Annexes – IOB Policy review of the support and collaboration with UNFPA and UNAIDS

Annex 1 – Terms of Reference

Policy review: Dutch cooperation with the United Nations on reaching the goals of the four key themes of Dutch development policy

Background
The Netherlands attaches great importance to working with the United Nations to meet its development policy goals. At the same time, the Netherlands is pushing for UN reform and a greater focus on coherence and efficiency in the organisation's work. Between 2012 and 2015, the Netherlands contributed a total of US$ 464 million to the UN. This amount includes both earmarked and unearmarked funding, with the exception of humanitarian aid. UNDP and UNICEF are the largest recipients of Dutch development aid. A major part of the earmarked funding consists of contributions to multi-partner trust funds.

On the instructions of the Ministry of Finance all ministries must conduct a policy review at least once every seven years of their most important policy areas, in order to account for their main budgetary expenditures. In line with this, the evaluation department of the Ministry of Foreign Affairs is conducting a policy review in 2016 of its development work with the United Nations Development System (UNDS).

The final report will be sent to parliament, accompanied by an official response from the Minister for Foreign Trade and Development Cooperation. Typically, this will be followed by further consultations between the Minister and the Permanent Parliamentary Committee for Foreign Trade and Development Cooperation on the policy implications of the review.

Scope
The scope of this policy review is limited to cooperation with those UN institutions that are significant for the Netherlands' development priorities, specifically:

- Sexual and reproductive health and rights (SRHR);
- Food security;
- Water, sanitation and hygiene; and
- Peacebuilding and conflict management.

The policy review does not encompass the subject of cooperation with UN bodies on humanitarian aid, because this issue was covered by a separate policy review by the Policy and Operations Evaluation Department (IOB), published in January 2016.

Objectives
The policy review has two objectives:

- Rendering account for the effectiveness and efficiency of the Dutch government's policy on cooperation with relevant UN organisations in the area of development cooperation;
- Identifying specific ways of improving policy in the future.

Evaluation questions

The evaluation questions relate to:

Policy on the UN, its underlying rationale and associated expenditures;

The effectiveness and efficiency of the activities financed, with a focus on evaluating:

- The presumed comparative advantages of the UN channel;
- The effectiveness of UN activities on the four key themes of the Dutch development cooperation policy;
- The quality of accountability practices;
- The progress that has been made on Dutch-backed UN reforms, especially as they relate to promoting coherence and reducing fragmentation and duplication.
- The effectiveness and efficiency of Dutch UN policy;
- Measures that could further boost the effectiveness and efficiency of the Netherlands' partnership with the UN.

Research activities

Under the terms of this policy review, there will be a separate study for each of the four priorities of Dutch development cooperation policy, with regard to cooperation with the relevant UN institutions:

SRHR: UNFPA and UNAIDS

Water, sanitation and hygiene: UNICEF

Food security: FAO and IFAD

Security and the rule of law: the UN in general and UNDP in particular

The lion's share of the research will involve a desk study of a selection of programmes in these four areas, relying on existing reports and evaluations by UN institutions and other evaluation services of the programmes' effectiveness and efficiency. In selecting the reports at country level, priority will be given to countries that are official Dutch development partners.

The separate studies on specific themes will each include the following elements:

A reconstruction of the decision-making processes regarding the choice of channel and the financing of the UN organisations mentioned above;

A systematic review of existing evaluations of programmes and projects, for the purpose of determining their level of accountability for effectiveness and efficiency.

Reports will be selected on the basis of the following criteria:

Synthesis or theme-based studies will be preferred to individual project evaluations;

Wherever possible, preference will be given to reports of programmes carried out in the Netherlands' development partner countries;

To the greatest possible extent, reports from UN programmes and projects financed directly by the Netherlands will also be included in the selection.

Assessing the expected comparative advantages of the UN organisation(s) in question on the basis of internal and external reports to the Board, reports by the internal UN inspectorates, external monitoring reports from bodies like the Multilateral Organization Performance Assessment Network (MOPAN), Development Effectiveness Reports (DERs) and reports by other bilateral donors.

Assessing accountability and evaluation practices on the basis of external and internal reviews of the evaluation function for each organisation. In evaluating the quality and design of the evaluation function, the criteria that have already been drawn up by the UN Evaluation Group (UNEG) can be retained.

A separate desk study will be conducted on the UN reforms intended to achieve greater coherence. This study will concentrate on efforts to boost coherence in the organisation and the UN's work. It will mainly address the implementation of the UN development assistance framework (UNDAF) in a number of selected countries.

Planning and organisation
IOB is responsible for conducting the review and producing a final report. Most of the separate studies on specific themes will be conducted by consultants.

A peer group comprising both external participants and managers from the departments concerned will safeguard the investigation's quality. Ultimately, the director of IOB will approve the final version of the report before it is submitted to the minister.

The review must be completed by the end of 2016, and it is expected to be sent to parliament in early 2017.

Annex 2 – Evaluation framework

The evaluation framework of the sub-study was built on the OECD guidance document for Development Effectiveness Reviews (Annex 2: Operational Guidelines for Classifying Evaluation Findings. OECD-DAC, 2012), addressing relevance, effectiveness, efficiency, sustainability, cross-cutting themes and application of learning. This formed the basis for drafting the evaluation questions for the sub-study on SRHR.

