



Ministry of Foreign Affairs

IOB Evaluation

Balancing ideals with practice

Policy evaluation of Dutch involvement in sexual and reproductive health and rights 2007-2012

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August 2013

Fifteen years ago in Cairo, for the first time, governments acknowledged that every person has the right to sexual and reproductive health.

United Nations Secretary-General, 2009

Preface

The 1994 International Conference on Population and Development (ICPD) in Cairo marked a remarkable shift in thinking about population and development. It emphasised the importance of taking a human rights approach, and including sexual health in the domain of reproductive health. Notwithstanding positive developments since this historical event – particularly in improving child health –, almost twenty years later several aspects of sexual and reproductive health and rights are even more controversial today, and envisaged targets in some areas are far from being achieved.

The promotion of sexual and reproductive health and rights (including the fight against HIV/AIDS) has been a priority in Dutch policy for years and substantial funds have been made available to this end. Central to the policy of the Netherlands has been to promote the right of everyone – regardless of age or gender – to make choices about their own sexuality and reproduction, as long as this does not infringe on the rights of others.

This report presents the findings of an evaluation of the Dutch policy in the field of sexual and reproductive health and rights during the period 2007-2012. This policy evaluation has been conducted by the Policy and Operations Evaluation Department (IOB) of the Dutch Ministry of Foreign Affairs and is based on a number of sub-studies, including country impact studies in Bangladesh, Nicaragua and Mali, desk-studies of Ghana and Tanzania, and desk-studies of existing evaluations of multilateral organisations and NGOs.

The principal research question is to what extent the policy objectives have been achieved and to what extent the instruments applied and channels of implementation have contributed to the results. The policy evaluation concludes that Dutch support has contributed to better availability of commodities and medicines, to increased use of perinatal and maternal health services and to reduced infant and maternal mortality. Contributions to changes in contraceptive use are less conclusive. Moreover, inequalities between households, regions and countries were hardly reduced and support to health systems improvement became neglected. Dutch support also contributed to the realisation of sexual and reproductive health and rights for people who may be denied these rights but efforts in these areas could be strengthened.

IOB senior evaluator Marijke Stegeman and IOB researcher Saskia Hesta have compiled the synthesis report on the basis of the underlying sub-studies and additional document study and interviews. A consortium of researchers from Ecorys, ETC Crystal and KIT has been contracted to carry out the Mali and Nicaragua country studies. Both studies are published on the IOB website. Leon Bijlmakers (ETC Crystal) was the team leader for the study on family planning in Mali and Hermen Ormel (KIT) was responsible for the impact study of a cervical cancer project in Nicaragua.

The Bangladesh impact study of a menstrual regulation programme was conducted by the Bangladesh Institute of Development Studies (BIDS), with Dr Mannan as the team leader. The desk studies Ghana and Tanzania were carried out by IOB on the basis of existing documents, verified by interviews. The study of results of multilateral organisations was carried out by Esther Jurgens, an external consultant, on the basis of existing evaluations. Finally, the study of results of NGOs was carried out by Muriel Visser, external consultant, together with Saskia Hesta from IOB, also on the basis of existing evaluations.

The policy evaluation has been guided by a reference group, consisting of representatives of the Social Development Department (DSO) at the Netherlands Ministry of Foreign Affairs: Reina Buijs (former head of the health and AIDS division, Rebekka van Roemburg and Dicky Methorst (presently heading this division) and policy officers Monique Kamphuis, Elly Leemhuis and Lily Talapessy. Rob Baltussen (NICHE; UMC St. Radboud, Nijmegen) and Mariette Wiebenga (public health consultant) were the external experts to complete the reference group. IOB senior evaluators Rita Tesselaar, Phil Compernelle and Jan Klugkist have peer reviewed the ToR and final report. All have provided their invaluable comments.

Special thanks go to the embassy staff and of the permanent representative in Geneva, for their cooperation and guidance provided prior to, during and after the country studies, and for elaborately scrutinizing and commenting on the draft reports.

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Finally, I would like to thank all people who were so patient and kind to participate in surveys, focus group discussions and interviews and enabled us to report on the results of Dutch support to sexual and reproductive health and rights.

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

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List of Abbreviations

ART	Antiretroviral therapy
AMPPF	<i>Association Maliennne pour la Protection et Promotion de la Famille</i> (Family Planning Association in Mali)
ANC	Antenatal care
BRAC	Bangladesh Rural Advancement Committee (former acronym)
CRS	Creditor reporting system
DHS	Demographic and Health Surveys
DFID	Department for International Development
DMM	Multilateral Institutions and Human Rights Department
EKN	Embassy of the Kingdom of the Netherlands
EU	European Union
FC	Female condom
FGC	Female genital cutting
FGM	Female genital mutilation
FP	Family planning
FPAB	Family Planning Association of Bangladesh
GAVI	Global Alliance for Vaccines and Immunisation (former acronym)
GDP	Gross domestic product
GFATM	Global Fund to Fight AIDS, TB and Malaria (Global Fund)
HIRD	High impact rapid delivery
HNPSP	Health, Nutrition and Population Sector Programme
HRP	Human Reproduction Programme (WHO)
ICPD	International Conference on Population and Development
ICT	Information and communication technology
ILO	International Labour Organization
IOB	Policy and Operations Evaluation Department (Dutch MFA)
IPPF	International Planned Parenthood Federation
IUD	Intra uterine device
KAP	Knowledge, attitude and practice (research method)
MDG	Millennium development goals
MFA	Ministry of Foreign Affairs
MFS	Co-financing system (Dutch MFA)
MoH	Ministry of Health
MOPAN	Multilateral Organisation Performance Assessment Network
MSI	Marie Stopes International
MSM	Men having sex with men
NACP	National AIDS Control Programme
NGO	Non-governmental organisation
ODA	Official development assistance
OVC	Orphans and Vulnerable Children
PCB	Programme coordinating board
PHWS	Public Health, Welfare and Sports
PLHIV	People living with HIV/AIDS

PMCT	Prevention of mother-to-child transmission
PMH	Perinatal and maternal health
PMTCT	Preventing mother-to-child transmission
PPP	Public-private partnerships
PSI	Population Services International
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
SSA	Sub-Saharan Africa
STI	Sexually transmitted infections
TBA	Traditional birth attendants
THMIS	Tanzania HIV/AIDS and malaria indicator survey
TMF	Thematic co-financing (Dutch MFA)
UBRAF	Unified budget, results and accountability framework
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UNFPA	UN Fund for Population Activities (United Nations Population Fund)
VAW	Violence against women
WHO	World Health Organization

Main findings and issues for the future

1 Introduction

Over decades, Dutch development cooperation has defined as a priority area the promotion and realisation of sexual and reproductive health and rights (SRHR). Dutch SRHR policy emphasises that SRHR is grounded in human rights standards and that there is a strong link between SRHR and HIV/AIDS. It highlights the importance of prevention and the need to address young people and key populations.

The policy evaluation presented here had two objectives:

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

The central research question is whether Dutch support to the public sector, to multilateral organisations and global funds and to NGOs has contributed to achieving the envisaged outcome and impact of their SRHR programmes and, if so, to what extent. The envisaged intermediate results (outcome) are improved knowledge levels on SRHR among young people, increased availability of SRHR commodities and medicines, increased access to SRHR services and a guarantee that the sexual and reproductive rights of people who may have been denied these rights are respected. The envisaged impact is a reduction of new HIV infections and maternal deaths. In addition to the central research question, more specific research questions were formulated, in accordance with the standard questions posed in a policy evaluation: they related to policy setting, budget allocation and the effects of policy implementation.¹

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The policy evaluation is based on seven sub-studies. Three of these (Bangladesh, Mali and Nicaragua) are based on primary data collected from the beneficiaries by the evaluators of the programme. These studies are described in detail. The remaining four sub-studies are desk studies of literature (published and unpublished evaluations of multilateral organisations, the Global Fund to Fight AIDS, Tuberculosis and Malaria (hereafter referred to as the Global Fund) and non-governmental organisations, and reports and files from multilateral organisations), augmented by interviews with policy officers of the implementing organisations. Together these sub-studies address all thematic areas of the SRHR strategy of the World Health Organisation (WHO), and they cover most instruments and implementation channels. Also included in this policy evaluation are findings on SRHR that were published in previous IOB evaluations, such as the country study on Nicaragua and the evaluation of budget support in Zambia, as well as a recent European Union (EU) evaluation on health programmes.

¹ Staatscourant 2012, 18352. Chapter 1 provides more details on the research questions.

The period evaluated is 2007-2012.² The sub-studies cover about 20% of Dutch development cooperation expenditure on SRHR. Although the evaluation did not examine all Dutch support to SRHR, it provides a good illustration of the range of this support. A consequence of including a wide variety of studies is that there are differences in the detail and robustness of the evidence they provide. Chapter 1 will present more details on the sub-studies, the quality of the evidence and the coverage.

The structure of the report is thematic and follows the five elements of WHO's SRHR strategy: perinatal and maternal health, family planning, preventing unsafe abortion, prevention of sexually transmitted infections (including HIV/AIDS), and promoting sexual health.

2 Main findings

The findings are grouped into two categories: policy and strategy, and results at outcome and impact level. The findings on outcome and impact are presented thematically and relate to knowledge, availability of SRHR commodities and medicines, access to services and, if applicable, HIV infections and maternal deaths.³

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Policy and strategy

1) *Dutch policy in the field of sexual and reproductive health and rights has been consistent. It is in line with internationally agreed human rights standards and contains a clear vision and well-defined priorities.*

The period evaluated covers three Dutch governments, but despite the changes in government the core of SRHR policy has remained unchanged: emphasising the human rights framework and the links between SRHR and HIV/AIDS. Much attention is given to prevention and a multi-sector approach. In policy documents, clear priorities are outlined, including the need to address the sexual and reproductive rights of young people and others at risk of being denied these rights.

2) *In international forums, the Netherlands has successfully defended the agreed language on SRHR and the importance of including Dutch priorities in resolutions, declarations and policy setting.*

Agreed language on SRHR, more particularly statements on sensitive issues such as ensuring that abortions are safe, has been regularly disputed in the international arena, including by some EU member states. Some countries also dispute the importance of ensuring the protection of sexual and reproductive rights of people who may be denied these rights, such as young people. On several occasions, the Netherlands has firmly upheld agreed language and the need to address the rights of all people. In the periods that the Netherlands

² In some cases, for instance the Ghana sub-study, a different period has been covered, because data were not available on all six years (2007-2012).

³ Chapter 1 gives information on the data and level of evidence on which these findings are based. In the final chapter (Discussion), however, data have been organised in relation to the research questions (knowledge, availability of SRHR commodities and drugs, service use, rights, impact).

co-chaired or chaired the programme coordination board of the Joint United Nations Programme on HIV/AIDS (UNAIDS), the new UNAIDS strategy (2011-2015) was prepared and adopted. This strategy comprises most of the Dutch priorities. These successes can be attributed to the Netherlands' good knowledge of and respect for the position of other countries, its good negotiating skills and its ability to broker coalitions.

3) *The decision made in year 2011 to reduce sector budget support has affected Dutch efforts to strengthen health systems. Evidence to justify this decision is not forthcoming from evaluations.*

As a result of the decision, Dutch SRHR policy objectives and priorities have remained largely the same, but policy implementation has changed. The most important change is that in line with a trend in overall Dutch international cooperation policy, health sector budget support has declined since 2011. In the countries reviewed, the percentage of the gross domestic product spent on health has remained similar, so it is unlikely that the gap has been filled by national governments. As a consequence, less support is being provided to strengthen health systems in these countries, despite the fact that SRHR cannot be improved unless the health system is functioning well. For example, the availability and accessibility of emergency obstetric care is a precondition for preventing neonatal and maternal deaths. The literature studies that formed part of this policy evaluation show that health sector budget support has helped to increase service use and to decrease infant and maternal mortality.

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Outcome and impact

4) *Dutch support to health and SRHR programmes has contributed to increased use of perinatal and maternal health services and to decreased neonatal and maternal mortality. Inequities between educational levels and wealth quintiles have hardly reduced. Differences also persist between countries and between regions within countries.*

Dutch health sector budget support, both directly and through the EU, has contributed to the strengthening of health systems, resulting in all population categories having better access to antenatal care, obstetric care and care for newborns. In Bangladesh, for example, skilled birth attendance rose from 16% in 2004 to 32% in 2011. In Nicaragua and Zambia, a slight increase in institutional deliveries could be observed. Dutch support to SRHR through the health sector has also contributed to a steady decline of neonatal, infant and child mortality and, to a lesser extent, to maternal mortality. Tanzania provides an example.⁴

In general, in national policies it is emphasised that all people should have equal access to health services; additionally, during dialogue on health sector support with development partners, appropriate budget allocation to underserved regions is discussed. Gaps in service use and mortality rates between the better-off people and poor people with low educational levels have narrowed hardly, if at all. An exception is Nicaragua, where a slight reduction of the gap in service use between poor and better-off regions can be observed.

⁴ Details will be provided in chapter 4.

The persistence of inequities can partly be explained by factors that are related to the health sector, such as insufficient targeting of human and financial resources. Factors outside the health sector also play an important role. Access to services may also be impeded by indirect costs, such as lack of cheap means of transportation and loss of income, and by cultural barriers. Dutch support to SRHR programmes cannot be expected to have much influence on these latter aspects.

Dutch financial support to WHO, the United Nations Population Fund (UNFPA) and the United Nations Children's Fund (UNICEF) has helped these organisations to develop policies and guidelines and to assist countries in policy setting, creating conditions for implementation and, in some instances, providing funding for policy implementation. The multilateral organisations emphasise the importance of equity. The evaluations of these organisations' programmes did not provide information about whether, and how, equity issues were pursued and they only occasionally report results at beneficiary level in terms of service use. Dutch support to NGOs has enabled these organisations to implement initiatives on perinatal and maternal health in underserved areas, thus reaching population groups that have less access to services.

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5) *Dutch support to SRHR has contributed to improved knowledge and availability of contraceptive methods. Data on changes in the use of these methods is less conclusive. Inequities between better-off and less well-off people persist, though there are some notable exceptions.*

Dutch health sector support and financial contributions to UNFPA, international NGOs and their affiliates at country level include support to family planning (including contraceptive choice). Findings from a country study on Mali and desk studies on Bangladesh and Ghana show diverse results. Steady progress can be observed only in Bangladesh. Here, the contraceptive prevalence rate rose from 40% in 2000 to 57% in 2011 and the unmet need for family planning is low (11%). In Ghana and Mali, knowledge of family planning methods has increased. In Mali, the use of modern methods has slightly increased from 6% in 2003 to 8% in 2009. In Ghana, the contraceptive prevalence rate was 24% in 2008, a percentage similar to that of 1998. Since 2008, there has been a substantial increase (34% in 2012). In general, data on family planning among young people point to increased use of family planning methods, but the unmet need for family planning among this group has not declined. Gaps between the poor and rich and between women with different educational levels have remained similar. These findings are in line with global data, though there are exceptions.

The most important obstacles to improved family planning as defined in the evaluation reports were insufficient stocks of contraceptives, fear of side effects and cultural barriers. However, in the Mali study a shift to views that are more receptive to family planning was discernible. Another positive development in Mali is the slight increase in use of long-term methods, mostly due to the work of international NGOs. Though of limited scale, this increase has had a high and positive impact on avoiding unplanned pregnancies and maternal deaths.

The support to UNFPA has contributed to policy development, the setting up of logistical systems for commodity purchase and distribution at country level, and improved availability

of family planning methods, thus facilitating the use of family planning. UNFPA's contribution to the use of these methods could only occasionally be demonstrated.

- 6) *Dutch policy defines the prevention of unsafe abortions as a priority. The Netherlands is outspoken in defending its position internationally and supports concrete interventions, but these are scarce by comparison with the situation for other policy themes. Dutch support to an initiative for improving the government programme to prevent unsafe abortion in Bangladesh was proven effective.*

At the International Conference on Population and Development (ICPD) in 1994 it was agreed that reproductive health also comprises providing access to safe abortion where it is not against the law. The Netherlands has been outspoken and successful in upholding the agreed language. Dutch support to WHO and international NGOs (Guttmacher Institute; Ipas; Marie Stopes International) has contributed to research and development of guidelines on safe abortions. It has also enabled the NGOs to provide technical assistance to countries and to deliver safe abortion services in countries where this is legally permitted.

Some examples of Dutch support to concrete interventions were included in this policy evaluation. In Nicaragua, the restrictive abortion law has been brought up regularly by the Netherlands in bilateral dialogues with the government and support has been provided to Nicaraguan civil society organisations to lobby for changes to the legislation on abortion. However, the law has not been changed. In Bangladesh, a substantial financial contribution was given to a joint initiative of WHO and the Ministry of Health to strengthen the existing menstrual regulation programme. It was implemented by several NGOs. The project proved to be effective in increasing knowledge about safe procedures, improving the quality of care and providing pre- and post-procedure counselling to clients. It thus helped to avoid unsafe abortions, future unplanned pregnancies and maternal deaths. It also contributed to drafting and adopting national guidelines.

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No evaluations could be found of safe abortion programmes carried out by the multilateral organisations or by the Dutch NGOs included in this policy evaluation.

- 7) *Dutch support to the prevention of HIV transmission has contributed to improvements in knowledge, to increased prevention of mother-to-child transmission and to treatment. Policy documents prioritise key populations, but support for the implementation of initiatives for these groups has been limited.*

Dutch support for the prevention of HIV/AIDS has been provided through health sector support, financial contributions to multilateral organisations, global initiatives and NGOs. A desk study on Tanzania, evaluations of multilateral organisations and the Global Fund and evaluations of NGO projects show that the support has contributed to improving knowledge levels, including among young people. Dutch support has also contributed to a substantial increase in prevention of mother-to-child transmission. Worldwide, the coverage increased from 19% in 2004 to over 50% in 2010; in Tanzania, 90% of pregnant women with HIV had access to preventive treatment in 2010. The coverage of HIV-related treatment also increased substantially. Worldwide, in 2010 about one third of people in need of this therapy received it and in Tanzania in 2010, treatment coverage was about 50%. The number of new HIV infections is declining.

In Dutch policy documents and interventions from the Netherlands in international forums, the importance of addressing key populations is emphasised. It is important to protect the rights of these groups because many countries still have inhibitive laws regarding key populations. However, Dutch support for policy implementation does not match the rhetoric. Support to UNAIDS has helped achieve the inclusion of key populations in the organisation's policy, but UNAIDS is not an implementing agency. UNFPA does not seem to direct initiatives at key populations. The Global Fund has explicitly included key populations in its strategy and provides funding for initiatives for these groups. Available evaluations are scarce and show mixed results.

Several Dutch-supported NGOs have implemented projects for key populations. Evaluations of these projects show that they have contributed to improved knowledge levels among key populations and to the reduction of social discrimination. Important factors for the reduction of stigma and discrimination were peer groups and counselling.

The establishment of the Key Population Fund in 2011 and the Stepping Up Fund in 2012 is intended to fill the gap regarding implementation of initiatives for key populations.⁵ However, merely from examining the budgets of these funds, it is clear that the proportion allocated to initiatives for key populations is small.

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8) Although the Netherlands has successfully pleaded in international forums for the promotion of sexual and reproductive rights, the implementation of concrete initiatives for people who may be denied these rights has lagged behind. It has been mostly limited to NGOs and the results include greater knowledge among young people on sexuality.

Promoting sexual and reproductive rights is a broad concept that includes applying a rights-based approach and securing these rights for people who may be denied these rights or whose rights are violated. The principle of defending sexual and reproductive rights, especially the rights of young people or of key populations, is not generally accepted internationally. Nevertheless, the Netherlands has successfully promoted these rights: for example, by contributing to the adoption of declarations and resolutions regarding sexuality of young people and violence against women. Support to multilateral organisations and the Global Fund has helped these organisations to outline a policy on sexual health: for example, by including the need to address key population groups.

Evaluations of the promotion of sexual health by these organisations were scarce and show mixed results. A UNICEF country programme on violence against women in Senegal was effective; a UNFPA global programme on gender contributed to policy setting at country level, but did not have demonstrable tangible results for the beneficiaries. A UNFPA programme in conflict areas helped to increase mobility but could not provide all services that were envisaged.

NGOs that were financed through the co-financing mechanism have carried out several projects to promote sexual health, especially related to the needs and rights of adolescents

⁵ These funds could not be included in this policy evaluation because no results were yet available.

and prevention of harmful practices such as female genital mutilation or sexual violence. Evaluations show that efforts to improve knowledge and awareness have been successful: for example, about issues such as sexuality and the prevention of HIV and unwanted pregnancies. There is less evidence that this knowledge has been translated into increased use of contraceptive methods.

Dutch support to a joint programme of a Nicaraguan NGO and the Nicaraguan Ministry of Health that explicitly applied a rights-based approach was effective. The programme had as its objective was the prevention of cervical cancer among poor women in remote areas, and it led to a substantial increase in service use among these people.

3 Overall conclusions

Summarising the main findings, it can be concluded that the Netherlands has successfully defended agreed language on SRHR in international forums. Dutch policy is consistent and emphasises the more 'sensitive' issues, such as protection of the rights of young people and key populations, who risk being denied these rights. The overall conclusion of this assessment of Dutch support to SRHR is that the support has contributed to:

- Improved knowledge levels on SRHR, including among young people.
- Increased availability of SRHR commodities and SRHR-related medicines.
- Increased use of SRHR services, but hardly of family planning services.
- Decreased incidence of HIV and of maternal mortality.

The findings are less positive regarding achieving increased access to SRHR for those who may be denied sexual rights and access to services. Shortcomings include:

- Inequalities between rich and poor people and between people with higher and lower educational levels have hardly been reduced. Inequities between poor and rich regions within a country and inequities between countries also persist. This policy evaluation presents the findings on equity regarding use of perinatal and maternal services and of family planning, and infant and maternal mortality rates. Equity issues regarding access to safe abortion, HIV prevention and treatment and the realisation of sexual rights were not studied systematically, but examples of inequity were also found in these areas.
- Insufficient implementation of interventions regarding some policy priorities, particularly relating to the prevention of preventing unsafe abortion, the promotion of sexual health and access to SRHR for key populations.

Another critical remark is that in most of the evaluations of multilateral organisations the results presented of the organisation's involvement in SRHR at beneficiary level display shortcomings: for example, relating to service use. In general, NGO evaluations provide better information about results for the beneficiaries, but there is room for improvement in quantifying the results and comparing the results with baseline data.

4 Issues for the future

- a) The consistency in policy formulation, including the objectives and priorities, has contributed to the visibility and credibility of the Dutch commitment to SRHR. It is advisable to continue along the same lines.
- b) Strengthening health systems is an essential condition for achieving the Dutch policy objectives, particularly regarding the reduction of maternal mortality. The current shift away from such support is creating a gap which will need to be filled.
- c) Intensifying the attention for inequalities in access to commodities and services would facilitate the achievement of the policy objectives.
- d) Intensifying the support for initiatives regarding safe abortion and sexual and reproductive health for key populations would enhance the consistency between policy formulation and policy implementation.
- e) Reconsidering the channel choice for funding particular activities could bring policy implementation more in line with the Dutch priorities.
- f) Enhancing evaluation practices improves the visibility of the contribution of multilateral organisations and NGOs to achieving the policy objectives.

1

Introduction

This chapter presents succinct background information on the policy evaluation. It also describes the main research questions, the scope of the study and the research methods.

1.1 Background

Justification

Promoting SRHR, preventing HIV infections and providing treatment and care for people living with HIV figure prominently on the agenda in the international arena. For over a decade, Dutch foreign policy has defined SRHR and HIV/AIDS as a priority area.⁶ In 2007, the Policy and Operations Evaluation Department (IOB) issued a policy evaluation on SRHR. The current evaluation was undertaken in 2011 because of the legal requirement to review policy areas regularly. In contrast to the first evaluation it is based on a number of impact evaluations in countries that have received financial support for SRHR from the Netherlands.

Definitions

Reproductive health is defined in terms of physical, mental and social well-being, not merely as the absence of disease. It addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.⁷

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Reproductive rights and sexual rights are grounded in international human rights treaties. These rights enable people to enjoy a mutually satisfying and safe relationship, free from coercion or violence and without fear of infection or pregnancy, and they enable them to regulate their fertility without adverse or dangerous consequences. Sexual and reproductive rights provide the framework within which sexual and reproductive well-being can be achieved.⁸ Twelve rights are identified as essential: the right to life; the rights to liberty and security of the person; the rights to equality and to be free from all forms of discrimination; the right to privacy; the right to freedom of thought; the right to information and education; the right to choose whether or not to marry and to found and plan a family; the right to decide whether or when to have children; the right to health care and health protection; the right to the benefits of scientific progress; the right to freedom of assembly and political participation; and the right to be free from torture and ill treatment.

⁶ TK 2012-2013, 33 400 V, no. 2. It is section 5.4 of the article on social and human development (article 5). Policy evaluations in other areas mentioned in article 5 have either been conducted recently or will be conducted in the next two years.

⁷ http://www.who.int/topics/reproductive_health/en/.

⁸ IPPF 2003: 3.

International framework

In 1994, widespread support was given to the ICPD Programme of Action. Most notably and in contrast to previous conferences on population, in this Programme of Action family planning was incorporated into a broader agenda of women's empowerment and reproductive health and rights. The Programme of Action explicitly mentions that men and women have the right to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice.⁹ Despite opposition, the language on reproductive health agreed on at the ICPD in Cairo was maintained at later conferences. In 2000, the eight millennium development goals (MDGs) were launched, setting specific targets for the year 2015. Four of the eight MDGs are directly linked to SRHR: gender equality and women's empowerment (no. 3); the reduction of child mortality (no. 4); improvement of maternal health (no. 5); and combating HIV/AIDS, malaria and other diseases (no. 6). Initially, MDG 5 had only one target: a 75% reduction in maternal mortality. In 2006 an additional target was added: the achievement of universal access to reproductive health.

In 2004 the WHO strategy for promoting SRHR was adopted.¹⁰ It defines five thematic areas:

- Improving antenatal, perinatal, postpartum and newborn care.
- Providing high qualitative services for family planning, including infertility services.
- Eliminating unsafe abortions.¹¹
- Combating sexual transmitted infections, including HIV.
- Promoting sexual health.

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WHO recognises the close links between the different aspects of reproductive and sexual health, and the fact that interventions in one area are likely to have a positive impact in another. The organisation recognises that it is critical for countries to strengthen existing systems, avoiding unnecessary parallel programming.

The Cairo agenda is confronted with strong and well-organised opposition. Despite this, on various occasions, such as follow-up conferences and high-level meetings, the agreed language on SRHR has been confirmed internationally. In the field of HIV/AIDS several resolutions have been adopted by the United Nations General Assembly, describing the threat of the epidemic and expressing the political will to prevent and combat HIV/AIDS.

⁹ <http://www.un.org/popin/icpd/conference/offeng/poa.html>.

¹⁰ WHO 2004.

¹¹ The WHO strategy uses the terminology elimination of unsafe abortion. In Dutch policy ICPD language is used: access to safe abortions.

1.2 Goal of the evaluation and research questions

The policy evaluation had two overall goals:

- To account for the budget spent on sexual and reproductive health and rights by assessing the effectiveness of Dutch efforts in this area.
- To provide lessons that can be learnt, by identifying the factors which have contributed to the results obtained or to the lack of results.

The central research question is to what extent the policy objectives have been achieved and to what extent the instruments applied through various channels have contributed to the results. In line with the outline for a policy evaluation, more specific research questions were formulated, relating to policy setting, budget allocation and the effects of policy implementation; these were then applied to each of the evaluations analysed.¹²

- 1) What grounds were there for the Dutch government's involvement in SRHR and are they still relevant?
- 2) Who were the actors involved in implementing SRHR policy?
- 3) What SRHR objectives were set and which instruments were deployed for policy implementation? How were the instruments interlinked?
- 4) How much financial support was provided for the implementation of SRHR policy and how was the budget divided over regions and channels?
- 5) What were the grounds on which the choices regarding instruments and budget allocation were made?
- 6) Have the efforts in the field of SRHR contributed to:
 - a. More knowledge on sexuality among young people?
 - b. Better access to HIV therapy, contraceptive methods and life-saving drugs?
 - c. Better access to and improved quality of reproductive health services?
 - d. Ensuring that the sexual and reproductive rights of people who are denied these rights will be respected?
- 7) Have the results obtained (question 6) contributed to a decrease of maternal mortality and to fewer new HIV infections?
- 8) Has the policy implementation had unforeseen effects?

¹² Staatscourant 2012,18352. The terms of reference for this policy evaluation were drafted according to a previous version of the regulation. The outline of the present report complies with the current regulation and therefore is slightly different from the one suggested in the terms of reference.

1.3 Scope, methods and limitations

The period evaluated was 2007-2012. The evaluation covers all areas of SRHR and all implementation channels. It covers about 20% of Dutch expenditure on SRHR and provides a good illustration of the efforts undertaken and the programmes supported.

The policy evaluation is based on various sub-studies. Three country case studies were conducted (Bangladesh, Mali and Nicaragua), based on document review, interviews, existing databases and primary quantitative and qualitative data collection. Interviews were held with a variety of actors, such as representatives of the Netherlands embassy, government representatives, health professionals, representatives of multilateral organisations, project staff and representatives of the beneficiaries. Statistical analyses were applied, to ascertain the net results of programmes, and qualitative methods were applied in order to validate and explain the results of the quantitative analyses.¹³

In addition, two country desk studies (Ghana and Tanzania) were conducted, to summarise the published and grey literature on progress achieved.¹⁴ The information was verified by interviews with key stakeholders. The findings of previous IOB evaluations on Nicaragua (country evaluation)¹⁵ and Zambia (budget support)¹⁶ are also succinctly presented in this policy evaluation. Support provided indirectly through the EU was assessed on the basis of recent evaluations by the European Commission (of the health sector) and IOB.¹⁷ Regarding the multilateral channel, the Dutch influence on multilateral organisations was assessed on the basis of documents and interviews. This policy evaluation also includes a desk study of evaluations of four multilateral organisations and the Global Fund. The contribution of NGOs was assessed by an analysis of evaluations of NGOs that are financed through the co-financing system, complemented by interviews and an examination of the existing evaluations and reports of international NGOs.

The support given via the World Bank has been excluded from this policy evaluation. The reason is that the overall World Bank evaluation on health, nutrition and population (2009) covers the period 1997-2007.¹⁸ Where relevant, however, findings in this IOB evaluation are compared with the World Bank findings. It should also be noted that Dutch financial support to the World Bank has indirectly contributed to some of the achievements mentioned in this policy evaluation. Most notable are the contribution of the World Bank to the Global Fund and to national HIV/AIDS programmes.

¹³ Details on data collection and analysis are provided in the country study reports (Bijlmakers et al. 2012; IOB 2012, Mannan et al. 2013).

¹⁴ The sections on problem setting also present worldwide data. The policy evaluation does not include separate DHS data for all Dutch partner countries.

¹⁵ IOB 2010.

¹⁶ IOB 2011.

¹⁷ EC 2012. IOB 2013c.

¹⁸ World Bank 2009.

The policy evaluation thus includes most of the financially important channels of implementation. The countries and the interventions vary substantially, so therefore, the policy evaluation does not claim to be representative of all the implementations of Dutch SRHR policy. An important limitation was the limited availability of good quality evaluations of multilateral organisations, the Global Fund and NGOs that provide information about the organisations' contribution at outcome level: for example, service use. Another limitation is that recent policy developments are only described qualitatively. The results of newly established financing mechanisms, such as the Key Population Fund, the SRHR fund and the Stepping Up Fund could not be included in the evaluation, because no project results were yet available at the time of the study.

The strength of evidence for the link between the findings and Dutch support to SRHR varies considerably between the sub-studies. In the Bangladesh and Nicaragua case studies, primary data collection by the IOB evaluators made it possible to compare findings of the 'intervention group' with those of a 'no intervention' group. In addition, the Netherlands was the only foreign partner that provided financial support to the programmes, so the findings could be unequivocally linked with Dutch support to SRHR. These two studies are important building blocks for this policy evaluation and will be described in detail, even though the budgets involved were limited. The rationale is that both studies address important thematic areas that have not yet been extensively evaluated. In the Mali evaluation of family planning, the IOB evaluators complemented and explained existing data by collecting and qualitatively analysing primary data. The study therefore has added value to the existing reviews of quantitative data on family planning and will also be presented in more detail.

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The other sub-studies rely on available data and/or evaluations, in most cases complemented by interviews with representatives from the Netherlands Ministry of Foreign Affairs and the implementing agencies, conducted in 2010-2012. These studies are described more succinctly. The strength of evidence between Dutch support to SRHR and the findings from these studies varies, but overall the evidence is at best moderate, because in most cases no comparison could be made with a control 'no Dutch support' situation. In addition, the trends presented in the country desk studies reflect many factors, not only the health system and the SRHR interventions and donors' support to these.

Table 1 visualises how the different thematic areas of SRHR and the different implementation channels figure in the case and literature studies. The table also gives information on the budget that the sub-studies covered. It should be noted that the amounts for the multilateral organisations, the Global Fund and the NGOs are estimates from available data. The reason is that the evaluation reports do not always provide information on financial inputs, and occasionally they do not report on the total budget involved. The table includes the most important sources and indicates the strength of the evidence regarding the link between Dutch (and other donors') support to SRHR and the findings. Strong evidence means that a link could be established by comparing a 'Dutch support' situation with a 'no Dutch support' situation. Moderate evidence means that a link may be assumed on the basis of secondary studies: for example, the study on the link

between sector support and child health.¹⁹ The term ‘modest evidence’ is used when the findings rely on self-reporting by the implementing organisation. The level of evidence will be referred to in the chapters about the results at outcome level.

Table 1 Building blocks of the policy evaluation				
Study*	Thematic area	Sources	Budget** mln. EUR	Quality of data and level of evidence
Country study Bangladesh	PMH; FP; preventing unsafe abortion	DHS; project documents; primary data from quantitative and qualitative research; Interviews	33.5 (75%)	Reliable data. Evidence moderate for PMH and FP; strong for preventing unsafe abortion
Country study Mali	FP	DHS; MICS; sector reviews; primary data from qualitative research; interviews	24.5 (52%)	Reliable data Moderate evidence
Country study Nicaragua	PMH; promoting sexual health	DHS; project documents; primary data from quantitative and qualitative research; Interviews	16 (42%)	Reliable data. Evidence moderate for PMH; strong for prevention and treatment of cervical cancer.
Literature study Ghana	PMH; FP	DHS, health sector reviews; project documents, interviews	111.5 (99%)	Reliable data Moderate evidence
Literature study Tanzania	PMH HIV/AIDS	DHS; health sector reviews; project documents, interviews (mostly by phone)	98.7 (90%)	Reliable data Moderate evidence
Desk study UNAIDS, UNICEF, UNFPA, WHO and GFATM	PMH; FP; HIV/AIDS; promoting sexual rights	Existing reports, evaluations and reviews of the organisations' performance; interviews	282	Quality of data varies; level of evidence varies (moderate to strong regarding output; modest to moderate regarding outcome).
Desk study NGOs	PMH; FP; HIV/AIDS; promoting sexual rights	Existing evaluations of the organisations; interviews; reports of international NGOs	172	Quality of data varies; level of evidence varies (moderate to strong regarding output; modest to moderate regarding outcome).
Zambia EU evaluation	PMH	Document review and interviews		Quality of data varies; evidence for output moderate; for outcome varying from modest to moderate.

Legend: DHS = demographic and health survey(s); FP = family planning; MICS = Multi-indicator cluster survey; PMH = Perinatal and maternal health

*The period evaluated is 2007-2012. However, some building blocks were published in 2010 and cover a different period. The budget mentioned only includes the period 2007-2012.

** The amounts mentioned under the country studies are fairly accurate; the percentage refers to the proportion of the total Dutch funding for SRHR in the country concerned that was covered by the study. Precise data were not available for the multilateral organisations, the Global Fund and NGOs because the programmes that were included also received other funding. From the available data of the evaluation reports included in this policy evaluation it was estimated that Dutch financial support accounted for 20% of the funding for multilateral organisations and NGOs and about 30% of the financial support to NGOs.

