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UNITE FOR BODY RIGHTS – SRHR ALLIANCE

END-OF-PROGRAMME EVALUATION, SYNTHESIS REPORT

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DISCLAIMER

The research team of ICRH and Kaleidos Research wishes to emphasize that we cannot guarantee the accuracy of data from documents on the UFBR programme which were compiled by the SRHR Alliance and used as an input into the desk research part of this research. Responsibility for the interpretation of data and the information provided based on the field research and the online surveys lies entirely with the research team.

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The report is based on desk research, mainly of project documentation provided by the SRHR Alliance, undertaken between October 2015 and February 2016. Field research was carried out between November 2015 and January 2016 in three countries - Kenya, Uganda and Indonesia - by researchers attached to ICRH and Kaleidos Research in close cooperation with local researchers. The research group wishes to thank the partner organisations of the SRHR Alliance, and in particular Liesbeth Hofs of the alliance office and Ruth van Zorge of Rutgers, lead organisation of the alliance, for providing guidance to the research. Furthermore, we wish to thank all partner organisations in the countries where the UFBR programme was implemented for their input in the form of participating in the online survey as well as in the field research (interviews and focus group discussions) and feedback sessions. The research team also wishes to express its gratitude to all other respondents, including external stakeholders, teachers, service providers and programme beneficiaries, who have enriched us with many new perspectives; their knowledge and experience provided a valuable input into the analysis described in the report. Furthermore, we would like to thank Marieke Devillé (Ma, MSc) and Justine Jensen (Ma) from Hera, Belgium for their contributions to the report.

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ACRONYMS AND ABBREVIATIONS

5C	5 capabilities (approach)
AIDS	Acquired Immune Deficiency Syndrome
ASK	Access, Knowledge, Services
CHI	Child Helpline International
CORP	Community-Owned Resource Person
CSE	Comprehensive sexuality education
CSO	Civil society organization
CSS	Civil society strengthening
e&m health	Electronic and mobile health (technologies)
FGD	Focus group discussion
FGM	Female genital mutilation
HIV	Human Immunodeficiency Virus
ICRH	International Centre for Reproductive Health
IPPF	International Planned Parenthood Federation
LGBT	Lesbian, gay, bisexual, transgender
LGBTQI	Lesbian, gay, bisexual, transgender, questioning and intersex
LSBE	Life-skills-based education
M&E	Monitoring and evaluation
MSC	Most significant change
NGO	Non-governmental organization
NPC	National Programme Coordinator
OCA	Organizational Capacity Assessment
OMR	Outcome Measurement Report
PME	Planning, monitoring and evaluation
SDG	Sustainable Development Goal
SGBV	Sexual and gender-based violence
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
ToC	Theory of Change
UFBR	Unite For Body Rights
WHO	World Health Organization
YFS	Youth-friendly services

1. INTRODUCTION AND OBJECTIVES

1.1. The Unite for Body Rights programme

With its Unite for Body Rights (UFBR) programme (2011–2015) the Sexual and Reproductive Health and Rights (SRHR) Alliance works in nine countries in Africa and Asia towards a society free of poverty, where all women and men, girls and boys, including marginalized groups, have the same rights. Through the provision of good-quality SRHR education, the programme empowers young people and women to make healthy and well-informed decisions. Furthermore, the programme strengthens the provision of quality public and private sexual and reproductive health (SRH) services that are accessible, acceptable and affordable for young people and women. Also, UFBR implements community sensitization and participation activities to create an environment that accepts and supports (adolescent) SRHR.

Alliance

The SRHR Alliance was established in 2011, as a requirement in the MFSII framework of the Netherlands Ministry of Foreign Affairs. It consists of five Dutch members (Rutgers, the lead agency; Amref Flying Doctors the Netherlands; CHOICE for Youth and Sexuality; dance4life; and Simavi) and approximately 50 partner organisations which all form local SRHR Alliances in their country. The SRHR Alliance implemented the UFBR programme in nine countries in Africa and Asia: Ethiopia, Kenya, Uganda, Pakistan, Indonesia, India, Bangladesh, Malawi and Tanzania.

Result areas

The SRHR Alliance implemented the UFBR programme from 2011 until 2015. With UFBR, the SRHR Alliance worked towards a society free of poverty, in which all women and men, girls and boys and marginalized groups have the same rights, irrespective of their ethnic, cultural and religious background, age, gender and sexual orientation. Following the framework of the Ministry of Foreign Affairs, the programme consisted of four result areas: i) civil society strengthening (CSS); ii) Millennium Development Goals (MGDs); iii) organizational capacity-strengthening; and iv) international lobbying and advocacy.

Strategies and process of change

The programme targeted young people (aged 10–24 years) and women. To improve the SRHR situation of these groups, the UFBR programme combined three strategies:

- improving access to and the quality of SRHR education (increasing SRHR demand);
- improving access to and the quality of SRH services (increasing SRH supply); and
- improving the enabling environment (increasing SRHR support).

Through the provision of good-quality in- and out-of-school SRHR education (Strategy 1), the UFBR programme empowers young people and women to make healthy and well-informed decisions. When these informed decisions are made, demand for youth- and women-friendly SRH services will increase. The UFBR programme strengthens the provision of quality public and private SRH services that are accessible, acceptable and affordable for young people and women (Strategy 2) to meet the increased demand. Community sensitization, participation and mobilization activities are implemented to create an environment that accepts (adolescent) SRHR and helps to increase community support for sexuality education, youth-friendly SRH services and maternal health services (Strategy 3).

The SRHR Alliance's Theory of Change (ToC) is based on the conviction of this multi-component approach: all components (supply, demand and an enabling environment) need to be addressed to be most effective in realizing results. For more information on the ToC, see Chapter 3.

In addition to the programmatic activities, the UFBR programme has developed a learning agenda which includes two research questions: one on the multi-component approach, and one on mainstreaming sexual diversity and preventing sexual and gender-based violence (SGBV).

Budget

The total budget for UFBR over the programme period of five years was nearly €45 million. As Table 1.1 shows, the budget was more or less equally distributed over the five years, while some countries received a substantially larger amount than others. As Table 1.2 illustrates, the comprehensive sexuality education (CSE) component received by far the largest share of the total programme budget.

Table 1.1: Overview of the total budget by country and year (€ '000s).

Country	2011	2012	2013	2014	2015	Total
Kenya	1,442	1,471	1,428	1,380	1,333	**7,055**
Tanzania	1,110	1,203	1,230	1,268	1,317	**6,127**
Pakistan	598	608	605	607	620	**5,954**
Bangladesh	1,058	1,071	1,089	1,109	1,133	**5,461**
Malawi	759	771	771	776	794	**3,870**
Indonesia	736	738	752	767	772	**3,766**
Ethiopia	688	763	869	776	518	**3,614**
Uganda	656	667	678	691	707	**3,399**
India	541	551	569	618	638	**2,916**
Global	532	537	547	558	577	**2,752**
Ghana	0	0	0	0	0	**0**
Total activity budgets	**8,120**	**8,382**	**8,538**	**8,550**	**8,408**	**41,999**
Costs of M&A	563	577	591	606	621	**2,959**
Total SRHR coalition	**8,683**	**8,959**	**9,130**	**9,156**	**9,029**	**44,958**

Table 1.2: Total budget by year and for each ToC component ((€ '000s).

	Budget				
	Total	CSS	MDGs	Partner organisations	International advocacy
2011	**8,683**	**871**	**6,410**	**885**	517
2012	8,959	903	6,634	900	521
2013	9,130	924	6,764	911	531
2014	9,156	924	6,777	914	541
2014	9,029	894	6,681	897	558
Total SRHR coalition	**44,958**	**4,516**	**33,266**	**4,507**	**2,668**

1.2. Objectives and research questions

The SRHR Alliance commissioned an assessment of its achievements and the lessons that need to be learned. This end-of-programme evaluation was done by Kaleidos Research (the Netherlands) and the International Centre for Reproductive Health (ICRH) (Ghent University, Belgium) with the objectives of:

- assessing the results achieved by the UFBR programme;
- understanding what processes have led to these results, including the enabling and hampering factors; and
- proposing feasible recommendations to inform future programme design.

The evaluation assesses the programme's relevance, sustainability, impact, effectiveness and efficiency in specific dimensions. It also fosters learning within the alliance, and is expected to add to the current knowledge base on relevant planning, monitoring and evaluation (PME) approaches. The research questions and sub-questions this evaluation answers are shown in Table 1.3

Table 1.3: The evaluation matrix.

Dimension and leading question	Sub-questions
Dimension 1: Results and changes What are the results of the programme, and are they relevant and sustainable?	1. Did the programme achieve the expected results? In terms of outputs and outcomes? What were the enabling and constraining factors?
	Add 1: In the areas of: CSS/CSE and SRHR information/SRH services/SRHR enabling environment?
	2. Did the programme achieve the overall goal/results according to the main stakeholders?
	3. What are the unexpected results (positive and negative)?
	4. What can be concluded about the sustainability of the results?
Dimension 2: Implementation processes Which have been effective, efficient and sustainable strategies under the UFBR and ASK programmes?	1. Which strategies have been implemented to reach vulnerable groups in the programmes?
	2. Which strategies have been implemented to*…. And which have been effective? With reference to the result chain - * Quality of (youth-friendly) SRH services - * Access to (youth-friendly) SRH services - * Quality of SRHR information/education - * Access to SRHR information and education - * Change values and norms at the beneficiary level, personal relationship level, community level and policy level
	3. Has the multi-component approach been implemented? How/why/why not?
	4. Is the country affected by a change in the values and norms of the enabling environment? If yes, how has the increase in conservative forces influenced the programme, and how have partners dealt with these?
	5. Which have been effective strategies for meaningful youth participation, and how has this contributed to results?
	6. Have strategies led to sustainable results? If yes, which strategies?
	7. What can be concluded concerning the efficiency of the (implementation of) strategies?
Dimension 3: Country alliance and partners Has working in the ASK/UFBR programme been relevant, effective and efficient for partner organizations, in terms of their capacity?	1. How do partners perceive the collaboration with the Northern alliance and its members? How do partners value the in-country collaboration (with each other and NPCs)? To what extent do partners feel they are part of an international/regional alliance or movement?
	2. Has the partnership led to changes in the capacity of NGOs and NGO staff, specifically in SRHR technical expertise, collaboration and advocacy?
	3. Has the partnership led to changes in values and norms around SRHR (including gender, sexual diversity and SGBV) and meaningful youth participation, and (how) has this been incorporated into programming and organizational policies?
	4. Are gains/outputs of being part of the country alliances in line with the required input of the individual partners?
Dimension 4: Northern alliance and members To what extent has the partnership been relevant, effective, and efficient for the individual members and the programme?	1. Has the partnership been effective in increasing the professionalization of the individual members in SRHR and collaboration?
	2. Has the partnership (including the alliance office) limited or constrained the members compared to working alone, or has it provided more opportunities? In which areas (PME, operational research, advocacy etc.)?
	3. Has the partnership led to any changes in the programming of the members and partners? (what and how?)
	4. Are gains/outputs of the partnership in line with the input of the individual partners?
	5. How has working in the alliances affected the programmatic processes and results in the South? To what extent has the alliance stimulated or hampered equal partnerships in their North–South collaboration?

2. METHODOLOGY

In this chapter we will present the overall evaluation framework, which is based on a realist approach, as well as the different methods that were used to answer the research questions.

2.1. Evaluation framework

2.1.1. Simplified realist evaluation

While the official definition of health is straightforward, the promotion of positive health behaviours, including SRHR, is a challenging domain. Alongside individual and interpersonal factors, health behaviour largely depends on social and structural factors. Determinants on these different levels interact to form a complex - often context-specific - web that influences individuals' health behaviour and society's health status. Such complex problems are characterized by the existence of non-linear causal relationships, multiple causal pathways and feedback loops, and embeddedness in multi-layered contexts and systems.

Accepting the complexity of health has an impact on the design, implementation and evaluation of health promotion interventions and programmes. The UFBR programme is clearly aware of this complexity, as it not only focuses on one aspect but aims to address SRHR issues from a number of angles that are situated on the different levels of the socio-ecological spectrum (education, services, enabling environment). Furthermore, it includes a multitude of different strategies and activities implemented by a variety of partner organizations.

An appropriate evaluation framework should take this complexity into account. Therefore, we use a realist evaluation approach. Where traditional evaluations focus on the question 'Does the programme work?', realist evaluation studies try to answer 'What works for whom, in which contexts, and how?'.

Hence, a realist evaluation approach not only looks at outputs and outcomes but equally studies the processes through which these outcomes are being influenced. Basically, a realist evaluation approach is an iterative process that follows three main steps:

- describing and understanding the programme: this includes elaboration of the programme's theory. In this step, the evaluators make the processes through which the programme aims to achieve the desired outcomes explicit, and uncover the assumptions that come with these processes (see Chapter 3);
- collecting data on mechanisms, context and outcomes to test the theory and its assumptions (country reports); and
- analysing (patterns in) the data taking into account that both context and mechanism lead to certain outcomes (synthesis report).

2.1.2. Five capabilities approach

For the capacity-building analysis we intended to use the five core capabilities (5C) approach, developed by the European Centre for Development Policy Management (Keijzer et al., 2011). The five core capabilities are the capability to: 1) act and commit; 2) deliver on development objectives; 3) adapt and self-renew; 4) relate to external stakeholders; and 5) achieve coherence. This framework is mainly used to report on the strengthening of capabilities within the UFBR programme. Although we integrated the 5C model into the questions in the online survey and used the model in document analysis, we felt that the 5C approach was only partly useful to assess the actual capabilities strengthened. First, the five capabilities are too general to gain good insights into the actual capabilities strengthened. Second, the project documentation provided limited information, and at the

time of writing the report, the information from 2015 on the 5C approach was not yet available. The 5C model was, therefore, only partly used as a framework to answer questions in research dimensions 3 and 4, and more specific information was added on strengthening of capabilities.

2.1.3. Assessing partnerships

The academic and management literature on cross-sectoral partnerships mentions several factors contributing to the success of partnerships: commitment (investment in time and resources, involvement of managers etc.), coordination, trust and communication (frequency, quality, sources etc.). Conflict resolution strategies within the partnership are also sometimes mentioned. In the evaluation we used these factors as a framework to assess how the alliances are functioning.

2.2. Desk study

The realist approach aims to provide an answer to the question 'What works for whom, in which contexts, and how?'. This has implications for our evaluation, as we did not limit ourselves to describing results but also linked them to context and mechanism. This required the use of different research methods. An overview of research methods and how they are linked to the evaluation questions can be found in Table 2.1.

2.2.1. Document analysis

A number of research questions can be answered using existing documents compiled by the SRHR Alliance. We focused on a selection of documents: overall proposals, country work plans, synthesis report of all countries for each year, annual reports and operational research reports. In agreement with the PME team of the alliance office, only documents at country level and the overall UFBR level were included in the analyses.[1] The desk review of available documents serves three purposes:

- answering several research questions: monitoring and evaluation and additional research has been carefully planned from the start of the UFBR programme. This means a large amount of both quantitative and qualitative data are available to answer (part of) the research questions;
- preparation for the field research: the desk study was also used to identify remaining questions for the online survey and field research. We assessed gaps and identified remaining questions; and
- based on the documents, we analysed whether the ToC, which is central to UFBR, has been put into practice. Furthermore, the evaluation aims to elaborate on the ToC model. A more explicit ToC is a good tool to use to identify programmatic strengths and weaknesses during the field research (dimensions 1, 2 and 3).

The analytical software tool ATLAS.ti was used to systematically code, assess and analyse all sources of information that were made available by Rutgers, the SRHR Alliance's coordinating agency. The evaluators jointly developed a closed coding tree based on the research questions (and allowing them to develop additional grounded codes) that was used by all evaluators to code the documents.

[1] The outcome measurement reports (OMRs), which present the results of the effectiveness study, including the results from baseline and endline studies, were only available at the end of the evaluation project and could not help inform the field studies.

Table 2.1: Overview of the research methods crossed with the research dimensions and questions they will address.

Dimensions and questions	Sub-questions/points of attention	Desk study					Field study			
		Desk study — all countries	Matrix input/output	Online survey — all countries	Online survey — Northern partners	Interviews — Northern partners	Field research: interviews	Site visits and observation	Field research: focus groups	Field research: most significant change
Dimension 1: results and changes: What are the results of the programme? Are they relevant and sustainable?	Did the programme achieve the expected output and outcome results for all result areas, and did the programme achieve the overall results according to the main stakeholders, such as young people?	x					x	x	x	x
	How did the programmes contribute to these changes?	x				x	x	x	x	x
	What were the enabling and constraining factors when implementing the programme?	x				x	x		x	
	Are there unexpected results? If so, what are the unexpected results?					x	x		x	x
	What can be concluded about the sustainability of the results?	x				x	x		x	
	Analysis on a sub-set of activities vs. costs vs. results	x	x				x			
Dimension 2: implementation process: Which have been effective, efficient and sustainable strategies under the UFBR and ASK programmes?	Which strategies were implemented in each of the result areas, and in meaningful youth participation? This includes a review of the multi-component approach and an assessment of processes that led to change in values and norms at different levels (beneficiary to policy level).	x				x	x	x	x	
	Which strategies have been effective and led to sustainable results, and what can be concluded about the efficiency of the processes and strategies implemented?	x				x	x	x	x	
Dimension 3: country alliances and partners: Has working in the ASK/UFBR programme been relevant, effective and efficient for partner organizations, in terms of their capacity?	How do partners value the in-country collaboration, and to what extent do partners feel they are part of an international/regional alliance or movement?			x			x			
	What is the added value of the alliance in the country and/or region?			x			x	x	x	x
	Did the partnership lead to changes in the capacity of NGOs and NGO staff, and in which areas? (e.g. SRHR technical expertise, joint programming, advocacy, values and norms around SRHR and meaningful youth participation)			x			x	x		
	Are gains/outputs of being part of the alliance in line with the required time and efforts/input of the individual partners?			x			x			
	The alliance wishes to map current plans to continue the alliances, even without future support of the current programmes.				x		x			
Dimension 4: Northern alliance and members: To what extent has the partnership been relevant, effective and efficient for the individual members and the programme?	Has the partnership in the North led to any changes for the individual members (e.g.in their professionalization, capacities, expertise) and in which areas (e.g. advocacy, PME, research)?				x	x				
	How has working through this partnership affected the programmatic processes and results in the South?				x	x				
	How has the partnership constrained or provided more opportunities compared to working individually? Are gains/outputs of being part of the alliance in line with the required time and efforts/input of the individual partners?				x	x				
	In addition: to what extent and how have the ASK and UFBR programmes influenced each other?				x	x	x			

2.2.2. *Efficiency study*

In addition to the analysis of existing documents, we included a proposal for an internal comparison of selected strategies, with the objective of gaining insights into the efficiency of a number of activities. Two additional analyses were foreseen for UFBR and Access, Knowledge, Services (ASK): 1) a cross-country comparison of one of the key activities of the ASK programme, to complement the information from the documents available; and 2) an analysis of the comparison of efficiency of different strategies with the same objective: CSE in/out of school in the three selected countries where fieldwork was undertaken.

The objective was to use this input together with other research findings to analyse the efficiency of the UFBR and ASK programmes. The study was set up in close cooperation with the alliance office. Obtaining the data collected was, however, more difficult and required more time and effort than anticipated, which was mainly related to the financial set-up along the lines of the programme's result areas, the short time frame available for the evaluation, the closure of the UFBR and ASK programmes and the set-up of a new programme. The end of 2015 and beginning of 2016 was a challenging time for all alliance partners. Obtaining the data not only required input from the alliance office and the finance department of Rutgers but also from partner organizations in the programme countries. Because of these constraints, it was decided, together with the alliance office, to only focus on the ASK programme. Looking back, the efficiency study needed a quicker start and more time. A general lesson is to build in mechanisms to measure efficiency right from the start of the programme and to ensure that the financial administration connects to them.

2.2.3. *Web-based survey*

An online survey was used to: i) assess whether local partners in all countries feel that their organisation has benefitted and has developed through the programme; and ii) gain insights into and consensus on the core strengths and weaknesses of the programme design, implementation and evaluation, and on the main results. The link to the online survey was sent to all partners (the Northern alliance partners and their local partners). The survey consisted of different topics:

- background information on the respondent;
- open and closed questions on the programme design, implementation and main results;
- functioning of the international partnership;
- functioning of the national partnership;
- perceived value of in-country collaboration;
- cost and benefit of being part of the alliance;
- capacity-building; and
- sustainability.

For part of the survey (open-ended questions on programme design, implementation and results) we used a Delphi approach. After the first survey round, the open-ended questions were analysed, and answers were grouped into categories and, subsequently, into questions with closed answer categories. These questions were sent to the same respondents. The online surveys can be found in Annex 2.

The survey was sent to 139 contacts (both for UFBR and ASK). It was completed by 91 respondents in the first round and 76 respondents in the second round. Their characteristics are shown in Tables 2.2 and 2.3.

Table 2.2: Characteristics of respondents from Survey 1.

		Programme			
		UFBR	ASK	UFBR and ASK	Total
		Count	Count	Count	
North vs South	North	1	7	18	26
	South	22	32	10	64
Gender	Male	10	21	8	39
	Female	13	18	20	51
	Other	0	0	0	0
Organization	AMREF	1	3	1	5
	CHI	0	3	0	3
	Choice for Youth and Sexuality	0	0	2	2
	Dance4Life	2	0	8	10
	IPPF	0	4	0	4
	Rutgers	5	6	9	20
	Simavi	7	10	2	19
	Stop AIDS Now	0	8	0	8
	Other/NPC	2	1	3	6
	Multiple organizations	6	4	3	13
Country	Bangladesh	6	0	0	6
	Ethiopia	0	1	1	2
	Ghana	0	6	0	6
	India	4	0	1	5
	Indonesia	2	5	3	10
	Kenya	3	7	4	14
	Malawi	1	0	0	1
	Pakistan	0	7	1	8
	Senegal	0	3	0	3
	Tanzania	6	0	0	6
	Uganda	0	7	3	10
	Other: multiple countries	1	3	15	19

Table 2.3: Characteristics of respondents from Survey 2.

		Programme			
		UFBR	ASK	UFBR and ASK	Total
		Count	Count	Count	
North vs South	North	3	6	19	28
	South	14	32	2	48
Gender	Male				
	Female				
	Other				
Organization*	AMREF	2	2	2	4
	CHI	0	2	1	3
	Choice for Youth and Sexuality	0	2	3	5
	Dance4Life	2	2	10	12
	IPPF	0	5	1	6
	Rutgers	5	6	13	24
	Simavi	8	9	3	20
	Stop AIDS Now	0	15	1	16
	Other/NPC	2	0	5	7

		Programme			
		UFBR Count	ASK Count	UFBR and ASK Count	Total
Country*	Bangladesh	3	0	2	5
	Ethiopia	0	2	6	8
	Ghana	0	8	5	13
	India	3	0	5	8
	Indonesia	0	3	8	11
	Kenya	2	17	14	33
	Malawi	1	0	5	6
	Pakistan	0	4	6	10
	Senegal	0	6	4	10
	Tanzania	8	0	7	15
	Uganda	0	10	10	20

2.2.4. Face-to-face and telephone interviews followed by a workshop (Northern alliance partners)

To obtain more in-depth knowledge about the added value of the SRHR Alliance, we did a series of interviews with Northern alliance partners. Complementary to the online survey, the interviews focused on the management level of the organizations included in the SRHR Alliance. We included one person per member organization. In total 11 people were interviewed using a semi-structured interview guide; six interviews were done face to face, and two by telephone/skype.

Following the analysis of the online survey and the interviews, we organized a three-hour workshop with representatives of each Northern alliance partner to discuss in depth the added value of the alliance based on the results. Three topics were discussed during the workshop:

- the preliminary results from the online survey and interviews were presented, discussed and interpreted;
- the preliminary stakeholder map - based on document analysis and field studies - was presented and discussed; and
- the explicit ToC (see Chapter 3) was presented and discussed.

The methodological aspects of the analysis are explained in a separate report on the partnership (see *Partnership Assessment: SRHR Alliance and Youth Empowerment Alliance*).

2.3. Field study

As set out in the Terms of Reference for the evaluation, four countries were selected to do in-depth field research: Indonesia, Uganda, Kenya and Ethiopia. At the beginning of November, in consultation with the Rutgers monitoring and evaluation (M&E) coordinators and the project team in Ethiopia, it was decided to leave Ethiopia out of the field study. This allowed more time for the evaluations in Kenya, Uganda and Indonesia. In collaboration with the respective country team, we selected two or three settings per country to allow us to obtain an in-depth understanding of the mechanisms through which the UFBR programme was implemented in each country.

The selection criteria for the study sites were:

- perceived success and/or perceived quality of the implementation of the programme (e.g. including one setting that is known to be successful and one that is known to be less successful);
- feasibility of the setting: ability to access the study sites (location, transport); existence of structures to enable coordination of focus group discussions (FGDs) and interviews; partners and

human resources attached to the UFBR programme available to provide the necessary support and information during the field study; and

- relevance to country team/programme: study settings that will provide opportunities to address the research questions outlined, and are also relevant for country teams in terms of learning.

A number of different methods were used to collect data at these sites. These are described in detail in the field study reports; therefore, we will only provide a short overview here.

2.3.1. Semi-structured interviews

The semi-structured interviews provided information to answer a large number of research questions in all dimensions of the evaluation (see Annex 3). We interviewed various stakeholders and programme staff - approximately 10 per country. The exact composition was discussed with the country lead and/or National Programme Coordinator (NPC) and differed between countries. Generally we aimed to include programme staff, people involved in the implementation (community leader, health care provider, teacher, peer educators) and external stakeholders (ministries/administrations, policymakers, local health authority, embassy employees, members of councils, knowledge institutions).

Topics for the semi-structured interviews with those involved in the programmes included: verification of stakeholder maps, outputs and outcomes, strategies (processes), partnerships, capacity-building, enabling and constraining factors, relevance and sustainability.

2.3.2. Focus group discussions

The FGDs provided information to answer a large number of research questions in all dimensions of the evaluation (see Table 2.1). We organised FGDs with a variety of stakeholders (policymakers, community leaders and youth-led organizations), service providers (health care providers/educators) and beneficiaries. The groups involved were related to the specific regions and focus of the UFBR programme. As it was not possible to cover all groups in each location, we aimed to work with heterogeneous groups with various kinds of actors. In total we organized six FGDs in two different locations per country. Each group included 6–10 participants.

The main topics addressed in the FGDs were the same as those in the semi-structured interviews, though the emphasis may have differed, depending on the type of respondents. However, the FGDs will provide opportunities to understand the context and perspectives of different stakeholders on the different research dimensions. They will also be used to verify other data; using data from different sources will make it possible to triangulate data. The FGD guide can be found in Annex 4.

2.3.3. Most Significant Change method

We used the Most Significant Change (MSC) method to assess whether and how the programmes achieved changes, to identify the most significant changes according to young people as key stakeholders and target groups, and to identify unexpected changes. By engaging the target group in the data analysis, the researchers received additional information on the norms and values of the target groups.

For both programmes, young people (aged 15–24 years) themselves, coached by the research team, collected data among their peers, and another group of young people contributed to the analysis. We tried to involve young people who had already been involved in the operational research in the field research countries or who had been working as peer educators.

2.3.4. Site visits and observations

For each study setting in each country, we selected between two and four sites that correspond to the different strategies implemented (e.g. increasing knowledge, improving SRH services, promoting an enabling environment). These sites included health centres, youth clubs, schools and other relevant implementation settings. The sites were selected in consultation with the NPC and other relevant partners. During the site visit, the staff member from the implementing partner responsible for the project was asked to provide information, and a young person (mostly peer educators) was included in the tour. The checklist used during the site visits can be found in Annex 5.

2.4. Feedback

Throughout the evaluation, the evaluation team was in continuous contact with the M&E coordinator of the UFBR programme. All methods proposed were discussed and agreed. There were also several opportunities for other stakeholders to provide feedback: NPCs and Country Leads revised the country reports by fact-checking and providing information on inconsistencies in the documents; and in the countries where field research was done, the local consultant organized a feedback workshop. The workshop was jointly prepared by the evaluation team member responsible for this country and the local consultant.

3. THEORY OF CHANGE

3.1. What is a ToC?

A first step in this evaluation is to make the ToC of the UFBR programme explicit. A ToC can be described as *"the process through which it is expected that inputs will be converted to expected outputs, outcome and impact"*[2] or, in other words, a *"set of assumptions that explain both the steps that lead to the long-term goal and the connections between programme activities and outcomes that occur at each step of the way".*[3]

A ToC needs to include an explanation of how the programme's activities will contribute to the results, instead of just having a list of activities followed by the outputs and outcomes, without an explanation of how these are linked. Hence, a ToC articulates the theories and assumptions which underpin the anticipated change process, and provides the supporting evidence.

A ToC often combines a 'simple' visual presentation which quickly communicates the theory to all audiences and a more detailed narrative that does justice to the complexity of the programme and explores the assumptions and evidence that underpin it. The ToC should also be consistent with the logical framework of the programme.

3.2. The ToC of the SRHR Alliance

According to the information available, the SRHR Alliance has developed a ToC or 'multi-component approach' that reflects how it envisages change to happen through the UFBR programme. The multi-component approach comprises three elements: **demand**, **supply** and **support,** which each have their own strategy but also influence each other:

1. Through the provision of in- and out-of-school SRHR education, the UFBR programme empowers young people to make healthy and well-informed decisions. By providing SRHR education, **young people' demand for services will grow**, and the demand for youth-friendly SRH services will increase.
2. The UFBR programme strengthens the provision of quality public and private SRH services (accessible, acceptable and affordable for young people) to meet the increased demand. **By strengthening the provision of services, the supply increases.**
3. Community sensitization, participation and mobilization activities are implemented to create an environment that accepts adolescent SRHR and **increases broad community support for sexuality education and youth-friendly SRH services**. Furthermore, lobbying and advocacy is undertaken to facilitate the creation of policies and laws that support young people's rights and needs.

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[2] DFID, Further Business Case Guidance 'Theory of Change'.
[3] Carol Weiss, M&E Specialist, 1995.

The ToC is visualized as follows:

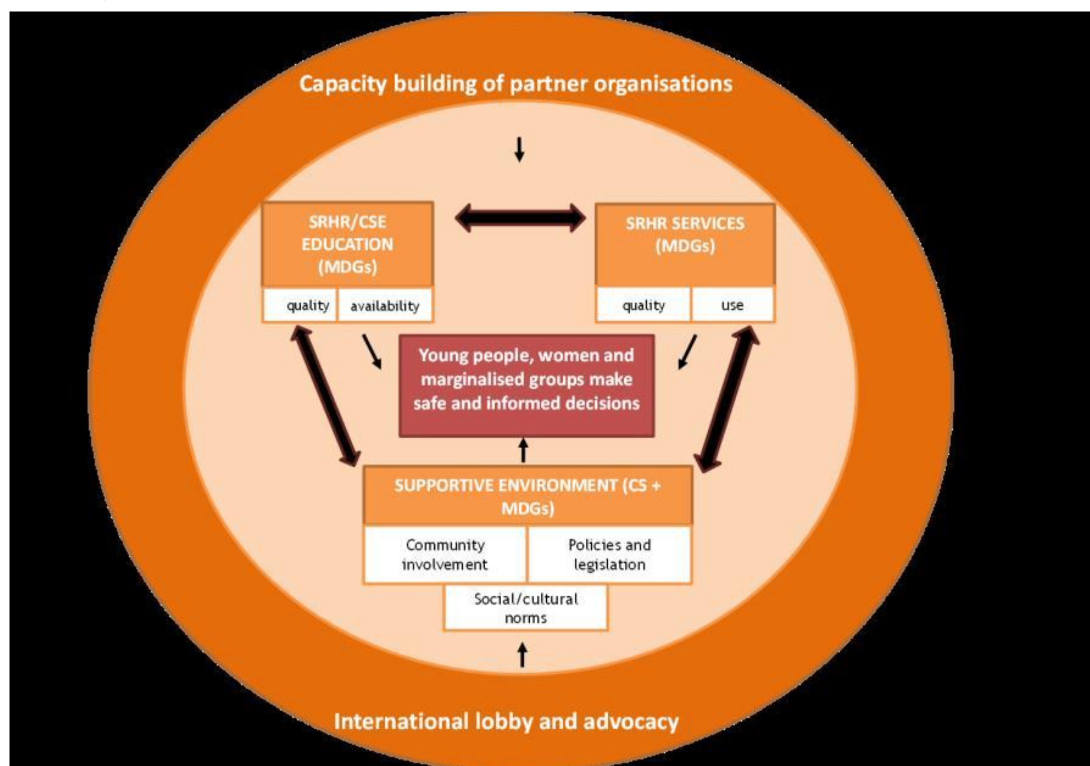

Figure 3.1: General Theory of Change of the UFBR programme.

3.3. Review of the existing ToC

The SRHR Alliance's existing ToC is well developed. It explains how the three specific components of the programme interact and has spelled out the assumptions of how change will occur in each area.

The ToC is being used as a tool to improve learning and to reflect on the overall programme and country achievements. Each country programme has reflected on the ToC, making different links between the components based on its own country context. The ToC has also helped the different partners in countries to have a better understanding of the UFBR programme and their specific role. Furthermore, the mid-term evaluation also highlights that the ToC has helped to improve collaboration among Northern partners.

In 2012, as part of the learning agenda, research was conducted to review the evidence base of the effectiveness of a multi-component approach. The literature review concluded that multi-component approaches are more effective than single-component approaches for improving the sexual health and behaviour of adolescents, particularly when they address structural factors and barriers, such as demand, supply and support. Nevertheless, the literature also identified challenges of such an approach in terms of structural barriers (such as poverty, gender inequality), organizational challenges (fragmentation of programmes, interventions and stakeholders) and a lack of rigorous evidence that supports the ToC. So, while the existing ToC and the multi-component approach are useful to the overall programme, there are still some flaws from both a theoretical and a practical point of view.

First, it is unclear for those who are not familiar with the UFBR programme **what social change** is desired and **how the programme activities will achieve this.** The visual presentation refers to

‘capacity-building of partners’ and ‘international advocacy’, but the narrative does not explain *how* these will influence the provision of SRHR education, strengthening of SRH services and a supportive environment. Furthermore, the diagram is unclear about what the desired outcomes are.
Second, although the explanation of the ToC on the website explains the assumptions of how change will happen in the medium to longer term, and the ‘results table’ explains how outputs lead to outcomes, it lacks an explanation of how the programme activities will generate the outputs and short-term changes that in turn will allow for the improved provision of SRHR education, SRH services and supportive environment. Also, the interlinkages between different activities, outputs and outcomes are not made explicit. Several explanations are available in various programme documents, but they are not clear from the visual presentation or the ToC descriptions on the website.

Finally, the annual reports, learning agenda and outcome measurements have gathered experiences and information on how different components interlink and reinforce each other. However, there is still a **lack of ‘evidence’** that demonstrates how these interlinkages and changes lead to concrete outputs, outcomes and impact.

In the remainder of this chapter we will try to develop a more detailed version of the ToC. It will spell out the assumptions at all levels of the programme. This more detailed ToC was tested by the evaluation team during the field visits and used to gather further evidence, and Northern alliance members provided their feedback. The ultimate goal of this exercise is to help the SRHR Alliance to gain a complete understanding of how each participant/stakeholder will facilitate change in the short, medium and long term. Furthermore, by spelling out all the assumptions and seeking evidence for these assumptions during the evaluation, the SRHR Alliance will have a stronger ‘evidence base’ for its ToC and the wider UFBR programme.

3.4. More detailed ToC and evidence base

Figure 3.2 presents a more detailed version of the ToC, linking it to the existing logical framework.

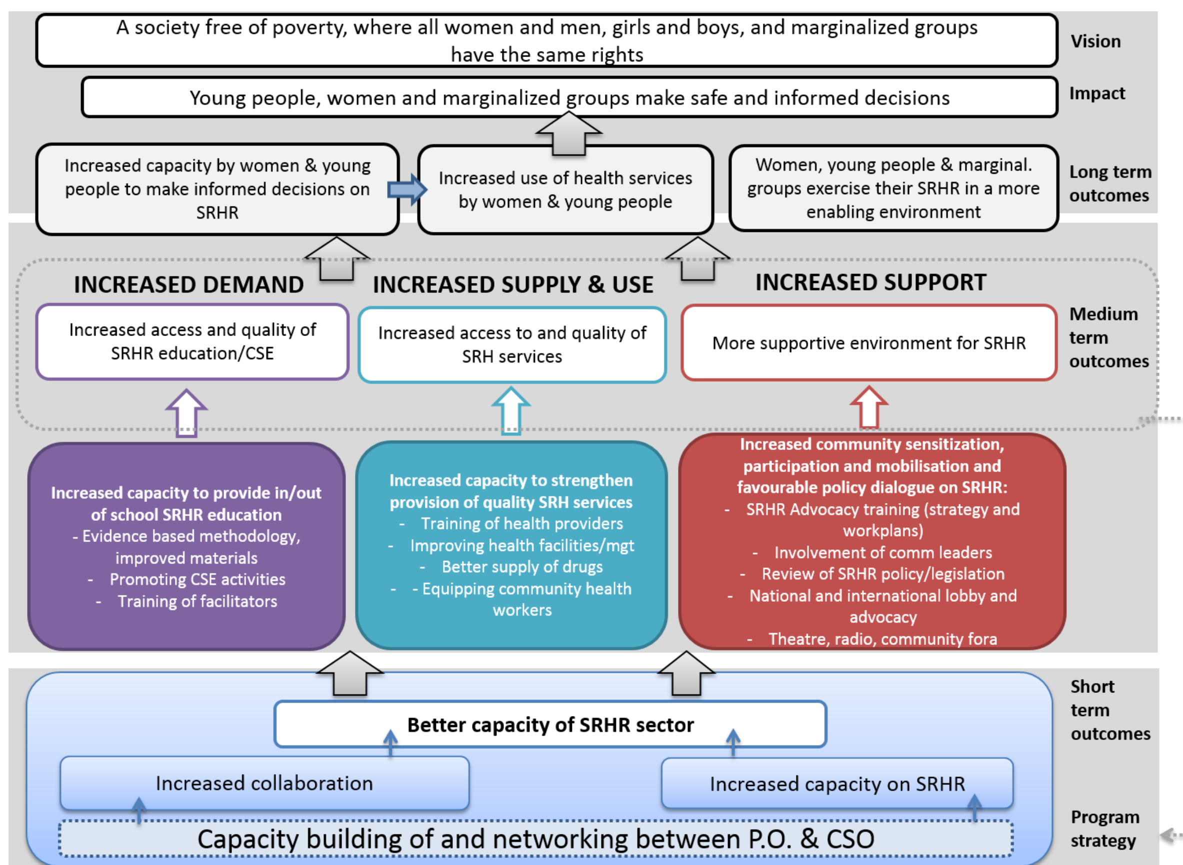

Figure 3.2: Explicit Theory of Change of the UFBR programme.