Evaluation frame SRHR study			
Item	Criteria / questions	Sources	Formats / guidelines
Questions related to the justification of policy and the objectives pursued by the policy			
Justification of cooperation with the UN the channel (policy)	Relevance of the policy (overall context) Policy reconstruction (theory of change); what was aim of the policy, relevance? Coherence NL policy with policy UN organisations	MFA: policy papers; scorecards; formal correspondence; *kaderinstructies*, BEMOs of programmes financed Interviews with key respondents (KIIs)	Checklist for policy review Semi-structured questionnaire
Financial contribution + justification	Financial overviews Trend analysis Benchmarking	Piramide, Management information system /DASH KIIs	Semi-structured questionnaire
Monitoring and quality improvements in M&E	Role evaluations in decision to finance Opportunities to influence policy	Correspondence BEMO's, Scorecards KIIs	Semi-structured questionnaire
Questions related to the understanding the effectiveness and efficiency of the activities funded			
Quality of evaluation functions at UNFPA and UNAIDS	Following the criteria from the JIU (scores UNFPA and UNAIDS) 6 criteria from the Assessment Technical Ability list	Joint Inspection Report (www.unjiu.org) MOPAN UNFPA MOPAN UNAIDS Reports, documents on M&E External reviews KIIs	JIU checklist he report IOB Assessment Technical Ability list

Evaluation frame SRHR study			
Item	Criteria / questions	Sources	Formats / guidelines
Effectiveness of UNFPA and UNAIDS programmes	Systematic review of evaluations on the 4 result areas	Evaluations (thematic) Other evidence (published reports, statements etc.) KIIs	IOB format[1]
Question related to the comparative advantages of the UN			
Efficiency advantages of UN channels (UNFPA and UNAIDS) / comparative advantages	Economies of scale Combat fragmentation Implementation capacity Concentration of knowledge Standardization and coordination	Evaluation reports KIIs	Section 6 of the IOB format
Question related to the effectiveness and efficiency of the Dutch policy + choice for the channel			
Effectiveness and efficiency of the Dutch policy	Did the channel selection for the UN contributed to the realization of the Dutch priorities in SRHR? To what extent have the benefits influenced the effectiveness? Conclusions regarding the financing policy (size, modalities and conditions) Conclusions whether the Dutch policy dialogue contributed to (better conditions) for effective funding and planning of the activities of the UNFPA and UNAIDS?	Evaluation reports KIIs	

[1] Operational Guidelines for Classifying Evaluation Findings on selected UN interventions relevant to Dutch Development Cooperation Priorities

Assessing the technical quality of evaluations (IOB)	
Requirements	Conditions to be met
1. Proper indicators and methods used to measure results	1.1 SMART indicators: Specific (unambiguous), Measurable (based on accessible data), Appropriate (for evaluation goals), Reliable (measuring what is intended; different people/methods get same results) and Time-bound (period-specific)
	1.2 Indicators cover at least two levels within the results chain
2. Transparent and reliable sources, collection and analysis of data	2.1 Detailed and complete description of data process given
	2.2 Enough information available to answer the research questions
	2.3 Data process is rigorous, i.e. meets scientific standards
3. Independent from stakeholders	3.1. Researches are not part of, or connected by interests to, the agency/ies being researched
4. Attribution possible	4.1 Quantitative study model compares of study and control group with a double difference approach
	4.2 Qualitative study model discusses alternative options, explains influence contextual factors and verifies each step of the causal chain
5. Conclusions grounded in findings	5.1 Conclusions are clearly presented and follow logically from the findings

Annex 3 – List of key informants

Ministry of Foreign Affairs	
Name	**Position**
Baak Joke	Senior Advisor DMM
Berg Seriana van den	Policy Officer WHO and UNAIDS
Buijs Reina	Deputy Director-General for International Cooperation Ministry of Foreign Affairs, Netherlands
De Voogd Ella	Former first secretary on SRHR at the Embassy of the Kingdom of the Netherlands in Bangladesh
Gerritsen Marco	SRHR/Health specialist at Embassy of the Kingdom of the Netherlands in Ethiopia (former Senior Development/Health Specialist)
Grijns Lambert	Director Social Development Departement and Special Ambassador SRHR & HIV/AIDS
Gulik Henriëtte van	Senior Adviser Rights, Gender, Prevention, Community Mobilization Department at UNAIDS in Geneva
Klinkert Els	Senior Health Advisor DSO/GA
Leemhuis Elly	Senior Advisor SRHR DSO/GA
Middelhoff Monique	Senior Advisor DSO/GA
Mopo-Imperator Jennyfer	First Secretary Permanent Representation of the Kingdom of the Netherlands in Geneva
Munster Leonoor van	Deputy Head of Economic and Social Affairs Section, First Secretary at Permanent Mission of the Netherlands to the UN
Smeding Bouwe-Jan	Senior Programme Advisor with UNFPA at Ministry of Foreign Affairs, Netherlands (formerly First Secretary Health, at Embassy of the Kingdom of the Netherlands in Ethiopia)
Snijders Vincent	Policy Coordinating Officer, Sexual & Reproductive Health and Rights at Ministry of Foreign Affairs, Netherlands
Vos Reinout	Deputy Permanent Representative at Permanent Representation of the Kingdom of the Netherlands
Waals Renet van der	Head Health and Aids Division

UNAIDS – Geneva	
Name	**Position**
Bosio Laetitia	Policy & Strategy Officer Strategic Policy Directions
Brenny Patrick	Deputy Chief of Staff Executive Office
Buse Kent	Chief Political Affairs and Strategy
Cabal Luisa	Chief, Human Rights and Law
David Abigail	Senior Planning and Monitoring Adviser Programme Planning & Performance Management
Joosten Veglio Fraukje	Resource Mobilization Advisor
Matineau Tim	Chief of Staff Director, Executive Office

Simao Mariangela	Director, Rights, Gender, Prevention and Community Mobilization
Ussing Morton	Chief Governance and Multilateral Affairs
Wagan Hege	Senior Advisor Gender Equality and Diversity

WHO/ Reproductive Health and Research (RHR) – Geneva	
Name	**Position**
Askew Ian	Director Department of RHR
Khosla Rajat	Human Rights Adviser Department of RHR
Lissner Graig	Programme Manager Department of RHR
Kiarie James	Coordinator Human Reproduction Team Department of RHR
Say Layle	Coordinator, Adolescents and At-Risk Populations

