IOB Evaluation

Consistent Efforts, Persisting Challenges

Evaluation of Dutch contribution to sexual and reproductive health and rights (2012–2022)

December 2023

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Executive summary

Introduction

Promoting the universal fulfilment of sexual and reproductive health and rights (SRHR) – including HIV/AIDS – has been a priority of Dutch development cooperation for many years. The previous evaluation on SRHR conducted by the Policy and Operations Evaluation Department (IOB), the independent evaluation directorate of the Netherlands Ministry of Foreign Affairs, was published in 2013 and covered the period 2007–2012. In the period 2012–2022, the Netherlands Ministry of Foreign Affairs allocated 10% of the Dutch development-cooperation budget to this theme, nearly EUR 5 billion.[i] During that period, the ministry focused on 10 specific 'SRHR target countries', where Dutch embassies played an important role in the implementation of SRHR-related projects and activities. In addition, the Netherlands provided financial support to numerous organisations working on SRHR across the globe, including multilateral organisations, international funds, (I)NGOs, commercial companies and knowledge institutes.

Dutch international policy on SRHR has a strong human-rights element, recognising that sexual and reproductive health and rights are human rights that apply to everyone, regardless of age, gender identity or sexual orientation. In international forums the Netherlands is, furthermore, an outspoken actor on SRHR issues that are considered to be 'sensitive' in large parts of the world, for example abortion, sex workers, and equal rights for Lesbian, Gay, Bisexual, Trans, Intersex, Questioning/Queer and more (LGBTIQ+) people. The Netherlands is one of the few donor countries that has consistently supported projects on these topics. In contrast, across the globe civic space for supported organisations active on these issues has been shrinking. Issues important for the Netherlands, such as access to safe abortion or equal rights for LGBTIQ+ people, have come increasingly under pressure from a diverse coalition of governments, religious organisations and advocacy groups that oppose and aim to restrict advancements that have been achieved.

Through its policy on SRHR, the Netherlands strives to contribute to commitments made in the Sustainable Development Goals (SDGs). In particular, it aims to contribute to SDG targets on maternal and child mortality (SDGs 3.1 and 3.2), the AIDS epidemic (SDG 3.3), achieving universal access to sexual and reproductive health (SDG 3.7) and achieving universal access to sexual and reproductive health and and reproductive rights (SDG 5.6). Although certain countries have recorded notable advancements on certain SDGs, numerous SRHR-related SDG targets continue to be out of reach in Dutch SRHR target countries. Furthermore, the 'rights' element of the Dutch SRHR agenda faces mounting challenges, partly due to the growing conservative opposition.

Against that background, IOB has evaluated the Dutch policy on SRHR and HIV/AIDS in low- and lower-middle-income countries for the period 2012–2022. The main research question the evaluation aims to answer is:

To what extent has the Netherlands contributed to the improvement of Sexual and Reproductive Health and Rights and contributed to halting the spread of HIV/AIDS in low- and lower-middle-income countries and what lessons can be learned for future policy?

IOB's evaluation draws on the available evaluation reports of supported projects that have been implemented by NGOs and by international and multilateral organisations and funds. In addition, IOB commissioned and performed primary data collection in Uganda and Bangladesh, two purposefully sampled Dutch SRHR target countries, and additionally investigated whether through its diplomatic efforts the Netherlands was able to uphold and expand existing agreements in the most important SRHR forums. To broaden the evidence base about what works and what doesn't, IOB commissioned a systematic search for systematic reviews on interventions targeting SRHR in sub-Saharan Africa, which yielded a comprehensive database of 368 systematic reviews on SRHR.

Conclusions

Based on its evaluation, IOB concluded that the Netherlands has contributed to improvements in SRHR and a reduction of the burden of HIV/AIDS in low- and lower-middle-income countries. Dutch support of SRHR contributed to improved SRHR outcomes through increased access to reproductive- and health commodities. At the same time, the evaluation also revealed that various supported interventions did not lead to the expected results, including behavioural change of and decision-making by young people about sexuality or reproduction. There are, furthermore, various 'blind spots' for which there was either no evaluation available at all, or the evidence on effectiveness was inconclusive or of insufficient quality. Consequently, IOB has been unable to determine the extent of the contribution of the entire Dutch policy to SRHR.

IOB bases this main conclusion on the subsequent six sub-conclusions:

Sub-conclusion 1 Dutch policy on SRHR has been consistent over the years and has simultaneously responded to the existing and emerging needs of intended target groups in low- and lower-middle-income countries. However, key policy assumptions were often not clearly articulated, and policy choices were not always evidence-based.

The Dutch policy on SRHR is a human-rights-based approach and has been consistent over time. The ministry has reacted to various international developments that threatened to undermine progress on SRHR, such as the Mexico City Policy, the 'Global Gag Rule' in 2017 and the COVID-19 pandemic.

However, the current SRHR policy does not articulate key assumptions, especially those regarding coherence and sustainability, nor does it take the existing evidence base on what works into account. Notable policy choices that were not evidence-based include the decision to sharply reduce health-sector budgetary support and the decision to provide mainly project-based support to enhance the capacity of civil society organisations.

Sub-conclusion 2 Efforts towards enhancing SRHR and addressing the spread of HIV/AIDS in low- and lower-middle-income countries have resulted in a variety of effects.

The Netherlands has contributed to:
- upholding international agreements and maintaining previously agreed language in main international SRHR forums and, in some instances, advancing agreed language;
- increasing access to SRHR-related information for young people, at times contributing to improved knowledge and attitudes;
- improving access to and the use of reproductive- and health commodities, including family planning commodities and antiretroviral therapy; and
- increasing care-seeking and mother and child health at the community level.

Still, introducing comprehensive sexuality education has proven difficult in countries with a limited national curriculum on sexuality education. Even so, improved knowledge and changing attitudes of young people hardly led to actual changes in their behaviour or decision-making. Ultimately, although the Netherlands contributed to short-term improvements in health systems, it realised few systemic effects.

IOB's evaluation also highlights that although Dutch policy prioritises young women and girls, implementation of relevant activities suffers from a lack of attention for gender mainstreaming, starting with project design through to monitoring and evaluation (M&E). Moreover, supported activities often didn't succeed in bridging 'the last mile' and reaching the most-isolated and economically-deprived people.

Owing to poor evaluation quality, it remains unclear whether supported lobby- and advocacy-related initiatives and capacity strengthening of CSOs have been effective or not.

Sub-conclusion 3 Although Dutch parliament and the general Dutch public are annually informed of the results achieved on SRHR, the M&E systems have several limitations that hinder the validity and reliability of reported results, especially at outcome and impact levels.

Monitoring systems of supported NGOs are largely aligned with the ministry's SRHR results framework. Some of the included indicators are defined at outcome and impact levels, which, although useful for evaluation, are not suitable for monitoring. In addition, IOB has low confidence in the quality of many of the evaluations of the ministry's SRHR projects and programmes, implemented both by NGOs and by international and multilateral organisations. Often, the methods applied are not suitable for assessing the contribution made by the supported interventions to observed results, especially at outcome and impact levels. This limited IOB's insight into the effectiveness of supported activities.

Sub-conclusion 4 Economic efficiency of supported SRHR projects and interventions is unknown. The organisational efficiency and timeliness of supported organisations presents a mixed picture, with room for improvement, both for multilateral and international organisations and for NGO partnership projects.

Given the absence of cost-effectiveness and cost-efficiency analyses, the economic efficiency of supported SRHR projects is unknown. IOB also assessed the operational efficiency and timeliness of supported projects and organisations. Although on the one hand supported multilateral and international organisations were able to leverage their position to attain commodities for lower prices, on the other hand complex administrative procedures simultaneously affected their timeliness. Due to the complex setup of NGO partnership projects, these projects also suffered from bureaucratic management practices, high indirect costs and delays in implementation.

IOB concludes that, despite improvements in the last few years, the ministry has limited staff capacity and did not always prioritise programme management. As a result, the ministry is not always able to sufficiently play its 'partnership role' and policy staff have limited insight in project implementation on the ground, thus hampering adaptive programming, learning from implementation and establishing feedback loops.

Sub-conclusion 5 Coherence within and between instruments and organisations supported by the Netherlands was insufficient.

Despite steps taken to reduce the total number of SRHR-related activities, fragmentation of SRHR activities persists at national and local levels in several SRHR target countries. While the ministry expected that implementing organisations would coordinate their efforts and cooperate with each other at country level, this did not sufficiently materialise. Few synergies were achieved between organisations and projects financed directly by the ministry in The Hague and those supported by the relevant embassies. Similarly, linkages between the SRHR partnership projects were also weak at country level. The level of collaboration among multilateral organisations and international funds was mixed at the global level, while there was clearly room for improvement at country level, with various parallel coordination mechanisms and limited government capacity and interest.

Sub-conclusion 6 SRHR projects generally come to a halt once Dutch funding ends, since there are hardly any stakeholders willing and able to take over supported activities. In addition, there is only limited insight into the sustainability of results achieved.

IOB observed that in the case of Bangladesh, most supported activities came to a halt after Dutch funding had ended. In other countries, too, supported NGOs had difficulties in handing over activities to other stakeholders, especially if these activities were focused on key populations. Lack of domestic government spending on healthcare in Dutch SRHR target countries also makes it difficult to hand over 'less sensitive' medical or reproductive health activities to national authorities.

The extent to which supported activities led to lasting effects remains uncertain, mainly because most evaluations are conducted during, and not after, implementation. Despite the ministry's expectation that capacity strengthening of CSOs and lobbying and advocacy efforts would yield lasting impacts, existing evaluations only provide limited insights into whether this was the case.

Recommendations

In light of these conclusions, IOB recommends the following:

Recommendation 1 Clearly formulate the Dutch policy on SRHR in an updated policy document (the previous one was published in 2012), which could include the objectives, policy choices, priorities, channels and the relationship of SRHR with the Dutch global health strategy.

The updated policy document could include:
- an analysis of all policy assumptions, including those concerning coherence and sustainability;
- existing high-quality evidence to assess the validity of the assumptions;
- an explicit poverty focus, a strategy that outlines to which degree and how the ministry intends to reach people of lower socio-economic status, and a strategy for including gender mainstreaming;
- where possible, the policy decision to decrease health-sector support could be reconsidered;
- a strategy for policy dialogue on health and SRHR with the governments in the SRHR target countries.

Recommendation 2 Attach more weight to programme management, balancing it with diplomatic and more ad-hoc activities of the policy staff responsible for SRHR.

Specifically, the ministry could:
- increase staff capacity for programme management and invest in staff with expertise in development cooperation and SRHR;
- minimise delays in approval of reports;
- learn from implementation through improved engagement;
- more actively try to connect projects and activities at the country level.

Recommendation 3 To reduce high management costs and fragmentation at the country level, reconsider the current strategic-partnership operational model.

Future subsidy frameworks could include:
- a review of the added value of a multi-layered and multi-country setup;
- a strategy to allocate direct core funding to national NGOs and CSOs;
- a reconsideration of the policy decision to increasingly focus on lobbying and advocacy and decrease focus on service delivery in SRHR partnership projects.

Recommendation 4 Have a realistic outlook on the limited possibilities to achieve continuation of activities beyond project support. Given the human-rights-based approach of Dutch SRHR policy, and considering the often limited national and international ownership, possibilities to hand activities over are inherently narrow.

With this in mind, the Netherlands could:
- acknowledge that in the SRHR target countries there might be little national ownership of the rights aspect of SRHR;
- if this is the case, make a political commitment that it intends to continue supporting SRHR activities;
- introduce longer time frames for projects;
- investigate possibilities to continue funding activities that have proven to be effective.

Recommendation 5 Be cautious about what can realistically be monitored at the (intermediate) outcome and impact levels. Indicators at these levels generally require (i) independent evaluation, (ii) robust research designs, and (iii) longer time spans to validly establish a causal relationship between results and supported interventions.

Therefore, the ministry could:
- jointly with implementing organisations, strategically select a limited number of indicators for monitoring, with a focus on activities, inputs and outputs, and the quality of implementation;
- reformulate both overall budget indicators for SRHR for the Ministry of Foreign Trade and Development Cooperation's budget Article 3.1 (SRHR).

Recommendation 6 Improve the quality of decentralised evaluations, managed by implementing organisations or by involved policy departments of the ministry.

Therefore:
- the ministry could ensure that ex-post evaluations can be conducted;
- implementing organisations could hire evaluators for baseline, mid-term and end evaluations already before project implementation;
- the ministry, implementing organisations and evaluators could jointly identify a number of outcome indicators, for a number of strategically-selected, large projects, to be independently measured at baseline, mid-term and ex-post, possibly also in comparison areas;
- evaluations could include an assessment of gender mainstreaming;
- evaluations could include an assessment of economic efficiency;
- the ministry could assess the uptake of statements and resolutions derived from SRHR diplomacy at country level.

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Photography

Front: © UNFPA Mozambique/Alejandra Perez, 2023.
An artist paints graffiti advocating against child marriage in Monapo, Mozambique.

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A nurse conducts an awareness session on sexual and reproductive health at an internally displaced persons accommodation center in Cabo Delgado, Mozambique.

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COVID-19 vaccines arrived in Kyrgyzstan through COVAX in 2021.

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Minister Schreinemacher at an event on shaping feminist foreign policy in 2022.

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Deputy Secretary-General Willem van Ee raising the pride flag on Coming Out Day 2018.

Ch 5: © Cordaid/Lisa Murray, 2020.
A staff member of PASCO, a partner of Cordaid in Kinshasa, Democratic Republic of the Congo, carries out free HIV tests at a bar which is frequented by sex workers.

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The President of Uganda Yoweri Museveni speaking at an event on family planning.

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Creative arts as a component in psychosocial support for adolescent girls in Bangladesh.

Ch 8: © Cordaid/Lisa Murray, 2020.
A chief nurse checks on hospitalised HIV patients in the Democratic Republic of the Congo.

Ch 9: © Robin Nieuwenkamp, 2013.
Anti-HIV/AIDS campaign on a signpost in the capital city of Uganda, Kampala.

Ch 10: © Terre des Hommes/Down to Zero/Marieke van der Velden, 2019.
Som (16) grew up in Bangkok, Thailand, and is now engaged in alternative schooling. This photo is part of the This is Me project, with children who were or are victims of sexual commercial abuse holding their own drawing.

Annexes: © UNFPA Uganda, 2011.
SRHR information posters on a wall outside a health center in Uganda.

1 Introduction

1.1 Rationale and main evaluation question

This report provides the results of IOB's evaluation of Dutch policy on sexual and reproductive health and rights (SRHR) in development cooperation.[1] Promoting the universal fulfilment of SRHR (including HIV/AIDS) has been a priority of Dutch development cooperation for many years. IOB's previous evaluation on SRHR, titled 'Balancing Ideals with Practice', was published in 2013 and covered the period 2007–2012. In the period 2012–2022, the Netherlands Ministry of Foreign Affairs allocated 10% of the Dutch development-cooperation budget to SRHR, nearly EUR 5 billion.[ii] During that period, the ministry focused on 10 specific 'SRHR target countries', where Dutch embassies played an important role in the implementation of SRHR-related projects and activities. In addition, the Netherlands provided financial support to numerous organisations working on SRHR across the globe, including multilateral organisations, international funds, (international) non-governmental organisations ((I)NGOs), companies and knowledge institutes.

Dutch international policy on SRHR has a strong human-rights element, recognising that sexual and reproductive health and rights are human rights that apply to everyone, regardless of age, gender or sexual orientation. In international forums, the Netherlands is, furthermore, an outspoken actor on SRHR issues considered as 'sensitive' in large parts of the world, for example abortion, sex work, and human

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[1] In this evaluation, IOB has adopted the comprehensive definition of SRHR as introduced by the Guttmacher-*Lancet* commission; for a summary, see Annex 1.

rights of Lesbian, Gay, Bisexual, Trans, Intersex, Questioning/Queer and more (LGBTIQ+). The Netherlands is one of the few donor countries that has consistently supported projects on these topics. In contrast, across the globe civic space for supported organisations active on these issues has been shrinking. Issues important for the Netherlands, such as access to safe abortion or equal rights for LGBTIQ+ people, have come increasingly under pressure from a diverse coalition of governments, religious organisations and advocacy groups that oppose and aim to restrict advancements that have been achieved.

Through its policy on SRHR, the Netherland strives to contribute to commitments made in the Sustainable Development Goals (SDGs). In particular, it aims to contribute to SDG targets on maternal and child mortality (SDGs 3.1 and 3.2), the AIDS epidemic (SDG 3.3), achieving universal access to sexual and reproductive health and reproductive rights (SDG 3.7) and achieving universal access to sexual and reproductive health and reproductive rights (SDG 5.6). An overview of progress recorded between 2012 and 2022 on SRHR-related indicators can be summarised as follows:[2]

- Global efforts to expand the reach of antiretroviral therapy (ART) have led to a notable decline in HIV-related incidence and mortality, bringing significant health advantages to people living with HIV. The proportion of people in sub-Saharan Africa living with HIV that received ART increased from 37% in 2012 to 79% in 2021. Currently, seven out of the 10 Dutch target countries are on track with achieving SDG targets on reducing the number people newly infected with HIV.
- From 2012 to 2021, a decline in maternal and child mortality has been observed across all Dutch SRHR target countries, with the exception of Yemen. Despite progress achieved, nine out of the 10 target countries are not on track towards achieving the respective SDG targets (e.g. less than 70 maternal deaths per 100,000 live births by 2030).
- Eight of the 10 Dutch SRHR target countries are located in sub-Saharan Africa. The proportion of women in that region that used modern contraceptive methods increased from 18% in 2010 to 29% in 2019. Major challenges remain, however, for achieving universal access to sexual and reproductive health in all Dutch SRHR target countries. Notably, unmet demand for family planning is more pronounced among economically disadvantaged segments of the population in most of these countries.
- Less than half of women in sub-Saharan Africa have the autonomy to make informed decisions regarding sexual relations, contraceptive use, and reproductive healthcare.[iii] This not only violates their basic human rights but also poses a threat to their health and well-being and can have consequences such as unintended or teenage pregnancies and various forms of intimate-partner violence.[iv] In addition, same-sex sexual acts were criminalised in over half of the Dutch SRHR target countries. In 2023, the Ugandan president signed a bill criminalising both same-sex conduct and the 'promotion of homosexuality'. The law includes the death penalty for acts considered as 'aggravated homosexuality'.

In view of these developments, it is evident that while certain countries have recorded notable advancements, numerous relevant SDG targets remain out of reach in Dutch SRHR target countries. Furthermore, the 'rights' element of the Dutch SRHR agenda faces mounting challenges, partly because of growing conservative opposition.

Against this background, IOB has undertaken an evaluation of the ministry's policy on SRHR and HIV/AIDS in low- and lower-middle-income countries for the period 2012–2022. The main research question the evaluation aims to answer is:

To what extent has the Netherlands contributed to the improvement of Sexual and Reproductive Health and Rights and contributed to halting the spread of HIV/AIDS in low- and lower-middle-income countries and what lessons can be learned for future policy?

The Terms of Reference (ToR) for the evaluation outline the 11 sub-questions that guided the evaluation. These sub-questions address various aspects of the effectiveness, efficiency, coherence and sustainability of the ministry's policy on SRHR and HIV/AIDS. An overview that links these sub-questions with the respective chapters in this evaluation is presented in Annex 2.

2 In recent years, progress on SRHR-related indicators has been hampered by the effects of the COVID-19 pandemic, which disrupted health systems and supply chains, leading to shortages of contraceptives and reduced access to SRHR services.

1.2 Methods

1.2.1 Meta-evaluation

This evaluation relies largely on secondary data. To some extent, the evaluation exhibits characteristics of a meta-evaluation. IOB included final external evaluations of projects and programmes on SRHR that were financed by the ministry between 2012 and 2022. These included NGO partnership projects, programmes financed through multilateral and international organisations and funds, and the Product Development Partnerships (PDPs) – see Annex 3. IOB also systematically included available documentation and reports from all delegated projects from the two selected case studies (see below), but did not include projects managed by Dutch embassies in other countries.

The confidence in the evaluation reports has been assessed by two separate studies and by IOB:

- In 2016, the ministry commissioned the Amsterdam Institute for Global Health and Development (AIGHD) to perform a meta-evaluation of 21 SRHR projects implemented between 2011 and 2015. The study included a quality assessment of the projects' study designs.[v]
- In 2022, IOB commissioned a team from the Global Development Network to conduct a meta-evaluation of 32 strategic partnership projects, including 10 projects on SRHR, implemented between 2016 and 2020. That study assessed the research methods used in the evaluations and specifically focused on qualitative research methodologies for evaluating lobbying and advocacy-related activities.[vi]
- IOB conducted a semi-systematic search to identify and assess the quality of SRHR-related evaluations from seven multilateral and international organisations and funds that the Netherlands supported in the period 2012–2022: Gavi, the Global Fund, Global Financing Facility in Support of Every Woman Every Child (GFF), United Nations Joint Programme on HIV/AIDS (UNAIDS), United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF) and the World Health Organisation (WHO). Annex 4 presents the protocol IOB used for the search and assessment.[3]

The findings in this evaluation are structured according to the research questions underpinning the evaluation (see Annex 2 for an overview of research questions per chapter). Findings from existing evaluations were only taken into account if confidence in those evaluations was sufficient.

Chapter 6 contains sections with a summary of the existing evidence base of comparable SRHR interventions. The literature presented in these sections consists of systematic reviews with underlying high-quality impact evaluations for sub-Saharan Africa. To compile these systematic reviews, IOB contracted the Campbell Collaboration to conduct a systematic search for systematic reviews on interventions targeting SRHR in sub-Saharan Africa. The search yielded a comprehensive database of 368 systematic reviews on SRHR, which have also been depicted in an Evidence & Gap Map that is available here.[4]

1.2.2 Primary data collection

Although this evaluation largely focuses on secondary data, some primary research data are included.[5] IOB collected primary data in Bangladesh and Uganda. IOB purposefully sampled these two countries: Bangladesh presented an opportunity to assess the sustainability of SRHR interventions as between 2019 and 2021 the ministry phased out its support for SRHR in the country; while in Uganda, the Dutch embassy only recently started directly supporting SRHR projects with delegated funding. Uganda presented an interesting case given the multitude of centrally-funded partnership projects active in the country – currently 15 on SRHR and gender issues. These country case studies used a theory-based method of evaluation, which allowed IOB to explore the contribution of the interventions to SRHR results through verifying important assumptions and taking other influencing factors into account. Primary data collection comprised the following steps:

3 As a result of the quality assessment IOB included 21 of the 45 identified evaluations.

4 While the map shows whether there is evidence – or not – it does not tell us what the evidence says about what works, and why. Therefore, the researchers from the Campbell Collaboration prepared evidence summaries, which provide a concise summary of all identified evidence for specific interventions or outcomes relevant to Dutch policy. The full report, including all 14 evidence summaries, can be accessed here.

5 This included primary-data collection for the policy reconstruction. For that, IOB conducted 35 interviews with former and current ministry staff and 18 interviews with staff from SRHR partnership projects.

1. Geographically mapping all SRHR projects in Uganda and Bangladesh.
2. Sampling by selecting the regions in Bangladesh and Uganda with the most SRHR projects financed (either entirely or partly) by the ministry between 2012 and 2022.[6]
3. Formulating cause-effect contribution questions and assumptions for the supported activities.
4. Collecting primary and secondary data to test the assumptions, taking alternative explanations and unintended effects into account as much as possible.
5. Validating or falsifying the assumptions by triangulating the available primary and secondary data, with the aim of establishing reasonable evidence of the contribution made by the activity to the formulated and observed outcomes.

IOB carried out Steps 1-3 together with two Ugandan consultants and one Bangladeshi consultant. The consultants subsequently performed Step 4; three IOB researchers accompanied the consultants during the first two weeks in both countries.[7] In total, the Ugandan consultants each collected data for six weeks and the Bangladeshi consultant for 12 weeks. The consultants interviewed district officials, staff from the implementing organisations and used snowballing techniques to sample the (former) participants of projects.[8] To counter respondent bias as far as possible and to triangulate findings, for interviews and focus group discussions the consultants targeted both participants and non-participants that were from the same towns. These included key populations, youth, health facility users, health workers, civil society organisations (CSOs) not supported through ministry-funded projects and community and religious leaders.[9]

IOB collected primary data on SRHR diplomacy (Chapter 4). In consultation with the Social Development Department (DSO), IOB selected the following forums to assess the contribution of SRHR diplomacy: the European Union (EU), the Commission on Population and Development (CPD), the Commission on the Status of Women (CSW) and the Human Rights Council (HRC). In addition, IOB also selected UNFPA and the Global Fund to assess the role of the Netherlands representation on the boards of these organisations. To assess the contribution to SRHR diplomacy, IOB deployed elements of process tracing to determine the Netherlands' contribution to the intended results.[10] To assess whether other factors might have contributed to the observed results, IOB took into account internal reports and reflection documents, minutes of meetings, positions of like-minded countries and opponents, and speeches given on behalf of the Netherlands. In addition, IOB conducted 30 semi-structured interviews with ministry staff at headquarters in The Hague, at Dutch embassies elsewhere and with the Permanent Representations in New York and Geneva, as well as representatives from CSOs.

In total, IOB and the consultants performed 44 spot-checks (21 schools and 23 police stations) for the country studies and conducted 302 interviews for policy reconstruction, the country studies and the assessment of SRHR diplomacy.

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6 The regionally based sampling strategy used in Bangladesh and Uganda, which focused on areas with most activities, might also not be representative for the rest of these two countries. We purposely used this strategy, however, as it specifically offered an opportunity to take the coherence and synergies between the implemented activities into account.

7 During the two country visits, in addition IOB conducted 40 interviews with the respective embassy staff and with representatives from government, international organisations and other donors.

8 Jointly, the Ugandan consultants conducted 140 separate interviews and focus group discussions covering eight projects in eight districts. This included interviews and focus group discussions with NGOs and CSOs (44), beneficiaries (23), non-beneficiaries (11), UN agencies (12) and health workers (22). The Bangladeshi consultant held 39 interviews and focus group discussions with former beneficiaries, CSOs and UN agencies covering five projects in two districts. In addition, she performed spot-checks at 23 schools and 21 police stations to assess the sustainability of two projects. The researcher applied convenience sampling for the spot-checks, including schools and police stations, mostly in and around Dhaka.

9 To address potential evaluator-bias during data collection for the evaluation, the analysis of collected data and individual interview and focus-group reports into project- and country-specific findings was always performed by at least two researchers: first, the researchers simultaneously performed separate analyses and, then, jointly compared their findings and reached consensus.

10 In line with IOB's evaluation of support for policy influencing, lobbying and advocacy, we define SRHR diplomacy as: *'A wide range of activities that are conducted to influence decision-makers in the public and private sectors at international, national or local levels towards the overall aim of realizing SDGs 3 and 5 and other key commitments such as the ICPD Programme of Action and the outcomes of its reviews, and the human rights agreements pertaining to SRHR'* (IOB, Opening doors and unlocking potential*: Key lessons from an evaluation of support for Policy Influencing, Lobbying and Advocacy (PILA)*, The Hague, Policy and Operations Evaluation Department (IOB), 2015, p. 19).

1.2.3 Limitations

A first limitation worth noting is that determination of the level of integration between the four SRHR objectives (see Section 3.2) and the level of coherence between instruments is challenging. Many reports of supported projects structured their findings according to the different SRHR objectives, without going into detail about interlinkages (see Section 6.5). Chapter 8 examines coherence between channels and instruments, based on existing evaluation reports and in-country data collection. Although some evaluation reports examined coherence and coordination, these mostly focused on coordination either between NGOs or between multilateral organisations.

More primary research at the country level would have resulted in a more thorough investigation about interlinkages between instruments. As a result of traveling restrictions during the COVID-19 pandemic, however, IOB had to reduce the number of planned country studies from four to two. Because these countries were purposefully sampled, findings from the country studies are not automatically representative for the entire SRHR portfolio. IOB aimed to mitigate this by complementing the analysis with evaluation reports that also covered other countries, as well as by interviewing staff from supported multilateral organisations and NGO partnership projects that were active in other countries. Finally, IOB also conducted virtual interviews with staff at Dutch embassies in Ethiopia, Kenya, Mozambique, Benin, Indonesia, Egypt and Yemen.

Another limitation of the research is that the available evaluation reports do not cover the effectiveness of the entire SRHR portfolio. For part of the Dutch SRHR portfolio, no evaluations are available or evaluations do not provide information on effectiveness.[11] This is exacerbated by the low confidence IOB has in many evaluations. When IOB determines that the quality of an evaluation is inadequate, the findings on effectiveness from that evaluation are not taken into account in the study. This means that there are several 'blind spots': certain activities are not covered by an evaluation or by an evaluation of sufficient quality. Consequently, at times IOB is unable to draw definite conclusions about their effectiveness. While absence of available evidence does not mean absence of effects, it does highlight the need for improved evaluation methods in the future. To overcome some of the mentioned 'blind spots' and complement the analysis of effectiveness, IOB incorporated the academic literature about the effectiveness of SRHR-related interventions and the validity of policy assumptions as best as possible.

Regarding SRHR diplomacy, this evaluation did not examine the extent to which resolutions and documents were actually implemented on the ground and was, therefore, not able to assess the results of SRHR diplomacy on the outcome or impact levels for individuals. The focus of the study was to determine the Dutch contribution to results at the level of SRHR-agreed language, a first step for increasing the impact of diplomacy.

[11] This is the case for the Global Financing Facility for Women, Children and Adolescents, the Product Development Partnerships, the Health Insurance Fund and, to some extent, the Global Fund (see Chapter 5).

2 Context

This chapter provides an overview of the context in which Dutch policy on SRHR has been implemented in the period 2012–2022 and highlights several factors that may influence worldwide progress on SRHR. Note that the global trends for SRHR-related indicators are presented in Chapter 6. Section 2.1 examines the impact of COVID-19 on SRHR progress in low- and lower-middle-income countries. Growing conservative opposition to SRHR at the international level is discussed in Section 2.2. Finally, Section 2.3 addresses the issue of shrinking civic space and its impact on SRHR.

Key takeaways

The available literature suggests that the COVID-19 pandemic has had a significant impact on SRHR in low- and lower-middle-income countries. Evidence shows that the pandemic decreased access to and use of sexual and reproductive health supplies and services, as well as maternal healthcare. School closures increased vulnerabilities of girls, contributing to early marriage, violence and adolescent pregnancy. The pandemic particularly reinforced existing health inequalities, with poor and vulnerable groups disproportionately affected. Civil society organisations generally postponed or cancelled planned activities, decreased group size or switched to virtual activities (Section 2.1).

Conservative opposition from governments, religious groups and CSOs has gained momentum in advocating conservative points of view on gender, family and women's health. It has gained ground at the UN and in the EU, as well as at country levels, thus posing a potential challenge to the Netherlands' objectives on SRHR (Section 2.2).

Civic space is increasingly under pressure worldwide, with governments restricting the work of NGOs and independent media. This may limit access to SRHR services and information, especially in countries where the government does not provide or only partially provides access to this (Section 2.3).

2.1 COVID-19

The COVID-19 pandemic has likely had a significant impact on SRHR in low- and lower-middle-income countries, exacerbating pre-existing inequalities. The pandemic has disrupted health systems and supply chains, leading to shortages in essential medicines, including contraceptives, and reduced access to SRHR services. Lockdowns made it difficult for individuals to access healthcare facilities, particularly in rural areas, leading to a reduction in routine care and an increase in unintended pregnancies and maternal and infant mortality rates, as well as gender-based violence (GBV).

Good data on the impact of COVID-19 on the full range of SRHR services and inputs have remained somewhat scarce.[vii] The available literature shows that COVID-19-related disruptions may have exacerbated already existing inequalities in countries where sexual and reproductive health (SRH) services were virtually non-existent to begin with.[viii] Most studies found a decline in access to and use of facility delivery, antenatal care and family planning.[ix] Some studies noted improvements after initial declines, but in other cases initial declines were sustained over time.[x] Barriers to access SRH care were more pronounced in countries where restrictions or economic disadvantages existed before the pandemic. Health inequalities were reinforced with the pandemic disproportionately affecting the poor and other vulnerable groups that are more at risk and have less access to quality healthcare.[xi] Adolescents and young people also faced increased challenges when accessing SRH services. [xii]

School closures and the economic hardship brought about by the COVID-19 pandemic increased the vulnerabilities of adolescent girls in debuting sex or increasing sexual activity, and contributed in some countries to increased rates of early marriages among adolescents and adolescent pregnancy.[xiii] There are also some indications that adolescent girls experienced greater exposure to sexual and gender-based violence and involvement in risky or exploitative work.[xiv] School closures also affected school-delivered SRHR interventions such as comprehensive sexuality education.[xv]

The increased cost of medicines, supplies and healthcare, along with reduced incomes (especially for those people working in the informal sector and during the lockdown), have meant that people could not afford to buy medicines and supplies, nor pay for services needed.[xvi] Affordability was also a factor that contributed to poor access to menstrual products.[xvii] Moreover, the literature refers to changes in health-seeking behaviour, influenced by perceptions that family planning and contraceptive services were not considered to be 'essential' for healthcare, along with fear of contracting COVID-19 in medical settings and insufficient information on the continuation of SRH services during the pandemic.[xviii]

Closure of healthcare facilities and/or reduction of their operating hours, coupled with a lack of skilled healthcare workers as a result of the diversion of workers towards COVID-19 response and illness among these workers, led to reduced availability of healthcare and SRH services, such as reproductive and maternal care, HIV testing and family planning services.[xix] In addition, quarantine measures and curfews at times made it impossible for people to access these services and social distancing furthermore limited the number of clients permitted in clinics.[xx] Moreover, many countries experienced a scarcity of SRH supplies.[xxi] Disrupted supply chains due to lockdowns and border closures, and transportation and mobility restrictions further limited access to SRH services.[xxii]

The operability of CSOs active in SRHR and women's rights was also reduced during the COVID-19 crisis, for instance because of suspended services.[xxiii] [xxiv] CSOs financed through Dutch-funded SRHR partnership projects generally postponed, adjusted or even cancelled planned activities. Most often, sensitisation and awareness campaigns were shifted to virtual platforms or radio and television. Budgets of cancelled in-person activities were used to scale-up online activities. In-person activities that did continue meant smaller participant groups when respecting COVID-19 guidelines, or these were adjusted to one-on-one or door-to-door sessions. Most partnerships included COVID-19 awareness-raising in their programmes,

as well as the provision of hygiene products. Recurring challenges included reaching participants with no access to mobile phones, radio or social media, and conducting virtual lobbying and advocacy with government officials.[xxv]

2.2 Conservative opposition

A number of governments and various groups and organisations (some religious) have been actively promoting conservative ideas about gender, family and women's health during the evaluation period. This conservative opposition is not homogenous, rather it comprises a diverse coalition of actors who share similar values and beliefs. It has become 'a key factor in the resistance to SRHR' with monogamous hetero-normative family values as its main driving force.[xxvi] This opposition is well-endowed and organised and operates at the level of the United Nations (UN), where it has obtained a consultative status[12] and has joined state delegations to the meetings of the Commission on the Status of Women, as well as stepping up its involvement in official UN committees such as those on Freedom of Religion and Belief and the Family.

Having been able to gain ground within the UN, the conservative opposition uses the same language for women's and LGBTIQ+ rights and SRHR as the governments of countries like Russia, Belarus, Nicaragua, Iran, Syria, Saudi Arabia, the conservative members of the Africa Group, and the Holy See delegation.[xxvii] In 2017, former United States (US) President Trump reinstated the Mexico City Policy, often referred to as the 'Global Gag Rule', which prohibited US Agency for International Development (USAID) funding to organisations that provide or lobby for abortion services, even if they do so with non-US funds.[13]

Closer to home, plentiful European anti-gender and anti-SRHR campaigners are playing their part in the global backlash, in particular the governments of Poland and Hungary, who regularly join in with the conservative voices mentioned above. Poland and Hungary have been increasingly using their voice against SRHR in EU discussions about development cooperation and have played a role in softening the language and propositions on SRHR in the European Consensus on Development (2017) and the negotiating mandate for the Post-Cotonou Agreement (2018). The current divide among EU member states on SRHR is increasingly damaging the EU's credibility and ability to influence global politics (see Subsection 4.3.1).[14]

2.3 Shrinking civic space

Across the globe, civil society is increasingly under pressure as governments continue to place restrictions on the ability of citizens to engage in civil society activities, and on independent media and non-governmental organisations. This affects the ability of citizens to freely express their opinions, associate with others or participate in decision-making processes. CIVICUS data of 2019 and 2022 (see Figure 1) show a decline in the number of states where the civic space is open and a considerable increase in the number of countries where civic space is under pressure.

