

International Planned Parenthood Federation

DFID PPA Mid-Term Independent Progress Review

October 2012

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Annexes

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Acknowledgements

The review team would like to thank Fleur Pollard and Heidi Marriott for the excellent support and management that they have provided throughout the review process. The team is also very grateful for the time and thoughtful responses that IPPF CO, RO and MA staff have given to the interviews, focus groups and the survey. A very big thanks is also due to CIES, R-FPAP and FGAE directors, management and staff for their significant efforts in organising and accompanying the visits.

Abbreviations

AM	Associate Member
AR/ARO	Africa Region/Africa Region Office
AWRO	Arab World Regional Office
BCC	Behaviour Change Communication
CIES	Centro de Investigación, Educación y Servicios (IPPF MA in Bolivia)
CO	Central Office
CORE	Cost Revenue Analysis Tool
CAC	Comprehensive Abortion Care
CPR	Contraceptive Prevalence Rate
CYP	Couple Years Protection
CSO	Civil Society Organisation
CSW	Commercial Sex Worker or Commission on the Status of Women
DALY	Disability Adjusted Life Year
DFID	Department for International Development
EIMS	Electronic Integrated Management System
EN	European Network
FGAE	Family Guidance Association Ethiopia
FGD	Focus Group Discussion
FP	Family Planning
GBV	Gender-Based Violence
GPAF	Global Poverty Action Fund
HPV	Human Papilloma Virus (causes cervical cancer)
HQ	Head Quarters
IEC	Information, Education and Communication
IF	Innovation Fund
IPR	Independent Progress Review
IPPF	International Planned Parenthood Foundation
LGBT	Lesbian, Gay, Bisexual and Transsexual
MA	Member Association or Medical Abortion
MH	Maternal Health
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MIS	Management Information System
MMR	Maternal Mortality Rate
MP	Member of Parliament
MSI	Marie Stopes International
PAC	Post Abortion Care
PBF	Performance Based Funding
PPA	Programme Partnership Arrangement
RO	Regional Office
R-FPAP	Rahnuma - Family Planning Association of Pakistan
RH/SRH/SRHR	Reproductive Health / Sexual and Reproductive Health / and Rights
SARO	South Asia Regional Office
UE	Uterine Evacuation
VfM	Value for Money
WHO	World Health Organisation
WHR	Western Hemisphere Region

Executive Summary

DFID has a Programme Partnership Arrangement (PPA) for £25.8m of flexible strategic funding to the International Planned Parenthood Federation (IPPF) between 2011 and 2014. IPPF is a federation of 152 Member Associations (MAs), working in 172 countries. IPPF MAs provide sexual and reproductive health (SRH) and other health services. They also work on improving the social and cultural enabling environment for sexual and reproductive health and rights (SRHR). Collectively IPPF MAs are delivering 89.6 million¹ sexual and reproductive health services through 65,000 service points which include their own clinics, and other MA-supported private and government facilities. MAs are well known in a number of countries for their work with government on service delivery and policy issues, and are also active participants in global SRHR advocacy.

The Independent Progress Review (IPR) has involved the assessment of results and overall organisational competence against a series of criteria as follows:

- Results – quantitative and qualitative results against logframe indicators; intended and unintended effects on poor and marginalised people.
- Relevance – representativeness and targeting.
- Effectiveness – learning, innovation, partnership and sustainability.
- Efficiency – organisational efficiency and monitoring of costs of inputs and outputs.
- Impact – demonstrable impact and impact assessment methods.
- Overall Value for Money – including issues of economy and quantitative VfM.

As the PPA provides unrestricted funding, this review aims to present an overall institutional assessment which tests the theory of change assumptions, and verifies stories and data. The review is comprised of seven elements:

- (i) Desk study of IPPF documents, data and MA annual reports – May/June 2012
- (ii) Central Office theory of change workshop – 23 May 2012
- (iii) Web survey of the 45 MAs (50% response) – June 2012
- (iv) Central Office interviews – May/June/July 2012
- (v) Regional Office interviews – June 2012
- (vi) Three country case studies – Bolivia, Ethiopia and Pakistan – June 2012
- (vii) Analysis, report writing and final presentation – Aug/Sep 2012

Findings: This IPR has found that IPPF is performing well against all of the evaluation criteria, and that there is good evidence for cost effectiveness and value for money in specific cases that can be generalised across the federation. There is room for improvement in monitoring and evaluation and measuring value for money.

Results: The *logframe* outcome: “to improve the health status of poor and young people, in particular women and girls” is being achieved by the following three outputs:

- i. Service delivery: Increase in access and use of a package of essential services, centred around family planning through IPPF Member Associations (MA);

¹ IPPF website: <http://www.ippf.org/about-us>

- ii. Enabling environment: Engaging and influencing policy mechanisms for SRH and choice at global, regional and national levels; and
- iii. Strengthen the economy, efficiency and effectiveness of IPPF's network.

This logframe is a suitable monitoring framework for the PPA as it closely mirrors the three IPPF change goals of Unite, Deliver, Perform, and also monitors performance against IPPF's five strategic "As" - Abortion, Adolescents, AIDS, Advocacy and Access. Value for money features strongly with key institutional and VfM indicators in Output 3.

The **quality of the data** used for reporting against the logframe overall is good. The service delivery statistics (relating to Output 1) come from internal IPPF data collection systems, which are reliable, but depend on the capacity of the MA to accurately collect and report data. However both the Regional Offices (ROs) and the Central Office (CO) described good systems for verifying and ensuring data quality. Output 2 indicators on the enabling environment are reported through the annual IPPF "Global Indicator" survey and were generally verified by the IPR through the country studies and the survey. Output 3 indicators were all found to have good sources except for the indicator measuring cost/CYP. This did not correspond with the data calculated in the country studies as the CO methodology relies on an inadequate level of detail on expenditure data from the MAs.

The review collected evidence on the **impact of initiatives on people's lives** through the survey, the RO interviews and the MA studies. It found evidence of changes in the lives of the poor, vulnerable and underserved people in terms of their access to services and their ability, as a result, to exercise greater control over their SRH. This was particularly notable for young people. This increase in utilisation is largely due to the following reasons:

- Clinic and mobile service locations;
- Accessible and differentiated pricing;
- Good quality of services based on client centred and rights based approaches;
- Linked and complementary services and targeting particularly vulnerable groups;
- Partnerships with public and private sector providers;
- Initiatives to enhance gender equality and women and young people's empowerment;
- Influence on policy and legal change to enhance SRHR.

The IPR team observed unintended impacts on stigma, self esteem and the wider cultural enabling environment for SRH. Wider impacts on civil society were also observed in the country studies. For example, women, and young people in particular, were found to be mobilising to demand accountability from the public health sector in terms of addressing their SRHR.

Relevance: The IPR finds that the IPPF PPA programme is designed to address major global sexual and reproductive health problems and that the objectives and planned outcomes still remain highly relevant. The choice of focus countries, the regional emphasis and the country strategies are all responding to an accurate assessment of SRHR realities at all levels.

The Federation is responding to some of the major SRHR issues affecting low income countries. 222 million women aged 15 – 49 years (26%) in developing countries have unmet need for modern contraception. The situation is particularly serious in Sub-Saharan Africa

where unmet need for modern methods stands at 53%², adolescent birth rates are 122 per 1,000 women of 15 – 19 years³, and, in 2010, 4.7% of adults aged 15 to 49 were living with HIV.⁴ 16 of the 45 IPPF PPA countries account for 63% of global maternal deaths. 28 of the IPPF PPA countries are in Africa.⁵

Gender inequality continues to be a major barrier to improvements in SRHR, both at the family, community, and policy level. Unsafe abortion and HIV and AIDS continue to contribute to high mortality and morbidity rates amongst women aged 15 – 49 years. All of the country studies noted increasing awareness of the importance of women’s empowerment to promoting SRHR, as well as the impact of violence against women on SRHR.

The IPR observed how IPPF MAs ensure that their programmes are relevant and targeted to poor and vulnerable people. They are supported by the ROs to undertake situational assessments and develop strategic plans based on a context-specific analysis of SRHR issues, and the overall enabling environment. While country-level situational assessment methodologies could be improved, MAs demonstrate a high level of contextual knowledge about the barriers for people wanting to access SRH services and rights.

Effectiveness: The IPR found that IPPF’s approach to **learning** is effective and respected throughout the organisation. This approach includes formal systems and processes, alongside more informal learning through ongoing communications. The formal mechanisms include meetings, technical assistance, visits, learning sessions and communications initiatives. These can be used as forums for interaction between the RO and MA, CO and RO or MA, or between MAs, and ensure a vibrant exchange of information and expertise as part of a continual process.

Ongoing learning about context and needs, including from monitoring and evaluation (M&E) systems is also strong. However, these processes should be further strengthened through the use of rigorous research methodologies for understanding changes and impacts. IPPF is active in sharing their learning with other stakeholders through websites, printed material and meetings and conferences. However, better use could be made of international networks for dissemination and sharing in the future.

IPPF has a strong focus on implementing tried and tested approaches, particularly in terms of providing services that have been proven to have an impact on SRHR. This is balanced against a good culture of innovation (where a certain level of risk is accepted, and seen as a learning opportunity). The PPA funding has been particularly effective in promoting and **growing innovation** within the organisation. IPPF innovates by providing services that others neglect and by simultaneously advocating for government commitment to SRHR. The Innovation Fund (IF) (supported by DFID PPA funds) has been successful at introducing new approaches, sometimes in very challenging situations. A preliminary internal review of the 2005 - 2011 portfolio of IF projects found that all 41 projects were viewed to have been innovative for the implementing MA and have advanced IPPF’s strategic priorities. 35 projects focus on

² Singh and Darroch (2012)

³ UNFPA (2011)

⁴ WHO/UNAIDS website

⁵ However, Sudan and Mauritania fall under IPPF’s Arab World region.

empowering vulnerable groups, and 30 projects tackle sensitive and taboo issues. All projects include a capacity building component. Several IF projects have been scaled up by government or by the MA with external donor funding, helping to ensure the sustainability of project activities.

Partnerships are an essential ingredient for IPPF's success in advocacy (both global and country level) and in impacting wider health systems. The IPR observed multiple examples of partnerships with government (co-implementation), civil society organisations, the private sector and community based organisations. On the whole partnerships were found to be working well and partners appeared very positive about the strong technical capability of IPPF MAs and their approach to partnership working.

As IPPF is a Federation of locally owned organisations, there is also a high level of local commitment and ownership which further supports institutional **sustainability**. Financial sustainability is more elusive as some MAs are struggling to reconcile their social objectives with profit making imperatives. The Western Hemisphere region (WHR) and some middle income countries in South East Asia and South Asia have made the most progress on financial sustainability, not least because of the insistence by USAID, a major donor in WHR, and because of these countries' relatively higher wealth status. Many MAs now focus considerable effort on health systems strengthening and government capacity building in order to have a wider impact on country wide SRHR. This type of activity increases the sustainability of outcomes and impact as long as there is sufficient time for changes to become institutionalised.

Efficiency: Organisation efficiency was observed to be good, with examples of excellent leadership at several different levels, clear and owned strategies, good human resource management and improving financial management. Measurements of efficiency and cost effectiveness are gaining traction within the organisation, but have a way to go. The country studies showed that unit costs were either not being calculated, or if they were, were not being updated and used effectively to make management decisions. The IPR calculated the cost per CYP for Rahnuma – Family Planning Association of Pakistan (R-FPAP) at £3.19, and for the Centro de Investigación, Investigación y servicios (CIES) in Bolivia at £2.90, both comparing favourably with the regional averages. Cost per DALY for R-FPAP was £14 - 52 times lower than the current GDP per capita of £750 in Pakistan. For CIES the cost per DALY was £76, which is also less considerably than the GDP per capita of £1,103.

Impact and VfM of PPA funding: The DFID PPA contributes 20% of all of IPPF's strategic flexible funding (or unrestricted) funding. Though this funding is not specifically allocated to a set of activities it is clear that the unrestricted funding supports the secretariat (ROs and CO) and all of the support activities that contribute to MA VfM. A CO interviewee stated that the secretariat would lose one in five employees without the DFID funds. Since the ROs and CO are currently an important resource for the MAs to improve their efficiency and effectiveness, it can be assumed that the whole organisation's VfM would suffer without the DFID PPA. Regional Offices stated that the benefits of unrestricted funding include the following:

- Provides flexibility to respond to emerging needs;
- Provides opportunity to take risks and innovate;
- Enables institutional capacity building – an area that is rarely funded by donors; and

- Ensures the continuity of SRH services.

Conclusions: The review team has been particularly struck by how effective the 5As framework has been in mainstreaming previously neglected health areas and target groups throughout the federation. There is still more work to do, but the focus on the 5As has been extremely effective. The review also noted a high level of commitment and passion among Secretariat and MA staff which clearly impacts the effectiveness of the organisation. The IPR found that IPPF is performing well against all of the review criteria and the theory of change assumptions appear to be holding, though they need more rigorous evidence to prove two of the assumptions. Areas for strengthening include: strategy development and implementation, financial and service data recording and reporting, research methodologies for situational analysis and M&E, and unit cost and VfM measurement and monitoring.

Lessons learned: The following lessons were learned through the IPR process:

- The SRHR policy environment continues to be challenging in many countries. Donor funding is becoming more project based.
- Health systems strengthening is becoming a more important part of IPPF's work and wider impact is being achieved through this kind of work.
- Coordination between PPA holders in the same sector is essential
- Local donors can impact significantly on institutional strengthening and effectiveness
- Good leadership and management are essential for efficient value for money and can improve the ability of the MA to reach poor and vulnerable groups.
- The CORE system used to calculate unit costs is useful, but relies on service norms and strong management and information systems.
- Exchange visits between MAs are particularly effective for learning and building capacity.
- The clinic counsellor is an important part of IPPF's approach for reaching vulnerable groups
- IPPF MAs are implementing interesting work on violence against women and on building women's and young people's capacity to hold the government to account.
- Financial sustainability can go hand in hand with good targeting and access to poor, vulnerable and hard to reach groups.

Recommendations:

1. IPPF should invest more time and money developing methodologies for, and carrying out needs assessments and M&E activities should be increased in order to better target programmes and to gain efficiencies and effectiveness.
2. RO and MA capacity to measure and improve value for money.
3. Organisational learning in the following two areas:
 - South-South learning, which may include exchange visits and/or technical hubs.
 - Technical assistance to MAs to improve financial management, resource mobilisation and IT systems introduction, and strengthen other components of organisational effectiveness
4. When developing the new strategy and structure of the organisation over the next two years lessons from the previous experience should be fully analysed and used to develop a more functional and efficient organisation, with the skills needed for the next ten years of progress.

1. Introduction

1.1 Purpose of the evaluation

DFID has a Programme Partnership Arrangement (PPA) for £25.8m of flexible strategic funding to the International Planned Parenthood Federation (IPPF) between 2011 and 2014. This is equivalent to £8.6m per year, the same amount that IPPF has already been receiving annually from DFID since 2008. Whilst IPPF is a global organisation working in more than 173 countries, this PPA gives particular priority to **45 focus** countries, as well as directing funding to the Regional and Central Offices. The PPA desired outcome is: to improve the health status of poor and young people, in particular women and girls. There are three target outputs:

1. Increase in access to and use of a package of essential services centred around family planning;
2. Engage and influence policy mechanisms for SRH and choice at global, regional and national levels; and
3. Strengthen the economy, efficiency and effectiveness of IPPF's network

The purpose of the Independent Progress Review (IPR) is to measure the achievements, challenges, outcomes and impacts (both positive and negative) resulting from IPPFs funding through the DFID PPA. The IPR documents progress to date and presents recommendations for IPPF on areas that could be strengthened. This mid-term IPR will feed into the overall IPPF and PPA fund-level evaluation.

1.2 Scope of the evaluation⁶

The IPR has involved the assessment of results and overall organisational competence against a series of criteria as follows:

- Results – quantitative and qualitative results against logframe indicators; intended and unintended effects on poor and marginalised people
- Relevance – representativeness and targeting
- Effectiveness – learning, innovation, partnership and sustainability.
- Efficiency – organisational efficiency and monitoring of costs of inputs and outputs.
- Impact – demonstrable impact and impact assessment methods
- Overall Value for Money – including issues of economy and quantitative VfM

1.3 Focus of the evaluation

The evaluation focuses on the overall IPPF's overall institutional capability, value for money and results at CO, RO and MA level. It is based on a review of IPPF generated documentation and data; it provides verification of data and programme information; it undertakes first hand interviews at CO, RO and MA level and the testing of methodologies for measuring cost and financial management effectiveness.

1.4 Organisation context

The International Planned Parenthood Federation (IPPF) was launched in 1952 with just eight national family planning associations. It has since grown to 152 Member Associations (MAs),

⁶ See also the terms of reference in Annex A

working in 172 countries. Collectively IPPF MAs are delivering 89 million⁷ sexual and reproductive health services through their own 65,000 service points which include their own clinics and other MA- supported government and private providers. IPPF originally started as a social movement to promote women's rights to control their own fertility.

IPPF MAs provide SRH and other health services in clinics, hospitals, mobile clinics and other service delivery points. They also work on the social and cultural enabling environment for sexual and reproductive health and rights (SRHR) through information, counselling and special community based projects. IPPF's MAs are well known in a number of countries for their work with government and in the policy and law development process.

In 2005, IPPF developed a Strategic Framework incorporating five key strategic objectives known in short as the "Five A's": Abortion, Access, Adolescents, Advocacy and AIDS. The organisational structure follows the strategic objectives in the Central Office (CO) and in many of the Regional Offices (ROs) and MAs, though it does vary depending on the MAs own objectives. Technical assistance tends to be provided through the five As and the four supporting strategies: (i) Capacity Building (capacity to effectively implement the Framework), (ii) Resource Mobilisation and Finance, (iii) Governance and Accreditation, (iv) Knowledge Management, Monitoring and Evaluation.

IPPF consists of the Secretariat which is based in the Central Office in London and in six regional offices: Africa – Nairobi, Arab World (Tunis), East and South East Asia and Oceania (Kuala Lumpur), European Network (Brussels), South Asia (New Delhi) and Western Hemisphere (New York). It is overseen by a Governing Council that consists of four volunteer representatives from MAs in each region. Several million volunteers support the work of IPPF in their MA countries.

The IPPF Director General, Tewodros Melesse, has been in the post since September 2011. The recent change in leadership has inevitably started a planned internal change process that is impacting the structure and strategic objectives of the organisation as a whole. It is expected that two new directors will be in post by the autumn.

The majority of IPPF's core or unrestricted funding comes from ten government donors⁸ providing between \$1m and \$13m per year. Total funding for 2011 was \$66.909m (£41.622m), a drop of 16% since 2009. This is distributed to the MAs through the Regional Offices (ROs) and through specific funds, such as the Innovation Fund, directly from the CO. The ROs also provide technical assistance, strategic thinking, communications and learning support to the MAs. IPPF has been receiving unrestricted funding from DFID since 1969. The grant was previously managed in the DFID Policy Department and moved to the Civil Society Department in 2009. The first PPA was awarded in 2011, which replaced the existing four year contract for an unrestricted grant that had been awarded in 2009.

⁷ IPPF website: <http://www.ippf.org/about-us>

⁸ Australia, Denmark, Finland, Germany, Japan, New Zealand, Norway, Sweden, Switzerland, UK. Netherlands has recently moved from unrestricted to restricted funding. Source: IPPF Resource Mobilisation Dept.

1.5 Logic and assumptions

The theory of change provided in the IPPF PPA Business Case is limited, and therefore, the review included a theory of change workshop in the Central Office (CO) in London at the beginning of the review process. This was then discussed with IPPF and selected MAs. The draft theory of change resulting from that discussion is presented here with key assumptions highlighted.

The premise of the theory of change is that a range of activities need to be undertaken simultaneously for change to take place with regard to SRH. Figure 1 provides a very broad framework describing the institutional and methodological background to the IPPF approach. The overall theory is that service delivery, the social and cultural enabling environment and the legal and political enabling environment need to be addressed in a coordinated and mutually reinforcing way in order to produce results.

There are a number of assumptions that can be unpacked along the “value chain” of IPPF’s work and this is illustrated on page 10 with a country level example. The whole organisation TOC includes the following assumptions:

Output to outcome level assumptions (“initiatives” to “outcome” in Figure 1 below)

(i) *Legal and policy changes in favour of SRHR will enable better and more accessible SRH services and peoples’ sexual and reproductive rights will be protected by the state and relevant institutions.* This assumption is based on the premise that the state will respond to and implement laws and policies that are produced. IPPF and other organisations do support implementation of public sector policies and laws by developing protocols and guidelines for implementation. They also provide relevant services within their own organisation – and by training public sector providers. The unknown in terms of evidence is whether this kind of action is enough and what kind of state response is required. It is also important to understand better the length of time needed for legal and policy changes to be translated into health results – and under what conditions results are more speedily apparent. The change in Mexico City abortion law for example, change very quickly had an impact on the delivery of services, with numbers and quality of safe abortion and family planning services rising rapidly. In contrast there are examples where a favourable abortion law has been in place for some time - such as in- Zambia and still the country experiences high levels of unsafe abortion due to health system deficiencies, stigma and lack of information about legal entitlement and rights. A recent Ipas study (2012) has demonstrated that cases of unsafe abortion decline significantly when health care facilities are equipped and stocked, health personnel are trained to provide safe, legal abortion care, and women are informed of their legal abortion options.⁹⁾

(ii) *The provision of quality SRHR services, which include counselling and youth differentiated services ensuring attention to special groups and providing access to poor and vulnerable groups will result in utilisation of the SRH services by a range of different groups, especially women and girls.* This will impact on a number of SRH utilisation indicators such as CYPs, CPR, facility based delivery, skilled birth attendance, HIV services including VCT, HPV and other

⁹ Ipas Website: <http://www.ipas.org/en/News/2012/June/New-research-from-Zambia-identifies-promising-strategies-to-reduce-unsafe-abortion.aspx>

vaccination rates. As this assumption is directly related to the delivery of IPPF services, they can more easily establish evidence that the assumption holds.

(iii) *Women's empowerment, youth leadership training, community based support; and information and education programmes will impact on the social and cultural enabling environment and improve access to SRHR information, health seeking behaviour and utilisation of SRH services.* This assumption is also central to a significant number of the IPPF activities, but less easy to prove that it holds.

(iv) *Empowered and better skilled women, young people and special interest groups (such as people living with HIV and AIDS) will demand their sexual and reproductive rights and influence government to develop better policies and deliver better health services.* This will contribute to accountability within the health system. This part of IPPF's work is in its infancy, but there is already some evidence to show that the assumption holds.

(v) A more efficient organisation will impact on VfM and enables better access to health services for poor, marginalised and underserved people.

Figure 1. IPPF Theory of Change

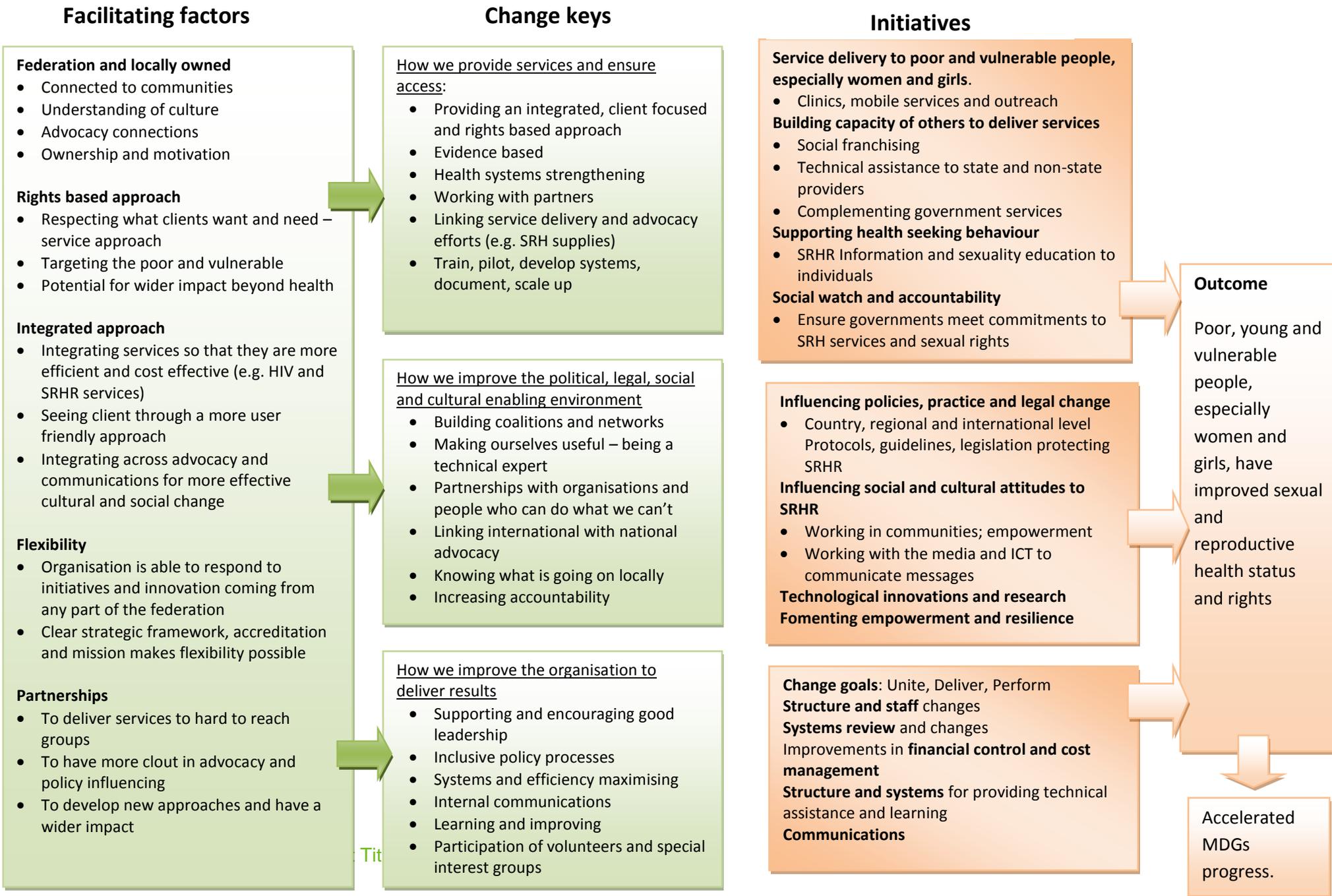
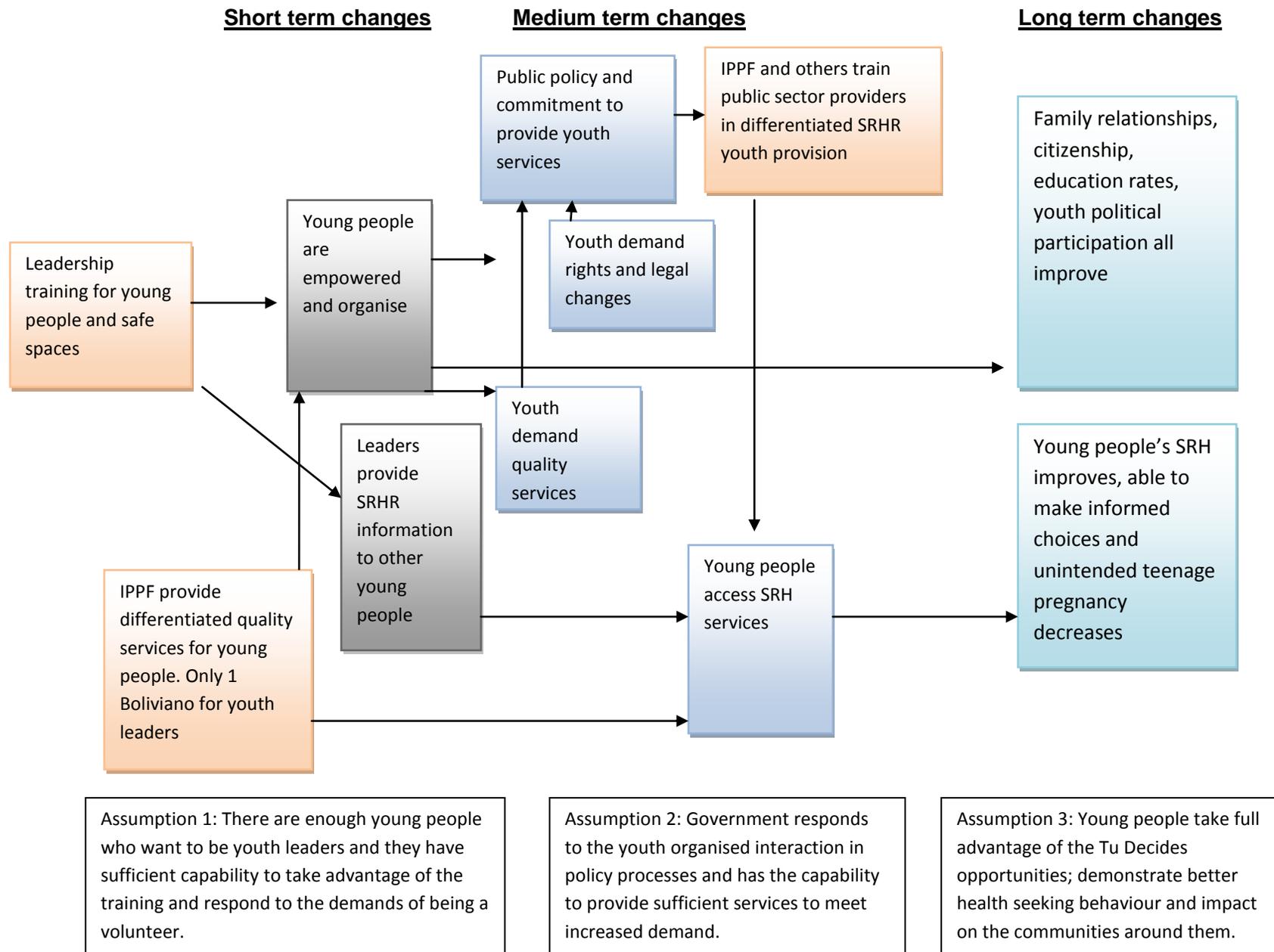


Figure 2. CIES Bolivia "Tu Decides" youth programme Theory of Change



1.6 Overview of PPA funded activities

The **PPA logframe** establishes the framework for the activities funded under this PPA.