It should be noted that the strength of the evidence provides information about the type and quality of the evaluation, but not necessarily information on the quality of the activity evaluated.

Chapter 4 will give information about the budget allocation to the countries included in this review, and it will be shown that about 44% of the budget allocation to countries is allocated to the five countries included in this policy evaluation. The evaluation coverage of Dutch-funded SRHR projects in each of these five countries differs: it ranges from 40% to almost complete coverage. The percentages for Ghana and Tanzania are high because most of the funding was allocated to basket funding and sector budget support. For Ghana this was EUR 18 million per year. It must be noted that this sector support to Ghana was assessed only using data from existing demographic health surveys. It must also be noted that the period covered by the Ghana evaluations only partly overlapped with the 2007-2012 period, but it did also cover at least six years.

The findings will be presented thematically. The rationale is that in order to realise sexual and reproductive rights and improve sexual and reproductive health, all the different aspects should be addressed, as they are interlinked. For example, reduction of the unmet need for family planning will contribute to the improvement of maternal health and the prevention of maternal deaths. It should be noted that in this policy evaluation, sexuality education, preventing and combating female genital mutilation and preventing and combating gender-based violence (sexual or otherwise) will be dealt with under the theme 'promoting sexual health'. The findings of the study on cervical cancer prevention in Nicaragua will also be presented in the chapter on promoting sexual health. The rationale for doing so is that this project had an explicitly rights-based approach.

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The advantages of a thematic presentation are that all themes will be dealt with and that it is easy to define which areas receive proportionally more attention and funding and which areas are lagging behind. It also reveals the main actors involved in implementing initiatives. A thematic presentation does have some limitations, however. The links between the themes may be overlooked and, in addition, in many cases Dutch-supported programmes address various themes of WHO SRHR strategy simultaneously. The most obvious example is health sector budget support, which usually includes perinatal and maternal health, family planning and the prevention and treatment of sexually transmitted infections and HIV. However, the advantages of a thematic presentation outweigh its limitations. It should be noted that a thematic presentation is not a plea for supporting single-issue vertical programmes, such as those solely addressing HIV or family planning.

1.4 Outline of the report

The report is structured according to the research questions. Each chapter will start with a short introduction, followed by the main findings. Chapter 2 addresses the research questions 1 and 2 that relate to the Dutch government's involvement in the policy area. In chapter 3 a reconstruction of Dutch policy on SRHR is presented, including a description of

instruments and an overview of budget expenditure on SRHR (research questions 3, 4 and 5). Chapters 4 to 8 address the effectiveness and, where possible, the efficiency of Dutch involvement (research questions 5, 6 and 7) in five SRHR areas: maternal and perinatal health; family planning; elimination of unsafe abortion; preventing and combating sexually transmitted infections and HIV/AIDS; and promoting sexual health. Each of these five chapters will start by briefly setting the problem in context, before describing how these themes are addressed in international and Dutch policy. The core of these five chapters consists of the findings of the case studies and the desk studies. Chapter 9 will draw general conclusions and identify issues of concern that are relevant to most or all themes.



2

World Health Assembly 2007, WHO/Peter Williams

The involvement of Dutch central government in SRHR

This chapter describes the involvement of central government in SRHR and justifies this involvement. The main findings are:

Research questions	Main findings
Grounds for involvement	The involvement of the Dutch government in SRHR is grounded in international conventions and soft law.
Actors involved	The Ministry of Foreign Affairs is the primary actor responsible for the development and implementation of international SRHR policy. Other actors, including multilateral organisations and private agents (both profit and non-profit) are involved in policy implementation.

2.1 Grounds for the government's involvement in SRHR

Sexual and reproductive health and rights are grounded in international human rights covenants and conventions ratified by the Netherlands. In addition, the definition of and steps to be taken related to sexual and reproductive health and rights have been defined in various forms of soft law, such as resolutions and declarations of the United Nations (UN) and other standard-setting bodies, as have the steps to be taken in relation to SRHR. Milestones are the adoption of the declaration and plan of action of the Fourth International Conference on Population and Development (the Cairo agenda) in 1994 and the subsequent five-, ten- and fifteen-year reviews; the declaration and platform of action of the Fourth World Conference on Women (Beijing, 1995) and its five-, ten- and fifteen-year reviews; and the Millennium Declaration (2000) and follow-up. International agreements include protecting, promoting and pursuing SRHR for all individuals. The SRHR-related covenants and conventions ratified and the resolutions and declarations adopted contain exhortations to implementation. Thus the Netherlands government is committed to fostering SRHR both in the Netherlands and in international cooperation, including the reduction of existing inequities in SRHR and inequitable access to SRHR services. Other actors are involved in policy implementation, such as international organisations and funds, businesses and non-profit private organisations.

In addition, the Netherlands has a good domestic track record in the area of SRHR. The number of teenage pregnancies is low, as is the percentage of induced abortions. This good track record puts the Netherlands in a strong position to take an authoritative stance on, for example, preventing unsafe abortion by legalising abortion. It also provides the Netherlands with lessons learnt that can be shared with other countries.

2.2 Description of central government's involvement in SRHR

2.2.1 Ministry of Foreign Affairs

Sexual and reproductive health and rights, including HIV/AIDS, has been a priority in Dutch development cooperation policy since 1994. Chapter 3 will describe objectives and areas of work of SRHR policy. Here, a succinct overview of the most relevant actors within the Ministry of Foreign Affairs (MFA) will be presented.

A key actor for the further elaboration of the SRHR policy and for facilitating its implementation is the health and AIDS division of the MFA's social development department (DSO/GA). It participates in international political work regarding resolutions and in discussions on standard setting and implementation strategies in the field of SRHR in various bodies, including those of the UN and the EU. The division also has an important advisory role regarding the implementation of SRHR policy through multilateral, bilateral and private channels. Finally, the division provides financial support to worldwide initiatives of global partnerships and of international NGOs in the area of SRHR.

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SRHR policy implementation through the multilateral channel is a shared responsibility of the Multilateral Institutions and Human Rights Department (now called DMM; during part of the period evaluated it was known as DVF), DSO/GA and the Dutch permanent representations based in Geneva and New York. By participating in the executive boards of various multilateral organisations, the Netherlands intends to influence the policy setting of these organisations. In addition, DMM provides voluntary non-earmarked funds to multilateral organisations focusing on SRHR, such as the Global Fund, UNAIDS, UNFPA, UNICEF and WHO. When other Dutch ministries are also involved in the drafting of the instructions for international conferences or board meetings, MFA, and more in particular DMM, coordinates the input and, when feasible, includes it in the instructions.

In 2004 the Netherlands appointed its first AIDS ambassador and in 2010 the ambassador's remit was broadened to the wider field of SRHR. The remit includes profiling Dutch policy among international organisations and building consensus among parties in the international arena that may have different views on HIV/AIDS and SRHR tissues, particularly regarding key populations such as men having sex with men, sex workers and drug users. It also includes propagating the HIV/AIDS and SRHR policy of the MFA among Dutch organisations involved in these areas.

DSO/GA has umbrella responsibility for SRHR expenditure, which includes being involved in allocating budgets to – at present, eight – Embassies of the Kingdom of the Netherlands (EKN) and monitoring the results of the funded activities. The EKNs are responsible for the implementation of SRHR policy in bilateral relations, for example by discussing SRHR issues and pushing for legislation on SRHR that is in line with internationally agreed standards. In countries selected for development cooperation, the implementation includes providing funds for SRHR programmes and projects. SRHR is part of the multiannual strategies that

are developed by the embassies and approved by the MFA management. After a multiannual strategy has been approved, the EKN in question decides how it will be translated into concrete action or financial support. The health and aids division has overall responsibility for providing backstopping to EKNs on the implementation of SRHR policy.

The civil society division of the social development department (DSO/MO) is responsible for the funds provided to individual or consortiums of civil society organisations active in the field of SRHR.²⁰ During the period evaluated the modalities changed: as a result, only one complete cycle (2007-2010) falls within the period evaluated.

2.2.2 Other ministries

Various ministries other than the MFA are involved in SRHR in foreign policy.²¹ The most important is the Ministry of Public Health, Welfare and Sports (PHWS). As standards in the field of SRHR that are agreed upon internationally will also apply, PHWS is a member of and/or participates in numerous international forums on SRHR and in addition it provides financial support to projects. Although MFA and PHWS provide financial support to WHO through a partnership, this does not include funding for SRHR.

The Ministry of Social Affairs and Employment is involved in the drafting and adapting international rules and regulations of the International Labour Organisation (ILO). These regulations include pregnancy leave and also the protection of pregnant women against chemical products that may harm the unborn baby. ILO has also drafted rules and guidelines on how to deal with HIV and AIDS in the workplace.

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The Ministry of Defence has expressed its intention to include attention for HIV/AIDS and sexual violence in peace missions, especially the missions in Africa. As evaluations of these missions are not accessible to the public, it is not possible to verify whether and how these intentions have been translated into practice.

2.3 Conclusion

The grounds for the Dutch government's involvement in SRHR policy and the responsibilities of the different ministries are clearly defined. There are both formal and informal mechanisms for coordination and cooperation between the ministries. Responsibilities within the MFA are also clearly defined and coordination is mostly informal and seems to be functioning well.

Regarding implementation, the choice of actors is defined in policy documents and their responsibilities are defined in subsidy arrangements and/or contracts.

²⁰ In the framework of the co-financing system (MFS).

²¹ In the 2007 policy review (IOB 2007) the involvement of other ministries was described more in detail. As no major changes have occurred since then, the description in this review is succinct.

3

Netherlands SRHR policy: vision, objectives and priorities

SRHR has been a priority in Dutch development cooperation for the last two decades. This chapter first provides a succinct overview of the most important documents that guided SRHR policy during the period evaluated. Then, the vision, objectives, strategy, and priorities will be described. Policy implementation will be addressed in subsequent chapters. The main findings on policy setting are:

Research questions	Main findings
Policy objectives and instruments	The SRHR policy contains a clear vision and clear priorities and these remained unchanged over the period evaluated. The instruments applied the most include negotiation, dialogue, and earmarked and non-earmarked funding.
Budget	On average, about EUR 435 million was spent per year on SRHR during the period evaluated.
Grounds for choice of instruments and channels	During the period evaluated, the strategies and the choice of instruments have been modified to bring them in line with new policy developments. The decision to spend a large part of the funds (over 50%) through multilateral organisations and global initiatives was based on various arguments, including economy of scale and the possibility of participation in the agenda setting of these organisations. Evaluations on the organisations' contributions at beneficiary level are scarce.

3.1 Overview of policy documents

While emphasising the necessity of basic health care, the 2003 development cooperation policy document of the Ministry of Foreign Affairs titled *Mutual interests, mutual benefits* (in Dutch: *Aan elkaar verplicht* (AEV)) stated that two of the four main themes for Dutch development policy were prevention of AIDS and increased efforts in the field of reproductive health.

In 2006, a specific Africa Policy, titled *Strong people, weak states* (in Dutch) *Sterke mensen, zwakke staten*) was formulated. In it, the importance of giving due attention to reproductive health and HIV/AIDS was noted. In addition, the document emphasises the necessity of investing in people by giving due attention to reproductive health, education and HIV/AIDS

In 2007, a new MFA development policy document *Our common concern* (in Dutch *Een zaak van iedereen*) defined gender and sexual and reproductive health and rights as one of the four points of intensification within existing policy. The importance of opening up the dialogue on gender equality and sexuality at national and international levels was stressed.

In 2008, a policy document focusing specifically on SRHR was drafted: *Choices and opportunities: HIV/AIDS and sexual and reproductive health and rights in foreign policy* (in Dutch: *Keuzes en kansen*). It is the first Dutch policy document to address both SRHR and HIV/AIDS. It summarises the international agreements and sets forth a number of challenges: human rights violations, insufficient investments in the health sector, insufficient efforts in other, non-health, sectors, and insufficient cooperation between various partners.

A 2012 letter to Parliament titled *Focus letter*, (in Dutch: *Focusbrief*) went into more detail on the SRHR policy that had been outlined in the general policy document on development cooperation issued in 2011. It reaffirmed the importance of implementing the Cairo agenda and the existence of a link between human rights and SRHR; it also defined expected results at outcome level and impact levels.²² In 2012 the government again reaffirmed defined SRHR as a priority area.²³

3.2 Vision

Throughout the period evaluated, the link between SRHR and human rights and the links between SRHR and HIV/AIDS have been at the core of Dutch SRHR policy. The Netherlands takes the position that health, including reproductive health, is a human right, and sexual and reproductive rights are implicitly included in a number of other human rights.²⁴ This vision implies an emphasis on the individual's free choice regarding sexuality and reproduction. It also implies that special attention will be given to *key populations*, because these groups are at risk of HIV infection and vulnerable to human rights violations related to SRHR. In addition, they may have less access to SRHR and HIV/AIDS services.

3.3 Objectives

In general terms, during the period evaluated, Dutch SRHR policy has aimed at implementing the Cairo agenda and achieving the SRHR-related MDGs, including the specific targets set for these goals. The 2012 policy document defined specific objectives at outcome and impact levels. For some outcomes, specific targets are defined, according to the internationally agreed indicators. These objectives are either implicitly similar to those mentioned in previous policy documents, or are more detailed. The MDGs guide the expected results at impact level.

Millennium Development Goals 4, 5, 6



²² TK 2011-2012, 32 605, no. 93.

²³ At the time of writing, new policy guidelines had not yet been translated into new SRHR policy documents.

²⁴ Art. 12, Covenant Economic Social and Cultural Rights.
<http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>.

Outcomes

- Improved knowledge of sexuality among young people in order to enable them to make healthy decisions on sexuality.
- Improved access to AIDS-related drugs, contraceptive methods and life-saving drugs that ensure good sexual health.
- Increased use of and improved quality of public and private sexual and reproductive health services.
- More respect for sexual and reproductive rights of groups who are denied these rights.

Impact

- Decreased maternal mortality (target is a 75% decrease between 1990 and 2015) and universal access to reproductive health.
- To halt HIV transmission (target is a reduction of 50% among young people between 2011 and 2015).

The 2012 policy document also specifies what actions the Netherlands intends to take in order to achieve the outcomes. For example, internationally and bilaterally the Netherlands will raise the issue of the rights of groups who may be denied sexual and reproductive rights and will promote a rights-based approach in partner countries. Of the other actions, one has already been achieved: two special funds have been established to meet the needs of groups who may be denied sexual and reproductive rights: the Key Population Fund and the Stepping Up Fund.²⁵

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3.4 Strategy and priorities

Although the priorities have remained the same during the period evaluated, there have been changes in strategy. These are grounded in changes in the SRHR situation, alterations to the approach defined at the international level and alterations to Dutch development cooperation policy.

Strategy

Dutch SRHR policy is implemented through a mix of channels, the assumption being that there is complementarity between the channels. The assumption is that multilateral organisations are to keep SRHR on the international agenda, to set standards and to assist countries in drafting and implementing policies. Despite criticism of the functioning of certain organisations, their role is considered essential and the Netherlands tries to influence their functioning.²⁶ Support through the bilateral channel is to enable countries to implement SRHR policy. NGOs are considered to have a watchdog function, to generate innovative ideas and approaches and to be the most appropriate channel for ensuring SRHR for people who are difficult to reach, including young people and key populations.

²⁵ TK 2011-2012, 32 605, no. 93: 4-10. These funds were established so recently that they could not be included in this policy evaluation.

²⁶ TK 2011-2012, 32605, no. 108.

At the international level, the strategy consists of participating in high-level meetings and other events on SRHR topics, and financially supporting international SRHR organisations and partnerships. The Netherlands aspires to incorporate the sensitive topics of the Cairo agenda and the needs of key populations into official declarations. A substantial part of the budget (over 50 %) has gone to multilateral organisations, global initiatives or partnerships that address SRHR and/or the prevention of HIV infections. Support to public private partnerships usually involves research or the production of drugs and commodities. The rationale behind providing such a substantial part of the budget to multilateral organisations and global initiatives is the assumed economy of scale: when many services are delivered at the same time, the price per service delivered will be lower. An example is the purchase and distribution of SRHR commodities. Buying in bulk will lower the price. Other arguments for allocating a substantial part of the budget to multilateral organisations include the possibilities of influencing major funding flows, preventing fragmentation, working in more countries than only the partner countries, and reducing the management load of large numbers of separate contracts.

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At the bilateral level, in principle in all countries the Dutch strategy consists of enhancing the national government's political commitment to SRHR and pointing to the links between SRHR and HIV/AIDS. The objectives and targets of the Dutch government are laid down in multiannual strategic plans and year plans. In addition, in a selected number of countries, the Dutch government provides bilateral funding for SRHR and HIV/AIDS work.²⁷ Until 2011, in partner countries that were considered stable and had selected the health sector as one of the sectors for cooperation, a substantial part of these bilateral funds was allocated as sector budget support to the Ministry of Health, complemented by financial support to projects of multilateral organisations or NGOs. The rationale for budget support was that a properly functioning health system is conditional for improving reproductive health, in particular maternal health. Since 2011, in line with new development policy, budget support has substantially decreased and been substituted by project support. At present, only a few countries still receive health sector budget support. The reasons for withdrawing from sector budget support vary. Several countries that had received budget support over a long period were among the so-called exit countries (Tanzania, Nicaragua, Zambia). In the case of Zambia, the decision to refrain from budget support had already been taken due to allegations of corruption in the sector. In the case of Mali, it was the political situation that influenced the decision to suspend budget support because there was no legitimate government to work with. In the case of Bangladesh, the decision to withdraw from health sector support had already been made in 2008. It was argued that the Netherlands would be able to make more of a difference by supporting specific initiatives. In the case of Ghana, there was no obvious reason for withdrawing from sector budget support.

²⁷ Different categories of countries are mentioned in the general development policy documents. During the period evaluated both the categories and the countries in certain categories changed.

In countries facing or recently having faced conflicts, funds were provided to multilateral organisations and international NGOs that provide humanitarian support including support for SRHR.

During the period evaluated, the share of public private partnerships (PPPs) in the overall SRHR budget remained stable at about 4%. Most partnerships are related to product development, and the Netherlands has structural or informal dialogues with the partnership's management.

Implementation of SRHR through the private non-profit channel includes three types of financial support. Firstly, the MFA provides funding for consortia of Dutch NGOs. Secondly, NGOs may be funded directly through embassies. Finally, a number of international NGOs in the field of SRHR are supported from the central budget. Until 2011, they received core funding; since then, in line with new rules and regulations relating to subsidies, they have received programme support. The rationale of providing support to NGOs is that these organisations are assumed to complement the public sector, especially regarding the more sensitive topics of the Cairo agenda and regarding population groups that are difficult to reach.

Priorities

Priorities can be defined for the type of intervention, the topic, the approach and the target population.

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Regarding the *type of intervention*: one of the chief priorities in Dutch policy has always been prevention, though it figures less prominently in the 2012 policy document than in previous documents. Prevention relates to all areas of SRHR: for example, the prevention of unintended pregnancies, the prevention of unsafe abortions and the prevention of HIV infections. Prevention includes both the prevention of a problem, for example HIV transmission, and the prevention of the adverse effects of a problem, for example preventing that people living with AIDS will be discriminated against. The rationale is that notwithstanding the importance of ensuring access to antiretroviral therapy (ART), prevention of transmission is the only way to halt expansion of the HIV epidemic.

Regarding the *topic*: priority is given to those areas that are considered the sensitive themes of the Cairo agenda. A prominent example is ensuring the prevention of unsafe abortion, because the Netherlands is among the few countries that openly defend this issue. The prevention of unsafe abortion may entail the adaptation of legislation and the provision of information on family planning and on safe abortion procedures. Another example of a priority topic is the reduction of harm among drug users.

Regarding the *approach*: the need for a multi-sector approach is consistently mentioned in policy documents. The 2012 policy document, for example, points to the interrelationship between SRHR and the other priority areas of Dutch international cooperation policy. It is argued that not only the cause and the consequences of SRHR-related problems but also the solutions for these problems are strongly linked to various other sectors. Therefore, prevention and treatment require interventions in various sectors.

An example: maternal mortality will occur more frequently among poor and less educated women. Therefore, maternal deaths can be reduced by increasing girls' access to education and improving the quality of that education.

Regarding the *target population*: Dutch policy documents consistently emphasise the need to address adolescent and young people. An example is the access to information on and use of family planning methods among young, unmarried women. In many countries, this is not matter of course. A second priority is ensuring access to SRHR for all groups that are at risk of discrimination and human rights violations. In the first years of the period evaluated, these groups were referred to as vulnerable groups; now they are called key populations. Key populations are diverse and may, for example, include men having sex with men, and sex workers.

3.5 Instruments applied

The most important instruments deployed in pursuit of the Dutch government's SRHR aims are participation in various types of negotiations and dialogues and the provision of financial support. A selection of these instruments is provided in Table 2.

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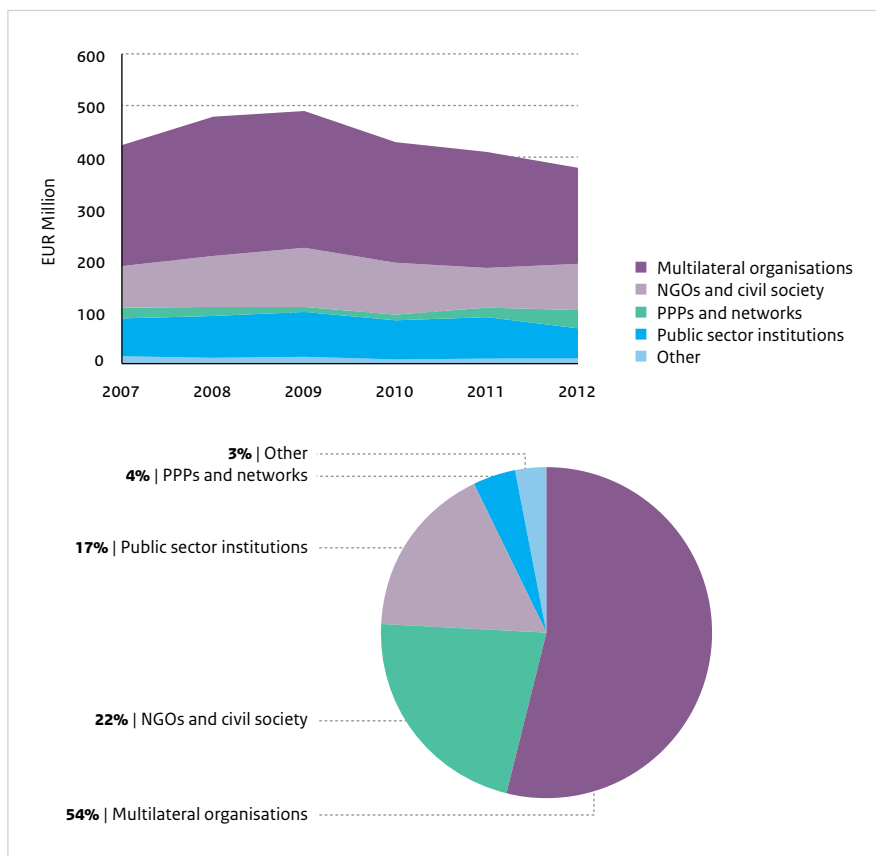
Instrument	Application
Negotiation	<ul style="list-style-type: none"> • Participation in the preparations for or the process of drafting of declarations and other forms of soft law in the framework of UN or regional intergovernmental organisations such as the Council of Europe. • Participation in the policy setting of multilateral organisations by acting as member or observer in the governing bodies of these organisations.
Dialogue	<ul style="list-style-type: none"> • Policy dialogue on SRHR in bilateral relations, aiming at achieving political commitment to SRHR, including the sensitive themes as well as HIV/ AIDS, and at combating exclusion of and discrimination against key populations. • Dialogue regarding sector budget support, emphasising equity issues.
Public state-ments	<ul style="list-style-type: none"> • Speeches. • Contributions to conferences and seminars. • Articles in newspapers and periodicals.
Financial support	<ul style="list-style-type: none"> • Support to the health, education and other sectors of partner countries. In general, these funds are not earmarked, but exceptions do exist. Usually, representatives of the Netherlands participate in a group that accompanies budget support, with the aim of influencing and ensuring procedures are transparent. Core funding and programme funding of multilateral organisations and Dutch NGOs (either individual NGOs or consortiums). • Core funding of global initiatives such as the Global Fund and GAVI Alliance. • Earmarked funding of multilateral organisations for and projects, usually addressing thematic priorities or deprived geographical areas. • Earmarked funding of PPPs, usually aimed at product development. • Earmarked funding to other partnerships. • Earmarked funding for NGO projects, usually those that address areas of work that are not prioritised or even not included in national policies.

3.6 Budget

During the period evaluated, average annual development cooperation by the Netherlands expenditure on health and SRHR was EUR 435 million. Note that this figure is for the whole health sector and thus includes health issues that are not related to SRHR. Figure 1 summarises the expenditure through the various channels and the trend over the period 2007-2012. It excludes support to SRHR through the EU.

Until 2009 the budget increased, but after that a steady decline can be observed. Over 50% of the budget was spent on contributions to multilateral organisations and global initiatives, such as the Global Fund. The proportion allocated to public sector institutions was 17%. The private channel, including the co-financing system, international and local NGOs, accounted for 22%. PPPs accounted for about 4% of the budget.

Figure 1 *Netherlands development cooperation expenditure (EUR million) on health, SRHR and HIV/AIDS in 2007-2012, per channel, excluding support given through the European Union; trend and breakdown for the entire 6 year period.*

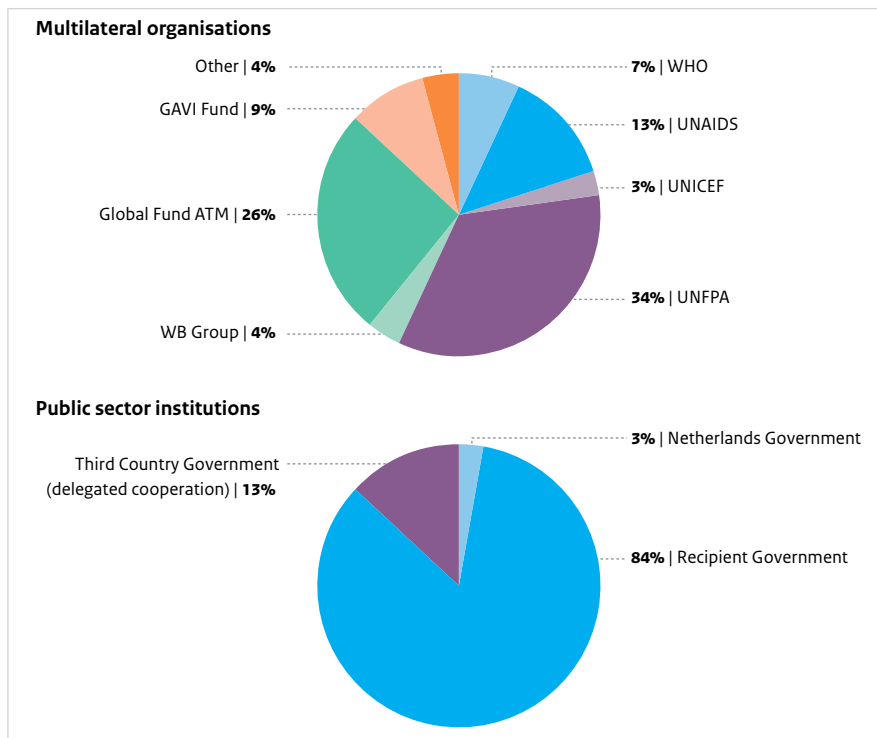


The largest proportion of expenditure from the multilateral channel – over a third – went to UNFPA, followed by the Global Fund (26%), UNAIDS (13%) and the GAVI Fund (9%). Other multilateral organisations and global initiatives supported include WHO (7%), the World Bank (4%) and UNICEF (3%). In addition, these organisations are also supported by Dutch funding indirectly through the EU’s and World Bank’s financial support to them and their initiatives.

On top of the budget described, a substantial proportion (about EUR 450 million per year) of EU development cooperation funds is allocated to health. Over the years, EU funding has increased, but there has been substantial variation between years. About one third of the funding has been allocated to either sector programmes or sector budget support.²⁸ The major part can be labelled as ‘basic health’, and includes issues with an SRHR component. Funding specifically for SRHR accounted for about 5% of the budget.

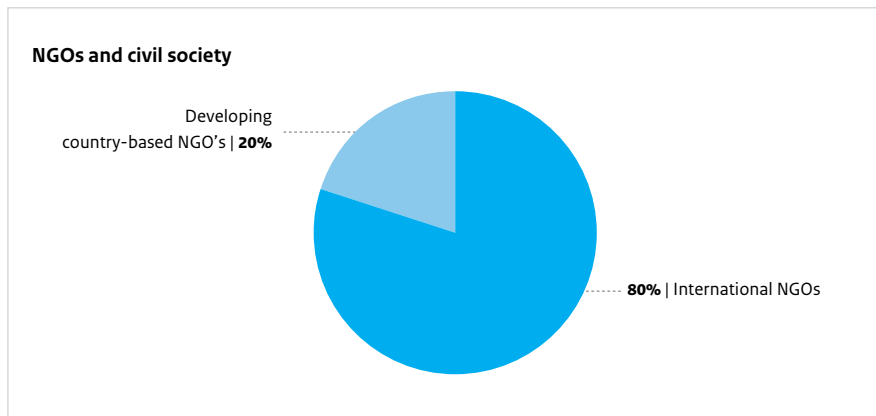
Figure 2 shows the distribution within the channels of delivery.²⁹ It demonstrates that the recipients of the largest Dutch financial allocations for health and SRHR are UNFPA and the Global Fund. It also shows that funding through NGOs mostly involves NGOs working internationally (including Netherlands-based NGOs).

Figure 2 *The breakdown of the expenditure for the three most important channels*



²⁸ European Commission 2012: 13. The amount is a yearly average over the period 2002–2010.

²⁹ By channel of delivery is meant: the first implementing partner. It is the entity that has implementing responsibility over the funds. <http://www.oecd.org/dac/stats/channelofdelivery.htm>.



Source: Piramide (MFA information system) and OECD DAC Channel Codes.

Table 3 makes a distinction between expenditure specifically on SRHR and ‘other health’, which does not necessarily include SRHR-related issues. Other health comprises all activities included in the MFA information system that relate to general health, i.e. health policy and administrative management, medical research, basic health care, infectious disease control (excluding the Global Fund), malaria control, tuberculosis control, health personnel development, human rights and multi-sector aid.³⁰

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SRHR-specific includes all activities included in the MFA information system under specific SRHR CRS-codes plus other CRS-codes under SRHR-related budget categories, i.e. HIV/AIDS (decentral), Reproductive health (decentral), HIV/AIDS (central) UNFPA, MFS/TMF: HIV/AIDS, tuberculosis, malaria, Reproductive health (central) and the Global Fund.³¹

	2007	2008	2009	2010	2011	2012	2007-2012
SRHR-specific	284 (67%)	336 (70%)	347 (71%)	307 (71%)	271 (66%)	248 (65%)	1793 (69%)
Health	138 (33%)	143 (30%)	142 (29%)	122 (28%)	139 (34%)	131 (35%)	815 (31%)
Total	422	478	489	429	410	379	2,608

Source: Based on Piramide.

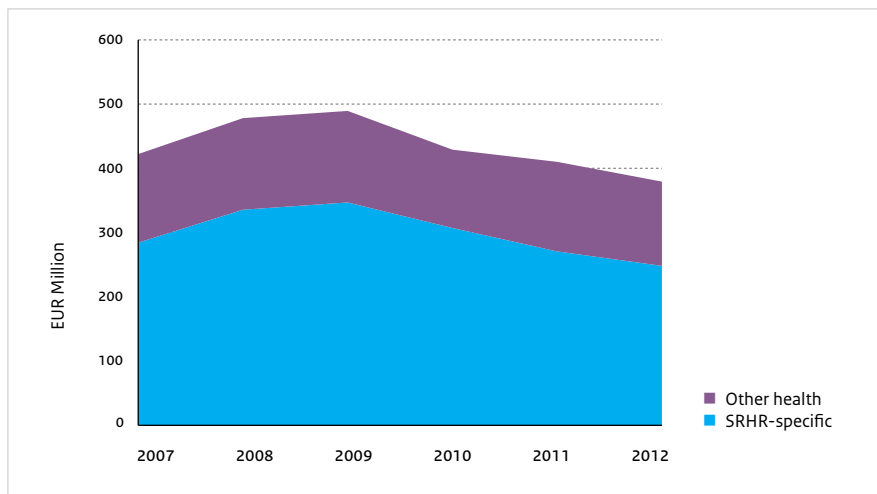
Figure 3 complements Table 3. It presents the trend over 2007-2012. Note that the financial contribution to the Global Fund has been included in SRHR-specific expenditure, on the grounds that most Global Fund financing is related to SRHR. The figure shows that overall

³⁰ OECD CRS codes 12110, 12182, 12220, 12250, 12250, 12261, 12263, 12281, 15160, 43010.

³¹ OECD CRS codes 13010, 13020, 13030, 13040, 13081, 16064 plus other CRS codes under SBE 0610S19, 0610S20, 0620S15, 0803S00, 1908S00, 1925S00.

somewhat less than one third of total expenditure was on 'other health' and slightly over two thirds was SRHR- specific. Expenditure on 'other health' remained fairly constant in absolute numbers but increased slightly in relative terms because of a reduction in the financial contributions to UNAIDS.

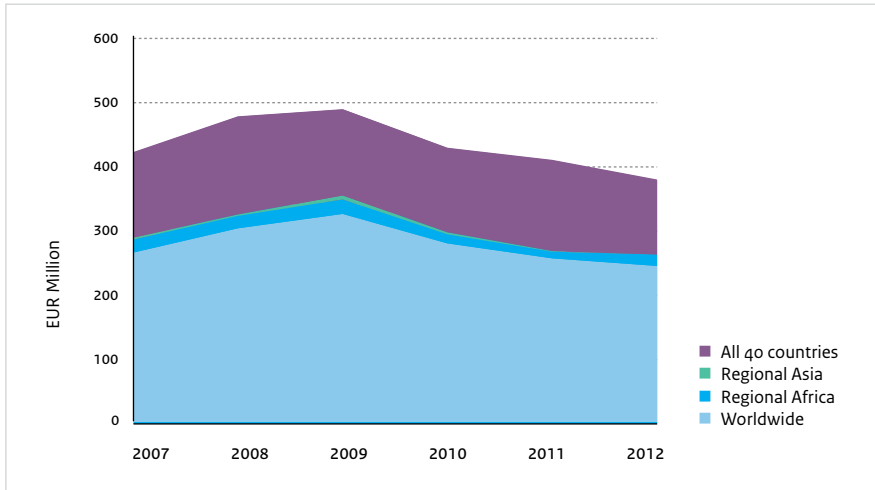
Figure 3 Trend in Netherlands development cooperation budget allocation specifically to SRHR and to SRHR-related health 2007-2012 (EUR million)



Source: Piramide (MFA information system) and OECD DAC Channel Codes.

In total, 40 countries received SRHR funding from the Netherlands in the period evaluated. Figures 4 and 5 present more details on the geographical allocation of the budget. Figure 4 shows that the largest part of the budget was allocated to programmes with a worldwide scope. This is in line with the fact that a substantial part of the budget was allocated to multilateral organisations and global initiatives.