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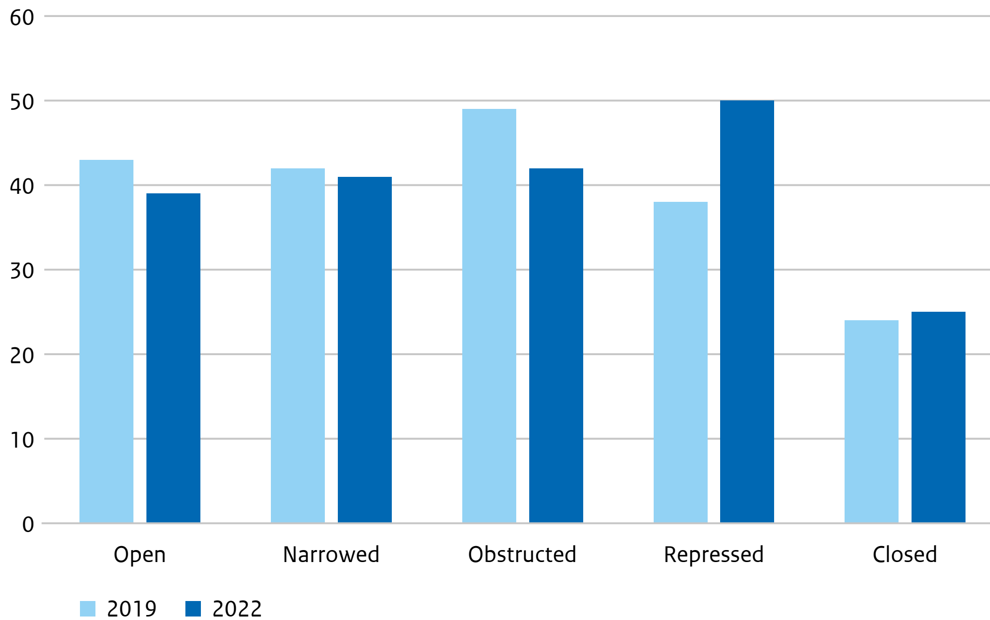
[12] A consultative status with the Economic and Social Council (ECOSOC) of the UN provides NGOs with access to ECOSOC and its subsidiary bodies (e.g. CPD and CSW), as well as access to various human rights mechanisms of the UN.

[13] This decision was followed by a US Department of State guideline on 'Protecting life in Global Health Assistance' of May 2017 to extend restrictions to global (local) health organisations. See: KFF, The Mexico City Policy: An Explainer [Website], 28 January 2021; C. Cotroneo and P. Jeney, 'Evaluating the EU's Response to the US Global Gag Rule', Policy Department for Citizens' Rights and Constitutional Affairs, Directorate-General for Internal Policies, European Parliament, September 2020, p.12-15. The decision affected, amongst other things, the President's Emergency Plan for Aids Relief (PEPFAR) and global maternal and child health programmes, including those of UNFPA (which stopped receiving US funding from April 2017 onwards). IPPF (International Planned Parenthood Federation) lost USD 100 million, intended, for example, for comprehensive sexuality education and SRHR.

[14] This is implicitly recognised in the June 2019 conclusions on EU action to strengthen rules-based multilateralism, which underline the need to 'further strengthen internal cooperation and cohesion within the EU', the issue being that the EU can only speak with one voice when after extensive coordination all EU member states are on board. Oftentimes this implies that the EU's single voice is restricted to the lowest common denominator (A. Medinilla, P. Veron and V. Mazzara, 'EU-UN cooperation: confronting change in the multilateral system', Discussion Paper No. 260, *ECDPM*, September 2019, p. 10).

Figure 1. *Trends in civil space (number of countries)*[15]



The shrinking civic and political space around SRHR is interlinked with wider global opposition against gender justice.[xxviii] Shrinking civic space can have a significant effect on SRHR: when civil society is unable to operate freely, the ability of individuals to access SRHR services and information can be limited, especially in countries where the government does not or only partially provides access to SRH services. Laws restricting freedom of expression can also prevent people from sharing information about reproductive health, contraceptive use or sexually transmitted infections (STIs). Furthermore, governments may use restrictions on civil society to silence groups advocating for access to safe abortion, the rights of LGBTIQ+ persons, sex workers and people who use drugs, or comprehensive sexuality education.

[15] In 2022, CIVICUS included data from 197 countries, in 2019 from 196 countries. In view of data limitations, it is not possible to compare the worldwide trend prior to 2019. CIVICUS rates the civic space in a country as closed when a country's combined score is between 1 and 21, restricted for scores between 21 and 41, obstructed for scores between 41 and 61, narrowed for scores between 61 and 81 and open for scores between 81 and 100. (Civicus, 'People Power Under Attack, A Report Based on Data from the Civicus Monitor', Johannesburg, CIVICUS: World Alliance for Citizen Participation, December 2019; Civicus Monitor, In Numbers [website])

3 Policy reconstruction

This chapter presents IOB's reconstruction of the Netherlands Ministry of Foreign Affairs' policy on SRHR. Section 3.1 outlines the rationale of SRHR policy, while Section 3.2 describes the ministry's mission and policy objectives. Section 3.3 summarises SRHR policy over the years. IOB reconstructed a Theory of Change (ToC) based on all policy documents and interviews with current and former staff of the ministry's Social Development Department and embassies, which is presented in Section 3.4. A brief financial overview is provided in Section 3.5.

Key takeaways

For many years, the Netherlands has prioritised SRHR in its development cooperation. Dutch international SRHR policy follows a strong human-rights-based approach, recognising SRHR as fundamental rights for everybody, including groups for whom these rights are denied, such as LGBTIQ+ people, people who use drugs and sex workers. The focus on SRHR is rooted in domestic experience in the Netherlands in areas such as access to safe abortion and rights of sexual minorities and sex workers (Section 3.1).

By supporting SRHR, the Netherlands aims to contribute to the SDGs for maternal and child mortality, ending the AIDS epidemic, universal access to sexual and reproductive health, and to reproductive health and rights. Its four main objectives are: (i) increased freedom of choice for young people, (ii) enhancing demand and supply of acceptable and affordable products for SRHR, (iii) reproductive and sexual health care and services are available to all, (iv) more respect for sexual and reproductive rights (Section 3.2).

In terms of SRHR funding, between 2012 and 2022 the Netherlands allocated EUR 4.9 billion to SRHR, 80% of which was allocated directly from The Hague; the remaining 20% was allocated to Dutch embassies in SRHR priority countries. The available budget was distributed as follows:

- EUR 2.8 billion went to multilateral organisations and international funds working on SRHR and health, with UNFPA, the Global Fund and Gavi receiving the largest shares. Towards the end of the evaluation period, the proportion of SRHR budget allocated to multilateral organisations increased due to COVID-19 related expenditures.
- EUR 1.4 billion went to NGOs and CSOs involved in SRHR. This included various subsidy frameworks through which NGOs (individually or in alliances) received support, as well as direct support to INGOs, such as Ipas, IPPF (International Planned Parenthood Federation) and PSI (Population Services International).
- EUR 316 million was used for private-sector support, including various rounds of Product Development Partnerships (PDPs).
- Health-sector support accounted for a total of EUR 269 million, with Ethiopia, Mozambique and Mali being the largest recipients. This was reduced from EUR 58 million in 2012 to EUR 5 million in 2022.
- The majority of the remaining EUR 94 million was allocated to SRHR-related research (Section 3.5)

Main factors that have influenced funding decisions made over the years include: (i) the ministry's reaction to the Mexico City Policy, or Global Gag Rule, implemented by the Trump administration in 2017, resulting in the launch of the *SheDecides* initiative; (ii) the COVID-19 pandemic, which prompted the Netherlands to develop a Global Health Strategy in 2022, placing increased focus on national health systems, pandemic preparedness and the impact of climate change; and (iii) a ministry-wide strategy to reduce fragmentation ('Less, Better, More Flexible') that resulted in the decision to discontinue central funding to several INGOs, including MSI Reproductive Choices. Additionally, certain funding choices were influenced by parliamentary motions and lobbying by organisations active in SRHR (Section 3.3).

3.1 Policy rationale

SRHR has been a policy priority in Dutch development cooperation for many years.[16] Policy documents on SRHR outline various reasons that explain this:[17]

- Young people, women, and marginalised groups continue to experience limited freedom of choice, which undermines their autonomy, human rights, and empowerment.
- Ongoing SRHR challenges in many low- and middle-income countries, for instance limited access to commodities and healthcare, and poor health and SRH outcomes. Most of these countries are not on-track to achieve the relevant SDG objectives.
- Domestic experience in the Netherlands with certain aspects of the SRHR agenda, i.e. low national prevalence of teenage pregnancies, low abortion rates, no HIV transmission to babies, and the positive effects of harm-reduction policies for people who inject drugs.[xxix]

16 Already in the period 2004–2006, Dutch policy paid specific attention to sensitive SRHR and HIV/AIDS topics among youth and vulnerable groups. The Dutch international reputation in SRHR was built particularly on support for such topics that others found too sensitive to address such as abortion, adolescent SRHR, and LGBTIQ+ and other key populations rights. See IOB, Beleidsdoorlichting seksuele en reproductieve gezondheid en rechten en hiv/aids, 2004–2006, Ministerie van Buitenlandse Zaken, The Hague, Policy and Operations Evaluation Department (IOB), 2007.

17 These arguments have not changed much and can e.g. be found in Ministerie van Buitenlandse Zaken, 'Lijst van Vragen en Antwoorden', kst 33625-5, 21 May 2013; Ministerie van Buitenlandse Zaken, 'Brief van de Minister voor Buitenlandse Handel en Ontwikkelingssamenwerking', kst 33625-184, 9 November 2015; Ministerie van Buitenlandse Zaken, 'Verslag houdende lijst van vragen en antwoorden', kst 34775-XVII-7, 7 November 2017; Ministerie van Buitenlandse Zaken, 'Memorie van Toelichting', kst 34775-XVII-2, 2017; Ministerie van Buitenlandse Zaken, 'Verslag van een schriftelijk overleg', kst 33625-296, 19 May 2020; Ministerie van Buitenlandse Zaken, 'Memorie van Toelichting', kst 36200-XVII-2, 2022.

The ministry's most recent policy letter on SRHR, published in 2012, also argued that investing in SRHR would contribute to lower population growth, which, in turn, would contribute to development in countries where natural ecosystems, education and health systems were under pressure. Similarly, the ministry's ToC of 2018 mentioned that investments in family planning can contribute to sustainable development and achieving a demographic dividend.[xxx]

Dutch policy is based on the comprehensive definition of SRHR of the Guttmacher-*Lancet* commission (see Annex 1) and has a strong human rights-based approach, recognising that SRHR are fundamental human rights that apply to all individuals, irrespective of gender or sexual orientation.[xxxi] [xxxii] These rights explicitly include equal rights for LGBTIQ+ people and other groups that have been denied their rights, such as sex workers, people who use drugs, socio-economically marginalised populations, young people, vulnerable children, and women and girls in rural and conflict areas.[xxxiii]

3.2 Mission and policy objectives

There have been no drastic changes in the Dutch SRHR policy since the previous SRHR policy letter of 2012, which reconfirmed that the focus on SRHR also included support for HIV/AIDS initiatives. The ministry's SRHR mission, as captured in its Theory of Change in 2018, reads:

> *To promote the universal fulfilment of Sexual and Reproductive Health and Rights and thus contribute to lower maternal and child mortality (SDG 3.1 and 3.2), stopping the AIDS epidemic (SDG 3.3), universal access to sexual and reproductive health (SDG 3.7) and universal access to reproductive health and rights (SDG 5.6). All actions should contribute to the overall SDG goals of ensuring healthy lives and promoting the well-being for all at all ages (SDG 3) and achieving gender equality and empowerment of all women and girls (SDG 5).*

Dutch SRHR policy has established four result areas, which have been constant over time:[18]

1. Young people have more **freedom of choice** with respect to their sexuality. This implies attention for sexuality education both boys and girls, providing menstrual services at school and creating opportunities for meaningful youth participation in decision-making.
2. Demand for and supply of **acceptable and affordable products** for SRHR (including antiretroviral drugs, contraceptives and other life-saving substances for preventing maternal mortality and sexual health problems) for women, youths and key populations are improved.
3. Comprehensive, good quality **reproductive and sexual healthcare and services** available to all, including women and men in crisis or humanitarian settings. This includes the provision of safe abortion and mental health and psychosocial support. HIV services should be available to all at risk, regardless of their sexual identity, gender or profession.
4. Greater respect for the **sexual and reproductive rights** of groups for whom these rights are being denied, for example LGBTIQ+ people, people who use drugs and sex workers – i.e. key populations. This includes advocacy for self-determination of women and girls on their sexuality and tackling, amongst other things, illegal and unsafe abortions, child marriages, sexual harassment, gender-based violence (including female genital mutilation (FGM) and other discriminatory and criminal practices).

During the evaluation period, policy on development cooperation focused on 10 specific SRHR target countries.[19] Dutch (core)funding through multilateral and international organisations and funds has a much wider geographical reach, however. This wide reach was also the case for the 10 SRHR partnership projects financed between 2016 and 2020 (see Figure 2).[20]

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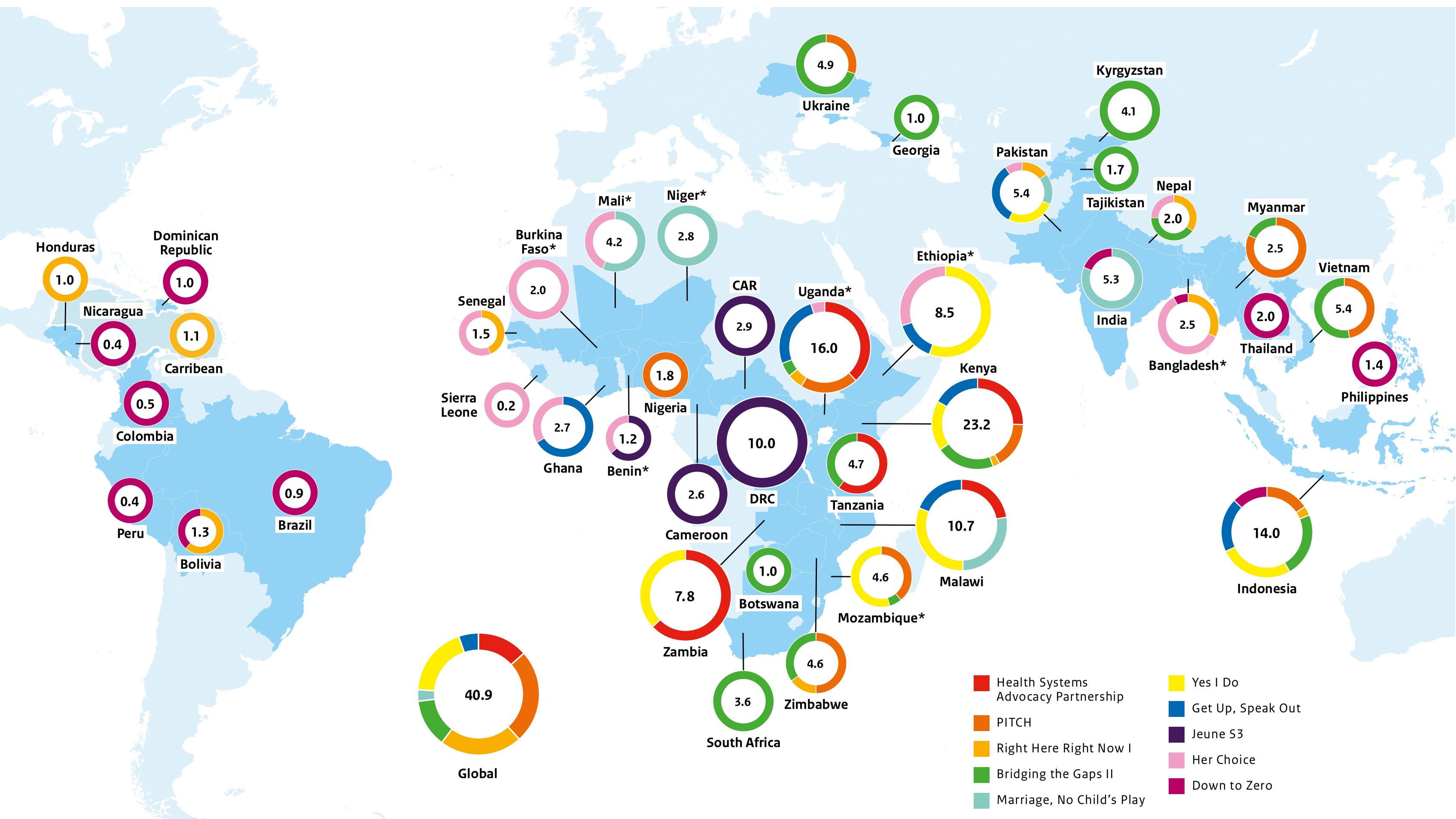
18 Ministerie van Buitenlandse Zaken, 'Beleid ten aanzien van ontwikkelingssamenwerking', kst 32605-114, 2 November 2012; Ministerie van Buitenlandse Zaken, 'Theory of Change Sexual and Reproductive Health and Rights'.

19 SRHR target countries through the years have included Bangladesh, Benin, Burkina Faso, Burundi, Ethiopia, Mali, Mozambique, Niger, Uganda and Yemen.

20 Note that this current evaluation classifies the seven SRHR partnership projects and three Dialogue and Dissent projects that focused on SRHR, implemented between 2016 and 2020, jointly as 'the SRHR partnership projects (2016–2020)'.

Figure 2. *Partnership project expenditures (EUR millions) per country for SRHR and Dialogue and Dissent partnerships in the period 2016–2020*[xxxiv]



NB: Dutch SRHR target countries are indicated by an asterisk (*). Global expenditures refer to activities that cannot be allocated to a single country, for example international lobbying.

3.3 Policy over the years

Minor shifts in focal points since the 2012 policy letter have been described in the Foreign Trade and Development Cooperation policy notes of 2013, 2018 and 2022, as well as the Dutch Global Health Strategy in 2022. The 2013 policy note (*'A World to Gain'*) specifically described efforts on preventing child marriages and sexual violence, amongst other things, via the Girls Not Brides campaign and through improving the implementation of existing resolutions, such as the UN Security Council Resolution 1325 on Women, Peace and Security. The policy note additionally described financial support for eHealth, to improve the accessibility and decrease the costs of healthcare in low-income countries. Examples include healthcare information via SMS (via the Connect4Change Alliance), and remote care via video technology (Pharm Access, Medical Credit Fund and Health Insurance Fund).[xxxv]

An important development in Dutch SRHR policy was the launch of the *SheDecides* initiative in early 2017 as a response to political developments in the United States that affected international funding of SRHR-related activities (see Box 1).

Box 1 *SheDecides*

On 24 January 2017, one day after President Trump had reinstated the Global Gag Rule, the Dutch minister for Foreign Trade and Development Cooperation launched *SheDecides*, a fund-raising platform to support the rights of girls and women. The intention was to gain international political and financial support to offset the deficit resulting from loss of US funding for SRHR.[xxxvi]

The Netherlands launched the initiative with an initial commitment of EUR 10 million. A Rutgers-led NGO lobby made a joint statement in support of the initiative. In March 2017, over 50 countries, UN organisations, NGOs and other stakeholders attended an international conference in Brussels in support of the fund-raising initiative.[xxxvii] Many stakeholders pledged to contribute to the initiative, both during and after the conference. By October 2017, EUR 292 million had been raised. Amounts raised generally went to organisations that were directly affected by the US policy.

Thanks to the initiative, the Netherlands was put on the map as a champion for freedom of choice and for equal rights and opportunities for women and girls.[xxxviii] The ministry saw *SheDecides* as a flagship initiative but did not assign to it a specific budgetary status. Although pledges continued to be made, it was decided to discontinue monitoring and counting the contributions beyond the first year, because spending and monitoring funds was primarily the responsibility of the individual donors themselves. The network of the *SheDecides* movement was used in Dutch international diplomacy on themes such as sexuality education, rights and safe abortion.[xxxix] The *SheDecides* movement is supported by a support unit hosted by IPPF.[xl]

Firstly, the 2018 policy note (*'Investing in Global Prospects'*) included gender equality and empowerment of women and girls as a cross-cutting aim in development cooperation, and announced the intention to take further steps on gender mainstreaming. Secondly, it announced increased allocations to development cooperation in West Africa, the Horn of Africa and the Middle East and North Africa (MENA) region. Specifically in West Africa, the Netherlands would scale-up contributions to support access to contraceptives for women and girls. Thirdly, the policy note announced attention for SRHR in humanitarian crises, through promoting access to sexual and reproductive health and by implementing the 'Minimal Initial Service Package for Reproductive health in Crisis'.[21] Fourth, and lastly, it again mentioned efforts to prevent and punish sexual and gender-based violence and child marriages, as well as the sexual exploitation and abuse of children, abuse in the sex industry, gendercide,[22] and other discriminatory practices.[xli]

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21 Although the ministry announced plans to increase its focus on SRHR in humanitarian settings in 2018, this has not been operationalised further. Prior to 2018, the Netherlands already supported SRHR in fragile and humanitarian settings through organisations such as UNFPA, MSI, IPPF, Ipas, and WHO, as well as through the Jeune S3 partnership project and this has not substantially changed.

22 Gendercide is the deliberate killing of people on account of their gender or sex. Typically this includes females, especially by infanticide or selective abortion. We did not identify specific programming on gendercide in this evaluation.

In 2019, the ministry launched the internal 'Less, Better, More Flexible' strategy, which aimed to reduce the number of centrally-funded projects, scale-up successful projects, improve coherence and increase flexibility of funding.[xlii] This strategy was formulated in response to an IOB evaluation[xliii] that had concluded that results of certain centrally-funded NGO projects focusing on security and rule of law were limited due to funds being spread over many small and geographically dispersed activities. The ministry's strategy also flagged that there were various 'popular' target countries ('donor darlings') in which there were many centrally-funded activities, for example Uganda and Ethiopia.[xliv] The document expressed concern that certain local organisations were being supported centrally from The Hague, despite their unfavourable local reputation or their efforts conflicting with the objectives of embassy-funded projects.

Small and dispersed activities were also apparent in SRHR partnership projects (2016–2020) – Figure 2 provides an overview per country. There was no geographical delimitation in the ministry's tendering documents and, combined, the 10 projects covered 42 countries. Over a five-year period, Dutch civil society organisations in several Dutch target countries received minimal support from these partnerships, examples being Benin (EUR 1.1 million) and Burkina Faso (EUR 2.2 million). At the same time, there are still 'popular' target countries, in which many centrally-funded activities are active. Currently, out of the seven SRHR partnership projects, six are currently active in Kenya and five in Uganda.[23]

With current SRHR partnership projects (2021–2025), small and dispersed budgets, as well as 'popular' countries, still persist. On average, SRHR partnership projects are being implemented in eight different countries, inevitably leading to relatively small budgets and limited activities per country. Although project proposals were awarded more points for implementation in Dutch priority countries, there was no limit to the number of countries that could be included per project.[xlv]

The 'Less, Better, More Flexible' strategy was also applied to other activities supported through the partnership project budget and led to a reduction in the total number of SRHR activities. The ministry ended its core funding to the INGOs MSI Reproductive Choices, Population Services International, Frontline AIDS, AmplifyChange and the global partnership Girls not Brides, whereas support for IPPF, Ipas and the Sexual Rights Initiative was retained.[xlvi] [24] At the same time, however, the ministry permitted embassies to provide delegated funding to these organisations, from which it withdrew core funding. This led de facto to earmarking support to the country level instead of addressing fragmentation at that level.

To some extent, Dutch parliament and lobbying organisations have influenced the operationalisation of SRHR policy, for instance by lobbying for funding for specific organisations or earmarking funding for specific themes (such as sexual exploitation of children and child marriage). Certain funding decisions were the result of parliamentary motions and lobbying from the organisations concerned. Examples include:

- The subsidy framework for the Dialogue and Dissent (D&D) programme for the 2016–2020 period, which was published in 2014. It set aside EUR 925 million for Dutch NGOs without specific thematic delimitation and, thus, including SRHR. Interviewees at the ministry indicated that as a result of lobbying by Dutch CSOs, the ministry also published a separate subsidy framework specifically for Dutch CSOs active in SRHR, with a budget of EUR 215 million for the same period.[xlvii] Organisations were allowed to submit proposals for both frameworks during the 2016–2020 partnership round.[25]
- Financial support to international funds like the Global Fund and Gavi has remained substantial, in part thanks to external lobbying, even though Gavi's role in SRHR is limited.[xlviii]
- In 2019, parliament thematically safeguarded funding for combating sexual exploitation of children (EUR 5 million a year).[xlix] Earlier, in 2012, this was the case with the introduction of the Step Up Fund, also focused on combating sexual exploitation of children (EUR 8 million for three years) and the Child Marriage Fund (four projects with a total budget of EUR 6 million for one year), with parliament

[23] In Uganda, there are currently 25 centrally-funded partnership projects active: in addition to the five SRHR partnerships, there are also five projects financed through the Power of Women framework, and fifteen through the Power of Voices framework.

[24] The ministry based this decision on four factors: the extent to which the organisation fitted the Dutch SRHR profile on contraception, safe abortion, and comprehensive sexuality education; the dependency of the organisation on Dutch funding; possibilities to delegate funding to Dutch embassies; and the input of the INGO for Dutch policy development.

[25] Organisations were no longer allowed to submit proposals to both the SRHR and Power of Voices subsidy frameworks in the 2021–2025 round of strategic partnership projects.

furthermore stipulating the requirement to tender among Dutch organisations.[l]
- Continued funding for PDPs was set aside in the Ministry of Foreign Trade and Development Cooperation (BHOS) budget following a parliamentary motion in June 2021. In practice this meant that the commitment to continue funding PDPs was made prior to the publication of the external evaluation.[li]

In 2022, the most recent policy note (‘*Do what we do best*’) introduced additional investments in global health, primarily in strengthening primary health systems, and indicated that these would be described in a new Dutch Global Health Strategy. Moreover, the policy note reaffirmed SRHR as a policy priority and announced (once again) the ministry’s intention to increase focus on eHealth and to provide digital support to health workers.[lii] That year, the Minister for Foreign Trade and Development Cooperation and the Minister of Health, Welfare and Sport jointly published the Dutch Global Health Strategy.[liii] Three priorities were mentioned: 1) strengthening global health architecture and national health systems; 2) improving international pandemic preparedness and minimising cross-border health threats; and 3) addressing the impact of climate change on public health and vice versa. The strategy announced that the Netherlands would increase global health financing and that, during the period 2023–2026, an additional EUR 530 million would be allocated to global health and SRHR. These additional funds would be allocated to international organisations such as the WHO and the GFF, to scale-up SRHR programmes at the country level and to support innovations through alliances with private companies, knowledge institutions and CSOs.

In 2022 the Ministry of Foreign Affairs published a policy letter explaining its plans to improve and expand the Netherlands’ feminist foreign policy in its attempt to reduce inequality and work towards achieving equal status for men, women and non-binary people; there is a particular focus on the position of LGBTIQ+ people.[liv] The policy letter mentioned IOB’s evaluation on gender mainstreaming,[lv] which had concluded that there was room for improvement in putting steps taken towards gender mainstreaming into practise. Over the coming years, Dutch policy on gender mainstreaming will be developed further.

3.4 Reconstructed Theory of Change

IOB’s reconstruction of the ministry’s Theory of Change is in Figure 3. Although the Theory of Change published by the ministry itself describes some assumptions, most were abstract and none were backed by scientific evidence or supported by evaluations. In addition, the ToC did not formulate strategies to test underlying policy assumptions and various key assumptions were not made explicit. IOB’s reconstruction of the ministry’s key assumptions are also shown in Figure 3.

Figure 3. *The reconstructed Theory of Change on SRHR*

SDG 3: Ensure healthy lives and promote well-being for all at all ages; and
SDG 5: Achieve gender equality and empower all women and girls

SDGs 3.1 and 3.2: Lower maternal and child mortality
SDG 3.3: Contain AIDS epidemic
SDG 3.7: Universal access to sexual and reproductive healthcare services
SDG 5.6: Universal access to sexual and reproductive health and reproductive rights

Overall mission of Ministry of Foreign Affairs: universal realisation of Sexual and Reproductive Health and Rights

Result area 1: Increased freedom of choice for youth about their sexuality	Result area 2: SRH and HIV/AIDS medicines and commodities	Result area 3: Reproductive and sexual health care and service are available for all	Result area 4: Sexual and reproductive health and rights are maintained and strengthened
Envisaged results: • Active and meaningful involvement of young people in policy and decision-making. • Healthy sexual behaviour of young people, both in and out of school. • Increased use of youth-friendly SRH and HIV/AIDS services.	**Envisaged results:** • Improved usage of (innovative) SRH medicines, commodities and diagnostics.	**Envisaged results:** • Provision of SRH, including HIV/AIDS services and safe abortion care. • Increased private-sector commitment for embedding SRH and HIV/AIDS within health systems.	**Envisaged results:** • Laws and policies supporting the sexual and reproductive rights of all people, including those belonging to marginalised groups. • Civil society organisations and networks lobby and advocate for SRHR for all people.
Main activities: • Comprehensive Sexuality Education, including developing and distributing suitable curricula for comprehensive sexuality education and the training and sensitising of teachers to provide the courses. • Raising awareness of SRHR out of school. The focus is on giving young people the knowledge, skills and resources to make informed decisions about their sexual and reproductive health. • Activities to enhance information sharing and organisation of the youth voice.	**Main activities:** • Provision of SRH commodities, e.g. modern family planning commodities and safe abortion care. • Provision of HIV/AIDS commodities, including antiretrovirals. • Provision of child and HPV vaccines. • Support innovation for SRH and HIV/AIDS medicines and commodities, to develop and bring to the market drugs, vaccines and diagnostics for vulnerable people, to prevent poverty-related diseases and conditions associated with SRHR and HIV/AIDS.	**Main activities:** • Direct SRH service delivery, including prevention, diagnosis, counseling, treatment and care related to sexual and reproductive health, e.g. contraception, pregnancy, HIV, STIs and safe abortion. • Health systems strengthening. Activities included training of the health workforce, development of national health policies and plans, and improving data and accountability. Health systems strengthening has been done both through improving existing SRH services and through strengthening the general health system.	**Main activities:** • Lobby and advocacy. This includes engaging directly with government officials to influence policy and legislation on sexual and reproductive rights. • Awareness-raising activities to increase respect for the sexual and reproductive rights of all people. • Capacity strengthening of CSOs by providing training to national and local CSOs on diverse topics.
Assumptions • Limited knowledge of SRHR can be addressed by providing young people with SRHR information. • Limited knowledge of SRHR restricts young people to make their own informed choices about their sexuality, reproduction and health. • Barriers that prevent young people from making informed decisions, e.g. cultural or policy/legislative barriers, can be overcome partly through youth empowerment.	**Assumptions** • Enhancing availability to SRHR and HIV/AIDS medicines and commodities will improve access to SRHR and HIV/AIDS medicines and remove a significant barrier to their uptake. • Supporting innovation through PDPs can lead to lasting and increased improvements in access to medicines, vaccines and diagnostics to combat SRHR-related diseases.	**Assumptions** • Making additional SRH services available leads to increased use of services and improved SRH outcomes, including for young people and key populations. • Strengthened health systems can have positive and lasting effects on the sexual and reproductive health and rights of people, including young people and key populations.	**Assumptions** • Providing people with information can alter their attitudes and acceptance of sexual and reproductive rights for all people. • Capacity strengthening of CSOs can enhance the effectiveness of their lobby and advocacy. • Lobby and advocacy by CSOs can effectively contribute to improved SRHR for all people.

Cross-cutting assumptions:

- Through interventions in various SRHR fora, the Netherlands is able to uphold and expand existing agreements.
- Through its board membership in multilateral organisations, the Netherlands is able to influence agendas, policies and implementation of programmes.
- These organisations had added value in leveraging national governments.
- The implementing organisations connect their activities in the different results areas at the national and local levels.
- Implementing partners operationalise gender mainstreaming in their project design and implementation.
- NGOs have a special role to play in networking with local CSOs and in approaching groups that are more difficult to reach.
- Multilateral organisations and international funds, due to their size, reach and economies of scale, could achieve results that the Netherlands alone could not.
- Various channels and instruments will complement each other at country level.
- Other stakeholders (including governments or other donors) in target countries are willing to take over the broad range of SRHR services provided by the ministry's implementing partners, which would lead to a continuation of interventions ('sustainability of activities').
- Governments in target countries are willing and able to increase domestic health expenditure, which is a necessary precondition for strengthened health systems.
- Results achieved through SRHR interventions, e.g. improved capacity of CSOs, changes in norms, or improved policies due to lobby and advocacy, will have lasting effects ('sustainability of results').

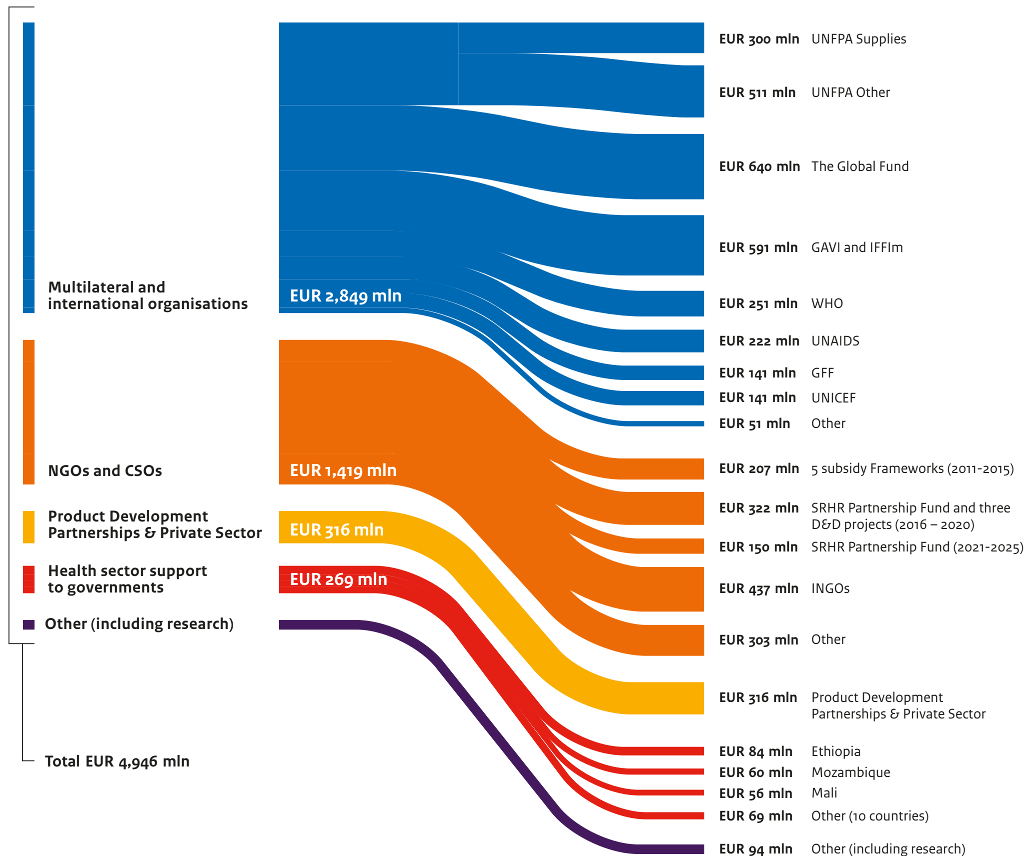
3.5 Instruments and financial overview

To implement SRHR policy the Netherlands uses both funding and diplomatic efforts (for details on the latter, see Chapter 4). The Netherlands has been providing financial support to a multitude of organisations working on SRHR, such as multilateral organisations, international funds, NGOs, companies and knowledge institutes. The funding for SRHR comes from different parts of the BHOS budget,[26] with Article 3.1 being the main source. The total amount spent on SRHR from 2012 to 2022 was around EUR 4.9 billion, equal to some 10% of the overall Dutch budget for Official Development Assistance during that period.

Figure 4 depicts SRHR expenditure during the evaluation period, 2012–2022. For a comprehensive overview of annual distribution of SRHR expenditure among multilateral and international organisations, subsidy frameworks and the supported projects and programmes, see Annex 3.

[26] Other budgetary resources include Article 3.2 (Women's rights and gender equality) – which is the main source for interventions on combating gender-based violence; Article 3.3 (civil society) of the Foreign Trade and Development Cooperation budget; and Article 1.2 of the Ministry of Foreign Affairs budget (protection and promotion of human rights), which also addresses issues confronting LHBTQI+ persons, gender-based violence and child marriages.

Figure 4. *Total SRHR expenditure (EUR millions) per instrument between 2012 and 2022*[lvi]



Dutch SRHR policy acknowledges that well-functioning primary health systems are crucial for its implementation and progress in SRHR. A portion of the SRHR budget has been used for supporting the strengthening of health systems through organisations such as Gavi, the Global Fund, and GFF. During the evaluation period, 58% (EUR 2.8 billion) of the SRHR budget was directed towards multilateral organisations and international funds. This proportion increased to 65% in 2021 and 69% in 2022, primarily the result of COVID-19-related expenditures such as COVAX and the GFF's COVID-19 response. Through UNFPA, the Global Fund, Gavi and the International Finance Facility for Immunisation (IFFIm), the ministry contributed to the provision of SRH commodities, antiretroviral drugs and vaccines in low- and lower-middle-income countries. The Netherlands has traditionally favoured core or non-earmarked contributions, but at times funds are earmarked in line with its policy priorities, such as WHO's Tuberculosis (TB) programme, UNFPA and UNICEF's Joint Global Programme to End Child Marriage and its contribution to UNFPA's Supplies Partnership.

The ministry began supporting the Global Financing Facility for Women, Children and Adolescents (GFF) in 2018, a few years after the facility's launch in 2015. The GFF requires implementing countries to invest their own resources in a national 'investment case' and it is active in 36 countries, including eight Dutch target countries.[27] As a donor, the Netherlands is a member of the facility's Trust Fund Committee and its Investors Group. When it joined the GFF, the Netherlands' position was that the GFF should focus on increased attention for SRHR, gender equality, a more inclusive role for CSOs and increased domestic responsibilities.

[27] Afghanistan, Ethiopia, Malawi, Senegal, Bangladesh, Ghana, Mali, Sierra Leone, Burkina Faso, Guatemala, Mauritania, Somalia, Cambodia, Guinea, Mozambique, Tajikistan, Cameroon, Haiti, Myanmar, Tanzania, Central African Republic, Indonesia, Niger, Uganda, Chad, Kenya, Nigeria, Vietnam, Cote d'Ivoire, Liberia, Pakistan, Zambia, Democratic Republic of Congo, Madagascar, Rwanda, Zimbabwe.