UNFPA – New York	
Name	**Position**
Addico Gifty	Technical Adviser Commodity Security Branch
Alakbarov Ramiz	Director, Programme Division
Annamuhamedova Aynabat	Audit focal point
Benomar Elizabeth	Technical Adviser, HIV/AIDS; OIC at the HIV Branch
Bierring Christina	Chief Quality Management Unit
Chalasani Satvika	Technical specialist at the Sexual & Reproductive Branch
Collins Lynn	Technical Adviser, HIV at the HIV Branch
Cook Andrea	Director Evaluation Office
Cutillo Mariarosa	Chief, Strategic Partnerships Branch at the Division of Communications and Strategic Partnerships
Daniel Ugochi	Chief Humanitarian & Fragile Context Branch at Programme Division
Deperthes Bidia	Senior HIV Tech. Advisor/CCP at HIV Branch
Erin Anastasia	Coordinator (a.i.), Campaign to End Fistula & Technical Specialist, Obstetric Fistula
Erken Arthur	Director of UNFPA's Division of Communication and Strategic Partnerships
Espinoza Noemi	Multilateral Affairs Specialist (Partnerships)Division of Governmental and Multilateral Affairs
Gupta Subhash	Director, Division of Management Services
Johansson Eva	Gender Equality, Rights and Sustainable Development Adviser at the Gender, Culture & Human Rights Branch
Kalassa Benoit	Director Technical Division
Kim Nicole	Strategy Policy and Standards Branch Programme Specialist
Lal Geeta	Senior Advisor Strategic Partnerships Human Resources for Health
Lasky Laura	Chief Sexual & Reproductive Branch
Light Benedict	Technical Adviser on Reproductive Health Commodity Security
Mora de la Beatriz	Resource Mobilization Specialist

UNFPA – New York	
Mosoti John	Chief Multilateral Affairs Branch at the Division of Governmental and Multilateral Affairs
Neelam Bhardwaj Neelam	Maternal Health/Sexual and Reproductive Health Technical Adviser
Pak Alexander	UN Reform Coordinator
Robinson Harold	Chief Post-2015 Branch at the Division of Governmental and Multilateral Affairs
Said Ragaa	Parliamentary Affairs Specialist at Information and External Relations Division
Sandino Oscar	Programme Specialist GPS
Sharafi Leyla	Technical Specialist at the Gender, Culture & Human Rights Branch
Simoni Pedersen Klaus	Chief, Resource Mobilization Branch at the Division of Communications and Strategic Partnerships
Sladden Tim	Senior Adviser, HIV & Key Populations at HIV Branch
Wong Eric	Audit Specialist
Zhukov Ilya	Technical Analyst at the HIV Branch
UNFPA – Geneva Office	
Barragues Alfonso	Deputy Director Geneva Office
Hoope-Bender Petra ten	Technical Advisor Sexual and Reproductive Health

Others (donors, organisations)		
Organisation	**Name**	**Position**
AIDS Fonds – STOP AIDS NOW (Amsterdam)	Keizer Irene	Manager Policy and Grants
Guttmacher Institute (New York)	Ann Stars	President and CEO
International Women's Health Coalition (New York)	Shannon Kowalski	Director of Advocacy and Policy IWHC
International Women's Health Coalition (New York)	Girard Francoise	President of the IWHC
North Star Alliance (Utrecht, by Skype)	Disney Luke	Former executive director North Star Alliance
Permanent Mission of Canada to the United Nations (New York)	Hentic Isabelle	First Secretary (Development) U.N. Funds & Programs
Population Council (in New York)	RamaRao Saumya	
Reproductive Health Supplies Coalition (Brussels, by Skype)	Skibiak John	Director
Stop AIDS Alliance (Geneva)	Ruiz Villafranca David	Senior Policy Adviser - Stop AIDS Alliance, Geneva
United Kingdom Mission to the United Nations (in New York)	Morizet Julie	Senior Policy Adviser Development and Human Rights

United Kingdom Mission to the United Nations (in New York)	Holtz Aaron	Senior Policy Adviser: Human Rights and Gender Equality
Universal Access to the Female Condom Programme (The Hague)	Siemerink Marie-Christine	Former programme coordinator

Annex 4 – Dutch policy intentions in SRHR

Overview MFA policy prioritisation of SRHR (2003-2015)	
2003	*Mutual interests, mutual benefits* (in Dutch *Aan elkaar verplicht*) reports on the main themes for prevention of AIDS and increased efforts in the field of reproductive health.
2006	The policy *Strong people, weak states* (in Dutch *Sterke mensen, zwakke staten*), specifically focusing on Africa underlines the need to address reproductive health and HIV/AIDS. The document states the importance of investing in people by giving due attention to reproductive health, education and HIV/AIDS.
2007	A new MFA policy document *Our common concern* (in Dutch *Een zaak van iedereen*) defined gender and sexual and reproductive health and rights as one of the four points of intensification within existing policy. Specific importance was given to gender equality and sexuality at national and international levels.
2008	*Choices and Opportunities* (in Dutch *Keuzes en kansen*) is the first Dutch policy document specifically focusing on SRHR and addressing both SRHR and HIV/AIDS. It describes the challenges of human rights violations, insufficient investments in the health sector, insufficient efforts in other non-health sectors and insufficient cooperation between various partners.
2010	Basic letter International Development (in Dutch *Basisbrief Ontwikkelingssamenwerking*) outlines the contours of the new policy in international development: reduced number of partner countries, reduced number of thematic areas (and a clear choice for thematic priorities), and increased focus on coherence and partnering with others (private companies, research and knowledge institutes, citizens).
2011	The letter to Parliament, *Focus Letter* (in Dutch *Focusbrief*), details the four spearheads of the Netherlands, one of which includes Sexual and Reproductive Health and Rights. In the letter the Ministry's reaffirms the importance of implementing the Cairo Agenda and of linking human rights and Sexual and Reproductive Health and Rights.
2012	The 2012 Letter to Parliament (TK 2011-2012, 32 605, no.93) further details the concrete ambitions and anticipated results on each of the four spearheads of the Netherlands.
2013	The report 'A World to Gain. A New Agenda for Aid, Trade and Investment' reaffirms Dutch commitments to investing in equal rights for women and SRHR. The report sketches a new agenda based on three important ambitions: to ban extreme poverty in one generation (*getting to zero*); sustainable and inclusive growth globally; and success for Dutch companies abroad.