Impact: Support the achievement of the Millennium Development Goals, especially MDG3, MDG5 and MDG6.

Outcome: To improve the health status of poor and young people, in particular women and girls, through an enabling sexual and reproductive health policy environment and access to a range of cost effective, high impact health services.

Output 1: Service delivery: Increase in access to and use of a package of essential services, centred around family planning through IPPF Member Associations (MAs), increasing knowledge, access and choice that will improve the health of women and girls, particularly poor and young people.

Output 2: Enabling environment: Engaging and influencing policy mechanisms for SRH and choice at global, regional and national levels. Specifically contributing to 1. Access to family planning/SRH, 2. Initiatives that reduce recourse to unsafe abortion, 3. Comprehensive sexuality education and child protection, 4. Integrated HIV/AIDS and SRH, including stigma reduction, 5. National budget allocations for SRH.

Output 3: Institutional strengthening: Strengthen the economy, efficiency and effectiveness of IPPF's network.

Since 2009 DFID has disbursed £10,750,000 to IPPF, just under half of the total three year commitment (expenditure is not necessarily in line with this figure).

Table 1. Types of initiatives that are funded by the PPA

Type of activity	Central Office	Regional Office	MA
Service delivery	Standards and guidelines, 5As strategy and guidance	ROs provide technical assistance for service delivery, especially for enabling the access of poor, vulnerable and hard to reach groups South-south sharing	Varying levels of PPA support will enable provision of a standard package of SRH services by MAs
Enabling environment	International advocacy	Regional advocacy and technical assistance to MAs South-south sharing	Country advocacy and communications, behaviour change
Innovation Fund projects	Organisation and allocation of funds Technical leadership Sharing of lessons	Technical assistance to MAs Monitoring and evaluation	Implementation of Innovation Fund projects for service delivery or enabling environment
Institutional strengthening	Internal reviews of processes and systems, leadership strengthening, change process, development of tools for the MAs (e.g. costing methodology, M&E)	Regional sharing of organisational development issues and technical support	Organisational and technical improvements (such as MIS system)

Activities funded by the PPA can be at CO, RO or MA level. The PPA funds are disbursed along with unrestricted funds provided by other donors to the MAs through the ROs.

Under this PPA, IPPF has given particular priority to improving performance in **45 focus** countries. This group includes 39 of the 49 countries identified by the United Nations Global Strategy for Women’s and Children’s Health (GSWACH), plus an additional six countries (Bolivia, Brazil, Guatemala, India, Peru and Sudan) where IPPF Member Associations are primarily supporting poor and vulnerable groups, and are well - positioned to scale up service delivery over the PPA period:

Table 2. IPPF PPA focus countries

Western Hemisphere Region (WHR) (5) <ul style="list-style-type: none"> • Bolivia • Brazil • Guatemala • Haiti (AM)¹⁰ • Peru 	South Asia Region (SAR) (5) <ul style="list-style-type: none"> • Afghanistan • Bangladesh • India • Nepal • Pakistan 	East and South East Asia and Oceania Region (ESEAOR) (5) <ul style="list-style-type: none"> • Cambodia (AM) • Dem People’s Republic of Korea • Myanmar (non-member) • Solomon Islands (AM) • Vietnam
Arab World Region (AWR) (3) <ul style="list-style-type: none"> • Mauritania • Sudan • Yemen (AM) 	European Network (EN) (1) <ul style="list-style-type: none"> • Kyrgyz Republic (Kyrgyzstan) 	
Africa Region (AR) (26) <ul style="list-style-type: none"> • Benin • Burkina Faso • Burundi • Central Africa Republic • Chad • Democratic Republic of Congo (DRC) (AM) • Cote D’Ivoire • Ethiopia 	Africa Region continued <ul style="list-style-type: none"> • Ghana • Guinea • Guinea Bissau • Kenya • Liberia • Madagascar • Mali • Malawi (AM) • Mozambique 	Africa Region continued. <ul style="list-style-type: none"> • Niger • Nigeria • Rwanda • Senegal • Sierra Leone • Tanzania • Togo • Uganda • Zambia

1.7 Relationship of DFID PPA funded activities to other IPPF programme activities

As the PPA funding is unrestricted, it is utilised as part of the overall unrestricted funds that IPPF receives from other donors. DFID PPA funds account for approximately 20% of all unrestricted funds. The IPPF contribution to MA overall budgets varies by MA and can be as low as 8% (Bolivia) or as high as 78% (Democratic Republic of Congo). This tends to depend on the level of funding that the MA is receiving locally from other donors, their level of internally generated funds and the size of the MA. Low income countries are also likely to receive a higher

¹⁰ Associate Member (AM)

proportion of their funding from IPPF. 60% of the unrestricted funding is channelled to the MAs. A further 37% goes to the Secretariat (CO and ROs) and 3% is spent on governance.

2. Evaluation methodology

Because the PPA is unrestricted this review presents an overall institutional assessment, testing of theory of change assumptions and verifying stories and data.

The review is comprised of 7 elements:

- Desk study of IPPF documents, data and MA annual reports – May/June 2012
- Web survey of the 45 MAs – June 2012
- Central Office theory of change workshop – 23 May 2012
- Central Office interviews – May/June/July 2012
- Regional Office interviews – June/July 2012
- Three country case studies – Bolivia, Ethiopia and Pakistan – June/July 2012
- Analysis, report writing and final presentation – Aug/Sept/Oct 2012

The use of this range of methods is intended to enable the triangulation of data collected at each level of the organisation. This has allowed us to understand overall picture of how functional the organisation is.

2.1 Evaluation plan

Table 3. Evaluation planning against criteria

Evaluation criteria	Target group and methodology	Analysis and presentation of results
Verifying the PPA theory of change	1. IPPF CO Workshop 2. MA senior staff, close government contacts, other stakeholders Interviews.	Workshop agreements presented after the workshop.
Relevance	1. Desk review of relevant documentation, including government health strategies, relevant donor documents and IPPF project documentation. 2. Country interviews with IPPF partners, government and service users. 3. IPPF CO and RO interviews 4. MA survey	Strands on relevance are identified across all of the desk reviews and interviews. Evidence is presented in both the country case studies and the synthesis document.
Efficiency & value for money	1. IPPF CO interviews and focus groups 2. Country Case studies (MA staff interviews, clinic staff interviews, clinic observation and data collection, financial management assessment, VfM analysis in two case study countries)	Efficiency is analysed across a range of institutional areas: leadership and management, human resource management, financial management, systems and processes, supplies and equipment inventory management and procurement. Value for money data is presented separately in terms of cost effectiveness of the interventions in comparison to international benchmarks and unit costs.

Effectiveness results and impact	<ol style="list-style-type: none"> 1. Desk review and collection of latest reported data from logframe indicators and other IPPF indicators. 2. All MAs in PPA focus countries (web survey). MA head office staff and one clinic manager who is linked to outreach services 3. Country case studies: partner advocacy CSOs, Ministries of Health, MA HQ staff, service users, young people with no access to services (where relevant) <p>Methodology includes semi-structured interviews and focus groups.</p>	<ol style="list-style-type: none"> 1. Presentation of indicator results in logframe format, calculation of change incremental, charts where relevant. 2. Focus group qualitative findings are presented within the country reports. 3. Overall themes of effectiveness are pulled out of all country and CO work and presented in the synthesis document.
Learning and innovation	<ol style="list-style-type: none"> 1. IPPF CO focus groups and interviews 2. Country Case studies (MA staff interviews, Government and partner interviews) 3. MA survey 	Key learning areas are collated and presented in the synthesis report
Sustainability	<ol style="list-style-type: none"> 1. IPPF CO focus groups and interviews 2. Country Case studies (MA staff interviews, Government and partner interviews) 3. MA survey 	A section on sustainability appears in each country document and for the synthesis report.

2.1.1 Evaluation questions

A full set of questions are provided in Annex K. The main review questions are:

1. Is IPPF implementing its overall work with good value for money in terms of economy, efficiency and effectiveness?
2. Is the IPPF SRHR work relevant to global, regional and national situations?
3. What are the institutional strengths and weaknesses in terms of value for money (economy, efficiency and effectiveness); and organisational culture and systems for learning? Which areas do the IPPF Secretariat and MAs need to strengthen?
4. What evidence is there that the theory of change assumptions are correct?
5. Would IPPF MAs and the IPPF Secretariat survive without DFID's PPA funding? What would be lost?

2.1.2 Evaluation design (and rationale for design)

The evaluation was designed to be undertaken in stages and for each stage to inform the next. The initial theory of change workshop and CO interviews fed into the design of tools for the interviews and focus group discussions for the country visits and RO interviews. The survey questionnaire was designed after undertaking the MA Annual Report review and the RO interviews in order to address gaps in information and to triangulate with RO data. The MA visits were designed to address the evaluation questions overall, but also to further explore any issues that had come up in the theory of change workshop, the CO interviews and FGDs and the desk research.

All stages of the review were discussed and monitored with the IPPF review team. Meetings and phone calls took place on a regular basis and adjustments were discussed and agreed with the IPPF team. The IPPF team also provided input into all of the tools developed, the theory of change workshop draft report and the country case study draft reports.

2.1.3 Research methodology (data collection strategy)

1. **Detailed document review:** This included detailed analysis of IPPF global and regional policies, strategies and approaches relating to delivering services, advocacy, and strengthening networks, as well as analysis of alignment with international standards and good practices. Documentation on unit costs, and other financial information was reviewed as part of the value for money assessment.

2. **Semi-structured interviews with key IPPF staff:** On the basis of an interview guide, the team interviewed key IPPF staff at CO and regional level to get initial views on IPPF's policies, strategies and approaches, where and how these are effective, the opportunities and challenges etc.

3. **CO focus groups** to assess cultural aspects of PPA implementation and management for the evaluation. Three small group discussions were organised during the pre-visit stage in the IPPF Central Office. Two of the groups were with "A" teams and the other was a mixed group from a range of Central Office departments.

4. **Three country case studies.** The MAs to be visited for the country case studies were chosen by IPPF in collaboration with the consultants to cover the three main regions: Africa, South Asia and Latin America. IPPF aimed to ensure that larger MAs with substantial and varied programmes would be part of the country studies. They also wanted to cover MAs that are implementing IPPF initiatives aimed at advancing value for money methodology and assessing how vulnerable groups are being reached.

5. A **web-based survey** of MA staff was undertaken. The survey was sent to all 45 MAs and there was a response rate of about 50%. The survey placed particular emphasis on gathering MA perspectives about the IPPF federation and the quality of RO and CO input.

6. **Country visits** took place over one week and consisted of:

- Semi-structured interviews with MA management and staff, including clinic staff;
- A Financial Management Assessment (Pakistan and Bolivia only);
- Clinic observation and interviews
- Interviews with government representatives;
- Interviews with civil society partners, non-partners and related organisations;
- Focus groups with service users and non-service users

The interviews and focus groups aimed to include people from excluded and underserved groups, including young people.

7. **Clinic based value for money and unit cost measurement survey** in Bolivia and Pakistan only.

This included assessment of cost per CYP, cost per DALY and unit cost analysis for the country programmes and selected clinics. The clinic based unit cost methodology for Pakistan was as follows:

- Ensure there is a bookkeeping system that keeps an accurate record of expenditure which can be easily tracked to the activities.
- Establish a full inventory of costs incurred in the clinic – including direct (variable and fixed costs) and indirect costs.
- Select an appropriate unit of measurement (e.g. cost per ANC, cost per IUD insertion)
- Determine the basis for apportioning the indirect costs to services. This involved selecting appropriate costs drivers/basis for apportionment. In the case of IPPF clinics this will include salaries for doctors and other health staff and the workload (e.g. number of patients and number of visits). Indirect costs would include administration, depreciation, etc.
- Calculation of the hourly rate of the full cost of employing staff (including admin and cleaning staff and casual labour).
- Undertake a facility-based survey of tasks and organisational practice in relation to a specific range of services related to family planning.
- Undertake a survey of outreach and clinic based services.
- Calculate the unit cost of providing each service including direct and apportioned indirect costs.

CYPs were calculated using the USAID agreed CYP conversion factors. Cost per CYP for Pakistan and Bolivia MAs were calculated by building up a total family planning expenditure estimate using unit costs and service figures by method – and then dividing by total number of CYPs. DALYs and other outcome indicators were calculated by using the MSI Impact2 Estimator. The IPR team decided to use Impact2 as this is the tool that DFID have been using recently and it was thought that it would be more comparable with other PPA IPRs in the same sector. It is also useful for IPPF to compare the methodology with their own.

2.1.4 Analytical framework

The analytical framework follows the main evaluation questions shown above in point 2.1.1 and in particular tests the assumptions in the theory of change.

2.1.5 Approach to quality assurance of research.

Quality assurance has been maintained by ensuring regular communications between the IPPF and review teams, and between the team leader and the other consultants involved. Team workshops have been used to plan the country visits and undertake the analysis for the final report. The team leader has reviewed all products throughout the process before delivery to IPPF. Each of the country reports were reviewed by the relevant MA, who were able to correct any factual errors. Three rounds of comments were received for the main IPR report with factual and quality comments addressed.

2.2 Research problems encountered

The following drawbacks were encountered when undertaking the research:

- Interviews with IPPF MA non service-users were set up through the MA in two of the countries. This meant that it was difficult to reach people who had no contact at all with

the MA, however useful interviews were possible in some cases. The other country visit engaged a local CSO to organise these FGDs and were able to collect some useful data with non-users.

- More time in the country visits would have allowed the review team to get a better understanding of the services provided in remote regions to some of the most underserved. However this would have required a higher budget than was available.
- The timing of the 45 MA survey also had to be changed due to another internal IPPF survey that was due to go out at the same time. This meant that the survey data could not be used for the country studies. However this did not ultimately prove to be a significant problem.

2.3 Strengths and weaknesses of the selected evaluation design and research methods in retrospect

Strengths: the IPR had a long lead period and sufficient time to develop the methodology and to stagger inputs so that they could reinforce and inform each stage as planned. The interview and FGD tools were used successfully and data was collected efficiently. The theory of change workshop worked particularly well to establish a framework for analysis and identify assumptions. The combination of CO, RO and MA interviews and the survey has produced very useful data and cross referencing. The unit cost methodology worked well and was successfully adapted for the different contexts of the two relevant study countries. The Financial Management tool was also effectively used in both Bolivia and Pakistan and provided useful results.

Weaknesses: At the country level, the review team had intended to undertake an analysis of the barriers to reaching IPPF MA services in the countries by undertaking focus groups with non-service users. The aim of this was to develop a better understanding of the demand side barriers to accessing SRHR. In retrospect this methodology was not entirely effective for all groups – particularly street children.

Another limitation was the lack of a thorough assessment of the global advocacy work. Although interviews with the Advocacy Team in the CO were undertaken, there were no interviews with international partners (such as other international NGOs) or advocacy targets (such as the AU or the UN). However an assessment of this type has been recently undertaken as part of another evaluation.

3. Findings

The findings described in this section will focus on evidence collected from the CO and RO interviews and FGDs, the MA country studies and the MA survey. This section will not repeat information from the IPPF PPA 2011 Annual Review.

3.1 Results

3.1.1 Performance assessment against logframe

The IPPF PPA 2011 Annual Review provides a good analysis of the reported data for 2011 for the indicators in the logframe (a summary of this data is provided in Annex L). This section of the IPR provides an evaluation of the suitability of the logframe (summarised in section 1.6), the quality of the data reported in the Annual Review, and some examples of anomalies in results.

Suitability of logframe

There are no recommendations to change the logframe outputs and indicators. The three outputs are linked to the IPPF change goals: Deliver, Unite, Perform and so provide a good framework to support the current IPPF change process. The Outputs also collectively encompass the current Strategic Framework of the 5As (Abortion, HIV, Adolescents, Access and Advocacy). Output One indicators cover SRH service delivery overall and to young people; HIV services; safe abortion services; and access indicators (% of poor and vulnerable clients). This accounts for four of the five A's and the fifth A is covered by Output Two. Output One also has an indicator providing information on the number of MAs that are providing an integrated package of essential services. This provides the organisation with information on a key effectiveness indicator that supports IPPF's holistic and integrated approach to SRH. MAs are being encouraged to cover an essential package of care with their services and by the end of this PPA period 100% of the PPA MAs should be providing the essential package of care.

Output Three has three value for money (VfM) indicators. One of these measures cost effectiveness in the form of cost per CYP and cost per unintended pregnancy averted. The other two indicators measure the progress of two key institutional initiatives that should enable better management of efficiency and an improved VfM culture – performance based funding (PBF) and the use of standardised activity cost data. IPPF's initiative to introduce performance based financing to its MAs has already demonstrated that MAs are focusing more on metrics and are improving their data. In fact the PBF initiative is driving the improvement in data quality as all

MAs will be required to join the scheme over the next year. The ROs are supporting MAs to improve data collection and data quality. Progress against this indicator will depend on how rapidly MAs can improve monitoring systems.

Quality of data sources

All of the indicators in Outputs One and Two are tracked in the Global Indicators and MA service statistics, which are reported to the IPPF Secretariat through the eIMS (electronic Integrated Management System). The IPR country studies provided evidence verifying results reported in the logframe – data that had

Box 1. Global Indicators

The Global Indicator survey is an annual survey of IPPF's MAs. It consists of a qualitative questionnaire with 58 questions about the MAs' activities and programmes. The questionnaire is closely connected to the strategic and technical objectives of the 5As and is a way of testing how closely the MAs are applying corporate methodologies and good practice. It also provides an important database of information about the Federation's activities. The data collected is verified through regular visits by the Regional offices.

mostly been reported through internal IPPF systems. In particular information from country partners and government verified the impressive level of advocacy work that was being undertaken in the three countries. There was also good firsthand experience, in the country studies, of the clinical and linked services provided to reduce recourse to unsafe abortion, increase access to SRH services for young people and the poorest and most vulnerable groups.

Because IPPF is a federation of independent, locally owned organisations, a range of different paper-based and electronic clinic management information systems are used by the MAs which do not always match up directly with the eIMS classifications. As a result, each MA has to map from their own set of service categories onto the IPPF defined ones. This makes it difficult to verify data without re-calculating from locally sourced data. This also has implications for the quality of reported data as MAs may have to input data in the eIMS system differently to the way that they are recording it. Several interviewees in the Secretariat voiced concerns about the variable quality of service data. The IPPF Regional Offices (ROs) are supporting MAs to improve data collection and verification. As mentioned above the PBF process is also providing a pull to improve data quality.

The percentage of poor and vulnerable clients is an important indicator for this PPA and this is a challenging indicator to measure. IPPF has developed a good methodology known as the Vulnerability Assessment. This is an MA implemented random survey of clients, which includes questions about their status in terms of poverty, vulnerability and whether they are underserved. The methodology is adapted to the country situation and local definitions of poverty and vulnerability. CIES in Bolivia was one of the first MAs to use their methodology and has a particularly advanced survey execution and data analysis methodology (see Box 2).

Box 2. Vulnerability Assessment Survey

CIES has been using the IPPF Vulnerability Assessment methodology for the last two years. It has been adapted to the local context by using local poverty classifications. The National Health Survey (ENSA) questions have been used for the questionnaire. The Assessment has also been developed into a computerised system that randomly selects service users for a vulnerability interview over the whole year. Each clinic (or site) interviews up to 100 people every year. The data is collected by the health educator/counsellor and is directly input into the computer programme. This means that the head office can extract real time data at any point in the year. However, the full sample is only available at the end of the year. Verification of data is done when CIES undertakes routine QA visits.

The following classifications are used:

- Poor - People living on less than US\$2 a day.
- Marginalised and socially excluded – People who do not have access to health, education or employment opportunities for reasons of poverty, physical distance, language, religion, education, employment, migration, or other disadvantage.
- Underserved – People who are not normally served by SRHR services or programmes

In 2010, 56% of CIES's clients were categorised by this survey as poor, excluded or underserved. The 2011 data showed that this had risen to 72% due to measures taken by the clinics and organisation to better target vulnerable groups. CIES uses the data to monitor clinics' performance and to improve strategies for reaching poor and vulnerable groups.

Though IPPF is rolling this methodology out to all MAs, the survey is not yet used widely. For example FGAE in Ethiopia and R-FPAP in Pakistan were both using non-survey methodology to estimate their percentage of poor and vulnerable clients. ROs reported that MAs who are not using the Vulnerability Assessment methodology are estimating the percentage of clients who are poor, marginalised, socially excluded or underserved¹¹ using the following assumptions:

- all clients entering through outreach services are considered underserved; and
- all clients of special projects are considered marginalised or socially excluded.

Reporting against this indicator is therefore variable. It may be useful to report two figures: those MAs that are using the Vulnerability Assessment methodology and those that are not. This would provide more accurate data, as well as an idea of progress in rolling out the tool.

The third Output Three indicator is cost per CYP and cost per unintended pregnancy averted. The source of information for reporting on the global logframe is not reliable. The figure is calculated by the Central Office using family planning (FP) service data, which is reliable, and MA level expenditure data, which does not have enough detail to extract FP expenditure data accurately. Expenditure is reported to IPPF by the 5As. As family planning can cut across the As, it is almost impossible to extract the data needed to accurately count actual spend on family planning services. The calculations are also only done for a sample of 20 MAs, and not all. As there is no universal unit cost methodology used by MAs it is virtually impossible to undertake accurate cost/CYP calculations. The IPR undertook a costing analysis and the differences presented below (Table 4) serve to highlight the limitations of this approach. It would be useful to present the data alongside the global cost/CYP data in future and to add any MAs who have developed and used the methodology to calculate local cost/CYP figures:

Table 4. Cost per CYP for country studies

Country study	Cost/CYP from IPR study	Cost/CYP reported in logframe
Bolivia	£4.90	£24.80
Pakistan	£3.19	£2.00

What the numbers don't tell you.

At both country office and CO levels, various IPPF interviewees emphasised the importance of results that were not reflected by CYPs or other service utilisation statistics. For example, the work with young people on sex education, or awareness raising, does not necessarily result in increased utilisation of services and may even result in a decrease. However this kind of work clearly has an important impact on attitudes and health seeking behaviour as seen in the country study interviews and focus groups. Work with government on health systems is also unreported and potentially has a wider impact on access than just the MA services alone.

A quick look at the service figures that are reported against the logframe (provided by the IPPF CO) shows that there are some trends that don't follow the overall upward trend in service delivery. The conditions in some countries or work with government can impact on service

¹¹ This is one of the PPA logframe indicators.

statistics negatively for reasons related to the particular country context and not necessarily through poor performance of the MA. This has happened in both Ethiopia and Brazil.

Ethiopia: While the number of SRH services increased from 1.7 million in 2009 to 2.8 million in 2010, CYPs decreased from 228,000 to 105,000 in the same period. There was also a drop in the percentage of poor and vulnerable clients from 90% to 70%. During this period FGAE had to hand over much of its volunteer community-based work (which delivered high levels of short-term contraception to mostly low income communities) to government due to the expansion of its Health Extension Worker programme. Interestingly, the overall SRH service numbers increased, which shows that there was an impressive increase in facility based care.

Brazil: Between 2009 and 2011, Brazil's figures for the number of SRH services provided and the number of SRH services provided to young people fell significantly, although important increases were made in the provision of comprehensive abortion services. CYPs fell from 714,883 in 2009 to 355,968 in 2011. The CO noticed this drop in services during the data cleaning process and followed up with BEMFAM, the Brazilian MA. Evidently, condom price increases within Brazil and a problem with BEMFAM's main condom supplier had affected BEMFAM's ability to provide low cost FP services. Also in 2011, BEMFAM suspended contracts with a number of associated clinics in the city of Natal, leading to reductions in some service categories. Figures are expected to recover in 2012 as BEMFAM signs up with better value suppliers.

Assessment of IPPF's progress in addressing DFID's feedback

DFID did not outline any specific action points for institutional or programme changes in the feedback to the Annual Review report. However there were some requests for further information. IPPF provided a good response and sufficient information for most of the points. There were three areas that could do with further development and are related to this IPR.

(i). As mentioned above the cost per CYP calculations for reporting against the logframe are estimated using estimated expenditure data for MA family planning. The explanation given to DFID in answer to their questions about CYPs may need to be updated in the light of the IPR findings.

(ii) No specific information on the amount of money that has been leveraged by the PPA has been provided in the response to DFID. It is understandable that it is difficult to identify whether the PPA has been directly responsible for the actions of particular donors as crowding tends to take place. However some analysis of donor funding could be undertaken.

(iii) DFID asks for more information about monitoring and evaluation – and particularly monitoring. IPPF has provided a few examples of monitoring tools and how information is used for management, which are relevant to MAs' specific requirements right now (e.g. the vulnerability assessments). It is to IPPF's credit that they are designing monitoring tools for specific purposes and to support management decision making– and not just to satisfy donor reporting requirements. This should be brought out more explicitly. IPPF should also mention the 2009 M&E handbook and how it is used.

3.1.2 Intended and unintended effects on poor and marginalised groups and civil society

How and why initiatives led to changes in people's lives – Service Delivery

An increase in service provision in the 45 PPA countries (63 million SRH services in 2011), and an increase in the percentage of poor and vulnerable clients (78% in 2010 to 80% in 2011), means that more poor and vulnerable people are accessing SRH services. This has a demonstrated impact on fertility rates, maternal health and reduction in mortality and morbidity from unsafe abortion. Just under 42% of SRH services were provided to young people, with many of these being young women. In Bolivia 85% of young people using the services were women or girls.

Evidence was collected on the impact of initiatives on people's lives through the survey, the RO interviews and the MA studies. There was evidence of changes in people's lives in terms of their access to services and how this has enabled them to have a better control of their SRHR. This was particularly notable for young people.

The increase in utilisation by the poor, vulnerable and underserved and the reported impact on people's lives is largely due to the following service delivery approaches:

(i) Clinic and mobile service locations

The mobile clinics and location of clinics in low income or inaccessible areas was enabling hard to reach populations to use the services. Mobile units were reaching areas where there are no other services available.

(ii) Accessible and differentiated pricing

Young people in Bolivia stated that the differentiated pricing enabled them to use the services and had increased the chances of them continuing a relationship with the CIES clinics. Differentiated pricing is possible due to cross-subsidising of services. Whilst this could be developed further there was good evidence in the country studies that cross subsidisation is a successful strategy for ensuring accessible prices for different groups.

(iii) Good quality of services based on a client centred and rights based approach.

In Bolivia, Pakistan and Ethiopia, clients and other stakeholders consistently referred to the good quality services as a reason for using the MA clinics or mobile services. Young people in particular referred to the ability of service providers to treat them appropriately and with respect for their decision making and rights.

Good quality services not only improve service access and utilisation, they also increase effectiveness and impact. For example, service quality has an impact on uptake and continuation of contraception, effectiveness of MVA use for post-abortion care to minimise complications and effective HIV testing and referral. The country studies revealed that counselling and orientation was an important part of service quality and effectiveness and also had an impact on access.

(iv) Linked and complementary services and targeting particularly vulnerable groups.

Respondents to the MA survey listed a range of initiatives/programmes that are making an impact on people's health and other aspects of their lives, including encouraging pregnant women to attend routine antenatal check-ups (Nepal), providing reproductive health (RH) information to young people and preventing early marriage (Afghanistan), projects targeted at prison inmates (Nigeria), and working with minorities and hearing impaired patients (Mozambique) (see Box 3 for examples).

Box 3. Examples of how IPPF programmes are making an impact on vulnerable people's lives

"FPAB implemented a project 'Combat Violence Against Women during pregnancy time among the vulnerable women' in Khulna district - one of FPAB's working area. The findings of the end-line evaluation showed that a significant number of women (98%) received pre-natal care and 80% of deliveries were attended by skilled persons. (Bangladesh)

"Implementing a model of vaccination for girls from 9 to 13 against HPV, which causes cervical cancer which is now in the government's plan for mass implementation in the country." (Bolivia)

"The Community Based Distribution (DBC) programme allowed women in local villages to access contraceptives so as to space out the frequency of childbirth." (Niger)

(v) Partnerships with public and private sector links and changes in the health system.

Specific examples of this were provided from both the Africa and South Asia Regions. The South Asia Regional Office reported how, in Sri Lanka, a partnership between the MA and the Plantation Board had increased the reach of services to plantation workers in their workplace. In India, establishment of small rural based satellite clinics connected to a larger Reproductive Health and Family Planning Centre not only increased access to services, but also facilitated task shifting between clinics, particularly in the areas of family planning and medical abortion, and promoted a better continuum of care and client follow up. The Africa Regional Office (ARO) also reported that the formation of partnerships between the MA and public and private sector organisations had been key in increasing the MA's service utilisation rates in Burkina Faso. ARO also felt that partnerships helped increase influence at a policy level. The Pakistan country case study it found that about 50% of the reported CYPs were being achieved through partnerships with private providers.