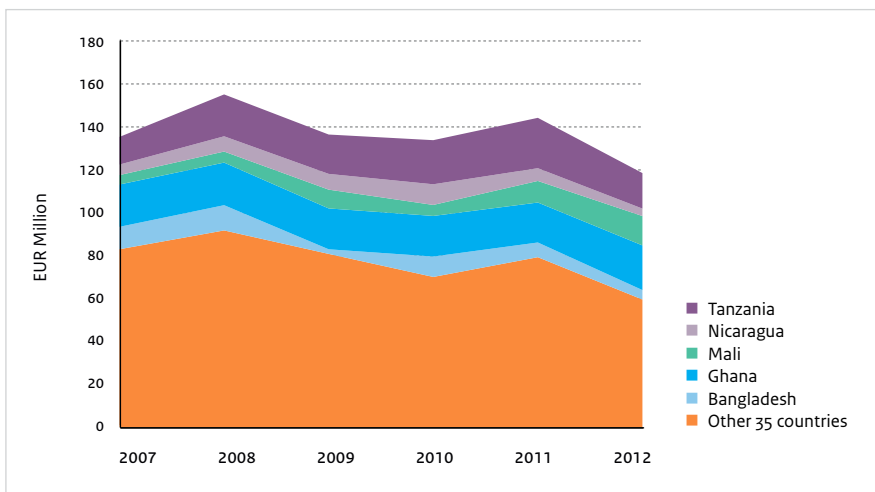
Figure 4 *Trend in Netherlands development cooperation budget allocation to SRHR 2007-2012 (EUR million), by geographical area*



Source: Piramide (MFA information system).

Figure 5 presents the budget allocation to the five case-study countries in this policy evaluation and compares this with the budget allocation to the remaining 35 countries. During the period evaluated, these five countries received about 44% of the total budget for 40 countries.

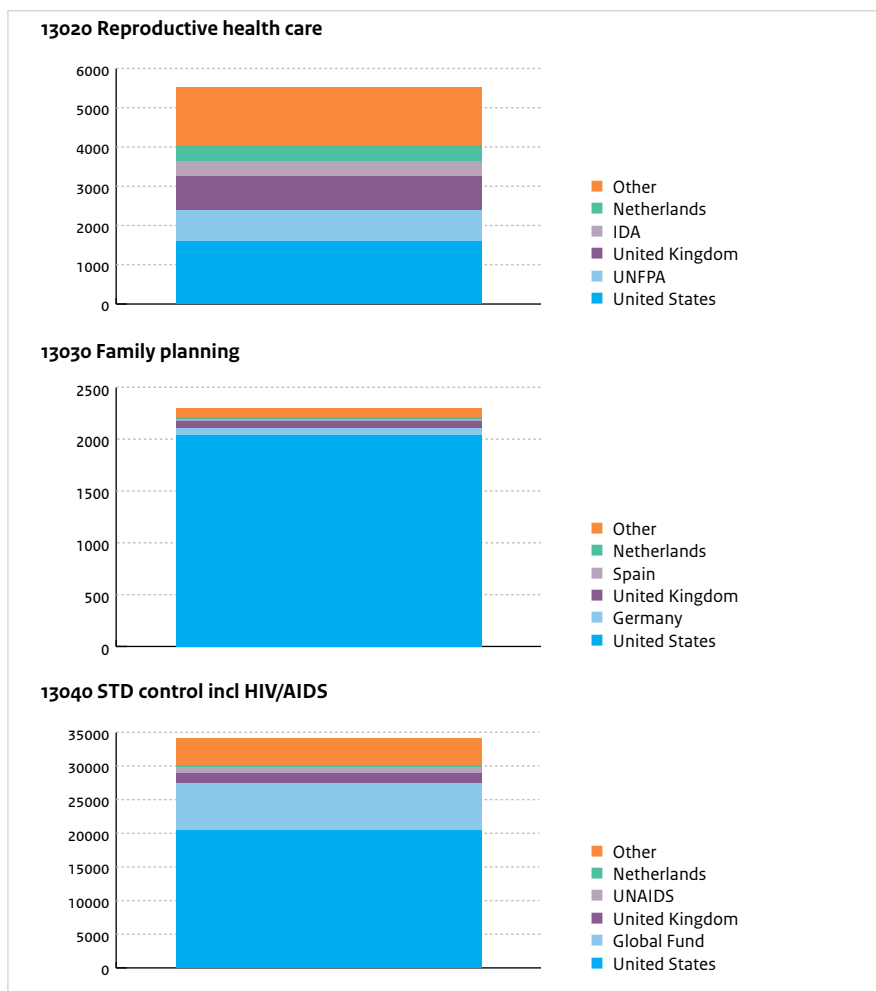
Figure 5 *Breakdown of the budget allocation 2007-2012 (EUR million), showing the 5 case-study countries in relation to the total budget for 40 countries*



Source: Piramide (MFA information system).

The largest bilateral donor regarding SRHR³² is, by far, the United States of America, followed by the UK and Germany. The Netherlands is the sixth largest donor. It should be taken into consideration that the contribution to general health is not included in these figures.³³ Figure 6 presents the data for specific SRHR areas. It is to be noted that the data regarding the bilateral donors exclude these donors' contributions to multilateral organisations, EU institutions and global initiatives.

Figure 6 Donors' involvement in three OECD thematic areas of SRHR in 2007-2012 (Total, in million US Dollar)



Source: OECD.

³² Population policies/programmes & Reproductive health, CRS Codes: 13010, 13020, 13030, 13040, 13081. Source: OECD website.

³³ <http://stats.oecd.org/qwids/#?x=1&y=6&f=4:1,2:1,3:51,5:3,7:1&q=4:1+2:1+3:51+5:3+7:1+1:2+6:2007,2008,2009,2010,2011,2012>

3.7 Discussion

It is clear that Netherlands SRHR policy is consistent and the decision to prioritise the sensitive topics of the Cairo agenda, young people and key populations is in line with its commitment to emphasise human rights. Dutch SRHR policy reflects the fact that the Netherlands is party to all relevant international conventions on SRHR and a signatory to the relevant resolutions and declarations. In addition, the themes and key populations prioritised by the Netherlands are at risk of not being included in national policies. The Netherlands has spoken out to keep the sensitive issues on the international agenda, while other countries have been more hesitant. Although it has been reported that political commitment to these topics and target groups declined in the Netherlands in the period 2011-2012³⁴, statements from the present Minister point to the Dutch government's renewed commitment to SRHR.

The policy objectives are well defined and, though their phrasing changed, have remained consistent during the period evaluated. In quantitative terms, the Netherlands is committed to achieving the MDGs and thus to achieving the MDGs relating to SRHR. The multi-annual strategic plans drawn up by the Netherlands for individual countries usually include specific targets, but they are not always realistic.

The prioritisation of prevention is appropriate, given that most SRHR-related problems are preventable. Prevention is worded in very general terms and interventions are not usually based on an assessment of the evidence. In the area of HIV/AIDS, for example, the distribution of educational materials has definitely contributed to increasing recipients' knowledge about HIV transmission, but there is little evidence that knowledge also leads to behaviour change. Most SRHR problems are closely related to socio-economic and cultural factors. The decision to adopt a multi-sector approach is therefore logical. Dutch policy documents provide little on how to make this approach operational, and the contribution of other sectors to SRHR outcomes has been largely undocumented.³⁵

The decision to allocate a substantial part of the Netherlands budget for SRHR to multilateral organisations is guided by the economy of scale and the possibility of participation in the agenda setting of these organisations. The decision is not based on a review of the literature or by evidence-based evaluations on whether these organisations have contributed to improvements in the area of SRHR and, if so, how.

The decision to reduce sector budget support is guided by an overall decision to reduce support to the public sector and health systems in general and not by evidence from literature studies or evaluations of general or sectoral budget support.

³⁴ Interview in 2012. Food security and water were given more emphasis. An example: no member of the government of the Netherlands attended the 2011 UN high-level meeting on HIV/AIDS.

³⁵ World Bank 2009: xix.



4

Ethiopia, mother and child (Esther Jurgens, 2013)

Maternal and perinatal health

This chapter will assess whether Dutch international cooperation in the area of SRHR has contributed to better maternal and perinatal health. It reports on the results of country studies in Ghana, Bangladesh, Nicaragua and Tanzania, on an evaluation of budget support in Zambia and on the results of evaluations of the EU, international organisations and NGOs. The main findings are:

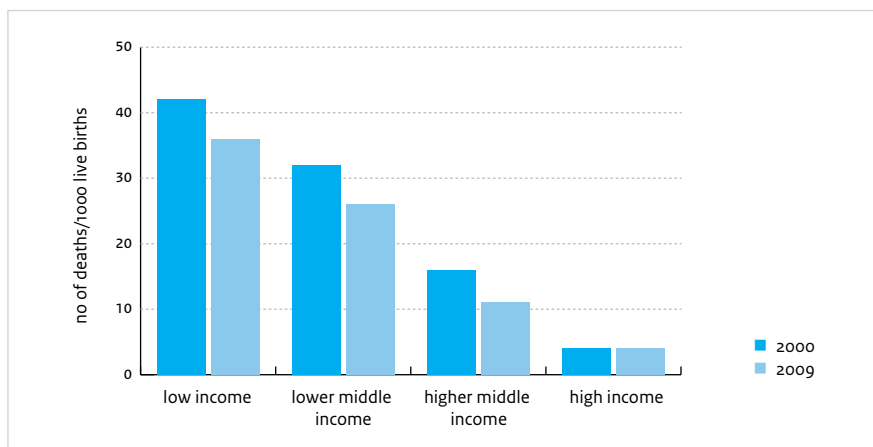
Research questions	Main findings
Access to emergency drugs and reproductive health services	Dutch support to the health sector and to multilateral organisations and NGOs has contributed to improved access to maternal and perinatal health services, including obstetric emergency care. Inequities between population groups have hardly decreased.
Pregnancy-related mortality	Dutch support to SRHR has contributed to the reduction of infant and maternal mortality. There are substantial inequities, except for infant mortality in Tanzania.

4.1 Problem setting

In recent decades, mortality among young children has declined steadily worldwide. There are still striking differences between poor and rich countries and between poor and rich population groups. Figure 7 shows the data for the very young, the neonates.³⁶ Data are aggregated for countries with different income levels. The figure shows that in relative terms, most progress has been achieved in the middle income countries.³⁷

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Figure 7 Global neonatal mortality rates in 2000 and 2009, by country income level



Source: WHO 2011a: 54.

³⁶ Neonatal mortality refers to the number of deaths among children <28 days/1,000 live births. Child mortality refers to the number of deaths among under-fives/1,000 live births. It includes the neonatal mortality.

³⁷ In 2000 the neonatal mortality rate was already very low in high income countries.

Mortality and morbidity among children is strongly related to the mother's educational level. About half of the reduction in the child mortality in recent decades can be attributed to improved educational attainments of young women. Economic development has also played a role, but to a lesser extent than the mother's educational level.³⁸ Another factor that has contributed to the reduction of child mortality is better access to health services.

The impact of access to health services is stronger for neonates than for older children. Maternal mortality has also decreased.³⁹ It is estimated that the number of maternal deaths fell by one third over the last two decades, with striking differences between the developed and developing countries (see Table 4). The decrease was smallest in Africa.⁴⁰

	Maternal mortality rate (per 100,000 live births)		
	1990	2000	2011
Worldwide	299.3 (280.2-320.4)	299.5 (286.9-313.3)	201.8 (189.2-215.3)
Developing countries	335.8 (314.2-358.6)	332.2 (318.0-347.2)	224.7 (210.3-239.8)
Developed countries	21.7 (21.0-22.5)	20.8 (20.1-21.6)	18.0 (16.4-19.8)

Source: Lozano et al. 2011.

About 90% of maternal deaths are caused by severe bleeding, infections, high blood pressure during pregnancy, obstructed labour and unsafe abortion; there are large regional variations. Most causes are either preventable or treatable.⁴¹ In malaria-endemic areas, malarial anaemia contributes to more than half of maternal deaths.⁴² Indirect causes include a variety of factors, such as income, educational level, nutritional status during pregnancy, gender equality and the availability of emergency obstetric care.

An analysis of the availability and quality of emergency obstetric care worldwide showed that in all the dimensions of these services the key component is human resources. It also presented robust data on the negative impacts of staff shortages on emergency obstetric care and reported that certain qualitative imbalances such as in gender or social class affect the quality of such care.⁴³

³⁸ Gakidou et al. 2010: 969-970.

³⁹ Maternal mortality refers to the number of deaths due to pregnancy or delivery/100,000 live births.

⁴⁰ Lozano et al. 2011.

⁴¹ <http://www.who.int/mediacentre/factsheets/fs348/en/>.

⁴² http://www.rbm.who.int/cmcc_upload/0/000/015/369/RBMInfosheet_4.htm and http://www.who.int/malaria/high_risk_groups/pregnancy/en/index.html.

⁴³ <http://www.human-resources-health.com/content/7/1/7#B42>.

4.2 Policy

For decades, maternal and child health have been high on the international agenda and several initiatives have been taken to improve maternal and child health. Examples include the Safe Motherhood Initiative, launched in 1987 by several multilateral organisations and in 2004 expanded to Partnership for Safe Motherhood and Newborn Health, and the integrated management of childhood diseases. One of the key factors for improving maternal and perinatal health is skilled birth attendance. In countries with low health services coverage, the training of community health workers may be an intermediate way to reach those in greatest need. There is evidence that interventions at community level have reduced deaths among newborns.⁴⁴

In 2010, the United Nations Secretary-General launched a global strategy for women's and children's health (Every Woman, Every Child), calling upon partners to take action to increase the efficient delivery of services and accelerate progress towards MDGs 4 and 5. The strategy includes support for country-led health plans, integrated delivery of health services and life-saving interventions, innovative approaches to financing, and improved monitoring and evaluation. In 2010, the Partnership for Maternal, Neonatal and Child Health launched a package of interventions to address inadequacies at health services level, following a continuum of care approach and including actions at community and household levels, such as care for transport.⁴⁵

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The EU's political commitment to SRHR is strong. Examples include a 2003 regulation on 'Aid for policies and actions on reproductive and sexual health and rights in developing countries', the EU agenda for action on MDGs (2008) and the 2010 'Council conclusions on the EU role in global health'. In contrast to this commitment, SRHR does not figure prominently in the strategic planning of the European Commission regarding health. However, support to basic health care is a priority and this includes maternal and child health. In addition, a small part of the SRHR-specific EU budget has been specifically allocated to maternal and child health.⁴⁶

In bilateral relations, until 2011 Dutch support to maternal and child health was provided mainly through health sector budget support. The rationale is that a well-functioning health system is conditional for perinatal and maternal health and for lowering perinatal, neonatal and maternal mortality. In addition, non-earmarked funds have been allocated to multilateral organisations. Dutch support helped to enable WHO to develop guidelines and support for countries, to strengthen their health systems and improve their perinatal and maternal health services. NGOs received both non-earmarked and programme funding for carrying out health programmes and projects that are intended to complement the public sector, for example in remote areas.

⁴⁴ White (2005) quoted in IOB 2009: 24.

⁴⁵ WHO 2010c.

⁴⁶ European Commission 2012: 43-44. The total amount of the specific MCH funding is about EUR 3 million per year.

4.3 Ghana

Ghana is an important partner for the Netherlands.⁴⁷ It is the third trading partner in Africa and there is a large Ghanaian community (about 40,000 people) in the Netherlands. The largest donor to health in Ghana during the period studied was the Netherlands. It provided both sector budget support and project support, totalling about EUR 19 million per year. In the area of SRHR, the Netherlands was among the ten largest donors, but its share was small: 1.5% of the total.⁴⁸ In addition, SRHR in Ghana benefited from Dutch core funding to headquarters of multilateral organisations and international NGOs implementing SRHR programmes and policies in Ghana. The most important of these organisations were UNFPA, the international Planned Parenthood Federation, Marie Stopes International and Ipas.

Ghana's domestic expenditure on health was about 4.8% of the gross national product in 2011, a slight decrease compared to the previous three years.⁴⁹ Ghanaian health policy is laid down in a programme of work. The programme emphasises the need for equal access to basic health services, and several initiatives, such as the high impact rapid delivery programme (HIRD) seek to accelerate access for underserved people. Through sector budget support the Netherlands provided funds for the implementation of this programme and the EKN participated in dialogues on its development and implementation. The 2007-2011 programme of work includes several targets in the area of perinatal and maternal health, such as improving the quality of antenatal care, an increase in the number of skilled attended deliveries and ensuring that all health facilities offer access to basic, comprehensive essential obstetric care.

Access to and quality of services

Perinatal and maternal health is strongly related to the availability of good quality health services that can respond to unforeseen obstetric emergencies and to problems with the newborn. Overall, use of health care services in Ghana has substantially increased since 2003, mainly due to the introduction of a national health insurance system. However, the health care system has been unable to deal with the large increase in demand in terms of resources and provision of medicines, thus compromising the quality of care. A major barrier preventing access to facilities is the negative attitude of public health staff.⁵⁰

Findings from Greater Accra, Kumasi and Tema in 2006 indicate that women in urban areas choose a clinic on the basis of their views on the professionalism and attitudes of the health

⁴⁷ Unless otherwise indicated, the information in this section is based on IOB 2012a.

⁴⁸ Data OECD 2003-2011 on Population policies/programmes & Reproductive health. Global Fund and USA contributed over half of the total of the yearly amount of USD 56.6 million that was allocated to specific population and reproductive health programmes. CRS Codes: 13010, 13020, 13030, 13040, 13081, <http://stats.oecd.org/qwids/#?x=1&y=6&f=q:1,2:1,3:51,5:3,7:1&q=4:1+2:1+3:51+5:3+7:1+1:2+6:2007,2008,2009,2010,2011,2012>.

⁴⁹ <http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS>. Expenditure by the other countries that are mentioned below is also based on this World Bank data.

⁵⁰ Verification mission March 2011.

staff. Preference for a health facility is also influenced by queuing time and cost.⁵¹ A monitoring report by the Alliance for Reproductive Health Rights claims that simply removing user fees for maternal care will not be sufficient to lead to improvements in the use of health care services: to effectively increase the uptake of services, the behaviour of health care providers must be improved.⁵²

The overall increase in health care use is reflected in data on SRHR services use. The *antenatal coverage* (at least four visits) increased from 69% in 2003 to 78% in 2008. Differences between urban and rural areas were already small in 2003 and had slightly decreased in 2008. Differences between the regions were substantial in 2003, but had decreased in 2008.

The quality of care differs between socio-economic groups. Care for higher income groups is more frequently provided by doctors and midwives, while lower income groups receive care from lower level medical staff. This results in differences in the service offered: only women from the higher income groups and education levels received information about complications. There are also substantial regional differences in the quality of care, and these have remained unchanged since 2003. Nationwide, antenatal care includes blood and urine tests in 90% of pregnant women, but in the Northern and Upper West regions this percentage is only 60%. The targeting of underprivileged regions has thus contributed to more equal access to antenatal care, but differences in the quality of care have remained substantial.

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Skilled birth attendance increased gradually over the last decade. Demographic health surveys report an increase from 47% in 2003 to 59% in 2008; this compares with the 55% for 2008 reported by WHO for the global average.⁵³ The percentage comes close to the percentage of institutional deliveries but remains low in comparison to the antenatal care coverage. Explanations for the low uptake of skilled delivery are claimed to be provider attitudes, socio-cultural challenges and insufficient availability of midwives. In 2003, over three quarters of institutional deliveries took place in the public sector; in 2008, the public sector was even more important.

In institutional deliveries, large discrepancies remain between socio-economic groups and regions. In urban areas the probability that a woman will deliver in a health facility is twice as high as in rural areas, and in the Northern Region one in four deliveries takes place in a clinic, against four in five deliveries in Greater Accra. The lowest education and income groups most often deliver at home, but home delivery is rare for women in the highest education or income groups. The role of traditional birth attendants within communities is large, especially in remote areas. The percentage of women who received *postnatal care* is the same as that of women who received skilled delivery attendance.

⁵¹ Steedman Group Market 2006. Ghana Health Sector Research Report, prepared for Marie Stopes International.

⁵² Alliance for Reproductive Health Rights 2010. Tracking Health MDGs. Beneficiary Perspectives (p. 38).

⁵³ <http://www.who.int/gho/countries/gha/en/>. WHO does not provide more recent data on this indicator.

Access to caesarean sections has increased nationwide, from 4% in 2003 to 7% in 2008. Access has increased the most in Central Region (from 1% to 10%) and the number of caesarean sections in Greater Accra has fallen slightly (from 12% to 10%). These numbers are strongly related to access to professionally assisted deliveries.

Mortality trends

Ghana has made great progress towards attaining the MDG on child mortality. Since 1990, child mortality has decreased by 40%. Neonatal mortality has also decreased, but more slowly: it declined from 40 per 1,000 in 1990 to 30 per 1,000 in 2008 (a fall of 25%) and was 28 per 1,000 in 2010.⁵⁴ As a consequence, the proportion of under-five deaths that were newborns increased (to 38% in 2008). In addition, there is a great variation between the regions, pointing to unequal access to safe delivery. This conclusion is reinforced by the fact that more than half of the neonatal deaths were caused by infections or asphyxia.

Though the maternal mortality rate also declined substantially over the period 1990-2008, it is still very high. It was estimated at 400 per 100,000 live births in 2008, and for the year 2010 it was estimated at 350.⁵⁵ Maternal mortality rates show great regional differences, pointing to unequal access to and varying quality of health services. The proportion of maternal mortality among teenagers is not known. However, teenage pregnancies are common, and teenagers have a high risk of undergoing unsafe abortions and complications during childbirth.⁵⁶

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Conclusion

There is moderate evidence that Dutch support to the health sector has contributed to increased perinatal and maternal health service use and to decreased maternal and child mortality.

4.4 Bangladesh

This section will provide information on Dutch support to the Health, Nutrition and Population Sector Programme (HNPS) and to a project carried out by UNICEF and the NGO BRAC to reduce maternal, neonatal and child mortality and morbidity. It is mainly based on document review, complemented with interviews with BRAC staff in 2012.

In the last decade or so, financial contributions to Bangladesh from the Netherlands included EUR 37.5 million to the HNPS (2005-2010) and EUR 5.9 million to a joint UNICEF/BRAC government programme (2008-2012). The programme also received financial support

⁵⁴ http://www.unicef.org/infobycountry/ghana_statistics.html.

⁵⁵ http://cdrwww.who.int/pmnch/topics/maternal/20100402_ihmearticle.pdf. This 2008 estimate is based on a survey: <http://data.worldbank.org/indicator/SH.STA.MMRT>. The 2010 estimate by the World Bank is based on modelling.

⁵⁶ <http://data.worldbank.org/indicator/SP.MTR.1519.ZS/countries>. In 2008 13% of girls between 15 and 19 were either pregnant or had already borne a child.

from the United Kingdom and Australia. In 2009, after the Minister for Development Cooperation had visited Bangladesh, it was decided to discontinue support to HNPS and to focus on specific SRHR issues and on programmes that directly address the health needs of the population.⁵⁷ The implication was that strengthening the health system was no longer considered to be a priority area, though Bangladesh was still confronted with high maternal mortality. It also excluded the Netherlands from dialogue with the government. The multiannual strategic plan reconsiders providing limited support to HNPS, enabling the Netherlands to participate in dialogues on equity and gender issues.⁵⁸

During 2007-2012, average annual Dutch expenditure on health and reproductive health programmes in Bangladesh was about EUR 7.5 million.⁵⁹ Although the Netherlands is among the ten largest donors in the area of SRHR, it is still a relatively small player. The Dutch share of total funding for population and reproductive health received by Bangladesh in the period 2007-2011 is about 3.2%.⁶⁰

In Bangladesh, domestic expenditure on health is low: about 3.5% of GDP in 2011, similar to the 2008 percentage. The Bangladeshi government has outlined a national health policy which includes 15 goals and objectives, 10 policy principles and 32 strategies. At the core of the policy is making necessary medical utilities available for people from all strata of the population. Important goals are the reduction of malnutrition, child mortality and maternal mortality. Strategies include prevention, providing health services and ensuring that these services are of good quality.⁶¹

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Access to and quality of services

The preliminary results of the 2011 demographic health survey point to increased *antenatal care* coverage.⁶² In 2011, 68% of women giving birth in the three years preceding the survey had received antenatal care at least once from a provider. Most of these women (55%) had received care from a medically trained provider. Comparable data from the 2004 and 2007 surveys show that antenatal care from any provider increased by 17% over the past few years (from 58% in 2004 to 68% in 2011), but during the same period antenatal care from a medically trained provider increased by only 4% (from 51% to 55%). In 2011, women also received antenatal care more often than previously.

The likelihood of receiving antenatal care from a trained provider declines rapidly with increasing age and birth order. Women in rural areas used antenatal care services less than urban women. There are also considerable inequalities between regions and between

⁵⁷ Archives MFA; internal memo DAO 411/09; dossier note 2008.

⁵⁸ Multi-annual strategic plan 2010-2011. Archives MFA. At the time of writing, a contribution was under consideration.

⁵⁹ Data Piramide, MFA.

⁶⁰ Largest ODA-donors in Population policies/programmes & reproductive health; CRS Codes: 13010, 13020, 13030, 13040, 13081. This includes multilateral organisations and funds. <http://stats.oecd.org/qwids/#?x=1&y=6&f=4:1,2:1,3:51,5:3,7:1&q=q:4:1+2:1+3:51+5:3+7:1+1:2+6:2007,2008,2009,2010,2011,2012>.

⁶¹ http://www.mohfw.gov.bd/index.php?option=com_content&view=article&id=74%3.

⁶² <http://www.measuredhs.com/pubs/pdf/PR15/PR15.pdf>.

wealth quintiles and educational status. These have not narrowed but instead have slightly widened. Between 2007 and 2011 antenatal care from a trained provider declined among women who had not had any formal education, women in the lowest wealth quintile and women in Sylhet and Kulna divisions.

Skilled birth attendance has doubled in recent years, from 16% in 2004 to 32% in 2011. The coverage is still substantially lower than the target of 50% set for 2016 in the HNPSP. Delivery by medically trained personnel is more likely for births to mothers with secondary or higher education, and for births to mothers in the highest wealth quintile. Table 5 summarises the findings on the increase of service use, but data on service use also point to *gaps in quality*: the *high* proportion of caesarean sections is an issue of concern, raising questions about the quality of care.

Table 5 Women's use of perinatal services in Bangladesh (%) in 2004 and 2011		
	2004	2011
Antenatal care by any provider	58%	68%
Antenatal care by medically trained provider	51%	55%
Skilled birth attendance	16%	32%
Postnatal care	-	34%

Source: preliminary data DHS 2011.

About 29% of women received *postnatal care* within 42 days of delivery. Postnatal check-ups are slightly more common for newborns (34%). Coverage is still far below the target of 50% set for 2016.

A WHO study revealed that equity gaps were greatest for interventions that require 24-hour availability of services and have a higher potential cost, i.e. those services that are most needed in the case of obstetric emergencies. Equity gaps were smallest for interventions that are available outside the health system.⁶³

The 2011 review of the UNICEF/BRAC/government programme reports points to increased services use in the districts covered by the programme, though without providing specific data.

Mortality trends

Over the last two decades, Bangladesh has made steady progress in decreasing child mortality rates. Child mortality declined by more than half in the period 1993-2011 (from 133/1,000 live births to 53/1,000). Neonatal mortality, an indicator that is strongly related to the functioning of the health system, also decreased, but less steeply (from 52/1,000 in 1993 to 32/1,000 in 2011). According to an impact study carried out in 2005, the progress made is largely due to economic growth and the support from international partners to public health interventions.⁶⁴

⁶³ http://www.who.int/pmnch/media/press_materials/pr/2012/bangladesh_casestudy.pdf.

⁶⁴ White 2005.

Since 2001, maternal mortality has declined by 40% from 322/100,000 live births to 194/100,000 in 2010.⁶⁵ This reduction is in line with an overall mortality reduction among women. All causes of direct obstetric death have declined. The reduction of the contribution of abortion is notable: in 2001 it was estimated that abortion was the direct cause of 5% of maternal death, but in 2010, only 1% was attributed to abortion.⁶⁶ The decline of maternal mortality is in line with data on increased use of antenatal care and skilled birth attendance. Underlying factors are better communication (mobile phones) and better transport means, allowing for timely treatment of obstetric emergencies. The overall rise in educational level has also contributed to better maternal health, because it has led to more appropriate health-seeking behaviour.⁶⁷

Conclusion

There is moderate evidence that Dutch support to SRHR has contributed to increased service use and to decreased child and maternal mortality. There are still substantial gaps between better-off women and women with less education or income.

4.5 Nicaragua

The findings of a Nicaraguan country evaluation are similar to those of Ghana and Bangladesh.⁶⁸ Until 2011, the Netherlands provided about EUR 6 million per year to the health sector, but the amounts declined over the years. The most important channel was sector budget support, though the share of the total was much smaller than in Ghana. The objective of sector budget support was to increase access to good quality basic health care for everyone. In 2008, domestic expenditure on health was about 9% and in 2011 it increased slightly (to 10%).

From 2007-2012, Dutch yearly expenditure on health and SRHR programmes in Nicaragua was EUR 6.3 million⁶⁹ and the Netherlands was the third largest bilateral donor in the area of SRHR, with a share of 9.3% of total donor funding in the period 2007-2011.⁷⁰

Health services use has increased and become slightly more equitable. Uptake of health care in poor regions is still considerably less than in richer regions. Regarding SRHR services, the percentage of institutional deliveries in public services hardly changed (60% in 2005 and 62% in 2008). The gaps between poor and richer regions remained the same.

⁶⁵ <http://www.cpc.unc.edu/measure/our-work/family-planning/BMMS%202010%20summary%20-%20implications.pdf/view>.

⁶⁶ <http://www.bids.org.bd/RcntRsrchDetails.php?id=100&Page=Research%20Details>.

⁶⁷ http://www.unfpa.org/sowmy/resources/docs/library/R257_StreatfieldP_2010_Bangladesh_MMR_HealthCare_Survey.pdf

⁶⁸ IOB 2010 chapter 7.

⁶⁹ Data Piramide, MFA.

⁷⁰ Largest ODA-donors in Population policies/programmes & reproductive health; CRS Codes: 13010, 13020, 13030, 13040, 13081. This includes multilateral organisations and funds. <http://stats.oecd.org/qwids/#?x=1&y=6&f=4:1,2:1,3:51,5:3,7:1&q=4:1+2:1+3:51+5:3+7:1+1:2+6:2007,2008,2009,2010,2011,2012>.

In the case of obstetric emergencies, many women still do not have easy access to emergency obstetric care. No evidence could be found that the Netherlands brought up inequity issues during the regular dialogues about sector budget support.

In common with Ghana and Bangladesh, health indicators for Nicaragua improved steadily over the last decade. Infant and child mortality decreased to 31 and 35 per 1,000 live births respectively (2006/7). Maternal mortality also decreased. There are great differences between the regions: in the poor Northern coastal region, infant and child mortality rates were double the average.

In conclusion, there is moderate evidence that Dutch support to SRHR has contributed to increased services use and decreased mortality rates.

4.6 Tanzania

This section gives information on the results of Dutch support to health and SRHR, which totalled about EUR 18.4 million per year in the period 2007-2012.⁷¹ The support was mostly health basket funding and health sector budget support, complemented with financial support to NGOs active in the areas of HIV (see chapter 7) and female genital mutilation. Domestic expenditure on health as percentage of the GDP has risen: from 5.4 % in 2008 to 7.4% in 2011.

In the period 2007-2011, the Netherlands was the seventh largest bilateral donor in the area of SRHR. However, its share in the total funding of this area was small: slightly over 1%.⁷²

The Tanzanian government's five-year health sector strategic plan 2009-2015 aims at improving the health and wellbeing of all Tanzanians, with a focus on those at high risk, and on improving the quality and accessibility of health services. Underlying principles emphasise gender equity and key populations as cross-cutting themes. The plan also focuses on decentralisation, community participation and inter-sector collaboration.

Access to and quality of services

The results of the 2010 demographic health survey show that *antenatal care* coverage (ANC) was very high.⁷³ Of women who gave birth in the five years preceding the survey, 96% received ANC from a skilled provider at least once, and in most cases the ANC had been provided twice or three times. In most cases, ANC was most cases provided by nurses and midwives. Differences between regions, educational levels and wealth quintiles exist, but are small.

⁷¹ Data Piramide, MFA.

⁷² Largest ODA-donors in Population policies/programmes & reproductive health; CRS Codes: 13010, 13020, 13030, 13040, 13081. This includes multilateral organisations and funds. <http://stats.oecd.org/qwids/#?x=1&y=6&f=4:1,2:1,3:5:1,5:3,7:1&q=4:1+2:1+3:5:1+5:3+7:1+1:2+6:2007,2008,2009,2010,2011,2012>.

⁷³ [http://www.measuredhs.com/pubs/pdf/FR243/FR243\[24June2011\].pdf](http://www.measuredhs.com/pubs/pdf/FR243/FR243[24June2011].pdf).

Despite this high coverage, there is still room for improvement. The majority of Tanzanian women did not make the recommended number of ANC visits, and women came quite late in pregnancy. Only 15% made their first visit before the fourth month, and one third of the women waited until the sixth month. There is also room for improvement regarding the quality of care. For example, based on reporting by the women, it can be concluded that not all women received correct information on possible complications regarding deliveries, and that there were large regional differences in this and in other quality of care aspects.

Skilled birth attendance has slightly increased since 2004: in 2010, half of women were assisted by a skilled provider – in the majority of cases in a public health facility. There are substantial differences between women with different income and educational levels. About one third of women with no formal education received assistance from a skilled provider, compared with 86% of women with secondary education. Data on wealth quintiles reveal similar differences. As may be expected, there are also important regional differences: the coverage of skilled birth attendance varied from one third in Kigoma and Shinyanga to 90% in Dar es Salaam.

About 35% of women received *postnatal care* within 42 days of delivery, mostly within the first days.

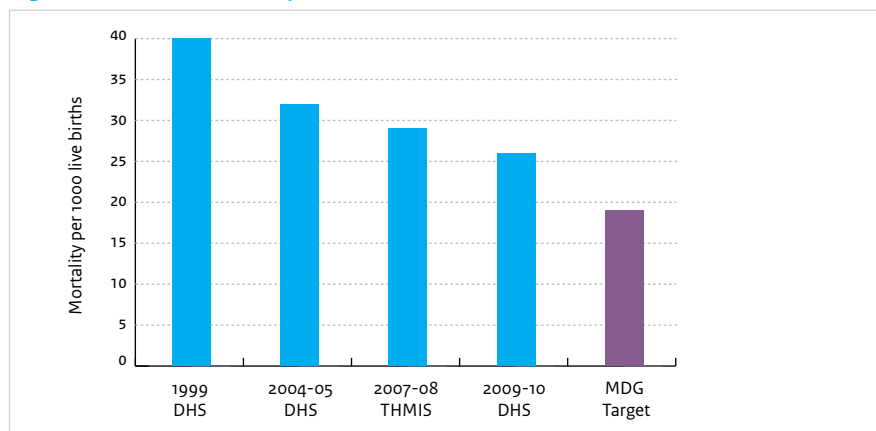
The DHS included questions on the reasons why women did not access health services. Over one third of women reported at least one barrier: in most cases, lack of money or distance to the health centre. Obtaining permission was rarely mentioned as a barrier (2%).

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Mortality trends

Over the last two decades, neonatal, infant and child mortality has declined steadily. Since 1999, infant mortality has declined by half (from 99/1,000 live births to 51/1,000 in 2010) and child mortality has declined by 40% (from 147/1,000 to 81/1,000). Neonatal mortality, the indicator that is most related to a well-functioning health system, decreased from 40/1,000 to 26/1,000. Figure 8 shows the trend.

Figure 8 Neonatal mortality in Tanzania; trend 1999-2010



Source: DHS and THMIS.

There are still considerable differences in child mortality between children of mothers with low educational and children of mothers with high educational levels, but the differences in infant mortality are much smaller. For the wealth quintiles, differences in infant mortality are even almost non-existent. This is an indication of equitable access to services for the less well-off.

Maternal mortality has also declined, but more slowly. In 2010 it was estimated at 454 per 100,000 live births, compared with 578/100,000 in 2004 and 529/100,000 in 1996.

Conclusion

There is moderate evidence that Dutch support to the health sector and SRHR, mostly through sector budget support and basket funding, has contributed to decreased child and maternal mortality. Regarding infant mortality, the inequities between the educational and wealth levels are smaller than in the other countries included in this chapter. This is an indication of more equal access to health services.

