Terms of Reference
Evaluation
Dutch policy
on Sexual and Reproductive Health and Rights
(SRHR) - BHOS Article 3.1

Ministry of Foreign Affairs

Policy and Operations Evaluation Department (IOB)

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Contents

Acronyms and abbreviations

BHOS	Buitenlandse Handel en Ontwikkelingssamenwerking / Foreign Trade and Development Cooperation
EUR	Euro
Gavi	Global Alliance for Vaccines and Immunizations
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GFF	Global Financing Facility in Support of Every Woman Every Child
ICPD	International Conference on Population and Development
IOB	Policy and Operations Evaluation Department of the Netherlands Ministry of Foreign Affairs
IPPF	International Planned Parenthood Federation
LGBTI	Lesbian, Gay, Bisexual, Trans and Intersex people
NGO	Non-governmental organisation
R&D	Research and Development
RVO	Netherlands Enterprise Agency
SDG	Sustainable Development Goal
SRHR	Sexual and Reproductive Health and Rights
ToR	Terms of Reference
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

1. Introduction and rationale

1.1 Rationale

The Policy and Operations Evaluation Department (IOB) has scheduled to evaluate the Dutch policy implemented under article 3 'Social Progress' of the general budget for Foreign Trade and Development Cooperation (BHOS), by 2022. The evaluation of Sexual and Reproductive Health and Rights (SRHR; see textbox) and HIV/AIDS, sub-article 3.1 on the BHOS budget and one of the main policy priorities of Dutch development cooperation for many years, is an important building block for this overall policy evaluation.

These Terms of Reference (ToR) present the outline for this evaluation of Dutch SRHR and HIV/AIDS policy. It is the third time, that such an evaluation takes place. The first IOB evaluation covered the period 2004-2006 and was published in 2007, the second evaluation was published in 2013 and covered the years 2007-2012. These Terms of Reference cover the period 2012-2020. This period marked the start of a shift in Dutch development cooperation; despite the restructuring of Dutch aid policy and the *deprioritisation* of (basic) health care, SRHR remained a policy priority in the three subsequent governments covered in the evaluation period.

Text box: SRHR key terms[1]

Reproductive health is defined in terms of physical, mental and social well-being, not merely as the absence of disease. It addresses the reproductive processes, functions and system at all stages of life. It implies, as mentioned in the World Health Organisation's (WHO) working definitions of SRHR, *that people are able to have a responsible, satisfying and safe sex life, the capability to reproduce and the freedom to decide if, when and how often to do so*. *Reproductive rights and sexual rights* are grounded in international human rights treaties and provide the framework within which sexual and reproductive well-being can be achieved.[2] These rights enable people to enjoy a mutually satisfying and safe relationship, free from coercion or violence and without fear of infection or pregnancy, and to regulate their fertility without adverse or dangerous consequences. The WHO's Global Strategy on Reproductive Health (2004) outlines five core SRHR-themes[3][4]:

(1) Improving antenatal, perinatal, postpartum and newborn care;
(2) Providing high qualitative services for family planning, including infertility services and ensuring contraceptive choice and safety, and fertility services;
(3) Eliminating unsafe abortions and providing post-abortion care;
(4) Reducing sexual transmitted infections, including HIV and other reproductive morbidities; and
(5) Promoting sexual health, including adolescent health and reducing harmful practices.

These ToR start with the policy background and priorities as well as financial channels and their resources disbursed between 2012-2019. Subsequently, they sketch the main purpose of the evaluation, the evaluation focus and questions as well as its limitations. The ToR furthermore describe the proposed evaluation approach and methods and finally some practical matters regarding the implementation of the evaluation.

1.2 Policy priorities

In the past, the Netherlands supported (basic) health care and SRHR in low- and lower middle-income countries. It contributed to public health institutions through general budget support, sector budget support and multi-donor basket funds. This changed in 2010, when it was decided to reduce

[1] De Kok et al, 2017: 20.
[2] International Planned Parenthood Federation, 1997, IPPF charter on sexual and reproductive rights.
[3] WHO, 2004, Reproductive Health Strategy to accelerate progress towards the attainment of international development goals and targets.
[4] DSO also uses the Guttmacher-Lancet Commission's comprehensive and integrated definition of SRHR with an even stronger emphasis on sexual pleasure (Starrs, et al, 2018).

the aid budget for supporting integral health systems. Though SRHR remained a policy priority in Dutch development cooperation, this was not the case for the health sector as a whole and support to integral health systems was phased out between 2011 and 2015.

The Netherlands is party to all relevant international conventions and a signatory to the relevant resolutions and declarations on SRHR. The Dutch international position on SRHR is a reflection of its domestic SRHR-policies and of the experiences it has generated over the years on topics like youth and sexuality, access to contraceptives, the rights of key populations and public-private collaboration in e.g. health insurance (KST 32605-2, 2011: 11). As a progressive and determined advocate of SRHR, the Netherlands has promoted the Cairo Agenda, aiming to keep themes like the prevention of unsafe abortions on the international agenda, linking SRHR with human rights, and focusing on the need to address SRHR of key populations (Jürgen's, 2017: 14). [5]

The 2018 policy document '*Investing in Global Prospects - For the World, For the Netherlands*' makes clear that SRHR will remain a policy priority, also in emergencies and humanitarian crises. According to the policy note, more funding is to be set aside for the new priority regions; West African Sahel, the Horn of Africa, North Africa and the Middle East. Increasing SRHR-efforts in the new focus regions will mainly be done through country-specific programmes making use of funding originally set aside by the ministry for BHOS for the global programmes of multilateral organisations (KST 35000-XVII-2, 2018: 54).

Prevention has been a priority in Dutch SRHR policy – from preventing unintended pregnancies, unwanted and unsafe abortions, to preventing HIV transmission and preventing gender-based violence. *Investing in Global Prospects* and the ministry's SRHR-intervention strategies of 2015 and 2018 refer to an integrated approach[6] to SRHR based on four pillars: [7]

(1) Access to (youth friendly) information and resources: sexuality education, good quality and affordable contraceptives, safe pregnancy and delivery services and, where necessary, safe abortions and antiretroviral drugs, i.e. the sensitive topics of the Cairo agenda. This should allow young people to make their own choices in relationships, sex and contraceptive use;[8]
(2) Access to preventive medicine and medical care without discrimination on the basis of gender, sexual orientation or profession, including for refugees and displaced persons and in crisis situations;
(3) Ensuring good quality sexual and reproductive healthcare, including abortion and psychosocial support for all, irrespective sexual identity, gender or profession;
(4) More respect for the sexual and reproductive rights of groups who are currently denied these rights. This includes combating sexual intimidation, gender related violence, child prostitution and abuse in the sex industry, child marriages and the criminalization of homosexuality.

1.3 Channels and instruments

Article 3 of the BHOS budget focuses on promoting inclusive human development and social equality. Sub article 3.1 intends to contribute to SRHR for all and to put a stop to the spread of HIV/AIDS.

