# Reaching Poor People with Services in Sexual and Reproductive Health

An Evaluation of the IPPF

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Commissioned by Sida and Norad

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# Reaching Poor People with Services in Sexual and Reproductive Health: An Evaluation of the IPPF

## Volume I. Synthesis Report

**Commissioned by Sida and Norad**

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**Anna Nilsdotter**

**15th November 2006**

# Executive Summary

*Background and purpose*
The International Planned Parenthood Federation, IPPF, is recognised as the major international non-governmental organisation in the field of sexual and reproductive health and rights (SRHR). This evaluation was commissioned by two of its donors, Sida and Norad, to assess the relevance and effectiveness of IPPF's work in promoting the SRHR rights for poor and vulnerable people. The evaluation has been undertaken by an external team of Scandinavian and national evaluators working in cooperation with the funding agencies and IPPF. The evaluation builds on field studies in Bangladesh, Ethiopia and Uganda. It was carried out from April to November 2006.

*Evaluation methods*
The evaluation was designed to reach people who are directly involved in, or affected by, the work of IPPF and collect data from them. Our informants have included users and non-users of clinical and non-clinical services, community leaders, religious leaders, traditional birth attendants and healers, district administration officers, local, national and international NGOs, and member association staff and volunteers. We have interviewed more than 1,000 people. The evaluation also used structured observation of clinics and outreach clinics, government health units, NGO clinics and hospitals, youth centres, and non-clinical activities such as drama performances and puppetry shows.

*Reaching poor and vulnerable people*
Our conclusion is that the member associations reach poor and vulnerable groups to a large extent. Many of the clients have no alternative provider of quality SRHR services. Where alternatives exist, the IPPF member association is often preferred because of its high quality, relatively low fees and privacy – no questions asked.

The evaluation data show that the outreach clinics and outreach programmes run by volunteers are more effective in reaching poor and vulnerable groups than are the branch clinics. In fact, the difference between the profile of clients is sometimes quite striking. Having said that, it is our assessment that most clients at the branch clinics are also poor.

The evaluation distinguished between relative poverty and absolute poverty. The data from exit interviews suggest that the clients are often better educated and appear to have access to more assets. Nevertheless, most would still be considered poor in an absolute sense. The terms are useful, but the data are at times difficult to interpret and the managerial choices on allocation of resources can be questioned.

In the major cities in particular, the member associations appear to also serve people with high incomes. Here is important to bear in mind that clients in urban areas might be deprived of sexual and reproductive health and rights. In these areas there is more commercial sex activity, gender based violence, and perhaps also conservative attitudes and social turbulence on a larger scale. The branch clinics provide a base from which the member associations can reach out to slums with permanent services and also with targeted projects to vulnerable groups.

*Relevance of services*
Our assessment is that the member associations offer very relevant services that are needed and appreciated by the people they serve. The services are relevant in their client's eyes and they are in line with national and global needs, as well as with the donors' policies. Relations to government authorities in the countries visited are generally very good, although the role of the member association is often to push for more and stronger government activities in SRHR.

We have found no examples of member associations offering services they should not offer, or any outstanding examples of services they should offer instead of the present services. Opinions heard during the evaluation generally focus on more services, rather than different services. The member associations operate in areas with a large unmet need. We have seen no examples of duplication of work. Coordination with government administration and other NGOs seems to work very well in most cases.

*Effectiveness*
Client satisfaction with services is very high, which is clearly documented from exit interviews at clinics as well as interviews with users of non-clinical services. The high quality of services is recognised by partner organisations and other SRHR stakeholders, as well as by the users. The member associations are acknowledged as solid service providers and acclaimed as the pioneers in family planning in their respective countries. In Uganda and Ethiopia they are especially acknowledged for their youth-friendly services, offered by few others, and outreach work to poor, rural communities. For this work, their extensive network of youth and adult volunteers is of particular importance.

*Impact*
The evaluation distinguishes four broad categories of impact; (1) impact of family planning counselling and access to contraceptives, (2) impact due to advice and treatment in respect of sexual and reproductive health, (3) impact of primary health care (which can be distinguished in preventive and curative), and (4) impact related to improved life chances. In each category, we distinguish between impact at the level of individuals and at the level of the population. Given these categories and the evidence collected through our interviews and observations, it would seem that the highest impact is found in the both the first and second category, family planning, contraceptives, advice and treatment for reproductive health, while lower impact is found in relation to primary health care. Individual impact is very high in relation to the fourth category, improving life chances, but as projects are few, funding uncertain, and the risks considerable, the overall impact is likely to be lower.

It is primarily in relation to the first mission of IPPF, family planning in the traditional sense of that word, that there is a clear and unquestionable impact at the population level. The scale of these operations, the length of time that the services have been provided, and the relative ease of service delivery all help to explain the high impact. The wider sexual and reproductive health agenda is far more difficult and challenging and it will take time before any impact at the population level becomes equally significant. It is possible to combine the assessment of impact with the evidence reaching poor people. The very poor and marginalised groups are primarily reached by the services that yield an impact of the fourth category, improving life chances – and that impact is not as high as in relation to the other categories of impact, and certainly not at the

population level. Relevance appears to be high in all categories of impact, and so is the effectiveness.

*Advocacy*
The assessment of advocacy has been difficult due to some confusion around what advocacy is and how it should be developed in respect of target groups, instruments, and levels in the political and administrative systems. Advocacy is both a strategic priority in its own right and an integrated component in almost all activities. This is not seen in the strategic plan and in budgets, and hence the organisations do not have a good overview of what they are actually doing in terms of advocacy.

The member associations implement a variety of local advocacy initiatives that are relevant to the needs of poor people. The organisations address major barriers to SRHR within the communities. SRHR has a broad agenda, and there are also many areas where the member associations are silent. They have not had the resources, or they had other priorities, or there are other reasons - but there is a need for more advocacy at all levels and on most subjects. In a challenging environment, all three member associations have the potential to play a significant role in informing national policies, but the organisations are playing a relatively minor role at present. With their high level of "brand recognition" and relationships with major agencies working in the field of SRHR, they could make a major contribution to the SRHR field if they became more involved in informing national policies, argued for resource allocation to SRHR, and worked with the follow-up to international agreements.

*Organisational issues*
The focus of this evaluation has been on whether the member associations reach poor people. But whether they do depends on whether the organisations' structures and processes are conducive to supporting member associations to develop effective and relevant programmes that meet the needs of poor people and vulnerable groups. The evaluation points to four areas that need further attention:

- The role and composition of volunteer bards. The accountability of boards and management is not clear and there are overlapping functions between the two. In most cases, there is a need for more women on boards, more young people. Furthermore, boards often need to be smaller to be effective
- Strategic planning, in particular the use of the Five A's. The evaluation found that resource allocation is difficult to follow with the use of the Five A's, and hence it is also difficult to trace results and report back on the use of funds when using these concepts.
- Human resource management. Gender balance continues to be eschewed in favour of men in two of the three member associations. There is a need for further training, particularly for field volunteers. Policies for, and strategies to cope with staff turnover need to be developed, not least to ensure staff rotation and access to new competencies.
- Monitoring and evaluation. IPPF has made progress in evaluation and has a policy in place. It is important to stress the qualitative aspects of evaluation, which is also an aspect of organisational culture. Evaluative information must also be safely stored, easily available, and put to use. High quality monitoring data are as important as evaluation exercises.

*Conclusions and recommendations*

Sida's and Norad's decisions on future support to the IPPF should be based on evidence about relevance and effectiveness, and IPPF's ability to reach poor people and marginalised groups. There is clear and trustworthy evidence that the member associations reach poor people and vulnerable groups. There is clear evidence that they are relevant and effective service providers. But it is also clear that there is scope for improvement. The evaluation identifies five areas that Sida and Norad should follow closely in their future partnership with IPPF, and recommends both organisation to provide continued support to IPPF. The country studies in Volume 2 of this evaluation contains detailed recommendations to the member associations in each country. The five areas that we recommend IPPF, Norad and Sida to follow-up on are:

- Poverty and vulnerable groups. IPPF has initiated a study of poverty. The discussion needs to be continued and the organisation needs more and better quality data on a continuing basis. It is necessary to know more about who poor people are, how they are best reached, and how they are affected by the activities. The issue of fees for services is not sufficiently clear and there is not enough information on how fees affect clients.

- Advocacy. Even though advocacy is one of the Five A's, the member associations did not have a sufficient grasp of advocacy and they did not always know what they were doing nor what the effects were. The skills and competencies to plan, implement, and assess results need to be strengthened.

- Impact assessment. The organisation needs to develop competence and capacities around impact assessment to decide when it is possible and desirable to measure and/or assess impact.

- Governance and management. The volunteer boards at all levels represent an asset to the organisation, but their roles need to be clarified. Accountability is sometimes obscured, when the responsibilities of management and board are mixed, and where boards are not sufficiently clear on what decisions are to be taken by management and which decisions are the responsibility of the board.

- Human resource management. The member organisations have been in operation for many years. Organisational learning needs be developed, not least through a healthy turnover of staff. In some member associations staff turnover appears to be too high, in others too low. FPAU appears to have a clear strategy for sound and equal gender balance among staff and management and the other member associations can learn from them.

*Contractual framework*

The evaluation provides sufficient evidence of relevance, effectiveness, and reaching poor people, hence the advantages for all partners to work within the framework of a three-year contractual period are considerable. The main advantages are longer planning horizons, more concrete feedback on follow-up issues, and time to document and assess real results.

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**List of Acronyms**

| | |
|---|---|
| DHS | Demographic and Health Survey |
| FGAE | Family Guidance Association of Ethiopia |
| FIGO | |
| FPAB | Family Planning Association of Bangladesh |
| FPAU | Family Planning Association of Uganda |
| ICM | |
| ICPD | The Cairo International Conference on Population and Development |
| IEC | Information Education Communication |
| IPPF | International Planned Parenthood Federation |
| NGO | Non Governmental Organization |
| Norad | Norwegian Agency for Development |
| Sida | Swedish International Development Cooperation Agency |
| SRH | Sexual and Reproductive Health |
| SRHR | Sexual and Reproductive Health and Rights |
| UNFPA | United Nations Population Fund, |
| VCT | Voluntary Counselling and Testing |
| WHO | World Health Organisation |

# Acknowledgement

This evaluation is a cooperative effort. The three of us who stand as authors on the front page could not have accomplished this complex evaluation task without extensive help and support from others.

First of all we would like to express our gratitude to the people who took the time to share their views and insights during the course of this evaluation. We have interviewed a large number of clients of the IPPF member organisations. We have visited people in their homes and at work and we have often disrupted their daily lives. We are grateful to all who gave us their time and responded patiently to our questions.

We would like to thank management, staff, and volunteers at the member associations in Bangladesh, Uganda and Ethiopia for their assistance in facilitating the evaluation teams' visits and interviews. We received detailed information and valuable assistance from IPPF's Central Office in London, as well as from the regional IPPF offices in New Delhi and Nairobi.

The country visits were planned by our three colleagues; Parveen Salaam in Bangladesh, Jim Arinaitwe in Uganda, and Samuel Hadera in Ethiopia. They were our research partners in the three country studies and they have also contributed with comments on the synthesis report.

The evaluation has a focus on young people, their needs in relation to sexual and reproductive health, and their opinion on services. The three of us and our national consultants would not have been able to get reliable information from this group of informants on our own. Hence, young consultants joined us as research assistants in each country; Gazi Murtoza Abbas and Nasrin Nahar in Bangladesh; David M. Doya, Jacqueline Karuhanga and Ketty Komugabo in Uganda; Seifu Hailu, Fikeralem Mezgebu, Kidist Negash, Romel Yosef, and Abju Girma in Ethiopia. They contributed to writing each of the country reports in volume II, and they have also read and shared their views on the synthesis report.

The evaluation has been undertaken in cooperation with IPPF, Norad and Sida. Staff from the organisations joined the evaluation team in each country. They had research tasks as the other team members and contributed to the data collection and analysis and are co-authors of the country reports. Many thanks to Alison Pollard and Pratima Mittra of IPPF, Sølvi Taraldsen of Norad, and Mattias Lindgren of Sida.

We have tried to reflect the insights of all evaluation team members in this synthesis. Any remaining mistakes or misunderstanding are of course ours and we are also responsible for the final assessment and recommendations in this report. .

Stockholm and Oslo, November 2006

Kim Forss Marilyn Lauglo Anna Nilsdotter

# Chapter 1. Introduction

## *Background and purpose*

The International Planned Parenthood Federation (IPPF), established in 1952 and headquartered in London is recognised as the major international non-governmental organisation in the field of sexual and reproductive health and rights (SRHR). It has hundreds of thousands of volunteers, 37,000 service delivery points, and 151 member associations. A pioneer in the advocacy and provision of family planning, IPPF has, since the early 1990s broadened the scope of its activities to a wider range of services and the advocacy of sexual and reproductive rights.

There have been four evaluations[1] of IPPF over the past eight years, mainly focusing on the background and relevance of IPPF's work, its performance, partnerships and management structures. However, none of them focused on the people using and benefiting from the services provided. This evaluation was commissioned to fill that gap of knowledge, and has been funded by two of IPPF's major donors, Sida and Norad. The purpose of the evaluation is to assess the relevance and effectiveness of IPPF's work in promoting sexual reproductive health and rights through its services, advocacy efforts, and information sharing. The evaluation has a particular interest in how IPPF works at country level and assesses the extent to which the member associations reach poor and vulnerable people and marginalised groups. The terms of reference are enclosed in Annex 1.

The evaluation was carried out in three phases: 1) preparation of field studies and writing of inception report, 2) field studies, and 3) analysis and synthesis. The evaluation team consisted of a Scandinavian team of three persons, a national SRHR expert in each country, and 2-5 youth consultants in each country to assist with the data collection. The terms of reference specify that the evaluation should be conducted in a participatory manner. IPPF, Sida and Norad were invited to take active part and each had one or two staff members join the evaluation team for one of the country visits. Management and staff at the member associations were briefed on the findings and have reviewed the draft country reports. Preparations started in April; field studies were carried out from August to October; and the report was finalised in November 2006.

## *Key question*

Poverty is the central issue in this evaluation. Other evaluation tasks, such as the assessment of relevance, effectiveness and impact, should all be assessed in relation to poverty. Do the services of the IPPF member associations reach poor people? What difference does it make? How are they affected? The meaning of poverty has been widely debated in international development the past decades. Sen (1987, 1999) was one of the first to argue for a broad definition of poverty. Instead

[1] " *Performance Assessment of IPPF: Policy and Effectiveness at Country and Regional Levels* " (1998) commissioned by Sida, Norad and DFID; "*Joint Review of the IPPF and USAID Partnership*" (2000) commissioned by USAID and IPPF; "*Addressing the Reproductive Health Needs and Rights of Young People since ICPD – The Contribution of UNFPA and IPPF*" (2004) commissioned by Germany, the Netherlands, Denmark, Norway and the UK; and "*Management Audit of the Planned Parenthood Federation*" (2005) commissioned by Sida. These four evaluation were reviewed and analysed in the Inception report of this evaluation and are used again in chapter 7 in this report.

of only seeing poverty as a lack of income, poverty should rather be understood as a lack of basic capabilities. This has now become the approach commonly used in development cooperation, and the view shared by the donors commissioning this evaluation (Sida, 2002, Norad, 2002). Some of the main features of this view on poverty are: (Sen, 1999)

- While a lack of income is one of the major reasons for a lack of basic capabilities, and thus poverty, it is not the only one.
- The relation between the lack of capability and the low income varies from society to society, and between individuals. It is affected by the age (for example different needs of children and old people), gender and social roles (for example motherhood and family duties), where you live (risks for natural disasters such as floods), levels of safety and violence (for example in some urban areas) etc.
- A purely income-related view of poverty misses out on the dynamics of power within the family, for example if the collected resources are systematically being used by certain individuals and not others (e.g. women and girls). Lack of income and lack of capabilities affect each other in two ways. Increased capabilities to live your life as you wish to is likely to increase your income, and an increased income is likely to increase your capabilities.

The World Bank initiated study *Voices of the Poor* brings together in three volumes the experiences of over 60,000 poor women and men from all over the world (Narayan, 1999). The study underlines the multidimensionality of poverty, and the variation in pattern and shape. It includes illness as one of the important dimensions of poverty. Illness deprives vulnerable individuals of incomes related to work. The cost of treatment can push a household deeply into poverty and take children (in many countries first the girls) out of school. Additional expenses such as travelling to a place where health care can be received, or bribes and "gifts" presented to doctors and other health care workers to ensure adequate treatment is many times a significant barrier to access, along with others such as the stigma of having to be treated for certain diseases such as HIV/ AIDS. In addition, access to health is often heavily influenced by gender (Narayan 1999: 46, 90).

The study also points out that a poor person's access to opportunities is influenced not only by the relations with institutions outside the household, but also by those within the household. Health care for women is often given a low priority in poor households, and access to health care for women may be seriously affected by social norms that restrict their mobility and public activity. In some places the agreement of the husband or another male community member is essential before women and children may go to the health centres (Narayan, 1999)

The link between SRHR and poverty reduction is widely acknowledged in international research and political documents. The relation can be described in different ways. If poverty is defined as a lack of capabilities, and health is one of those essential capabilities, poor sexual and reproductive health *is* poverty. An improvement of the sexual and reproductive health is therefore per se a reduction of poverty. However, the different dimensions of poverty also influence each other. There is much research showing the direct links between sexual and reproductive health and income poverty, for example the connection between high fertility and income poverty, or the fact that inability to work causes loss of a wage income (UNDP, 2005; Sachs 2005: chapter 3, 5).

Drawing from the capability approach to poverty, it follows that someone deprived of basic capabilities can be considered poor, although the financial resources in the family might not indicate this. For example, a young teenage girl in a middle-class family is to be considered poor in some aspects, if she does not have a voice over her own sexuality and physical integrity. When we use the word poverty in the remaining parts of this evaluation, we do so against this background. We do not equate poverty with low incomes, but low income is one of several manifestations of poverty. Income is relatively easy to measure and hence it is used more than it should be used. We have sometimes taken the shortcut to approximate poverty with low incomes, but it should be clear from the context what we mean and what exact data we have in each situation. The key question posed to the evaluation is whether IPPF reaches poor people, and poor people means not only people with low incomes but also people deprived of capacities in other respects, and particularly in respect of sexual and reproductive health and rights.

## *Methodological choices*

### Evaluation design

The first task in an evaluation is to choose an appropriate design, given the questions that have been formulated. Design is a methodological choice, but it is often is confused with the methods themselves, that is, which data collection methods to use. Different authors have proposed different ways of categorizing the design alternatives, but the main distinction is between the following three categories;

1. experimental design with randomised test groups and control groups, with pre-tests and post-tests of variables;
2. quasi-experimental design, where there are still test groups and control groups, but where these might not be randomly selected, or the pre-tests could not be done;
3. case study design, where the study only covers a test group, with no forms of control.

This evaluation has a quasi-experimental approach to the task. The most essential data comes from meetings with clients and users of services. We gathered data at clinics and other service delivery points, and we gathered that data both from these clients and from those we call "non-users", i.e. persons who for some reason choose not to use the services of the member association. This approach provided some of the additional perspectives that a control group could have provided the evaluation.

We interviewed staff and management at the national level in the member associations and we interviewed and visited relevant ministries, the NGO community and multilateral organisations to hear their views of SRHR issues and challenges, their opinion on the member associations, and their views on collaboration and networks. These interviews served as a form of "shadow controls" to establish perspectives on data and to give a more valid and reliable interpretation. As we studied three countries the data could be used for a comparative analysis. The situation in each country differed from that of the others and the comparative perspective gave new insights and introduced benchmarks. This is thus a stronger evaluation design than a single case study would have been.

The evaluation was conducted in Bangladesh, Uganda, and Ethiopia. The countries were selected by Sida, Norad and IPPF, and for us who carried out the evaluation this choice was a given fact. However, it is a feature that needs to be commented on. First, the terms of reference define the purpose as follows; "*to review the work of IPPF so as to help Sida, Norad, and other donors make informed decisions about the relevance and effectiveness of IPPF's work …. There is a particular interest in how IPPF works at country level and with young people*." The formulation implies an expectation that the study of these three countries will have something to say about IPPF in other countries too.

However, as we did not visit any other countries it is not possible to say anything about relevance, effectiveness, or outreach in countries other than these three. Those who know the operations of IPPF member associations in other countries could probably say whether our findings seem to reflect the situation there too, but that is beyond us. We do not have that knowledge. It may be interesting to reflect on the choice of countries. Are these the three "best" member associations? Our interviews at the IPPF headquarters seem to indicate that they are among those that have a rather good reputation inside and outside the organisation.

## Selection of Evaluation Objects

Looking at the purpose of the evaluation, our selection of evaluation objects was guided by the need to talk to people at the grassroots level and to meet as many intended beneficiaries as possible. When selecting service delivery points, clinical and non-clinical, the following criteria guided us:

1. Mix of urban/ partly urban/ rural sites.
2. Regional geographical cross section (to include ethnic diversity if appropriate).
3. Range of activities intended for different beneficiary groups e.g. young people of different age groups (including out-of-school and in-school youth), males, females, married, unmarried, mix of household income groups, people living with HIV/AIDS, marginalised groups e.g. internally displaced people or men-who-have-sex-with-men
4. Range of activities from the strategic dimensions[2] plus family planning and safe motherhood.
5. Range of size of service delivery points and attachment of non-clinical service delivery points.

IPPF's secretariat and regional offices provided information about the field study countries regarding activities, budget, locations of clinics, numbers of volunteers, and to some extent, the non-clinical activities. The selection of places to visit was also guided by local knowledge of the national consultants. Each country visit was completed in two weeks time. The country reports in Volume 2 provide the lists of persons met, but in brief, the evaluation team spent the first two to three days visiting the member association headquarters, government ministries, and other SRHR stakeholders at national levels. The team then split into two or three groups who visited different clinics and districts according to the selection mentioned above. After a week of field work, the teams met, had additional interviews at the national level, and wrote a draft report.

[2] The strategic framework of IPPF identifies Five A's that serve as the key dimensions of planning, allocation of resources, project and program implementation, and results. They are: access, adolescents, advocacy, abortion, and HIV/AIDS.

*Interview with village elders, to the left, and community leaders, both in Ethiopia. The picture to the left illustrates the "public" nature of some interviews; the village elders' opinions and responses were open to the community.*

## Methods and data collection

There are basically four ways to collect information during an evaluation. The first is to *interview* people, one at a time or in groups, the second to send out *surveys or questionnaires*, the third is to *observe* people, behaviour, or environmental conditions. Finally, an evaluation can build on *written documentation*, for example analysis of documents, statistics, etc. In this evaluation we used three of the four possible methods: interviews, observation, and document analysis.

*Document review:* From IPPF in London we received reports, strategies and planning documents, brochures, books and papers, as well as previous evaluations. We also received information concerning the three selected countries and the projects in each country. This written material was used to give background information on the organisation, its structure, and ways of operating.

*Observation:* Structured observations were used as an important source of information. The objects observed were clinics, satellite and outreach clinics, clinics of alternative providers (government and NGOs), outreach activities (e.g. home-based HIV/AIDS care, puppetry shows, drama shows etc.)

*Interviews:* In the first phase of the evaluation, two meetings were conducted with staff at the IPPF Central Office in London. We held unstructured, open interviews to gain understanding of issues of relevance for the evaluation. We also conducted phone interviews with key persons at the regional offices, in order to get background information about the activities and structure of the member associations to be visited. The data collection instruments for the field visits include both interviews and focus group interviews, which were used depending on what was locally possible and adequate. The figure below shows the different interview protocols used in the evaluation.

The interviews were our most important source of information. In the course of the evaluation we have met with more than 1,200 people, sometimes in individual interviews and sometimes in group interviews. The vast majority are users of clinical and non-clinical services. The non-users

are few and less than 20% of the users. But we have a large number of voices other than those of the member associations' staff and management, as there are almost more than twice as many in the latter category, that is, member associations staff. Table 2 shows the number of people we received information from in respect of each data collection instrument.

## Validity and reliability

Even with careful design and appropriate methodological choices, there are threats to the validity and reliability of an evaluation. First of all, we must again remind the reader that we conclude on evidence from Bangladesh, Uganda, and Ethiopia only. Any references or statements about other countries, regions or global operations are hypothetical only. Second, all three countries are large and the member associations have large-scale operations in each country. We met 234 service users in Bangladesh, but the organisation there claims to meet the needs of 1.6 million clients. We visited 3 branches out of 20. Even our overall conclusions at country level are based on a sample, and we actually do not know how representative that sample is of total operations in the country.