As part of the process of developing the ToC, it is important to identify 'evidence' that confirms the assumptions and theory. A review of the literature, conducted in 2012, demonstrated that some academic research exists to support a multi-component approach. However, there is no rigorous evidence available yet to support each of the assumptions of the ToC. Hence, the evaluation will be useful to also verify and collect evidence for these assumptions, which are spelled out below:

Capacity-building

- Capacity-building and networking provide a platform for knowledge-sharing, learning and increased collaboration between organizations.
- Linking and learning between organizations leads to better programming.
- Individual capacity-building on SRHR increases the SRHR knowledge and skills among staff of partner organizations and civil society organizations (CSOs).
- Organizational capacity-building on project management, research and PME leads to improved implementation and monitoring of the programme.
- Better-connected and strengthened organizations contribute to a stronger national SRHR sector.

Increased SRHR education (demand side)

- Improved quality of CSE content, methodology and materials enables facilitators to deliver more comprehensive CSE
- Improved quality of CSE will improve the uptake of CSE messages and learning.
- Training educators to deliver quality CSE leads to improved capacities of educators to deliver CSE.
- Promotion of formal and informal CSE activities leads to increased access to SRHR education.

- Increased access to quality SRHR education and CSE leads to increased knowledge, better attitudes and improved skills among young people and women.
- Increased knowledge, better attitudes and improved skills lead to increased capacity to make informed decisions about SRHR.
- Increased capacity (knowledge, confidence and attitudes) of young people, women and men on SRHR leads to greater demand for quality SRHR services.

Strengthening SRH services (supply side)

- Training of service providers to deliver quality SRH services leads to improved capacity of service providers to deliver quality SRH services.
- Renovating health facilities improves access to formal SRH services.
- Equipping community health workers and trained birth attendants with necessary means improves access to SRH services through referrals.
- Better supply of commodities and drugs leads to better quality of SRH services.
- Improved quality of SRH services leads to greater client satisfaction.
- Improved access to formal and informal SRH services leads to better uptake of health services.

Supportive environment for SRHR

- Effective advocacy in-country leads to a favourable policy dialogue on SRHR in-country.
- Development of an advocacy strategy and work plans leads to the implementation of advocacy campaigns for improved SRHR policies and legislation.
- Advocacy meetings at the local, regional or national level leads to improved SRHR policies and legislation (better aligned with the programme's objectives);
- Promotion of SRHR awareness-raising activities at community level leads to increased involvement of communities and community leaders in SRHR awareness-raising activities.
- Promotion of SRHR awareness-raising activities at national level using (new) media leads to increased involvement of communities and community leaders in SRHR awareness-raising activities.
- Increased involvement of communities and community leaders in SRHR activities leads to a more supportive environment for SRHR.
- Improved SRHR policies and legislation lead to a more supportive environment for SRHR.
- A more supportive environment for SRHR provides more support to young people, women and marginalized groups to exercise their sexual and reproductive rights.

Long-term changes

- More demand, supply and support for quality and equitable SRHR leads to improved preventive behaviours by young people.
- More demand, supply and support for quality and equitable SRHR leads to improved use of quality SRH services.
- More demand, supply and support for quality and equitable SRHR leads to improved acceptance of SRHR and gender equality within the community.
- Improved prevention behaviours, utilization of quality SRH services and increased acceptance of SRHR and gender equality lead to improved SRH and equal sexual and reproductive rights for young people, women and marginalized groups.

4. DIMENSION 4: NORTHERN ALLIANCE AND MEMBERS

To what extent has the partnership been relevant, effective and efficient for the individual members and the programme?

Key messages

- Partners assess the collaboration as positive, perceiving many benefits by collaborating together that outweigh the challenges that were also experienced.
- The partnership has been effective in increasing the professionalization of the alliance members, at both the individual and the organizational level.
- The international lobbying and advocacy strategy of the SRHR Alliance was relevant and effective, and adapted to changing national and international situations. It helped to keep SRHR high on the national and international agendas, which contributes to a more enabling environment for the programme.
- A key factor that contributed to the success of this strategy is the close collaboration across national, international and in-country advocacy.

4.1. Assessment of the partnership

Five alliance organizations in the Netherlands, working together in the SRHR Alliance, implemented the UFBR programme in nine countries from 2011 to 2015. In 2013, a second programme, ASK, was initiated, and an additional alliance was established for the implementation of the new programme: the Youth Empowerment Alliance (YEA). Two additional partners, one from the Netherlands and one from the UK, joined the initial five members. The ASK programme was implemented in seven countries from 2013 to 2015. This report focuses on the added value and enabling and constraining factors within these two alliances. In general, we can conclude that the partnership was a good way to implement both programmes. For more information on these conclusions, see the separate evaluation report on the partnership that is part of this end evaluation (*Partnership Assessment: SRHR Alliance and Youth Empowerment Alliance*).

Positive assessment of the collaboration

We can conclude that the prerequisites are in place for the alliances to function well. The goals of the partnership fitted well with the mission and objectives of each individual organization. The ToC was a common framework as well as a ‘bonding agent’ for the collaboration. Members feel that all relevant expertise was present in the alliances to implement the programmes.

Partners assess the collaboration as positive, perceiving many benefits of working together. Partnering created synergy, which improved the quality of the work and resulted in better outcomes. Together the alliances are more visible, making it easier to lobby and advocate for SRHR. The collaboration also facilitated and stimulated learning.

Challenges

Collaboration was, however, not an entirely positive experience. Especially at the top level of the alliances, alliance members struggled with tensions between organizational and alliance interests, sometimes leading to mistrust and negative energy. Collaboration was also found to be bureaucratic and time-consuming. In addition, it was found that the alliances established a consensus-seeking culture, where most decisions were made democratically. This made the alliance less agile. All in all,

however, the members feel that the benefits outweigh the disadvantages. This is also proven by the continuation of the partnership in a new programme, in which all but one organization are participating.

Increased professionalization
We can also conclude that the partnership has been effective in increasing the professionalization of the alliance members. This is strongest on the level of individual staff. In particular, the knowledge and skills acquired on PME and research, meaningful youth participation and CSE were mentioned as valuable. Organizational learning has also been acknowledged and appreciated, but to a lesser extent than individual capacity-building. Three of the seven alliance members feel that their organization has been positively changed by the programme, and two of these adopted programming with more attention to SRHR, especially with regards to rights.

Top-down approach
Both alliance members and partner organizations assess the international cooperation as positive, although Southern partners are more positive than Northern partners. In general, however, the UFBR programme was found to suffer from a top-down approach — and to a greater extent than ASK — which hindered ownership and sustainability of the programme in the South.

4.2. Assesment of lobbying and advocacy

Result area 4: International lobbying and advocacy	
Expected outcome	Sustained or increased political and financial commitment towards SRHR for all in the Netherlands and at United Nations level
Expected outputs	Policy dialogue is influenced in favour of SRHR at the international level and in the Netherlands

Lobbying and advocacy in the Netherlands
In the Netherlands, the SRHR Alliance has contributed towards a more favourable environment for SRHR, particularly by engaging with the Dutch Parliament and the Ministry of Foreign Affairs. In terms of output (number of contacts between alliance members and policymakers at national level), the SRHR Alliance had already exceeded its target by 2013. These contacts have yielded important results.

In the first year of the programme (2011) the SRHR Alliance successfully campaigned against the proposed budget cut of €35 million by the Secretary of Development Cooperation from the overall SRHR budget. Due to intense lobbying and advocacy from the SRHR Alliance in collaboration with other organizations, the government decided to reverse the budget cut and instead increased it by €8 million and launched an SRHR fund through which the SRHR Alliance funded the ASK programme.

When the Dutch government resigned in April 2012, the Dutch alliance members lobbied the interim government on the development of the SRHR policy brief. As a result of strong lobbying efforts, the Ministry of Foreign Affairs maintained SRHR as a policy priority on the international SRHR agenda. Efforts were also undertaken to raise awareness of SRHR among parliamentarians and policymakers for greater recognition of the role of SRHR in economic, social and sustainable development.

In 2013 the Dutch government developed a new policy for aid, trade and development. The SRHR Alliance lobbied the relevant stakeholders to maintain SRHR as a high policy priority and invited the Minister of Foreign Affairs to visit the alliance programme in Ethiopia. The final policy refrained from

cutting the SRHR budget and maintained SRHR as a key priority. In the same year, the SRHR Alliance advocated for the importance of advocacy and Southern and international civil society networks in the new Dutch framework for civil society funding. Advocacy has been included as a key focus of the funding structure, and the importance of civil society has been reconfirmed; however, the intense advocacy did not stop the funding cuts for civil society programming.

In 2014 the SRHR Alliance focused on monitoring the implementation of the Dutch SRHR policy and met with ministries and parliamentarians to address the shortcomings of the policy (as identified by an evaluation by the Policy and Operations Evaluation Department - IOB). Also, the SRHR Alliance continued to put pressure on the government to keep SRHR and in particular 'taboo' issues on the table. This issue was picked up by parliamentarians, who addressed it in the discussion on the Multi-Year Strategies of the Embassies.

Throughout the duration of the programme, the SRHR Alliance used multiple opportunities to put SRHR in front of parliamentarians, in particular through the Multi-Party Initiative for SRHR and HIV/AIDS. Among other activities, meetings were facilitated between the NPCs and parliamentarians, field visits were organized, and questions from parliamentarians were answered. In 2014 the SRHR Alliance also contributed to the future of the Multi-Party Initiative on SRHR and HIV/AIDS by advocating for its continued existence with Members of Parliament.

International lobbying and advocacy
At international level, the SRHR Alliance has focused on United Nations review processes that are relevant to the International Conference on Population and Development (ICPD) Programme of Action and the post-2015 framework. Advocacy at this level was done jointly with other networks and organizations, including the Southern partners. The output target for this strategy (number of international meetings with political relevance on SRHR attended by alliance members or partner organizations) had already been achieved in 2013. This is confirmed by the 'MFSII Joint Evaluation of International Lobbying and Advocacy', which concluded that the international lobbying and advocacy strategy of the SRHR Alliance was relevant and effective, and adapted to changing national and international situations.

In 2012 and 2013 the SRHR Alliance participated in the operational review processes of the ICPD Programme of Action beyond 2014 both at country level and internationally. This involved the participation of Southern alliance members in national consultation mechanisms and active involvement in a variety of international and regional conferences and review meetings. During the 46th CPD and 57th Commission on the Status of Women (CSW), the SRHR Alliance was part of the Dutch government delegation and advocated for strong SRHR language, in addition to facilitating youth participation.

In 2014 all alliance members actively participated in the 47th CPD to negotiate for strong SRHR language. Southern alliance members were supported in their advocacy efforts towards their governments, which resulted in many countries voicing their support for SRHR issues. Unfortunately, this did not result in a progressive document.

The SRHR Alliance also participated actively in the Post-2015 process. It cooperated intensively in organizing briefings with the Dutch government, writing joint responses to key Post-2015 documents and actively participating in Open Working Group 8. As a result of joint advocacy by civil society, the outcome document and 2030 Agenda include SRHR targets for two Sustainable Development Goals (SDGs): SDG 3 on health and SDG 5 on gender equality and women's and girls' empowerment.

Unfortunately, due to strong resistance from various governments, no language is included on sexual rights and sexual diversity.

In addition to these two main areas of work at the international level, the SRHR Alliance also engaged in international events to promote the SRH and special needs of youth and adolescents as well as the importance of youth participation in SRHR advocacy.

Finally, partner organizations were also involved in international advocacy. Partners from Malawi, Kenya, Tanzania and Pakistan contributed to international position papers and pre-CPD meetings with their governments, and have had meetings with international stakeholders and country representatives at African Union or United Nations level.

Conclusion
Result area 4 of the UFBR programme was relevant to the programme. It helped to keep SRHR high on national and international agendas, which contributed to a more enabling environment for the programme. The activities and outputs were also consistent with the overall objectives of the programme and contributed to key results.

The international lobbying and advocacy strategies were also effective. The proportion of Dutch Official Development Assistance allocated to SRHR increased from 3.2% to 5.2%. Dutch parliamentarians have been made more aware of the importance of SRHR for economic, social and sustainable development. Engagement with international review processes ensured that SRHR language was kept in the final outcome documents of the SDGs and the ICPD review process. Finally, national partners were increasingly involved in international advocacy, which contributed to a stronger positioning of the SRHR Alliance.

A key factor that contributed to the success of this strategy is the close collaboration across national, international and in-country advocacy. The Advocacy Working Group which was established for this purpose has successfully contributed to sharing knowledge, joint activities and shared analysis. However, the SRHR Alliances operates in a global environment where many different interests prevail. Hence, continued strong advocacy will be necessary to ensure that SRHR remains high on the international agenda and is closely monitored over the next 15 years, the agreed timeline for the SDGs.

5. DIMENSION 3: COUNTRY ALLIANCES AND PARTNERS

Has working in the UFBR programme been relevant, effective and efficient for partner organizations, in terms of their capacity?

Key messages

- While partners clearly have to invest time and effort (and, in some instances, finances) to participate in the country alliance, the benefits of working together, learning from each other and jointly improving the quality of the SRHR sector in the country seem to compensate for these inputs.
- The NPC plays an important role in keeping the alliance active. His/her position is, however, not always easy, because of the need to work with the country alliance, the host organization, the Country Lead and his/her member organization. A stronger role for the NPC is recommended.
- The focus on capacity-building was very much appreciated by the partner organizations and led to a significant increase in individual capacity and also to an increase in organizational capacity. This strategy is crucial for sustainability.
- More attention should be paid to value clarification to also build capacity and change norms on more sensitive SRHR topics.

5.1. In-country and international collaboration

5.1.1. National alliance

How do partners value the in-country collaboration (with each other and NPCs)?

The UFBR programme helped to strengthen the in-country network of organizations working on SRHR, thereby increasing their collaboration, networking capacity and sharing of SRHR knowledge. All nine countries participating in UFBR valued this aspect of the programme highly. The findings are very much in line with the mid-term review of the country alliances.

In most countries, the collaboration between SRHR partners became much stronger. The increased sharing among SRHR organizations and joint planning of activities (in particular on advocacy) led to a better understanding of SRHR as well as an increased commitment of partners to SRHR. By joining forces, partners were better able to influence policy change, move SRHR higher up the national agenda and reach more people. Factors that enabled this networking and learning include: the participation in other national networks and coalitions to share lessons and harmonize activities (e.g. Ethiopia and India); media coverage to increase the programme's visibility (e.g. Malawi); and the complementarity of partners with different experiences and institutional capacities.

This is also confirmed by the online survey, in which Southern partners working on the UFBR programme identified the two main strengths of the overall partnership as the establishment of the country alliances (24% of respondents) and the mutual learning between partners (22%) (see Figure 5.1).

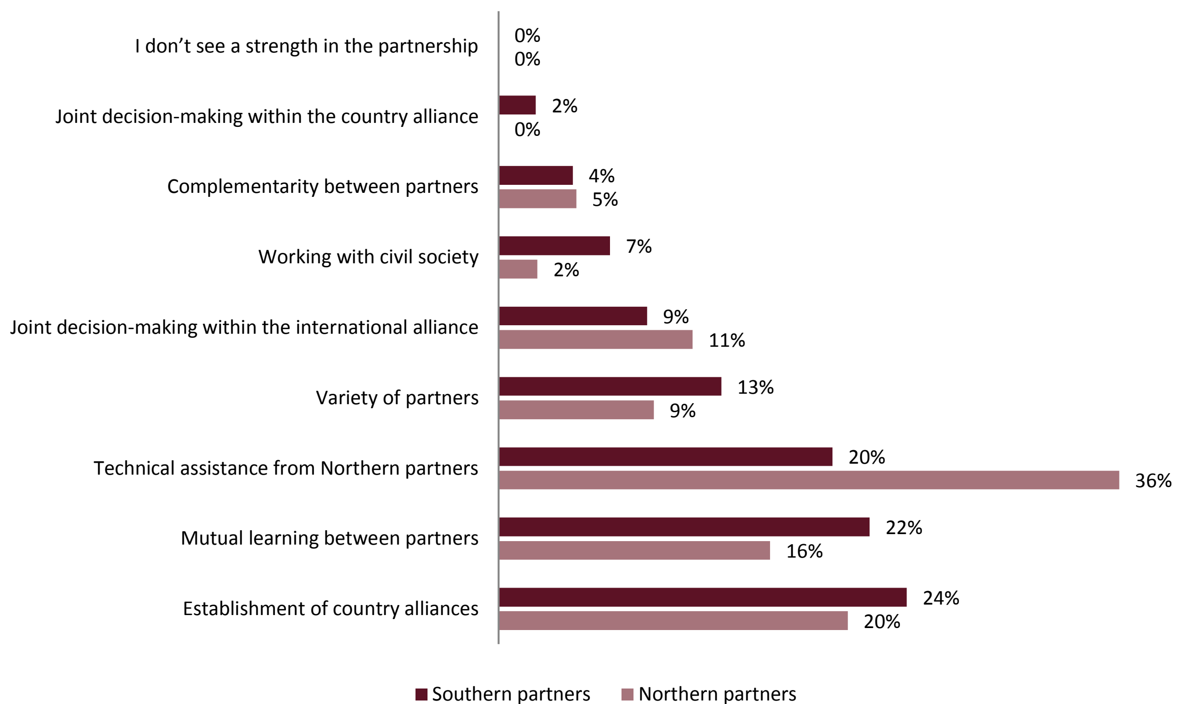

Figure 5.1: Main strengths of partnership (UFBR, all partners, second online survey).

Furthermore, most country reports show that working together is more effective for lobbying and advocacy. Through the national alliance, partners were able to meet with other stakeholders and join efforts in pushing for policy changes and resisting political pressure. Working as a network, therefore, increased their power to be heard. This was, however, not the case in Indonesia, where partners had difficulties working together on advocacy. The joint partnership also increased access to other target groups and, subsequently, the reach of some partners. In Ethiopia, where the Proclamation to Provide for the Registration and Regulation of Charities and Societies of 2009 prevented joint advocacy and lobbying activities, partners tackled this issue by establishing networks and cooperating with government authorities across all levels to implement SRHR policy changes.

Three factors have contributed to relevant and effective in-country collaboration. First, a good mix of partners (mentioned by 13% of survey respondents) in the national alliances was important to encourage mutual learning. For example, in Tanzania, a research institute joined the country alliance, and other partners benefitted directly from capacity-building on M&E and indirectly from their operational research. Second, the establishment of mechanisms for formal interaction and joint planning also contributed to effective collaboration. Mechanisms used by country alliances include regular progress meetings (e.g. Malawi), signing of a Memorandum of Understanding (e.g. Tanzania), advisory committee meetings (e.g. Malawi) and learning visits (most countries). Partners felt that these ensured good working relationships and better understanding of SRHR issues.

Third, the NPC also played an important role in keeping the alliance active, although this was not the case in every country. The NPC is dependent on his/her relationship with the host organization. The host organization, therefore, plays an important but informal role that has a direct impact on the effectiveness of the programme. In Kenya, for example, the host organization played a very constructive role, whereas in Bangladesh the bureaucracy of the host organization limited the opportunities for the NPC. Hence, the governance structure of the national alliance and the role of the host organization have an impact on the effectiveness of the national partnership.

However, not all country alliances were as effective in their collaboration from the start or even at the end of the programme. Weak mechanisms for interaction (Pakistan) but also a wide geographical spread between partners (India, Indonesia and Tanzania) meant that formal collaboration was more difficult and costly. In Ethiopia it took a while for the partners to find their synergy and identify areas for complementarity, partly due to different capacities in components of the ToC, as well as different organizational priorities.

In some countries this lack of clarity seems to have contributed to governance and decision-making problems which affected the effective management of the country alliances. For example, in Tanzania, due to the large distances and the lack of formal mechanisms at the start, Tanzanian partners did not interact as often and were seen to prioritize their own organization's interests above those of the alliance. However, once more formal interaction mechanisms were in place, and a new NPC took office, collaboration improved considerably due to more frequent communication and joint planning. In India, on the other hand, while the partners valued the joint lobbying and advocacy, the mid-term evaluation did not consider the national alliance a collaborative group, and even the alliance members were dissatisfied with the impact they achieved through working together.

Asked in the online survey about the two main weaknesses of the overall partnership, Southern UFBR respondents mentioned the large geographical spread and lack of clarity about how to build the partnership (see Figure 5.2). Furthermore, the online survey also highlights that the partner selection had not been strategic but, rather, chosen based on existing relationships. This meant that the partnerships did not grow 'naturally', which in some countries was a barrier to effective collaboration.

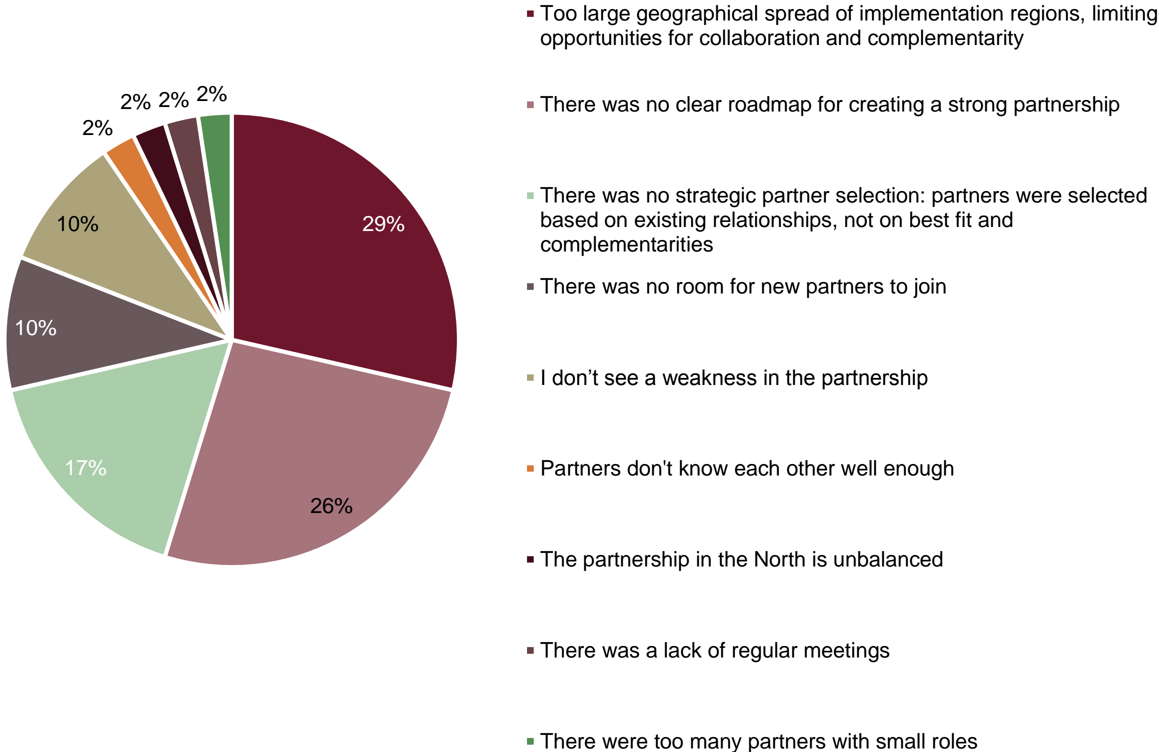

Figure 5.2: Main weaknesses of the partnership (UFBR, Southern partners).

5.1.2. International alliance

How do partners perceive the collaboration with the Northern alliance and its members? To what extent do partners feel they are part of an international/regional alliance or movement?

The Southern partners appreciated the collaboration with the Northern partners, particularly in terms of the technical assistance provided by the latter (see Figure 5.2). When asked about the international alliance in the online survey (see Table 5.1), respondents from Southern UFBR partners were most confident about the capacity of the international alliance to cater for the three components of the ToC and the fact that it is clear what the international partnership stands for. Most Southern partners also appreciated that national programmes were built on the basis of local needs (except in Tanzania, where respondents scored this criterion the lowest) and that Northern and Southern partners have a mutual understanding of the mission and objectives of the international alliance.

Table 5.1: Assessment of the functioning of the international partnership by Southern and Northern UFBR partners (on a scale of 0–10)

Questions	Northern partners		Southern partners	
	Mean	Variance	Mean	Variance
3.1. The Dutch/UK organizations, on the one hand, and the national alliances in the countries in the global South, on the other hand, have a mutual understanding of the mission and objectives of the international partnership	7.37	1.36	8.26	3.60
3.2. I know what the international partnership stands for	8.47	1.15	8.65	2.64
3.3. There is transparent communication between the Northern and Southern partners	6.26	2.09	8.03	4.10
3.4. The appropriate governance systems and procedures are in place for the international partnership to function properly	6.11	4.10	7.74	3.20
3.5. There are enough monitoring and evaluation moments in place to manage the international partnership properly	7.63	3.02	7.80	3.06
3.6. There is mutual trust between the partners of the international partnership	6.32	3.34	8.28	4.21
3.7. The programmes are built on the basis of local needs	6.26	4.09	8.53	2.32
3.8. The international members of the partnership combined have the necessary competencies and knowledge to cover the three components	8.05	1.72	8.69	1.71

However, concerns were expressed with regards to the governance systems and procedures in place for the international alliance to function properly. Some were of the opinion that the decision-making power on the use of resources was skewed to the Northern partners and that this meant that decisions made by the national governance bodies were often delayed, as approval had to be sought from the funders in the North. This top-down approach did not allow sufficient space for ownership of the country alliances; on the other hand, the set-up of the programme - with the general framework of the Millennium Development Goals (MDGs) being set by the donor, the Dutch Ministry of Foreign Affairs - may also have influenced this top-down approach to some extent.

Southern partners were also less confident that sufficient M&E moments were in place to monitor the international alliance appropriately. While there were a large number of outputs and outcomes - and subsequently M&E strategies - on the level of the implemented activities, there was little monitoring of

the partnership itself. The mid-term review indicated some areas of improvement, but this could not resolve all problems. In the interviews, Northern partners agreed that the current governance systems are not sufficiently strong yet.

Interestingly, there were some differences of opinion between the Northern and Southern partners. Overall, the Northern partners gave lower scores to the statements, indicating a more critical stance and possibly different scoring preferences compared to the Southern partners. In particular, Northern partners were more negative about the transparency of communication and mutual trust between the North and the South. There was also disagreement about whether the programme was built on local needs.

Overall, the Southern partners valued the exchanges and networking among countries, both at regional level and with Northern partners, although their focus remained on their own country and work.

5.2. Changed capacity of partners

Has the partnership led to changes in the capacity of NGOs and NGO staff, specifically in SRHR technical expertise, collaboration and advocacy?

Result area 3		Indicator
Outcome	Partner organizations have increased capacities, especially in SRHR	Percentage of all partner organizations that have progressed on SRHR capacities and three other prioritized areas (SoV: 5C assessment)
		Percentage of partner organizations with improved involvement of target groups in all aspects of the programme
Output	Increased/improved capacity of key persons in partner organizations on: SRHR, sexual diversity, SGBV, gender, meaningful youth participation, lobbying and advocacy, PME and research	Number of key staff members trained in the areas mentioned
		Number of partner organizations that have developed and implemented a capacity-building plan

Southern partners attached great importance to the capacity-building component of the UFBR programme. Particularly at the individual level, staff of non-governmental organizations (NGOs) were confident that they had obtained technical expertise and experience on SRHR issues, and that they were able to integrate this knowledge and transfer it to other people. Almost 50,000 key staff members were trained on SRHR issues, against a target of 1,000. No information was provided for the indicator 'Number of partner organizations that have developed and implemented a capacity-building plan'.

In terms of SRHR, the online survey showed that Southern partners' staff capacities were mostly strengthened in CSE (20% of respondents), the enabling environment (11%), meaningful participation of target groups (11%), meaningful youth participation (8%) and SGBV (8%). Conversely, staff felt least satisfied with their improved capacities in sexual diversity (16%), stigma and discrimination (13%), health service delivery (11%) and gender equality (8%) (see Figure 5.1).

Partners were encouraged to develop and implement gender policies. This was confirmed by the online survey, where Southern respondents awarded a mean score of 7.32 out of 10 for the statement 'Due to the programme, gender concerns are now part of my organization's policy and practice'. Different approaches were used to mainstream gender. Some partners appointed a gender point person (Kenya), whereas others organized value clarification sessions to counteract the conservative

views of staff on the role of men versus women. Furthermore, a gender component was included in the training of partner organizations and CSOs. However, results from the online survey show that staff members did not feel that their capacity on gender equality had been strengthened significantly (see Figure 5.1).

Sexual diversity is also a sensitive topic in most countries, but one that is crucial to address to improve the rights of marginalized groups such as lesbian, gay, bisexual, transgender, questioning and intersex (LGBTQI) people - one of the programme's objectives. It was, therefore, chosen as one of the topics for the learning agenda that was implemented in Kenya and Indonesia. Both countries were chosen for being (moderately) tolerant on sexual diversity; however, it is still not widely accepted. Because stigmatization appeared stronger in Kenya, more effort was spent on changing individual attitudes, whereas Indonesia focused more on organizational development and networking.

Staff members from Kenyan partner organizations reported that their attitudes on sexual diversity and gender equality had changed positively as a result of the training sessions. Also, in Indonesia an LGBT organization reported increased attention to sexual diversity in the national alliance as a result of an internship programme which allowed staff members from other organizations to better understand the needs of the LGBT community. Following the value clarification training organized by the Tanzanian alliance, where members of LGBTQI networks shared their experiences, staff members reported a better understanding of the challenges confronting LGBTQI groups. However, the results of the online survey demonstrate that staff members in most countries do not yet feel confident to address issues of sexual diversity. This is possibly because sexual diversity was not addressed in the same way across the SRHR Alliance (for example, in countries such as Uganda and Tanzania), even though it was a key aspect of the programme. There were no output or outcome measures for sexual diversity.[4] On the other hand, capacity may not be the only issue preventing the partner organizations from addressing this topic more fully. In the societies where UFBR was implemented this is still largely a taboo area, and it takes time to change attitudes. The alliance is doing a lot to address the topic and change mindsets among partner organizations. Some countries were clearly working more on this topic (Pakistan, Bangladesh) than others (Uganda, Senegal).

[4] Possible outcome measures could be changes in the attitudes of agents of change (e.g. partner organization staff, teachers, policymakers). Expecting change at the community level or among the target population is likely to be too ambitious after a five-year programme.

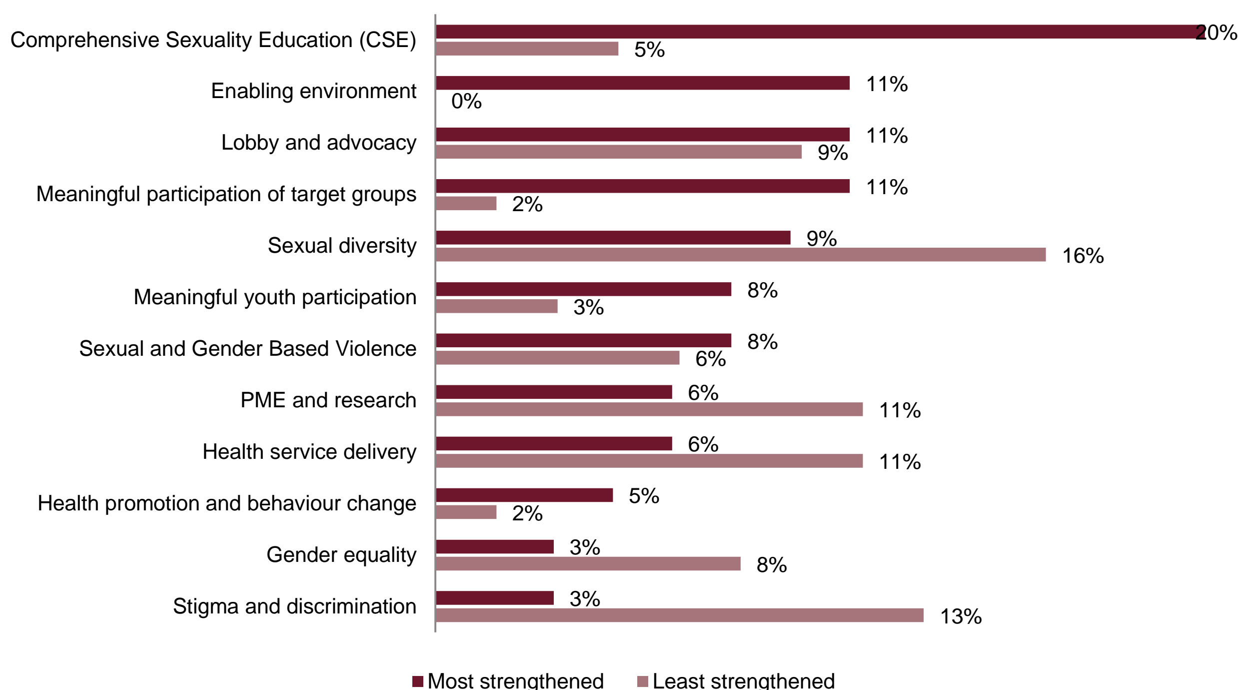

Figure 5.1: Capacities most and least strengthened (UFBR, Southern partners).

Staff capacity was also built specifically on lobbying and advocacy and project management, including M&E, research, project cycle management, resource mobilization and financial management. Interestingly, in terms of the actual capacities strengthened, opinions were divided. Lobbying and advocacy received relatively high scores for being most strengthened (11%) and least strengthened (9%). Equally, PME and research was regarded as one of the capacities that was both least strengthened (11%) and most strengthened (6%).

These differences of opinion on capacity-building can be explained by two factors. First, the different partners and their staff have different levels of capacity and, therefore, different needs. Capacity-strengthening activities were organized following the gaps identified by the Organizational Capacity Assessment and were, therefore, different for many partners and country alliances. Second, high turnover of staff throughout the programme period had a negative impact on the changes in capacity registered at the end of the programme. Roughly one third of the current UFBR staff members started working for the programme less than two years ago. This has an impact on the overall individual staff capacity built over the duration of the programme. Furthermore, some countries observed that knowledge acquired is not systematically institutionalized within organizations, so when staff members leave, the knowledge disappears as well.

It is, therefore, not surprising that respondents to the online survey gave an overall lower score for level of organizational capacity built (mean of 8.50 out of 10) than for level of individual capacity built (9.12 out of 10). Nevertheless, Southern partners were generally satisfied with the level of organizational capacity-building (see Table 5.2). In the survey, partners agreed most with the statement that the organization had improved its capacity to carry out actions and achieve results

aimed for. This statement is connected to the capacity to act and commit from the 5C framework.[5] Partners are also very positive that they can better build and maintain networks with external stakeholders (related to the capacity to relate to external stakeholders). Partners awarded slightly lower, but still very positive, scores to the internal structure to share knowledge and learn internally and the adaptability of the organizations in case of new challenges or external changes (both related to the capacity to adapt and self-renew). Similarly, partners felt that their organization was able to achieve its aim in a better way because of the partnership (related to the capacity to achieve coherence).

Southern partners awarded their lowest score (a mean of 8.3) to the statement *'Gender concerns are now part of my organization's policy and practice'*. Partners' opinions differed quite a lot on this statement, as can be seen from the high variance, showing that some partners probably adjusted their policies, while others did not. This could, however, also be because some organizations already had gender policies and practices in place. These positive findings are backed up by information from the project documents and interviews in the field study. Partner organizations felt that they themselves and their organization had learned and benefitted a lot from being an implementing partner of the programme.

Table 5.2: Assessment of organizational capacity-building by Southern UFBR partners.

Statements	Southern partners	
	Mean	Variance
7.6. My organization has improved its capacity (knowledge, experience, expertise) to carry out actions and achieve results aimed for	8.71	2.28
7.7. My organization has better structures in place to share knowledge and learn internally	8.58	1.65
7.8. My organization is better able to adapt its strategies in case there are new challenges or external changes (e.g. shift in government policies)	8.61	1.78
7.9. My organization can now better build and maintain networks with external stakeholders	8.71	1.55
7.10. Due to the programme, gender concerns are now part of my organization's policy and practice	8.00	5.17
1.11. My organization is able to achieve its aims in a better way because of the partnership	8.55	2.26

Various mechanisms were used to strengthen organizational capacity, ranging from tailored workshops, the organization of symposiums, an online SRHR course (in Pakistan), internal exchange visits, cross-country exchanges, quarterly National Partners' Technical Committee (NPTC) meetings and annual harmonization meetings. Partners were able to strengthen each other's capacity and jointly contract external trainers, which helped to reduce costs and increase efficiency.

5.3. Changed values and norms on SRHR

Has the partnership led to changes in values and norms around SRHR (including gender, sexual diversity and SGBV) and meaningful youth participation, and (how) has this been incorporated into programming and organizational policies?

[5] The 5C framework was developed by the European Centre for Development Policy Management (ECDPM) and chosen as a monitoring framework for the result area 'Capacity development of Southern partner organizations' in MFSII by the Ministry of Foreign Affairs.

The partnership has contributed to value clarification on gender, sexual diversity and meaningful youth participation, although not consistently in every country alliance.

Positive changes of attitudes on sexual diversity and misconceptions about sex were reported specifically in two countries. In India, staff members of partner organizations obtained a wide range of knowledge on SRHR and CSE issues, which helped to invalidate myths and misconceptions related to sex and sexuality. In Kenya and Indonesia, a thematic learning programme was developed to mainstream sexual diversity. The training programmes addressed specific gender norms, attitudes and perceptions of staff using a public health approach. As a result, staff members reported better attitudes to and perceptions of gender and sexual identity.

In three other countries, partners were more reluctant to address gender and sexual diversity, due to legal or cultural barriers. In Uganda almost no attention was paid to gender diversity (one of the goals for UFBR) because of legal and cultural restrictions. This meant that vulnerable groups such as LGBTQI were not very well served by the programme. Similarly, in Tanzania and Ethiopia partners were very reluctant to work on sexual diversity because it is culturally not accepted, or, as was explained by the NPC of Tanzania, it was not prioritized at the start of the programme. However, several programmes and training courses were organized to address this issue among staff, and their attitude is very slowly changing on this topic. As mentioned in the partnership report, this dilemma boils down to a philosophical discussion between the importance of local ownership (and having partner organizations decide on priorities) and a rights perspective (defending the rights of marginalized and even discriminated groups).

In other countries, partners conducted activities to address gender and sexual diversity issues such as the inclusion of modules on sexual orientation and gender identity (SOGI) in specific training (Indonesia), the development of a gender tool to support programming (Malawi), the organization of internships in an LGBTQI organization (Indonesia) and the adoption of gender policies (Bangladesh). However, little information is available as to how these activities changed the norms and values of staff members, except for in Kenya where changed behaviour was documented among staff.

With regards to meaningful youth participation, all country programmes have made efforts to integrate interventions on meaningful youth participation into their programmes, and some have developed specific polices on youth involvement. In most countries, however, this integration remained mostly at the level of young people's participation in design and implementation, rather than in decision-making. A few examples of meaningful engagement at organizational and decision-making level were found in Ethiopia, Kenya and Indonesia, where young people are part of the Board of Directors. In Indonesia, the alliance has a policy that young people should make up 20% of the management team. However, these few positive examples are not replicated sufficiently across the whole of the SRHR Alliance.

SGBV is also one of the topics where little change was found in terms of policies, norms and values of the partner organizations. In some countries gender equality attitudes even decreased (e.g. in Tanzania during the Outcome Measurement Report (OMR) of 2013 almost 25% of respondents said that 'girls and boys have the same rights', while in 2015 this figure reduced to 9%) or remained stable (e.g. in Uganda there was no change in attitudes to the statement 'Women deserve to be beaten by their husbands sometimes'). Qualitative data from Ethiopia suggest a high tolerance of SGBV among young men.