[5] The Cairo agenda refers to the Declaration and Plan of Action of the 4th International Conference on Population and Development (ICPD) that was held in Cairo in 1994. In 2014 an evaluation was done of 20 years of work on the 'ICPD-agenda'. See further on this topic e.g. KST 34775-XVII-2, 2018: 51-52.
[6] The ***integrated approach*** exists already in the policy note *Keuzes en Kansen* of November 2008, the first policy paper focusing on SRHR (and HIV/AIDS). IOB's policy evaluation of 2013 also refers to a multi-sector approach even though 'Dutch policy documents provide little on how to make this approach operational, and the contribution of other sectors to SRHR outcomes has been largely undocumented' (IOB, 2013: 49).
[7] See Annex 1 for a further operationalization of the four policy pillars.
[8] See also KST 32605-2, 2011: 10-11; KST 34000-XVII-2, 2014: 48 and more recently KST 34775-XVII-2, 2018: 51-52.

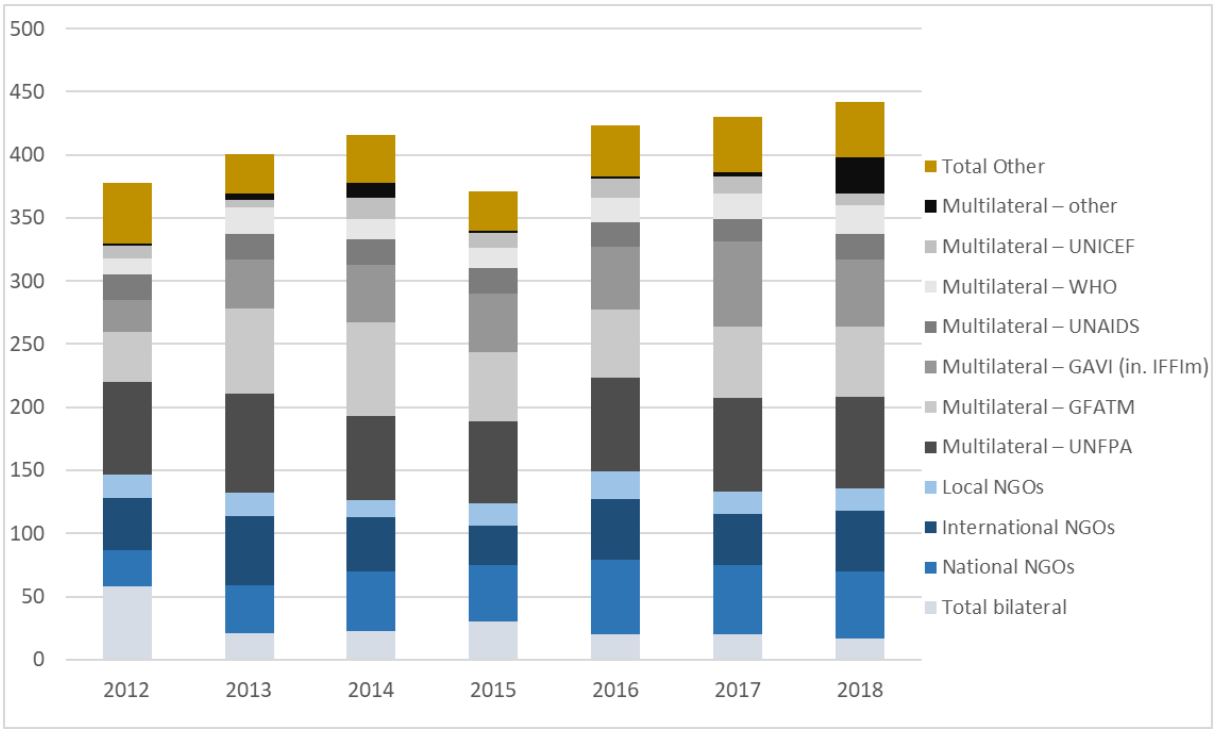
Between 2012 and 2018, the ministry spent approximately EUR 2,858 million on SRHR and health, roughly 44% of the entire budget for article 3.

To realise its aims regarding sub-article 3.1, the Netherlands deploys a range of instruments. It uses its political, human and financial weight as well as its technical and political expertise and skills to address the issues referred to above and topics such as the follow-up of the ICPD beyond 2014 and SRHR and gender equality as part of the post-2015 development agenda.[9] [10]

Though the policy priorities within SRHR policy did not change radically over time, financing modalities have shifted somewhat over the years as is also clear from figure 1. Annex 2 presents the underlying data.

The share of bilateral support to SRHR dropped from 16% in 2012 to around 4-6% in the period 2013-2018, mainly because of the restructuring of Dutch foreign aid. Funding for NGOs remained relatively stable and averaged around 26% of the total expenditure on SRHR. NGO support, however, was increasingly channelled through Dutch organisations. Support to multilateral and international organisations increased both absolutely and relatively in 2013, compared to 2012 and remained relatively stable in the period 2013-2018, adding up to around 59% of the expenditure.

Figure 1. Expenditure article 3.1 – SRHR, by channel (in EUR million)



Data: Management information system ministry of Foreign Affairs

Until 2011, in stable partner countries where the health sector was a priority, a substantial part of bilateral funds was allocated as sector budget support to the Ministry of Health to support maternal and child health (IOB, 2013: 39-40, 53). After restructuring of the Dutch aid policy, programmes and projects have replaced budget support and bilateral support and integral support to health systems was phased out between 2011 and 2015 (IOB, 2016). Simultaneously, in that period, support to SRHR was phased out in the former partner countries. The remaining bilateral cooperation in SRHR and health focuses on cooperation with national government bodies and lower-level authorities, mostly in Ethiopia and Mali.

[9] See e.g. Investing in Global Prospects, 2018: 36.
[10] KST 33750-XVII-2, 2013: 39; KST 34000-XVII-2, 2014: 44.

Support through NGOs remained an important channel for supporting SRHR. In recent years, the ministry adopted a new approach to working with civil society organisations, as formulated in the policy letter *'Cooperation with the civil society in a new context'*. Strategic Partnerships were introduced, based on mutually agreed objectives and a certain level of operational freedom for implementing partners (TK 2013-2014, 33 625, nr. 39). Partnerships with national and international NGOs in the field of SRHR include:

(1) From 2011 until 2015: (a) the *Choices and Opportunities fund* (EUR 50 million for activities of International Planned Parenthood Federation (IPPF), International HIV/AIDS Alliance (IHAA), Ipas and Population Services International (PSI); (b) the *Key Populations fund* (EUR 35 million); (c) the SRGR *Fonds*; (d) the *Opstapfonds* (phase I and II), and (e) the Child marriages fund;
(2) From 2015/6 until 2021: the Strategic Partnerships SRHR (EUR 215 million);
(3) Partnerships and projects financed through other sub-articles. From 2015/6 until 2021: 3 SRHR-health partnerships under the Dialogue and Dissent (D&D) programme and, where relevant, SRHR related activities funded through *Voice* or the *Accountability Fund* or through *Leading from the South*, *the Female Leadership Programme* or *Women Peace and Security*.

The Netherlands traditionally allocates the largest part of its SRHR budget through international channels, supporting UN organisations such as the United Nations Population Fund (UNFPA) and UNAIDS. It also gives substantial amounts to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and Gavi-the vaccine alliance. This support mainly consists of contributions to core funding of these organisations (unearmarked) as well as earmarked funding for specific programmes. Figure 1 shows the Dutch contributions to major multilateral and international organizations. More recently, the Netherlands has also been involved in institutions and partnerships such as the TB Alliance and Family Planning 2020 and since 2018, the Netherlands also contributes to the Global Financing Facility (GFF) in support of 'Every Woman, Every Child'.[11] Through the core funding of multilateral and international organisations, the Netherlands (indirectly) still contributes part of its budget to strengthening national health systems.