During the evaluation period, 29% of the SRHR budget (EUR 1.4 billion) was allocated to NGOs and CSOs, mainly through a series of subsidy frameworks. In 2013, the ministry announced a new approach to working with CSOs that would play a more political role than before and focus more on lobbying and advocacy than on service delivery.[lvii] The 2014 subsidy framework for the Dialogue and Dissent programme focused on strengthening CSOs' capacity for lobbying and advocacy.[lviii] Three partnerships (with a budget totaling EUR 107 million) funded from the D&D programme were active on SRHR between 2016 and 2020. During the same time period the ministry also funded seven partnership projects from its SRHR Partnership Fund; their budgets totaled EUR 215 million. The main difference being that projects funded through the SRHR Partnership Fund were allowed to provide some service delivery, while this was not the case for SRHR projects financed from D&D subsidies.

In 2020, a grant instrument for a new SRHR Partnership Fund was launched, with a budget between 2021 and 2025 accounting for EUR 315 million, once more focusing on strengthening CSOs in their role of lobbying and advocacy to promote the universal fulfilment of SRHR. Including a service-delivery component was allowed if it was clarified how the component 'served the primary commitment to lobbying and advocacy' in the interest of young people or people who are currently denied their sexual and reproductive rights.[lix]

Additionally, the Ministry of Foreign Affairs supported international NGOs that were active in SRHR and/or HIV/AIDS, such as Ipas (safe abortion), the International Planned Parenthood Federation (IPPF, family planning and SRHR) and Population Services International (PSI, social marketing of contraceptives and health commodities) and Girls Not Brides (international network on child marriages).[28]

The ministry has also delegated funds to the Dutch embassies to support SRHR-related projects in target countries where SRHR was selected as a thematic priority: Ethiopia, Mali, Burundi, Uganda, Benin and Yemen; since 2019, also Burkina Faso (after being phased out in 2014) and Niger. In addition, during the review period, the ministry had regional programmes in Southern Africa (on SRHR and HIV/AIDS) and the African Great Lakes region (on SRHR in fragile states). The SRHR programmes that existed in Bangladesh and Mozambique had been phased out by 2022.[29] In some target countries the Dutch embassy there also directly provided health-sector support. In 2019, the ministry also intended to select Egypt as a thematic target country considering the increased policy attention for the MENA region. In the end, however, this did not occur.[lx]

SRHR policy and decisions on the allocation of funds across different channels and implementing partners continue to be highly centralised in The Hague, with about 80% of the total SRHR budget allocated directly from the ministry's headquarters.[30] The amount of funding delegated to embassies for SRHR and HIV/AIDS has not changed substantially during the evaluation period and continues to be about 20% of the total budget: in 2011 it was EUR 99 million and in 2021 it amounted to EUR 105 million.

The Netherlands has been co-financing the Product Development Partnerships. These partnerships support the development of healthcare products for SRHR and poverty-related disease that are unlikely to attract private investment while in development. The aim is to ensure that these healthcare products are made available in countries outside of the EU. The Dutch contribution was EUR 169 million during the evaluation period.

The ministry's policy focus on SRHR is value-driven: it has a strong human-rights based approach and focuses on the more sensitive rights aspect of the SRHR agenda, such as access to safe and legal abortion, with an additional focus on groups that may be denied their rights, such as young people, women who have abortions, people who inject drugs, sex workers or LGBTIQ+ people.[lxi] Nevertheless,

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28 The idea was that these organisations would focus on themes and approaches that were not picked up by the current Dutch partnerships and would also work in regions in which Dutch NGOs typically do not have significant added value.

29 A regional SRHR and HIV/AIDS programme in Southern Africa still exists.

30 According to an internal ministerial note '*The proportion of SRHR total budget allocated to embassies has been roughly 20% of the total SRHR budget in the last 15 years*', and at the time of this note the delegated budget went to 13 delegated programmes, of which two were being ended. (Ministerie van Buitenlandse Zaken, 'Budget delegation in the SRHR theme', p. 1 (Internal policy document, Ministerie van Buitenlandse Zaken, August 2021)).

in the period 2012–2022 these intentions have not translated into financing decisions that reflect these thematic priorities. A large share of the budget was allocated to multilateral organisations that do not solely focus on SRHR (most notably, Gavi and the Global Fund). By comparison, the financial allocation to organisations that focus specifically on safe abortion (e.g. Ipas and IPPF's Safe Abortion Action Fund) was relatively modest.

There was, moreover, no thematic earmarking of funds within the SRHR partnership projects. This resulted in partnerships that focused on a wide range of SRHR topics, such as child marriage, sexual exploitation of children, and health systems, with, overall, limited explicit attention paid to the sensitive aspects being emphasised by the Netherlands. For instance, only two of the 10 SRHR partnerships advocated for access to safe abortion, and it remains unclear to what extent key populations were meaningfully targeted and involved (see also Subsection 6.7.2).

4 SRHR diplomacy

This chapter examines the Netherlands' role in SRHR diplomacy, which has been a significant instrument in achieving Dutch policy objectives. Section 4.1 outlines the specific objectives of SRHR diplomacy during the evaluation period. After a brief stakeholder analysis in Section 4.2, Section 4.3 discusses the results achieved through Dutch SRHR diplomacy within the EU, CPD, CSW, HRC, UNFPA, the Global Fund and, lastly, at the country level in Uganda and Bangladesh.

Key takeaways

Emphasising the importance of SRHR diplomacy, the Netherlands has continuously been actively involved in all main international SRHR forums, contributing through resolutions, speeches, statements and side events. Main niches have included attention for key populations and comprehensive sexuality education (Section 4.1). Often, the Netherlands operated through the European Union to strengthen its position in the international SRHR arena. While EU statements in recent years reflect Dutch priority issues, the growing internal division within the EU has reduced the EU's influence somewhat (Section 4.2).

Through its SRHR diplomacy, the Netherlands assumed that it would be able to uphold and expand existing agreements in the most important SRHR forums. Based on the evidence from various forums, IOB concludes that this assumption is largely valid. Despite growing international pushback, the Netherlands has contributed to preserving SRHR's position on the international agenda and upholding agreements. It is plausible that without Dutch inputs, maintaining the same level of agreed language would have been difficult. At times, the Netherlands contributed to

advancing agreed language. Still, there were some instances where it was not possible to maintain the language previously agreed upon.

The Netherlands also played an active role in boards of multilateral organisations. The underlying assumptions are that: (i) through its board membership, the Netherlands would be able to influence agendas, policies and implementation of the programmes, and; (ii) that these organisations have added value in leveraging national governments. IOB's evaluation could not fully verify or falsify either policy assumption. There are indications that multilateral organisations have good working relationships with national governments, but they were hesitant to leverage these relationships on issues that were considered politically sensitive.

4.1 Objectives of SRHR diplomacy

For decades, SRHR diplomacy has been an important instrument for the Netherlands to achieve its SRHR policy objectives. According to the 2018 SRHR ToC, the Netherlands had added value as an 'influencer and diplomat', with staff in The Hague, New York, Geneva and at embassies engaged in SRHR diplomacy and working on strengthening international consensus and the international human-rights framework.[lxii]

Over the years, there has been continuity in the Dutch commitment to SRHR diplomacy. This commitment can be mainly explained by the ongoing violation of SRHR worldwide, exacerbated by the COVID-19 pandemic, and increasing resistance to international consensus on these issues in many parts of the world, as outlined Chapter 2.[lxiii] As a minimum, Dutch diplomacy aimed to uphold existing agreements, at the same time aiming for the inclusion of the full definition of 'sexual and reproductive health and rights'. In its advocacy, the Netherlands has specifically paid attention to sensitive themes such as comprehensive sexuality education (CSE),[31] the rights element of SRHR and access to safe abortion.[lxiv] Through membership of governing bodies of multilateral and international organisations and funds, the Netherlands also set out to influence their agendas, policies and the implementation of their programmes.

The assumptions underlying SRHR diplomacy efforts are therefore:
1. Through interventions in various SRHR forums, the Netherlands is able to uphold and expand existing agreements.
2. Through its board membership in multilateral organisations, the Netherlands is able to influence agendas, policies and the implementation of their programmes.
3. These organisations had added value in leveraging national governments.

Important actors in Dutch SRHR diplomacy are the Ministers of Foreign Affairs and of Foreign Trade and Development Cooperation, designated thematic ambassadors,[32] staff from the Social Development Department (DSO), the Multilateral Organisations and Human Rights Department, the Taskforce Women's Rights and Gender Equality, the European Integration Department, regional departments of the ministry, Dutch embassy staff and the permanent missions in Geneva, Brussels, New York and Washington. It is the assessment of IOB that the stakeholders involved had good knowledge of the Dutch SRHR agenda, of the 'agreed language' for SRHR in the diverse international forums and of the positions of other member states. The staff prepared detailed instructions for international meetings, specifying Dutch priorities, aims and preferred language in documents and resolutions. This set-up has enabled the Netherlands to be well-prepared and participate effectively in these meetings.

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31 Comprehensive sexuality education is broader than education on reproduction-focused sexuality and aims to provide children and young people with knowledge, skills, attitudes and values concerning the cognitive, emotional, physical and social aspects of sexuality. However, contexts vary and there is no minimum standard as to what constitutes 'comprehensive'. (UNESCO, 'International technical guidance on sexuality education: an evidence-informed approach', Paris, 2018UNESCO, 2021)

32 In particular the human rights ambassador and the SRHR & AIDS ambassador (ASRA), now the ambassador for women's rights and gender equality, and the youth ambassador SRHR, gender equality and bodily autonomy.

4.2 Stakeholder analysis

As decision-making in international forums is geared towards consensus, to achieve its aims the Netherlands has to look for allies and needs to establish common ground with other countries. To fulfil its diplomatic objectives, the Netherlands has therefore partnered with countries that have similar values and objectives. These include, for instance, the Scandinavian countries, the UK, France, Germany, the US (except during Trump years), New Zealand, Australia, Canada, South Africa (sometimes less explicitly) and Costa Rica. The SRHR stance of some like-minded countries has shifted over the years. Main pushback actors include Hungary, Poland, Russia, the Holy See delegation, Egypt and the Africa Group.

The level of vocality of like-minded partners may differ per topic. The Dutch position on sex workers, for example, is rather unique. The grouping – like-minded countries versus pushback countries – is not unvaryingly stable and elections may result in countries becoming less like-minded than before (or vice versa). Moreover, there is quite a large group of African and Asian countries belonging to the G-77 that are not so outspoken in favour of or against SRHR, although they may still adhere to international consensus on SRHR and gender.

To support lobbying by like-minded countries and organisations, and to counter the conservative opposition, the *Nexus initiative* was launched 2018, recognising that international collaboration and coordination in making international statements is important. [33] The Netherlands was among the founders of the initiative and the ministry sees it as a way to expand its diplomatic effectiveness.

4.3 Results of SRHR diplomacy

Dutch SRHR diplomacy included a wide range of activities, such as drafting and/or sponsoring SRHR-related resolutions, making statements and giving speeches at meetings, organising or participating in side events. Working as much as possible through the European Union, main platforms for SRHR diplomacy included the UN General Assembly and its subsidiary organs: the Third Committee, the Commission on Population and Development (CPD) and the Commission on the Status of Women (CSW), as well as the Human Rights Council (HRC). SRHR diplomacy also involved engaging in bilateral relations with target countries, policy dialogues with, amongst others, UNFPA and the WHO, and participation in councils and executive boards of organisations such as the GFF, UNICEF, UN Women and the Global Fund.[34] [35]

Through its SRHR diplomacy, the Netherlands has contributed to upholding international agreements and maintaining most previously agreed language in major international SRHR forums. Still, there have been instances where, despite Dutch diplomacy, it was not possible to maintain previously agreed language, for example on 'sexual rights' or comprehensive sexuality education in the CSW.

The remainder of this section illustrates the results of Dutch SRHR diplomacy in several important forums in which the Netherlands participates.

4.3.1 European Union

A key instrument for Dutch SRHR diplomacy was and continues to be the European Union. At this level, diplomacy mainly focuses on reaching agreement on common EU positions on particular issues with other EU member states and making sure that the EU position in the international arena reflects the Dutch position on SRHR. In addition, the Netherlands wants to ensure that SRHR is sufficiently incorporated in the Union's external aid policies, treaties and programmes, such as, for example, the Neighbourhood, Development and International Cooperation Instrument.

[33] *Nexus* functions as a secretariat that is hosted at IPPF and works with, for example, Ipas and Right Here, Right Now. It has 21 members, including the Netherlands.

[34] The Netherlands has also used funding as a diplomatic instrument: the Ministry of Foreign Affairs cut its contribution to UNFPA by a symbolic EUR 2 million because the organisation did not stick sufficiently to Dutch priorities on the SRHR agenda. This also occurred in 2019, when the Netherlands did not agree to raise its contributions to the Global Fund.

[35] In 2018, the Netherlands hosted the 22nd International AIDS Conference. The purpose of the conference was to share academic research and the successes and failures of AIDS response, and to promote a constructive dialogue.

Despite broad agreement on the importance of action for women's rights and gender equality, topics such as access to legal and safe abortion and equal rights for LGBTIQ+ persons have been continuously debated in the EU. The 2015 Council Conclusions on Gender in Development and the European Consensus on Development of 2017, and many other EU documents since, include a standard text in agreed language on SRHR,[36] which must at the least be adhered to. For the Netherlands, the standard texts from the above-mentioned Council Conclusions and European Consensus documents were the bare minimum and going below those was unacceptable.

Maintaining EU consensus and keeping Hungary and Poland on board for SRHR has not been easy. Often, the EU is internally divided and much time is spent on internal debate, leaving the EU sometimes little time to devise a suitable strategy and reach out to like-minded countries outside the EU. In recent years, EU statements have contained a standard text and refer to Dutch priority issues.[37] Together, the time-consuming internal division and the fixed standard text weaken the EU's international negotiating position.

In the Netherlands, an important development was that in 2020 the Council for European Affairs (a subsidiary council of the Dutch Council of Ministers) agreed to an action framework and 'red lines' on gender equality, LGBTIQ+ and SRHR to deal with pushback in EU decision-making in Brussels. This allowed the Netherlands to react more firmly and consistently against attempts by other EU member states to water down or delete texts and gave Dutch negotiators the opportunity to not agree to Council conclusions. The decision also includes the agreement to proactively and strategically participate in various EU forums and to enlist support from like-minded member countries more proactively.

4.3.2 Commission on Population and Development (CPD)

The CPD is valued by the Netherlands as it provides a multilateral space to discuss progress on the ICPD Programme of Action of 1994, its linkages with the SDGs, and in particular SRHR (see Box 2). The Netherlands was a member of the CPD from 2014 to 2017, from 2019 to 2022, and was re-elected for the period 2022–2026. As the outcomes of the commission's work could influence global progress on SRHR, the Netherlands used the commission to push for stronger wording on promoting access to SRHR.[38] Generally, the objectives for the Netherlands in the CPD were two-fold: (i) the outcome document should not cross Dutch 'red lines', and (ii) the outcome document should be adopted by consensus.[lxv]

36 This standard paragraph reads: 'The EU remains committed to the promotion, protection and fulfilment of all human rights and to the full and effective implementation of the Beijing Platform for Action and the Programme of Action of the International Conference on Population and Development and the outcomes of their review conferences and remains committed to sexual and reproductive health and rights (SRHR), in this context. Having that in mind, the EU reaffirms its commitment to the promotion, protection and fulfilment of the right of every individual to have full control over and decide freely and responsibly on matters related to their sexuality and sexual and reproductive health, free from discrimination, coercion and violence. The EU further stresses the need for universal access to quality and affordable comprehensive sexual and reproductive health information, education, including comprehensive sexuality education, and health-care services'. See European Commission, Directorate-General for International Cooperation and Development, 'The New European Consensus on Development, 'Our World, Our Dignity, Our Future'', Publications Office, 2018, p. 7.

37 These are: the right of autonomy for every woman to make their own decisions about their health and body (2020); the importance of countering pushback (2021); the eradication of all forms of sexual and gender-based violence (also against LGBTIQ+ persons) (2021); the meaningful participation of women and youth 'in all their diversity' (2021); and the importance of access to affordable and quality social and care services and SRHR (2021).

38 Over the years, the Netherlands has advocated for compliance with the ICPD agenda and SRHR for sustainable development and the 2030 Agenda for Sustainable Development Goals; non-discrimination and combating violence and persistent inequality; the human-rights approach in addressing population dynamics, guiding demographic transition and demographic dividend; removing the causes and consequences of unnecessary mortality and human-rights violations, especially among women, girls and adolescents, such as unsafe abortion, early, forced and child marriages and HIV/AIDS; the rights of young people and access to comprehensive sexuality education; integrating population issues into sustainable development, including those in the post-2015 agenda.

Box 2 *ICPD, ICPD+20 and ICPD+25*

In 1994, 179 national governments adopted a Programme of Action (PoA) at the first International Conference on Population and Development (ICPD) in Cairo. It was the largest intergovernmental conference on population and development ever held and was organised by the UN Department of Economic and Social Affairs and UNFPA. The PoA called for all people to have access to comprehensive reproductive healthcare and for women's empowerment.[lxvi] The PoA, together with the Beijing Platform for Action (1995) and the outcomes of the review conferences, are often referred to in international agreements.[39]

In 2013, the Netherlands, UNFPA, and the Office of the United Nations High Commissioner on Human Rights organised the ICPD Beyond 2014 International Conference on Human Rights (ICPD+20). The meeting resulted in an extension of the ICPD agenda, with a renewed focus on gaps and emerging issues. The Netherlands participated in the review and advocated for greater attention to human rights in ICPD implementation, working closely with UNFPA.[lxvii]

In 2019, the Netherlands participated in the ICPD+25 summit in Nairobi, where it endorsed a cross-regional statement supported by 55 pro-SRHR countries. The statement, delivered by the South African government, with Finnish and Dutch ministers present, resulted in the adoption of the Nairobi Statement on ICPD+25: Accelerating the Promise. The statement incorporated key actions for further implementation of the ICPD's PoA, the outcomes of its reviews, and the 2030 Agenda for Sustainable Development Goals, which aligned with Dutch SRHR priorities.

The Netherlands has primarily worked together with the EU within the CPD. Maintaining European consensus on SRHR topics was not possible in 2014, 2015 and 2017, and difficult in 2016, because of the positions of Hungary and Poland.[40]

During the evaluation period, the Netherlands has made joint statements with other countries and spoken on behalf of other countries many times. In 2021, the Netherlands also organised and participated in several side events on topics such as the impact of COVID-19 on the ICPD agenda. In these events, the Netherlands cooperated with other countries, UN organisations, NGOs and the Right Here, Right Now (RHRN) partnership.

The CPD failed to agree on outcome documents in 2015, 2017, 2018 and 2020 because of differing views between like-minded countries and other actors, such as US, Russia, the Holy See, Pakistan and Egypt.[41] In 2017 and 2018, instead, a summary of the Chair and a short Political Declaration were respectively adopted. In 2018, the Netherlands worked with like-minded countries to ensure that this Political Declaration reaffirmed the ICPD's PoA and did not refer to the right of each country to implement CPD resolutions consistent with national laws. The meetings in 2016, 2021 and 2022 were more successful.

In 2016, language that was acceptable to the Netherlands was used in texts on human rights, women's empowerment, civil society participation and youth participation. The Netherlands was also pleased that EU unity on SRHR was maintained. At the same time, the Netherlands was unable to ensure inclusion of language proposed on 'multiple and intersecting forms of discrimination' or references to comprehensive sexuality education.

The 2021 session of the CPD was expected to be contentious, but strong collaboration and outreach by like-minded countries, effective facilitation, a CPD chair from the African Group (Burkina Faso), and a broadly-shared priority theme helped ensure the adoption of an outcome document.[lxviii] At the 2022

[39] The ICPD Programme of Action in 1994, and the 1995 Beijing Declaration Platform for Action recognized the right to SRHR, enabling women to make their own decisions about their bodies. These agreements committed states to provide universal access to sexual and reproductive health services, including information and education, access to modern contraceptives, and safe abortion where legal.

[40] For example, in 2018, Poland could not accept a reference to the importance of providing information and education on SRHR for adolescents and youth.

[41] The Trump Administration tried to exclude gender and SRHR texts that could previously count on consensus and would not accept any reference to abortion or CSE. It demanded texts describing SRHR be accompanied by qualifications. This had never previously been the case in the CPD.

CPD session the Netherlands was vice-chair at the CPD Bureau and co-facilitator of the resolution. A consensus resolution was adopted again, with new references to the human rights of older persons, migrants, women, girls and youth, and first referrals to gender-responsiveness and mainstreaming a gender perspective into all development and humanitarian efforts.

4.3.3 Commission on the Status of Women (CSW)

As an intergovernmental body dedicated to the promotion of women's rights, the CSW plays a leading role in monitoring the implementation of the Beijing Platform for Action (BPfA) and aims to contribute to the gender-responsive implementation of the 2030 Agenda for Sustainable Development. Each year it assesses where countries stand in terms of implementing the BPfA on a specific priority theme and what needs to be done to realise further progress. The member states subsequently document this in an outcome document, the so-called Agreed Conclusions.

For the Netherlands, the overall intention was to maintain the minimum of previously agreed language and to call attention to its further implementation. During CSW meetings the Netherlands has made statements on themes such as preventing child marriages, supporting safe abortion, promoting access to affordable SRHR services, and ensuring equal rights for LGBTIQ+ people. The Netherlands aligns its actions at the CSW as much as possible with the EU framework and supports the European External Action Service in CSW negotiations.[42] With respect to the EU position at CSW meetings, it has been difficult to keep Hungary, Poland and, at times, Bulgaria on board. In 2021, EU unity was maintained, enabling the EU to negotiate on behalf of all member states. Recent EU statements at the CSW included the standard paragraph on SRHR (see Footnote 36).

Discussions in the CSW about SRHR issues have been challenging in recent years. Controversial issues over the years included knowledge and awareness-raising on SRHR for adolescents, and sexual orientation and gender identity.[43] A review of the CSW's agreed conclusions between 2013 and 2020[44] shows that – from a Dutch standpoint – there have been both achievements and setbacks. On the positive side, the conclusions underscored the importance of the 1994 ICPD PoA, the 1995 BPfA and the outcome documents of their review conferences. However, since 2017 the conclusions of the outcome documents refer to 'sexual and reproductive health and reproductive rights' – thus omitting 'sexual rights'. In addition, while education is referred to, the notion of 'comprehensive sexuality education' is no longer used. Furthermore, references to accessing safe abortion 'where such services are permitted by national law' have disappeared since 2017.[lxix]

4.3.4 Human Rights Council (HRC)

The Human Rights Council is the UN intergovernmental body responsible for the promotion and protection of human rights worldwide. It consists of 47 member states elected by the United Nations General Assembly. For the Netherlands, the council is an important forum for promoting human rights globally and holding countries accountable for human-rights violations.[lxx] [45] The Netherlands was a council member during the periods 2015–2017 and 2020–2022. The council convenes three sessions per year, providing a platform for

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42 In CSW meetings the Netherlands is represented by the Minister of Education, Culture and Science, as well as counterparts from the Caribbean Netherlands and the Ministry of Foreign Affairs. The delegation also includes Dutch CSOs and the Youth Ambassador.

43 For example, in 2019, with gender-equal social protection as the priority theme of the CSW, there were objections from USA, Russia, Saudi Arabia and Malaysia about the use of the terms sexual health and reproductive rights, and comprehensive sexuality education. (Birchall, 'Rollback on gender equality and women and girls' rights in international fora since 2016', p. 14).

44 In 2015 and 2020 a political declaration was adopted instead of conclusions. Conclusions and declarations are published on the UN Women website, Commission on the Status of Women, Outcomes.

45 The relevance of addressing SRHR issues in the HRC, thus using the UN human rights system framework, is to forge an alternative path for making progress on sexual rights at the UN (M. Doherty, 'Shifting the ground on sexual rights at the UN', in *Arrow for Change, SRHR in the Era of the SDGs*, vol. 23, no. 2, 2017, p. 22; Birchall, 'Rollback on gender equality and women and girls' rights in international fora since 2016', p. 15). In theory, HRC resolutions that are strong on SRHR language can 'provide domestic advocacy opportunities' and 'can help create dialogue, momentum and advocacy in support of SRHR issues that otherwise might not have received the same degree of attention and scrutiny', thus helping 'to spur on more progressive programming in UN agencies'. SRHR language gains from one resolution 'can migrate to other relevant thematic resolutions'. Since the HRC is the 'foremost state-constituted global body focused on human rights, gains in advancing SRHR here can legitimise and reinforce SRH concerns as rights-based issues in other state-constituted forums (as well as in other HRC resolutions).' (Aylward and Halford, 'How gains for SRHR in the UN have remained possible in a changing political climate', p. 165-167).

member states to engage in negotiations and adopt resolutions on a wide range of human-rights issues. These resolutions are adopted either by consensus or by vote. Additionally, the council utilises the Universal Periodic Review (UPR) mechanism to assess the human-rights situation in all UN Member States.

In 2013 the Netherlands, on behalf of a cross-regional core group of 14 countries, initiated the bi-annual resolution 'Strengthening efforts to prevent and eliminate child, early and forced marriage'.[46] In 2015, it became the first UN resolution to affirm girls' right 'to control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health'.[47] In recent years, hostile amendments have been proposed by countries such as Bahrain, Egypt and Russia. Against this background, in 2019 and again in 2021 the ministry asked Dutch embassies to reach out to relevant national authorities to get support for the consequences of the resolution on child, early and forced marriage. In 2021, the resolution was adopted by consensus and received co-sponsorship from 74 countries.

The Netherlands sees the UPRs as an important tool to address countries bilaterally on human rights and SRHR. Between 2012 and 2022, the Netherlands made 401 recommendations to other countries on SRHR- and LHBTQI-related topics.[lxxi] Among the topics most frequently addressed during that time were discrimination based on sexual orientation (64 times), gender-based violence (42 times), and intersex persons' rights (37 times). Recommendations concerning gender-based violence or gender equality were more readily accepted than those on abortion or the broader LGBTIQ+ agenda, which, more often than not, were rejected or met with an unclear or non-response.

4.3.5 UNFPA

The Netherlands participated in UNFPA's annual Executive Board meetings, even when not a board member. It also held regular bilateral talks with UNFPA management. A priority topic was the importance of the Nairobi Summit on the ICPD's and UNFPA's roles in ensuring that sexual and reproductive health and rights are fulfilled without undermining the ICPD PoA (see Box 2). As in the case of UN specialised agencies dealing with SRHR issues, also for UNFPA, the Dutch position is that the organisation should adhere to its normative mandate and its role in the 2030 Agenda for Sustainable Development.

In its policy dialogue with UNFPA, the Netherlands has stressed the importance of exploring new innovative forms of financing and diversifying the donor base. In addition, the Netherlands has also underlined the importance of UNFPA's efforts in humanitarian settings, and the inefficiency of its Supplies Partnership in reaching end-users. The Netherlands has participated in reviewing the UNFPA country-programme documents of Kazakhstan, China and Uganda. Except for UNFPA's Supplies Partnership, the Netherlands did not favour earmarked funding as this hindered UNFPA's operational activities.

UNFPA board meetings mostly focused on organisational processes such as UN Reform, Sexual Exploitation, Abuse and Harassment (SEAH) and evaluation capacity.[48] According to various interviewees, diplomatic interventions of the Netherlands and other like-minded donors have resulted in maintaining references to SRHR in UNFPA's Strategic Plan 2018–2021, despite the term being initially left out in a draft version.[49]

4.3.6 The Global Fund to Fight AIDS, Tuberculosis and Malaria

The Netherlands has participated in Global Fund meetings and, at times, organised side events. In November 2019, representing a multi-country 'Point Seven' constituency, it became a member of the 20-seat Global Fund board for a period of two years and was elected to its Strategy Committee in

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[46] The resolution made child marriages a human-rights violation, putting child marriages on the HRC agenda and asked the Office of the United Nations High Commissioner for Human Rights to research best practices in addressing child marriages.

[47] This 'hard-fought language' is considered significant since girls' right to decide on matters related to their sexuality has been another contested component of SRHR negotiations (Aylward and Halford, 'How gains for SRHR in the UN have remained possible in a changing political climate', p. 165).

[48] The Netherlands joined the Nordic in asking UNFPA to work towards the benchmark of spending 3% of resources for evaluation.

[49] This observation is in line with a recent evaluation of Finnish development policy influencing activities in multilateral organisations, which found that that *'(a) strong Finnish focus–jointly with the Nordic countries, the Netherlands, and other like-minded countries – resulted in the maintenance of references to SRHR in maar UNFPA's Strategic Plan for 2018–2021.'* Source: M. Palenberg et al., 'Evaluation of Finnish development policy influencing activities in multilateral organisations, Volume 2 – Annexes', *Ministry of Foreign Affairs of Finland*, 2020, p. 173.

2020.[50] Interviews and board-meeting documents show that during the period it was a board member the Netherlands encouraged the Global Fund to pay more attention to engagement with civil society organisations and key populations, as they were disproportionately affected by HIV/AIDS, tuberculosis and malaria. For years, the Netherlands has also been stressing the importance of further integrating the strengthening of health systems into the Global Fund's strategy. In 2019, as one of a few donors, it decided to symbolically not increase its financial contribution with EUR 2 million, to flag the need for the Global Fund to adopt a more integrated health systems approach and for implementing countries to increase domestic investments in health.

The Netherlands was disappointed that the 'disease split' between the three diseases remained unchanged during the 6th replenishment meeting of 2019, even though most board members agreed that more funds were needed for TB programmes.[lxxii] Interviewees conceded that such decisions at the Global Fund were largely political and reflected the strong influence of the United States to protect the share of funds for HIV/AIDS. In the most recent multi-year plan, however, it is now possible to integrate HIV services with those for TB.

The COVID-19 pandemic reinforced consensus among board members that a new multi-year strategy should indeed focus more on the development of resilient health systems.[lxxiii] Although the new strategy for the period 2023–2028 mentions the objective to rise above the disease silos to build sustainable health systems, the Point Seven constituency indicated that the operationalisation needed to achieve this was not very clear during the 47th Board Meeting (May 2022).

4.3.7 Bilateral diplomacy in Uganda and Bangladesh

Bilateral diplomatic efforts related to SRHR have been made in many target countries, including Bangladesh and Uganda, selected as case studies for this evaluation.

The Dutch embassy in Uganda made diplomatic efforts at the national level, often in collaboration with other countries and/or the EU Delegation in Kampala. Diplomacy on SRHR included démarches,[51] for example on the country's Anti-Homosexuality Act in 2013 and Uganda's co-sponsoring of the Geneva Consensus Declaration in 2020.[52] In addition, the embassy practised 'silent diplomacy',[53] integrating SRHR and human rights-related messages into the ambassador's speeches and in its more technical policy dialogues with the government and international organisations. In Bangladesh, the embassy also preferred 'silent diplomacy' on SRHR, for example through its policy dialogue with the government. In its SRHR diplomacy the embassy in Dhaka focused mainly on topics such as menstrual regulation, GBV, CSE and child marriage.

Given the political climate in both countries, interviewees indicated that the respective embassies were less outspoken on SRHR than the ministry in its diplomacy in international forums or at headquarters. The centrally-funded SRHR partnership projects were more vocal in their SRHR lobbying and advocacy than embassy-funded projects in the two countries. The embassies also funded programmes of UN organisations such as UNFPA or UNICEF, which also engaged in policy dialogues with the government on SRHR. The underlying policy assumption was that these organisations had added value in leveraging national governments. The evaluators observed, however, that the country offices of these UN organisations were hesitant to address the rights aspects of SRHR.[lxxiv] This observation corresponds with evaluations of multilateral organisations, which conclude that, although the country offices were generally able to leverage governments through ongoing policy dialogues, they were, nevertheless, hesitant to use this leverage on more politically sensitive issues.[lxxv]

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50 The Netherlands joined the board on behalf of the Point Seven constituency that also includes Denmark, Norway, Sweden, Ireland and Luxemburg. Large donors such as USA, UK, Japan, Germany and France have their own seats on the board.

51 A démarche is a formal diplomatic representation or approach made by one government to another regarding a specific issue or concern.

52 The latter was a démarche in which the Netherlands, the EU, the UK and Denmark, with the support of Canada, Norway and Sweden, expressed concerns about the Geneva Consensus Declaration, of which Uganda was to be a signatory, according to a draft document. Although the Director-General for Health Services at the Ministry of Health noted the concerns and indicated that the ministry had no intention of moving backwards on international agreements, Uganda eventually co-sponsored the declaration and signed in 2020.

53 'Silent' or 'quiet' diplomacy refers to 'one state's efforts to influence the behavior of another state through discreet negotiations or actions' and takes place behind the scenes rather than publicly. See Political Dictionary, quiet diplomacy [website]; and K. Dlamini, 'Is quiet diplomacy an effective conflict resolution strategy?', *South African Yearbook of International Affairs*, vol. 3, 2002.

5 Monitoring and evaluation (M&E)

As outlined in Section 1.2 (Methods), this evaluation relies partially on the monitoring systems established by implementing organisations and the evaluation reports produced using those systems. In this chapter, IOB reflects on the monitoring (Section 5.1) and evaluation systems (Section 5.2) of the Dutch portfolio of projects and programmes on SRHR.

Key takeaways

Each year the Ministry of Foreign Affairs informs Dutch parliament and the general public about results achieved from development cooperation in SRHR. The current evaluation shows, however, that the ministry's results framework for reported SRHR indicators has several significant limitations. These limitations are especially relevant given the substantial amount of time and effort invested in data collection and reporting.

First, the results framework includes SRHR indicators at outcome and impact levels, which are not suitable for annual monitoring. These indicators require (i) independent evaluation, (ii) robust research designs, and (iii) a longer timespan to establish a valid causal relationship between the reported results and the supported interventions. Second, several output indicators are included that mainly serve accountability purposes. However, in some instances the validity of the reported

results is undermined by double-counting and aggregating different groups of people under the same denominator (see Section 5.1)

The ministry's results framework for SRHR influences the monitoring systems of the supported NGO partnership projects, thereby incorporating the limitations mentioned above. This current evaluation also shows that many of evaluations supported SRHR projects, for both NGOs and multilateral organisations, are of insufficient quality. Valid measurement of outcomes in evaluation reports is often lacking owing to methodological limitations. As a consequence, it frequently remains unclear whether the evaluated interventions have actually contributed to the observed results, particularly at outcome and impact levels.

Because funds for evaluations need to be spent within the project implementation period, there are currently no *ex-post* evaluations of the ministry's supported SRHR activities. As a result, there is limited insight into the impact and sustainability of supported interventions (see Section 5.2).

5.1 Monitoring

The Ministry of Foreign Affairs has been publishing the results of its development cooperation efforts according to the guidelines of International Aid Transparency Initiative (IATI) since 2011.[lxxvi] Over time, this reporting has become more detailed, in part as a result of requests from members of Dutch parliament. Indicators and target values for policy themes such as SRHR have been included since 2017.[lxxvii] In 2022, the overall budget indicators for the Ministry of Foreign Trade and Development Cooperation's (BHOS) budget Article 3.1 (SRHR) were:[lxxviii]

1. The number of additional women and girls using modern contraceptives (compared to 2012).[54]
2. The number of communities, CSOs and advocacy networks with increased lobbying and advocacy capacities for the promotion of SRHR.

The ministry publishes data annually for these two overall budget indicators in conjunction with a range of other indicators: the SRHR results framework. Box 3 presents the current SRHR results framework.[55] [56]

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[54] For 2023, this indicator was changed to the number of 20 selected countries with an annual increase in their modern contraceptive prevalence rate (mCPR) (Ministerie van Buitenlandse Zaken, 'Memorie van Toelichting', kst 36200-XVII-2, 2022).

[55] The Ministry additionally requires its partners to report disaggregated information on several indicators and, where relevant, to provide qualitative descriptions of baseline, target and actual values.

[56] Although some indicators have been adjusted over the years, most have remained the same.