Overview MFA policy prioritisation of SRHR (2003-2015)	
2013	Priorities in the human rights policy: Respect and justice for all (in Dutch *Respect en recht voor ieder mens*) are protecting human rights defenders, championing the equal rights of lesbians, gays, bisexuals and transgenders (LGBTs) and promoting equal rights for women, including SRHR. Thereby underling that reproductive and sexual rights are human rights, falling under the heading of economic, social and cultural rights. The policy refers to restrictive legislation, hindering access of women and young people to information and services regarding sexual health, and in relation to safe abortion. Also reference is made to large-scale violations of the rights of marginalised groups (sexual minorities, drug users and sex workers) and the how stigmatisation and discrimination lead to limited access to information and/or sexual health care.
2013-2015	No new SRHR; the 'Dialogue and Dissent' paper presenting the policy contours on SRHR for the period 2016-2020 (in the context of establishing strategic partnership with civil society organisations) can be seen as a continuation of the policy formulated in 2011/2012.

Annex 5 – Key issues in Sexual and Reproductive Health and Rights

Below an overview of the key issues in SRHRR following the four result areas of the MFA

The situation of adolescents and youth at a glance

Globally, there are 1.8 billion young people between the ages of 10 and 24 (one quarter of the world's population), and this demographic dividend is growing fastest in the poorest nations.[2] Young people are generally healthy, however young people are vulnerable to environmental and social changes (challenges), such as rapid urbanisation and rapid spread of mass media communications which have influenced the sexual behaviour and relationship of young people. changes: earlier puberty, rising mean age of marriage and steady decline in the extended family. On the other hand, increasingly young people are having sexual relations at an earlier age, this coupled with the 'traditional' problems of unwanted or early pregnancy has intensified other SRH problems, such as rise of infertility because of STIs and unsafe abortions, infection with HIV.[3]

Main health issues young people are facing are early pregnancy and childbirth (stats), HIV and other infectious diseases, violence, mental health, harmful drinking, tobacco and drug use, malnutrition and obesity, and unintentional injuries.[4] Young peoples' rights have advanced, but building on the achievements and safeguarding these rights –including particularly sexual and reproductive health rights (SRHR) and the rights of young girls– remains a major concern.

In 2012, an estimated 1.3 million adolescents died from preventable or treatable causes, including HIV/AIDS. While estimated AIDS-related deaths have declined in younger children, they did not for adolescents.[5] The distribution of the burden of disease is also very uneven, the highest numbers of adolescents living with HIV are sub-Saharan Africa and South Asia.

Despite the prominence of youth on the global agenda, young people are often left behind in national HIV responses. Access to high quality HIV prevention, treatment and care for young people is often lower than for their older adult counterparts. For example, modeling suggests that, between 2005 and 2012, the number of AIDS-related deaths among adolescents increased by 50%, while the overall number of AIDS-related deaths fell by 30%. While there has been progress in the HIV response for young people, with HIV prevalence in sub-Saharan Africa among young women and men aged 15-24 falling by 42% from 2001 to 2012, young people aged 15-24 still accounted for 39% of the 2 000 000 new adult infections in 2012.[6]

Early marriage is most rampant in South Central Asia and Western Africa: nearly half of all women ages 20 to 24 in these regions were married by age 18, putting them at a higher risk for early pregnancy and maternal disability and death, and limiting their access to education and employment.[7]

[2] UNFPA (2015). Annex 8: Progress on implementation of the UNFPA Adolescent and Youth Strategy
[3] IOB (2009). Synthesis of impact evaluations in SRHR
[4] UNFPA (201X). Inception report A&Y study
[5] UNICEF, 2015 in UNFPA 2016 – inception report
[6] UNAIDS (2013). Background note on Y and A
[7] (PRB, 2013 in UNFPA IR 2016).

The situation of adolescents and youth at a glance

Unsafe abortions: according to data published by WHO an estimated 22 million unsafe abortions occur every year, including 3 million unsafe abortions among young women ages 15 to 19 annually. Young women under the age of 25 accounts for approximately half of all abortion-related deaths.[8]

Globally, it is estimated that between 100 million to 140 million girls and women alive today have undergone some form of female genital mutilation1 (FGM). If current trends continue, 15 million additional girls between ages 15 and 19 will be subjected to it by 2030. FGM is a deeply entrenched social and cultural norm in many countries2 with devastating medical, social, emotional, legal and economic repercussions for young girls and women.

Violence is also a leading cause of death. An estimated 180 adolescents die every day as a result of interpersonal violence and globally around 30% of adolescent girls experience violence by a partner.[9]

Accessing SRH commodities at a glance

People need diverse commodities (contraceptives, medicines and medical devices) that enable them to have safe sex, safe pregnancy and safe delivery, and – if women so desire – safe abortions. However, many people lack the knowledge about and access to essential products and commodities leading to a host of undesirable consequences. Furthermore, the chains – from research, development, and production, distribution of commodities and products to people using these commodities and products – are long and complex. Gaps, barriers or interruptions anywhere along those chains currently severely reduce impact. Below an overview of the SRH context in which SRH commodities are crucial:

The numbers AIDS related mortality continues to decline because of the increased availability of antiretroviral therapy. Between 2010 and 2015 the amount of people receiving ART has doubled from 7.5 to 15 million. Of all people with HIV, globally 38% is receiving ART. The percentage of HIV positive pregnant women receiving ART to prevent transmission increased from 48% in 2010 to approximately 73% in 2015. In twenty-one high priority countries in Sub-Saharan Africa about 77% of women are reached with services that help prevent mother-to-child transmission of HIV. (UNAIDS MDG 6 report, 2015).

40 % of pregnancies worldwide are unintended (85 million of the 213 million).[10] Many of these unintended pregnancies end up in an abortion or miscarriage. Family planning is one of the most effective and cost-effective ways in saving women's, girl's and children's lives and improving their health. The unmet need for family planning is still 12% worldwide and 24% in Sub-Saharan Africa for women of reproductive age that are married (MDG report 2015). In other words one in four women that is married and aged 15-49 does not have access to family planning services.