Part of the Dutch support to SRHR is channelled through public-private partnerships (PPPs) for research and production of (SRHR) drugs and commodities. In addition, a range of private sector instruments[12], managed by the Dutch Enterprise Agency (RVO), has been used for SRHR and health-related activities. It concerns some 110 projects with a total value of over EUR 270 million during the evaluation period. This support is not included in the financial overview above, which only concerns article 3.1 of the ministry's budget. In addition, SRHR and health related funding has been provided through the EU, with the Netherlands contributing some 5% of the EU-budget.

1.4 Assumptions

There are various assumptions underlying the Dutch SRHR policy sketched above. In the policy reconstruction, one of the key elements of this evaluation, we will seek to identify strategies for SRHR linked to the main priorities (see Annex 1. SRHR Priorities).

One important assumption is that through support to SRHR the Netherlands contributes to the development of basic health care in the Dutch partner countries. Available evidence clearly demonstrates that effective health systems are a prerequisite for lowering abortion figures, lowering death rates during delivery, and less teenage pregnancy (IOB, 2016). In this regard, the previous IOB policy review already concluded that Dutch non-earmarked funding for (basic) health decreased maternal and child mortality (IOB, 2013). Especially the poorest groups benefited from improved health services, although health inequalities remained substantial. In 2016, an IOB evaluation concluded that the de-prioritisation of basic health care created a distinction between the two

[11] This a World Bank administered trust fund for development of SRHR and the health sector in (selected) developing countries that was launched in July 2015. See further https://www.globalfinancingfacility.org/introduction.
[12] These include ORIO, PSI, PSD Toolkit, TF, LS&H4D, DHI, DHK, D2B, DRIVE, and PDP III.

interlinked policy themes. The evaluation stated that the Netherlands ended programmes that effectively contributed to objectives of SRHR (IOB, 2016).

Another important assumption underlying Dutch SRHR policy is that the different channels and instruments are complementary to one another:

- Because of their size, (geographical) reach (and related economies of scale that can be realised) and governance structures, multilateral and international organisations and funds can realise results that the Netherlands alone cannot accomplish. Through membership of their governing bodies, the Netherlands can have a bearing on agenda setting and on their policies and the implementation of their programmes. Moreover, multilateral organisations set international health standards, keep SRHR on the international agenda, and assist countries in drafting and implementing (preventive) health policies.
- NGOs can contribute to change in a way that is impossible for both government and international organisations. This is especially true for the more sensitive topics of the Cairo agenda (like HIV/AIDS and safe abortions) and for reaching hard-to-reach, stigmatised and discriminated groups such as youth, sexual minorities and drug users. NGOs also have a special role in introducing innovations, in organising and demanding government accountability, in advocacy against discrimination and taboos, as well as in capacity building of and in networking with local civil society organisations. Finally, they have a role in preparing and implementing preventive programmes.
- The impact of interventions can be strengthened when they are based on or accompanied by operational research and government funding has a role in shaping a R&D agenda that is focused on the accessibility and affordability of products that are important in underdeveloped areas. Moreover, the Netherlands collaborates with academia, private enterprises and national and international civil society to improve access to contraceptives and other provisions.[13]

1.5 SRHR diplomacy

Diplomacy and policy dialogue are important instruments in Dutch SRHR policy. They are used to address a broad set of SRHR-topics, ranging from violence against women to financing of the World Bank-administered GFF for SRGR. Various international and multilateral forums provide the stage for SRHR-diplomacy. The main ones are:

- The General Assembly of the United Nations (UN) and the Third Committee of the UN (the Social, Humanitarian and Cultural Committee)
- The Executive Boards of multilateral organisations such as the United Nations Population Fund (UNFPA), UN Women, UNAIDS and UNICEF as well as the Executive Board and World Health Assembly of the WHO
- The Boards of the GFATM and Gavi – the Vaccine Alliance – and the GFF
- The United Nations Human Rights Council
- The Commission on the Status of Women (CSW)
- Dialogue between Dutch embassy staff and government representatives in partner countries.

Actors involved include the ministers (Foreign Affairs, Health, Welfare and Sports, and for Foreign Trade and Development Cooperation), staff from the Ministry of Foreign Affairs in The Hague, representatives of the ministry of Health, Welfare and Sports, embassy staff in Dutch partner countries and people working at the permanent missions that represent the Netherlands at the international bodies mentioned above. In its SRHR-diplomacy, the Netherlands uses a range of tools,

[13] KST 33750-XVII-2, 2014: KST 34300-XVII-2, 2015: 45; 39; KST 34550-XVII-2, 2016: 47; KST 34775-XVII-2, 2017: 44; KST 34775-XVII-2, 2018: 50-51.

taking into account also the traditions of the forum in which it operates, including but not limited to[14]:

- Participation in international negotiations, other high-level meetings and events on SRHR topics[15] including the drafting and/or sponsoring SRHR-related resolutions in the Third Committee, either alone or in cooperation with like-minded countries (and/or non-governmental organisations).
- Statements and speeches at the meetings of these multilateral organisations.
- The organisation of and/or participation in *side events* – e.g. during sessions of the UN General Assembly or the Human Rights Council.[16]
- Bilateral political and/or (health) policy dialogue with government representatives in Dutch partner countries (e.g. on comprehensive sexuality education and safe abortions).
- The dialogue with opinion leaders to address conservative social, cultural and religious values and norms and opposition to SRHR rights.[17]
- Fund-raising for SRHR through e.g. the *SheDecides* movement that the Dutch minister for Foreign Aid and Development Cooperation initiated in 2017, accompanied by public statements and financial contributions.[18]
- Funding – an important tool (especially earmarked funding) to influence the expenditures of international organisations and NGO's.

Supplementing its formal diplomatic interventions and initiatives, the Netherlands uses informal diplomatic channels – also during the above-mentioned formal international events. Both government officials and representatives of the (non-governmental) organisations that the Netherlands supports and/or works with, undertake such informal diplomacy.

2. Delimitation

In terms of evaluation **period**, the evaluation is a follow-up to the policy review *Balancing Ideals with Practice* that covered the period 2007-2012.[19] The evaluation period starts with the state secretary of Foreign Affairs' policy letter on SRHR of May 2012 which was followed in the course of 2013 by the overall BHOS-policy note *Wat de wereld verdient - Een nieuwe agenda voor hulp, handel en investeringen*[20] and the human rights policy note *Respect en recht voor ieder mens*.[21] These three policy documents have had a large impact on the Dutch SRHR-policy in recent years. Since the previous policy evaluation came too early to assess the SRHR-related partnerships that were introduced in 2010, these partnerships will be included in this evaluation. For these partnerships we will thus go back two more years. The evaluation period ends in December 2020 allowing IOB to incorporate the findings of the final evaluations of the SRGR-partnerships.

In terms of **geographical focus**, the evaluation concentrates on countries that have been and continue to be Dutch aid partner countries, and that have had sizeable SRHR programmes over the years (see Table 1). The selection of countries for country studies will be done in a separate ToR.