However, some partner organizations developed institutional policies on gender mainstreaming in their programmes and interventions, while others focused on addressing prevention of female genital

mutilation (FGM) and child marriage through community outreach and advocacy. Gender is included in CSE, partly as an entry point for discussing SGBV. Staff and volunteers also received training to encourage referrals, and attempts were made to engage with organizations working on gender-based violence and male engagement, to gather secondary evidence on the issue. We do not have any information on how the attitudes of staff of partner organizations changed in this field (6% of respondents said it was among the capacities strengthened least , while 8% said it was one of the capacities strengthened most).

5.4. Value of being part of the alliance

Are there gains/outputs of being part of the country alliances, in line with the required input of the individual partners?

The benefits of being part of the country alliances clearly outweighed the required input and challenges of working as an alliance in most countries. The programme documentation and online survey confirm that being part of the alliance was relevant to most Southern partners. First, the online survey confirmed that the mission and objectives of the partnership were aligned with their organizational objectives. Second, the country reports highlighted that working together with other partners led to an increase in the quality of their programming and improved leverage in terms of advocacy and greater visibility and professional credibility. Despite these gains, it was not always easy to reconcile their organizational interests and priorities with those of other partners. This required time and effort to build up mutual trust and a joint strategy.

In terms of the effectiveness of working in partnership, the benefits also outweighed the difficulties. By joining forces, partners were able to reduce duplication of services and deliver their activities more effectively. Working together also inspired more discipline, a greater focus on results and more accountability in terms of the resources. The capacity-building activities strengthened the staff's ability to implement programmes and also improved their confidence. However, quite a few partners also confirmed that working as an alliance is complex. Partners work on different programmes and, therefore, have different implementation timelines. Decision-making is also more difficult, since it requires good governance structures, clear rules and regulations and, again, a lot of time and effort. The partnerships worked more effectively when formal mechanisms were in place to facilitate interaction, joint planning and decision-making among partners.

When looking at the efficiency of the partnerships at country level, the benefits mentioned included cost savings due to jointly organizing capacity-building activities and more efficient resource allocation. However, in some countries working in partnership also added costs, particularly in those countries where partners are geographically disconnected. Furthermore, a lot of time and input was needed to fulfil the reporting requirements, adding to the already high burden on country staff. This was particularly the case for smaller organizations that were working in an alliance structure for the first time. In terms of resource mobilization, some countries felt that they had acquired greater bargaining power to mobilize resources jointly and now have concrete plans for submitting joint funding proposals. However, quite a few partners also mentioned in the online survey that competition among alliance members had increased.

To conclude, while partners clearly have to invest time and effort (and, in some instances, finances) to participate in the country alliance, the benefits of working together, learning from each other and jointly improving the quality of the SRHR sector in the country seem to compensate for these inputs, particularly in countries where the alliances functioned well.

6. DIMENSION 1: WHAT ARE THE RESULTS OF THE PROGRAMME, AND ARE THEY RELEVANT AND SUSTAINABLE?

This chapter reviews the results achieved by the UFBR programme, which consists of three core strategies for improving the SRHR of young people and women:
- improving access to and the quality of SRHR education (increasing SRHR demand);
- improving access to and the quality of SRH services (increasing SRHR supply) ; and
- improving the enabling environment (increasing SRHR support).

In addition, and to enable these strategies to be implemented effectively, the programme aims to strengthen the capacity of partner organizations and CSOs as well as to increase learning and networking (civil society strengthening).

Key messages
- The outputs of the programme are impressive and far exceed the targets set.
- While the evidence of the individual studies is not strong enough to draw causal conclusions, the combination of studies allows us to build a plausible case for the effectiveness of UFBR.
- The programme is acceptable to and appreciated by the target groups.
- Throughout the result areas, it becomes clear that less change can be found on more sensitive SRHR topics. While this was to be expected, target-setting for these topics may be beneficial.
- PME: do not try to measure everything everywhere, but focus on a few well-designed effectiveness studies and process evaluations.

6.1. General observations on results

Before delving into specific results, some findings from the online survey give an idea of how partners feel about the overall effectiveness of the programme. Items are scored on a scale of 0 ('absolutely disagree') to 10 ('absolutely agree'). As seen from Table 6.1, both Northern as Southern partners rated the overall effectiveness of the UFBR programme quite highly. In the online survey they awarded it a mean score of 7.8 (7.6 for the Northern and 7.9 for the Southern respondents). Interestingly, when asked about the comparative effectiveness of the programme, Southern partners were even more positive (8.2), whereas Northern partners awarded a slightly lower score (7.1). Nevertheless, both scores indicate that respondents agreed with the statement that UFBR was more effective than other programmes they worked on.

Table 6.1: Assessment of the effectiveness of the programme by Northern and Southern partners.

	North vs South	
	North Mean	South Mean
Overall score for effectiveness of UFBR	7.6	7.9
Overall comparative effectiveness of UFBR	7.1	8.2

Looking at effectiveness at the country level, we do not see any real deviations. Only Malawi awarded a relatively low score, but only one respondent answered this question.

Table 6.2: Assessment of the effectiveness of the programme by country.

	Country								
	Bangladesh Mean	Ethiopia Mean	India Mean	Indonesia Mean	Kenya Mean	Malawi Mean	Pakistan Mean	Tanzania Mean	Uganda Mean
Effectiveness of UFBR	7.5	8.5	8.5	7.3	8.5	6.0	8.0	7.5	8.3
Comparative effectiveness of UFBR	8.6	9.0	8.0	7.0	8.5		9.0	7.5	9.0

Respondents who worked on both the UFBR and ASK programmes were able to compare their (comparative) effectiveness. On both measures, UFBR scores slightly higher than ASK. The most likely reason is that UFBR ran for two years longer than ASK and had more time to build a strong alliance and generate results.

Table 6.3: Effectiveness of UFBR and ASK according to respondents involved in both programmes.

	Mean	N	Std. deviation	Std. error mean
Overall effectiveness of UFBR	7.8214	28	1.09048	0.20608
Overall effectiveness of ASK	7.5000	28	1.47824	0.27936
Overall comparative effectiveness of UFBR	7.6818	22	1.46015	0.31130
Overall comparative effectiveness of ASK	7.5455	22	1.89554	0.40413

Overall, the UFBR programme achieved a lot in a short period of time. Taken all countries together, the outputs achieved exceeded the targets set. They even surpassed some targets by a factor of 3.5 (disregarding the extremely high result for indicator 2.3.1c). Only one target was not entirely - though almost — reached (2.4.2c: the number of people trained in awareness-raising activities).

Table 6.4: Outputs achieved by the UFBR programme against targets.

	Indicators	Number of times targets were achieved
1.1.1	Partner organizations are actively involved in x number of networks	2.3
1.1.2	No. of CSO (staff) members trained to increase their knowledge and skills on SRHR, based on identified needs	4.9
2.1.1a	No. of SRHR education programmes improved on quality standards of SRHR education	8.7
2.1.2a	No. of educators trained to deliver SRHR education	2.6
2.1.3a	No. of young people, women and men who participated in SRHR education	3.2
2.2.1a	No. of service providers trained to deliver SRH services	3.0
2.3.1a	No. of health facilities renovated	3.3
2.3.1b	No. of SRH services provided by partner organizations to young people and adults	3.1
2.3.1c	No. of SRH services provided by subcontractors/government facilitated by partner organizations	76.1
2.4.1a	No. of partner organizations with an implemented advocacy strategy and advocacy work plan on SRHR	1.7
2.4.1b	No. of advocacy meetings conducted at local, regional or national level	1.7
2.4.2a	No. of community members and community leaders participating in SRHR awareness-raising activities at community level	2.7
2.4.2b	No. of people reached by SRHR awareness-raising activities through (new) media	4.7
2.4.2c	No. of people trained in awareness-raising activities	0.9
3.1.1a	No. of key staff members trained in the areas mentioned	3.4
3.1.1b	Partner organizations have developed and implemented a capacity-building plan	1.3

	Indicators	Number of times targets were achieved
4.1.1a	No. of contact moments of alliance members with policymakers at (Dutch) national level	2.1
4.1.1b	No. of international meetings with political relevance on SRHR attended by alliance members or partner organizations	

While these output results are impressive, it does raise some questions about whether the targets set were realistic and interpreted in the same way by all partners. Furthermore, we do not have clear insight into how these data have been collected and their sources. Therefore, we cannot guarantee accuracy. Nevertheless, given the consistency of the positive results for outputs throughout all indicators and countries, it is plausible that UFBR did indeed achieve the outputs.

With regards to the outcomes, although the PME approach was very comprehensive, we also noticed some methodological flaws in the outcome measurement of the programme. For that reason, Box 6.1 provides a more in-depth assessment of the PME approach. The results in this chapter should be interpreted with this in mind.

Box 6.1: Preface on the UFBR programme M&E strategy

The end-of-programme evaluation focused on answering the research question 'What works for who, and how?' This question also entails a reflection on the programme's M&E strategy: what is measured by the programmes (and what not), and how is it measured? Here we briefly highlight the strengths of the PME strategy and formulate a number of recommendations.

Compared to similar programmes, the UFBR programme's PME strategy has been thorough, elaborate and well conceived. Many aspects could be taken over directly by future programmes. Its comprehensiveness differentiates it from many other PME frameworks, which often focus solely on quantitative outputs and outcomes using experimental study designs. The UFBR PME strategy has a number of clear **strengths**:

- Design: The programme used a plausibility design, combining different data sources to build a plausible case for the effectiveness of the programme. This is different from a probability design, which aims to draw conclusions on the direct causal relationship between a programme and an outcome (often done through randomized controlled trials). Given the complexity of the topic (SRHR) and the many other factors influencing SRH, this is an appropriate evaluation design.
- Data: The evaluation combines different data collection methods, including quasi-experimental designs, in-depth interviews and FGDs, and the methods are adapted to the evaluation questions, using several original methods (such as mystery client and MSC). It uses existing data sources and monitoring systems, such as clinical data from health services or the Demographic and Health Survey. Furthermore, the results are triangulated.
- Expertise: Local consultants are used for contextualized interpretation of the data obtained. The PME officers at the alliance office have a high level of expertise.
- Learning approach: The different evaluation studies have been valuable throughout the course of the programme as a basis for joint reflection and sharing, stimulating mutual accountability and transparency, and for capacity-building.

Nevertheless, we also identified room for improvement. Several **recommendations** can be made to strengthen the PME in future programmes:

- In general, a good evaluation framework for a complex programme such as UFBR that includes a number of activities and multiple stakeholders includes three types of evaluation (programme, process, output/outcome evaluation), uses different data sources (depending on the evaluation question) and triangulates the findings to answer the evaluation questions.
- While the output and outcomes are monitored in the UFBR PME strategy, there is no real programme or process evaluation.
    - A programme evaluation assesses the quality of the (country) programme against the overall programme (or international standards), and could have provided evidence on whether, for instance, gender equality and sexual diversity are sufficiently addressed in the programme documents, and why (not).
    - A process evaluation studies whether the intervention was implemented as planned, and what contributed to or hindered this. For example, several of the MSC stories collected during the field studies contained references to abstinence-

only messages. This was not the objective of the CSE included in UFBR, and is even proven to be ineffective by a number of studies. Capacity-building among teachers and service providers could be assessed to identify what they have learned and implemented and what the main challenges are.

- There is a clear focus on outputs and outcomes linked to public health. While these are crucial, it remains important not to overlook other aspects of SRHR — for example, sexual well-being, equitable relationships and self-esteem. Furthermore, it is important to formulate specific indicators for all aspects, target groups and objectives of the programme, including sexual diversity and marginalized groups.
- Results from different data sources (e.g. outcome measurements, FGDs) are often jointly presented; often they are contradictory. This is not problematic as such, but often no real reflection is made on this discrepancy, nor is a definitive conclusion possible.
- There are important differences between countries in the quality of the outcome measurements — ranging from good (Bangladesh, Kenya) to relatively poor (Senegal, Indonesia). In a number of countries the outcome measurement has been a missed opportunity. While much time and resources were invested in recruiting health centres and respondents to participate in the baseline and endline measurements, there are major problems in the selection of health centres/respondents, comparability between baseline and endline groups, lack of a control group, and the analysis (limited use of multivariate analysis and/or disaggregation). Furthermore, no sample size or power calculations have been done; subsequently, it is possible that changes took place but could not be observed with the available sample. *Post hoc* power calculations demonstrate that several (sub-)samples have small power (<50%). This means that, even if a change occurred, this could not be measured in the sample. These issues are related to doing research in a real-life setting, and M&E of many programmes is confronted with similar problems. Nevertheless, there are a number of other tools that can be used to make the quantitative outcome measurement data more reliable, such as using multivariate analysis or propensity scores to control for baseline differences, or working with an internal control group (only doing an endline survey in a random sample of the population and differentiating the respondents based on their level of exposure to the programme).
- It was the strategy of UFBR to work with local partners for the M&E of the programme. This had two purposes: building their research capacity, and using their contextual knowledge to organize the studies and interpret the results. They were supported by PME advisors but may not all have had the same sound methodological background (demonstrated by large differences in the quality of the OMRs).

In presenting the results on the different outcomes, we make a distinction in the strength of evidence. Unreliable data are left out of the tables, partly reliable data are put in italics, and reliable data are presented in normal font.

Before deciding on the PME strategy for future programmes, it is important to make a thorough analysis of the objectives of the evaluation and to weigh the costs against benefits. We recommend: 1) focusing on monitoring the quality of activities (process evaluation) in all sites; and 2) choosing a limited number of sites to do a comprehensive effectiveness study in a qualitative manner. Including research institutions in the alliance may help to maintain this strategy.

6.2. Expected results

Did the programme achieve the expected results? In terms of outputs and outcomes? What were enabling and constraining factors? Add 1: In the areas of: CSS/CSE&SRHR information/SRH services/SRHR enabling environment

6.2.1. Civil society strengthening

Result area 1		Indicator
Outcome	The SRHR sector is better able to individually and jointly implement interventions, learn and carry out lobbying/advocacy activities and achieve sustainable results	Increased strength of the SRHR sector in the Civil Society Index (CSI) dimensions
Output	Increased collaboration between SRHR partners	Partner organizations are actively involved in x number of networks
Output	Increased capacity of CSO staff on SRHR	Number of CSO (staff) members trained to increase their knowledge and skills on SRHR, based on identified needs

Dimension 3 already discussed the increased collaboration between SRHR partners, so here the focus will be on networking and capacity-building of CSOs. The targets for strengthening the capacity of CSO staff members on SRHR were achieved in most countries. Partners and the organizations they work with reported a greater awareness of and capacity on SRHR and increased confidence among staff to work on specific SRHR issues. In some countries (e.g. Kenya) the training was used to address gender norms and attitudes of staff members. Nevertheless, while numerous training sessions were organized, and people participated, it is still unclear to what extent they contributed to better programming or even changing the ways in which CSOs operate. This is further compounded by the fact that most countries complained about high rates of staff turnover - in particular, about people who had received training leaving the organization.

Overall, the available information demonstrates positive results on CSS. There are examples of greater collaboration, learning and joint programming, as well as improved knowledge of and capacities on SRHR. At the end of the programme, partner organizations were actively involved in 458 networks, against a target of 200. Networks are of a various nature: local, provincial, national and regional; formal and informal; and with community-based organizations, NGOs and government. Over 49,000 CSO staff members were trained on SRHR, based on identified needs, exceeding the target of 10,000. For both output indicators, the results far exceeded the set targets.

According to the annual reports, most training was on SRHR, advocacy, CSE, gender and sexual diversity. Examples of more country-specific training topics include facilitation techniques, communication about SRHR, men care, violence against LGBT, and maternal health. A considerable part of training focuses on capacities related to project implementation and organizational development such as PME, communication, youth participation, team-building, networking, policy analysis, proposal writing, leadership and accountability. Often CSO staff in conservative countries enter training courses with strict, conservative norms on sexuality, which requires a sensitive approach. Tanzanian partners shared the experience that more general workshops and training, such as on proposal writing, are a good entry point to discuss the more sensitive issues in a less threatening way.

The outcomes have not yet been reported for 2015, so we will report on the results of the mid-term review (2013). A mix of data sources has been used to analyse the current situation on CSS. These are: the Organizational Capacity Assessment (light) executed with all partners; CIVICUS (if available) or other civil society reports in a country; information from interviews with important stakeholders (often including the Royal Netherlands Embassy); data from annual reports; and/or information from the mid-term review.

CSS was measured in all countries by assessing whether the country alliances were increasingly able to influence the SRHR civil society in their own country. Table 6.5 shows that all countries have progressed on between one and four of the CIVICUS dimensions. Six of the nine countries implementing UFBR have progressed in three or more CIVICUS dimensions. The results were reported on the basis of the CIVICUS framework, assessing the five CIVICUS result areas: civic engagement; level of organization; practice of values; perception of impact; and environment. The areas that changed most were level of organization and civil engagement. No country progressed on the area of environment. As no information from the 2015 assessment was available, no conclusive statement can be made about the increased capacity of the SRHR sector.

Table 6.5: Country alliances with an increased influence on civil society in SRHR.

Progress on the CIVICUS dimensions					
	Progress on 1 out of 5 dimensions	Progress on 2 out of 5	Progress on 3 out of 5	Progress on 4 out of 5	Progress on 5 out of 5
Country alliance is increasingly influencing SRHR civil society in the CIVICUS dimensions	**1 country:** Indonesia	**2 countries:** Ethiopia Malawi	**4 countries:** Tanzania Uganda Pakistan Kenya	**2 countries:** India Bangladesh	**0 countries**

6.2.2. Comprehensive sexuality education and SRHR information

Result area 2.1		Indicator
Outcome	Increased capacity of young people, women and men to make safe and informed decisions on SRHR issues	Percentage of the exposed target groups has an increased capacity to make safe and informed decisions
		Changes in knowledge
		Changes in attitudes
		Changes in confidence
Output	Improved quality of content, methods and materials of sexuality education methods and materials	Number of SRHR education programmes improved on quality standards of SRHR education
Output	Improved capacity of educators to deliver SRHR education	Number of educators trained to deliver SRHR education
Output	Access of target groups to SRHR education	Number of young people, women and men who participated in SRHR education

For the outputs, the programmes were on track to achieve the targets for the three output indicators in most countries. A total of 136 SRH education programmes were improved on quality standards of SRHR education, against an overall target of 20. Different approaches were used across the countries. Malawi and Pakistan, for instance, used the life-skills-based education (LSBE) methodology, whereas Kenya and Uganda piloted the whole-school approach. In other countries CSE was taught outside the curriculum. Factors that enabled countries to make progress against this indicator included a close collaboration with and involvement of the local and national governments; including the Ministry of Education (e.g. Ethiopia, India and Kenya); concerted advocacy for integrating CSE into the national curriculum (e.g. Uganda); enhancing the understanding of CSE among the communities and school management (e.g. Malawi); and linking schools to health facilities (e.g. Tanzania). In other countries, however, working on CSE was difficult, given the political and conservative environments (Bangladesh, Kenya and Pakistan).[6] In Indonesia the failure to link CSE to national policies also made it more difficult to make progress at local level. An interesting strategy in this perspective was applied by the alliance in Bangladesh. In this very conservative society, young people generally lack the space and opportunity to discuss or question any issues relating to their sexuality, reproductive health or gender. UFBR in Bangladesh, therefore, opted to start with less sensitive SRHR education. This basic curriculum was well accepted by educators and parents and opened the door for discussing more comprehensive aspects.

[6] Nevertheless, the results from Pakistan are positive despite the difficult conditions.

It is important to point out that, while several countries report having CSE, the content of the programme does not align with a real CSE programme. Most importantly, several sensitive issues, such as abortion, contraception and condom use are not being addressed. For example, Pakistan and Bangladesh have a large LSBE curriculum in which partners carefully address issues of choice etc. but need to avoid the term ‘sexuality’. The aim of the UFBR programme was to make it more comprehensive. In Indonesia, FGDs conducted with teachers during our field work indicated that - because of time limitations - it was not possible to teach the entire curriculum. The topics that were excluded were the more sensitive and progressive topics. Furthermore, several MSC stories, in particular from Uganda, demonstrate that the CSE activities still had a strong focus on abstinence, hence were largely denying adolescent sexuality.

Building the capacity of teachers and peer educators was also seen as a key strategy to increase the confidence of teachers to work on SRHR. By the end of the programme, 38,862 educators had been trained to deliver SRHR education, exceeding by far the overall target of 15,000. This intervention fostered a greater openness between teachers and students. Peer educators also played an important role in more informal settings and were the first person many young people turned to when seeking information on SRHR. This strategy is discussed in more detail in Dimension 2 (Chapter 4).

Nevertheless, quite a few constraints were mentioned. Teachers were often overburdened or lacked time to participate in the SRHR trainings. Furthermore, the programme has seen a high turnover of teachers and, in particular, a high drop-out rate among peer educators (Bangladesh, Indonesia, Kenya, Tanzania, Uganda and Ethiopia). Often, no budget for re-training was available, which meant that the new teachers did not have the opportunity to build up the same knowledge or skills to work on SRHR as the former teachers engaged in the programmes. In other countries, the teachers and peer educators who received training faced negative attitudes and prejudice from their direct environments, including their colleagues or peers, for talking about SRHR (Bangladesh and Indonesia).

When looking at the numbers of people who participated in SRHR education activities (over 4 million, against the overall target of 1.25 million), it is obvious that access to SRHR education has increased for the target groups.

The stakeholders involved varied from country to country. In Bangladesh, for example, *madrassas* (religious schools) were included in the peer educator trainings and showed a surprisingly high level of acceptance of CSE. During one youth fair, *madrasa* students shared their experiences openly and thanked the UFBR programme for its interventions. In other countries, particular work was done with parents (Malawi, Uganda and Bangladesh); however, in others a limited involvement of parents was mentioned as a key barrier (Indonesia and Kenya), which can be confirmed by scientific literature.

According to the results chain and ToC, this combination of activities is supposed to increase the capacity of target groups to make safe and informed decisions on SRHR. The progress against this outcome indicator was measured through the OMRs. For this indicator, seven OMRs conducted a baseline–endline analysis test,[7] allowing for a comparison between the results prior to and after the intervention. There were, however, problems with the sample procedures used between the baseline and the endline in several countries. The samples included respondents with different age and gender

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[7] In Ethiopia, while a quantitative analysis was conducted, it was not compared to the baseline. No quantitative data were available for Bangladesh.

compared to the baseline. In some countries the OMR controlled for these differences by performing a multivariate logistic regression or disaggregating data (e.g. Kenya, Tanzania); however, in other countries this evidence remains scientifically weak because no measures were taken to control for differences between groups.

To calculate young people's capacity to make safe and informed decisions, the different scales for SRHR knowledge, rights-based sexuality attitude and SRHR confidence were combined into a capacity index. The results from the OMRs reported a significantly increased capacity of young people and women to make safe and informed decisions on SRHR in at least seven of the eight UFBR programme countries that reported on this (see Table 6.6).

Overall, the capacity to make informed and safe decisions on SRHR improved in all countries for which OMRs were available. Kenya, however, has a more negative score overall because young people reported little significant difference, whereas women showed a significant, though small, decrease in capacity. Malawi was the only country that also measured the changes in capacity of LGBTQI to make informed decisions; however, no significant changes were reported based on the knowledge and skills of LGBTQI assessed in the impact areas.

Box 6.2: MSC story Kenya

I am 17 years old. I have four siblings, and I'm the last born and the only girl in my family. I have a single mother who works as a farmer on a contract basis on people's farms. She is always busy and only checks on us when we are sick or she needs to talk to us.

I came to learn about this programme [UFBR] two years ago when I was 15 years old. The GLUK people and the Youth-Friendly Nurse came to my school for a health talk and to inform us on the services they provide.

A day before their visit, I started experiencing my period. I was afraid to tell my mother. I, therefore, used pieces of clothes and a tissue paper which I stole from my school. It was after their visit that I learned about the effects of using tissue papers and rags which could have caused me infections. Out of curiosity I went to the youth centre where I was registered as a member. I received quality services such as free sanitary towels, free counselling and even different kinds of SRHR services.

We have also undergone computer training in our centre, making me computer literate. In turn, I am able to teach other young people on how to use a computer. The web-based training has also helped us a great deal. We have also turned our centre into an income-generating activity by typing, printing, scanning and offering internet services to the public.

The World Starts with Me programme has also helped me in matters concerning sexual and reproductive health and rights issues. We have learned about various issues pertaining to early pregnancy, school drop-out, drugs and substance abuse, STIs, HIV/AIDS, advocacy and even leadership and governance. These training courses have been so important.

The most significant change the programme has brought us is the comprehensive sexual education that we have undergone. I am able to think and reason without being dictated to. I am also able to overcome challenges affecting me and also in a position to help my friends with different challenges. The exchange visits conducted between us and other young people in different regions have also helped us, since we are able to share and interact with other young people.

Before, I used to be shy, and unable to talk in front of people, but now I am able to create a rapport with people, especially my fellow young people. I am able to advocate for our rights and follow better protocols to get help.

The programme also contributed to increasing young people's knowledge of SRHR in six countries. Knowledge levels increased in particular for better awareness of modern contraception, HIV, sexually transmitted infections (STIs), hepatitis and a girl's menstrual cycle. In Kenya no significant increase was reported in young people's overall knowledge of HIV, while there was a significant increase on knowledge of STIs, but women scored significantly worse on HIV. There were, however, limitations in comparing data, as the sample for the endline was much smaller than for the baseline. In Uganda,

after controlling for differences in the sample, young people were no more likely to have really good knowledge or even sufficient knowledge of SRHR compared to the baseline.

Rights-based attitudes, in particular on education for girls and reducing early marriages, early pregnancies and school drop-outs, improved significantly in all countries except Malawi. In Malawi the OMR highlighted a more overall negative attitude, and specifically on girls having sex before marriage and the acceptability of refusing sex. While the overall attitudes improved in Tanzania, fewer respondents found it acceptable for young people to have sex before marriage and for girls and boys to have the same rights. We do note that the operationalization of rights-based attitudes is not fully comprehensive, focusing on acceptance of adolescent sexuality, gender equality, HIV stigma, sexual violence and refusing unwanted sex and hardly including topics such as sexual diversity (exceptions are one item in the surveys from Uganda and Bangladesh), abortion, pleasure or sex work.

With regards to confidence, respondents in six out of seven countries reported better skills and confidence to talk about SRHR. In Pakistan students felt confident about speaking in front of their classes and approaching their teachers in case of any problem. In Uganda the decrease in confidence was attributed to the environment in the districts where UFBR was being implemented which are not supportive of behaviour change. It is in line with international evidence that skills tend to take more time to change.

Table 6.6: Progress against SRHR education indicators, overview of the countries[8].

Outcome indicators	Positive change	No improvement	Negative change
Target groups has an increased capacity to make safe and informed decisions	Malawi, *Pakistan*, Tanzania, Uganda, Bangladesh	Kenya	
Target group has increased SRHR knowledge	Malawi, *Pakistan*, Tanzania, Bangladesh	Kenya , Uganda	
Target group has improved attitude on SRHR	*Pakistan*, Tanzania, Uganda, Bangladesh	Kenya	Malawi
Target group has increased confidence and skills related to SRHR	*Pakistan*, Tanzania, Bangladesh	Malawi, Kenya	Uganda

Note: Data from Indonesia and Ethiopia were considered unreliable because of large differences between baseline and endline that were not controlled for. The OMRs from Bangladesh was not available.

Six countries provided relatively reliable scores on all three outcome indicators (Tanzania, Bangladesh, Kenya, Malawi, Uganda and Pakistan). Malawi and Uganda reported a positive change in terms of capacity but no improvement or a significant negative change on two of the other indicators. Kenya, on the other hand, had no overall improvement in attitudes towards SRHR when data for young people and women were aggregated. While these results need to bear in mind the issues of

[8] As mentioned in the preface to this section, the OMRs were confronted with a number of methodological challenges, in particular related to the selection of respondents (differences between endline and baseline respondents) and the lack of controlling for the sampling design and these differences in the analysis. Therefore, we have put the OMRs into three categories: 1) unreliable: large differences between baseline and endline that are not controlled for, or only endline data available; 2) medium: small differences between baseline and endline that are not controlled for, backed up with qualitative data; 3) OK: differences between baseline and endline data that are controlled for, backed up with qualitative data.
In the table the first category is omitted, the second is presented in italics, and the third in regular font.

comparability between baseline and endline, they also show that changing the capacity of the target groups is dependent on many factors and not just the increased availability of (quality) CSE.

Box 6.3. Impact of UFBR according to young people

As part of this end evaluation, 23 stories of change were collected from young people in the target group in Kenya and East Uganda.* In Kenya programme beneficiaries were interviewed via youth clubs and at the youth-friendly health centres where the programme was implemented. In East Uganda, young people were interviewed through a health facility, a primary and secondary school where the programme was implemented. In both countries, stories were collected in the districts where ASK was also implemented alongside UFBR, so it is possibly that ASK elements can be found in UFBR stories of change.

Many of these stories reveal the powerful impact the UFBR programme had on young people's lives. What changes do young people mention when they are asked for the most significant change in their life due to the programme? UFBR had a strong focus on delivering CSE activities, and this is reflected in the stories: 21 respondents referred to increased knowledge as an important result. Many of them mentioned several topics they acquired knowledge on, such as STIs, HIV and contraception. In line with the character of the UFBR, education is mentioned more than in the ASK stories. To a lesser extent, young people felt they changed their behaviour (12x). They mentioned behavioural changes such as using contraceptives, focusing more on school, quitting addictions and 'bad' friendships etc. Empowerment was also mentioned (10x), but not as frequently as in ASK. That might be because UFBR focused on youth in general, whereas ASK targeted marginalized groups that were in more need of support and empowerment. Changes in attitudes were also mentioned (7x).

We also assessed what kinds of topics were central to the stories. Young people talked most about HIV (11). This is probably influenced by the selection of respondents and the fact that HIV is an urgent health problem in Kenya and Uganda. Contraception and family planning were also important to young people (7x). Interestingly, income generation is also referred to seven times. Although not a core element of UFBR, some partner organizations also provided income-generating activities that were important to the young people, both in Uganda as in Kenya. Additionally, five stories dealt with menstrual issues. Especially for girls, learning how to deal with menstruation and how to make pads was very important to reduce absenteeism from school. Although the attitudes of service providers were not mentioned a lot, there were still some quotes that showed that youth-friendly attitudes of service providers are key to improving the accessibility of services.

** In East Uganda and Kenya stories of change were collected from young people who were reached by the ASK programme. These stories are analysed in the ASK synthesis report.*

Topic	Quote
Obtaining knowledge (21 x)	*"The World Starts with Me has also helped me in matters concerning sexual and reproductive health and rights issues. We have learned about various issues pertaining to early pregnancy, school drop-outs, drugs and substance abuse, STIs, HIV/AIDS, advocacy and even leadership and governance. These training courses have been so important […] I am able to think and reason without being dictated to." (17-year-old female, Kenya)*
Behavioural change (12x)	*"I dropped out of school as a result of peer pressure and because I felt I was a man enough to marry. I got married, but the lady ran away, saying that I was too poor to maintain her. I started abusing drugs, where I took both the oral and the injectable ones. Moreover, I engaged in sexual activities with anybody who gave in to my request without using any protection. […] When I reached the youth centre, and listened to the comprehensive sexual education they were being taken through, I realized that I had really wasted my time and also deteriorated my health. That day, the topic was about drug and substance abuse and general health. […] The most significant change in my life is how I stopped abusing drugs. At the moment, I work so hard that I can't get time to do other illicit behaviours. In the coming future, I am dreaming about having my own firm." (20-year-old male Kenya)*
Empowerment (10x)	*"I was someone who went through abuse when I was very young — at the age of 14 years. I am a total orphan, and my uncle used to take me to his friends for sexual favours in return for money. I ran away from our home and stayed with one of the community health volunteers who I had known since my school days. She protected me and made sure I got myself something constructive to do as a peer educator through trainings. I feel that a lot of young girls have been through what I have and given up. They need to have hope, and they need to be empowered. If you are a young lady and you are alive, you should know that you can fulfil your dreams." (19-year-old female, Kenya)*

Topic	Quote
	"I have also come to know my HIV status. I was part of this group [of friends], and they were telling me that even if you have a test they will not give you the right results. I shared this with the counsellor, who encouraged me that what they were saying was not true. She advised me to tell them what is right and that I should come for the services. I have gained experience on how to associate with others in the community more than most of my age, and I am confident that I can pass on health information without fear." (16-year-old boy, Uganda)
Attitudinal change (7x)	*"Before, when a boy saw a stained dress with menstrual blood, he could laugh at that particular girl, and isolate her, but now when he sees it, he will even tell you the dress is stained and even help to take you to the teacher. Therefore, at school we are brothers and sisters." (14-year-old female, Uganda)*
HIV testing (11x)	*"I have also been tested for HIV. My results were negative, and I felt very good. I also learned that if my friend is infected, I should not avoid him or her because she would feel isolated, and when the time comes for going to take the drugs, I ought to remind him or her." (15-year-old male, Uganda)*
Income generation (7x)	*"At the moment, we have a group in which we participate in a lot of activities that help generate income. We are now keeping poultry and planting trees, fruits and even vegetables. This has really generated a lot of income, and at the same time the programme taught us about leadership skills, and advocacy, which has ensured that our rights are well taken care of." (23-year-old female with disability, Kenya)*
Contraceptives/family planning (7x)	*"The counsellor advised us to be faithful to each other, and also to use condoms during sexual intercourse because this will help us to avoid unwanted pregnancies and transmission of STIs. This greatly created a big impact in our marriage because now me and my husband have decided to have child spacing, and we shall have our second child after two years. I don't regret having used these services, and I send my appreciation to our service providers." (19-year-old female, Uganda)*
Menstruation (x5)	*"The first day I menstruated I will never forget in my life because I had never experienced such a pain […] I thought that dying was the only solution I had. […]. I was very happy to learn about my menstrual cycle and how to manage it. As a teenage girl, it was important to me because before getting the information, the process seemed to me to look like a punishment from God, and I was afraid of it, but after getting the information I felt fine with it, and now I use the same information to teach my fellow teenagers." (17-year-old female, Uganda)*
Attitude service providers (2x)	*"The nurse sat with me and asked me to share my story with her. It was the friendly atmosphere that she created for me which enabled me to open up. Before, the health attendants were always rude, and that is why most of us never felt comfortable sharing our stories with them." (19-year-old female, Kenya)*

Qualitative data from the OMRs indicate that changes in knowledge and attitudes mainly occured on issues related to HIV and body knowledge (wet dreams, menstrual hygiene).

6.2.3. SRH services

On the supply side, the UFBR programme has been working on improving the quality of SRH services and contributing to an increased use of SRH services by young people and women.

Result area 2.2		Indicators
Outcomes	Improved quality of SRH services	Percentage of targeted SRHR facilities increasingly complying with IPPF standards for youth-friendly services
		Percentage of SRHR facilities with an increase in satisfaction among young people
		Percentage of targeted facilities increasing their compliance with the (national) quality standard
		Percentage of maternal health facilities with an increase in satisfaction among women
Output	Improved capacity of service providers to deliver SRH services	Number of service providers trained to deliver SRH services

To improve the quality of SRH services, the UFBR programme worked mainly with service providers to improve their capacity to deliver SRH services. This was done by training public and private health care providers, community volunteers and other groups. At the end of the programme, a total of 66,791 service providers had been trained to deliver SRHR services, against an overall target of 22,000. All countries that reported on this output achieved their targets, except for Ethiopia.

According to the country reports, the training of these service providers contributed directly to a reduction of misconceptions on sexuality and gender (Bangladesh), changed health care providers' attitudes towards young people (Pakistan and Tanzania) and improved capacity for SGBV screenings (Bangladesh). Indirectly the capacity of health care providers was also strengthened through improved referral mechanisms (Kenya) and the provision of more comprehensive public health services (India).

A high number of drop-outs or transfers among the trained service providers (Tanzania and Kenya), however, affected this output result. The knowledge and capacities acquired were not institutionalized by service providers, so the outflow of trained staff led to an important knowledge drain. Furthermore, questions were raised about whether training health staff is sufficient to ensure a sustainable provision of youth-friendly services (YFS) (Uganda). Finally, a key constraint in some of the UFBR programme countries is the poor quality of public health services, particularly in rural areas. Due to a lack of human resources, laboratory tests and stock-outs of medicines, the public health services available are often limited, and the provision of training does not address this challenge; on the contrary, it can only add to the workload of already overstretched health care workers.

To assess whether this training led to an increased quality of health services, information on the outcome indicators was available for eight of the nine programme countries, although not all countries worked on it, thus did not report on all the outcome indicators (see Table 6.7). Again, problems with the samples meant that often the data were not comparable between the baseline and endline, so conclusions need to be drawn cautiously.

Four countries (Kenya, Pakistan, Tanzania and Uganda) contributed to a significant increase in the number of health facilities that comply with IPPF standards for YFS. For this indicator the parameters included training of the service providers, privacy, opening hours, accessibility, referral, and community and parental support. In Malawi, on the other hand, only 20% of facilities (one of five) increased their score between 2011 and 2015, and no improvements were made between 2013 and 2015. Conversely, in Bangladesh three of the four facilities reported a lower score than at baseline. The overall scores were influenced by low mean scores on availability of trained service providers, privacy of service delivery, special entrance and waiting area for young people, and convenience of opening hours.

Table 6.7: Progress against indicators of increased quality of SRH services.

Outcome indicators	Positive change	No improvement	Negative change
Percentage of targeted SRHR facilities increasingly complying with IPPF standards for youth-friendly services	Kenya, Pakistan, Tanzania, Uganda	Malawi, Indonesia	Bangladesh
Percentage of SRHR facilities with an increase in satisfaction among young people*	*Indonesia, Malawi, Tanzania, Uganda*		*Kenya, Bangladesh*
Percentage of targeted facilities increasing their compliance with the (national) quality standard	Bangladesh, Kenya, Malawi, Tanzania		
Percentage of maternal health facilities with an increase in satisfaction among women*	*Kenya, Malawi, Tanzania*		*Bangladesh*

* *The data in this section are considered 'weaker', as no or very little information was given on the characteristics of the respondents at the baseline and endline. Ethiopia, India, Uganda and Pakistan were not included in between two and four of the indicators, as these indicators were either not relevant for the setting or there were no reliable baseline data available. There was no OMR for Bangladesh.*

These same reasons were mentioned by Kenyan respondents when asked about their satisfaction with YFS (outcome indicator 2.2b). Interestingly, while in Kenya the quality of YFS improved, this did not automatically lead to increased client satisfaction. Conversely, in Malawi, only 20% of facilities complied with the IPPF standards, yet all YFS registered an increase in the satisfaction of their clients. Young people seem to attach high value to two key factors when accessing YFS: the privacy and confidentiality of health care providers and the opening hours. For example, in Uganda young people appreciated the extended opening hours of YFS at the weekends, whereas in Indonesia the limited opening hours (until 2.30 pm) of the government facilities were mentioned as a real barrier. Indonesia was the only country which also measured the satisfaction of YFS by LGBTQI people. According to the OMR, most informants were accessing the clinics for voluntary counselling and testing, STI treatment or consultation services, and most of the informants were satisfied with the services, including privacy and friendliness for the health facility staff. An additional comment can be made about the definition of 'quality of services', which is mainly limited to aspects of provider–patient interaction, rather than the quality of the clinical services.