[8] WHO, 2014

[9] WHO, 2014

[10] Guttmacher 2014

According to UNFPA (SOWP 2014), 46.3% of unmarried and/or sexually active girls aged 15-19 living in West/Central Africa, have an unmet need for family planning. This same age group in East/Southern Africa has an unmet need of 48.7%. For both regions the age group 20-24 has a slightly lower unmet need for family planning (respectively 35,1% and 29,9%), but these percentages are still considerably higher than the average unmet need for family planning in Sub-Saharan Africa (which is 24%, MDG report 2015). Large differences also persist between urban and rural residents, rich and poor households, and the educated and uneducated.

The UN Secretary-General's *Global Strategy for Women's and Children's Health* (2010) called on the global community to work together to save 16 million lives by 2015. This challenge was taken up by the UN Commission on Life-Saving Commodities for Women and Children, which identified and endorsed an initial list of 13 overlooked life-saving commodities that, if more widely accessed and properly used, could save the lives of more than 6 million women and children.[11, 12] A review of the state of the art on the 13 essential commodities showed that CMH commodities had fewer bottlenecks than reproductive and neonatal commodities. Common bottlenecks included regulatory challenges, poor quality assurance, insufficient staff training, and weak supply chains systems with stock-outs of priority commodities in about 40% of facilities on average.[13]

SRH and health strengthening

An accessible health system of good quality is vital in improving sexual and reproductive health and rights. Safe deliveries require skilled health personnel, including midwives. Health facilities need to be equipped to respond to emergencies. Health commodities and technologies need to be available, up to the lowest levels of the health care system. Health system strengthening therefore is at the heart of the Netherlands policy in SRHR.[14] Specific focus is on:

- Reducing maternal mortality, through increased attention to skilled health personnel during delivery. Despite progress there remains a large discrepancy between poorer and richer populations, and gaps in urban and rural access to quality health care facilities.[15] Capacity development of health workers is crucial in HSS, in particular of midwives.
- A well functioning health system is needed to deliver services to all, including young people and disadvantaged groups. Ideally these services are delivered in an integrated manner – i.e. all services that someone needs in one place – for example antenatal care and STI including HIV testing combined; post-abortion care combined with counselling on contraceptives. To ensure this, public and private partners have to play a role in quality control, service delivery,

[11] See more at: http://www.unfpa.org/publications/un-commission-life-saving-commodities-women-and-children#sthash.nnd7hgFC.dpuf

[12] Maternal health commodities: Oxytocin – post-partum haemorrhage (PPH); Misoprostol – PPH; Magnesium sulfate – eclampsia and severe pre- eclampsia. Newborn health commodities: Injectable antibiotics – newborn sepsis; Antenatal corticosteroids (ANCs) – preterm respiratory distress syndrome; Chlorhexidine – newborn cord care; Resuscitation devices – newborn asphyxia. Child health commodities: Amoxicillin – pneumonia; Oral rehydration salts (ORS) – diarrhea. Reproductive health commodities: female condoms; contraceptive implants – FP, contraception; emergency contraception: FP, contraception

[13] Pronyk P., et al. (2016). The UN Commission on Life Saving Commodities 3 years on: global progress update and results of a multicountry assessment. Lancet Glob Health 2016; 4: e276–86

[14] Several policy documents, see annex 4. This policy is being continued, see: Letter to the Parliament on Policy intentions on health system strengthening (2016. MINBUZA2016.203198).

[15] DSO results report, see annex 7

staffing, and financing.[16] The goal is to bring services closer to the client, therefore task shifting is increasingly more apllied; also new modes of communication are introduced, and is e-health gaining grounds. The role of private partners in these developments is increasing.

- Universal access to reproductive health care is far of track and only slowly improving (figures). Therefore more attention is being given to community and innovative, holistic approaches to service delivery, aiming to reach out to all, including the poorest populations. The Global Financing Facility (GFF) / operated by the World Bank / footnote explain, can play a role in effective collaboration between the private and public sectors.

State of the art sexual and reproductive rights of key populations

In every part of the world, including the Netherlands, some people are denied their sexual and reproductive rights. Protecting, respecting and fulfilling sexual and reproductive rights is therefore a truly universal objective, but at the same time the approach may need to be context-specific.

Reforms are however happening slowly and results will take some time. Legal reforms that are in line with internationally agreed human rights are important steps in fulfilling the sexual and reproductive rights of people. Apart from the legal environment, there is the policy reform and its implementation that will make a real difference for the people. After all, respecting people's rights requires a behavioural change, from the general population in the communities and from the professionals implementing this policy and laws such as health workers, the police, the legal forces. Power relations, religious barriers, different norms and values in the communities are not easily changing and require time. The Netherlands will need to remain consistent in its message, coming up for the rights of youth, sexual minorities, and marginalised people, while building alliances with like-minded southern and northern partners.

Men who have sex with men (MSM) and commercial sex workers have 13 times the rate of HIV infection than the general population. People who inject drugs even 22 times that rate (UNAIDS 2012 Global Report). Nevertheless these groups are more difficult to reach, especially in countries where their status is illegal under national law. In more than 100 countries, commercial sex workers are criminalised. LGBT are criminalised in 71 out of 106 countries, 8 less than 2 years ago. It is estimated that there are 22 million unsafe abortions annually, which account for the death of about 47,000 women and disabilities of about 5 million women. Though the global abortion rate has declined since 1995, it has stalled in the last 10 years. All this suffering could be prevented through sexuality education, family planning and the possibility of safe legally induced abortion and care. However, in 82 countries, abortion cannot be legally induced after rape or incest. Most allow though an abortion to save a woman's life. Studies show that highly restrictive abortion laws do not tend to lower abortion rates. On the contrary, they tend to make them unsafe. In Nepal, abortion related complications dropped by half from 54% to 28% when abortion was made legal on broad grounds in 2002.

However, on the international level, progress has been made in facilitating an open atmosphere in which to discuss the agenda agreed at the International Conference on Population and

[16] DSO results reports, see annex 7

State of the art sexual and reproductive rights of key populations
Development (ICPD, Cairo, 1994). The ICPD Global Review process published a concept note that confirmed large support from several countries and other actors in the field of SRHR. The number of child marriages is still unacceptably high: UNFPA reported that in the period 2005-2015 65% of girls between 20-24 years old got married before the age of 18 (no new data on 2013). Besides, female genital mutilation (FGM) is still taking place in 29 countries, with rates varying between 1% (Uganda/Cameroon) up to 98% (Somalia). UFPA reports 40% of girls in Sub-Saharan Africa have undergone FGM in the period 2002-2011.