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[14] See the ministry's SRHR theory of change of October 2018.
[15] For example, the Netherlands was co-sponsor of a UN-resolution calling for the development of policy and legislation aimed at preventing child marriages. 116 countries adopted the resolution.
[16] The Netherlands e.g. participated in the information series on SRHR during the 29th Session of the Human Rights Council in 2015 that was organised by the UN Office of the Higher Commissioner for Human Rights.
[17] KST 34000-XVII-2, 2014: 44.
[18] On the *She Decides* movement and its aims and the role of the Netherlands, see e.g. KST 347750XVII-2, 2017: 45 KST 35000-XVII-2, 2018: 55.
[19] In this case country-level evaluations were done in Bangladesh, Ghana, Mali, Nicaragua, and Tanzania. Use was also made of an evaluation of budget support in Zambia.
[20] KST 33625-1, 2013, 33625 Hulp, handel en investeringen Nr. 1, Brief van de minister voor Buitenlandse Handel en Ontwikkelingssamenwerking, 5 april 2013.
[21] KST 32735-7, 2013.

The evaluation deals with **all** channels of implementation of the SRHR policy, including the public-private channel as represented by the fund for product development partnerships (PDPs).

Evaluation limitations

SRHR and health are broad areas that encompass a considerable range of topics; the evaluation focuses on those topics that have been a priority in the Dutch SRHR policy for some time. Because the evaluation incorporates reviews of evaluation reports and primary data collection through fieldwork in four countries, the coverage is substantial. We are therefore confident that the evaluation results are to a sufficient level generalizable to sub article 3.1.

Evaluation reports of the organisations that benefit from Dutch SRHR-funding are an important source for this evaluation; this applies for both multilateral and international organisations, as well as NGOs. IOB is not in a position to crosscheck all information that these reports provide; at the same time, it will ensure that reports pass through a systematic quality check *before* evaluation findings are used. It is not clear at this stage, what implications this will have for the evidence that the evaluation can use. The risk exists, therefore, that there will be insufficient information about the effectiveness and sustainability of certain SRGR programmes or funds. Because the country studies will rely on primary data collection, these studies could, to some extent, fill potential knowledge gaps.

3. Evaluation purposes

The evaluation has the following main purposes:

(1) To formulate lessons for future SRHR/health-policy making and implementation, e.g. by making available state-of-the-art evidence on the effectiveness of SRHR interventions and about the results of multilateral organisations working in the field of SRHR and health;
(2) To assist the Ministry's accountability to Parliament and Dutch society for the expenditures incurred;
(3) To examine what follow-up has been given to the SRHR policy evaluation of 2013; and
(4) To contribute to the broader policy evaluation of article 3 of the BHOS-budget for Social Progress, scheduled for 2022.

4. Evaluation questions

The main 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 developing countries and what lessons can be learned for future policy?

To answer this question, the following sub-questions[22] will guide the evaluation:

Descriptive/ Context

(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 groups? How do global trends compare to the developments in Dutch aid priority countries?
(2) What instruments, financing modalities and channels did the Netherlands use to realize its goals and what explains the choices made over the years?

[22] The sub-questions are structured according to the OECD evaluation criteria that were revised in 2019.

Relevance

(3) What were 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?

Effectiveness and impact

(7) What are the results (at output, outcome and, where possible, impact level) of the interventions of multilateral and international organisations, local, national and international NGOs (co-) financed 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 levels and, in a selection of Dutch aid partner countries, bilateral levels and what have been the effects?

Efficiency

(9) What does the available evidence report and conclude on the efficiency of Dutch support to SRHR?

Coherence

(10) What mechanisms and funding modalities were in place to ensure coherence among SRHR interventions and were the results?

Sustainability

(11) How likely is it that the benefits of recently completed Dutch (co-)financed SRHR-interventions will be sustainable?

5. Approach and methodology

To answer these evaluation questions, the following building blocks will feed into the overall SRHR evaluation:

(1) Desk study on SRHR developments
(2) SRHR policy reconstruction
(3) Literature review on SRHR
(4) Desk review on multilateral and international organisations
(5) Desk review on local, national and international NGOs and partnerships
(6) Study on Dutch SRHR diplomacy
(7) Country case studies on all (co-)financed SRHR initiatives

The following paragraphs provide the main features of these building blocks. For building blocks 3-7, separate terms of reference will be prepared. These will provide additional details on the delineation of the building blocks as well as on research questions and methodology. In the evaluation matrix (table 2 at the end of this section), we show which research questions are answered by the above-mentioned building blocks.

Desk study on main developments in SRHR and health

IOB will perform a short desk study on global developments in the field SRHR and health and on developments in the field of SRHR in a selection of Dutch priority aid countries. This will include a desk review of international documents and data (statistics). IOB will also use the information generated by the desk review of the multilateral and international channel. Focus will be on the key SRHR indicators that also feature in the different chapters of IOB's SRHR policy evaluation of 2013.

SRHR policy reconstruction

For the policy reconstruction IOB will undertake:

(i) a desk review of parliamentary documents (letters, policy documents, Theories of Change etc.) as well as internal policy documents and annual plans/reports of SRHR-policy departments and embassies, and
(ii) (semi-structured) interviews with civil servants of the ministries of Foreign Affairs and Health, Welfare and Sports, representatives of selected Dutch NGOs and multilateral organisations and other international bodies working on SRHR and health topics.

In the policy reconstruction IOB will:

(i) formulate the implicit and explicit assumptions underlying the SRHR policy,
(ii) pay attention to the follow-up given to the recommendations of IOB's SRHR-policy evaluation of 2013
(iii) assess how policies were translated into financial allocations[23] and
(iv) compare the Dutch SRHR policies with priority areas for interventions emanating from the literature review on SRHR.

IOB will complete the policy reconstruction in the fourth quarter of 2020.

Literature review on SRHR

IOB will subcontract the review to a (team of) consultant(s) with ample experience in undertaking (systematic) literature reviews and in reporting on the outcomes of such reviews. IOB will contract an information consultant to advise on user-friendly digital publication of the findings of the review in order to enhance its usefulness. IOB will ensure that it is not only known whether information is available but also on what this information tells us and that the results are presented in an accessible manner. The review will be completed in the third quarter of 2020.

The outcomes of this review will (i) help IOB in establishing the evidence base behind the (reconstructed) assumptions underlying the Dutch SRHR policy and (ii) may be useful for the assessment of proposals for new SRHR-partnerships and for further Dutch SRHR policymaking in the future. By making the review findings available, IOB may also stimulate the debate among the different SRHR-stakeholders by organising several meetings that will serve to present the results of the review.

Desk review on multilateral and international organisations

The study primarily deals with UNFPA, GFATM, Gavi, UNAIDS, UNICEF and the WHO, i.e. multilateral and international organisations that have received substantial funding from the Netherlands.[24]

IOB will sub-contract the desk review of multilateral and international SRHR interventions. This study only includes documents that meet IOB's quality criteria (see Annex 3). From the studies and reports included in the review, the consultants will compile information about:

[23] The financial overview will contain information on e.g. allocations by channel (multilateral, NGOs, etc.), types of funding (earmarked, unearmarked, etc.), geographical distribution, types of supported activities.
[24] Information and data available for the Global Financing Facility and UNESCO (sexuality education) will also be used where possible.

(i) the effectiveness, the efficiency, impact and sustainability of the supported programmes;
(ii) their coherence with other sources of SRHR-funding;
(iii) the evidence for the assumption that the multilateral channel has added value in terms of economies of scale, geographic reach and governance and;
(iv) the attention for gender equality as a cross-cutting theme.