Third, the interaction between the interviewer and the respondent is always a weak link in the evaluation process. The interview situation might put the respondent under a social pressure, where they are influenced by expectations they think that society or the interviewer has. The risk is that this influences the interview situation, especially concerning sensitive issues such as SRHR. In addition we have the problem of language and interpretation. To limit these problems as much as possible, we worked with national consultants and youth consultants. They were essential to collect and interpret the data we needed. Fourth, power relations between people can negatively influence group discussions. As far as possible, we tried to separate boys and girls, men and women, and adolescents of different ages into different groups.

**Table 1. Overview of different interview guidelines**

| | **Provision and use of services** | | **Stakeholders concerning SRHR** |
|---|---|---|---|
| **National level** | Interview guidelines for Board, management and staff at national headquarters | | Interview guidelines for government ministries, research agencies, NGO community, and international organisations |
| **District level** | Interview guidelines for Board and management at district headquarters | | Interview guidelines for community leaders (village elders, religious leaders, local government, other NGO service providers |
| | Interview guidelines clinical service providers | Interview guidelines non-clinical service providers | |
| | Exit interviews clinical service users | Interviews non-clinical service users | Interviews with non-users |

Source. The evaluation's data collection instruments, presented in the Inception report and in Volume 2 of the final report.

**Table 2. Numbers of people met and data collection according to country, method and data collection instrument.**

| | Bangladesh | Ethiopia | Uganda | Total |
|---|---|---|---|---|
| INTERVIEWS | | | | |
| District level | | | | |
| Exit interviews at clinics | 34 | 73 | 75 | 182 |
| Interviews/focus groups non-clinical service users | 200 | 43 | 28 | 271 |
| Interviews/ focus groups non-users | 52 | 53 | 30 | 135 |
| Interviews/focus groups clinical service providers | 35 | 17 | 26 | 78 |
| Interviews/focus groups non-clinical service providers | 85 | 60 | 147 | 292 |
| Interviews community leaders | 61 | 35 | 40 | 136 |
| National level | | | | |
| Interviews with member associations | 18 | 22 | 22 | 62 |
| Interviews with other SRHR stakeholders | 12 | 20 | 15 | 47 |
| Sum of people met | 497 | 323 | 383 | 1203 |
| OBSERVATION | | | | |
| Member Association clinic | 5 | 10 | 4 | 23 |
| NGO/Government clinic | 5 | 5 | 4 | 11 |
| Non-clinical activities | 1 | 3 | 2 | 4 |

Source: Completed interview formats from the evaluation process.

Finally, there is the question of how impact is created and how essential the IPPF member associations were in achieving the desired outcomes. In no single instance would we attribute the achievement of objectives and results in relation to SRHR to the activities of the IPPF member associations only. The results are always of a complex and multidimensional nature. In many cases we are certain that the member associations have played a major role, and they have significantly contributed to shape the outcomes. But other actors were always involved, and it must be recognised that attribution is complex and is an effect of many actors working together.

## *Guide to the reader*

The evaluation is presented in 2 volumes. This is Volume 1 and it contains the main report, which summarises the three country studies in relation to the overall objective of the evaluation. The report follows a simple narrative structure where each chapter responds to a major question that is derived from the Terms of Reference:

- Do the member associations reach poor people and marginalised groups? (Chapter 2)
- Are the operations relevant and effective (Chapter 3)
- What impact have the operations contributed to? (Chapter 4)
- Are the advocacy activities effective? (Chapter 5)
- Can the organisation be improved? (Chapter 6)
- What decisions should Sida and Norad make on the basis of this evaluation? (Chapter 7)

*The evaluation team had a number of focus group interviews, for example with adolescents who had taken part of awareness raising projects on HIV/AIDS.*

Volume 2 contains the three country studies. Each country study is made up of a main report of varying lengths, and annexes. Each country study could be read on its own, without reference to other texts or to the main report. There are annexes to each country report; the list of persons interviewed and other material that we deemed relevant to understand the main text. As we have used the same data collection instruments in all countries, these are presented in a separate section rather than in each country report.

# Chapter 2. Reaching poor and vulnerable groups

## *Introduction*

IPPF is an organisation with a long history, and though its mandate has broadened its focus from family planning to SRHR. The dimension of poverty as a specific aim and objective is of more recent date, and thus something the organisation has to work to put on the agenda of all member associations. During 2006 IPPF commissioned a study which documents and assesses how IPPF is working to reach poor, vulnerable, and marginalised groups, and suggests a definition of poverty to guide the organisation in its future work.

The overall mission statement contains a clear and direct reference to the need to reach poor people. In the Strategic Framework 2005-2009, the mission statement is: *"IPPF aims to improve the quality of life of individuals by campaigning for sexual and reproductive health and rights through advocacy and services, especially for poor and vulnerable groups*. At a global level, the intent is followed in practice as IPPF channels 91.8% of its unrestricted grants to its member associations in countries identified as having the highest or a high need in the area of sexual and reproductive health and rights by UNFPA (IPPF, 2006).

Moving from the mission statement to the strategic framework, the Governing Council in 2003 approved a strategic framework for the organisation. This framework outlines five priority areas: adolescents, HIV/AIDS, abortion, access, and advocacy (the Five A's). The question is how the Five A's relate to poverty: Do they supplement the concept of poverty? Do they possibly move strategic attention from poverty to something else? However, the mission statement sets the stage, with its emphasis on serving the "poor and vulnerable", as well as on its commitment to defend and promote sexual and reproductive rights, and reduce the spread and impact of HIV/AIDS. As long as this is kept in focus and operationalised in the Five A's, there should not be any risk that the concepts oppose each other.

**Table 3. The IPPF estimated percentage of clients who are poor, marginalised, socially excluded or underserved. Figures from 2005.**[3]

| | |
|---|---|
| Bangladesh | 76% |
| Uganda | 62% |
| Ethiopia | 90% |
| IPPF globally | 57% |
| IPPF Africa | 72% |

Source: "Monitoring IPPF's implementation of the Strategic Framework 2005–2015: Report of the Global Indicators Survey 2005" and "Global Indicators Survey" for Bangladesh, Ethiopia and Uganda 2005.

[3] It should be noted that the global IPPF data includes countries such as UK, Germany, Sweden, Finland, Hong Kong and others with low numbers of poor, marginalised, socially excluded or under-served clients.

For the sake of this evaluation, the poverty focus can be assessed though the service statistics gathered by the member associations for 2005. The statistics show that well over half (56.6 per cent) of their 35.6 million clients were poor, marginalised or socially excluded. In the Africa region, this proportion rises to 71.9 per cent; in the Arab World more than three-quarters of those served (76.8 per cent) came from one or more of these populations. Table 3 presents the global figures and singles out the three countries covered by the evaluation.

Can these figures be trusted? From what we understand, these figures are rough estimations and it is not clear for us how the data were collected. During the field visits, we understood that the member associations do not collect any socio-economic information about their clients. Our data suggest that the number of poor people served by the organisation might be higher in both Bangladesh and Uganda, however it is impossible for us to estimate any exact figures. Many of the respondents to exit interviews can clearly be defined as poor, if one utilises a human capabilities approach to defining poverty. Participants in focus group discussions described communities where most young people were unemployed, where young girls commonly died of abortions and where many girls were raped in the streets at night or in the schools during the daytime. We visited rural outreaches which were very isolated, with poorly dressed children, who had deeply infected wounds on their bodies. We saw small clinics in urban slums without functioning waste disposal or drainage systems, with children running around in the mud with poor clothes and without shoes. However, we also saw nice-looking and large clinics in urban areas, with affluent clientele. We will return to our observations and data below.

## *Identifying the poor and vulnerable*

The country studies provide backgrounds of the poverty situations and SRHR needs in the countries visited. The Human Development Index, which is a composite index that measures average achievements in three basic dimensions of human development: a long and healthy life[4], knowledge[5], and a decent standard of living [6], gives an indication of poverty levels. Ethiopia, Uganda and Bangladesh rank as number 170, 144 and 133 respectively, out of 181 listed countries. In these countries, the number of people living on less than USD 2 a day is 78%, 97% and 83% respectively (UNDP II 2005, Population Reference Bureau, 2005).

Some particular SRHR-related problems identified by Freedom House (Freedom House, 2006) and Amnesty International (Amnesty International, 2006) are widespread violence against women, including acid attacks and dowry-related assaults in Bangladesh, forced marriage and female genital mutilation in Ethiopia and high levels of discrimination against lesbians, gays, bisexuals and transgender people in Uganda. We have identified the following groups who are poor and vulnerable, and face specific challenges in accessing SRHR care and information.

- People with low income and education
- Young people
- Women with little power over their own lives

[4] As measured by life expectancy at birth.
[5] As measured by the adult literacy rate and the combined gross enrolment ratio for primary, secondary and tertiary schools.
[6] As measured by GDP per capita in purchasing power parity (PPP) US dollars.

- Commercial sex workers, street children and homeless people
- People facing stigma and discrimination, e.g. HIV-positive and men who have sex with men.

For the purpose of analysis, these groups will be kept separate here, although of course in reality the groups are cross-cutting and many individuals belong to several of these groups.

## People with low income and low education

The general conclusion when analysing the three countries is that the member associations do reach many people with low incomes. This is especially the case when it comes to the outreach sites. The locations of these are mostly in very poor urban or rural areas, and the majority of clients live close by. The urban branch clinics seem to serve a somewhat more mixed clientele. In many urban clinics, staff pointed out that the high quality of services made the clinics attractive also for some better-off clients.

Below we present some of the data from our exit interviews. The data have to be interpreted with great care. Our sample of interviews is small, and in Ethiopia our outreach sample comes from only one outreach site. A non-representative sample of certain age groups might affect the outcomes in important ways. There are differences in poverty levels between the districts that affect the national statistics derived from the Demographic and Health Study. The data could only indicate potential interesting areas to investigate further.[7] Tables 4 and 5 below show the education levels of clients in Uganda and Ethiopia. The differences between the static clinics and the outreach clinics/ sites are obvious.

**Table 4. Level of completed education among respondents to exit interviews in Uganda.**

| | **None/ preschool** | **7 year primary** | **4 year lower secondary** | **2 year upper secondary** | **Higher education** | **No of observations** |
|---|---|---|---|---|---|---|
| **Static clinics** | 0% | 33% | 31% | 8% | 29% | 52 |
| **Outreach clinics** | 17% | 43% | 26% | 4% | 9% | 23 |

Source. The evaluation's exit interviews in Uganda

**Table 5. Level of completed education among respondents to exit interviews in Ethiopia.**

| | None/ preschool | 4 year primary | 2 year lower secondary | 2 yr upper secondary | 2 year post secondary | Post secondary | No of observations |
|---|---|---|---|---|---|---|---|
| Type of clinic | | | | | | | |
| Static clinic | 15% | 13% | 15% | 15% | 33% | 9% | 46 |
| Outreach site | 67% | 22% | 7% | 4% | 0% | 0% | 27 |
| | | | | | | | |

Source. The evaluation's exit interviews in Ethiopia

[7] Only data from Ethiopia and Uganda is presented. The number of exit interviews from Bangladesh is low, and the quality of the data poorer than in the other countries.

In Uganda, none of the 52 interviewed persons at static clinics lacked schooling completely, whereas 17% of the people interviewed at the outreach clinics did so. Twenty-nine percent of the clients from the static clinic had a higher education, whereas only 9% at the outreach clinics were in the same category. In Ethiopia, 67% of the clients at the outreach clinic had no education at all, whereas only 15% of the clients at the static clinics fell into the same category. No one interviewed at the outreach clinic had a post-secondary education or higher education, whereas 33% and 9% respectively of the people interviewed at the static clinic had.

So what does this tell us about the clients we have met – are they poor? When answering this question, one has to look at it in both an absolute and a relative way. Let us start with comparing our clients with the national statistics. It is very hard to compare the data from Uganda with national statistics, because the last Demographic and Health Survey in Uganda was carried out in 2000, and the socio-economic situation has changed substantially in the past years. However, the DHS data from Ethiopia is newer, and there are some interesting findings there.

- Of the population in the lowest wealth quintile, 84% of the women and 73% of the men lack formal education, whereas 38% of the women and 24% of the men in the highest quintile of the population fall into the same category. Of the clients we interviewed in the static, urban clinics, 15% lack formal education. In the countryside it is 67%. Hence, the urban clients we have met have far better education levels than the highest wealth quintile in the country. If we look at the rural clients we interviewed, they had substantially higher levels of education than the poorest groups in society.

- Of the population in the lowest quintile of the population, none has more than secondary education, whereas 3% of the women and 6% of the men in the highest quintile fall into the same category. Of the interviewed urban clients, 33% have a post secondary education and 9% have a higher education. Hence, also here they show far higher levels of education than the top wealth quintile of the country. Turning our eyes to the rural clients, they show the same figures as the lowest wealth quintile.

- If one looks at the DHS data divided into the rural and urban population, 31% of the urban women and 16% of the urban men lack formal education, whereas 73% of the rural women and 57% of the rural men fall into the same category. Repeating our data from above, 15% of the urban clients we have interviewed lack schooling, whereas 67% of the rural clients fall into the same category. These data also show that when separating the urban and rural population, especially the urban clients seem to be very much better off than the average urban population. (Especially when taking into consideration that only 12% of our urban respondents were male.)

- The picture is confirmed when looking at higher education. Four percent of the urban women have more than secondary education and 8% of the urban men. None of the rural population has more than secondary education. In our sample, 33% of the clients at the urban, static clinics have a post secondary education and 9% of them higher education. At the outreach clinic, none has any post-secondary education.

So, now, what do we know about the clients? We see that the urban services at least in Ethiopia reach some people who are very poor in an absolute sense. Thirty percent have no education at all, or only 4 years of primary school education. But the services also seem to reach some people who are quite well off in an absolute sense. In Ethiopia 40% of those interviewed had a post-secondary education. In Uganda 30% were in the same category. We also see that the urban clients reached do not belong to the poorest urban groups; in fact they are relatively seen far better off than most urban people. Hence, the picture of the urban services is mixed.

Turning our eyes to the rural services, we see that they reach many people who are very poor in an absolute sense. In Uganda 20% lack formal education, whereas the figure is 70% in Ethiopia. This is clearly a very poor and vulnerable group of people, especially exposed to SRHR problems. Relatively seen, they might not belong to the very poorest groups, but that is not very interesting when looking at their poverty level.

Apart from education levels, we have other indicators of socio-economic status. The table below shows the reported occupations of the clients in Ethiopia. The picture confirms the education data. In the urban static clinics, there is a wide range of occupations. At least 40% seem to be quite well off, judging by their occupation. Opticians, bookstore owners, or pharmacists can hardly be among the income poorest in a society.

We also have data on a number of assets from both Uganda and Ethiopia. Table 7 presents the data from Uganda. We can make a rough assessment of absolute poverty, and of differences between outreach clinics and static clinics, but again we cannot compare it with DHS data. First of all, we see that the general pattern of differences between the outreaches and the clinics remains. It is also clear that there are many indications of absolute poverty, for example 40% of clients from the outreaches have homes with a natural floor, and 30% do not have a radio.

**Table 6. Occupations of respondents to exit interviews in Ethiopia**

| **Occupations at static clinics** | |
|---|---|
| House wives, not employed | 40% |
| Cleaner, maid | 5% |
| Petty trader, construction worker | 5% |
| Student | 13% |
| Employed businessmen | 15% |
| Own business | 15% |
| Optician, pharmacist, secretary | 8% |
| **Total number of observations** | **40** |
| **Occupations at the outreach site** | |
| Housewives and farmers | 100% |
| **Total number of observations** | **27** |

Source. The evaluation's exit interviews in Ethiopia

**Table 7. Assets as an indication of poverty status, data from exit interviews in Uganda**

| Asset | Alternative | Outreach clinics | Static clinics |
|---|---|---|---|
| ***Number of observations*** | | 23 | 52 |
| **Drinking water** | Water from open well | 9% | 8% |
| | Water from covered well | 4% | 4% |
| | Water from borehole | 26% | 4% |
| | Surface water | 4% | 0% |
| | Other source | 0% | 4% |
| | Piped water | 57% | 81% |
| **Toilet facility** | No / bush / field | 4% | 0% |
| | Pit toilet / latrine | 91% | 73% |
| | Septic tank / modern | 4% | 27% |
| **Bicycle** | No bicycle | 78% | 65% |
| | Have bicycle | 22% | 35% |
| **Radio** | No radio | 30% | 6% |
| | Have radio | 65% | 94% |
| | NA | 4% | 0% |
| **Roof** | Thatched | 13% | 2% |
| | Iron sheets | 87% | 92% |
| | Tiles | 0% | 6% |
| **Floor** | Natural floor | 39% | 25% |
| | Finnished floor | 61% | 75% |
| **Walls** | Mud and pole | 17% | 15% |
| | Unburnt bricks | 0% | 10% |
| | Burnt bricks with mud | 22% | 38% |
| | Cement | 61% | 12% |
| | Burnt bricks with mud & cement | 0% | 25% |
| **Housing** | Rent | 61% | 54% |
| | Own | 39% | 46% |

Source. The evaluation's exit interviews in Uganda

Table 8 presents the Ethiopian data on assets. The same pattern of differences between the outreach sites and the static clinics is seen. There are also many indicators of absolute poverty, for example none of the people from the outreach site has piped water and no one has a radio. Everyone at the outreach site has homes with grass roofs, natural floor, and walls made of mud and poles. Even in the static clinics, half of the clients have homes with natural floors and walls made of mud and poles. Turning to the picture of relative poverty, comparing with the DHS data, we find the following:

- 90% of the urban population have some sort of piped water compared to 13% of the rural population. Of the clients surveyed, 96% of the urban clients have piped water compared to none of the rural clients.

- 12% of the urban population and 70% of the rural population have no toilet. In our sample, 2% of the urban clients and none of the rural fell into the same category.
- 46% of the urban population have earth, sand or dung as flooring material, compared to 98% of the rural population. In our sample, 50% of the urban clients' homes have a natural floor compared to 100% of the rural clients.

**Table 8. Assets as an indication of poverty status, data from exit interviews in Ethiopia**

| Asset | Alternative | Outreach | Static |
|---|---|---|---|
| **Number of observations** | | **27** | **46** |
| | | | |
| Drinking water | Water from open well | 26% | 0% |
| | Water from well | 0% | 0% |
| | Water from borehole | 15% | 0% |
| | Surface water | 0% | 0% |
| | Rainwater | 59% | 0% |
| | Other source | 0% | 2% |
| | Piped water | 0% | 96% |
| | NA | 0% | 2% |
| Toilet facility | No / bush / field | 0% | 2% |
| | Pit toilet / latrine | 100% | 85% |
| | Septic tank / modern | 0% | 11% |
| | NA | 0% | 2% |
| Radio | No radio | 100% | 2% |
| | Have radio | 0% | 89% |
| | NA | 0% | 9% |
| Roof | Grass | 100% | 0% |
| | Plastic sheet | 0% | 0% |
| | Iron sheets | 0% | 89% |
| | Tiles | 0% | 2% |
| | NA | 0% | 9% |
| Floor | Natural floor | 100% | 50% |
| | Finished floor | 0% | 43% |
| | NA | 0% | 7% |
| Walls | Grass | 0% | 0% |
| | Mud and pole | 100% | 52% |
| | Unburnt bricks | 0% | 9% |
| | Burnt bricks with mud | 0% | 0% |
| | Cement | 0% | 20% |
| | Other | 0% | 7% |
| | NA | 0% | 13% |
| Housing | Rent | 0% | 61% |
| | Own | 100% | 30% |
| | Don't know | 0% | 4% |
| | NA | 0% | 4% |

Source. The evaluation's exit interviews in Ethiopia

- 76% of the urban population owns a radio, compared to 27% of the rural population. Of our interviewees, the urban figure is 89% and the rural figure is 0%.

The relative picture here is a bit mixed, but generally the urban clients are better off than the average urban population and the rural population is worse off. However, the pattern is not as striking as with the education levels. To conclude the analysis of how well IPPF reaches people with low incomes and low levels of education, our limited sample gives the following picture:

- Many of the clients in the rural outreach sites are very poor in an absolute sense. Relatively seen, they are sometimes slightly better off than the average rural population, and sometimes slightly worse off.
- Some of the clients in the urban static clients are poor, and some are quite well off, in an absolute sense. In a relative sense, they seem to be far better off than the average urban population.
- There are large differences between the static clinics and the outreach sites, with a strikingly larger share of poor people reached at the latter.

This picture is confirmed in interviews with staff at the member associations. Many point out that it is at the outreach sites that most poor people and very poor people are reached. In some branch clinics we heard stories about some better-off clients coming for the quality services. A logical question then is whether some or a few of the clients coming to the branch clinics would actually be able to afford non-subsidised private services. The picture is not clear and is not possible for us to analyse this fully. We got some indications that this might be the case in the Katego clinic in Kampala, whereas we were told in Ethiopia that also the relative "middle class" earns so little that they would not be able to afford alternative quality services. When discussing possible cross-financing with some senior management staff in Ethiopia, we also heard insightful arguments about the danger of losing the NGO image of the organisation, which might lead to a loss of poorer clients. Practically, it might also be difficult to administer different fees for various groups of clients. Hence, we understand that this is a delicate balance where one has to consider many different dimensions, specific for each member association and country.

## Fees and exemption policies

One constraint for income-poor people is that of fees. The three member associations visited all charge fees for most of their services. The fees are lower than those charged in the private sector, and often lower than those charged by other NGOs. To some extent, the fees also differ depending on location and target group, for example with lower fees at the outreach sites. While the member association's fees are higher than those charged by the public sector, quality and access to public services is so low that this is often not a real option. The question of interest concerning fees is whether, and if so, to what extent, they limit access to health services for the poorest people. All the member associations that were visited have exemption rules, and the basic rule is that no one in need of help shall be denied services because of inability to pay the stipulated fee. In Bangladesh and Ethiopia we did not find any major problems with this approach. Very few people reported that fees were a problem.


*The waiting room in one of the clinics in Chittagong. There were separate waiting rooms for men and women, and also separate toilets. The information on fees was clearly visible at the entrance.*

However, in Uganda, we were told repeatedly that the fees were a problem for the poorest and that there were many people who would never seek services, due to a lack of money. Peer educators said that they could not inform people about the exemption policy, as that would cause "everyone" to demand free services. As a result, they sometimes ended up paying themselves. Some community leaders also reported that the exemption rules were arbitrary, and that they had to bring poor community members in person to increase their chances of getting services for free.

It is important to keep in mind that exemption policies only work to the extent that people are aware of them, and the interviews from Uganda clearly show that the fees stop some poor people from even coming to the clinics. The Katego clinic in Kampala was the only clinic of those visited that included information about the exemption policy in the price list in the waiting room, although this clinic is probably the clinic with the lowest need to exempt clients. According to another provider that works with poor clients, the insecurity of what the costs might end up being in itself can be a serious constraint. Potentially then, a fixed and well-known fee might attract more clients than a fee that is somewhat lower on average, but which is not possible to predict.

The two main arguments for applying a fee is that it adds value to the services, i.e. that people do not appreciate services that are for free, and that a fee stimulates a change of life-style. For example, we were told that charging a fee stimulated poor people to investment and saving. Another example is when an informant said that deciding to go for VCT was a process and included starting to appreciate health and think about the future. If the person did not realise that this was important, and hence did not prioritise the VCT enough to manage to save some money, there would be no behavioural change after the test and the person would be back within a few months for a new test. Interviews with volunteers partly confirmed this picture.

This argument might overlook the situation for women in very vulnerable situations, i.e. women with little or no influence over the household finances who simply do not have access to cash. It might therefore be analytically more useful to apply different arguments and policies, and possibly a more varied range of fees, for different target groups.


*The FPAB clinic in Chittagong is set in a side street in a quiet residential area. The sign introduces the services and points clients to registration.*

## Young people

Young people are highly vulnerable for a variety of reasons. They have special needs for SRHR services and they face legal constraints. Mostly they also lack their own financial resources – resources that might be needed to pay for SRHR services. The member associations in Uganda and Ethiopia are generally very good in reaching out to young people. They offer services to the youth that no one else offers, and they are credited by other stakeholders for their youth centres and youth-friendly services. In Uganda the age of consent is 18, which makes the issue of distribution of contraceptives to minors a sensitive topic. There, the FPAU youth centres and volunteers have an important gap to fill. In Ethiopia, there is a government policy not to offer VCT to minors without parental notification, but exceptions are made for providers offering youth-friendly services, so FGAE might be the only provider assisting minors with VCT in some areas.