When looking at whether targeted facilities comply with national quality standards, data were available for four countries (Bangladesh, Kenya, Malawi and Tanzania), and all registered a positive change. Similarly, women interviewed in those countries reported increased satisfaction with services. Overall, women interviewed felt that the quality of services improved, health care providers were friendly, privacy was provided, and in some countries services and medicines were free of charge (Kenya). Reasons for not being satisfied included long waiting times, the lack of availability of important services at all times and a lack of communication skills among health care providers. In Bangladesh qualitative data show that women were more satisfied with the services provided but seemed to have become more demanding with regards to the quality of services since 2013. This affected their overall satisfaction with the health facilities.

Bangladesh, Tanzania, Malawi and Kenya provided scores for all four outcome indicators. Tanzania scored well against all four indicators; Malawi and Kenya scored well on three indicators, but not on compliance with the IPPF standards (Malawi), and client satisfaction actually reduced in Kenya. Indonesia and Uganda reported (positively) on client satisfaction. Based on these results, it can be stated that the quality of SRHR services has increased for some or more services in three to six countries where the programme was implemented. It is also clear that the training has contributed to increased levels of satisfaction among young people and women with the behaviour of the service

providers. However, as mentioned above, training alone cannot change other challenges the health services face, such as a lack of human resources, which leads to long waiting times, or the constant stock-out of essential commodities.

Increased used of SRH services

Expected results		Indicators
Outcomes	Young people and women are increasingly using SRH services	Percentage increase in the use of targeted SRHR services by young people and women
		Percentage increase in number of births in targeted areas that were attended by skilled birth attendants
		Percentage increase in targeted health facilities of women who have one to four antenatal consultations
		Number of facilities with increased availability of contraceptives, antiretroviral therapy, artemisin combination therapy and antibiotics
Output	Providing target groups with access to formal and non-formal SRH services	Number of health facilities renovated
		Number of SRH services provided by partner organizations to young people and adults
		Number of SRH services provided by subcontractors/government facilitated by Partner Organizations

To encourage young people and women to use SRH services more, the UFBR programme acted on two different levels: (1) the rehabilitation of existing facilities; and (2) the provision of services by either partners or subcontracted providers. By the end of the programme, 215 health facilities had been renovated, against a set target of 65. Most of the time, the renovated facilities offered YFS. While this activity has contributed to an increased availability of services and was well received by most stakeholders, it was not always possible due to the political environment (Pakistan) or to find adequate spaces for YFS (Malawi). Furthermore, respondents to the online survey considered this activity one of the least important.

The UFBR programme also contributed to an increased number of services being provided by either partners (3.8 million services provided against the target of 1.25 million) or subcontractors (7.1 million services provided facilitated by partner organizations, far exceeding the target of 750,000). Examples of these services include the organization of Village Health and Nutrition Days (India), provision of outreach services through community volunteers or mobile clinics (Indonesia) and supporting YFS. The vast majority of services focused on counselling (partners) and contraception (subcontractors). While few countries had set targets for these activities, the number of services provided was high and will have contributed to increasing access to SRH services in the target areas. However, as already mentioned above, the lack of quality of mainly public services can deter people from seeking health care, especially if alternative options are either not available or expensive.

To assess whether these outputs have contributed to an increased use of health services by the target population (SRH services for young people and antenatal care and assisted child births for women), data were available for, respectively, six and four countries. As mentioned before, some of the figures should be interpreted with caution, as in some cases the composition of groups at baseline and endline were different, often no significance tests were done, and it was not always clear how the data were collected.

Regarding the use of SRH services by young people, a positive change was observed in five countries. In Uganda and Indonesia the use of SRH services increased by, respectively, 147% and 239% between 2013 and 2015. In Indonesia the largest increase was reported for boys aged 15–19 years. Malawi also reported an increase of 128% between 2011 and 2015, with an estimated 440% increase for boys aged 10–24. In Kenya the uptake of services was measured for different services. The OMR showed an increase in uptake of HIV testing and counselling services; however, there were significant declines in the uptake of STI screenings and of contraceptives. In Pakistan, while a positive change was reported in terms of overall access, young people still face difficulties due to existing cultural norms. Bangladesh, on the other hand, reported a significant increase in the use of services by young people (59%) but also a significant decrease in service use by adults (52%). In total, service use decreased by 22% in the country.

Four countries measured whether there was an increase in the number of births assisted by skilled birth attendants, and three (Ethiopia, Kenya and Malawi) reported a significant increase. In Indonesia, the situation did not change during the intervention period. Malawi, Ethiopia and Kenya are also among the four countries where the programme reported an increased proportion of women and girls accessing antenatal care services. In Malawi the proportion accessing more than one antenatal care consultation increased by 79% between 2011 and 2015.

In Bangladesh, on the other hand, a decrease was reported in the number of births assisted by skilled birth attendants. Reasons cited by Bangladeshi women (mostly in rural areas) for not delivering at health facilities included the remoteness of the facilities, the lack of transport and the fact that traditionally children are delivered at home. However, and interestingly, these reasons did not have a similar impact on the indicator for antenatal care services - i.e. the proportion of women and girls accessing antenatal care services - which increased substantially in Bangladesh and in particular for girls aged 10–24 years.

In five countries a total of 19 facilities reported an improved availability of antiretrovirals and contraceptive commodities (Ethiopia: 79% of facilities;[9] Malawi: 80%; Tanzania: 33%; and Uganda: 100%). Particularly in Ethiopia the UFBR programme improved drug supplies in 11 facilities through the Revolving Drug Supply Fund and improved health management information systems. In Kenya the availability of antiretroviral therapy and contraception remained stable, but the stock of antibiotics decreased. Similarly, in Indonesia the availability of contraceptives and antibiotics remained the same; however, the stock of antiretrovirals increased in two of the five facilities.

Indonesia also measured the level of use of SGBV services among female clients, but the number of girls who used the services declined significantly between the baseline and the endline. Reasons for this decline are linked to reduced availability of the services (or not enough integration by the partners), low awareness of the services and continued high stigma around SGBV, particularly for young girls. It is surprising that only one country reported on this indicator, especially because SGBV was considered an important part of the programme. Furthermore, no indicator could be found on how health services address sexual diversity.

[9] In Ethiopia, facilities only reported on stock-outs of antiretrovirals and not on contraceptive commodities.

Table 6.8: Progress against increased use of SRH services.

Outcome indicators	Positive change	No improvement	Negative change
Percentage increase in the use of targeted SRHR services by young people and women	*Ethiopia, Indonesia Malawi, Pakistan, Uganda, Tanzania, Bangladesh*	*Kenya*	
Percentage increase in the number of births in targeted areas that were attended by skilled birth attendants	*Kenya, Malawi*	*Ethiopia, Indonesia*	*Bangladesh*
Percentage increase in targeted health facilities of women who have one to four antenatal consultations	*Ethiopia, Kenya Malawi, Tanzania, Bangladesh*		
Number of facilities with increased availability of contraceptives, antiretroviral therapy, artemisin combination therapy and antibiotics	*Ethiopia, Malawi, Tanzania, Uganda*	*Indonesia, Kenya, Bangladesh*	

Note: If a country is not mentioned, there was insufficient or reliable information.

Bangladesh, Ethiopia, Malawi and Kenya reported on the four main outcome indicators. Malawi scored well on all four indicators, whereas Ethiopia and Kenya saw no change for, respectively, one and two of the four indicators, and Bangladesh scored positively on one indicator, no change for two others and a negative change for the fourth. Indonesia reported on two indicators, neither of which had changed. Tanzania and Uganda scored positively on the two indicators for which data were provided.

Box 6.4. MSC story Kenya

I am an 18-year-old girl and a student at Highway secondary school in form three. I am an orphan, and I am currently staying with a well-wisher guardian who took me and my sisters in. I used to do sex work to get money to buy clothes and food. I dropped out of school because life was so hard and life had to go on. I never cared about the dangers I exposed myself to. Some of my customers would demand sex without a condom, and I could not refuse because I feared losing the money. At that time I never cared about my secondary education; all I needed was money.

One day a young woman came into our house and introduced herself. She had been informed about us because some of my customers were even my neighbours. I am telling you all this because I believe you are not going to expose me. My guardian took me to the centre at Rotary, where I met friendly counsellors who taught me about so many ways to protect myself, gave me hope and encouraged me that indeed life has to go on. I go for cervical cancer screening every month because it's free. I also go for an HIV test regularly to be sure of my status. One fact that I like about the centre is that the services are free. I still regret my past but also thank God, for without him I wouldn't be who I am right now. Right now I always refer my classmates to the centre, and whenever I visit the centre I am warmly welcomed by the staff.

We can conclude from these results that young people and women are increasingly accessing SRH services in countries for which data are available. The extent to which the UFBR programme influenced these changes is difficult to assess; however, according to the figures in the OMRs, the programme has definitely contributed to this increased access to SRH services.

6.2.4. SRHR enabling environment

Expected results		Indicators
Outcomes	Young people, women and marginalized groups can exercise their SRHR in a more enabling environment	SRHR policies and legislation implemented, changed or adopted at local, institutional or national level: at least two per country
		Increased involvement of community leaders in realization of SRHR in x% of the targeted communities
		Increased acceptance of SRHR at community level in x% of the targeted communities
Output	Advocacy conducted on SRHR by partner organizations or country alliance	Number of partner organizations implementing an advocacy strategy and with an advocacy work plan on SRHR
		Number of advocacy meetings conducted at local, regional or national level
Output	Involvement of communities and community leaders in SRHR awareness-raising activities	Number of community members and community leaders participating in SRHR awareness-raising activities at community level
		Number of people reached by SRHR awareness-raising activities through (new) media
		Number of people trained in awareness-raising activities

To contribute to a more enabling environment where young people, women and marginalized groups can realize their SRHR, the UFBR programme aimed to: (1) change SRHR policies and legislation; (2) increase the involvement of community leaders and community members in the realization of SRHR; and (3) contribute to an increased acceptance of SRHR at community level. To achieve these outcomes, the country alliances conducted advocacy on SRHR and encouraged the involvement of communities and community leaders in awareness-raising activities on SRHR.

The existence of a joint advocacy strategy seems to have contributed to making an impact through advocacy, as this led to joint planning and greater visibility. By the end of the programme, 48 partners had implemented an advocacy strategy, against the overall target of 30, and 1,933 advocacy meetings had taken place, exceeding the target of 1,600. The involvement of various government departments was also seen as an enabling factor in that it promoted more ownership by government officials in Malawi, whereas participation in working groups and steering committees facilitated advocacy efforts in Tanzania and Ethiopia. At district level, a positive and continued engagement with local-level officials was also seen as effective in most countries.

Advocacy efforts in Indonesia, on the other hand, were less successful. While various partners took on specific issues and advocated for these, no effective changes were reported on SRHR policies. The OneVision alliance confirmed that this was because of the lack of an advocacy strategy as well as the limited collaboration among partners. Surprisingly though, in the Indonesian alliance 11 partners had implemented an advocacy strategy and conducted 67 advocacy meetings by 2014. However, most of these efforts were from individual partners without joint collaboration.

All country alliances that had set targets for increasing the participation of community leaders were on track to achieve these. By the end of the programme, a total of 3.58 million community members and leaders had participated in awareness-raising activities, against an overall target of 1.85 million. Only Ethiopia did not reach the set targets.

Furthermore, a total of 55.2 million people had been reached through new media by the end of the programme, against an overall target of 15.2 million. All countries were on track to achieve their

targets for reaching people with awareness-raising activities. A huge variety of activities and strategies was used by the country alliances (see Chapter 7). The extent to which these activities contributed to a greater acceptance of and openness towards SRHR was influenced by different aspects. Working through existing structures such as Village Health Committees and the commitment of community leaders in mobilization activities were important enabling factors. Furthermore, strategies and methods that exposed communities to SRHR discussions for a long period of time were successful, as was the use of new media. On the other hand, a conservative political environment and cultural and religious values were often barriers to change. Also, a lack of continuity in activities, a limited follow-up with participants and a random choice of communities were not conducive for achieving sustainable results.

UFBR partner organizations together trained 61,406 people in awareness-raising activities, against the overall target of 100,000. This is the only target the countries failed to achieve. This training was intended for peer educators, community and (youth) volunteers, teachers, religious leaders, community leaders, parents and health workers. Following the training, these people were expected to communicate SRHR messages within their community and to support awareness-raising activities by mobilizing community members. In a few countries (e.g. Kenya and Ethiopia), this has reportedly influenced an increased uptake of services; however, overall very little evidence is available linking the impact of the training to the actual outcomes.

OMRs were available for eight of the nine countries; they demonstrated significant positive changes in six countries. Information for these indicators was obtained through desk reviews, FGDs and interpretation workshops. There were few quantitative data available.

Seven country alliances reported on changes to SRHR policies; only Indonesia reported no change. At national level, joint advocacy by the Tanzanian alliance ensured that the new education and training policy included a policy on girls' return to school after pregnancy. In Kenya the national alliance participated in the review and revision of the National Adolescent Sexual and Reproductive Health Policy. At district level, advocacy efforts were concentrated more towards the inclusion of CSE in the curriculum and the provision of YFS. Advocacy efforts by the Malawian alliance on LSBE training for teachers led to the allocation of increased funding by District Education Managers to this training. Similarly, in Uganda and Bangladesh efforts focused on including SRHR in the CSE curriculum. In Uganda CSE became a mandatory component of the curriculum in UFBR programme districts, whereas in Bangladesh the alliance will be involved in the upcoming curriculum review process. In Punjab (Pakistan), the Parwan alliance signed a Memorandum of Understanding with the District Health Authority for including youth-friendly health services in government-led initiatives, following successful advocacy. In Ethiopia, because of the political and legal restrictions on joint activities (including lobbying and advocacy) by organizations with more than 30% funding from international donors, advocacy was done directly through collaboration with government authorities, and the alliance focused on adopting the Family Law for the Afar region, which was achieved in 2015. It also set up a consortium of Dutch-funded programmes on SRHR, which worked on integrating CSE into school curricula by adapting an existing government manual on population and family life education.

The involvement of local leaders was considered a key enabling factor for improving the environment for SRHR, as local leaders are key agents of change for cultural values and social norms. In Malawi and Tanzania local leaders contributed to putting in place by-laws on the need for antenatal care visits and for keeping girls in school; however, the extent to which these by-laws actually change the behaviour of communities is still unclear. Conversely, in some communities (in Kenya, Malawi,

Pakistan and Uganda) local leaders were considered a barrier for the effective implementation of the programme because of their negative attitudes towards SRHR.

Table 6.9: Progress on contributing to an improved enabling environment.

Outcome indicators	Positive change	No improvement	Negative change
SRHR policies and legislation implemented, changed or adopted at local, institutional or national level: at least two per country	Ethiopia, Malawi, Kenya, Pakistan, Uganda and Tanzania, Bangladesh	Indonesia	
Increased involvement of community leaders in realization of SRHR in x% of the targeted communities	Ethiopia, Kenya, Malawi, Pakistan, Uganda, Tanzania, Bangladesh		Indonesia
Increased acceptance of SRHR at community level in x% of the targeted communities	Ethiopia, India, Malawi, Pakistan, Uganda, Tanzania, Bangladesh	Kenya	Indonesia

Finally, while almost all countries reported an increased acceptance of SRHR issues by the communities, these results should be interpreted cautiously, as they were based on a limited number of FGDs with young people, women and staff members. There is limited information on young people's and women's perceptions of changes in the environment related to exercising their SRHR. However, examples of positive changes include an increased awareness of sexual rights (India), greater acceptance of the importance of addressing SGBV and puberty (Indonesia), greater acceptance of condom use and opposition to SGBV and FGM (Kenya, Ethiopia), greater recognition of the importance of antenatal care and delivery in health facilities (Malawi, Tanzania), increased openness for talking about SRHR (Malawi, Pakistan), reducing early and forced marriages (Malawi) and better acceptance of CSE for young people (Uganda). Interestingly, acceptance of SRHR has increased more with regards to uptake of services than actually changing cultural and religious norms. These are still mentioned by all countries as a major barrier to the programme. When traditions such as early marriage or FGM are being challenged, it is also mainly from a health perspective (it is harmful to health) than from a rights perspective (body integrity).

Hence, while positive results are being achieved, this component of the programme still requires substantial and long-term investment. On the other hand, with increasingly loud conservative voices at national and international level, it is already an achievement that the enabling environment has not worsened.

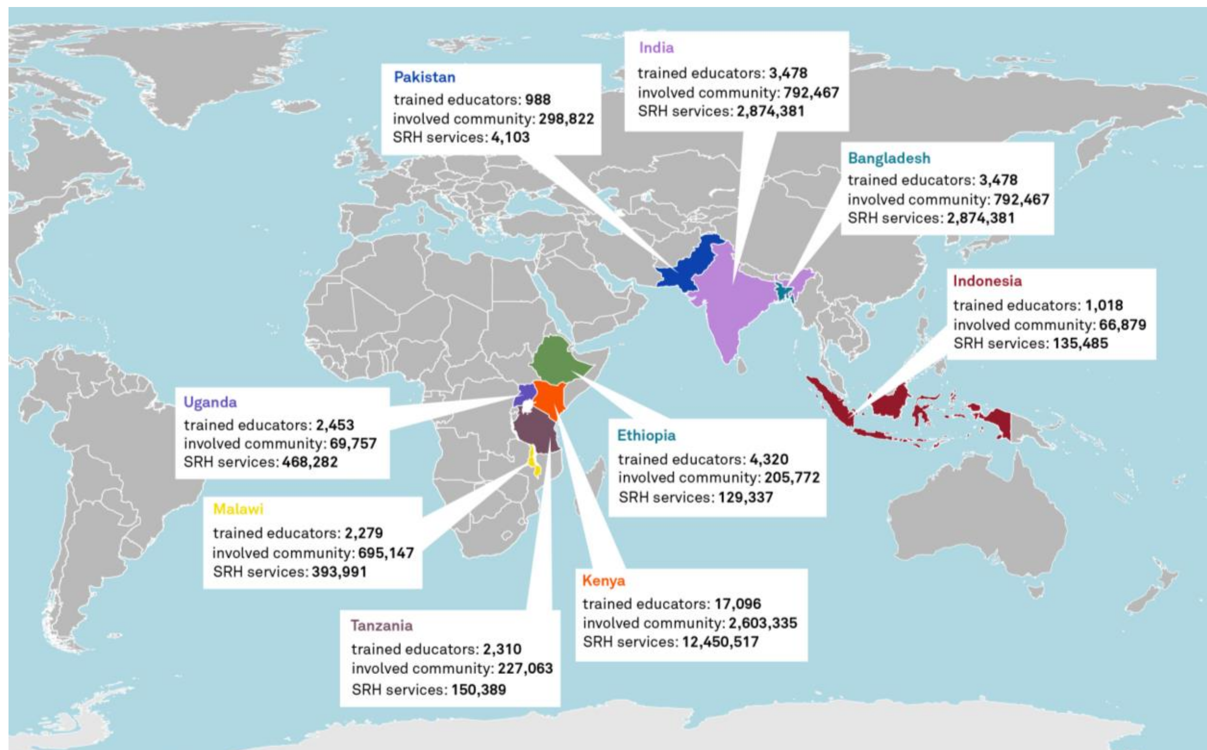

Figure 6.1: Key output numbers for the UFBR programme. (Trained educators = number of educators trained to deliver SRHR education. Involved community = number of community members and community leaders participating in SRHR awareness-raising activities at community level. SRH services = number of SRH services provided to young people and adults (by partner organizations and subcontractors/government facilitated by partner organizations))

6.3. Enabling and constraining factors

The previous chapter already mentioned specific factors that either enabled or constrained each result area. However, there are some more generic factors which are worth summarizing.

In countries with a **supportive national policy environment** it was easier to implement the programme. With national policies already present and sometimes implemented, it was easier to work on certain priorities within the UFBR programme because they were already prioritized at a national level. These policies could also provide opportunities for strategic collaboration with the national government in promoting specific policy documents and strategies. In those countries, however, where this supportive national policy environment does not exist, the implementation of the programme can be more frustrating, but advocacy and lobbying activities then become even more important.

Good cooperation with authorities is also an important enabling factor. When the authorities were actively involved, the implementation of the programme was more effective, and often also more sustainable due to increased ownership. Sometimes cooperation with local governments followed focused advocacy efforts; sometimes it evolved naturally.

Partner organizations were brought together into an alliance mainly due to former relationships with Northern alliance members. Generally, alliances were composed based on existing collaborations and organizations' expertise, and strengths were not necessarily matched in such a way that they would form a winning team. The fact that in some countries the **complementarity of partners** was found an enabling factor shows that in some cases this composition really worked out well. The partners' established presence in the communities enhanced their effectiveness.

The main barrier to the success of the programme is the **entrenched socio-cultural and religious values and norms in the target communities**. The actual content of these norms might differ between countries, but all countries reported that a disabling environment hindered programme acceptance and implementation. This has limited the scope of programme implementation activities and has also affected the attitudes and perceptions of staff members. A shift in socio-cultural and religious values and norms, especially surrounding sexuality and SRHR, usually takes a long time and may negatively impact the programme objectives in the short term. This is not only an issue at the national level; also internationally, conservative voices are becoming stronger, and opposition to SRHR is widespread.

National policies and the political environment can also be a limiting factor. For example, in Indonesia the programme was hindered by legislation that prohibited delivering SRHR services for unmarried couples. In Uganda criminalizing consensual same-sex activities created a barrier to address sexual diversity. In Ethiopia and Kenya sometimes laws were present, but a lack of knowledge of these laws within communities or among providers created barriers to implementation. In Bangladesh and Pakistan the political crisis and conservative governments had negative impacts on the partners' ability to implement the programme (for more details, see Section 4.2.5).

As mentioned before**, a high mobility of trained staff** in partner organizations, schools, health services and within communities created a practical barrier of losing valuable SRHR knowledge. These people needed to be replaced and trained again, to ensure the continuity of activities.

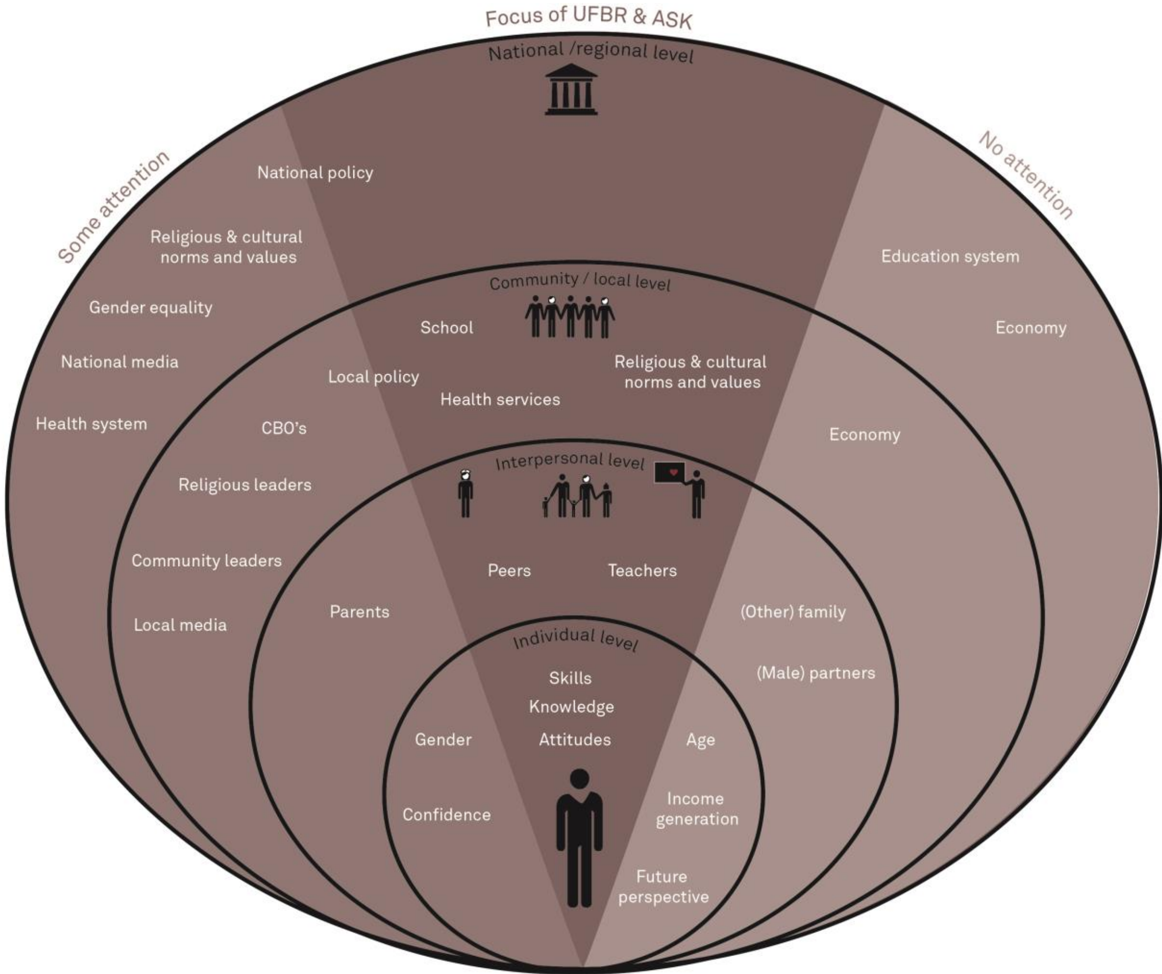

Figure 6.2: Socio-ecological model for UFBR and ASK: different levels of influence of the UFBR and ASK programmes divided by focus of the programme, some attention and no attention.

6.4. Unexpected results

What are the unexpected results (positive and negative)?

The UFBR programme is very comprehensive, with many complementary strategies, hence only a few results could be considered ‘unexpected’. At the level of the partnership, one result seen by the country alliance in Uganda was that partners started to collaborate more intensively with each other, both individually and as a team, on new initiatives outside the scope of the SRHR Alliance and to source more funding. This new collaboration might also be between individual alliance members, but in general organizations have improved their attempts to forge partnerships. A significant overall result is that several alliances have been registered and will continue to work together. They were brought together by an external ‘force’ but are now continuing to collaborate voluntarily.

In Indonesia an unexpected but successful collaboration was reported with the Ministry of Religious Affairs. Through this collaboration, the Ministry is now cooperating with relevant institutions to teach SRHR to students at Islamic boarding schools.

In Kenya, while this was not a primary aim of the programmes, it was noted that some beneficiaries, by virtue of being involved in programme activities, had decided to take up a career path in health as HIV testing and counselling providers, laboratory technicians and/or formal health workers. This was primarily related to their involvement in either demand creation or aspects of SRHR service provision during the implementation of these programmes.

6.5. Sustainability of results

What can be concluded about the sustainability of the results?

6.5.1. Sustainability of activities and collaboration

The joint collaboration and networking is one of the main results of the UFBR programme. As can be seen from Table 6.10, almost all partners are confident that they will continue to share knowledge and experiences even if the programme comes to an end. This is an important result in terms of the sustainability of the partnership. A majority of partners also believe that they will continue the activities even without funding from UFBR; particularly in Kenya partners reported that they had integrated the activities into the wider organizational plan to ensure they could be continued. Very few alliances were able to mobilize additional funding so far, and they are not very confident that funding can be raised from the local or national government. However, some country alliances have made plans for continued collaboration after 2015; for example, Tanzania has made a plan for continued joint advocacy, and the Kenyan alliance obtained funding to support its joint activities.

Table 6.10: Opinions on sustainability of the UFBR programme (Northern and Southern respondents, online survey 1).

UFBR partners	Mean	Stand Dev
9.1. My organization will certainly continue to implement activities in this field, even if financial support from Dutch partners/the Ministry of Foreign Affairs comes to an end	7.72	2.51
9.2. My organization will continue implementing projects, as we already have funding from other sources (e.g. another donor)	5.87	3.62
9.3. My organization will only continue within a new multi-annual funded programme	5.19	3.72
9.4. The local government/Ministry of Foreign Affairs or communities are (financially) supporting certain activities	5.37	3.72
9.5. My organization has undertaken actions (hiring staff, blocking budgets, looking for new partners) to be able to continue working on the activities even if the programmes come to an end	6.37	2.98

UFBR partners	Mean	Stand Dev
9.6. My organization will continue to share knowledge and experiences with other SRHR organizations in my country even if the programmes come to an end	9.02	1.09

6.5.2. Sustainability of results

With regards to the results achieved in increasing access to CSE, four countries (Indonesia, Malawi, Pakistan and Uganda) were confident that these results were sustainable. The inclusion of CSE in the district or national curriculum was seen as a particularly important milestone that would continue to have an impact. For example, in Indonesia the DAKU! CSE programme was included in the senior high school curriculum and is still being implemented even though financial support has ended. Also, the links established between schools and health facilities are likely to remain after the end of the programme (Uganda). In Kenya the work of the alliance on CSE allowed for linkages between ministries (Education and Youth Affairs), which encouraged better implementation.

At the level of health services, the new policies on YFS that were developed (Indonesia and Pakistan) are likely to have an impact on the quality of services beyond the time-frame of the programme. However, due to the high turnover and mobility of trained health providers, it is unclear to what extent the increased capacity of health providers will continue to contribute to quality services. Furthermore, the results achieved in increased use of health services and the comprehensiveness of the services could be affected if partners are not able to continue providing the current health services.

The progress that has been made in terms of the enabling environment will most likely continue in most countries because sustainable strategies were used to ensure the involvement and ownership of communities (India, Malawi, Tanzania, Uganda) and to foster collaboration between the communities and the local government. In Tanzania, for example, the district council has taken charge of many activities, including mobilization, construction, providing equipment and deploying staff in health facilities. Furthermore, the increased collaboration between different ministries in Pakistan is seen as a key output that will continue to yield results.

Hence, every outcome area has yielded results which are likely to continue after the end of the programme. However, a lack of continued funding will be a major barrier to ensuring that many of the other results are maintained.

7. DIMENSION 2: WHICH HAVE BEEN EFFECTIVE, EFFICIENT AND SUSTAINABLE STRATEGIES AND IMPLEMENTATION PROCESSES UNDER THE UFBR AND ASK PROGRAMMES?

This chapter reviews the relevance, effectiveness, efficiency and sustainability of the strategies used by the UFBR programme.

Key messages

- UFBR was found to correspondent to a real and urgent need and can be considered very relevant.
- The combination of different components has the potential to achieve real and substantial change.
- The different strategies are well adapted to the context. Especially the level of decentralization, the strength of the health system and the level of integration of health into curricula were important determinants for choosing appropriate strategies.

7.1. Relevance of strategies implemented

The relevance of the strategies implemented was assessed on three levels: (1) was the underlying ToC implemented, and did it help to achieve the objectives of the programme?; (2) were the programme strategies appropriate for the target groups?; and (3) to what extent was the programme objective still valid in the context of the UFBR countries, in particular with regards to the changed norms and values of the enabling environment?

7.1.1. Implementation of the Theory of Change

Has the multi-component approach been implemented? How/why/why not?

According to the second online survey, both Northern and Southern partners considered the multi-component approach the greatest strength of the UFBR programme.

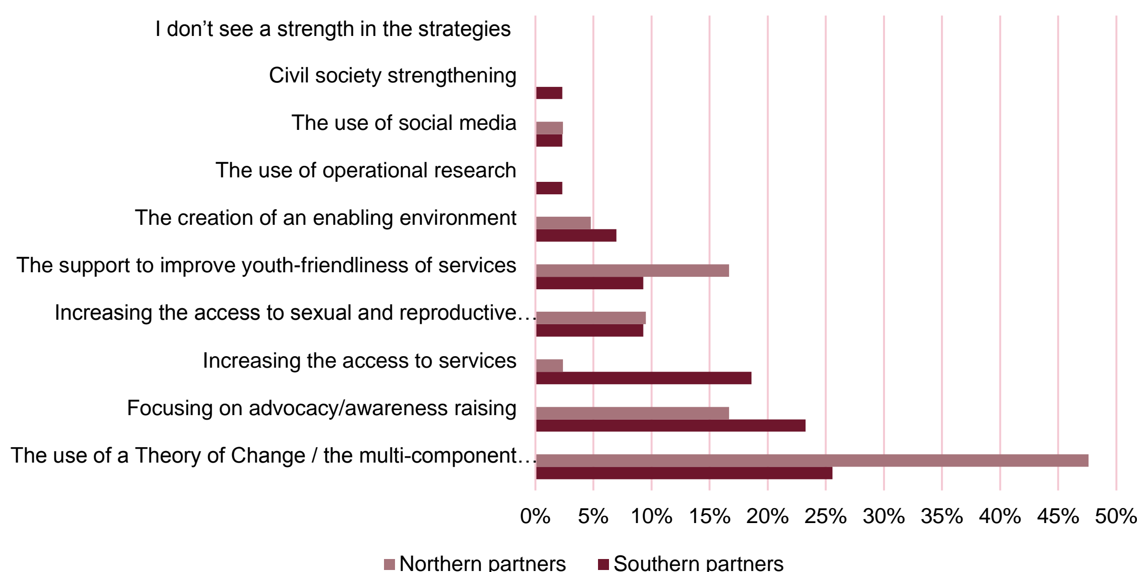

Figure 7.1: Assessment of the strategies implemented (UFBR, online survey 2).

It was implemented successfully in most of the countries and contributed to strengthened collaboration and improved results. A key strength of the multi-component approach is that it involves the entire

chain of stakeholders, from the community - with a particular focus on young people and women - to education and health providers and various levels of decision-makers.

In particular, the collaboration with policymakers and the enabling environment have contributed to quality programmes, including government programmes. Furthermore, the involvement of community leaders in the planning and implementation of SRHR services helped to increase the acceptance of SRHR by other community members.

The country alliances also mentioned that through the ToC the links between each component became much clearer. In particular, the link between increased demand (due to better SRHR education) and improved supply of SRH services became much stronger in Bangladesh, India and Tanzania, where the importance of referral systems was repeatedly mentioned.

Box 7.1. Integrating the three components in Ethiopia

AMREF, YNSD and FGAE are working on the three pillars of the ToC and have created linkages between the areas. In addition, the different areas of expertise of the partners allowed the different elements to be linked. Referral systems have been created between the schools where TaYA and YNSD are working and FGAE clinics and government health facilities with which AMREF is working. For this purpose partners jointly developed a referral slip. TaYA reported that its national advocacy efforts were informed by the experiences of YNSD and AMREF Health Africa

However, the adoption and implementation of the multi-component strategy was less successful in a few countries for different reasons. Partners in Tanzania worked in different districts, which made it more difficult to integrate their work. Therefore, one or two components of the multi-component approach were implemented, and some organizations were required to implement activities which were not part of their core strength. While this may have been an issue at the set-up of the programme, the partner organizations helped each other to strengthen their capacities to be able to implement all components in all geographic areas. Also, while the Indonesian alliance had a good understanding of the ToC, it was not often used or integrated into programming, and not all partners had strategies in place to link the various components. Conversely, in Pakistan it was much harder to implement the multi-component strategy due to political restrictions on working on service delivery. Hence, most of the efforts were concentrated on CSS and SRHR education. Similarly, in Kenya most partners were working on the demand side and the enabling environment, with only a few focusing on service delivery and linking it to demand creation.

Box 7.2. Mutual influence between UFBR and ASK

An open-ended question in the online survey probed for the influence of UFBR on ASK, and vice versa. The influence of UFBR on ASK is quite clear: it served as a solid basis for the start of the new programme. Several topics are particularly mentioned as strengths. First, the fact that the organzsational structure was already in place facilitated the start of ASK. Second, the YEA was able to incorporate lessons learned from UFBR. UFBR provided insights into good practices and areas of weakness that could inform ASK. One respondent said that UFBR was like a pilot for ASK. ASK also had an influence on UFBR. Several topics are mentioned, including the operational research and innovative strategies done for ASK, which helped improve the UFBR programme. Positive experiences with meaningful youth participation for ASK boosted the involvement of young people in UFBR. Strengthening health services and outreach activities that were initiated under ASK also helped to improve access to services for UFBR target groups.

7.1.2. Relevance of the programme for vulnerable groups

Which strategies have been implemented to reach vulnerable groups in the programmes?

Each country alliance identified which vulnerable groups they would target. Throughout the programme, various vulnerable groups were reached through service provision, education or advocacy. The strategies used were appropriate and adapted to the various target groups, although some vulnerable groups received less attention than others.

In terms of service provision, **hard-to-reach groups** in Bangladesh, such as slum dwellers, rural people, students and people with disabilities, were reached through health camps or satellite clinics. This service was provided in communities, schools and garment factories and combines the provision of contraceptives with counselling, SRH and non-SRH services. Similarly, in Indonesia and Tanzania, partners facilitated outreach services to provide basic access to health services in remote villages and regions.

In some countries specific attention was paid to vulnerable groups through the facilitation of SRHR education interventions. For nomadic and out-of-school youth in Kenya, one partner adapted the existing CSE curriculum to their context and needs.

Some attention was paid to improving **male involvement** and engagement in SRHR, though not consistently across the programme. In Malawi alliance partners drafted a gender position paper which included suggestions for improving male involvement in organizations and interventions. Male engagement was also mainstreamed in the Kenyan alliance programme, and in Pakistan the alliance launched the Green Ribbon Campaign, focusing on the role of men in reducing domestic violence and child marriage. Women's organizations were encouraged to work with men and boys (India), and FGDs on SRHR were organized specifically with men (Tanzania). The extent to which this increased male involvement is generating improved results for SRHR is still unclear. In Malawi and Tanzania there was increased acceptance in communities of husbands accompanying their wives to antenatal clinics as well as of the need for husbands to take a greater role in safe motherhood, but in Uganda male involvement is still an issue, particularly for cross-generational couples.

With regards to addressing **sexual diversity** in interventions, a few positive examples are worth mentioning. In Indonesia one alliance partner conducted a public discussion entitled 'Violence against LGBT on behalf of religion', which resulted in increased commitment from prominent Islam, Catholic and Protestant leaders to end violence against LGBT people. In Kenya health workers received support to organize dialogue meetings with key community leaders on sexual diversity. Malawi was the only country where a partner included sexual diversity as a programmatic intervention. For example, partners advocated among service providers and government officials for the right of LGBTQI people to access health services. It also supported community dialogue and awareness-raising activities focusing on creating an enabling environment for LGBTQI and other minorities. However, no significant changes have been reported in improving the acceptance of LGBTQI rights; targeted communities remain firmly opposed to gender identity issues and the rights of LGBTQI people. Hence, despite these activities, sexual diversity remains a very sensitive issue in all countries. While acceptance of sexual diversity was a key component of the overall international programme, it was not central to the country programmes.

Finally, Malawi addressed the needs of **sex workers** by setting up safe spaces for sex workers to access SRHR education and by enabling them to claim collective rights for female sex workers. As a result of this education and networking, sex workers successfully challenged the police to end abuse

against sex workers. This activity also facilitated dialogue with law enforcement agencies on the promotion of human rights for sex workers.