IOB will hold semi-structured interviews at the Ministry of Foreign Affairs, the Ministry of Health, Welfare and Sports, multilateral organisations and international funds, other key donors in SRHR, as well as staff of SRGR/health think-tanks, NGOs and enterprises to further discuss developments in international SRHR landscape and to shed light on the mix of financing modalities. The desk review does not include primary data collection. This study supports the ministry in making up the position of the Netherlands with respect to the long-term funding of several multilateral organisations and international funds (both earmarked and non-earmarked). To be able to play this role, the results of the study will be available by the end of 2020.

Desk review on local, national and international NGOs and partnerships

The main question in this study is: what does the available evidence state about the results that have been achieved through the NGO channel? The review will use evaluations of the international NGOs that the Netherlands has been supporting (such as Marie Stopes, the International Planned Parenthood Federation, Population Services International, the Guttmacher Institute, Frontline AIDS, Sexual Rights Initiative and Ipas) as well as the evaluations of the seven Strategic Partnerships SRGR and the three SRGR related partnerships of the Dialogue and Dissent programme. The review may also use evaluations of supported local NGOs, reports of PPPs and private sector instruments.

This study will be based on the evaluation material provided by these organisations, supplemented by interviews. The approach resembles the desk review on multilateral and international organisations: the first step is to establish whether the evaluation is of sufficient quality to be incorporated in the review.[25] For evaluations of sufficient quality, information will be compiled about:

(i) the effectiveness, the efficiency, impact and sustainability of the supported programmes;
(ii) their coherence with other sources of SRHR-funding;
(iii) the evidence for the assumptions of the added value of the NGOs, such as the premise that they can touch upon the more sensitive topics of the Cairo agenda and can reach the hard-to-reach stigmatized and discriminated groups; and
(iv) the attention for gender equality as a cross-cutting theme.

The study will be completed early 2021 to be able to take the final evaluations of the Dutch SRHR-partnerships on board. IOB will sub-contract the desk review of documents.

Study on Dutch SRHR diplomacy and policy dialogue

The study on Dutch SRHR diplomacy and policy dialogue will have the following elements:

(i) A comprehensive reconstruction of Dutch interventions on SRHR in a selection of key international and multilateral (SRHR-related) forums: what did the Netherlands say, addressing who and with whom, and where and did it do so consistently? Given the (media) importance of the different forums, the focus will be on: (a) The meetings of the Third Committee of the UN and the follow-up meetings on the *International Conference on Population and Development* (such as in Kenya in 2019); (b) The Executive Boards of UNFPA, the GFATM, the Global Financing Facility, UNAIDS, and the WHO and the UN Human Rights Council
(ii) An assessment of policy dialogue in a selection of Dutch aid partner countries
(iii) An assessment of the *SheDecides Initiative* that was launched in 2017.

[25] IOB has provided advice on the ToR for the evaluations of the SRHR partnerships. The organisations concerned and DSO/GA remain responsible for the evaluations.

For the study, IOB will perform a desk review of documents (papers, statements, accounts of meetings and events) and conduct semi-structured interviews with staff of the *DSO-Diploteam,* the Dutch permanent missions in Geneva and New York, and with staff of like-minded donors working on SRHR. IOB will also conduct interviews in a selection of Dutch aid partner countries (embassy staff, Government officials, representatives of national and international NGOs) as part of the country case studies. The study on SRHR-diplomacy and policy dialogue will be completed early 2021. IOB will publish the study separately. Publication will go hand-in-hand with an event, primarily targeting ministry staff, focused on the lessons learned.

Country case studies on all (co-)financed SRHR initiatives

IOB will conduct four country case studies that will cover all Dutch (co-) financed SRHR interventions at country-level in those countries. The main question for these case studies will evolve around the results achieved through the various supported interventions and the coherence and synergy of these interventions. The country case studies will use the information generated by the desk reviews of the multilateral and international organisations and funds and of the NGOs and partnerships. They are an opportunity:

(i) To analyse the added value of the different SRHR instruments and channels, including the assumption that the various channels are complementary to each other;
(ii) To evaluate synergies possible between different activities and coordination (e.g. between centrally funded and embassy programmes) and cooperation with other actors and
(iii) To validate the reported results on paper with results from fieldwork.

Separate terms of reference, including country selection criteria, will be written at a later stage. By January 2021, based on the quality of the information generated through the above studies and the resources available, IOB will take a decision on the undertaking of further fieldwork. In case of a go-decision, IOB will subcontract local consultants to assist in the fieldwork.

Table 1 presents the expenditure to the various (former) partner countries. Note that the table might present a partially distorted picture, because the contributions of multilateral and international organisations are not (yet) attributed to specific countries.

Table 1. SRHR expenditure (in EUR million), by country

	2012	2013	2014	2015	2016	2017	2018	2012-2018
Not defined	260,5	310,4	337,2	295,7	349,2	356,3	355,4	2264,8
Ethiopia	14,1	16,3	21,1	22,2	19,0	19,0	21,8	133,6
Mali	13,6	17,2	13,0	14,1	13,7	14,3	19,2	105,1
Mozambique	11,4	15,1	13,3	11,7	9,2	10,9	13,2	84,7
Bangladesh	3,8	4,4	6,8	5,7	7,0	7,7	9,8	45,2
Ghana	20,6	6,3	5,3	5,6	2,9	0,7	0,0	41,4
Yemen	4,7	5,7	5,3	4,7	5,8	6,3	7,6	40,0
Benin	1,7	3,2	3,6	5,0	6,4	7,2	7,3	34,4
Burundi	0,7	3,4	5,4	4,5	5,4	4,8	6,4	30,6
Tanzania	16,4	5,5	0,4	0,0	0,0	0,0	0,0	22,2
DRC	0,0	0,0	0,0	0,5	3,4	4,8	4,2	12,8
Other	28,4	12,1	4,1	2,0	2,0	0,3	0,0	49,2
Total	**375,9**	**399,5**	**415,6**	**371,8**	**424,0**	**432,3**	**445,0**	**2.864,1**

Data: Management information system ministry of Foreign Affairs

Evaluation Matrix

Table 2 shows how the building blocks will contribute to answering the different evaluation questions.