Box 3 *The ministry's current SRHR results framework*[lxxix]

Outcome 1: Better information and greater freedom of choice for young people about their sexuality	*Outcome indicator:* 1.1 Number of youth using SRH services.
Objective A: Promote active and meaningful involvement of young people in policy- and decision-making	*Output indicator:* • Number of youth who participate in policy- and decision-making bodies that perceive their participation as meaningful.
Objective B: Promote good quality, gender transformative, comprehensive sexuality education that encourages healthy sexual behaviour and reaches all youth (in and out of school)	*Output indicator:* • Number of young people reached with comprehensive, correct information on sexuality, HIV/AIDS, STIs, pregnancy and contraception.
Objective C: Boost access to and use of youth-friendly SRH and HIV/AIDS services	*Output indicator:* • Number of health facilities that adopt and implement youth-friendly SRH and HIV/AIDS services.
Outcome 2: Improved access to SRH and HIV/AIDS medicines and commodities	*Outcome indicators:* 2.1 Modern contraceptive prevalence rate; 2.2 Level of unmet need; 2.3 Contraceptive-method mix (use).
Objective D: Support innovation for SRH and HIV/AIDS medicines and commodities	*Output indicator:* • The number of innovative SRH (incl. HIV/AIDS) medicines and commodities or production/distribution options that have proof of concept or have successfully been brought up to scale.
Objective E: Promote access to and correct usage of safe, effective, qualitative and affordable medicines and commodities for: 1. Safe pregnancy and baby delivery, modern family planning, safe abortion and post-abortion care; 2. Prevention and treatment of HIV/AIDS.	*Output indicators:* • Number of women and girls using modern contraceptives; • Couple–years of protection; • Family planning contraceptive method mix (availability); • Number of service-delivery points with continuous availability of commodities related to safe abortion; • Proportion of people living with HIV that receive ART.
Outcome 3: Better public and private healthcare for family planning, pregnancies and childbirth, including safe abortions	*Outcome indicators:* 3.1 Quality of health-policy dialogue and partners' impact on this dialogue; 3.2 Number of unintended pregnancies averted.
Objective F: Strengthen health systems to support provision of SRH, including HIV/AIDS services and safe abortions	*Output indicators:* • Number of health workers trained in providing SRH services, including safe abortions; • Number of comprehensive services providing abortion care (including post-abortion care).
Objective G: Increase private-sector commitment to embed SRH and HIV/AIDS services within health systems	*Output indicator:* • Number of initiatives to promote private-sector involvement in SRH and HIV/AIDS services.
Outcome 4: The sexual and reproductive rights of all people, including those belonging to marginalised groups, are institutionally respected and protected	*Outcome indicator:* 4.1 Number of countries actively supporting SRHR for all in joint statements and the language chosen in resolutions and agreements.
Objective H: Promote the adoption and implementation of and accountability for laws and policies on the sexual and reproductive rights of all people, including those belonging to marginalised groups, by governments and national and international institutions	*Output indicator:* • Changes in national and international laws, policies, norms and practices leading to a decrease in barriers to SRHR and HIV/AIDS services.
Objective I: Strengthen accountability mechanisms between citizens/communities and governments, health-service providers and other actors to realise SRHR of all people	*Output indicator:* • Description of the effective use of accountability mechanisms by citizens/communities and CSOs in realising SRHR of all people.
Objective J: Strengthen the capacities of communities, CSOs and advocacy networks to lobby and advocate for SRHR for all people	*Output indicator:* • Number of communities, CSOs and advocacy networks with increased lobbying and advocacy capacities.
***Cross-cutting indicator humanitarian settings*: Description of reduced barriers to accessing SRHR (including HIV/AIDS) information, services and supplies in humanitarian settings**	

This comprehensive SRHR results framework primarily serves as a means for increasing (upward) accountability. It enables contracted organisations to report their progress to the ministry, which, in turn informs Dutch parliament and the general public of the results achieved through development interventions for SRHR. It is IOB's assessment, however, that there are some limitations within this framework that are particularly notable given the substantial time and effort invested by implementing organisations in collecting the data.

Current budget indicators and indicators in the SRHR results framework seem to reflect two diverging approaches. On one hand, the results framework includes various high-level outcome results that do not necessarily capture the achievements of ministry-supported projects and programmes, even though they are presented as 'results' of Dutch SRHR policy.[57] Increases in numbers of women and girls using modern contraceptives (budget indicator 1 above) cannot be attributed to Dutch support for SRHR.[58] Similarly, changes in national and international laws, policies, norms and practices (the indicator for Objective H) depend on many factors and might also have taken place in the absence of the supported interventions.[59] Establishing a causal relationship between the supported activities and results at the outcome level requires rigorous evaluation using robust research designs and appropriate methodologies.[60] Such causal links cannot be reliably determined through monitoring efforts conducted by implementing organisations.[lxxx] The intended results at the outcome and impact level also involve, in addition, long-term processes (e.g. norm change), making them unsuitable for annual reporting.

On the other hand, the results framework also includes many output indicators that, for instance, capture the number of people reached or trained, or the number of contraceptives provided (couple–years of protection). These indicators largely serve the increasing need for (upward) accountability purposes and are not meant to provide information about the validity of underlying policy assumptions or the quality of implementation: The number of young people reached with information on SRHR (the indicator for Objective B), for example, does not give insight into the extent to which information has improved the knowledge of participants, or whether it led to a change in behaviour. Similarly, the number of health workers trained (indicator for Objective F) does not capture whether the trained health workers had improved their skills or whether they had put them to use.[61]

However, IOB has identified several issues regarding validity and reliability of the annually aggregated and reported results at the output level. To start with, there is a 'double-counting' issue for several indicators. Some supported organisations lobby and advocate for similar SRHR issues in the same countries but report separately on, for example, changes in laws (the indicator for Objective H).[62] Issues concerning double-counting also exist for indicators that measure 'number of young people reached' (the indicator for Objective B) or 'number of health workers trained' (the indicator for Objective F), particularly when individuals attend multiple comparable events.[lxxxi] Additionally, the number of young people reached with comprehensive, correct SRHR information (the indicator for Objective B) cannot be meaningfully interpreted as it aggregates a diverse range of young people reached, including those engaged through social media, community outreach activities or comprehensive sexuality education courses. Finally, at times it was difficult to interpret the outputs because the monitoring reports provided little information about the activities and inputs that led to the reported outputs.

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57 In addition to the outcome indicators in the results framework in Box 3, high-level indicators also include the following indicators, falsely classified as 'output' in the framework: number of women and girls using modern contraceptives; proportion of people living with HIV that receive ART; changes in national and international laws, policies, norms and practices leading to decrease in barriers to SRHR and HIV/AIDS services; number of communities, CSOs and advocacy networks with increased lobbying and advocacy capacities.

58 The same problem exists for the 2023 budget indicator: number of 20 selected countries with an annual increase in modern contraceptive prevalence rate.

59 Although the ministry asks implementing organisations to describe how the supported projects have contributed to reported changes, this implies self-evaluation by the supported organisations.

60 A robust research design does not automatically imply quantitative (large n) methods. With regards to qualitative methods for evaluating lobby- and advocacy-related activities, see, for example, Waddington et al., 'The effectiveness of support to lobby and advocacy' for guidance.

61 Additionally, none of the indicators for Objective E relate to quality or affordability of medicines or commodities and, similarly, none capture their correct use. Also, the indicator for Objective G only captures the activity level, but does not shed any light on achieved results. The output indicator for Objective I does not capture whether accountability mechanisms have improved or not. Finally, outcome indicator 4.1 gives no information about actual protection of SRHR rights at the country level.

62 For example, IPPF, Ipas and Rutgers' Rutgers' Right Here, Right Now 2 project (2021–2025) all reported to have contributed to Benin's expansion of the legal grounds for abortion in 2021.

With regards to the outcome indicator 'the number of communities, CSOs and advocacy networks with increased lobbying and advocacy capacities' (budget indicator 2 above), IOB notes that it was not, and still is not, validly measured during previous or current SRHR partnership projects. Very few of the supported organisations performed independent organisational capacity assessments of the local and national CSOs supported.[63] Although various currently-supported SRHR partnership projects (2021–2025) include organisational capacity assessments, these are mostly self-reported. In addition, there are several projects that only report on the number of trained CSOs, without measuring their capacity at all. As a result, it was impossible to validly estimate the effects of the supported projects on the capacity of the national and local CSOs.

5.2 Evaluation

5.2.1 NGO projects

A significant challenge encountered during this evaluation was the low confidence that IOB has in the evaluation reports of many of the supported NGO projects. In part, this can be attributed to the limitations of the ministry's results framework (see Section 5.1), because the monitoring systems of NGO projects were to a large extent aligned with the ministry's framework, incorporating several of the limitations already mentioned. Furthermore, the fact that many of the NGO projects only contracted evaluators for a final evaluation towards the end of the project limited their ability to make necessary adjustments to data collection during implementation.

The need to improve the quality of existing evaluations is not a new phenomenon and has been highlighted several times in the past. Already in 2013, IOB's previous policy evaluation on SRHR highlighted the need to improve evaluations of SRHR programmes across the board, both for NGOs and multilateral organisations and international funds.[lxxxii] The previous IOB evaluation already highlighted that there was a need for better quantification of results beyond the output level and comparisons against baseline information.

A synthesis evaluation of 21 SRHR NGO-led projects financed by the ministry arrived at similar conclusions in 2017.[lxxxiii] The evaluation report noted that study designs primarily focused on quantitative results at the output level, while results at the outcome level, such as knowledge, attitudes or behaviour, were hardly measured. Additionally, the methods used hardly included pre- and post-testing, control groups, or tests of significance, which made it difficult to attribute any observed results to the interventions being evaluated. This limited the researchers' ability to assess programme effectiveness.

In 2022, IOB commissioned a meta-evaluation of 32 project evaluations that were financed through the ministry's policy framework on Strengthening Civil Society, including 10 projects that focused on SRHR. The report highlighted several shortcomings in the evaluation methods used in these evaluations.[lxxxiv] [64] It found that these methods were not adequately equipped to capture null or negative outcomes, thereby leading to a bias for positive results.[65] Furthermore, the report showed that the evaluation reports did not provide a clear explanation of how the programme activities had contributed to the results described.[66] In fact, the meta-evaluation found that for 82% of the outcomes captured in these evaluations, the contribution of the project activities to attaining the objectives remained unclear. Evaluations also tended to overlook alternative hypotheses and other factors that may have played a role in the observed or measured outcomes.

63 This indicator was only recently selected as an overall budget indicator, but it was already one of the indicators in the results framework.

64 Several evaluations themselves mentioned limitations to data or resource availability as a result of the COVID-19 pandemic. The meta-evaluation's focus was to assess the methods used to evaluate lobbying and advocacy.

65 For the seven SRHR Partnership projects, 80% of the reported outcomes were positive. In the 25 Dialogue and Dissent projects, of which three focused on SRHR, 89% of the reported outcomes were positive.

66 This was the case for both evaluations that relied on participatory evaluation methods, such as outcome harvesting or most significant change, and for evaluations that used quasi-experimental methods, where often the causal mechanism that links the intervention to the measured outcomes was not clearly described.

The ministry's regulations require all allocated funds, including those for the evaluation, to be spent within the project period. As a result, supported organisations generally carry out their end evaluations in the final year of implementation, which is too early to be able to assess whether the achieved results were sustainable and/or what impact was achieved. Many evaluations only express – possibly biased – opinions of key stakeholders about the likelihood of continuation of programme results and activities.[lxxxv] [67]

5.2.2 Multilateral and international organisations

According to IOB's policy evaluation on SRHR in 2013, there was also ample room for improvement for evaluations of multilateral organisations and it often remained unclear if the SRH services provided by these organisations were actually used.[lxxxvi] In 2017, IOB concluded that the evaluation functions of UNAIDS and UNFPA scored relatively low on evaluation quality criteria.[lxxxvii]

IOB conducted a semi-systematic search of SRHR-related evaluations from seven multilateral and international organisations published after 2013 – see Annex 4 for the protocol. After a quality assessment, IOB included 21 of the 45 identified evaluations. However, upon conducting a full-text assessment of the 21 evaluations, it was found that although most evaluations presented results achieved at the output level, none of them systematically measured results achieved at the outcome or impact level, and baseline information was often missing. The evaluations qualitatively described outcomes achieved but were often unable to convincingly attribute results to programmes.

For example, for the UNFPA's Supplies Partnership the results at output level are relatively straightforward: the number of SRH commodities procured per year, measured in couple–years of protection.[68] However, the link between these outputs and the programme's indicators on contraceptive use is not well captured. As a result, it remains largely unclear how many of the procured commodities are actually used by the intended users of the service. A mid-term evaluation of the Supplies Partnership (2013–2020) therefore recommended that the country offices improve monitoring, strengthen programme oversight and provide assurance that commodities are reaching users.[lxxxviii]

The gap between results reported at the output and outcome levels also exists with the Global Fund. The M&E system focuses largely on the combined effects of all interventions in the countries in which it provided grants, rather than aiming to estimate the effects of specific projects and/or interventions that the Global Fund financed.[lxxxix] [69] According to the Global Fund, this avoids misleading attribution of achieved results, because supported programmes and interventions are generally also funded through national governments and other donors.[70] The flipside, however, is that it remains unclear how the specific grants performed, because the large majority of key performance indicators focus on reporting progress against national indicators; only 5% of the indicators focus on the performance of the actual interventions supported.[xc] [xci]

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67 The 2022 policy note describes the intention to conduct more often evaluations a few years after interventions have finished, in order to check the sustainability of those interventions.

68 Couple–years of protection is the estimated protection provided by family planning methods during a one-year period, based on the volume of all contraceptives supplied.

69 As argued by Friebel et al., 2019, it is difficult to interpret the modelled outcome claims of The Global Fund, for example in terms of *lives saved*, because the counterfactual is a hypothetical scenario in which all activities for HIV treatment and prevention stopped in 2000, which probably overestimates the Fund's impact. The Global Fund's methods and resulting estimates cannot, furthermore, be verified or reproduced by external researchers. (R. Friebel et al., 'On results reporting and evidentiary standards: spotlight on the Global Fund', *The Lancet*, vol. 393, no. 10184, 2019).

70 For the period 2017–2022, The Global Fund presented details of funding sources per country.

6 Effectiveness

This chapter describes the effectiveness of Dutch SRHR policy and is structured according to the four result areas outlined in the Theory of Change. Sections 6.1 to 6.4 present the findings for each of the result areas based on the project evaluations, existing literature and the data collected in Bangladesh and Uganda. Each of these four sections begins with an overview of the worldwide state of affairs for the result area (e.g. Subsection 6.1.1); it is important to note that we do not imply any causal relationship between context described and the activities funded by the Netherlands. A description of the implementation of the ministry's policy, the evidence base, and the findings for the result area follows (e.g. Subsections 6.1.2–6.1.4). Subsequently, in Section 6.5 the interlinkages between the four result areas are discussed. The final two sections of the chapter examine the extent to which the ministry's policy has mainstreamed gender (Section 6.6) and served specific target groups (Section 6.7).

6.1 Result area 1: Better information and greater freedom of choice for young people

Key takeaways

Access to SRHR information for young people (15–24 years) in low- and lower-middle-income countries continues to be limited. Moreover, lack of autonomy in making informed decisions about SRHR puts them at a higher risk of experiencing poor SRH outcomes as compared to other age groups (see Subsection 6.1.1).

Addressing this issue was one of the Dutch SRHR-policy priorities (discussed in Subsection 6.1.2). Through NGO partnerships and collaboration with, amongst others, UNFPA, the Netherlands supported comprehensive sexuality education interventions and initiatives to make SRHR information accessible out of school. The underlying policy assumptions of these interventions were that (i) providing adolescents with SRHR information can improve their knowledge, whereas (ii) limited knowledge about SRHR restricts young people in making their own informed choices.

Based on the existing literature (Subsection 6.1.3) and evaluations of projects supported by the Netherlands (Subsection 6.1.4), this evaluation can partially validate the first assumption. Supplying SRHR information can indeed improve knowledge and attitudes, with some types of interventions (e.g. peer education) more effective than others. It is unlikely, however, that such interventions will result in actual behavioural change of the young people targeted in the short term. The second assumption is therefore not valid.

In addition, implementing comprehensive sexuality education courses that are beyond the scope of national school curricula is challenging and such initiatives are generally discontinued after external support ends. There is no evidence to suggest that technology-based (eHealth) interventions result in better SRHR outcomes for young people.

The ministry also aimed to facilitate youth empowerment, assuming that it would help them to overcome the barriers to making informed SRHR decisions. It remains unclear, however, whether this approach has been effective. There are indications that reaching vulnerable adolescents out of school proved to be challenging.

6.1.1 Description of context: state of affairs

In 2013, 20 countries in East and Southern Africa made a commitment to provide comprehensive sexuality education (CSE) and SRH services for adolescents and young people. Because these countries did not monitor progress, it remains unclear how many schools are actually providing CSE and whether this changed during the evaluation period.[xcii] The proportion of young people (15–24 years) in East and Southern Africa with comprehensive knowledge of HIV was 39% and 47%, respectively, in the period 2011–2018. In West and Central Africa the respective percentages were 28% and 31%.[xciii]

In low- and lower-middle-income countries, married adolescent girls aged 15 to 19 years have limited control over their sexual and reproductive health decisions: they are less likely to have the autonomy to make decisions about sexual relations, contraceptive use and reproductive healthcare compared to other age groups. For instance, in Uganda in 2016, 44% of married adolescent girls were able to make informed decisions about their sexual and reproductive health compared to 62% of all married women. Among Dutch target countries, Mali and Benin have the lowest figures, as only 3% and 12% of married adolescent girls, respectively, were able to make their own informed decisions on SRH in 2018.[xciv]

Adolescent fertility has decreased worldwide, including the Dutch SRHR-focus countries. Worldwide, the adolescent fertility rate dropped from 51 births per 1,000 girls between 15 and 19 years in 2012 to 43 per 1,000 in 2020. During the same time period, in sub-Saharan Africa the fertility rate dropped from 112 to about 98. As a result of population growth in sub-Saharan Africa, however, the absolute number of girls between 15 and 19 years of age giving birth increased from 5.5 million in 2012 to 6 million in 2020.[xcv]

Among the Dutch target countries, Niger, Mozambique and Mali have had the highest rates, with 170, 166 and 150 births per 1,000 girls.

6.1.2 Policy

The first result area (Result area 1) in the Ministry of Foreign Affairs policy on SRHR aimed to address the freedom of choice for young people by focusing on providing access to information on their sexuality. Most NGO programmes under the five subsidy frameworks (2011–2015) were active on this result area, as well all SRHR partnership projects (2016–2020) and, to a lesser extent, PSI, Ipas and IPPF. UNFPA also focused on freedom of choice for young people. The Netherlands supported UNFPA with core funds, with earmarked fund for the Global Programme to End Child Marriage and in target countries such as Uganda or Bangladesh. For this result area a wide variety of activities has been implemented, which broadly speaking can be divided into three main categories:

1. **Comprehensive Sexuality Education.** This includes developing suitable curricula for comprehensive sexuality education, developing teaching and learning materials, and the training of teachers to provide the courses.
2. **SRHR awareness-raising, out of school.** The focus in this category is on giving young people the knowledge, skills and resources to make informed decisions about their sexual and reproductive health. This included providing access to technology-based SRHR information through media such as radio, mobile phone or the internet. This category also included various behavioural interventions, such as life-skills training to equip young people with, for example, communication or negotiation skills and awareness-raising through peer educators, who were often young people from the same community.
3. **Activities to organise youth voice.** Various projects established youth centres as a platform for young people to come together, share information and discuss issues related to SRHR in a safe environment. Peer educators can also act as representatives for other young people, to advocate for policies that support their needs. Some projects also organised community and adolescent dialogues to facilitate youth empowerment. Other interventions that aim to address cultural, religious and policy/legislative barriers are described in Result area 4.

There are several important assumptions underlying Dutch policy for Result area 1:
1. Limited knowledge of SRHR can be addressed by providing young people with SRHR information.
2. Limited knowledge of SRHR restricts young people in making their own informed choices about their sexuality, reproduction and health.
3. Barriers that prevent young people from making informed decisions, e.g. cultural or policy/legislative barriers, can be partly overcome through youth empowerment.[71]

6.1.3 Evidence base

The findings from systematic reviews used in the Evidence & Gap Map suggest:
- There is mixed evidence about the effects of comprehensive sexuality education on contraceptive use. In addition, there are no effects of CSE on STI levels, including HIV.[xcvi]
- Findings for the effects of 'behavioural interventions' on knowledge of the adolescent participants are inconsistent.[72] The effect of such interventions on contraceptive use and HIV incidence were, however, either very modest or non-significant.[xcvii] There are some indications that peer education is more effective than other sorts of interventions.
- There is no evidence that interventions focusing on technology-based information (e.g. from mobile phones, radio or the internet) contribute to achieving SRH outcomes, such as condom use, for adolescents and young people.[xcviii]

In addition, there is only little insight into the effectiveness of interventions that aim to facilitate empowerment of young people. The establishment of youth centres is the only intervention for which a systematic review of the effects on SRH outcomes is available,[73] but this review found no effects of youth centres on contraceptive use. Numbers of visitors and the uptake of SRH services were low and these centres often failed to attract the most-vulnerable young people.[xcix]

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71 Attempts to address such religious and policy/legislative barriers are partially described in Result area 4.
72 Behavioural interventions are those designed to influence the actions that individuals take regarding their health.
73 This systematic review was not identified in the Evidence & Gap Map, as it was published before 2015.

The literature suggests that multi-component interventions tend to yield better results than stand-alone activities to provide information, although the effects remain relatively small.[c] Including gender and power dynamics in sexuality education has a greater effect, for example.[ci] The literature reveals that linking access to information to SRH services seems to be effective; incorporating access to family planning (FP) information with existing HIV care and treatment has been linked to increased modern contraceptive use among women living with HIV.[cii] Similarly, combining CSE with existing health services resulted in more positive effects.[ciii]

6.1.4 Findings

The 21 projects supported through the 2011–2015 subsidy frameworks and the 10 SRHR partnership projects (2016–2020) reported on a variety of output results, including:

- the number of young people – sometimes disaggregated by gender – who gained access to information through comprehensive sexuality education;
- the number of healthcare staff, teachers, facilitators, peer educators or community workers sensitised or trained on SRHR issues;
- the number of young people – sometimes disaggregated by gender – that were reached through out-of-school information campaigns, life-skills trainings, community-awareness-raising activities or digital media campaigns;
- the number of youth clubs/forums/groups established or strengthened; and
- the number of adolescent dialogues organised and the numbers of youth participating.

Comprehensive sexuality education

Introducing CSE has been difficult in countries where the national curriculum on sexuality education was relatively limited. The Get Up Speak Out! (GUSO) strategic partnership project (2016–2020) focused on sexuality education in a number of countries, including Uganda. Before the start of the project partnership project, integrating teacher-led sessions on CSE in Uganda would already have been difficult because the topics were not examinable and teachers focused more on topics that were in the curriculum.[civ] The GUSO project was further compromised as a result of the 2016 ban on comprehensive sexuality education. In Uganda, programme staff had to use guidelines that primarily focused on HIV/AIDS and abstinence, instead of providing comprehensive sexuality education.[74] Similarly, the Kenyan Ministry of Education reviewed the curriculum implemented by the GUSO alliance and approved it with the exception of topics about LGBTIQ+ and pleasure.[cv]

Similar barriers for CSE were also encountered in other countries. In Bangladesh, for example, the Dutch embassy funded UNFPA's *Generation Breakthrough* project, which focuses on teachers delivering in-school sessions on the Gender Equity Manual for Schools (GEMS) in 350 schools and madrasahs, and 150 out-of-school youth clubs, with the intention of increasing gender equitable behaviour among young people and improving their knowledge about SRHR.[75] [76] The out-of-school youth-club component was discontinued in 2017 because it was difficult to reach out-of-school adolescents in Bangladesh. A consultant contracted by IOB visited 21 targeted schools and madrasas and concluded that during project implementation most teachers faced resistance from colleagues and parents and, as a result, did not teach the more 'sensitive' topics from the GEMS module (for example, family planning methods).[77] This was possible because the National Curriculum Board had not incorporated GEMS topics into the national curriculum. GEMS topics that had been included were not mandatory.

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74 The Presidential Initiative on Aids Strategy for Communication to Youth (PIASCY) is a strategy introduced by the Ministry of Education and Sports in Uganda. The Initiative was funded by the US government through USAID.

75 The project had a budget of USD 8 million and was implemented between 2012 and 2019 by INFPA, in collaboration with Plan International and the Bangladesh Ministry of Education and Ministry of Women and Children Affairs.

76 UNFPA commissioned baseline (2015), midline (2018) and endline (2019) surveys in two intervention groups, as well as in a third control group. However, one should be cautious in interpreting the results from this assessment: the sampling strategy remains unclear; there is no discussion of selection bias; and it remains unclear whether reported differences between intervention and control groups are statistically significant.

77 Our findings are in line with those described in R. Roodsaz, 'Probing the politics of comprehensive sexuality education: 'Universality' versus 'Cultural Sensitivity': a Dutch–Bangladeshi collaboration on adolescent sexuality education', *Sex Education*, vol. 18, no. 1, 2018.

Out-of-school SRHR awareness-raising and activities to organise youth voice

The final evaluations of the Marriage, No Child's Play (MNCP), Get Up, Speak Out! and Her Choice SRHR partnership projects are examples of best practices and show that it is both desirable and possible to rigorously measure the intended objectives of SRHR interventions at baseline, midline and endline and also work with comparison groups to estimate project effectiveness. Table 1 presents their main characteristics of the first two projects.[78]

Table 1. *Main characteristics of MNCP and GUSO projects*

Project title	Marriage No Child's Play	Get Up, Speak Out!
Lead partner	Save the Children	Rutgers
Framework	SRHR Strategic Partnership Fund 2016–2020	SRHR Strategic Partnership Fund 2016–2020
Target countries	India, Malawi, Mali, Niger, Pakistan	Ethiopia, Ghana, Indonesia, Kenya, Malawi, Pakistan, Uganda
Total budget	EUR 30 million	EUR 40 million
Objective	Empower at-risk and already-married adolescent girls with life-skills education, SRHR information and peer-support groups	To enhance the skills and knowledge of young people to make informed decisions about SRHR
Main outputs	• Established/strengthened 3,000 youth groups • Trained 150,000 young people on SRHR topics	• Trained 21,000 SRHR (peer) educators • Supported 1,200 networks for young people

Household surveys were conducted at baseline and endline in both intervention and comparison areas for both projects.[79] The results of the MNCP project showed some positive effects of the project on girls' knowledge about contraceptives and child marriage.[80] There were, however, few effects on actual change in behaviour. The evaluation of the GUSO project did not reveal significant effects on various indicators of empowerment, such as decisions about dating, choice of partners or contraceptive use.[cvi] In addition, the assessments from both projects did not find significant differences between intervention and control groups in the change in proportions of young girls that had ever been pregnant.[81] Figure 5 presents the results for the MNCP project.[82] These findings show that although the project contributed to increased knowledge, there were no effects on the behaviour of the intended target group.

[78] Due to ethical considerations, the Her Choice project only started implementing in the comparison areas after the collection of midline data.

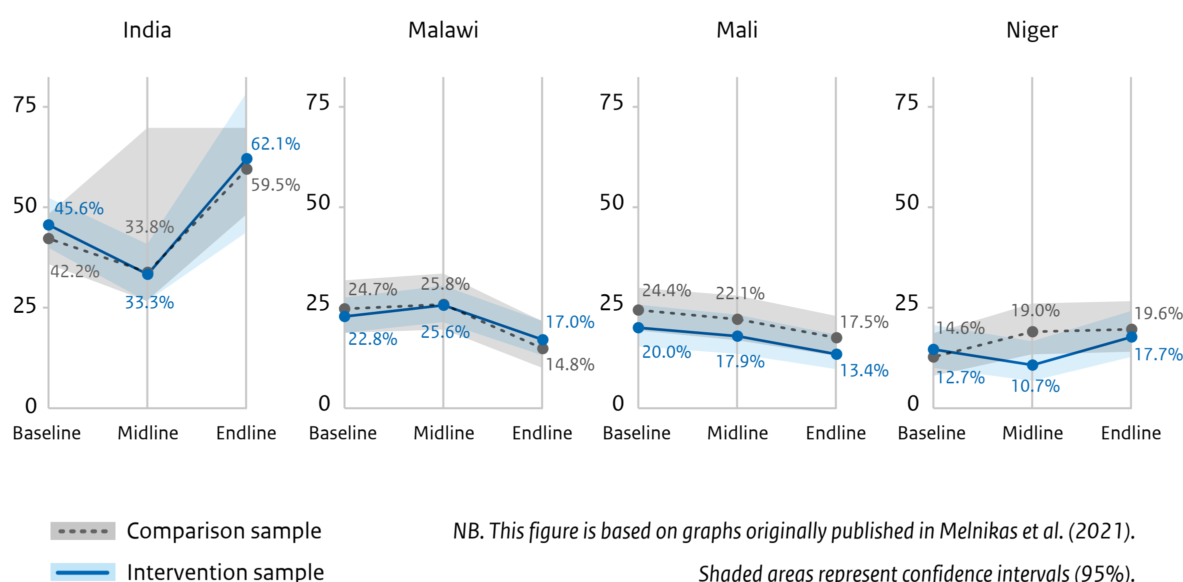
[79] For MNCP, household surveys were conducted at baseline, midline and endline among girls between 12 and 19 years in both intervention and comparison areas in four countries. For GUSO, data was collected though surveys among young people at baseline and endline in intervention areas in six countries, and in Uganda and Kenya also in control areas.

[80] In three out of four countries, the proportion of girls that could correctly identify the legal age of marriage increased significantly compared to the control group. The project had an effect on the proportion of girls that could identify at least three adverse effects of child marriage. This increased in two countries, and in one country there was an increase for knowledge about contraceptives.

[81] Note that these are household surveys that didn't follow or sample the same respondents at baseline, midline and endline.

[82] Results from India cannot be compared against other countries because data were only collected from girls who had ever been married.

Figure 5. *Difference-in-difference analysis: proportion of girls (15-19 years old) ever pregnant*[cvii]



NB. This figure is based on graphs originally published in Melnikas et al. (2021).

Shaded areas represent confidence intervals (95%).

These findings are largely in line with those from less rigorous project evaluations, such as the MenCare+ and Access, Services and Knowledge projects.[83] [84] Improvements in the knowledge of young people does not directly result in more empowerment or behavioural change (see also Subsection 6.1.3). This may in part be the result of existing barriers in the target countries. The GUSO evaluation in Uganda and Kenya revealed that only very few young people indeed felt supported by traditional, political and religious leaders in accessing sexuality education and SRH services. Another possible explanation is that the programmes implemented were too short to facilitate empowerment or achieve behavioural change.

The Ministry of Foreign Affairs was also an important contributor to the first phase of UNFPA and UNICEF's Global Programme to End Child Marriage (2016–2019). The evaluation mentioned that the programme reached nearly 5.5 million girls, far exceeding its objective of reaching 2.5 million girls.[cviii] Although the programme did not structurally measure data at the outcome level, the evaluation did present some anecdotal evidence that there was an increase in knowledge on child protection issues, particularly those concerning teenage pregnancy and child marriage. Attitudes and practices, however, have not undergone the same level of change. The evaluation also concluded that it was difficult to reach out-of-school young people and those from the most-vulnerable groups.

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[83] The MenCare+ project, funded through the SRHR Fund (2013–2015) had a budget of EUR 8.7 million. Main outputs included training of 2,500 health providers on youth friendly services and SRHR group sessions of 8,600 young men and women in five countries. Survey results showed that between baseline and endline there were some changes in the attitudes of project participants, but there were fewer changes in behaviour, such as contraceptive use.

[84] The ASK project was also funded through the SRHR Fund (2013–2015) and had a budget of EUR 30 million. The project enabled educators through e-learning and provided young people with SRHR information in seven countries. Although the evaluation found that knowledge improved in four out of five countries, levels of confidence and skills only improved in two.

6.2 Result area 2: Improved access to (reproductive) health commodities

Key takeaways

Access to reproductive- and health commodities has improved in sub-Saharan Africa over the past decade. Modern contraceptive use increased between 2010 and 2019, although it remains lower than in other regions in the world. HIV-related incidence and mortality fell sharply as a result of enhanced antiretroviral therapy. Seven of the 10 Dutch target countries are on-track to achieving SDG targets for reducing the number of people newly infected with HIV. Nevertheless, even before the COVID-19 pandemic, no Dutch SRHR target countries were on course to meet the UNAIDS target of a 90% reduction in new HIV infections between 2010 and 2030 (see Subsection 6.2.1).

In this result area, Dutch policy is aimed at improving access to health commodities, in particular for reproductive health, through support for the UNFPA Supplies Partnership, the Global Fund and Gavi (as discussed in Subsection 6.2.2). The first underlying policy assumption is that improving availability of SRHR and HIV/AIDS medicines and commodities will improve access to and, thereby actual use, of these medicines and commodities.

The academic literature reveals that availability of affordable contraceptives does not directly translate into their greater use and that there are other factors at play (see Subsection 6.2.3). Thus, the above assumption appears to be only partially valid. Based on monitoring and evaluation reports (see Subsection 6.2.4), this evaluation concludes that UNFPA and the Global Fund have contributed to improved availability and, in consequence, partially to increased use of SRH and HIV/AIDS medicines. Due to limitations in available data, it is challenging to precisely quantify the extent of their contributions. The Netherlands also supported Gavi, which has included human papillomavirus vaccines against cervical cancer since 2014, although supply could not keep up with rapidly increasing demand.

The Netherlands has also supported product development partnerships, assuming that they could lead to increased and lasting improvements in access to medicines, vaccines and diagnostics to combat, amongst other things, SRHR-related diseases. Although there have been some successes in bringing products to market, most were still in the development phase, making it challenging to ascertain whether the objective will be realised.

6.2.1 Description of context: state of affairs

The proportion of women between 15 and 49 years in sub-Saharan Africa that use modern contraceptive methods increased from 18% in 2010 to 29% in 2019, but this remains substantially lower than in other regions.[cix] [85] In sub-Saharan Africa the unmet need for modern contraception methods for married women declined only slightly, from 24% in 2010 to 22% in 2019.[86] [cx] In absolute terms, unmet need increased owing to high population growth and, in recent times, during the COVID-19 pandemic, primarily due to supply-chain disruptions, travel restrictions, clinic closures and the availability of healthcare workers.[cxi] UNFPA estimated that 12 million women were unable to access contraceptives as a result of the pandemic, leading to 1.4 million unintended pregnancies in 2020.[cxii] The unintended pregnancy rate in sub-Saharan Africa has remained largely stable, with 93 unintended pregnancies per 1,000 women in 2010 against 91 per 1,000 women in 2019.[cxiii]

[85] Modern methods of contraception include female and male sterilisation, oral hormonal pills, the intra-uterine device (IUD), the male condom, injectables, the implant (including Norplant), vaginal barrier methods, the female condom and emergency contraception.

[86] Unmet need for contraception is the proportion of fertile married women of reproductive age who do not want to become pregnant and are not using contraception.

Globally, HIV-related incidence and mortality has declined. Antiretroviral therapy (ART) has significant health benefits for people living with HIV, including improved immune function and increased life expectancy.[cxiv] In sub-Saharan Africa, the proportion of people living with HIV that received ART was about 37% in 2012, increasing to about 79% in 2021.[cxv] As a result, mortality from HIV has continued to decline:[cxvi] In 2012 there were 131 deaths from HIV/AIDS per 100,000 people in sub-Saharan Africa, while by 2017 this had decreased to 90 per 100,000.[cxvii] Incidence of HIV decreased as well: in Uganda, for instance, there were five new HIV infections per 1,000 uninfected people between 15 and 49 in 2012; by 2021 this had decreased to 2 per 1,000.[cxviii] Currently, seven of the 10 Dutch target countries are on-track to achieving SDG targets for reducing the number people newly infected with HIV. The largest challenges remain in countries in Southern Africa.[cxix]

Despite these general trends, nevertheless, there are large differences between sub-populations. Key populations including gay men, men who have sex with men (MSM), transgender people and sex workers make up a small proportion of the total population but account for more than half of new HIV infections.[cxx] HIV prevalence among female sex workers in East and Southern Africa is about 33%.[cxxi] COVID-19 led to disruptions in HIV services, as HIV testing declined by 41% and referrals for diagnosis and treatment by 37% worldwide.[cxxii]

6.2.2 Policy

Result area 2 of the ministry's SRHR policy focuses on improved access to a wide range of SRH and HIV/AIDS medicines and other health commodities, such as modern family planning commodities, child vaccinations and the prevention and treatment of HIV/AIDS. Through the UNFPA Supplies Partnership, the Global Fund and Gavi, the ministry has provided direct access to (reproductive) health commodities in a number of countries. Various NGO partnerships and embassy projects have also provided access to commodities, albeit on a smaller scale.[87]

In addition, by supporting innovation for SRH and HIV/AIDS medicines and other health commodities through PDPs, the ministry aimed to improve access to drugs, vaccines and diagnostics for vulnerable people by developing and bringing necessary products to the market to prevent poverty-related diseases and conditions associated with SRHR and HIV/AIDS.[88]

The most important assumptions related to the ministry's interventions in Result area 2 are:

1. Enhancing availability to SRHR and HIV/AIDS medicines and commodities will improve access to SRHR and HIV/AIDS medicines and remove a significant barrier to their uptake.
2. Supporting innovation through PDPs can lead to increased and lasting improvements in access to medicines, vaccines and diagnostics to combat SRHR-related diseases.

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[87] The Ministry of Foreign Affairs is also amongst the funders of the International Planned Parenthood Federation (IPPF), which according to its annual report (IPPF, 'Annual Performance Report 2020', 6 July 2021) provided 90 million contraceptives (including counseling) in 2020. The GUSO partnership provided 17.3 million contraceptives to young people in seven countries, as outlined in their 2019 annual report (Get Up Speak Out, 'Annual Report 2019', 1 June 2020). The ASK project provided 25 million contraceptives to young people under 25, according to its end report (Youth Empowerment Alliance, 'End Report, Access, Services and Knowledge (ASK)', October 2016). Dutch funding has also been used for a DKT International programme to improve access to contraceptives and increase choice in Ethiopia, Kenya, and Uganda. Nine NGO partnership projects financed by the ministry between 2011 and 2015, and three financed between 2016 and 2020, provided access to SRH and HIV/AIDS medicines and commodities.

[88] The Netherlands also supported the Human Reproduction Programme of UNDP, UNFPA, UNICEF, the World Bank and the WHO with EUR 25 million during the period 2018–2022.