The Youth Centre in Awassa in Ethiopia may be cited as a good example of youth friendly services. Young people coming there could get VCT, they could get information and advice on contraceptives. There were discussion groups, a circus troupe to generate revenue, a library, and other meeting places. The centre was located in one of the poor areas of town, and some distance from the branch clinic. It had a lively atmosphere and during the visit of the evaluation team there were some 150 young people there. The centre also arranged discos, sports activities, etc. During the interviews some of the young people who attended the centre criticised management for not being responsive enough to their needs, and they also complained that some of the equipment was out of date and not properly maintained.

Nevertheless, in comparison to a youth friendly service in Bangladesh, the one in Ethiopia seemed vibrant, lively and interesting. In Bangladesh the youth friendly service was no more than a single room in a clinic, and it had no such things as discos, sports activities and the like. An

evaluation may be culturally blind, but it seemed as though the youth friendly service in Bangladesh was more designed according to what adults want adolescents to be like, rather than to how they themselves want to be and behave.

While there is no doubt that youth friendly centres reach some young people, we would still be speaking in terms of a few hundred at most, who attend the centres. The majority of young people served by the member associations would approach them as regular clients coming to the clinics or outreach sites. The exit interviews contain information on age and it seems as more than half of the respondents were below age 25.

As the mean age at marriage for women in all three countries is low, between 17 and 19 on the average, this is hardly surprising. The demographic profile of each country is that the majority of the population is below 20, and hence it is likely that the clients of the member associations would very often be below that age too. When the evaluation team visited clinics, we normally saw that most of the people in the waiting rooms were between 15 and 25 years of age, though it is of course quite difficult to tell. Still, there is no doubt that the member associations to a large extent reach adolescents both through the general services and through the youth friendly activities. Most adolescents have access through the regular services of the member associations, and for a smaller number the youth friendly services are important.

## Women with little power over their own lives

Some women are living in situations that make them more vulnerable than others. Some live in households where they have little say over when to seek care for themselves or their children or whether to use household resources for things they think are important. This has implications for their access to reproductive health services. At one outreach site there were women who had agreed with their husbands to limit their family size. However, the women had to find the money for the contraceptives by themselves. Their only source of income was to work as day labourers on other peoples' gardens, which in turn meant that they had to neglect their own gardens.

The outreach activities and low fees that characterise the member associations are especially important to these groups of women, since transport and money might be a particularly severe constraint for them. The analysis concerning the low-income groups and the fees apply here. Hence, it is our conclusion that the member associations do reach many women with little influence over their own lives.

Included in this group are also women facing gender-based violence, early marriage, harmful traditional practices such as female genital mutilation, etc. We saw and heard of some different projects addressing these problems. For example, the clinic in Addis Ababa, Ethiopia, has a unique programme of services for rape survivors. The unmet need is large and we were told that the allocated staff was under pressure because of the demand for their services. However, when talking to local stakeholders for example in Ethiopia, the member association was not recognised as an organisation working with these issues. While this is interesting information as such, it may indicate that the FGAE is not highly visible in advocacy, it must also be understood that the interview respondent may not know what, in this case, FGAE is actually doing.

*To the left, a lively discussion at the Youth Centre in Awassa on sex before marriage. To the right, a peer educator in Uganda.*

In one of the areas visited, a clinic had an outreach programme. The participants set up a mutual savings fund. Part of the income was used to ensure a steady and cheap supply of contraceptives, the other part was used to provide members with loans for commercial activities. But another part of the project was to stop harmful traditional practices, in particular female genital mutilation which is widespread in the area. The major impact of the programme was in mutual savings and though awareness around the harmful practices was said to be increasing, there has not been much behaviour change. There were similar projects in other parts of Ethiopia.

Another point of interest is the need to work with men. The importance of working with awareness raising for men was highlighted in many interviews in Uganda, but not so often in Ethiopia or Bangladesh. Perhaps this reflects the fact that there were many more women at all levels in the member association in Uganda, but both the other member associations tended to be dominated by men in staff and management positions.

## Commercial sex workers, street children and homeless people

Commercial sex workers, street children and homeless people are other vulnerable groups. They have certain features in common. They live in urban areas and mostly migrate there from rural areas, they spend most of their time in the streets, they are very mobile and thus hard to reach in a regular way. If they are young, they are mostly out of school. Hence, they are particularly vulnerable to reproductive health risks and have low access to education and information which could help and protect them.

We have seen several projects targeting these groups both in Ethiopia and in Uganda. For example in Mbarara, Uganda, there is a project with a large number of peer educators, all recruited from transient traders who reach out to their peers on a large scale. Also in other places we saw examples of peer educators recruited from these specific groups. However, the same was

not true in Bangladesh, where we could not observe any projects that particularly targeted these groups.

The links between income-generation and SRHR has been highlighted in many interviews, and is acknowledged in interviews with staff and volunteers. The argument is that it is very hard to teach people about SRHR when they have no money to eat tomorrow, i.e. that many very poor people simply find it impossible to bother about long-term consequences of their actions when their daily life is so hard and demanding. This is true not only for the group of people being analysed here, but also for other people with low or no incomes. But it might be of specific relevance for this group, because of the uncertainties of their lives. We have seen different approaches dealing with this problem, such as skills trainings, micro-credit programmes, community dialogues and assistance to create income-generating organisations.

### People facing stigma and discrimination

Another group facing constraints in many aspects are HIV-positive people. Apart from their need for medical attention and treatment, very ill people need financial support for themselves and their families, care in their homes etc. Another important area is that of stigma reduction. The member association in Ethiopia carries out some support activities and reported about some project activities in the area of stigma reduction, but these do not seem to be on a large scale and are not well known by organisations working for people living with HIV/AIDS, except in the vicinity of the project activities.

In Uganda, while we did not hear of any specific stigma reduction work, we heard that the member association works closely with organisations such the AIDS Information Centre. For example in Mbarara in Uganda, they refer clients to each other, train each others staff, exchange experiences and so on. The mere fact that member associations in Ethiopia and Uganda have successfully integrated VCT and offer support to people living with HIV and AIDS as part of their overall care, serves to reduce stigma and discrimination. In none of the countries visited have we seen examples of any kind of work with men who have sex with men, nor any stigma reduction work generally when it comes to the community of gays, lesbians, bisexuals and transgendered persons.

## *Targeting strategies*

After having assessed the degree to which the member associations reach the groups above, the next question is to what extent they consciously target these groups and whether anything could be improved. Three common target strategies are available in theory:

1. Only give the service to *individuals* identified as poor and vulnerable.
2. Only give the service to *groups* with a high share of poor people, for example people living in a certain area.
3. *Self targeting* by designing the intervention in such a way that non-poor are discouraged from utilising it, e.g. by offering a service with low quality in some non-essential aspect (such as outward appearances or location).

It is important to keep in mind that targeting sometimes entails costs and might be less suitable in environments where the majority of people could be considered poor in an absolute sense, where poor people are not concentrated in easily identifiable ways, and where the general administrative capacity is low.

When asked about selection criteria for outreach locations, the common answer among staff members was that they selected underserved areas with low access and high SRHR needs. In addition, in Ethiopia, they tried to select locations which could be accessed by many people. The selection of areas are done in cooperation with the local government and other NGOs.

In Bangladesh there is a long history to explain the location and the clients they serve. In the past, the government directed NGOs to serve urban areas whereas the government served rural areas. Hence the FPAB clinics were established in urban centres according to government directives. Later, it has become clear that the government services do not all rural areas and there are areas in between rural and urban that are underserved. NGOs are increasingly asked to establish operations in rural areas and many projects are now located in rural districts to reach poor people there. The main clinics have clients of different income groups, but the areas covered by Health Promoters are often poor.

Many activities and services target youth specifically, and some projects target commercial sex workers, street children, and homeless people. Women with little influence and power over their own lives were never specifically mentioned and neither were people with low income as such. There were never any discussions of different poverty levels in the rural areas, even in cases where there were some clear differences according to the district administration.

Having the pattern of poverty in mind, it is however clear that criteria such as “low access” in reality mostly equals those with low income, as well as women with little influence and power over their own lives. Virtually everyone is poor, or very poor, in the rural areas, and women face many gender-based constraints, such as harmful traditional practices. These are also the areas where public services are most deficient and are sparsely spread out. For example in interviews with poor women at a rural outreach in southern Ethiopia, we were told that the location of the FGAE clinic was such that women would pass it on their way to the market and hence they could access contraceptives without the permission or knowledge of their husbands.

In order to gain a better picture of what the clientele looks like in different clinics and outreach sites, it might be useful to collect data on socio-economic indicators in a systematic way. This is done in some clinics today, but there is no system to feed back to the national data collection. Such indicators could possibly guide decisions on resource allocation in a more systematic way than today, for example by shifting resources to clinics serving a higher proportion of poor people.

## *Conclusion*

Do the member associations reach poor people? To answer, it is necessary to consider three aspects on poverty.

1) **Relative poverty.** Assessments of relative poverty say something about differences between different groups of clients. Such knowledge could guide a more systematic comparison and allocation of resources, as described above. It also answers the question of whether the poorest groups in society are reached.

2) **Absolute poverty.** With a multidimensional view on poverty it is hard to define exact indicators, but still one can describe and discuss the different indicators. In our opinion, absolute poverty is more interesting than relative poverty. One could question how important it is to reach the very poorest in countries where large proportions of the population is very poor, and where the very poorest often live in extremely remote and sparsely populated areas. If one has a limited amount of resources, is it better to reach 100 extremely poor persons, than it is to reach 2000 very poor persons or 10 000 quite poor persons?

3) **Affordability of un-subsidised SRHR services.** A third dimension is the affordability of quality SRHR services. Regardless of the absolute and relative poverty – can people afford to pay for alternative un-subsidised services or not?

So, back to the question, do the member associations reach poor people? Yes, they certainly do. From our limited data we cannot provide any exact figures. But our assessment is that a lot of very poor people are reached in the rural outreach areas. They are clearly poor in virtually all aspects one could consider. In the urban areas, the socio-economic indicators show a mixed picture. Looking only at the income poverty dimension, one would say that they reach some poor people. However, here it is important to keep in mind that it is in the urban areas that the raped women (e.g. Addis Abeba), the young petty traders (e.g. Mbarara), the street children (e.g. Bahir Dar), the commercial sex workers (e.g. Dire Dawa) and some other very vulnerable groups are reached. Looking at the different vulnerable groups, it is primarily the urban youth that the Ethiopian and Ugandan member associations reach on any major scale. The other vulnerable groups are mostly reached in particular projects. Even if the projects are effective, the clients are mostly counted in numbers of hundreds and up to some thousands.

When we look at the third aspect, affordability of un-subsidised services, the picture is probably mixed and it has to be assessed on the national level. The only place where we have clear indications that some clients could pay much more for their services is the Katego clinic in Kampala. As already pointed out, we understand that this is a delicate balance where one has to consider different aspects and arguments. Having said that, the differences between static clinics and outreach clinics/ sites indicate that it would be worthwhile to collect information on clients' poverty status, at registration or through targeted surveys. That could possibly guide the member associations to reach even more poor people in the future, and to allocate resources in a more systematic way than today.

# Chapter. 3 Assessment of Services

## *Introduction*

A central concern for this evaluation is the relevance and effectiveness of IPPF's work. Here we look at services provided by the member associations visited while advocacy work is addressed in Chapter 5. Sida's Evaluation Manual defines relevance as *"The extent to which the objectives of a development intervention are consistent with beneficiaries' requirements, country needs, global priorities and partners' and donors' policies"*. Effectiveness is defined as *"The extent to which the development intervention's objectives were achieved, or are expected to be achieved, taking into account their relative importance"* (Sida, 2004). In this chapter, we focus on the interventions themselves, i.e. IPPF's services.

The beneficiaries' requirements and country needs are shown by SRHR indicators to the extent that they exist. Indicators for some aspects of sexual reproductive health are available, e.g. unmet contraceptive need, maternal mortality, skilled attendance at delivery, HIV prevalence. Others are more difficult to ascertain, e.g. prevalence of gender-based violence, extent of unsafe abortion, autonomous decision-making. There may be discussions about the values reported for the indicators as countries may have different calculation methods, e.g. for maternal mortality. Here we use the values accepted by UN sources, except in cases where new evidence is available, such as the Demographic and Health Surveys. Additionally, relevant national policies have been reviewed in the countries visited.

Global priorities and key concerns in partners' policies have been identified by reviewing reports published by the global SRHR stakeholders and relevant policy documents for Sida and Norad. This chapter begins with a brief description of the consensus around what needs to be done to progress the 1994 Cairo Programme of Action and improve SRHR of women, men, and youth around the world. It then provides a table of SRHR indicators for the three countries visited during the evaluation. The chapter goes on to provide observations from the country visits including those related to the added value of the member associations' work. It concludes with main points raised in the chapter.

## *Global Priorities*

Cairo ICPD marked a paradigm shift in the approach to population activities as the focus moved from population reduction to a wider range of SRHR concerns. Women, their needs and circumstances were put at the centre of SRH decision-making. The ensurance of women's human rights to improve their SRH was viewed as essential to improving women's SRH.

A decade later, when reviewing progress toward achieving the Cairo Programme of Action, gender equality and meeting health needs (family planning, safe motherhood, safe abortion, HIV/AIDS) especially for adolescents were identified as the key issues (Schlangen, 2005). A report from the Millennium Project discusses the importance of integrating SRHR services into strengthened health systems and noted the importance of two priority areas: improving access to information and services, including family planning information and services, and closing the funding gap for commodities, supplies and logistics.

Reports from various Task Forces for the UN Millennium Project note the importance of SRHR for their work. The Overview report and Task Force on hunger note the importance of family planning information and services. The Task Force on Education and Gender Equality observes that *"gender equality cannot be achieved without guaranteeing women's and girls' SRH and rights"* and identifies access to SRHR information and services as one of the seven priorities. The Task Force on Child Health and Maternal Health points out the unwanted pregnancies contribute directly to maternal mortality and that attention needs to be given to the SRH need of adolescents. The Task Force on HIV/AIDS, Malaria, Tuberculosis, and Access to Essential Medicines points to the special vulnerability of women and girls to HIV/AIDS and also underlines that access to SRHR services and information are an integral part of the HIV/AIDS response. The Task Force on Improving the Lives of Slum Dwellers observes significant intra-urban health disparities exist, especially in terms of SRHR outcomes and the high prevalence of STI, including HIV/AIDS in urban settings (UN Millennium Project; 2006).

Recommendations from the UN Millennium Project related to SRHR include investment in rural development, investment in health systems characterised by a holistic, integrated approach to SRH including HIV/AIDS, and investments in gender equality. In their report, *Adding it Up: The Benefits of Investing in Sexual and Reproductive Health Care,* the Alan Guttmacher Institute and UNFPA identify three major areas of SRHR interventions: contraceptive services, maternal health services including abortion related services, and the prevention, diagnosis, and treatment of sexually transmitted infections including HIV/AIDS (Singh *et al,* 2003).

While some SRHR information gaps have been closed over the past decade e.g. there is more widespread awareness of modern contraceptive methods, other significant gaps still exist in relation to the health risks of home deliveries without a skilled attendant, misconceptions about some contraceptive methods, comprehensive knowledge of HIV/AIDS, and knowledge of the availability, access, and quality of services.

The Millennium Project Report on how improved SRH outcomes contribute to achieving the Millenium Development Goals emphasis the importance of an integration of the continuum of services and a continuum over time. While these comments are mainly directed to national systems, they are also important to bear in mind for NGOs when drawing attention to the integration of primary health care with family planning, the inclusion of young people, and the integration of HIV/AIDS prevention. Other areas for attention are meeting unmet contraceptive need and supporting correct and consistent use of contraceptives. This latter area is particularly important to stem the discontinuation of contraceptive use for women who do not wish to become pregnant. Meeting the needs of groups with special SRH needs is important. Most prominent here are young people for whom youth friendly services are appropriate and young married adolescents who need a differently focused set of interventions. Community participation and appreciation of cultural norms are required when implementing SRH activities in this highly personal and sensitive area.

Based on the above, when assessing IPPF's member associations' services, this report focuses on *contraceptive services; safe abortion services; a focus on young people; HIV/AIDS prevention, care, and support; maternal health services; and strengthening SRH decision-making*.

## *Donor policies*

Sweden's international policy on Sexual and Reproductive Health and Rights 2006 notes two underlying perspectives for Sweden's global development policy: a) the rights perspective and b) perspectives of poor people. The strategic areas for Sweden's work for SRHR include empowering women and girls to shape society and their own lives; the health and rights of young women and men; the role and responsibility of men in the promotion of gender equality; increased focus on homosexual, bisexual, and transgendered persons, gender – based violence and sexual exploitation; and a range of services relating to contraception, maternal health care, safe abortion; and HIV/AIDS and sexually transmitted infections.

Compared to the global consensus summarised above, the starting point for Sweden's policy on SRHR is clearly from a rights and poverty perspective with a concern over empowerment. Norway does not have a SRHR policy but refers to UNFPA's quick reference guide for policy dialogue and priority setting, 'Ensuring reproductive health for all.' Quite naturally, the starting point here is the International Conference on Population and Development and its follow-ups, and then the Millennium Development Goals. The unfinished agenda reflects documents written for the Millennium Development Project and issues identified above under 'global priorities' (UNFPA, 2005).

## *Country Needs*

What are the SRHR needs in Bangladesh, Ethiopia, and Uganda - the countries visited by the Evaluation Team? Table 5 gives some indication of the challenges facing each of the member organisations. The governments of all three countries consider their birth rates to be too high. Although there may be some differences of views among the leadership, the position taken by the ministries of finance which often have responsibility for leading the country's poverty reduction efforts, is that their country' s birth rate should be reduced. Of key importance is the population momentum resulting from the population age structure. Here reaching young people becomes critical.

We see that the three countries share some common characteristics while there are also differences among them. Contraceptive prevalence among women 15 – 49 is substantially higher in Bangladesh (47%) compared with Ethiopia (9.7%) and Uganda (18.2) Unmet contraceptive need is thus lower in Bangladesh but nevertheless exists (11%) compared to 33.8% and 34.6% in Ethiopia and Uganda respectively.

Maternal mortality is also considerably lower in Bangladesh which may reflect the higher contraceptive prevalence rate and the availability of menstrual regulation as an option for women suspecting an unwanted pregnancy. Deliveries attended by a skilled attendant are considerably higher in Uganda (38%) compared to Bangladesh and Ethiopia (12% and 10% respectively) pointing to the importance of working with traditional birth attendants in those countries. Young people (aged 10 – 24) make up a sizable portion of the population on all the countries. Although all three countries share the same proportion of population aged 15 – 24, there are differences in their population structure e.g. Uganda has the lowest median age. Women marry at a younger age in Ethiopia and Bangladesh than in Uganda whose high age specific fertility rate of those aged 15-20 presents a stark contrast.

## Table 9. Sexual Reproductive Health Indicators for the Three Countries Visited

| **Indicator** | Bangladesh | Ethiopia | Uganda |
|---|---|---|---|
| Contraceptive prevalence rate for women 15 – 49, modern method per cent | 47.3[8] | 9.7[9] | 18.2 |
| Unmet need for family planning, total per cent | 11.0 | 33.8[10] | 34.6 |
| Maternal mortality ratio (MMR) per 100,000 live births | 380 | 850 | 880 |
| MMR low bound | 320 | 500 | 510 |
| MMR upper bound | 450 | 1200 | 1200 |
| Deliveries attended by skilled attendant, per cent | 12 | 10 | 38 |
| Total fertility rate per woman 15 - 49 | 3.4 | 5.4 | 6.9 |
| Married by age 18, per cent, female 15 - 49 | 83 | 70 | 53 |
| Median age at first sexual intercourse, female 15 – 49 | n/a | 16.0 | 16.6 |
| Proportion of population 15 – 24 | 20.4 | 20.0 | 20.1 |
| Median age of total population | 21.2 | 17.2 | 14.9 |
| Age specific fertility rate per 1000 women 15 – 20 | 116.9 | 100.2 | 211.3 |
| Mean age at marriage, male | 25.5 | 23.3 | 23.7 |
| Mean age at marriage, female | 18.0 | 17.1 | 19.4 |
| HIV knowledge, men 15 – 24 who know that a person can protect himself from HIV by consistent condom use, per cent | n/a | 63 | 81 |
| HIV knowledge, women 15 – 24 who know that a person can protect herself from HIV by consistent condom use, per cent | n/a | 37 | 68 |
| HIV/AIDS prevalence, 15 – 24 lower bound, male | 0.0 | 3.2 | 1.6 |
| HIV/AIDS prevalence, 15 – 24 upper bound, male | 0.0 | 5.6 | 2.4 |
| HIV/AIDS prevalence, 15 – 24 lower bound, female | 0.0 | 5.7 | 3.7 |
| HIV/AIDS prevalence, 15 – 24 upper bound, female | 0.0 | 10.0 | 5.6 |
| Per cent men who agree the husband is justified in hitting/beating his wife if she fails to provide food on time, argues with him, goes out without telling him, or neglects the children, | 44.6[11] | 51.1[12] or 81[13] | 76.5[14] |

Source: UNFPA, 2006

[8] "Bangladesh Demographic and Health Survey 2004".
[9] "Ethiopia Demographic and Health Survey 2005."
[10] "Ethiopia Demographic and Health Survey 2005."
[11] "Bangladesh Demographic and Health Survey 2005".
[12] "Ethiopia Demographic and Health Survey 2005".
[13] "Ethiopia Demographic and Health Survey 2005".
[14] "Uganda Demographic and Health Survey 2000-2001".

The HIV/AIDS epidemic has stabilised in Uganda but has shown no signs of stabilising in Ethiopia. HIV prevalence in Bangladesh is estimated to still be below 1% but it has increased substantially in recent years in some 'at risk' groups e.g. injecting drug users. HIV/AIDS awareness differs substantially across the three countries reflecting their differences in how the epidemic has developed.

Autonomous SRHR decision-making is difficult to measure although the demographic and health surveys sometimes include modules asking about the extent of influence in other areas of household management. Gender-based violence is a SRH problem in itself and may give a clue to the level of SRH decision-making available to women in each country. Gender-based violence covers many issues; different forms of it can be found in each country including rape, acid throwing, coerced marriage, domestic violence, and female genital mutilation.

## *Relevance and Effectiveness*

In the discussion of the relevance and effectiveness of services below, we include a section on the value added by the member associations' work. The quality of services is discussed there along with user views gained from the exit interviews and focus group discussions. Issues of duplication and overlap with other service providers are also taken up in that section.

### Contraceptive services

FPAB, FGAE, and FPAU are recognised as the leading family planning organisation in their respective countries. They are viewed as strong and trusted partners of their governments. They were known for having gotten family planning on the national agenda and were the first to provide contraceptive services. After family planning was taken up by the governments, the member associations became well known for their service delivery. This is surprising because according to the demographic and health surveys in each country, governments are the main provider for family planning in the three countries visited. In Bangladesh, only 6% of people get their contraceptives from NGOs while in Ethiopia, 17% listed NGO health facilities as their contraceptive source. In Uganda, the proportion getting contraceptives from private clinics or hospitals (which includes both NGO and private-for-profit providers) rose to 37% with only 0.4% receiving family planning from NGO community-based agents.

In *Bangladesh*, with its relatively high contraceptive coverage, one finds the structure of FPAB's family planning service is similar to the government's with domiciliary visitors providing the backbone of the service. FPAB branch clinics also provide the government's Essential Service Package of primary health care services.

In *Ethiopia*, FGAE is recognised as the leading family planning organisation being the first to talk about and provide family planning. It has continued to maintain its leading position through the introduction of new contraceptive methods, sharing it technical knowledge through training other NGO and government providers. A Ministry of Health overview of the distribution of short-term contraceptives during 2002 – 2005 showed that FGAE had the widest range of contraceptives. In addition, FGAE is seen as an important provider of permanent methods. Outreach services appear to be limited largely to the provision of injectable contraceptives to supplement the community based distribution of pills and condoms.

*An outreach clinic in Ethiopia which is served once a month by staff from the Yirg-Alem subdistrict branch clinic. Women line up and pay, and then get their injections.*

In *Uganda,* FPAU was repeatedly referred to as a 'good and solid service provider' by other SRHR stakeholders. Moreover, it is seen as the only provider with a systematic and comprehensive reach into rural communities.

*An Incomplete Picture:* Emergency contraception is a family planning method that does not appear to be in wide demand although available at all the clinics. It is not clear whether this is due to licensing or other problems with the logistics chain in each country. The availability of this important method of contraception should be widely known to young people and in areas where coerced sex is unfortunately a common occurrence.

