluatie van het Nederlands beleid voor stedelijke armoedebestrijding	978-90-5328-365-3
318	2008	Samenwerking met Clingendael	978-90-5328-367-7
317	2008	Sectorsteun in milieu en water	978-90-5328-369-1
316	2008	Be our guests. (Sommaire)	978-90-5328-372-1

316	2008	Be our guests. (Summary)	978-90-5328-371-4
316	2008	Be our guests. (Main report English)	978-90-5328-371-4
316	2008	Be our guests. (Samenvatting)	978-90-5328-370-7
316	2008	Be our guests. (Hoofdrapport)	978-90-5328-370-7
315	2008	Support to Rural Water Supply and Sanitation in Dhamar and Hodeidah Governorates, Republic of Yemen	978-90-5328-368-4
314	2008	Primus Inter Pares; een evaluatie van het Nederlandse EU-voorzitterschap 2004	978-90-5328-364-6
313	2008	Xplore-programma	978-90-5328-362-2
312	2008	Primary Education Zambia	978-90-5328-360-8
311	2008	Primary Education Uganda	978-90-5328-361-5
310	2008	Clean and Sustainable?	978-90-5328-356-1
309	2008	Het vakbondsmedefinancieringsprogramma – Summary English	978-90-5328-357-8
309	2008	Het vakbondsmedefinancieringsprogramma – Resumen Español	978-90-5328-357-8
309	2008	Het vakbondsmedefinancieringsprogramma	978-90-5328-357-8
308	2008	Het Nederlandse Afrikabeleid 1998-2006. Evaluatie van de bilaterale samenwerking	978-90-5328-359-2
308	2008	Het Nederlandse Afrikabeleid 1998-2006. Evaluatie van de bilaterale samenwerking. (Samenvatting)	978-90-5328-359-2
307	2008	Beleidsdoorlichting seksuele en reproductieve gezondheid en rechten en hiv/aids 2004-2006	978-90-5328-358-5

If you would like to receive a publication in printed form, please send an e-mail to IOB@minbuza.nl, mentioning the title and IOB number.

Published by:

Ministry of Foreign Affairs
P.O. Box 20061 | 2500 EB The Hague | The Netherlands
Policy and Operations Evaluation Department (IOB)

www.government.nl/foreign-policy-evaluations
www.iob-evaluatie.nl
www.twitter.com/IOBevaluatie
www.oecd.org/derec

Photo cover: Nigeria, Universal Access to Female Condoms, 2011 (Esther Jurgens)
Layout: Vijfkeerblauw | Rijswijk
Print: Zalsman
ISBN: 978-90-5328-445-2

This report presents the findings of a desk-study of the results of multilateral organisations in the field of sexual and reproductive health and rights (SRHR).

It is part of a number of sub-studies of a policy evaluation of Dutch involvement in SRHR, conducted by the Policy and Operations Evaluation Department (IOB) of the Ministry of Foreign Affairs of the Netherlands.

The contribution of the multilateral channel was assessed by an analysis of existing evaluations and policy briefs of five organisations: UNICEF, UNFPA, the Global Fund to Fight AIDS, TB and Malaria (GFATM), UNAIDS, and WHO.

Published by:

Ministry of Foreign Affairs
Policy and Operations Evaluation Department (IOB)
P.O.Box 20061 | 2500 EB The Hague | The Netherlands

www.government.nl/foreign-policy-evaluations
www.iob-evaluatie.nl
www.twitter.com/IOBevaluatie
www.oecd.org/derec

13BUZ620179 | E