SGBV negatively affects the rights of girls, boys, men and women. Practices such as domestic violence, rape, FGM and child marriage have a particularly negative impact on girls and women. All countries reported working on SGBV in some way or another. The most common activities were trainings of partners and community-based organizations on SGBV. Partner organizations were also engaged in projects with communities, schools, health facilities and local authorities to address SGBV, mostly by raising awareness. Projects included: short movies for young people (India); the development of by-laws related to SGBV (Malawi); gender desks at police stations (Tanzania); and a referral system for SGBV to health facilities (Tanzania). Lessons were also shared among countries - for example, a delegation of partners from Malawi visited NGOs in Zimbabwe working on SGBV interventions. In terms of advocacy, partners worked on including an SGBV module in the CSE curriculum (Indonesia) and participated in campaigns to end child marriage (Pakistan). As a result of these activities, positive changes were reported in terms of community attitudes, in particular regarding early marriage, teenage pregnancies and FGM. However, there is a lack of strong evidence that demonstrates a reduction in SGBV in most countries.

7.1.3. Relevance of the programme within a changed enabling environment

Is the country affected by a change in the values and norms of the enabling environment? If yes, how has the increase in conservative forces influenced the programme, and how have partners dealt with them?

As already mentioned, changing the norms and values of the enabling environment is a complex and long-term process. All countries referred to entrenched cultural and religious norms as a serious barrier to improving access and use of SRHR. Furthermore, three countries (Bangladesh, Kenya and Pakistan) have seen an increase in conservative forces that has had a negative impacted on the programme.

In Bangladesh the deepening political crisis, election violence and a rigid stance taken by polarized political parties has been a concern for the programme. Conservative leaders have questioned the need for SRHR education for young people, and articles in newspapers have backed up this conservative position. This impact was felt by the programme when teachers, guardians and government officials criticized SRHR education materials because they included too many sensitive issues and pictures. The Bangladesh country alliance tried to circumvent these barriers through more concerted advocacy efforts, by engaging the local media and addressing young people at youth fairs.

Conservative leaders in both Kenya and Pakistan also questioned the introduction of CSE materials in schools. In Kenya false allegations that the Ministry of Health and Education was planning to introduce sex education for young children and distribute family planning commodities caused a week-long furore and a public backlash. Similarly, in one province in Pakistan (Punjab) the Chief Minister ordered the education department not to accommodate any syllabus endorsed by NGOs, resulting in difficulties in creating agreements with new schools. This challenge has been compounded by an article written by a well-known journalist in a national newspaper on how LSBE is promoting indecency in the community and corrupting the minds of the youth. Both country alliances also tried to mitigate the negative impact of this political and public backlash by working more closely with the local media. Within this context, the UFBR programme - and, in particular, the work on the enabling environment - is very important. Through continued awareness-raising using local media and lobbying of key stakeholders the partners are addressing norms and values that negatively affect the SRHR of target

groups. However, not all countries were successful in addressing the enabling environment effectively, as was already discussed for Indonesia in Dimension 3 (Chapter 1).

7.2. Effectiveness of strategies

Which strategies have been implemented, and which have been effective? With reference to the result chain.

In this section the effectiveness of strategies used by the UFBR partners in the nine countries will be reviewed in terms of: (1) improving the quality of youth-friendly SRHR services; (2) increasing access to (youth-friendly) SRH services; (3) improving the quality of SRHR education; (4) increasing access to SRHR education; (5) changing the values and norms related to SRHR at different levels; and (6) meaningful youth participation.

7.2.1. Quality of (youth-friendly) SRH services

The main strategy used to improve the quality of SRH services was the training of health care providers, including community health volunteers. While this is likely to have increased the quality of some health services and was, therefore, effective, the sustainability of this strategy is unclear because of the high turnover of trained staff. Instead of training a select number of service providers, it may be more effective to include training on youth-friendly service provision in the formal curriculum for nurses and physicians.

Another strategy reported in India and Malawi was the use of scorecards to monitor and provide an opportunity to discuss the bottlenecks of service provision with service provides. In India these scorecards showed impressive results. Between 2012 and 2014, 11 of the 16 health facilities increased their available family planning services, and health facility data showed a 90% increase in the uptake of family planning services.

In Tanzania SRHR focal points were appointed at health facilities to help strengthen the data collection and documentation of the community health services. The extent to which this influenced the quality of the services delivered, however, is unclear.

Finally, work undertaken to strengthen the commodity supply system, such as through the Revolving Drug Supply Fund in Ethiopia, was successful in increasing the availability of essential commodities in targeted health facilities.

7.2.2. Access to (youth-friendly) SRH services

Access to SRH services was improved by making SRH service more readily available to the target populations. Three strategies were used for this purpose: (1) the renovation of existing health facilities to include YFS; (2) increasing the provision of outreach services by working with either the government or private providers; and (3) referral systems.

According to the online survey, the renovation or improvement of health services was considered one of the least useful strategies of the SRH service component. The challenges of engaging with contractors, as well as budget constraints, are factors that probably influenced this opinion. While in principle this activity should have contributed to a greater availability of (youth-friendly) health services in the countries, not a lot of information about the effectiveness of this strategy was available in the country reports.

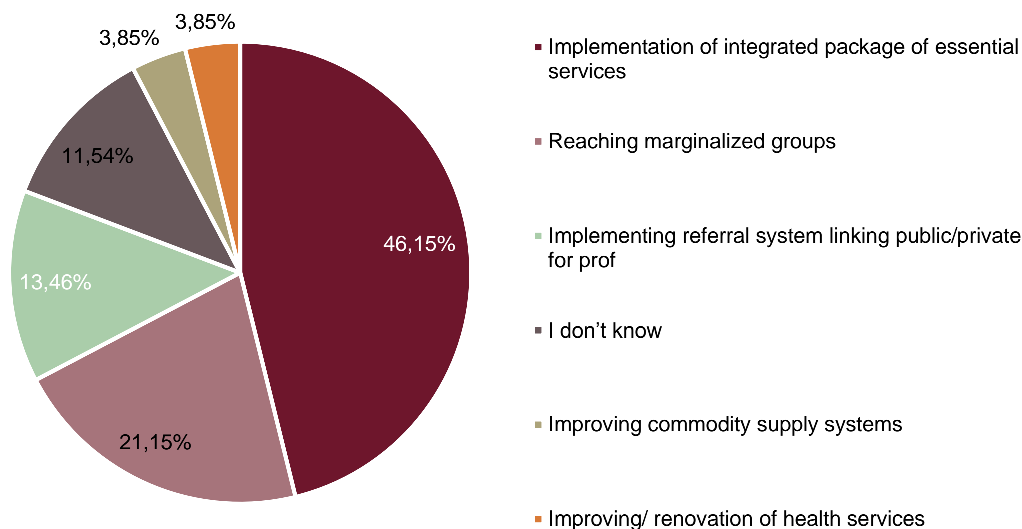

Figure 7.2: Assessment of the most useful activities to improve access to SRH services (UFBR all respondents, online survey 1).

The implementation of an integrated package of essential services, on the other hand, was considered by far the most useful strategy. Different approaches were used within this strategy, including facilitating the provision of comprehensive YFS in existing health facilities or as a standalone facility. In existing health facilities, a designated youth desk or corner would serve as the triage point for young people seeking SRHR services and information. From here young people were referred to the relevant services within the facility where staff members had been trained on providing youth-friendly and non-stigmatizing services. Due to space constraints, however, this integration was not always possible. In standalone facilities, all services were exclusively for young people. SRHR services that were most commonly provided include HIV testing and counselling, STI screening and treatment, modern contraception and distribution of information, education and communication materials. Often these places also served as youth resource centres where young people could interact with each other in a safe environment.

Other strategies to improve service provision include reaching out to marginalized groups through outreach services such as mobile clinics, weekly health and nutrition days and door-to-door services. As can be seen in Figure 7.2, this specific approach was valued by most respondents.
Moreover, the implementation of referral systems to public health facilities and the development of a community-based distribution system for contraceptives and other essential commodities were also mentioned as effective approaches for increasing access to SRH services. Furthermore, setting up a referral system between public and private health services was important to address the SRHR of unmarried couples in Indonesia. Government regulations do not allow health facilities to provide SRH services to unmarried couples or to provide safe abortion, although some private clinics do provide these services. Hence, by strengthening the referral system, the programme contributed to increasing access to these services.

Another strategy that helped to motivate people to access health care services in various countries was the use of village-level health volunteers (Community-Owned Resource Persons — CORPs). These CORPs were trained on YFS and were able to persuade and mobilize young people to use

these services. As a result of their engagement, more young people were seen to access health services, and more parents were supportive of YFS in some countries. This strategy used a combination of increasing access to SRHR information while at the same time also encouraging people to access health services.

Furthermore, UFBR placed strong emphasis on referral mechanisms. Through a number of channels, including outreach activities, peer educators, CSE teachers and school nurses, target groups were motivated to visit health centres and use services.

Figure 7.1 demonstrates that Southern partners considered increasing access to health services a key strength of the programme. Some partners reported that it was crucial to participate in the provision of health services to be able to cater for the increased demand that is created by the other components of the programme. Northern partners, on the other hand, awarded this component a rather low score, which points to a different understanding by the alliance partners of the effectiveness of this strategy. This may be explained by the fact that service provision was the main focus for only 13.5% of the respondents.

7.2.3. Quality of SRHR information/education

Two key strategies were used to improve the quality of SRHR information: (1) efforts were made to include CSE in national or district school curricula, and when this was not possible, CSE was provided outside the school curriculum through the use of peer educators (during or outside school hours); and (2) educators were trained on SRHR to be able to better deliver SRHR information.

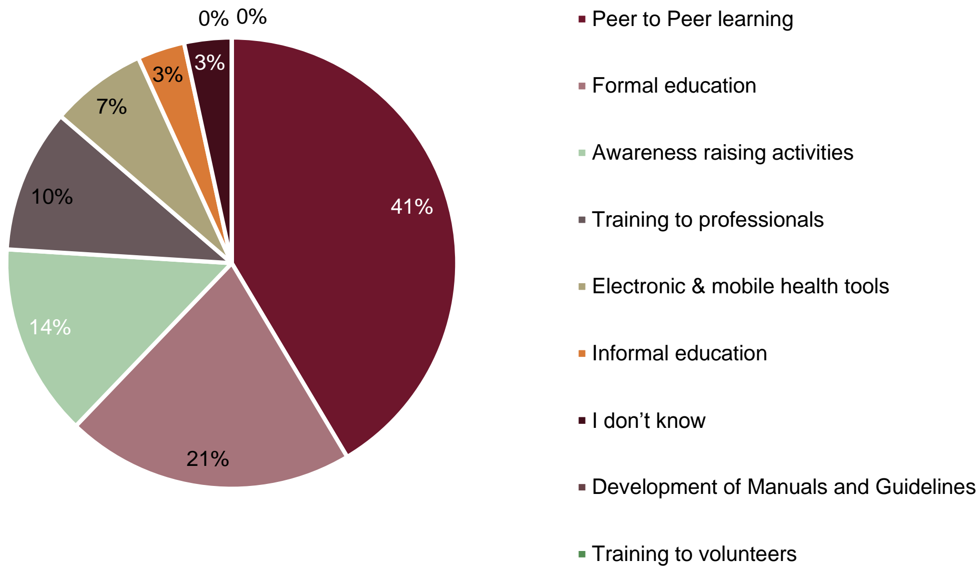

Figure 7.3: Assessment of the most useful activities to improve SRHR education (UFBR all respondents, online survey 1).

In quite a few countries the alliances worked within the formal education system to integrate SRHR into the school curriculum. This strategy, while not always straightforward, was very important to ensure, first that there was general acceptance of addressing SRHR at school; and, second, that students received good-quality SRHR information. The effectiveness of this strategy was highly dependent on close collaboration with and the involvement of local and national governments and general acceptance by communities and parents of the importance of CSE. In addition, the countries

that used a more ‘institutional’ approach to formal CSE education, such as LSBE or the whole-school approach, seem to have been more successful than other countries in integrating CSE into the school curriculum. One disadvantage of using this ‘institutional’ approach in Tanzania, however, is that the LSBE curriculum is not very comprehensive.

In other countries CSE was also provided outside the school curriculum with materials developed by the country alliances in collaboration with others. The appropriateness of the CSE materials for the target population is, however, an important factor for success. For example, in Indonesia the CSE syllabus was developed by a university on one island and (partly) not considered appropriate by teachers in another region. For example, teachers in one region found that the information on reproductive organs was too explicit, and also they did not feel confident addressing the topic of sexual diversity. In another region, however, some teachers reported having changed their personal attitudes on sexual diversity following the training and felt more confident addressing this topic with students. This demonstrates the importance of SRHR training for educators.

The training of teachers is important, on the one hand, to improve their knowledge on SRHR and, on the other hand, to increase their confidence to address SRHR in the classroom. Teachers can be important agents of change and exert significant influence on young people, if they themselves are confident and feel supported. For this strategy to be successful, it is again important to have formal approval and endorsement from local officials and communities. For example, in Indonesia the SRHR activities in one school had to be stopped because the new principal did not approve of them. Teachers in this country often experienced negative attitudes from the communities and felt they were isolated ‘CSE islands’. In these circumstances, it is much more difficult to openly address SRHR and fulfil the role of agent of change.

Access to information was also very much increased by community events and by peer educators, CORPs and medical staff starting to provide information. The quality of this information improved because of collaboration with medical staff. By aligning the messages from the different stakeholders, including community leaders, they resonated better among the target groups.

The problem with this strategy is that the quality of the information provided depends on the teacher’s interpretation. As mentioned before, in Uganda students reported that they should only have sex from the age of 18, whereas this was not what the programme intended. Also, respondents in the FGDs among teachers in Indonesia said that if there where time constraints and the entire curriculum could not be taught, the more progressive elements were dropped. In short, while the original manuals and most CSE activities could be considered comprehensive at the outset of the programme, the activities that were actually implemented were less comprehensive. Often, the more controversial topics - such as sexual diversity, rights and abortion - were taken out, and sometimes activities were reduced to abstinence promotion (see also Figure 7.4).

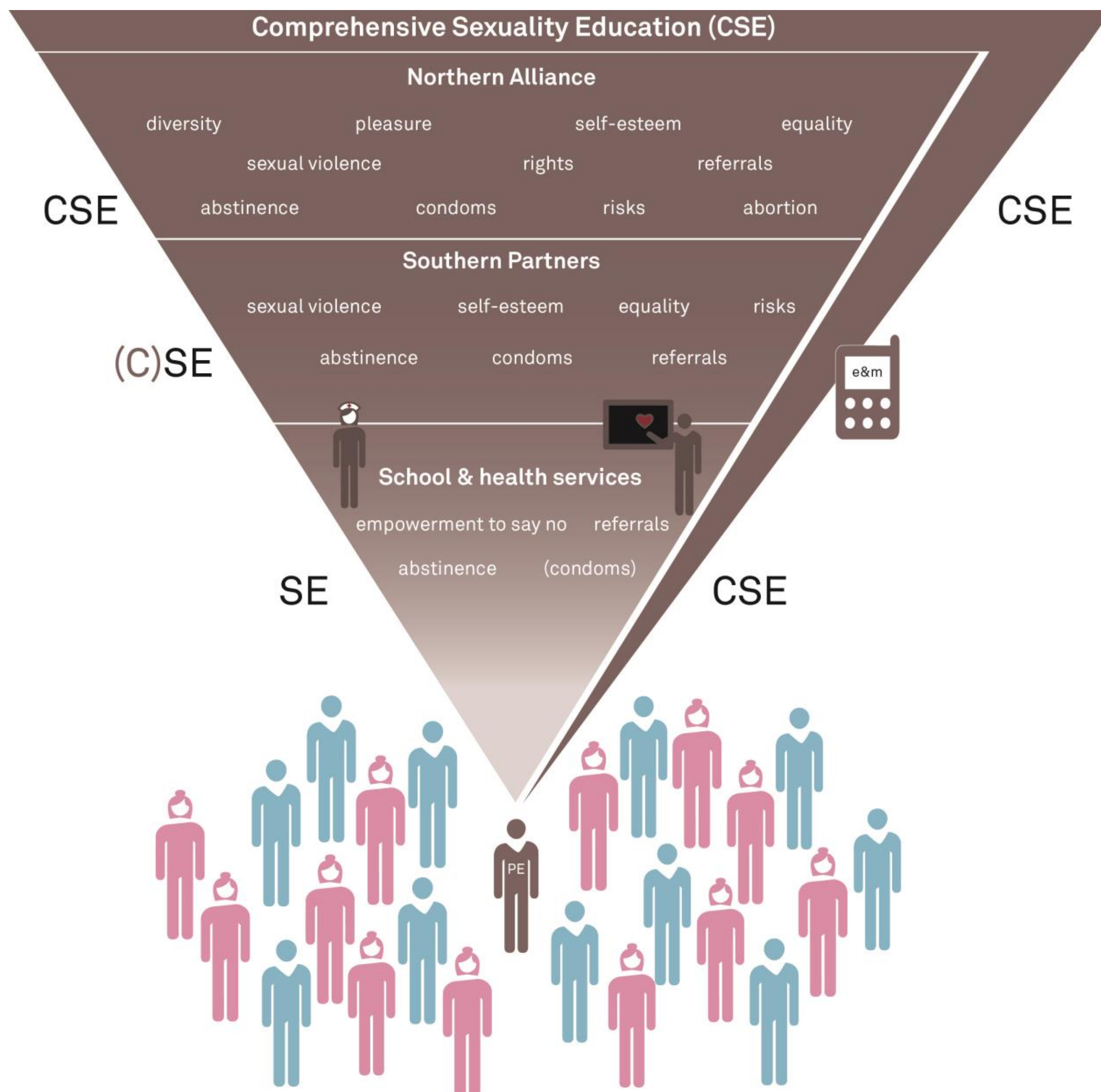

Figure 7.4. The extent of comprehensiveness of comprehensive sexuality education (CSE)
(SE = sexuality education; PE = peer educator; e&m = electronic and mobile health technologies used in ASK)

In quite a few countries computer- and web-based CSE programmes were used to promote CSE to young people. This strategy was appreciated by its users, as it provides privacy, while allowing educators and young people to engage in a participatory learning process.

The online survey demonstrated that peer-to-peer learning was the most valued strategy within the CSE component. Also, from the qualitative results, we see that target groups appreciate this strategy and that it reduces the barrier to access information (and subsequently services). MSC stories sometimes even show that people who have been approached by peer educators afterwards become involved in the programme as well. Two downsides of peer education are the high turnover rate and constant investment in training, and the comprehensiveness of the messages. One cannot expect that young people can provide CSE after just a few days of training. Therefore, instructing them on referral systems is crucial, which was done well in UFBR.

7.2.4. *Access to SRHR information and education*

Alongside providing CSE modules in formal schooling (as discussed above), most countries also used the strategy of peer-to-peer learning to increase access to SRHR information, in and out of school. It was considered the most important strategy by both Southern (26% of respondents) and Northern partners (41%) - see Figure 7.1. Students in and out of schools were trained as peer educators to reduce the workload for teachers but also as an important means to educate young people in a more informal and approachable manner. These young people would often also become village-level health volunteers (CORPs) and be trained to refer people to health facilities.

Community members were reported to be more receptive to SRHR information when it was provided by their peers. This use of peer educators is, therefore, considered an effective strategy for the dissemination of information on SRHR in most countries. The success of this strategy was also confirmed by operational research in Uganda on the significant influence of peer educators in promoting the use of SRH services. However, as already mentioned before, there were significant problems with the high drop-out rates of peer educators. In particular, peer educators expect an allowance for carrying out the work, which the programme is not able to fulfil. Hence, it was often difficult to keep peer educators motivated. Furthermore, many peer educators also have limited usable knowledge and skills for delivering CSE.

Another strategy used to increase access to and raise awareness of CSE was the use of arts such as dance, music and drama (in collaboration with Dance4Life). This strategy was very much appreciated by community members and schools. In Indonesia a growing number of schools were interested in implementing the CSE programme because of the Dance4Life component. In Tanzania partners also integrated SRHR education sessions into livelihoods training, hence increasing access to CSE through different outlets.

7.2.5. *Changed values and norms at the beneficiary level, personal relationship level, community level and policy level*

To change values and norms and develop an enabling environment, the alliance worked at different levels: at the personal level through peer-to-peer learning; at community level by raising awareness and working with community leaders; at district level by engaging the local government and institutions; at national level by engaging the national government and advocating for policy changes; and at international level by contributing to writing international policy papers.

While peer-to-peer learning was seen to be effective for changing individual behaviour, changing social and cultural values and norms required a ‘whole-community’ approach. This approach included various strategies such as raising awareness through a variety of methods, involving traditional and religious leaders and working through existing community structures.

The alliance worked within communities to change prevailing cultural norms on, for instance, SGBV, FGM, family planning, early marriage and young people’s access to SRHR information and SRH services. Various methods were used such as community meetings, music performances, folk shows, dance competitions, theatre group performances, football leagues and radio broadcasts, among others. Often these activities were conducted or supported by peer educators and theatre groups, community-based organizations and women’s groups and served to discuss specific SRHR issues. Many people were reached through these activities.

However, these activities alone were not sufficient to change entrenched cultural norms. As can be seen in various countries and from the online survey (see Figure 7.4), the involvement and support of

community stakeholders, such as traditional and religious leaders, is key to making it acceptable to change social norms. These leaders were trained on SRHR and involved in participatory planning exercises. The programme not only engaged these leaders but also worked through existing community structures and distribution systems to enhance accountability between decision-makers, service providers and communities. For example, in Tanzania Village Health Committees helped to mediate misunderstandings between health providers and community members. As a result, negative attitudes towards antenatal care were transformed into positive ones due to the regular availability of delivery kits, drugs and cost-sharing. This holistic approach, as seen in quite a few countries, was also key for coming up with strategies to change norms around FGM (e.g. Kenya) and early marriage (e.g. Tanzania and Malawi through by-laws).

Close collaboration with district and national government bodies was also important for influencing policy change. Various partners participated in district- and national-level working groups, where they had opportunities to influence policy dialogues. These and other lobbying and advocacy activities at district and national level were considered one of the most useful strategies to change the enabling environment (see Figure 7.5). However, it is also apparent that when this close collaboration with government bodies was missing or when there was no effective advocacy strategy, such as in Indonesia, this would also be a barrier for other components of the programme.

Figure 7.5: Assessment of the most useful activities for developing an enabling environment (UFBR all respondents, online survey 1).

Alongside working with the government, another key strategy for changing opinions nationally was the involvement of media (print, TV, radio) to disseminate messages. In Pakistan, for example, training was organized for journalists and media professionals on SRHR, and the country alliance participated in two talk shows on national television to raise awareness of child marriage. Regular posts on Facebook, Twitter and blogs have been successful in addressing the younger audience, but are limited to urban areas. In Ethiopia the country alliance produced an eight-programme television series on SRHR in the Afari language, in partnership with the Afar government's communication and media office.

7.2.6. Meaningful youth participation

Which have been effective strategies for meaningful youth participation, and how has they contributed to results?

Meaningful youth participation was incorporated into most of the UFBR country programmes. Young people were reported to participate at different levels of the programme, but in particular in the implementation and design of programmes. Meaningful youth participation received an extra impulse with the start of ASK (see Box 7.2: Mutual influence between UFBR and ASK).

Young people are engaged in the actual programmes by working as peer educators, supporting the provision of YFS and participating in outreach and awareness-raising activities. The involvement of young people in these activities has been meaningful, as it led to an increase in knowledge, skills and confidence as well as a greater acceptance of young people discussing SRHR with adults.

In most countries adolescents were also invited to participate in the design and development of activities. For example, in Pakistan young people contributed to the development of LSBE materials, whereas in Indonesia young people provided input into the development of one partner organization's communication strategy. In Bangladesh mini youth parliaments were set up in the intervention areas, and youth leaders participated in the planning, implementation and monitoring of youth participation. By involving young people in the design and development of programmes, they take on more ownership, and communities are more likely to accept the interventions.

Moreover, in some countries young people were also capacitated to participate in data collection and research and encouraged to engage with the local authorities to demand improvements in services (Uganda). In Tanzania young people were involved in operational research and the outcome measurement studies. In some countries young people were also seen to participate meaningfully in advocacy initiatives and platforms (Ethiopia, Pakistan). This strategy is important because it equips young people with important skills that will help them in their further career development.

However, only a few positive examples were found of young people being engaged at the organizational and decision-making level. In some countries partners have policies in place on youth participation and involve young people on the Board of Directors (Kenya, Ethiopia). In Indonesia the alliance has a policy that young people should make up 20% of the management team. However, this was not done consistently across the SRHR Alliance.

While this increased participation of young people is appreciated in all countries, there are also a few challenges of keeping them engaged. As mentioned before, a high turnover of peer educators was a challenge in many countries. Furthermore, there was tension between training young people for certain activities and their expectation of being supported financially. In one country, for example, volunteers would become really inspired and propose strategies for addressing specific issues in the communities, but often limited funding was available to support these initiatives.

Overall, UFBR countries have meaningfully engaged young people, in particular at the level of programme design and implementation. The online survey also confirms that Southern UFBR partners consider that partners are more open to working with young people. However, more work needs to be done to ensure the meaningful participation of young people at organizational and decision-making levels. Furthermore, young people should also be involved in an assessment of the effectiveness of this strategy, to enable a better understanding as to what extent their involvement is actually meaningful.

7.3. Sustainability of strategies

Have strategies led to sustainable results? If yes, which strategies?

Quite a few strategies are seen to have contributed to sustainable results: meaningful youth participation; networking and learning among SRHR stakeholders; alignment with national policies and government; and using existing local structures to ensure local ownership, community involvement and integration of SRHR services into formal and existing structures.

As mentioned above, the meaningful participation of young people has led to increased knowledge, capacity and confidence to address SRHR issues at different levels. Because of this, young people are taking more ownership of their own health but also of the SRHR interventions at community, district and even national level. This is a result that is likely to remain after the end of the programme; however, for it to continue to be effective, young people should be motivated and continue to be engaged.

As already noted in Dimension 3, partners are confident that they will continue to network and share lessons with each other even if the programme comes to an end. Hence, the strategy to build a partnership and facilitate learning has fostered a dynamic that is likely to be sustained.

Quite a few partners mentioned that alignment with local and national governments had led to increased ownership of the programme by these stakeholders. This is seen, for example, in countries where CSE was included in the curriculum or where district councils were becoming increasingly involved in the delivery of health services.

Furthermore, involving key community stakeholders in the design of the interventions as well as working through existing community structures has led to increased community ownership of the interventions, which is important for their continuation.

Finally, the integration of CSE into formal education systems has generated sustainable results. Also, the integration of YFS in existing health facilities is also likely to be more sustainable than setting up standalone YFS.

7.4. Efficiency of strategies

What can be concluded concerning the efficiency of the (implementation of) strategies?

Overall, participants in the online survey awarded the efficiency of the UFBR programme a mean score of 7.65, which is relatively high. However, little information was found in the available documentation on efficiency, which indicates that partners were not required to report on the cost-effectiveness of their programmes.

As mentioned in Dimension 3, the increased collaboration between partners is said to have led to better use of resources among partners. For example, the sharing of materials and resources for capacity-building were direct cost savings for partners. The extent to which this happened is, however, unclear. For some country alliances, on the other hand, the amount of time and resources spent on joint collaboration was high compared to the perceived results. Some partners also indicated that working through local CSOs was more cost-effective than implementing the activities directly.

The use of peer educators, youth advocates, community volunteers and existing community structures was an efficient strategy. The resources spent were mainly on training of educators and, therefore,

relatively little compared to the perceived results of this strategy. However, since these volunteers did not receive an allowance, it was often difficult to keep them interested and motivated.

The integration of SRHR services into existing health facilities was also a more efficient strategy than setting up standalone SRHR facilities. Integrating YFS in existing settings was a more efficient and sustainable use of resources because, instead of focusing on the operation of the services, which is costly, the programme focused on sensitizing health service providers on how to deliver non-stigmatizing care, which will have an impact not only on young people but also on the wider group of people attending the facility.

Combining the different components of the ToC can also be seen as a strategy to increase efficiency. While it requires more investment than only focusing on one component, it has the potential to lead to larger and sustainable results.

In addition to the analysis of existing documents, we aimed to include an analysis of CSE in and out of school in the three selected countries where fieldwork was conducted. As explained in Chapter 2, obtaining the data collected was, however, more difficult and required more time and effort than anticipated. The financial set-up of UFBR is arranged along the lines of the programme's result areas, which meant that data on budgets for specific strategies or programme activities were not easily available at the alliance office or offices of partner organizations in the North, and obtaining the data also required input from partner organizations in the three partner countries. It was decided, together with the alliance office, to focus the efficiency study on the ASK programme, as the end of 2015 and beginning of 2016 was a challenging time for all alliance partners, with the closure of the UFBR programme and set-up of a new programme. Moreover, the deadline for the evaluation was tight.

To conclude, the use of existing and available resources (such as community volunteers and peer educators) and structures (such as existing CSOs, health facilities and community structures) was seen to increase the efficiency of the programme. However, no details are available as to the extent to which the programme was more cost-effective as a result of these strategies.

8. CONCLUSION

To conclude, this synthesis report reviews to what extent the UFBR programme achieved its overall goal, by assessing the assumptions of the ToC and progress made on each of the components. It also summarizes the programme's relevance, effectiveness, efficiency and sustainability.

8.1. Achievement of the overall goal

With UFBR, the SRHR Alliance is working towards a society free of poverty, in which all women and men, girls and boys, and marginalized groups have the same rights, irrespective of their ethnic, cultural or religious background, age, gender or sexual orientation.

To contribute to this ultimate goal, the UFBR programme acted on five different levels:

1. It has strengthened the capacity of 49,174 staff of partners and CSOs to address SRHR issues, and has encouraged the collaboration of partners in 458 networks
2. It has contributed to a more supportive international environment for SRHR through sustained commitment from the Dutch government and the United Nations to SRHR. A total of 85 international meetings were conducted for this purpose.
3. It has contributed to improved quality of and access to SRHR education by improving the quality standards of 174 SRHR education programmes, training a total of 38,862 educators on CSE and enabling the participation of over 4 million young people, women and men in CSE.
4. The programme has contributed to improving the quality and use of SRH services by training 66,791 service providers on SRHR, providing 3.8 million SRHR services by partner organizations and 13.3 million by subcontractors, and enabling the renovation of 215 health facilities.
5. Finally, UFBR has also contributed to a more enabling environment at community and national level by conducting 2,745 advocacy meetings, involving 5.4 million community members and leaders in awareness-raising activities and reaching a total of 70.5 million people through awareness-raising activities on SRHR.

However, did these achievements at output level contribute to the outcomes and final goal? Here we assess the assumptions of the ToC and progress made on each of its components.

8.1.1. General reflections

The UFBR programme was implemented in societies with significant SRHR issues for the target populations. While SRH issues prevail in many settings (teenage pregnancies, FGM, early marriages, lack of antenatal care etc.), in many cases, SRH is not seen as a priority, and in particular the concept of sexual and reproductive rights is not accepted. UFBR took up the challenge of addressing these topics in a comprehensive manner, often going against dominant socio-cultural beliefs and deep-rooted traditions. When not only many national contexts are becoming more conservative, but also in the international context less attention is being paid to SRHR (see the limited attention to SRHR in the recently developed SDGs), this deserves particular praise.

Compared to other programmes in the same field, we can clearly identify a number of key **strengths** of the UFBR programme.

The use of the **ToC and the multi-component approach:** UFBR addresses SRHR in a comprehensive way. SRHR is influenced by a large number of factors operating on individual, interpersonal, environmental and social-structural levels. While many programmes focus on only one aspect, UFBR has chosen to tackle a large number of the determining factors of SRHR and, therefore,

has the basic set-up to make real changes. Furthermore, these factors are influenced by a range of different strategies and key stakeholders. This gives UFBR a clear advantage over other programmes. The multi-component approach is able to strengthen **trust**, because so many stakeholders at different levels are involved. If someone is taught about SRH services and then has the opportunity to also go to a health centre and receive care from a trained youth-friendly health provider, this creates trust. Especially in countries with weak services it will remain important to address this issue, and governments may not have the resources and capacities to guarantee sustainability.

The UFBR programme received a **large budget** from the Dutch government, which differentiates it from other programmes that can only include a small number of partners, countries and activities. Therefore, it can really make a difference at the population level.

While many programmes enter a country and deliver a programme without much involvement of **different partners**, UFBR created a new wave in, or sometimes even established, the national SRHR sector in several countries. The strategy of bringing together different (types of) organizations to join forces is not only relevant for improving learning between organizations but also serves as a guarantee of comprehensiveness, stimulates adaptation to the local context and is a strategy for sustainability. Furthermore, UFBR invested a lot in both individual and organizational capacity-building.

Linking up with local and national **governments** and involving key **stakeholders**, such as community leaders and teachers, is crucial for any innovative intervention. Nevertheless, it is often overlooked or only done minimally. UFBR developed a comprehensive strategy to lobby governments and involve key stakeholders - a basis for sustainable change.

Compared to similar programmes, the **M&E** of UFBR has been thorough, elaborate and well conceived. Many aspects could be directly taken over by future programmes. Its comprehensiveness differentiates it from many other PME frameworks that often solely focus on quantitative outputs and outcomes using experimental study designs.

Overall, we could also identify a few **weaker points**. These are issues that we have seen in a number of SRHR programmes and, hence, are not specific to UFBR, except one (the governance structure).

The rather complicated **structure** of the SHRH Alliance, with different communication lines, may have led to a bureaucratic burden for the participating organizations. Especially at the top level of the alliance, members struggled with tensions between organizational and alliance interests, sometimes leading to mistrust and negative energy. Collaboration was also found to be bureaucratic and time-consuming. However, it was found that the alliances established a consensus-seeking culture, where most decisions were made democratically.

UFBR set out to approach SRHR with an ambitious proposal, using a rights-based approach, including addressing SGBV and sexual diversity, and implementing CSE. Nevertheless, in practice an approach was used in which **public health** was central. This is probably related to feasibility: in more conservative settings it is easier to focus on health than on rights.

UFBR focuses on young people and women. More attention could be paid to **young adolescents** (aged 10–14 years). Research has shown that addressing the needs and questions of young adolescents has a stronger and more sustainable effect on their knowledge, attitudes and behaviours that targeting those with already established attitudes and behaviours.

Linked to this, there have been issues of value clarification among the partners. While the Northern partners had an ambitious progressive agenda, this conflicted with the more conservative norms and values of the partner organizations. While the ASK programme included a process of **value clarification**, this was not the case for UFBR. Hence, implementing organizations did not fully embrace the more progressive parts of the programme (e.g. gender diversity, real CSE).

While the **PME strategy** was very comprehensive, a stronger focus on programme and process evaluation could have helped address and provide solutions to some of these weaknesses. Studying the programme itself and the way it is implemented is also crucial for the interpretation of the results.

8.1.2. Results by result area

Capacity-building and civil society strengthening leads to a stronger SRHR sector
The UFBR programme has brought together different organizations at country level to collaborate on SRHR. Through this partnership, partners have become better connected and able to learn from each other. In many countries this contributed to effective joint and better-quality programming and to establishing/strengthening the national SRHR sector. However, collaboration was not as effective in all the countries.

The capacity-building of individual staff members was important to address misconceptions around sex and clarify values on sexual diversity in a few countries. Staff members of partner organizations felt more confident about their ability to address certain SRHR issues; however, capacity on SGBV and sexual diversity was not sufficiently strengthened. This can be explained by two factors. First, although addressing these topics was an objective of the UFBR programme, there were no clear goals or indicators developed, which may explain this observation. Second, working on these topics is challenging in many countries, although a number of partner organizations did undertake activities in this field. This underlines the importance of value clarification throughout the entire programme.

At the organizational level, the online survey indicated that capacity was strengthened (a mean score of 8 out of 10 for five items). Internal learning capacity and gender-sensitiveness remained the weakest links, while capacity to plan for results and for networking/advocacy increased most. However, based on field studies, organizational learning seemed to be an issue of concern, in particular related to disseminating knowledge within the organization and translating learning into programming. An additional constraining factor for this was the high mobility of staff.

Hence, the UFBR programme has contributed to increased learning and joint advocacy, and the majority of partners reported having become better at implementing SRHR activities both individually and jointly.

National and international advocacy and lobbying leads to a more supportive enabling environment for SRHR
In UFBR programme countries all partner organizations have implemented advocacy strategies and work plans to improve the national environment for SRHR. Most country alliances have successfully conducted joint advocacy, and SRHR policies changed in at least seven UFBR programme countries. Joint advocacy was not successful in only one country (Indonesia) due to the lack of a joint advocacy strategy. In Indonesia, the responsibility for advocacy was given to a youth-led organization, which was unable to fulfil the task alone. Even though it was already clear after one year that it was not working, the strategy was not adapted.

The importance of advocacy for sustainability cannot be overstated. Advocacy is crucial for government buy-in in the programme. In the UFBR programme national governments were informed about but not closely involved in the programme. This may make it difficult for the government to sustain the project. Especially if the programme starts with a large budget, this may even destabilize the sector, since new initiatives may not be able to continue after the donor leaves.

Of particular interest is the level at which partners focus their advocacy strategy. Based on the available data, it seems that the SRHR Alliance has been addressing the national level, while the partners have been focusing on the local level. For example, Kenya adapted its strategy after the devolution of decision-making power to local authorities.[10]

At the international level, the SRHR alliance has successfully advocated for a positive policy dialogue on SRHR. Funding cuts to the Dutch SRHR budget were avoided through concerted advocacy campaigns, and parliamentarians were lobbied to ensure that SRHR remains on the Dutch priority list. However, continued advocacy will be needed to ensure that SRHR - and, in particular, sexual and reproductive rights - remain high on the international development agenda.

Improved quality of and increased access to SRHR education leads to an increased capacity of young people, women and men to make informed decisions about their SRHR
All country alliances have worked to improving the quality of CSE and SRHR education materials in and out of schools. The integration of CSE into the formal curriculum but also conducting SRHR education activities out of school has ensured greater availability of SRHR education in UFBR programme countries. While sexuality education is still a contentious topic in some countries, there has been overall increased acceptance of the need for SRHR education for young people. This is also due to the training of educators, which improved their capacities and confidence to deliver SRHR education. This promotion of formal and informal CSE activities led to increased access to SRHR education for target populations. However, there were again differences across countries. In countries where the local or national governments were supportive of CSE, schools were overall also more receptive to CSE, and educators were also seen to be more active. While supportive governments are a facilitating factor, they are not a necessity: in Indonesia teachers did succeed in implementing CSE in schools even without official support from governments. Personal conviction and persistence from the partner organizations and teachers were the main facilitators there. Furthermore, throughout all countries there were problems keeping trained educators engaged, in particular peer educators.

The whole-school approach was positively evaluated based on the available data (field study in Uganda and Kenya). While not fully implemented in all contexts, the concept received positive feedback. A main strength identified is that CSE (and health more broadly) is integrated throughout the entire school and even beyond, linking it to services. An additional positive point is that different teachers are made responsible for implementing parts of the CSE curriculum.

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[10] At the start of UFBR, Kenya decentralized several institutional powers to the local level. This became beneficial to both UFBR and ASK. The decentralization of health services saw some counties spend additional finances on putting up infrastructure and employing additional human resources to deal with health issues. It also saw some elected leaders take on contemporary SRHR issues as their pet projects, thereby putting renewed focus on them. As one of the respondents indicated: *"….I think in some counties they* [local authorities] *have enabled* [the implementation]. *I think it's also because of the time that we started this; it was the beginning of devolution to county governments …it was all new to them, so they didn't really know their responsibilities. I think they were happy CSOs came in and offered them things."*

Furthermore, a critical note needs to be made relating to the comprehensiveness of CSE. While the original manuals and most CSE activities could be considered comprehensive at the outset of the programme, the activities that were actually implemented were less comprehensive. Often, the more controversial topics - such as sexual diversity, rights and abortion - were taken out, and sometimes activities were reduced to abstinence promotion.