Source: Several policy documents and letters to the parliament [17]

[17] DSO annual reports; A World to Gain; and others, including: Kamerbrief 26 – 11 – 2010. Basisletter Internationale Samenwerking; TK 2010 – 2011, 32 605, nr. 3. Beleid ten aanzien van ontwikkelingssamenwerking; TK 2011 – 2012, 32 605 nr. 93. Beleid ten aanzien van ontwikkelingssamenwerking; Kamerbrief 7 – 10 – 2011. Focusbrief ontwikkelingssamenwerking; TK 2012 – 2013, 33 625, nr.1. Hulp, handel en investeringen; MJSP DSO 2014-17

Annex 5 – SRHR results report of the Social Development Department, MFA

Thematic area 1: Adolescent SRH						
	Baseline 2002	Objective 2015	Result 2012	Result 2013	Result 2014	Source
Question 1a: To what extent are young people better informed? What evidence is there that they are making healthier choices regarding their sexuality?						
Percentage of 15-24 year olds using condoms at last high-risk sex (MDG indicator 6.2) in Sub Saharan Africa	25% (F) 40% (M)	no target set	30% (F) 49% (M)	(2006-2012) F: 37% M: 57%	F: 40% M: 59%	2012: MDG report 2013 2013: UN MDG report 2014, p.35 UN MDG report 2010, p.12 2014: UN MDG report 2014, p.35 UN MDG report 2010, p.12 UN MDG report 2015, p.45
1b (1): With which results has your programme contributed to comprehensive sexuality education for young people in and outside of school and 1.b (2): With which results has your programme contributed to opportunities for young people to have their voice heard and stand up for their rights?						
Percentage of young people (15-24) with comprehensive and correct knowledge of HIV/aids (MDG indicator 6.3) in Sub Saharan Africa	25% (F) 31% (M)	95%	28% (F) 36% (M)	(2006-2012) F: 28% M: 39%	(2007-2014) F: 30% M:37%	2012: MDG report 2013 2013: UN MDG report 2014, p.35 2014: UN MDG report 2014, p.35 UN MDG report 2015, p. 45
Optional indicators						
Number (or %) of youth-friendly (health) centres	-	Target (2017) SRHR Alliance:	SRHR Alliance: 443.403	SRHR Alliance: 1.053.287	SRHR Alliance:	SRHR Alliance (2014, p. 78) UFBR p. 19

Thematic area 1: Adolescent SRH						
	Baseline 2002	Objective 2015	Result 2012	Result 2013	Result 2014	Source
		1.250.000 (2015)			994.063, UFBR: 70	
Number of youth (10-24) using sexual and reproductive health services by organisation supported (2013)	-	Ask: 1250000	-	IPPF: 11.066.037 ASK: 1.053.287	Sum IPPF, ASK, FTA & UFBR = 28.466.679	IPPF Annual Report Choices & Opportunities ASK 2014: IPPF Annual Report Choices & Opportunities ASK, ASK 2014 p.19, UFBR p.19, F2A.
Number of schools that adopt comprehensive sexuality education (2013)	-	NA	-	ASK, ICCO, T4C, SRHR Alliance & KIR = 2294	ASK, ICCO, T4C, SRHR All., KiR & UFBR = 17.418	2013: Annual Reports IPPF Choices & Opportunities, ICCO Alliance 2014: 2013: Annual Reports IPPF Choices & Opportunities, ICCO Alliance, 2014: ASK p.19, UFBR p.19, ICCO Alliance p.142, T4C p.26, SRHR Alliance p.76, KiR p.7
Number of young people being counselled for HIV/STI/contraception and/or tested for HIV/STIs (2012)	PSI: 491.180 IPPF:					IPPF PSI progress report 2011
Number of youth (10-24) in school & out of school reached with	-	Ask: 150000	FTA: 341.000	Link-UP: 14498	5.756.907	Annual Reports 2013 IHAA, Link-Up, ASK, Keep it Real, Faith to Action,

Thematic area 1: Adolescent SRH						
	Baseline 2002	Objective 2015	Result 2012	Result 2013	Result 2014	Source
information on sexuality, HIV, STIs, pregnancy, contraceptives (2013)				ASK: 16.451.642 FTA: 341.000 2.085.800		SRHR Alliance 2013/2014 Annual Reports Link-Up, ASK, KiR, FtA, SRHR Alliance, IPPF, ICCO Alliance, T4C, CVY.
Remaining indicator						
	Baseline	Target 2017	Result 2012	Result 2013	Result 2014	Source
Number of schools with HIV/Aids education	191	75	208	702	-	ICCO Alliance
Pupils and teachers with changed attitudes as well as improved knowledge and skills for protection against HIV/STI transmission and unwanted pregnancies	1098	60%	1266	8016 (52%)	2.370 (IPPF)*	ICCO Alliance, *IPPF Annual Report 2014: young people were trained as advocates for CSE.
Children and young people demonstrate positive behavioural change on SRHR	1263	3641	-	5576	1.279.195 (UFBR)	Together 4 Care, UFBR p.19

Thematic area 2: SRH commodities						
	Baseline 1990	Objective 2015	Result 2012	Result 2013	Result 2014	Source
Question 2a: To what extent do more people have access to anti-retroviral drugs, contraceptives and other commodities required for good sexual and reproductive health?						
Contraceptive Prevalence Rate - modern methods- all Women 15-49 (MDG indicator 5.3) (2012 ind)	55%		63%			2012: State of the World Pop. Rprt 2012 UNFPA
Sub Saharan Africa (2012 Ind)	12%		20%			2012: SoWP Report
Unmet need for family planning (per age group, where available and relevant)(MDG indicator 5.6)	15%	0%	12%			2012: MDG report 2013
Sub Saharan Africa (2012 ind)	26.5%	0%	25%			2012: MDG report 2013
Proportion of population with advanced HIV infection (according to CD4) with access to antiretroviral drugs (MDG indicator 6.5)	2009: 40%	80%	2011: 55%			
Contraceptive Prevalence Rate - modern methods- all married women 15-49 in developing regions	1990: 52% (all methods)	NA	63% (all methods) Sub-Saharan Africa: 20%	57% (modern methods) 64% (all methods) – 2013 report 44% modern methods,	44,5% modern methods, 51% all methods.	PRB 2013: World Population Data sheet, p.13, MDG report 2014, p.32, UNFPA State of the World Population, p. 105 (2013 report) PRB 2013: World Population Data sheet, p.13, MDG report 2014, p.32, UNFPA State of the World Population 2013, p.105, UNFPA