A wider, and often unquantified impact was found in all three of the IPR country studies, in terms of MA interaction with government. In all three countries the MAs were active in building the clinical and educational capacity of government providers. This includes developing capacity on, and developing protocols for addressing violence against women, HPV vaccination, comprehensive sexuality education and youth services. Often, this work is taking place as a result of successful advocacy efforts by the MA and their partners, but it is closely related to perceptions of the MA as a "technical expert" with experience of delivering high quality services. Government in Bolivia were particularly drawing on the expertise of CIES to develop their own services, while CIES maintained its relationship with government by "being useful" and responding efficiently to a number of requests from the Ministry of Health and the Ministry of Education.

How and why interventions led to changes - Enabling Environment

IPPF MAs work on the legal and political enabling environment in order to bring about change that will protect and enhance SRHR and enable better access to services. All MAs apart from Afghanistan conduct some kind of SRHR advocacy activities that were aiming to impact on wider access to services. The most common reported advocacy objective is to increase budget allocation to SRH services (e.g. in Bangladesh, Benin, Nepal Senegal and Uganda), family planning in particular, or to increase access to SRH services more broadly (Brazil, Burkina Faso, Burundi, Democratic Republic of Congo, Ghana, Nigeria, Tanzania and Togo). The particular focus for this can be quite varied, for example, in the DRC, the MA is seeking to abolish article 178 of the Penal Code, which prevents the distribution and sale of contraceptives. Campaigns to liberalise abortion laws are also being pursued in a number of countries (e.g. Kyrgyzstan, Mozambique, Rwanda, Sierra Leone and Zambia). Advocacy to improve women's rights through the elimination of female genital circumcision and forced marriages is also underway in several countries, including Mali, Mauritania and Pakistan. In 2011, R-FPAP reported particular successes in this area, in terms of its work through networks which led to National Assembly Bill forbidding customs such as forced marriages and *swara*¹².

A focus on rights and specific demand-side barriers to service access has also improved service utilisation and had a wider impact. The three country study MAs are implementing various programmes to improve gender equality, increase women and young people's empowerment, tackle violence against women and girls, and address the issues of street children. Overall, there was evidence that service utilisation had increased and that there were wider impacts on the target groups. In Ethiopia FGAE counselling has empowered women to discuss SRH issues more openly with family and friends. Women reported being more able to discuss family planning, abortion and other SRH issues with their husbands and having greater control over their reproductive lives as a result of FGAE initiatives. R-FPAP's work with peer educators has created advocates for SRH in a challenging environment. Peer educators interviewed reported how their own attitudes towards people, especially women seeking family planning services had changed as a result of their engagement with R-FPAP. They are now impressive communicators on SRHR issues, demonstrating a strong empathy and understanding of the issues faced by young people.

Unintended Impacts

The IPR team observed positive unintended impacts on stigma, self-esteem and the wider cultural enabling environment for SRH.

FGAE's approach to service provision in Ethiopia, which de-stigmatises certain behaviours and health status, enables increased uptake of services by vulnerable groups. Commercial Sex Workers, for example, felt that services specially designated for them combined with non-judgmental staff helped to de-stigmatise their behaviours, enabling them to feel comfortable seeking services.

¹² The practice, particularly prevalent in north-western Pakistan, of providing young girls as compensation for a crime.

An unintended impact was also observed in the Bolivia study in the “Tu Decides” (You Decide) youth leadership programme. Young people interviewed reported having better and more open family relationships.

Wider impact on civil society’s accountability role

There was some evidence from the country case studies and from the MA survey, that IPPF MA activities were supporting young people and women to hold governments to account and demand SRH services and rights. Some of this work is in the initial stages, but capacity and networks are emerging.

Women and young people in Bolivia trained by CIES reported being involved in discussions with local health providers and local government about the quality and provision of health services. Some were also involved in legislative and policy making processes. Wider networks of young people were also influenced by the Tu Decides leaders and this was strengthening the whole youth movement. Several of the youth leaders interviewed related how they had transformed from shy and quiet people into confident leaders and some even said that they would like to become politicians as a result of their experience and learning at CIES. In addition CIES was playing a leadership role in the main SRH CSO network (PROCOSI) and were widely acclaimed by other CSOs in interviews as technical and political leaders on SRHR.

In Bangladesh, a youth parliament has been set up (with the support of unrestricted funds) which aims to ensure the SRHR of young people by protecting their rights of access to comprehensive sexuality education, youth friendly services, gender equity, participation in decision making process and to ensure accountability. Members of the parliament are chosen through a “grass roots level election”. This is an innovative platform for young people to raise their voices freely and to potentially have an impact on government accountability to citizens.

Barriers and enablers to IPPF’s work (See Annex Q for the TOC workshop report)

The theory of change workshop included an analysis of barriers and enabling factors for IPPF’s work on SRHR. Below are the key messages which emerged from the workshop, many of which were also reflected in the country studies and Central Office interviews.

The most frequently reported external barriers to IPPF’s work were the following:

- (i) Religious conservatives campaigning against safe abortion and against family planning.
- (ii) Stigma associated with HIV status, abortion, adolescent sexuality.
- (iii) Discrimination in public sector and other private sector service delivery as a barrier to overall uptake of services among certain groups such as street children, commercial sex workers, adolescents, different ethnic groups and the very poor.
- (iv) Lack of political will of leaders and governments.
- (v) Poor legislation and lack of legal rights – particularly in relation to abortion, adolescent and LGBT access to SRH health services and HIV and AIDS prevention, treatment and care.
- (vi) Social and cultural barriers to SRHR.

Internal barriers, reported by interviewees in the IPR, that affect the success of the MAs initiatives include:

- High staff turnover – often due to lower salaries than most international NGOs or donor-funded programmes and sometimes even lower than public sector pay.
- Transition of leadership – e.g. Ethiopia.
- Inadequate reporting and monitoring systems.
- Poor management capability, particularly for complex financial management.

External enablers reported in the IPR include:

- Government commitment to SRHR and to improvement in equality and women's health (e.g. Ethiopia and Bolivia).
- Recognition from donors that SRHR is an important investment to enable pro-poor and inclusive economic growth.
- Supportive partners and networks.

Internal enablers include:

- Federated structure and locally owned organisations.
- Good quality personnel.
- Some examples of successful learning systems.
- Examples of excellent leaders at clinic, project, MA, RO and CO levels.
- An inclusive governance system that takes into account complexity and enables learning and adaptation.
- Availability of regionally based expertise to support learning and assure quality.

The cascading nature of technical assistance is a particularly important enabling factor. The ROs, for example, make an important contribution to improving service quality and facilitating service expansion in a number of ways¹³, including:

- Provision of technical assistance to MAs, including through country visits (ESEAOR, EN, ARO). The shift in approach in the Burkina Faso programme, for example, resulted from recommendations made during a Regional Office visit to the country.
- Training service providers (ARO, EN, ESEAOR). For example, ARO reported training service providers on abortion in Uganda, Mozambique, Swaziland and Ethiopia, whilst the EN Office had trained youth volunteers.
- Provision of self-assessment systems to quality assure the MAs' performance, with Regional Offices overseeing these systems (ESEAOR).
- Bridging funding gaps in service provision where necessary (ESEAOR).
- Supporting MA fundraising efforts (AWRO).
- Supporting experience sharing and networking events (EN, AR). For example, the European Network has hosted networking meetings on youth work.

3.2 Relevance

The IPR assesses that the IPPF PPA programme is designed to address major global SRH problems and that the objectives and planned outcomes still remain highly relevant. The choice

¹³ These examples were given by the Regional Offices in interviews and are not exhaustive. The RO source of the information is given in each statement to ensure we can track the information, but there may be other ROs who are also implementing the initiative, but did not mention it in the interview.

of focus countries, the regional emphasis and the country strategies are all responding to an accurate assessment of SRHR realities at all levels.

The Federation is responding to some of the major SRHR issues affecting low income countries. Gender inequality continues to be a major barrier to improvements in SRHR, both at the family and community level and at the policy level. Unsafe abortion and HIV and AIDS continue to contribute to high mortality and morbidity rates of women aged 15 – 49 years. There is an increasing awareness of the prevalence and impact of violence against women on SRHR and women's empowerment in all of the country studies.

3.2.1 Representativeness

Addressing the realities of the SRHR situation

Despite progress in maternal health over the last 20 years – there has been a drop in the global maternal mortality rate (MMR) from 400 in 1990 to 210 in 2010 - there are still many countries where SRH remains a major health concern that impacts on population growth and economic development. Most maternal deaths occur in low-income countries and just six countries account for 50% of the 287,000 annual maternal deaths (India, Pakistan, Ethiopia, DRC, Sudan and Nigeria¹⁴). Sixteen of the 45 IPPF PPA countries account for 63% of global maternal deaths. 222 million women aged 15 – 49 years (26%) in developing countries have unmet need for modern contraception, with over half of those living in South and South East Asia. Sub-Saharan Africa experiences the worst problems with access to services and cultural barriers to SRHR. Fertility rate is still fairly high at 4.8, contraceptive prevalence rates (CPR) are as low as 19% and unmet need for modern methods is 53%¹⁵. Adolescent birth rates are 122 per 1,000 women of 15 – 19 years¹⁶. 4.7% of adults aged 15 to 49 were living with HIV in Africa in 2010¹⁷. Twenty-eight of the IPPF PPA countries are in Africa (though Sudan and Mauritania are part of IPPFs Arab World region).

The three IPR country studies provide examples of how dramatic the SRH problems are and how poor SRHR affects poor groups, youth and other excluded and vulnerable populations. It is also relevant to note that there are different levels of government commitment to SRHR in each country and this impacts on the way the MA can work.

IPPF responds to the global and MA country needs through a programme of service delivery and advocacy that adapts to each country's situation. Whilst IPPF strategy, quality and targeting are rigorously applied by IPPF CO and ROs, there is a great deal of flexibility in designing services and programmes that address the specific needs of the population. The country case studies found that the locally owned MAs have high levels of local contextual knowledge that is applied to the development of programmes. However it was also noted that rigorous context analysis was lacking (see section 3.2.2).

¹⁴ Trends in Maternal Mortality 1990 to 2010. WHO, UNICEF, UNFPA and World Bank Estimates.

¹⁵ Singh and Darroch (2012)

¹⁶ UNFPA (2011)

¹⁷ WHO/UNAIDS website

The IPPF **Regional Offices** explained that relevance of services to target audiences is achieved through:

- Conducting needs assessments often at the start of interventions, or broader situation analyses; and
- Working closely with government to ensure that SRH services are in line with government policy and complement available government services.

The needs assessments might be supported by the RO, for example by conducting data analysis, highlighting relevant reports, providing technical inputs to the needs assessment tools and methodologies, or even providing small amounts of funding for the assessments. In the case of AWRO, situation analyses, including document review and stakeholder analysis are conducted annually. These are led by the RO and undertaken in partnership with MA staff. With current levels of political change in the region, it was reported that this level of frequency was inadequate to remain in touch with the emerging threats and opportunities.

The country study findings were not always consistent with the RO interview findings. In Pakistan, the IPR team were unable to find any evidence of baseline studies undertaken before the establishment of a clinic. Feasibility studies are undertaken consistently but these include limited data (no poverty profile and only national rather than local data) and unclear methodology. Interesting methodology was used however in a social audit exercise carried out in Chakwal. This included focus group discussions and interviews with women, men and adolescent girls and boys about their SRH needs. It also included a village based mapping of health facilities and service providers, a facility survey, provider interviews and client exit interviews. The IPR team expressed concern that none of the R-FPAP interviewees were able to talk about how this kind of data was used.

Alignment with government policies and co-implementation

Many MAs appear to have close working relationships with national governments and use this as a means to align their programmes to supportive government policy and ensure their services are complementary to those provided by government. Examples of this include:

- In Bangladesh, the government has requested the MA to provide family planning services in specific regions of the country.
- In Afghanistan, the MA complements government clinic based services through mobile clinics.
- In India, the MA has worked closely with government to reposition family planning in rural areas.

The three country case studies also provided evidence of a high level of alignment with, and support for, government services. In Bolivia CIES has collaborated with government on HPV vaccines and violence against women protocols and methodology, and has responded to a range of government requests for technical assistance.

In Ethiopia, close working relationships with all levels of government ensures good alignment with government policy, adherence to government standards and helps maximise available resources. This relationship is interactive and symbiotic.

There are cases where MA priorities may diverge from those of the government. This tends to be where the legal or policy space for the provision of certain services or SRHR is limited e.g. for abortion. In these contexts, the MA may focus efforts on extending this space, e.g. WHR on abortion. For these cases the MA maintains a delicate balance of working collaboratively with government while actively advocating for changes in policy.

Box 4. Examples of Member Associations using national health plans or strategy to guide programming - response to MA survey

“We link our activities to Ministry of Health Reproductive Health strategy 2011-2015” (Yemen)

“The National Health Sector Strategic Plan and the Community strategy are extensively used to design programmes” (Kenya)

“We work closely with the line government bodies and we are requested to adapt our programmes to the national framework” (Rwanda)

“The MA has strong relationship with the federal and state Ministries of Health and signed an MOU with them. In each service delivery point of the MA you find the protocols and Guideline of the MOH. The supervision teams regularly visited our service delivery points. In addition the MA representative regularly attends the MOH meeting. Before we write our proposals we contact the MOH and have long discussions and sometimes technical assistance. (Sudan)

All Member Associations who responded to the MA survey use national health plans or wider strategies (for example, youth, population and poverty strategies) to guide their programming. Member Associations said they used national strategies as reference documents when deciding areas of intervention, to inform development partnerships with the government, to provide priority areas of intervention, and to support advocacy activities. Examples of this are provided in Box 4 above.

3.2.2 Targeting

There is evidence that the MAs understand the context they are working in well, and that they use this understanding to inform the design of their programmes. However they are not undertaking particularly rigorous research into evidence of needs.

Overall targeting strategies in the countries is based on:

- Location of clinics and services in low income or remote areas (e.g. location near commercial sex worker (CSW) areas in Ethiopia);
- Mobile units or outreach services (e.g. the mobile units in Pakistan and Bolivia);
- Addressing gaps in SRH service coverage;
- Pricing of services and a no refusal policy. Fees were reported to be significantly lower than other NGO or private providers in all of the country studies. The no refusal policy is a requirement in the accreditation process;
- Service quality;
- Design of services for particular groups (e.g. young people); and
- Community awareness and sensitisation activities.

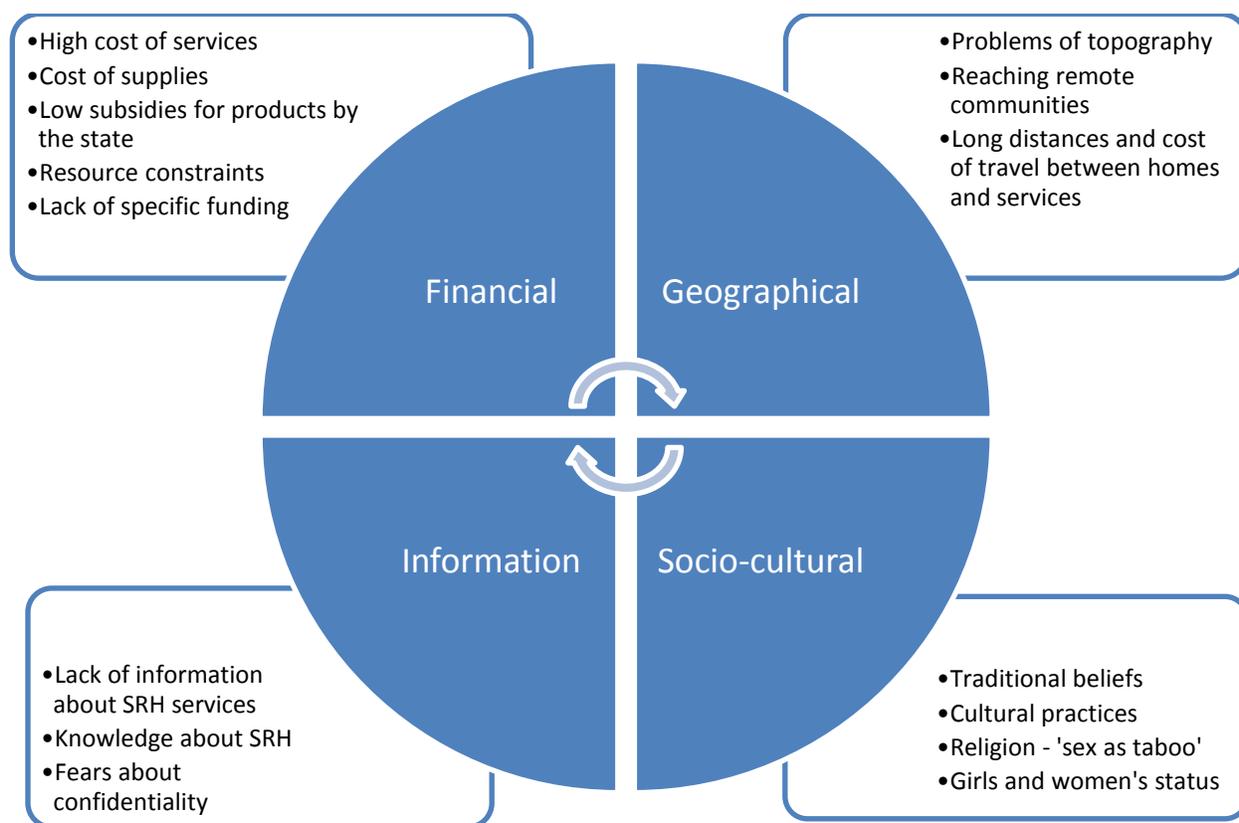
Evidence on all of these target methods was collected by observation and interviews in the three country studies. However it was not possible to verify the quality of the outreach and mobile service due to their remote locations. There was film in Bolivia and documented evidence.

Fees for services were reported to be significantly lower than other NGO or private providers in all of the country studies. A no refusal policy is also in place for all of the MAs interviewed. In Bolivia the “*orientadora*” or counsellor is the first point of contact for clients who cannot pay. She asks them a range of questions about their living conditions and income and then recommends services and/ or refers them to a doctor or other health provider. Young people interviewed in Bolivia were particularly positive about the type and quality of services that they were receiving, saying that they were treated with respect and were given choice. In Bolivia the “Tu Decides” programme is training youth leaders to spread information about SRHR to other young people in communities and schools. This is a very effective way of targeting young people and implementing organised word of mouth communications methods.

In addition to these methods for targeting there are various MA managed projects that target particularly vulnerable groups. For example the ‘Women as Compensation’ project in Pakistan targets women and girls who had been given away in forced marriage as compensation for a crime, a custom prevalent in the Mardan and Swabi districts in north-western Pakistan. This project was financed by the Innovation Fund. The Bolivia MA is also implementing a programme to reach street children in two locations. Targeting is achieved by working with local partners and refuges. However beyond these special projects, there is variable quality of baseline and assessment methodology to understand the situation and needs of very poor and vulnerable groups. In Bolivia baselines were being undertaken for the women’s empowerment project in the most remote and marginalised indigenous communities (See Box 7). However this was not apparent for all of the activities. It was also not always clear to what extent MA staff and management use situation information to effectively target initiatives in Pakistan and Ethiopia.

Analysis of the situation and barriers to access are essential for good targeting of SRH services. When asked about the biggest barriers to delivering SRH services to the poorest and most vulnerable groups, MA respondents identified four key types, which can be categorised as financial, geographical, socio-cultural and information barriers (see Figure 3). In this way, the MA survey confirmed analysis that was presented by the ROs and the CO. Other constraints mentioned less frequently include security issues, availability of trained service providers, lack of committed support and transparency from the state, difficulties identifying LGBT people (as they try to hide their identity), lack of skills to use evidence, and lack of adequate monitoring systems.

Figure 3. Most frequently mentioned barriers by IPPF MAs



3.3 Effectiveness

This section on “Effectiveness” addresses learning, innovation, partnership and sustainability. In all of these areas IPPF is performing well and is improving, particularly in the area of learning and innovation. The strategic change goals of Unite, Deliver, Perform propose an even stronger emphasis on learning, partnerships and sustainability and IPPF leadership have some interesting and ambitious plans for the future.

The IPR has collected some encouraging information on IPPF’s learning processes and mechanisms, and its work with partners. Formal internal learning and MA exchange is particularly strong. However not all initiatives are being documented and shared, and more international level learning should be encouraged. Financial sustainability for many MAs is a long way off, but institutional sustainability and sustainability of outcomes are an important aspect of the design of much of IPPF’s work. Innovation is also a central part of IPPF’s work and the organisation is constantly pushing boundaries by working with underserved groups such as sex workers (Ethiopia) and LGBT (Bolivia) groups. Innovation is also used to identify new ways of increasing the acceptability of SRHR in some incredibly conservative and difficult environments.

3.3.1 Learning

The IPR found that IPPF's approach to learning was effective and respected throughout the organisation. The approach includes formal systems and processes and more informal learning through ongoing communications.

There are strong formal mechanisms for internal learning, which include meetings, technical assistance, visits, learning sessions and communications initiatives. These mechanisms can be used as a forum for interaction between the RO and MA, the CO and RO or MA, or between MAs, and ensure a vibrant exchange of information and expertise in an ongoing process.

Learning to provide contextual knowledge is also strong, but needs to be informed by more rigorous research methodologies and funding to better understand contexts and changing situations. IPPF is active in sharing their learning with others through websites, printed material and meetings and conferences. Greater use should be made of international networks for dissemination and sharing in the future.

Learning that improves the organisation's own capacity

Approaches to support federation and office internal learning

Promoting learning and innovation is one of the responsibilities of the IPPF CO and RO. A number of different approaches to this were mentioned in the RO interviews, including the following:

- A "focal point" is a contact person who specialises on certain issues (such as organisational development or technical issues) within the organisation. The Secretariat organises annual focal point meetings, where the CO and ROs meet, coordinate technical issues and share good practices.
- Exchanges between MAs is an opportunity for one MA to gain in-depth knowledge of a particular practice initiated by another MA, for example the MA in Togo visited Cameroon to explore services for lesbians, gays and transsexuals. In addition, the Africa Region Office has initiated a buddy system, which pairs a strong MA with a weaker MA for organisational strengthening.
- Technical assistance visits by RO staff and/or CO staff to MAs.
- Organisational learning sessions, held quarterly in the ARO, where, with the assistance of internal and external speakers staff are able to learn about thinking and approaches in relevant areas, new IPPF programmes in the region and outcomes from ongoing programmes.
- IPPF intranet providing updates on global, regional and national activities and achievements.
- Regional Office task force meetings, held monthly for each IPPF task force to think about strategies and innovation to strengthen performance.

Within the IPPF Central Office itself there is a changing culture with respect to internal learning and this will be an inspiration to other parts of the secretariat. Internal communications within the London office have been recently improved, through more effective internal meetings and

ongoing sharing of experiences. Interviewees reported that this has encouraged greater cross-departmental learning and innovation.

For example, the IPR interviews revealed how the CO 5As teams have been learning from each other, and particularly from the success of the HIV and AIDS and Adolescents teams. External and internal factors for success were discussed and analysed in interviews with different members of the As teams. This will be very useful material for the new directors who will be in post this Autumn and for the Regional Offices. It will also be important material for the 2013 strategy development process.

Secretariat learning responsibilities

A few interviewees in the Central Office remarked that there was a lack of consistency with their role with respect to the MAs. In general the ROs are supposed to be responsible for technical assistance, learning and capacity building. However there are examples of direct CO to MA support through centrally funded restricted projects, usually covering a number of countries across regions. This can be an effective way of supporting new initiatives and innovation, but the processes can result in some confusion on responsibility. However interviewees generally thought that all technical assistance should be coordinated by the ROs. There is no easy solution to this issue as there are some clear advantages to both the ROs and the CO providing capacity building, learning and TA. Also it appears to be working in practice and is not a huge area of concern.

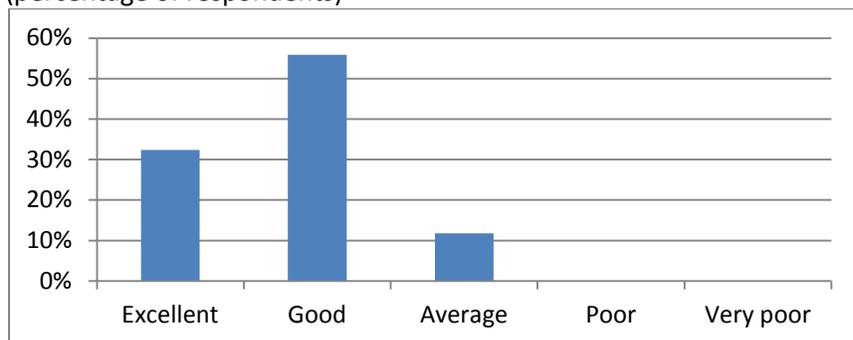
Learning through technical assistance

In the IPR MA survey a high percentage (over 80%) of respondents had both requested and received support of some kind from their RO in a range of technical and organisational areas. Between 15 and 30% of respondents had received support from the CO. Most requests were satisfied, but a small percentage of respondents said that their request was not addressed. These tended to be highest in the areas of Resource mobilisation, EIMS, Human Resources, Advocacy and IT. These results tie in with the interviews in CO, many of which acknowledged that their advocacy and resource mobilisation departments could be strengthened. Also the institutional development focal points are not always as visible as the 5As who have specific teams.

The MA survey results showed that both the ROs and the CO are well respected and valued for the quality of their technical assistance and general support (see Figure 4). The four respondents who rated support as 'average' came from different countries and regions, as did the eleven respondents rating support as 'excellent', suggesting that there is not one particular Regional Office that is offering better or worse quality of technical assistance than the others. Member Associations also gave high ratings to the overall quality of the technical assistance from IPPF CO, with 29 per cent of respondents rating it as excellent, and 45.2 per cent as good. Overall, comments were very positive about CO, with several respondents noting a recent improvement in communications. For example: "*Previously ... the Central Office was very distant from our member association. With the new director and current team, communications are much more proactive.*"

Figure 4. How would you rate the overall quality of the technical assistance from the IPPF Regional Office?

(percentage of respondents)



A range of recommendations for the ROs and CO have emerged from the MA survey¹⁸. These include requests for more learning opportunities through networking and events, more technical assistance for resource mobilisation and IT systems, more in-country visits from the RO and CO, and support with financial gaps and wage issues.

The interviews with RO staff revealed a more critical view of the CO, but with some positive comments that were consistent with the survey results. Some ROs felt that the line of action for the new agenda of Unite, Deliver, Perform needed further clarification. ARO also suggested that there was duplication in available expertise in the RO and the CO and, as a result, technical support from the CO was not generally needed. Compared to other organisations, one Regional Office felt that IPPF's systems were well behind (WHR). WHR does appear to be ahead in terms of strengthening MA systems – however virtually all of the MA countries in the WHR region are middle income. Another RO recommended more extensive use of technology to improve information sharing, especially for the benefit of the MAs.

South-South or Exchange Learning: A strong feature of IPPF is the way it enables Member Associations with similar challenges to share their experiences and learn from innovation solutions. RO interviews identified numerous examples of lesson learning between MAs and ROs (see Box 5), evidence that internal knowledge sharing approaches are having some impact. Encouragingly, it was also reported that formal strategic planning processes included the opportunity to reflect on lessons learnt, thereby making some link between learning and planning.

Box 5. RO Interviews: Examples of experience sharing within the IPPF network

- WHR experience in clinical management systems and performance management systems has been drawn upon by both the EN and ESEAOR.
- WHR has hosted an exchange with the Philippines MA to learn about the provision of safe abortion services.
- A social marketing model developed in Sri Lanka has attracted interest in ECR and Africa Region (SAR).
- The MA in Pakistan has assisted the MA in India to design age-appropriate materials on comprehensive sexuality education.

¹⁸ See Annex O for a full list of recommendations.

Most respondents in the MA survey (81.8 per cent) communicate with other Member Associations to share their experiences, lessons learnt and best practice. Communication is “fluid” and includes networking at regional and international meetings, sharing documentation, capacity exchange, technical support with specific issues, and informal communication by phone/email. South-South sharing of knowledge tends to be between Member Associations in the same region, which speak the same language and are similar socio-culturally. For example over the last year Yemen has learnt from Morocco, Tunisia and Egypt; Pakistan has learnt from India and Nepal; Cote d’Ivoire has learnt from Togo, Cameroon and Benin; and Peru has learnt from Bolivia and Colombia¹⁹. Technical, institutional development and practical support was provided.

Though there are examples of experience sharing, South-South learning between ROs and between MAs does not tend to be systematic. As mentioned in the survey analysis the majority of learning takes place within the region and several interviewees testified that a more strategic approach to inter-region learning would be useful. In addition it is clear that budgets and planning for intra-region learning are also required. The Western Hemisphere Region Office (WHRO) has an interesting South-South learning fund. There is on average \$15,000 per MA in the western hemisphere available for south-south learning visits, material and meetings. This funding is provided by the regional office in New York in response to requests from the MAs in the region. It is financed from IPPF core funds, and so the PPA directly contributes. The country case study in Bolivia verified the power and effectiveness of this South-South learning in the WHR (see Annex G).

Monitoring and evaluation: IPPF monitors the progress of MAs through the following processes:

- Routine annual reports
- Service statistics collection through the eMIS
- Global Indicator Survey (annual)
- Accreditation system (every 5 years)

The annual reports vary greatly in quality, with some running to over a hundred pages (FPA India’s report is 273 pages). However the reports do demonstrate the depth and breadth of achievements and an organisational culture of examining what works well, what hasn’t worked well and what could be improved upon. Verification of service data and GI responses is undertaken by the ROs through regular visits and checking. Data is cleaned and reviewed for quality at the CO.