As confirmed by the OMR, the capacity of young people and women to make safe and informed choices significantly improved in all countries that provided reliable information. Hence, it is possible to link improved quality of and access to SRHR education to an increased capacity of target populations to make informed decisions about their SRHR. However, three countries reported no or a significant negative change in either capacity, attitudes or skills, which highlights that the quality of CSE is not guaranteed and that it alone is not enough, in particular when the environment is opposed to it.

Improved quality of and access to SRH services (and information) will lead to increased use of health services by young people and women

By linking schools with SRH facilities, the programme has also directly contributed to increasing young people's demand for SRH services. To satisfy this increased demand, the UFBR programme worked to improve the quality of and increase access to services. To increase access, health facilities were renovated, community volunteers were equipped with necessary means to conduct outreach activities, and other SRHR providers were subcontracted. These activities and, in particular, the last two were effective in increasing access to formal and informal SRH services for the target population, including LGBTQI people in some countries. The UFBR programme also worked on improving the availability of essential commodities, which was achieved in 19 health facilities.

The ToC assumes that the increased capacity of young people and women to make informed decisions about SRHR will lead to increased demand for quality SRH services. The OMRs from five of the seven countries that reported on this indicator confirmed that the proportion of young people and women who used health services significantly increased. Two countries reported a significant decrease, which was mainly due to lower usage by women, whereas usage by young people increased.

To improve the quality of SRH services, the programme trained health service providers. This training has led to better attitudes among health care providers regarding the provision of SRH. However, this has not necessarily affected the satisfaction of young people and women with the services provided, as the quality of services is affected by more variables than just the attitudes of health care providers. Other factors such as weak health systems, opening hours and availability of commodities are also important. With the start of the ASK programme, this component was clearly strengthened, and the quality of services improved in those countries where ASK was implemented alongside UFBR.

The available public health services are often limited, and the provision of training does not address this challenge; on the contrary, it can only add to the workload of already overstretched health care workers. Training health care providers to provide youth-friendly and SRHR-friendly services could be more effective if integrated into the national curriculum for nurses and physicians. Young people's satisfaction with SRH services increased significantly in four countries, whereas women's satisfaction increased in only three countries (for which data were available or reliable).

While the UFBR programme has been successful in increasing demand for quality SRH services among young people, women and men, the supply of these services still remains an issue in many of the UFBR countries - in particular, in those where public health services are weak. In most countries

the minority of partners were service providers, which possibly explains why this aspect of the programme received less emphasis.[11]

A more supportive environment for SRHR will allow young people, women and marginalized groups to exercise their sexual and reproductive rights
As mentioned before, working on CSE and services alone was not enough to change perceptions on SRHR, and cultural and religious norms were often mentioned as barriers. To address these issues and contribute to a more enabling normative and policy environment, the UFBR programme worked to improve SRHR policies and legislation as well as raising awareness with communities and community leaders. Joint advocacy was successful in most countries and contributed to changing local or national policies on SRHR.

To change the environment at local level, communities and community leaders were trained in SRHR and encouraged to participate in SRHR awareness-raising activities. By using various types of awareness-raising activities, including peer-to-peer learning, dance, drama, music, discussions, films and social media at community and national level, the programme was able to reach a huge number of people. The involvement of community leaders has been particularly important to address specific cultural and religious barriers. According to the OMRs, there is increased acceptance of SRHR issues in all countries; however, this greater acceptance is still more about the uptake of SRH services and education than about changes to norms and values that affect SRHR. In particular, topics such as sexual diversity, sexual rights and SGBV remain contentious issues in most countries. This component of the programme is unlikely to change dramatically in a short-term programme, since a long-term horizon and investment are required for norms and values to change, especially in a global society with strong conservative voices.

8.2. Relevance, effectiveness, efficiency and sustainability of the programme
The UFBR programme was relevant to young people and women, as it addressed their real and urgent needs. These were different in each country but included issues such as access to contraceptives, HIV/AIDS counselling, STI screening, early and forced marriage, FGM, school drop-outs, stock-outs of essential medicines and others. The programme was also adapted to the local context and well received by the people it reached.

As described above, the multi-component approach was appropriate in that it enabled the partners to address all three components, which were closely interrelated. In those countries where all three components were addressed consistently, more progress was achieved. However, in those countries where the supply of SRH services is weak, specific attention should be paid to this component to ensure that the increased demand will be satisfied. In contexts where services are strong but access is low (e.g. Indonesia), more attention should be paid to accessibility and demand creation.

Nonetheless, and even though sexual diversity was a key component, not all countries were successful in addressing the needs of marginalized groups such as LGBTQI people or sex workers. In those countries where specific attention was paid to marginalized groups (Malawi, Indonesia), only a few positive changes were achieved, although overall the topic remained difficult to address. While

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[11] In the online survey the respondents were asked on which topics they worked most. Of the respondents that worked on UFBR or UFBR and ASK, 23 stated that they worked most on CSE, 6 on services, 10 on enabling environment, and 12 on other aspects of the programme.

SGBV has been integrated more consistently in most countries, the fact that no indicator for this topic was streamlined through the programme meant that it often disappeared into the background. Furthermore, some countries have made efforts to engage men in the programme, but again this was not done consistently across the programme. The lack of clear indicators for these components may have contributed to this. This relates to a possible clash between the progressive character of the Northern alliance and more conservative attitudes of Southern partners and the aforementioned discussion on ownership and a rights-based perspective. Clear value clarification at the start of the programme (as was done in ASK) can reduce the gap between these two philosophical stances.

When looking merely at the targets reached, the programme has been extremely effective. Questions can, however, be raised about how targets were set or about how robust the monitoring and evaluation of data has been.[12] Furthermore, there are issues with the data collected for the outcome measurements, in particular for the comparison between baseline and endline. Nevertheless, based on all the data we gathered (desk study and field research), we can make a plausible case that the programme has met its objectives.

Strategies that were particularly effective include aligning the programme with the local and national government and obtaining their buy-in where possible. Using teachers, peer educators and community leaders as agents of change was also effective; when the programme was able to get them fully on board, students and community members were more likely to accept SRHR issues. However, more thought should be given to how the impact of training can sustained. For example, the training of service providers could be more effective when integrated into the national curriculum. Also, involving young people in the implementation and design of the programmes was essential, although more could be done to ensure their meaningful engagement in advocacy and at organizational decision-making level.

Insufficient information is available to make conclusive statements about the programme's efficiency. While there have been cost savings by working in a partnership and sharing resources, more effort should be made to measure efficiency.

The programme has contributed to sustainable results. In particular, the inclusion of CSE in the formal curriculum and the integration of YFS into existing facilities are results that will continue to have an impact. The programme also used existing community structures and engaged local and national governments where possible. This has contributed to increased ownership by key stakeholders. Finally, the country partnerships are likely to continue after the programme, in particular for sharing lessons and learning and joint advocacy.

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[12] The targets were set based on the sum of the targets of the individual partners. This did not take into account the increased outputs as a result of collaboration.

9. ASSESSMENT OF THE STRENGTH OF EVIDENCE FOR THE TOC ASSUMPTIONS

This chapter presents an assessment of the strength of evidence for the assumptions for the UFBR programme. As was explained in Chapter 3, as part of the process of developing the ToC, it is important to identify 'evidence' that confirms the assumptions and theory of the ToC. As there is no rigorous evidence available yet to support each of the assumptions of the ToC, the evaluation will be useful to verify and collect evidence for these assumptions. The explicit ToC and the assumptions connected to it are described in Chapter 3. The table that is central in this chapter aims to provide an estimation of the strength of the evidence of the ToC. It is based on available evidence from the UFBR documentation and the end-of-programme evaluation. The colour codes refer to the strength of evidence for the causal link defined in the assumption, not to the effect of the UFBR programme itself.

To assess the evidence of the ToC assumptions, the following criteria[13] can be used:

Very strong	High quality, large in size, consistent, closely matched to programme context
Strong	High quality, large or medium in size, generally consistent, matched to programme context
Medium	Moderate quality, medium size, generally consistent, matched to programme context
Limited	Moderate or low quality, small or medium size, inconsistent, not matched to programme context
No evidence	No evidence identified

Table 9.1. Assessment of strength of evidence for the ToC assumptions

CAPACITY-BUILDING ASSUMPTIONS	
Capacity-building and networking provide a platform for sharing knowledge and learning and increased collaboration between organizations	The country reports demonstrate that there is increased participation in different national networks on SRHR. The online survey, country reports and field research also provide evidence that organizations shared knowledge and mutually learned from each other.
Linking and learning between organizations leads to better programming	The evaluation has found strong indications that, due to the country partnerships, partners are better connected and were able to learn from each other. In many countries this contributed to better-quality programming.
Individual capacity-building on SRHR increased knowledge and skills on SRHR among staff of partner organizations and CSOs	Large numbers of staff were trained, and respondents to the online survey and field research indicated that their individual capacity on SRHR has strengthened.
Organizational capacity-building on project management, research and PME leads to improved implementation and monitoring of the programme	While it is clear that the level of individual capacity was strengthened, evidence for strengthening the capacity of partner organizations as a result of working in the alliance is more limited. Field research in Indonesia confirms this. Scores from the online survey for organizational capacity-building were lower than for individual capacity-building. Additional information from Organizational Capacity Assessments may improve the strength of the evidence.
Better-connected and strengthened organizations contribute to a stronger national SRHR sector	Some country alliances reported greater visibility and credibility of their work, which is an indication of a stronger national SRHR sector. However, there were also examples of less visible alliances which only partly used the potential of the partnership. The online survey also indicated positive scores (mean 8.2) for the statement 'The SRHR sector in my country has been substantially strengthened through working in this alliance'.

[13] DFID (2013). *How To Note on Assessing the Strength of Evidence.* London: DFID: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/158000/HtN_-_Strength_of_Evidence.pdf.

DEMAND-SIDE ASSUMPTIONS	
Improved quality of CSE content, methodology and materials enable facilitators to deliver more comprehensive CSE	The available evidence (country reports and field studies) shows that the availability of quality materials provides a good reference point and guidance for CSE activities. However, the comprehensiveness of the delivery is influenced by the values and priorities of the facilitators. Value clarification and buy-in from facilitators and partner organizations may improve the comprehensiveness of the delivered CSE.
Improved quality of CSE will improve uptake of CSE messages and learning	Snapshots from the field work, MSC stories and scientific evidence indicate that quality CSE messages, delivered in a youth-friendly and participatory way, encouraged uptake and learning of the messages.
Training educators to deliver quality CSE leads to improved capacities of educators to deliver CSE	Qualitative research from FGDs and interviews showed that facilitators felt strengthened and more motivated to deliver CSE. An important prerequisite is that there is no conflict with their own value systems and beliefs (which should be part of a good training programme). Nevertheless, during the field studies, several educators indicated that their capacity was not sufficiently built to address certain sensitive issues such as sexual diversity. Also, some felt that their professional background limited the possibility to address certain issues.
Promotion of formal and informal CSE activities leads to increased access to SRHR education	Different promotional methods (such as TV advertisements, community outreach, IEC materials, community meetings) all promoted access to CSE for different target groups. The output data clearly indicate that a large number of people have been reached. We do note that this does not necessarily also lead to increased uptake of CSE messages and activities.
Increased access to quality SRHR education and CSE leads to increased knowledge, better attitudes and improved skills of young people and women	Outcome data from the OMRs show that knowledge, attitudes and skills improved in almost all countries. While there are some methodological flaws in the OMRs (differences between baseline and endline, no control group and not controlling for other programmes in the area) that limit the reliability of attributing changes to the programme, the fact that all countries report similar results supports the assumption. Attitudes were measured in a rather limited way, with not very much assessment of attitudes towards aspects such as gender diversity or pleasure.
Increased knowledge, better attitudes and improved skills lead to increased capacity to make informed decisions about their SRHR	The quantitative data demonstrate that increased knowledge, better attitudes and improved skills generally lead to reported better capacity to make informed decisions. However, qualitative data show that an enabling environment is a prerequisite for feeling empowered to make and implement decisions. Currently persisting norms and values limit young people's space to make and implement these decisions.
Increased capacity (knowledge, confidence and attitudes) of young people, women and men on SRHR leads to greater demand for quality SRHR services	Output data and secondary data give an indication that uptake of services increased. Qualitative data demonstrate that people (young people and women) feel capacitated to access services. However, there are still barriers to accessing services (legislation, opening hours, confidentiality, stock-outs) — in particular, specific services (such as abortion services). Also, the establishment of linkages between schools and health services was important in increasing access to services.
SUPPLY-SIDE ASSUMPTIONS	
Training of service providers on delivering quality SRH services leads to improved capacity of service providers to deliver quality SRH services	Quality was measured in a rather limited way. There was no objective measurement of quality of the services performed (e.g. management of illnesses). The OMRs do indicate that youth-friendliness improved (though this evidence is weak). Only a limited number of countries reported on compliance with quality standards. A condition for success is the institutional buy-in or adoption of quality guidelines and monitoring systems in place. Nevertheless, MSC stories provide several examples of service providers with improved capacities.
Renovating health facilities improves access to formal SRH services	The online survey indicated that renovating health facilities was one of the least valued strategies. Renovation is probably useful as part of a holistic health systems strengthening approach.

Equipping community health workers and trained birth attendants with the necessary means improves access to SRH services through referrals	The field studies (interviews and FGDs) and desk research indicate that training and involving community health workers and trained birth attendants improves referrals to health services.
Better supply of commodities and drugs leads to better quality of SRH services	Stock-outs of commodities and drugs were identified as a barrier to satisfaction with health services. Hence, we can say that good supply is an important component of quality of services. While there were some problems in stock management within UFBR, ASK complemented this activity with a clear focus on strengthening service provision.
Improved quality of SRH services leads to greater client satisfaction	The quantitative outcomes indicate improvement in some countries (though a reduction in client satisfaction was also recorded). The qualitative data indicate that clients think attitudes of health providers have improved, but also report dissatisfaction with certain aspects of services. The OMR found different types of relations between the quality of services and client satisfaction (better quality and worse satisfaction, and vice versa). The use of scorecards in a few countries provided evidence of the inverse relationship: if clients complain about a certain aspect of the service, the necessary changes are made, and the quality is improved.
Improved access to formal and informal SRH services leads to better uptake of health services	There are limited data to support this assumption. Outcome data on uptake are based on secondary data that cannot be linked directly to the programme. The qualitative evidence from the field study and country reports indicated an increased uptake of antenatal services and YFS. Also, outreach activities had a positive effect on uptake of commodities.
ENABLING ENVIRONMENT ASSUMPTIONS:	
Effective advocacy in-country leads to a favourable policy dialogue on SRHR in-country	Several positive examples of changed policy dialogue have been observed in this evaluation. While the causal link can be demonstrated, it must be said that really changing the policy dialogue requires a continuous effort, as conservative voices at district, national and international levels can provide strong opposition.
The development of advocacy strategy and work plans leads to implementation of advocacy campaigns to improve SRHR policies and legislation	If there was no advocacy plan, very little action was undertaken. On the contrary, the advocacy plans were a necessary prerequisite for action.
Advocacy meetings at local, regional or national level lead to improved SRHR policies and legislation (more aligned with the programme's objectives)	The organization of advocacy meetings led to increased involvement of partner organizations in policy development and implementation processes. However, there is not always evidence of the outcomes of their involvement.
Promotion of SRHR awareness-raising activities at community level leads to increased involvement of communities and community leaders in SRHR awareness-raising activities	Qualitative evidence showed that specific strategies were used to engage community members and leaders. This increased their involvement in the programme activities and a sense of support. Output data show that a lot of community leaders have participated in awareness-raising activities, but there is no evidence of their real involvement.
Promotion of SRHR awareness-raising activities at national level using (new) media leads to increased involvement of communities and community leaders in SRHR awareness-raising activities	There is limited evidence to prove that use of new media prompted increased involvement by community leaders. It was found as an effective way to communicate messages, but there is no clear linkage with increased community involvement.
Increased involvement of communities and community leaders in SRHR activities leads to a more supportive environment for SRHR	There is strong evidence from the qualitative data from the OMRs as well as the country annual reports that the involvement of community leaders and other stakeholders led to a more supportive environment for implementation of the SRHR programme. However, the extent of involvement was also another important factor and determined the degree of support. In instances where ownership was promoted, this led to more sustainable engagement. On the other hand, qualitative data show that there is increased support for several aspects of SRHR within the communities, but not for the entire spectrum (such as gender diversity).

<table>
<tr><td>Improved SRHR policies and legislation lead to a more supportive environment for SRHR</td><td>There is sufficient evidence that unsupportive policies and legislation hinder the implementation of the programmes and the realization of sexual and reproductive rights. Positive examples can also be found: CSE being made compulsory in Uganda generated a sense of importance for its implementation. In Malawi the alliance contributed to a change in the law that allowed adolescent mothers to return to school; they used this law in advocacy for this measure in schools and communities.</td></tr>
<tr><td>A more supportive environment for SRHR provides more support to young people, women and marginalized groups to exercise their sexual and reproductive rights</td><td>There is strong evidence that the lack of an enabling environment hinders the realization of sexual and reproductive rights. Community opposition was often seen as a major barrier for target groups to exercise their rights. Policies and legislation made it more difficult for people to exercise their SRHR (e.g. unmarried couple cannot access contraceptives in Indonesia; LGBTQI rights are violated in Uganda).</td></tr>
<tr><td colspan="2">LONG-TERM CHANGES</td></tr>
<tr><td>More demand, supply and support for quality and equitable SRHR leads to improved preventive behaviours by young people</td><td rowspan="4">Theoretically these statements seem valid. Looking at the socio-ecological model (see infographic) the SRH of individuals is influenced by a large set of factors at the individual, interpersonal, community and socio-structural level. With UFBR, the SRHR Alliance implemented a comprehensive programme, addressing several factors at these different levels. It can, therefore, be expected that its impact is greater than when only one or a few factors are addressed.

Furthermore, there is strong evidence of the individual links (from improved preventive behavior, utilization of quality SRH services or improved enabling environment to improved SRHR). Therefore, we can assume that the combination of factors will only generate a larger effect.</td></tr>
<tr><td>More demand, supply and support for quality and equitable SRHR leads to improved use of quality SRH services</td></tr>
<tr><td>More demand, supply and support for quality and equitable SRHR leads to improved acceptance of SRHR and gender equality within the community</td></tr>
<tr><td>Improved prevention behaviours, utilization of quality SRH services and increased acceptance of SRHR and gender equality lead to improved SRH and equal sexual and reproductive rights for young people, women and marginalized groups</td></tr>
</table>

10. RECOMMENDATIONS

At the level of the partnership and the overall programme

- Ensure that sexual diversity, gender equality and SGBV are mainstreamed in the programme by, for example, including specific output indicators. Incorporating an analytical framework to guide programme implementation and interventions will be useful for future programming, and can serve as a compass for estimating programmes' responsiveness to these different topics. An example of such a framework for gender-responsiveness can be found in Annex 6.
- UFBR alliance partners in the different countries have been very effective in engaging in networks for joint advocacy and lobbying. However, engaging other stakeholders in the development and implementation process of the programmes would help the interventions to be stronger and more sustainable. The programme could develop 'communities of practice' or working groups of different stakeholders to ensure continuous engagement in the implementation and learning process of the programmes. This would mean engagement of not only other CSOs but also research institutes, 'think tanks', private organizations, teacher training programmes etc. through the programme's entire intervention timeline. Communities of practice are defined as groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly.
- Increase the interaction between the programme staff of alliance members by way of job rotation within partner organizations. This may resolve the challenges of collaboration, participation and delayed feedback.
- To increase efficiency, country alliances should critically assess when joint activities are useful and at what level they should be organized.
- Review the current governance structure in the international alliance to ensure that country alliances have sufficient ownership. In some countries, the alliances have found ways to ensure sustainability of the partnership structure beyond the UFBR programme. However, the need for more ownership of the programmes at the alliance, and also at the partnership, level is required. In some countries, partners took some time before they could identify their complementary roles, as sometimes organizational priorities did not align with alliance priorities.
- The network model of governance provides opportunities for partners to work in 'task forces', providing opportunities for them to learn, decentralize management and create more shared ownership of the programmes. This can be done in different ways, either by developing working groups on specific components of the programme and allowing different partner organizations to lead this process or develop task forces. This will also increase the interaction between the programme staff of alliance members.
- Find ways in each alliance organization to institutionalize knowledge to make more use of the individual capacity-building that is achieved. Organize informal 'bring-a-colleague' meetings in each working group every once in a while. Share lessons learned or new approaches from the field for working groups to reflect together, but with new input from staff outside the programme. In this way staff not involved in the programme also share in knowledge exchanges.
- Integrate an implementation science approach within programme interventions. UFBR was developed as an intervention programme targeted at achieving specific goals, but without requiring strong proof of evidence at the end. Incorporating an implementation science approach, especially for the new programme, will mean that significant planning will be involved in choosing target sites, sampling for endline and baseline measurements and also in the decision on which interventions to implement. The focus of the programmes would also be to generate evidence on what works best and where for the uptake and sustainability of the interventions. This would also require consideration of the type of staff employed at the different country/partner organizations and the need to collaborate with research institutes within the country as partners.

For improving SRHR education

- Make more effort to ensure a participatory value clarification with regards to CSE with all stakeholders. There are examples of different participatory methods that were used across the different organizations and partners (e.g. photo voice and grass-roots comics or the Heart Connection tours). These approaches were mostly targeted at young people, but not at staff level or among parents. Quick participatory appraisals can also be done in communities and among implementers (service providers, peer educators and programme staff) to assess the differences in value systems and attitudes towards their programme interventions. This can be only at baseline, mid-term and evaluation points. The findings can be used to improve the programmes and make them more relevant to the context to address these values and belief systems.
- In those countries where CSE is included in the national curriculum, ensure that effective monitoring systems are in place to monitor the implementation - in particular, the comprehensiveness of the education - at district level.
- Create youth platforms for continuous development of knowledge and skills.
- Continue to strengthen links between schools and SRHR services.

For improving SRH services

- Lobby for changes in educational institutes for health care providers, to create more awareness of YFS in the curriculum.
- Continue to sensitize health care providers on providing youth-friendly SRHR services.
- Involve community leaders and parents in YFS programme activities, especially with regards to their role in promoting information dissemination and use of youth-friendly SRH services.
- Create more opportunities for linkages and referral between public and private institutions, as this might provide opportunities for sustainable funding mechanisms.
- In some countries value clarification is needed for health care providers, particularly on topics that are sensitive due to religious norms, such as safe abortion and access to contraception.
- Outreach activities are useful as a first entry point for access and referral to services. Furthermore, they are valued highly by the target groups. However, the sustainability of these activities over the long term is questionable, and a cost-effectiveness analysis could be beneficial to assess the real value of these activities.
- Employ a 'health systems approach' to improving service delivery: develop interventions that aim to improve not only specific components of health institutions but the structure of service delivery and the health system as a whole, as this provides more opportunities for sustainable changes in SRHR service delivery in the target health centres. This is already being done in some countries, but not systematically. This also provides better opportunities for joint funding with government institutions and local authorities, which is likely to increase sustainability, as they will see the interventions as being holistic and not specifically directed at certain components of health care which might not be a priority for them.

For a more supportive enabling environment

- Advocate nationally for YFS in health facilities, not only at policy but also at budgeting level.
- Continue to work with religious and cultural leaders to define and uphold positive SRH practices among young people and the communities.
- Ensure continuous community dialogue to find the best way to deal with persisting negative cultural and religious norms.
- Continue the use of several kinds of (new) media to raise awareness of SRHR for young people and women.
- Encourage mothers and fathers (especially the latter) to take responsibility for sharing SRHR messages with their children.

- Move from community mobilization to community engagement. Proper community engagement provides opportunities for sustainability and opportunities to ensure that interventions are relevant and context-specific. It requires a well-thought-out process to help identify and engage different stakeholders that influence the programme and their impact on beneficiaries at the personal, interpersonal, community, national and global level. During this end-of-programme evaluation, stakeholder mapping exercises were used in the different fieldwork exercises in the different countries, and they were useful for assessing stakeholders that were strategically placed to either improve or hinder the impact of the programme.
- Develop effective and relevant communication tools. There is a need to incorporate a clear communication strategy within the programme implementation plan, to increase visibility of the programme and also improve uptake of interventions.
- Involve community leaders and parents in YFS programme activities, especially with regards to their role in promoting information dissemination and use of youth-friendly SRH services.
- Create more opportunities for linkages and referral between public and private institutions, as this might provide opportunities for sustainable funding mechanisms.

For improving/assessing efficiency

- Build in mechanisms to measure efficiency right from the start of the programme, and ensure that the financial administration is connected to them.
- Report on efficiency — for instance, by incorporating information on budgets at the level of programme interventions in annual reports.
- In future SRHR programmes, make better use of comparing programme strategies and interventions between countries involved in previous programmes.
- Increase transparency of budgets and the costs of programme activities, to increase partner organizations' awareness of efficiency — for instance, by including information on programme budgets in general project documents.

EPILOGUE

The SRHR Alliance commissioned this external evaluation, with an accountability and learning objective. After five years of implementation of the UFBR programme, the SRHR Alliance generally felt positively about the UFBR programme and it's progress, but was keen on having a validation of this assumption. Furthermore, the Alliance desired an external eye to critically assess the programme and fill in the blind spots that might occur after being closely involved in the UFBR programming for five years.

In reaching these objectives, the Alliance has not been let down by the evaluation of ICRH and Kaleidos research. Our positive understanding of the results of the programme has been confirmed. We are proud that the evaluation team has identified a number of key strengths of the UFBR programme compared to other programmes in the same field, like 1) the comprehensiveness of the programme because of our multi-component approach, 2) the building of SRHR country alliance (*creating a new wave*), 3) the collaboration with governments and key stakeholders, and 4) the comprehensiveness of the monitoring and evaluation.

As important as these positive and endorsing findings are the recommendations of the evaluation team for our future programmes. From 2016-2020, the Get Up Speak Out (GUSO) programme funded by the Dutch Ministry of Foreign Affairs, will build upon the results and lessons learned from the UFBR programme. The assessment of the strength and evidence for the UFBR Theory of Change by the evaluators, is an important tool to (re-)check our assumptions and strengthen our GUSO Theory of Change. GUSO will use the practical recommendations on partnership development as well as on the programmatic level to improve both governance structures at the alliances, and the quality, efficiency and sustainability of the programme. A number of the recommendations are part and parcel of the new programme, like increasing the ownership of country alliances over the programme, and a stronger focus on gender and gender transformative approaches. In addition, recommendations for assessing efficiency, and a stronger focus on quality and process monitoring will be seriously explored to strengthen the PMEL system, and to timely adjust the programmes strategies where relevant. The implementation of a scientifically-based implementation approach will enable a stronger focus on what works best, where, on for whom, for uptake and sustainability of interventions.

SRHR alliance

ANNEX 1: OUTPUTS AND OUTCOMES TABLE

This annex provides an overview of all achievements of the output and outcome targets for UFBR, based on the project documentation provided by the SRHR alliance office.

The following criteria are used for the outcomes and outputs:

Effect/ outcome	significant positive change - strong evidence (adjusted)	Significant possitive change - weak evidence (not-adjusted)
	no significant change - strong evidence (adjusted)	No significant change - weak evidence (not-adjusted)
	significant negative change - strong evidence (adjusted)	Significant negative change - weak evidence (not-adjusted)
	No information	
Outputs	Achieved targets	no target but output
	Not achieved targets	no target no output
	No information	

Result area 1

		Ethiopia	Kenya	Uganda	Indonesia	Pakistan	India	Bangladesh	Malawi	Tanzania
							latest version not included	received too late		
		medium	+	+	unreliable	medium	unreliable		+	+
Outcomes										
1a	Increased strength of the SRHR sector in the Civil Society Index (CSI) dimensions									
Outputs										
1.1.1	Partner organisations (POs) are actively involved in x nr. of networks									
1.1.2	No. of CSO (staff) members trained to increase their knowledge and skills on SRHR, based on identified needs									

Result area 2

		Ethiopia	Kenya	Uganda	Indonesia	Pakistan	India	Bangladesh	Malawi	Tanzania
							latest version not included	received too late		
		medium	+	+	unreliable	medium	unreliable		+	+
Outcomes										
2.1a	% of the exposed target groups has an increased capacity to make safe and informed decisions									
	knowledge									
	attitudes									
	confidence									
	QUALITATIVE DATA									
2.2a	% of targeted SRHR facilities increasingly comply with IPPF standards for youth friendly services									
2.2b	% of SRHR facilities with an increase in satisfaction by young people									
	QUALITATIVE DATA									
2.2c	% of targeted facilities increased their compliance to the (national) quality standard									
2.2d	% of maternal health facilities with an increase in satisfaction by women									
2.3a	% increase in the use of targeted SRHR services by young people and women									
2.3b	% increase in number of births in targeted areas that were attended by skilled birth attendants									
2.3c	% increase in targeted health facilities of women who have 1-4 antenatal consultations									
2.3d	Nr of facilities with increased availability of contraceptives, ART, ACT & antibiotics									
2.4a	SRHR policies and legislation implemented, changed, or adopted at local, institutional or national level, at least 2 per country									
2.4b	Increased involvement of community leaders in realisation of SRHR in x% of the targeted communities									
2.4c	Increased acceptance of SRHR at community level in x% of the targeted communities									

Result area 2

		Ethiopia	Kenya	Uganda	Indonesia	Pakistan	India	Bangladesh	Malawi	Tanzania
							latest version not included	received too late		
		medium	+	+	unreliable	medium	unreliable		+	+
Outputs										
2.1.1a	No. of SRHR education programmes improved on quality standards of SRHR education									
2.1.2a	No. of educators trained to deliver SRHR education									
2.1.3a	No. of young people, women and men who participated in SRHR education									
2.2.1a	No. of service providers trained to deliver SRH services									
2.3.1a	No. of health facilities renovated									
2.3.1b	No. of SRH services provided by partner organisations to young people and adults									
2.3.1c	No. of SRH services provided by subcontractors/government facilitated by Partner Organizations									
2.4.1a	No. of partner organisations with an implemented advocacy strategy and advocacy work plan on SRHR									
2.4.1b	No. of advocacy meetings conducted at local, regional or national level									
2.4.2a	No. of community members and community leaders participating in SRHR awareness-raising activities at community level									
2.4.2b	No. of persons reached by SRHR awareness raising activities through (new) media									
2.4.2c	No. of persons trained in awareness raising activities									

Result area 3

		Ethiopia	Kenya	Uganda	Indonesia	Pakistan	India	Bangladesh	Malawi	Tanzania
							latest version not included	received too late		
		medium	+	+	unreliable	medium	unreliable		+	+
Outcomes										
3.1a	% of all partner organisations have progressed on SRHR capacities and three other prioritised areas (SoV: 5C assessment)									
3.1b	% of partner organisations with improved involvement of target groups in all aspects of the programme									
Outputs										
3.1.1a	No. of key staff members trained in the areas mentioned									
3.1.1b	POs have developed and implemented a capacity building plan									

Result area 4

		Ethiopia	Kenya	Uganda	Indonesia	Pakistan	India	Bangladesh	Malawi	Tanzania
							latest version not included	received too late		
		medium	+	+	unreliable	medium	unreliable		+	+
Outcomes										
4.1a	The % of the budget for Dutch development cooperation assigned to SRHR is maintained or increased									
4.1b	Renewed SRHR agenda at UN level after 2014									
Outputs										
4.1.1a	No. of contact moments of Alliance members with policy makers at (Dutch) national level									
4.1.1b	No. of international meetings with political relevance on SRHR attended by Alliance members or partner organisations									

ANNEX 2A: ONLINE SURVEY I - UFBR AND ASK

Objectives

- To get a complete view of whether local partners in all countries feel that their organization has benefitted and has developed through one or both programmes
- To gain insights into and consensus on the core strengths and weaknesses of the programmes' design, implementation and PME, and on their main results.

Methods

We will develop a short online survey that will be sent to all partners: the Northern alliance partners of both programmes and their local partners. This survey will consist of two parts: one general section that is applicable to all partners, and one section that is specifically for Southern or Northern partners. For each Northern partner organization we aim to have one respondent per organization fill in the questionnaire: the person most experienced in working in the alliance (in most cases the country leads) and the implementation of the programme. Due to the already heavy PME workload of Southern partners we also aim for only one person per organization to fill in the survey. To increase response, the invitation email will be personalized, and we will ask each country lead to emphasize to these people the importance of cooperation. In cases where two people work on the coordination of activities due to the high number of activities (e.g. Kenya and Indonesia), both can be involved in this survey.

The survey will consist of two parts:

- The first part consists of questions on the programme design, implementation, evaluation and main results. This part will use a Delphi method in which multiple rounds of online surveys will be run. This will allow us to extract insights into and consensus on the three core strengths and weaknesses of the programme design, implementation and evaluation (Dimensions 1, 2, 3 and 4). The survey will include open-ended questions on the following topics:
    - Strengths and weaknesses of the design
    - Strengths and weaknesses of implementation
    - Outcomes of the programmes
- The second part will explore capacity-building and partnership collaboration at the international and national level. It will include the following topics:
    - Perceived value of in-country collaboration
    - Value of the alliance (added value/benefits/costs/disadvantage)
    - Changes in capacity (in line with the 5C approach)
    - Mutual influence between UFBR and ASK
    - Sustainability at the project level and of the partnership/alliance (plans to continue the alliance and activities, even without future support from the current programmes)
    - Willingness to use other donor funding to continue ASK/UFBR interventions
    - Statements on critical success factors on working in partnerships
    - Development of the partnership after the recommendations of the mid-term partnership review.

START: INTRODUCTION

Dear Madam, dear Sir,

Over the past years you have been a member of the Sexual and Reproductive Health and Rights Alliance (SRHR Alliance) and/or the Youth Empowerment Alliance (YEA). Both partnerships have been implementing programs for the promotion of sexual and reproductive health and rights: the Unite for Body Rights Program (UFBR) and/or Access, Services and Knowledge program (ASK). Researchers from Kaleidos Research (NCDO foundation) and the International Centre for Reproductive Health (ICRH, Ghent University) are currently conducting an evaluation of both programs.

As a key partner in one or both programs, we would like to include your expert opinion in this evaluation. Therefore, we would like to invite you to participate in an **online survey** on a several important aspects of the program(s). While part of the survey will be classic *closed questions* focusing on capacity building and partnerships, a second part will use a *Delphi approach* with questions on strengths and weaknesses in the program(s). This approach is typically used for consensus building among experts in the field. After a first survey round of open questions, the answers in this part will be analyzed and fed back to the participants for a second and possibly third round of questioning, in order to arrive at a common set of key conclusions. The answers that you will give will be treated anonymously and confidentially.

We would highly appreciate your cooperation. Participation in this survey will take approximately 20 minutes. Thank you very much for participating in the research.

Please contact us at Emilomo.Ogbe@ugent.be, if you have any further questions about the survey.

Click here to start the survey

[p. 1 FILTER QUESTION:]

1.1. For which program do you work?

- UFBR → SURVEY 1: only show answer options for UFBR
- ASK → SURVEY 2: only show answer options for ASK
- Both → SURVEY 3: show answer option for both

[p. 2]
1.2. In which country do you work?

- The Netherlands
- United Kingdom
- A country where the program is implemented

1.3. In which country programs are you involved? *[more than one option is possible]*

- Bangladesh
- Ethiopia
- Ghana
- India
- Indonesia
- Kenya
- Malawi
- Pakistan
- Senegal
- Tanzania
- Uganda
- Other: …

1.4. Which Dutch/ UK counterpart organization are you working for or are you affiliated with? (This information and any personal identifiers will be anonymised and kept confidential) *[more than one option is possible]*

- AMREF Flying Doctors
- Child Helpline International (CHI)
- Choice for Youth and Sexuality
- dance4life
- International Planned Parenthood Federation (IPPF)
- Rutgers
- Simavi
- STOP AIDS NOW!
- Other / I am a National Program Coordinator

1.5. Please specify what component of the program(s) you work mostly in?
- SRHR Education
- SRH Services
- Enabling environment
- Other / I am a National Program Coordinator

1.6.a. When did you start working for the UFBR program?

- 2010
- 2011
- 2012
- 2013
- 2014
- 2015

1.6.b. When did you start working for the ASK program?

- 2013
- 2014
- 2015

1.7. What is your position in the SRHR Alliance?

- Project Officer
- Country Lead
- Program officer
- PME-officer
- Advocacy officer
- NPC
- Director
- Other: ……

1.8. What is your gender?

- Male
- Female
- Other: …….

1.9. How old are you? … years

[p. 3]
2. We will start with a number of open questions on the program design, implementation and main results. This part will use a Delphi method in which two rounds of online surveys will be run. This will allow us to extract insights and consensus on the core strengths and weaknesses of the program design, implementation and results.

You will be asked to provide between one and three answers to the questions.

[AT LEAST ONE ANSWER, before they can move to the next page]

2.1. As a partner in the UFBR/ASK program(s) what are, according to you, the **three greatest strengths** of the general set-up and core principles of the program(s)?

	2.1.a UFBR	2.1.b ASK
1		
2		
3		

2.2. What are, according to you, the **three weakest points** in the general set-up of the program(s)?

	2.2.a UFBR	2.2.b ASK
1		
2		
3		

[p.4]

2.3. You and your organization have been implementing several activities within the UFBR/ASK program(s). What are, according to you, the **three strongest activities;** if only three activities could be continued, which ones would you choose?

	2.3.a UFBR	2.3.b ASK
1		
2		
3		

2.4. What are, according to you, the **three weakest activities;** if three activities were to be stopped immediately, which ones would you choose?

	2.4.a UFBR	2.4.b ASK
1		
2		
3		

[p.5]

2.5. What was according to you the **most useful** activity in each of the domains?

2.5.1. Education
- o Awareness raising activities
- o Electronic & mobile health tools
- o Formal education
- o Informal education
- o Development of Manuals and Guidelines
- o Peer to Peer learning
- o Training to professionals
- o Training to volunteers
- o I don’t know

2.5.2. Services
- o Implementation of integrated package of essential services
- o Implementing referral system linking public/private for profit SRH services
- o Improving commodity supply systems
- o Improving/ renovation of health services
- o Reaching marginalized groups
- o I don’t know

2.5.3. Enabling environment
- o Awareness raising activities
- o Community stakeholders support
- o Lobby and advocacy activities
- o Policy reviews and analysis
- o Training in awareness raising activities for Community based organizations and civil society organizations

- Training in awareness activities for young people and volunteers
- Training on lobby and advocacy
- I don’t know

[p.6]

2.6. What was according to you the **least useful** activity in each of the domains?

2.6.1. Education

- Awareness raising activities
- Electronic & mobile health tools
- Formal education
- Informal education
- Development of Manuals and Guidelines
- Peer to Peer learning
- Training to professionals
- Training to volunteers
- I don’t know

2.6.2. Services

- Implementation of integrated package of essential services
- Implementing referral system linking public/private for profit SRH services
- Improving commodity supply systems
- Improving/ renovation of health services
- Reaching marginalised groups
- I don’t know

2.6.3. Enabling environment

- Awareness raising activities
- Community stakeholders support
- Lobby and advocacy activities
- Policy reviews and analysis
- Training in awareness raising activities for Community based organizations and civil society organizations
- Training in awareness activities for young people and volunteers
- Training on lobby and advocacy

- I don’t know

[p.7]

2.7. You and your organization have been implementing several activities within the UFBR/ASK program(s). What are, according to you, the **three main barriers** in the implementation of activities? What hindered the implementation of the activities the most?