Thematic area 2: SRH commodities						
	Baseline 1990	Objective 2015	Result 2012	Result 2013	Result 2014	Source
				50,5% all methods. (2014 report)		SWOP 2014, p.109. (2014 report)
Contraceptive Prevalence Rate - modern methods- all girls 15-19	-	NA	-	21%		UNFPA State of World Population 2013, p.37
Unmet need for family planning of married women 15-49 years old, in developing regions	17% Sub-Saharan Africa: 28%	NA	12% Sub-Saharan Africa: 25,1%	-	24% in Sub-Saharan Africa	MDG report 2014, p.32 (2013 report) MDG report 2015, p.41 (2014 reportage DSO)
Unmet need for family planning of girls 15-19 years old	-	NA	-	15%		UNFPA State of World Pop. Report 2013, p.37
Remaining indicators						
	Baseline	Target 2017	Result 2012	Result 2013	Result 2014	Source
Proportion and number of the access to antiretroviral therapy of people living with HIV (MDG indicator 6.5), in developing regions	2003: 800.000	15 million people (80% of HIV patients) (2015)	9,7 million	(globally): nearly 13 million	(globally): 13.6 million	UN MDG Report 2014, p.36, UNAIDS Global report 2013 + Gap Report, july 2014, 2014: UN MDG Report 2015, p.6/44.
Question 2b: With which results has your programme contributed to a greater choice in and sufficient availability of contraceptives/medicines? *Result Question 2b (2): With which results has your programme contributed to addressing sociocultural barriers preventing women from using contraceptives?*						
Optional indicators						

Thematic area 2: SRH commodities						
	Baseline 1990	Objective 2015	Result 2012	Result 2013	Result 2014	Source
Type of new, user-friendly products / medicines on the market for improved sexual and reproductive health	Baseline 2011 1 female condom (FC)	NA	2 female condoms	2 FC	2 FC (cumulative)	UAFC Annual report 2013
Number of couples protected by various contraceptives (Couple Year Protection) – 2012	11,450,000		29,244,814			GP RHCS annual report 2012
	19,000,000		21,153,796			PSI impact report 2012
	9,100,000		11,800,000			IPPF annual reports
			13,291			UAFC
Number of couples protected by various contraceptives (Couple Year Protection) – 2013	-	NA	IPPF: 3.000.000 GP: 29.244.814	IPPF: 4.400.000 GP: 35.079.117 UAFC: 32.418	PPF: 6.142.313 GP: 28.400.000 PSI/COF: 241.424	Annual Reports 2013 IPPF and PSI COF, UAFC, GPRHCS220324+16100000 Annual Reports 2013 IPPF and PSI COF, UAFC, GPRHCS. Annual reports IPPF, PSI & UAFC.
Number of male and female condoms distributed	PPF: 11.000.000	NA	IPPF: 17.000.000	IPPF: 16.100.000 male: 236.956.324 female: 19.447.26	334.264.030, male: 438.420.000 female:13.364.500	IPPF male: GPRHCS + PSI cumulative female: GPRHCS +UAFC cumulative Unspecified is IPPF, ASK, PSI , GFATM cumulative male: GPRHCS, female: GPRHCS + UAFC cumulative. Cumulative all

Thematic area 2: SRH commodities						
	Baseline 1990	Objective 2015	Result 2012	Result 2013	Result 2014	Source
						= 786.048.530 (2014)
Number of children immunised with vaccines	2010: 296 million	plus 243 million) 539 million	393 million 538 million	447 million	503 million	GAVI progress report 2013, 2014
Number of people being treated with anti-retroviral drugs	3.543.000		8,000,000			UNAIDS
Remaining indicators						
	Baseline	Target 2017	Result 2012	Result 2013	Result 2014	Source
Annual outreach of innovative/alternative models and pilots for service delivery in SRH are implemented: 5,000 people given access to aids prevention, legal aid and other services	5000 (2011)	-	-	-	7000	Hivos Alliance (2014, p.69).

Thematic area 3: health system strengthening for SRH						
	Baseline 1990	Objective 2015	Result 2012	Result 2013	Result 2014	Source
Question 3a: To what extent has the use of sexual and reproductive healthcare services in the public and private sector changed?						
Antenatal care coverage (at least	1 visit: 63%	80%	1 visit: 81%			

Thematic area 3: health system strengthening for SRH						
	Baseline 1990	Objective 2015	Result 2012	Result 2013	Result 2014	Source
one visit and at least 4 visits) (MDG indicator 5.5): developing countries	> 4: 37%		> 4 : 51%			
SSA	1 visit: % > 4: 52%	80%	1 visit: 81% > 4 : 49%			
Proportion of births attended by skilled health personnel (MDG indicator 5.2): developing countries	55%	80%	66%			
SSA	41%	80%	50%			
Percentage of HIV-positive pregnant women receiving treatment to prevent mother-to-child transmission of HIV	57% (2009)	90%	64% (900,000)			UN Aids 2012, together we will end aids
Antenatal care coverage of at least one visit (MDG indicator 5.5) - developing countries (2013 ind)	65%	80%	81%	82%	(2007-2014) 77% WHO African region,83%globally	MDG Report 2014, p.30 WHO World Health Statistics 2015, p. 12
Antenatal care coverage of at least four visits (MDG indicator 5.5) - developing countries	37	80	51	52	52	MDG Report 2014, p.30 MDG report 2015, p.41.
Proportion of births attended by	56	90	66	68	70	MDG 2014 Report