Besides the task of monitoring MA performance, there is also a need to monitor progress and performance of the ROs and the CO. IPPF CO does not monitor the performance of the different levels of the secretariat routinely and does not appear to ask its MAs or ROs for feedback on the quality of its technical assistance, organisational development and international learning, besides individual TA feedback forms. ROs do have strategies and workplans that they have to deliver and they report to their regional boards. Regional Directors report to the IPPF Director General, but at a higher level.

¹⁹ For full information see Table 3 in Annex O

As mentioned previously (section 3.1.1) monitoring and evaluation systems are strongly focused on internal management and learning. The Accreditation process provides opportunities for learning and development and the IPPF Secretariat encourages and builds capacity for good quality M&E for internal learning. An M&E handbook²⁰ (Putting the IPPF Monitoring and Evaluation Policy into Practice) was published in 2009, and includes the theory and methodology for M&E guidance on how to monitor and evaluate projects and the use of the Global Indicators. The IPR commends this publication as a clear and practical tool for MAs. It would need a regular review and update to make sure it continues to be useful and used.

Detailed service and financial data is essential for monitoring and reporting and for internal VfM and PBF initiatives. Therefore IPPF is working to improve these systems that are variable throughout the federation. For example FGAE is thought, by IPPF CO, to be organisationally a strong MA, but there is still progress to be made in M&E systems. R-FPAP had similar issues with service statistics and financial reporting. The economist working on the R-FPAP VfM analysis spent considerable time trying to extract expenditure figures from the organisation and process them. CIES was stronger, but the IPR team had similar difficulties in verifying service figures.

Impact assessment learning: None of the country case studies were able to present findings or learning from impact assessment. For example FGAE conducts relatively little qualitative impact assessment to complement its quantitative data. Where the latter is available, quality is not always assured. The review of the multi-agency action to address child marriage in Ethiopia, conducted by consultants, fails to identify specific outcomes, which can be clearly attributed to the intervention. In contrast the Rapid Peer²¹ review adopted an innovative methodology, which provides unique access to target group views (see Box 6). This, combined with a strong analysis of the findings has delivered insightful reports, which clearly demonstrate impact on clients' lives, and provide lessons which can inform ongoing service improvements.

Box 6. Successful qualitative research methodology

The research presented in the *IPPF Changing Lives Case Study* and the *Qualitative review of two FGAE clinics in Addis Ababa* used a participatory ethnographic evaluation and research, or rapid PEER, methodology. This is where members of the beneficiary group – in this case, FGAE clients – gather the qualitative data. After being trained in interview skills, they hold conversational interviews discussing key research questions with their peers who use FGAE services, to obtain their stories and perspectives. These stories are then narrated back to the PEER research team where themes across these individual stories can be identified. This approach produces rapid results – the rapid PEER review methodology used by IPPF can be completed in 1 week – with generalised learning that is grounded in the realities of client experiences. FGAE were positive about the methodology and wanted to use it regularly and to invest in it. In fact IPPF is rolling out training for this rapid PEER methodology to ROs and MAs and the CO uses it as part of restricted projects.

²⁰ Putting the IPPF Monitoring and Evaluation Policy into Practice. A handbook on collecting, analysing and utilising data for improved performance.

²¹ This methodology was adapted from the Options PEER approach <http://www.options.co.uk/rapid-peer>

It is difficult to quantify and assess impact of the work with government. Often governments do not want to attribute their successes to donors or CSOs and so can act as barriers. Capacity building of public sector service providers or the development of protocols for service delivery in the public sector can have a huge impact on the scaling up of services. However there is no quantification of this impact in IPPFs reporting. And there is no methodology for measuring the impact on the health system. There tends to just be qualitative reporting of processes – which is valuable, but clearly not enough. As this will be an expanding area of work, more thought needs to be put into M&E.

There is also no work on the long term impact of IPPF's programmes through the MAs. It would be interesting to start a longitudinal survey focusing specifically on young people, to see how the SRHR initiatives are changing lives over the medium to long term. This could also provide useful data on the process of change in the social and cultural enabling environment.

Learning that provides contextual knowledge

A discussion about the lack of MA rigour in situational analyses has already been undertaken in section 3.2.2 on targeting. This is something that the CO is working on improving by developing methodologies for more in-depth assessment of the social, economic and cultural barriers to SRHR in the MA countries. The Rapid PEER methodology mentioned in the previous section is clearly an interesting methodology that could be adapted for context and situation analysis too. This would be especially important for issues such as violence against women and unsafe abortions, or for understanding the SRH needs of commercial sex workers or LGBT, or in vulnerable and remote communities. Other tools are also being used by MAs and it may be useful to share more widely. CIES has been using a survey based tool for baseline assessments that provide important contextual knowledge for project design and monitoring. (see Box 7).

Box 7. Assessment of vulnerable communities

There has been a recent (2011) baseline survey of several of the communities where CIES is implementing the USAID funded women's empowerment project and the mobile clinics. Results for a rural municipality, Tarvita in Chiquisata, shows a very low level of awareness of contraception, and high levels of violence and gender inequality. More than 50% of those interviewed had recently suffered from intimate partner violence. The area is one of the poorest in the country with 97.9% of the population classified as poor; 85.7% of the population are ethnic Quechuas, nearly 50% are illiterate and they mostly live in very basic conditions, with only 9.9% coverage of electricity and 13.9% of drinking water. Fertility is 7.9 and supposedly 90% of births take place in a facility – though the baseline survey revealed that under 50% of births were taking place in the facility.

Learning that can be shared with others

IPPF produces a huge range of documentation that is available to others. Documentation provided to the review team consisted largely of strategies, policies and annual reports. However there is some material on partnership research, such as the Integra Initiative (Strengthening the evidence base for integrating HIV and SRH services). This is a joint

programme with the Population Council and the London School of Hygiene and Tropical Medicine which has produced a range of products that include webinars, research documents, tools and policy briefs.

There are several other interesting initiatives picked up in both the country studies and CO interviews that were not being systematically recorded, analysed and shared. For example interviewees in CO referred to a range of demand side financing initiatives such as vouchers and different strategic partnerships such as social franchising. It would be useful to understand how successful these initiatives are for reaching poor and vulnerable groups. There are also several examples of empowerment projects evolving into social accountability initiatives (e.g. Bolivia women's empowerment and youth programmes). Interviewees recognised that more effort needs to be put into recording and evaluating these initiatives to share internally and externally.

RO interviews revealed that though internal lesson learning appeared to be working well, links to international networks are less obvious. At the country level, there is a sense that MAs depend on their own national contacts and the IPPF network for new thinking. There was little evidence of MAs being directly connected to international networks for two way learning.

Learning plans for the future

As part of the IPPF's vision for its future there are plans to develop centres of excellence and learning hubs. These are already emerging (for example in Ethiopia). IPPF aims to support MAs or ROs to develop an area in which they have particular expertise and success. ROs and the CO would support a process for the MA to develop training and capacity building resources so that other MAs and external partners may learn from them. The type of activities possible could include:

- Strengthen capacity and facilities for clinical training sites.
- Build on demonstration and learning visits to streamline and plan better.
- Develop shadowing opportunities for leaders and managers in order to build leadership and organisational development capacity.

There is potential for the development of an internal market for technical assistance and learning, whereby the MAs or ROs with the best facilities and capacity would be able to market their learning services widely within and outside of the federation. This would potentially improve value for money and choice as MAs would be able to choose the type of TA that would best suit their requirements. It would also motivate better communication of good practice and learning opportunities. There could even be an internal learning accreditation system where qualifications can be earned.

There are also plans for evaluating specific elements of IPPF's standard methodology and approaches. For example, the role of counsellors or educators in the clinics and in communities has long been thought to be an important part of the rights based approach and essential to quality of care. In the Bolivia case study the counsellor was seen to be an important gate keeper and facilitator for the most poor and vulnerable who needed to reach services. IPPF plans to assess the value of this service over 2012/2013 and will evaluate the impact on empowerment and rights as well as on uptake of services. It should also specifically look at how this service

facilitates access for the poorest and most vulnerable. IPPF is also developing indicators for its comprehensive sexuality education work.

3.3.2 Innovation

IPPF has always been an innovator and has provided SRH services as a pioneer. The organisation started as a movement 60 years ago at a time when sexuality, contraception and women's rights were just beginning to gain traction and cultural acceptance in many countries in Europe and North America. However many members of the federation still work in extremely conservative contexts with severe health system and cultural constraints, or in conflict or disaster affected environments.

IPPF innovates by providing services that others neglect and by simultaneously advocating for government commitment to SRHR. IPPF has a strong focus on implementing tried and tested approaches, particularly in terms of providing services that have been proven to have an impact on SRHR. This is balanced against a good culture of innovation (where a certain level of risk is accepted, and seen as a learning opportunity). The PPA funding has been particularly effective in promoting and **growing innovation** within the organisation.

According to the RO interviews, the CO approach to innovation is well thought through - it pilots new initiatives, promotes lesson learning and facilitates scale up. For initiatives led by CO, an initial pilot in a small number of countries is supported. At the end of the pilot, outcomes and lessons learnt are packaged in attractive and focused presentations and supporting documentation, and are discussed at technical meetings with MAs. MAs are then able to express an interest in piloting the methodology in their own country. A series of discussions with the MA then follows to determine their readiness to implement the initiative, including fit with national needs and the availability of necessary financial and human resources.

IPPF CO also innovates effectively through the introduction of new policies. An example of this is the recently adopted Child Protection Policy. The MAs and ROs have been involved in very practical ways to ensure its implementation, and tools have been developed for the MAs to be provided alongside ongoing mentoring and support. While this has not been an easy process, the CO is now seeing the emergence of a deeper understanding of the need for the Charter.

The DFID PPA directly funds an **Innovation Fund** (IF) run by the CO, which supports this process of innovation. Since 2005, the IF has funded a total of 41 projects, by "A" and geographical spread, including for example, addressing coerced marriage (Pakistan); empowering men who have sex with men (China); piloting medical abortion (North Korea); and advocacy for combating female genital mutilation (Cote d'Ivoire).

In a preliminary review of the portfolio of IF projects, all 41 projects were viewed to have been innovative for the implementing MA and have advanced IPPF's strategic priorities. 35 projects have worked to empower vulnerable groups, 30 projects have addressed sensitive and taboo issues. All projects include a capacity building component. Several IF projects have been scaled-up by the government or by the MA with external donor funding, which has ensured the sustainability of project activities.

Innovation Fund projects are showcased on the IPPF website, with a recognition that some projects will not be so successful - and it is important to learn from the pitfalls and take up good practice. Lessons learned have also been communicated to other MAs in a series of three 'Learning from Innovation' publications. The disadvantage of Innovation Fund projects is that they are short-term funded and may not always provide the lead time for projects to be assimilated into standard MA practice or core business. However the IPR has found that 73% of the projects were sustained by the MA after the IF funding ended. 96% of projects resulted in some kind of organisational change within the MA and 88% resulted in the systematic roll out of new tools or integrated lessons learned from the project into the MA's wider programme. 58% of projects resulted in a new service which could be continued with the existing clinic infrastructure. The risky nature of the IF projects can make it difficult to raise funds from elsewhere unless they have a demonstrated impact. Phase II of the Innovation Fund will have a much stronger M&E component to address this.

Innovation reported by MAs in the survey: Over two-thirds (69 per cent) of respondents had heard of ideas or innovations from within IPPF this year that they might try and implement. When asked what these ideas/innovations were, Member Associations mentioned:

- Vulnerability assessments.
- Computerised commodity tracking and forecasting system.
- Implementation of Integrated Package on Essential Services (IPES) from all SDPs.
- Concept of social franchising as a means to double the family planning performance.
- Kenya model of HIV/AIDS prevention.
- Subsidies focused on performance.
- Social marketing process via partnership with major show-business personalities, sports stars and others.
- Use of mobile health units.
- To change the way of electing Youth Advocacy Movement members and guarantee their active participation in governance bodies.

Just over a half (53.5 per cent) of respondents said their Member Association's ideas or

Box 8. Examples of Member Associations' ideas and innovations used elsewhere in the IPPF federation

"FPAB implemented a project on "Madrasa students initiative for adolescents health in Bangladesh". The Madrasa system is a religious form of education. The project improved the knowledge and understanding of SRHR to increase access to youth friendly SRH services to Madrasa students and teachers. Other member associations were interested in this idea and innovation. Member Association (Pakistan) RAHNUMA and Afghanistan visited our country to learn how to implement the project. And Rutgers WPF Pakistan has been using this idea - they started a similar project in their country." (Bangladesh)

"Our methodology for developing statutory documents such as policies of resource mobilisation, of prevention and risk management, has been used in Angola and Cape Verde." (Mozambique)

"Community Based Distribution (DBC) in rural areas where the majority of populations live so as to facilitate access to reproductive health/family planning services. This strategy, which has rapid gains, was considered as best practice in light of the results achieved." (Niger)

innovations had been used within other Member Associations, or at RO and/or CO level. Some examples mentioned are shown in Box 8.

3.3.3 Partnership working

The review team came into contact with various MA partners during the country studies. The RO interviews and MA survey also described partnerships. Table 5 shows a selection of the numerous and diverse types of partnerships that the IPPF Secretariat and MAs are involved in.

On the whole partners were very positive about the high technical capability of IPPF MAs and the good partnership working. There was some concern about overlap of service areas with MSI in Bolivia as both organisations were serving the same location in some cases. This is something that needs to be discussed at CO level between the two organisations as they both hold DFID PPAs.

Table 5. IPPF Partnerships

Initiative type	Partners	Examples
International Advocacy	International NGOs and NGO networks Country governments through MAs Donor governments	UN conferences – CSW, Post 2015 etc.
International Research	Universities International NGOs Donors	Integra project ²² (assessing the efficiency and effectiveness of integrated HIV and SRH services)
National and Sub-National Advocacy	Networks of local CSOs International NGOs Specialist groups such as youth, indigenous women and LGBT networks Local government Parliamentarians	Bolivia youth law and sexual and reproductive health law. Pakistan budget allocations for SRHR
National service delivery	National and local governments CSOs Private clinics, research laboratories and health providers	Violence against women protocol and capacity building in public sector (Bolivia) Policy and guidelines for service providers (Ethiopia) Supplies and services through private providers (Pakistan)
Demand generation	Networks of special groups such as youth, women, indigenous groups etc Religious leaders and organisations	Information through religious leaders (Pakistan) Information and supplies for young people through theatre, school visits and community fairs (Bolivia)

The DFID PPA has an impact on partnership working because of the longstanding aid effectiveness agenda and because of shared advocacy goals. DFID opens doors with other European donors and contributes to the legitimacy of IPPF’s advocacy objectives both internationally and in target countries. Important quality assurance and organisational technical assistance enabled through unrestricted funding support has allowed the MAs to be seen as

²² <http://www.integrainitiative.org/>

'technical experts'. This has definitely facilitated local respect and legitimacy for the MAs, making it easier for them to contribute to and lead both service delivery and advocacy initiatives.

Box 9. R-FPAP in Pakistan has three interesting examples of partnership

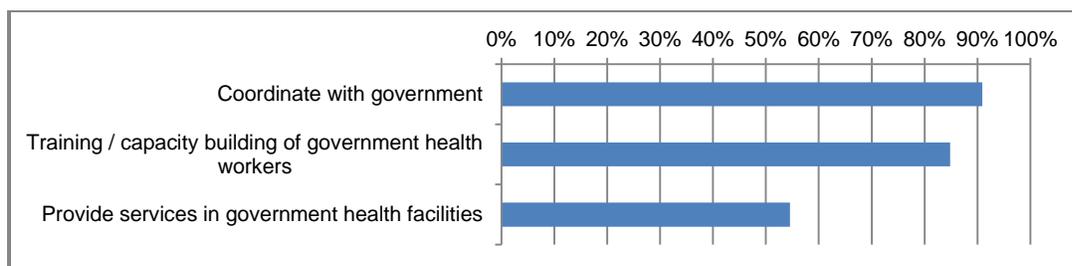
(i) R-FPAP was instrumental in establishing the MDG 5b Alliance, whose members feel that it has changed the way advocacy is done in Pakistan. The Alliance is able to work more strategically, and because of their collective profile, exercise more increased influence than if they were acting individually. One interviewee suggested: *"It's a collective movement. Everyone has ownership. Earlier, people were territorial"*.

(ii) R-FPAP provides technical support to the Saathi Foundation - a Lahore-based NGO working to support the transgender community. They have been supporting Saathi in advocacy efforts to have transgenders recognised as a separate gender by the government. Capacity building support is also provided in management and resource mobilisation. R-FPAP's partnership with Saathi is an excellent demonstration of how a marginalised group can be organised to voice their concerns, and engage in positive health seeking behaviour.

(iii) R-FPAP enjoy a high level of credibility and a strong working relationship with government. They are invited to meetings in the Federal Planning Division, and provide technical input to the Provincial Departments of Health and Population Welfare. R-FPAP works in consultation with the district government to site their clinics, and to develop referral links. In the province of Azad Jammu and Kashmir, they have had a long-standing arrangement with the government to provide services and free contraceptives in 148 government clinics. Few facilities run by the Department of Health provide family planning services, and this is the first model where both are provided under the same roof. This partnership model will be replicated in South Punjab – one of the poorest regions in Pakistan. R-FPAP have also established referral links with government-run health facilities.

Results from the MA survey showed that MAs **work in partnership with government** in a variety of ways: 90.9 per cent of respondents coordinate with government, 94.8 per cent provide training / capacity building of government health workers, and 54.5 per cent provide services in government health facilities (see Figure 5). Other ways that Member Associations work in partnership with government include: co-financing in areas of interest; providing joint services in mobile units; provision of personnel for government health facilities; supply of commodities and supplies (by government); and allocation of land by the State for construction of infrastructure (clinics, child and youth centres and other service delivery points).

Figure 5. How does your Member Association work in partnership with government?
(percentage of respondents)



3.3.4 Sustainability

As IPPF is a Federation of locally owned organisations, there is a high level of local commitment and ownership which, in turn, supports institutional sustainability. Financial sustainability is more elusive as some MAs are struggling to square their social objectives with profit making. The WHR and some middle income countries in South East Asia and South Asia have made the most progress on financial sustainability, not least because of the insistence by USAID, a major donor in WHR, and because of the countries' relative wealth status.

Many MAs now focus considerable effort on health systems strengthening and government capacity building in order to have a wider impact on national SRHR. This type of activity increases the sustainability of outcomes and impact as long as there is sufficient time for changes to become institutionalised. The IPPF Change Goals are proposing more of this health systems strengthening work.

Social and cultural sustainability potential is often high with IPPF MA programmes as these are not just about behaviour change. They include a more integrated approach to the overall social and cultural enabling environment which is addressed as part of service delivery and advocacy programmes. This usually entails complex and multi-dimensional systems of empowerment, leadership capability, attitudinal change and protection and promotion of rights. Work usually takes place with political and community leaders, with vulnerable groups, individual power holders as well as institutions. See Figure 2 in Section 1.5 at the beginning of the document to see a very simplified version of the theory of change for this kind of work.

The impact of work on the legal and political enabling environment also improves the potential for sustainability of outcomes. For example MAs have worked with partners effectively to improve the legal protection for women's and young people's rights (Bolivia) and for access to safe abortion (Ethiopia).

Financial sustainability

Regional offices are active in supporting MAs in working on financial sustainability. Achieving financial sustainability is a long term process, which requires gradual diversification of funding sources²³. Strategies to increase financial sustainability include:

- (i) Increasing the level of internally generated funds – especially from fees.
- (ii) Generating income from non-service delivery initiatives – e.g. technical assistance or capacity building.
- (iii) Increasing contributions from national and local governments.
- (iv) Increasing and diversifying funds from donors.

(i) Internally generated funds: Poverty levels were identified as a critical obstacle to achieving financial sustainability in most regions. IPPF is committed to ensuring access to SRH services by poor and marginalised groups and opportunities for increasing internally generated revenue must be carefully balanced with what target groups are able to pay. However CIES has demonstrated that financial sustainability can be enhanced at the same time as increasing access to poor and vulnerable people. The CIES clinics ratio of sustainability increased from

²³ Comment from ARO

60% in 2009 to 77% in 2011. At the same time the vulnerability assessment shows that percentage of CIES clients who are vulnerable rose from 45% in 2009 to 72% in 2011. CIES in fact has two clinics that are financially sustainable – which is not always the case for MAs.

Currently, virtually none of IPPF's clinics are self-sustaining, although a small proportion of them are within striking distance of sustainability and many are conscious of the need to gradually increase internally generated revenue. For example, Bolivia²⁴, Morocco, Egypt and Sudan²⁵ were all cited as examples of MAs that are achieving high levels of internally generated resources and could potentially achieve financial sustainability in the years to come.

In the Africa Region, about 10 MAs were reported to be improving levels of internally generated revenue, including Cote d'Ivoire, Gabon, Kenya and Nigeria. However, none had exceeded 30% of their annual costs.

Financial sustainability could be enhanced with better cross subsidisation and better cost and market analysis. MAs (verified in CIES in particular) use cross subsidisation between clinics and between different services. This process, if used most effectively, can be the basis of combining financial sustainability with serving the poor and vulnerable. If the MAs were able to use unit cost data and market research together to better price and market services, they would stand a higher chance of achieving financially sustainable clinics. CIES is further ahead in this work as it has a good understanding and use of cross subsidisation. However management are not using cost data to maximise income whilst at the same time ensuring that services remain accessible to the poorest.

(ii) Income from non-service delivery initiatives: The establishment of training hubs, which would sell training courses, was highlighted as a key strategy for diversifying local income streams in the Africa region.

(iii) Increasing contribution from national and local governments: In Brazil, Cambodia, India, Pakistan and Zimbabwe government funding delivered through different modalities²⁶ is an important factor in moving towards sustainability. CIES in Bolivia has purposefully pursued funding from government for their programmes that target the most vulnerable populations: street children and indigenous women in the most remote mountain regions. Both these programmes now have small amounts of local government funding, which is set to increase year on year until the work is totally funded by government. There is no certainty of this yet and CIES needs to demonstrate impact and results to ensure it happens.

(iv) Increasing and diversifying funds from donors: In South Asia, efforts have been made to reduce the financial dependence on IPPF. In 2003, SAR MAs received approximately 53% of their annual budget direct from IPPF. By 2010, this figure had been reduced to 35%. International donor funding has largely replaced that of IPPF with the proportion of funding from international sources increasing from 14% in 2003 to 38% in 2010. This is, of course, positive,

²⁴ WHR office comment: "Bolivia needs a 5 year sustainability plan to eventually operate without external funding".

²⁵ Morocco, Egypt and Sudan were reported to meet approximately 50-60% of their costs through internally generated revenue.

²⁶ In Brazil, a partnership with local authorities provides government funding for five clinics; in Cambodia, clinics benefit from a government voucher scheme to cover some costs for the poor accessing SRH services; in India and Pakistan, MAs run some clinics on behalf of government, with government providing funding; in Zimbabwe, half the MA's services are supported financially by national government.

since it would seem to indicate a growing confidence amongst international donors in the MAs. However, it has been accompanied by a fall in the amount of locally generated resources, from 32% of annual budgets in 2003 to 27% in 2010, and concerns about the self sufficiency of SAR clinics still remain.

Social and cultural sustainability

Ensuring MA staff share the organisation's values is critical to organisational effectiveness and sustainability. This can be demonstrated by the work that R-FPAP have done on changing knowledge, attitudes and behaviours of their own staff. All service providers participate in value clarification exercises which, according to the Trainer's Manual, aim to create awareness and "move participants towards support, acceptance and advocacy" for various issues, including SRH, abortion, HIV, STIs, working with adolescents, etc. They also use a rights-based approach, and provide guidance on the standards of care that all clients should expect to receive. When R-FPAP introduced MVA to its services, all R-FPAP doctors in Khyber Pakhtunkhwa (KPK) province refused. After undertaking value clarification activities, the greatest demand for MVA now comes from Peshawar in KPK.

Conservative religious movements can also challenge an organisation's sustainability. The increasing political influence of ultra-conservative religious leaders means that R-FPAP has to be very careful about raising the profile of the organisation, communicating its work, and selecting advocacy topics. For example, they undertake limited advocacy on abortion for fear that if the issue were spotlighted, this might make the space even more restrictive.

3.4 Efficiency

The IPR's interpretation of efficiency centres on the quality of the organisation that is implementing the PPA. As this is not a one dimensional project it is essential to make an assessment of the capability of the organisation in terms of various attributes:

- Vision, Mission, values and strategy – what holds the Federation together;
- Leadership and management;
- Governance and structure;
- Financial management and information systems;
- Human resource management;
- Monitoring and evaluation (see section 3.3.1); and
- Communications and marketing.

The organisation is the engine for producing outputs and outcomes and it can do this to a high standard and for a reasonable cost if all of the components are working efficiently. The organisation works as a complex system that does not have simple metrics for measurement, and so the IPR uses qualitative evidence to describe and evaluate each of the components, but with the understanding that they are interconnected and dependent on each other. There is no simple calculation that can accurately provide figures for the cost effectiveness (output to outcome) of the whole organisation, and so the IPR has focused on two of the country case studies which illustrate how their delivery of family planning services is achieving good value for money in comparison with regional averages.

The RO interviews provided useful insight into organisational efficiency. IPPF ROs point to some factors, which they believe contribute to organisational efficiencies. These are in line with the other IPR observations and include:

- Clear leadership by the Board and senior management, with the roles of each clearly defined;
- Strong management systems;
- Stable funding streams, which allows investment to be made in MA systems and procedures;
- RO quality assurance to ensure minimum standards, for example in strategic plans, strategies for resource mobilisation, implementation of M&E systems etc. The accreditation process was highlighted as a critical means of quality assurance, as well as desk-based support, and TA/monitoring visits to MAs by the Regional Offices; and
- Size of MA, with larger MAs e.g. India, Nepal, Pakistan, Bangladesh, able to achieve economies of scale.

Vision, Mission, Values and Strategy

The IPR team has observed a high level of organisational coherence with the vision, mission and values throughout the different parts of the Federation that were part of the review.

Box 10. Vision and Mission Statement - IPPF website

Vision

IPPF strives for a world in which all women, men and young people have access to the sexual and reproductive health information and services they need; a world in which sexuality is recognized both as a natural and precious aspect of life and as a fundamental right; a world in which choices are fully respected and where stigma and discrimination have no place.

Mission

IPPF aims to improve the quality of life of individuals by providing and campaigning for sexual and reproductive health and rights (SRHR) through advocacy and services, especially for poor and vulnerable people. The Federation defends the right of all people to enjoy sexual lives free from ill health, unwanted pregnancy, violence and discrimination. IPPF works to ensure that women are not put at unnecessary risk of injury, illness and death as a result of pregnancy and childbirth, and it supports a woman's right to choose to terminate her pregnancy legally and safely. IPPF strives to eliminate sexually transmitted infections (STIs) and to reduce the spread and impact of HIV and AIDS.

IPPF's stated core values are based on human rights, gender equality, universal SRHR and partnership working and have been visible in all parts of the IPR, in FGDs, interviews in the MAs and in the CO interviews. Most of the people interviewed in the organisation referred to a "rights based approach" that is integral to service quality and to the design of initiatives. MAs consistently referred to approaches that are clearly linked to the IPPF Mission statement (see Box 10). The strategic 5As and the three change goals (Unite, Deliver, Perform) are visible through the MA's and ROs own objectives (e.g. the 2012 ARO strategy) and the structure of the organisation (Bolivia and ROs). The review team was

particularly struck by how effective the 5As framework has been in mainstreaming an emphasis on previously neglected health areas and target groups throughout the federation. However, the overlap between parts of the 5As and the way in which they address different categories, such as target groups or health areas, has resulted in some inefficiency. A CO interviewee mentioned

that there are no clear targets or indicators for the 5As strategy and that the As include different types of strategic objectives, mixing target groups with vertical health initiatives. There was also a feeling that the 5As can be interpreted broadly to include a wide range of areas, and this represents a risk to the organisation in terms of lack of focus and fragmentation. The organisation is moving more towards an integrated package of essential services and now needs to start working on framing future strategic objectives.

Each Regional Office has a 5 year strategic plan, which is complemented by annual programme budgets. The ARO reported that the needs of MAs, as expressed in their own strategic plans and annual programme budgets, determined their own focus. ARO supports 44 MAs and so further prioritisation is necessary. ARO uses a set of criteria, including unmet need for contraceptives, potential of the MA, scale of donor interest, to determine priority countries for ARO's financial and technical support. Current priority countries are Nigeria, Ethiopia, Uganda, Tanzania, Kenya and Burkina Faso (See Annex R).

Regional Offices and MAs reported a strong sense of belonging to the IPPF Federation. Affiliation to the federation is seen as a mark of credibility by members with certain standards assured through the accreditation process. The wide ranging technical and organisational management support available through the network is also particularly valued, as is the fundraising assistance available.

The MA survey confirmed this finding. The vast majority of respondents have a very strong sense of belonging (57.6 per cent) or strong sense of belonging (36.4 per cent) to a wider international federation (see Figure 3). Those respondents who said they were indifferent or had a weak sense of belonging had been with their Member Association for less than five years (0-4 years), so it is possible that their weak sense of belonging is due to those individuals being relatively new to IPPF.

Leadership and management

The IPR found strong and thoughtful leadership and good quality management to be consistent with efficient organisation and results. For example, CIES in Bolivia clearly benefits from excellent leadership at director level and clinic level. CIES's leadership has strong expectations of performance and efficiency but has also empowered personnel to make decisions and take ownership of their work responsibilities. The successful implementation of the SAP (integrated financial and project management) IT system would not have been possible without well prepared managers. The unit costing methodology used in the clinics (CORE), though not entirely up to date, could not have been implemented and used without clear service time norms and standards that were rigorously monitored by clinic managers and the head office.