	2.7.a UFBR	2.7.b ASK
1		
2		
3		

2.8. Could you name **three facilitating factors** that made it easier to implement activities? What facilitated the implementation of the activities the most?

	2.8.a UFBR	2.8.b ASK
1		
2		
3		

2.9. As the UFBR/ASK program(s) will be rounded off: What are, according to you, the **three main achievements/results** of the program(s)?

	2.9.a UFBR	2.9.b ASK
1		
2		
3		

[p.8]

2.10. Within the different outcome domains, which are the most and least achieved outcomes? Increased SRHR education

	2.10a UFBR		2.10.b ASK	
	Most positively changed (1 option)	Least changed or worsened (1 option)	Most positively changed (1 option)	Least changed or worsened (1 option)
quality of SRHR education program and comprehensive sexuality education				
capacities of educators to deliver comprehensive sexuality education				
access to formal SRHR education				
access to informal SRHR education				
access to quality SRHR education and CSE				
capacity (knowledge) of young people, women and men to make informed decisions about their SRHR				
demand for quality SRH services				

2.11. Within the different outcome domains, which are the most and least achieved outcomes? Strengthening SRH Services

	2.11.a UFBR		2.11.b ASK	
	Most positively changed (1 option)	Least changed or worsened (1 option)	Most positively changed (1 option)	Least changed or worsened (1 option)
capacity of service providers to deliver SRH services				
access to SRH services in health centres				
access to SRH services outside health centres				
quality of SRH services				
client satisfaction				
uptake of health services				
Access to services for marginalised groups				

2.12. Within the different outcome domains, which are the most and least achieved outcomes? Supportive environment for SRHR

	2.12.a UFBR		2.12.b ASK	
	Most positively changed (1 option)	Least changed or worsened (1 option)	Most positively changed (1 option)	Least changed or worsened (1 option)
advocacy campaigns				
SRHR policies and legislation				
involvement of communities and community leaders in SRHR awareness activities				
acceptance of sexual diversity and gender equality				
equal sexual and reproductive rights for young people, women, men and marginalised groups				

[p.9]

	UFBR	ASK
2.13. How would you score the overall effectiveness of the program, meaning how well the objectives of the program are reached?	0-10	0-10
2.14. How would you score the overall efficiency of the program? (are results proportionate to investments?)	0-10	0-10
2.15. I feel that the programs of UFBR and ASK are more effective then programs we implement(ed) for other donors.	0-10	0-10

2.16. UFBR and ASK are two distinct programs, yet several organizations are involved in both partnerships. According to you, what is the main influence of UFBR on ASK?

2.17. And of ASK on UFBR?

[p.10] 3. The UFBR and ASK alliances have an international component and a national component. The following set of items will ask for your perspective on **the international partnership** between all organizations involved in the entire program (in The Netherlands, UK, countries in the South). Can you indicate, on a scale from 0 to 10 how much you agree with the statement, with 0 meaning completely disagree and 10 meaning completely agree, or you can answer ‘I don’t know’, if you feel a statement is not applicable to you.

FUNCTIONING OF THE INTERNATIONAL PARTNERSHIPS	**UFBR**	**ASK**
3.1. The Dutch/UK organizations on the one hand and the national alliances in the countries in the global South on the other hand have a mutual understanding of the mission and objectives of the international partnership.	0-1-2-3-4-5-6-7-8-9-10-I don’t know	0-1-2-3-4-5-6-7-8-9-10-I don’t know
3.2. I know what the international partnership stands for	0-1-2-3-4-5-6-7-8-9-10-I don’t know	0-1-2-3-4-5-6-7-8-9-10-I don’t know
3.3. There is transparent communication between the northern and southern partners	0-1-2-3-4-5-6-7-8-9-10-I don’t know	0-1-2-3-4-5-6-7-8-9-10-I don’t know
3.4. The appropriate governance systems and procedures are in place in order for the international partnership can function properly	0-1-2-3-4-5-6-7-8-9-10-I don’t know	0-1-2-3-4-5-6-7-8-9-10-I don’t know
3.5. There are enough monitoring and evaluation moments in place to manage the international partnership properly	0-1-2-3-4-5-6-7-8-9-10-I don’t know	0-1-2-3-4-5-6-7-8-9-10-I don’t know
3.6. There is mutual trust between the partners of the international partnership	0-1-2-3-4-5-6-7-8-9-10-I don’t know	0-1-2-3-4-5-6-7-8-9-10-I don’t know
3.7. The programs are built on the basis of local needs.	0-1-2-3-4-5-6-7-8-9-10-I don’t know	0-1-2-3-4-5-6-7-8-9-10-I don’t know
3.8. The international members of the partnership combined have the necessary competencies and knowledge to cover the three components	0-1-2-3-4-5-6-7-8-9-10-I don’t know	0-1-2-3-4-5-6-7-8-9-10-I don’t know

[p.11] 4. The UFBR and ASK alliances have an international component and a national component. The following set of items will ask for your perspective on **the national partnership between all organizations involved in your country**. Can you indicate, on a scale from 0 to 10 how much you agree with the statement, with 0 meaning completely disagree and 10 meaning completely agree, or you can answer ‘I don’t know’, if you feel a statement is not applicable to you.
Note: Dutch/ UK respondents are asked to consider the partnership in the Netherlands when completing the following items.

FUNCTIONING OF THE NATIONAL PARTNERSHIPS	**UFBR**	**ASK**
4.1. In my country, every partner has clear roles and responsibilities	0-1-2-3-4-5-6-7-8-9-10-I don’t know	0-1-2-3-4-5-6-7-8-9-10-I don’t know
4.2. The organizational structure of the partnership is clear in my country	0-1-2-3-4-5-6-7-8-9-10-I don’t know	0-1-2-3-4-5-6-7-8-9-10-I don’t know
4.3. Each partner in my country has a strong sense of ownership of the program	0-1-2-3-4-5-6-7-8-9-10-I don’t know	0-1-2-3-4-5-6-7-8-9-10-I don’t know
4.4. The organization I work for understands the importance of the partnership and aligns with this	0-1-2-3-4-5-6-7-8-9-10-I don’t know	0-1-2-3-4-5-6-7-8-9-10-I don’t know
4.5. I feel the partners in my country work in a transparent and accountable manner	0-1-2-3-4-5-6-7-8-9-10-I don’t know	0-1-2-3-4-5-6-7-8-9-10-I don’t know

4.6. All partners in my country invest enough time and resource in the partnership	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know
4.7. The Theory of Change of the Alliance (and its three components) is known to me	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know
4.8. The national members of the partnership combined have the necessary competencies and knowledge to cover the three components of the Theory of Change	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know
4.9. In the national partnership, we share and agree with the joint objectives of the program(s)	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know
4.10. There are strategies in place to resolve conflict between national partners	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know
4.11. In the international partnership, we celebrate our successes with each other.	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know
4.12. I think the national partnership is a strong brand; in our sector everybody knows who we are.	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know

[p. 12] 5. The following set of statements will ask your perception on and experiences with working in such a partnership. Can you indicate, on a scale from 0 to 10 how much you agree with the statement, with 0 meaning completely disagree and 10 meaning completely agree, or you can answer ‘I don’t know’, if you feel a statement is not applicable to you.

***[PERCEIVED VALUE OF]* IN-COUNTRY COLLABORATION**	**UFBR**	**ASK**
5.1. Working with partners in my country has generated a new positive dynamic in the SRHR sector in my country	0-1-2-3-4-5-6-7-8-9-10-I don’t know	0-1-2-3-4-5-6-7-8-9-10-I don’t know
5.2. Working with partners in my country has increased competition in the SRHR sector in my country	0-1-2-3-4-5-6-7-8-9-10-I don’t know	0-1-2-3-4-5-6-7-8-9-10-I don’t know
5.3. It is easier to produce changes in relevant policies through individual advocacy of different organizations than through advocating in partnership	0-1-2-3-4-5-6-7-8-9-10-I don’t know	0-1-2-3-4-5-6-7-8-9-10-I don’t know

[p.13] 6. This set of statements will ask your perception on the costs and benefits of working in a partnership. Can you indicate, on a scale from 0 to 10 how much you agree with the statement, with 0 meaning completely disagree and 10 meaning completely agree, or you can answer ‘I don’t know’, if you feel a statement is not applicable to you.

COST-BENEFIT OF BEING PART OF THE ALLIANCE	**UFBR**	**ASK**
6.1. The complementarity of the partners in the partnership ensures that SRHR problems are dealt with in a comprehensive way	0-1-2-3-4-5-6-7-8-9-10-I don’t know	0-1-2-3-4-5-6-7-8-9-10-I don’t know
6.2. Aligning different views on SRHR within the partnership takes little time and effort	0-1-2-3-4-5-6-7-8-9-10-I don’t know	0-1-2-3-4-5-6-7-8-9-10-I don’t know
6.3. The mission and objectives of the partnership are in line with the mission and objectives of my organization	0-1-2-3-4-5-6-7-8-9-10-I don’t know	0-1-2-3-4-5-6-7-8-9-10-I don’t know
6.4. The results of the program would have been less if the activities were implemented by individual partners rather than by a partnership	0-1-2-3-4-5-6-7-8-9-10-I don’t know	0-1-2-3-4-5-6-7-8-9-10-I don’t know
6.5. Resources, such as knowledge, know-how and ideas are shared within the partnership, and partners can learn from each other	0-1-2-3-4-5-6-7-8-9-10-I don’t know	0-1-2-3-4-5-6-7-8-9-10-I don’t know
6.6. I feel my contributions within the partnership are acknowledged and valued by other partners	0-1-2-3-4-5-6-7-8-9-10-I don’t know	0-1-2-3-4-5-6-7-8-9-10-I don’t know
6.7. As a result of the alliance our organization is collaborating with other organizations outside of the partnership which we did not know before	0-1-2-3-4-5-6-7-8-9-10-I don’t know	0-1-2-3-4-5-6-7-8-9-10-I don’t know

[p.14] 7. The following set of items will ask for your perspective on the changes in your personal capacity and that of your organization since the start of the program(s). Can you indicate, on a scale from 0 to 10 how much you agree with the statement, with 0 meaning completely disagree and 10 meaning completely agree, or you can answer ‘I don’t know’, if you feel a statement is not applicable to you.

CAPACITY BUILDING	UFBR	ASK
Please think about your own functioning before and at the end of UFBR/ASK programs. Could you indicate to what extent you agree or disagree with the following statements: 7.1. I have obtained new knowledge, experience and expertise on SRHR issues 7.2. I was able to also integrate this new knowledge, experience and expertise in my own work 7.3. I am able to transfer what I learned to other people (e.g. staff at schools or service providers). 7.4. I have improved my project management capacity as a result of UFBR/ ASK programs 7.5. I can now better build and maintain networks with external stakeholders	0-1-2-3-4-5-6-7-8-9-10-I don’t know	0-1-2-3-4-5-6-7-8-9-10-I don’t know
Please think about the functioning of your organization before and at the end of UFBR/ASK programs. Could you indicate to what extent you agree or disagree with the following statements. 7.6. My organization has improved its capacity (knowledge, experience, expertise) to carry out actions and achieve results aimed for 7.7. My organization has better structures in place to share knowledge and learn internally 7.8. My organization is better able to adapt its strategies in case there are new challenges or external changes (e.g. shift in government policies) 7.9. My organization can now better build and maintain networks with external stakeholders 7.10. Due to the program’s gender concerns are now part of my organization’s policy and practice. 7.11. My organization is able to achieve its aims in a better way because of the partnership	0-1-2-3-4-5-6-7-8-9-10-I don’t know	0-1-2-3-4-5-6-7-8-9-10-I don’t know

STRENGTHENING OF SRHR SECTOR		
Please think about the functioning of the SRHR sector (including health services, schools, governments, NGOs etc.) before and during the implementation of UFBR/ASK programs. Could you indicate to what extent you agree or disagree with the following statements? 7.12. The SRHR sector in my country has been substantially strengthened through working in this Alliance. 7.13. There is a strong in-country network of partners that will continue to collaborate and learn from each other, even in the case the program would come to an end.	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know

[p.15]
8.1. On which topics of SRHR was your organization's capacity most strengthened? Please rank the three most strengthened capacities.

- PME and research
- Lobby and advocacy
- Meaningful participation of target groups
- Meaningful youth participation
- Gender equality
- Health promotion and behaviour change
- Sexual diversity
- Sexual and Gender Based Violence
- Stigma and discrimination
- Health service delivery
- Comprehensive Sexuality Education (CSE)
- Enabling environment
- Other: ...

8.2. On which topics of SRHR was your organization's capacity least strengthened? Please rank the three least strengthened capacities.

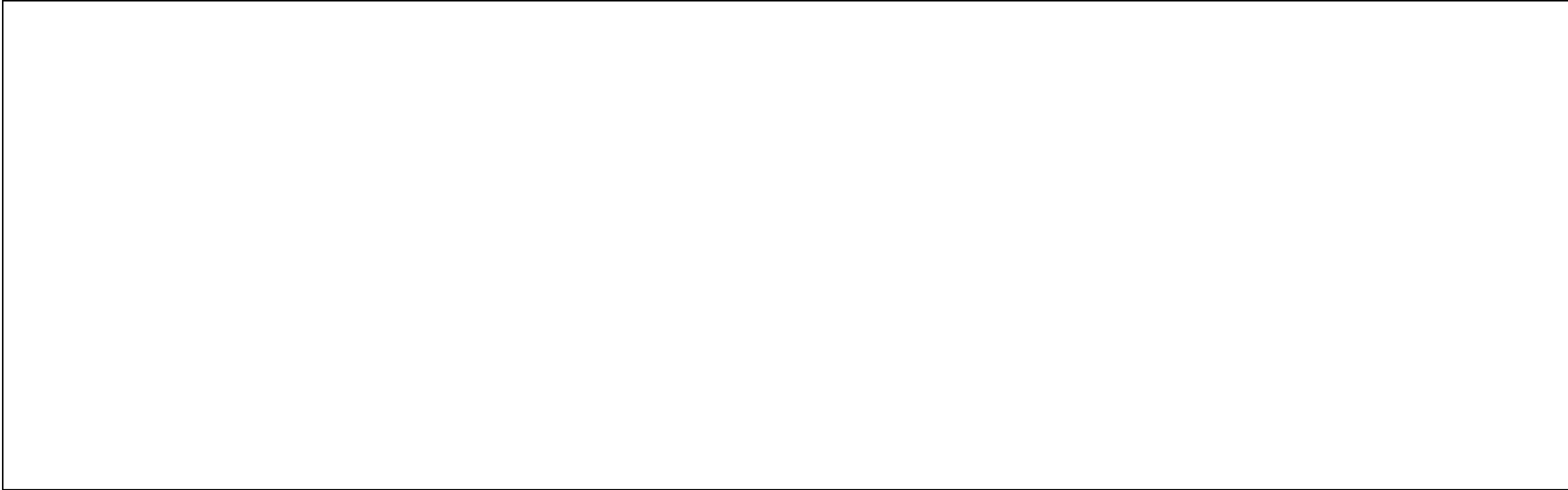
- PME and research
- Lobby and advocacy
- Meaningful participation of target groups
- Meaningful youth participation
- Gender equality
- Health promotion and behaviour change
- Sexual diversity
- Sexual and Gender Based Violence
- Stigma and discrimination
- Health service delivery
- Comprehensive Sexuality Education (CSE)
- Enabling environment
- Other: ...

[p.16] 9. The following set of items will ask for your perspective on the sustainability of the programs. Can you indicate, on a scale from 0 to 10 how much you agree with the statement, with 0 meaning completely disagree and 10 meaning completely agree.

SUSTAINABILITY	**UFBR**	**ASK**
9.1. My organization will certainly continue to implement activities in this field, even if financial support from Dutch partners would come to an end 9.2. My organization will continue implementing projects, as we already have funding from other sources (e.g. another donor) 9.3. My organization will only continue within a new multi-annual funded program	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know
9.4. The local government or communities are (financially) supporting certain activities	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know
9.5. My organization has undertaken actions (hire staff, block budget, look for new partners) to be able to continue working on the activities even in case the programs would come to an end.	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know
9.6. My organization will continue to share knowledge and experiences with other SRHR organizations in my country even in case the programs would come to an end	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know

[p.17]

10. Anything you would like to share with the evaluation team?



ANNEX 2B: ONLINE SURVEY I - UFBR

Objectives

- To get a complete view of whether local partners in all countries feel that their organization has benefitted and has developed through one or both programmes
- To gain insights into and consensus on the core strengths and weaknesses of the programme's design, implementation and PME, and on their main results.

Methods

We will develop a short online survey that will be sent to all partners: the Northern alliance partners of both programmes and their local partners. This survey will consist of two parts: one general section that is applicable for all partners, and one section that is specific for Southern or Northern partners. For each Northern partner organization we aim to have one respondent per organization fill in the questionnaire: the person most experienced in working in the alliance (in most cases, the country leads) and the implementation of the programme. Due to the already heavy PME workload of the Southern partners, we also aim for only one person per organization to fill in the survey. To increase the response, the invitation email will be personalized, and we will ask each country lead to emphasize to these people the importance of cooperation. In cases where two people work on the coordination of activities, due the high number of activities (e.g. Kenya and Indonesia), both can be involved in this survey.

The survey will consist of two parts:

- The first part consists of questions on the programme design, implementation, evaluation and main results. This part will use a Delphi method in which multiple rounds of online surveys will be run. This will allow us to extract insights into and consensus on the three core strengths and weaknesses of the programme design, implementation and evaluation (Dimensions 1, 2, 3 and 4). The survey will include open-ended questions on the following topics:
    - Strengths and weaknesses of the design
    - Strengths and weaknesses of implementation
    - Outcomes of the programmes
- The second part will explore capacity-building and partnership collaboration at the international and national level. It will include the following topics:
    - Perceived value of in-country collaboration
    - Value of the alliance (added value/benefits/costs/disadvantage)
    - Changes in capacity (in line with the 5C approach)
    - Mutual influence between UFBR and ASK
    - Sustainability at the project level and of the partnership/alliance (plans to continue the alliance and activities, even without future support from the current programmes)
    - Willingness to use other donor funding to continue ASK/UFBR interventions
    - Statements on critical success factors on working in partnerships
    - Development of the partnership after the recommendations of the mid-term partnership review.

START: INTRODUCTION

Dear Madam, dear Sir,

Over the past years you have been a member of the Sexual and Reproductive Health and Rights Alliance (SRHR Alliance) and/or the Youth Empowerment Alliance (YEA). Both partnerships have been implementing programmes for the promotion of SRHR: the Unite for Body Rights (UFBR) and/or Access, Services and Knowledge (ASK) programmes. Researchers from Kaleidos Research (NCDO Foundation) and the International Centre for Reproductive Health (ICRH, Ghent University) are currently conducting an evaluation of both programmes.

As you are a key partner in one or both programmes, we would like to include your expert opinion in this evaluation. Therefore, we would like to invite you to participate in an **online survey** on several important aspects of the programme(s). While part of the survey will be classic *closed questions* focusing on capacity-building and partnerships, a second part will use a *Delphi approach* with questions on strengths and weaknesses of the programme(s). This approach is typically used to build consensus among experts in the field. After a first survey round of open questions, the answers in this part will be analysed and fed back to the participants for a second and possibly third round of questioning, to arrive at a common set of key conclusions. The answers you give will be treated anonymously and confidentially.

We would highly appreciate your cooperation. Participation in this survey will take approximately 20 minutes. Thank you very much for participating in the research.

Please contact us at Emilomo.Ogbe@ugent.be if you have any further questions about the survey.

Click here to start the survey.

[p. 1 FILTER QUESTION:]

1.1. For which programme do you work?

- UFBR → SURVEY 1: only show answer options for UFBR
- ASK → SURVEY 2: only show answer options for ASK
- Both → SURVEY 3: show answer option for both

[p. 2]

1.2. In which country do you work?

- The Netherlands
- United Kingdom
- A country where the programme is implemented

1.3. In which country programmes are you involved? *[more than one option is possible]*

- Bangladesh
- Ethiopia
- Ghana
- India
- Indonesia
- Kenya
- Malawi
- Pakistan
- Senegal
- Tanzania
- Uganda
- Other: …

1.4. Which Dutch/ UK counterpart organization are you working for or are you affiliated with? (This information and any personal identifiers will be anonymized and kept confidential) *[more than one option is possible]*

- AMREF Flying Doctors
- Child Helpline International (CHI)
- Choice for Youth and Sexuality
- dance4life
- International Planned Parenthood Federation (IPPF)
- Rutgers
- Simavi
- STOP AIDS NOW!
- Other / I am a National Programme Coordinator

1.5. Please specify which component of the programme(s) you work on most

- SRHR Education
- SRH Services
- Enabling environment
- Other / I am a National Programme Coordinator

1.6.a. When did you start working for the UFBR programme?

- 2010
- 2011
- 2012
- 2013

- 2014
- 2015

1.7. What is your position in the SRHR Alliance?
- Project Officer
- Country Lead
- Programme officer
- PME-officer
- Advocacy officer
- NPC
- Director
- Other: ……

1.8. What is your gender?
- Male
- Female
- Other: …….

1.9. How old are you? … years

[p. 3]
2. We will start with a number of open questions on the program design, implementation and main results. This part will use a Delphi method in which two rounds of online surveys will be run. This will allow us to extract insights and consensus on the core strengths and weaknesses of the program design, implementation and results.
You will be asked to provide between one and three answers to the questions.
[AT LEAST ONE ANSWER, before they can move to the next page]
2.4. As a partner in the UFBR program what are, according to you, the **three greatest strengths** of the general set-up and core principles of the program?

	2.1.a UFBR
1	
2	
3	

2.5. What are, according to you, the **three weakest points** in the general set-up of the program?

	2.2.a UFBR
1	
2	
3	

[p.4]
2.6. You and your organization have been implementing several activities within the UFBR program. What are, according to you, the **three strongest activities;** if only three activities could be continued, which ones would you choose?

	2.3.a UFBR
1	
2	
3	

2.4. What are, according to you, the **three weakest activities;** if three activities were to be stopped immediately, which ones would you choose?

	2.4.a UFBR
1	

2	
3	

[p.5]

2.5. What was according to you the **most useful** activity in each of the domains?

2.5.4. Education

- Awareness raising activities
- Electronic & mobile health tools
- Formal education
- Informal education
- Development of Manuals and Guidelines
- Peer to Peer learning
- Training to professionals
- Training to volunteers
- I don’t know

2.5.5. Services

- Implementation of integrated package of essential services
- Implementing referral system linking public/private for profit SRH services
- Improving commodity supply systems
- Improving/ renovation of health services
- Reaching marginalized groups
- I don’t know

2.5.6. Enabling environment

- Awareness raising activities
- Community stakeholders support
- Lobby and advocacy activities
- Policy reviews and analysis
- Training in awareness raising activities for Community based organizations and civil society organizations
- Training in awareness activities for young people and volunteers
- Training on lobby and advocacy
- I don’t know

[p.6]

2.6. What was according to you the **least useful** activity in each of the domains?

2.9.1. Education

- Awareness raising activities
- Electronic & mobile health tools
- Formal education
- Informal education
- Development of Manuals and Guidelines
- Peer to Peer learning
- Training to professionals
- Training to volunteers
- I don’t know

2.9.2. Services

- Implementation of integrated package of essential services
- Implementing referral system linking public/private for profit SRH services
- Improving commodity supply systems
- Improving/ renovation of health services
- Reaching marginalised groups
- I don’t know

2.9.3. Enabling environment

- Awareness raising activities
- Community stakeholders support
- Lobby and advocacy activities
- Policy reviews and analysis
- Training in awareness raising activities for Community based organizations and civil society organizations
- Training in awareness activities for young people and volunteers
- Training on lobby and advocacy
- I don’t know

[p.7]

2.10. You and your organization have been implementing several activities within the UFBR program. What are, according to you, the **three main barriers** in the implementation of activities? What hindered the implementation of the activities the most?

	2.7.a UFBR
1	
2	
3	

2.11. Could you name **three facilitating factors** that made it easier to implement activities? What facilitated the implementation of the activities the most?

	2.8.a UFBR
1	
2	
3	

2.12. As the UFBR program will be rounded off: What are, according to you, the **three main achievements/results** of the program?

	2.9.a UFBR
1	
2	
3	

[p.8]

2.10. Within the different outcome domains, which are the most and least achieved outcomes? Increased SRHR education

	2.10a UFBR	
	Most positively changed (1 option)	Least changed or worsened (1 option)
quality of SRHR education program and comprehensive sexuality education		
capacities of educators to deliver comprehensive sexuality education		
access to formal SRHR education		

access to informal SRHR education		
access to quality SRHR education and CSE		
capacity (knowledge) of young people, women and men to make informed decisions about their SRHR		
demand for quality SRH services		

2.11. Within the different outcome domains, which are the most and least achieved outcomes? Strengthening SRH Services

	2.11.a UFBR	
	Most positively changed (1 option)	Least changed or worsened (1 option)
capacity of service providers to deliver SRH services		
access to SRH services in health centres		
access to SRH services outside health centres		
quality of SRH services		
client satisfaction		
uptake of health services		
Access to services for marginalised groups		

2.12. Within the different outcome domains, which are the most and least achieved outcomes? Supportive environment for SRHR

	2.12.a UFBR	
	Most positively changed (1 option)	Least changed or worsened (1 option)
advocacy campaigns		
SRHR policies and legislation		
involvement of communities and community leaders in SRHR awareness activities		
acceptance of sexual diversity and gender equality		
equal sexual and reproductive rights for young people, women, men and marginalised groups		

[p.9]

	UFBR
2.13. How would you score the overall effectiveness of the program, meaning how well the objectives of the program are reached? 0 being not effective at all, 10 being very effective.	0-1-2-3-4-5-6-7-8-9-10-I don't know
2.14. How would you score the overall efficiency of the program? (are results proportionate to investments?) 0 being not efficient at all, 10 being very efficient.	0-1-2-3-4-5-6-7-8-9-10-I don't know
2.15. I feel that the UFBR program is more effective than programs we implement(ed) for other donors. 0 being a lot less effective, 10 being a lot more effective.	0-1-2-3-4-5-6-7-8-9-10-I don't know

[p.10] **3**. The UFBR alliance has an international component and a national component. The following set of items will ask for your perspective on **the international partnership** between all organizations involved in the entire program (in The Netherlands, UK, countries in the South). Can you indicate, on a scale from 0 to 10 how much you agree with the statement, with 0 meaning completely disagree and 10 meaning completely agree, or you can answer 'I don't know', if you feel a statement is not applicable to you.

FUNCTIONING OF THE INTERNATIONAL PARTNERSHIP	**UFBR**
3.1. The Dutch/UK organizations on the one hand and the national alliances in the countries in the global South on the other hand have a mutual understanding of the mission and objectives of the international partnership.	0-1-2-3-4-5-6-7-8-9-10-I don't know
3.2. I know what the international partnership stands for	0-1-2-3-4-5-6-7-8-9-10-I don't know
3.3. There is transparent communication between the northern and southern partners	0-1-2-3-4-5-6-7-8-9-10-I don't know
3.4. The appropriate governance systems and procedures are in place in order for the international partnership can function properly	0-1-2-3-4-5-6-7-8-9-10-I don't know
3.5. There are enough monitoring and evaluation moments in place to manage the international partnership properly	0-1-2-3-4-5-6-7-8-9-10-I don't know
3.6. There is mutual trust between the partners of the international partnership	0-1-2-3-4-5-6-7-8-9-10-I don't know
3.7. The program are built on the basis of local needs.	0-1-2-3-4-5-6-7-8-9-10-I don't know
3.8. The international members of the partnership combined have the necessary competencies and knowledge to cover the three components	0-1-2-3-4-5-6-7-8-9-10-I don't know

[p.11] **4**. The UFBR alliance has an international component and a national component. The following set of items will ask for your perspective on **the national partnership between all organizations involved in your country**. Can you indicate, on a scale from 0 to 10 how much you agree with the statement, with 0 meaning completely disagree and 10 meaning completely agree, or you can answer 'I don't know', if you feel a statement is not applicable to you.
Note: Dutch/ UK respondents are asked to consider the partnership in the Netherlands when completing the following items.

FUNCTIONING OF THE NATIONAL PARTNERSHIP	**UFBR**
4.1. In my country, every partner has clear roles and responsibilities	0-1-2-3-4-5-6-7-8-9-10-I don't know
4.2. The organizational structure of the partnership is clear in my country	0-1-2-3-4-5-6-7-8-9-10-I don't know
4.3. Each partner in my country has a strong sense of ownership of the program	0-1-2-3-4-5-6-7-8-9-10-I don't know
4.4. The organization I work for understands the importance of the partnership and aligns with this	0-1-2-3-4-5-6-7-8-9-10-I don't know
4.5. I feel the partners in my country work in a transparent and accountable manner	0-1-2-3-4-5-6-7-8-9-10-I don't know
4.6. All partners in my country invest enough time and resource in the partnership	0-1-2-3-4-5-6-7-8-9-10-I don't know
4.7. The Theory of Change of the Alliance (and its three components) is known to me	0-1-2-3-4-5-6-7-8-9-10-I don't know
4.8. The national members of the partnership combined have the necessary competencies and knowledge to cover the three components of the Theory of Change	0-1-2-3-4-5-6-7-8-9-10-I don't know
4.9. In the national partnership, we share and agree with the joint objectives of the program	0-1-2-3-4-5-6-7-8-9-10-I don't know

4.10. There are strategies in place to resolve conflict between national partners	0-1-2-3-4-5-6-7-8-9-10-I don’t know

4.11. In the international partnership, we celebrate our successes with each other.	0-1-2-3-4-5-6-7-8-9-10-I don’t know
4.12. I think the national partnership is a strong brand; in our sector everybody knows who we are.	0-1-2-3-4-5-6-7-8-9-10-I don’t know

[p. 12] 5. The following set of statements will ask your perception on and experiences with working in such a partnership. Can you indicate, on a scale from 0 to 10 how much you agree with the statement, with 0 meaning completely disagree and 10 meaning completely agree, or you can answer 'I don't know', if you feel a statement is not applicable to you.

[PERCEIVED VALUE OF] **IN-COUNTRY COLLABORATION**	**UFBR**
5.1. Working with partners in my country has generated a new positive dynamic in the SRHR sector in my country	0-1-2-3-4-5-6-7-8-9-10-I don't know
5.2. Working with partners in my country has increased competition in the SRHR sector in my country	0-1-2-3-4-5-6-7-8-9-10-I don't know
5.3. It is easier to produce changes in relevant policies through individual advocacy of different organizations then through advocating in partnership	0-1-2-3-4-5-6-7-8-9-10-I don't know

[p.13] 6. This set of statements will ask your perception on the costs and benefits of working in a partnership. Can you indicate, on a scale from 0 to 10 how much you agree with the statement, with 0 meaning completely disagree and 10 meaning completely agree, or you can answer 'I don't know', if you feel a statement is not applicable to you.

COST-BENEFIT OF BEING PART OF THE ALLIANCE	**UFBR**
6.1. The complementarity of the partners in the partnership ensures that SRHR problems are dealt with in a comprehensive way	0-1-2-3-4-5-6-7-8-9-10-I don't know
6.2. Aligning different views on SRHR within the partnership takes little time and effort	0-1-2-3-4-5-6-7-8-9-10-I don't know
6.3. The mission and objectives of the partnership are in line with the mission and objectives of my organization	0-1-2-3-4-5-6-7-8-9-10-I don't know
6.4. The results of the program would have been less if the activities were implemented by individual partners rather than by a partnership	0-1-2-3-4-5-6-7-8-9-10-I don't know
6.5. Resources, such as knowledge, know-how and ideas are shared within the partnership, and partners can learn from each other	0-1-2-3-4-5-6-7-8-9-10-I don't know
6.6. I feel my contributions within the partnership are acknowledged and valued by other partners	0-1-2-3-4-5-6-7-8-9-10-I don't know
6.7. As a result of the alliance our organization is collaborating with other organizations outside of the partnership which we did not know before	0-1-2-3-4-5-6-7-8-9-10-I don't know

[p.14] 7. The following set of items will ask for your perspective on the changes in your personal capacity and that of your organization since the start of the program. Can you indicate, on a scale from 0 to 10 how much you agree with the statement, with 0 meaning completely disagree and 10 meaning completely agree, or you can answer 'I don't know', if you feel a statement is not applicable to you.

CAPACITY BUILDING	UFBR
Please think about your own functioning before and at the end of UFBR program. Could you indicate to what extent you agree or disagree with the following statements: 7.14. I have obtained new knowledge, experience and expertise on SRHR issues 7.15. I was able to also integrate this new knowledge, experience and expertise in my own work 7.16. I am able to transfer what I learned to other people (e.g. staff at schools or service providers). 7.17. I have improved my project management capacity 7.18. I can now better build and maintain networks with external stakeholders	0-1-2-3-4-5-6-7-8-9-10-I don't know
Please think about the functioning of your organization before and at the end of UFBR program. Could you indicate to what extent you agree or disagree with the following statements. 7.19. My organization has improved its capacity (knowledge, experience, expertise) to carry out actions and achieve results aimed for 7.20. My organization has better structures in place to share knowledge and learn internally 7.21. My organization is better able to adapt its strategies in case there are new challenges or external changes (e.g. shift in government policies) 7.22. My organization can now better build and maintain networks with external stakeholders 7.23. Due to the program's gender concerns are now part of my organization's policy and practice. 7.24. My organization is able to achieve its aims in a better way because of the partnership	0-1-2-3-4-5-6-7-8-9-10-I don't know
STRENGTHENING OF SRHR SECTOR	
Please think about the functioning of the SRHR sector (including health services, schools, governments, NGOs etc.) before and during the implementation of the UFBR program. Could you indicate to what extent you agree or disagree with the following statements? 7.25. The SRHR sector in my country has been substantially strengthened through working in this Alliance. 7.26. There is a strong in-country network of partners that will continue to collaborate and learn from each other, even in the case the program would come to an end.	0-1-2-3-4-5-6-7-8-9-10-I don't know

[p.15]
8.1. On which topics of SRHR was your organization's capacity most strengthened? Please rank the three most strengthened capacities.

- PME and research
- Lobby and advocacy
- Meaningful participation of target groups
- Meaningful youth participation
- Gender equality
- Health promotion and behaviour change
- Sexual diversity
- Sexual and Gender Based Violence
- Stigma and discrimination
- Health service delivery
- Comprehensive Sexuality Education (CSE)
- Enabling environment
- Other: ...

8.2. On which topics of SRHR was your organization's capacity least strengthened? Please rank the three least strengthened capacities.

- PME and research
- Lobby and advocacy
- Meaningful participation of target groups
- Meaningful youth participation
- Gender equality
- Health promotion and behaviour change
- Sexual diversity
- Sexual and Gender Based Violence
- Stigma and discrimination
- Health service delivery
- Comprehensive Sexuality Education (CSE)
- Enabling environment
- Other: ...

[p.16] 9. The following set of items will ask for your perspective on the sustainability of the program. Can you indicate, on a scale from 0 to 10 how much you agree with the statement, with 0 meaning completely disagree and 10 meaning completely agree.

SUSTAINABILITY	UFBR
9.7. My organization will certainly continue to implement activities in this field, even if financial support from Dutch partners would come to an end 9.8. My organization will continue implementing projects, as we already have funding from other sources (e.g. another donor) 9.9. My organization will only continue within a new multi-annual funded program	0-1-2-3-4-5-6-7-8-9-10-I don't know
9.10. The local government or communities are (financially) supporting certain activities	0-1-2-3-4-5-6-7-8-9-10-I don't know
9.11. My organization has undertaken actions (hire staff, block budget, look for new partners) to be able to continue working on the activities even in case the program would come to an end.	0-1-2-3-4-5-6-7-8-9-10-I don't know
9.12. My organization will continue to share knowledge and experiences with other SRHR organizations in my country even in case the program would come to an end	0-1-2-3-4-5-6-7-8-9-10-I don't know

[p.17]

10. Anything you would like to share with the evaluation team?

ANNEX 2C: ONLINE SURVEY II - UFBR AND ASK

Dear,

First of all, we would like to thank you for your participation in the online survey. The information you have provided will be very helpful in the evaluation of the UFBR and ASK programmes and in future programming.

As we announced at the start of the online survey, a part of the survey uses a Delphi method. This means that answers to the open questions from the first round will be used to develop a second round of questions. The advantage of this method is that you can reflect on answers from other respondents that you may not have thought of yourself.

This second round of questions is very short, contains only 20 questions and will only take you about 10 minutes to complete. We would highly appreciate your collaboration in this second online survey.

To start the survey, please click on this link:

1. For which programme do you work?

- UFBR programme
- ASK programme
- UFBR and ASK programmes

Because of the anonymity of the previous survey, we will need to ask three questions on your affiliation with the programme again.

2.1. In which country do you work?
- The Netherlands
- United Kingdom
- A country where the programme is implemented

2.2. In which country programmes are you involved? *[more than one option is possible]*
- Bangladesh
- Ethiopia
- Ghana
- India
- Indonesia
- Kenya
- Malawi
- Pakistan
- Senegal
- Tanzania
- Uganda
- Other: …

2.3. Which Dutch/ UK counterpart organization are you working for or are you affiliated with? (This information and any personal identifiers will be anonymised and kept confidential) *[more than one option is possible]*
- AMREF Flying Doctors
- Child Helpline International (CHI)
- Choice for Youth and Sexuality
- dance4life
- International Planned Parenthood Federation (IPPF)
- Rutgers
- Simavi
- STOP AIDS NOW!
- Other / I am a National Programme Coordinator

3. **In the previous survey we asked you to note down <u>the strengths of the general set-up</u> of the UFBR/ASK programme. We have analysed and regrouped the answers of all respondents and now aim to get a better insight into the consensus among these answers. We would like to know, for each of the groups, which are <u>the two greatest strengths</u> of the UFBR/ASK programme: what makes up the essence of UFBR/ASK?**

3.1. General set-up: When looking at the overall ***principles*** of UBFR/ASK, what are according to you the two greatest strengths?

- Sex positive approach
- Rights-based approach
- Evidence-based approach
- Attention to diversity
- Working on sensitive topics (LGBT, SGBV, abortion)
- Focus on hard-to-reach target groups
- Adapted to local context
- Local ownership
- *ASK: Participation of young people*
- I don't see a strength in the overall principles

3.2. General set-up: When looking at the overall ***partnership*** of UBFR/ASK, what are according to you the two greatest strengths?

- Variety of partners
- Complementarity between partners
- Mutual learning between partners
- Establishment of country alliances
- Technical assistance from Northern partners
- Joint decision-making of the partners
- Working with civil society
- *ASK: Building on UFBR*
- I don't see a strength in the partnership

3.3. General set-up: When looking at the overall ***strategies*** of UBFR/ASK, what are according to you the two greatest strengths?