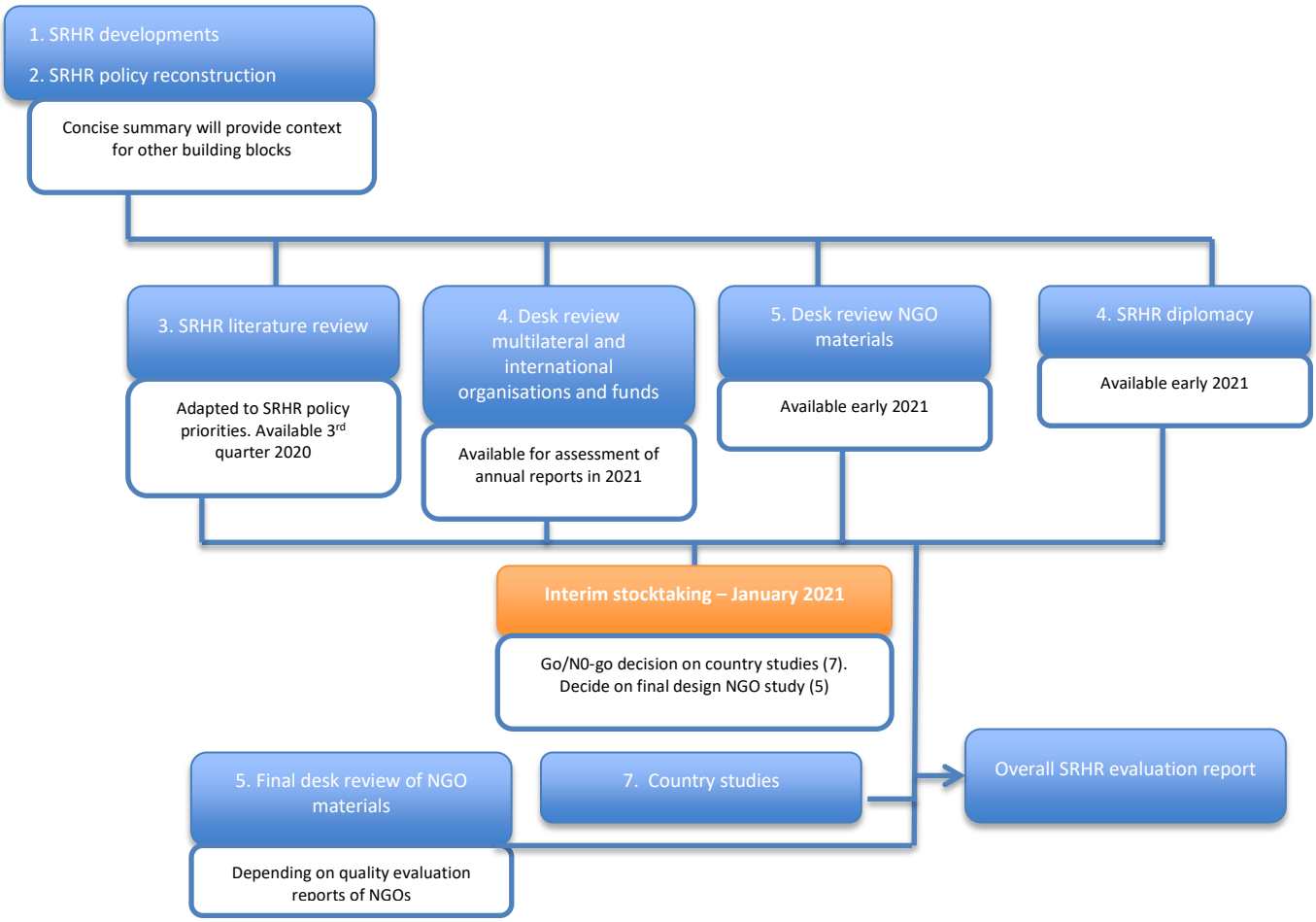
Table 2: Evaluation matrix

#	Research Question / Building Block	Desk study on SRHR developments	SRHR policy reconstruction	Literature review on SRHR	Desk review on multilateral and international	Desk review on NGOs and partnerships	Study on Dutch SRHR diplomacy	Country case studies on all (co-)financed SRHR initiatives
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 groups? How do global trends compare to the developments in Dutch aid priority countries?	■	■	■	■			■
2	What instruments, financing modalities and channels did the Netherlands use to realize 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, local, national and international NGOs (co-)financed 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 levels and bilateral levels in a selection of Dutch aid partner countries and what have been the effects?		■				■	
9	What does the available evidence report and conclude on 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 (co-)financed SRHR-interventions will be sustainable?			■	■	■		■

Flowchart

The division into building blocks serves to mitigate undue delay and inform stakeholders on interim results during the evaluation process as is shown in the flowchart in Figure 2. The context description and policy analysis (1 & 2) will feed into other building blocks and, together with the literature review on SRHR (3) will enable a comparison between Dutch policy priorities, SRHR developments and scientific knowledge. These building blocks will be the first available, i.e. by the end of 2020. The information on multilateral institutions and international organisations and funds and SRHR diplomacy (4 & 6) will be available early 2021 and can feed into the ministry's decision-making on the future of support to these institutions in the course of that year.[26] In December 2020, evaluation reports from many NGOs will become available. IOB will review these reports in January 2021. At the same time building blocks 1, 2, 3, 4 and 6 will be available. Based on the analysis of the results of these five building blocks, and on a cost/benefit analysis in terms of the overall available IOB time, IOB means and IOB priorities a decision as to the relevance, the design and planning of the study on (Dutch) NGOs (5) and the country studies (7) will be taken in January 2021.

Figure 2: Flowchart of products



[26] The information may come too late as an input for decisions on the contracts with Gavi, UNFPA and several iNGOs that will expire end 2020. DSO is considering two options; one is to extend the duration of the current contracts, the other is to include a clause on an interim decision after two years. By the end of March 2020, DSO expects to take a decision on these options.

6. Administrative matters

Organisation of the evaluation – responsibilities IOB

Within IOB, Caspar Lobbrecht, Bart van Rijsbergen and Paul de Nooijer are responsible for the evaluation. Several assignments will be subcontracted in line with current rules and regulations and based on more detailed terms of reference. IOB will provide selected consultants with the information needed, and supervise the quality of their work and reports. IOB remains responsible for the quality of the products that are to be delivered.

Internal and external quality mechanisms and procedures

Pim de Beer, Meie Kiel and Wendy van der Neut will ensure **internal peer review** at least every 6 weeks. They will review and comment upon all key evaluation outputs (from concept notes, terms of reference, to the draft final report) and advice on methodological issues. Rob van Poelje will chair the meetings with the peer reviewers.

IOB has set up a **reference group** to advise IOB's director on the conduct of the evaluation and to provide substantive and methodological commentary and advice concerning the terms of reference, evaluation building blocks and the draft final report. Members also may alert the evaluation team on possible complications and political sensitivity of evaluation findings and report. Rob van Poelje will chair the meetings of the group. The reference group consists of a representative from the ministry's policy department responsible for SRHR (DSO/GA) and three external members:

1. *Marleen Temmerman*, Belgian gynaecologist, professor and former Senator, currently heading the Centre of Excellence in Women and Child Health at Aga Khan University, Nairobi, Kenya.
2. *Evert Ketting*, international consultant Sexual and Reproductive Health; senior researcher Radboud University and senior fellow Guttmacher Institute,
3. *Denise Namburete*, Director N'weti, a Mozambican non-profit organization dedicated to communication for health that aims to contribute to better health of citizens and Mozambican communities

Members of the reference group will be asked to send written feedback prior to the meetings. External members that are not able to join the meeting physically will send elaborate written feedback, which will be discussed during the meetings. Following up on the meetings, the IOB team will share a document in which it responds to the feedback of all reference group members. The reference group will meet approximately four to six times (see Table 2 below).

Timing and programming of the evaluation

IOB will conduct the evaluation in the period March 2020 to December 2021. The overall planning of the exercise is summarized in Table 2 below.

Table 2: Time schedule

	2020				2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Approval Terms of Reference	■							
Building blocks								
• Literature review on SRHR	■	■	■	■				
• Review multilateral and international funds		■	■	■				
• SRHR diplomacy		■	■	■				
• Review international NGOs			■	■				

	2020				2021			
• Study on Dutch and international NGOs								
• SRHR at country level*								
Draft and final report								

Envisaged products and communication initiatives

All building blocks will produce written reports that will be available at IOB's website and will feed into the overall report on article 3.1. An exception is the policy reconstruction, which will directly feed into the overall report. The following publications are foreseen:

- Report on SRHR literature review
- Report on multilateral and international funds
- Report on Dutch and international NGOs
- Report on SRHR diplomacy
- Report on SRHR at country level
- Overall report on Article 3.1

In addition, the findings from the SRHR literature review will be translated into an interactive online tool. Furthermore, the overall report on Article 3.1 will be available as an interactive online publication.