Not all MA leadership and management were observed to be of high quality. FGAE is in the process of changing leadership and this was found to be impacting on the overall direction and drive of the organisation.

There were examples of excellent leadership and management in the CO leading to results. The HIV team has pioneered a focus strategy where initiatives are being directed at 25 high priority countries. 14 of those countries increased HIV-related services from 315,939 in 2005 to 1.7 million in 2009, a much more substantial increase (435.2%) than was seen across all MAs

(219.6%) reporting consistently during that period. This method of focusing has implications for further thinking on organisational focus and strategic planning. Several interviewees also reported good quality leadership since the arrival of the new IPPF Director-General in September 2011.

In the RO interviews it was found that the WHR is slightly more advanced in understanding organisational efficiency. It has just finalised a peer assessment of its MAs to establish the relationship between IPPF investment and service outputs. It has concluded that the Bolivia MA is a highly efficient MA due to high SRH needs, a large implementation budget and strong leadership at Board and Executive Director level. This ties in strongly with the evidence emerging from the IPR visit. The WHR office stated that Nicaragua appeared to be less efficient, with weaker leadership at the Board and Executive Director levels being key differences.

Communications is considered to be weak within the organisation. The Advocacy team in the CO is small and they are also responsible for communications. The communications experts indicated that there is a lack of recognition of the importance of professional expertise in communications and advocacy, with many people within the organisation thinking they can just “do communications”. Advocacy and communications capacity within the ROs is also thought to be variable, and the Secretariat finds it difficult to ensure the provision of sufficient levels of expertise to the MAs for technical assistance. This kind of technical assistance can happen through restricted projects so that targeting is clear. This is consistent with the findings of the survey and RO interviews outlined in section 3.3.1.

Governance and structure

An important strength of the IPPF governance structure is the inclusivity of the Governing and Regional Councils, which include MA volunteers from every region, and the 50% representation of women and 20% of young people. These governance structures are replicated at the MA level. Interviews with youth representatives on the CIES Board revealed a high level of appreciation of, and active participation in, the decision making processes of the MA.

However, there are some limitations to IPPF’s wider organisational structure. Organising departments by the 5As results in overlap (as mentioned before), and also the apparent neglect of some key technical areas. For example, the structure does not fully recognise issues around gender, which are currently the responsibility of the Access team in the CO. Some interviewees highlighted that IPPF’s gender focus should have a clearer position in the organisation and strategy. Various interviewees also argued that the structure – created to emphasise the 5As - was no longer the optimum way of organising, even though it may have met important needs at the time. Certainly, some reorganisation is already taking place, such as for the Advocacy and Communications roles. This should address some of the perceived weaknesses in those teams, and significantly support the professionalisation of the communications function. A fuller reorganisation will probably take place over the next two years.

Financial management and information

As part of the IPR, a financial management assessment was undertaken in CIES and R-FPAP (Pakistan). The assessment used a tool developed for the IPR, which focussed on nine core functions: i) organisational structure and human resource; ii) accounting system and reporting;

iii) budgeting and planning systems; iv) purchases and payables; v) invoicing and receivables; vi) treasury functions; vii) payroll; viii) asset management system; and ix) audit. The assessment found that R-FPAP is delivering medium VfM. This means that most of the necessary basic controls exist and are being used to a certain extent. There is however significant room for improvement, related mainly to capacity building, improving and building upon existing systems, introducing new controls and using more efficient accounting software. Improvements are also needed on financial management reporting and costing of services (see also section 3.4.2). The assessment for CIES was significantly better, with most criteria showing high VfM. Asset management, payroll and audit were found to require improvements, but were still showing medium VfM.

Work to measure and promote efficiency remains at an early stage of development across IPPF ROs and there is little quantitative evidence in this area. Several MAs are in the process of costing services (ARO, AWRO, ESEAOR and SAR) - an important step in determining the efficiency of services and where improvements can be made. IPPF has developed a branch performance tool to enable MAs to identify the more efficient clinics in their networks and potential areas for improvement in others. The tool has been piloted in two regions including SARO. It will be used in 12 further MAs in ARO, AWRO, SARO and ESEAOR in late 2012. Performance based financing was piloted in 2011 and has been used by five out of the six regions as a basis for 2013 funding levels. It will be used in all regions by 2013. A key lesson emerging from this experience is that strong M&E systems need to be in place to make PBF a workable system.

Financial reporting from MAs to the ROs and CO is problematic. For most MAs, reporting to the CO entails using a financial reporting format that does not necessarily match their financial management systems. As financial reporting is organised around the 5As, this often does not provide the information that would enable the CO to undertake important analysis of expenditure figures. There is also considerable ambiguity and some overlap between the As, and they are not logical categories to use for financial reporting.

Information systems function fairly well overall, but this is variable across the organisation. For example, many MAs in low income countries are using paper based systems which link to IT systems. The Secretariat has been helping 23 MAs to implement an electronic clinical management information system (OpenEMR) for recording clinical data. These MAs still use some paper based recording methods for outreach or other service delivery points. However all MAs introduce data into the electronic Integrated Management System (eIMS) – a separate system, which is used for reporting to the CO.

A CO-led Systems Review was recently undertaken, and covered reporting, planning, budgeting, communications, financial systems processes, restricted projects and electronic systems. Several inefficiencies were identified, particularly in the area of reporting – which was found to include too much detail, and insufficient evidence of learning and strategic thinking. An implementation plan is now in place, which is helping to address a number of issues that were identified.

Human Resource Management

High staff turnover has been highlighted as a key factor which undermines MA efficiency. MAs are essentially local non-government organisations (NGOs), and so cannot compete with salaries offered by international NGOs and donors. As a result, they frequently lose staff to them. In Pakistan, salaries for clinic staff are even lower than those paid by government – this is clearly a key driver of R-FPAP’s high staff turnover. Human resource management was not much mentioned by the MAs interviewed except in relation to the salary issues just mentioned, but it was an area of support that was requested in the MA survey.

The Systems Review also found that the induction system lacks information and orientation about how to navigate and manoeuvre within the organisation, and that there are a number of unwritten, informally agreed practices that could be clarified and documented. IPPF is currently reviewing this.

3.4.1 Value for money assessment in terms of unit costs and cost effectiveness

The CO and RO interviews revealed an observable process of culture change around value for money and financial management. Interviewees reported an increased emphasis on results and more interest in cost effectiveness metrics such as unit costs and cost per DALY (CIES was particularly interested in developing this methodology). Reportedly this interest precedes the current DFID PPA, but clearly DFID is enabling further efforts in this direction.

The full value for money assessment was only undertaken in Pakistan and Bolivia. This section will focus on the specific information collected for these case studies.

In Pakistan, the concept of VfM is differently understood throughout the organisation and is mostly confined to delivering services at the lowest cost. Greater understanding needs to be built on linking inputs with results (linking financial inputs with non-financial outputs). R-FPAP reported in the survey that they were using unit cost data to compare with international and regional standards. However the country study found that R-FPAP do not have the in-house mechanisms and expertise needed to enable them to adequately cost their services, and measure cost effectiveness.

CIES uses the CORE system to calculate unit costs, and they have the expertise for this. However, the review team found that their data collection was not up to date, and this made it difficult to extract unit costs for all of the FP services required. In addition there is very little understanding of the use of unit costs in clinic management and pricing strategies.

Unit Costs - Pakistan

A comprehensive unit costing exercise was conducted for three R-FPAP service delivery points:

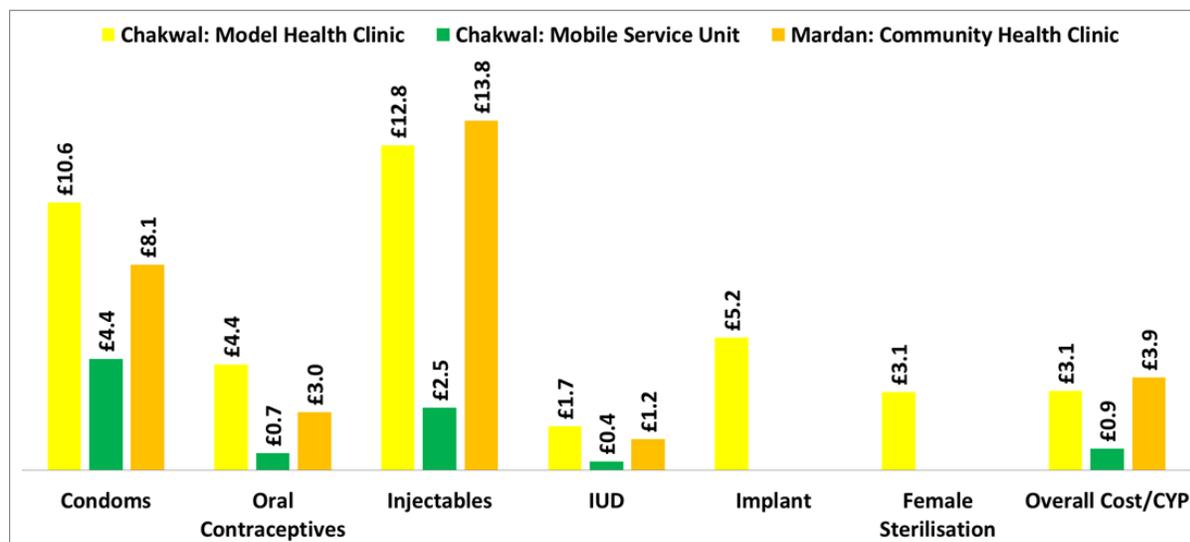
- (i) Model Health Clinic (Chakwal);
- (ii) Mobile Service Unit (Chakwal); and
- (iii) Community Health Clinic (Mardan).

The results were applied at the organisational level to obtain unit costs for R-FPAP as a whole. For the detailed methodology please refer to Annex G – FPAP case study document.

Costing Results: Clinical Level Costing

The figure below summarises the cost per CYP for each FP method offered and by the three service delivery points.

Figure 6. Cost per CYP, R-FPAP



The average cost (method mix) per CYP ranges from £3.85 to £0.86. The main factors behind this variation are different level of service utilisation, and the increase in overheads with increased level of facility. Analysis of the costing results show that short-term methods are costly to provide compared to long-term methods, however clinic managers noted that there is greater acceptability for short-term methods.

Costing Results: Organisational Level

Using the findings of the clinic costing exercise, a further exercise was carried in order to calculate costs per visit and CYP at the organisational level. Unit costs were also analysed by service delivery channel. Table 6 below presents the overall costs per visit for FPAP service delivery points only.

Table 6. Comparison of direct costs of providing FP methods

Methods	R-FPAP ²⁷ £	Asia ²⁸ £
IUD	0.53	0.40
Injectable	2.67	4.23
Implant	3.28	5.00
Condom	11.98	2.53
Oral Pills	6.77	3.65
Sterilization	0.67	1.01

²⁷ Source: R-FPAP, FP costing exercise

²⁸ Source: Guttmacher Institute (2012)

The Guttmacher study also reported that the average cost of providing a method mix of services in Asia is £2.80. Similar services are provided by R-FPAP at an average cost of £3.19 per user (not including CYPs from private practitioners).

The cost per DALY averted is only £14, which is 52 times less than the current GDP per capita of Pakistan (£750). The Commission on Macroeconomics & Health and the World Health Organisation (WHO) suggest that an intervention is considered to be very cost-effective if the ratio does not exceed the average GDP per capita of the country. Using this benchmark FP services provided by R-FPAP are highly cost effective. The interventions are also producing a very high benefit to cost ratio of 73. This means that for every £1 invested in the FP services gets a return of £73.

CIES

Calculations for CIES were undertaken in a similar way to R-FPAP. However CIES already had the CORE tool in use, even though the data being generated by the system was not up to date. CORE is a spreadsheet-based analysis tool for determining clinic costs and revenues. The costs of services are estimated from the bottom up, based on normative staffing, or the amount of time staff members spend delivering services; the amount of time staff members spend on administrative tasks; and estimation of the use of resources. CIES is able to use this tool because they have established norms for service times that are monitored by clinic managers. Health professionals are also obliged to stay within the service norms to maximise clinic efficiency. The tool can be used to do a cost and revenue analysis, comparing the current situation to future scenarios. Revenue analysis includes fees, donations, and external sources.

Table 7. Unit cost of FP services²⁹

Services	Unit Cost (GBP) – 2012	Source
Long-acting and permanent methods		
Implants-5 year	34.6	CIES -- Cochabamba Clinic 2012
IUD-10 year	2.5	CIES -- Cochabamba Clinic 2012
Short-term methods		
1-month injectables	8.5	CIES – email communication 2012
3-month injectables	2.7	CIES – email communication 2012
Condoms	0.6	CIES -- Cochabamba Clinic 2012
Pills (cycles)	6.9	CIES -- Cochabamba Clinic 2012

The average cost per CYP (mixed methods) of £4.90 compares very favourably to the cost per user per year of £9.20 (\$14.46) in the Latin America region from a recent Guttmacher/UNFPA

²⁹ It is important to note that the service diversification and growth of the CIES clinics is leaving the core services of FP underreported in the CORE spreadsheet module. For example in the La Paz Clinic the services are grouped under a Family Planning label and information is not available on the unit cost of individual contraceptives methods. In contrast, in Cochabamba, where there are a lower range of services, the unit costs for most important contraceptives services are available under CORE.

report³⁰. The average cost per DALY saved is £76. The mobile units have the highest cost per DALY at £187, which is not surprising as the clinics travel large distances in often rough terrain. The next highest cost per DALY is the clinic located in Beni at £176. According to WHO, an intervention with a cost-effectiveness ratio less than the national GDP per capita for each DALY gained should be considered highly cost-effective. The GDP per capita in Bolivia is US\$1,731 (£1,103), 14 times the average cost per DALY, suggesting that all FP services provided by all the clinics are highly cost-effective investments.

3.5 Impact and value for money of PPA funding

3.5.1 Attributable impacts of PPA funding on results, relevance, effectiveness and efficiency

With such a large number of stakeholders involved in the field of SRH, it is difficult to quantify with any certainty the contribution IPPF is making towards reducing maternal mortality (MDG 5) and combating HIV/AIDS (MDG 6). The outcome data does however suggest that IPPF is making an important, and growing, contribution to these two MDGs, especially to reducing maternal mortality. In 2011 alone, in the GSWACH+MA countries, IPPF was able to avert over 1 million unintended pregnancies and 388,000 unsafe abortions (one of three leading causes of maternal mortality (WHO 2008)).³¹

Direct service provision is, of course, a critical factor in this important contribution. However, Regional Offices have also highlighted the importance of IPPF's advocacy work, as well as partnerships with other organisations. Advocacy conducted at the national, regional and global levels is reported to be improving the enabling environment for RH services, which in turn allows the expansion of services, and, it is assumed, also translates into reduced maternal mortality and prevalence of HIV/AIDS. Table 8 below provides an MA level example from Pakistan of the other health impacts that can arise as a consequence of delivering the FP services by R-FPAP and the proportion of these attributable directly to the PPA grant.

Table 8. Other estimated health impacts of R-FPAP's FP service delivery 2011³²

Other Impacts due to FP Services	Numbers	Attribution to PPA Grant ³³
Maternal deaths averted	119	5
Child deaths averted	1,314	59
Unsafe abortions averted	8,621	388
Unintended pregnancies averted	79,118	3,560
Births averted	51,942	2,337
DALYs averted	55,078	2,479

Source: MSI Impact 2 using service statistics from R-FPAP

³⁰ Singh and Darroch (2012)

³¹ Source: IPPF logframe report. IPPF is collaborating with the Guttmacher Institute to develop a methodology to calculate this based on the independent 'Adding it Up' research. This research, which was part funded by IPPF, takes an objective and comprehensive perspective on the costs and benefits of investing in a range of family planning, maternal and newborn health interventions. IPPF is in discussion with other agencies on an ongoing basis (MSI, Guttmacher and others) to achieve convergence on methodologies used to make these calculations.'

³² The MSI Impact 2 tool was used to calculate these estimated impacts. This uses a different methodology to the results presented in the logframe. This methodology for calculating these impacts is different from that used by IPPF

³³ Calculation (2011 data): (IPPF unrestricted funding to R-FPAP ÷ Total Funding of R-FPAP) x (DFID's PPA Funding); (PKR134,899,440÷PKR597,826,629=23%). (23% x 20%) = 4.5%

Nationally R-FPAP contributes 8% of the national CYPs. 0.4% of these can be attributed to DFID PPA funding received by R-FPAP.

Does the PPA add value to IPPF's work and is it additional?

Feedback from ROs suggests that the impact at country level of the DFID PPA depends on the context in that particular country. In countries where few donors support SRH and where high poverty levels mean that few people can afford to pay for services, the impact of DFID's funding is significant. For example, AWRO reported that in the absence of DFID support, about 50% of their clinics would be forced to close³⁴. Vietnam, similarly, would be forced to close some clinics if DFID funding were not forthcoming. In contrast, countries such as Myanmar, Indonesia and Cambodia are reported to have a range of funding sources for SRH services, including income from services, and could therefore survive without DFID support. Large South Asian MAs, such as Bangladesh, India, Nepal, Pakistan and Sri Lanka are considered to be relatively stable, having strengthened their institutional base and diversified funding sources through previous core funding. However, some of them remain heavily dependent on external funding sources (not including the MA in Sri Lanka).

DFID core funding clearly enables IPPF to do certain things which - if the organisation were dependent on restricted funding - would be more challenging. Key benefits reported by the ROs include:

- Provides **flexibility to respond to emerging needs**, whether at government, MA, clinic or community level;
- Provides the opportunity to **take risks and innovate**;
- Enables **institutional capacity building**, an area where funding is normally inadequate³⁵; and
- Ensures the **continuity of SRH services**, particularly at times when other large donors withdraw e.g. under the Bush administration.

In the MA survey respondents were asked: 'Out of your most successful projects over the last year, what have the core funds from IPPF Central Office enabled you to do, that you would not have been able to do without them?' Respondents gave numerous examples of projects that Member Associations were able to implement as a result of flexible strategic funds from the IPPF CO, including, for example: capacity building of staff (e.g. Yemen); construction of new clinics and improvement of clinic infrastructure, employment of staff, and procurement of drugs and supplies (e.g. Kenya); provision of mobile health clinic services in rural areas to the poor including RH services, youth friendly services and GBV (e.g. Afghanistan); provision of abortion-related services (e.g. Sudan); advocacy initiatives (e.g. Madagascar); and programmes for young people (e.g. Peru and Mozambique). Box 11 highlights some of the respondents' views about the importance of core funds from IPPF CO.

³⁴ MAs would choose to maintain a wide range of services in fewer clinics, rather than reducing the range of services in clinics.

³⁵ As a result of strengthened institutional capacity, MAs in Nepal and India are now accredited to train government doctors

The MA country study interviews also testified to the importance of the core funds for institutional strengthening and enhancing efficiency. In Ethiopia, the contribution of FGAE core funders, including DFID, to the MA's achievements is significant³⁶. As FGAE uses unrestricted funding to cover the costs of its core SRH services, this funding, first and foremost, secures SRH services, which otherwise would mostly not be available. Secondly, it provides a platform – the basic SRH services - for service innovation, training and influencing. Although the DFID PPA contributes just under 2% of CIES total funding, this and other core funds are used mostly for institutional strengthening and advocacy (an area that is increasingly difficult to get restricted funding for). CIES has also been able to contribute significantly to initiatives that are supported by core funds through the ROs and the CO. This includes capacity building for institutional strengthening initiatives in the region, such as the introduction of systems for financial and project management, and participation in the performance based financing pilot.

Box 11. Out of your most successful projects over the last year, what have the core funds from IPPF Central Office enabled you to do, that you would not have been able to do without them?

“The IPPF core funds are a stabilizing factor in PPFN; it is always there for us. It has helped us to do almost everything” (Nigeria)

“IPPF Central Office core funds contribute a major share for implementing successful projects and if there are weaknesses in some project, financial and technical insufficient will be the main reason” (Myanmar)

“The 5As projects would not have been implemented but most importantly the Access Project through which the poorest and most vulnerable is served” (Nigeria)

“We would not be able to continue projects without the support of IPPF core funds” (Nepal)

“Due to outstanding achievement and innovative approaches adopted during the first phase of the Swara project, Rahnuma FPAP has decided to continue with the project from IPPF core. Similarly, HIV/AIDS project in Quetta initially funded by Japanese Trust Fund (JTF), which at the conclusion of agreement with JTF, was taken up from IPPF core funds due to its access to socially excluded and vulnerable population in one of the most conservative society. Without this support, the success achieved in both the projects would have been lost” (Pakistan)

“IPPF played a very determinant role in moving our advocacy forward – IPPF has helped us apply the concept of ‘Comprehensive Sexuality Education’ in our programs and advocate for it nationwide - IPPF helped us increase our Monitoring and Evaluation skills” (Rwanda)

“IPPF core funding supports all the five program areas and supporting strategies such as human resource, program coordination, and governance. It is the main funding source for the MA. A lot of projects would not have been carried out without the core grants from IPPF CO” (Ghana)

“Even if our organization had all the donors under the restricted funding which run projects, without IPPF core grant we would not exist. We would close down” (Kenya)

“The core funding we receive from IPPF CO is the base for garnering other funding. Core helps us to exist and other funding helps us to expand and extend” (India)

³⁶ FGAE has a number of core funders, comprising Royal Netherlands Embassy, Irish Aid and IPPF, which includes the DFID PPA contribution. Core funders provided approximately 50% of FGAE's 2011 budget. Resources from each of these donors are used in a similar way and it is therefore difficult, and somewhat artificial, to isolate the individual impact of one of the donors.

3.5.2 Value for Money of PPA funding

Is IPPF overall delivering good value for money?

In terms of Efficiency, Effectiveness and Economy there is fairly good evidence from the IPR to suggest that IPPF is delivering good value for money. Though there are only two country examples of the economy (unit cost) figures and cost effectiveness calculations, it can be assumed that many other MAs are delivering the same good value as CIES and R-FPAP, not least because of the low salaries that are paid to staff – a key cost driver. IPPF MAs should balance their salary costs in order to make sure that staff turnover does not negatively impact on effectiveness and efficiency. They should make sure that salaries are competitive in the local market, and that employees feel rewarded for their work. MAs should also have human resource policies that provide non-tangible incentives to employees. Given that unit costs, cost per CYP and cost per DALY are extremely low, there is clearly room for increasing salaries. Value for money is about getting the best quality and most impact for the money, and not just about keeping the costs as low as possible. The DALY methodology only calculates health impact and does not take into account the numerous other impacts of IPPF's work that would be impossible without the committed and able staff that work in the organisation. Efficiency improvements must be driven and supported by better organisational development support from the ROs and the CO.

Is the PPA contributing significantly to the IPPF VfM?

The DFID PPA contributes 20% of all of IPPF's strategic flexible funding (or unrestricted) funding. Though this is not specifically allocated to a set of activities it is clear that the unrestricted funding is responsible for the existence of the Secretariat (ROs and CO) and all of the support activities that contribute to MA VfM. One CO interviewee stated that the Secretariat would lose one in five employees without the DFID funds. Since the ROs and CO are currently an important resource for the MAs to improve their efficiency and effectiveness, it can be assumed that the whole organisation's VfM would suffer without the DFID PPA. As institutional strength is critical for value for money the IPPF Secretariat would do well to provide more support to MAs in their areas of need over the final years of the PPA, particularly in the area of unit cost calculations.

4. Conclusions

4.1 Summary of achievements against evaluation criteria

Most of the findings in this report can be attributed to two or more sources included in the review process. Findings from the RO interviews, CO interviews, MA survey and the country studies were found to be, on the whole, in line with each other and provided similar perspectives.

Results: Achievements of results are positive against logframe targets and the IPR team observed that the sources of data are of good quality. Eighty percent of the 63 million services IPPF provided in 2011 were accessed by poor, vulnerable and underserved people. Although this percentage is an estimation, the interviews and in-country verification give the IPR team good reason to believe that IPPF MAs are prioritising services to these groups. This is mainly

achieved through locating clinics in under-served areas, using accessible and differentiated pricing, providing appropriate and good quality services, as well as linked services and referral to reach the poor, vulnerable and underserved.

The review also finds a good level of coherence between the results of outputs 2 and 3. The country studies, survey and RO interviews all testify to the existence of a vibrant and dynamic set of initiatives for improving the enabling environment for SRHR in both the legal and political, and the social and cultural spheres.

CO and RO interviews, in particular, provided useful evidence of the change process and the organisational improvements that are taking place, particularly the Systems Review, financial management initiatives, strategy development and leadership and management improvements. There is good evidence of a growing value for money culture - however this needs to be strengthened in some of the MAs.

Relevance: All three of the country studies found good levels of representativeness and effective targeting. All of the MAs studied and those reported in the RO interviews are using government policies and strategies, and their strong knowledge of the local context, to inform their approach, and design and target initiatives.

Effectiveness:

(i) Learning was a particular strength of IPPF's ROs. Most MAs reported a high level of satisfaction with the quality of technical assistance provided by the ROs and the CO, and there was also evidence of good intra-regional learning – particularly in the WHR.

(ii) The innovation culture was observed to be strong in the MAs and ROs. The PPA supported Innovation Fund has helped to strengthen this culture, and fund useful projects to demonstrate introduction of new technology and new methodologies for scale up.

(iii) IPPF's CO, ROs and MAs are using partnerships to increase effectiveness in advocacy, service delivery and demand generation. Partners interviewed were positive about their interaction with IPPF and considered them technical experts.

(iv) Financial sustainability is low for most MAs, but some of the MAs in middle income countries are, to a great extent, covering expenditure with internally generated funds. MAs are also active in developing cost sharing with local and national governments.

Efficiency: Organisational efficiency is good with some areas for improvement. The organisational mission, values and strategy are well owned by IPPF staff at RO, CO and MA levels. Leadership, management and governance are key areas of strength. Financial management and reporting are variable across the MAs and the CO is making systems improvements. Unit costs and cost per CYP are lower in general than regional averages in Bolivia and Pakistan and so are considered to be good value considering the high quality of services.

4.2 Summary of achievements against rationale for PPA

The IPR team have found that IPPF has maintained and built on the strengths mentioned in the Business Case as the rationale for funding the PPA. There was considerable evidence of work to promote gender equality both internally within the organisation and externally through the

programmes, as well to empower excluded and vulnerable groups. As mentioned above, learning systems and use of evidence for programming have been observed alongside an effective management and governance system.

The overall theory of change for the investment as written in the business case was: *“that by providing strategic support for the Federation to test and refine its most promising evidence-based development models, connect this evidence to policy-makers to influence best practice and attract funds from other donors, and support governments and other agencies to adopt innovative approaches where they prove relevant and effective, the PPA will leverage the local level impact of IPPF’s best initiatives to influence national and international development policy and effect much wider change in the lives of poor people”*. The IPR has found a great deal of evidence in the country studies, RO interviews and the MA survey to support this theory of change – particularly in the area of working with governments and other partners, influencing policy makers through technical expertise and “making themselves useful”, and having a wider impact on poor and excluded people’s lives – especially women in remote areas and young people.

IPPF Theory of Change assumptions

(i) Legal and policy changes in favour of SRHR will enable better and more accessible SRH services and peoples’ sexual and reproductive rights will be protected by the state and relevant institutions.

There is evidence of increases in safe abortion services following legal change, for example in Ethiopia since 2007. The IPR was able to verify the data on abortion related services in Ethiopia. There was also some evidence on increased services within the public sector as a result of CIES work on government policy in the areas of violence against women and HPV vaccination. However it has not been possible to quantify the increase in services as a result of policy changes. This is an area for further research and impact assessment.

(ii) The provision of quality SRHR services that include counselling, youth differentiated services, attention to special groups and access to poor and vulnerable groups will result in utilisation of the SRH services by a range of different groups, especially women and girls.

All of the country case studies, the regional interviews and the MA survey presented evidence to support this assumption. Utilisation has increased as a result of IPPF’s efforts, and interviewees testified that specialist services and good quality were important aspects of this (particularly for young people).

(iii) Women’s empowerment, youth leadership training and community based support; information and education programmes will impact on the social and cultural enabling environment and improve access to SRHR information, health seeking behaviour and utilisation of SRH services.

There is some anecdotal evidence from the IPR that this assumption holds. However this is an area that would benefit from some rigorous research in order to better understand the change process and to validate the link between some of IPPF’s important initiatives and results.

(iv) Empowered and better skilled women, young people and special interest groups (such as people living with HIV and AIDS) will demand their sexual and reproductive rights and influence government to produce better policies and better health services.

Some of the women's groups, LGBT groups and youth groups in Bolivia were beginning to demand better services from government and to demand their rights. However this is in an environment where the government is encouraging excluded groups, particularly indigenous populations, to demand their rights. Further work is needed to collect evidence that this assumption holds.

4.3 Summary of challenges

The review did not find any fundamental weaknesses, however there are some areas where IPPF's performance could be strengthened. In many cases, these areas are already receiving some level of attention, and this review serves to further highlight them. Following is a short summary of the high level areas for development.

Strategy: The 5As Framework has proved an effective strategy, which has led to significant progress on service delivery and advocacy on abortion, HIV and AIDS and overall access for poor and underserved people. However, it has over-complicated some organisational structures and financial reporting processes. This has possibly led to some level of inefficiency in the CO and ROs. It has also led to some cases (e.g. R-FPAP) where adherence to the Framework has undermined the MA's ability to reflect at their head office level, the realities and priorities of its own service delivery network

Financial and service data reporting: The IPR team found it difficult to reconcile the service figures provided at MA level with those reported to IPPF CO through the eIMS, and noted a clear weakness in the levels of financial reporting. Considerable work is needed to enhance reporting to a high enough level of detail so that the Secretariat can use the data for analysis and reporting to donors.