## Safe Abortion Services

Safe abortion is an important option to have available so that women have a full range of means to control their fertility. Reports on the high levels of coerced sex, especially among young women, also underline the need for safe abortion. It has been estimated that globally, abortion contributes 13% to maternal mortality although in some countries, up to 30% of maternal deaths are attributed to unsafe abortion. This high number argues for the provision of safe abortion on public health grounds.

In *Bangladesh*, menstrual regulation is available as a family planning method. Figures on its use are not kept, but the 2004 DHS found that 6% of women had used it at some point in their lives. This is mirrored in FPAB where menstrual regulation does not appear to be much sought after. The need to make this method more widely known, especially among married and unmarried adolescents has been noted by other researchers. When talking about this with staff in Sylhet, the impression is that those who attend for menstrual regulation are slightly older 'young people' i.e. age 20 – 24. It is not uncommon that they attend with their partners.

In *Ethiopia*, FGAE is working in a environment where the legal framework around abortion has recently changed allowing for greater flexibility in providing abortion services. FGAE is itself,

one of the leaders in area and together with others, has written the 'Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia'. It is providing post-abortion care and planning to expand its abortion services.

In *Uganda,* unsafe abortion is regarded as the third commonest cause of maternal death. It has been estimated that 300,000 induced abortions were performed in 2003 and that 86,000 women suffered from complications of abortion (Singh *et al,* 2005). FPAU's Strategic Plan for 2004 – 2009 indicates that the its provision is limited post-abortion family planning and assessment of other sexual reproductive health conditions and plans for capacity building among staff in this area. In the 2006 Approved Programme Budget, abortion comprises only 1% of the budget[15]. We recognise that FPAU is working in the most difficult abortion environment of the three countries visited and cannot offer abortion services. Nevertheless, it does not appear to be offering all elements of post-abortion care, most notably treatment of incomplete and unsafe abortion.

The policy environment around abortion varies considerably in the member associations visited as is reflected in the level of abortion related activities carried out by member associations. The presence of a USAID in each of the countries also plays a role in setting the overall policy environment and in determining which organisations collaborate with the member association. Abortion is one of IPPF's five strategic areas. We found there are lessons to be shared from FGAE's abortion work in terms of consolidation and expansion of existing services, networking with other stakeholders, and developing a systematic advocacy approach to abortion.

*These pictures illustrate the practical daily work of doctors and paramedics, here in a satellite clinic. There is a long line of people who seek advice, but here privacy is not provided for, as it is in the main clinics.*

[15] As discussed in Ch. 6 of this report, the Approved Programme Budget gives a limited picture of the extent to which member associations are working in a particular programme area.

## A Focus on Young People

The importance of directing attention to the SRHR needs of youth is recognised in the Millennium Project documents and by those working on HIV/AIDS. Young people are a diverse group with different health, service, and information needs according to their age, gender, marital status, whether they are in-school, and the extent to which they are close to or cut off from their families and communities.

Conventional reproductive health services (e.g. family planning services, maternal-child health services) are usually designed for married women. But the needs of young married women are often forgotten. These call for a different emphasis in the cluster of services available to them. This points to: immunisation, communication and negotiation, delaying first pregnancy, returning to school, and life skills emphasising reading, awareness of legal rights, and financial literacy.

Conventional reproductive health services are often provided in a manner that raises barriers for unmarried adolescents, especially for adolescent males. Responding to a different constellation of needs, services for unmarried young people have been provided through youth friendly services, youth centres, peer education programmes, and family life education programmes. Respect, confidentiality, privacy, convenient opening hours with flexible drop-in possibilities, affordable fees, and welcoming arrangements for males are needed in the youth friendly services. Awareness raising, self-determination skills, and entry to service provision figure strongly in the other programmes.

In *Bangladesh* the majority of young women are married while still in their teens. Interventions do not appear to be particularly tailored to their needs i.e. the emphasis in services mentioned above as once they are married they are served through the usual domiciliary and clinical services. The evaluation team visited one income-generating group but it is unclear how widespread such activities are. Activities aimed at unmarried young people seemed to play a minor role compared to the overall work of FPAB. And, it is unclear whether the awareness raising, centering on pregnancy and infection prevention has any long-term effect.

In *Ethiopia,* FGAE is recognised as having been the first organisation to design and provide youth friendly services at its clinics. VCT for HIV is provided at these clinics and because it is provided under the auspices of a youth friendly services, it is offered to under 18's without parental notification as required in Ethiopia. Here too, the majority of young women are married during their teens and, as in Bangladesh, the outreach services do not appear to be designed for them.

Associated with the clinics are the youth centres, located near the clinics that are intended to provide a space for young people to meet and to provide the entry point to SRHR services. However, the evaluation team questions whether all youth centres function as intended. Users of the youth centre appeared to be largely older males; few users appeared to be married; and the library service seemed most suitable for in-school young people. These findings are in consistent with findings from another study of Ethiopian youth-serving organisations (Bruce and Chong, 2006). The evaluation team also spoke to several young peer service providers, who highlighted what they perceived as a lack of participation in decision making. They also complained about insufficient training and re-imbursements for transport.


*To the left, boys at the Youth centre in Mbarara. To the right, Community Based Reproductive Health Agents at the FPAU satellite clinic at the Owina market, a very large market in Kampala. The volunteers all work at the market, and provide information and contraceptives to their colleagues, many of whom have no time or money to go to alternative providers.*

On the other hand, in Ethiopia, there appears to be additional concerted efforts to reach groups of especially vulnerable adolescents. Collaboration was established with local chapters of the Forum for Street Children so that FGAE provided SRH and general medical services for residents of the Forum's Drop-In centre. Activities to reach commercial sex workers and domestic workers were also seen in more than one location. It was however, interesting to note that in a focus group discussion with the street children, only 2 out of 14 had heard about the Youth Centre despite all having been to the youth clinic for health services.

It is in *Uganda* that the evaluation team found the most encouraging demonstrations of work with young people. Although here too, there seemed to be little activity aimed at married youth, we saw the usual range of activities for unmarried young people: youth centres, youth friendly services, peer educators, and family life education courses. At one youth centre particularly, there were equal numbers of females, more out-of-school young people, easy access to the equipment, more active peer educators in the rural areas, and easy movement between the youth centre and the clinic. Youth centres visited were located adjacent to sports playing fields. At one site, boys were found playing cards on the steps to the lab whose services included VCT. At another, children aged around 10 to 12 years were seen dropping into the clinic waiting room to select and watch information videos.

The evaluation team concluded that the vibrancy of FPAU's youth efforts was because of the greater participation of young people at all levels of the organisation: running the youth centres, participation on the Branch Board, and participation at national levels. We met outspoken, competent and self-confident young volunteers, introducing themselves as "general secretary" or "president" for different groups within the organisation. With the established institutional structure for youth participation in the planning and management of activities, Uganda seemed well placed to extend its activities to uncovered groups of young people. It is already directing

some activities to 'transient traders' in one urban centre and this included commercial sex workers.

## HIV/AIDS prevention, care, and support

The three countries visited represent countries at different stages in the epidemic. Uganda has a mature generalised epidemic where the government, NGOs, and international community have been working together on HIV/AIDS for decades. Comprehensive knowledge of HIV/AIDS [16] is 27% among women and 35% among men. Ethiopia's epidemic is more recent. Although there is a general awareness of AIDS, there are considerable differences based on region of residence, educational background, and household wealth status. Comprehensive knowledge of HIV/AIDS is 16% for women and 29% for men. In Bangladesh, HIV prevalence is estimated to be around 1% but high in certain at – risk groups such as injecting drug users, commercial sex workers, and migrant workers.

In *Bangladesh,* we found little interest in work around HIV/AIDS. Visits at the Branch level revealed that some Board members were unable to identify vulnerable groups at-risk for HIV, a local Branch senior manager who was not aware of the local NGOs working with the different at-risk groups, and one senior Branch staff member who claimed there were no brothels in the area. Although VCT is offered at a selected number of static clinics, there appears to be a need for capacity building before the organisation can begin to work effectively in this field.

In *Ethiopia and Uganda*, the context is entirely different. Here there are national AIDS policies and national coordinating mechanisms. Many donors are in the arena with considerable funds directed to specific prevention, diagnosis, treatment, care, and support services. In Uganda, the care and support network is well developed. The member associations in Ethiopia and Uganda are offering VCT and its inclusion as part of the member associations SRHR activities is important as an example of integrated services which is too often lacking with vertical HIV/AIDS interventions. Mainstreaming HIV/AIDS prevention, care, and support also contributes to the reduction of stigma and discrimination which still surrounds HIV/AIDS.

Fragmentation of HIV/AIDS efforts is one of the most serious challenges to the fight against AIDS in all countries. As IPPF member associations continue to expand their work in this area, there is the danger that their efforts too, will contribute to fragmentation in their countries. This did not appear to be the case in Uganda where stakeholders saw FPAU as raising awareness of HIV/AIDS, especially among young people, providing them with easily accessible VCT, and then when appropriate, referring to the other organisations.

However, in Ethiopia, FGAE's role is not that clearly defined. The member association itself said that generally, they see themselves partly as 'gap fillers' – providing services where other services are not available. That this might be the case is illustrated by a partner NGO at one of the Branch clinic centres which has selected FGAE to provide its youth VCT service. The provision of opportunistic infections treatment offered at some clinics shows the need for coordination with

[16] Defined as a) knowing that using a condom at every sexual intercourse and having just one uninfected and faithful partner can reduce the risk of getting the AIDS virus, b) knowing that a health-looking person can have the AIDS virus, and c) rejects the two most common local misconceptions about AIDS transmission.

the wider range of AIDS treatment facilities. This indicates that potential for fragmentation is great and should be guarded against.

Given the tempting lure of substantial funds for HIV/AIDS, the member associations need to stand strong in continuing to maintain their commitment to the wider range of SRHR issues – something the member associations in Ethiopia and Uganda appear to be doing.

## Maternal Health Care

Reducing maternal mortality is an important SRHR challenge that can be tackled on many levels. At the community level, attitudes towards to family size, early marriage, prevention of unwanted pregnancies, recognition of the signs of complications during pregnancy and delivery, and getting women to health facilities when needed all play a part. Awareness of the availability and importance of quality maternal health services is also needed. At the service level: the provision of contraceptives to avoid an unwanted pregnancy, safe abortion for women who wish to terminate their pregnancy, provision of post-abortion care for complications arising from spontaneous and provoked abortions, focused ante-natal care, skilled attendance at delivery, preventing mother-to-child-transmission, referral to higher level health facilities for complications arising during delivery, and post-natal care are all part of the continuum of maternal care.

Although all the three member associations visited provide interventions at both the community and service levels, it appears that the interventions are fragmented and not part of an overall continuum of care within a local area. It would of course, be impossible for member associations not to provide ante-natal care or post-natal care since these components are rightly part of the SRHR primary care repertoire. But one reason many women attend the member association for these services is because there are no other service providers nearby which means that the continuum of care is broken. The question to be asked is how these services are linked to the government system that should be providing a continuum of care. One of the most significant components is the traditional birth attendant, the person most likely to provide delivery services to clients in Bangladesh, Ethiopia, and in rural parts of Uganda.

In *Bangladesh*, the local level volunteers discuss these issues with the families they visit. Groups meeting at the Family Development Centres and youth clubs had discussions around some of these topics. However, little is known about the content of these awareness raising activities and whether beneficiaries had opportunities to incorporate what they learned in their everyday lives.

At the service level, FPAB is poised to provide deliveries in selected clinics. In preparation for this, clinics are working with traditional birth attendants aiming to inform them about what is required for a safe delivery. This training does not bring the traditional birth attendants up to the standard of a 'skilled birth attendant' as defined in the Joint Statement on skilled birth attendants issued by WHO, ICM, and FIGO. The traditional birth attendants themselves view the training as enhancing their skills which may serve to raise their status within their communities to skilled attendants. It remains to be seen whether FPAB's safe motherhood efforts are able to involve traditional birth attendants in a meaningful manner which results in more women being attended by skilled attendants according to standards set at the international level.

*The post-natal care service at the model clinic in Awassa, Ethiopia*

*Ethiopia* is also planning to offer delivery services in a few selected sites. In other areas, the provision of the continuum of care appears to be fragmented with FGAE offering ante-natal care at some of its static clinics. While this is in keeping with the call to provide integrated services, it is unclear how ante-natal care for a woman is coordinated with provider who then attends her at delivery.

In *Uganda*, although there is some provision of maternal child health care, it does not appear to play a significant part of their overall program.

## Strengthening Sexual Reproductive Health and Rights Decision–making

In the countries visited, protecting SRHR requires working to change a wide range of attitudes which pose barriers to the SRH of men, women, and young people. Gender issues are at the core of poor SRH and the HIV/AIDS epidemic. Women's empowerment in decision-making in the highly intimate area of SRHR matters is central to improved SRHR. Empowerment includes deciding whether to have children and if so, when and how many; whether to use contraceptives and if so, which one; and whether to continue an unwanted pregnancy and if not, how to terminate it under safe conditions.

Empowerment also includes access to information and the ability to use it to protect one's own health. Women must be able to a) recognise when they need to seek out services, b) know where services can be found, c) use services when needed, and d) carry out the advice of health professions to protect their own health. Gender-based power imbalances especially at the household level are effective obstacles to autonomous decision-making in these areas.

Empowering women to be able to make decisions requires work to be done with individuals at the household level, in communities and at the national level with policy change. Awareness

raising is an important first step in strengthening decision-making among women and attitude change in the community overall. We observed and saw a number of activities: drama, puppet shows, music and dance, group discussions among young people, and written materials such as posters, leaflets, magazines, newsletters, and information cards. We were also repeatedly told that a significant part of the work of the community based reproductive health agents, peer educators, and local level volunteers was 'sensitisation' and 'awareness raising.' It was difficult to form a clear picture of what this encompassed although much seemed to focus on pregnancy and infection prevention.

Written information, education, and communication (IEC) materials appear to be very much sought after by other organisations and institutions in *Uganda* but not so widely available in *Ethiopia*. Some beneficiaries pointed out that the Ethiopian IEC materials seemed clinical, boring and old, with few pictures, and little information on social and psychological aspects of SRHR. In *Uganda* however, IEC materials go through a thorough pre- and post-test process to ensure that the intended message is conveyed. Adjustments are continually made after post-testing, especially when posters are introduced in different areas where small details, such as the type of clothes a figure is wearing or colours used, have unexpected local significance.

Because FPAU has focused much of its attention on young people, we asked the youth consultants on the Uganda Evaluation Team to assess the IEC materials. In summary, they found that the written messages are aimed at behaviour change covering a wide range of SRH issues including unsafe abortion, early or forced marriage, cross-generational sex, male involvement, as well as other issues. The materials are found to use catchy messages and language appropriate to the target group, youth. Importantly, they thought that the graphics and pictures are easily understood by people who cannot read. Moreover, they found the messages to be relevant to the life situation of poor people e.g. people in familiar village settings. More details of the assessment of FPAU's IEC materials can be found in the annex to the Uganda country report.

The final comment in the young consultants' assessment is that 'there is a need for a good monitoring system to test the effectiveness of the materials'. This is a comment that we would apply to nearly all of the awareness raising activities carried out by the community-based field workers. It is not clear whether the messages conveyed and the way they are conveyed resonate with beneficiaries in a way that they are able to incorporate them in their everyday lives. To be sure, some activities are aimed at improving communication and negotiation skills, imparting general and financial literacy, and improving time and financial planning. But, there is a need to better link these to the overall strengthening SRH decision-making activities in each member association. We did find one encouraging exception to this lack of evidence of lasting effectiveness. In Mbarara, Uganda, the life planning skills training efforts have resulted in a community based organisation called Youth Action Initiative for Health and Development. With practicable, marketable skills, not only have members found some means of financial self-sufficiency, they have also started working with street children on their own.

## FPAB, FGAE, and FPAU's Added Value

Since the member associations are only providing a small portion of their countries' overall SRH service, what is their added value? Or, do they duplicate existing services?

***Reach into Rural Communities***

In *Bangladesh* local government authorities allocate those areas in which FPAB works so there is no overlap with government provision. Originally, these were in urban areas. Later, when rural areas were allocated, it was said by non-FPAB stakeholders, that FPAB was given remote and difficult to reach locations. In *Uganda,* other SRHR stakeholders, including those in government, said that FPAU was the only provider with a systematic and comprehensive reach into remote, rural communities.

One NGO said that there was no other option of a partner with such extensive links to rural communities. This is borne out by the 48% of users interviewed for this evaluation who gave the close location to their home as their reason for attending the outreach service. Some clinical outreaches may be located in areas where there are government facilities but government officers and health workers themselves noted that their facilities were under-staffed and often experienced drug shortages so that they were not functional. This was confirmed by the evaluation team who visited a government Health Centre III and Health Centre II facility. Where functional, government health units were known to be over-crowded. In *Ethiopia*, we were not able to develop as clear a picture about the availability of government facilities in the areas where FGAE operates. Some informants pointed out the same shortcomings with government services noted in Uganda but the feeling about this did not seem to be as strong.

At one of the outreach sites, users said that short distance was an important reason why they attended the outreach. We did note, however, that in the past few years, there has been an expansion of government facilities and there is a potential for overlap with the government's Health Service Extension Package which is training health extension workers in each kebele[17].

***Primary Health Care in Under-Served Areas***

Related to the issue of reaching into rural communities, is the provision of primary health care. Because they are in under-served areas, member association services may be the only contact people in remote areas have with the modern health care system. Particularly in *Bangladesh and Uganda* where their satellite and outreach clinics provide a range of services, this is a much needed service. According to our exit interviews, half of the people attending in Bangladesh and half of the attendants of the clinical outreach in Uganda were attending for curative primary health care, including some elderly males.

This presents some other requirements on the providers. In focus group discussions with users, women talked about symptoms that were not resolved after attending the FPAB clinic. They attributed their symptoms to their contraceptive method and when their complaints were not resolved, seemed less motivated to continue with family planning. It may be that their complaints were due to something else which needed better investigation than could be offered at the FPAB satellite clinic. In a similar vein, the local level volunteers felt that they did not have sufficient training that enabled them to help with the different problems people consulted them about. Peer educators in Uganda raised issues of a similar nature indicating that member associations' domiciliary workers are not adequately trained nor given supportive supervision for the primary health care queries they receive.

[17] a kebele – township, neighbourhood - is the lowest administrative unit in Ethiopia

In *Ethiopia* the situation appears to be somewhat different, partly because the outreach efforts generally only supplement the community-based condoms and pills with injectable contraceptives. It is only at the static clinics that there is a range of primary health care.

***Higher Quality Care***

Service quality can be assessed according to technical quality and other dimensions but here we focus on user satisfaction.

In *Bangladesh* users at both the static and satellite clinics were satisfied with the services they received and many use FPAU clinics despite having other service providers available. One reason given by FPAB users for selecting their services was that they 'don't ask as many questions' about issues that the client wants kept private. Confidentiality seems to be better respected by FPAB than by many other providers

In *Ethiopia,* users select FGAE because of staff friendliness, short waiting times, and superior technical quality. Users were satisfied with the service they receive, would return in the future, and would recommend the clinic to others with the same problem. Other SRHR stakeholders commented on the high technical quality of FGAE's services.

It was however, interesting to hear the views of street children who were mainly teenage girls, in a focus group discussion. Many felt that although their SRHR needs were attended to, when consulting FGAE for general medical care, they received indifferent treatment; their complaints were not taken seriously. They cited examples of proper diagnostic tests not being carried out and that they were not examined properly saying, 'They never touch us.'

*Uganda:* Here too, users cited FPAU's welcoming approach to clients, short distances they needed to travel, better technical quality, and that services were cheaper than alternatives. The exit interviews revealed a high degree of satisfaction: users received the service they came for; plan to return in the future, and would recommend the clinic to others with the same problem. Although we did not visit the clinic in Mityana which had been part of a quality of care effort, it was cited an as excellent provider by another SRHR stakeholder.

***Innovative***

Particularly in *Ethiopia,* FGAE was seen to be an innovative leader in family planning through its continued introduction of new conceptive methods and because it was the first service provider to focus on the SRHR needs of young people. Figures provided by the Ministry of Health show that in 2004, FGAE had the widest range of contraceptives and brands of contraceptives compared to the Ministry of Health, a social marketing agency, and another NGO. FGAE is also a leader in the provision of voluntary surgical methods of contraception, often providing training to the staff of the Ministry of Health and other NGOs.

FGAE was referred to as an important actor in, a consortium of reproductive health organisations, that developed the in-service curriculum for community-based services. The national AIDS coordinating agency pointed out the FGAE was one of the first founding members of the AIDS Council when it took on NGO members. The Ministry of Youth and Sport said that it looked to FGAE for advice when designing services for young people.

*To the left, meeting with Community Based Reproductive Health Agents and women using their services in a rural village served by the outreach programme outside Dire Dawa, Ethiopia. To the right, women assembling outside outreach clinic.*

***Other NGOs***

*Marie Stopes International* is another SRHR organisation that works with governments and other NGOs to design and deliver high-quality programmes of sexual and reproductive health care in 38 countries globally. Marie Stopes is present in the three countries included in our evaluation and was visited in each country. Depending on the country context, the IPPF member associations collaborated to varying degrees with the local Marie Stopes clinics. The impression from *Uganda* and *Ethiopia* is that the member associations are not duplicating Marie Stopes' work with the same type of clients, partly because Marie Stopes' fees are considerably higher than the member associations'.

Although providing a range of SRHR services, Marie Stopes is known in *Uganda* for its abortion-related work and we were informed that FPAU users were referred to Marie Stopes for post-abortion care. One SRHR stakeholder looking for an NGO to sub-contract pointed out that Marie Stopes did not have the extensive reach into the rural communities that the FPAU did. Not only does this mean that they were not able to reach the same large numbers of people but that they did not have a presence in rural communities to follow-up on clients they had reached with long-term contraceptive methods through their mobile service. One government provider said, 'We receive the problems that Marie Stopes leaves.' In *Ethiopia*, we were told that earlier there had been cooperation around contraceptive supplies.

In *Bangladesh*, it is possible that there is some competition with regard to clients for family planning and menstrual regulation. The Marie Stopes clinics visited were busy; staff was younger; and there were many men accompanying their partners who were attending. At one site, privacy appeared to be better ensured than at the Branch FPAB clinic in the same town. Interestingly, community leaders, including FPAB community based agents, were aware of Marie Stopes as provider of menstrual regulation but were unaware that the Branch FPAB also provided it at a lower cost!

## *Concluding Remarks*

In sum, the areas of work carried out by IPPF's member associations are in keeping with international consensus on what needs to be done to improve sexual reproductive health and ensure rights in their countries. Member associations are responding to their country's SRHR needs as indicated by SRH and other indicators. In Ethiopia and Uganda, the member association is recognised to be the leading family planning organisation even though government facilities are the largest source for contraceptives in the country. Member associations services are recognised for their welcoming approach to clients and high technical quality. In Ethiopia, government and other NGOs have looked to FGAE for technical assistance in training for contraceptive methods, especially voluntary surgical contraception, in the development of guidelines of community-based services, and in the design and development of services for young people.

The picture with regard to abortion related services however, shows gaps. Menstrual regulation is offered at the clinics in Bangladesh but does not appear to be frequently requested. Uganda is not offering the full range of post-abortion care. Focusing on young people is an important part of the member associations' activities in Uganda and Ethiopia. In Uganda, there appears to be genuine youth involvement in the planning and managing of activities. In both Ethiopia and Uganda, youth centres, youth friendly services, peer educators, and family life education form part of the programme. But, services in Uganda appear to be better designed and implemented to engage the interest of young people. This may be a reflection on the greater active participation of young people in all levels of FPAU. We observed few activities in Bangladesh designed for unmarried young people. None of the member associations are offering specially tailored activities directed to young married women.

HIV/AIDS activities in Uganda and Ethiopia are focused on VCT, especially for young people. In Ethiopia, providing care and support for people-living-with- HIV/AIDS is part of the programme in a few locations. While the HIV/AIDS activities in Uganda appear to be coordinated with the overall national efforts, in Ethiopia they appear to be somewhat fragmented. Whether this is a problem requires a more thorough review of the overall AIDS arena in each country. HIV/AIDS activities do not figure significantly in Bangladesh's work and we think there is a need for capacity building before FPAB expands its work in this area.

Components of maternal health care are offered but there is a need to ensure that they are linked to the continuum of care available in each local area. Of particular concern is the way in which member associations work with traditional birth attendants to bring them into the modern health care system. Much of the member associations' work is related to awareness raising and sensitisation. This is more closely related to Sida's starting point for work in SRHR. To examine the effectiveness of these activities requires resources beyond the scope of this evaluation. We found an encouraging sign of this in Uganda with the Youth Action Initiative for Health and Development. But, in general, member associations do not seem to be tackling the area of strengthened decision-making in a systematic manner and there is a need to see more demonstrations of their results.