Publication of key studies will be accompanied by presentations for selective audiences, both in the Netherlands and abroad. IOB will discuss with the policy departments responsible for SRHR, embassies involved and other stakeholders on the most appropriate format and timing of such presentations. On the basis of these consultations, IOB will draw up a brief internal communication plan for the evaluation (second half of 2020).

Documents used in preparing these terms of reference

- Amsterdam Institute for Global Health & Development, Amsterdam Institute for Social Science Research, University of Amsterdam, 2017, *Synthesis Evaluation of SRHR Subsidy Frameworks 2011-2015*, Final Report, 14 July 2017
- A World to Gain, A New Agenda for Aid, Trade and Investment, April 2013
- Brief van de minister voor BHOS, 5 november 2015, Betreft ontwikkelingsresultaten in Beeld – editie 2015 - Voortgang prioriteiten ontwikkelingssamenwerking. Ref MINBUZA-2015.573896
- de Kok Bregje, Trudie Gerrits, Erica van der Sijpt, Charles Picavet, Dorothea Dechau, Steven Russell, Chris Elbers and Marleen Temmerman, 2017, Synthesis Evaluation of SRHR Subsidy Frameworks 2011-2015, Final Report 14 July 2017, Amsterdam Institute for Global Health & Development and Amsterdam Institute for Social Science Research, University of Amsterdam
- Infographic Results Sexual and Reproductive Health and Rights 2014
- IOB, 2009, Evaluation policy and guidelines for evaluations, Ministry of Foreign Affairs
- IOB, 2013, Evaluation Balancing ideals with practice Policy evaluation of Dutch involvement in sexual and reproductive health and rights 2007-2012
- IOB, 2016, An evaluation of the impact of ending aid – The gaps left behind
- Jurgens, E., 2017, IOB policy review of the support to and collaboration with UNFPA and UNAIDS, Final draft, January 2017
- KST 32605-2, 2011, 32 605 Beleid ten aanzien van ontwikkelingssamenwerking, Brief van de staatssecretaris van Buitenlandse Zaken, Nr. 2, 18 maart 2011 (Focusbrief ontwikkelingssamenwerking)
- KST 32605-3, 2011, 32 605 Beleid ten aanzien van ontwikkelingssamenwerking Nr. 3, Brief van de staatssecretaris van Buitenlandse Zaken, 18 april 2011 (nadere informatie over enkele aspecten van het beleid op gebied van seksuele en reproductieve gezondheid en rechten (SRGR) inclusief hiv/AIDS)
- KST 33750-XVII-2, 2013, 33750 XVII Vaststelling van de begrotingsstaat van de begroting voor Buitenlandse Handel en Ontwikkelingssamenwerking voor het jaar 2014. Nr. 2 Memorie van Toelichting, page 39, 42
- KST 34000-XVII-2, 2014, 34000 XVII Vaststelling van de begrotingsstaat van de begroting voor Buitenlandse Handel en Ontwikkelingssamenwerking voor het jaar 2015. Nr. 2 Memorie van Toelichting page 44-45, 48,49
- KST 34300-XVII-2, 2015, 34300 XVII Vaststelling van de begrotingsstaat van Buitenlandse Handel en Ontwikkelingssamenwerking (XVII) voor het jaar 2016. Nr. 2 Memorie van Toelichting page 45-46, 48-49
- KST 34550-XVII-2, 2016, 34550 XVII Vaststelling van de begrotingsstaat van Buitenlandse Handel en Ontwikkelingssamenwerking (XVII) voor het jaar 2017. Nr. 2 Memorie van Toelichting page 47, 48-49, 51
- KST 34775-XVII-2, 2016, 34 775 XVII Vaststelling van de begrotingsstaat van Buitenlandse Handel en Ontwikkelingssamenwerking (XVII) voor het jaar 2017. Nr. 2 MEMORIE VAN TOELICHTING
- KST 33625-215, 2016, 33625 Hulp, handel en investeringen. Nr. 215 Brief van de minister voor Buitenlandse Handel en Ontwikkelingssamenwerking, 6 juni 2016.
- KST 33625-229, 2016, 33625 Hulp, handel en investeringen. Nr. 229. Brief van de ministers voor Buitenlandse Handel en Ontwikkelingssamenwerking en van Volksgezondheid, Welzijn en Sport. 8 juli 2016
- KST 34775-XVII-2, 2017, 34775 XVII Vaststelling van de begrotingsstaat van Buitenlandse Handel en Ontwikkelingssamenwerking (XVII) voor het jaar 2018. Nr. 2 Memorie van Toelichting pages 45, 47
- KST 35000-XVII-2, 2018, 35000 XVII Vaststelling van de begrotingsstaat van Buitenlandse Handel en Ontwikkelingssamenwerking (XVII) voor het jaar 2019. Nr. 2 Memorie van Toelichting, page 50, 51, 54-56.
- Mensenrechten nota juni 2013: Respect en recht voor ieder mens
- Nieuw beleidskader voor SRGR voor de periode 2016-2020
- OECD, 2002, Glossary of Key Terms in Evaluation and Results Based Management
- Starrs, A. M., et al. (2018). Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission. The Lancet, 391(10140), 2642-2692.

Annex 1. SRHR Priorities[27]

Youth better informed on options and possibilities and have more freedom of choice about their sexuality
• Freedom of choice regarding sexuality (including the use of contraceptives, safe abortion), health and number of children coupled with advocacy for women's and girls' right to self-determination.
• Access to sexuality information and education (both inside and outside school) for young people, especially girls, and to (youth-friendly) SRHR-products that can prevent unwanted pregnancies, sexually transmitted diseases and sexual violence, especially for women and girls
• An enabling environment without juridical restrictions or health-system related legal obstacles to implementation (SRG/health facilities, health workers, medicines) and opportunities for youth to have their voices heard - youth involvement in SRHR policy and decision-making.
Improved access to (affordable) reproductive health commodities, including medicine, that address the specific needs of women, youth and key populations – also in the most hard to reach areas
• Continuous availability and accessibility of vaccines (especially for children in the poorest countries), improved and more varied availability of (modern) contraceptives (including emergency contraceptives, condoms) and medication through R&D, the production of the appropriate raw materials, supply-chain management, appropriate health financing systems (including affordable health insurance).[28] It is about research and (product) development and innovation – ensuring that the right products with the right price become available to the right people. It is also about strengthening the role of Governments in fixing norms, certification and product quality control as well as supply chain management.
• Funding for family planning – addressing the unmet need for family planning.
• Access to health facilities and resources for key population groups, also in the most hard to reach areas, in crises and humanitarian situations.
• Addressing demand-related juridical, social, cultural and religious norms, stigmatization and discrimination.
Good quality public and private SRH and healthcare and services that are accessible for all – including SRH and health services for women and men in crisis or humanitarian situations – and including safe abortions.
• SRHR-programmes in specific countries contribute to strengthening of local health services and/or national health systems (planning, health sector policy development).[29]
• Improved public-private health care cooperation coupled with a changing role of the public sector in health moving away from direct implementation to regulation and enforcement.[30]
• Public and private health clinics offer better quality SHR for an increasing number of people
• Health services during (and after) childbirth – increased availability of medical resources to prevent maternal deaths as well as better obstetric care (provided by midwifes)
• Mental and psychological support to victims of violence.
• Better integration of HIV and SRHR in national health policies in partner countries and better HIV-AIDS-related services for all groups at risk, including HIV prevention, AIDS inhibitors, condom distribution, and harm reduction services
• Addressing the *politisation* of the SRHR-debate and cultural, social and religious barriers against elements of the SRHR-agenda – removing cultural and knowledge related barriers that prevent women from using contraceptives
• Accountability re the quality of health services
• Innovative approaches to keep SRHR accessible and affordable (such as performance based funding of health)

[27] Main sources used are KST 33750-XVII-2, 2013:39, 42; KST 34000-XVII-2, 2014: 44-45, 48,49; KST 34300-XVII-2, 2015: 45-46, 48-49; KST 34550-XVII-2, 2016: 47, 48-49, 51; KST 34775-XVII-2, 2017: 45, 47; KST 35000-XVII-2, 2018: 50, 51, 54-56. The table also contains key elements from the multi-annual plans of Dutch embassies (2014-2017 and 2018-2022) for Bangladesh, Benin, Ethiopia, Mali and Mozambique, i.e. Dutch partner countries with a high volume of SRGR-related expenditures in the period 2015-2018.