Research methodologies for situational analysis and M&E: The IPR found that rigorous research methodologies are rarely used for situation analyses and assessments, and on some areas – such as work with health systems and government – there appears to be very little measurement and monitoring of work.

Unit costs and VfM measurement and monitoring: Although there has been some work on unit costs there is still a long way to go. The CO and ROs do not have a strong understanding of the progress or lack of progress on ability to calculate and use unit costs within the MAs. Also there is a lack of understanding about unit cost methodology and overall VfM measurement.

4.4 Overall impact and value for money of PPA funded activities

In 2011 the MAs in the PPA focus countries were able to avert over one million unintended pregnancies and 388,000 unsafe abortions (one of the leading causes of maternal mortality). ROs and MAs reported significant additionality in country work. There were several examples of work with very poor, vulnerable and hard to reach populations that would not have been possible to implement without the PPA funding. The IPR team also found that significant

technical and institutional support from the CO and ROs is having a positive impact on VfM, but would not have been possible without the DFID PPA.

5. Utility

The IPR team will make a presentation to IPPF at the beginning of October in order to discuss emerging issues from the report and to finalise the IPR process. This will coincide with two new directors starting at IPPF and so will feed into their induction and discussions about further organisational change.

6. Lessons learned

6.1 Policy lessons

- There continues to be a difficult and conservative policy environment for SRHR in many countries, with MAs reporting political and legal barriers, and resistance from religious conservatives.
- Donor funding for SRHR is becoming more project-based and restricted, and donors are prioritising service statistics and quantitative impact. This means it is increasingly difficult to raise funds for advocacy, policy influencing, institutional strengthening and accountability initiatives. In this context the PPA is even more valuable.

6.2 Sector level

Health systems strengthening is an important part of IPPF's work, particularly in terms of its potential for wider impact on people's lives. IPPF MAs' experience in service delivery and their rights based approach enables them to be credible and expert capacity builders for governments. However there are some health systems issues that are beyond the MAs' remit. Being overly responsive to government crises can dilute the IPPF mission.

6.3 PPA fund level

There is a need for PPA-funded SRHR organisations to coordinate and agree policy on competition in order to improve value for money. It would also be useful to have more communication between the PPA reviewers so that country visits could be done together and notes compared.

6.4 Organisation level

The local presence of donors can play an important role in the development of good leadership, management and systems in MAs. For example, USAID has played an important role in the re-engineering of CIES and the resulting good management practice. IPPF and DFID could aim to take a more active role in supporting institutional improvements – particularly for better VfM and reaching the most marginalised. Good leadership, management and financial information systems are essential for efficient implementation and this can improve the ability of the MA to reach poor and vulnerable groups.

It is not always possible for MAs to produce and use unit costs with the expertise they have in house. The CORE programme for producing and analysing unit costs can be used by an MA

that has a sophisticated and efficient management system. CORE requires a strict definition of norms and standards for service times (so each service provided needs to be done within a certain standard period of time). The calculations of the unit cost are based on these norms rather than clinic surveys of actual time spent on each service. This means that the unit cost is only accurate if there is a high level of discipline in adhering to the norms – a situation which would preclude MAs that do not have adequate clinic management or monitoring systems.

The exchange (South-South) learning programme funded and managed by the Western Hemisphere RO has been very active and successful. This is a lesson for other regions to be more systematic in their approach to South-South learning.

The importance of the clinic “educator” or counsellor is underplayed and does not get enough visibility. The educator acts as a gatekeeper and facilitator for the most difficult situations and services. He/ she appears contributes to increasing access for young people and for poor people by providing essential information about access to FP, harm reduction services, free services, HIV and STI prevention and detection, etc. This is something that marks IPPF MAs out from other providers.

Through their youth and women’s empowerment programmes, IPPF MAs have significant experience of issues around the link between SRHR, and empowerment, accountability and violence against women. Better impact assessment processes should be implemented in order to maximise learning.

Both CIES and FGAE were found to provide limited transparency about their differentiated pricing policies (see country case study annexes). FGAE non-user groups reported not knowing about the services and said the costs of the services were a barrier. It may be that if the MAs were to advertise free services they might become inundated with demand. Research should be undertaken on the implications of greater transparency for the service delivery points’ ability to meet demand, and their ability to continue to reach poor and vulnerable groups.

Some of the data collected in the country studies indicated that financial sustainability can go hand in hand with good targeting of and access to the poor, vulnerable and hard to reach. However this appears to be linked to good management systems and may not work in every location.

7. Recommendations

Recommendation One

The IPR team finds that the collection and use of data for making programming decisions is not always rigorous enough. The methodology and processes for monitoring, situational analysis, needs assessment, evaluation or impact assessment have sometimes lacked rigour or been completely absent. Specific issues identified include:

(i) Monitoring and verification of results is difficult due to the variety of data collection methods and service categories used by the MAs. This causes inefficiencies as a significant amount of time is spent cleaning and verifying data.

(ii) There is a general feeling amongst staff in the Secretariat and the MAs that investment in rigorous research needs to be balanced with investment in service delivery. The return on investment of data collection and rigorous methodology has not been fully explored and accepted by MAs.

(iii) Some areas of work have had no impact assessment, such as the work to strengthen health systems, or the work to enable individuals and communities to hold governments to account.

Although there have been increases in investment by the CO into M&E over the last few years, there is still progress to be made. As a result there remains a level of uncertainty around the targeting and effectiveness of IPPF programmes. There are also missed opportunities to communicate the Federation's experiences with different methodologies, or their achievement of results. Investment in better needs assessment and M&E has the potential to pay off significantly with increases in efficiencies and effectiveness, and increased donor funding.

Recommendation 1: IPPF to invest more time and money into needs assessment and monitoring and evaluation in order to better target programmes and to gain efficiencies and effectiveness. This should be directed from the CO and with increased technical assistance from the ROs to the MAs. Low cost methodologies, such as the rapid PEER methodology, are already being developed for documenting stories of change. This methodology could also be used for situational and needs assessments. There should also be an emphasis on MAs learning from each other to better use different methodologies and for research capability to be developed. In some cases resources could be pooled to undertake assessments or impact evaluations in the same region. In particular the following areas need attention:

(i) Investigating how to further standardise service reporting categories so that it is easier for MAs to report and to verify the figures.

(ii) Better designing baselines and needs assessments to enable understanding of the range of social, gender and stigma issues that act as barriers to the utilisation of health services. This type of investigation would also give important market research information that could support marketing and pricing strategy development through a better understanding of both clients who can pay and clients who can't pay.

(iii) Considering developing a longitudinal survey in a sample of countries in order to measure impact, changing lives and changes in the social and cultural enabling environment over the medium to long term.

(iv) Evaluating and communicating areas of work that show wider impact. This includes work with government on health systems, demand side financing, social franchising, social accountability, and community monitoring initiatives that are impacting on public sector service delivery.

(v) Developing a system for monitoring and reporting performance of ROs and the CO to the wider Federation.

Recommendation Two

The IPR found that most MAs are not routinely using unit cost data for management decisions and they are also not calculating the cost effectiveness of different approaches. The CO does calculate cost/CYP and cost/unintended pregnancy averted, but is hampered by a financial reporting system that does not provide enough detailed line information about MA expenditure. The review team recognises that many countries do not have the resources or expertise to invest in extensive IT systems for financial and project management. However the IPR found significant efficiency gains in MAs that do have these kinds of IT systems.

Recommendation 2: Increase RO and MA capacity to measure and improve value for money. Overall the Secretariat should have higher expectations of MAs in terms of financial and organisational management, and should ensure effective leaders are rewarded. As this involves greater investment in organisational development overall, it may be advisable to schedule the support over a number of years by prioritisation – much as ARO have done with their support to the MAs. Investment in better systems, processes and especially financial management should accelerate improvements in efficiency and effectiveness. The following areas of work need particular attention:

(i) Developing a methodology for calculations of unit costs and cost benefit – this could target a subset of MAs in the low income countries to pilot both of the approaches to unit cost calculation, particularly in those where there is no electronic MIS system. It could also include training and mentoring for managers at the MA and clinic level so that they can use the information and market research together to make decisions and improve efficiency. This should help MAs to understand their market and their costs better, in order to improve pricing strategies. The Secretariat should also assess the best way to calculate impact measures (including DALYs), agree to implement an internationally peer-reviewed methodology with donors and train MAs to use it.

(iii) Analysing and changing the process and categories of financial reporting from the MAs. Functional reporting lines would be more useful than reporting against the 5As. Ideally there should be enough data to enable extracting of expenditure data for a number of different categories. If possible there should be a move towards standardisation of financial management approaches. This could include supporting the phased introduction of an integrated IT solution. The MA in Bolivia has implemented SAP Business One. This or lower cost versions available in Latin America could provide a platform for other MAs.

Recommendation Three

The South-South learning initiative in the Western Hemisphere Region has been successful and is well valued. There are also several other learning links in different regions. However these have not been so systematically coordinated and there is a lack of coordinated inter-regional exchange. Technical assistance (TA) is also an important and effective mechanism for learning within IPPF. Currently, this provided to the MAs mainly by the ROs, and predominantly on SRHR technical areas. However, MAs are asking for more assistance to improve their organisational development and systems. Linked to the previous recommendation to improve financial reporting and management this recommendation encourages processes for supporting MAs to address some of their learning challenges.

Recommendation 3: Further develop organisational learning in the following two areas:

- **South-South learning, which may include exchange visits and/or technical hubs.** Include a more strategic approach to inter-region learning. This would increase motivation to share information and expertise more widely in the federation. It would also ensure a more south-south based network of experts.
- **Technical assistance to MAs to improve financial management, support IT systems introduction, improve resource mobilisation and strengthen other components of organisational effectiveness.**

Recommendation Four

This review team has been particularly struck by how effective the 5As framework has been in mainstreaming work on previously neglected health areas and target groups throughout the federation. However the overlap between the 5As has resulted in some inefficiency. The IPR also finds that the structure of the organisation around the 5As is not necessarily the best way of organising as the institution develops further. This is particularly as the 5As can be interpreted broadly to include a wide range of areas, and this represents a risk to the organisation in terms of lack of focus and fragmentation.

Recommendation 4: When developing the new strategy and structure of the organisation over the next two years ensure that lessons from the previous experience are fully analysed and used to develop a more functional and efficient organisation, with the kind of skills needed for the next ten years of progress.

IPPF should consider the challenges of the implementation of the 5 As and question whether the whole organisation has to be structured around the strategic priorities or whether there are other ways of ensuring delivery – such as clear indicators and targets for success.

There are three areas to consider when planning for future strategy:

(i) Focus: Build on the experience of prioritisation and focus from the HIV team and the ARO country prioritisation. IPPF should consider how best to focus on and prioritise: (a) activity areas and (b) support to MAs. This should aim to maximise results for IPPF's core business: SRHR for poor and vulnerable people. Effective work on SRHR requires addressing multiple issues, such as the 5As and beyond. IPPF should make sure that the strategic focus and its core SRHR commitment does not expand into too many initiatives, as this can become unmanageable. There should also be further prioritisation and phasing of support to the MAs in order to maximise impact over the medium to long term. This is especially important in an environment of potentially shrinking and restricted donor funding.

(ii) Review the expertise needed by the organisation. The IPR would recommend that IPPF should especially increase the professional capacity of communications and advocacy experts throughout the organisation.

(iii) Target groups: The new strategic goals should address the issue of target groups, which may differ by country. For example, in some countries the MAs have not yet fully developed work with men through service delivery and norm change activities, although the youth work does target both boys and girls. IPPF should consider how to develop work with men (as

change agents, service users, supporters of women and girls SRHR), particularly where MA clinics are primarily serving women (e.g. Bolivia, Ethiopia, Pakistan).

Recommendation for DFID

Some overlap in clinic location and outreach services was found with Marie Stopes International (MSI), which is also a PPA holder. It appears that MSI have a strategy of locating service delivery where there is already demonstrated demand. This has not been verified with MSI in London. However there is a clear need to address this issue at central office level with both organisations.

DFID should discuss any overlap and competition between PPA holders in the same sector. DFID's engagement should aim to ensure that the grantees take action to eradicate negative competition by prioritising their social and development objectives. DFID should also aim to facilitate agreement between SRHR organisations to grow the whole market of demand for SRHR, and not just the CYPs of each organisation.

Annex 1. PPA IPR TOR

Terms of Reference for the Independent Programme Review (mid-term) of the Programme Partnership Arrangement between IPPF and DFID. February 2012

IPPF has been implementing activities under its Programme Partnership Arrangement (PPA) with DFID since April 2011. The external mid-term Independent Programme Review of this grant will evaluate results and outcomes to date and provide recommendations for the remaining period of the grant.

IPPF would like to invite applications from a coordinating consultant or group, to assess IPPF's work at the global level, alongside a small number of more in-depth country level reviews. The IPR must be available for DFID by mid-October 2012 so IPPF anticipates draft reports from the consultant to be completed by the beginning of September 2012 to comply with this deadline.

If you are interested, please reply to Fleur Pollard, Evaluation Officer (fpollard@ippf.org) with a one page expression of interest that outlines your approach to meeting the Terms of Reference below. Applicants that meet the relevant criteria will be invited to submit a full proposal.

Please submit expressions of interest by close of business on 22nd February 2012.

1. Background

IPPF is the largest global NGO working in the field of sexual and reproductive health and rights. Through its Member Associations (MAs) IPPF provides a comprehensive range of services and is a leading advocate of sexual and reproductive health and rights for all at the local, national, regional and global levels.

IPPF is currently receiving unrestricted funding through DFID's Programme Partnership Arrangement (PPA). This strategic level agreement provides a grant from 2011 to 2014, up to a maximum value of £8.6 million per year (for three years). This is part of DFID's significant funding to civil society organisations in line with its overall strategy to alleviate poverty and promote peace, stability and good governance.

One of the key tools in the performance assessment of IPPF by DFID is the Independent Progress Review. This is to be commissioned by IPPF on the basis of this Terms of Reference and will report on performance against DFID criteria after 18 months of implementation (grant mid-point).

2. Purpose:

The purpose of the Independent Progress Review is to measure the achievements, challenges, outcomes and impacts (both positive and negative) resulting from IPPF's funding through the DFID PPA. The IPR will identify progress to date and develop recommendations for IPPF to guide the remaining 18 months of the funding period. The information generated by this IPR will feed into the overall IPPF and PPA fund-level evaluation.

3. Impact and outcome of IPPF's PPA:

At the highest level of impact, IPPF is contributing to sustainable improvement in the lives of poor and vulnerable groups through progress in three Millennium Development Goals:

- Promoting gender equality and empowering women (MDG 3)
- Contributing to maternal and child health (MDGs 5&4)
- Curbing the HIV/AIDS epidemic (MDG6)

Outcome: To improve the health status of poor and young people, in particular women and girls, through an enabling sexual and reproductive health (SRH) policy environment and access to a range of cost-effective, high-impact health services.

In particular, investment through the PPA is supporting innovative programming models from across the IPPF membership in the following policy priorities:

- Deliver high impact comprehensive family planning services.
- Improve the policy environment for SRH and choice at global, regional and national levels.
- Strengthen the economy, efficiency and effectiveness of IPPF's network

IPPF is targeting the underserved, poor and vulnerable people and those in crisis, especially young women. Empowerment of women and girls is central to IPPF's work including supporting a woman's right to choose to terminate her pregnancy legally and safely. IPPF strives to eliminate sexually transmitted infections (STIs) and reduce the spread and impact of HIV/AIDS.

Whilst IPPF is a global organisation working in more than 173 countries, we are giving particular priority under this PPA to improving performance in 45 focus (Global Strategy for Women's and Children's Health -GSWACH) countries. This group includes 39 of the 49 UN GSWACH countries, and six additional countries (Bolivia, Brazil, Guatemala, India, Peru and Sudan) where IPPF Member Associations are primarily supporting poor and vulnerable groups, and are positioned to scale up service delivery over the PPA period.

IPPF's PPA with DFID will further the goals and objectives of our Strategic Framework (2005-2015) which focuses on five priority areas, known as the five 'A's; Adolescents/young people; HIV and AIDS; Abortion; Access and Advocacy. While IPPF recognizes that the vision and commitments made at the International Conference on Population and Development (ICPD) represent a true international consensus, these goals are far from being achieved and require renewed financial and political support.

For more information, including expected results and the list of focus countries, please refer to the full Business Case for our Programme Partnership Arrangement with DFID, as published on the DFID website.

4. Objectives of the IPR

The objective of the IPR is to provide comprehensive assessments of the criteria listed below, as developed by Coffey, the DFID PPA Evaluation Manager. The IPR should also examine the extent to which IPPF has taken into account the comments and recommendations arising from DFID's annual review (to be completed by the end of June 2012) and verify the case studies

that are a DFID reporting requirement (due for submission to DFID by the end of May 2012).

4.1 Organisational culture

- How has IPPF's organisational culture promoted or impeded learning and innovation?

4.2 Relevance

- Representativeness. Do the interventions and outcomes (as expressed in the Log Frame) reflect the needs and wishes of the target population?
- Targeting. To what degree do the interventions and outcomes reach the poorest and most marginalized?

4.3 Efficiency

- To what extent is IPPF able to evidence its cost effectiveness and value for money?

4.4 Effectiveness

- Distinctive offering. What is the distinctive offering of IPPF and how does it complement or add value to DFID's portfolio?

4.5 Learning and innovation

- To what extent has IPPF learned from its work and has incorporated the lessons into improved performance?
- To what extent has IPPF produced generalizable learning that has been incorporated into our own practice and shared with others?
- Assess the extent to which IPPF innovates in terms of developing, testing, and achieving the adoption by others of new knowledge.
- Assess IPPF's monitoring and evaluation capacity and in particular its ability to measure results (focusing on the quality of reported results and lessons learned rather than an assessment of M&E systems themselves).

4.6 Sustainability

- Assess the extent to which an intervention or its results are likely to be sustainable.

4.7 Results

- Performance against the Log Frame: to what extent is IPPF achieving (or progressing towards) the intended outcomes?
- Changes in lives. Assess the information about what changes these outcomes are making in people's lives and how many people are affected.
- Changes in civil society. To what extent are citizens doing things for themselves? To what extent is civil society enabled to hold government to account?
- Assess what conditions led to success and failure – external, internal combination of Interventions.
- To what extent does DFID funding achieve additionality, i.e. enable IPPF to achieve things they would have otherwise not been able to achieve?

5. Roles and responsibilities:

The selected consultant or group will, in close consultation with IPPF staff:

- Develop a methodology and appropriate tools for the IPR (see table below)
- Conduct a desk based review
- Conduct key informant interviews
- Conduct field work in a small sample of selected IPPF partners (Member Associations)
- Produce a report for each country visit and overall synthesis report accompanied by a presentation.

IPPF will support all stages of the evaluation process including: providing relevant documentation, assisting in organising travel logistics, assisting in the organisation of data collection (ensuring availability of interviewees and relevant data), providing feedback on drafts of all agreed outputs, including the methodology.

6. Methodology:

The IPR will cover two levels of IPPF's work – the global level (incorporating the work of our Central and Regional Offices and the aggregated results from the 45 focus countries) and more in-depth data collection among a small sample of Member Associations. The methodology at each level will be finalised in consultation with IPPF but is likely to incorporate the following components as described below.

Global Level(IPPF Central and Regional Offices & 45 focus countries)

Desk Review including - Key PPA documents (Business Case, logframe, financial and programmatic reports, case studies) and IPPF documents (Global Indicator data, IPPF's Strategic Framework, relevant policies and materials).

Interviews - Key staff members from IPPF Central Office and relevant Regional Offices. Representatives of key partners.

Country Level(IPPF Member Associations)

Desk Review including - MA Strategic Plan, Global Indicator data (including service statistics), relevant policies, materials and programmatic and financial reports.

Interviews - Key staff members and representatives of partners.

Qualitative - For example; MA volunteers, beneficiaries, community representatives etc

Quantitative - For example; collection of cost per service data for value for money analysis.

7. Outputs:

- Complete, finalised tools used for the evaluation.
- Reports for each of the countries visited (in English).
- Presentation of findings (at country level as part of each country visit) and at IPPF CO in

London.

- An overall synthesis report incorporating IPPF's work at the global level and highlighting those countries in which fieldwork took place (in English).

8. Profile of the coordinating evaluator

IPPF will recruit one coordinating consultant or group to conduct the evaluation. The successful bidder will be expected to have:

- One or more team members who are specialists with a minimum of 7 years experience in programme/project delivery in an international development context.
- Previous experience in monitoring and evaluating SRHR projects
- Knowledge of DFID priorities and expectations with regard to evaluation
- Sensitivity to different cultural and religious contexts
- Capacity to analyse results-based qualitative and quantitative monitoring and evaluation data in a systematic way
- Ability to present complex information in a systematic way
- Excellent writing, analytical and communication skills
- Fluency in written and spoken English
- Ability and commitment to deliver the expected results within the agreed period of time

Timetable

The indicative timetable for this process is outlined below:

- 22nd Feb – One page Expressions of Interest submitted to IPPF
- 27th Feb – Shortlist of consultants invited to submit full proposals
- 16th March – Submission of full proposals to IPPF
- 26th March – Selection of consultants by IPPF
- End March to End August – Evaluation conducted
- 1st Sept – Draft evaluation reports submitted to IPPF
- Mid Oct – Finalised reports submitted to DFID

Organisation International Planned Parenthood Federation

Country United Kingdom

Annex 2. Evaluation research schedule and timescales – within report

Annex 3. Data collection tools– attached separately

**IPPF Independent Progress Review
Annex C: Data Collection**

International Planned Parenthood Federation

September 2012



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Central Office Interview Questions

IPPF HQ interviews for the DFID PPA IPR (Monday 28th May 2012)

A) John Good, Finance Director, Liam Blake, Head Finance

Main focus topics: value for money and efficiency

Secondary topics: M&E, equity, and sustainability, organizational culture

Value for Money and Efficiency

1. Please explain how IPPF is articulating and managing the value for money offer.

- Are there any innovations in calculations or presentation of cost effectiveness or VfM data – e.g. unit costs or other costing methodologies?
- What is the level of understanding of VfM in HQ, ROs and in the MAs?
- What can be done to encourage a VfM culture?

2. How does IPPF improve efficiency?

- What are the elements of efficiency?
- How is it measured?
- Are there any initiatives to improve efficiency in the MAs?
- How is the current organizational change process and re-structuring impacting on efficiency?

Monitoring and Evaluation

3. How does your department contribute to the monitoring and evaluation function of the organization?

- What challenges do you face when collecting and reporting data? What can be done about this?
- Do you think the donors are happy with the M&E methodologies and processes used?

Equity and Sustainability

4. How does the organization increase access to the poorest and most vulnerable people whilst at the same time charging for health services?

- Do your clients have consumer rights if they are not paying for services?
- Who is the organization accountable to?

5. How does IPPF encourage and monitor efforts to increase sustainability of initiatives?

Organisational Culture

6. What do you think needs to be changed in the organizational culture to:

- i. Increase learning and innovation
- ii. Encourage collaboration

B) Tewodros Melesse, Director General

Main topics: Relevance, Efficiency (leadership and vision), Value for money, Effectiveness, organizational culture.

Relevance

1. What would you say are the main challenges for progress on SRHR and HIV prevention, treatment and care in the world today?

2. What is IPPF doing to address these?

3. How does IPPF have to change in order to do this?

Efficiency

4. Where do you think that IPPF faces the biggest challenges in delivering efficiency?

- Service delivery
- Organizational efficiency

5. How is the current organizational change process and re-structuring impacting on efficiency?

6. How would you describe your leadership style and its use for the requirements of IPPFs organizational efficiency?

Value for Money

7. Please explain how IPPF is articulating and managing the value for money offer.

Effectiveness and Impact

8. How has IPPF's work impacted on poor and vulnerable people in the last two years?

- Do you think that poor and vulnerable people's utilization of health services has been increased by IPPF?
- What evidence do you have?
- How are people's lives changing?
- What is IPPF's distinctive offer?

Organisational culture

9. How do you increase the potential for intra-federation learning?

10. What is your biggest priority for this year?

11. How will the organization help you to achieve your goals?

C) Kevin Osbourne, Acting Director of Programmes

Main topics: relevance, efficiency, effectiveness, value for money

Relevance

1. Do you think that the MAs have a good understanding of the context that they work in and the government health priorities?

- Should MAs always follow government strategies?
- Do MAs understand the main barriers to access and main political and social issues that relate to SRHR?
- How do MAs analyse vulnerability and social exclusion?

Efficiency

2. Where do you think that IPPF faces the biggest challenges in delivering efficiency?

- Service delivery
- Organizational efficiency

3. Are there any initiatives to improve efficiency in the MAs?

4. How is the current organizational change process and re-structuring impacting on efficiency?

Effectiveness

5. How has IPPF's work impacted on poor and vulnerable people in the last two years?

- Do you think that poor and vulnerable people's utilization of health services has been increased by IPPF?
- What evidence do you have?
- How are people's lives changing?
- What is IPPF's distinctive offer?
- How do you think HQ and ROs could better serve the MAs in their mission?

Value for Money

6. Please explain how IPPF is articulating and managing the value for money offer.

D) Doortje Braeken, Senior Advisor Adolescents/Youth

Main topics: Relevance, effectiveness, impact and equity, efficiency, learning and innovation

Relevance

1. How is IPPF's work relevant to the situation of poor and vulnerable young people?

- Are the MAs able to do the analysis required to understand this situation?
- What is the aware of young people's specific requirements are clinic and outreach staff?
- How well do you think you are addressing young people's situation?

Effectiveness, impact and equity

2. How has IPPF's work impacted on poor and vulnerable people in the last two years?

- Do you think that poor and vulnerable people's utilization of health services has been increased by IPPF?
- What evidence do you have?
- How are people's lives changing?
- What is IPPF's distinctive offer?

3. Do you know who is not reaching IPPF's services and why this should be?

- Are the barriers that are specific to girls or to boys?
- How do MAs address these barriers?

Efficiency

4. Where do you think that IPPF faces the biggest challenges in delivering efficiency?

- Service delivery
- Organizational efficiency

5. Are there any initiatives to improve efficiency in the MAs?

- How do you measure the value for money of serving young people in IPPFs programmes?

6. How is the current organizational change process and re-structuring impacting on efficiency?

Learning and innovation

7. How are MAs able to improve youth relevant programming?

- How does intra-federation learning work?
- How do you and your team encourage it?
- What is the best example of learning that you have experienced this year?

Group discussion, Advocacy Team (Tuesday 29th May 2012)

How are the measuring 3Es, what are the main results over last two years?

What do you think the main advocacy objectives are at the moment to achieve a real step change for SRHR and HIV and AIDS in low income countries?

What would you change in this organization if you could?

Group discussion Access Team

Is there a problem with increasing access to services of poor and vulnerable people? What is the key to scaling this up? Is it IPPF's role?

Do you know who is not reaching IPPF's services and why this should be?

Describe your current cutting edge initiatives.

What would you change in this organization if you could?

General group discussion

Why do you work for IPPF? – discussion about the main motivations and aspirations of staff.

Does IPPF manage to increase access to poor and vulnerable people in low income countries? – how are you most successful? What is the key to success?

What would you change in this organization if you could?

What do you personally do to improve the value for money of the work IPPF does?

Regional Offices Interview Questions

Questionnaire for IPPF Regional Office staff

Name	Position	Organisation	Date

I. Relevance

1a. To what extent do the UK Aid's unrestricted core funding activities implemented by the RO relate to sexual and reproductive health priorities at national level your region? Please use specific country examples to explain.

1b. Representativeness

Have you analysed the main barriers and main political and social issues relevant to SRHR in the region? How have barriers been identified? How do you support MAs to overcome these barriers? Please use specific country examples to explain.

1c. Based on the above assessments,

- i.) how relevant is the level of UK Aid's unrestricted core funding for activities implemented by the RO for addressing SRHR needs of the poorest and most vulnerable?
- ii.) how relevant is this type of funding (ie unrestricted, core funding from IPPF) for activities implemented by the RO for addressing SRHR needs of the poorest and most vulnerable?

Relevance	Highly relevant	Relevant	Less relevant	Irrelevant
i.)				
ii.)				

II. Efficiency

2a. How would you rate the efficiency of MAs? Please use specific country examples to explain.

2b. Could the same results have been achieved for less money or more quickly? Please explain by using country examples.

III. Effectiveness

3a. Which areas of SRH service delivery are in most demand by poor and vulnerable people in this region? Please use specific country examples to explain.

3b. Have the MAs been successful in increasing utilization of these services by poor and vulnerable people – and specifically for women and girls? Please use specific country examples to explain.

3c. How have you supported the MAs in this process? Please use specific country examples to explain.

3d. Based on the above assessments, how effective UK Aid's unrestricted core funding for addressing SRHR needs of the poorest and most marginalized?

IV. Impact

4a. To what extent do you think IPPF and MAs have contributed to progress in achieving MDG 5 and 6 in your region? Please use specific country examples to explain.

4b. What might have happened in MA's and clinics in this region without the UK Aid's unrestricted core funding over the period 2011-2012?

4c. Without the 20% UK Aid's unrestricted core funding, which activities would MAs in the region have to cut back in general?

RO

Country I

Country II

Country III

4d. Based on the above assessments, how would you assess the overall impact of UK Aid's unrestricted core funding for addressing SRHR needs of the poorest and most marginalized?