6.2.3 Evidence base

The academic literature shows that availability of affordable contraceptives is only one factor influencing their use and that increased availability does not directly translate into greater use. In addition to limited availability, there are many other factors that either stimulate or act as barriers to the actual use of modern contraceptives. Factors that play a role in the decision of women and men in low- and lower-middle-income countries to use contraceptives are:[cxxiii] [89]

- **Socio-economic status**, including level of education, poverty level and employment status.
- **The characteristics of health systems**, including the availability of contraceptives, but also accessibility, confidentiality and cost of SRH health services.
- **Social networks and the wider social context**, including, at the individual level, the influence and knowledge of male partners and the views and experiences of peers. With regards to the wider social context, social norms and values, attitudes towards sex, social pressure on women, religious beliefs and female agency play an important role.
- **Individual characteristics,** including age; relationship status; likelihood and appeal of pregnancy; knowledge, beliefs and perceptions of health risks; previous experience with contraceptives; and frequency of sex.

The literature also shows that utilisation of existing health services can be improved by providing financial incentives, although this is not a common feature of interventions supported by the Netherlands. Financial incentives such as cash transfers and vouchers have been shown to have a positive effect on utilisation of maternal health services (antenatal care, skilled birth attendance, facility delivery, postpartum care), HIV testing and subsequent HIV treatment, and voluntary uptake of male circumcision.[cxxiv]

6.2.4 Findings

A 2020 study of the ministry's Social Development Department strategy for reproductive health commodities concluded that evidence of results achieved through Dutch interventions on reproductive health commodities was limited and that in-depth understanding of which interventions worked was lacking.[cxxv] This evaluation in large part concurs with that conclusion. The following sections present the most important results, the majority of them at output level, achieved through UNFPA, the Global Fund, Gavi and the PDPs.

UNFPA Supplies Partnership

The UNFPA Supplies Partnership is a thematic fund to expand access to reproductive health commodities. During the evaluation period, the Supplies Partnership supported 46-48 countries where 'maternal death rates are high, modern contraceptive use is low and economic indicators demonstrate pressing need'. These include many Dutch priority countries. The Netherlands has been among the largest donors of UNFPA supplies since its establishment in 2007. It allocated EUR 262 million to the fund during the evaluation period, which accounts for 20% of all UNFPA supplies expenditure – see Table 2.

Table 2. *Dutch contribution to UNFPA Supplies Partnership (in USD millions)*[cxxvi]

	2013	2014	2015	2016	2017	2018	2019	2020	2021	2013–2021
Dutch contribution	44	26	29	38	28	29	25	14	39	273
Total expenditure	164	185	148	132	119	189	157	178	112	1,384
Dutch share	27%	14%	20%	29%	24%	16%	16%	8%	35%	20%

Note: contributions received in the last quarter of each year are used to place orders for commodities in the beginning of the next year.

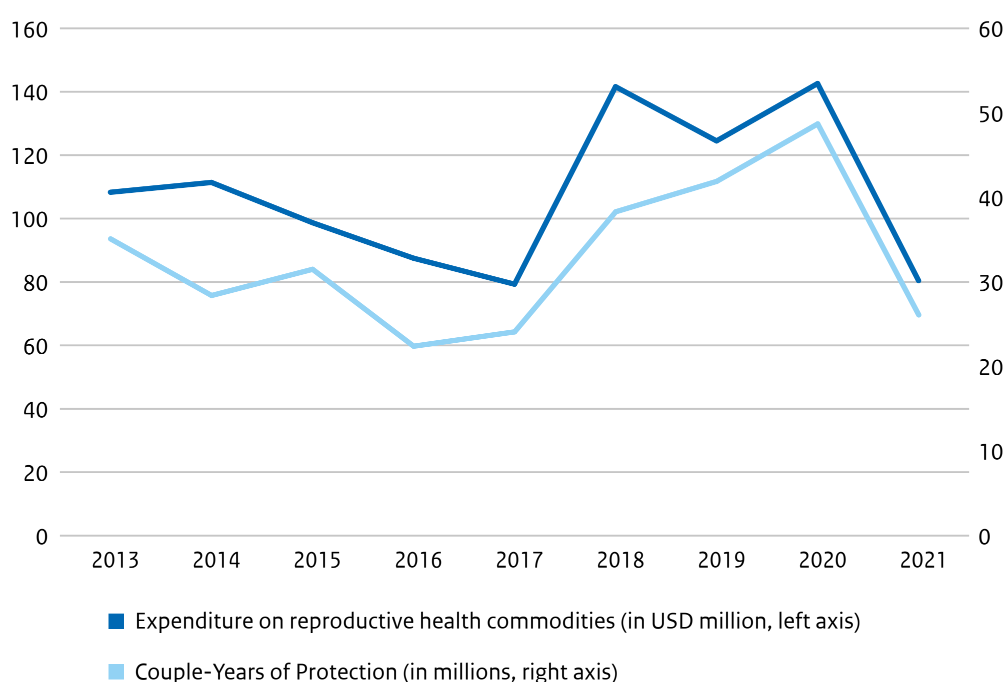
[89] Most studies concerned sexually active women of 15–49 years with demand for contraception not satisfied and used Demographic and Health Survey data. The reasons for non-use are based on only one question and the responses do not therefore necessarily capture the potentially complex interplay of barriers that contribute to non-use (G. Sedgh, L. S. Ashford and R. Hussain, 'Unmet Need for Contraception in Developing Countries: Explaining Women's Reasons of Not Using a Method', New York, Guttmacher Institute, June 2016, p. 4). Moreover, the stated reasons for non-use might reflect the reasons respondents feel most comfortable with, or the most immediate or pressing obstacles (G. Sedgh and R. Hossain, 'Reasons for contraceptive nonuse among women having unmet need for contraception in developing countries', *Studies in Faily Planning*, vol. 45, no. 2, 2014, p. 165).

The Netherlands became an even more important donor in 2021, when the UK drastically reduced its contribution. In 2022, the ministry committed EUR 15 million in additional funds to partially address the gap left behind by the UK's reduction.

In 2019 the Netherlands applied a results-based financing (RBF) pilot to its support of the UNFPA Supplies Partnership. The intention was to promote efficient and effective procurement and supply management. The pilot meant that the second half of annual commitments would be disbursed based on performance in the previous year. An evaluation of this pilot concluded that because UNFPA pools funds from different donors and adopts a needs-based funding approach, it was difficult to link results-based financing to country performance. The evaluation also concluded that the pilot increased the workload for UNFPA and the Netherlands (including additional data collection outside UNFPA's M&E system).[cxxvii]

There is a direct relation between the number of contraceptives provided, measured in couple–years of protection (see Footnote 68), and the amount of donor funding received – see Figure 6. The UK was the programme's largest donor and its decision to significantly cut funding to the Supplies Partnership from British pound sterling (GBP) 154 million in 2020 to GBP 23 million in 2021, for instance, has had a direct effect on the number of commodities provided by the programme.[cxxviii]

Figure 6. *UNFPA Supplies Partnership expenditure on reproductive health commodities and couple-years of protection* [cxxix]



A mid-term evaluation of the Supplies Partnership concluded in 2018 that it had contributed to expanding access to family planning products and services, increased the range of contraceptive options, and that reproductive health and family planning services were accessible to marginalised women and girls, also in cases of humanitarian emergencies.[cxxx] Various indicators of contraceptive use improved from 2013 to 2021 in the 46 target countries of the UNFPA Supplies Partnership – see Table 3. The proportion of women of reproductive age who expressed a desire to avoid pregnancy but were not using any family planning method decreased by about 4% in these countries and the proportion women using modern contraceptives increased.

Table 3. *Key indicators for UNFPA Supplies Partnership in its 46 target countries*[cxxxi]

	2013	2014	2015	2016	2017	2018	2019	2020	2021
Average unmet need for family planning (%)	29	29	28	28	28	27	28	27	25
Modern contraceptive prevalence rate (%)	20	21	22	23	24	25	25	25	24
Demand for family planning satisfied by modern methods (%)	43	45	46	47	48	49	49	51	55

The UNFPA Supplies Partnership was an important source of commodities used by the public sector in almost all of its programme countries.[cxxxii] [90] In Benin, UNFPA accounted for 43% of the funds for delivering SRH commodities in 2022, the remainder coming from the government (20%) and other NGOs and UN organisations (36%). The proportion of UNFPA funds in the total amount funded for commodities was also substantial in other Dutch SRHR target countries in 2022, such as Mali (46%), Mozambique (55%) or Ethiopia (46%).[cxxxiii] Given the important role of UNFPA in providing access to contraceptives in the target countries, it is likely that the Supplies Partnership contributed to increased contraceptive use in those countries. Due to limitations in monitoring, however, it remains unclear how many of the commodities actually reached the intended service users and it is not possible to quantify the contribution of the Supplies Partnership the modern contraceptive prevalence rate as reported in Table 3.[91]

Previously, the Supplies Partnership linked demand creation for SRH services with service delivery, for example through mobile outreach services, to reach remote and marginalised populations. The UNFPA Supplies Partnership contracted national NGOs to perform community engagement work and to link demand creation with service-delivery activities.[cxxxiv] In 2017, UNFPA Supplies Partnership decided to discontinue its demand creation activities, as advocated by donors, including the Netherlands. The evaluation concluded that this decision was counterproductive in contexts in which demand for modern contraception was limited. There continues to be inequality in access to and use of contraceptives in target countries. Facility-based surveys show that in 2021 availability of at least three contraceptive methods was lower at service-delivery points in rural areas (65%) than in urban areas (73%).[cxxxv] There is also a gap between the lowest (21.5%) and highest (32.6%) wealth quintiles regarding the proportion of women using modern contraception.[cxxxvi]

The Global Fund

The Global Fund to Fight AIDS, Tuberculosis and Malaria, also known as the Global Fund, was set up in 2002 to accelerate the defeat of AIDS, tuberculosis and malaria. It is a global public–private partnership between governments, civil society, the private sector and people affected by the diseases, to mobilise and disburse funds for prevention and treatment. It distributes the funds to programmes in countries and communities most in need – those with the highest burdens of disease and least economic capacity to address them. The Netherlands has been supporting the Global Fund since its inception. It is a relatively small donor, accounting for only 1.7% of all contributions in the period 2011–2022 – see Table 4.

Table 4. *Dutch contribution to the Global Fund (in USD millions)*[cxxxvii]

	2011–2013	2014–2016	2017–2019	2020–2022	2011–2022
Dutch contribution	209	244	181	202	835
All donor contributions	10,304	11,713	11,452	16,109	49,577
Dutch share	2.0%	2.1%	1.6%	1.3%	1.7%

Between 2013 and 2022 the Global Fund allocated about 37% of its resources to HIV-related programmes and another 16% to joint HIV/TB activities.[cxxxviii] During the evaluation period, the Global Fund provided resources for HIV programmes in 103 countries, including most of the Dutch target countries. The Fund's key indicators for the period 2017–2021 are shown in Table 5. The reduction in the total number of HIV tests taken in 2021 is the result of disruptions arising from COVID-19 pandemic.[cxxxix]

[90] The public sector, including hospitals, clinics and community health workers, supplies about two-thirds of all modern contraceptive users in 36 low- and lower-middle-income countries. For more information and country-specific estimates, see S. E. K. Bradley and T. Shiras, 'Sources for Family Planning in 36 Countries: Where Women Go and Why It Matters', Rockville, Sustaining Health Outcomes Through the Private Sector Plus Project, Abt Associates, 2020

[91] The evaluation of UNFPA's Supplies Partnership concluded, moreover, that it had faced difficulties in its annual needs assessments, ordering, and shipping commodities to recipient countries. See: L. Charpentier, 'Mid-Term Evaluation of the UNFPA Supplies Programme (2013-2020)', New York, UNFPA Evaluation Office, 2018.

Table 5. *Key Indicators for the Global Fund's HIV programmes, worldwide*[cxl]					
	2017	**2018**	**2019**	**2020**	**2021**
People on antiretroviral therapy (ART) for HIV (millions)	17.5	17.5	20.2	21.9	23.3
HIV-positive pregnant women who received ART (millions)	0.7	0.7	0.7	0.7	0.7
Total number of HIV tests taken (millions)	79.9	125.3	126.8	102.5	70.8
Number of HIV tests taken by key populations[92] (millions)	2.9	3.5	4.3	4.0	5.4
Male circumcisions (millions)	1.0	1.5	1.3	1.2	1.1

The Fund played a substantial role in many of the Dutch priority countries: in Uganda and Mozambique it accounted for 21% and 27%, respectively, of all expenditures on HIV treatment and care, including ART.[cxli] Worldwide, the coverage of ART increased sharply over the previous decade, decreasing mortality and transmission – see Subsection 6.2.1. This is in part the result of the Global Fund's investments, but quantifying the exact contribution is not possible since the Fund only measures combined results for the countries in which it invests, including efforts of domestic government and other donors.[cxlii]

Gavi

Gavi was established in 2000 to act as a financing mechanism to improve access to vaccines in low- and middle-income countries and accelerate the development of vaccines. Gavi supports vaccines against 19 infectious diseases, including, most recently, COVID-19, Ebola and malaria and it is also a co-convener of COVAX, supplying free COVID-19 vaccines to low-income countries. SRHR is a relatively small part of Gavi's work. Human papillomavirus (HPV) vaccines for protection against cervical cancer have been included since 2014. In addition, Gavi is active in strengthening health systems, which can indirectly affect SRHR services (see Subsection 6.3.3). The Netherlands is a relatively small donor to Gavi: its total contribution during the evaluation period was 2.3% of all contributions received by Gavi – see Table 6.[93] [94]

Table 6. *Dutch contribution to Gavi (in USD millions)*[cxliii] [95]				
	2011–2015	**2016–2020**	**2021–2025**	**2011–2025**
Dutch contribution	220	304	326	850
All donor contributions	7,396	9,238	19,726	36,360
Dutch share	3.0%	3.0%	1.7%	2.3%

An evaluation of Gavi's second Supply and Procurement Strategy for the years 2016–2020 concluded that Gavi had contributed to improved market health across a number of vaccine markets and that Gavi had helped facilitate the phasing out of low-quality cold chain equipment, while significantly increasing the uptake of high-quality products. Some markets have seen improvements in supply security (e.g. yellow fever) but this was not overall the case: for HPV there were major supply-side challenges. Production could not keep up with rapidly expanding demand following the WHO recommendation to start vaccinating girls between 9 and 14, which limited the rollout of HPV vaccines in Gavi-supported countries.[cxliv]

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92 Key populations: MSM, people who use drugs, prisoners, sex workers and transgender people.

93 The largest donors were the UK, the US and the Bill and Melinda Gates Foundation. Jointly they account for 55% of all contributions.

94 Gavi was active in all Dutch SRHR target countries. Countries eligible for Gavi support can implement a portfolio of activities, including support for strengthening health systems, vaccines, cold chain equipment optimisation and what is referred to as targeted country assistance.

95 Contributions include those to the International Finance Facility for Immunisation (IFFIm) , COVAX and the Matching Fund. IFFIm is a component of Gavi's capital structure and issues Vaccine Bonds on the capital markets against long-term donor pledges. The money raised through Vaccine Bonds provides immediate funding for Gavi. The purpose of the Matching Fund is to incentivise the Dutch and international private sectors to engage with Gavi to find innovative solutions for achieving the objectives of the Vaccine Alliance. By matching private sector contributions in cash or in kind, this mechanism aims to help Gavi secure the resources and expertise required to modernise vaccine delivery systems.

Product Development Partnerships

The PDPs are public–private partnerships for the research and development (R&D) of medicines, vaccines and diagnostics to combat poverty-related diseases and conditions, some of which are related to SRHR. The Netherlands has been supporting the PDPs since 2006; the Netherlands Enterprise Agency (RVO) currently administers Dutch support for the PDPs on behalf of the Ministry of Foreign Affairs. The Netherlands contributed EUR 70 million to seven PDPs from 2011 to 2014 (PDP II) and EUR 104 million for six PDPs from 2015 to 2021 (PDP III) – see Table 7. The contribution of the Netherlands was about 11% of total funding from all bilateral donors, and accounted for between 3% and 10% per PDP.[cxlv] [96]

Table 7. *Supported PDPs in phases II (2011–2014) and III (2015–2021) (in EUR millions)*[cxlvi]

PDP	Disease	PDP II	PDP III
Aeras	Tuberculosis, including co-infection with HIV	12	
Medicines for Malaria Venture	Malaria		18
International Partnership for Microbicides	HIV/AIDS	9	17
TB Alliance	Tuberculosis		18
Foundation for Innovative New Diagnostics	HIV, tuberculosis, Malaria, Human African Trypanosomiasis, Leishmaniasis, Chagas disease, Buruli ulcer, hepatitis C, and trachoma (peripheral focus)	10	12
International AIDS Vaccine Initiative	HIV/AIDS	13	19
Drugs for Neglected Diseases Initiative	Human African trypanosomiasis, Leishmaniasis, Chagas disease, Mycetoma	14	19
Sabin Vaccine Institute	Human hookworm, schistosomiasis, ascariasis, trichuriasis, Chagas disease, leishmaniasis, onchocerciasis	6	
Protection Options for Women Product Development Partnerships	Focused on building supply and market introduction of the Female condom	5	
Total		**70**	**104**

Evaluations of the PDPs concluded that these have had some success in developing and bringing products to the market that are needed to combat or prevent poverty-related diseases and conditions associated with SRHR and HIV/AIDS.[97] They have also made progress with respect to the development of a pipeline of drugs, vaccines and diagnostic tools, although many years of R&D, including clinical trials, will be needed to realise their impact.[cxlvii] The 2019 mid-term review (MTR) of PDP III indicated that because most products financed by PDP III funds were still in development, it was difficult to verify whether the objective of Dutch funding, i.e. better access to drugs, vaccines and diagnostics for vulnerable populations, would be realised.[98] While the PDPs had stimulated supply, there had been no systematic efforts to improve access for specific groups (in particular women of childbearing age and children). Furthermore, issues of accessibility to end-users, regulatory approval and financial affordability of many PDP products that are on the market or ready to market need to be addressed.[cxlviii]

[96] The largest donors of PDPs are the Bill & Melinda Gates Foundation (USD 100 million between 2008 and 2022), USAID (USD 45 million between 2017 and 2023) and the Foreign, Commonwealth and Development Office (GBP 32.6 between 2017 and 2022).

[97] A review of the Product Development Partnerships Fund was made in 2014, a MTR in 2019 and an evaluation of the PDPIII Fund in November 2021. All these assessments primarily relied on internal documentation and the views of limited numbers of directly-involved PDP stakeholders. Only the 2019 MTR dealt with the PDPs in more detail.

[98] The 2019 MTR refers to, for example, the TB Alliance, which had developed a pediatric TB treatment that is now made available in over 85 countries through PDP III support and a DNDi-developed fexinidazole for Human African Trypanosomiasis (Act for Performance, 'Mid-term Review of PDP III Fund, Evaluation report', Ede, 17 February 2019, p. 2). The 2021 evaluation of the PDP III fund refers to 375 new products in the pipeline, with 30 products moving one phase in the development process, and 12 products having reached the marketing stage. These 12 products have been registered with national authorities or international organisations.

Dutch core funding of PDPs has been substantial and flexible, and entailed a relatively light administrative burden; it functioned to keep research and trials going. It has also helped to push forward research activities that otherwise might not have been possible, as well as also attracting other funding. Because of the funding model – support for products that are not deemed financially viable by the private sector – the 2019 MTR also concluded that continued funding by donors was critical for PDPs.[cxlix]

6.3 Result area 3: Better public and private health care for family planning, pregnancies and childbirth, including safe abortions

Key takeaways

Health systems in most Dutch target countries continue to be severely underfunded. As a result, maternal mortality SDG targets are out of reach in these countries. Unsafe abortions remain a major cause of maternal mortality in sub-Saharan Africa (Section 6.3.1).

In this result area, Dutch policy is focused on contributing to the improvement of public and private healthcare by supporting organisations involved in delivering SRH services and by implementing interventions to strengthen health systems. Such initiatives were meant to enhance the responsiveness of these systems to the specific needs of young people or key populations, as well as support government health programmes (Subsection 6.3.2). The underlying policy assumptions of these interventions are that (i) increased access to healthcare and SRH services can lead to higher utilisation rates and improved SRH outcomes, also for young people and key populations; and that (ii) the Netherlands is able to contribute to strengthening health systems, which in turn can have positive (and lasting) effects on SRHR outcomes.

The scientific literature (Subsection 6.1.3) and evaluation reports (Subsection 6.1.4) largely support the first assumption. Many supported NGO partnerships and INGOs have implemented community-based reproductive health interventions, which have probably contributed to improved SRHR outcomes for the direct users of the services. Supported INGOs have also provided access to safe abortion services in low- and lower-middle-income countries.

The second assumption is, however, not valid. Although the Netherlands has contributed to improved service delivery in the short term, the supported programmes were not consistently integrated into the existing, broader health systems. The literature confirms that interventions to strengthen health systems can indeed enhance mother- and child-health outcomes. Evaluations of UNFPA, UNICEF, the Global Fund, and Gavi have confirmed their contributions to increased availability, quality and utilisation of SRH and health services. Nevertheless, these evaluations also highlight that the results have predominantly been short term and that the supported activities were not consistently integrated into broader health systems. Furthermore, the available evidence shows mixed outcomes regarding efforts to make existing SRH services more responsive to the needs of young people. Finally, there is no evidence that the GFF has mobilised additional funding for health systems.

6.3.1 Description of context: state of affairs

Health systems in Dutch target countries continue to be severely underfunded. Low domestic health expenditure continues to be a major challenge in achieving results in SRHR and healthcare.[99] Health statistics, such as the births attended by skilled health staff and maternal, neonatal (<28 days) and infant (<1 year) mortality have improved only slowly in the last decade.[cl] Some 94% of maternal deaths worldwide occur in low- and lower-middle-income countries and most of these are preventable with adequate healthcare.[cli] The current maternal mortality ratios in all the ministry's target countries are well above the SDG 3 target (< 70 deaths per 100,000 live births by 2030) and are not on-track to reaching this target.[clii] Benin and Burundi have the highest ratios among the Dutch target countries, with 523 and 494 maternal deaths per 100,000 live births, respectively.[cliii] Unsafe abortion remains a leading cause of

[99] See also Section 9.4.

maternal mortality in sub-Saharan Africa.[cliv] Currently, only 23% of abortions in the region are considered safe.[100] As a result, the abortion case-fatality rate is the highest in the world, with 185 deaths per 100,000 abortions in 2019.[clv] [101]

Young people and adolescents in low- and middle-income countries continue to be more at risk of poor SRHR outcomes, e.g. maternal and child mortality, sexually transmitted infections and sexual and gender-based violence.[clvi] Adolescents are more likely to experience complications during childbirth,[clvii] receive less antenatal care than older first-time mothers,[clviii] and encounter additional barriers to obtaining contraceptive care, such as the need for parental consent or restrictions related to age and marital status.[clix] Adolescents also have higher unmet needs for SRH care; adolescent girls have a 43% unmet need for modern contraception as compared to 24% unmet need for all reproductive-age women in low- and middle-income countries.[clx]

Accessibility of overall health and SRH services continues to be a problem for many key populations. Studies show that LGBTIQ+ persons experience many barriers to accessing healthcare, such as stigmatisation, denial of care and abuse, leading to reluctance to disclose sexual orientation and poor overall health outcomes for this group.[clxi]

6.3.2 Policy

Result area 3 of the Ministry of Foreign Affairs' policy on SRHR aims to ensure better public and private healthcare for family planning, pregnancies and childbirth, including safe abortions. Since 2018, this result area has also explicitly focused on people in crisis and humanitarian situations.

Various NGO partnerships from different subsidy frameworks directly or indirectly provided SRH services. Service delivery was a relatively small part of the more recent SRHR partnership programmes, in line with Dutch policy; it was more common in the 2011–2015 partnership programmes. Various supported INGOs provided safe abortion services and post-abortion care. The majority of supported multilateral organisations had health-system strengthening components in their programmes. Various Dutch embassies in target countries funded health-sector support programmes, the largest of which were in Ethiopia, Mozambique and Mali, jointly accounting for EUR 199 million during the evaluation period:

- In Ethiopia, the Dutch embassy supported the MDG (Millennium Development Goals) and SDG Performance Funds with EUR 84 million from 2012 to 2020. These contributions were used to support health-sector development programmes of the Ethiopian Ministry of Health.
- During the evaluation period, the Netherlands contributed EUR 60 million to the health-sector support programme in Mozambique. An evaluation showed that training capacity of the Ministry of Health had improved and the shortage of human resources decreased, although concerns about the quality of training and graduates remained.[clxii] The current programme (2018–2024) is managed by the GFF.
- The Netherlands has between 2012 and 2021 contributed EUR 56 million to the health sector in Mali through consecutive sector support programmes and results-based financing.[clxiii] [102]

Broadly speaking, the activities implemented in this results area can be divided into two groups:

1. **Direct SRH service delivery.** This includes prevention, diagnosis, counselling, treatment and care for issues related to sexual and reproductive health, such as contraception, pregnancy, HIV, STIs and safe abortion. Direct SRH service delivery takes place at facilities of service-providing organisations supported by the ministry, or via mobile clinics or door-to-door outreach by community health workers.
2. **Health systems strengthening.** In terms of improving SRH services, activities included efforts to make existing SRH services more responsive to the specific needs of youth or key populations, sensitising health-service providers to key population-friendly procedures and guidelines, and providing training for these providers on safe abortion and post-abortion care to reduce abortion-related stigma and promote safe and respectful care. Health-sector support programmes generally contributed to health systems strengthening by supporting existing government programmes, for instance to achieve global targets on maternal and child health.

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[100] Safe abortions are those that use a WHO-recommended method appropriate for the duration of pregnancy and are carried out by a trained provider. This includes medical and surgical abortions.
[101] The abortion case-fatality rate fell from 315 per 100,000 in the year 2000.
[102] The evaluation of the Programme de Développement Sanitaire et Social focused largely on operational and structural recommendations for future programming of financing healthcare and RBF.

Two assumptions underly the ministry's activities in Result area 3:
1. Making additional SRH services available leads to increased use of services and improved SRH outcomes, including those for young people and key populations.
2. Strengthened health systems can have positive and lasting effects on the sexual and reproductive health and rights of people, including young people and key populations.

6.3.3 Evidence base

The findings from systematic reviews used in the Evidence & Gap Map suggest:
- There is substantial evidence that community-based interventions concerning reproductive health increase care-seeking, improve maternal health, increase contraceptive use and ART adherence in low- and lower-middle-income countries.[clxiv] [103]
- Interventions to strengthen health systems (including training health workers, providing health equipment and enhancing human resources) improves mother- and child-health outcomes in sub-Saharan Africa. These interventions can also be cost-effective.[clxv]
- Previous IOB evaluations on general and sector budget support found that budget support contributed to increased domestic health expenditure. The studies found a positive relationship with health outcomes and concluded that particularly the poorest groups benefited from improved health services.[clxvi]
- The evidence on the effects of interventions that aim to make SRH services more responsive to the specific needs of young people is inconsistent and it is unclear whether such interventions lead to improved SRH outcomes.[clxvii]

6.3.4 Findings

Direct delivery of SRH services

During the 2011–2015 subsidy frameworks, 17 out of the 21 supported projects included aspects of SRH service delivery.[clxviii] In line with Dutch policy, service-delivery components in the 2016–2020 partnership projects were relatively small in scale and often meant to complement lobbying and advocacy efforts. Among the results reported at the output level were:
- number of people who received SRH services;
- number of people reached with community mobilisation campaigns;
- number of outreach clinics supported.

When taking the broad evidence base behind community-based reproductive health interventions (see Subsection 6.3.3) into account, it appears likely that direct SRH services contributed to improved SRH outcomes for users of the services.

The Bridging the Gaps II project (2016–2020) was to contribute to halting the spread of HIV/AIDS among key populations, defined as LGBT people, people who use drugs and sex workers.[104] The final evaluation showed that the project provided HIV testing services to over 250,000 members of key populations and treatment services to more than 100,000 people. The project's main focus was on a community-led response, and it aimed to integrate this with public health services. For instance, in Nairobi the project opened a community-led clinic for HIV prevention, treatment and care for male sex workers and MSM.[clxix] This clinic assisted over 6,000 individuals from key population communities and played a vital role in fostering dialogue between community-led organisations and the government. According to the evaluation, the Kenyan government has approved the establishment of community-led clinics for key populations based on this clinic's success.

Although the focus in the Get Up, Speak Out! partnership programme was not on service delivery, the project did provide SRH services to young people.[clxx] [clxxi] In Uganda, GUSO provided commodities for family planning and pregnancy test kits to health facilities. In addition, the project supported peer educators and village health teams to mobilise communities during outreach activities.[clxxii]

103 Community-based health interventions generally extend SRH services beyond health facilities, for example by engaging community groups in participatory health activities, through home visits, and by the presence of community health workers or mobile services.

104 The project, led by Aidsfonds, had a budget of EUR 51 million and was active in 16 countries.

Services provided by INGOs generally operated on a larger scale. Various INGOs supported by the Ministry of Foreign Affairs provided SRH and abortion services and post-abortion care in low- and lower-middle-income countries:

- Between 2016 and 2021, the ministry accounted for 8% of all donor contributions received by Ipas.[clxxiii] In 2021, the health facilities supported by Ipas provided 468,000 women and girls with abortion services and post-abortion care.[clxxiv]
- The ministry contributed 1.8% of all resources of MSI Reproductive Choices (previously Marie Stopes International) between 2013 and 2021.[clxxv] Through partnerships across 37 countries, in 2021 MSI Reproductive Choices provided 4 million clients with safe abortion services and post-abortion care.[clxxvi]
- During the evaluation period, the ministry provided EUR 107 million to Population Services International (PSI). The Dutch contribution between 2016 and 2021 represented about 1.6% of the organisation's total expenditure.[clxxvii] In 2021, PSI reached 1.4 million women with safe abortion products and services.[clxxviii]
- During the evaluation period, the Netherlands accounted for 3–5% of the annual contributions to the International Planned Parenthood Federation (IPPF).[clxxix] In 2021, IPPF delivered a total of 4.5 million abortion-related services, including 583,000 clinical abortion services.[clxxx]

Health systems strengthening

For years, the ministry has advocated for increased focus on health systems strengthening in the multilateral organisations and international funds it supports. Since 2018, the GFF has been an important vehicle for the ministry to contribute to health systems strengthening.[105] The GFF is a financing platform that aims to catalyse additional funding for SRHR and reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N) in 67 low- and lower-middle-income countries.[106] According to the GFF, 30% of its funds goes to family planning, something the Netherlands Ministry of Foreign Affairs had advocated prior to joining the GFF. Since 2018, the ministry allocated EUR 78 million to the GFF, which is about 4% of all contributions received by the GFF since 2015.[clxxxi]

The GFF's main approach is to work with partner countries to develop investment cases, which are comprehensive plans outlining the country's health and nutrition priorities and strategies. It aims to create a financing platform that can leverage additional funds from various sources, including concessional financing from the World Bank, domestic governments, international donors, and private-sector investments. However, there is no evidence that the GFF has catalysed additional domestic health funding.[107] A comparative analysis of the GFF in seven countries has demonstrated that although the mechanism was expected to unlock additional domestic resources for RMNCAH-N, there was no evidence that this actually happened.[clxxxii] A recent publication also noted that Country Platforms, the main governance structure of the GFF in-country, do not function effectively and that civil society organisations are often not meaningfully included in the process.[clxxxiii]

Multilateral organisations and international funds contributed substantially to the increased availability, quality and use of SRH and health services in low- and lower-middle-income countries. Thematic evaluations of UNFPA, UNICEF, the Global Fund and Gavi programmes concluded that while short-term results were achieved, the programmes were not consistently integrated into broader health systems.[clxxxiv]

Since the launch of its new funding model in 2014, the Global Fund has focused on directly contributing to the strengthening of in-country health systems.[clxxxv] [108] Recent activities included training the health workforce, improving surveillance, diagnostics, laboratories or improving community systems and

[105] According to the ministry, the added value of the GFF was that it stimulates investments in mother and childcare, including SRHR, by national governments themselves. In this way, GFF contributes to a sustainable anchoring in national policy of sexuality education, contraception and the prevention of gender-based violence as well as to strengthening of basic health care (Ministerie van Buitenlandse Zaken, 'Memorie van Toelichting', 2018, p. 15, 51-52, 54-56).

[106] It provides small grants from the GFF Trust Fund to countries which enables the use of concessional loans and grants from the World Bank to leverage private sector finance and generate increased domestic resource mobilisation for health.

[107] To date, there has not been a formal evaluation of the GFF.

[108] The Fund both distinguished *direct* investments in resilient and sustainable health systems (via stand-alone or cross-cutting HSS modules within disease grants), from *contributory* investments (disease-specific programmes that also benefit health systems), together accounting for 27% of total Global Fund investments

responses.[clxxxvi] However, most of the Fund's investments in health systems were used for operational costs and short-term system support for combating AIDS, tuberculosis and malaria rather than longer-term investments supporting the resilience and sustainability of the health system.[clxxxvii] According to the Global Fund's Strategic Review 2020, therefore, its investments can only be expected to make a marginal contribution to resilient and sustainable health systems.[clxxxviii] In addition, a Global Fund programme that aimed to reduce HIV infections among adolescent girls and young women also had weak linkages to the national health system, including national health plans, other disease programmes and coordination platforms and, as a result, missed opportunities for achieving integrated service delivery.[clxxxix]

Between 2008 and 2016, Gavi provided USD 239 million in grants for strengthening health systems to address bottlenecks in the delivery of maternal and child-health services and immunisation. According to an evaluation, this positively contributed to government capacity, planning and human resources in various countries. However, the evaluation also noted that grants for strengthening health systems suffered substantial delays in implementation and that country-programme management had been poor.[cxc] In 2016, Gavi launched a health system and immunisation strengthening framework. Gavi currently does not use specific indicators to measure whether vaccination is integrated with other primary healthcare services, however.[cxci] [109]

Various NGO projects worked on improving existing services through training health workers on issues such as youth friendliness, rights, gender, prevention of child marriage, and female genital mutilation (FGM). These organisations often reported how many healthcare providers they trained on youth-friendly services.[110] [cxcii] At times, the implementing organisations organised monitoring visits (anonymous or announced) or provided score cards to check the youth-friendly attitude, scope of information, and/or level of privacy provided at health centres with trained staff. Among these was the Jeune S3 project. During monitoring visits, targeted health services in the Democratic Republic of Congo in 2017 initially scored 41 (out of 100) on youth friendliness; this figure increased to 73 in 2020. One of the challenges identified was that clients were not informed about the full package of contraceptives: they were only informed about long-term contraceptive methods if they asked about it.[cxciii]

A few programmes also aimed at measuring user perceptions. The Marriage, No Childs Play project in Pakistan engaged with female health workers and doctors in healthcare facilities to remove barriers for young people in accessing healthcare. Nevertheless, girls' perceptions of the services offered did not improve significantly between baseline and endline.[cxciv] For the GUSO project, endline respondents' views on whether health workers were friendly or not were mixed.[cxcv]

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[109] Gavi measures the integration of immunisation delivery into health services by taking the proportion of countries that meet the Gavi-defined benchmark for integrated delivery of antenatal care and immunisation services at PHC level. A country meets this benchmark if coverage levels for four interventions – antenatal care, administration of neonatal tetanus, pentavalent and measles vaccines – are within 10 percentage points of each other and are all above 70%.

[110] According to the respective final reports, the Her Choice project has trained 11,210 providers and the Marriage, No Childs Play project reported training 2,850 providers. The GUSO project has trained 6,950 healthcare providers and Jeune S3 has trained 580. Supported INGOs generally provided training on safe abortion. PSI reported training over 1,600 health providers on safe abortion and post-abortion care in the Ignite project from 2016 to 2020, as well as providing both technical training and value clarification workshops.

6.4 Result area 4: More respect for the sexual and reproductive rights of all people, including those of marginalised groups

Key takeaways

In most Dutch target countries, sexual and reproductive rights of key populations and the rights to safe abortion remain largely restricted. Tolerance towards LGBTIQ+ persons remains limited (see Subsection 6.4.1). The Netherlands aims at tackling these issues by supporting organisations to conduct lobbying and advocacy, undertake awareness-raising activities and conduct capacity strengthening of CSOs focused on lobbying and advocacy (see Subsection 6.4.2).

The first underlying assumption of Dutch policy on this is that providing people with information can lead to changes in attitudes and acceptance of sexual and reproductive rights for all people. However, the literature does not support this assumption (see Subsection 6.4.3), suggesting that interventions focusing on awareness-raising alone may not be sufficient to improve the SRHR of the target population. Project evaluations provide little additional insights (see Subsection 6.4.4).

Two other assumptions underlying policy for this result area are that (i) capacity strengthening efforts for CSOs can enhance the effectiveness of their lobbying and advocacy efforts, and that (ii) these efforts can effectively contribute to improved SRHR for all people.

There have been very few efforts to measure whether the capacity of supported CSOs increased or not, making it unclear if the first assumption is valid. Conversely, the literature suggests that providing core funds to CSOs can promote local ownership and autonomy, enabling them to conduct advocacy more effectively when compared to project-based support. For the second assumption, existing evaluation reports do not convincingly show that the supported lobbying and advocacy efforts have contributed to improved SRHR outcomes.