# Chapter 4. Impact on people's lives

## *Introduction*

The purpose of this chapter is to analyse how the activities of IPPF affect people. In the previous two chapters we discussed first, to what extent IPPF and its member associations reach poor people, and second, whether the programmes are relevant and effective. But what is it that actually happens in peoples lives; to what extent do they change, and what difference does it make? These are questions that need to be addressed at both the individual level and at the population level.

Let us quote an example. The FGAE had a few projects that addressed female genital mutilation. The project objectives were to increase awareness of why and how these practices are harmful. The evaluation found that the projects were effective; that is, by and large the objectives were reached. People were indeed better informed and attitudes were changing. But have practices changed? Are fewer girls circumcised? And if so, how does that change the sexual and reproductive health of people in these villages? What are the side effects, positive and negative, for individual human beings?

Another example; the FPAB outreach activities through field volunteers provide advice on contraceptives and supply the goods or services. Families, women in particular, get introduced to family planning and there are case studies of impact on peoples lives as a consequence of spacing child birth and having fewer children. But what is the overall impact on the community and the district? Are there visible changes in fertility rates and population growth. Do the activities of FPAB have an impact beyond the individual cases?

The question of impact[18] is complex but there is no doubt that some knowledge of impact is a key dimension of an assessment of worth and merit. During the field studies, in particular in the meetings with clients and user groups, the evaluation gathered much evidence on the nature of impact, the difficulties in creating an impact, and the diversity of impacts. This chapter is meant to structure that information and thus also to take the analysis of target groups and effectiveness one step further. Yet another reason to include this chapter in the report is that some informants were of the opinion that impact cannot be evaluated. We think impact can be evaluated and it is of importance that IPPF tries to find out about impact.

## *Can impact be measured?*

The Terms of Reference for this evaluation do not specify that impact should be measured. In the course of study the question has often been raised, and people often asked whether it is possible to measure impact. The answer to that question is; "Yes, of course". But that does not necessarily mean that it is a useful exercise. Impact can be measured but one must remember that measurement presupposes a scale. The question is rather, what kind of a scale and what does it

[18] The common definition of impact in development cooperation is " *positive and negative, primary and secondary long-term effects produced by a development intervention, directly or indirectly, intended or unintended*" (Molund & Schill 2004: 102). We use impact in the same sense, the purpose here is not to define the word but to find out and describe what it means in practice.

mean to assign values on a scale. In research, several scales are used, from simple ordinal scales to ratio scales. A ratio scale is more sophisticated and requires very precise data. An ordinal scale is more basic and can use qualitative data and would consist of categories that rank activities, such as these:

Highly satisfactory
Satisfactory
Unsatisfactory
Highly unsatisfactory

Many agencies in development cooperation use such ranking scales when they assess impact (the World Bank, to mention one). In the course of this evaluation we have observed several activities labelled as projects of the member associations, plus activities in clinics and at headquarters. We could surely have rated them on a scale such as this. The question is whether that information would be of much interest and relevance?

The value judgement that such measures are based on is subjective. The problem is, whose judgement would be used to measure and what kind of empirical data would support the measurement? There are different kinds of impact, with a variety of potential consequences, and it is difficult to say, for example, that ensuring a regular and affordable supply of contraceptives to low income families is worth more than assisting people living with AIDS to get access to treatment. There is no objective way to judge one to be better than the other, nor even to pronounce them equally good, which is implied on a scale such as the one illustrated above.

In order to measure impact, it is also necessary to study the universal population. This would necessitate a classical application of causality, that is, the project is both necessary and sufficient for the impact to be observed. We have never, during the conduct of this evaluation, encountered any such causal links. The IPPF programmes have often had a role to play, but they have always been one contributing factor among others for the change we observed. The idea of measuring impact should thus be abandoned and forgotten. It could be done, but it would neither be relevant nor interesting. It would be a costly and impractical exercise, yielding little of valuable information. It is better to use the resources to assess impact.

## *Assessment of impact*

Instead of measuring impact, we can describe impact and based on this description we can assess it and make a conclusion on its worth and merit[19]. Information and knowledge are effectively contained and disseminated in narrative form. By providing concrete and evocative examples of how programme activities affect people we can proceed to discuss whether that impact is good or not, whether it has been achieved at a reasonable cost, what the obstacles were, and how it can be sustained or increased. That is a far more interesting discussion than to present measurements on a scale.

[19] Evaluation is commonly defines as "a systematic inquiry into the worth or merit of an object" (Joint Committee on Standards, 1994)

Let us give an example of how impact can be assessed. The model clinic in Awassa, in Ethiopia, operates outreach centres in rural areas some distance from the town itself. The outreach program is part of a "safe-motherhood" programme, and provides pregnant women with ante-natal care and advice. The outreach service consists of a nurse visiting the area once a month, and at each such visit a number of women (and some men) will come for advice. The area in question has a population of around 9,000 people. There is a government health clinic, but that does not offer ante-natal care. The nurse is helped by two traditional birth attendants, and they visit families and motivate women to come for their check up and advice. The evaluation team met with one man who was at the clinic during our visit, and his story can be retold as follows.

> "My wife become pregnant ten months ago. We already had three children, aged 12, 8 and 6, but wanted one child more. Soon after she got pregnant she came to the outreach clinic. There was no problem. She came a second and a third time. The third time, which was in the eighth month, the nurse discovered she was carrying twins. She was classified as a high risk pregnancy, and we were advised to take her to the government health centre when the labours began. I did so, but at the centre they said it was such a difficult pregnancy and they could not help. We got help with an ambulance to take her to Awassa. We could not afford it, but the joint fund provided money. The twins were delivered safely and she is all right now."

This is a simple story, but at least two things are evident. Either the woman, or the children, or possibly all three, were likely (according to the staff at the outreach clinic) to have died in case this pregnancy had not been discovered and classified as a high risk delivery. If she had given birth at home, the risks of complications would have been much higher. That would have been the usual course of action, and thus, without the ante-natal care service, the three of them might not have survived. Furthermore, as this was a poor family, where the husband earned his money as day labourer, they could not have afforded the transport costs on their own. The mutual savings fund set up under the project helped and provided part of the money for the transport cost. That was also a necessary factor, without it, the delivery would have occurred at the government health centre, and that too would have been more dangerous.

This may seem to be a sentimental story and anecdotal as evidence of impact. However, in the reality of life in rural Ethiopia, this is what impact means. A surviving mother will increase the chances that the five children reach adulthood, get an education, and employment. But of course many other things will happen along the way, and in the short run the impact of surviving the delivery is as much as can be said. Much as that is an impact, a full analysis of the ante-natal service needs to take into account that this kind of outreach is associated with several problems as well. Similar services often miss, or fail to prevent, other kinds of risks at pregnancy, or can do nothing about them. To identify twin births and take precautionary action is perhaps one of the few lasting impacts to be expected from the service. The strategy to work with traditional birth attendants can also be questioned. Their training is limited and sometimes the services they provide are poor and ill-informed. They are "traditional", meaning that they sometimes remain champions for female circumcision. The strategy to work with traditional birth attendants must also be questioned as mentioned above (page 42).

As this example shows, impact is observed as a case that can be revealing and instructive. It is best described as a short story. It should not be frowned upon as anecdotal - stories form the

stepping stones of knowledge, and case studies can be observed and recounted systematically, objectively and with scientific rigor. Stories have always been effective and efficient means of communication, and such cases can be vehicles to convey information on how impact is created and how it can be supported. It is also possible to proceed and analyse the different kinds of impact, whether some forms of impact are more desirable than others, what kinds of impact are most common and whether they are planned or occur by chance, and whether some kinds of impact are more sustainable than other kinds.

## *Main types of impact*

Before proceeding to the analysis of impact, it may be necessary to unpack the concept. The word impact is deceptively simple, but it covers a wide variety of empirical facts. In order to analyse and discuss impact, we found it necessary to sort the discussion into a number of different categories. We distinguish categories of impact building on what happens when people have access to services of the IPPF member associations:

**#1. Use of contraceptives and decisions on family size.**

This category of impact should be mentioned first, but the rank order of the others can be discussed. In the three countries we visited, the IPPF member associations claim to have a total of some 3 million clients. In spite of the range of services and the differences among projects and programmes, the majority of service users receive advice on the use of contraceptives and they buy/receive some kind of contraceptive service. There is little doubt most of them actually use the contraceptives. The first effect of that is that childbirths are spaced. In many of our interviews we asked how many children the respondent had, and how old the children were. There was no doubt that almost all – there were a few exceptions – had longer birth intervals than they would have had if no contraceptives had been used. Some of our interviews in the control group, or where we had access to "shadow control groups" also indicate that this was an obvious effect.

> "Sometimes those [women] with 7 or 8 [children] come to me and cry. They say they wish they had known about family planning before, so they could have spaced their children. Women who work a lot don't want to be pregnant the whole time". (Female Community Based Reproductive Health Agent, Owina market, Uganda)

Whereas access to contraceptives lead to changing behaviour and thus to spacing childbirths, it is less obvious that this leads to an impact on population growth. In the long run, there can hardly be any doubt that knowledge and use of contraceptives will reduce population growth. In the short run the link is not so obvious. In some of the districts visited in Ethiopia, the total fertility rate was above 7 some years ago, and it was reported to us in interviews that the figure was now approaching 6 (which could not be verified).

However, in many interviews we also asked what the ideal family size was, for example when speaking to village elders, to young people in youth centres, or to people at the clinics. First, people said, it was always important to stress the balance between sexes; there should be both girls and boys, often in equal numbers. Second, the vast majority said that the ideal family size would be around 4 to 6 children – even among the younger respondents. This was in marked contrast to Bangladesh, where many interview respondents said the ideal family size would be 2 – 4 children. However, the ideal is one thing, practice another:

*The counselling services are everywhere important.*

> "People still need to have many children. In these villages child mortality is very high, and thus people have many children because they know that some will die. You have to address the wider picture of health and access to health services, birth rates is not only a question of knowing about contraceptives". (Volunteer Board Member, Yirg-Alem, Ethiopia)

As early as the 1950s, economists like Gunnar Myrdal pointed to the link between birth rate and child mortality, and it seems to be as apparent in Ethiopia today as in India then. It illustrates that the "program theory" to affect population growth through supplies of contraceptives remains a tenuous link. Declining birth rates will depend on a range of other social and economic development factors.

**#2. Advice and treatment on sexual and reproductive health**

Apart from advice and supplies of contraceptives, the most common reason for people to visit the clinics and the outreach services, is to consult health personnel on some form of symptom that relates to their sexual life; such as pregnancy tests, problems with the menstrual cycle, complications around pregnancies or after childbirth, consultations around potential side effects of contraceptive use, sexually transmitted infections, and so on. These meetings between the client and service provider mainly occur at the clinics, but also at outreach facilities. In the African countries there were outreach activities associated with the clinics. In Bangladesh, the outreach was also permanently organised through field level volunteers – these did not exist within a project structure but were part of the direct chain of command in the organisation.

The question is what happens after these meetings between clients and service providers as that is where the impact can be observed. One of the non-clinical service providers described impact as follows:

> "Last month 15 women came to me for pregnancy tests. I helped them with the tests and they paid 12 thaka. Five tests were positive, two of these girls were unmarried, the other three were married. I talked to the unmarried girls about menstrual regulation and referred them to the clinic. Both chose to terminate their pregnancies that way. Their families were not informed. (Community Health Promoter, Chittagong, Bangladesh)

What is actually the impact on the life of an unmarried teenage girl in Bangladesh when she gets pregnant? We can only guess at the problems childbirth would give rise to. The fact that girls could have a test done and received help to terminate their pregnancies discreetly must be vital for their futures. This is no doubt a significant impact, but could that impact be created in some other way? First, there are other private service providers, but the prices of their services both for carrying out a pregnancy test and for abortion are higher, some said up to twice or three times the fee charged by the FPAB clinic. Second, there are government run clinics, but their services have a poor reputation and besides they require contact with families. The FPAB service is, in this situation, the only one that combined being quick, reliable, affordable and discreet.

In the two African countries visited in the evaluation, the member associations have extensive services in VCT for HIV/AIDS, and in Bangladesh such services appear to be increasing. But there are many other service providers. Some people prefer to go to the member associations clinics, but others go elsewhere; either because of the reputation of clinics, sometimes because of the price, but most of the time, it seems, because of geographic location. The possibility of privacy is also an important factor in the choice of service. In Sheshemane the evaluation visited people who were clients of the Home-Based Care Project. The volunteers in the project sought out people who were very ill, chronically bedridden in their homes or in some makeshift shelter. The volunteers helped them get access to VCT, and most were HIV positive and had AIDS. They were then assisted to access treatment at the government health centres.

*To the left, a lab technician holds up a sample of the card for people coming for VCT which is exemplary in its respect for integrity. The VCT tent used for testing at one of the market places in Uganda.*

In one such case, a 14-year old girl lived with her two sisters. She was very sick, coughing and spitting blood and had high fever. She was said to be close to death. The field volunteers found her and took her to a health centre. She was given treatment and was getting better, she was starting school again and had plans for the future. An assessment of impact has to take account of what would have happened if something had not occurred? The contra-factual is always difficult, but in this, and the other cases, it seems likely that the persons would have died. That is what they themselves and their relatives thought.

**#3. Preventing and curing primary health care conditions**

Quite a large number of people come to the member associations' clinics for reasons other than family planning or sexual and reproductive health problems. They come because health workers are health workers and can be expected to help with anything. Some people come for malaria and other fevers, colds, stomach diseases, diarrhoea, coughing, skin diseases and general weakness. Not only do people travel to the clinics for these reasons, they also approach the field volunteers and ask for their advice.

In many areas that the evaluation visited, the IPPF member associations' services appeared to be the only form of modern health care available. Thus, when people were ill, they had no choice but to go there. They were also received and treated by the staff, and it would seem that in many clinics such primary health care cases would constitute more than 25% of the clients.

This might seem to be a waste of the specialised services that the clinics offer. But offering some primary health care can serve as an entry point for many to seek advice on SRHR issues, and is in line with an international consensus on the integration of SRHR and primary health care. In reality it is also hard to distinguish some SRHR related problems from primary health care problems. For example, in communities where people are poorly educated and misconceptions and myths about contraceptives common, women and men might think that any health problem is related to the use of contraceptives. However, it might be malaria or another condition.

The interesting question is whether there are any alternatives. Sometimes there are not, but at other times there are. In Uganda, the alternatives in the areas we visited were the government health units, private-for-profits, and NGO's, including faith-based organisations. The government health units in theory offer services for free. However, in all interviews the picture is clear and uniform. A number of obstacles prevent people's access to the government health services they need.

- Time and costs. There are few government health units and the number does not in any way meet the needs arising from the present health situation. Because most people live far from a government health unit, it is expensive to go there. Also, although the services are for supposed to be free, informal fees are often charged in some countries.
- Staff shortages. Health units are badly understaffed.
- Interpersonal patient care. The government health units have a number of quality problems according to our informants. The staff is often perceived to be rude and unfriendly. There are normally no youth-friendly services. Anonymity is often

compromised, which makes people reluctant to go to a government health facility for many problems.

- Shortage of drugs and supplies. A problem cited in virtually all interviews is the scarcity of drugs and supplies. The services are theoretically free, but after having waited for hours the client is often met by the message that no drugs are available, and that they have to be bought somewhere else.
- Overload of clients. One can count on waiting for many hours, which adds to time costs at the expense of time that could be spent working. In one of the focus group discussions we had, we were told that some people even faint in the lines, because of the long waiting time.

The impact in this category would be whether people have their problems solved or not. The exit interviews show a high rate of satisfaction in all countries, but focus group interviews suggest that at least some people, although satisfied, still did not have all their problems resolved (Bangladesh and Ethiopia). Whereas the impact as such could be described in a variety of ways, it would also seem that there are conditions that the doctors and paramedics of the member associations are not fully trained to address, and although there is theoretically a referral system, it may not work in practice.

**#4. Improving life chances**

The IPPF member associations have started projects and programmes of various kinds, more or less closely related to sexual and reproductive health. They are of many different kinds; reaching out to victims of gender-based violence, promoting and organising mutual savings funds and micro-credit schemes, life-skills training, etc. If we look at the first example, projects on gender based violence, the most immediate impact is when someone who has been beaten and mistreated finds a safe refuge and can get hospital treatment and also legal aid to protect from her from further violence.

In Barisal, Bangladesh, FPAB had a project working with 'survivors of gender – based violence'. The project gives women and their children shelter and seeks to develop skills and provide loans for them to start a business in sewing, tailoring, poultry raising, etc. One of the interviewees had for some years been beaten and tortured by her husband and his family. She was at a loss for what to do, and had at times sought refuge at her parents home. She had no means to support herself and was a burden to her parents who wished her to move out. She could not return to her husband as she feared for her life. She contacted the project personnel in Barisal, got a temporary refuge, and learnt to support herself. She also became engaged in the project and has gained so much confidence and organisational skills that she now also works on the Board of the project – helping to address the needs of others in the same situation.

The impact can be understood in terms of the life that woman is now leading. Here too, we have to consider the counterfactual; what would have happened if she had not come into contact with the project? Suicide, murder, continued misery being beaten and tortured, or possibly having the problems solved and reunited with her husband? We cannot know, but our assessment is that the impact on that individual level is high and very much for the better.

*In some rural project areas, FPAB is providing women with credits to develop income-generating activities. The women to the left work with textiles, selling on local markets. Some have repaid their loans and invested in their own sewing machines.*

Another similar form of impact is created by the life planning skills training observed in Mbarara and Kampala. Many peer educators highlighted the issue of poverty as an obstacle to improved sexual and reproductive health. This problem has led to initiatives to integrate sexual and reproductive health information with life planning skills training. The evaluation team interviewed a group of project members to hear about their experiences. A 19-year old female hair-dresser told about how the skills training changed her ways of thinking. She had dropped out of upper secondary school when her parents died and she could not afford to pay the school fees.

> Before we had many partners, now we have changed. Now we have friends, but not boyfriends.We use what we learnt every day. We learnt how to live our lives. How to make small business. How to manage work and manage time, to plan my day. If I get 500 ush every day, how will I use it? I didn't know about saving before. Before when I made 500 ush I used the money immediately. Now I make 1000 ush every day and I save 300 ush. In the end of the month I have enough money to buy something, maybe a skirt or a goat. I have 2 goats now. After that I will buy a cow, so I have milk. I will start selling the milk.[20]

When the girl has managed to save enough money, her dream is to finish secondary school and then study medicine. Young people who came to the youth clinic in Awassa, in Ethiopia, told of similar changes in behaviour. A group in Uganda started carrying out projects of their own. Two members told the evaluation team about their work with street children. On a volunteer basis, they have worked with a group of about 30 street children. We were told that many of these children now have been rehabilitated, some have been relocated back to their homes whereas others are in drama and sports training. The volunteers also reported noticeable behaviour changes among the former street children.

[20] 1840 ush = $1

## *Towards a model of impact*

The starting point for the examples of impact above was what happened as a result of a meeting between clients and service providers. What happened in people's lives, how did they change – for better or for worse (though we have no examples of changes for the worse)? Much as that is important, it is also interesting to find out what happens at community levels. Quite often the impact objectives of project and programmes are expressed at the community level; for example, to reduce the maternal deaths and promote safe motherhood, to increase the numbers of safe abortions, or what the case may be.

The degree and magnitude of change would of course vary among communities. One of the objectives in Bangladesh is said to be to "eradicate unsafe abortions", which is an absolute target, for the whole country. That impact, if achieved, must be described in other terms than the impact of a safe abortion on any one woman's life – which one could often assess in terms of a likely counter-factual event. Each of the four categories of impact that we described above can be analysed at a personal level as well as at a population level, and thus we have a model of impact that can be used for analytical purposes.

**Table 10. Model for impact assessment**

| Impact category | Individual level | Population level |
|---|---|---|
| Use of contraceptives, child spacing. | Smaller families, higher age differences between siblings, increased welfare, | Lower fertility rates, reduced population growth |
| Detecting and treating sexual and reproductive health problems | Better health bringing people back to work and to school, and to community life | Higher health standards in DHS and other surveys |
| Advising and curing primary health care conditions | Better health bringing people back to work and to school, and to community life | Higher health standards in DHS and other surveys |
| Improving life chances | Refuge and care, survival and chances to resume life, education and work | Reduced levels of violence, higher economic activity, social development. |

There is one thing to remember in this analysis. So far we have looked for impact and our purpose has been to find out what it is. However, it is well known that many activities in development cooperation have no impact, or even a negative impact. In the case of IPPF the issue of negative impact is also value laden. Some would consider a project that reached its objectives in providing safe abortion to be a negative impact. Many others would see the provision of contraceptives a setback morally and socially. From our point of view, such objections are not in line with what we consider to be sexual and reproductive health rights. But are there are other forms of negative impact?

One possible form of negative impact could be the involvement of traditional birth attendants in outreach programs. This could condone their practices and delay investments in modern training and services – to the long run detriment of the community. We have not observed any other

instances of negative impact. Yet another issue is when there is no impact, and that could be analysed with the help of the model above.

The IPPF member associations have a scale of operations that mean most programs have multiple objectives and in the activities they interact with many people. Sometimes the result is limited. We have seen that Health Promotion Officers in Bangladesh reach some categories of clients more easily than others. High income residents in their areas tended to prefer other service providers, or they were not interested in the services at all. It was easier to reach the low income residents. There was no impact in relation to around 25% of the people in the area that the health promotion officers were to reach – but on the other hand, this is not a problem as these had alternative sources of advice and supplies!

At an aggregate level, it seems that the member associations create the highest impact in the first category we describe (contraceptives); they reach more people and the changes are significant. Furthermore, these services are more sustainable than others as they also generate incomes, and have been integrated in the operational line of the member associations for many years. The impact is felt both in peoples' lives and at the population level in aggregate measures of development.

In respect of the second category, the member associations reach large numbers of people, but as these are more complex services the numbers are not as high as in the first category. On the other hand, in the second category the impact on peoples' life can, when the service is successful, be of an altogether different magnitude as it may concern life or death, or at least a difference between severe illness and health. At a population level, the impact of the member associations would be limited though as many other factors contribute to changes which are captured in the DHS statistics.

In the third category, curative primary health care, the impact is probably less. This is not an area of expertise for the member associations' staff. They provide these services because the clients have limited choice. The quality of care is not as high as it would have been in a comprehensive primary health care system and many of the clients do not get the treatment they really need. It cannot be expected that the curative primary health care here makes a big difference at population level. On the other hand, in many areas there is no alternative but to provide services, and there are also strong advantages with integrated services.

In the last category, the member associations have responded to the challenge to broaden the sexual and reproductive health and rights agenda. The opportunities to provide useful and much needed services is high, but the risks of failing or not reaching people in sufficiently large numbers are also high. In many cases the member associations enter into new fields. In Bangladesh one project provided micro-credits in a rural area. Bangladesh is home to some of the best rural banks in the world, and one wonders how an FPAB project could have a competitive edge over many other service providers there. Also, even though many of the projects observed in the evaluation appeared to successful and reached several of their objectives, there were often problems with sustainability. We did not actually see any examples where a successfully completed project was taken to scale and integrated in regular services. High impact at individual levels could often not be translated to high impact at community level.

## *Concluding remarks*

In Table 11 we make a combined assessment of the different kinds of impact; how many people are affected, what is the level of change in their lives, what are the risks and are there other service providers. Given these categories and the evidence collected through our interviews and observations, it would seem that the highest impact is found in the second category, advice and treatment for reproductive health, while lower impact is found in relation to primary health care. There is no doubt that the individual impact often is very high in relation to the fourth category, improving life chances, but as the projects are comparatively few, funding uncertain, and the risks in implementation and delivery considerable, the overall impact is still likely to be lower.

It is also interesting to note that it is primarily in relation to the first mission of IPPF, family planning in the traditional sense of that word, that there is a clear and unquestionable connection to an impact at the population level. The scale of these operations, the length of time that the services have been provided, and the relative ease of service delivery all help to explain the high impact. But the same factors also suggest that we need to adjust our expectations of an impact at population level. The wider sexual and reproductive health agenda is far more difficult and challenging, and it will take time before any impact at community level becomes equally significant.