4.7 Zambia

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A 2011 evaluation of budget support to Zambia includes the health sector, though it does not focus on SRHR.⁷⁴ The study shows that since 2005 health expenditure by the government of Zambia had increased. In 2008 it was 6% of GDP; the percentage remained about the same until 2011. Donors' sector basket funding and sector budget support gradually decreased. Donors made up only part of this decrease by giving more general budget support.⁷⁵ Overall, despite major challenges this budget increase has contributed to more health care use and improved health. Most notably, the number of malaria deaths has decreased substantially. Among the challenges, the lack of sufficient qualified staff, partly due to a brain drain to neighbouring countries, is an important factor that has impeded progress.

Regarding SRHR, the study revealed that the coverage of immunisation increased, but that there was little change in the coverage of antenatal care and the percentage of institutional deliveries (43% in 2003 and 24% in 2010). Data on equity issues are scarce and inconclusive. In urban areas the increase in the percentage of institutional deliveries was greater than in rural areas. On the other hand, in 2007, home births among women who had no formal education occurred less frequently (72%) than in 2001 (82%). Data on infant and maternal mortality rates in the period 2000 until 2008 show a downward trend; WHO data on the period after 2008 confirm this decline.⁷⁶

⁷⁴ IOB 2011 chapters 8 and 9.

⁷⁵ The study showed that over the period 2004-2009 an average of 10.5% of general budget support was allocated to the health sector. Because of corruption in the health sector, development partners did not disburse funds to this sector.

⁷⁶ <http://www.who.int/gho/countries/zmb.pdf>.

In conclusion, there is moderate evidence that Dutch sector budget support has contributed to these downward trends.

4.8 EU

As EU support to health and SRHR is indirectly co-financed by the Netherlands, this policy evaluation presents a succinct summary of the findings of a recent (2012) thematic evaluation of EU involvement in the health sector.⁷⁷ It includes all countries benefiting from the EC cooperation and the support to multilateral organisations and global initiatives, but excludes emergency relief and EC support to HIV/AIDS. It must be noted that the Netherlands has had only indirect – and limited – influence on the implementation of EU-funded programmes.

The thematic evaluation shows that sector budget support and programme support have achieved considerable outputs: increased availability of basic health services and, to a lesser extent, increased availability of secondary services. Women and children are the most important clientele of basic services. The evaluation also demonstrates that the increased availability has led to better access to health services, particularly for poor and disadvantaged population, and gives examples from Afghanistan. However, due to population growth, the construction of facilities has not necessarily led to more facilities per capita. The evaluation does not provide a systematic overview of changes in use of SRHR services such as perinatal and maternal care. It does provide anecdotal evidence, for example on Burkina Faso.

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In addition to programme and budget support, funds were allocated to specific projects on perinatal and maternal health. Mostly targeting rural areas or conflict areas, they targeted poor, underprivileged and indigenous people. Overall, the evaluation notes increased service use among the target population. Benefits were mostly found in awareness-raising on behaviour related to pregnancy and neonatal care.

In conclusion, there is moderate evidence that EU support contributed to increased availability of health services and modest evidence that it contributed to increased use of these services.

4.9 Multilateral organisations and the Global Fund

This section will summarise the findings of eight evaluations of UNFPA programmes, one evaluation of a UNICEF health and nutrition programme and one evaluation of a health system programme that received financial support from the Global Fund.

⁷⁷ European Commission 2012.

UNFPA

The UNFPA evaluations include one global thematic evaluation on maternal health, five country evaluations, an evaluation on safe motherhood, and a country-specific programme on prevention and treatment of obstetric fistulas in Uganda.

The results of the UNFPA programme in Uganda are promising. Due to this programme the consequences of female genital mutilation were made more visible at policy level. The programme also supported the training of surgeons and obstetricians in order to address the large backlog of women with obstetric fistula. At the outcome level, an increase in knowledge has been reported but not specified. A major achievement is an increased awareness of causes and consequences of obstetric fistula at the community level. The evaluation also reports on increased service use. In most evaluations, the quality of care is an underreported area, but the Uganda evaluation paid attention to quality aspects, such as availability of written consent and post-operative nursing protocols in health facilities. Written pre- and intra-operative protocols and infection prevention protocols were not available in the health facilities. The evaluation reports high success rates of repair and a low incidence of second or third repairs.

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UNFPA country programmes and the two global programmes have contributed to the development of SRH policies and plans in the countries supported. An example is the support to ensure that cervical and breast cancer is included in the national equal opportunities plan in Bolivia. All UNFPA evaluations point to the organisation's contribution to institutional strengthening. The evaluations did not provide information on UNFPA's role regarding the improvement of the quality of care. A critical remark is that the organisation was unable to gauge the contributions made by maternal health programmes to higher level maternal outcomes. This was one of the overall conclusions of the thematic evaluation. UNFPA also failed to learn lessons from pilot interventions that could be applied to future maternal health support. In addition, the organisation did not reach out sufficiently to vulnerable and hard to reach population groups. Both the positive and the more critical findings on the UNFPA programmes are in line with the findings of a 2011 report of the Multilateral Organisation Performance Assessment Network (MOPAN), in which UNFPA is applauded for its support to national plans and its contribution to policy dialogue. However, the document review that is part of this assessment revealed limitations in UNFPA's results frameworks, such as the definition of outputs and outcomes and the lack of clarity in the results chain, and it pointed out the effects of these limitations on UNFPA's reporting on results.⁷⁸

These findings on UNFPA's involvement in maternal and perinatal health are also in line with those of a review of multilateral aid carried out in 2011 by the Department for International Development of the United Kingdom (DFID). This review points to UNFPA's critical role in advancing MDG 5 through global advocacy. The organisation also proved to be able to build strong partnerships with civil society and partner countries and reinforce

⁷⁸ MOPAN 2011.

country-led approaches. Its delivery in-country is mixed and reporting on results at impact level is rare.⁷⁹

UNICEF and the Global Fund

A recent publication on UNICEF's effectiveness, including its involvement in child health programmes, found that overall UNICEF has been effective.⁸⁰ The evaluation of the UNICEF health and nutrition programme in Sudan that was included in the policy evaluation found that the conflict impeded the implementation of this programme. The health programme in Ethiopia, financed through the Global Fund, was confronted with a shortage of health workers, which impeding its implementation. Nonetheless, the programme did succeed in increasing use of maternal and perinatal services.

Conclusion

Multilateral organisations have contributed to policy development and have assisted countries in strengthening the health system, thus creating conditions favourable for increased use of services. Evidence for the organisations' contribution to increased service use, including use by those for whom these services are less accessible, is scarce.

4.10 NGOs

The contribution of NGOs to improving maternal and perinatal health is based on the assessment of five evaluations of NGOs that have received support from the Netherlands through the co-financing mechanism. They address a variety of themes, ranging from specific interventions, such as treatment and support to women with obstetric fistulas, to more general projects to improve basic health care for underserved populations. Table 6 provides an overview.

⁷⁹ DFID 2011: 197.

⁸⁰ OECD DAC Network on Development Cooperation 2013.

Table 6 Initiatives relating to maternal and perinatal health, supported by Dutch-funded NGOs during 2007-2010		
Country	Theme	Objectives
Niger	Obstetric fistula	Treatment of women with fistulas
Uganda	Childhood diseases and maternal health	To reduce delays in seeking health care that lead to unsafe motherhood and infant deaths.
Uganda	Health insurance pilot	To reduce delays in seeking health care and to improve the management of child illnesses and young mothers' health.
Cameroon	General health care	To improve access to health care among underserved populations.
Ghana	General health care	To improve the health of resource-poor individuals and communities marginalised from mainstream health services.

Source: Evaluation reports examined in this study.

All the projects addressed poor or underserved individuals and communities. All the projects included a component of improving knowledge among the target group, and most projects also focused on enhancing the knowledge of decision makers as well as of health staff. A key aspect in many of the interventions was found to be capacity building: for example, of Catholic health centres to support pregnant or lactating mothers in Cameroon. A common strategy was the use of community workers to provide information and health services, such as antenatal care. Two projects also used media as a tool for enhancing knowledge and bringing about behaviour change, e.g. through ICT resource centres.

Results on knowledge, attitudes and behaviour

Overall, as a result of the interventions, the target population became more knowledgeable about maternal and perinatal health and other SRHR issues, such as family planning. For example, in Ghana it was reported that citizens became more aware about their rights, and in certain cases duty bearers had become more aware of their responsibilities. In Uganda, sensitisation of young couples by community health volunteers had led to increased knowledge of family planning methods and an increase in spousal communication around family planning matters, compared to a control group.

Access to and quality of services

Some evaluations quantified the outcomes in terms of service use, but others did not. Overall, modest evidence (self-reporting) is provided that the projects contributed to improved access to maternal and neonatal health services. For example, in Uganda there were increases in the number of supervised antenatal visits, the use of contraceptives and the proportion of adolescent mothers receiving post-delivery advice. In Niger, 1183 women with obstetric fistula were treated: twice the number planned. The project was less successful in reintegrating the women in their communities. Only 7% of the women operated on in a two-year period were able to reintegrate in their communities.

In two districts in Ghana the coverage of the national Health Insurance System had increased during the project's implementation. In the project area of the Uganda health insurance project, health service use increased by 30%. In both cases it is plausible that the projects contributed to the increase. Quality of services was not found to have improved. While advocacy efforts in the Ghana project resulted in the integration of MDGs 4, 5 and 6 in district health planning, the evaluation of the Ugandan health insurance scheme initiative concluded that advocacy was a missing element in the design of the project.

In a number of initiatives, the use of community volunteers appeared to be a success factor. They proved to be invaluable for distributing information on health among community members. The status of these volunteers was not always clear, and projects did not always acknowledge the limitations of community workers volunteers regarding service delivery. In some projects, community participation was an important success factor. With the exception of the project in Niger, the partnership between the implementing NGO and public health workers was mostly good.

Among the bottlenecks to achieving results that were identified in the evaluations were high staff turnover, lack of strategic planning in project plans, and the limited thematic scope of some interventions. An example of the latter issue is the Uganda child health project, in which the focus was on curative services: the evaluation noted that prevention and promotion services are cheaper and that the project should have included family planning services.

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Conclusion

There is modest evidence (self-reporting) that NGOs have contributed to improved knowledge levels and increased access to services. In some cases the results could be quantified.

4.11 Discussion

There is moderate evidence that Dutch sector budget support in the five case-study countries has contributed to an overall improvement of perinatal and maternal health. Morbidity, mortality and use of health services are defined by various factors, some of which (such as quality of care) are linked to the health sector, whereas others (such as educational level) are not directly linked. In Bangladesh, after controlling for factors outside the scope of the health system, it has been demonstrated that sector support has led to improved child health⁸¹. Data from Tanzania and evaluations of general budget support and sector budget support in Zambia also point to a positive impact on health care.⁸²

⁸¹ White 2005.

⁸² IOB 2012d. IOB 2011.

Over the last decade the gap between poor and better-off people has remained wide. Though equitable access to services is an important priority in national policies, implementation has lagged behind. The persistence of inequities is also related to health sector factors and to factors outside the health domain. Health sector related factors include insufficient budget allocation to poor regions and lack of qualified health staff willing to work in remote areas. Other factors include the direct and indirect costs involved in health service use, perceived bad quality of services and cultural factors that may impede women from visiting health services.

These findings are in line with studies on public expenditure, which have frequently shown that public spending favours the non-poor. The multi-country evaluation of the World Bank's support to health, nutrition and population found that poor people were insufficiently targeted. Though many projects were implemented in geographical areas with a high incidence of poverty, only in some cases did the poor benefit most from the projects.⁸³ A recently published evaluation of the European Development Fund also showed that poor sections of the populations were not usually targeted.⁸⁴

Most of the factors that impede equal access to services lie beyond the scope of influence of the Netherlands and other development partners. Sector support can be used – and indeed is – frequently used by development partners to influence budget allocation to underserved regions. More attention to quality of care, both in terms of availability of medicines and equipment and in terms of respectful treatment of the clients, will also help to increase equal access.

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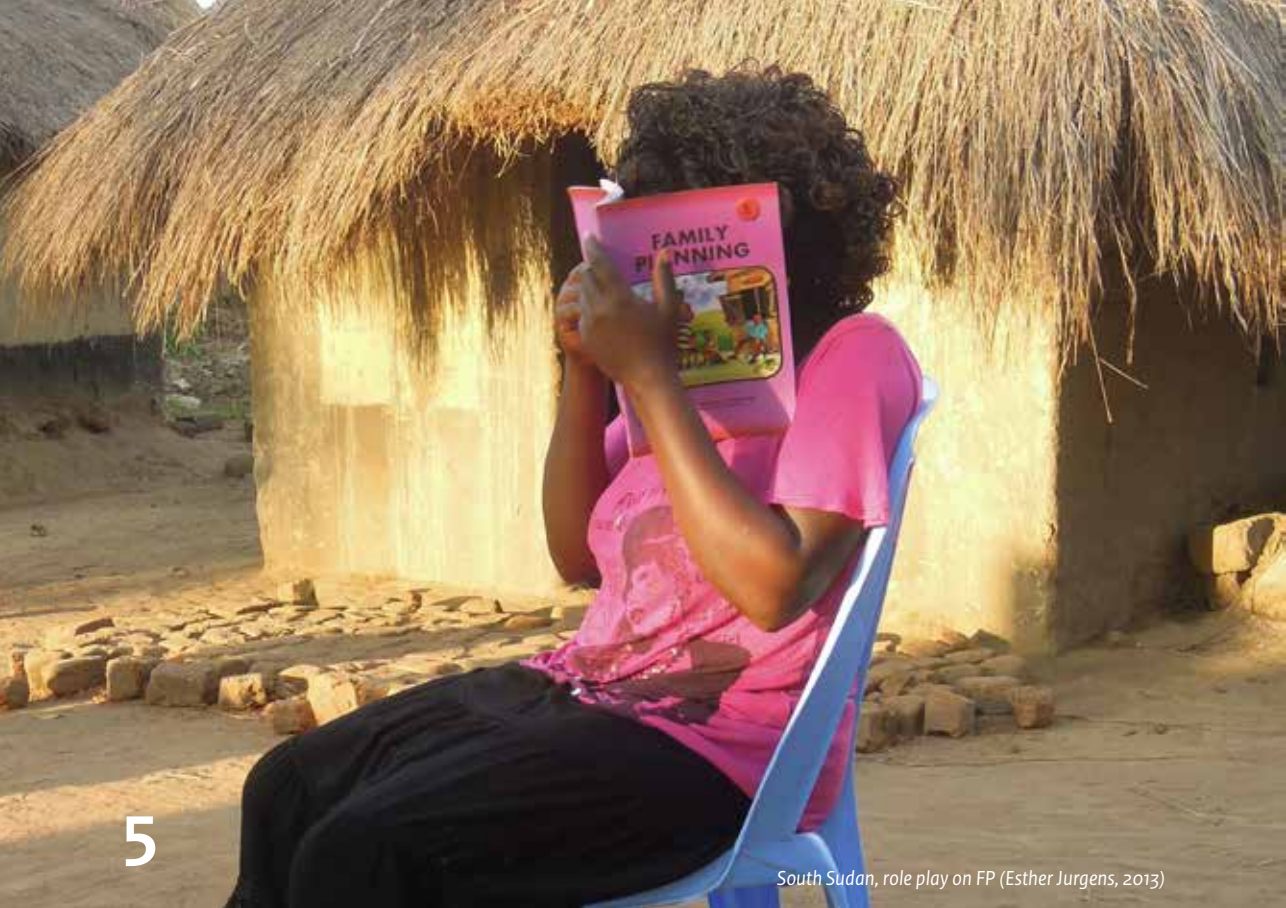
In future, as the focus will shift to more specific SRHR issues it can be expected that the instrument of sector budget support or support to public services at a more decentralised level will become less important. This brings the risk that perinatal and maternal health will be neglected, because these health issues are by nature dependent on a well-functioning health system. Obstetric emergencies provide a striking illustration of the problem. Neglecting this sector risks increasing health gaps between the poor and better-off, especially in countries where poor people are heavily dependent on the public sector. However, it should be avoided that foreign aid results in domestic expenditure on health being diverted to other sectors. A 2010 study pointed out this risk, especially in sub-Saharan Africa.⁸⁵ It showed that over the period 1995-2006, in many countries in this area such aid led to reduced shares of government expenditure on health. The authors recommended careful monitoring of domestic expenditure. The Zambia evaluation did not confirm the findings: since 2005, domestic expenditure on health has increased. In 2008 it was 6% of GDP and since then the percentage has remained stable. In the other countries included in this chapter, health expenditure as percentage of GDP did not show major variations between 2008 and 2011. There are remarkable differences in public expenditure on health as a percentage of the GDP between the countries: the share was lowest in Bangladesh (3.5%).

⁸³ World Bank 2009: xvi-xvii.

⁸⁴ IOB 2013c: 195-196.

⁸⁵ Lu et al. 2010.

Dutch support to multilateral organisations has contributed to standard setting and to enabling them to assist countries to strengthen the health sector or implement specific maternal and perinatal health programmes. The organisations occasionally report on the impact of their work on the population. As these organisations are not mandated to provide services, they cannot fill the gap left by reducing sector support. Dutch support to NGOs has helped to improve knowledge levels and to increase service use among underserved population groups, but NGOs will not fill the gap of sector support either. The balance in the support to different channels will be dealt with in the final chapter (Discussion).



5

South Sudan, role play on FP (Esther Jurgens, 2013)

Family planning

Family planning use varies substantially among countries and in some countries there is still a high unmet need for contraceptive methods.⁸⁶ This chapter will assess whether Dutch efforts in the field of family planning have contributed to more knowledge on family planning and to better access to family planning services. The chapter draws heavily on the Mali case study, complemented by the findings of the Ghana and Bangladesh desk studies and the case studies on evaluations of UNFPA and NGOs. The main findings are:

Research questions	Main findings
Knowledge of FP among young people	Support to the health sector, UNFPA and NGOs has contributed to an increased knowledge of family planning methods. With the exception of anecdotal evidence from NGO evaluations, few data are available on knowledge among young people. The fact that use has increased (see access) may imply that knowledge has increased too.
Access to commodities and FP services	Overall, support to the health sector, UNFPA and international NGOs has led to a slightly increased use of family planning services. Inequalities persist. In Ghana and Mali the unmet need has not decreased.
Access to commodities and FP services among young people	The use of contraception among adolescents has increased. The unmet need has hardly declined.
Maternal mortality	Despite the stagnation in the overall use of contraceptive methods, in Mali the shift to longer-term methods is a promising development. Though still modest, it has led to fewer unintended pregnancies and probably to fewer maternal deaths.

5.1 Problem setting

Contraceptive use has the potential to improve child survival and to reduce maternal deaths substantially⁸⁷. It also enables women to shape their lives and, therefore, creates conditions for the achievement of women's rights.

Worldwide, at present the use of modern contraceptive methods among women aged 15-49 is about 55%, a percentage similar to that in 2001. Due to the population growth, however, the absolute number of users of contraceptive methods has substantially increased. There are important differences between the individual countries, and between countries with the same income level. In general, the average contraceptive prevalence in the least developed

⁸⁶ The term family planning is used in WHO publications. A more correct wording is contraceptive choice and fertility planning. Both terms will be used in this policy evaluation and in this chapter.

⁸⁷ Cleland et al. (2012) present estimates of changes in maternal death attributable to contraceptive use over the last two decades.

countries is much lower (22%) than the average contraceptive prevalence worldwide.⁸⁸ Due to low contraceptive use, each year there are still more than 80 million mistimed or unwanted pregnancies.⁸⁹

Differences in the desired number of children and differences in contraceptive use are determined by personal choice and a mixture of socio-economic, cultural and individual factors, such as education, income, religious prescriptions, male opposition and concern about possible side effects of contraceptives. In addition, an important factor is lack of access to family planning services that provide a wide variety of commodities and inform women on their use. Many barriers impede women's use of these services, such as lack of information, insufficient confidentiality, high fees, long distances and lack of commodities.⁹⁰

Data on contraceptive prevalence do not take into consideration whether or not women have expressed a desire to become pregnant, whereas the concept 'unmet need' does. It is defined as the percentage of women who have expressed the wish not to become pregnant but are not using contraception. Data on unmet need portray a great variety among countries.⁹¹ Generally the unmet need in sub-Saharan Africa is substantially higher than in the other regions. Important determinants for the unmet need are income, age, educational level and residence. In all regions except Central Asia, aggregated data show a much higher unmet need among women in the lowest income quintile than among women in the highest income quintile. There are important exceptions. Looking at individual countries in the regions (excluding Central Asia), in about one quarter of the countries there are much smaller or hardly any differences between wealth quintiles. Bangladesh is an example.

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The unmet need is substantially higher among young women aged 15-19, including married girls, than among women in the other age categories. Residence and educational level are other determining factors. The unmet need among urban women is lower than among women living in rural areas. Generally, women with secondary education or higher are more likely to meet their need for family planning than women who are lacking education, though again there is a great variation between countries.

Several approaches have been deployed to increase the use of family planning. Demand-side interventions, such as mass media campaigns, have led to improvements in knowledge and attitudes on family planning. Interventions aimed at increasing the supply side, whether or not addressing demand, have had positive effects on the use of family planning methods. A long-term effect on fertility outcomes could be demonstrated in only a small number of these supply side or demand and supply side studies.⁹²

⁸⁸ UNFPA 2010: 99 and UNFPA 2002: 67. Aggregated data for contraceptive use in the least developed countries is not available in the 2002 UNFPA report.

⁸⁹ Mwaikambo et al. 2011: 67.

⁹⁰ Cottingham et al. 2012.

⁹¹ Ortayli & Malarcher 2010. In an analysis of data from household surveys in 64 countries the authors derived the percentage of contraceptive demand satisfied (the opposite of unmet need) from the response to a number of questions on family planning.

⁹² Mwaikambo et al. 2011:77-79.

Women who are least able to protect themselves from an unwanted pregnancy generally also have the least access to antenatal controls and skilled birth attendance. Problems that may occur during pregnancy or childbirth remain untreated, with the result that unintended pregnancies contribute to maternal and child morbidity and mortality. In addition, when women opt for the termination of the pregnancy, they are at risk of undergoing an unsafe abortion.

Summarising the current situation, it can be concluded that countries have not yet ensured universal access through various channels to a variety of contraceptive choices for both short- and long-term methods.⁹³

5.2 Policy

When family planning programmes were introduced in the 1960s they mainly focused on the reduction of population growth. Since the Cairo declaration and programme of action, the focus has shifted to a human rights perspective. It is now widely acknowledged that ongoing access to a wide range of approved contraceptives is a human right and that individuals should themselves decide on the use of these methods, on the basis of comprehensive information. The London Family Planning Summit (2012) reconfirmed the importance of including family planning in the international agenda. Drawing on Cleland et al. (2006), an earlier report (IOB 2009) noted that the prerequisites for successfully promoting family planning are a climate supportive of modern contraceptive use and the ideal of smaller families, dissemination of knowledge on different methods, accessible family planning services and products, and in addition, assurance that related health concerns will be addressed. Reducing the unmet need thus requires both increasing the availability of commodities and addressing the demand side.

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Dutch policy underlines the human rights perspective and emphasises the need to guarantee access to information and services for all, including adolescents and key populations. Support for family planning has been provided through budget support to the health sector, support to multilateral organisations and their programmes, and support to international NGOs.

5.3 Mali case study

Since 2002, the Netherlands has provided EUR 4 million per year to the Ministry of Health (MoH) in Mali for the implementation of its successive health and decentralisation plans. The health attaché at the EKN has participated in the dialogues on these health plans between MoH and the development partners. During the period 2007-2012, the Dutch government's mean annual expenditure on health and SRHR programmes in Mali was about EUR 7.8 million.⁹⁴ The Netherlands was the second bilateral donor in the field of

⁹³ Main conclusion of Ross & Smith 2011.

⁹⁴ Data Piramide, MFA.

SRHR: it provided about 6.3% of total funding in the period 2007-2011.⁹⁵

Dutch support to population and reproductive health programmes in Mali implemented by NGOs has increased substantially since 2008. It includes a financial contribution to the Malian family planning association (Association for the Protection and Promotion of the Family, better known as AMPPF, which is affiliated to the International Planned Parenthood Federation) and an indirect contribution, through headquarters, to the country offices of Population Services International (PSI) and Marie Stopes International.

The Mali case study gives insight into the trend in the use of contraception over the period 2001-2009.⁹⁶ It also describes cultural factors that may facilitate or impede the acceptance of family planning methods. The trend description is based on successive demographic health surveys and a multi-cluster survey. The information on interfering factors is based on qualitative research in six so-called *cercles* (administrative subdivisions) in three regions. The main data collection methods were individual interviews with both family planning users and non-users, and focus group discussions.

Knowledge on sexuality and avoiding pregnancy

Although knowledge on both the ovulation cycle and on modern contraceptive methods among women in the reproductive age group in Mali has increased in recent decades, coverage is still very low. In the capital Bamako, about one quarter of women are sufficiently knowledgeable on the ovulation cycle, but in some regions no more than 10% have adequate knowledge. Knowledge of modern contraceptive methods is much more widespread among Malian women. At present between 70% and 90% of women have sufficient knowledge of these methods, and in recent decades the overall knowledge has increased. Bamako has the highest percentage, but shows a slight decrease. In the northern region, no more than half of the women have sufficient knowledge of modern methods.

An important factor that has contributed to better knowledge on contraceptive methods is the intensified effort to promote family planning by radio messages. Other determining factors include decreased male dominance and more decision-making power among women. The factors that contribute to increased knowledge are closely linked to factors that influence the acceptance and use of family planning. The next section will provide more details.

Access to family planning methods

The use of family planning methods in Mali is low compared to neighbouring countries. In 2009, about 8% of women aged 15-45 were using a modern method. This is only a slight increase compared to 2001 (6%). In line with this low contraceptive prevalence rate, in 2009

⁹⁵ Largest ODA-donors in Population policies/programmes & reproductive health; CRS Codes: 13010, 13020, 13030, 13040, 13081. This includes multilateral organisations and funds.

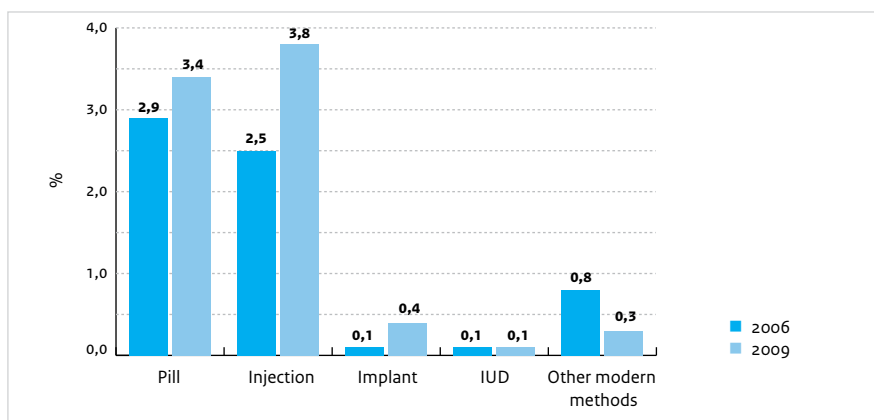
<http://stats.oecd.org/qwids/#?x=1&y=6&f=4:1,2:1,3:51,5:3,7:1&q=4:1+2:1+3:51+5:3+7:1+1:2+6:2007,2008,2009,2010,2011,2012>

⁹⁶ Findings in this section are based on research by Bijlmakers et al. 2012, consisting of an analysis of DHS and multi-cluster survey data and qualitative research by the evaluation team.

the unmet need was as high as 30%, even slightly higher than in 2006. Thus in 2009, less than one quarter of the total demand for family planning (prevalence plus unmet need) was satisfied. Birth-spacing is the most common motive for the use of family planning methods. Roughly two thirds of users indicated that they wanted to space their children; the remaining third said they wanted to limit the number of children.

Figure 9 shows that the two most widely used modern methods are the pill and hormone injections.⁹⁷ The use of both methods increased slightly between 2006 and 2009. The use of hormone implants is low in absolute numbers, but in relative terms it has increased substantially. The use of IUDs and other modern methods has so far been very low.

Figure 9 Female utilisation rate of modern contraceptive methods in Mali in 2006 and 2009



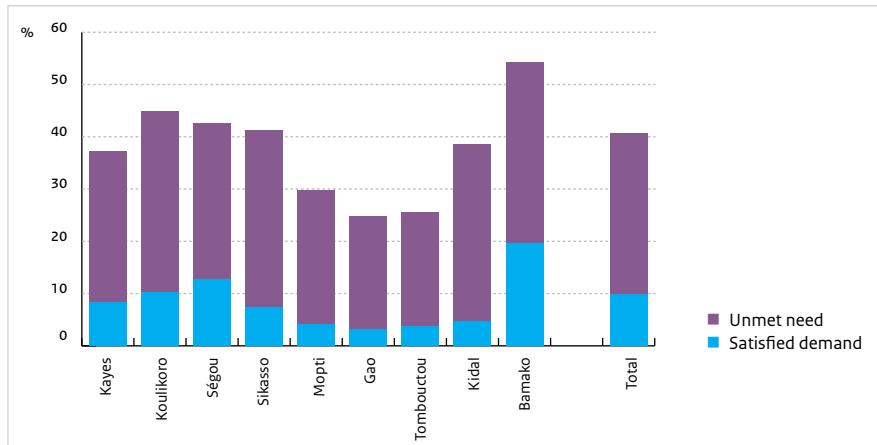
Source: Bijlmakers et al. 2012: 39.

Bijlmakers et al. (2012) report that in the period 2006-2009, about half of the contraceptives used by women in Mali were obtained through the public sector. However, the private medical sector has become more important since 2001: in 2006 almost 40% of users obtained their contraception methods through this sector. The share of other sources was about 20% in 2001 but has decreased since then.

Figure 10 shows that there are substantial regional differences in contraceptive use and also in unmet need. In Bamako the use of modern methods is about twice the mean for Mali, while the northern regions show very low use rates (satisfied demand). In relative terms, e.g. compared to the total need, there are striking differences among the regions. For the country as a whole, slightly over 20% of the total need is fulfilled. Again, the data for Bamako is most favourable. By contrast, the northern regions and Kayes show the most unfavourable data, with a fulfilled need of slightly more than 10% of the total need.

⁹⁷ Unless otherwise indicated, the tables in this section relate to women aged 15-49 in a relationship.

Figure 10 Unmet need and satisfied demand for modern family planning methods in Mali, per region in 2009.

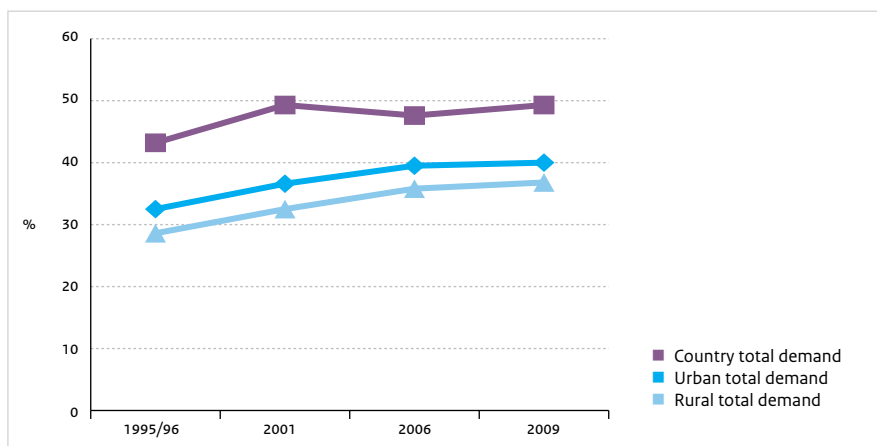


Source: adapted from Bijlmakers et al. 2012: 42-45.

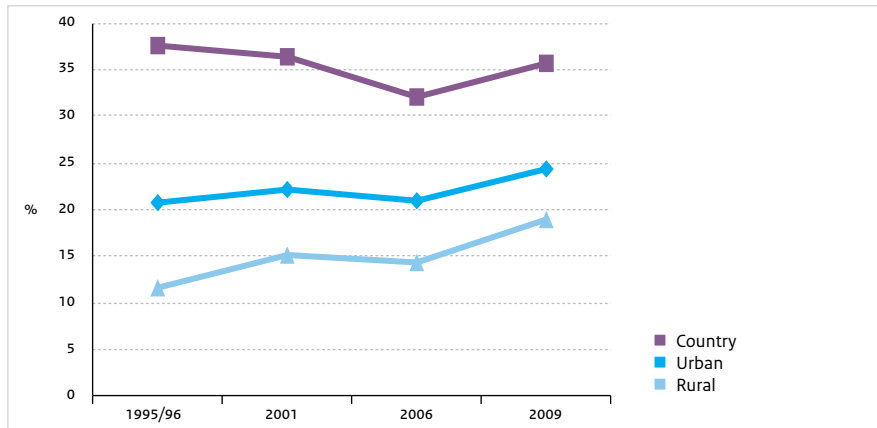
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Not surprisingly, there are also striking differences between urban and rural areas in the use of modern methods. Use of family planning by urban women has always been much higher than by women living in rural areas. However, since 1995 the gap has been shrinking steadily. As Figures 11 and 12 show, both the total demand and the satisfied demand have increased in the rural milieu. In urban areas, both the total demand and the percentage of demand satisfied have stagnated since 2001.

Figure 11 Total contraceptive demand by women in Mali in urban and rural areas: trend 1995-2009



Source: based on Bijlmakers et al. 2012

Figure 12 Percentage demand satisfied in Mali: trend 1995-2009

Source: based on Bijlmakers et al. 2012: 48

Factors that influence the use of modern family planning methods

In Mali, several efforts have been made to increase family planning use, including national campaigns, improvements in the availability and distribution of commodities, research to ascertain the reasons for the low use and an expansion of the work domain of international NGOs.

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The case study described here identified several impediments to family planning use. They include unavailability of modern methods and perceived bad quality of service delivery of health services in remote areas. In addition, there are socio-cultural barriers to utilising contraceptive methods, such as religious prescriptions and male dominance, although over the last decade religion has become less influential and it has become easier to negotiate family planning with male partners. Family planning among young unmarried girls has also become more socially acceptable in recent years. Box 1 presents two viewpoints.

Box 1 Views on family planning among young unmarried women in Mali

‘Parents do not want their daughters to get pregnant before they are married. Unmarried girls with children are a financial burden and a shame for the family. I know a mother who went to the health service to get family planning for her daughter. Parents should help their daughters to use family planning before their marriage.’ (male respondent)

And in the words of a teacher, the results are visible.

‘In the past, many cases of pregnancy could be observed at schools. Ten years ago, we had about 8 pregnancies among the students. Following a suggestion by the director of the health post, many students have now started to use contraceptive methods, and pregnancies have become rare.’ (teacher)

Source: Bijlmakers et al. 2012.

Unintended pregnancies

Although the prevalence rate and unmet need have hardly changed since 2006, the increased use of long-term methods has resulted in a fall in the number of unintended pregnancies. For 2009, it has been calculated that the use of family planning methods prevented about 16,000 pregnancies, and led to 12,000 fewer births and 175 fewer abortions. In terms of mortality, it is estimated that the use of modern methods has led to about 1,200 fewer infant deaths and 100 fewer maternal deaths. Compared to 2006 data, these numbers have increased more than twofold (2.4). This is due to the increased use of longer-term methods at the cost of the use of short-term methods. Implants are responsible for about half of the avoided pregnancies, while the use of oral contraception accounts for only 12% of the avoided pregnancies.

Conclusion

Summarising, it can be concluded that there has been little progress regarding family planning in Mali. However, the sharp increase in long-lasting methods, though still small, is promising and has the potential to further decrease unintended pregnancies. International NGOs strongly support the shift to longer-term methods and the Netherlands has provided substantial funding for these NGOs. Therefore, there is moderate evidence that Dutch support to SRHR in Mali has contributed to the shift.