6.4.1 Description of context: state of affairs

Women's SRHR can be violated in many ways, such as denying access to services, requiring third-party authorisation for access to services, forced sterilisation, FGM or early marriage.[cxcvi] For LGBTIQ+ persons, systemic barriers such as lack of legal recognition, stigmatisation, discrimination and violence can exacerbate their rights violations, even in medical and educational settings.[cxcvii]

International agreements often refer to 'SRH' (sexual and reproductive health), leaving out the 'R' for 'rights', which can result in failure to protect, respect and fulfil the sexual and reproductive rights of women and key populations.[cxcviii] For instance, the SDGs refer to SRH and reproductive rights (RR), thus limiting the scope of SRHR, and don't mention sexual rights, safe abortion, or sexual orientation and gender identity (SOGI).[cxcix]

In all Dutch SRHR target countries, same-sex marriages are illegal, and in over half of these countries, same-sex sexual acts are criminalised. During the evaluation period, only Mozambique legalised same-sex sexual activity, in 2015.[cc] Sex work is also typically criminalised, with selling and/or buying sexual services being illegal in most countries.[cci] In addition, access to safe abortion remains restricted in most Dutch SRHR target countries. The legal status of abortion has, however, little influence on the abortion rate, as restrictions often force women to take legal and physical risks to seek abortion.[ccii] Since 2012, the legal grounds for abortion have been expanded in Mozambique (in 2014) and Benin (in 2021).[cciii]

Restricted sexual rights in many countries often coincide with limited tolerance towards LGBTIQ+ individuals. Household surveys conducted in 34 sub-Saharan African countries have shown that the overall tolerance towards LGBTIQ+ persons was low, with an average of approximately 20% in 2018.[111] This figure has remained relatively unchanged since 2014, with minor variations observed at the country level. Notable exceptions among Dutch target countries were Mozambique on the one hand, which in 2018 scored well above average at 48%, and on the other hand Uganda and Burkina Faso, which exhibited particularly low levels of tolerance at 3% and 8%, respectively.[112]

6.4.2 Policy

The fourth result area of the Ministry of Foreign Affairs' policy on SRHR focuses on increasing respect for the sexual and reproductive rights of all people, including marginalised groups, by creating awareness and promoting conducive policy and legislative environments. Most NGO projects implemented activities under this result area, as well as, to a lesser extent, INGOs, UNAIDS and the Global Fund. Broadly speaking, there three types of activity are undertaken:

1. **Awareness.** In order to increase respect for the sexual and reproductive rights of all people, NGO partners organise awareness-raising activities on this topic. Activities include organising community dialogues, engaging traditional and/or religious leaders and communicating through traditional and social media.
2. **Capacity strengthening of civil society organisations.** In the partnership programmes, alliance partners and sometimes national CSOs provided training for local and national CSOs included in the partnership programmes. Training focuses on a wide array of topics, ranging from lobbying and advocacy skills to governance and financial management.
3. **Lobby and advocacy.** These activities include lobbying at the regional and global level, such as the East African Countries SRHR bill and the Human Rights Council. In addition, these activities encompasses direct engagement with (national or sub-national) government officials, with the intention of influencing policy and legislation on sexual and reproductive rights. Examples include advocating for de-criminalisation and de-stigmatisation of key populations or access to safe and legal abortion.

Assumptions underlying Results area 4 include:
1. Providing people with information can alter their attitudes and acceptance of sexual and reproductive rights for all people.
2. Capacity strengthening of CSOs can enhance the effectiveness of their lobby and advocacy.
3. Lobby and advocacy efforts of CSOs can effectively contribute to improved SRHR for all people.

An important prerequisite here is that there is sufficient civic space for the CSOs being supported to operate freely and that national and sub-national authorities are receptive to the lobby and advocacy efforts of the supported organisations, which is not always the case. Civic space is under pressure worldwide, as outlined in Section 2.3.

6.4.3 Evidence base

The existing literature on rights-based approaches to SRHR in low- and lower-middle-income countries is limited and may be subject to bias,[113] which underlines a need for caution in interpreting the available studies.[cciv] There are only a few studies on advocacy approaches that address gender and power imbalances for women living with HIV.[ccv] Evidence suggests that interventions focused solely promoting awareness of rights may not be sufficient to improve SRHR. There are some studies that show that embedding advocacy or awareness-raising activities within multifaceted programmes that also include service delivery has contributed to improved SRHR outcomes.[ccvi]

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[111] Tolerance is measured as the proportion of people who responded 'would strongly like', 'would somewhat like' or 'would not care' to the question *'Please tell me whether you would like having people from this group as neighbors, dislike it, or not care.'* See: B. Howard, ''All in this together': Africans tolerant on ethnic, religious, national, but not sexual differences, Afrobarometer Dispatch No. 362', 19 May 2020.

[112] The results show that education is associated with higher levels of tolerance, with only 11% of respondents without formal education expressing tolerant views towards LGBTIQ+ persons, compared 27% with post-secondary education.

[113] According to the authors, all studies were classed as having a high, serious or critical risk of bias, meaning that because of issues with the quality of the studies, there was a substantial risk that included studies over- or under-estimated the actual effect of the interventions.

In terms of capacity building for CSOs working on SRHR in low- and middle-income countries, the evidence is scarce, with no systematic reviews identified in the Evidence & Gap Map.[ccvii] The literature suggests that providing core funding to CSOs, instead of project-specific funding, can promote local ownership and autonomy, allowing these organisations to conduct advocacy more effectively.[ccviii]

6.4.4 Findings

Awareness

Several NGO partnerships projects included efforts to increase awareness of sexual and reproductive rights at the community level. Outputs reported included:

- number of awareness-raising, community sensitisation activities or the number of people reached through these activities;
- number of people reached through media activities, including social media;
- number of dialogue sessions conducted;
- number of community, traditional and/or religious leaders reached or trained.

Community awareness-raising interventions that focused on the sexual and reproductive rights of marginalised groups such as LGBTIQ+ people or sex workers were rare, although some projects organised media activities on these issues. Most community sensitisation or dialogue activities focused on the SRHR of young people and addressed issues such as teenage pregnancy, child marriage or sexual exploitation of children – see also Section 6.1. The Her Choice project and the Marriage, No Child's Play project organised awareness-raising sessions on child marriages during baptisms and weddings, and held court-yard meetings and door-to-door visits.[ccix]

It is generally unclear how effective awareness-raising activities have been, based on project evaluations. According to the final evaluation of the Marriage, No Child's Play project, the proportion of girls who had ever been married decreased faster in the intervention area compared to the control area in one of the four countries, but there were no significant differences in the other three countries.[ccx] For the Her Choice project, researchers also collected intermediate outcome data in intervention and comparison areas. Because of ethical considerations, however, the implementing organisations also started project activities in the comparison areas after the MTR.[ccxi] [ccxii]

Various Ugandan community members interviewed for this evaluation didn't understand why healthcare workers, supported by NGO partnership projects, conducted community awareness sessions or information outreach without offering actual services or commodities.[ccxiii]

Capacity strengthening of civil society organisations

The supported SRHR partnership projects aimed to strengthen the capacity of national and local CSOs in lobbying and advocacy. Some partnerships reported output-level results such as the number of CSO training sessions and staff trained. Training generally focused on lobby and advocacy strategies or networking, but more practical skills were also included, such as proposal writing and financial accountability.

It remains unclear to what extent capacity building has been effective. None of the final evaluations had performed independent organisational capacity assessments of the CSOs supported. Some evaluations didn't focus on the capacity of the supported CSOs at all, while others depended on self-reported assessments, mostly without baseline information.

Lobby and Advocacy

Through previous and current NGO partnership projects, the ministry aimed to support lobby and advocacy for sexual and reproductive rights. Lobby and advocacy are defined as instruments and strategies used in order to place or keep issues on the political or corporate agenda and to achieve sustainable policy changes. This can take place at the local, national, and international level.[ccxiv] As there was no thematic earmarking within the partnership projects, the advocacy focus varied substantially and projects were not equally active on the rights of LGBTIQ+ people or safe abortion. The final evaluation of the Health System Advocacy Programme (HSAP), for example, observed that the project had not put forward a rights-based perspective for SRHR because consortium partners lacked a shared advocacy agenda on SRHR and intended to work within the parameters of existing laws.[ccxv]

Four out of the 10 partnerships (in the period 2016–2020) explicitly addressed the rights of LGBTIQ+ people. Documentation of two of these projects mentioned challenges in addressing LGBTIQ+ rights due to political constraints and restricted civic space.[ccxvi] [114] Other topics addressed in the advocacy work of partnership projects were child marriages (three projects) and child sexual exploitation (one project). Box 4 presents the focus of lobby and advocacy in partnership projects active in Uganda.

Box 4. *Focus of lobby and advocacy in Uganda*

Seven partnership projects were actively lobbying on SRHR issues at the national level in Uganda between 2016 and 2020, focusing mostly on CSE, increasing government expenditure on health, abortion, the anti-FMG bill, the narcotic drugs bill and the Medically-Assisted Therapy programme for treating substance use disorder.[ccxvii] Although various supported partners contributed to the finalisation of the sexuality education framework of the Ugandan government, partners largely saw the framework as a setback, because it was not comprehensive. Efforts to convince the government to increase domestic health expenditure have not been successful – see Section 9.4.

Supported INGOs and NGOs reported extensively on advocacy-related results, including:
- number of meetings with policy-makers or parliamentarians;
- number of advocacy products or documents developed and/or disseminated;
- number of government officials trained, including judiciary and police staff.

Several supported NGOs additionally reported at the intermediate outcome level, such as on the number of laws or policies influenced. IPPF reported to have contributed to 121 policy and legislative changes in support of SRHR and gender equality in 2021.[ccxviii] [ccxix] Notable results include the expansion of legal grounds for abortion in Benin and the de-criminalisation of abortion in Northern Mexico. Ipas reported to have contributed to 77 policy changes in 15 countries, including the legalisation of abortion in Benin.[ccxx] An important limitation of these reported results is that they are self-reported and may therefore be subject to bias. Furthermore, it almost always remains unclear as to what extent the observed policy changes can – at least partially – be attributed to the activities of the respective NGO, and, if so, how strong the contribution was.[115] A similar issue exists with lobby and advocacy-related activities of multilateral organisations. Although UNAIDS' annual reports present important legislative and policy changes around the world, they do not highlight whether, and if so, how, UNAIDS contributed to these changes.[ccxxi]

Only a few evaluations thoroughly substantiated the effects of advocacy activities across the board, and it remains largely unclear how effective the lobby and advocacy approach has been.[ccxxii] The evaluation of the Bridging the Gaps project provided some relatively well-substantiated illustrations.[ccxxiii] It showed, for example, that the Kenyan government was initially unwilling to address transgender issues. Throughout the implementation of the project four national partners advocated for the recognition of transgender persons in the National AIDS Strategic Framework. One of the supported partners hosted conversations between the government and transgender persons. These activities led to the adoption of the WHO blueprint for transgender healthcare. As a result, government services now recognise trans men and trans women. The report concluded that this brought about an increase in the use of health services among transgender people.[ccxxiv]

[114] For example, one indirectly supported national NGO in Uganda that advocated for the rights of sexual minorities was de-registered by the authorities in 2022, purportedly because their name did not conform to national regulations. Consequently, the organisation had to halt its operations, suspend workshops and awareness-raising activities, and close its headquarters.

[115] Although it is challenging to evaluate lobby and advocacy programmes, there are various qualitative evaluation methodologies suitable for establishing the contribution of lobby and advocacy-related interventions. For more guidance, see Waddington et al., 'The effectiveness of support to lobby and advocacy'.

6.5 Coherence between the four result areas

Key takeaway

The ministry expects that the implementing organisations connect their activities in the different results areas at the national and local levels. The literature shows that this would indeed lead to better SRHR outcomes (see Subsections 6.1.3 and 6.4.3). Although there are examples of SRHR partnership projects linking access to information services, the available evidence is not always clear as to whether the different activities were actually linked at country level (see also the limitations described in Subsection 1.2.3).

The intention of Dutch policy is that the activities supported through the different result areas work together at national and local levels. This approach is supported by existing literature. For instance, research indicates that provision of SRHR information is more effective when integrated with health services (see Subsection 6.1.4). And incorporating advocacy interventions within comprehensive programmes that offer services also appears to be more effective than stand-alone advocacy interventions (see Subsection 6.4.4). This section briefly describes some interlinkages between result areas within the same projects. Chapter 8 discusses the coherence between different projects and instruments.

Project documentation shows that for several SRHR partnership projects providing access to information was linked to providing services. In some projects, the organisations intended to strengthen referral systems between education and health services.[ccxxv] The evaluation of the GUSO project concluded that the project's multi-component approach effectively improved access to SRHR information and education services and created an enabling environment for young people.[ccxxvi] The project's education interventions also included information about services provided in nearby youth centre clinics or health centres.[ccxxvii] [116] The evaluation of the Jeune S3 project also identified synergistic effects between different pathways in the project, including knowledge skills and youth voice. In the Yes I Do Alliance (YIDA) project, local healthcare providers were invited to visit schools to provide information and encourage young people to seek services at facilities.[ccxxviii] In some contexts, supply could not meet the newly created demand for SRH services, causing some participants to lose motivation.[ccxxix] A similar problem had been identified in the MNCP project. The final report noted that although the SRHR knowledge of participants had increased, there was a persistent lack of youth-friendly SRH services that prevented participants from making informed decisions.[ccxxx] From the M&E reports it was not always clear whether the various Dutch-supported activities were actually linked at the country level (see limitations described in Subsection 1.2.3).

Dutch support to the NGO sector increasingly focuses on lobby and advocacy. Whereas the previous SRHR partnership projects could deliver services, [ccxxxi] the main focus in the current partnership projects is on strengthening the capacity of CSOs in lobby and advocacy. Services delivery can only be included if these contribute to lobby and advocacy and if they are in the interests of either young people or people whose sexual and reproductive rights are currently denied.[ccxxxii] Similarly, Ugandan NGOs and CSOs staff also questioned the main focus of projects on lobby and advocacy, highlighting the need to also provide SRH services.[ccxxxiii]

[116] In similar fashion, the Jeune S3 project also aimed to actively implement different SRHR activities within the same communities with the intention of achieving synergies between the result areas. The project's evaluation concluded that, indeed, there were synergistic effects between the project's pathways, including focusing on knowledge, skills and youth voice and confidence.

6.6 Gender mainstreaming

Key takeaway

Half the evaluations of supported SRHR partnership projects (in the period 2016–2020) and various evaluations of multilateral organisations did not assess the extent to which gender had been mainstreamed in the project's design or implementation. Findings from evaluations that did examine gender mainstreaming revealed a mixed picture, leaving room for improvement.

6.6.1 Policy

The Ministry of Foreign Affairs has maintained a gender-mainstreaming strategy for decades and reconfirmed its importance in the 2018 development policy note.[ccxxxiv] In 2022 the ministry announced its intention to pursue a feminist foreign policy, further enhancing the gender mainstreaming approach and making equal rights and equality the main focus of all aspects of Dutch foreign policy.[ccxxxv]

Gender mainstreaming is a strategy that aims to achieve gender equality and combat gender-based discrimination. It entails integrating a gender perspective into the preparation, design, implementation, monitoring and evaluation of policies and decision-making of organisations, governments and programmes. By incorporating the concerns and experiences of different genders, mainstreaming gender aims to derive equal benefits for all, without perpetuating inequality.[ccxxxvi] [ccxxxvii] The ministry assumes that its implementing partners to operationalise gender mainstreaming in their project design and implementation.

6.6.2 Findings

Five project evaluations of the 10 SRHR partnership projects did not refer to the extent to which gender had been mainstreamed in their projects. The evaluation findings from the other five strategic partnership projects present a mixed picture, as Box 5 shows.

Box 5. *Evaluation findings on gender mainstreaming*

Bridging the Gaps II	Gender was clearly a core issue in the Bridging the Gap project, but according to the evaluation gender-sensitive approaches and gender-transformative outcomes were not always clearly defined. The evaluation noted that the male-female binary construct is harmful and should be replaced, also when attempting to disaggregate data for M&E purposes.
Yes I Do Alliance	The evaluation concluded that the project was designed in a gender-transformative way to address causes of inequality, for example by challenging discriminatory social norms.
Jeune S3	The evaluation only makes few remarks about gender, but it concludes that by not separating young people by gender might have affected quality of implementation, because young girls faced difficulties in putting questions to male teachers or educators.
Health Systems Advocacy Partnership Project	Gender and inclusivity were initially not part of the project. In 2019, a gender specialist was hired to integrate gender-sensitivity into the project. Given this late introduction, the evaluation could not assess the effectiveness of the approach, but according to the evaluation, the project did not address discrimination, exclusion or intersectionality.
Partnership to Inspire, Transform and Connect the HIV response (PITCH)	Gender-sensitive and transformative approaches were not built into the project from the start and were not integrated within the M&E framework. Partners lacked guidance and the implementation depended strongly on the individual capacity of partners. In 2018, the project allocated human and financial resources to gender mainstreaming, which led to increased gender-sensitive and transformative approaches, although there were considerable differences in quality among partners.

Several evaluations of multilateral organisations and international funds discussed the quality of gender analyses and gender-transformative approaches. An evaluation of UNFPA's capacity in humanitarian action found that the organisation often did not use gender analysis,[ccxxxviii] but another mentioned some examples of gender-transformative programming in UNFPA's support for the prevention of GBV.[ccxxxix] The gender analysis used by the Global Fund had been labelled as inadequate by evaluators, because it lacked age-disaggregated data and social and cultural factors.[ccxl] In practice, funding requests to the Global Fund were often gender blind.[ccxli] An evaluation of Gavi's gender policy concluded that some progress had been achieved with respect to gender programming guidelines and integrating gender issues in application templates, but no examples of gender-transformative approaches were found.[ccxlii]

6.7 Target groups

Key takeaways

Despite the pledge in 2013 to incorporate a more explicit poverty focus in Dutch SRHR policy, this did not materialise. This evaluation reveals that supported NGO projects, multilateral organisations and international funds faced challenges in reaching the economically most-vulnerable individuals.

The ministry also operates under the assumption that NGOs are able to reach groups that are most difficult to reach. However, although various NGO projects implemented outreach activities targeting key populations, it remains unclear whether this was effective or not.

6.7.1 Policy

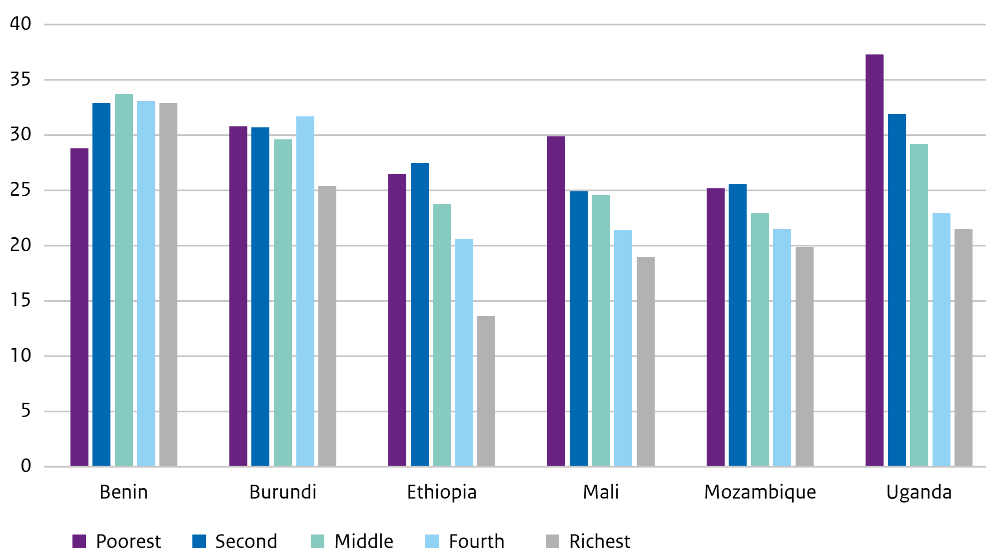
This section takes stock of the different target groups identified in Dutch policy and the extent to which the supported activities have successfully reached key populations and people of lower socio-economic status.

Although Dutch policy focuses on 'key populations', it does not clearly define who these are. The term key populations generally refers to people that experience additional barriers in realising their SRHR. The ministry's most recent ToC mentioned LGBTIQ+ people, sex workers and people who inject drugs among its key populations. The ToC also mentions child brides, young people and women who have abortions as groups that face challenges.

In 2013, IOB's previous SRHR policy evaluation advised the ministry to pay more attention to inequalities in access to SRHR commodities and services.[ccxliii] The minister's policy reaction indicated that inequality and effects on the 'poorest of the poor' would be incorporated in the design of new SRHR programmes and in related programming and monitoring. The new ministry's ToC, however, does not specifically refer to the socio-economic status of the intended target population.[ccxliv]

Currently, none of the low- and lower-middle-income countries have universal healthcare and access to healthcare continues to be impeded by high out-of-pocket expenditure, especially for the poorest segments of the population.[ccxlv] Recent research indicates that pro-rich coverage patterns for several SRHR indicators continue to exist.[ccxlvi] This is also the case in the ministry's SRHR target countries; Figure 7 shows that the unmet need for family planning is higher among poorer groups of the population in most target countries.

Figure 7. *Unmet need for family planning (proportion, in % of married women) by wealth quintile*[ccxlvii]



The 2018 ToC indicated that the ministry assumed that NGOs could contribute to change in SRHR in a way that government and international organisations could not. According to the ToC, they have a special role to play in, amongst other things, networking with local CSOs and in approaching groups that are more difficult to reach.[ccxlviii]

6.7.2 Findings

Key populations

The synthesis evaluation of the 2011–2015 NGO projects found that most of the 21 projects didn't have outreach for specific (key population) subgroups and tended to exclude the more vulnerable adolescents.[ccxlix] Different partners used different definitions of 'key populations' and some also included 'vulnerable' and 'marginalised' people, although it often remains unclear how these groups were defined. Although various SRHR partnership projects (2016–2020) did have strategies to reach specific key populations, none of the evaluations assessed if these efforts were successful in practice.

During various interviews with representatives from key populations in Uganda, IOB's consultants noted occasional problems with 'tokenism': there were instances where national and local CSOs symbolically included LGBTIQ+ populations in their proposals to appease donors, but without meaningfully including them in the activities.[ccl]

Socio-economic status

Poverty is an important barrier that prevents access to SRH services; various Ugandan sex workers interviewed for this evaluation indicated that, although they were provided with PrEP through development initiatives,[117] they did not take their pills regularly because the medicine was difficult to take on an empty stomach.[ccli] Lack of resources for transport was also mentioned by various interviewees in Uganda as an important barrier to access health and SRH services.[cclii]

There are various indications that the SRHR projects supported by the ministry had difficulties in reaching people of lower socio-economic status. The evaluation of the YIDA project highlighted that needs of certain marginalised groups were not well addressed by the project and that despite efforts to include out-of-school youth, it was a challenge to reach them.[ccliii] In similar fashion, the Generation Breakthrough project in Bangladesh also discontinued its youth-club component, because in practice it was difficult to reach out-of-school adolescents.[ccliv] Several interviewees with CSOs in Uganda also indicated that the poorest segments of the population were often not reached through SRHR projects. One representative from a local CSO indicated that it was necessary to link SRHR project to economic

[117] PrEP (Pre-exposure prophylaxis) is a preventive approach used to reduce the risk of contracting HIV before exposure to the virus occurs. It involves the regular use of antiretroviral drugs by individuals who are at high risk of HIV infection.

empowerment activities to engage young girls at risk of becoming sex workers because '*you can't eat policy change*'.

Evaluations of multilateral programs and international funds also mention concerns about getting resources to populations most in need,[cclv] with the Global Fund's Strategic Review 2020 concluding that efficiency and/or effectiveness considerations appear to have taken precedence over equity considerations in the design of grants. The review suggested that that 'a reprioritization of Global Fund resources for the current and next strategic period' should focus on the poorest and most-vulnerable communities, whose economic circumstances exacerbated their susceptibility to COVID-19, but also to HIV, TB and malaria.[cclvi]

UNFPA's Supplies Partnership did not specifically target any of the key populations of Dutch SRHR policy. On paper, it focused on remote, poor and marginalised women, girls and youth – referred to as 'last mile' distribution. In practice, however, ensuring delivery of reproductive health and family planning commodities to 'the last mile' had not been easy. The mid-term evaluation of UNFPA's Supplies Partnership concluded that 'last mile' distribution has been a major weakness in the programme and that distribution to primary healthcare units was difficult due to fragmented supply chains, lack of funding for in-country distribution and poor infrastructure in national and local warehouses.[cclvii] [cclviii]

The UNFPA-UNICEF Global Programme to Accelerate Action to End Child Marriage experienced similar challenges in reaching 'the most vulnerable', even though it generally targeted areas 'with the highest prevalence of child marriage, sometimes combined with other indicators of vulnerability such as socio-economic indicators, high rates of teenage pregnancy and out-of-school girls and poor access to services'.[cclix] The UNFPA-UNICEF Joint Programme on FGM also outlined practical challenges in reaching the most marginalised population due to logistics and security concerns, as well as procedural issues of working with CSOs.[cclx]

7 Efficiency

This chapter examines the efficiency of interventions supported through the Dutch policy on SRHR. Efficiency, as defined by the OECD-DAC, refers to the extent to which an intervention delivers or is likely to deliver results in an economic and timely way. Therefore, this chapter considers elements of economic efficiency, operational efficiency and timeliness.[118] Section 7.1 discusses the efficiency of the NGO partnership programmes. Section 7.2 examines the efficiency of international and multilateral organisations and, lastly, Section 7.3 reports on the ministry's programme management of SRHR in terms of efficiency.

Key takeaways

None of the evaluations of supported SRHR projects or programmes included cost-efficiency or cost-effectiveness analyses. Consequently, it is unclear whether the chosen interventions were the most efficient or whether results were achieved in the most efficient manner.

The organisational structure of many NGO partnership projects was complex, involving multiple layers of implementation and numerous stakeholders in different countries. Consequently, these

[118] According to the OECD, '"Economic" is the conversion of inputs (funds, expertise, natural resources, time, etc.) into outputs, outcomes and impacts, in the most cost-effective way possible, as compared to feasible alternatives in the context. "Timely" delivery is within the intended timeframe, or a timeframe reasonably adjusted to the demands of the evolving context. This may include assessing operational efficiency (how well the intervention was managed).' (OECD, Evaluation criteria [website]).

projects faced challenges such as bureaucratic programme management, high indirect costs and implementation delays (Section 7.1).

The ministry operated under the assumption that multilateral organisations and international funds, because of their size, reach and economies of scale, could achieve results that the Netherlands alone could not. This assumption is supported by evidence showing that UNFPA, the Global Fund, and Gavi have successfully leveraged their position through pooled procurement, leading to lower prices for health and SRHR commodities. As a result of the ministry's multi-annual commitments to these organisations, it is likely that it contributed to the achieved economies of scale.

Complex administrative procedures and unpredictable, short-term funding from other donors caused implementation delays for these multilateral organisations and international funds (Section 7.2).

Despite some improvements in recent years, the ministry faced limitations in terms of staff capacity and did not always prioritise programme management sufficiently. As a result, the ministry could not sufficiently play its 'partnership role' and the policy staff had limited insight into project implementation on the ground (Section 7.3).

7.1 NGO partnership programmes

7.1.1 Subsidy frameworks (2011–2015)

The synthesis evaluation of the 21 projects financed through the five subsidy frameworks in the period 2011–2015 concluded that it was impossible to determine whether programme costs were reasonable in relation to outputs achieved.[119] The evaluation mentioned that some partners needed a few years of 'trial and error' before they could successfully implement interventions and found that most outputs were realised towards the end of the projects. It also concluded that working in alliances involved substantial investments in coordination, communication and, therefore, transaction costs.[cclxi]

7.1.2 SRHR partnership programmes (2016–2020)

None of the 10 evaluations of the SRHR partnership projects analysed the cost-efficiency or cost-effectiveness of supported projects and activities. Some evaluations did discuss elements of operational efficiency, however. Those findings are discussed in this subsection.[120]

Bureaucratic programme management

Many of the SRHR partnership projects (2016–2020) had complex operational models and governance structures. This was because the 10 projects operated, on average, in nine countries and on a global level, as well as involving four alliance partners that each worked with their own national and local organisations. Moreover, many of these national and local organisations were not involved in the design phase of the programmes and continued to be bound by annual contracts and activity-based budgets.[cclxii] The layered structure of the partnership projects at times led to complex coordination structures and lack of clarity about responsibilities in various projects.[cclxiii] [121] The evaluation of the Partnership to Inspire, Transform and Connect the HIV response (PITCH) project, for instance, mentioned that the complex organisational structure resulted in confusion about responsibilities and affected the coordination among implementing partners.[cclxiv]

High indirect costs

The complex organisational models of the projects led to high indirect costs. Total expenditure of the

[119] For instance, the final evaluation of the Rutgers' EUR 30 million project called 'Access, Services and Knowledge' (ASK) also concluded that there was insufficient information available to make conclusive statements about the efficiency of the project, in part because partners were not required to report on cost-effectiveness.

[120] According to OECD-DAC, operational efficiency deals with how well the intervention was managed. IOB therefore included elements of human and financial resources in its analysis, by focusing on management structures, logistics and resource allocation.

[121] In similar fashion, in-country data collection in Uganda revealed that various local and national organisations supported through the current round of SRHR partnerships in Uganda also complained about the bureaucracy in the partnerships, which resulted in inefficient implementation.

10 partnership projects was approximately EUR 316 million, with around EUR 100 million not directly allocated to the implementation of interventions but spent on overhead, management, administration, coordination, communication, and monitoring, evaluation and learning (MEL).[122] It is not possible to compare these costs against those of other instruments and programmes because of the unique structure of the partnerships and lack of standardised reporting. Nevertheless, it is IOB's assessment that the allocation of one-third of programme expenditure to indirect costs is very high.

Delays in implementation

Building effective partnerships between the lead organisation, alliance members and national and local organisations took longer than expected and led to delays in implementation. It often took months or even years for partners to agree on a common perception of programme objectives. Building partnerships was particularly difficult if the selected partners had previously not worked together or if the organisations had previously not been active in the country.[cclxv] The final report of the Right Here, Right Now partnership project revealed that it took about a year and a half before the created country platforms and consortium members were sufficiently aligned to be able to actually start their advocacy activities. These findings correspond with more recent observations by the IOB team: during in-country data collection in Uganda and Bangladesh in mid-2022 it became clear that various current SRHR-partnerships (2021-2025) active in those countries were not fully operational.

7.2 International and multilateral organisations

7.2.1 Economies of scale

The ministry's assumption that multilateral organisations and international funds, because of their size, reach and economies of scale, could achieve results that the Netherlands alone could not, is valid. Indeed, international funds and multilateral organisations have been successful in leveraging their position through pooled procurement, resulting in lower prices for health and SRH commodities:

- UNFPA's Supplies Partnership has been able to use its purchasing power to influence global markets by making greater volume commitments, resulting in lower prices.[cclxvi] The Supplies Partnership managed to reduce prices between 8% and 34% compared to the average prices of key commodities.[cclxvii] Predictability and longer-term donor funding could lead to further unit cost reductions as it would help UNPFA's efforts to agree on multi-year commitments with manufacturers.[123]
- The Global Fund has consolidated demand from low- and middle-income countries and procured health commodities such as mosquito nets, contraceptives and diagnostic tests in bulk at favourable prices through its pooled procurement mechanism. In 2019 this resulted in USD 174 million in savings.[cclxviii] According to the Global Fund's 2020 Strategic Review, the majority of the programmes assessed showed gains in economic efficiency in terms of reducing the cost per life saved or infection prevented in the period 2017–2019, but that further gains were necessary and achievable.[124] [125]
- Gavi's Supply and Procurement Strategy contributed to declines in prices of key vaccines, including a 53% decline in the pentavalent market, which resulted in USD 350 million in savings, and more modest price declines in the rotavirus and PCV markets.[cclxix] In 2016, as a result of Gavi engagement and advocacy GlaxoSmithKline announced a 10% reduction in the price of pneumococcal conjugate vaccine to the lowest-ever global price, which had substantial impact because that vaccine represented over 40% of Gavi's vaccine expenditure.[cclxx]

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[122] This figure is based on the financial reports of the 10 SRHR and Dialogue and Dissent partnership projects. It does not include costs for management, coordination, communication or MEL activities that the financial reports labelled as belonging to lobbying and advocacy strategies.

[123] According to the Mid-Term evaluation of the Supplies Partnership, the bridge-fund mechanism only partially addressed this problem. (Charpentier, 'Mid-Term Evaluation of the UNFPA Supplies Programme (2013-2020)')

[124] The report stresses that the results have to be carefully interpreted and noted that there are many caveats to this analysis, such as exclusion of the private sector.

[125] Efficiency gains at the aggregate, portfolio level arose from efficiency improvements in country programmes, which were a function of choices about (a) which services and accompanying health products to provide where and to whom – i.e. allocative efficiency; and (b) how to provide those services, including who should deliver them and what government's role should be – i.e. technical efficiency.

The ministry has contributed to these economies of scale through unearmarked and multi-annual commitments to these organisations. For example, in 2020 the Ministry of Foreign Affairs committed to continue supporting Gavi until 2030, initially with EUR 50 million in core funding and EUR 25 million through the Matching Fund between 2020 and 2026. Similarly, the ministry also committed a total contribution of EUR 156 million to the Global Fund between 2019 and 2022, to be followed by another EUR 180 million between 2023 and 2025.

An evaluation of the Social Development Department's strategy for reproductive health commodities concluded that further efficiency gains could be achieved if large international procuring entities of medicines and health commodities could harmonise their procedures and processes.[cclxxi]

7.2.2 Other efficiency issues

Multilateral organisations and international funds are confronted with several common efficiency issues:

- **Unpredictable, earmarked and short-term donor funding.** In the case of the Supplies Partnership, unpredictable funds from other donors has resulted in funding delays and mismatches between needs and UNFPA allocations at the country level, making it difficult to respond to changing conditions.[cclxxii] [126] Unpredictable donor funding had a similar impact on UNFPA and UNICEF's Joint Programme on the Abandonment of FGM.[cclxxiii] Moreover, the way in which many other donors finance UNFPA, with an increasing share of earmarked funding, affected longer-term programming and interrupted implementation because of the many administrative tasks to be performed (signing agreements, reporting and reconciling accounts). Furthermore, it created pressure to implement activities at year-end, as options to 'carry-over' funds to the next year were limited.[cclxxiv]
- **Internal: complex procedures.** MOPAN's assessment of UNFPA observed that the organisation's complex administrative procedures resulted in administrative delays that negatively affected programme implementation and partnerships.[127] [cclxxv] Similar findings were reported for Gavi, with an evaluation of its CSO model observing that because of Gavi's internal processes (e.g. complex governance structures and management arrangements) disbursements to CSOs were delayed.[cclxxvi] In case of the Global Fund, MOPAN's assessment found that, though generally efficient, there were some inefficiencies in its grant development processes, while weak coordination between and within grants could lead to delays.[cclxxvii] According to Global Fund's 2020 review, working with decentralised government structures affected coordination and led to higher transaction costs.[cclxxviii] While previous lengthy selection and contracting processes had delayed the implementation of health-system strengthening and human rights activities, recent improvements to the Fund's business model have led to more efficient funding-request processes.
- **External: complex environments.** Problems in national supply chains affected the efficiency of the Supplies Partnership for distributing family planning commodities to primary healthcare units.[cclxxix] Moreover, an evaluation of UNFPA's humanitarian response found that UNFPA's supply-chain management was not well-suited to humanitarian situations, which entail higher financial risk to ensure timely supply of commodities.[cclxxx]

[126] Similarly, in its policy evaluation on humanitarian assistance, IOB concluded that predictable multi-year unearmarked funding for UN agencies, Red Cross and NGOs allowed for more efficient and effective aid delivery, thereby responding better to changing needs. See: IOB, Trust, Risk and Learn. Humanitarian Assistance Given by The Netherlands – Funding and Diplomacy 2015-2021, The Hague, Policy and Operations Evaluation Department (IOB), February 2023.

[127] The Multilateral Organisation Performance Assessment Network (MOPAN) is an independent network of member states.

7.3 Programme management

A 2019 IOB study of the ministry's partnership programmes concluded that limited staff capacity within the Ministry of Foreign Affairs was a major constraint on it playing its partnership role.[cclxxxi] [128] This current evaluation agrees with that finding and additionally concludes that programme management was not prioritised sufficiently by the ministry's policy department. As a result of heavy workloads and limited staff capacity, DSO staff regularly prioritise more urgent ad-hoc tasks such as preparing materials for the minister or answering parliamentary questions, leaving less time for programme management.[cclxxxii] Furthermore, some interviewees pointed to a lack of adequate time for substantive in-depth engagement with the projects and programmes that they manage. This, together with the layered organisational structure of central NGO partnership projects (see Section 7.1), resulted in limited insight by the responsible policy officer in The Hague of project implementation in-country. Consequently, it was challenging to assess the reported results or the relationship between budgets, activities and outcomes.

This situation was further exacerbated by the departure of several senior SRHR experts from the policy department within a rather short period of time.[129] Finally, staff rotations at the ministry have meant that throughout their contract periods most organisations have had to liaise with changing contact persons. Interviewees from partner organisations noted that the approach to programme management varied depending on their individual contact person.[cclxxxiii]

The approval process for various types of reports frequently experienced delays, as indicated in Table 8. As the ministry does not track instances for which approval deadlines are put on hold when reporting requirements are not fulfilled by partners, it is not possible to determine the frequency of deadline overruns from the data presented in the table.

Table 8. *Ministry of Foreign Affairs approval-times of reports submitted by SRHR Partnership projects* [cclxxxiv]

	Number of reports	Deadline (weeks)	Fastest approval (weeks)	Longest approval (weeks)	Average (weeks)
Annual plan	40	8	2	35	15
Annual report	28	8	8	63	30
Annual IATI	23	8	7	50	27
Final report	12	13	10	40	29
Final evaluation	10	13	10	42	27

Since 2020, the ministry's DSO has one Full-Time Equivalent (FTE) dedicated entirely to MEL. This has since led to increased attention for monitoring, evaluation and programme management within the department. As a direct result, the department has commissioned independent baseline studies, mid-term reviews, data-quality assessments and third-party monitoring of the ministry's strategic partnership projects, including SRHR partnership projects at the country level in four countries: Burkina Faso, Lebanon, the Palestinian territories and Uganda.