**Table 11. Combined impact assessment**

| Impact category | Individual level | Population level |
|---|---|---|
| Use of contraceptives and decisions on family size | Many people reached, major changes, low risks and few alternative service providers | Sustainable changes in key variables of social and economic development |
| Advice and treatment for sexual and reproductive health | Several people reached, very significant changes, some risks and few alternative services | Some changes, but many intervening variables and complex attribution |
| Preventing and curing primary health care conditions | Many reached, but limited training for services, some risks and other providers | Limited change, also because of intervening variables |
| Improving life chances | Few people reached but very significant changes, high risks and sometimes other service providers | Difficult to move from individual to community impact, low sustainability and many intervening variables |

Colour code: blue – very high impact, green – high impact, yellow – low impact, orange – very limited impact.

It is also possible to combine the assessment of impact done here with the evidence we have of reaching poor people. It would seem that the very poor and marginalised groups are primarily reached by the services that yield an impact of the fourth category, improving life chances – and the overall impact here is not as high as in relation to the other categories of impact, and certainly not at population level. The relevance appears to be high in all categories of impact, and so is the effectiveness, albeit perhaps somewhat lower and more uncertain in respect of the curative primary health care.

The analysis that has started here needs to be taken further and the consequences for the IPPF in terms of allocation of funds could be considerable. The IPPF makes extensive use of case studies in its annual reports and in other material. This is good, and as we have said above, stories are the starting points of knowledge. However, it is necessary to make sure that the stories represent reality properly and that they are collected with the appropriate scientific rigour. That is, there must be some control of the sample, some means of verification that the story is true, some discussion of the counterfactual events, and an assessment of alternative courses of events. For the sake of credibility, there must be stories of limited impact or negative impact (to the extent that these exist in real life, and they usually do). In the long run, it should possible to categorise stories/case studies and analyse their overall pattern.

# Chapter 5. Advocacy

## *Introduction*

The three member associations that were visited during this evaluation all started as advocacy organisations, and it could possibly be argued that the roots of IPPF in general are more in advocacy than anywhere else. To take an example, FPAB played a major role in creating a climate of opinion where family planning was widely accepted in Bangladesh. Through focused advocacy initiatives at the national and local levels, the organisation made a major contribution to ensuring that the government developed relevant policies and a national service-based programme that responded to the needs of the population for family planning programmes. Although younger, the member associations in Ethiopia and Uganda have a similar history and track record.

Since then, all three organisations have turned increasingly towards service provision rather than advocacy. Also, when the organisations were founded, their advocacy cause was a one-dimensional focus on family planning. Today the organisations have moved to more complex advocacy around a broad range of SRHR issues, and hence the visibility in any one cause is not so prominent. An organisation is heard and seen more when it cries out loudly and repeatedly on a single issue, than when it speaks on many issues, at irregular intervals and in different arenas. It seems that advocacy is a concept somewhat difficult to understand fully. At first, advocacy is primarily understood as promoting something in general. But when it comes to specifying what the organisations actually do, there is some discrepancy among the member associations. Therefore this chapter starts with a model of advocacy so that we can both structure our inquiry and do justice to the activities that the member associations are engaged in.

Can impact from advocacy activities be assessed at all? It is important to recognise that it is difficult to isolate the specific impact or outcome of one agency, as the overwhelming majority of organisations that work in an advocacy-based capacity do not work alone. This is because advocacy initiatives often have a broad base of support from a range of organisations. When many organisations act together they are more successful in achieving their objectives, but it is also more difficult to pinpoint the contribution from any one actor. This chapter uses data gained through interviews and focus groups with key local and national government decision-makers, community and religious leaders, and major NGOs working in the field of SRHR to make an assessment of the member associations' advocacy work.

## *What is advocacy?*

Advocacy is defined as '*the provision of accurate and relevant information to educate and create awareness about SRHR, behaviour change communication initiatives to create a broad and effective constituency of support and wider political advocacy that targets local and national decision-makers.*' This broad definition of advocacy recognises that opposition to and/or a lack of understanding about SRHR among key decision-makers and community leaders can lead to a lack of access to SRHR services through inappropriate national legislation and services that do not respond to the SRHR needs and rights of the local population. In particular this chapter looks at:

i. Advocacy initiatives that are focused at the local level and target the general population and key community level decision-makers such as religious leaders
ii. The extent to which the three member associations contribute towards the development of 'an enabling environment' where support for SRHR is acceptable and addressed by key Government agencies and NGOs
iii. Whether and how the member associations engage in policy dialogues with the governments to contribute to national policies that focus on a range of SRHR issues

It would thus be possible to "map out" the advocacy activities of the member associations along the two dimensions of, first, whether the work occurs at national level or at district or lower administrative levels, and second whether the target is government policy as such (expressed in legislation, action plans, organisational structures and systems of implementation), or whether it is directed at the policy environment (journalists, other NGOs, community leaders), or whether the advocacy efforts are directed at the community at large through awareness raising activities. These different approaches are illustrated in Table 12.

**Table 12. Dimensions of advocacy activities.**

| | Government policy | Policy environment | Public awareness |
|---|---|---|---|
| **National level** | | | |
| **District/community level** | | | |

In the following we will use this "map" of potential advocacy activities to analyse what the three member associations are doing. We know from background studies that all of them started by working with advocacy for family planning at the national level, and since their foundations they have broadened this to advocacy at district and community levels as well. But it is not so clear to what extent and at which levels they are advocating for the broader range of SRHR issues.

This analysis focuses on the three member associations in Bangladesh, Uganda and Ethiopia. The figure above could be supplemented with two more rows, one for a regional (for example East African) level, and one for a global level. Both the Regional Offices of IPPF and the global headquarters engage in advocacy activities, and they could also target the three different groups at the head of each column and thus supplement national efforts. That is an analysis for another study, and possibly for IPPF itself to report back on activities in this field.

## *Planning advocacy work*

As advocacy is one of the Five A's it is obvious that all three member associations incorporate advocacy in their strategic planning framework. The share of the budget that goes to advocacy activities varies. In Bangladesh it is a low of 3% of total budget resources for the five year plan, and there is only one advocacy project. However, the organisation does a lot more, and there is hardly an activity that does not have an advocacy component related to it. There are, for example, clear advocacy components of the gender based violence projects, of the youth centres, and in the

activities of the community based health promoters. The figure of 3% does not adequately reflect the amount and diversity of advocacy activities that the FPAB actually is engaged in.

Turning to Ethiopia, advocacy is one of the five programmatic areas in FGAE's Strategic Plan 2005-2009. The strategic goal is an enhanced enabling environment for the commitment, acceptance and attainment of SRH rights at all levels. The objectives identified are: a) political commitment of high level policymakers, b) increased resource commitment, and c) reduction of socio-cultural barriers that negatively impact the acceptance of SRHR by the community. The Strategic Plan further identifies different stakeholders for specific advocacy topics. But the FGAE has the same problem as in FPAB, the strategic plan does not properly reflect what it does and intends to do.

It is no different in Uganda. While FPAU has identified an advocacy goal and set of objectives and strategies to achieve its goal, it is difficult to gain a clear picture of what FPAU is doing in the field of advocacy. The Annual Programme Budget lists 3 projects under the IPPF advocacy programmatic area. Together these have been allocated 9% of the annual budget. But a closer review of the budget reveals that there are funds and supporting activities in the other project activities for radio talk shows, drama, community sensitisation etc.

The situation is thus similar in all three countries. The programmatic area of Advocacy appears to have a low priority at first sight. The area does not reach the 20% share of allocations that would be expected if it was as important as other areas. However, most projects and programs in other programmatic areas have more or less significant advocacy components. The problem is thus that neither the strategic plan nor the annual program budget give a correct information on the extent of advocacy.

## *A strategic overview of advocacy*

Turning from the plans to the actual realities, we will now provide examples of what the member associations do in terms of advocacy in Bangladesh, Ethiopia and Uganda. The map of advocacy introduced above will be used, and we have selected one or two case studies from each cell. It is not meant to be a comprehensive picture of advocacy activities, nor is it a list of best practice. It shows some examples, all with their strengths and weaknesses.

**Table 12. Dimensions of advocacy activities.**

| | **Government policy** | **Policy environment** | **Public awareness** |
|---|---|---|---|
| **National level** | Case 1. Legislation on abortion, Ethiopia | Case 2. Reaching out to religious leaders, Bangladesh | Case 3. Radio broadcasting, Uganda |
| **District/community level** | Case 4. Networking, all countries | Case 5. Working with volunteer members, all countries | Case 6, Street drama, Bangladesh |

## Case 1. Legislation on abortion, Ethiopia

Policies change for a number of reasons; as a result of steady lobbying and pressuring over time, or because a significant event captures public attention and mobilises public opinion, or after negotiating among competing stakeholders. Analysing the effectiveness of FGAE's advocacy efforts on policy change requires resources beyond this evaluation. However, there are two areas of policy change recently noted in Ethiopia where it is highly plausible that FGAE played a significant role but where we are unable to attribute the extent of FGAE's contribution.

- There has been a significant shift in the government's view on population growth. While the earlier government view was that a large population was important for a strong country, the current poverty reduction strategy, recognises that reducing population growth is essential for the country's development. This policy shift is demonstrated by the explosive increase in the distribution of contraceptives in government facilities between 2002 and 2005. FGAE has long been recognised as the leading advocate for family planning.

- The National Criminal Code regarding abortion was changed in 2005 and is seen as allowing a more open practice regarding legal abortions. FGAE helped to create an enabling environment around the issue of abortion through its high quality post-abortion care. Because of the high regard in which it is held and through its practice standards, FGAE was an influential voice in the debate around changing the legal framework for abortion so that there is more flexibility around who is eligible for an abortion. FGAE is credited by many as having been a significant actor in effecting this change of legislation. Equally important, FGAE was a member of a Working Group together with professional associations, Addis Ababa University and WHO, established under the Ministry of Health that developed the newly launched '*Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia.*' This is a clear example of how FGAE's technical competence is translated into advocacy.

Yet another example of advocacy at this level comes from Bangladesh. FPAB played a significant role in creating a societal climate of opinion in Bangladesh that is largely accepting of family planning during the 1950s and 1960s. However, feedback from NGOs and key government ministries illustrates that in recent years, the organisation's involvement in national and local policy debates has declined and is currently relatively limited. Representatives of Government agencies stated that while FPAB has strong relationships and works closely with the Ministries of Family Planning and Health, this work is primarily implemented to share working,knowledge and to co-ordinate service delivery rather than inform policy legislation and ensure the appropriate interpretation and implementation of legislation.

The majority of interviews with NGOs and Government Ministries identified the reputation and/or the history of FPAB as a strength of the organisation. It is clear from the interviews that FPAB is a well respected organisation that has strong brand recognition and relationships with relevant Government ministries. This places FPAB in a very good position to engage in advocacy initiatives to influence and inform national and local government policies about a range of SRHR issues. Comments from interviewees included:

> 'FPAB is well established and respected in Bangladesh'

'They were the first organisation to speak about family planning'
They have shaped government policy in family planning'

However, the 'brand' is closely associated with family planning, rather than the wider SRHR agenda. This is closely related to the name of the organisation – which makes reference to 'family planning' rather that wider SRHR issues and this may be a barrier to the organisation being seen and consulted in policies relating to the wider SRHR agenda.

## Case 2. Reaching out to religious leaders, Bangladesh

FPAB's Islamic Research Cell was established in 1984 in response to the strength and number of religious leaders who were opposed to family planning, on the grounds that it was seen as artificial and against God's will. Since 1984, the Cell has focused on reaching out to and interacting with imams to sensitise and create awareness about passages in the Holy Quran that support SRHR. The Cell provides an open environment where Imams can engage in theological debates about references to reproductive health within the Holy Quran.

In particular, the Cell's programmes identify key passages from the Holy Quran that refer to respect for one's conjugal partner, taking care of one's body, only having the number of children that one can take good material care of and the importance placed upon caring and respecting reproductive organs – as evidence of the Holy Quran's support for reproductive health and family planning in particular. In Bangladesh approximately twenty-four percent of all children attend madrasas (religious schools), and the Cell also works to raise awareness and support for SRHR with teachers who are employed in these schools.

Analysis of the interviews with representatives from the Bangladeshi Government's Ministries for Family Planning and Health and NGOs working on a national level in Dhaka highlighted the importance of this work and a number of respondents commented on how effective this programme had been in creating a wide platform of community-based acceptance for family planning in Bangladesh. In Chittagong, one of the more conservative areas of the country that were visited by the evaluation team, four out of the seven representatives from major NGOs that are working in the field of SRHR and ministries of health and family planning identified the attitudes of religious leaders as major barriers to SRHR. Feedback obtained from interviews about this programme included:

'FPAB has done some very impressive work with religious leaders – any organisation that wants to work with these leaders about SRHR should contact FPAB. This work is very well recognised in Bangladesh'
'The quality of FPAB's work with religious leaders is a strength of the organisation'
'FPAB is implementing important work with Imams in conservative areas of the country'

Through its work with religious leaders the Cell has also been successful in reaching out to men, and raising awareness and support for sexual and reproductive health and rights among men, a group that has largely been neglected in SRHR programmes. In a focus group discussion with thirteen religious leaders in Barisal, four had attended training sessions implemented by the Islamic Research Cell and all requested further information and training from the Cell.

*To the left, a drama performance at an outreach activity in Mbarara. The drama performance was mixed with different SRHR messages, and staff from the clinic provided VCT to 30 persons during 6 hours. 17 of the 30 tested HIV positive. To the right, children watching a puppetry show with SRHR messages in the urban slum Kwampe in Kampala, Uganda.*

The Imams provided positive feedback about the work of the Cell and commented that they thought the work of the Cell had had the outcome of encouraging people to 'open up' and discuss family planning and wider health issues. The leaders stated that they were supportive of a range of SRHR issues including family planning and FPAB's initiatives to address gender-based violence. They confirmed that as a result of the sessions they had spoken about these issues during the Friday sermons in mosques. The Imams also revealed that prior to their involvement with FPAB, they and other religious leaders in the area were very sceptical about the work of the NGO sector in Bangladesh. As a result of involvement with FPAB, religious leaders in the community are now more supportive of and committed to working with a range of NGOs in Barisal.

Similarly, in a focus group discussion in Syhlet all five religious leaders confirmed that they were aware of and supported the work of the Islamic Research Cell and programmes implemented by FPAB. One member of the group had attended FPAB's seminars and had discussed the seminar with his peers. All five confirmed that they had discussed early marriage, breast-feeding, HIV/AIDS, gender-based violence and discrimination in their mosques. In Chittagong the local Government recently established a major programme that aims to educate and raise awareness about SRHR among religious leaders. The Manager of FPAB's Islamic Research Cell was asked by the Government to join the advisory group and he is now an active part of this group. The Cell is planning to organise targeted seminars and training programmes to raise awareness of early marriage among marriage registrars in the near future.

Interviews with key SRHR stakeholders showed that the activities of FPAB in this area are relevant to the SRHR needs of Bangladesh, as they are addressing major community barriers to SRHR whilst the focus groups with Imams who have attended seminars indicate that this work has been effective in creating a broad level of support for SRHR among the public.

## Case 3. Radio Broadcasting to Raise Awareness, Uganda

FPAU has used radio broadcasting a number of times to raise awareness around SRHR issues. For the past 3 years, together with the AIDS Information Centre (AIC) and The AIDS Support Organisation (TASO), it has run a joint programme on Radio Capital aimed at empowering young people to demand and access SRH services. At the time of the evaluation team's visit, FPAU was running phone-in radio programmes where the public could personally talk to government officials and members of Parliament. Most recently, the Minister for Youth and Sports was on the programme and discussed the issue of liberalising the legal status of prostitutes. While in Tororo, we observed a local radio broadcast, 'Youth Crossroads Talk Show' - a forum of youth to discuss youth activities. Discussants were representatives of youth clubs started by FPAU. All these efforts reach a wide audience in Uganda where the broadcasting media are important for the dissemination of information and influencing public opinion.

## Case 4. Networking, all countries

The interviews with 20 representatives of NGOs and government agencies revealed that FPAB currently co-ordinates and co-operates with a broad range of NGOs and government agencies that work in the field of SRHR. In particular, shared working and programmatic collaboration with Marie Stopes and the Ministries of Health and Family Planning were highlighted in the interviews. In general FPAB has informal working relationships with NGOs and government agencies, but it also has formal Memorandums of Understanding and referral relationships with NGOs such as Bangladesh Legal Aid and Services Trust in Barisal.

At the branch level, FPAB is involved in the district planning process and co-ordinates with relevant Government Ministries regarding the allocation of health and family planning service provisions in different regions of the country. Representation and co-ordination at this level prevents the duplication of medical services in Bangladesh and also ensures collaboration with NGOs and Government clinical facilities.

Over eighty percent of the NGOs and Government agencies that were interviewed stated that they worked closely or had a working relationship with FPAB. This shows that FPAB is engaging in debates and dialogues with agencies that are responsible for meeting the SRHR needs of the a wide range of groups and that FPAB has clear channels of communication to inform the service delivery programmes. However, co-ordination and dialogues appear to be focused on programme delivery rather than on the policy environment.

FGAE collaborates closely with governmental bodies at all administrative levels. Government officers are on FGAE's board and at zonal level government officers participate in FGAE planning exercises. FGAE is member of advisory boards for government bodies such as the National HIV/AIDS Prevention Council. The government are also providing facilities for free, for example for the clinics in Dire Dawa and Chiro. In some rural areas, FGAE also uses the government's health posts for their clinical outreach work.

FPAU is part of the Uganda Reproductive Health Advocacy Network which has been identified as the lead for a number of initiatives in the National Advocacy Strategy in support of

reproductive health, population and development programmes. However, it is not clear whether FPAU has a lead or central part in relation to these activities.

A close working relationship with government has advantages and disadvantages. The advantage is that the member associations can influence government activities and policies. However, some people perceive the association as being so close that it makes it difficult for them to speak out on sensitive issues or at least, cause them to mute their voice. A number of stakeholders expressed the view that they would like to see them take on a stronger advocacy role in lobbying and pressuring for change and have a stronger voice on some controversial issues. One informant felt providing good services was not enough and that FGAE should be more vocal. But, another informant indicated that perhaps the 'soft' voice was a strategic choice made by FGAE. Similar comments were heard about both FPAB and FPAU.

## Case 5. Working with volunteer members, Uganda

The advocacy activities do share a number of similarities among the countries. In both Uganda and Ethiopia there were street dramas and other forms of performances. In all three countries, the volunteer boards also play a role in advocacy. People we spoke to at the Branch organisation in Tororo gave highly personal accounts of why they had 'joined family planning.' The men on a Branch Executive Committee spoke of their awareness of the difficulties of providing for a large family, especially among farmers with limited tracts of land. A woman spoke of how, at age 13, she realised that her life would have been different had her father not had multiple wives and many children. Another woman said that she 'saw the light' after having six children. All of these people seemed quite committed to persuading others to limit their family size by using contraceptives. We were told that efforts are made to recruit volunteers who are influential in their communities as they are seen as effective change agents.

*To the left, community conversation in an outreach area outside Harar, Ethiopia. The topic of the day was the problems of having too many children. Informative posters were placed in the trees, one of them informed about the danger of unsafe abortions. To the right, the board of the mutual savings fund to provide transport for women in need.*

The volunteer members and community based volunteers play an important role in combating strongly held myths and misconceptions concerning SRHR. We heard about this so often from such a range of informants that we realise how strongly held many of these beliefs are.

- In a focus group interview with male non-users in Kakoba Ward, Mbarara, it was claimed that family planning encourages women to go for extra-marital sex and consequently get infections including HIV/AIDS.

- In a focus group interview with volunteers and peer educators in Mbarara, the evaluation team was told that some men believe they can wash the condoms and re-use them.

- In a focus group interview with peer educators in Tororo, the evaluation team was told that the first time they came to the village, people were hesitant to come to the information session because it was said that those going there would be infected with HIV/ AIDS.

It is important that such misconceptions are immediately confronted, challenged, and repudiated. We cannot tell how effective the volunteers are. It is bound to vary quite a lot. It is nevertheless an important mission, and efforts must start at this level too.

## Case 6. Street drama performance, Bangladesh

Street drama has been implemented by FPAB to increase community awareness and acceptance for SRHR. Drama performances are generally implemented by young volunteers and focus on a range of SRHR. They target the general public and community decision-makers. In Chittagong the team observed a drama performance that was focused on creating greater understanding of gender-based violence and HIV/AIDS. A crowd of approximately 800 people from poorer backgrounds watched the performances (it was staged on a Saturday evening in a slum area close to the port in Chittagong). The drama portrayed a range of easily understandable messages about these issues. Interviews with representatives from NGOs revealed that this form of communication is particularly relevant to meeting the need for information among poor communities

> *'this method of communication is very important and relevant in meeting the needs of the poor as there are very low levels of literacy among the poor populations in Bangladesh, and limited access to televisions and radio'. Leading Bangladeshi NGO working in the field of communication and advocacy*

The question is of course if a drama such as this is sufficient to have an impact on behaviour change? It is probably likely that more messages are needed, and that drama as such must be part and parcel of a broader awareness campaign. A short drama of around 1 hour cannot cover all issues surrounding HIV/AIDS, and though worthwhile in itself, it is definitely not a panacea.


*Two scenes from the drama developed by peer educators in Chittagong. To the left, a lead female actor performs an introductory dance, to the right the paramedic consults with the teacher and gives advice to a young woman in love (with the wrong man).*

The Chittagong branch set up the drama at a cost of Thaka 8,000, which is just slightly more than USD 100. The drama was performed twice a month over a period of six months, and at each performance there was an audience of around 1,000 people. This suggests that the drama by peer educators is a highly cost-effective way of working. A total of 12,000 persons have been reached with basic messages around how HIV/AIDS is spread at a very low cost.

FPAB also coordinates with the Ministries of Health, Family Planning and key NGOs to organise rallies and advocacy events to raise awareness of SRHR and wider health issues. FPAB co-ordinates with these organisations to organise a variety of events to mark 'Tuberculosis Day', 'World AIDS Day' and a number of other initiatives to raise awareness of health initiatives. In Chittagong this was identified as an important method of communication to raise community-based awareness about these issues, particularly among young people.

## *Resistance against advocacy*

When discussing the SRHR policy and programme environment it is important to appreciate the dominance of USAID as a donor and a major actor within the policy and service-delivery environment. IPPF and its member associations chose not to sign USAID's Mexico City Policy (also known as the Global Gag Rule) which prohibits any international NGO that receives USAID funding from providing abortion-related services, information or referrals to abortion service providers, with the exception of post-abortion care. The policy also prevents any organisation that is a recipient of USAID sexual and reproductive health funding from working in an advocacy or service provision basis with NGOs that provide abortion services, information about abortion or referrals for abortion services. USAID is currently providing significant financial and technical support to governments in both Bangladesh, Uganda, and Ethiopia.

It is probably true to say that none of the governments in the three countries welcome criticism and hence they are not enthusiastic about advocacy directed at themselves. Interviews with representatives from the Bangladeshi Ministries of Health and Family Planning revealed some reluctance about the role that it is felt NGOs should play in informing the national SRHR agenda. For example, one interviewee commented that *"NGOs should not be involved in determining national policies, but should focus their attention to community-based advocacy and awareness raising initiatives"*. Despite generally difficult environments, the evaluation team found that the member associations are engaged in initiatives with key stakeholders to shape the SRHR environment.

## *Missed opportunities in advocacy?*

There are striking similarities in respect of advocacy activities in the three countries. We were repeatedly told that FPAB, FPAU and FGAE are recognised as a 'good and solid service providers,' 'an organisation with a long history of service provision,' 'the only organisation that reaches deep into the community,' ' the organisation with the best developed networks at grassroots level.'

With such strong reputations in the field of SRHR, they are well positioned to advocate for sensitive issues. However, neither FPAB or FPAU is perceived to be a major actor in the field of advocacy today. Still, it is widely believed among those we interviewed that because of their well established credibility, people would listen to them if they disseminated research and information about taboo topics such as abortion. A number of stakeholders, including partners, expressed a desire to see FPAU take a more aggressive stand on a number of issues such as abortion, pushing the government to provide adequate services, coordinating the non-governmental stakeholders.

SRHR is, no doubt, a wide field. There is much advocacy work to be done in all three countries. In the text above we noted some things that we thought the three organisations did particularly well. We were also surprised at the lack of activities in other fields. For example, in Uganda we did not find any advocacy efforts related to reducing maternal mortality (perhaps because the FPAU regards the national policies as sufficient and adequate). Also, deliveries are not carried out at FPAU facilities so that safe deliveries must be carried out at government health units or other private facilities. It is quite clear that government facilities are not providing adequate delivery services hampered as they are by understaffing, lack of drugs, and poor infrastructure.