Impact	Very high	High	Low	Very low
Country I				
Country II				
Country III				

V. Sustainability

5a. What estimated % of RO's capacity building goes to people outside your organisation? (e.g. training of government health workers or other CSO health workers?)

5b. How many MA supported clinics could operate without external funding? Please use specific country examples to explain.

5c. Are there any other social or political factors that could affect the long-term sustainability of the clinics?

5d. Based on the above assessments, how would you assess the overall sustainability of UK Aid's unrestricted core funding for addressing SRHR needs of the poorest and most marginalized?

Sustainability	Very high	High	Low	Very low
Country I				
Country II				
Country III				

VI. Organisational culture

6a. How would you describe your organizational culture and values in the RO?

6b. To what extent do MAs have the sense of belonging to a wider international federation?

VII Learning and innovation

7a. Do you network and communicate with other ROs or MAs from other regions? Have you taken up any practices/ innovations from other ROs or MAs from other regions?

7.b To what extent has the RO learned from its work and has incorporated the lessons into improved performance?

7c. Do you encourage staff to try out new ways of working and doing things? Give specific examples.

7d. Based on the above assessments, how does UK Aid’s support to IPPF influence ROs and MAs organizational culture for learning and innovation in your region?

Learning and innovation	Very high	High	Low	Very low
RO				
Country I				
Country II				
Country III				

8. How are you supported by IPPF Central Office in the UK?

8a. Do you have clear lines of communication and support to technical experts in the organization?

8b. How would you rate the IPPF Central Office overall in terms of their

- Strategic leadership
- Technical support
- Management and systems support
- Communications

Rate 5=very poor, 4=poor, 3=average, 2=good, 1=very good

IPPF MAs and Regional Offices Survey (survey monkey)

Survey for IPPF MAs and regional offices – 2012 independent review

INTRODUCTION

From 2011 to 2014, DfID (the UK Government) is a key provider of money to IPPF to help Member Associations to provide services to the poorest people, promote peace, stability and good governance. This grant has a maximum value of £8.6 million per year (for 3 years) which is about 20% of IPPF's core, unrestricted grants to Member Associations.

At this time, halfway through the funding period, DfID is carrying out a review of programmes it is supporting to establish what is working well, what could be improved and what positive (or negative) impacts programmes are having. Your opinion is therefore very important to us as you are in the best position to see how programmes are being implemented.

This survey should take up to 45 minutes to complete. It is anonymous so you do not need to enter your name or job title on the form. IPPF will not see the results as they will be analysed by an external company (Social Development Direct).

Please complete this survey by 27 July 2012. If you have any questions about the survey, please contact Georgia Taylor at gtaylor@sddirect.org.uk.

Thank you very much for taking the time to complete this survey.

RESPONDENT PROFILE

(This is a confidential survey. The information in this section is only being asked to obtain disaggregated statistics for analysis. It will not be used for any other purposes.)

1. What is your country of operation?

Text box

2. How many years have you worked for your IPPF member association?

0-4 years

5-9 years

10-14 years

15-19 years

more than 20 years

SUPPORT FROM REGIONAL OFFICE

(Please note that this survey is confidential - Regional Offices will not see the results as they will be analysed by an external company)

3. What technical assistance have you received from your Regional Office? (For each area, please choose 'yes' or 'no' from the dropdown menus under the three questions).

	In which of the following areas did you request support from your Regional Office?	If yes, did you receive the support you needed from your Regional Office?	If not from your Regional Office, or in addition to your Regional Office, did you receive support from IPPF Central Office?
Adolescents			
HIV and AIDS			
Access			
Gender			
Sexual and reproductive rights			
Abortion			
Advocacy			
Governance			
Accreditation			
Resource Mobilization			
Capacity building			
Monitoring and evaluation			
eIMS (electronic Integrated Management System)			
IT			
Financial management			
Human resource management			
Commodities			

Please describe other areas of support received from your Regional Office.

Text box

4. How would you rate the overall quality of the technical assistance from the Regional Office?

Excellent

Good

Average

Poor

Very poor

5. What more could the Regional Office do to support your work?

Text box

SUPPORT FROM IPPF Central Office

(Please note that this survey is confidential – Central Office will not see the results as they will be analysed by an external company)

6. How would you rate the quality of the technical assistance from the Central Office?

- Excellent
- Good
- Average
- Poor
- Very poor
- Not applicable

7. What more could Central Office do to support your work?

Text box

NETWORKING AND COMMUNICATING WITH OTHER MEMBER ASSOCIATIONS

8. Do you communicate with other member associations?

- Yes
- No

If yes, please provide an example of this communication, briefly describing what you communicated about, how and why in the text box below

Text box

9. Which member association did you learn the most from this year?

Text box

10. Why?

Text box

IDEAS AND INNOVATIONS

11. Have you heard of any ideas or innovations this year that you might try and implement in your member association?

- Yes
- No

If yes, please describe more about this innovation and where you heard it from.

Text box

12. Do you know if your ideas and innovations have been used within other member associations, at Regional Offices or at Central Office?

- Yes
- No

If yes, please describe more about your innovation and where it is being used?

Text box

SENSE OF BELONGING

13. To what extent do you have a sense of belonging to a wider international federation?

- Very strong sense of belonging
- Strong sense of belonging
- Indifferent / haven't thought about it
- Weak sense of belonging
- Very weak / No sense of belonging

14. What more could be done by the Central Office or Regional Offices to increase your sense of belonging to a wider international federation?

Text box

15. Is it important to you to be part of the IPPF Federation?

- Yes
- No

If yes, please explain what the IPPF brand means to you and how you use it? (e.g. do you use it on your website?)

Text box

ACCESS & SERVICE DELIVERY

16. How do you estimate the percentage of clients who are poor and vulnerable?

Text box

17. What do you do to make sure that the poorest and most vulnerable have access to SRHR services?

Text box

18. What areas of service delivery are in most demand by poor and vulnerable people in your country? Please tick up to three options.

- Family planning / contraception
- Ante natal and post natal care
- Vaccinations
- Safe delivery
- HIV-related services
- Abortion-related services
- Other (Text box)

19. What are the biggest barriers to delivering sexual and reproductive health services to the poorest and most vulnerable groups?

Text box

RELEVANCE

20. Do you use your country's national health plan or strategy to guide your programming?

Yes

No

Not applicable (no national health strategy for programmatic area)

If yes, please explain.

Text Box

21. Are you involved in national or local planning processes?

Yes

No

If yes, please explain.

Text Box

22. How does your member association work in partnership with government?

Please select all that apply

Training / capacity building of government health workers

Provide services in government health facilities

Coordinate with government

Other (please specify)

Text box

MONITORING AND VALUE FOR MONEY

23. Do you regularly calculate the cost of specific clinical services (e.g. allowing you to specify the cost of providing one family planning service)?

Yes

No

No clinical services provided

If yes, how do you use this information to help you minimise costs?

Text Box

24. How do you measure results and lessons learned? Please select all that apply.

Routinely collected data (such as service statistics and client demographic data)

Surveys

Exit interviews

Case studies

Other (please specify) Text box

25. Please provide an example of how one of your programmes/initiatives is making an impact on people's health or other areas of their lives.

Text box

DONOR FUNDING

26. What trends have you noticed in donor funding (excluding IPPF core grant funds) over the last five years?

Increased

No change

Decreased

Any comments – text box

27. Do you have a sustainability plan or resource mobilisation strategy?

Yes – Please go to question 27a

No – Please go to question 28

27a. Did you receive technical support from IPPF Central Office or Regional Offices developing this strategy?

Yes (Central Office)

Yes (Regional Office)

No

28. Out of your most successful projects over the last year, what have the core funds from IPPF Central Office enabled you to do, that you would not have been able to do without it?

Text box

29. Any other comments

Text box

Thank you very much for completing this survey.

Bolivia

Questionnaire for semi-structured interviews with MA HQ staff – numbered questions to be asked, bullet points are for probing further depth or detail.

Introduction question

1. What is your role and main tasks in the organization?

- How long have you been with CIES?
- What motivated you to start working with this kind of organization?

Services

2. How is CIES's programme addressing the specific SRHR context for poor and vulnerable people in Bolivia? *(you may have been given information about this in the presentation so you will need to probe for further detail only – particularly for information that will verify what you already know)*

- What analysis have you undertaken of the SRHR needs of underserved, poor and vulnerable people, particularly young women? Were key stakeholders involved in this process?
- Is there a gender and/ or social exclusion policy and/ or strategy that clearly analyses poor women's barriers to SRHR and guides staff? If not, how does CIES ensure that gender equality is central to its work? How is this strategy implemented in the clinics and with volunteer staff? What specific initiatives were used to address gender issues in relation to access and acceptability at community level?
- Are targeting strategies used to direct benefits towards the poorest and vulnerable groups?
- How does CIES monitor the reach of services among poor and excluded groups and in remote areas?
- What kind of feedback and communication do you have from the poorest and most marginalized

3. Has utilisation of services increased over the last two years?

- What areas of service delivery are in most demand by poor and vulnerable people?
- How do poor people hear about services?
- What level of coverage do you have in the population?

Advocacy

4. Please describe the advocacy projects or campaigns you are working on.

- How do you work with partners and networks to build advocacy capacity and momentum in Bolivia?

5. What advocacy objectives had you achieved over the last 2 years?

- Can you provide examples of CIES national advocacy messages being taken up and repeated by others?
- What are the factors of your success? (linked to TOC)

6. Are you involved in IPPF's international advocacy?

- Has the international advocacy made a difference in Bolivia?

Partnerships

7. How do you interact or coordinate with government?

- Do you use or follow provincial or district health or SRH strategies for strategic planning?
- Are any of CIES's services delivered in partnership or through public health facilities? Does referral take place between CIES facilities and public hospitals?

8. How do you support the development of the SRHR sector overall?

- Do you provide capacity building and training support to other organisations? Please describe and quantify.

Results and impact

9. What evidence do you have of the impact of your work?

- On people's health?
- On poor and vulnerable people's lives?
- Is the IPPF core funding contributing to improvements in the health status of poor and vulnerable people in particular?
- Would you be able to reach these people without the core funding?
- Do you have the tools needed to effectively measure impact and results?

10. Why do you think your approach delivers results? (linked to theory of change)

- What assumptions have you made?

Management

12. How have you improved efficiency¹ in the head office and overall operations of CIES?

- Have you made any management, communications, systems, leadership or human resource improvements?
- Which of your clinics or outreach services would you say is the most efficient at delivering services? Why is this?
- Which clinics or outreach are underperforming and why?
- How are you planning improvements?
- How have organisation improvements impacted on results?

13. How do you measure and monitor efficiency and value for money in your organisation?

- Do you think your clinics deliver good value for money?
- How have you been able to achieve more for less money or more quickly? Please give an example
- Do you have any examples of economies of scale being achieved since 2011?
- How do you ensure good value for money in procurement and logistics?
- Have you received any guidance from IPPF RO or CO?

Sustainability

14. How sustainable and resilient are CIES's clinics and outreach services?

¹ If they do not understand efficiency or value for money probe by asking what they think these terms mean and then explain that it means doing things better and achieving more for the money. Efficiency could include any organisational and system improvements that increase the outputs and outcome per input. For example treating more clients per clinic, or providing more training with the same team in the head office, or better leadership motivating staff to work harder and be committed to a clear strategy and workplan. Value for money

- How many CIES supported clinics could operate without non-income (user fees and other) funding?
- Are there any other social or political factors that could affect the long-term survival of the clinics? How does CIES address these?

15. If your unrestricted funding from IPPF had been cut by 20% over the last two years, what would have happened to CIES's work?

- Which activities would you have to cut back?
- Would any particular programmes have suffered?

Learning and innovation

16. To what extent is CIES an innovative or learning organization?

- Provide examples of how this manifests – e.g. how CIES has learned from its work and has incorporated the lessons into improved performance
- How does the organizational culture help or hinder learning? Provide examples.
- How do you encourage staff to try out new ways of working and doing things?

17. What systems are in place for learning between IPPF's MAs?

- Do you network and communicate with other MAs and externally?
- What practices/innovations have you adopted from other MAs either in the Latin America region or more widely (please specify both)?
- What practices/innovations have you adopted from other local or international organisations?

18. How are IPPF's strategies and planning influenced by CIES?

IPPF CO and RO service quality

19. What does IPPF mean to you?

- Do you feel like you are part of a wider international federation?
- What benefits do you get from this?

20. How would you rate the quality of the technical assistance from the regional office? 1=excellent, 2=good, 3=average, 4=poor, 5 = very poor

21. How would you rate the quality of technical assistance from the IPPF CO (if any) 1=excellent, 2=good, 3=average, 4=poor, 5=very poor

22. Do you have any suggestions for improvements?

Questionnaire for semi-structured interviews with clinic and outreach staff (clinic manager, service providers, supplies and Commodities Manager, Receptionist) - *numbered questions to be asked, bullet points are for probing further depth or detail.*

Introduction

1. What is your job/role in this clinic or outreach service?

- How long have you been with the organisation?

Service delivery

2. What are the main sexual and reproductive health requirements for poor and vulnerable populations in this district?

- How easily are they reaching services?
- What other service providers exist in this district and nearby?
- Where do most poor and vulnerable people go for SRHR services?

3. Which people do you think find it hardest to access SRHR services?

- Are you serving any of these people?
- Are fees a barrier for poor people to use your services?
- Which people in the community would you say are not able to use your services and why?

4. How do you handle particularly vulnerable clients?

- What does the clinic do if a client cannot pay the bill? How do you know they have no resources?
- What do you do if a teenage girl comes to the clinic asking for an abortion? What if she has been raped?

5. Do you collect information from clients and use it to design and implement services that address their specific needs and situation? **(manager only)**

- Do you collect socio-economic data about your clients?
- Are you able to disaggregate information from clients for example by age or poverty level? Do you use this data to make management decisions?

Partnership and networking

6. Do your clinic or outreach services have a relationship with the public sector?

- Do you interact with public sector facilities?
- Do you refer clients to public sector facilities?
- The EDO and local government?

7. How do the clinics work with public sector community based health workers such as Lady Health Workers, Community Midwives and Traditional Birth Attendants or Dais?

- Do they refer people to your clinic?

8. How effective is this relationship with the public sector for improving provision of services to the very poor and vulnerable?

9. What other organisations are you connected with to improve access?

- Do you refer clients to these organisations?
- How do you decide where to refer a client?

Management and Organisational culture

10. How many staff work in your clinic? **(clinic manager only)**

Include part time staff, full time staff, volunteers, professional trained or casual staff

11. How are staff managed and supervised? **(clinic manager only)**

12. How are supplies managed?

- How is inventory controlled?
- How often do you make orders for supplies and who to?
- How efficient is the supply and delivery process?
- Can I see the supplies cupboard? Show me all the methods of contraception.

13. What does IPPF mean to you - beyond your relationship with CIES HQ?

- Can you give me some examples of CIES's policies? Were you consulted about those policies?

14. Has CIES provided the clinic with any guidance – TA, training?

- How good is this? (score 1 – 5)
- How regularly is this provided?
- Do you get training or guidance from specific IPPF initiatives or projects?
- How would you rate this training? (1 – 5)

15. How is quality assurance managed?

- Does CIES make regular visits to the clinic and outreach services?
- How often and who does the visits?
- Is there a quality guidance and checklist? Can I see it?

Service data and results

16. How many men and women (separately counted) has the clinic served (include family planning, maternal health services, STI and HIV diagnosis, treatment and care, other)? (per month in 2011 and 2012)

17. How many (or what percentage) of these are

- Women?
- Young people under 24 years?
- poor and vulnerable?

18. How do poor women and girls find out about the clinic or outreach and its services?

19. Do you know whether women and girls are satisfied with the treatment they receive at the clinic or through outreach services? How do you know?

- Does the clinic collect feedback from clients? How? Is this feedback integrated into services

20. How is information recorded in the clinic and by outreach health workers?

- Is there a report or logbook you can show me?

21. Do you feel supported in your work by your manager or other personnel in CIES or IPPF?

- Please give suggestions of how this support could be improved.

Learning and Innovation

20. Do staff have the opportunity to try out innovative approaches to service delivery and to reaching the poorest and most vulnerable populations? How does the clinic communicate innovations to CIES? Would the innovation be adopted by other clinics?

21. Do CIES staff visit the clinics? Do they visit client communities? How often?

Sustainability

23. How does the clinic generate income from fees to clients? **(clinic manager only)**

24. Would the clinic continue without external funding? **(clinic/finance manager only)**

- How much of the income is from CIES?
- How much income is generated locally from fees and other sources?

25. Are there any other social or political factors that could affect the long-term survival of the clinic?

Questionnaire for semi-structured interviews with partners – *numbered questions to be asked, bullet points are for probing further depth or detail.*

Introduction

1. What kind of interaction do you have with CIES?
 - Please describe the work of your organisation
 - Please describe the nature of the partnership if there is one.
 - Do you implement projects together? Receive funding from CIES? Participate in advocacy networks together? Coordinate work?
 - How would you describe CIES?

Partnership and networks

2. How effective is your partnership with CIES?
 - What is the benefit to your organisation of partnership with CIES?
 - How does your partnership contribute to the overall SRHR agenda in Bolivia?
 - How would your work be affected if you were not working with CIES?
3. Does CIES and your organization share lessons, best practice and methodology?
 - How does this happen?
 - Give some examples
4. Does your organization participate with CIES in networks?
 - Does CIES coordinate well with other organizations?
 - Has CIES initiated any networks?
 - What role do they play?
5. What systems are in place for learning between SRHR organisations, women's groups and other CSOs in Bolivia?

Service delivery

6. What is the main problem for poor and vulnerable women and men trying to access sexual and reproductive health services?
9. Are there any social or political barriers to the provision of good SRHR services for poor and vulnerable women and men? What about young women and men?
10. To what extent does CIES address the needs of poor and vulnerable women and girls with their SRHR services and advocacy?
 - Can you tell me about the approach that CIES uses to target and reach poor and vulnerable people with services?
 - How effective are they at addressing the gender related barriers to SRHR? Would you say that CIES is aware of how gender inequality impacts on SRHR?
10. Are you aware of how CIES may have increased utilisation of SRH services over the last two years either through their own services or through other providers (public and non-state)?

Advocacy

12. What advocacy objectives have been achieved over the last 2 years?

- Can you provide examples of CIES national/international advocacy messages being taken up and repeated by others?

13. Is CIES known for their advocacy?

- Are they thought to be effective and successful?
- If yes, what is it about their work that makes them successful?

Management

14. What do you think of the CIES leadership and management capability?

Sustainability

16. How does CIES contribute to or support the development of the SRHR sector overall?

- Do they provide technical assistance or funds to other organisations and public sector?
- How do they support networks and partnerships and build capacity and inter-organisational learning?

17. How sustainable and resilient are CIES clinics and outreach services?

- Are there any other social or political factors that could affect the long-term performance of the clinics?

Overall quality

18. How would you rate the quality of CIES service delivery and advocacy work?

- How would you rate the quality of the service delivery? 1=excellent, 2=good, 3=average, 4=poor, 5=very poor
- How would you rate the quality of the advocacy work. 1=excellent, 2=good, 3=average, 4=poor, 5=very poor

19. Do you have any suggestions for CIES to improve performance or partnership?

Questionnaire for government staff – *numbered questions to be asked, bullet points are for probing further depth or detail.*

1. Please describe to me the interaction you have had with CIES and how CIES supports government policy on SRHR.
2. What role does the private sector or non-state providers have providing services and improving access?
3. What is the role of CIES and how effective do you think CIES is at what they do?
 - What kind of services does CIES provide?
 - Have CIES been successful at reaching poor and vulnerable populations?
 - What essential service is CIES not able to deliver?
 - Is it necessary for CIES to be working in this district/province?
 - Would you consider that CIES is important for the delivery of your SRHR strategy or plan?
4. Who are the other non-state organisations that provide SRHR services in this district/province and how do they compare with CIES?
5. Are poor and vulnerable women and men able to access sexual and reproductive health services? What are the main barriers?
6. What kind of relationship do you have with CIES?
 - Do you discuss SRHR, HIV and AIDS or MNH policy with CIES?
 - Do you value their technical expertise and input into discussions?
 - Does CIES participate in networks with other CSOs to campaign for better SRHR for poor and vulnerable people?
 - Do you find this useful?
7. Does CIES provide any services or training within the public sector?
 - What is the quality of their technical input? (1 – 5 score)
 - Does CIES input directly into the management of government clinics or to the delivery of health services in the public sector?
 - Do CIES and government clinics or community health workers refer clients to each other?
8. Do you think CIES is an innovative organisation with new ways of improving the populations SRHR?
 - Has the government adopted any of CIES's methods for providing services, or learnt from their approach?
 - Is CIES thought of as a technical leader in the area of SRHR?
9. Do you think that CIES will still be providing SRHR services to the population in 20 years time?
 - Would you like to see their services expand or reduce?
 - Are there any social or political factors that could affect the long-term survival of CIES run clinics or outreach services?
10. What more could CIES be doing to improve the health of poor and vulnerable people in Bolivia/this district?
 - Do you have any specific recommendations for CIES?

IPPF Evaluation Questions Focus Group Discussions

OBJECTIVES

- Identifying the factors that impede or facilitate poor and vulnerable women and girls' access to and receipt of quality SRH services – at the individual, household, community, facility and society level.
- Understanding perceptions of quality of SRH care and related services.

TARGET GROUPS

- Women Service Users aged 25-49
- Women Service Users aged 15-24
- Women Non-service users aged 25-49
- Men non-service users aged 25-49

The primary aim of the focus groups will be to map the process of accessing and receiving SRH services. We would like to explore the various barriers and facilitating factors – from the point of the need for SRH services arising to the point of having received the treatment – that affect poor people's access to healthcare. These barriers and facilitating factors can exist at the household, community, facility and society levels. We have adapted our methodology to make it more appropriate to the Bolivia context, and have decided to opt for the story telling method for the discussion. This will involve introducing the project, and outlining clearly the questions we hope to get answered, and asking one woman to volunteer to tell her story – or that of someone she knows - about accessing family planning services. The volunteer will be encouraged to tell the story from the point of her perceiving need, to the point of receiving the services. Other participants will be encouraged to not intervene until after the story is completed – this may take up to 10 minutes. Once the story is completed, the other participants will be encouraged to share their perspectives on the volunteers' experiences, and to discuss agreement and differences.

The story telling will be used to focus discussion, and the facilitator will ask specific questions throughout the discussion. The focus group will be limited to between 6-8 participants.

The questions for each of the four groups have been given below and organised by level:

1. Women Users aged 25-49

At the **individual/ general** level:

1. Where do you get your information about SRH?
2. How did you first find out about the CIES clinic/ services?
3. Do you go the CIES clinic/ services for all your SRH needs? Or do you go to different providers for different services?

At the **household** level:

1. Do you ever discuss family planning with your husband or other family members or friends?
2. Who in the household decides if you can go to a healthcare provider?
3. How was the decision to access CIES's services made? What are the issues that were important, i.e. cost, distance, reputation for quality?

At the **community** level:

1. Does a LHW or CMW visit you? If so, what kind of support does she provide? If not, do you see a dai? What kind of support does the dai provide?
2. Does the community support women's access to SRH services?
3. Are there any community mechanisms to support women's ability to access services, i.e. Health education, community funds for healthcare of transport, support groups for pregnant women? Is there anything else the community could do to help?
4. What is the communities view about marriage before the age of 16 years. What is your view?
5. At what age do you think a woman should have her first child? Do you think that young women under 16 years are old enough to have children?
6. What kind of support does the CIES volunteer provide?

At the **healthcare provider** level:

1. Do you go the CIES clinic for all your SRH needs? Or do you go to different providers for different services?
2. Do you have to pay for the service? Is the cost reasonable?
3. How are you received at the facility? How long are you expected to wait?
7. How are you treated by the nurse/ doctor? Do you feel safe? What information/ advice do you receive? Is this helpful? Do you feel comfortable asking questions related to SRH?
8. Do you think the FP service receive is of good quality? Was it safe and effective?
9. What is it about the CIES clinic/ services that makes you choose them above the other providers?
10. Have you ever been referred to the DHQ by the clinic? What kind of service did you get at the hospital?

2. Women Users aged 15-24

At the **individual/ general** level:

1. Where do you get your information about SRH?
2. How did you first find out about the CIES clinic/ services?
3. Do you go the CIES clinic/ services for all your SRH needs? Or do you go to different providers for different services?

At the **household** level:

1. Do you ever discuss health services with your husband , mother or other family members?
2. Who in the household decides if you can go to a healthcare provider?
3. How was the decision to access CIES's services made? What are the issues that were important, i.e. cost, distance, reputation for quality?

At the **community** level:

1. Has a LHW or CMW ever visited you? If so, what kind of support does she provide? If not, do you see a dai? What kind of support does the dai provide?
2. Does the community support young women's access to SRH services?
3. Are there any community mechanisms to support young women's ability to access services, i.e health education, community funds for healthcare or transport? Is there anything else the community could do to help?
4. Is there a place in your community where young people like you are able to visit to talk and find out about SRH issues? What is the communities view about marriage before the age of 16 years. What is your view?
5. At what age do you think a woman should have her first child? Do you think that young women under 16 years are old enough to have children?
6. How do you reach/ travel to the service provider?
7. What kind of support does the CIES volunteer provide?

At the **healthcare provider** level:

1. Do you go the CIES clinic for all your SRH needs? Or do you go to different providers for different services?
2. Do you have to pay for the service? Is the cost reasonable?
3. How are you received at the facility? How long are you expected to wait?
4. How are you treated by the nurse/ doctor? Are you given privacy and is confidentiality ensured? Are you provided with proper information and advice to help you make decisions? Do you feel comfortable asking questions related to SRH?
5. Do you think the medical care you receive is of good quality? Does the treatment work?
6. Have you ever been referred to the DHQ by the clinic? What kind of service did you get at the hospital?

3. Women Non-Users aged 25-49

At the **individual/ general** level:

1. Where do you get your information about SRH? If you have a question about SRH, what do you do? Did you talk to someone about it? Who? If not, why not?
2. If you had a SRH problem, what would you do? Would you go to see someone? If yes, who would it be? If no, why not?
3. Where would you go to get contraceptives if you needed them? Is it difficult or easy to get contraceptives?
4. Sometimes women get pregnant when they don't want to. What do women do when they are pregnant but do not want to be?

At the **household** level:

1. Do you ever discuss family planning with your husband?
2. Who in the household decides if you can go to a healthcare provider? How is the decision to access healthcare made? What are the issues that come up in the discussion, i.e. cost, distance, reputation for quality?
3. Are different care providers chosen for different services?

At the **community** level:

1. Has a LHW or CMW ever visited you? If so, what kind of support does she provide? If not, do you see a dai? What kind of support does the dai provide?
2. Does the community support women's access to SRH services?
3. What is the communities view about marriage before the age of 16 years. What is your view?
4. At what age do you think a woman should have her first child? Do you think that young women under 16 years are old enough to have children?
5. Are there any community mechanisms to support women's ability to access services, i.e Health education, community funds for healthcare of transport, support groups for pregnant women? Is there anything else the community could do to help?
6. How do you reach the service provider?

At the **healthcare provider** level:

1. Who do you go to for your SRH needs?
2. Do you have to pay for the service? Is the cost reasonable?
3. How are you received at the facility? How long are you expected to wait?
4. How are you treated by the nurse/ doctor? Are you given privacy and is confidentiality ensured? What information/ advice do you receive? Is this helpful?? Do you feel comfortable asking questions related to SRH?
5. Do you think the medical care you receive is of good quality? Does the treatment work?
6. Have you ever been referred to the DHQ? What kind of service did you receive at the hospital?
7. Have you heard of the CIES clinic or services? Why do you not use these services?

4. Men Non-Users aged 25-49

At the **individual/ general** level:

1. Where do you get your information about SRH? If you have a question about SRH, what do you do? Did you talk to someone about it? Who? If not, why not?
2. If you had a SRH problem, what would you do? Would you go to see someone? If yes, who would it be? If no, why not?
3. Where would you go to get contraceptives if you needed them? Is it difficult or easy to get contraceptives?
4. What other services do you need? HIV and AIDS, STI, advice?

At the **household** level:

1. Do you ever discuss family planning with your wife? Do you think you, your wife or other family members should use family planning services to space pregnancies or delay first birth or to limit the size of your family? Are there any other reasons for which you might use family planning services?
2. How do you decide which service provider to go to for you SRH needs? What are the issues, i.e. cost, distance, reputation for quality?
3. Do you choose different care providers for different services?

At the **community** level:

1. Do you think the community is supportive of men and women's SRH needs?
2. What is the communities view about marriage before the age of 16 years. What is your view?
3. At what age do you think a woman should have her first child? Do you think that young women under 16 years are old enough to have children?
4. Are there any community mechanisms to support women's ability to access services, i.e. health education, community support groups?

At the **healthcare provider** level:

1. Have you heard of the CIES clinic and outreach services? Would you consider going there? Why have you not used it so far?
2. What kind of provider do you go to for your SRH needs?
3. Do you have to pay for the service? Is the cost reasonable?
4. How are you received at the facility? How long are you expected to wait?
5. How are you treated by the nurse/ doctor? Are you given privacy and is confidentiality ensured? Are you provided with proper information and advice to help you make decisions? Do you feel comfortable asking questions related to SRH?
6. Do you think the medical care you receive is of good quality? Does the treatment work?
7. Have you ever been referred to the DHQ? What kind of service did you receive at the hospital?

Ethiopia

Questionnaire for semi-structured interviews with MA HQ staff – numbered questions to be asked, bullet points are for probing further depth or detail.