Overall, it is IOB's assessment that there would be benefits in further enhancing staff capacity and prioritising programme management, including monitoring progress throughout the year, learning from implementation, and establishing feedback loops.

[128] This is a structural problem within the Ministry of Foreign Affairs; IOB has arrived at similar conclusions in 12 evaluations since 2018.

[129] In part, this also aligns with a broader trend within the Ministry of Foreign Affairs, where (i) many thematic experts on development cooperation have retired and (ii) there is a system of frequent staff rotation.

8 Coherence

This chapter examines to what extent Dutch SRHR policy was coherent and what mechanisms and funding modalities were in place to ensure this. The OECD-DAC defines coherence as 'the compatibility of the intervention with other interventions in a country, sector or institution'.[cclxxxv] Section 8.1 outlines the ministry's policy on coherence. As already noted in Subsection 1.2.3, one limitation is that it was challenging to assess the coherence between instruments, most notably between supported NGO alliances and multilateral organisations. For example, improved access to commodities provided through the UNFPA Supplies Partnership can be complemented by increased access to information through supported NGOs, but there is only limited information available about these interlinkages across channels at the country level.

The extent to which the NGO partnership projects were coherent with the activities of embassies, with each other and with other stakeholders is examined in Section 8.2. Coherence of multilateral and international organisations and funds at different levels is discussed in Section 8.3.

Key takeaways

Dutch SRHR policy operates under the assumption that various channels and instruments will complement each other at country level and coordinate with the Dutch embassies (Section 8.1). This evaluation identifies several challenges regarding coherence and coordination among NGOs, among multilateral organisations, and with the embassies, partially invalidating the assumption.

Evidence on the functioning of the NGO partnership model is mixed at best. The strategic linkages

within (Subsection 8.2.1) and between NGO alliances (Subsection 8.2.2) are relatively weak at country level. In addition, there is little involvement of national and local civil society organisations in global advocacy efforts or the SRHR partnership projects.

Although the influence of Southern partners has increased over time, strategic and programme decisions are mostly taken by the international lead organisations involved. Moreover, national and local CSOs continue to be funded on a project-by-project basis, with limited options to fund core staff, thus potentially affecting their long-term capacities (Subsection 8.2.1).

The involvement of embassies during the implementation of the centrally-funded SRHR partnership projects was limited and, as a result, there were few connections and synergies between these NGO partnership projects and activities supported by the embassies (Subsection 8.2.3).

The level of coherence and coordination among supported multilateral organisations varied at the global level, with some coordination mechanisms functioning relatively well. At the national level, however, there is room for improvement regarding the coordination and coherence between multilateral organisations. At country level, limited government capacity and parallel coordination mechanisms created challenges for improving coordination (Section 8.3)

8.1 Policy

The ministry expects that implementing organisations coordinate their efforts and cooperate with each other, particularly at country level.[cclxxxvi] In addition, the ministry aims to complement its programming with diplomatic and political actions (see, for example, Subsection 4.3.5). It sees NGO partnership projects as a vehicle to enhance collaboration and complementarity, and for realising objectives that one partner alone cannot achieve.[130] An implicit assumption underlying Dutch policy is that the different channels and instruments can, and indeed do, complement each other, enhancing the likelihood of achieving sustainable results and increases in the efficiency of SRHR development cooperation.

8.2 NGO strategic partnership coherence

8.2.1 Partnership-level collaboration

The final evaluations of the ten previous SRHR partnership projects paint a mixed picture of the functioning strategic partnership model. Two partnership evaluations concluded that synergies had been created and that the strategic partnerships achieved better outcomes than what could have been accomplished individually.[cclxxxvii] On the other hand, the evaluation of the HSAP project revealed that while collaboration among partners was effective, it was often more operational than strategic in nature, with most partners indicating that they had operated as autonomous organisations pursuing their own agendas rather than functioning as a cohesive partnership.[cclxxxviii] The evaluation of the YIDA project reached similar conclusions, highlighting that supported partners primarily worked independently and only came together during annual meetings.[cclxxxix] Four of the project SRHR partnership project evaluations flagged that there had been limited involvement by national partners in global advocacy efforts and less progress than anticipated in terms of national follow-up for international processes.[ccxc]

In many partnership projects there was a perception that programmatic vision and communication from the global to the country level were predominantly top-down.[ccxci] [131] Although Southern partners' engagement in the current round of strategic partnerships increased, several national and local CSOs indicated that strategic and programmatic decisions were still predominantly made by the

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[130] Under the Policy Framework for Strengthening Civil Society, Grant Instrument SRHR Partnership Fund (2021–2025), potential partnerships were thereafter assessed on their partnership agreement as well as a description of the partnership's proposed vision on working with local organisations (Ministerie van Buitenlandse Zaken, 'Policy Framework for Strengthening Civil Society, Grant Instrument SRHR Partnership Fund').

[131] In a survey amongst partners during the 2011–2015 partnership programmes, 29% of the respondents disagreed with the statement that the agenda of the alliance was too much determined by organisations from the North. See: Kok et al., 'Synthesis Evaluation of SRHR Subsidy Frameworks 2011-2015', p. 140.

international lead organisations.[ccxcii] In Uganda and Bangladesh, CSOs funded through the current round of SRHR partnerships (2021–2025) were primarily financed on a project-by-project basis and through intermediary CSOs. Training for capacity strengthening was often linked to the implementation or monitoring of specific project activities.[ccxciii] With limited options to fund core staff, the finalisation of projects frequently led to staff turnover, possibly affecting the CSO's capacities.[ccxciv] These findings are consistent with a recent IOB study on the functioning of strategic partnerships, which concluded that the long-term commitment and flexibility that the ministry provided to Northern NGOs was not always extended to southern CSOs. These organisations were often bound to annual contracts and strict reporting requirements.[ccxcv]

8.2.2 External alignment

Some strategic partnership projects cooperated with each other. Especially the three partnerships dealing with child marriages (Yes I Do Alliance, More than Brides Alliance and Her Choice) have worked together over the years, also at the country level (e.g. Pakistan and Malawi) and within the Girls Not Brides Netherlands network.[ccxcvi] The child marriage alliances regularly met with the ministry's child marriage focal point.[ccxcvii] Joint efforts took place at both country and international levels (e.g. a joint submission of Universal Periodic Reviews to the Human Rights Council).[ccxcviii]

There was some overlap between organisations involved in the partnership projects.[132] Several organisations made efforts to align their activities, particularly when they operated in the same countries. However, the strategic partnership projects generally employed different approaches and targeted distinct groups.[ccxcix] Some of the Dutch partnerships established and/or participated in country-level coordination mechanisms and occasionally also worked directly with national governments.[ccc] The final evaluations provided limited insight into the practical implementation of coordination and collaboration between the strategic partnerships or with other stakeholders, as well as limited insight as to whether that resulted in synergies at the national level.

Although numerous strategic partnerships were active in Uganda, many of these projects had modest budgets available for their activities (see Figure 2). Currently, there are 15 partnership projects active in the country that focus on SRHR and gender issues, funded directly from The Hague, with each partnership working through a number of national and local organisations.[133] Many of these organisations engage in lobby and advocacy on similar issues, such as domestic health expenditure, comprehensive sexuality education, youth and equal rights for LGBTIQ+ people. Similarly, many projects focus on bring about behavioural change and on capacity development of CSOs. Several of national CSOs are involved in a number of partnership projects simultaneously, with one national CSO even receiving funding through six distinct funding streams from the Netherlands.[134] [135] This complex network of funding and projects creates challenges in coordinating and aligning efforts.[ccci]

At the national and local levels in Uganda, the connections between the CSOs supported through different strategic partnerships were predominantly ad hoc and were often limited to the exchange of information. Many of the supported national and local CSOs did not utilise existing coordination structures at district and national level, consequently increasing the risk of duplication.[cccii] Government officials indicated that the lack of transparency of NGOs hindered effective coordination. That may in part be due to the limited civic space that NGOs and CSOs operate in. Moreover, several national and local CSOs acknowledged that competition between organisations occasionally hindered their ability to coordinate efforts effectively.[ccciii]

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[132] Rutgers served as the lead organisation in Right Here, Right Now and GUSO projects and it also participated as an alliance partner in the YIDA project. Aidsfonds took the lead in PITCH and Bridging the Gaps II projects.

[133] SRHR partnerships: Love Alliance; Power to You(th); We Lead; Right Here, Right Now 2; Make Way. Power of Women: Women Gaining Ground; Feminist Power; Power Up!; We Cannot Wait; AWESOME. Power of Voices: Power of Pride; Our Voices Our Futures; Count me in!; She leads; Generation G.

[134] Reproductive Health Uganda was a partner with *(i)* Right Here, Right Now and *(ii)* GUSO. During the same period, the organisation also received support through *(iii)* Prevention+, a gender project financed by the ministry in The Hague, *(iv)* the AmplifyChange Fund, *(v)* the IPPF and *(vi)* Frontline AIDS, also entirely or in part financed through the Netherlands. Similarly, another national NGO, CEHURD, received funding from five separate funding streams from the ministry.

[135] Similar issues with the same CSOs involved in a number of partnership projects were identified by interviewees from the embassy in Kenya.

8.2.3 Working with the embassies

SRHR partnership projects are funded and managed by the Ministry of Foreign Affairs in The Hague. The level of embassy engagement varied from country to country, but, across the board, their involvement was limited, especially when embassies did not have an SRHR focal point.[136] [ccciv] In comparison to Dutch embassies in other countries, the Dutch embassy in Kampala exhibited a relatively proactive approach in trying to facilitate coordination among the CSOs involved.[cccv] While embassies were generally involved during the design phases of the partnership programmes (2016–2020), their involvement was modest once projects started.[137] Embassy staff in various countries made clear that their capacity to effectively monitor and coordinate partnership projects was limited.[cccvi] At times, they spoke at partnership events and some of the supported NGOs participated in embassy meetings, but this rarely resulted in active collaboration between embassies and partnership projects.[138] [cccvii] Consequently, there were few connections and synergies arising between the centrally-funded SRHR partnership projects and projects funded through the embassies. Embassy staff from various countries indicated that they were not always informed about the presence or contents of other SRHR-related activities financed by the ministry in The Hague.[cccviii]

8.3 Multilateral and international organisations' coherence

The SDG 3 *Global Action Plan for Healthy Lives and Well-being for All* was launched at the UN General Assembly in 2019. It commits multilateral and international organisations to more effective collaboration in order to help countries accelerate progress in achieving health-related SDGs. Currently there are 13 organisations involved, including Gavi, GFF, the Global Fund, UNFPA, UNICEF, UNAIDS and the WHO. The available evidence on collaboration among these actors presents a mixed picture, with, at the global level, some coordination mechanisms working relatively well while there is room for improvement for others:[139]

- An evaluation of Gavi's Supply and Procurement Strategy found that the organisation's collaboration at the global level was important for successful implementation. The evaluation highlighted the importance of the partnership between the WHO and Gavi in ensuring market shaping results.[cccix]
- Along with USAID and other development partners, UNFPA is a member of the Coordinated Supply Planning Group (CSPG). The CSPG attempts to coordinate and harmonise global forecasting and provision of reproductive health and family planning commodities globally and to avoid global gaps or duplications in allocations and commodity flows. According to a mid-term evaluation of UNFPA Supplies Partnership (2013–2020), the CSPG has helped to identify potential stockouts before they occurred, so that additional funds could be allocated for commodity procurement.[cccx] [140]
- To improve collaboration, in 2018 the Global Fund signed Strategic Cooperation Frameworks (SCFs) with WHO and UNAIDS. These SCFs specifically identified joint programme priorities.[cccxi] The Global Fund's 2020 Strategic Review concluded that there was some value in having these global agreements, but it also mentioned that it was difficult to operationalise these global frameworks in partner engagement at regional and country levels. The most important problem was that there was no funding allocated to the SCFs.[cccxii]
- There is room for improvement in the Global Fund's global level of coordination and harmonisation with partners for HIV prevention. An evaluation concluded that the Global Fund could play a more active role in facilitating the exchange of information between partners and donors at the global level on the programmes being supported.[cccxiii] On the other hand, improved collaboration between the Global Fund and PEPFAR (President's Emergency Plan for AIDS Relief) at the global level is reported to have aided further harmonisation of investments at the country level.[cccxiv]

[136] In a survey amongst partners during the 2011–2015 partnership programmes, 33% of the respondents disagreed with the statement that the Dutch embassies or consulates did not play an important role in the implementation of the respective projects. See: Kok et al., 'Synthesis Evaluation of SRHR Subsidy Frameworks 2011-2015', p. 139.

[137] This finding corresponds to 'IOB, Strategies for partners: balancing complementarity and autonomy', which also found that both Northern and Southern CSOs had expected the Dutch embassies to be more involved.

[138] At the operational level, some embassies also offered support in establishing contacts and addressing administrative, security, and logistics issues.

[139] As outlined in the methodology (Section 1.2), this section is based on a selection of evaluations and, hence, the presented findings are not necessarily representative for the organisations as a whole.

[140] There are also: (i) the Reproductive Health Supplies Coalition a global partnership of organisations that aims to ensure that all people can choose, obtain and use family planning supplies; and (ii) the global Visibility Analytics Network (VAN), a platform that captures data to assess supply needs and begin incorporating family planning products with the intent of encompassing all health products and development partners.

Interviewees from CSOs, NGOs and multilateral and international organisations in Uganda revealed that, although on paper there are several coordination systems in place, achieving collaboration on the ground, beyond the level of information sharing or geographical distribution, continued to be a challenge.[cccxv] [cccxvi] With respect to the coordination mechanisms of multilateral organisations at the national level, available evidence suggests that there is room for improvement across most organisations, as the cases below illustrate:

- The evaluation of UNFPA-UNICEF's Joint Programme on Ending Child Marriage outlined that the agencies still operated in parallel. Geographic convergence at the provincial or district level did not necessarily translate into convergence at the village level.[cccxvii] Similar findings were reported for the Joint Programme on the abandonment of FGM with the partnering organisations not calling on their comparative strengths.[cccxviii]
- UNICEF's 2021 MOPAN assessment observed that although country-programme documents often referred to 'strategic partnerships', they seldom defined what the different partners would do.[cccxix] Programme strategy notes did not thoroughly assess what others were doing and how UNICEF would complement this. Nor did they always clearly explain how duplication or fragmentation was to be avoided.
- A recent Global Fund prospective country evaluation found that funding for strengthening health systems is not aligned in terms of timing/duration and that information sharing (also of reviews and evaluations) between donors was insufficient and constrained implementation.[cccxx] [141] At the country level, the Global Fund engages with key development partners through Country Coordinating Mechanisms to ensure external coherence.[142] However, the effectiveness and functioning of these mechanisms varies widely and depends on the host country and whether members are new or experienced.[cccxxi]
- An evaluation of Gavi's gender policy concludes that civil society voices were overlooked in consultations at the national level and that there was room for improvement in making the country-engagement process more participatory.[cccxxii]
- Coordination at the national level between UNAIDS, governments and donors was aligned with country priorities. Collaborative programmes, for example the Spotlight Initiative, provided a platform for enhanced collaboration.[cccxxiii] In addition, the active Gender and HIV thematic working groups contributed to the coordination of activities. However, these working groups sometimes operated in isolation, which occasionally hindered the overall synergy and coherence of efforts. Although UNAIDS performed well, the evaluation also notes that this was not always sufficient to ensure coherence across all co-sponsor programmes.[cccxxiv]

Factors affecting multilateral organisations' efforts to improve coordination:[cccxxv]

- Limited government capacity for coordination and lack of clarity concerning national coordination procedures. On the other hand, government stewardship of donor funding supported effective coordination.[cccxxvi]
- The ways in which particular tasks (e.g. for HIV prevention and treatment) were divided among government agencies and administrative structures that did not facilitate implementation and coordination of activities.
- The existence of parallel coordination mechanisms that duplicated national structures and/or different organisations introducing different mechanisms and committees at country level.
- Partnership agreements reflecting a case-by-case approach for formalising partnerships and mandates, mostly centred on funding-specific activities, but were generally narrow in scope.[cccxxvii]
- Donor funding was unpredictable, disjointed and not aligned in terms of timing, duration or eligibility criteria.[cccxxviii]

[141] In similar fashion, an evaluation of the Global Fund's health systems strengthening concluded that across the board, there have been general improvements in donor coordination with regards to health systems, although progress varies country by country. The study concludes however, that there is still an extensive need for further improvement of donor coordination. See: CEPA, 'Technical Evaluation Reference Group (TERG) Thematic Review to assess the current approach to investments in Resilient and Sustainable Systems for Health (RSSH)', CEPA, 13 February 2019, p. 12

[142] The CCM is a national committee that submits funding applications to the Global Fund and oversees grants on behalf of the relevant countries.

9 Sustainability

This chapter discusses the sustainability of interventions supported through Dutch policy on SRHR. It distinguishes between 'continuation of activities' and sustainability of results ('lasting effects'). Section 9.1 briefly presents a reconstruction of the ministry's policy on sustainability. Section 9.2 subsequently outlines the evidence gathered in the Bangladesh case study. Section 9.3 outlines the implementation of exit strategies of the NGO partnership projects. To finish, Section 9.4 discusses the role of domestic health expenditure, which is a precondition for sustainable health systems.

Key takeaways

Component 1: Continuation of activities
The Netherlands is committed to contributing to sustainable improvements in SRHR for all persons. It expects to achieve this based on the assumptions that: (i) over time, other stakeholders (such as governments or other donors) in target countries will take over the SRHR services currently provided by the ministry's partners; and (ii) governments in target countries are willing and able to increase domestic health expenditure, which is a necessary precondition for strengthening health systems and, in turn, for providing SRHR services to all (Section 9.1).

The first assumption was found to be not valid in the Bangladesh case study, as there were no stakeholders willing or able to take over the services provided through Dutch projects. Most projects were not in line with the government's priorities and other donors placed less emphasis on the rights aspect of SRHR. Consequently, most of the supported SRHR activities came to an end once support through the embassy stopped (Section 9.2). Similarly, in other countries, supported

NGOs also had difficulties in handing over activities to government authorities, especially when the projects focused on key populations (Section 9.3).

The second assumption is also invalid. In most of the Dutch SRHR target countries, governments did not significantly increase domestic health expenditure. As a result, none of the Dutch SRHR target countries is on-track to attain the SDG objective of universal health coverage by 2030 (Section 9.4).

Component 2: Sustainability of effects
The ministry also operates under the assumption that specific results achieved through SRHR interventions, such as improved policies through lobbying and advocacy efforts or enhanced capacity of supported CSOs will have lasting effects (Section 9.1)

This evaluation cannot entirely validate or falsify that assumption, primarily because the effects of these specific interventions remain largely unclear. Some evaluations of supported NGO projects have highlighted the challenges in retaining trained staff and high staff turnover rates in supported CSOs (Section 9.3). This is in line with findings in the literature that core funding to CSOs was more effective than project-based support in enhancing their advocacy capacities (Section 6.4).

9.1 Policy

Through lobby and advocacy, and by strengthening CSOs, the ministry intends to promote policy and legislative environments conducive to SRHR. In theory, these efforts should contribute to lasting effects, as the respective government would take over health financing and the focus on SRHR for all. Partnership projects have meant to empower end-users to demand good quality services and thereby strengthen the accountability of all levels of government and service providers to their users.

The ministry's 2018 ToC for SRHR refers to the importance of sustainable and resilient health systems that meet the needs of the users. Several of the supported multilateral and international organisations have formulated their own sustainability strategies and have generally emphasised that additional domestic investments are necessary to achieve them:

- The Global Fund's Strategy for the period 2023–2028 mentions that its investments in strengthening health systems are a way to promote the sustainability of its investments for addressing the three diseases on which it focuses.[cccxxix] In addition, it emphasises that increased domestic resources are essential for achieving more sustainable results and, therefore, the Global Fund will enhance its advocacy to catalyse domestic investments. The Global Fund has a co-financing incentive that is made available if countries realise additional domestic commitments. Once a country reaches the upper-middle-income status, it is no longer eligible for funding if there is less than a 'high' disease burden. The Fund supports countries in transition planning.[cccxxx]
- Gavi's Phase V strategy for the period 2021–2025 mentions that mobilisation of domestic public resources is key to achieve sustainability.[cccxxxi] Improving sustainability of immunisation programmes through promoting domestic public resources for immunisation and primary healthcare is one of the strategy's goals. Gavi also has a co-financing policy that requires individual countries to contribute a portion of the cost, starting with USD 0.20 per vaccine and with increasing proportions over time until the country graduates–its Gross National Income per capita exceeds the specified threshold – from support. Between 2016 and 2022, 19 countries transitioned beyond Gavi support.
- The UNFPA Supplies Strategy for Family Planning for the period 2022–2030 outlines the ambition to move from a donor-assistance model for providing contraceptives towards a more sustainable model: one based on domestic financing.[cccxxxii] Advocacy for increased domestic resource mobilisation is an important aspect of the strategy, which identifies the GFF and the WHO as key actors in advocacy for increased resource mobilisation.

IOB has broadly translated the ministry's policy into the following assumptions, which are not explicitly stated in policy documents:

1. Other stakeholders (including governments or other donors) in target countries are willing to take over the broad range of SRHR services provided by the ministry's implementing partners, thus leading to a continuation of interventions ('sustainability of activities').
2. Governments in target countries are willing and able to increase domestic health expenditure, which is a necessary precondition for strengthened health systems.
3. Results achieved through SRHR interventions, e.g. improved capacity of CSOs, changes in norms or improved policies due to lobby and advocacy, will have lasting effects ('sustainability of results').

9.2 Bangladesh case study

In Bangladesh, the Netherlands was seen as one of the frontrunners of the SRHR agenda. In 2013, the Netherlands announced that it would shift its relationship with Bangladesh from aid to trade. In 2018, subsequently, the ministry announced that it would gradually phase out its development cooperation.[cccxxxiii]

Box 6. *State of affairs with SRHR in Bangladesh*

While Bangladesh made progress on various health and SRHR indicators during the evaluation period, major challenges remain to attain the SDG objectives. In 2019, Bangladesh only allocated 0.5% of its GDP to domestic health expenditure, ranking it the second-to-lowest country in the world.[143] As a result, Bangladesh is unlikely to achieve universal healthcare by 2030.[144]

The country's adolescent fertility rate declined only slightly between 2012 and 2020 (falling from 89 births annually per 1,000 women aged 15-19 to 81 per 1,000), thus remaining more than double the rate of an average lower-middle-income country.[cccxxxiv] In 2018, 64% of women in Bangladesh made informed decisions about sexual relations, contraceptive use and reproductive health.[145]

Between 2012 and 2021, the Dutch embassy in Dhaka allocated EUR 57 million to a diverse SRHR portfolio. The largest contribution was allocated to a World-Bank-administered trust fund in support of the health sector. Although this contribution was relatively modest, it allowed the embassy to engage in policy dialogues with the government and other stakeholders and to advocate for SRHR. In its exit strategy, the embassy outlined that SRHR would continue to be an important element in its human rights and gender programming, as well as in its advocacy and policy dialogue with government. However, ending support to the health sector made it more difficult to put this plan into practice.[cccxxxv]

The embassy sought to partially hand over its SRHR agenda to other stakeholders in attempt to sustain and institutionalise the results achieved. However, most projects were not in line with the government's priorities, making it difficult transfer responsibilities to the government. Handing over to other donors such as Sweden or Canada also did not occur as these countries focused more on the 'medical' side of SRHR and less on the rights aspect. In addition, the embassy's gender and human rights portfolio was too modest to absorb the activities previously supported through SRHR projects, which were often heavily or totally dependent on Dutch funding. Most projects did not have a sound exit strategy in place that included plans for financial diversification of funds beyond the project's lifetime.[146]

143 Mcintyre, Meheus & Røttingen (2017) estimated that government spending on health of at least 5% of GDP is necessary to progress towards achieving universal health care (D. Mcintyre, F. Meheus and J. Røttingen, 'What level of domestic government health expenditure should we aspire to for universal health coverage?', *Health Economics, Policy and Law*, vol. 12, no. 2, 2017, pp. 125-137).

144 External donors only made up a relatively small part (8%) of health expenditure and households paid 72% of total health expenditure out of pocket, with 7% of the population falling below the poverty line as a result. See: World Health Organization, The Global Health Observatory [website]

145 The modern contraceptive prevalence rate among married women remained unchanged between 2013 and 2019 at 59%. See The World Bank, World Development Indicators [website]

146 One exception was the health insurance component of the Working with Women 2 project in Bangladesh, the idea was that the health insurance premium would initially be shared between project, factories and workers and that the contribution from the project would gradually be reduced to zero in the fourth year.

The embassy's entire portfolio on SRHR, health and gender is presented in Annex 5. Data collection performed for this evaluation in Bangladesh revealed that most activities that had previously been supported through the embassy's SRHR programming stopped after project support ended:[cccxxxvi]

- None of the peer case workers trained in the SHOKHI project (on women's health, rights and choices) continued their activities due to lack of funding and women's groups created during the project no longer met frequently.
- The adolescent corners set up in family-welfare centres through the NIRAPOD-I and NIRAPOD-II projects were no longer in use and the established health committees no longer met regularly.[147]
- None of the 21 visited schools, targeted by the Generation Breakthrough project, still used the gender-equity materials that had been provided. The main reason for this was that the government did not include the entire curriculum in the national curriculum and, as a result, teachers were not obliged to use the materials. Also, adolescent corners set up in the schools during the Generation Breakthrough project were no longer used by students.

One example of an activity that has continued beyond termination of project funding is the Women Desks in police stations. During the project, these desks were set up in 12 police stations to provide protection and legal services to survivors of gender-based violence. After the project ended, the government extended this intervention to 632 police stations nationwide under the name 'Women, Children, People with Disabilities and Elders'. Despite the government's extension of the project, persistent challenges were noted in the 23 visited police stations, prominently including the inadequate representation of female police officers and the limited availability of services tailored to women in most of the stations visited.[cccxxxvii]

9.3 NGO partnership projects

Not all supported NGO partnership projects developed an exit strategy that outlined the steps to be taken before and after donor funding ended. Additionally, exit strategies were not always included in the programme design from the outset, and in some cases were only developed in the final year of implementation.[cccxxxviii] At times, there was an exit strategy at the alliance level, but not at the level of individual alliance members, which hindered sustainability.[cccxxxix]

The synthesis evaluation of the 21 projects funded from 2011 to 2015 through the five subsidy frameworks logically concluded that withdrawing Dutch funding would create a gap. Many of these projects operated in resource-limited settings, where few other donors were active, and they focused on addressing SRHR issues that national governments did not want to address.[cccxl] The synthesis evaluation concluded that achieving sustainable results in SRHR requires long-term funding.[148] This is particularly true for the rights-based approach adopted in many projects, which aims to bring about cultural and normative changes that cannot be achieved overnight.[cccxli]

Evaluations of the SRHR partnerships between 2016 and 2020 acknowledged that the sustainability of the projects remained uncertain in the face of their approaching closure.[cccxlii] Services that had been provided to users free of charge, and that had been financed through the supported projects, were particularly at risk of being discontinued because of lack certainty about future funding.[cccxliii] While there are a few instances where government authorities were motivated to continue funding activities that had been started with specific projects, often this was not realistic when projects focused on key populations (particularly those politically marginalised) or when recurrent cost implications were significant.[cccxliv]

Most NGO partnership projects aimed to strengthen the capacity of supported national and local organisations, but a variety of challenges to achieving sustainable results arose with this approach. Several evaluations concluded that it was difficult to retain trained staff and that the turnover of trained individuals was high, including peer educators, sex workers and staff of community-based organisations, which impacted the capacity of supported organisations.[cccxlv] Some reports concluded that capacity

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147 Already in the end-evaluation of the project, 70% of the 1261 surveyed community members and garment workers believed that the achieved results of the project would not be sustained if project activities would end.

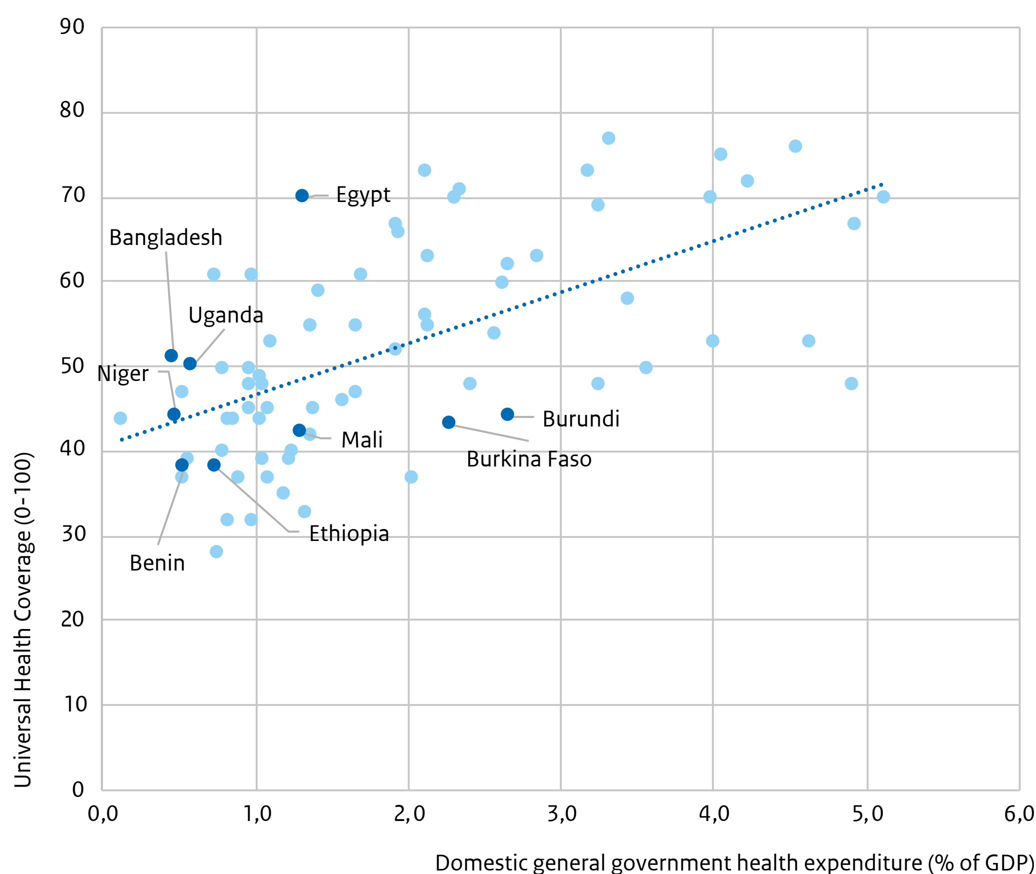
148 A survey among lead and partner organisations active in the 21 projects confirmed this: 91% of the 151 respondents indicated that continued investments were necessary to sustain results achieved through their projects.

development received too little attention and too few resources and that the capacity development that was received lacked quality or was too short to have a sustainable effect.[cccxlvi]

9.4 Government health expenditure

Low domestic health expenditure remains a major challenge to achieving sustainable results in SRHR and health. There is a direct association between domestic allocation of resources to the health sector and the strength of health systems, as Figure 8 shows. This association also exists for mother- and child-health outcomes, meaning that countries with higher government health expenditure have lower mother, infant and child mortality rates.

Figure 8. *Association between government health expenditure and universal health coverage (2019)*[cccxlvii]



NB. Universal health coverage is based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and services capacity and access.

Already in 2001, members of the African Union pledged to increase their health budgets to at least 15% of their government budgets to improve their healthcare systems. They also called on donor countries to meet the target of 0.7% of their Gross National Product as Official Development Assistance to low- and lower-middle-income countries.[cccxlviii] [149] Despite the pledges made and lobby and advocacy efforts of NGO partnership programmes and international and multilateral organisations, the willingness or ability to increase domestic government health expenditure in Dutch SRHR target countries was rather mixed – see Table 9. Between 2012 and 2020, none of the Dutch target countries in sub-Saharan Africa adhered to the 15% budgetary target. Currently, none of the Dutch SRHR target countries is on track to attain the SDG objectives of universal health coverage by 2030.[150]

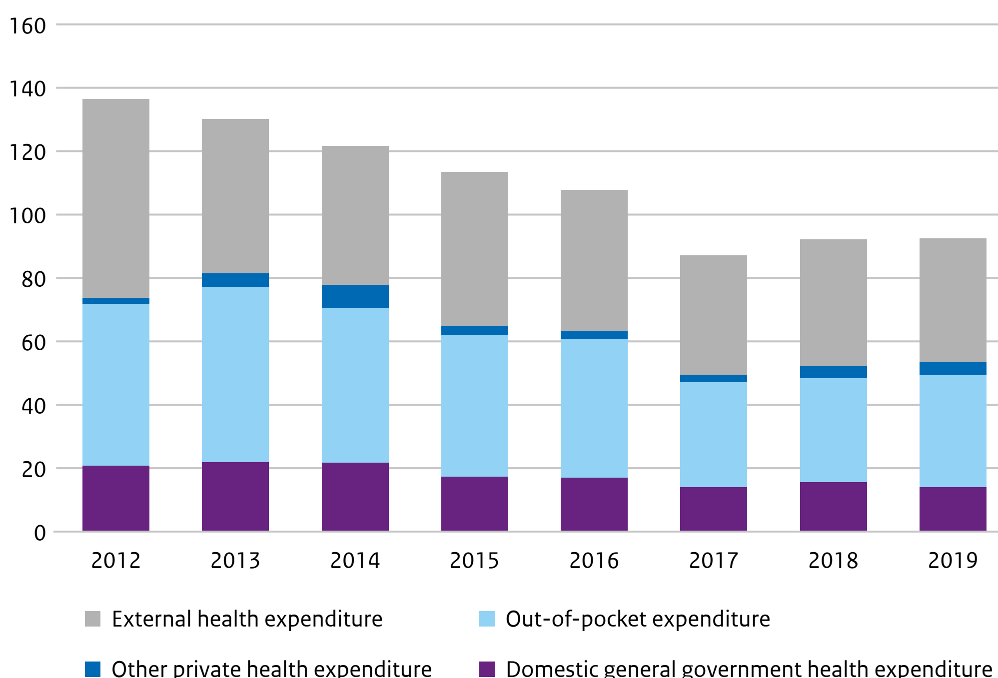
[149] Donor support to the health sector in sub-Saharan African countries increased steadily until 2013, but it remained relatively stable after that.
[150] Sustainable Development Report, Sustainable Development Report 2023 [website]

Table 9. *Domestic government health expenditure as a proportion (%) of total government expenditure in Dutch SRHR target countries*[cccxlix]

	2012	2013	2014	2015	2016	2017	2018	2019	2020	
Bangladesh	4.0	3.6	3.6	3.4	4.1	4.1	3.8	3.3	3.1	↘
Benin	5.2	5.1	4.0	3.2	3.7	4.6	3.0	3.7	4.6	↘
Burkina Faso	4.7	6.4	7.8	7.2	11.0	10.0	8.8	9.6	11.5	↗
Burundi	7.1	4.4	9.8	10.4	8.5	8.5	8.5	8.5	8.3	↗
Ethiopia	6.4	6.2	4.1	5.6	5.0	4.8	4.8	4.8	6.8	↗
Mali	2.7	4.1	4.5	4.4	5.4	5.1	5.7	5.7	5.7	↗
Mozambique	4.4	4.7	4.3	5.6	6.0	6.0	5.8	6.2	7.3	↗
Niger	6.2	6.6	5.4	4.6	5.7	9.7	8.3	9.4	10.2	↗
Uganda	7.1	7.3	7.0	5.1	5.2	3.9	4.2	3.1	3.1	↘
Yemen, Republic	3.4	3.2	2.8	2.2						

Bangladesh and Uganda rank alongst the lowest in the world regarding domestic health expenditure.[151] Analysis of total health expenditure in Uganda reveals that the majority of expenditure is either out-of-pocket or funded by external donors. Government expenditure represented only about 16% of total health expenditure – see Figure 9. During the evaluation period, per capita health expenditure dropped in Uganda, in part the result of reductions in health sector support from donors.

Figure 9. *Uganda's total health expenditure (USD per capita)*



An evaluation of the UNFPA Supplies Partnership noted that advocacy and engagement of UNFPA country offices had had no effect in terms of enhancing national investment in reproductive health and family planning. In six out of nine case-study countries, UNFPA still procured between 90% and 100% of all family planning commodities, while national budgets for commodities remained very small.[cccl]

[151] According to modeled estimations, countries need to allocate at least 5% of their GDP to their health sector in order to achieve universal health care – see Mcintyre, Meheus and Røttingen, What level of domestic government health expenditure should we aspire to for universal health coverage?'

10 Conclusions and recommendations

10.1 Conclusions

Promoting universal fulfilment of SRHR, including HIV/AIDS, has been a long-standing priority within Dutch development cooperation. Between 2012 and 2022, the Netherlands Ministry of Foreign Affairs allocated roughly EUR 4.9 billion to SRHR, equal to some 10% of the Dutch development-cooperation budget. This evaluation assesses the effectiveness, efficiency, coherence and sustainability of the Dutch SRHR policy.

The main research question this evaluation aims to answer is:

To what extent has the Netherlands contributed to the improvement of Sexual and Reproductive Health and Rights and contributed to halting the spread of HIV/AIDS in low- and lower-middle-income countries and what lessons can be learned for future policy?