We did not hear of any FPAU advocacy efforts aimed at resource mobilisation for SRHR nor did we hear of any efforts at social mobilisation to hold government authorities accountable for the services they offer. Another obstacle to emergency obstetric care for women suffering complications during delivery is timely transport to health facilities.

Transport in remote areas represents a considerable cost to a woman and her family; we were told that when emergency transport is needed the price of that transport is doubled. Developing community emergency transport schemes could assist in reducing this delay in getting to health facilities. Such a scheme would be in keeping with the government's reproductive health policy. Moreover, the involvement of FPAU volunteers in such a scheme would demonstrate an active understanding that the SRH agenda has moved to issues beyond family planning.



*Information, Education and Communication material from Ethiopia. The effectiveness of such materials vary, and the member associations could learn much from ach other.*

The FGAE had a projects aimed at challenging harmful traditional practices, such as genital mutilation which is widespread throughout the country. However, the number of projects was small and they were all directed at awareness raising in communities. While the 2005 Annual Report cites an example of work against genital mutilation in peasant association in the Eastern Branch, the evaluation team did not find this work to have been prominent and widespread at the sites it visited. Moreover, when talking to stakeholders and partners, FGAE is not identified as an organisation doing significant work in this area. We found moreover, that in the area of gender – based violence and other harmful traditional practices, FGAE's efforts were less focused.

Turning to Bangladesh, although FPAB is well placed to be a key player in policy development, the organisation is not currently taking the lead in this area. Interviews with UNFPA, USAID and Save the Children show that while a number of SRHR policy initiatives have recently been developed, including the HIV/AIDS curriculum agenda for schools and an adolescent reproductive health policy they have been developed largely without consultation and input from FPAB. The adolescent reproductive health policy dialogues with the government were led by Marie Stopes, with the support of a consortium of NGOs, including FPAB. FPAB is not represented on the NGOs forum of the national health sector program and FPAB is also not currently working with Save the Children, the managing agent of the Global Fund for AIDS, Tuberculosis and Malaria in Bangladesh. The notable exception to this pattern is FPAB's involvement in the development of the 2004 national population policy. FPAB was consulted by the Ministry of Family Planning and attended a number of meetings to inform the development of this policy.

## *Systems to monitor and evaluate advocacy initiatives.*

At the present time member associations have very limited systems and capacity to monitor and evaluate the outcome or impact of advocacy initiatives at the local and national level. The FPAB is an exception; outputs of advocacy initiatives such as newspaper clippings of articles about SRHR and number of religious leaders attending Islamic Research Cell initiatives are collected,

and they also have sporadic information on the impact of broadcasting, etc. But there is no systematic follow-up.

The organisations currently have limited capacities to assess the outcome and impact of their advocacy initiatives. If they decide to become more strategically focused on advocacy and decide to invest resources in this area it is important that they also are enabled to make an assessment about effectiveness of different advocacy initiatives. Methods and systems of assessing the impact of policy and advocacy campaigns have been developed and well documented by key NGOs, research and academic institutions in Europe and America. These systems could be adapted for the member associations with focused technical support from IPPF.

## *Concluding remarks*

This chapter has provided an overview of the advocacy initiatives of the FPAB, FPAU and FGAE. Although there are differences among the countries, the overall conclusions are rather similar: There has been some confusion around what advocacy is and how it should be developed in respect of target groups, instruments, and levels in the political and administrative systems.

Advocacy is both a strategic priority in its own right and an integrated component in almost all other activities. This creates confusion in the strategic plan and in the annual budgets, and the organisations do not have a good overview of what they are actually doing. Thus, it is difficult to present results in respect of this "A", and accountability is low. The organisations all have a track record of successful advocacy at national level, in respect of family planning, and this has also reached district and municipal levels. They are widely recognised as having been quite successful in this.

If we now return to the analysis of advocacy at the beginning of this chapter, it is also clear that the activities are concentrated in some areas of the "map", while others are almost empty. In Figure 13 below, we use the same map to illustrate where activities are focused (green), and where there is a loss of opportunities (red)[21], with areas in between where there are some activities, but less than in the focus areas (yellow).

**Table 13 . Focus of advocacy activities.**

| | Government policy | Policy environment | Public awareness |
|---|---|---|---|
| **National level** | | | |
| **District/community level** | | | |

[21] There are no red areas in the combined assessment. However, when the member associations are analysed one by one, some of them do not direct advocacy activities in certain areas.

There is no doubt that the member associations implement a variety of local advocacy initiatives that are relevant to the needs of poor people. The organisations address major barriers to SRHR within the communities. SRHR has a broad agenda, and there are also many areas where the member associations are silent. They have not had the resources, or they had other priorities, or there are other reasons - but there is a need for more advocacy at all levels and on most subjects.

In a challenging environment, all the member associations have the potential to play a significant role in informing national policies, but the organisations are playing a relatively minor role in this area at the present time. With their high level of brand recognition and relationships with major agencies working in the field of SRHR, they could make a major contribution to the SRHR field if they become more involved in informing national policies. At the present time they have very limited capacity to assess the impact and effectiveness of the advocacy initiatives, and the question is if the organisation at present has the knowledge and competence to undertake major and sustained advocacy campaigns at the national level. But there is no doubt that these are areas that require much attention in the future.

# Chapter 6. Governance and management.

## *Introduction*

The focus of this evaluation is directed squarely on peoples' sexual and reproductive health and rights. We were interested in whether their needs are met by the IPPF member organisations and if so, how and to what extent, and whether there are any differences among clients – for example, poor and marginalised groups. Most of the people we met in the course of our country studies were people who had come to the clinics or who were involved in some of the outreach activities or projects of the member associations. Our second group of informants were other SRHR stakeholders. We met many of the staff members and management in the member associations, but primarily in their capacity as service providers. We have not analysed organisational structures and processes thoroughly, and that was not part of our Terms of Reference.

This evaluation has a history which explains why management is treated as a black box in this report. In connection with Sweden's financial support to IPPF, a management audit was carried out in 2005. This was the first of a two-part evaluation of which the current evaluation is the second part. The purpose of the first part was to assess IPPF's management systems and its ability to govern and control operations in a manner to ensure that external funds are appropriately utilised, documented and reported. This required a) examining the reliability and validity of existing systems for operational and financial management, b) determining, on the basis of the audit, whether the documentation which is received by Sida under current agreements reflects the real state of affairs and can thus be regarded as satisfactory material on which Sida can base its decisions, and c) providing recommendations for future development. Member associations in India, Kenya, and Sierra Leone together with the regional offices for Africa and South Asia were selected for field studies. The conclusions are*:*

> 'IPPF is in a sensitive phase of a comprehensive development process. The progress over the last few years is impressive. The newly implemented management systems are relevant and reliable, generally well developed, known to the personnel and to a large extent applied in practice. ….recent applications to Sida provide a reasonable reflection of actual conditions……there is a good chance that the reporting of results will also be acceptable in the near future.' (Svensson, 2005: 8).

Because that study was completed in 2005 and because it produced a comprehensive review of management, there was no need for this evaluation to look specifically at organisational issues. However, much as we have seen evidence of relevance, effectiveness and impact of the member associations operations, we have also seen considerable shortcomings. Some of these can be directly related to organisational issues and to management, and hence we collect these observations on structures and process in this chapter. We would like to emphasise again that this is in no way a study of management and there is some risk that our haphazard observations and remarks are off the mark. We have no ambition to cover management and organisation comprehensively, but limit our remarks to four areas we had reason to reflect on during the field visits; governance, strategic planning, human resource management, as well as monitoring and evaluation.

## *Governance: the role of volunteer boards*

The IPPF member associations are member based organisations; the members are organised at district level and/or subdistrict level. In each district there is a board, and the board elects the National Council. The National Council appoints some form of an Executive Committee. This means that somewhere around 200 volunteers may serve as board members in any one of the three countries. This is a great asset, but it is also a challenge to make sure that their devotion and commitment to the cause of SRHR is properly channelled so it becomes useful. Whether they are an asset or not depends on how their skills are put to use.

The first issue to raise relates to the role of the boards (SOU: 1993:1). A board could in theory take one of several roles, It could exercise power over the organisation, it could be advisory, or it could be representative (that is, contributing with networks to other people, assist in lobbying, inform other stakeholders of the organisation's activities). The three roles are illustrated in the table with some examples of boards that were found to work according to each "role model".

**Table 14. Different roles for volunteer boards**

| Type of board | Decision-making | Advisory | Representative |
|---|---|---|---|
| Key task of the board | The board decides on major issues in the organisation, for example strategy, personnel, finances. It follows activities closely and it can be held accountable by members. | The board is not responsible for operations, but is elected to provide advice to management, which is accountable to owners/members. Management decides whether to act on the advice or not. | The board members primarily work in relation to the outside world, that is, they represent the organisation and its cause outside the organisational boundaries. |
| Some organisational consequences | Small board, meets often, works closely with management | Board can be larger, members can circulate, less frequent meetings | Board can be quite large, should not meet often, and management works selectively with members |
| Some examples of IPPF member associations boards | District board Chitttagong, Bangladesh | Subdistrict board, Yirg-Alem, Ethiopia | District board Awassa, Ethiopia |

IPPF as a Federation, and each individual member association, may choose to have a variety of boards, depending on what serves the organisations best at any point in time. The problem we found, is that there is no discussion of the different roles a board could have, what the consequences are, and how one should choose one type of a board rather than another. Furthermore, several of boards appeared to be quite active in the management of the organisation while at the same time there is a professional management structure. For example, members of the National Council in Bangladesh had full-fledged offices in the organisation headquarters, and even at branch offices. This leads to a duplication of effort and confusion over responsibilities. Management cannot be held accountable when the board members are present in the daily operations of the organisation and are involved in decisions on the use of funds, access to services, appointment of personnel, etc. The board cannot be held accountable either, because there are still a number of operational decisions taken by management.

*Registration and payment at the model clinic in Awassa, Ethiopia.*

The present constitutions of the member associations appear to make the boards responsible for the management of the organisation, and hence board members are actively engaged. Many NGOs find it useful to have advisory boards and to leave managerial responsibility to professional management. During our visits we found only one board that was clear about its role and which, in no uncertain terms, defined it as advisory, and that was in Yirg Alem in Ethiopia. Their experiences could be further elaborated and brought up as an example of good practice to other parts of the IPPF organisation.

Apart from the general observation regarding the role of the boards and the division of labour between boards and management, and the consequences for accountability, our meetings gave rise to some more practical observations. The first regards the age of board members. Some boards were dominated by people who are approaching the end of their careers or have already retired. There is a need to rejuvenate the boards at all levels to make sure that the insights, understandings and dynamism of young people are brought to the governance of the organisation. All the member associations emphasise the need to reach young people, but those who formulate key policies and strategies at the boards may not have the required backgrounds to take the right decisions for that purpose to be reached. It is notable that the member association that had the best youth friendly services also had more young people on the boards at all levels!

The gender balance on the boards is also a cause for concern. The aim of IPPF is to have an equal representation of men and women, but this does not seem to be achieved, But it is not only the number of women that count, but also their voice in the decision-making process. The organisations need to ascertain that the women who serve as volunteers on the boards also have an equal say in decisions. FPAU appears to be the member association that has done the most to have an equal and strong representation of women on boards at all levels.

Yet another issue concerns how the boards work and how large they are. The boards in Bangladesh are generally large, the National Council has 21 members, and the district boards we visited had around 15 members. The boards in Uganda were smaller, and in Ethiopia we met with boards at district and subdistrict level that consisted of five members. It is generally said that a board should consist of 5 to 9 members if it is to work effectively. (Styrelseakademin, 2005)

In some member associations volunteers on the boards can serve up to 15 years, but not more than two consecutive terms (6 years) in any one position. It is also commonly said that persons have outlived their usefulness if they serve more than 6 years on a board. From the organisation's point of view, a maximum period of six years on a board would provide a steady access to fresh insights and inputs to decision-making.

In short, there are many issues around the governance structure that require a closer analysis than we offer here. We have not been able to analyse closely how management at different levels work together with board members. There is a risk that the unclear responsibilities could create conflicts. In any case, the duplication of responsibilities makes the organisation less efficient than it could otherwise be. Several of the evaluations done in the past five years have pointed to the need to reform the governance structure of IPPF and its member associations and we cannot but lend our voice to the same request.

## *Strategic planning*

Strategic planning is an exercise to define the overall purpose (vision and mission) of the organisation and translating that into action through a strategic plan. The member associations are in the same five year planning cycle. The Five A's serve as the guiding concepts for the strategic plans. In FPAB, we observed that the strategic plan had the character of a list of projects. Under each of the strategic objectives (the Five A's) come a number of boxes, wherein each box has a statement of strategic goal, situation analysis, and strategic objective. This is in itself a good and useful structure. The problem was that there was no sense of how these projects address a common purpose in respect of advocacy, adolescents, or any of the other Five A's, or in the other areas for that matter. There was no sense of purpose at the programmatic level, where one would want to see how the projects combine to achieve certain objectives, or contribute to a common purpose. The strategic plan gives the impression of a list of loosely assembled project activities that are somewhat arbitrarily sorted under the Five A's.

It is not easy for the member associations to present its activities under the Five A's. When one looks at the projects, it seems that they normally contain activities, outputs and outcomes that relate to several of the A's. A youth project may contain a large number of advocacy activities, the projects in access contain activities that relate to abortion and advocacy. The advocacy projects could also be seen as AIDS-related activities. Under the overall title of abortion, there are several components that relate to safe motherhood, even projects on safe motherhood. Safe motherhood is obviously a much broader concept and will certainly include many activities that are not abortion related.

This is a problem with the Five A's in general as a management tool, and the weaknesses in how they are conceptualised becomes apparent in the strategic plan of FPAB. This also implies that the data on financial expenditures organised under the Five A's do not accurately reflect the activities of the organisation. So for example, the obvious conclusion from the budget that Abortion is the largest programme sector at 25% of the total budget would not be true, as only a minor share of the funds spent under that title would be related to abortion as such. This also suggest that it would not be possible to present results in respect of the Five A's either.

The FPAB had no statement of a vision, but does have a mission. The Vision of FPAU, which had one, is concise: 'A society which enjoys full sexual and reproductive health and rights.' The mission statement is also short and conveys three messages: a) addressing unmet need, b) gender sensitivity, and c) youth focus. The language is important. FPAB had a mission statement which was long and rather difficult to read in English, but there was short and concise statement in Bangla. In comparison, the FGAE vision is: "An Ethiopian society where all people, particularly young people have the right to and enjoy quality sexual and reproductive health." FGAE's mission statement identifies the role the organisation wishes to play in Ethiopia, highlights the services and thematic areas it intends to work in, stresses the importance of collaborating with volunteers, local communities, and government, and states its future ambition to become a centre of excellence in information, service provision, and capacity building.

The Strategic Plan 2004 – 2008 is the third such strategic plan for FPAU and according to the Executive Director, it was developed in a participatory manner by relevant stakeholders in 2003. The Strategic Plan is approved by the association's National Council. The Plan reflects international developments and agreements such as the 1994 ICPD Cairo Programme of Action, the Beijing + 5 Platform for Action, the IPPF Strategic Plan (Vision 2000) and national policies and represented a paradigm shift with the following features:

- Broadening the service package from family planning to a wider range of SRHR issues
- Shift of target audience from women of reproductive age (15 – 44) to a focus on youth (10 – 24)
- Shift from a predominantly urban based static clinic to a mix of static clinics and rural based community based providers
- A renewed focus on cross-cutting issues such as gender mainstreaming, youth focus, and quality of care
- A greater recognition of the socio-political developments which had a bearing on the work of the Association.

The Strategic Plan is precise and includes sufficient text under each section. It presents the programme grouped under IPPF Five A's in a logframe format listing a goal, strategic objective and its strategies, output and impact indicators and a budget to implement each objective. The strategic plan summarises key issues after each theme.

There are differences in strategic planning among the three organisations; first, it is important that the overarching purpose is clearly stated, known and accepted by all, and reflected in the practice of the organisation. Second, the strategic plan should hold a programmatic content relating to the major dimensions of work. Third, there are difficulties in using the Five A's as a planning tool due to the overlapping nature of key concepts.

## *Human resource management*

The IPPF member organisations have three categories of staff, broadly speaking. There are the volunteers who serve on boards, that is, the governance structure of the organisation. There are the salaried employees, managers, office and service staff, project staff, and the staff at clinics. And finally, there are the field level volunteers, often community based, who provide non-clinical

services, often within the framework of a project but also as part of the regular line management of services.

The first problem that we observed refer to the gender balance in the organisation. In the category of field volunteers there are many women but a lack of men. In all other staff categories there is an overweight of men in Ethiopia and Bangladesh, and particularly so at middle management levels. This has also been pointed out in past evaluations and it is regretable that it takes so long for the organisations to change. In Uganda, however, we found a very good gender balance at all levels, including middle management. We also found an almost perfect gender balance among the peer educators that we met with.

The second problem relates to human resource development; professional upgrading. In some cases there seemed to be sufficient resources for training and career development. The FPAB clinical staff had often been involved in training almost every year, but in other countries the opportunities for professional development were fewer. The board in Bangladesh, that is, at the national level, also had access to training funds. However, the last category, of field volunteers, had far less training, and it seemed that priorities were consistently set in "higher" categories of staff. But it is often the field volunteers who make a difference to clients, and in our opinion the training priorities should be reversed.

The third problem concerns staff turnover. Both FGAE and FPAU were said to have too high a turnover of staff members, that created problems. The environment is competitive and other NGOs could at times offer higher salaries. Medically trained personnel in FGAE were particularly much in demand. The staff turn over problems in FPAB appeared to be less severe, in fact, it was almost the other way round. Management encouraged staff to leave, partly as a way to create opportunities to employ more women, to rejuvenate the organisation with younger people, and to get access to new skills. Staff turnover is in itself not negative and is to be expected. It is often said that a turnover of around 5% annually would be quite healthy – regularly bringing new competence and capacity to the organisation. Some member associations might have too high staff turnover, others too low.

## *Monitoring and evaluation*

Monitoring and evaluation are key functions in the organisation, and they are worth far more extensive consideration than we devote to them here. The IPPF has published a policy for monitoring and evaluation, and this is a step in the right direction. It sets the purpose for the efforts in this field and it gives some direction. Some of the observations from the field are:

When we visited the District offices in Awassa we asked whether some evaluations had been produced over the past few years, and if we could see them. The manager looked in his shelves and could, within a few minutes, produce six volumes of evaluation reports. Some were studies commissioned locally, and others were larger national evaluations that also had gathered data from the southern region. Some were recently published, others went back ten years in time.

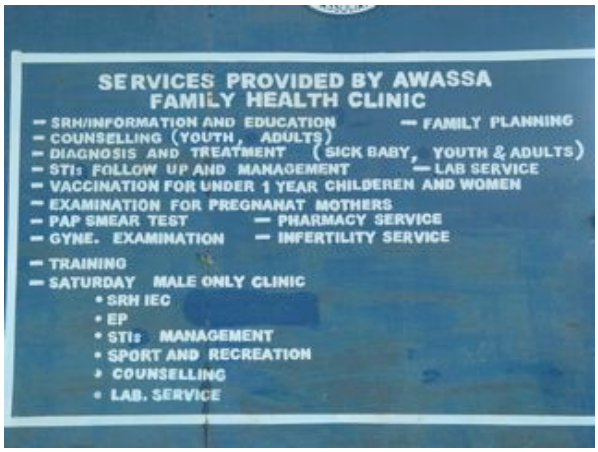
The point is that evaluation reports should be stored, they should be retrievable, and they should be retrieved on demand – exactly as they were in Awassa. The content should be known by

people in the organisation. Though the extent of knowledge varied, some key decision-makers in Awassa had a good grasp of the main conclusions of the evaluation. This is quoted as an example of best practice. However, there were not many branch managers who had such a good command of the history of evaluation in their regions/districts. Obviously, if resources are spent on evaluation, it is important to make good use of the knowledge gained.

Evaluation is not only a routine production of reports. It is a process that encourages as well as requires on an open and investigative spirit. We could observe how managers and staff acted within the context of an evaluative inquiry such as ours. Many – a clear majority - interacted well with us, responded to our needs for information, were curious to learn about our findings, and engaged in a professional discussion. A few demonstrated a lack of understanding of the job we were doing, for example by manipulating the selection of informants, by intimidating respondents in interview situations, and by avoiding problem issues. Whereas we could cope with these interventions, it does remain a problem for the member associations. There are still a few staff members who do not understand evaluation, who do not appreciate the nature of inquiry, and worse – who are not willing or interested in listening to the opinions of their clients. When the monitoring and evaluation policy is developed and spread through the organisation, it is necessary to bear in mind that for some, this requires a shift in culture and service orientation. It is not merely a bureaucratic requirement.

Within the overall framework of the monitoring and evaluation policy, it is necessary to remember that monitoring data are very important. We found that some clinics have suggestion boxes, and others systematically conduct exit interviews and reviews the data in staff meetings every month. We cannot vouch for the quality of either the data or the ensuing discussion, but in theory this is fine. The use of data is important and to the extent that an evaluative inquiry can be based directly on monitoring data, this can be a cost effective way of developing the function and connect it to organisational learning.

*The list of services provided that meets the visitors to the model clinic in Awassa, and the suggestion box, placed nearby as one leaves.*

In order to measure IPPF's progress in implementing the Strategic Framework 2005 – 2015, global indicators have been developed for each of the programme areas under the Five A's. All together 30 indicators have been developed, an average of 6 indicators for each programme area. An indicator is often made up of more than one question: a total of 55 questions form the basis for the indicators.

Developing this system is a colossal undertaking, requiring substantial changes in approach throughout the organisation. Earlier, statistics available were service statistics which reflect the pre-Cairo focus on contraceptives. The new global indicators might help IPPF complete the Cairo paradigm shift by providing it with a tool to report on the wider range of SRHR issues which are included in the Strategic Framework 2005–2015. It is expected that the survey will be completed every year.

As with any new information system, it will take time before the data are accurate and complete. Data usually improve as people become more familiar with what is required and see how the data are used. Data from 2005 is the first year that IPPF will be reporting on the global indicators. In that year 126 member associations completed the online survey. The lowest response rate was 77% which was in the Africa region. A report on the first survey came out in June 2006.

In addition to seeing the overall responses from the 126 countries, the individual responses from the member associations visited for the evaluation were made available. Here we found some surprising responses which did not match our observations in country. Uganda, for example, said it did not have a gender equity policy in place while Bangladesh does. Yet, Uganda was the obviously most gender balanced organisation we visited. All organisations said that they advocate for their national governments to commit more financial resources to SRHR yet this did not match our findings in country. By looking at the country responses, an observer gains some insight into the member association's work in the fields of adolescents, HIV/AIDS, abortion, access, and advocacy. Donors will be able to follow IPPF's implementation progress in these areas.

## *Concluding remarks*

The focus of this evaluation has been on whether the member associations reach poor people. But whether they do depends on whether the organisations' structures and processes are conducive to supporting member associations to develop effective and relevant programmes that meet the needs of poor people and vulnerable groups. The past four chapters gave evidence that the results are indeed satisfactory, but they can also be improved. Addressing some of the features and structures of the organisation to make it more responsive to needs and hence more relevant, and also to establish clearer responsibilities and accountability could improve effectiveness and impact. It should be mentioned that IPPF's accreditation system appears to be an important vehicle to trigger and assess organisational reforms. Of the three member associations visited in the evaluation, it is only Uganda that has been accredited so far – the other two are in the process still.

# Chapter 7. Conclusions and Recommendations

## *Evaluation purpose*

This chapter brings together the conclusions and observations resulting from the evaluation, and with this evidence in mind we turn back to the basic purpose of the evaluation. The terms of reference define the purpose of the evaluation as follows; "*to review the work of IPPF so as to help Sida, Norad, and other donors make informed decisions…..* What exactly does this mean? There seems to be two issues involved:

1. the first question is whether the two agencies should continue to fund IPPF at present levels, or whether they should consider increasing or decreasing their contributions to the work of IPPF;
2. the second question is whether the partnership between these agencies and IPPF should be consolidated in a short-term agreement of one year at a time (as at present) or whether longer term agreements would have some advantages.

Let us start with the first question. If the question is slightly rephrased as follows "*Should the agencies fund IPPF at present or somewhat increased levels?*" there could be three possible responses following an evaluation:

1. Yes, the evidence of the evaluation in respect of reaching poor people, relevance and effectiveness supports such a decision.
2. No, the evidence of the evaluation does not support such a decision.
3. Yes, the evidence of the evaluation supports that decision, but the findings of the evaluation also point to weaknesses that require the attention of the funding agencies as well as IPPF, and that continued support should be connected to a follow-up of these.