[28] The Netherlands supports the development of new medicines, vaccines and diagnostics through the funding of product development partnerships that subsidize research alliances and partnerships for the development of innovative products for the prevention, diagnosis and fight against poverty related diseases. Support to international organisations and NGOs is to make sure that these products become available for the poor (KST 33625-229, 2016).

[29] There is special attention for health during pregnancy and delivery, contraceptives, sexuality education and HIV-prevention and prevention of gender-based violence (KST 35000-XVII-2, 2018: 50). The reasoning has been that progress on SRHR requires good and accessible health care services, including well-trained and motivated nurses and midwifes and adequately equipped hospitals in case of emergencies. The availability of AIDS inhibitors and other health products and technologies at village level requires policy and capacity in terms of planning, purchase, logistics and medical knowledge. Henceforth, Dutch SRHR policies pay a lot of attention to strengthening of health systems in the poorest countries (KST 33625-215, 2016; KST 33625-229, 2016).

[30] KST 33625-215, 2016. The Netherlands aims at improved public-private cooperation on themes such as antimicrobial resistance, access to health resources and prevention (KST 33625-229, 2016).

• Integration of SRHR, including access to safe abortions, in humanitarian interventions and development efforts in fragile settings and in the approach to epidemics
More respect for the sexual and reproductive health rights of groups that are currently denied such rights – such as (unmarried) youth, child brides, drug users, sex workers, women going through an abortion and key population groups such Lesbian, Gay, Bisexual, Trans and Intersex (LGBTI) people, sex workers and drug users.
• Human rights of key population groups and advocacy for a rights-based approach in policies and legislation in partner countries • Addressing sexual intimidation, child marriages and other discriminatory and criminal practices • Addressing gender-related violence – amongst others through support for local (women's) organisations in partner countries and gender related violence, protection and empowerment of women and girls in humanitarian crises • Strengthening civil society in the South and of communities and networks of key populations

Annex 2. Expenditure article 3.1 – SRHR by channel (in EUR million)

	2012	2013	2014	2015	2016	2017	2018
Total bilateral	**58**	**21**	**23**	**30**	**20**	**20**	**17**
Local NGOs	19	18	13	18	22	18	18
National NGOs	29	38	47	45	59	55	53
International NGOs	41	55	43	31	48	40	48
Total NGOs	**88**	**111**	**103**	**94**	**129**	**113**	**119**
Multilateral – GAVI (in. IFFIm)	25	39	46	46	50	67	53
Multilateral – GFATM	40	67	74	55	54	57	56
Multilateral – UNAIDS	20	20	20	20	20	18	20
Multilateral – UNICEF	10	6	17	12	15	14	9
Multilateral – UNFPA	73	79	67	65	74	74	72
Multilateral – WHO	13	21	16	16	19	20	23
Multilateral – other	2	5	12	2	2	3	29
Total Multilateral	**181**	**236**	**251**	**217**	**235**	**253**	**261**
PPP and private sector	40	24	23	21	32	37	33
Universities and research	8	8	15	10	7	6	10
Other	0	0	1	0	1	2	2
Total Other	**48**	**32**	**38**	**31**	**40**	**44**	**44**
Total	**376**	**400**	**416**	**372**	**424**	**430**	**441**

Data: Management information system ministry of Foreign Affairs

Annex 3. Quality assessment criteria for evaluation reports

Validity

1. The report gives an overview of policy backgrounds and starting points and of the institutional setting and force field in which the evaluation object finds itself.
2. The report reflects and explains the policy theory that underlies the investigated intervention, including the assumptions about causal and final relationships, and about the means-ends hierarchy that is used together with the different result levels.
3. The problem statement concisely formulates the main objective of the evaluation. Together the research questions operationalize this problem statement.
4. The research questions provide a practical/unambiguous elaboration of the way in which evaluation criteria such as effectiveness and efficiency are operationalized (using indicators).
5. The methodological justification gives:
    a. a description and limitation of the collection of the research units (by type, target group, location, period, institution, financial size, etc.) to which the research results relate.
    b. a description and justification of the research methods and techniques used;
    c. the extent to which the indicators defined at the different result levels can be considered specific, measurable and time-bound.

    d. provides an explanation of the care with which the data sources used were selected, and the accuracy and transparency with which data from those sources were processed and analyzed
    e. information about the extent to which the conclusions from the sample that was examined or the case studies that were carried out apply to the entire study population.
    f. states (possible) shortcomings of the research and limitations to the generalizability of the findings and conclusions.
6. The report indicates how the quality control was carried out (internal quality control, guidance or steering group, involvement of independent external experts).
7. The conclusions are actually covered by the research findings.

Reliability

8. Independence of the evaluators, in particular their independence from the stakeholders of the research such as donor, clients, implementers and target audience.
9. The methodological justification provides information about the extent to which (i) data were checked and (ii) different sources/methods were used to collect information about the same characteristics and phenomena (including triangulation) and (iii) the course of the evaluation and any adjustments made in comparison with the original research design.
10. The report indicates the extent to which selection and content of data sources that were used, especially documentation and respondents, were independent of stakeholders in the evaluation such as donor, clients, implementers and target audience.

Effectiveness

11. The evaluation report gives a clear explanation of how effectiveness has been investigated and has used a valid approach for measuring effectiveness.
12. Were the changes in effect variables measured in relation to (a) the initial situation? and (b) a control group?
13. Can the observed changes in effect variables be attributed to the activity?
14. Are these observed changes and attributed changes in line with programme, project and/or policy objectives?

Efficiency

15. The report provides a clear explanation of the way in which efficiency was investigated and the evaluation has used a valid approach to the measurement.
16. The conclusions on efficiency answers questions such as: Were inputs used at the lowest possible costs? Were activities carried out in a simple manner? Were overhead costs kept as low as possible? Was duplication avoided? Were conflicts during implementation resolved / prevented in time? Was the program efficient compared to other interventions with the same goal?
17. These conclusions are supported by the findings.

Usability

18. Clarity of the specification of the (external) purpose of the evaluation for which the research results will be or have been used.
19. Clarity and comprehensiveness with which the evaluation report and its summary reflect the essence of the research, in particular the main findings.
20. Completeness with which all research questions are answered by the conclusions.
21. Practical feasibility of recommendations (that are clearly distinguished from conclusions) and the extent to which these recommendations are within the reach of the responsible policy makers.