Main conclusion

This evaluation finds that the Netherlands contributed to improvements in SRHR and a reduction of the HIV/AIDS burden in low- and lower-middle-income countries. Dutch support to SRHR contributed to improved SRHR outcomes through increased access to reproductive- and health

commodities, including antiretroviral therapy. At the same time, this evaluation also reports that various supported interventions did not produce the results expected, including behavioural change of and decision-making by young people about sexuality or reproduction. There are, furthermore, various 'blind spots' for which there was either no evaluation at all available, or the evidence about effectiveness was inconclusive or of insufficient quality. Consequently, IOB cannot determine the extent of the contribution of the entire Dutch policy to SRHR.

This main conclusion is based on a six sub-conclusions, which will be presented in the remainder of this section. Lessons for future policy will be presented in the subsequent 'Recommendations' section.

Sub-conclusions

Sub-conclusion 1 Dutch policy on SRHR has been consistent over the years and has simultaneously responded to the existing and emerging needs of the intended target groups in low- and lower-middle-income countries. However, key policy assumptions were often not clearly articulated, and policy choices were not always evidence-based.

Dutch policy on SRHR has always had a strong human-rights approach, recognising that sexual health and rights are fundamental human rights that apply to all individuals. The Netherlands is one of the few donor countries that consistently addresses issues considered to be 'sensitive' in large parts of the world, such as access to safe abortion, sex workers, and equal rights for LGBTIQ+ people.

Dutch SRHR policy has been implemented against a backlash of increasing conservative international opposition against SRHR, the shrinking of civic space, and limited progress for SRHR-related SDG targets in low- and lower-middle-income countries. In its policy on SRHR, the Ministry of Foreign Affairs has responded to international developments that threatened reversing progress on SRHR, such as the revival of the 'Global Gag Rule' by the Trump administration in 2017, which triggered the launch of the *SheDecides* initiative, and the COVID-19 pandemic, which stimulated the development of the first contours of a Dutch Global Health policy published in 2022.

To assess whether Dutch policy on SRHR was 'doing the right things' (i.e. if it was 'relevant'),[152] it is important to consider the evidence base behind policy choices and interventions. The current Dutch policy on SRHR does not, however, articulate all key assumptions, especially those regarding coherence and sustainability, nor does it always take the existing evidence base on what works into account.

For example, there is no evidence to support the policy choices made on eHealth, project-based support to enhance CSO capacity, or awareness raising and advocacy interventions with little service provision in the SRHR partnership projects. Moreover, there is evidence suggesting that providing health-sector budgetary support to governments and financial incentives such as cash transfers or vouchers directly to individuals has a positive impact on health and SRHR outcomes. Such interventions did not, however, play a significant role in Dutch SRHR policy.

Sub-conclusion 2 Efforts made to enhance SRHR and address the spread of HIV/AIDS in low- and lower-middle-income countries have resulted in a variety of effects:

Through its SRHR diplomacy, the Netherlands has contributed to upholding international agreements and maintaining previously agreed language in the main international SRHR forums and, in some instances, contributed to advancing agreed language. It has also worked through, for example, the Human Rights Council to make sure that countries comply with these agreements and implement agreed language. Still, there were some instances in which it was not possible to maintain previously agreed language.

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[152] According to the OECD, 'relevance' focuses on the question of whether the intervention (in this case, policy) is doing the right things: 'The extent to which objectives and design respond to beneficiaries, global, country and partner/institution needs, policies and priorities, and continue to do so if circumstances change.' *(OECD,* Evaluation criteria *[website]).*

Through its supported activities on SRHR, the Netherlands has contributed to:

- more access to SRHR-related information for young people, at times contributing to improved knowledge and attitudes;
- better access to and use of reproductive- and health commodities, including family planning commodities, for example through the UNFPA Supplies Partnership, and better access to and use of antiretroviral therapy and to decreasing AIDS-related mortality and HIV transmission, for example through the Global Fund;
- increased care-seeking and mother and child health at the community level, as well as access to safe abortion products and services.

At the same time, the Netherlands financed comprehensive sexuality education programmes, but introducing education on this subject was difficult in countries with a limited national curriculum on sexuality education. In these countries, the supported activities were generally discontinued once the support ended. More broadly, information-based interventions that contributed to improved knowledge and attitudes of young people hardly led to actual changes in their behaviour or decision-making about sexuality, reproduction or health.

Although the Netherlands contributed to short-term improvements in health systems in Dutch SRHR target countries, these had little systemic effect. Existing health systems in these countries continue to suffer from inadequate national health budgets.

Moreover, although Dutch policy on SRHR prioritises young women and girls, implementation continues to suffer from a lack of attention for gender mainstreaming – from project design through to monitoring and evaluation. Similarly, supported activities often did not succeed in bridging 'the last mile' and reaching the most-isolated and economically-deprived people.

The ministry supported many lobby- and advocacy-related initiatives and trained CSOs to promote conducive policy and legislative environments, but because of low evaluation quality it remains unclear whether these interventions were effective or not.

Sub-conclusion 3 Although Dutch parliament and the general public are annually informed about the 'results achieved' on SRHR, the M&E systems have several limitations that hinder the validity and reliability of reported results, especially at outcome and impact levels.

The ministry annually informs parliament and the general public about results achieved on SRHR, using a comprehensive results framework for SRHR and two overall budget indicators. The monitoring systems of supported NGOs are largely aligned with the ministry's results framework and budget indicators. Some of the annually reported indicators are defined at outcome and impact levels, which, although useful for evaluation, are not necessarily suitable for monitoring. In addition, IOB has also identified some concerns about the validity and reliability of various output indicators included. The limitations are especially relevant given the substantial time and effort invested in data collection and reporting each year.

IOB has low confidence in the quality of evaluations of many projects and programmes implemented by NGOs and multilateral organisations and international funds. More often than not, the methods employed were not suitable for assessing the contribution that the supported activities made to observed results, especially at outcome and impact levels. This inherently limits insight into the effectiveness of many of the SRHR-related activities financed by the Netherlands.

Sub-conclusion 4 Economic efficiency of supported SRHR projects and interventions is unknown. The organisational efficiency and timeliness of supported organisations presents a mixed picture with room for improvement, both for multilateral and international organisations and for NGO partnership projects.

The economic efficiency of the supported SRHR projects and interventions is largely unknown due to the absence of analyses of their cost-efficiency and cost-effectiveness. As a result, it is often not clear whether the chosen interventions were efficiently implemented or whether outputs or outcomes were achieved in the most cost-effective manner.

Available evidence regarding the efficiency of supported multilateral organisations and international funds presents a mixed picture. On one hand, international funds and multilateral organisations have successfully used their position to achieve lower prices for health and SRH commodities. On the other hand, the organisational efficiency and timeliness at these organisations was affected by complex administrative procedures and short-term funding from other donors than the Netherlands, which generally provides longer term and unearmarked support to the organisations concerned.

The operational efficiency and timeliness of the NGO partnership projects was weak. This is in part the result of their complex setup, involving multiple layers of implementation and numerous stakeholders in different countries for each project. The complex organisational structure of the projects resulted in bureaucratic management practices, high indirect costs and delays in implementation.

Despite improvements in the last few years, the ministry has limited staff capacity and has not prioritised programme management sufficiently. As a result, the ministry did not sufficiently play its 'partnership role' in the supported NGO partnership projects. Additionally, the policy staff in The Hague has limited insight in project implementation on the ground, thus hampering adaptive programming, learning from implementation and establishing feedback loops.

Sub-conclusion 5 Coherence within and between instruments and organisations supported by the Netherlands was insufficient.

The ministry expected that implementing organisations would coordinate their efforts and cooperate with each other at country level. This did not sufficiently materialise. Linkages among and within the SRHR partnership projects were relatively weak, predominantly ad hoc and often limited to the exchange of information. Few synergies were achieved between organisations and projects financed directly by the ministry in The Hague and those supported by the Dutch embassies.

At the global level, the level of collaboration among the multilateral organisations, international funds and governments varied, with some coordination efforts functioning relatively well. At the national level, however, there is room for improvement regarding the coordination and coherence between multilateral organisations. Coordination efforts were often hindered by the way in which donors financed these organisations and funds and by the existence of parallel coordination mechanisms, as well as limited government capacity and interest.

Despite steps taken to address fragmentation and to reduce the total number of SRHR-related projects financed by the ministry, there continue to be many small NGO activities in the ministry's SRHR target countries and fragmentation of activities persists at national and local levels.

Sub-conclusion 6 SRHR projects generally come to a halt once Dutch funding ends, since there are hardly any stakeholders willing and able to take over supported activities. In addition, there is only limited insight into the sustainability of results achieved.

In the Bangladesh case study, most activities supported through the embassy's SRHR portfolio came to a halt once funding ended. Transferring SRHR-related responsibilities to other donors or the government has proven to be exceptionally difficult, especially when the focus of projects was more on the rights aspect of SRHR.

In other countries, too, supported NGOs also had difficulties in handing over activities to governments, especially if projects focused on key populations. This challenge is further exacerbated by the lack of domestic government spending on healthcare in low- and lower-middle-income countries. Currently, none of the Dutch SRHR target countries is on track with achieving the SDG objective of universal health coverage by 2030. This, too, makes it difficult to hand over 'less sensitive', medical or reproductive health activities to national authorities.

There is limited insight into the sustainability of results achieved through the supported projects and programmes because the evaluations were conducted before completion of the interventions. Despite the ministry's expectation that capacity strengthening of CSOs and lobbying and advocacy efforts would yield lasting impacts, existing evaluations only provide limited insights into whether this was the case.

10.2 Recommendations

Recommendation 1 Clearly formulate the Dutch policy on SRHR in an updated policy document (the previous one was published in 2012), which could include the objectives, policy choices, priorities, channels and the relationship of SRHR with the Dutch global health strategy.

The updated policy document could include:
1. An analysis of all policy assumptions on SRHR, including those concerning coherence and sustainability. The policy document could consider the existing high-quality evidence (e.g. using the Evidence & Gap Map) to assess the validity of these assumptions. If the evidence contradicts the choice for specific policies, it seems appropriate to reconsider those policies. In situations where limited evidence is available, the ministry could develop evaluation strategies to test the underlying assumptions and learn what works, why and where.
2. An explicit poverty focus and a strategy that outlines to which degree, and how, the ministry intends to reach people of lower socio-economic status. In addition, it could also include an explicit strategy to include gender mainstreaming in the design, implementation and M&E of supported projects and organisations.
3. In countries where this is a policy option, the decision to decrease health-sector budget support could be reconsidered in the light of evidence of its effectiveness and the increased policy attention for strengthening health systems.
4. An explicit strategy for policy dialogue on health and SRHR with the governments in the SRHR target countries. Increasing domestic expenditure on health could be a core topic in the policy dialogue, ideally linked with sector support. In addition, policy dialogue could also focus on exploring shared objectives and/or approaches around curricula for sexuality education or services to key populations.

Recommendation 2 Attach more weight to programme management, balancing it with diplomatic and more ad-hoc activities of the policy staff responsible for SRHR.

Specifically, the ministry could:
1. Increase staff capacity for programme management and invest in staff with expertise in development cooperation and SRHR.
2. Minimise delays in the approval of annual plans, annual reports, final reports and final evaluations of supported organisations.
3. Further facilitate learning from implementation and establish feedback loops through improving the insight and increasing engagement of policy staff in project implementation at the country level.
4. More actively try to connect supported projects and activities at the country level. This includes linking (i) the delegated SRHR portfolio to centrally funded interventions, (ii) activities implemented by NGOs to those of the supported multilateral and international organisations, and (iii) supported activities to already existing initiatives, whether funded by government or other donors.

Recommendation 3 To reduce high management costs and fragmentation at the country level, reconsider the current strategic-partnership operational model.

Future subsidy frameworks could include:
1. A review of the necessity and added value of (i) the multi-layered alliance setups that include international NGOs, alliance partners and in-country national and local CSOs; and (ii) the multi-country setup of the partnership projects.
2. A strategy to allocate direct core funding to established national NGOs and CSOs in the SRHR target countries, prioritising it over short-term and project-based funding.
3. A reconsideration of the policy decision to increasingly focus on awareness raising and lobby and advocacy with decreased focus on service delivery in the SRHR partnership projects.

Recommendation 4 Have a realistic outlook on the limited possibilities to achieve continuation of activities beyond project support. Given the human-rights-based approach of Dutch SRHR policy and considering the often limited national and international ownership, possibilities to hand activities over are inherently narrow.

With this in mind, the Netherlands could:
1. Acknowledge that in the SRHR target countries, there is often little national ownership for the rights aspect of its SRHR portfolio, inherently limiting possibilities to hand activities over to other stakeholders. Where this is the case, the Netherlands could make a political commitment that it intends to continue supporting SRHR activities long term.
2. Introduce longer time frames for projects that aim to bring about cultural and normative changes.
3. Investigate possibilities to continue to fund or scale up activities or projects that are effective. This decision should be based on high-quality evaluations (see Recommendation 6).

Recommendation 5 Be cautious about what can realistically be monitored at the intermediate outcome, outcome and impact levels. Indicators at these levels generally require (i) independent evaluation, (ii) robust research designs, and (iii) longer time spans to validly establish a causal relationship between results and supported interventions.

Therefore:
1. Given the substantial time and effort invested in data collection and annual reporting, the ministry and contracted and implementing organisations could strategically select a limited number of indicators for monitoring, with a focus on describing (i) the implemented activities, (ii) the inputs and outputs, and (iii) the quality of implementation (*what went well, what did not, what were the challenges and how have they been addressed?*).
2. The ministry could reformulate its two overall budget indicators for SRHR.[153]

Recommendation 6 Improve the quality of decentralised evaluations, managed by implementing organisations or by involved policy departments of the ministry.

Therefore:
1. The ministry could ensure that that ex-post evaluations can be conducted, by allowing implementing organisations to allocate funds for M&E two years after finalisation of project activities.
2. Implementing organisations could hire evaluators for the baseline, mid-term and end evaluation prior to project implementation.
3. For a number of strategically-selected, large projects, identify jointly – the ministry, implementing organisations and evaluators – a number of outcome indicators (e.g. knowledge, attitudes or behaviour) to be independently measured at baseline, mid-term and ex-post, possibly also in comparison areas.[154] Best practices of this approach include final evaluations of the SRHR partnership projects 'Her Choice', 'Marriage, No Childs Play', and 'Get Up, Speak Out', all implemented between 2016 and 2020.[155]
4. Given the increased importance of gender mainstreaming and the Dutch Feminist Foreign Policy, all evaluations should include an assessment of gender mainstreaming. Additionally, evaluations could assess to what extent supported projects were able to reach their intended target groups and/or key populations.
5. Where possible, project and programme evaluations should include an assessment of economic efficiency.
6. The ministry could adopt a more systematic approach for assessing the uptake, at target country level, of statements and resolutions derived from its SRHR diplomacy in prominent international forums and in support of Dutch priority themes within SRHR.

[153] Reported 'results' on the first current budget indicator ('*number of 20 selected countries with annual increase in modern Contraceptive Prevalence Rate*') cannot be attributed to Dutch policy on SRHR and, therefore, cannot serve an accountability purpose. The second budget indicator *('number of communities, CSOs and advocacy networks with increased lobby & advocacy capacities*') could not be subjected to annual monitoring. Data on the second budget indicator would be more reliable and valid if based on an independent evaluation using a robust research design.

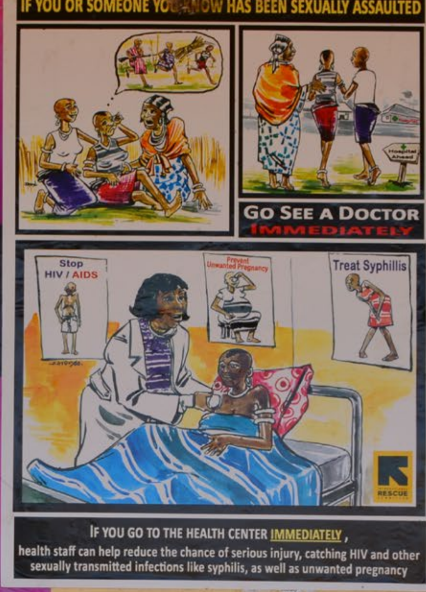
[154] Waddington et al., 'The effectiveness of support to lobby and advocacy' provide additional guidance on methods for evaluating lobbying and advocacy projects

[155] Such evaluations are most useful when there is (i) little evidence available for the selected activities, or (ii) the existing evidence is inconclusive. In case there is abundant evidence that the selected activities are likely to contribute to set objectives (e.g. cash based interventions), the focus could be more on the quality of implementation.

Overview of acronyms and abbreviations

AIGHD	Amsterdam Institute for Global Health and Development
ART	Antiretroviral therapy
BHOS	Ministry of Foreign Trade and Development Cooperation
BPfA	Beijing Platform for Action
CPD	Commission on Population and Development
CSE	Comprehensive sexuality education
CSO	Civil Society Organisation
CSW	Commission on the Status of Women
D&D	Dialogue and Dissent
DSO	Social Development Department
ECOSOC	Economic and Social Council
EU	European Union
EUR	Euro
FGM	Female genital mutilation
FP	Family planning
FTE	Full-Time Equivalent
GBV	Gender-based violence
GEMS	Gender Equity Manual for Schools
GFF	Global Financing Facility in Support of Every Woman Every Child
GBP	British pound sterling
GUSO	Get Up Speak Out!
HRC	Human Rights Council
HSAP	Health System Advocacy Programme
ICPD	International Conference on Population and Development
IFFIm	International Finance Facility for Immunisation
INGO	International non-governmental organisation
IOB	Policy and Operations Evaluation Department of the Netherlands Ministry of Foreign Affairs
IPPF	International Planned Parenthood Federation
LGBTIQ+	Lesbian, Gay, Bisexual, Trans, Intersex, Questioning/Queer and more
M&E	Monitoring and evaluation
MEL	Monitoring, evaluation and learning
MENA	Middle East and North Africa
MNCP	Marriage, No Child's Play
MOPAN	Multilateral Organisation Performance Assessment Network
MSM	Men who have sex with men
MTR	Mid-term review
NGO	Non-governmental organisation
PEPFAR	President's Emergency Plan for Aids Relief
PDP	Product Development Partnership
PITCH	Partnership to Inspire, Transform and Connect the HIV response (PITCH)
PoA	Programme of Action
PSI	Population Services International
R&D	Research and Development
RBF	Results-based financing
RHRN	Right Here, Right Now
RVO	Netherlands Enterprise Agency
SDG	Sustainable Development Goal
SOGI	Sexual orientation and gender identity
STIs	Sexually transmitted infections

SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
TB	Tuberculosis
ToR	Terms of Reference
UN	United Nations
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UPR	Universal Periodic Review
US	United States
USAID	United States Agency for International Development
USD	United States Dollar
WHO	World Health Organization
YIDA	Yes I Do Alliance



Annexes

Annex 1 – Definition of SRHR

Summary of the definition of SRHR that was adopted for this evaluation, as introduced by the Guttmacher-*Lancet* commission.[156]

Sexual Health	Sexual Rights
Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. Sexual health implies that all people have access to: • counselling and care related to sexuality, sexual identity, and sexual relationships; • services for the prevention and management of sexually transmitted infections, including HIV/AIDS 20 and other diseases of the genitourinary system; • psychosexual counselling, and treatment for sexual dysfunction and disorders; • prevention and management of cancers of the reproductive system.	Sexual rights are human rights and include the right of all persons, free of discrimination, coercion and violence, to: • achieve the highest attainable standard of sexual health, including access to sexual and reproductive health services; • seek, receive and impart information related to sexuality; • receive comprehensive, evidence-based sexuality education; • have their bodily integrity respected; • choose their sexual partner; • decide whether to be sexually active or not; • engage in consensual sexual relations; • choose whether, when and whom to marry; • enter into marriage with free and full consent, and with equality between spouses in and at dissolution of the marriage; • pursue a satisfying, safe, and pleasurable sexual life, free from stigma and discrimination; • make free, informed and voluntary decisions on their sexuality, sexual orientation and gender identity.

Reproductive Health	Reproductive Rights
Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health implies that all people are able to: • receive accurate information about the reproductive system and the services needed to maintain reproductive health; • manage menstruation in a hygienic way, in privacy and with dignity; • access multisectoral services to prevent and respond to intimate-partner violence and other forms of gender-based violence; • access safe, effective, affordable and acceptable methods of contraception of their choice; • access appropriate healthcare services to ensure safe and healthy pregnancy and childbirth, and healthy infants; • access safe abortion services, including post-abortion care; • access services for prevention, management and treatment of infertility.	Reproductive rights rest on the recognition of the human rights of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children, to have the information and means to do so, and the right to attain the highest standard of reproductive health. Reproductive rights also include: the right to make decisions concerning reproduction free of discrimination, coercion, and violence; the right to privacy, confidentiality, respect and informed consent; the right to mutually respectful and equitable gender relations.

[156] Starrs et al., 'Accelerate progress—sexual and reproductive health and rights for all'.

Annex 2 – Overview linking research questions to chapters

		Answered in chapter								
Number	**Research Question**	**Chapter 1 – Introduction**	**Chapter 2 – Context**	**Chapter 3 – Policy reconstruction**	**Chapter 4 – SRHR diplomacy**	**Chapter 5 – M&E**	**Chapter 6 – Effectiveness**	**Chapter 7 – Efficiency**	**Chapter 8 – Coherence**	**Chapter 9 – Sustainability**
1	How have key SRHR indicators developed in low- and lower-middle-income countries since 2012? What are the trends among adolescents, by gender and by income group? How do global trends compare to developments in the target countries?						■			
2	What instruments, financing modalities and channels did the Netherlands use to realise its goals, and what explains the choices made over the years?			■						
3	What have been the main developments in the international institutional health and SRHR landscape in recent years and how did the Netherlands respond?		■	■	■					
4	What does the available evidence tell us about what works and what does not work in SRHR interventions in low- and lower-middle-income countries? What does this mean for future Dutch SRHR policies and *modus operandi*?					■	■			
5	Do the assumptions underlying Dutch policy about (i) the added value and the role of the different organisations and (ii) the contribution made to health system development through the support for SRHR, hold?				■		■			
6	Were gender issues effectively mainstreamed in the design and implementation of SRHR policies and interventions?						■			
7	What are the results (at output, outcome and, where possible, impact level) of the interventions of multilateral and international organisations, and local, national and international NGOs financed – either partially or fully – by the Netherlands? Are the results different for women and for men, and for different income groups? What explains these results?						■			
8	What were the most important formal and informal diplomatic initiatives of the Netherlands at multilateral, international and bilateral levels in the selection of target countries, and what have been the effects?				■					
9	What does the available evidence report and conclude about the efficiency of Dutch support to SRHR?							■		
10	What mechanisms and funding modalities were in place to ensure coherence among SRHR interventions and what were the results?								■	
11	How likely is it that the benefits of recently completed Dutch financed (either partially or fully) SRHR interventions will be sustainable?									■

Annex 3 – Detailed overview of Dutch SRHR portfolio (EUR million)

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	total	
Health-sector support	**58**	**21**	**27**	**30**	**20**	**22**	**27**	**27**	**16**	**16**	**5**	**269**	**5%**
Ethiopia	4	6	11	12	10	11	10	11	9	0	0	84	
Mali	5	6	1	8	6	7	7	7	1	8	0	56	
Mozambique	8	8	8	9	1	2	6	6	6	6	0	60	
Ghana	2	0	0	0	0	0	0	0	0	0	0	2	
Yemen	2	0	1	0	2	0	0	0	0	0	0	6	
Tanzania	13	1	0	0	0	0	0	0	0	0	0	14	
Bangladesh	0	0	4	0	0	2	4	3	0	3	0	15	
Other	25	0	1	2	1	0	0	0	0	0	4	33	
Multilateral and international organisations	**181**	**236**	**247**	**217**	**235**	**253**	**255**	**247**	**229**	**348**	**400**	**2849**	**58%**
UNFPA	**73**	**79**	**67**	**65**	**74**	**74**	**72**	**71**	**64**	**85**	**89**	**811**	
Core	40	40	35	35	35	35	33	33	33	33	35	387	
Supplies	31	33	20	27	34	25	25	22	13	33	38	300	
Other	2	6	12	4	5	14	14	16	18	18	16	124	
The Global Fund	**40**	**67**	**74**	**55**	**54**	**57**	**56**	**64**	**42**	**69**	**62**	**640**	
GAVI and IFFIm	**25**	**39**	**46**	**46**	**50**	**67**	**53**	**52**	**44**	**103**	**67**	**591**	
UNAIDS	**20**	**20**	**20**	**20**	**20**	**18**	**20**	**10**	**31**	**20**	**23**	**222**	
UNICEF	**10**	**6**	**17**	**12**	**15**	**14**	**9**	**16**	**9**	**9**	**24**	**141**	
Core	0	0	5	5	5	5	5		0	0	0	25	
GPECM	0	0	5	5	5	5	0	12	7	7	9	55	
Social Protection	0	0	5	0	2	2	0	0	0	0	0	9	
Other	10	6	2	2	3	2	4	4	2	2	15	52	
WHO	**13**	**21**	**16**	**16**	**19**	**20**	**23**	**22**	**18**	**32**	**51**	**251**	
Core	0	7	6	6	7	6	6	6	6	6	16	72	
WHO Partnership Programme	13	14	10	10	12	12	5	4	4	9	0	94	
TB Innovations	0	0	0	0	0	0	0	5	0	0	0	5	
Human Reproduction Programme	0	0	0	0	0	0	5	5	5	5	6	25	
Other	0	0	0	1	1	1	6	2	2	12	30	55	
GFF (incl. COVID-19)	**0**	**0**	**0**	**0**	**0**	**0**	**19**	**10**	**20**	**30**	**63**	**141**	
Other multilateral	**2**	**5**	**8**	**2**	**2**	**4**	**5**	**1**	**2**	**1**	**20**	**51**	
NGOs and CSOs	**90**	**112**	**107**	**103**	**148**	**135**	**142**	**148**	**153**	**127**	**155**	**1419**	**29%**
Choices and Opportunities	**9**	**9**	**8**	**11**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**38**	
IHAA / Frontline AIDS	1	3	2	2	0	0	0	0	0	0	0	9	
IPAS	3	3	2	2	0	1	0	0	0	0	0	10	
IPPF	3	2	2	3	1	0	0	0	0	0	0	10	
PSI	3	2	2	3	0	0	0	0	0	0	0	10	
Key Populations Fund	**6**	**4**	**8**	**9**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**27**	
Child Marriage Fund	**0**	**0**	**6**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**6**	
Kinderpostzegels (SNACA)	0	0	2	0	0	0	0	0	0	0	0	2	
Save the Children (TNWTM)	0	0	2	0	0	0	0	0	0	0	0	2	
Simavi (UNCM)	0	0	1	0	0	0	0	0	0	0	0	1	
Plan (No, I Don't...)	0	0	1	0	0	0	0	0	0	0	0	1	
SRHR Fund (2013—2015)	**21**	**31**	**36**	**29**	**5**	**6**	**0**	**0**	**0**	**0**	**0**	**128**	
Amref (Staying Alive)	1	2	2	1	0	0	0	0	0	0	0	7	
BSR (HERproject)	0	0	1	0	0	0	0	0	0	0	0	1	

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	total	
DSW (Faith to Action)	0	0	1	0	0	0	0	0	0	0	0	1	
Frontline AIDS (Link Up)	6	6	9	8	3	2	0	0	0	0	0	34	
Hivos (Global Dialogues)	0	0	0	0	0	0	0	0	0	0	0	1	
KIT (SSHARP)	2	1	2	1	2	0	0	0	0	0	0	8	
KIT (MI+)	0	0	0	0	0	0	0	0	0	0	0	1	
Cordaid (MSRHSW)	5	5	9	9	0	1	0	0	0	0	0	29	
Save the Children (Keep it Real)	1	2	2	1	0	0	0	0	0	0	0	6	
Rutgers (ASK)	4	10	5	9	0	1	0	0	0	0	0	30	
Rutgers (MC+)	1	3	3	1	0	0	0	0	0	0	0	9	
Step up Fund (2012–2015)	**1**	**1**	**4**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**8**	
D&D SRHR (2016—2020)	**0**	**0**	**0**	**7**	**17**	**22**	**23**	**23**	**15**	**0**	**0**	**107**	
Stichting Aidsfonds (PITCH)	0	0	0	4	6	9	7	10	5	0	0	41	
Amref (HSAP)	0	0	0	3	4	6	8	5	5	0	0	32	
Stichting Rutgers (RHRN)	0	0	0	0	7	6	8	8	5	0	0	34	
SRHR partnerships (2016—2020)	**0**	**0**	**0**	**0**	**54**	**44**	**43**	**52**	**21**	**0**	**2**	**216**	
Cordaid (Jeune S3)	0	0	0	0	7	6	7	6	5	0	0	31	
Plan Nederland (YIDA)	0	0	0	0	6	6	6	5	3	0	0	28	
Save the Children (MNCP)	0	0	0	0	7	6	4	8	4	0	1	30	
Aidsfonds (BtGII)	0	0	0	0	15	10	10	16	1	0	0	51	
Kinderpostzegels (Her Choice)	0	0	0	0	6	4	4	4	1	0	0	19	
Rutgers (GUSO)	0	0	0	0	8	9	9	8	6	0	0	40	
Terre des Hommes (DtZ)	0	0	0	0	3	3	3	5	1	0	0	17	
SRHR partnerships (2021—2025)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**40**	**31**	**79**	**150**	
Amref (Power to You(th))	0	0	0	0	0	0	0	0	10	0	17	27	
Hivos (We Lead)	0	0	0	0	0	0	0	0	6	10	10	26	
Oxfam Novib (Masarouna)	0	0	0	0	0	0	0	0	9	0	20	29	
Plan Nederland (Break Free)	0	0	0	0	0	0	0	0	5	0	10	16	
Aidsfonds (Love Alliance)	0	0	0	0	0	0	0	0	0	13	9	22	
Rutgers (RHRN 2)	0	0	0	0	0	0	0	0	9	3	9	21	
Wemos (Make Way)	0	0	0	0	0	0	0	0	0	5	5	10	
PSI	**10**	**15**	**9**	**4**	**14**	**8**	**10**	**9**	**6**	**11**	**9**	**106**	
IPAS	**1**	**2**	**1**	**0**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**39**	
IPPF	**1**	**3**	**1**	**1**	**6**	**5**	**5**	**5**	**5**	**6**	**4**	**41**	
IPPF SAAF	0	2	0	0	2	1	1	1	1	1	0	9	
Other	1	1	1	1	4	4	4	4	4	5	4	32	
MSI Reproductive Choices	**5**	**6**	**6**	**6**	**7**	**8**	**7**	**5**	**5**	**4**	**4**	**61**	
Other NGO	**36**	**42**	**29**	**34**	**39**	**37**	**49**	**49**	**56**	**69**	**51**	**492**	
PDP and private sector	**40**	**24**	**23**	**21**	**32**	**37**	**33**	**29**	**31**	**33**	**12**	**316**	**6%**
Aeras (TB Vaccins)	2	3	3	1	0	0	0	0	0	0	0	8	
Foundation for Innovative New Diagnostics	1	3	2	0	1	0	0	0	0	0	0	7	
International Aids Vaccine Initiative	2	4	3	1	0	0	0	0	0	0	0	10	
PDP III fund	0	0	0	0	18	21	21	14	9	21	1	105	
PDP IV fund	0	0	0	0	0	0	0	0	0	0	8	8	
Health Insurance Fund	30	11	12	15	12	11	10	10	18	10	0	139	
AmplifyChange	0	0	0	2	2	4	1	5	3	0	0	17	
Other	5	3	2	2	0	1	1	1	2	2	3	21	
Research	**6**	**7**	**12**	**8**	**6**	**6**	**10**	**7**	**7**	**7**	**5**	**80**	**2%**

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	total	
International Organization for Migration	1	0	1	2	2	2	6	3	3	4	3	27	
Royal Tropical Institute (KIT)	0	0	1	2	3	2	2	3	3	2	2	20	
Guttmacher Institute	0	1	1	1	1	2	1	1	1	1	0	11	
Drugs for Neglected Diseases Initiative	2	4	3	1	0	0	0	0	0	0	0	10	
Nederlandse Organisatie voor Wetenschappelijk Onderzoek (NWO)	2	1	6	2	0	0	0	0	0	0	0	10	
Other	1	0	0	0	0	0	0	0	0	0	0	2	
Other	**0**	**0**	**0**	**0**	**1**	**2**	**2**	**4**	**1**	**2**	**2**	**13**	**0%**
Total	**376**	**400**	**416**	**379**	**441**	**454**	**468**	**462**	**438**	**534**	**579**	**4946**	

Annex 4 – Protocol used to identify and assess the quality of SRHR-related evaluations from multilateral and international organisations

1.1 PICOS eligibility criteria

A PICOS (Population, Intervention, Comparison, Outcomes and Study) design was used as the framework for formulating eligibility criteria for the review of SRHR evaluations from multilateral and international organisations and funds. Design elements were:

- Population: the actors of interest are seven main multilateral organisations in the field of SRHR (Gavi, the Global Fund, GFF, UNAIDS, UNFPA, UNICEF, WHO).
- Intervention / Comparator:
  - evaluations that focus on overall organisational efforts or specific programmes in at least one of the results areas of Dutch SRHR policy;
  - evaluations that focus on global programmes or multi-country programmes in MENA or African regions; and
  - evaluations that include programmes that are directly or indirectly funded by the Netherlands.
- Outcome: not applicable
- Study design:
  - inclusion criteria include a programme or organisation evaluation researched for the period of at least 2013 or later; and
  - exclusion criteria include annual reports and academic publications.

1.2 Search

- The search was conducted in November 2021 on the websites of the included organisations.
- An initial list of 40 identified evaluations that fitted the PICOS criteria was then shared with the ministry's Social Development Department, to check whether any evaluations had been missed. This resulted in a total of 45 evaluations that were screened.

1.3 Screening and coding

- For screening on quality, two IOB researchers independently followed the instructions below. In cases of disagreement about the final outcome, these were discussed among three IOB researchers.

Instructions followed / quality screening tool:

The following practical set of questions are meant to help in determining the quality of an evaluation. All questions should be answered with a 'yes':

1. Do the evaluators work independently of each other?
   - If the evaluators are part of the implementing organisation or there is a conflict of interest, the evaluation should not qualify.
2. Is the assumed ToC, causal chain or causal mechanisms for this evaluation mentioned?
   - Studies that do not mention causal mechanisms, logframe or ToCs should not qualify.
3. Does the evaluation contain adequate primary data?
   - Studies that rely entirely on narrative project documentation provided by an implementer do not qualify.
   - Studies that only include interviews with implementing staff do not qualify.
4. Does the evaluation collect data along the mentioned result chain? And does the evaluation assess results at the outcomes and/or impact level?
   - The study should not only collect information at output (e.g. number trainings provided) level. Studies that claim to assess outcomes, but only speculate about outcomes and do not collect primary data at the outcome level do not qualify.
5. Does the evaluation demonstrate that it is plausible that the observed outcomes can be attributed to the intervention(s)?
   - Studies that do not discuss the contribution/attribution do not qualify.
   - Studies that do not consider other factors that may have influenced the observed results do not qualify.

How to apply quality screening tool:
1. Search online for information about the evaluators, their prior affiliations and red-flag statements on conflicts of interest;
2. Scan the description of the programme;
3. Scan the methodology and data-collection sections. Look specifically for data beyond output level;
4. Read the methodology section, the study limitations and, if necessary, the description of the results.

1.4 Analysis and presentation of results

- Coding was done by one researcher using MAXQDA software. The coding schemed followed the relevant research questions from the overall Terms of Reference (Questions 5, 6, 7, 9, 10, 11). Research questions and codes were split into sub-questions to analyse the results.
- Coded information from all evaluation documents was then gathered in an Excel file, which was used for the analysis.
- Analysis consisted of deductively determining within sub-questions recurring themes in the data, going back and forth between the different documents.
- This enabled grouping of results to answer the each research question as dealt with in respective chapters of the final report.

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Annex 5 – Dutch embassy in Dhaka's former portfolio on SRHR, health and gender

Project name	Period	Budget (EUR mln)	Lead organisation	Objective
Health sector	2014–2022	15.3	World Bank	Unearmarked contribution to the Government of Bangladesh's health sector through a multi-donor trust fund
Generation Breakthrough	2012–2019	6.6	UNFPA	Deliver sessions about the gender equity and SRHR to adolescents and establishing adolescent corners in 350 schools and madrasahs
Unite for Body Rights 2	2015–2021	5.7	RHSTEP	Create access to CSE for in- and out-of-school adolescents in 350 schools and madrasahs
ADOHEARTS	2016–2021	4.4	UNICEF	Improve awareness of and access to quality adolescent health services for young girls and boys and reduction of teenage pregnancy
RITU	2015–2020	3.5	Simavi	Improve knowledge of and access to menstrual hygiene management
ASTHA	2017–2022	3.2	UNFPA	Increase access to multisectoral response services to GBV survivors and improve attitudes in four high-GBV-rated districts
SHOKHI	2014–2019	3.0	BLAST	Empower working women in 15 Dhaka slums and provide access to legal services and affordable, quality SRHR services
NIRAPOD-II	2015–2019	2.5	MSI Reproductive Choices Bangladesh	Increase awareness of and access to safe menstrual regulation and family planning for women in rural areas and garment factories
Working with Women 2	2017–2021	2.4	SNV	Promote SRHR through inclusive business practices in the ready-made garment industry
SANGJOG	2016–2020	1.9	PSCT	Increase awareness, access and health-seeking behaviour of vulnerable young people on SRHR and HIV services
Gender support fund	2016–2019	0.3	Rutgers	Finance small activities that support implementation of the embassy's SRHR and gender programmes

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i SRHR-related projects implemented included in the 'human rights' budget article of the Ministry were not taken into account in this evaluation. IOB is currently also evaluating Dutch efforts on human rights.

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Colophon

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