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5.4 Ghana

Dutch health sector support to Ghana has implicitly supported the implementation of Ghanaian health policy, including the scaling up of family planning services and ensuring a higher contraceptive prevalence.⁹⁸ Overall it can be stated that, contrary to the results obtained in the area of perinatal and maternal health presented in the previous chapter, until 2008 the results regarding family planning have been poor. Since 2008, there has been an increase in the use of family planning methods.⁹⁹ Knowledge of modern family planning methods is widespread among Ghanaian women but contraceptive use has remained low.¹⁰⁰ In 2008, only about 24% of women aged 15-49 were using a contraceptive method and this percentage was about the same as in 1998 (25%). Married women mostly used injectables, while unmarried sexually active women most often used the male condom. Ghana Health Services Department has reported a sharp increase in family planning use since 2008, however. In 2012, the contraceptive prevalence rate was 34%. As this more recent data is not based on a household survey but on data from the services, more details on the reasons behind this sharp increase are not available.

Over the period 2003-2008, socio-economic differences in contraceptive use among married women and differences between urban and rural women have decreased slightly and in

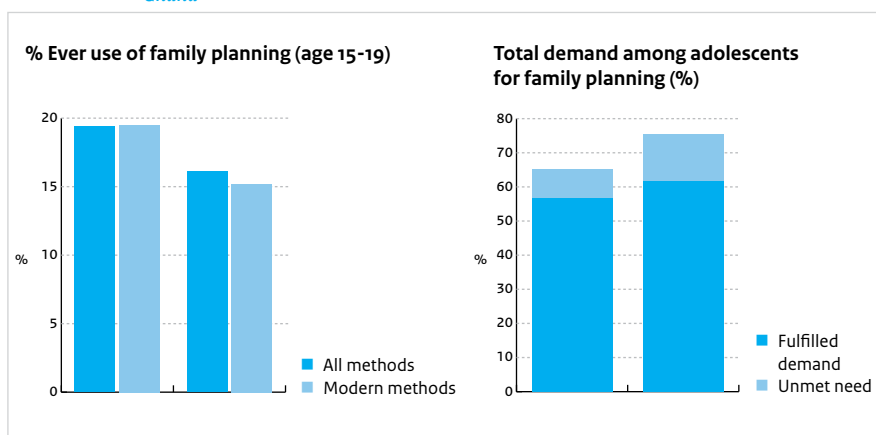
⁹⁸ Programmes of work of the Ministry of Health, summarised in IOB 2012b.

⁹⁹ The most recent detailed data (age categories; schooling, etc.) are for 2008. Data on the overall prevalence rate are more recent (2012).

¹⁰⁰ IOB 2012b. Data mostly from the 2008 DHS.

some cases, contraceptive use among better-off women has declined. For example, the use of all contraceptives (traditional and modern) decreased from 31% in 2003 to 27% in 2008) in the urban areas, while in rural areas the percentage remained unchanged. Contraceptive use among women with secondary schooling or higher is now significantly lower than in 2003 (30% in 2008, 40% in 2003). In addition, the percentage of women using contraceptives in the highest income category has decreased: from 35% in 2003 to 31% in 2008. Regional differences are striking: in 2008 the contraceptive prevalence rate in the Northern region had halved in comparison to 2003, whereas in the two other regions it had only slightly improved.

Figure 13 Use and demand for family planning methods among adolescents (15-19 years old) in Ghana



Source: DHS Ghana in IOB 2012b.

In the period 2003-2008, the unmet need for family planning of married women was high (35%) and increased slightly. Regional differences and differences between socio-economic groups decreased slightly, often to the detriment of the privileged groups. The unmet need among adolescents (15-19 years old) grew from 57% in 2003 to 62% in 2008 and is almost twice as high as for other groups. This is in line with the increase in the total demand for family planning in this age group. Figure 13 visualises the contraceptive use and contraceptive demand among adolescents.

The large unmet need in Ghana can to a great extent be explained by increased financial problems of sustaining a high contraceptive supply, partly caused by the changing donor environment. However, it has also been suggested that Ghanaian policies on family planning often stall at the implementation phase, possibly due to diminished interest of policy makers in reproductive health and rights policies.¹⁰¹ When it came to their implementation, family planning issues were often given lower priority than other health concerns. Political leadership is more likely to focus on HIV/AIDS, safe motherhood and

¹⁰¹ EKN Accra 2007. Sector track record. In IOB 2012b.

malaria, without making a link to family planning.¹⁰² The inclusion of family planning in community-based health services might increase uptake of family planning in remote rural areas, but expanding these services entails making the necessary provisions to ensure that there are enough resources to maintain the supply side, which is still a problematic issue in Ghana.

In dialogues with development partners on health sector budget support to Ghana, the Netherlands has regularly brought up the high unmet need and low use of family planning methods. Other participants have referred to the Dutch stance as outspoken, but realistic and tactful.¹⁰³

Explanations for the wish not to use contraceptive methods are related to the potential user's perceptions. Reasons married women give for not using family planning are foremost method-related, as women fear the side effects of family planning methods. The second most important reason is opposition to use, especially from the respondent herself. The third most important reason is fertility-related: women said they were infertile. Fertility-related reasons, especially the wish to have as many children as possible, were more important in 2003 than in 2008.¹⁰⁴

| 80 | Summarising, it can be observed that over the period 2003-2008, hardly any progress could be observed regarding family planning in Ghana. After 2008, there was a sharp increase in the use of family planning methods.

5.5 Bangladesh

The trend in family planning use in Bangladesh is very different from the trend in Mali and Ghana. Since 1975, the use of family planning methods has increased steadily and substantially, and fertility rates have decreased.¹⁰⁵ In 1975, women had on average 6.3 children; in 2011, this number was 2.3. As described in chapter 4, until 2010 the Netherlands provided substantial financial support to the Bangladesh health, nutrition and population programme. This programme included promoting family planning and providing the commodities. Therefore, it can be argued that the Netherlands has contributed to the increased use of family planning in Bangladesh.¹⁰⁶

¹⁰² Atkobi et al. 2009.

¹⁰³ Interviews conducted in 2010.

¹⁰⁴ Ghana Statistical Services et al. 2009.

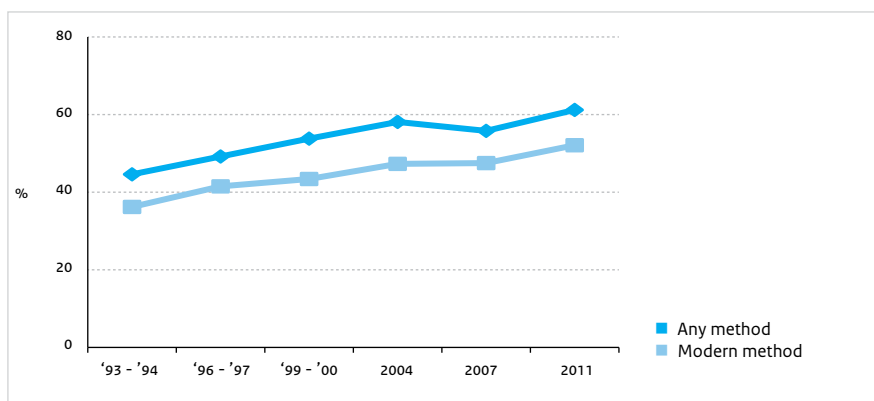
¹⁰⁵ Most of the information in this section comes from the Bangladesh Demographic and Health Survey 2011 Preliminary Report at <http://www.measuredhs.com/pubs/pdf/PR15/PR15.pdf>.

¹⁰⁶ White (2005) assessed the impact of the health nutrition and population programme and concluded that Bangladesh has experienced rapid fertility decline and reductions in under-five mortality. Economic growth has been important, but so have major public sector interventions, notably reproductive health and immunisation, supported by external assistance from the World Bank and other agencies. (<http://ideas.repec.org/p/wpa/wuwpdc/0510004.html>). It can be argued that this intervention continued to contribute to the effects.

There is widespread knowledge on family planning among women in Bangladesh, even among those living in areas where there is still a relatively great unmet need.¹⁰⁷ Almost every woman knows about the various modern contraceptive methods, such as the pill, the injection, the condom and female sterilisation. Most (80%) women also know about implants and intra-uterine devices.

In 1975, about 7% of women used a family planning method and, of these, about 5% a modern method. The use of methods has increased steadily: see Figure 14.

Figure 14 Family planning use in Bangladesh: trend 1993-2013



Source: preliminary data DHS 2011.

There are differences in use rates among women with different educational and income levels, but these are small. The same holds for the urban-rural and regional differences.

The most popular family planning method is the pill. It is used by about half of all women using any modern methods. It is the only method Family Welfare Assistants offer when visiting families, for two reasons. Firstly, because these assistants have not been trained about new modern family planning methods, and secondly, because to get other methods, women have to attend a clinic, which may be problematic. Other frequently used methods are the injectable, the condom and female sterilisation. Overall, about half of the contraceptives are obtained from the public sector, the breakdown being over 80% in the case of the long-lasting methods, 45% for the pill and 17% for the condom.

In line with high use rates, the unmet need for contraception is low: about 11.7%. In contrast to the situation in Ghana and Mali, the unmet need does not differ between the education and income groups. However, there is a slight difference in unmet need in

¹⁰⁷ The case study on the prevention of unsafe abortion in Sylhet (see next chapter) included questions on family planning. The preliminary data of the DHS survey provide no information on knowledge; previous DHS reports do.

different age groups: the percentage is above average (14%) in the age group 15-19 and below average (about 10%) in women over 35. Regional differences are more pronounced. In Chittagong and Sylhet the unmet need is over 15%, whereas in the other five regions the unmet is slightly below the average. There is also a small difference between the unmet need in urban areas (9.9%) and rural areas (12.4%), but the gap is narrowing.

Some of the reasons for non-use are similar to those in Ghana. They include fear of side effects, fear of risking infertility and 'husband does not like'.

Summarising, it can be concluded that substantial progress can be observed regarding family planning, and that there is moderate evidence that Dutch support to the health sector has contributed to this.

5.6 UNFPA

The UNFPA global programme to enhance reproductive health commodity security has received substantial Dutch funding and was still receiving funds at the time of writing. There are three types of countries: 11 stream 1 countries that receive up to USD 5 million per annum for commodity supply and capacity building of national systems; 30 stream 2 countries that receive some support for commodities and capacity building; and stream 3 countries for emergency procurement in countries with weak capacities and/or humanitarian emergency situations. In the stream 1 and 2 countries, one of the key routine activities is the establishment of a functional coordination system of forecasting, planning and distribution of methods.

The evaluation of this programme revealed that in all countries the programme is well aligned with national policies and strategies.¹⁰⁸ In each country, the need for reproductive health commodity security had been placed on the agenda. A critical note is that UNFPA places emphasis on supplying the state sector with commodities that are to be dispensed for free, but this means there is less incentive for NGOs and the private sector to issue or sell a wide range of contraceptives, because they are less likely to recoup their costs.

Although capacity building is a key activity in the UNFPA programme, according to the evaluation it has been carried out without an overall strategy. This is not surprising, given that programmes were well aligned with the national strategies. UNFPA's reaction to this observation was that countries, not the programme, should define the strategy. The evaluation reveals there is wide variation in the split between provision of commodities and providing support to capacity building in the different countries. No explanation could be found for these differences, other than that the national context defines the needs. Overall, there was a trend for spending on commodities to decrease and come closer to the budget target of 40% (the target for capacity building being 60%).

¹⁰⁸ IOB 2013a.

The availability of contraceptive methods (output) has been considerably increased by the programme. Contrary to intention, little attention has been paid to other health commodities, such as maternal health drugs and equipment. The rationale was that as the contraceptives were the commodities most lacking in the countries concerned, it would be most effective to focus on them. A possibly favourable spinoff from the programme was the increase in donor expenditure for family planning commodities.

The evaluators found it difficult to find clear links between the supply of the commodities and their use. In the few countries for which baseline data was available, some progress could be noted in the contraceptive prevalence rate. Burkina Faso could provide updated figures for the unmet need; these showed a slight decrease from 31.3 % in 2008 to 28.8% in 2010.

Summarising the evaluation findings, it can be concluded that the UNFPA global programme to enhance reproductive health security was successful in policy development, the development of supply chains and providing commodities. For some countries, moderate evidence could be provided that the availability of commodities had led to an increase in the use of family planning methods or to a decrease in the unmet need.

5.7 NGOs

Three interventions in the NGO desk study were analysed for their family planning activities, specifically in relation to their efforts to promote the female condom. One such effort was the large-scale Universal Access to Female Condoms Joint Programme, a partnership between the Ministry of Foreign Affairs and Oxfam Novib, Rutgers World Population Foundation and i+solutions.¹⁰⁹ The programme consisted of a research and development component, two country programmes (Nigeria and Cameroon) and an advocacy component. In the two countries, social marketing organisations were recruited to implement the programme. In the other NGO projects (in South Africa and Malawi) activities relating to the female condom were incorporated into wider interventions to empower women and to protect them against HIV/AIDS. This section summarises the results in this area.

This section will also present the findings of an independent review of the International Planned Parenthood Federation (IPPF), an international NGO with a worldwide network of affiliates.¹¹⁰ The Netherlands has supported IPPF with core funding for many years; it currently supports the organisation with programme funding. IPPF's area of work is wider than family planning, but as family planning is a core theme, findings on knowledge and service use will be presented here. As IPPF emphasises the importance of a rights-based approach and pays special attention to adolescents, some findings on IPPF will also be presented in chapter 8.

¹⁰⁹ <http://www.condomsqall.org/uploads/2012/05/Executive%20summary%20UAFRC%20end%20of%20term%20evaluation.pdf>.

¹¹⁰ Taylor et al. 2012.

Knowledge on contraceptives

All three evaluations of female condom interventions provided information about results in the domain of knowledge and awareness. Overall, the reported trends were good. In Nigeria, non-conventional actors such as barbers and hairdressers were involved in promotional activities, and about two million people were reached – a number equal to the target. In Cameroon, 750,000 people – many more than the target – were reached by educational activities. Two evaluations observed general acceptance of the female condom, provided that initial questions and concerns were addressed prior to the interventions. In Malawi, community sensitisation was mentioned as a contributing factor. However, in the evaluation of the South Africa project it was noted the impact could have been greater if the training and promotion materials had addressed issues related to empowering women in sexual relations: male patriarchal dominance, gender inequalities, and sex without consent.

The IPPF review provides a very positive picture on learning: over 80% of the respondents from member associations considered the technical assistance from the regional IPPF offices to be good or excellent. Member associations had also shared knowledge and experiences with other member associations. However, the review did not provide any information on the impact of this learning on the knowledge of IPPF's clients. Quoting the reviewers: 'It would be interesting to start a longitudinal survey focusing specifically on young people, to see how the SRHR initiatives are changing lives over the medium to long term. This could also provide useful data on the process of change in the social and cultural enabling environment'.¹¹¹

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Access to family planning services

The Universal Access to the Female Condom initiative has contributed to renewed interest in the female condom among several stakeholders and has succeeded in placing the issue on the international agenda. As a result of the programme, several manufacturers have made available their technical dossiers to the WHO for pre-qualification. The programme has also been effective in negotiating lower prices for procurement. This is an important finding, because before 2012 only one product was available for procurement by UN agencies and it was expensive. The programme has contributed to increased availability and access to the female condom and the reduction of prejudice about the condom.¹¹² The key factor responsible for the programme's success is considered to be substantial investment in social marketing. The ambitious goal, availability of the female condom for all, had not yet been realised, and no information is available on the number of women who report using the female condom. On the basis of data on condom sales, it can be assumed the use has increased. The South Africa project developed a business case for advocacy purposes, to show that the costs incurred by society in terms of health care, skills lost, ART medication, etc., when the female condom is not available outweighed the costs of producing it. However, the evaluation report was not able to report on the results of this strategy. In Malawi, advocacy at local, district and national levels had contributed to positive

¹¹¹ Taylor et al. 2012: 43.

¹¹² The evaluation states that about two thirds through the implementation period the sales were about 60% in Cameroon and 80% in Nigeria.

developments, such as the establishment of a public sector marketing plan for free male and female condoms.

An IPPF evaluation reports that in recent years the organisation has succeeded in increasing its reproductive health services delivery, including family planning, and that the vast majority of these services has been provided to poor and underserved peoples.¹¹³ Factors contributing to this increase include the use of mobile clinics, application of differentiated prices and the good quality of the services. In addition, the IPPF affiliates work closely together with government and are also involved in legal issues. IPPF's involvement in the Democratic Republic of Congo provides an example. Here, the member association is seeking to abolish an article of the Penal Code which prevents the distribution and sale of contraceptives.

Conclusion

The interventions have contributed to improved knowledge on family planning and to the acceptance of the female condom among the target group.

5.8 Discussion

Worldwide, progress on the use of family planning is lagging behind progress on other indicators. The findings from Mali confirm the overall trend: there was hardly any progress in the overall use of methods and no narrowing of the gaps between wealth strata, educational levels and regions. The only positive finding is a slight shift in type of methods, towards long-term methods. As a consequence, there have been less unintended pregnancies. In Bangladesh, and – since recently – to a lesser extent also in Ghana, the picture is more positive.

The factors that have contributed to the progress in Bangladesh include a strong and long-lasting commitment from the government to decrease fertility rates. Another factor is the substantial commitment from donor countries and international organisations, materialised in substantial financial funding. In other words, both the demand and the supply side have been addressed. However, it has to be taken into consideration that the DHS gives information about married women and thus not about unmarried women. In Bangladesh, for example, the government distributes contraceptives only to married couples, and statistics about young unmarried people do not exist. This is the reflection of the lack of acknowledgment that young people might be sexually active.

In Mali and Ghana, the government's commitment was not so strong and a lack of stocks of commodities was reported in health facilities in Mali. Cultural factors also contributed to the non-use of family planning methods, though it has been observed that there is a great variation in views. The Netherlands has brought up the issue of family planning in dialogues on health sector budget support, but has not succeeded in strengthening government

¹¹³ Taylor et al. 2012: 29.

commitment in Mali. UNFPA has played an important role in prioritising family planning and in supporting governments to manage the commodity chain, though more emphasis could have been given to capacity development. The organisation has thus contributed to better availability of family planning commodities. The programme could be enhanced by more careful monitoring of the use of family planning methods and better reporting of their use, using existing data.

With the exception of Bangladesh, the gap in unmet need between the better-off and less well-off people has narrowed only slightly. Therefore, it can be argued that governments and UNFPA are not paying sufficient attention to equity issues. NGOs fill this gap, but are unable to serve large population groups.

Looking into the future, ensuring greater government commitment to family planning is important. The commitments made at the London Family Planning Summit (2012) are promising. Ghana, for example, announced that more attention would be paid to making family planning methods available to young people. This is an important initiative, given the low use and high unmet need among people aged 15-24. Ghana also announced that more emphasis would be given to long-term methods. The Mali case study showed that these methods contribute substantially to better protection and to a decrease of unplanned pregnancies. Some donor countries and quite a few foundations also confirmed their financial commitment.¹¹⁴ At the summit, the Netherlands mentioned its commitment to SRHR in general terms. It is too early to assess to what extent the commitments have been translated into practice.

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Regarding the choice of channels, it can be stated that all channels can play a role in supply, though at a different scale and at different levels of the health system. In principle, if demand remains more or less stable, sufficient supply will decrease the unmet need. Raising the demand is much more complex and depends on education, income and various cultural factors. Prerequisites for fruitful cooperation in the area of family planning are knowledge of the complexity of the demand side and recognition of the importance of cultural factors. Given this complexity, the first priority may be to reduce the unmet need. As announced in the previous chapter, the balance between implementation channels will be discussed in the final chapter.

¹¹⁴ http://www.londonfamilyplanningsummit.co.uk/COMMITMENTS_090712.pdf.



6

Bangladesh, clinic in Sylhet Division, field visit IOB (2012)

Preventing unsafe abortion and access to safe abortion

This chapter elaborates on an important, but sensitive SRHR issue. It will assess whether Dutch efforts have contributed to preventing unsafe abortions. The chapter also presents the findings of an impact evaluation of Dutch support to a programme in Bangladesh managed by WHO and implemented by several international and Bangladeshi NGOs coordinated by the Ministry of Health. The main findings are:

Research questions	Main findings
Knowledge	Dutch support to a menstrual regulation programme in Bangladesh has led to improved knowledge on the appropriate time to undergo the procedure and on the appropriate service providers. Dutch support to WHO has contributed to the adaptation and distribution of guidelines on comprehensive services.
Access to services	Dutch support to a menstrual regulation programme in Bangladesh has contributed to improved quality of services (timelier; fewer unqualified providers; fewer complications). Dutch support to WHO and to international NGOs has helped to develop standards for safe abortion and to assist countries in implementing these standards.
Rights of people who may be denied these rights.	Dutch interventions have contributed to keep safe abortion on the international agenda.
Maternal mortality	In Bangladesh it is plausible that improved access to safe procedures for menstrual regulation has contributed to less maternal morbidity and mortality.

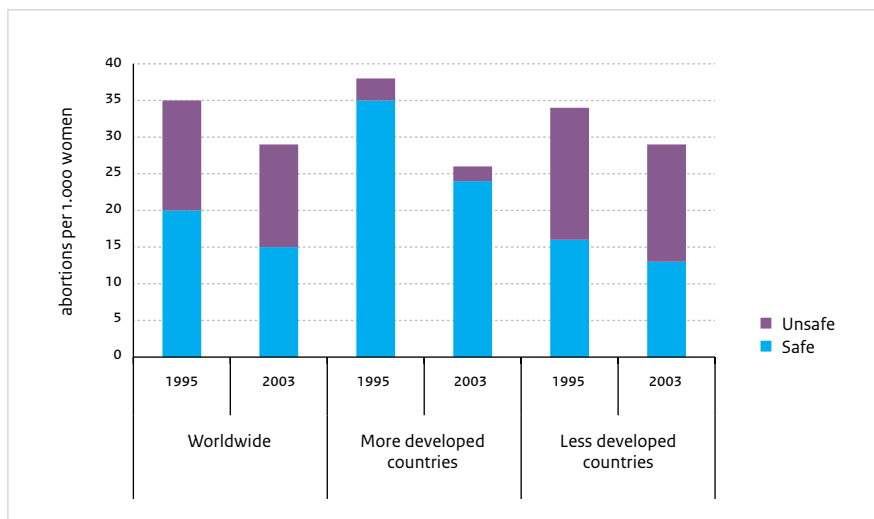
6.1 Problem setting

Global estimates from WHO indicate that since 1995 the abortion rate (proportion of women of childbearing age who ended a pregnancy) has declined. The absolute numbers fell by 600,000 in the developed world, but increased by 2.8 million in developing countries.¹¹⁵

The absolute number of induced abortions was about 41.6 million in 2003 and about half of these abortions were unsafe.¹¹⁶ An unsafe abortion is defined as a procedure intended to terminate an unintended pregnancy, which is performed by individuals without the necessary skills, or in an environment that does not conform to the minimum medical standards, or both.

¹¹⁵ Sedgh 2012.

¹¹⁶ Singh et al 2009: 16-17. This section is based on this publication, unless indicated otherwise.

Figure 15 Abortion rates in 1995 and 2003: worldwide and in developed and less developed countries

Source: Based on Singh et al. 2009.

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Figure 15 shows aggregated data for more developed and less developed countries. It shows that almost all unsafe abortions occur in less developed countries. The figure also shows that the decline of the abortion rate was most pronounced in the more developed countries and that most of the reduction was due to a decline in safe abortions.

The abortion rate is influenced by marital and sexual behaviour patterns, stigma regarding non-marital childbearing, stigma regarding having had an abortion, legislation and government policies on population and on sexual and reproductive health and rights, levels of religious and conservative opposition to modern methods of contraception, family-size aspirations and the existence or absence of programmes to serve the contraceptive needs of women and couples.

The legislation on abortion varies between countries. In general, legislation is more restricted in less developed countries than in more developed countries. Overall, about half the women of childbearing age in the less developed world live in countries where the procedure is banned altogether or permitted only to save a woman's life, to protect her physical or mental health, or in cases of rape, incest or foetal impairment.¹¹⁷

The overall abortion rate is not strongly related to the legislation on abortion. By contrast, the rate of unsafe abortions is strongly linked with abortion legislation: abortions that occur outside the legal framework are frequently performed by unqualified and unskilled providers, or are self-induced; such abortions often take place in unhygienic conditions and involve dangerous methods or incorrect administration of medication.

¹¹⁷ When China and India are excluded from the analysis, the percentage rises to 80%.

Unsafe abortions are dangerous: it is estimated that worldwide they account for 13% of maternal deaths. Maternal mortality has declined in recent decades, but this percentage has remained the same since 2003. Therefore, measures to reduce the incidence of unsafe abortions are crucial steps in further reducing maternal morbidity and mortality.¹¹⁸

These measures include good access to programmes that meet contraception needs, legal and policy reforms and improvements in the provision of medical care and of safe abortion procedures. They also include post-abortion care services comprising effective management of post-abortion complications, effective pain management and counselling on, or the provision of, family planning methods.¹¹⁹

6.2 Policy

The International Conference on Population and Development (1994) urged countries and organisations to deal with the health impact of unsafe abortion as a major public health concern. WHO's strategy on reproductive health (2004) states that unsafe abortion is a preventable cause of maternal mortality and morbidity that must be dealt with as part of the MDG on improving maternal health and other international development goals and targets.¹²⁰ In 2003, WHO published the first ever guidance on safe abortion: *Safe Abortion: Technical and Political Guidance for Health Systems*. The second edition (2012) includes the latest evidence on clinical care. Based on human rights principles, it outlines how to strengthen services, modify laws and develop policies on safe and comprehensive abortion care.¹²¹

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Dutch policy on abortions underlines the internationally agreed guidance on the prevention of unsafe abortion. The Netherlands' approach is pragmatic: abortions take place and they should always be performed safely.¹²²

6.3 Dutch contribution to policy setting

The Cairo agenda includes a text on abortion. Though the Netherlands would prefer to have a more precise text, it defends the existing compromise text, because on several occasions conservative forces have tried to make it less permissive. So far, in international forums the Netherlands has been successful in keeping the existing compromise.

In 2010 the Netherlands took the opportunity of Universal Periodic Review at the Human Rights Council in Geneva to express its views regarding Nicaragua, one of the few countries where since 2005 abortion has been illegal on all grounds. The Netherlands urged that the

¹¹⁸ WHO 2012a.

¹¹⁹ IOB 2009a: 39-40.

¹²⁰ http://www.who.int/reproductivehealth/topics/unsafe_abortion/hrpwork/en/.

¹²¹ WHO 2012b.

¹²² <http://geneva.nlmission.org/news/2012/05/the-netherlands-welcomes-new-who-guidelines-on-safe-abortion.html>.

human rights of women and girls be ensured by legalising abortion when the procedure is life-saving. It tried to achieve agreement on a common EU position in relation to Nicaragua, but did not succeed because of the divergent views on abortion and the domestic legislation in the EU countries. The Netherlands has also expressed its concern about the restrictive legislation in bilateral contacts. The Embassy of the Kingdom of the Netherlands in Nicaragua brought up the issue regularly in discussions with the government, among others in the dialogue on budget support. In addition, the Netherlands supported civil society to promote the discussion on abortion and to urge the government to take its responsibility to prevent unsafe abortions. The EKN also allocated funds to civil society organisations for projects that aimed at preventing unsafe abortions. To date, however, Nicaragua has not changed its legislation on abortion.¹²³

6.4 Menstrual regulation programme in Bangladesh

Bangladesh provides an example of a project to prevent unsafe abortions that was carried out with Dutch support. The project aims at reinforcing and enhancing the existing *National Menstrual Regulation Programme for Reduction of Maternal Mortality and Morbidity in Bangladesh*. The project was carried out under the joint auspices of WHO and the Ministry of Health, and various NGOs were involved in its implementation.

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Background information on menstrual regulation in Bangladesh

Bangladesh is unique in including menstrual regulation as part of its family planning programme. Menstrual regulation (MR) is defined as evacuation of the uterus without official confirmation of pregnancy, and is permitted up to 10 weeks after a woman's last menstrual period as an 'interim method of establishing non-pregnancy for a woman at risk of being pregnant, whether or not she actually is pregnant'.¹²⁴ In contrast, abortion is not legal in Bangladesh, except 'to save the life of a woman'. Bangladesh's national menstrual regulation programme was set up in the 1970s. It is the most decentralised system of pregnancy termination globally, and from the outset it has prioritised getting services to women at the primary care level.

Despite this MR programme, illegal and unsafe MR procedures frequently take place. This can be explained by taboos, shame, misconceptions, ignorance and power relations that limit the mobility of women. Therefore, women may go to unqualified providers (quacks), or go to appropriate providers too late and can be refused because the period during which MR is allowed has passed. There is room for improving the government's capacity regarding training, staffing and quality control of the MR programme. At present, the government relies heavily on NGOs for proper implementation of the programme.

¹²³ The case of Nicaragua is described in more detail in IOB 2010 chapter 8.

¹²⁴ <http://www.icddr.org/media-centre/news/2130-reducing-abortion-related-maternal-mortality>.

The initiative

In 2008, WHO launched the initiative to enhance the menstrual regulation programme because unsafe abortion procedures had been identified as an important cause of maternal mortality and morbidity. To this end, a challenge fund of USD 2.7 million was established for innovative projects. The overall objective was to improve equitable access to services for unwanted pregnancy and the prevention of unsafe abortion, especially for poor and underserved women in rural, urban and hard to reach areas of Bangladesh. Four closely linked components were identified: scaling up delivery of menstrual regulation services; generating rights-based demand from underserved women; improving the knowledge and evidence base; and strengthening the policy response.

After a bidding procedure, seven projects were selected, covering six of the seven divisions of Bangladesh and were implemented across 36 *upazilas* in 16 districts. The initiative was reviewed in 2011 and overall the seven projects were considered successful.¹²⁵ Almost all envisioned activities had been completed according to the plans and most targets had been achieved. The projects succeeded in ensuring equitable menstrual regulation services for poor and difficult to reach groups, and the uptake of temporary and permanent family planning methods had increased. The Ministry of Health provided good stewardship and overall project management was satisfactory. However, a critical remark was made about the time-consuming and not cost-effective bidding procedure. Another critical remark related to the menstrual regulation practices: the service delivery in the public sector was unable to cope with the demand created by the projects, and infection prevention practices were not carried out properly.

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In 2012, in order to assess the impact (net effect) of the intervention in one division (Sylhet) more precisely, an impact evaluation was carried out of two of the seven projects. One project had been carried out by the Family Planning Association of Bangladesh (FPAB) in peri-urban and rural areas of Sylhet district, part of the Sylhet division and home of the capital of the division (also called Sylhet). The other project was implemented by the Marie Stopes Clinic Society in the Maulvibazar district of the Sylhet division.¹²⁶ Both projects aimed at improving awareness of the existence of the menstrual regulation programme, enhancing the knowledge on the proper procedures and improving access to good quality services.

The net effect of these two projects was assessed by comparing the intervention area (four *upazilas*: two in Sylhet and two in Maulvibazar districts) with a control area (Habigonj district in the Sylhet division). In the control area there are no FPAB or Marie Stopes facilities. Limited baseline and end-line data on knowledge and use of services were available for both projects and they point to considerable progress.¹²⁷

¹²⁵ Islam & Venghaus 2011.

¹²⁶ Marie Stopes also has facilities where the procedure can be performed in the capital Sylhet, but these facilities did not receive extra project funding.

¹²⁷ Nielsen Company Ltd. 2011.

However, as no baseline data were available for the control area, a difference in differences method could not be applied.

The most important data collection methods were interviews with key persons, focus group discussions, a survey among randomly selected households and a survey among clients (not randomly selected). In the household survey, separate questionnaires were used for male heads of household and for women in the reproductive age group. A quantitative statistical analysis was applied to ascertain whether the differences between the intervention and the control areas were attributable to the intervention.¹²⁸

Awareness and knowledge on safe procedures

In the intervention areas, the attitude towards the termination of an unwanted pregnancy was more tolerant than in the control group, both among the male heads of household and among the female respondents. The difference between the two groups is highly significant.¹²⁹ The most frequently mentioned argument for undergoing the procedure was that poor parents with too many children should do so for the wellbeing of the family. Other arguments included pregnancy at a late stage of life, pregnancy outside wedlock and health risks for women. In the control group, many women argued that menstrual regulation is a sin, but in the intervention area this argument was rarely mentioned.

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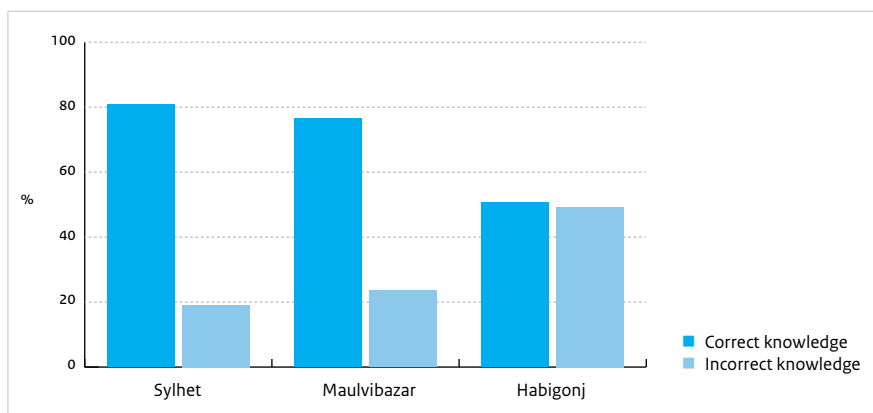
Religion has an influence on the openness to the menstrual regulation procedure. Overall, Muslims were more tolerant of menstrual regulation than Hindus, but the intervention itself had more effects on Hindus. This population group showed greater changes in attitude than the already more tolerant Muslim group. Another factor that influenced the openness to the procedure was residence. Women living in urban areas were more tolerant than women living in rural areas, but among men there were no statistically significant differences.

The intervention contributed to improved knowledge on the appropriate time (six to ten weeks) and the appropriate provider for the procedure. In the intervention areas, both men and women were well-informed that the procedure should be performed within ten weeks after the last menstruation, while in the control group, almost one third of the women thought that the procedure could also be performed later. Figure 16 compares the percentages for female respondents in the three areas where data were collected. Clients seemed to translate knowledge into practice: in the intervention areas the procedure was almost always performed timely, while in the control group this was not the case (details shown below, under access).

¹²⁸ More details on methods and the study in Mannan et al. 2013.

¹²⁹ Significant= 95% probability that the intervention group is indeed different from the control group; highly significant= 99% probability that intervention group is indeed different from the control group.

Figure 16 Knowledge of timeliness of menstrual regulation among Bangladesh women: results of a 2012 survey in upazilas in Sylhet and Maulvibazar districts (n=200) and in a control area (Habigonj district, Sylhet division; n=100)



Source: Mannan et al. 2013 (data from household survey). Habigonj is the control area.

Not surprisingly, in both the intervention and control areas, better educated women were better informed about the appropriate time. Women who had completed primary school had significantly better knowledge than other women who had not. For women with more than ten years of education the difference was highly significant.

Regarding knowledge on providers, in both the intervention and the control areas, public health facilities were frequently mentioned as potential service providers. In the intervention areas, the services of the implementing organisations, Family Planning Association Bangladesh and Marie Stopes International were also frequently mentioned; in the control group they were not mentioned at all. People in the control group more frequently mentioned a traditional provider than people in the intervention area, but the difference between the groups was not significant.

Access to safe procedures

In the control area almost half (44%) of the women had personal experience with menstrual regulation or had relatives or close friends who had such experience. This percentage is significantly higher than in the intervention area, where the equivalent figure was less than a quarter of the women. At first glance, this is surprising. However, it can be explained by the fact that in the intervention area the contraceptive use among young women is significantly higher. In addition, knowledge on emergency contraception was much higher in the intervention area than in the control area. Its use decreased the demand for menstrual regulation.

In all the areas (intervention and control), clients most frequently went to a public health facility for the menstrual regulation procedure. In all areas a high percentage of clients

reported complications, and about one quarter of the clients said that the room in which the procedure took place was not clean.¹³⁰ Other complaints included lack of a recovery place, long waiting times, lack of counselling and having to spend money.