Thematic area 3: health system strengthening for SRH						
	Baseline 1990	Objective 2015	Result 2012	Result 2013	Result 2014	Source
skilled health personnel (MDG indicator 5.2) - developing regions						
Proportion of births attended by skilled health personnel of 20% poorest	No baseline	90	-	(2007-2012: 31%	-	UN DATA (UN.DATA.ORG)
Remaining indicators						
	Baseline	Target 2017	Result 2012	Result 2013	Result 2014	Source
Proportion of births attended by skilled health personnel of 20% richest	-	90%		(2007-2012): 85%	-	UN DATA (un.data.org), 2014: no new data available
Percentage of HIV-positive pregnant women receiving treatment to prevent mother-to-child transmission of HIV - low- and middle income countries	(2005) 17% (2010) 48%	90	62	62	73% globally / 77% (in 22 focus countries)	UNAIDS 2013, UNAIDS 2015 MDG6 report 2005:p.366, 2014: p.33 / p.368.
% of government's budget allocated to health sector - Sub-Saharan Africa / Health expenditure, public (% of government expenditure) Sub-Saharan Africa	(2004) 11%	15-20% of governmental expenditure(WHO)		(2008-2012): 11.5%	No recent data available*	WHO Health Financing 2014 *The WHO African Region Expenditure Atlas from November 2014 uses data from 2012.
Result Question 3b (1): With which results has your programme contributed to improved cooperation between public and private healthcare services?						

Thematic area 3: health system strengthening for SRH						
	Baseline 1990	Objective 2015	Result 2012	Result 2013	Result 2014	Source
Result Question 3.b (2): With which results has sexual and reproductive health care including emergency obstetric care become more affordable and accessible?						
	Baseline	Target 2015	Result 2012	Result 2013	Result 2014	Source
Number of midwives/ skilled birth attendants trained	NA	NA	-	increase of 35% availability of midwives	13.084	UNFPA, 2014; UFBR
Number of health staff and community health workers trained in ante- and post natal care, safe deliveries and basic health care	NA	NA	HIF: 508-	Link up: 220* AMREF: 2168 HIF: 1276	AMREF: 1130, SRHR: 13084, CD: 1800. Total:16.014	Link - up; *number of private service providers trained AMREF Health Insurance Fund report 2013 Link - up; *no. of private service providers trained AMREF Health Insurance Fund rep 13, AMREF: Annual rep 14, SRHR Alliance p.77, CDA p.58.
Number of mothers receiving ante & post natal care	11.389	43.500	11.856	43.900	CD: 66.000 ASK: 169.354 Total: 235.354	CD Alliance CD Alliance, Child Development Alliance (2014, p.59), ASK p.19.

Thematic area 3: health system strengthening for SRH						
	Baseline 1990	Objective 2015	Result 2012	Result 2013	Result 2014	Source
	Baseline	Target 2015	Result 2012	Result 2013	Result 2014	Source
Partners have a staff policy in place that contributes to the sustainability, accessibility and quality of the health system at large	3	70%	13	41 (80%)	-	ICCO Alliance
% maternal health facilities with an increase in satisfaction by women	NA	40%	-	42.1%	-	SRHR Alliance

Thematic area 4: Respect for SRHR of key populations						
	Baseline	Target 2017	Result 2012	Result 2013	Result 2014	Source
Result Question 4a: To what extent have the conditions for women, young people, sexual minorities, sex workers and intravenous drug users improved with regards to their sexual and reproductive rights?						
Percentage of women married before age 18 in 20-24 year age group	(2010) 13,5% (2000-2011) 34%	NA	-	(2005-2012) 65%	(2005-2013) 40% in SSA, 45% in LDC, 27% globally	UNFPA Marrying too Young (2012), UNICEF global databases based on DHS, MICS and other national household surveys - last update Oct. 2014

Thematic area 4: Respect for SRHR of key populations						
	Baseline	Target 2017	Result 2012	Result 2013	Result 2014	Source
Percentage of female genital mutilation in 15-49 year age group - Sub-Saharan Africa	NA	NA	-	(2002-2011) 40%	(2005-2013) 39%	UN DATA (un.data.org), UNICEF global databases based on DHS, MICS and other national household surveys - last update Oct. 2014.
Result Question 4b (1): With which results has your programme contributed to the identification of or changes in legal and policy barriers for the sexual and reproductive health of women, young (unmarried) people, sexual minorities, intravenous drug users and sex workers? *Result Question 4b (2): With which results has your programme contributed to improving the access of these specific groups to sexual and reproductive health services and commodities?*						
	Baseline	Target 2017	Result 2012	Result 2013	Result 2014	Source
Perceived change in public statements made by leaders / personalities advocating for sexual and reproductive rights: of women, young (unmarried) people, sexual minorities, sex workers and intravenous drug users	2013: cross-regional statement in UN setting	NA	-	Statements in HRC and OWG4	Statements in OWG8, OWG13, 50,58, co-sponsors	HRC statement, OWG8 and OWG13 Joint SRHR Statements.
Number of key populations having received sexual and reproductive health services and information	NA	NA	-	544.090	364.564	Bridging the Gaps, Annual Report 2013 Stepping Up, Stepping Out, Annual Report 2013 CAHR Annual Report 2013

Thematic area 4: Respect for SRHR of key populations						
	Baseline	Target 2017	Result 2012	Result 2013	Result 2014	Source
Remaining indicators						
	Baseline	Target 2017	Result 2012	Result 2013	Result 2014	Source
Number of countries where health or health related policies changed to favor rights of vulnerable group	2	4	3	4	-	ICCO Alliance
Increased involvement of community leaders in realisation of SRHR in % of the targeted communities	NA	50%	-	65%	-	SRHR Alliance
Community members and community leaders participating in SRHR awareness-raising activities at community level	NA	2.000.000	536.843	989.680	1.587.261	SRHR Alliance (2014, p.79)
Persons reached by SRHR awareness-raising activities through (new) media	NA	15.000.000	7.396.478	16.451.642	27.597.254	SRHR Alliance (2014, p. 79)

Source: Social development department results reports 2012, 2013, 2014.