The response from the evaluation is in favor of the third alternative. The evidence gathered through the three country visits, the observations of daily activities, the analysis of written documents, and the interviews with some 1,000 people lend support to that decision. But the evidence also points to shortcomings in the organisation. Effectiveness and impact are not always high, but can be improved, brought to scale, and be made more sustainable. Let us briefly recapitulate the evidence from the evaluation.

## *Evidence of reaching poor people and vulnerable groups*

The evaluations' exit interviews indicate that many respondents were poor. The outreach programs in particular are often located in areas where poverty is widespread in the nation or in the province at large. Government authorities in Bangladesh and Ethiopia appear to direct NGOs in general to low-income and under-served areas. There is thus firm evidence that the services reach poor and vulnerable people, especially through the community-based family planning activities in all three countries and the clinical mobile services in Bangladesh and Uganda.

The member associations also have activities for certain vulnerable groups such as commercial sex workers, street children, petty traders. FGAE had projects that targeted female genital mutilation, FPAB had projects on gender-based violence. Still the capacity to identify vulnerable groups, develop programs, and bring these to scale, needs to be developed. The member associations charge fees for their services but this was not seen to be an obstacle to service use in Bangladesh or Ethiopia. In all three countries there were exemptions for very poor people.

## *Evidence of relevance*

IPPF's work as seen through the efforts of the three member associations of Bangladesh, Ethiopia, and Uganda is highly relevant to the SRHR agenda. The global priorities for achieving the SRHR Agenda as identified in the Cairo + 10 and the Millennium Development Project directs attention to integrated services, family planning, safe abortion services, a focus on young people, HIV/AIDS prevention, care and support, maternal health care, and strengthening SRHR decision-making.

IPPF has made the change from a focus on contraceptive services to a wider range of SRHR care and issues. Family planning services are integrated with other activities. In 2004, for IPPF overall, there were nearly 11 million family planning visits to member associations' outlets and nearly 24 million visits for non-contraceptive services.

IPPF's work is consistent with Sweden's international policy on Sexual and Reproductive Health and Rights where there is an emphasis placed on a rights based approach, a focus on young men and women, gender-equality, and a range of services including maternity care, access to contraceptives, safe and legal abortions, HIV/AIDS and other sexually transmitted infections and neonatal care.

A number of non-clinical project activities pertinent to reducing harmful tradition practices, preventing early marriage, addressing gender-based violence, meeting the needs of men and engaging their commitment to positive SRHR attitudes are reported in the Annual Program Review and in country documents. Some of these activities were also observed during the country visits and clients' views on them are reported in earlier chapters of this report.

In the documents reviewed, the interviews carried out, and the observations of member associations and their efforts, we did not find any activities which appeared not to be relevant to the SRHR agenda or which appeared to duplicate the efforts of other service providers.

## *Evidence of effectiveness*

In general, we found the member associations to be especially effective in their service provision and to be less effective in advocacy efforts. The three member associations are viewed in their own countries to be leading service providers especially in Ethiopia and Uganda. FGAE is seen to provide a wide range of contraceptives, introduce new contraceptive methods into the service, most notably long-term and permanent methods, and be a pioneer in introducing youth friendly services. FPAU was repeatedly referred to as a 'good and solid service provider.'

Work regarding abortion is less comprehensive in Bangladesh and Uganda, where it was found that that member associations were not fully using the opportunities available to them to provide abortion-related care. In Bangladesh, there is little demand for menstrual regulation which points to the need to raise awareness of the method especially among married and unmarried adolescents. In Uganda, only a few components of post-abortion care are provided. This points to the importance of carrying out the planned capacity building for abortion-related activities.

It appears that young married women are forgotten in the provision of services for adolescents. This is a shortcoming since the majority of women in the three countries visited are married before age 18. A different cluster of initiatives is needed to address the needs of this group. They include the provision of life-long skills relating to the ability to read, financial and legal literacy, income-generating activities that can be combined with the duties of a married woman, and provision of high quality family planning services to support women's contraceptive choice.

First generation services for young people were prominent in the service offerings in Ethiopia and Uganda. These included peer education, youth centres, family life education courses. The long-term impact of these activities is unclear and needs review in both countries. Youth focused activities in Uganda appeared to attract more girls and younger males and have a wider range of activities that appealed to young people. We thought this was a reflection of the more active youth participation at all levels in FPAU.

Considerable efforts are directed to information, education, and communication for the prevention of pregnancy and infections but it is unclear how much focus is placed upon IEC and behavior change communication for attitudes related to women's empowerment and gender equality. Different components of maternal health services are provided but in order to be effective, they need to be part of a continuum of care. A particularly weak link in the countries visited is the link with the people who will attend women at delivery. Effective ways need to be designed to work with traditional birth attendants in a manner that also increases the levels of skilled attendance at birth.

The efforts member associations were making in the field of HIV/AIDS were observed in Ethiopia and Uganda. HIV/ADS initiatives, like services for maternal health, run the risk of being fragmented and not coordinated with national and local efforts. In the countries visited, the member associations are held in high regard. The credibility they command places them in a position to advocate strongly for SRHR issues. With the notable exception of FGAE's role in the recent policy change around abortion, impacting on national policy appears to be a missed opportunity for the member associations. It may be that having a quiet advocacy voice is a strategic choice made by a member association, especially in a country where NGOs face a precarious position when speaking up against the government.

## *Recommendations*

With this overview in mind, what are then the issues that Sida and Norad need to follow up in their continued partnership with IPPF. The evaluation suggest that there are five areas in particular that need attention.

## Poverty and vulnerable groups.

IPPF has initiated a study of poverty. The discussion needs to be continued and the organisation needs more and better quality data on a continuing basis. It is necessary to know more about who poor people are, how they are best reached, and how they are affected by the activities. The issue of fees for services is not sufficiently clear and there is not enough information on how fees affect clients. We suggest that IPPF develop services to the member associations to:

- Assist member associations keep track of clients and on how best to assess poverty status, whether through information at registration, through exit surveys, or through targeted studies at regular intervals.
- Assist the member associations with policy information of exemption from fees, and the dilemmas that exemption policies give rise to.
- Develop guidelines on resource allocation when there is a choice between reaching poor people and vulnerable groups and achieving other objectives. These dilemmas are not always seen at present, and do not seem to be dilemmas. Boards and managers need to be trained to see the poverty consequences of resource allocation decisions.

## Advocacy

Even though advocacy is one of the Five A's, the member associations did not have a sufficient grasp of advocacy and they did not always know what they were doing nor what the effects were. The skills and competencies to plan, implement, and assess results need to be strengthened. In particular, the evaluation suggests that IPPF and the member associations need to:

- Undertake a comprehensive assessment of the advocacy work they do as part of present strategic frameworks, including activities that are now labelled advocacy, and where advocacy is part of projects under any of the other Five A's.
- Assess the competence and resources needed to do effective advocacy work at national levels, and provide a list checklist of critical factors that must be in place.
- Provide detailed examples of best practice in advocacy work, for example such as the above quoted input to changes in legislation on abortion in Ethiopia.
- Develop the instruments to monitor and assess advocacy activities.

## Impact

The organisation needs to develop competence and capacities around impact assessment to decide when it is possible and desirable to measure and/or assess impact.

- The evaluation policy needs to articulate clear choices on how to approach impact assessment.
- IPPF could develop guidelines to help member associations understand impact assessment and impact measurement, and help them focus on assessment.
- IPPF and member associations should take a step wise approach to impact, develop a plan for gradually increasing knowledge of impact, for example in respect of impact category, impact level, countries, regions, and strategic area. It must be possible to assess impact along the major results expressed within the strategic framework, but that is work that must be planned along with the implementation of the strategy.

## Governance

The volunteer boards at all levels represent an asset to the organisation, but their roles need to be clarified. Accountability is sometimes obscured, when the responsibilities of management and board are mixed, and where boards may not have been sufficiently clear on what decisions are to be taken by management and which decisions are the responsibility of the board. It is recommended that the three member associations visited, and possibly others:

- Set concrete targets for gender balance on boards and a time when the target is to be achieved (no less than two years)
- Set concrete targets for when young people should hold positions on boards at all levels, share of people under 25 and 35 respectively (no less than 40%) and when the target should be achieved (within two years)
- Establish guidelines on the size of boards, and good practice on the role of boards and the division of responsibilities between board and management.

## Human resource management

The member organisations have been in operation for many years. Organisational learning needs be developed, not least through a healthy turnover of staff. In some member associations staff turnover appears to be too high, in others to low. FPAU appears to have a clear strategy for sound and equal gender balance among staff and management and the other member associations can learn from them.

- Assess staff turnover and develop guidelines to manage turnover at a desirable level of 5 to 10% annually.
- Set targets for gender balance in respect of different categories of staff and set dates when these targets are to be achieved.
- Make sure there is a budget for staff development through training in the member association. Set targets for training allocated to different categories of personnel; for example: volunteer boards 5%, management 10 %, clinical staff, doctors paramedics, counsellors, etc. 40%, project staff, field volunteers, outreach service providers, 45%.

## Country specific recommendations

The evaluation has a number of observations, conclusions and recommendations that are directed at each of the three member associations visited. These are found in the three country reports that are presented in volume 2 of this evaluation. The recommendations in the country reports are specific and relate to the services provided more directly than do the recommendations above. The reader will also find a number of observations in the text above as well as in the country reports that suggests action. These are so many that they cannot possibly be listed in a short summary.

## Contractual framework

The evaluation does not really provide any evidence in favour of either short-term or longer-term agreements between IPPF and the funding agencies. There are two arguments concerning the issue that arise from the evaluation.

First, the planning of projects and programmes can be more effective if based on a longer period of time and a stable resource flow. Second, both IPPF and the funding agencies can plan for more accurate information in respect of the follow-up to the recommendations suggested above, if progress can be assessed for activities over a longer period of time.

The main point here is that the evaluation provides sufficient evidence of relevance, effectiveness, and reaching poor people, hence the advantages for all partners to work within the framework of a three-year contractual period are considerable.

## Taking the evaluation forward

This evaluation has looked at IPPF's activities in three countries. Are the activities there typical of other member associations? Are problems, challenges, opportunities and achievements similar? It should be relatively easy for a group of persons who are knowledgeable about IPPF's member associations to reflect on the analysis and to discuss where our analysis resonate with experiences from, for example, Kenya, Zambia, Senegal, South Africa, Egypt, Jordan, Sri Lanka, Laos, Vietnam or any other group of countries. If IPPF and the funding agencies think it would be of interest to carry out a structured discussion/workshop on this subject, this could be organised at the Annual Donors' Meeting in January 2007. Such a workshop could also be an opportunity to spread the evaluation and discuss its findings among a wider audience.

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# Annex 1. Terms of Reference

## Evaluation of the International Planned Parenthood Federation (IPPF)

### 1. BACKGROUND

#### 1.1 ICPD

More than ten years ago 179 countries met in Cairo to participate in the International Conference on Population and Development (ICPD). It then became clear that lack of knowledge, power and reproductive health services was severely harmful for the individual as well as for the development of a society. Lack of sexually reproductive health and rights (SRHR) and poverty are inextricably connected and mutually reinforcing.

#### 1.2 IPPF

The International Planned Parenthood Federation (IPPF), established in 1952 and headquartered in London, UK, is the world's largest voluntary organisation working in sexual and reproductive health (SRH). With its hundred of thousands of volunteers, 37 000 service delivery points, and 151 member associations (MA), it is recognised as the major international NGO in the field of SRH.

A pioneer in the advocacy of family planning, IPPF has, since the early 1990s broadened the scope of its activities to a wider range of SRH services and the advocacy of sexual reproductive rights. In 1992, its strategic plan, *Vision 2000* was published; in 1993, the 'Rights of the Client' were identified; in 1995, its Charter on Sexual and Reproductive Rights became available. Its current Strategic Framework 2005 – 2015 has prioritised five areas: adolescents, HIV/AIDS, abortion, advocacy, and access.

During the past ten years, IPPF has undergone organisational and management changes in keeping with the wider focus of its work. IPPF receives non-earmarked ('unrestricted') funding from 14 countries. The main donors are Japan, Sweden and the United Kingdom Among the other donors are Australia, Canada, Denmark, Finland, Norway, New Zealand, Great Britain, Netherlands, Germany and Switzerland.

#### 1.3 Sexual Reproductive Health and Rights and Poverty

The links between SRHR and poverty are many and complex. Poor SRH results from and contributes to poverty. Abridging sexual reproductive rights hampers poverty reduction. There is no doubt that improving SRH and guaranteeing sexual reproductive rights improves the lot of poor men and women. The ability to plan, space, and determine the number of children an individual and/or couple has is a critical factor impacting on later life opportunities for both the adults and the children involved. Pregnancy related conditions and sexually transmitted infections (STI) account for one-third of the global burden of disease among women aged 15 – 44. Women in poorer regions are disproportionately affected. In Sub-Saharan Africa, two-thirds of the disease burden for women of reproductive age is attributable to SRH problems. It is estimated that 250 million years of productive life are lost each year due to death or disability resulting from poor SRH.[22] Adolescents are particularly vulnerable to poor SRH outcomes.

The importance of SRHR is woven into many of the Millennium Development Project documents e.g. *Investing in Development: a Practical Plan to Achieve the Millennium Development Goals,* its summary Overview document, and the Task Force Reports. These reports underline that the key to achieving the

[22] Cohen, Susan, A., 'The Broad Benefits of Investing in Sexual and Reproductive Health,' *The Alan Guttmacher Report,* March 2004.

MDGs in low-income counries is to ensure that each person has the essential means to a productive life. These means include adequate *human capital, access to essential infrastructure, and core political, social, and economic rights*. SRH is one of the five key elements of adequate human capital. Equal rights, including reproductive rights for women and girls and equal access to public services are two of the five core rights.[23]

## 2. KNOWLEDGE GAPS: EVALUATION PURPOSE AND FOCUS

### 2.1 Starting Points for the Evaluation

An underlying premise for this Evaluation is that improved SRHR contributes to improving the lives of poor men and women. IPPF's core business is '….to improve the quality of life of individuals by campaigning for sexual and reproductive health and rights through advocacy and services, especially for poor and vulnerable groups.'[24] This Evaluation will not reiterate work done elsewhere that establishes the links between SRHR and poverty reduction. The assumption is that if IPPF's work is relevant to the SRHR agenda and if it is effective in carrying out its core business, it is contributing to poverty reduction.

### 2.2 Sida's s Perspective on Poverty

Sweden's new Policy for Global Development requires a sharpening of Sida's poverty focus.[25] The concept of poverty is not limited to economic and material aspects, but includes lack of power, lack of security, and lack of freedom and opportunity to decide over and shape one's own life. The perspectives of poor people means that the needs, interests, capacities, experiences and conditions of poor people should be a point of departure in all efforts to achieve equitable and sustainable development.

Core notions in Sida's poverty concept are:

- 'Lack of power' which draws attention to the additional hurdles, that poor (males and females, young and old) and marginalised individuals and groups face in determining their SHR.
- 'Lack of opportunity to decide over and shape one's own life' relates directly to key components of the SRHR agenda: family planning, safe abortion, safe pregnancy and childbirth, to be safe from sexually transmitted diseases (STI), including HIV/AIDS.
- 'Lack of security' which is especially relevant to the ability to determine when, how, and with whom to engage in sexual activity without fear of coercion, STIs including HIV, gender – based violence, and stigma and discrimination.

IPPF's Vision, Core Values, and Strategic Framework are fully consistent with Sweden's poverty focus. The strategic priority of adolescents is a specific focus for looking at a lack of power. Similarly, the provision of contraception, safe abortion, HIV/AIDS, and sexuality education are pertinent to the enhancing opportunities to decide over and shape one's own life.

### 2.3 Earlier Evaluations

Some donors have shown increasing concern over seeing 'results' of the support they provide. In 1997, Stenson and Brolin carried out a study of the IPPF Secretariat. This was followed in 1998, by a six country performance assessment conducted by Options Consultancy Services for the Norwegian Ministry of Foreign Affairs, Sida, and DFID. In 2003, a consortium of organisations evaluated UNFPA and IPPF work in addressing the needs of adolescents for GTZ, Danida, Norway's Ministry of Foreign Affairs, and DFID. Most recently a 'Management Audit of IPPF' was carried out by Professional Management AB for

[23] *Investing in Development: A Practical Plan to Achieve the MDGs, Overview*, p. 13
[24] pt. 1 under the IPPF mission
[25] Sida, 2002, *Perspectives on Poverty,*

Sida. Much valuable information about IPPF can be found in reports of these efforts. Of particular note is the lack of monitoring and evaluation observed in both the 2003 Evaluation and the recent management audit

### 2.4 Purpose of the Evaluation

The purpose of the Evaluation is to review the work of IPPF so as to help Sida, and NORAD, tomake informed decisions about the relevance and effectiveness of IPPF's work in promoting SRHR for poor and vulnerable people, and marginalised groups, through its services, advocacy efforts, and information sharing, . There is a particular interest in how IPPF works at country level and with young people.

## 3. METHODOLOGY

The Evaluation will use qualitative methods and data supplemented by management information where available. Data collection will rely upon document review, interviews with key informants, focus group discussions with intended beneficiaries, observations, and reworking of secondary data when available e.g. from IPPF's MIS. The Evaluation aims to be participative in that an open dialogue with IPPF and the MAs will be actively pursued.

### 3.1 The Evaluation will be carried out in 3 phases.

*Phase 1: Document Review; Inception Report*

The purpose of Phase 1 will be to develop the framework for analysis and refining the methodology for the country studies. Phase 1 will require document review, interviews of key IPPF informants, and review of IPPF's MIS. The Phase 1 product will be an Inception Report which will include:

- Conceptual framework for analysis based on the known links between SRHR and poverty with a focus on IPPF's Vision 2000 or Strategic Framework 2005 – 2015;
- Development of the data collection instruments including questions to be asked in the field studies
- Identification of data sources including:
    - Groups of key informants and stakeholders
    - Other service providers in order to obtain an overall picture of the context in which the MA operates
    - Management information when available
- Selection of countries for field studies. Propsed three countries could include Bangladesh, Uganda and Ethiopia..
- Proposed local consultants and youth consultants
- Proposed format for reporting
- Identification of the information that the IPPF HQ and MAs will be requested to provide to the Evaluation Team prior to the field visits
- Details of the responsibilities of each member of the Evaluation Team
- Proposed work plan
- An entire budget for the evaluation

The Steering Group will approve the proposals in the Inception Report, suggesting changes where necessary, before the field studies commence.

*Phase 2 Field Studies*

Given the wide diversity among MAs, field studies in 3 countries will be used to create the picture of how IPPF works at country level. It is recognised that different MAs are trying to achieve different outcomes

because the national context for promoting SRHR varies considerably across countries. Countries will be selected among the most needy, poor countries. Together they should provide regional representation.

Phase 2a: Field Study in one country. This will be used as a 'pilot' for the remaining field studies. This will test the methodology, data collection instruments, and overall plan for the field studies. Adjustments to the methodology will be made before embarking on the remaining field studies.

Phase 2b: Field Studies in the remaining countries. It is anticipated that the field studies will make use of information and data from IPPF HQ and MA, interviews with different stakeholder groups, observations, and document review.

*Phase 3 Synthesis Report; Reporting to donors and IPPF.*
The final phase of the study will make a synthesis of the country studies' findings. It may supplement the material by additional telephone interviews to fill existing gaps in information. The final report shall focus on the relevance and effectiveness of IPPF with regard to promoting SRHR for poor people and marginalised groups.

## 4. KEY EVALUATION QUESTIONS

The Evaluation Team will look at the relevance and effectiveness of IPPF's work within the SRHR agenda with special attention to:

a) How IPPF works to promote SRHR through its services to meet the needs of poor and marginalised individuals and groups.

b) Contraception, safe abortion, STIs including HIV/AIDS, and adolescents. Gender sensitivity, advocacy, and access are cross cutting issues to be addressed throughout the Evaluation.

c) IPPF's work in the promotion of sexual reproductive rights.

d) IPPF's work in SRHR information sharing and education.

## 5. PERFORMANCE OF THE EVALUATION

### 5.1 Evaluation Management

Sida is the lead agency for the Evaluation. Sida, in consultation with Norad will be responsible for the management of the Evaluation. IPPF will be consulted when necessary. An Advisory group (the formation and administration of which will be the responsibility of Sida/Health Division) will comprise the donors and IPPF. The Team Leader will participate in the Advisory Group as an observer. Other Evaluation Team members may be included when appropriate.

The consultancy will be undertaken in the period –April 2006 – November 2006. A draft final report shall be submitted no later than 20 October 2006 and the final report latest 15 November 2006.

### 5.2 The Evaluation Team

The Evaluation Team will be made up of a Team Leader; assistant Team Leader, international SRHR specialists, local SRHR consultants, and youth consultants. The field study teams will comprise the Team Leader, an international SRHR specialist, a local SRHR consultant, and a local male and female youth consultant. The Team Leader who will be selected and contracted by Sida will perform the following tasks:

- Lead, coordinate and manage the evaluation

- Design the detailed evaluation scope and methodology (incl the methods for data collection and analysis)
- Decide the division of labour within the evaluation team and be responsible for recruiting other consultants when necessary.
- Finalize the Inception report and submit to Sida not later than 30 June 2006
- Review documents
- Present draft findings and recommendations of the evaluation to the advisory group
- Participate in the draft finding of the country reports
- Finalize the evaluation report and submit to Sida not later than 15 November 2006

The Evaluation Team should fulfill the following requirements:

- All team members should have experience of carrying out evaluations and assessments in the area of health in general and SRHR in particular, including the use of qualitative methods and information from MIS. At least one of them must be a documented expert on povery analysis.
- All team members should be fluent in spoken and written English
- Team members shall have the ability to function as a team and work in a multi-cultural and multi-lingual context.
- Ideally, the team members will be familiar with the work of IPPF and at least one of them must have documented experience of working on poverty analysis.
- Additionally, the local consultant should have documented knowledge of the context for SRHR in his/her country; experience of working with a range of national/local SRHR networks; ability to liaise between the Evaluation Team and the groups to be interviewed, spoken and written fluency in the national language, and demonstrated evidence of being able to arrange the logistics of the field study for the Evaluation Team. The local consultant´s assignment should cover a period of four weeks in the country.
- Additionally, a local young male and female consultant will assist each field study. Their main responsibility will be to carry out interviews and/or focus group discussions with intended beneficiaries and young people participating in the MA's work. It is thus essential that the selected youth consultants are able to converse easily with a wide range of local youth and have earlier experience of qualitative evaluation methods. More generally, the young consultants will be expected to contribute to the overall work of the Evaluation Team for the field study.

## 6. TIMING

The consultancy will be undertaken in a period of April 2006 – November 2006.

The Inception Report should be provided to the Advisory Group by 30 June 2006.

A draft final report shall be submitted to the Advisory Group electronically no later than 30 October, 2006. A final version shall be submitted no later than 15 November, 2006.

## 7. REPORTING

The Evaluation Team shall produce the following outputs:

- Inception Report focussing on the conceptual framework for analysis, indicators, data, and data sources to be used during the field studies. This report shall be presented on 30 June, and the remainder of the assignment is subject to its approval by Sida, and NORAD

- Verbal reports to the Advisory Group outlining activities undertaken and results achieved, as well as possible bottlenecks or concerns and recommendations for improvement.

- A brief draft report from each of the field visits (ideally, some five to ten pages), analyzing the main findings in the local context in each country visited. This report shall be distributed to relevant stakeholders (including IPPF and the MA, NGOs, representatives of client groups, and other individual and/or groups who provide information to the Evaluation Team during the Field Visit) in each country within a week of departure. They shall be given the opportunity to comment on its contents.

- The Final Evaluation Report should ideally not exceed 60 pages, excluding annexes. The format and outline of the report shall follow the guidelines in Sida Evaluation Report - a Standardised Format. It will include recommendations to help the participating donor countries make informed decisions about its support to IPPF. In addition a Power Point presentation of 10 – 15 pages of main conclusions and findings.

All reports shall be written in English, and translated to the national language when necessary. The consultants shall make sure that all reports have been professionally edited and corrected before presentation.

## 8. BUDGET

Costs for the Team Leader will be covered by Sida
Costs for the SRHR consultants will be covered by NORAD
Costs for the youth consultants will be covered by Sida
Costs for the local SRHR consultants will be covered by Sida
**To be discussed:** Some local costs e.g. local transport, translators, convening the focus groups, and dissemination of the report will be covered by IPPF