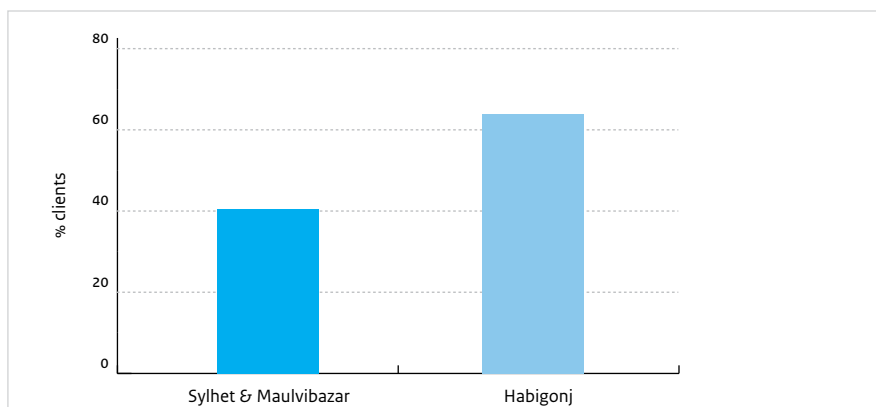
The findings of quality of care are fully in line with those of the 2011 MR project review mentioned above. A recent publication of the Guttmacher Institute also mentions shortcomings in the quality of care of menstrual regulation services, such as improper techniques, lack of sterilisation of equipment, unhygienic conditions, non-use of pain relief during procedures, and use of a single syringe more than the recommended number of times.¹³¹

The most frequently mentioned complications were excessive bleeding and abdominal pain. In the control area, a considerable proportion of women (36%) reported that after undergoing the procedure they developed a uterus infection: this is a more severe complication.

The great majority of the complications are avoidable by properly applying the appropriate standards. Therefore, the high number of complications in the intervention area is disappointing. However, a significantly higher percentage of women in the control group faced complications. This implies that the project has made some contribution to improving the quality of care. Figure 17 visualises the difference.

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Figure 17 *Complications among menstrual regulation clients in Bangladesh surveyed in 2012 (in %): the intervention areas compared with the control area*



Source: Mannan et al. 2013; survey among clients.

Several factors may have contributed to the difference. In the first place, as already briefly mentioned, women in the intervention area had almost always undergone the MR before

¹³⁰ This finding can be confirmed by observation during a preparatory mission of IOB early 2012.

¹³¹ <http://www.guttmacher.org/pubs/IB-Bangladesh-MR.pdf>.

week 11 after the last menstruation, and then the risk of complications is low. In the control area, about 30% of the women underwent the procedure too late and of these, 8% underwent it much too late: after the 12th week post-menorrhoea.

Secondly, in the intervention area about 40% of the clients had the procedure performed by a qualified doctor, but the percentage in the control area was negligible. This is a worrying finding, because women in the control area were most in need of a qualified doctor, as they frequently underwent the procedure too late.

Not surprisingly, both in the intervention areas and in the control area, high educational and income levels significantly increased the probability that the menstrual regulation service had been performed by a qualified physician.

The accessibility and perceived and actual quality of the services were also affected by the costs involved. Clients in the intervention group spent significantly less to undergo the procedure and buy drugs than clients in the control group.

Clients in the intervention areas received significantly more pre-counselling services than clients of the control group. However, in both areas the quality of the counselling was unsatisfactory. Box 2 lists the issues that should be brought up during pre-counselling, but in practice the counselling often included only some of these issues. Neither in the intervention nor in the control group did service providers sufficiently carefully explain how the procedure would be performed.

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Box 2 *Type of information that should be obtained during pre-counselling*

- Last date of menstruation
- Whether first pregnancy
- Age of last child
- Whether any caesarean section
- Whether permission obtained from guardians
- Knowledge related to menstrual regulation
- Whether any family planning method was used

Source: survey among clients.

The findings on post-counselling and follow-up are more promising: clients in the intervention group were more likely to have had post-counselling services including an appointment for a follow-up visit and information on family planning, and these services were better. Studies in various settings in other countries have found that post-abortion family planning can reduce unwanted pregnancies and repeated abortions by as much as half.¹³² In the Bangladesh case study presented here, contraceptive use among clients was

¹³² Curtis et al. 2010.

already high in the intervention and control areas (85% and 77% respectively) and there was no statistically significant difference between the two areas.

Pregnancy-related mortality

As discussed in chapter 4, Bangladesh has made considerable progress in decreasing maternal mortality. The project to strengthen the menstrual regulation programme was too limited in scope to influence national mortality data. However, the project also contributed to revising and improving the national protocol regarding menstrual regulation. It seems likely that applying this protocol will prevent maternal deaths.

Maternal mortality data at district level could not be traced. However, it may be assumed that the improvement of the quality of menstrual regulation services in the intervention areas contributed to decreasing the proportion of maternal morbidity and death caused by unsafe abortion.

Conclusion

In Bangladesh, a relatively small initiative on preventing unsafe abortion proved to be successful. There was strong evidence that Dutch financial support to the programme contributed to increased knowledge on safe procedures and improved quality of care. Good cooperation between the Ministry of Health and NGOs has helped to achieve these results. However, in the intervention area the number of complications is still high and there is room for improvement regarding the quality of care. Better explanation on how the procedure will be performed and more attention to careful post-counselling would also enhance the national menstrual regulation programme.

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6.5 Multilateral organisations

Dutch support to WHO has contributed to research on how to prevent unsafe abortions. Examples include studies on simplifying and improving regimens for medical abortion, improving regimens of pain control during the abortion process and the provision of services by mid-level health care providers.¹³³ Landmark studies on the involvement of mid-level personnel have been carried out in Nepal and South Africa. Randomised clinical trials showed that trained nurses and auxiliary nurses are able to provide surgical and non-surgical abortions as safely as physicians.¹³⁴ This finding is promising, as it has major implications for expanding access to safe abortion in resource-poor settings with a shortage of physicians.

The WHO studies also address the perception of abortion among health care providers and women. A study in Jamaica among providers showed that the majority did not have moral objections and that almost all professionals reported that they had been requested for abortions by their clients. Most providers considered that the availability of abortions

¹³³ WHO 2011b.

¹³⁴ Warriner et al. 2012.

would not encourage risk-taking behaviour. The findings of the study came in time to inform the policy-making process, as the government was considering amending the law on abortion.¹³⁵ A South Africa study showed different results. Here, health professionals expressed feelings of resistance against abortion, contrary to the legislation in the country.

Another study in South Africa addressed the views of HIV-positive women who had decided to have an abortion. Some reported that they had made the decision because of socio-economic hardship in combination with their HIV-positive status. They were generally aware that women have a right to free abortion and they did not feel discriminated against by health care providers. Most women also reported that they did not use contraceptives and that pregnancy came unexpectedly, thus indicating the need for counselling on family planning among HIV-positive women.¹³⁶

Dutch support has also helped to develop and update the abovementioned WHO *Safe Abortion: Technical and Political Guidance for Health Systems*. In 2012, the Netherlands hosted a World Health Assembly side event to accelerate the attainment of the MDG on maternal health (reducing maternal mortality and morbidity). During this event, the update of the *Safe Abortion: Technical and Policy Guidance for Health System* was launched, emphasising that safe abortion is an important priority in Dutch SRHR policy. It voiced the need to break taboos on discussing abortion and the detrimental effects of unsafe abortions on women's health and mortality.

6.6 NGOs

No evaluations were available for projects carried out by Dutch NGOs in the field of abortion.¹³⁷ However, the Netherlands has financed a number of international NGOs that specialise in preventing unsafe abortions and improving the enabling environment and quality service for safe abortions.¹³⁸ Prominent examples are the Guttmacher Institute, Marie Stopes International, Ipas and the IPPF. The Netherlands also provides funding for the Concept Foundation, an NGO that focuses on the identification and introduction of quality health technologies, pharmaceuticals and other reproductive health products, including access to safe medical abortions.

Ipas works through local, national and global partnerships to ensure that women can obtain safe, respectful and comprehensive abortion care, including counselling and contraception to prevent future unintended pregnancies. It aims at increasing skills and capacity to deliver safe abortion services and it works with nations' ministries of health to

¹³⁵ WHO 2012c.

¹³⁶ WHO 2012c.

¹³⁷ Abortion was, however, sometimes included by Dutch NGOs as one of the topics in sensitisation and awareness-raising activities.

¹³⁸ Until 2009, a number of international SRHR NGOs received core funding. After 2009 this modality was phased out and funding became limited and project-based.

interpret laws governing abortion in the broadest terms possible. Examples of their work could be found in Ghana and Ethiopia. In Ethiopia, after the adoption of new abortion legislation (2005) Ipas established safe abortion services and expanded access to high-quality comprehensive abortion care. A study (2008) on this work found positive developments. A high proportion (87%) of all abortion care was performed with appropriate technology and 75% of women who received abortion care left the facility with a contraceptive method.¹³⁹

The Guttmacher Institute seeks to advance sexual and reproductive health and rights through an interrelated programme of research, policy analysis and public education designed to generate new data supporting policy change and improved policy implementation.¹⁴⁰ WHO and the Guttmacher Institute are both responsible for outstanding ongoing work on worldwide data on the prevalence of abortion.

Marie Stopes International provides safe abortion services and post-abortion care. The organisation reports a sharp increase in delivering these services since 2011. The number of abortion services rose from 500,000 in 2010 to about one million in 2010 and 2 million in 2011. The increase is almost entirely due to an increase in medical abortions, mostly home-based. Over half of the services were provided in South Asia. The organisation also provides family planning services, thus contributing to preventing abortions.¹⁴¹ Member associations of the IPPF also address the prevention of unsafe abortion. In a number of countries, e.g. Kyrgyzstan, Mozambique, Rwanda, Sierra Leone and Zambia, they campaigned to liberalise abortion laws.

In conclusion, Dutch support to these international NGOs has contributed to the availability of studies, educational material and guidelines and to the increase of safe abortion services.

6.7 Discussion

The Dutch involvement in preventing unsafe abortions and providing access to safe abortions has been consistent and firm in recent decades, despite opposition from several countries, including EU member states, specifically against abortions and more generally against SRHR and the ICPD Programme of Action. Making abortions safer and fewer by providing knowledge on and access to contraceptive methods is the first step to take and is the preferred way to reduce the number of unwanted pregnancies and of unsafe abortions.

¹³⁹ <http://www.ipas.org/en/News/2013/June/Ipas-model-provides-national-snapshot-of-changes-since-law-reform-in-Ethiopia.aspx>; <http://www.ipas.org/en/Resources/Ipas%20External%20Publications/Evaluation-of-a-national-intervention-to-improve-the-postabortion-care-content-of-midwifer.aspx> provides one recent Ipas example: the introduction of medical abortion in Kenya.

¹⁴⁰ <http://www.guttmacher.org/search/index.jsp?query=evaluation&field=content&sortBy=relevance&fromMonth=12&fromYear=2005&toMonth=03&toYear=2013&startAt=50> provides articles on study results.

¹⁴¹ <http://www.maristopes.org/our-impact/section-5/global-trends-abortion-and-post-abortion-care-services>.

However, unwanted pregnancies and induced abortion will always continue to occur and should be addressed. Therefore, the Netherlands has – together with others – successfully kept safe abortion on the international agenda. In addition, it has raised the issue in bilateral contacts.

Support to WHO and to international NGOs has been effective regarding research and the production and distribution of technical guidelines.

Support for policy implementation has been provided mostly through specialised international NGOs, but the overall allocation to these organisations is limited (estimated at about 5% of the total budget) compared to allocation to multilateral organisations or to the bilateral channel. Results could be demonstrated in better data availability, studies and increased service delivery. A positive example of a bilaterally-funded project is the support for strengthening the menstrual regulation programme in Bangladesh: this programme has yielded results in increasing knowledge and improving the quality of care.

In countries with restrictive abortion legislation, support to policy implementation remains a challenge. Efforts to be taken may include emphasising the need to include contraceptive counselling and access to contraception for girls and women in post-abortion care, and pointing out the high costs of unsafe procedures.¹⁴²

¹⁴² <http://www.gutmacher.org/pubs/gpr/12/4/gpr120402.html>.



7

Nigeria, condoms (Esther Jurgens, 2011)

HIV/AIDS and other sexually transmitted diseases

This chapter presents the findings on the Dutch contribution to preventing and treating HIV/AIDS. The most important building blocks are the Tanzania literature study and the evaluations of multilateral organisations and NGOs. The most important findings are:

Research questions	Main findings
Policy	At the core of Dutch policy are the human rights perspective, the link between SRHR and HIV, the importance of prevention and the addressing of key populations. The Netherlands has successfully negotiated to include these elements in the UNAIDS strategy.
Knowledge	Dutch support to SRHR has contributed to increased knowledge on HIV transmission, including among young people.
Access to commodities, drugs and services	Dutch bilateral health sector support and support to UNAIDS and the Global Fund has contributed to substantially increased access to condom use, mother-to-child prevention and AIDS-related treatment. Inequities in access have not been reduced. NGOs' contribution to increased access could occasionally be quantified.
Access to commodities, drugs and services for those who may be denied these rights.	The implementation of concrete interventions for those at risk of being denied access is mostly limited to NGOs, UNICEF (young people) and, to a lesser extent, the Global Fund (key populations).
Less HIV infections	Dutch support to the health sector, UNAIDS and the Global Fund has contributed to declining HIV transmission and HIV-related mortality.

7.1 Problem setting

Sexually transmitted diseases are a major global cause of acute illness, infertility, long-term disability, psychological distress and death. Worldwide, about 446 million new curable sexually transmitted infections (STIs) occur each year.¹⁴³ Some STIs exist without symptoms. Untreated STIs can have critical implications for reproductive, maternal and newborn health. They are associated with congenital and perinatal infections in neonates, particularly in regions where rates of infection remain high. In pregnant women with an untreated STI, the pregnancy is at risk of resulting in stillbirth or neonatal death. Pregnancies among women with untreated STIs may also result in spontaneous abortions and premature deliveries, thus contributing to neonatal mortality and morbidity. Untreated STIs are a major cause of involuntary infertility.

In 2011, the number of people with HIV was estimated at 34 million, about two thirds of them living in sub-Saharan Africa. Compared to 2001 this was an increase of about 4.6 million.¹⁴⁴ This increase is due to population growth and to the fact that ART has become

¹⁴³ <http://www.who.int/mediacentre/factsheets/fs110/en/index.html>.

¹⁴⁴ http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/20121120_UNAIDS_Global_Report_2012_with_annexes_en.pdf.

available. When properly treated, people with HIV live much longer than they did a decade ago. In relative terms, HIV prevalence remained similar worldwide (0.8%). In Africa, however, HIV prevalence decreased from 5.9% to 5%.

The number of new infections/population (incidence rate) provides a more accurate picture of the epidemic's development. The data indicate that the epidemic has been stemmed. Despite population growth, the annual number of newly infected people has decreased from 3.1 million in 2002 to 2.5 million in 2011. In sub-Saharan Africa the HIV incidence rate has declined by one third (from 0.61% in 2001 to 0.41% in 2009). In Asia, the prevalence is still low, but in some Asian countries the number of newly infected people has increased. Data indicate that at present, in contrast to the past, women are more affected by the epidemic than men. This trend is most pronounced in sub-Saharan Africa.

Access to proper treatment has increased substantially over the last five years. It is estimated that in 2009, 14.6 million people with HIV (out of 33.3 million) were in need of ART and over one third of them (5.3 million) had access to that therapy.¹⁴⁵ HIV transmission from mother to child can be reduced to 5% if pregnant women with HIV are treated with ART. In 2009, over half of pregnant women with HIV in lower and middle income countries had access to ART, much more than in 2004 (19%).¹⁴⁶ The increase in ART and the prevention of mother-to-child transmission (PMCT) have contributed to a substantial reduction (19%) of the number of aids-related deaths since 2004.¹⁴⁷

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Knowledge on HIV transmission is regularly collected in DHS and other surveys. However, data is not compiled worldwide. Available data about women in urban areas show that since 1991, knowledge on HIV transmission has increased. In the period 2000- 2007 it ranged between half of women with correct knowledge in poor urban strata in Asia to 85% among rich urban strata in all continents.¹⁴⁸ However, knowledge among adolescents and young people is much less widespread. Only 20% of girls between 15 and 19 and 30% of boys between 15 and 19 have comprehensive knowledge on HIV.¹⁴⁹

Both the risk of becoming HIV-infected and the access to proper treatment are related to a number of economic, social and cultural factors, but the relation can change over time. Education is not correlated to HIV status. Though a higher level of education is associated with protective behaviour, such as condom use, it is also associated with a higher level of infidelity and a lower level of abstinence.¹⁵⁰ Poor people are hit harder by the impact of AIDS, but their chances of being exposed are not necessarily higher than those of wealthier people.¹⁵¹ HIV/AIDS should not be labelled as a poverty disease, but as a disease of inequality.

¹⁴⁵ <http://www.who.int/hiv/topics/treatment/en/>. ART is indicated only for certain people living with HIV.

¹⁴⁶ <http://www.who.int/hiv/topics/mtct/data/en/index3.html>.

¹⁴⁷ UNAIDS 2010: 8.

¹⁴⁸ http://search.who.int/search?q=data+on+knowledge+on+hiv&ie=utf8&site=who&clie nt=_en&proxystylesheet=_en&output=xml_no_dtd&oe=utf8&getfields=doctype.

¹⁴⁹ UNICEF 2012: 29.

¹⁵⁰ Walque 2009: 209.

¹⁵¹ Gillespie 2008: 15.

Key populations, such as sex workers, men having sex with men and drug users, are at high risk of HIV transmission. Discrimination against key populations increases this risk, because people may avoid testing and proper treatment.

7.2 Policy

Regarding the prevention and treatment of STIs, the most important intervention is the availability of cheap and accurate diagnostic tests, antibiotics and suppressive antiviral therapies. In resource-poor settings, many of these are not accessible. Dutch policy regarding STIs consists mainly of budget support to the health sector and support to WHO.

Regarding the HIV epidemic, various types of interventions are required and the participation of many actors is needed.¹⁵² WHO has developed a strategy that includes four elements: 1) optimising prevention, diagnosis, treatment and care outcomes; 2) leveraging broader health outcomes through HIV responses; 3) building strong, sustainable health systems; and 4) addressing inequalities and advancing human rights.¹⁵³ The UNAIDS strategy (2011-2015) points to the importance of prevention and combating discrimination and stigma (see box 4).

Dutch policy on preventing HIV transmission and treating and caring for people with HIV emphasises prevention and the human rights perspective. It includes keeping HIV on the international agenda and focusing on the rights of key populations. It also consists of financial support through various channels: health sector budget support; and financial contributions to the EU, UNAIDS and its cosponsors, the Global Fund and international and national NGOs, either based in the countries concerned or in the Netherlands. In 2011 a special fund was set up to support activities aiming at key populations.¹⁵⁴

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7.3 Dutch contribution to policy setting

On various occasions the Netherlands has emphasised the importance of human rights, the relation between SRHR and HIV/AIDS and the fact that the response to the epidemic should include prevention and should address young people and key populations.

UNAIDS, the most important agency regarding policy setting at the global level, shares the Netherlands' view regarding human rights. Box 3 presents the organisation's statement at the 2011 UN high-level meeting on HIV/AIDS.

¹⁵² Harman 2010: 5.

¹⁵³ WHO 2011c.

¹⁵⁴ <http://www.rijksoverheid.nl/documenten-en-publicaties/besluiten/2011/05/04/subsidiekader-key-populations-fonds.html>. The key populations fund could not be included in this policy evaluation because implementation had only just started.

Box 3 *UNAIDS statement on human rights at the 2011 UN high-level meeting*

...Women and girls, men who have sex with men, transgender people, sex workers, people who use drugs, prisoners, young people, persons with disabilities and other vulnerable groups are all fully entitled to respect for, and protection of, their human rights...

Every principle of effective HIV programming suggests that empowering those at risk to protect themselves from infection — to exercise informed and safe sexual autonomy, to use condoms and sterile syringes, to receive treatment to prevent parent-to-child transmission, and increasingly to use newer prevention methods, such as male circumcision and pre-exposure prophylaxis, as well as benefit from the prevention effects of treatment — works better than coercing, criminalizing or marginalizing them.

Source: <http://unaidspcbngo.org/wp-content/uploads/2011/04/HRRRefGrp-RightsCourse-ENG.pdf>.

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In 2010 the Netherlands chaired the programme coordinating board (PCB) of UNAIDS. The new UNAIDS strategy 2011-2015 was adopted during the Dutch presidency and, as shown in box 4, it gives more emphasis to prevention. The other PCB members have praised the Dutch presidency of the board. The Netherlands representatives are considered to be knowledgeable and good negotiators, building partnerships with other participants. The Netherlands also played an important role in policy setting for the Global Fund: for example, regarding the inclusion of key populations in the organisation's strategy.

Box 4 *Key elements of UNAIDS strategy*

Revolutionising HIV prevention politics, policies and practices will shift the debate from HIV prevalence to incidence, enabling us to identify transmission hot spots, empower people, particularly young people, to demand and own the response and incentivize political leaders to focus on populations and programmes that will make a difference in reducing new infections.

Advancing human rights and gender equality for the HIV response means ending the HIV-related stigma, discrimination, gender inequality and violence against women and girls that drive the risk of, and vulnerability to, HIV infection by keeping people from accessing prevention, treatment, care and support services. It means putting laws, policies and programmes in place to create legal environments that protect people from infection and support access to justice.

Source: UNAIDS 2010: 9-10.

7.4 Tanzania

In recent decades, Tanzania has been an important development partner for the Netherlands, but in 2011 it was decided to conclude development cooperation and to phase out the existing programmes. During the period evaluated, the cooperation in the field of STIs and HIV/AIDS included both health sector budget support and support to HIV/AIDS projects, totalling about EUR 18.4 million per year. Projects include support to the international NGO PSI for the promotion and distribution of condoms and to the Dutch company PharmAccess for scaling up the quality of HIV/AIDS care and treatment services.

Tanzanian health and HIV/AIDS policy

HIV/AIDS is an important public health and social problem in Tanzania, but the epidemic is on the decline (data on prevalence and mortality will be presented below). The Tanzanian government's health policy was outlined in chapter 4. Regarding HIV/AIDS, a National AIDS Control Programme (NACP) has been set up, focusing on four goals: 1) scaling up treatment and care services; 2) strengthening the health care infrastructure through expansion of human resources, facilities and equipment and through comprehensive training of health professionals; 3) increasing public understanding by information and education; and 4) strengthening the social support for care and treatment.

Knowledge

The Tanzanian government's policy on HIV/AIDS emphasizes the importance of information, education and communication and in 2009, HIV education had become integrated in about 60% of primary schools and 80% of secondary schools. Awareness on HIV/AIDS is very high (99%) and comprehensive knowledge on prevention of infection is also high (about 70%), but there are geographical variations. Between 2004 and 2010 there was little change. In rural areas, levels of comprehensive knowledge are slightly lower than in urban areas. Regarding comprehensive knowledge on HIV prevention, comprehensive knowledge among adolescents on HIV transmission is low (40% among women aged 15-24, 47% among men aged 15-24).¹⁵⁵ Since 2001, overall knowledge on the existence of HIV among adolescents has increased, but comprehensive knowledge on how to prevent transmission has slightly decreased.

Access to and quality of services

The number of health facilities providing HIV care and treatment in all districts increased from 210 in 2007 to 825 in 2011. The number of nurses, clinical officers, pharmacists and other staff also increased, but is still below the requirement.¹⁵⁶ Testing has become widely available, though adolescents have less access to testing.

¹⁵⁵ http://www.nbs.go.tz/index.php?option=com_content&view=article&id=353:2011-12-tanzania-hiv-aids-and-malaria-indicator-survey-thmis-report&catid=55:this&Itemid=145.

¹⁵⁶ <http://www.scribd.com/doc/30040268/Tanzania-Health-Sector-Strategic-Plan-III>; <http://www.nacp.go.tz/documents/report21.pdf>; [http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_TZ_Narrative_Report\[1\].pdf](http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_TZ_Narrative_Report[1].pdf).

Condoms have become widely available and at present over 80% of the villages have at least one outlet selling condoms. PSI plays an important role in condom distribution and sale. This NGO supports the work of the Tanzania Commission for AIDS to reduce the rate and number of new HIV infections through targeted behaviour change initiatives, including a campaign to address concurrent sexual partnerships, and through the national distribution and promotion of high-quality, affordable male and female condoms. In 2011, PSI was responsible for two thirds of the condom distribution: this is an increase compared to 2007, when PSI had half of the market share. Condom use among men varies and is highest (41%) in the Southern region.

Taking into consideration that funds for HIV were widely available, PSI broadened its scope and used its experience with private providers to also deliver family planning and maternal care services.¹⁵⁷

About half of the people with HIV who need treatment with antiretroviral drugs (ART) do indeed receive the necessary drugs. Treatment coverage for the prevention of HIV transmission from mother to child has increased substantially over the last five years and in 2011 was over 90%.¹⁵⁸ Despite the positive trend regarding the prevention of HIV transmission and treatment, there are striking demographic and geographical variations: treatment rates are highest in Dar es Salaam, Dodoma and Singida and lowest in Tabora and Kigoma.

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Despite efforts to improve equity in access to services, inequities might be increasing, mainly due to distorted income distribution. Low income hinders accessibility to health services. Though several poor groups are exempted from users' fees in public facilities, they have to pay for medicines and tests and these services are frequently unaffordable for them. Lack of funds from central government limits resource allocation aiming at improved accessibility. In the dialogue on sector budget support, the EKN experienced difficulties in initiating discussions on equity issues.¹⁵⁹

Regarding the quality of care, it has been reported that thanks to the contribution made by Pharmaccess, monitoring and reporting have become more streamlined. In addition, there has been capacity building at all levels of the health system and guidelines on quality have been put in place. Steps have been undertaken to install a quality certification scheme.¹⁶⁰ No nationwide information is available on the results of quality improvement on clients' satisfaction and health workers' behaviour. However, a study on another quality improvement initiative in a regional hospital concluded that this initiative was associated with improved services being offered to children living with HIV.¹⁶¹

¹⁵⁷ http://www.psi.org/sites/default/files/publication_files/tanzania-sf-casestudy.pdf.

¹⁵⁸ http://www.unaids.org/en/media/unaids/contentassets/documents/pcb/2012/20120524_CaseStudyTanzania_CRP3_en.pdf.

¹⁵⁹ Interview.

¹⁶⁰ http://regist2.virology-education.com/2011/5interest/docs/17_risha.pdf.

¹⁶¹ <http://www.pedaids.org/Press-Room/Events/2012/AIDS-2012-Abstracts/17>.

Regarding key populations, there are still laws and regulations or policies that present obstacles for effective prevention and treatment of HIV. The government recognises that sex workers and men having sex with men are at high risk for HIV transmission, but has not yet formulated policies to improve their access to information and treatment.

HIV prevalence and HIV-related mortality

Data from 2010 indicate that the number of people living with HIV has been stable over the last decade.¹⁶² It is estimated at 1.4 million (1.2 million adults and 0.2 million children). More than half of the adults living with HIV are female (0.7 million). Since 2001, the prevalence rate for adults has consistently declined; it is currently estimated at 5.3% (Table 7).

Table 7 HIV prevalence among adults in Tanzania 2003/2004 - 2007/2008 - 2011/2012			
Year	HIV prevalence (%)		
	Men 15-49	Women 15-49	Total
2003-2004	6.3	7.7	7.1
2007-2008	4.7	6.8	6.3
2011-2012	3.9	6.3	5.3

Source: THMIS¹⁶⁵.

The adolescent prevalence rate is 3.9% for women and 1.7% for men. Since 2000 the incidence rate has also steadily declined and at present it is estimated at 0.5%. AIDS-related deaths peaked in 2004 and since then have steadily declined. Disaggregated prevalence rates among key populations were not available.

Conclusion

There is moderate evidence that Dutch support to the Tanzanian health sector, UNAIDS and the Global Fund and to projects that directly address HIV/AIDS has contributed to improved knowledge on prevention of transmission in the country. It has also contributed to increased treatment. Both the HIV prevalence and the incidence rates have declined, though great regional differences can be observed and gaps are hardly closing. Dutch support to the health sector and to HIV projects does not include special attention for key populations.

¹⁶² http://158.232.15.29/CFS/downloadpdf.htm?country_id=AFRTZA&lng_code=en&pdfoption=epi.

¹⁶⁵ http://www.nbs.go.tz/index.php?option=com_content&view=article&id=353:2011-12-tanzania-hiv-aids-and-malaria-indicator-survey-thmis-report&catid=55:this&Itemid=145.

7.5 Multilateral organisations and the Global Fund

Dutch financial support to multilateral organisations in the area of STIs and HIV/AIDS has mainly been through financial contributions to UNAIDS, UNICEF and the Global Fund to Fight AIDS, TB and Malaria.

UNAIDS

The core UNAIDS work is advocacy for worldwide action against HIV/AIDS and the promotion of partnerships among and between a wide range of actors, such as UN agencies, governments, civil society organisations and networks of people living with HIV (PLHIV). In 2009 an external evaluation of UNAIDS pointed mostly to institutional issues.¹⁶⁴ The main conclusions were that UNAIDS has been successful regarding global leadership and broad-based political and social mobilisation, largely successful in advocating greater political commitment at global and country levels and partly successful in promoting and achieving global consensus in policy and programmes and in strengthening capacity at country level. Increasing involvement of civil society and PLHIV had been a key achievement and civil society influence at global level was clear. It was less evident at country level, but some positive examples could be mentioned, such as cases where PLHIV had influenced the debate on getting access to testing, treatment and counselling. Also, in a number of countries UNAIDS has helped to ensure the involvement of PLHIV in the introduction of legislation to protect their human and legal rights. Another conclusion is that UNAIDS' leadership role and support for effective HIV prevention has been inadequate. The evaluation was more positive on the technical support by UNAIDS. It is highly valued, but there is room for better coordination and avoiding duplication.

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Looking into the future, the evaluators concluded that the concept of AIDS 'exceptionalism' was still valid, given the specific factors that drive the epidemic and influence the response and the impact of HIV in some regions. However, they considered a more nuanced approach more appropriate: an approach that recognises the diversity of epidemics and configures support to the particular country's circumstances. The conclusions and recommendations of the evaluation were widely discussed in the Programme Coordination Board. The need to take into account the diversity of epidemics in different regions and the need to focus on prevention is reflected in the UNAIDS strategy 2011-2015.

DFID's assessment of UNAIDS (2011) includes similar positive and critical comments. The most important overall finding is that the organisation has made a significant contribution to progress on HIV/AIDS at the global level, but that delivery in countries is limited. In addition, it is mentioned that UNAIDS should scale up its technical leadership.¹⁶⁵

The implementation of the 2009 external evaluation's recommendations has yielded results. More UNAIDS staff are now based in regional and country offices. A results-based

¹⁶⁴ <http://www.unaids.org/en/ourwork/managementandgovernance/dxdmanagementandgovernance/secondindependentevaluationofunaids/secondindependentevaluationofunaids-oversightcommittee/>.

¹⁶⁵ DFID 2011: 30.

management and monitoring system has been set up: the unified budget, results and accountability framework (UBRAF). The 2012 report of (MOPAN concluded that this is an important improvement and that UNAIDS could still maximise its use of performance information and improve the way results-based management is applied, notably in moving from activity-based to results-based reporting and in the use of performance indicators, baselines and targets to provide information on its work at country level.¹⁶⁶

UNICEF

Four project evaluations of UNICEF were included in this policy evaluation, all targeted at children or young people: a global campaign, support to the national HIV response in Zanzibar, a programme directed at orphans and vulnerable children in Mozambique and a project aimed at adolescents in Namibia. The global campaign aimed at a more child-centred approach to the epidemic and the evaluation claims that UNICEF helped to set the global agenda on children and HIV/AIDS and also contributed to a more child-centred approach at the national level. However, only anecdotal evidence could be provided for the campaign's influence at the national level. The Zanzibar programme contributed to improved knowledge on and prevention of HIV at community level, but did not reach all communities. Preventive services, such as condom distribution, the use of safe blood and the prevention of mother-to-child transmission also increased. In Mozambique, the project was successful in involving local community members, in identifying families and children in need, and defining the type of assistance that should be provided. The Namibia project led to policy changes at national level, most notably the introduction of an extra-curricular life-skills programme at secondary and combined schools, endorsed by the Ministry of Education. It also showed results at beneficiary level: knowledge on SRH and service use increased.

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The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund)

The Global Fund is a financing mechanism, not an implementing agency. It provides financing to a wide scale of projects in the area of prevention, treatment and care. A major five-year external evaluation of the Global Fund's contribution to service availability and reduction of the disease burden was issued in 2009.¹⁶⁷ It summarises data from 17 countries, mostly from 2007 or before. It therefore includes only a small part of the period that is under review in the policy evaluation presented here. However, as the Global Fund has continued as a financing mechanism for providing HIV-related preventive and curative services, here we summarise of the most important results in terms of outcome and impact.

The overall conclusion of the 2009 evaluation is that collective efforts, including the programmes that received funding from the Global Fund, have resulted in improved service availability, better coverage, and a reduction of the disease burden regarding HIV/AIDS. However, the original plan to identify more precisely the Global Fund's contribution to these achievements could not be realised.

¹⁶⁶ MOPAN 2012.

¹⁶⁷ <http://www.theglobalfund.org/en/terg/evaluations/5year/>.

The evaluation demonstrated that the number of sites delivering HIV interventions had increased dramatically in all countries evaluated, especially since 2004. In most countries, the number of facilities that provide HIV testing and counselling or ART had more than doubled between 2004 and 2007. Coverage of HIV testing and counselling had increased in every country between 2003/2004 and 2006/2007. However, coverage rates remained very low, with only three countries having more than 15% of adults tested and counselled in the last year: Lesotho, Rwanda, and Tanzania. In most countries, preventing mother-to-child transmission (PMTCT) among pregnant women has at least doubled since 2004, but only three countries with a generalised epidemic reported over 50% of pregnant women tested and counselled. Only four countries reported that at least 35% of pregnant women received HIV prophylaxis. It was calculated that in the period 2003-2007, the number of infections averted due to PMTCT was over 16,000.

ART coverage had improved significantly in all countries evaluated. Countries with the most rapid increases in coverage between 2004 and 2007 were Rwanda, Tanzania, Zambia, Cambodia and Vietnam. On the basis of these findings on ART it was calculated that increased use of medicines contributed to over 570,000 life years saved in the period 2003-2007.

Successes were also shown in harm reduction activities, such as needle distribution, condom distribution to female sex workers and blood screening.

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A less positive finding was that no evidence was found of narrowing gaps in coverage between disadvantaged groups and those who are better-off. Only a few systems had been in place at country level or through the Global Fund's own systems to monitor equity. The monitoring of gender, sexual minorities, urban-rural, wealth, education, and other types of equity as part of grant performance or impact assessment was identified as a major gap. This finding resulted in the Sexual Orientation and Gender Identity Strategy by the Global Fund Secretariat (2007). Seven other, more recent, evaluations of projects financed through the Global Fund were also included in this policy evaluation. Four of these relate to HIV prevention and treatment (Bangladesh, Ethiopia, Tajikistan and Kenya) and two of them (Kenya and Bangladesh) specifically targeted children or young people.

The Global Fund Results Report 2012 provides more recent data on PMCT and ART coverage. It is estimated that in 2010, about 48% of pregnant women in need of prophylaxis received medication. Global Fund supported programmes accounted for almost a quarter of this. ART-coverage was about 46% in 2010 and Global Fund supported programmes accounted for slightly less than half of this. The report does not inform about equity issues.¹⁶⁸

In Ethiopia, support for the national HIV response has resulted in a rapid increase (400%) in the number of people tested for HIV and likewise in a phenomenal increase in the number of people starting ART (from 8,000 in 2005 to over 130,000 in 2008). Women's knowledge on HIV transmission had also improved, as well as condom use in higher risk sex. The trend in this country shows a stabilising HIV prevalence in the period 2004-2008 and even a declining trend in urban areas.

¹⁶⁸ <http://www.theglobalfund.org/en/library/publications/>.