- The use of a Theory of Change / the multi-component approach
- The multi-component approach
- Increasing the access to sexual and reproductive health information
- Increasing the access to services
- Focusing on advocacy/awareness raising
- The creation of an enabling environment
- UFBR: Civil society strengthening
- The use of operational research
- The support to improve youth-friendliness of services
- The use of social media
- I don't see a strength in the strategies

4. **In the previous survey we asked you to note down <u>the weaknesses of the general set-up</u> of the UFBR/ASK programme. We have analyzed and regrouped the answers of all respondents. and now aim to get a better insight on the consensus among these answers. We would like to know, for each of the groups, which are the <u>two greatest weaknesses</u> of the UFBR/ASK programme? What should be avoided in future programmes?**
Note: as there was a great variety of answers on this question, there are more answer categories for this question than in the question on strengths, where there was much more coherence in answers.

4.1. General set-up: When looking at the ***overall principles*** of UBFR/ASK, what are according to you the two greatest weaknesses?
- The Theory of Change and the logframe are weak (not context-specific; too much created in the North)
- The values of the different partners were not sufficiently made explicit (lack of value clarification)
- Not enough focus on gender
- Not enough involvement of high government representatives
- Not enough involvement of local authorities
- Not enough male involvement
- Not enough focus on youth leadership
- Lack of mainstreaming of sensitive issues (such as SGBV and LGBT)
- Not enough meaningful youth participation
- The focus was too much on quantity and not on quality
- There were no strong strategies to reach target groups
- I don't see a weakness in the overall principles

4.2. General set-up: When looking at the ***organization and planning*** of UBFR/ASK, what are according to you the two greatest weaknesses?
- Lack of strategic planning
- Lack of sustainability strategies
- Weak accountability structure
- The programme included too many countries, it is better to focus
- The programme was too short
- There was a lack of a centralized monitoring and evaluation system within the international alliance
- There was no economic empowerment of partners
- The funding was too limited
- *ASK: the funding was too much in relation to the programme period*
- *ASK: Lack of scaling-up strategy*
- I don't see a weakness in the organization and planning

4.3. General set-up: When looking at the ***partnership*** of UBFR/ASK, what are according to you the two greatest weaknesses?
- There was no strategic partner selection: partners were selected based on existing relationships, not on best fit and complementarities
- There was no clear roadmap for creating a strong partnership
- Partners don't know each other well enough
- The partnership in the North is unbalanced
- There was no room for new partners to join
- There was a lack of regular meetings
- Too large geographical spread of implementation regions, limiting opportunities for collaboration and complementarity

- ASK: There were too many partners with small roles
- ASK: There was a lack of collaboration resulting in fragmented work
- ASK: The programme did not always build well on UFBR (no learning from UFBR, thus no change in general set-up)
- I don't see a weakness in the partnership

4.4. General set-up: When looking at the ***alliance management*** of UBFR/ASK, what are according to you the two greatest weaknesses?

- The use of a top-down approach (uneven decision making power)
- Poor governance structure of the alliance (bureaucracy; lack of flexibility; delays in decision-making)
- The roles and responsibilities were unclear
- The link between the country alliances and the northern alliance was weak
- There were politics dominating the relations between the Northern partners
- There was too much emphasis on measuring results instead of implementation
- The country alliances were not sufficiently independent
- I don't see a weakness in the alliance management

4.5. General set-up: When looking at the ***capacity of partners*** in the UBFR/ASK programme, what are according to you the two greatest weaknesses?

- The available technical expertise was not sufficiently used
- The capacity of partners was not enough built
- There was a lack of dissemination of lessons learnt to stakeholders outside the alliance
- The capacity of the National Programme Coordinators (NPCs) was limited
- There was not enough sharing and exchange within the country
- There was not enough sharing and exchange within the international alliance
- I don't see a weakness in the capacity of partners

5. In the previous survey we asked you to note down the main barriers to the effective implementation of the UFBR/ASK programme. We have analyzed and regrouped the answers of all respondents. We would like to know, for each of the groups, which are the two main barriers for the implementation of the UFBR/ASK programme.

5.1. Implementation barriers: When looking at the ***environment*** in which UBFR/ASK was implemented, what are according to you the two main barriers?

- Cultural-religious barriers (e.g. gender inequality)
- Unfavorable national policies (e.g. condoms not allowed in schools or in health services)
- Infrastructural problems (e.g. roads, electricity)
- Resistance by important stakeholders (e.g. parents, service providers)
- Poor functioning health and education systems
- I don't see a barrier in the environment

5.2. Implementation barriers: When looking at the ***organization*** of the UBFR/ASK programme, what are according to you the two main barriers?

- High staff turnover
- High bureaucracy
- Donor-target driven approach
- Budget limitations
- Too much funding for secretariat in the North
- In-country variety in implementation areas was too large
- Too much emphasis on results

- No clear definition of results areas
- ASK: Combination with UFBR
- I don't see a barrier in the organization

5.3. Implementation barriers: When looking at the ***partnership*** within the UBFR/ASK programme, what are according to you the two main barriers?

- Some partners/implementers were too conservative (values of implementers)
- Non-agreement among partners on some sensitive issues
- Not knowing the other partners well
- Poor collaboration between Northern partners
- Little in-country ownership, because Northern partners took the lead
- Organizational versus alliance interest
- Youth-led organizations are not always seen as equal partners
- ASK: Too many small partners
- ASK: Too many partners in the Netherlands
- I don't see a barrier in the partnership

5.4. Implementation barriers: When looking at the ***capacity of partners*** in the UFBR/ASK programme, what are according to you the two main barriers?

- Lack of didactic skills of implementers
- Little capacity in operational research
- Lack of monitoring and evaluation capacity
- Lack of clear understanding of Meaningful Youth Participation
- Lack of capacity in innovative strategies
- Limited capacity of youth-led organizations
- Lack of understanding of the programme among partners
- I don't see a barrier in the capacity of partners

6. In the previous survey we asked you to note down <u>the main facilitators to the effective implementation</u> of the UFBR/ASK programme. We have analyzed and regrouped the answers of all respondents. We would like to know, for each of the groups, which are the <u>two main facilitators</u> of the UFBR/ASK programme.

6.1. Implementation facilitating factors: When looking at the ***environment*** in which UBFR/ASK was implemented, what are according to you the two main facilitating factors?

- The community support and engagement
- The cooperation from government facilities
- The support from the Ministry of Health
- The existing infrastructure
- The existing community-based structures
- I don't see any facilitating factors in the environment

6.2. Implementation facilitating factors: When looking at the ***capacity of the partnership*** through which UBFR/ASK was implemented, what are according to you the two main facilitating factors?

- The sexual and Reproductive Health expertise of the donor
- The sharing between and learning from partners (team work)
- The capacity building workshops
- Important role of individual change makers / inspirational staff members
- The good alliance offices in the north and south
- The equality between partners

- The partners were given freedom to focus on their interest
- The partners were committed
- I don’t see any facilitating factors in the capacity of the partnership

6.3. Implementation facilitating factors: When looking at the ***general organization*** of the UBFR/ASK programme, what are according to you the two main facilitating factors?

- The proper planning of the entire programme
- The good governance structure of the alliance
- The existence of the joint activities budget
- The National Programme Coordinator week
- The mid-term review
- The Memorandum of Understanding at start of programme
- The available funds for piloting and experimenting
- The integrated approach
- The learning agenda
- The close collaboration with on-the-ground staff
- I don’t see any facilitating factors in the general organization

7. In the previous survey we asked you to note down the main results of the UFBR/ASK programme. We have analyzed and regrouped the answers of all respondents. We would like to know, for each of the groups, which are the two main results related to the partnership/alliance of the UFBR/ASK programme.

- Almost every country alliance has become a national player
- There are strong advocacy movements in the countries
- The creation of strong working relationships with the local governments
- A clear insight that countries need more ownership in programme planning, design and evaluation.
- The Theory of Change is embraced at all levels (partners + stakeholders)
- Sensitive issues like sexual diversity are put on the agenda of the organizations
- Partners are better trained on Sexual and Reproductive Health and Rights
- Staff members and relevant stakeholders are sensitized to create a more open and progressive attitude
- Programmematic learning through participatory operational research
- The partners are more open to work with young people (and not only for young people)
- I don’t see any main results on the level of the partnership and alliance

8. Do you have any further comments?

ANNEX 3: SEMI-STRUCTURED INTERVIEWS NORTHERN PARTNERS

United for Body Rights (UFBR) and Access, Services and Knowledge (ASK)

Set-up of the document

This document consists of three main parts. It first outlines the objectives of the interviews and the target respondents and provides instructions. The second part provides introductory information that should be shared with the respondent. The third part is the interview guide. The guidelines are general for both programmes, but during the interviews it will be checked regularly if there are differences for UFBR and ASK. The interview guide consists of six main topics:

- Involvement in the UFBR/ASK programmes
- Partnerships/alliance collaboration in the North (effectiveness and efficiency)
- Partnerships/alliance collaboration with and in the South (effectiveness and efficiency)
- Capacity-building (relevance)
- Assessment of programmes
- Sustainability

Objective

The semi-structured interviews with the Northern alliance members will provide information to answer research question 4: To what extent has the partnership been relevant, effective and efficient for the individual members and the programme?

Participants

We will interview representatives of the seven alliance partners of both programmes at management/director level. Members of the programme team are managers within their organizations, and members of the steering committee are directors of organizations, with the exception of IPPF, where the member of the steering committee is Doortje Braeken, Senior Advisor at IPPF. We aim at seven in-depth face-to-face and (telephone) interviews. If one of them is available, that is fine, but the evaluators are also open to making this a duo-interview.

Northern alliance partners	Country Lead in
Amref	Ethiopia, Tanzania
D4L	Indonesia
IPPF (UK)	Senegal
Rutgers	Malawi, Uganda (Bangladesh in past)
Simavi	Ghana, Kenya, India, Bangladesh
Choice	-
Stop Aids Now	-

SEMI-STRUCTURED INTERVIEW GUIDES

United for Body Rights (UFBR) and Access, Services and Knowledge (ASK)

INTRODUCTION

Explanation of the goal of the interview, focus on the partnership
Anonymity of the information

6. Knowledge of and involvement in the UFBR/ASK project

Interview questions and prompts	
1.1.	Is your organization involved in the UFBR programme, ASK programme or both? Ask for confirmation in which countries they are you active in
1.2.	When did your organization get involved with the ASK/UFBR project? Prompt to find out specific programme areas/ interventions they are involved in and duration Prompt which focus this Dutch organization has (CSE, services, enabling environment, other) in ASK/UFBR and in their organization as such
1.3.	What is your role within the programme? When did you personally get involved with the ASK/ UFBR project? Is involvement in UFBR/ASK the only role/ responsibility, or does the respondent has other roles/responsibilities?
1.4.	What are, according to you, the main objectives of the ASK/ UFBR programme?
1.5.	[In case you are involved in both UFBR and ASK] We're evaluating two programmes, UFBR and ASK. Do you experience this as two specific programmes? What – in your view- are important differences?

2. Partnerships/alliance collaboration in the North

Interview questions and prompts	
2.1	UFBR/ASK include many different organizations and actors in the programmes and it is implemented in several countries. What are, according to your experience, the strengths of this comprehensive approach? Prompt for the added-value of working in such partnership/alliance (fruitful connections, ease of implementation, capacity building, increased knowledge of context, stronger advocacy and lobby, does the alliance helps to achieve the organisation's goals etc.)
2.2	What are, according to your experience, the weaknesses of this comprehensive approach? Do you experience any disadvantages in working in a partnership? (less efficiency, additional time in consultation And at what level (in countries, in Nl, at management level, at exchange level etc.)
2.3	How do you assess the cost-benefits ratio for working in the alliance? Do you feel the costs of working in an Alliance (refer to weaknesses the respondent mentioned) outweight the benefits (refer to the strengths). Why did your organization decide to join this alliance? What benefits did you expect from that? What does your organization bring, and what do you 'get out of it'? Please note that IPPF and SAN! are only involved in ASK and might only have a general first impression of UFBR. It could be interesting though to ask specifically whether they knew UFBR and why they were interested to become members of a similar alliance (that turned into the YEA-

Interview questions and prompts	
	Alliance) and how they experienced that process (possibly already in your questions below). Same for how UFBR-members experienced it when SAN! and IPPF joined in.
2.4	Do you feel there is a good balance between the partners here in the Netherlands? Probe for commitment of own organisation versus commitment other alliance partners (investment in time and resources, involvement of managers etc) and for an equal say in decision making
2.5	How do you describe the relationship between the alliance partners? Probe for trust and conflict strategies
2.6	What is in your opinion the role of the alliance office within both alliances? What is your assessment about how alliance office functions within both alliances ?
2.7	Is there a difference between the SRHR Alliance and YEA alliance? In what way? Probe for: decision making process, cooperation between partner, different expertises of partners etc.
2.8	Only for UFBR partners: a Mid Term Partnership Review was executed 2 years ago. Are you familiar with the findings? If so do you feel the outcomes have led to changes within the partnership? E.g. did it influence how the partners collaborate? Probe for examples and for the themes that were addressed
2.9	In general, how do you feel both alliances has developed through the years ? What are important milestones for SRHR alliance? And what are important milestones for UFBR (focus on period after 2013, in MTR there is already an overview of milestones for UFBR).
2.10	Do you feel cooperation with other actors (outside the alliance) in the Netherlands would help achieving the goals of the programmes? With which kind of actors would you like to cooperate?
2.11	Which lessons on the collaboration do you take with you from the last 3 to 5 yrs? Do you think these lessons will be incorporated in the new programme? (or in case of amref: will be incorporated in your activities in the future)

3. Partnerships/alliance collaboration with and in the South

Interview questions and prompts	
3.1	How would you describe the relationship between the Northern and Southern partners? How do you see the involvement of Southern Partners in the international alliance? It could be useful to also probe for the one-on-one-relationship they have with their partners, and the role they see for their partners in the international and local alliance. Probe for balance, trust, equality, power relations etc
3.2	Do you think that the governance structure for the international alliance – both North and South – is effective?
3.3	How do you assess the alliances in the Southern countries you are involved in? Do you feel it has added value that partners in the south are also (forced to) collaborating together in the south? Are the programmes more effective because of collaboration from Southern partners? Probe for difference between countries.

Interview questions and prompts
Probe if the southern alliance consists of the most relevant partners in that country, or that important players are missing.
3.4 Since the southern partners are collaborating in the programme, does this influence their efficiency? Do you feel they are more or maybe less efficient then before?
3.5 Do you feel between-country and in-country learning has been achieved in the alliance? Probe for added value of an international alliance from the perspective of the southern partner

4. Capacity building

Interview questions and prompts
4.1. Has collaborating in the alliances and participating in these programmes had any effects on you personally? Probe for new knowledge, skills, attitudes, level of responsibilities and tasks. What have been the most important lessons, changes of skills or attitudes that you have obtained? Can you give examples of these lessons? Could you also implement these lessons in your own work? In case theme has had an effect: did you share what you learned and obtained with other people within your organisation?
4.2. Has collaborating in the alliances and participating in these programmes had any effect on your organisation? Probe for sustainable changes within the organisation. Try to be as specific as possible (was the organisational strategy changed, are new guidelines developed…).

5. Sustainability

Interview questions and prompts
Why does your organisation wants to continue with this programme (or in case of AMREF: Why doesn't)
5.1. Do you feel that there are mechanism in place in the countries you're involved in to continue with activities, even when funding is stopped or reduced?
5.2. Some programmes might come to an end or the funding might be reduced: Does your organisation have plans to continue to work on the interventions, even without the current financial support from the Ministry of Foreign Affairs? What would be the conditions to do so?

6. Assessment of programmes (only if there is time left)

Interview questions and prompts
6.1. Please describe the most important impacts and results of the interventions in the countries your involved in for both UFBR and ASK programmes. Probe for changes in knowledge, attitudes, behaviours and health outcomes

	Probe for specific impact/outcome domains. Could you think of specific results in: o SRHR education o The delivery of service o The creation of an enabling environment Probe for changes in gender roles (position of girls in the household, access to schools for girls,…) Probe for results for specific target groups, like youth in general or marginalized groups What were the most important results for the interviewee (look at services, policies, etc) From the results that you mention, which one's were easy to achieve, which one's difficult? Probe for unexpected results Probe for results that were expected to achieve, that were not achieved Probe for negative results
6.2	What makes you most proud, looking at both programmes?
6.3.	Which lessons when it comes to improving SRHR in Southern countries do you take with you from your experience in ASK/UFBR?

ANNEX 4A: FOCUS GROUP DISCUSSION GUIDES FOR BENEFICIARIES

United for Body Rights (UFBR) and Access, Services and Knowledge (ASK)

Set-up of the document
This document consists of three main parts. It first outlines the objectives of the interviews and the target respondents and provides instructions. The second part provides introductory information that should be shared with the participants in the focus group discussion. The third part is the focus group discussion guide. The guide consists of six main topics:

- Knowledge of and involvement in the UFBR/ASK programmes
- Programme implementation - strategies and methods used for implementation
- Impact and outcomes of the programmes
- Stakeholder involvement and partnerships
- Capacity-building
- Sustainability

Objective
The focus group discussions will provide information to answer a large number of research questions in all dimensions of the evaluation (see Table 4.2).

Participants
We will organize focus group discussions with a variety of stakeholders (policymakers, community leaders and youth-led organizations), service providers (health care providers/educators) and beneficiaries. The groups to be involved will depend on the specific region and focus of the UFBR/ASK programmes. As it is not possible to cover all groups in each location, we aim to work with heterogeneous groups consisting of various kind of actors involved in both UFBR and ASK. Each focus group will include 6 to 10 participants.

In total we are aiming for three focus groups per country (covering both UFBR and ASK):

- beneficiaries (women, community members): one focus group (both UFBR and ASK). As the most significant change methods (see below) will focus on young people, we aim to include other beneficiaries from the programmes as much as possible. As the beneficiaries for ASK are exclusively young people, we will pay specific attention to community perceptions of activities for and changes in young people, and on the community as an enabling environment;
- service providers (health care providers - including village health workers -, teachers, representative of community-based organizations): one focus group (both UFBR and ASK); and
- local policymakers, district health authorities, community leaders: one focus group (both UFPR and ASK).

The selection of respondents will be different for each country and setting. Local partner organizations are expected to help in the selection of participants.

Instructions

Before the interview starts, it should be clear to the interviewer which topics are most important to focus on in depth. This decision needs to be made in agreement with the evaluation team.

Material

- Recorder
- Papers
- Pens
- Post-its
- Flip-charts
- Photo camera

FOCUS GROUP DISCUSSION GUIDES for BENEFICIARIES
United for Body Rights (UFBR) and Access, Services and Knowledge (ASK)

INTRODUCTION
Good morning. My name is ………………………….. (and my assistants names are)……………………

We are very pleased you have agreed to join us today. We are researchers working with *ICRH/Kaleidos Research/local researcher's organization* working on reviewing two programmes on sexual health and rights of the SRHR alliance in your country. One is called Unite for Body Rights, UFBR, and the second programme is called Access, Services and Knowledge, ASK. The goal of this evaluation is to determine what the results are of the programmes but also to recommend ways to improve the programmes performance.

We are here to discuss your knowledge and experiences of working with these programmes. You have been involved in these programmes because you implement activities as a … *[recipient, health service providers, community health worker, teacher, peer educator,…]*.

The discussion we are going to have is a Focus Group Discussion, for those of you who have never participated in one of these sessions; I would like to explain a little bit about this type of research.

Focus groups are used to gather information informally from a small group of individuals who either share common features / qualities or have a common interest in a particular subject. In focus group discussions, there are no right or wrong answers. We want to hear from everyone in the room. We are pleased you can be part of this group because we think your knowledge about the ASK and / UFBR programmes and interventions, will help improve our understanding of the projects. Don't hesitate to speak up when you have a point you would like to make.

I will be moderating the session and moving us along so that we touch on all of the key subjects on our agenda. I would like to avoid spending too much time on issues that don't pertain to everyone in the group. If I think that we are spending too much time on one subject, I will step in to keep the discussion moving.

We will record this discussion so that I don't have to take notes. I like to follow what is being said and then go back later to review what you said again so I can accurately convey your ideas and opinions. My assistants will transcribe our conversations but your identity and other personal identifiers will be anonymised. My role today is to see that we have a productive discussion and to summarize the group's feelings. I will not refer to any participant by name in the reports I prepare.
The information will be kept confidential and used only by our team to develop recommendations to help improve the performance of the ASK and/ UFBR programmes.
Was all the information I provided you with clear? Do you have any further questions?

Name of Interviewer	
Date of Interview	
Duration of the interview	
Composition of group	Male: Female: Age range: Other specificties?
Involvement in the programme (to be completed after the interview; based on responses to question 2.1)	**Which activities?** **Intensity of participation**

Throughout the interview: pay attention to gender attitudes. How do they talk about men/woman, boys/girls, masculinities/femininities? Probe for changes in this thinking when relevant.

Start with round of introduction: name

1. Knowledge of and involvement in the UFBR/ASK project (estimated time: 15 minutes)

Questions and prompts	Comments
1.1. When did you first hear about UFBR/ASK?	Find out how the respondents refer to UFBR/ASK, and use these term throughout the FGD. Always make sure the differences between UFBR and ASK are clearly specified.
1.2. What are, according to you, the main objectives of the ASK/UFBR programme? What does it try to reach? Prompt to understand familiarity with the programme	
1.3. We're evaluating two programmes, UFBR and ASK. Do you experience this as two specific approaches? What – in your view- are important differences?	
1.4. Are you aware of any other programmes in this domain (SRHR activities)?	

2. UFBR/ASK programme implementation – strategies and methods used for implementation (estimated time: 40 minutes)

Questions and prompts	Comments
2.1. What were the specific activities you participated in? Probe for participation in the different domains: o SRHR education o the delivery of services (e.g. train health providers, outreach health services) o the creation of an enabling environment Probe for the level of involvement/participation: how often/how actively did you participate? Probe for participation barriers/enablers in specific domains	Always make sure the differences between UFBR and ASK are clearly specified. Question 2.2. This questions asks about changes the implementers made to the activities. This can be sensitive. Ensure the participants that it was not a problem that they made changes, and that you are only trying to understand why they did so. For questions 2.3 and 2.6: check beforehand whether respondents are able to read/write. If not, don't use the post-it method, but write their different answers on the flip-chart. In both cases: use a H-diagram to organize the ideas. See last pages for instructions and example.
2.2. Could you please write on a post-it/piece of paper: Which of the activities did you feel was most useful/most relevant for yourself? Which one was least useful? If you were to choose one activity that could be continued, what would it be? Why? If you were to choose one activity that should be definitely ended, what would it be? Why?	
2.3. Do you have any suggestions of other approaches that could be used?	
2.4. Do you know any activities that were organized for the young people in your communities? Was it easy/difficult to get them involved? Why? Probe for participation barriers/enablers in specific domains	
2.5. Could you please write on a post-it/piece of paper: Which of the activities did you feel was most exciting (you remembered best, made you happy,…) for the young people in your community? Which activities did	

you feel were least exciting for the young people in your community? If you were to choose one method that could be continued, what would it be? Why? If you were to choose one method that should be definitely ended, what would it be? Why?	
2.6. Do you have any suggestions of other approaches that could be used to reach young people	
2.7. In general, do you think the messages you received in the activities you participated in were coherent? Or did they contradict each other sometimes? Probe for examples	

3. Results and outcomes (estimated time: 20 minutes)

Interview questions and prompts	Comments
3.1. Could you please write on a post-it/piece of paper, the most important impacts and results of the activities in your communities/country in general, and for young people in particular. Discuss results Probe for changes in knowledge, attitudes, behaviours and health outcomes Probe for specific impact/outcome domains. Could you think of specific results in: o SRHR education o The delivery of service o The creation of an enabling environment Probe for changes in gender roles (position of girls in the household, access to schools for girls,…)	Always make sure the differences between UFBR and ASK are clearly specified. Focus on the outcomes in the particular field of the respondents: • Beneficiaries: changes in themselves and young people For questions 3.1: check beforehand whether respondents are able to read/write. If not, don't use the post-it method, but write their different answers on the flip-chart. In both cases: use a H-diagram to organize the ideas. See last pages for instructions and example.
3.2. Except for these positive chances, did you also observe negative results?	

4. Stakeholder involvement and Partnerships

No questions for beneficiaries

5. Capacity building (estimated time: 10 minutes)

Interview questions and prompts	Comments
5.1. Have you noted any difference in the capacity of service providers (health services – formal and informal providers -, educational services)?	Always make sure the differences between UFBR and ASK are clearly specified. Indonesia (for service providers) and Ethiopia have indicated that this part is very important.

Which activities were NOT useful/relevant?

Overall score of activities:
0 - 1 - 2 - 3 - 4 - 5 - 6 -7 -8 -9 - 10

Which activities were useful/relevant?

What could be done to improve the activities?

In 'overall score of the activities', respondents are asked to put a cross below the value of their score.

Example:

ANNEX 4B: FOCUS GROUP DISCUSSION GUIDES FOR SERVICE PROVIDERS AND EXTERNAL STAKEHOLDERS

United for Body Rights (UFBR) and Access, Services and Knowledge (ASK)

Set-up of the document
This document consists of three main parts. It first outlines the objectives of the interviews and the target respondents and provides instructions. The second part provides introductory information that should be shared with the participants in the focus group discussion. The third part is the focus group discussion guide. The guide consists of six main topics:

- Knowledge of and involvement in the UFBR/ASK programmes
- Programme implementation: strategies and methods used for implementation
- Impact and outcomes of the programmes
- Stakeholder involvement and partnerships
- Capacity-building
- Sustainability

Objective
The focus group discussions will provide information to answer a large number of research questions in all dimensions of the evaluation (see Table 1 of inception report field study).

Participants
We will organize focus group discussions with a variety of stakeholders (policymakers, community leaders and youth-led organizations), service providers (health care providers/educators) and beneficiaries. The groups to be involved will depend on the specific region and focus of the UFBR/ASK programmes. As it is not possible to cover all groups in each location, we aim to work with heterogeneous groups consisting of various kind of actors involved in both UFBR and ASK. Each focus group will include 6 to 10 participants.

In total we are aiming for three focus groups per country (covering both UFBR and ASK):

- beneficiaries (women, community members): one focus group (both UFBR and ASK). As the most significant change methods (see below) will focus on young people, we aim to include other beneficiaries from the programmes as much as possible. As the beneficiaries for ASK are exclusively young people, we will pay specific attention to community perceptions of activities for and changes in young people, and on the community as an enabling environment;
- services providers (health care providers — including village health workers — teachers, representatives of community-based organizations): one focus group (both UFBR and ASK); and
- local policymakers, district health authorities and community leaders: one focus group (both UFBR and ASK).

The selection of respondents will be different for each country and setting. Local partner organizations are expected to help in the selection of participants.

Instructions
Before the interview starts, it should be clear to the interviewer which topics are most important to focus on in depth. This decision needs to be made in agreement with the evaluation team.

Material
- Recorder
- Papers
- Pens
- Post-its
- Flip-charts
- Photo camera

FOCUS GROUP DISCUSSION GUIDES for SERVICE PROVIDERS and EXTERNAL STAKEHOLDERS

United for Body Rights (UFBR) and Access, Services and Knowledge (ASK)

INTRODUCTION
Good morning. My name is ………………………….. (and my assistants' names are) ……………………………………………………………………………………………….

We are very pleased you have agreed to join us today. We are researchers working with *ICRH/Kaleidos Research/local researcher's organization* working on reviewing two programmes on sexual health and rights of the SRHR Alliance. One is called Unite for Body Rights (UFBR), and the second programme is called Access, Services and Knowledge (ASK). The goal of this evaluation is to determine what the results are of the programmes, but also to recommend ways to improve the programmes' performance.

We are here to discuss your knowledge and experiences of working with these programmes. You have been involved in these programmes because you implement activities as a … *[recipient, health service provider, community health worker, teacher, peer educator etc.]*.

The discussion we are going to have is a focus group discussion. For those of you who have never participated in one of these sessions, I would like to explain a little bit about this type of research.

Focus groups are used to gather information informally from a small group of individuals who either share common features/qualities or have a common interest in a particular subject. In focus group discussions there are no right or wrong answers. We want to hear from everyone in the room. We are pleased you can be part of this group because we think your knowledge about the ASK and/or UFBR programmes and interventions will help improve our understanding of the projects. Don't hesitate to speak up when you have a point you would like to make.

I will be moderating the session and moving us along so that we touch on all of the key subjects on our agenda. I would like to avoid spending too much time on issues that don't pertain to everyone in the group. If I think that we are spending too much time on one subject, I will step in to keep the discussion moving.

We will record this discussion so that I don't have to take notes. I like to follow what is being said and then go back later to review what you said again so that I can accurately convey your ideas and opinions. My assistants will transcribe our conversations, but your identity and other personal identifiers will be anonymized. My role today is to see that we have a productive discussion and to summarize the group's feelings. I will not refer to any participant by name in the reports I prepare.
The information will be kept confidential and used only by our team to develop recommendations to help improve the performance of the ASK and/or UFBR programmes. Was all the information I provided you with clear? Do you have any further questions?

Name of Interviewer	
Date of Interview	
Duration of the interview	
Role of respondents *(teacher, external stakeholders)*	
Composition of group	Male: Female: Age range: Other specificties?

Throughout the interview: pay attention to gender attitudes. How do they talk about men/woman, boys/girls, masculinities/femininities? Probe for changes in this thinking when relevant.

Start with round of introduction: name + organization and role in the programmes

3. Knowledge of and involvement in the UFBR/ASK project (estimated time: 10 minutes)

Questions and prompts	Comments
1.1. What are, according to you, the main objectives of the ASK/UFBR programme? Prompt to understand familiarity with the programme	Find out how the respondents refer to UFBR/ASK, and use these term throughout the FGD. Always make sure the differences between UFBR and ASK are clearly specified.
1.2. We're evaluating two programmes, UFBR and ASK. Do you experience this as two specific approaches? What – in your view- are important differences? Probe to find out if they are aware of the difference between UFBR and ASK, if they mention UFBR/ASK and if they're involved in both programmes or just one (or they don't know)	
1.3. Are you aware of any other programs in the field of SRHR? How are they aligned?	

2. UFBR/ASK program implementation – strategies and methods used for implementation (estimated time: 25 minutes)

Questions and prompts	Comments
2.1. What were the specific activities you worked on within the ASK/UFBR programme? Which target groups did these activities focus on? Probe for methods/ strategies to reach for specific target groups, like youth in general or marginalized groups	Always make sure the differences between UFBR and ASK are clearly specified. For health care providers, teachers and peer educators: focus on their specific activities. If the respondent indicates s/he has not implemented activities (e.g. external stakeholders), these questions will need to be asked in a more generalized way (e.g. in your opinion, what would be factors that would hinder/facilitate implementation of activities). The focus should then be on • the last prompt of question 2.2. • the multi-component approach (2.8.) • Probe to verify mandate and financial resources, extent of
2.2. In your experience, were these activities easy or difficult to implement in your communities/countries? What went good, what was challenging? Could you describe what made it easy/good or difficult/challenging? Was it easy/difficult to reach the target groups? Why? Probe for implementation barriers/enablers in specific domains (that have not yet been mentioned before). What are, according to you particular barriers/enablers in the field of implementing: o SRHR education o the delivery of SRHR service o the creation of an enabling environment	

	decentralization/ dependency of higher levels of government for the policy makers and local leaders •
2.3. During your participation in this program, you received trainings and were asked to implement several activities. Did you implement all activities that were asked? What changes did you make to which activities? Why? Which parts do they find hard to implement? Why? Probe for changes on the level of the content (e.g. discussions on sexual intercourse were left out of the sexuality education curriculum) and on the level of the method (e.g. participatory methods are more difficult to implement)	Question 2.3. This questions asks about changes the implementers made to the activities. This can be sensitive. Ensure the participants that it was not a problem that they made changes, and that you are only trying to understand why they did so.
2.4. Which of the activities or strategies (changes in the organization of your work) did you feel was most useful in the community or among the target groups? Note: a strategy can also mean changes in the organisation of your activities, e.g. making health centres accessible by making sure they are open after school hours; involving school nurses;… If you were to choose one method/strategy that could be continued, what would it be? Why?	
2.5. Which activities did you feel were least useful? If you were to choose one method that should be definitely ended, what would it be? Why?	
2.6. Do you have any suggestions of other approaches that could be used?	
2.7. UFBR/ASK opt for a 'multi-component approach', that is, focussing on knowledge, and services and the enabling environment. What are, according to you, the strengths and weaknesses of this approach? Probe: according to you, were the messages and services spread in the programs always coherent? Or did they contradict each other sometimes?	

3. Results and outcomes (estimated time: 25 minutes)

Interview questions and prompts	Comments
5.2. Could you please write on a post-it/piece of paper, the most important impacts and results of the activities in your communities/country in general, and for young people in particular. Discuss results and ask for relevance Probe for changes in knowledge, attitudes, behaviours and health outcomes	Always make sure the differences between UFBR and ASK are clearly specified. Focus on the outcomes in the particular field of the respondents: • Service providers: education and health services • External stakeholders: policies

Probe for specific impact/outcome domains. Could you think of specific results in: o SRHR education o The delivery of service o The creation of an enabling environment From the results that you mention, which one's were easy to achieve, which one's difficult? Probe for changes in gender roles (position of girls in the household, access to schools for girls,…)	For question 3.1:check beforehand whether respondents are able to read/write. If not, don't use the post-it method, but write their different answers on the flip-chart. In both cases: use a H-diagram to organize the ideas. See last pages for instructions and example.
5.3. Efficiency: do you think the results achieved were proportionate to the efforts (staff, money) invested in it? How could resources have been better spent?	
5.4. Were there any results that you did not expect? What were these unexpected results?	
5.5. Were there results you expected to achieve, that were not achieved? Can you think of any particular reason why these results were not achieved?	
5.6. Except for these positive chances, did you also observe negative results?	
5.7. Are there circumstances, people, policies or other factors that assisted or made it easier to achieve some of the results/ impacts we discussed above?	
5.8. Are there circumstances, people, policies or other factors that made it difficult to achieve some of the results/ impacts we discussed above?	
5.9. How do you assess the extent to which young people play an active role in shaping the programs? Can you give some examples in your own work how youngsters are involved in the activities? To what extent do you think it important for the programmes to succeed that they are involved?	

6. Stakeholder involvement and Partnerships (estimated time: 25 minutes)

Interview questions and prompts	Comments
6.1. UFBR/ASK include many different organizations and actors in their program. What are, according to your experience, the strengths and weaknesses of this approach? What is the added-value of working in such partnership/alliance Probe for added value/negative value of partnership/alliance (fruitful connections, ease of	Always make sure the differences between UFBR and ASK are clearly specified.

implementation, capacity building, increased knowledge of context, etc.)	
6.2. With which stakeholders do you interact? How? **(Let the respondents draw a map)** What are the results of these interactions? Probe for enablers (those that want change), blockers (those that don't want change), floaters (those that want change, but under certain conditions). Do you feel cooperation with other actors would help achieving the goals of the programmes? With which kind of actors would you like to cooperate? Probe for involvement of youth (meaningful)	

7. Capacity building (estimated time: 20 minutes)

Interview questions and prompts	**Comments**
7.1. Has participating in these programmes had any effects on your professional work? Probe for new knowledge, skills, attitudes, level of responsibilities and tasks. What have been the most important lessons, changes of skills or attitudes that you have obtained? In case the programme has had an effect: did you share what you learned and obtained with other people within your organisation?	Always make sure the differences between UFBR and ASK are clearly specified. Indonesia (for service providers) and Ethiopia have indicated that this part is very important.
7.2. Do you experience any tension between your professional actions and your personal opinions/attitudes? (e.g. the respondent can understand the health risks of unprotected sexual intercourse and sensitize young people to use a condom; but personally think that young people need to abstain until marriage) How do you deal with these tensions?	
7.3. Have these programmes had any effect on your organisation? Probe for sustainable changes within the organisation. Try to be as specific as possible (was the organisational strategy changed, are new guidelines developed…).	
7.4. Are there specific capacity building needs, that you think the programme should have addressed?	

8. Sustainability (estimated time: 10 minutes)

Interview questions and prompts	**Comments**
8.1. Would you like to continue to work with the ASK/UFBR programmes? In case you do: are there specific parts of the programmes you would like to continue? What are main reasons to continue (part of the) programmes?	Always make sure the differences between UFBR and ASK are clearly specified.

	Prompt for perceived benefits and challenges of continuing to work on the programmes.	Probe to see if sustainability mechanisms have been put in place (refer to appendix or guide on sustainability factors)
8.2.	Do you or your organisation have plans to continue to work on the interventions, even without these programmes? What would be the conditions to do so?	
8.3.	Did you undertake any actions, or did changes occur in your organization (staff hiring, strategic plan formation, grant applications or funding etc.) to allow for these programmes to continue?	

In ‘overall score of the activities’, respondents are asked to put a cross below the value of their score.

Which activities were NOT useful/relevant?	**Overall score of activities:** **0 - 1 - 2 - 3 - 4 - 5 - 6 -7 -8 -9 - 10**	**Which activities were useful/relevant?**
	What could be done to improve the activities?	

Example:

ANNEX 5: SITE VISITS CHECK LIST

Note: Try to be guided around the site by a project partner and a young person.
Note: Try not to attend activities that are specifically prepared for your visit, but rather see the reality.
Note: Bring a photo camera to take pictures of activities.

Topic	Assessment			Comments
	Yes	Partly	No	
VISIBILITY				
Is it clear from/at the sites that UFBR/ASK is implementing the activity *[beforehand: check with the local partner what the programmes are called]*				
Are activities advertised *[are they announced, how, sufficiently visible?]*				
Is the material present?				
Is material relevant?				
Is material culturally appropriate?				
In what way are activities at this site supported by the ASK/UFBR programme (staff trained, materials provided etc.)?				

Topic	Assessment			Comments
	Yes	Partly	No	
PARTICIPATION TARGET GROUP				

Are young people present at the site?				
Are young people meaningfully involved?				
Is the activity youth-friendly (language, visuals, content)?				
Are other target groups (specify) present at the site?				
Are they meaningfully involved?				
Is the activity adapted to the needs of the target group (language, visuals, content)?				
Is the activity gender-equitable? Are gender stereotypes used? Is sufficient attention paid to the specific needs of girls and boys?				

Topic	Assessment			Comments
	Yes	Partly	No	
CONTEXT				
Are there signs of links to other activities (e.g. poster in school that informs about where to get health services)?				
Are there any factors present hindering implementation of the activity (e.g. the health centre is in the centre of the village, making it difficult for young people to attend anonymously)? Are there mitigation strategies present?				
Are there any factors present facilitating implementation of the activity (external factors, or factors developed by the programme)?				
OTHER RELEVANT OBSERVATIONS				

ANNEX 6: EXAMPLE OF A GENDER RESPONSIVE FRAMEWORK

Gender-responsive framework

Gender analysis category	Gender-unequal	Gender-blind/neutral	Gender-sensitive	Gender-specific	Gender-transformative
Components	Does current context, project or policy reinforce unequal access to opportunities and resources?	Ignores differences in gender roles and access to resources	Acknowledges these differences, creates pathways to address them without changing the status quo	Targeted at a specific gender that is identified as being marginalized without addressing underlying causes	Engages with norms and underlying cause of inequalities, identity, power, hegemonic masculinities and gender roles