In Tajikistan, in line with the nature of the epidemic in this country, the project specifically addressed populations at high risk, such as injecting drug users, male and female sex workers and men having sex with men. Due to stigmatising, these groups had limited access to care and, in addition, medicines were often out of stock. The project contributed to increased treatment with antiviral drugs among these high-risk groups. The project in Kenya addressed the needs of orphans and vulnerable children.

The project in Bangladesh was specifically aimed at improving knowledge on HIV transmission and behaviour change among young people. It successfully applied a life-skills approach. This entails using an interactive educational methodology that focuses on acquiring knowledge, attitudes and interpersonal skills. It aims to enhance young people's ability to take greater responsibility for their own lives by making healthy choices, being more resistant to negative pressures, and avoiding risky behaviours.

Conclusion

Summarising, it can be concluded that UNAIDS has been important for setting the agenda at the global level. The organisation's coordinating role at the country level was less evident, but since 2011 the organisation has been more decentralised and has made structural adaptations in order to demonstrate the results of its work at regional and country levels. There is moderate evidence that the Global Fund has contributed to a significant increase (30-50%) of prevention of mother-to-child transmission and to increased treatment and care at services and community levels. As can be expected, UNICEF addressed the needs of children and young people. Underserved population groups and key populations were addressed only occasionally in evaluations of their work included in this policy evaluation.

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7.6 NGOs

As mentioned earlier, the policy evaluation in this report regarding the results of Dutch NGOs is based on existing evaluations, almost two thirds of which (31/51) are of projects in the field of HIV/AIDS.¹⁶⁹

The bulk of the projects aimed at prevention, treatment and care for the general population in high prevalence countries, including PLHIV and orphans and vulnerable children (OVC). Five projects included interventions for adolescents and young people, and six projects specifically addressed key populations. Most projects and programmes were carried out in one or more countries in sub-Saharan Africa; a small number of projects involved one or more Asian (including central Asia) countries, or projects in Latin America. The projects for key populations (i.e. intravenous drug users, sex workers, prisoners, lesbian, gay, bisexual and transgender people, and men having sex with men) were implemented in Central Asia, Latin America (Ecuador, Peru) and Asia (India, Indonesia and Myanmar).

¹⁶⁹ IOB 2013b reports on the findings from these evaluations. Here, the overall conclusions will be presented and illustrated with some examples.

Overall, projects and programmes had a strong focus on the strengthening of organisations in prevention, care and support. In addition, several projects particularly promoted the involvement of religious leaders and organisations. Building life skills and social protection were important components in a number of interventions, particularly for young people, PLHIV, OVC and key populations. Examples are self-help groups for PLHIV, social cash transfers and income-generating activities.

Some projects included policy influencing. Lobbying for policy changes was fairly successful at community and district levels. At the national level, there were only a few examples of changes that could be attributed to NGO intervention. Examples are revisions in the law to fight stigma and discrimination in India and Peru, and the adoption and endorsement of a model for training and management in prisons by Ministries of Justice in Kyrgyzstan and Tajikistan.

Knowledge

Overall, there was considerable evidence across the various interventions that the knowledge on HIV transmission and the uptake of condoms had increased. Some evaluations reported improved attitudes: for example, towards delaying sexual debut or willingness to disclose HIV status in the workplace.

| 114 | Applying a life-skills approach, either as the principal strategy or as one of several strategies, proved to be successful. The evaluations of the projects targeting young people in Kenya, Malawi and South provide evidence that this approach has contributed to better knowledge on HIV prevention.

Evaluations provide examples where interventions targeting key populations increased their understanding of their rights, but also resulted in changed attitudes of health care providers and police officers. Changes in attitudes towards HIV and PLHIV and improved self-esteem of PLHIV were also reported. For example, in Rwanda it is reported that self-help groups contributed to increased confidence among PLHIV. Box 5 provides an example from Cambodia, where Buddhist monks were involved in preventing HIV transmission and combating stigma and discrimination towards PLHIV.

Box 5 *Monks and Nuns HIV/AIDS and human rights (MONHAR) project, Cambodia*

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

The MONHAR project adopted a train the trainer approach and it was reported that the project has been successful in minimising the stigma and discrimination of PLHIV. They said that they felt more at ease in expressing concerns in public meetings and demanding proper treatment for children at school.

Through the project, support, including food, was provided to people with HIV. However, the monks tended to use their own approach in helping people with HIV, rather than the commonly agreed approach.

Source: evaluation report MONHAR project.

A common element that in most projects contributed to enhanced knowledge on and more tolerant attitudes towards HIV was the use of peer groups. Focusing on links with theological teaching and on links to social, ethical and human rights issues also proved successful. Less positive is the fact that little information could be provided on how experiences were shared and how information on lessons learnt was disseminated.

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Access to services

Access to services regarding HIV/AIDS includes access to preventive services, such as information and condoms, access to voluntary counselling and testing, access to ART and access to care for people living with HIV/AIDS. Care may include food, income generation and the provision of safety nets, legal protection and support for orphans.

There is modest evidence (mostly self-reported) that several projects contributed to increased condom uptake and/or improved access to voluntary counselling and testing. An example is a project in South Africa. It reports voluntary counselling and testing for 13,000 young people that had not been reached previously. In a few cases numbers are provided about increased access to ART. For example, a large-scale multi-country initiative had resulted in an increase in the number of people on ART: from 5,878 in 2006 to 19,342 in 2009. One of the main approaches of this initiative was capacity building through training and promoting linkages between organisations.

The projects addressing the needs of PLHIV had several approaches: establishing self-help groups (Rwanda); training member of self-help groups to give peer counselling (Zimbabwe); organisational strengthening of self-help groups (Peru); using self-help groups as an element of an overall strategy that focused on reduction of discrimination (Vietnam); social cash transfer (Malawi); and empowering volunteers to support families caring for people with HIV (South Africa).

In line with the different approaches, the results were also of a different order. For example, improved quality of treatment services was reported in Vietnam and increased service use in Peru. In Peru, after two years of implementation the project led to an increase of 20% in service uptake in terms of professional counselling on nutrition, on infectious diseases and on psychological issues. Box 6 summarises the Malawi project.

Box 6 *Social cash transfer in Malawi*

The project aimed at reducing poverty and hunger in vulnerable households and increasing children's school enrollment. The strategy was to provide small grants to ultra-poor households with no able-bodied household members. Results:

- More households were linked to farm subsidies.
- Some households graduated out of poverty.

- The anticipated impact on access to other social cash transfers could not be demonstrated.

Source: IOB 2013b, evaluation report cash transfer project.

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Despite the differences in approach and type of results, a number of lessons could be drawn from the projects for PLHIV.

- Using volunteers and peer counselling proved effective in helping increase self-confidence and contributed to break down stigmatisation and discrimination.
- Involvement of beneficiaries in priority setting and design was a success factor.
- Self-help groups were found to be a key ingredient to bringing about change.
- Strong partnerships at community level and partnerships with governments, churches and civil society organisations proved to be important success factors.

For key populations, examples of main lessons learnt were to emphasise a rights-based approach, to link medical services to 'soft services' such as counselling, and to use peer educators (e.g. female sex workers) to liaise with other sex workers (e.g. Myanmar).

Bangladesh provides an example where the Embassy of the Kingdom of the Netherlands supported a substantial project that aimed at preventing HIV transmission among a key population group through bilateral funding: the male sexual health project, implemented by an NGO. The project contributed to the establishment and maintenance of drop-in centres for men having sex with men (MSM), offering testing, condoms and health services. The project was reviewed in 2008. The evaluators conclude that the envisaged outputs in terms of MSM reached, condoms distributed, lubricants distributed and educational material distributed were achieved. Overall, the clients were satisfied with the services that were provided, but the evaluators identified several points for improvement. For example, more drop-in centres could provide counselling sessions, and the availability of doctors could be enhanced. The evaluators also advised the organisation to take initiatives to provide drugs to clients lacking the financial means

to buy the drugs. Another recommendation was that the organisation could take more initiatives on the wellbeing of female partners of MSM.¹⁷⁰

Conclusion

Support through NGOs is an important channel for addressing the needs of adolescents, key populations groups and people living with HIV. There is moderate evidence that overall the projects contributed to enhanced knowledge on HIV and HIV transmission. The life-skills training proved to be a useful approach. In some cases there is modest evidence (mostly self-reported) that the NGO interventions led to increased uptake of condoms, counselling and ART, but the increase was usually not quantified. Some NGO projects helped to increase the income of households with PLHIV.

7.8 Discussion

The efforts of many, including those of the Netherlands, to contain the HIV epidemic have yielded results. HIV transmission has declined and mother-to-child transmission and AIDS-related treatment rates have substantially increased.

The Netherlands has contributed to the recognition of the importance of prevention. It should be noted, however, that a systematic review of HIV evaluations showed that only some preventive interventions have proved to yield results.¹⁷¹ The most outstanding example is providing medicines to pregnant women with HIV. There is no evidence from evaluations that behaviour change programmes were effective, and this is considered a significant gap in the HIV knowledge base.

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Human rights standards and also a new understanding regarding the spread and transmission of HIV justify that Dutch policy prioritises addressing young people and key populations. Multilateral organisations do include these needs in policies, but evaluations of concrete interventions for these groups are scarce. NGOs play an important role regarding key populations. In general they work with community organisations, or with organisations of PLHIV. Lessons include the usefulness of a life-skills approach and the importance of involving peer educators.

The importance of the community involvement has been confirmed in a recently published evaluation by the World Bank. It summarises fifteen studies on the community response, which is defined as 'a combination of actions and steps taken by communities for the public good'. The activities included prevention, treatment, support, care and mitigating the consequences of HIV, including support for orphans and vulnerable children. The results were promising. Effects were reported regarding increased knowledge on HIV and AIDS, increased condom use, increased testing, increased use of PMTCT, increased timely use of ART, increased home-based care and increased support for people living with HIV or AIDS.¹⁷²

¹⁷⁰ Rahman 2008. This project was not included in the NGO desk study.

¹⁷¹ The review (2013) was carried out by DANIDA. http://www.oecd.org/dac/evaluation/Evaluation%20Insights%207_preventing%20HIV%20ofinal%20reformat.pdf.

¹⁷² Rodriguez-Garcia 2013.



8

Nicaragua, poster Ixchen (Hermen Ormel, 2011)

Promoting sexual health

The internationally adopted rights-based approach places emphasis on legally binding international treaties, many of which are relevant to population issues and sexual health. Proper knowledge on sexuality will contribute to better sexual health, and this section includes a variety of NGO initiatives in the field. Female genital mutilation and gender-based sexual violence are serious violations of a woman's sexual rights and are obstacles to achieving sexual health. This chapter includes initiatives that prevent and combat these practices. It will report on an impact evaluation of a cervical cancer prevention programme in Nicaragua and on evaluations of multilateral organisations and NGOs that particularly target people whose sexual and reproductive rights may be denied or violated. The main findings are:

Research Questions	Main findings
Knowledge	Dutch support to NGO projects has contributed to increased knowledge among young people about sexuality. The projects also contributed to improved knowledge and awareness of gender-based violence and female genital mutilation. In the Nicaraguan cervical cancer programme there is room for improvement of the education sessions.
Sexual rights of those people who may be denied these rights	WHO, UNICEF and UNFPA address gender-based violence and female genital mutilation. The three evaluations of their work showed mixed results. ¹⁷⁰ The organisations pay little attention to key populations. The Nicaragua cervical cancer programme increased the right to access early detection and appropriate treatment among underserved people.
Maternal deaths	In Nicaragua, mobile clinics for cervical cancer screening and appropriate follow-up treatment have led to over 10,000 life years saved.

8.1 Problem setting

A rights-based approach includes recognising that reproductive health is a basic right of couples and individuals and that sexual health is fundamental throughout a person's lifespan. It also includes ensuring that programmes reach marginalised population groups, such as sexual minorities, preventing female genital mutilation and preventing and combating gender-based violence. Recognition of these rights, let alone fulfilment, is far from universal, and education on sexual rights may contribute to better fulfilment of these rights.

¹⁷³ EKN in Mali and Tanzania supported initiatives to prevent and combat female genital mutilation. EKN in Bangladesh supported initiatives to prevent and combat gender-based violence. The country studies did not include an assessment of these projects.

Female genital cutting, also known as female genital mutilation (FGM), consists of all procedures that involve partial or total removal of the external genitalia or other injury to female genital organs, whether for cultural or other non-therapeutic motives. It has been recognised that FGM is a violation of human rights. It is estimated that worldwide over 100 million women have had FGM, over 90% of them living in Africa. Deliveries are significantly likely to be more complicated for women who have undergone FGM than for women who have not, resulting in maternal mortality and morbidity.¹⁷⁴ Comparing the data of different age groups shows that the practice is declining. However, there are other, less favourable widespread trends as well, such as the lowering of the age at which girls are subjected to FGM.

The prevention of FGM includes legislative measures and changing social norms and social conventions. Surveys point to a silent opposition against FGM: the number of women who state they want to end FGM is much higher than the number of women who have actually refused to undergo the practice. Actions to give the silent opposition a voice and to change social norms should engage traditional and religious leaders, government and civil society. Violence against women and sexual violence are widespread and mostly caused by intimate partners. A study in ten countries showed that between 13 and 61% of women reported physical abuse by their partner at some point in life up to 49 years of age; 6-59% reported sexual violence from their partner.¹⁷⁵ Men also experience violence by female partners, but less frequently. In contrast to women, they generally do not report living in fear of their partner. Violence is an important cause of morbidity. It contributes to multiple adverse physical, sexual and reproductive health outcomes, with profound, though difficult to quantify, broader social costs.¹⁷⁶

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There are many risk factors for gender-based violence and sexual violence by intimate partners and they are often interlinked. They include young age, low socio-economic status, exposure to child maltreatment, alcohol and/or substance abuse, gender role disputes, and lack of legislation against partner violence. Different risk and protective factors may operate in different countries and settings. Hence, it is important to identify and then address those risk factors most strongly associated with intimate partner violence and sexual violence in each setting. Primary prevention efforts should focus in the first place on younger age groups.

During armed conflict and displacement, violence by intimate partners may be exacerbated and other forms of gender-based violence also occur. These can range from random acts of sexual assault by enemy troops, bandits or border guards, to rape as a deliberate act of war, either explicitly ordered or tacitly condoned by military authorities. The exacerbation of gender-based violence during conflict is due to a variety of factors, such as a breakdown in law and order, with an increase in all forms of violence, the perception by perpetrators that they will not be brought to justice and the polarisation of gender roles. Violence and rape impact severely on the mental and physical health of the victims and this places a substantial burden on the health services.¹⁷⁷

¹⁷⁴ http://www.who.int/reproductivehealth/publications/fgm/rhr_11_18/en/index.html.

¹⁷⁵ WHO 2010a: 19.

¹⁷⁶ Garcia-Moreno & Watts: 2011: 2.

¹⁷⁷ http://whqlibdoc.who.int/hq/2001/WHO_RHR_00.13.pdf.

8.2 Policy

WHO has developed a framework for action on sexual health.¹⁷⁸ It presents complementary actions across five domains: laws, policies and human rights; education; society and culture; economics; and health systems. Actions to improve sexual health can take place within reproductive health programmes, within non-health sectors, such as education, economics and social welfare, or simultaneously within various sectors. An example of such a multi-sector approach is to combine life-skills programmes among youth with media campaigns targeting a wider environment. WHO has also developed a tool which helps countries to address legal, policy and regulatory barriers to people's access to SRHR.¹⁷⁹

Regarding FGM, in 2008 an interagency statement signed by a wide group of UN agencies highlighted the wide recognition of the human rights and legal dimensions of the problem. It underlined the crucial role of communities in the prevention of the violation. In 2010 WHO, UNICEF and UNFPA published a global strategy for a health sector response. Regarding violence against women, WHO stresses both the need for prevention and the need to address the problems faced by the victims of violence. In 2012, guidelines were adopted regarding the health sector response on violence against women.

Dutch policy emphasises the human rights approach, the importance of prevention and the inter-sector approach. The prevention of violence against women is a priority of the Dutch human rights strategy. In 2007, the Netherlands and France took the initiative for a UN General Assembly resolution that urged governments to address violence against women.¹⁸⁰ The Netherlands succeeded in keeping the issue on the international agenda. In addition, the Netherlands provided financial support to prevention of violence against women and assist victims.

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8.3 Nicaragua case study: turning a right into practice

In 2005, the Nicaraguan national alliance for cervical cancer prevention developed a programme to address the high incidence rate of cervical cancer.¹⁸¹ The programme was carried out by the Nicaraguan NGO Ixchen and by the Ministry of Health. It aimed to improve knowledge on reproductive health, to progressively increase the coverage of cervical cancer screening and to ensure opportune diagnosis and treatment, including palliative treatment for women diagnosed with invasive cancer. It also aimed at strengthening the institutional capacities of the Ministry of Health. In the period 2005-2008, the Netherlands provided funding (USD 2.4 million) for this programme.¹⁸²

¹⁷⁸ WHO 2010d.

¹⁷⁹ WHO 2011b.

¹⁸⁰ http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/61/143&Lang=E.

¹⁸¹ All information presented in this section is based on IOB 2012b.

¹⁸² In the period thereafter the implementing agency was partner in a broader NGO SRHR coalition that received Dutch funding.

The programme focused on poor women living in rural communities in 75 municipalities where the Ministry of Health had little coverage. At the request of the Ministry, the programme also covered a number of disadvantaged communities in urban areas. The programme consisted of mobile teams visiting remote communities and providing educational sessions on various SRHR issues, gynaecology consultations and preventive smears. Women with a positive diagnosis were referred to early lesions treatment clinics of two NGOs (Ixchen and the IPPF affiliate Profamilia). Women with advanced lesions were referred to the Ministry's regional or national hospitals for appropriate treatment. By applying quantitative and qualitative methods of data collection and analysis, the case study could determine the net effect of the programme and explain the results that were found.

Knowledge on SRHR

The results of the qualitative study indicate that most (76%) women had heard of cervical cancer and the existence of smears. The sources mentioned vary: radio, television, NGOs working in the community, health centres, women friends and family members, and also through the Ixchen programme. There was widespread knowledge that cervical cancer is related to other sexually transmitted infections and having multiple partners. Some women who expressed fear because they believed the disease is contagious and that people with HIV 'have to walk a little apart'.

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Though most had heard about cervical cancer, only one third of the women could correctly say why the disease occurs in women. They also had limited knowledge on the frequency of smear examination and on the procedures. Women who had not had the smear gave various reasons for their non-participation in the programme: they were embarrassed to go to the centre alone, they were afraid of 'catching' a disease, or they feared that their problems would be made public in the community.

The Ixchen clients did not show better knowledge on cervical cancer and smears than the non-clients. This suggests that the methods that Ixchen employed did not have the desired effects regarding increased awareness and knowledge on SRHR topics. The limited scope for asking questions during the examination may itself have been a missed opportunity.

Access to services

The programme had a substantial net effect regarding cervical cancer screening coverage and also succeeded in establishing a positive medium-term effect.

Box 7 *Key findings on service use*

- Of the more than 66,000 women who were reached for smears, between 42,000 and 46,000 can be attributed to the programme (63%-69%).
- Effects were sustained: in the three-year period after the intervention, smear coverage among clients was 14-15% higher than in the three years preceding the intervention.
- The successful treatment of between 1,082 and 1,188 extra women can be attributed to the programme.

Not surprisingly, community participation, measured through working in a health NGO, was strongly related to continuing to have smears. Having small children was negatively related to continuing to have smears, probably because care for children is time-consuming and does not allow time to attend educational sessions and having smears. The educational level of the women was not correlated with the probability of having a smear, possibly because this indicator did not show much variation among the women included in the surveys. Neither were having a partner and partner support correlated with having smears. Surprisingly, attendance at the education sessions at the mobile clinics did not show any association with having smears.

Another important result of the programme was that over a thousand extra women were successfully treated for cervical cancer. About two thirds of the women with a positive smear were between 26 and 45 years old and a surprisingly high percentage (7%) was younger than 25 years. They received pharmacological treatment, cryotherapy or hysterectomy. Cases of radiotherapy and chemotherapy were rare (only two).

Despite the high number of successfully treated women, it has to be mentioned that for 60% of the women that were referred for treatment, no information on the follow-up could be obtained. These clients either did not turn up for their check-up half-way through the treatment process or got lost in the follow-up process. Therefore, the number of 'extra treated women' is probably higher than the number mentioned in box 7.

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Reasons for not turning up for treatment included fear about the treatment, lack of money and lack of the husband's permission. The fact that women get lost in the follow-up process points to weak monitoring and to an inadequate referral tracking system. In both areas there is room for improvement: more attention to providing information on the need for treatment and more investments in administrative procedures regarding the client's follow-up.

The programme also succeeded in motivating women to seek services they would otherwise not have sought. Many of the female clients over 36 years of age had their first sexual and reproductive health consultation of their lives during the Ixchen intervention period, suggesting that their first smear may have led them to seek additional services.

The proximity of the mobile unit was one of the most important factors mentioned by the women as an advantage of using the services offered. In the vast majority of cases (82%) the mobile unit was located 15 minutes or less from the women's homes, so that in most cases (95%) the women did not have to spend any money on transport to have the test conducted. Distance is also a factor that may explain why many women did not have the appropriate follow-up treatment: referral clinics are located in urban areas and to reach them women have to spend money on transport.

Box 8 *Rosa's view on the quality of services*

'I went early to the location where the service had been set up. Everything was clean, the people were very friendly. I listened to the talk and had the Pap smear. It was an opportunity for all to learn. No time was wasted, it was quick and the conditions were good. Those who did not go missed the chance of receiving quality health care.....We should be more aware and take care of our health when we are healthy and not just do the Pap smear, there's other care we need'...

However, on the day indicated for delivery of results, she was told verbally that the results were negative, but they could not find the results.

'...I was very disappointed that they couldn't find the results. When this happens we feel that little value is attached to the efforts that women make to put things aside, to take time to have a Pap smear done, as if our health isn't important"...

Fortunately, everything ended well and Rosa did not need treatment.

Source: case study in IOB 2012.

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Quality of services

Most women (80%) described quality of the services as either very good or excellent and less than 2% qualified the services as only acceptable. This is another factor that contributed to the increase in service use. Box 8 summarises the experience of one of the clients.

The treatment received was highly valued. The fact that female health workers attended the clients was a deciding factor in inducing many of the women to have smears. They also appreciated the information provided, though some women were not happy with educational talks being held in the open, which they felt was not appropriate for a sensitive topic. The waiting time was considered acceptable. A few women questioned the privacy at the moment the Pap smears were taken and at the delivery of the results. Regarding the timely delivery of results, the vast majority (86%) said that they received the results from Ixchen in less than thirty days. If women did not show up to receive the results, Ixchen left the results at the nearest health centre. Five per cent of the clients claimed that they did not receive the results from Ixchen.

Cost-effectiveness of the programme

The fact that women live in remote areas makes the costs of detection relatively high. It is estimated that each smear done at the mobile units for women who would not have had a smear without the project cost USD 43. All women who were diagnosed as having a condition associated with cervical cancer were referred to early lesion treatment centres. Among women captured by the mobile units with a diagnosis related to cervical cancer, the costs for treatment of women with cervical cancer were USD 1570 per woman treated.

The costs per life saved are a parameter that can be used to compare approaches. Regarding the Ixchen programme, the evaluation includes a calculation of both the minimum and maximum costs. For all women who attended the mobile units, facilities of the Ministry of Health and all other facilities, the minimum costs per life year saved were on average USD 55 and the maximum costs were USD 184.

Compared to other interventions regarding the prevention and treatment of cervical cancer, there is a more cost-effective option: visual inspection with acetic acid. A comparative study in five countries showed that the medical costs for the two screening methods are not very different, but the costs of transport and time do indeed vary substantially.¹⁸³ There is thus room for decreasing the costs of the Ixchen programme by applying visual inspection with acetic acid.

Mortality

Taking into consideration the types of diagnosis, the average survival for each type of diagnosis, the average age of the women treated for each type of diagnosis and the calculation of life years saved for each type of diagnosis, it was calculated how many life years saved can be attributed to the programme.

For all women, including those captured by the mobile units, the Ministry of Health and other organisations, the minimum number was estimated at 12,500. For 60% of the women with a positive smear, no information on the follow-up could be found. If all these women were treated correctly, the maximum number of life years saved would be reached. This is estimated at 42,683. Including only the women who were captured through the mobile units, the estimated minimum and maximum life years saved are 6,556 and 23,323 respectively.

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Conclusion

Given that cervical cancer is a major public health problem in Nicaragua, leading to high mortality among women, the intervention was relevant. It has also been effective. Evidence could be provided that thanks to the programme, both prevention and treatment increased and that the number of life years saved was at least 12,000. Factors that contributed to the effectiveness are the use of mobile units and offering high-quality services. However, there is room for improvement of efficiency. The cost-effectiveness of the programme could be enhanced by applying a different detection method.

8.4 Multilateral organisations

This section includes three evaluations: two of UNFPA programmes (gender equality worldwide; dignity in conflict areas) and one of a UNICEF programme (gender-based violence / female genital mutilation in Senegal).

¹⁸³ IOB 2012b: 95 refers to a study of Goldie et al. in India, Kenya, Thailand, South Africa and Peru.

The evaluation of the UNICEF programme on FGM in Senegal showed positive changes in awareness at community level that this had led to steps to reduce or stop the practice.

Results of the two UNFPA programmes are less clear-cut. The introduction of dignity kits in humanitarian assistance is in line with UNFPA's mandate to incorporate reproductive health and women's needs in the humanitarian agenda. Some tangible results were obtained regarding increased mobility and access to services, but the evaluation was not conclusive on the extent to which the envisaged extra services had been provided.

The large-scale valuation of UNFPA's involvement in gender equality shows that UNFPA contributed to the incorporation of gender equality in national policies and laws and that UNFPA is well-known for its work on gender-based violence. However, the translation of these national frames into concrete action poses challenges. There is little information on the effectiveness of UNFPA's support for the implementation of systems and mechanisms to protect the rights of adolescents and girls, including the right to be free from violence.

8.5 NGOs

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From the NGO desk study, evaluations of five projects on addressing gender-based and sexual violence, including female genital mutilation and evaluations of five projects on adolescents SRHR will be described in this section. Table 8 provides an overview.

In addition, this section will include a recently evaluated project on gender-based violence in Sri Lanka that was financed through the Human Rights Fund.

Most projects addressing violence against women included awareness-raising, empowerment and advocacy to influence government policy. In two projects (in Nicaragua and South Africa) centres were established to provide shelter and care for victims of violence. The prevention work involved awareness-raising, education and training, and the use of media to educate the general public about gender-based violence and other issues. Care and counselling were offered to women who had experienced violence. The South Africa project set up their trauma centres adjacent to rural government hospitals, to refer women when necessary.

The project that aimed at reducing violence against women and children among displaced people in Sri Lanka developed educational materials and organised workshops. A tangible and sustainable outcome was the establishment of a mechanism for complaints and for settlement of disputes. It was also reported that women were empowered and successfully appealed to the government to provide them with a hospital.¹⁸⁴

The six evaluations of interventions in the field of adolescent SRHR shared an emphasis on conveying messages about sexual and reproductive health and rights *of and for* young

¹⁸⁴ IOB 2012c: 73-74.

people. This entailed providing youth with the information and services they need, and improving general acceptance of young people's sexuality. Links were made to gender issues, prevention of HIV/AIDS and unwanted pregnancies. Education of youth about SRHR across the interventions took place through adolescent clubs and through formal and informal education in and out of schools. Some projects also included service delivery – for example youth-friendly SRHR services.

The FGM projects specifically focused on awareness-raising and advocacy work to strengthen the enabling environment for addressing FGM.

Country	Theme	Objectives
Sri Lanka	Gender-based violence	Reduce gender-based violence among internally displaced people. ¹⁸¹
Nicaragua	Violence against women	Promote citizen participation of women, youth and adolescents to defend their human rights, in particular sexual and reproductive rights.
Africa (Horn, East and Southern), Uganda	Violence against women and children	Reduce social acceptance of violence against women and children and influence practice and policy for prevention
South Africa	Violence against women	Contribute to preventing rape, ending violence against women, dealing with effects of VAW and reducing the risk of HIV infections
Ghana	Adolescent SRHR	Contribute to integration of adolescent reproductive health into primary health care activities
32 countries worldwide	Adolescent SRHR	Implement innovative activities that link education, gender, HIV prevention and sexuality/SRHR
Bangladesh, Rwanda, Malawi, Tanzania, Mali	Adolescent SRHR	Improve the sexual and reproductive health of young people in developing countries
Uganda, Kenya, Thailand, Indonesia	Adolescent SRHR	Increase access to sexuality education to address the SRHR needs of young people and to empower young people to develop attitudes and healthy and responsible behaviour
Kenya, Ethiopia, Tanzania	Adolescent SRHR FGM	Increase support and services for adolescent sexual and reproductive health and rights, especially for nomadic youth
Sierra Leone	FGM	Train policymakers to lobby their peers in advocating for a change in national policy on banning child FGM

Knowledge

The evaluations of projects addressing violence against women found that knowledge and community awareness about violence against women had generally improved. However, this was based on qualitative data only. For example, in South Africa, awareness was said to have been increased about women's rights, domestic violence as a crime and HIV/AIDS prevention through a weekly radio programme. The evaluation noted that the NGO's messages particularly focused on technical and legal aspects, and needed to also address underlying reasons for issues such as sexual violence.

All the interventions on adolescents, particularly the project focusing on implementing comprehensive sexuality education, had a positive effect on improving knowledge among youth about SRH issues. Only a limited number of the evaluations sought and were able to show any effects of the interventions beyond the level of knowledge. The interventions had contributed to improved knowledge of issues such as HIV transmission, prevention methods, sexual development, early marriage, etc. In Uganda, sexuality education had led to a more positive attitude among young people about the right to decide about their own SRH and a more positive attitude to using a condom. In addition, the programme led to an increased belief in ability to delay first sexual intercourse, future use of condoms and dealing with force. For the other countries included in the project, results were mixed and less clear-cut.

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Across programmes there was an improved capacity of young people to exercise their SRHR within their local contexts. In one project this was evident in the reduction of stigma of young people living with HIV and the stigma associated with condom use. The evaluation of a programme targeting nomadic youth in Kenya, Tanzania and Ethiopia noted that significant progress was made towards abandonment of female genital cutting (FGC). Some evidence was provided of community members denouncing FGC. For example in Kenya, where community awareness campaigns on FGC and gender-based violence contributed to 175 girls and 281 parents publicly denouncing FGC and 147 girls undergoing alternative rites of passage, which was more than the envisaged target of 20% of girls and elders rejecting the practice in 2010. In 2007, only 10% of girls and elders rejected the practice.

Advocacy and lobbying

Results of advocacy efforts on adolescent SRHR are mixed and attribution is difficult. Nevertheless, examples were provided of changes in school curricula and inclusion of reproductive health in district plans and budget allocations.

Results in influencing district or higher levels regarding FGM were mixed. In Tanzania, the project led some village governments to formulate by-laws to prevent FGM. In Kenya, there was little evidence that the project was successful beyond the community level in advocating against FGM. In Ethiopia, the NGO became a member of the FGM network to advocate against FGC. Most stakeholders acknowledged that the project contributed positively to government policy and to changes in FGC practices, mainly because of its engagement with influential people in the community. The FGM project in Sierra Leone achieved only limited and partial support for a ban on FGM from the district authorities,

and did not manage to gain support from other important influential actors, such as the 'soweis' (traditional circumcisers). The evaluation highlighted the importance of addressing alternative means of livelihoods for these traditional circumcisers, as a ban on FGM deprives them of their main source of income, empowerment and influence in their chiefdom.

Access to services

The evaluations provided no quantification of service delivery to female victims of violence through the project centres. It was mentioned that for both the Nicaragua project and the South Africa project the centres were the only comprehensive services available to women. In South Africa this comprised HIV testing, post-exposure prophylaxis medication, counselling and also legal assistance to women wanting to file a case. Results of advocacy efforts are limited in the evaluations, except for anecdotal evidence of increased government participation and interest. The evaluation of the project in Africa noted a lack of an explicit advocacy strategy and an imbalanced focus on improving the quality of methodologies and discourses, as opposed to meeting the demand of partner organisations.

All projects mentioned that young people had gained increased access to services, both to information as well as health services (such as testing and counselling for HIV/AIDS) and access to condoms. However, not many evaluations quantified improved access to service delivery. For example, the evaluations in Tanzania, Kenya and Ethiopia reported an increased uptake of condoms and other family planning methods among youth, but this was not further substantiated. Youth-friendly services were indicated as an important contributing factor across the evaluations. Many projects had included a capacity-building component to improve provision of youth-friendly services by project partners.

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The evaluations provided several lessons in addressing adolescent SRHR. One often mentioned successful strategy is a combination of raising community awareness, provision of service delivery (education and health and family planning services) for youth and improved advocacy capacity. Another lesson that emerged was that peer educators were found to be very effective in conveying messages, as young people are more receptive to information about sexuality given by people of their own age.

Working on the acceptance of youth sexuality was found to be critical to the success of SRHR programmes that target youth. The most effective programmes were those that addressed young people's sexual health issues through the lens of positive sexuality, rather than through the lens of disease and death.

Conclusion

There is moderate evidence that NGOs have contributed to increased knowledge about harmful practices such as violence against women and female genital mutilation. Furthermore, the NGOs have contributed to increased access to information for young people, leading to improved knowledge about SRHR issues. Despite positive examples of changes in attitudes, there is only limited evidence for effectiveness of the NGO projects at

the level of improved practices, such as increased use of condoms, or a reduction in the number of females subjected to FGM.

8.6 Discussion

Ensuring sexual rights and health is included in the policy of multilateral organisations and in Dutch policy. The Netherlands has also strongly supported the promotion of sexual rights and combating human rights violations internationally.

Certain aspects of ensuring the sexual and reproductive rights of people who may be denied these rights or whose rights may be violated are included in the work of multilateral organisations, most notably gender equality and gender-based violence, including FGM. Other aspects receive less attention. In previous chapters it was shown that equity issues have been insufficiently addressed and that there has been insufficient attention for key populations.

Concrete interventions regarding ensuring sexual rights are mostly carried out by NGOs. The cervical cancer prevention programme in Nicaragua provides an example. It reached people living in remote areas that did not have easy access to this type of service at the start of the programme. The evaluation showed an increase in service use, mostly due to the fact that clients were satisfied with the quality of service delivery. There is, however, room for improvement regarding the follow-up of the clients.

NGOs that were financed through the co-financing mechanism also carried out projects concerning sexual rights and health. They were able to show results regarding knowledge about sexuality and awareness-raising about harmful practices. They were, however, less able to show results in terms of changing practices. However, it has to be admitted that it is difficult to measure impact on behaviour.

9

Discussion

Summarising the key findings, this chapter seeks to answer the research questions on effectiveness and to define issues that are common to all or most thematic areas. It also includes a discussion on the balance between the different channels of implementation.

9.1 Policy

The Netherlands SRHR policy is consistent. It is grounded in international human rights standards and emphasises the linkage between SRHR and HIV/AIDS and the importance of attention to prevention. Priority is given to the sensitive issues of the Cairo agenda and to addressing young people and key populations. Various countries, including some EU member states, have attempted to modify the Cairo agenda, especially regarding the sensitive topics. The Netherlands has successfully operated in the international arena to maintain the agreed language of the Cairo agenda and address the needs of young people and key populations. Policy documents of international organisations include most of the Dutch priorities.

9.2 Policy implementation

The country studies provided moderate evidence that health sector support contributed to achieving various envisaged results, most notably in the area of perinatal and maternal health. The reduction of health system support carries the risk of diminishing this contribution.

Evaluations and reviews of SRHR-related multilateral organisations point to the role of these organisations in setting policy at global level and to their contribution to standard setting, research and the development and distribution of guidelines. Some organisations, notably UNICEF, UNFPA and UNAIDS, are also relevant at country level in assisting countries to create conditions for policy implementation. An example is UNFPA's support for setting up and maintaining the logistics for importing and distributing SRHR commodities. The previous chapters showed that only few evaluations gave information on how people or special targeted groups benefited from this policy implementation. In contrast, evaluations of projects financed by the Global Fund and NGO projects frequently include the outcomes at beneficiary level, and the project evaluations have shown that these outcomes are mostly tangible.

9.3 Knowledge among young people on sexual and reproductive health

National data on knowledge on SRHR is mostly limited to knowledge on contraceptives and comprehensive knowledge on HIV.

Overall, knowledge on family planning and HIV among young people increased during the period evaluated. Dutch support to the health sector and to international organisations contributed to this increase. However, knowledge levels are still limited. In developing countries, only 20% of adolescent girls (aged 15-19) and 30% of adolescent boys (aged 15-19) have comprehensive knowledge on HIV.

Only a few good quality evaluations of initiatives for adolescents and young people carried out by multilateral organisations and the Global Fund could be included in this policy evaluation. They mostly address family planning and HIV. Overall, these evaluations showed that the interventions had contributed to improved knowledge on SRHR. Applying a life-skills approach in Namibia (UNICEF) and Bangladesh (Global Fund) proved to be successful.

A substantial number of NGO projects that received Dutch support aimed at enhancing knowledge on SRHR, either knowledge among young people or among the population in general. Evaluations of these projects show that most have contributed to better knowledge on HIV transmission. Studying the application of a life-skills approach in four countries revealed it had been successful in three of them. Important factors contributing to the results achieved were the use of peer educators and the involvement of religious leaders.

9.4 Access to SRHR commodities and medicines

Dutch support to SRHR has contributed to better availability of contraceptive methods. An important example is the support to a substantial UNFPA programme that helped countries obtain these methods and strengthened the logistics of their distribution of the commodities. The support to international NGOs has also played an important role, particularly regarding the availability of long-term family planning methods. Despite these improvements, the use of family planning methods has increased only slightly and the unmet need has not been reduced and in some cases has even increased. Gaps between the better-off and the less well-off have not been reduced.

Dutch support to SRHR has contributed to a substantially increased availability and use of condoms and HIV-related medicines. Most noteworthy is the increase in the use of medicines for the prevention of mother-to-child transmission: in the last five years the use has more than doubled. The increase in treatment coverage is also remarkable. However, gaps have hardly been reduced and not all population groups have equal access to these medicines (see section 9.6).

9.5 Access to SRHR services

Dutch support to SRHR has contributed to increased use of sexual and reproductive health services, including a modest increase of antenatal control coverage and coverage of professionally assisted deliveries. Despite the overall positive findings on access to services, some issues have been insufficiently addressed. These include quality of care, the prevention of unsafe abortion, and promoting sexual rights.

Quality of care

In Dutch policy documents the importance of good quality of care is emphasised. However, there is little data available on whether quality aspects have been taken into consideration sufficiently, either in health sector support or in support to multilateral organisations. With a few exceptions, evaluations of multilateral organisations and reviews of health sector support hardly report on the quality of care. One such exception is the study on the cervical cancer prevention programme in Nicaragua. It reports on clients' satisfaction with the services provided. The most important determinants for the women's positive judgment on the quality of services proved to be the use of female health workers and respect for the clients' privacy. Another exception is the study of the menstrual regulation programme in Bangladesh. It looked into the occurrence of complications. In the project areas these complications were far from absent, but significantly fewer were reported than in the control area.

Preventing unsafe abortion

Dutch policy emphasises the importance of preventing unsafe abortions, and this position has been successfully defended in the international arena. However, support to concrete initiatives has lagged behind. Sector support usually includes support to family planning services and thus the prevention of unplanned pregnancies and unsafe abortions. In countries with unrestrictive abortion legislation, it will also include support to safe abortion procedures and post-abortion care. In countries with restrictive abortion legislation it will at most include post-abortion counselling and care, and care for people who suffer complications from unsafe procedures. Support to multilateral organisations and funds includes support for the production and dissemination of guidelines on safe abortion procedures; however, support to concrete interventions is limited. One initiative, the support to the menstrual regulation programme, could be included in the policy evaluation. NGOs supported through the co-financing system MFS (*Medefinancieringsstelsel*) do not often address unsafe abortion either. International NGOs, most notably Marie Stopes International, Ipas and the Guttmacher Institute and, to a lesser extent, IPPF, work extensively in this area. The budget allocated to these organisations is limited compared to the budget allocated to multilateral organisations and the Dutch NGOs.

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Sexual rights and sexual health

The findings on Dutch support for realising sexual rights and sexual health show that these themes figure in policy documents. The Netherlands has made efforts to include these rights in resolutions and declarations and in the policies of multilateral organisations. Overall, these efforts have been successful. However, implementation is lagging behind. Health sector support includes only some aspects: for example, providing assistance to victims of sexual rights violations may include sexuality education, and so may sector support to education. Evaluations of initiatives by multilateral organisations are scarce: only three could be included in this policy evaluation. Two of these had a global scope (UNFPA) and one was limited to one country (UNICEF). Overall, the global programmes were successful in influencing policy setting, but evidence for effective implementation at country level is scarce. The country programme of UNICEF did have demonstrable effects for

the beneficiaries; community involvement was identified as an important factor for the results obtained.

NGOs were more involved in promoting sexual rights, mostly in the form of support to sexuality education programmes to enhance sexual and reproductive health and rights of adolescents. Other areas of attention were lobbying and advocacy for prevention of harmful practices such as violence against women or female genital mutilation, and provision of care and support for victims. Evaluations found that interventions often had a primary focus on prevention of HIV infections or prevention of unwanted pregnancies, and that issues such as gender inequalities, or a positive approach to sexuality received less attention.

9.6 People denied sexual and reproductive rights

Human rights are at the core of the Netherlands policy regarding SRHR. As a consequence, Dutch policy points to the need to address the SRHR needs of all people, including underserved population groups, people whose rights are violated, young people and key populations. During the period evaluated the Netherlands successfully pleaded for attention for these groups in international forums.

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Gender-based violence, including FGM

The issue of gender-based violence has been addressed by multilateral organisations, in bilateral policy and by NGOs. The evaluations of various initiatives that were included in this policy evaluation showed increased awareness and knowledge on this type of violence had been achieved. In some instances, there was limited evidence that practices had changed as well.

Equity

In national health policies and the policy and strategy of international organisations, the importance of social and gender equality is usually included. However, implementation is lagging behind. Despite the overall increase in service use, gaps between rich and poor people and between the better educated and less educated have hardly narrowed and sometimes they have even widened. Equity issues are usually discussed in dialogues on health sector support, and budget allocation to underserved areas is used as one of the indicators that inequity is being addressed. In addition, in some countries that were studied in this policy evaluation, special efforts have been made to address the needs of poor people or people living in remote areas. An example is the high impact rapid delivery programme in Ghana. However, differences between poor people with a low educational level and better-off people have hardly decreased.

The multilateral organisations included in this policy evaluation aimed partly at countries most in need, but gaps in the use of services remained the same. The NGOs included in the policy evaluation carry out programmes that specifically target poor people, often those living in remote areas. The strength of these organisations is their link with communities,

but usually they are not sufficiently equipped to provide the full package of basic preventive and curative services that is needed for reducing morbidity and mortality gaps.

Two joint initiatives of the public and private sector were included in this policy evaluation. They both aim at reducing unequal access to services, and their results are promising. The joint programme of the Ministry of Health and a NGO in Nicaragua for cervical cancer services has led to a substantial increase in service use among underserved women. Factors that contributed to the success were the use of mobile clinics, guaranteeing privacy to the clients and the fact that health staff were female and client-friendly. However, the programme could have been more effective if both follow-up of the clients and the informative sessions had been better. In addition, it could have been more cost-efficient by applying other detection and treatment procedures.

A joint initiative to upgrade a national programme to prevent unsafe abortion in Bangladesh in underprivileged areas also proved to be successful. It involved WHO, the Bangladesh Ministry of Health and several NGOs. In the project areas, women and men had more knowledge on safe procedures than in a comparable control area. Factors that contributed to the success include awareness-raising activities at community level and the good track record of the two implementing NGOs regarding service delivery.

Adolescents and young people

In national health policies and the policy and strategy of international organisations, special attention is given to adolescents and young people. National governments and also multilateral organisations, the Global Fund and NGOs have developed specific initiatives for adolescents and young people, though to a varying extent. The section on knowledge among adolescents and young people pointed to tangible results. In the area of family planning, however, only little progress could be observed.

Key populations

Criminalisation and stigmatisation of key populations prevent them from accessing services. They can thus become drivers of concentrated epidemics. Despite this, national health policies usually give little attention specifically to key populations. Regarding multilateral organisations and global initiatives, UNAIDS and (since 2008) the Global Fund have explicitly defined key populations as important target groups. However, an evaluation of the Global Fund's strategy on gender equality and sexual orientation and sexual identity concluded that the Global Fund had not consistently prioritised the implementation of the strategy.¹⁸⁶ There are also positive examples, however. An evaluation of a project financed by the Global Fund that targeted another key population group, intravenous drug users, yielded tangible results.

The policies and strategies of the other multilateral organisations that were studied in this policy evaluation pay less attention to key populations, and hardly any evidence could be found that these organisations support the implementation of specific initiatives for these

¹⁸⁶ <http://www.theglobalfund.org/en/library/publications/other/>.

groups. By contrast, NGOs frequently support initiatives for key populations, and they report that these have increased knowledge and increased access to SRHR services.¹⁸⁷

At global level, there is room for scaling up efforts to address key populations. In 2012, among 82 countries that report consistently on its legislation, 60% had laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations; this percentage was similar to that in 2006. Some progress can also be observed. Testing and condom use among men having sex with men and among sex workers are increasing, but are still far from universal.¹⁸⁸

9.7 Impact

The results regarding maternal mortality are similar to the results on access to commodities, medicines and services. Overall, there was considerable progress, but gaps between poor and rich women hardly disappeared.

Worldwide, HIV incidence is on the decline. In many countries, there is no consistent reporting on HIV incidence among key populations. However, available data on HIV prevalence and on condom use and testing suggest that HIV incidence is still much higher among these groups than among the population in general: it ranges from 9% in Kano (Nigeria) to 50% in Johannesburg (South Africa).

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9.8 Balance between implementation channels

During the period evaluated, over half of the budget was allocated to multilateral organisations and funds, about 20% to public institutions, about 25% to the private non-profit sector and 4% to public-private partnerships. On the basis of this policy evaluation the following observations can be made regarding the balance between implementation channels:

- The decision to allocate a substantial part of the budget to multilateral organisations is based on the economy of scale, including the possibility of reaching non-partner countries with severe SRHR problems. However, few of the available evaluations provide information on the effectiveness of projects and programmes at beneficiary level.
- The allocation of a substantial part of the budget to multilateral organisations has helped to keep Dutch priorities on the international SRHR agenda and to include these priorities in the strategies of multilateral organisations. However, policy implementation regarding three priorities (unsafe abortion, equal access to services, key populations) has lagged behind.

¹⁸⁷ As mentioned in chapter 1, the Netherlands has set up a special fund for these key populations. It could not be included in the evaluation because it had become operational only recently.

¹⁸⁸ UNAIDS 2012: 82.

- The decision to reduce sector budget support is based on overall policy changes and not on proved ineffectiveness. The shift implies that important elements of SRHR will be neglected, most notably perinatal and maternal health, family planning and post-abortion care and counselling. Progress in these areas depends to a great extent on a properly functioning health system. In addition, the focus on the importance of national health policy and its implementation may get lost. Multilateral organisations all agree on the importance of health system strengthening, but considering their mandates, each organisation can only support part of the health system. The Global Fund recently decided to address health system support, but its primary mandate concerns AIDS, tuberculosis and malaria. In addition, limiting the support for health systems to the Global Fund runs the risk that parallel systems for basic services will be created, which will compromise sustainability.
- Support through the EU is aimed at strengthening health systems. It has contributed to increased use of services, including of SRHR services. The foreseen increase of EU funds may – at least partly – fill the gap left by the reduction of sector budget support.
- NGO initiatives were mainly aimed at preventing and combating HIV and at promoting sexual rights. Though there are examples of cooperation between the NGOs and government, it cannot be expected that NGOs will fill the gap left by a reduction of sector budget support.
- The allocation of funds to NGOs has helped to implement concrete interventions for young people and key populations. Mainstreaming the rights of key populations in national policies has hardly been achieved.
- The budget allocation to international NGOs is limited compared to other recipient agencies, implying that relatively few financial means are available for an area that is defined as an important priority: safe abortions.

In conclusion, the decision to provide support through various channels is appropriate for addressing the various policy priorities. The decision regarding the distribution between the different channels is not fully in line with the policy priorities. The balance is appropriate for implementing some of the priorities and achieving the envisaged outcomes and impact, more particularly: improved knowledge on SRHR among young people and improved access to commodities; more access to HIV/AIDS testing and treatment; and fewer HIV infections. It is less appropriate regarding the realisation of increased use of perinatal, antenatal and family planning services and the reduction of maternal mortality. Neither is it fully appropriate for realising the sexual and reproductive rights of people who may be denied these rights.

9.9 Evaluation practice

The desk study on multilateral organisations shows that a substantial part of the evaluations do not sufficiently address the outcome and impact level. In most cases, they do not quantify results or compare findings with baseline data. Many of these evaluations are based on observations of stakeholders or self-reporting, so their evidence is not robust. Only rarely has a control group been used. The DFID review of multilateral organisation and

global initiatives also mentions that some organisations are unable to show results of their work at country level. A Danish review of evaluations of HIV programmes confirms that only one quarter of the evaluations qualify as good; prevention programmes do even worse: only 20% are rated 'good'.

The desk study on the NGOs revealed that projects and programmes were evaluated more accurately, though there is still much room for improvement.

Most multilateral organisations, global initiatives and NGOs carefully monitor their activities and regularly give information on achievements at output level (and on the budget spent on these activities). This is time-consuming and its major relevance is that it is possible to account for the budget spent.

Though specific interventions mostly rely on evidence of their effectiveness, global programmes and complex programmes are usually not evidence-based. At best they rely only on a presumed link between activities and envisaged outcomes.

It is certainly not recommendable to carry out impact evaluations in all cases, as they are costly and not always feasible. However, much more could be done to improve the evaluation policy of multilateral organisations and NGOs. For example, more efforts could be made to use existing data to establish a baseline and an end-line. Also, proposals for implementing interventions could yield information on why a certain intervention has been chosen and what evidence is available to justify the assumption that it will lead to the envisaged outcomes. Systematising the observations of stakeholders could also improve the quality of the evaluations. Better evaluations enable donors to make informed choices on budget allocation.

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Other sites consulted are mentioned in the footnotes.

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.

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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 for policy evaluation on SRHR, including HIV/AIDS

May 2012

1 Background

Promoting sexual and reproductive rights is a policy priority for which considerable funding is earmarked. The policy article on ‘promoting human and social development’ in the Ministry of Foreign Affairs’ Explanatory Memorandum of 2012 specifies sexual and reproductive health and rights for all as an operational policy objective (5.4). A similar goal could be found in the Explanatory Memorandums of previous years.¹⁸⁹ The Order on Periodic Evaluations and Policy Information (2006) states that all operational policy objectives should be systematically reviewed. In 2007 the Policy and Operations Evaluation Department carried out a policy evaluation of the 2004-2006 period. The policy evaluation to which the present terms of reference relate concerns the 2007-2011 period.

2 Context

Definition of terms

Sexual and reproductive health and rights (SRHR) concerns the right of everyone – young or old, male or female – to make choices regarding sexuality and reproduction, insofar as this does not infringe the rights of others. It comprises the right of access to information and services that enable these choices and promote health.¹⁹⁰

The WHO strategy on SRHR holds that SRHR comprises the following elements. These are all to be studied in the policy evaluation and determine its thematic structure.

1. Promoting antenatal, perinatal and postnatal care, including health care for infants.
2. Providing information on family planning and good family planning services.
3. Eliminating unsafe abortions.
4. Combating sexually transmitted infections, including HIV/AIDS.
5. Fostering sexual rights. These include the individual’s right to choose to engage in sex, combating gender-based violence and female genital mutilation (FGM) and protecting the rights of sexual minorities.

Although the WHO strategy does not separately refer to the sexual and reproductive health and rights of adolescents and young adults, these are to be specifically looked at in the

¹⁸⁹ In previous years there were separate goals for SRHR and HIV/AIDS.

¹⁹⁰ There is no internationally agreed definition of SRHR; this is a working definition devised by a Swedish NGO. The term reproductive health and rights was defined at the International Conference on Population and Development (1994); a definition of sexual rights was added to this at the Fourth World Conference on Women (1995).

policy evaluation, since the sexual and reproductive rights of young people often go unrecognised. They, too, are vulnerable to reproductive health problems and regular services do not always meet their needs.

All the above elements connect with the healthcare sector, but to a varied degree, and in varying ways.¹⁹¹ Prenatal and perinatal care, along with treatment for complications during and after childbirth, largely fall within the healthcare sector. Preventive activities in these areas fall partly within the healthcare sector and partly within other sectors, like education and water. Ensuring the availability and supply of contraceptives falls partly within the healthcare sector, as does providing information about contraception, though the latter activity also falls within the education sector. Eliminating unsafe abortions relies heavily on legislation, but also on information about contraception and the existence of healthcare facilities where safe abortions are performed. Treating sexually transmitted diseases and AIDS is a healthcare sector task, but preventing the spread of HIV covers a much larger field. Combating discrimination of people with HIV and dealing with the consequences of AIDS falls both within and outside the healthcare sector. Awareness-raising and legislation are crucial to the promotion of sexual rights. The healthcare sector plays an important role in caring for the victims of sexual violence and FGM.

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An inventory of impact studies in the field of SRHR shows that the first, second and fourth subthemes have been most thoroughly investigated. These studies largely concern interventions on a limited scale; there has been little investigation of sectoral support or support for large-scale programmes.¹⁹²

Dutch SRHR policy

Dutch policy takes the following as its international frame of reference: implementation of the Cairo Agenda of the International Conference on Population and Development (ICPD) drawn up in 1994, international conventions, UN resolutions and the MDGs on reducing child mortality (no. 4), reducing maternal mortality (no. 5) and combating HIV/AIDS, malaria and other serious diseases (no. 6) along with international human rights conventions.

Up to 2008, various memorandums on AIDS had been submitted to the House of Representatives, whereas the only memorandums on SRHR had been internal. Prompted in part by a policy evaluation in 2007, a policy memorandum on HIV/AIDS and sexual and reproductive health and rights in foreign policy, entitled *Choices and Opportunities*, was published in 2008. The letter to the House of Representatives presenting the spearheads of development cooperation policy (May 2011) named SRHR as one of the four spearheads of policy. The document fleshing out the above letter (May 2011) stated that Dutch efforts were focused on achieving universal access to sexual and reproductive health and rights. The

¹⁹¹ References to the healthcare sector in these terms of reference are exclusively to the formal healthcare sector; the evaluation of sectoral support relates to the public sector.

¹⁹² Jurgens 2009. The inventory also includes evaluations in Bangladesh and Nicaragua.

letter mentioned three results that could be defined as having impact. (These were not quantified.)

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

The envisaged outcomes are:

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

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The letter states that the Netherlands is internationally recognised as a particularly progressive and resolute advocate of sexual and reproductive health and rights, and as having a unique added value in this field. The Netherlands' strength lies in defending human rights and raising sensitive issues. Its approach is based on its own demonstratively effective approach (very low percentage of teenage pregnancies; one of the lowest abortion rates in the world; low rate of HIV among new drug users). The memorandum of 2008 also contained words to this effect.

The letter also looks at interfaces with foreign policy and at certain crosscutting themes, like gender and good governance, as well as at levels of intervention. The Netherlands lobbies for SRHR around the world and contributes to international organisations. At bilateral level, the intensity of effort varies greatly according to the priority attached to working with a particular country. Efforts through private channels take the form of support for international NGOs, Dutch NGOs targeting key populations and public-private partnerships.

Expenditure on health care, SRHR and HIV/AIDS 2007-2011

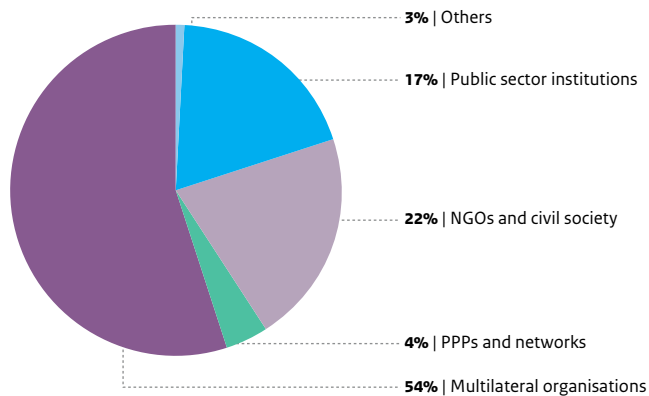
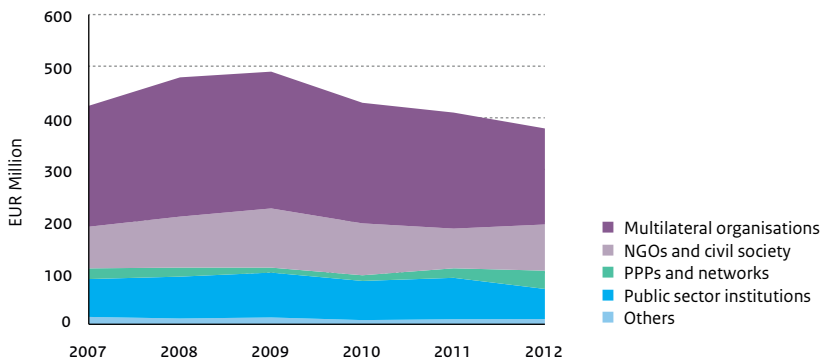
Expenditure on SRHR and HIV/AIDS¹⁹³ amounted to an average of €435 million a year from 2007 to 2011. Around one fifth of expenditure went through public sector institutions and over half through multilateral channels. Non-governmental channels accounted for around a quarter of expenditure (see figure 1). Around 40% of funding via non-governmental channels went to Dutch NGOs (via MFS), 40% to international NGOs and the remainder to local NGOs.

¹⁹³ Halting the spread of HIV/AIDS, malaria and other life-threatening diseases (policy objective 5.4); global commitment to SRHR and fully implementing the Cairo Agenda (policy objective 5.5).

Over a third of funding through multilateral channels went to UNFPA; followed by the Global Fund to Fight AIDS, Tuberculosis and Malaria (17%), the World Bank (14%) and UNAIDS (14%) as the largest recipients. The other recipient organisations/funds were WHO and the Global Alliance for Vaccines and Immunization Fund (8% each), and UNICEF (3%).

It should be noted that funding through bilateral channels largely took the form of sectoral support, and covered various health aspects besides SRHR. The same applies to part of the funding through multilateral channels (WHO; UNICEF). In 2012, the budget was reduced. The policy evaluation describes in more detail the size of the budget and the changes in expenditure during the period under evaluation.

Figure 1 Expenditure on health care, SRHR and HIV/AIDS per channel in EUR,¹⁹⁴ 2007-2011



Source: Piramide.

¹⁹⁴ CRS codes: 11220, 11230, 12110, 121801, 12182, 12191, 12220, 12230, 12240, 12250, 12261, 12262, 12263, 12281, 13010, 13020, 13030, 13040, 13081, 15150, 15160, 16010, 16064, 23050, 43010, 53040.

3 Aim of the policy evaluation and questions addressed

The evaluation has a dual objective:

- to account for policy on SRHR;
- to identify factors that have affected the effectiveness of efforts with a view to adjusting policy where necessary.

The central question under investigation is the extent to which the goals specified in policy documents have been achieved and the extent to which the instruments deployed via the various channels have contributed to this result. This also entails assessing the vision set out in the policy documents regarding the right mix of channels. The survey questions are modelled on the policy evaluation structure, which comprises five components.

Description and analysis of the problem

- 1) What changes have taken place since 2005, as revealed by the main indicators in the field of reproductive health (such as child mortality; infant mortality; maternal mortality; nutrition; use of family planning; unmet need; teenage pregnancies; unsafe abortions; prevalence and incidence of HIV; incidence of other sexually transmitted infections; knowledge of HIV/family planning; female genital mutilation; violence against women)?
- 2) Do these indicators show that the gap between rich and poor population groups is closing? What is the trend among adolescents (for specific indicators)?
- 3) Which factors impede positive developments?

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Description of and reasons for the Dutch government's role

- 4) On what grounds does the implementation of SRHR policy lie with the government and how is accountability for such policy laid down within the Ministry of Foreign Affairs?

Description of the policy objective under evaluation

- 5) How is the operational policy objective fleshed out?
- 6) To what extent are desired results specified (global level; countries; projects)?

Budget deployment

- 7) How has funding been deployed for SRHR, broken down by channel (multilateral/bilateral/private) and how are the bilateral resources allocated among the regions?

Description of the instruments used and their effect

- 8) What instruments has the Netherlands deployed to promote SRHR (e.g. negotiation; bilateral diplomatic contacts; support for UN organisations; sectoral support; support for international NGOs; funding for projects in partner countries; MFS)?
- 9) What are the reasons for the choice of instruments/mix of instruments and channels of implementation? To what extent have Dutch efforts during negotiations contributed to keeping the Cairo Agenda alive? Were issues raised that have priority for the Netherlands? If so, how and to what effect? To what extent can the Netherlands deliver added value compared to other countries?

- 10) Indicate the extent to which Dutch efforts have helped to:
- make young people better informed about sexuality, pregnancy and HIV. Which channels have been effective in this regard? Which factors have affected the outcome positively or negatively?
 - improve access to and choice of good-quality contraceptives and medicines and other commodities relating to reproductive health and HIV. Which channels have been effective in this regard? Which factors have affected the outcome positively or negatively?
 - improve the quality of public and private services relating to sexual and reproductive health, including safe abortion and HIV/AIDS treatment, as well as access to them, including by key populations. Which channels have been effective in this regard? Which factors have had positive or negative effects on the outcome?
 - remove the taboo on the subject of reproductive rights for all, but especially women and young people around the world and in partner countries, and anchor these rights more firmly in policy and legislation. Which channels have been effective in this regard? Which factors have had positive or negative effects on the outcome?
- 11) To what extent can it be demonstrated that achieving these results (question 10) has contributed to fewer unwanted pregnancies, fewer deaths through pregnancy and childbirth, and fewer HIV infections?

4 Definition and representativeness

Period

The period under evaluation is 2007-2012. The start date follows on from the previous policy evaluation (2005-2006). Some of the impact studies (see section 5) have an earlier start date (which has to do with the availability of data and a preference for measurements over a period of at least five years).

Themes and channels of implementation

The policy evaluation relates to all elements of WHO's SRHR strategy and all channels of implementation, except public-private channels (with the exception of the Schokland Fund – a partnership of representatives of government, NGOs and the private sector – referred to in the desk study of NGOs).

Where bilateral channels are concerned, the evaluation will look at five country studies. The choice of topic per country is such as to incorporate all the elements of the SRHR strategy. Impact studies have been carried out or are ongoing for three countries (Bangladesh, Mali and Nicaragua). In Mali, the focus is on family planning and the study looks at both the public sector and the private non-profit sector. In Nicaragua, the focus is on reproductive rights. The study charts the results of an NGO project aimed at the prevention and treatment of cervical cancer. In Bangladesh, the focus is on preventing unsafe abortion. The study looks at a project being carried out by a multilateral organisation working with several NGOs. In the case of two countries (Ghana and Tanzania) the desk studies were supplemented with interviews. In Ghana, the focus is on maternity and family planning, and the study encompasses both the public sector and the private non-profit sector. In Tanzania, emphasis is on sexually transmitted infections, including HIV, and the scope of the study spans the public sector, multilateral organisations and the private non-profit sector.

The sub-study of the multilateral channel will entail: 1) an examination of how negotiation on sensitive issues takes place within UNFPA, and 2) an evaluation of the efforts of multilateral organisations receiving sizeable core voluntary contributions from the Netherlands. The evaluation will take in all elements of the strategy, insofar as evaluations of it are available. It will be based on secondary sources, supplemented with interviews.

The sub-study on the results of support for international NGOs and NGOs with MFS financing will focus on sensitive issues (like unsafe abortion and harm reduction) and on key populations. Use will be made of secondary sources, supplemented with interviews.

Representativeness

The programmes covered by this policy evaluation concern an estimated 30% or more of expenditure on SRHR and are a good illustration of Dutch efforts in that field. In Nicaragua, the only SRHR programme supported by the Netherlands (in the field of preventing cervical cancer) will be investigated, making that country study representative by default. In Mali, the study is representative of efforts in the field of family planning. The Dutch contribution to the results is considerable, because the Netherlands is an important donor in Mali. In Bangladesh, the study looks at the only Dutch-supported bilateral project targeting unsafe abortion, and the object of the study covers a substantial portion of expenditure, making it representative. The Ghanaian desk study is representative of SRHR efforts in the area of maternity care and family planning. The Netherlands is an important donor in Ghana. In Tanzania, where the Netherlands is also an important donor, the desk study is representative of efforts in the field of HIV/AIDS. The desk study on NGOs aims to be comprehensive. If there are sufficient good-quality evaluations, the study will be representative. The sub-studies on multilateral organisations and policy influence only investigate some of the efforts. The studies form a good illustration of Dutch efforts, but are not representative.

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5 Approach

The policy evaluation synthesises a number of sub-studies:

- 1) Desk study on SRHR issues (ongoing). Answers evaluation questions 1-3.
- 2) Policy reconstruction. This consists of a desk study and archival research (policy memorandums; documentation from the House of Representatives; correspondence on Multi-Annual Strategic Plans), supplemented with interviews with policy officers (ongoing). Answers questions 4-9.
- 3) Desk studies on Ghana (completed) and Tanzania (ongoing). Answers questions 10 and 11.
- 4) Three impact evaluations: Mali and Nicaragua (ongoing) and Bangladesh (study proposal virtually complete; study has not yet started). For the methodology, see the TOR for the impact evaluation of SRHR in Bangladesh, Mali and Nicaragua. Answers questions 10 and 11.
- 5) Policy influence regarding 'sensitive issues' in key populations, within UNFPA and UNAIDS. Archival research and interviews will be used to establish the extent to which areas of priority for the Netherlands are raised during debate on the multi-year strategies of UNFPA and UNAIDS, and on the results. Sources: instructions for

meetings, staff of the international organisations concerned, representatives of the MFA and the Permanent Representative. Answers question 10. Preliminary file research started recently.

- 6) Desk study of the results of efforts by multilateral organisations (ongoing). The organisations concerned are: UNFPA, UNICEF and the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), WHO and UNAIDS. The study largely involves making an inventory of evaluations and assessing their quality. A summary will then be made of the evaluations deemed to be of sufficient quality. The evaluation questions constitute the linking theme. Answers questions 10-11.
- 7) Desk study on the results of efforts by international NGOs and organisations receiving MFS financing (preliminary study completed; study due to start mid-May). The evaluations of NGOs will be assessed in terms of quality and a summary will be made of those evaluations deemed to be of satisfactory quality. The evaluation questions will be used as the basis for the summary. Answers questions 10 and 11.

The table shows on which elements of the SRHR strategy the focus lies in the sub-studies.

Sub-study	Perinatal/ maternal health	Family planning	Eliminating unsafe abortions	STIs and HIV/ AIDS	Sexual and reproductive rights
SRHR issues	X	X	X	X	X
Policy reconstruction	X	X	X	X	X
Desk study Ghana	X	X			
Desk study Tanzania				X	
Impact eval. Bangladesh			X		
Impact eval. Mali		X			
Impact eval. Nicaragua					X
Policy influence		X	X		
Desk study multilateral orgs.	X	X		X	X
Desk study NGOs			X	X	X

6 Outline of synthesis report

- Ch 1 Introduction: reason for the evaluation, aim of the policy evaluation, main questions and a brief explanation of the methods of data collection. (Brief chapter; 2-3 pp).
- Ch 2 Description of the issues involved (summary of sub-study 1; brief chapter).
- Ch 3 Government's role. Reasons for government commitment (meeting its international obligations; same reasons as in the policy evaluation of 2007). (Brief chapter.)
- Ch 4 Overview of policy development and deployment of budget plus reasons for such deployment (summary of sub-study 2).
- Ch 5 Antenatal, perinatal and postpartum care: deployment of instruments and results. The desk studies on Ghana and international organisations form the building blocks.
- Ch 6 Family planning: deployment of instruments and results. The impact evaluation on Mali, the sub-study on policy influence (especially regarding family planning for adolescents) and the desk study of international organisations form the building blocks.
- Ch 7 Prevention of unsafe abortion: deployment of instruments and results. The Bangladesh evaluation, the sub-study on policy influence and the desk study on international NGOs/MFS form the building blocks.
- Ch 8 Prevention and treatment of sexually transmitted infections, including HIV/AIDS: deployment of instruments and results. Based on the Tanzania desk study, the sub-study on policy influence and the desk studies on multilateral organisations (particularly the Global Fund) and international NGOs/MFS.
- Ch 9 Sexual and reproductive rights: deployment of instruments and results. The impact evaluation on Nicaragua and the desk study on international NGOs/MFS form the building blocks.
- Ch 10 Conclusions: this chapter looks at the extent to which instruments have been cohesively deployed and, on the basis of the findings in chapters 5 to 9, answers questions on outcome and impact (10 and 11). An attempt will also be made to assess what instruments and channels have been most effective for the various themes.

7 Organisation

The IOB team consists of Marijke Stegeman (senior evaluator, overall responsibility for the evaluation), Saskia Hesta (researcher) and Erin Kuiper (intern). An external evaluation team was contracted for the impact evaluations on Mali and Nicaragua by means of a tender procedure. IOB has completed the first stage of the study in Bangladesh and contracted a Bangladeshi research institute to carry out the second stage. An external researcher has

been contracted for the desk studies on international organisations and the Global Fund (direct contracting). The same applies to the desk study on international NGOs and NGOs being financed by MFS. IOB is carrying out the other sub-studies itself and writing the synthesis report.

A reference group chaired by the director of IOB and consisting of Rebekka van Roemburg (head of DSO/GA) and two external experts (Ms Wiebenga and Mr Baltussen) will supervise the policy evaluation. Where the discussion of the various impact evaluations is concerned, the reference group will be joined by the country specialist at the regional department and the health specialist at DSO/GA with the relevant country in their portfolio. Phil Compernelle and Jan Klugkist will monitor the evaluation.

8 Products

The policy evaluation will be submitted to the House of Representatives as prescribed by law and then made public. The intention is to publish the impact study on Nicaragua separately. It has yet to be decided whether the impact studies on Bangladesh and Mali and the summaries of the evaluations of international organisations and NGOs will be made public in the form of IOB publications or placed online, citing the author's name. It is not proposed that the other studies be published (findings to be accounted for in notes).

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9 Timetable

Sub-study	1st quarter 2012	2nd quarter 2012	3rd quarter 2012	4th quarter 2012	1st quarter 2013	2nd quarter 2013
SRHR issues	Completed					
Policy		x				
Impact Ghana	Completed					
Impact Tanzania	x	x				
Impact Mali	x	x				
Impact Nicaragua	x	x				
Impact Bangladesh	x	x	x	x		
Policy influence		x	x	x		
Multilateral orgs	x	x	x			
NGOs		x	x			
Synthesis				x	x	
Publication						x

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This report presents the findings of a policy evaluation of the Dutch involvement in the field of sexual and reproductive health and rights during the period 2007-2012. This policy evaluation has been conducted by the Policy and Operations Evaluation Department (IOB) of the Dutch Ministry of Foreign Affairs and is based on a number of sub-studies, including country impact studies in Bangladesh, Nicaragua and Mali, desk-studies of Ghana and Tanzania, and desk-studies of existing evaluations of multilateral organisations and NGOs.

The findings show that Dutch support has contributed to improved knowledge about SRHR, better availability of commodities and medicines, to increased use of perinatal and maternal health services and to reduced infant and maternal mortality. However, contributions to changes in contraceptive use are less conclusive. Moreover, inequalities between households, regions and countries were hardly reduced and support to health systems improvement became neglected. Dutch support helped to realise sexual and reproductive health and rights for people who may be denied these rights but efforts in these areas could be strengthened.

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