(Instructions:

- *There will be a general presentation to the review team on the FGAE services and approach at the beginning of the visit. Presentation to cover as far as possible:*
 - *Scope of FGAE programme: core services; projects; no. clinics, outreach, other initiatives, no. clients per site*
 - *Scope of advocacy work: advocacy objectives, targets, partners, progress, outcomes*
 - *Nature of work with national, regional and local govt*
 - *Team organization*
 - *FGAE funding: %age annual income from IPPF; other donors*
 - *Outcomes: against PPA logframe and other significant outcomes*
 - *Major challenges encountered*
- *Other issues for discussion during general session*
 - *Targeting poorest and most vulnerable*
 - *How cost effectiveness and VFM are promoted*
 - *How learning is promoted*
- *In interviews, if you are short of time prioritize the bold underlined questions)*

Introduction question

1. What is your role and main tasks in the organization?

- How long have you been with FGAE?
- What motivated you to start working with this kind of organization?
- How does working with FGAE compare with other organizations you have worked at previously?

Services

2. How is FGAE's programme addressing the specific SRHR needs for poor and vulnerable people in Ethiopia? *(you may have been given information about this in the presentation so you will need to probe for further detail only – particularly for information that will verify what you already know)*

- Which particular poor and vulnerable groups is FGAE trying to reach? Why have you decided to focus on these? Probe regarding refugee population, size of CSW population.
- What analysis have you undertaken of the specific SRHR needs of these groups? Were key stakeholders involved in this process?
- What targeting strategies are used to direct benefits towards the poorest and vulnerable groups? Investigate poor people being exempted from service costs. How effective are these strategies? Evidence?
- How does FGAE monitor the reach of services among poor and excluded groups and in remote areas?
- How does the community, and particularly underserved, poor and vulnerable groups (such as adolescents, ethnic/religious minorities, indigenous communities, disabled persons, etc) participate in FGAE's projects?

- What kind of feedback and communication do you have from the poorest and most marginalized?
- Is there a gender and/ or social exclusion policy and/ or strategy that clearly analyses poor women's barriers to SRHR and guides staff? If not, how does FGAE ensure that gender equality is central to its work? How is this strategy implemented in the clinics and with volunteer staff? What specific initiatives were used to address gender issues in relation to access and acceptability at community level?

3. Has utilisation of services increased over the last two years?

- What areas of service delivery are in most demand by poor and vulnerable people? Why do you think this is?
- How do poor people hear about services?
- What level of coverage do you have in the population/catchment area?

Advocacy

4. Please describe the advocacy projects or campaigns you are working on.

- What are their objectives?
- Who are you working with?
- What progress have you made?
- What challenges have you met? How have you tried to overcome them?
- How do you ensure your campaigning is evidence-based?

5. What advocacy objectives had you achieved over the last 2 years?

- Can you provide examples of FGAE national advocacy messages being taken up and repeated by others?
- What are the factors of your success? (linked to TOC)

6. Are you involved in IPPF's international advocacy?

- Has the international advocacy made a difference in Ethiopia?

Partnerships

7. How do you work with government at national, regional and local levels?

- Do you use or follow provincial or district health or SRH strategies for strategic planning?
- Are any of FGAE's services delivered in partnership or through public health facilities? Does referral take place between FGAE facilities and public hospitals?

8. How do you support the development of the SRHR sector overall?

- Do you provide capacity building and training support to other organisations? Please describe and quantify.

Results and impact

9. What evidence do you have of the impact of your work?

- On people's health?
- On poor and vulnerable people's lives?
- Is the IPPF core funding contributing to improvements in the health status of poor and vulnerable people in particular?
- Would you be able to reach these people without the core funding?

- What tools do you have to measure results and impact? Are they adequate? What challenges do you encounter in measuring results and impact?

10. Why do you think your approach delivers results? (linked to theory of change)

- What assumptions have you made?

11. Is Ethiopia making progress on achieving MDG 5 and 6?

- Do you have any evidence of how FGAE has contributed to progress in achieving MDG 5 and 6?

Management

12. How have you improved efficiency² in the head office and overall operations of FGAE?

- Have you made any management, communications, systems, leadership or human resource improvements?
- Which of your clinics or outreach services would you say is the most efficient at delivering services? Why is this? How do you know this?
- Which clinics or outreach are underperforming and why?
- How are you planning improvements?
- How have organisation improvements impacted on results?

13. How do you measure and monitor efficiency and value for money in your organisation?

- Do you think your clinics deliver good value for money? What evidence do you have for this?
- How have you been able to achieve more for less money or more quickly? Please give an example
- Do you have any examples of economies of scale being achieved since 2011?
- How do you ensure good value for money in procurement and logistics?
- Have you received any guidance from IPPF RO or CO?

Sustainability

14. How sustainable and resilient are FGAE's clinics and outreach services?

- What proportion of FGAE clinics costs are covered through: a) user fees; b) IPPF funds; iii) other resources?
- What is your vision for the sustainability of FGAE clinics? Should they be self-sustaining through user fees?
- How do you balance the need for sustainable services with reaching poor and vulnerable groups?
- Are there any other social or political factors that could affect the long-term survival of the clinics? How does FGAE address these?

15. If your unrestricted funding from IPPF had been cut by 20% over the last two years, what would have happened to FGAE's work?

- Which activities would you have to cut back?

² If they do not understand efficiency or value for money probe by asking what they think these terms mean and then explain that it means doing things better and achieving more for the money. Efficiency could include any organisational and system improvements that increase the outputs and outcome per input. For example treating more clients per clinic, or providing more training with the same team in the head office, or better leadership motivating staff to work harder and be committed to a clear strategy and workplan. Value for money

- Would any particular programmes have suffered?

Learning and innovation

16. How does FGAE promote innovation and learning?

- Provide examples of how this manifests – e.g. how FGAE has learned from its work and has incorporated the lessons into improved performance
- How does the organizational culture help or hinder learning? Provide examples.
- How do you encourage staff to try out new ways of working and doing things?
- What are the channels used to disseminate best practice? How successful have they been? Do you have examples of other organizations taking up your practices?

17. What systems are in place for learning between IPPF's MAs?

- Do you network and communicate with other MAs and externally?
- What practices/innovations have you adopted from other MAs either in the South Asia region or more widely (please specify both)?
- What practices/innovations have you adopted from other local or international organisations?

18. How are IPPF's strategies and planning influenced by FGAE?

IPPF CO and RO service quality

19. What does IPPF mean to you?

- Do you feel part of a wider international federation?
- What benefits do you get from this?

20. How would you rate the quality of the technical assistance from the regional office? 1=excellent, 2=good, 3=average, 4=poor, 5 = very poor

21. How would you rate the quality of technical assistance from the IPPF CO (if any) 1=excellent, 2=good, 3=average, 4=poor, 5=very poor

22. Do you have any suggestions for improvements?

Questionnaire for semi-structured interviews with clinic and outreach staff (clinic manager, service providers, supplies and Commodities Manager, Receptionist, community mobilisers) - *numbered questions to be asked, bullet points are for probing further depth or detail.*

Introduction

1. What is your job/role in this clinic or outreach service?

- How long have you been with the organisation?

Service delivery

2. What are the main sexual and reproductive health requirements for poor and vulnerable populations in this district?

- How easily are they reaching services?
- What other service providers exist in this district and nearby?
- Where do most poor and vulnerable people go for SRHR services?

3. Which people do you think find it hardest to access SRHR services? Why is this?

- Are you serving any of these people?
- Are fees a barrier for poor people to use your services?
- Which people in the community would you say are not able to use your services and why?

4. How do you handle particularly vulnerable clients?

- What does the clinic do if a client cannot pay the bill? How do you confirm they have no resources?
- What do you do if a teenage girl comes to the clinic asking for an abortion? What if she has been raped?

5. Do you collect information from clients and use it to design and implement services that address their specific needs and situation? **(manager only)**

- Do you collect socio-economic data about your clients?
- Are you able to disaggregate information from clients for example by age or poverty level? Do you use this data to make management decisions?

Partnership and networking

6. Do your clinic or outreach services have a relationship with the public sector?

- Do you interact with public sector facilities?
- Do you refer clients to public sector facilities?
- With the kebele or woreda office?

7. How do the clinics work with public sector community based health workers such Health Extension Workers?

- Do they refer people to your clinic?

8. How effective is this relationship with the public sector for improving provision of services to the very poor and vulnerable?

9. What other organisations are you connected with to improve access?

- Do you refer clients to these organisations?
- How do you decide where to refer a client?

Management and Organisational culture

10. How many staff work in your clinic? **(clinic manager only)**

Include part time staff, full time staff, volunteers, professional trained or casual staff

11. How are staff managed and supervised? (**clinic manager only**)

12. How are supplies managed?

- How is inventory controlled?
- How often do you make orders for supplies and who to?
- How efficient is the supply and delivery process?
- Can I see the supplies cupboard? Show me all the methods of contraception.

13. What kind of support do you get from FGAE HQ?

- How good is it (score 1-5)?
- How regularly is it provided?
- Have you been able to learn about practices in other FGAE clinics, or experience from other IPPF MAs?

14. How is quality assurance managed in the clinic?

- Does FGAE make visits to the clinic and outreach services?
- How often and who does the visits?
- Is there a quality guidance and checklist? Can I see it?

15. How does your clinic influence the policies and practices of FGAE?

- Have you contributed to the development of any FGAE policies or good practices? How?

16. What does being a member of IPPF mean to you, beyond your relationship with FGAE HQ?

- What benefits are there from being an IPPF member?

17. Do you feel supported in your work by your manager or other personnel in FGAE or IPPF?

- Please give suggestions of how this support could be improved.

Service data and results

18. How many men and women (separately counted) has the clinic served (include family planning, maternal health services, STI and HIV diagnosis, treatment and care, other)? (per month in 2011 and 2012)

19. How many (or what percentage) of these are

- Women?
- Young people under 24 years?
- poor and vulnerable? How defined?

20. How do poor women and girls find out about the clinic or outreach and its services?

21. Do you know whether women and girls are satisfied with the treatment they receive at the clinic or through outreach services? How do you know?

- Does the clinic collect feedback from clients? How? Is this feedback used to inform services?

21. How is information recorded in the clinic and by outreach health workers?

- Is there a report or logbook you can show me?

Learning and Innovation

22. Do staff have the opportunity to try out new approaches to service delivery and to reaching the poorest and most vulnerable populations? How does the clinic communicate innovations to FGAE? If the approach proves to be successful, how would you inform other clinics about it?

23. Do Rahnuma staff visit the clinics? Do they visit client communities? How often?

Sustainability

24. How does the clinic generate income from fees to clients? **(clinic manager only)**

25. Would the clinic continue without external funding? **(clinic/finance manager only)**

- How much of the income is from FGAE?
- How much income is generated locally from fees and other sources?

26. Are there any other social or political factors that could affect the long-term survival of the clinic?

Questionnaire for semi-structured interviews with civil society partners – numbered questions to be asked, bullet points are for probing further depth or detail. Questions in bold and underlined are to be prioritized.

Record name, position and organization of respondents

Introduction

1. What kind of interaction do you have with FGAE?

- Please describe the work of your organisation
- Please describe the nature of the interaction with FGAE (implement projects together? Receive funding from FGAE? Participate in advocacy networks together? Coordinate work?)
- How do you find working with FGAE?

Partnership and networks

2. How effective is your partnership with FGAE?

- What is the benefit to your organisation of partnership with FGAE?
- What successes have you achieved as a result of your work with FGAE? Would you have been able to achieve these successes on your own? What was the benefit of FGAE's involvement?
- What challenges, if any, have you encountered in working with FGAE?
- How does your partnership contribute to the overall SRHR agenda in Ethiopia?
- How would your work be affected if you were not working with FGAE?

3. Do FGAE and your organization share lessons, best practice and methodology?

- How does this happen?
- Give some examples? Examples of FGAE adopting best practices from other organizations?

4. Does your organization participate with FGAE in networks?

- Does FGAE coordinate well with other organizations?
- Has FGAE initiated any networks?
- What role do they play?

5. What systems are in place for learning between SRHR organisations, women's groups and other CSOs in Ethiopia?

6. What interaction does FGAE have with government?

- Do they have direct contacts with departments of health and parliamentarians for advocacy? Are they consulted for SRH public sector strategies?
- Do they implement services with government?

Service delivery

7. What, in your view, is the main problem for poor and vulnerable women and men trying to access sexual and reproductive health services?

- Family planning?
- Maternal health services (ante natal care, post natal care, delivery)
- HIV and AIDS services

8. Are there any social or political barriers to the provision of good SRHR services for poor and vulnerable women and men? What about young women and men?

9. To what extent does FGAE address the needs of poor and vulnerable women and girls with their SRHR services and advocacy?

- Can you tell me about the approach that FGAE uses to target and reach poor and vulnerable people with services?
- How effective are they at addressing the gender related barriers to SRHR? Would you say that FGAE is aware of how gender inequality impacts on SRHR?

10. Are you aware of how FGAE may have increased utilisation of SRH services over the last two years either through their own services or through other providers (public and non-state)? What do you think of this approach?

11. What do you think has been the impact of FGAE's work in the past 2 years?

- Please describe or give a specific example.

Advocacy

12. What advocacy objectives have been achieved by civil society over the last 2 years?

- What has FGAE's role been in this?
- To what extent has this complemented the role of other CSOs?
- Can you provide examples of FGAE national/international advocacy messages being taken up and repeated by others?

13. What is FGAE's reputation in advocacy?

- Are they thought to be effective and successful?
- If yes, what is it about their work that makes them successful?

Management

14. Has FGAE undergone any changes in organisation recently that may have improved their work? Can you give an example?

15. To what extent does FGAE learn from its work and incorporate the lessons into improved performance?

- Do you think that FGAE is innovative and promotes learning? Have you any examples

Sustainability

16. How does FGAE contribute to or support the development of the SRHR sector overall?

- Do they provide technical assistance or funds to other organisations and public sector?
- How do they support networks and partnerships and build capacity and inter-organisational learning?

17. How sustainable are FGAE's clinics and outreach services? How could their sustainability be improved?

- Do you think they have the balance between sustainability and ensuring access for the poorest right? Why/why not?
- Are there any other social or political factors that could affect the long-term performance of the clinics?

Overall quality

18. How would you rate the quality of FGAE's: a) service delivery work; ii) advocacy work?

- 1=excellent, 2=good, 3=average, 4=poor, 5=very poor

19. What do you think are FGAE's strengths? And weaknesses?

20. Do you have any suggestions for FGAE to improve performance or partnership?

Questionnaire for government staff – *numbered questions to be asked, bullet points are for probing further depth or detail. Questions need to be tailored to the level of government – national, regional, woreda, kebele – being discussed and whether the focus is service delivery or advocacy/technical advice.*

Record name, position and organization of respondents

1. What, in your view, is the main problem for poor and vulnerable women and men trying to access sexual and reproductive health services?
 - Family planning?
 - Maternal health services (ante natal care, post natal care, delivery)
 - HIV and AIDS services
2. Are there any social or political barriers to the provision of good SRHR services for poor and vulnerable women and men? What about young women and men?
3. Do you have a strategy or plan for sexual and reproductive health services?
4. What role does the private sector or non-state providers have providing services and improving access?
5. Which are the main non-state organisations that provide SRHR services in this woreda/kebele?
 - What type of services do they provide?
6. What kind of relationship do you have with FGAE?
 - How do you work together?
 - On what issues?
7. How effective is FGAE's service delivery in this woreda/kebele?
 - What services does FGAE provide?
 - Have FGAE been successful at reaching poor and vulnerable populations? How do they do this?
 - What have been FGAE's biggest achievements in the area in the last 2 years?
 - Are there any essential services FGAE has not able to deliver? Why not?
 - How does FGAE complement or strengthen government's work to provide SRHR services?
 - What would be the impact if FGAE was not able to continue providing SRHR services in your woreda/kebele?
8. Has FGAE provided any services or training to within the public sector?
 - What impact have they had on public sector delivery? Give examples
 - How do you evaluate the quality of their training (1-5 score)?
 - Does FGAE input directly into the management of government clinics or to the delivery of health services in the public sector?
 - How successful are these clinics?
 - Do FGAE and government clinics or community health workers refer clients to each other?
9. What do you think of FGAE as an SRHR provider?
 - Do you think FGAE is an innovative organisation with new ways of improving the populations SRHR?
 - Has the government adopted any of FGAE's methods for providing services, or learnt from their approach?

- Is FGAE thought of as a technical leader in the area of SRHR?
10. Do you think that FGAE will still be providing SRHR services to the population in 20 years time? Why/why not?
- Would you like to see their services expand or reduce?
 - Are there any social or political factors that could affect the long-term survival of FGAE run clinics or outreach services?
11. What more could FGAE be doing to improve the health of poor and vulnerable people in this woreda/kebele/Ethiopia more broadly?
12. How influential do you think FGAE's advocacy has been?
- In the past 2 years, have there been any advocacy issues FGAE has campaigned for, which have been adopted by government? Cite examples.
 - In these examples, what was the root of their success?
 - Do they work with other organisations in their advocacy?
 - What are the overall benefits of FGAE's advocacy work for SRHR in Ethiopia?
 - Are there ways in which FGAE could improve its advocacy?
13. Do you have any specific recommendations for FGAE?

Questionnaire for clients/users

1. How do you get your information and services about SRH?
 - Family planning
 - Abortion
 - STI, HIV/AIDS
 - Gynaecological and obstetric care

2. Are there any community mechanisms to support women's/young adult ability to access information and services?
 - Youth groups/youth centres,
 - Women's group
 - Government health extension workers,
 - Community support groups,

3. What is the communities/personal view (perceptions) on
 - Marriage before the age of 18 years?
 - Family planning ---
 - Premarital sex,
 - Abortion

4. Who do you discuss SRH issues (family planning, abortion, STI, GBV/rape)? Why?
 - Spouses
 - Other family members
 - Friends
 - Others ---- support groups, government health extension workers

5. Who in the household decides if you can go to a healthcare provider/FGAE?

6. How did you first find out about the FGAE?

7. Why do you choose FGAE clinics?
 - Financial cost,
 - Time cost,
 - Distance,
 - Reputation for quality – specialized service

8. What do you like best about the service at FGAE clinics?
 - Cost of service,
 - Waiting time,
 - Types of services ---- FP including emergency contraceptives and choice of methods, abortion related care, HIV related, gynaecological and obstetric services, GBV screening),
 - Attitudes of nurses/ doctors,

- Quality of information/ advice - by volunteers, community mobilisers, media, youth centres,
 - Counselling services --- HIV (Voluntary testing and Counselling)
9. Do you go to FGAE for all your SRH needs? Or do you go to different providers for different services? How does the service compare with FGAE?
10. What are some of the impact (benefits/changes) resulting from SRH information and services provided by FGAE?
11. Any recommendations for improving the services at FGAE?

Questionnaire for non-users

1. How do you get your information and service about SRH?
 - Family planning
 - Abortion
 - STI, HIV/AIDS and gynaecological and obstetric care
2. If you had a SRH problem (unwanted pregnancy, STI, HIV/AIDS), what would you do? Whom do you consult (friends, family, and spouses)? Why?
3. Are there any community mechanisms to support women/young adult's ability to access information and services?
 - Youth groups/youth centres,
 - Women's group
 - Government health extension workers,
 - Community support groups,
4. How do you decide which service provider to go to for you SRH needs? What are some of the issues considered in decision making?
 - Financial cost,
 - Time cost,
 - Distance,
 - Specialized service
 - Reputation for quality
5. Have you ever visited/used one of the clinics run by the FGAE? If no, why not?
 - Lack of information or misconceptions
 - Cost (time and financial)
 - Stigma
 - Bad experience with other service providers
 - Other alternatives (traditional healers)
6. What are some of the reasons for not seeking SRH services?
 - socio cultural and religious factors (including stigma and discrimination)
 - Political/policy related – gov't budget allocation, qualification of health care providers, etc.
 - Economic factors
 - Perceptions on SRH providers (skills and attitude of care givers, quality of care)
7. Any recommendations for making SRH information and services accessible to all?
 - Young unmarried girls and boys
 - Couples
 - Persons with disability

Pakistan

Questionnaire for semi-structured interviews with MA HQ staff – *numbered questions to be asked, bullet points are for probing further depth or detail.*

(Instructions:

- *There will be a general presentation to the review team on the Rahnuma services and approach at the beginning of the visit – so general questions will not be asked about the services and the context*
- *If you are short of time prioritize the bold underlined questions)*

Introduction question

1. What is your role and main tasks in the organization?
 - How long have you been with Rahnuma?
 - What motivated you to start working with this kind of organization?

Services

2. How is Rahnuma's programme addressing the specific SRHR context for poor and vulnerable people in Pakistan? *(you may have been given information about this in the presentation so you will need to probe for further detail only – particularly for information that will verify what you already know)*

- What analysis have you undertaken of the SRHR needs of underserved, poor and vulnerable people, particularly young women? Were key stakeholders involved in this process?
 - Is there a gender and/ or social exclusion policy and/ or strategy that clearly analyses poor women's barriers to SRHR and guides staff? If not, how does Rahnuma ensure that gender equality is central to its work? How is this strategy implemented in the clinics and with volunteer staff? What specific initiatives were used to address gender issues in relation to access and acceptability at community level?
 - How does the community, and particularly underserved, poor and vulnerable groups (such as adolescents, ethnic/religious minorities, indigenous communities, disabled persons, etc) participate in the projects?
 - Are targeting strategies used to direct benefits towards the poorest and vulnerable groups?
 - How does Rahnuma monitor the reach of services among poor and excluded groups and in remote areas?
 - What kind of feedback and communication do you have from the poorest and most marginalized
3. Has utilisation of services increased over the last two years?
 - What areas of service delivery are in most demand by poor and vulnerable people?
 - How do poor people hear about services?
 - What level of coverage do you have in the population?

Advocacy

4. Please describe the advocacy projects or campaigns you are working on.
 - How do you work with partners and networks to build advocacy capacity and momentum in Pakistan?

5. What advocacy objectives had you achieved over the last 2 years?

- Can you provide examples of Rahnuma national advocacy messages being taken up and repeated by others?
- What are the factors of your success? (linked to TOC)

6. Are you involved in IPPF's international advocacy?

- Has the international advocacy made a difference in Pakistan?

Partnerships

7. How do you interact or coordinate with government?

- Do you use or follow provincial or district health or SRH strategies for strategic planning?
- Are any of Rahnuma's services delivered in partnership or through public health facilities? Does referral take place between Rahnuma facilities and public hospitals?

8. How do you support the development of the SRHR sector overall?

- Do you provide capacity building and training support to other organisations? Please describe and quantify.

Results and impact

9. What evidence do you have of the impact of your work?

- On people's health?
- On poor and vulnerable people's lives?
- Is the IPPF core funding contributing to improvements in the health status of poor and vulnerable people in particular?
- Would you be able to reach these people without the core funding?
- Do you have the tools needed to effectively measure impact and results?

10. Why do you think your approach delivers results? (linked to theory of change)

- What assumptions have you made?

11. Is Pakistan making progress on achieving MDG 5 and 6?

- Do you have any evidence of how Rahnuma has contributed to progress in achieving MDG 5 and 6?

Management

12. How have you improved efficiency³ in the head office and overall operations of Rahnuma?

- Have you made any management, communications, systems, leadership or human resource improvements?
- Which of your clinics or outreach services would you say is the most efficient at delivering services? Why is this?
- Which clinics or outreach are underperforming and why?

³ If they do not understand efficiency or value for money probe by asking what they think these terms mean and then explain that it means doing things better and achieving more for the money. Efficiency could include any organisational and system improvements that increase the outputs and outcome per input. For example treating more clients per clinic, or providing more training with the same team in the head office, or better leadership motivating staff to work harder and be committed to a clear strategy and workplan. Value for money

- How are you planning improvements?
- How have organisation improvements impacted on results?

13. How do you measure and monitor efficiency and value for money in your organisation?

- Do you think your clinics deliver good value for money?
- How have you been able to achieve more for less money or more quickly? Please give an example
- Do you have any examples of economies of scale being achieved since 2011?
- How do you ensure good value for money in procurement and logistics?
- Have you received any guidance from IPPF RO or CO on improving efficiency and value for money?

Sustainability

14. How sustainable and resilient are Rahnuma's clinics and outreach services?

- Could Rahnuma clinics sustain operations through income that they generate themselves (through user fees and any other income they generate locally)? How many clinics could do this?
- Are there any other social or political factors that could affect the long-term survival of the clinics? How does Rahnuma address these?

15. If your unrestricted funding from IPPF had been cut by 20% over the last two years, what would have happened to Rahnuma's work?

- Which activities would you have to cut back?
- Would any particular programmes have suffered?

Learning and innovation

16. To what extent is Rahnuma an innovative or learning organization?

- Provide examples of how this manifests – e.g. how Rahnuma has learned from its work and has incorporated the lessons into improved performance
- How does the organizational culture help or hinder learning? Provide examples.
- How do you encourage staff to try out new ways of working and doing things?

17. What systems are in place for learning between IPPF's MAs?

- Do you network and communicate with other MAs and externally?
- What practices/innovations have you adopted from other MAs either in the South Asia region or more widely (please specify both)?
- What practices/innovations have you adopted from other local or international organisations?

18. How are IPPF's strategies and planning influenced by Rahnuma?

IPPF CO and RO service quality

19. What does IPPF mean to you?

- Do you feel part of a wider international federation?
- What benefits do you get from this?

20. How would you rate the quality of the technical assistance from the regional office?

1=excellent, 2=good, 3=average, 4=poor, 5 = very poor

21. How would you rate the quality of technical assistance from the IPPF CO (if any) 1=excellent, 2=good, 3=average, 4=poor, 5=very poor

22. Do you have any suggestions for improvements?

Questionnaire for semi-structured interviews with clinic and outreach staff (clinic manager, service providers, supplies and Commodities Manager, Receptionist) - *numbered questions to be asked, bullet points are for probing further depth or detail.*

Introduction

1. What is your job/role in this clinic or outreach service?

- How long have you been with the organisation?

Service delivery

2. What are the main sexual and reproductive health requirements for poor and vulnerable populations in this district?

- How easily are they reaching services?
- What other service providers exist in this district and nearby?
- Where do most poor and vulnerable people go for SRHR services?

3. Which people do you think find it hardest to access SRHR services?

- Are you serving any of these people?
- Are fees a barrier for poor people to use your services?
- Which people in the community would you say are not able to use your services and why?

4. How do poor women and girls find out about the clinic or outreach and its services?

5. How do you handle particularly vulnerable clients?

- What does the clinic do if a client cannot pay the bill? How do you know they have no resources?
- What do you do if a teenage girl comes to the clinic asking for an abortion? What if she has been raped?

6. Do you collect information from clients and use it to design and implement services that address their specific needs and situation? (manager only)

- Do you collect socio-economic data about your clients?
- Are you able to disaggregate information from clients for example by age or poverty level? Do you use this data to make management decisions?

Partnership and networking

7. Do your clinic or outreach services have a relationship with the public sector?

- Do you interact with public sector facilities?
- Do you refer clients to public sector facilities?
- The EDO and local government?

8. How do the clinics work with public sector community based health workers such as Lady Health Workers, Community Midwives and Traditional Birth Attendants or Dais?

- Do they refer people to your clinic?

9. How effective is this relationship with the public sector for improving provision of services to the very poor and vulnerable?

10. What other organisations are you connected with to improve access?

- Do you refer clients to these organisations or receive referrals from them?
- How do you decide where to refer a client?

Management and Organisational culture

11. How many staff work in your clinic? (clinic manager only)

Include part time staff, full time staff, volunteers, professional trained or casual staff

12. How are staff managed and supervised? (clinic manager only)

13. How are supplies managed?

- How is inventory controlled?
- How often do you make orders for supplies and who to?
- How efficient is the supply and delivery process?
- Can I see the supplies cupboard? Show me all the methods of contraception.

14. What does IPPF mean to you - beyond your relationship with Rahnuma HQ?

15. Has Rahnuma provided the clinic with any guidance – TA, training?

- How good is this? (score 1 – 5)
- How regularly is this provided?
- Do you get training or guidance from specific IPPF initiatives or projects?
- How would you rate this training? (1 – 5)

16. Do you feel supported in your work by your manager or other personnel in Rahnuma or IPPF?

- Please give suggestions of how this support could be improved.

17. Can you give me some examples of Rahnuma's policies? Were you consulted about those policies?

18. How is quality assurance managed?

- Does Rahnuma make regular visits to the clinic and outreach services?
- How often and who does the visits?
- Is there a quality guidance and checklist? Can I see it?

19. Do you know whether women and girls are satisfied with the treatment they receive at the clinic or through outreach services? How do you know?

- Does the clinic collect feedback from clients? How? Is this feedback integrated into services?

Service data and results

20. How many men and women (separately counted) has the clinic served (include family planning, maternal health services, STI and HIV diagnosis, treatment and care, other)? (per month in 2011 and 2012)

21. How many (or what percentage) of these are

- Women?
- Young people under 24 years?
- poor and vulnerable?

22. How is information recorded in the clinic and by outreach health workers?

- Is there a report or logbook you can show me?

Learning and Innovation

23. Do staff have the opportunity to try out innovative approaches to service delivery and to reaching the poorest and most vulnerable populations? How does the clinic communicate innovations to Rahnuma? Would the innovation be adopted by other clinics?

24. Do Rahnuma staff visit the clinics? Do they visit client communities? How often?

Sustainability

25. How does the clinic generate income from fees to clients? (clinic manager only)

26. Would the clinic continue without external funding? (clinic/finance manager only)

How much of the income is from Rahnuma?

How much income is generated locally from fees and other sources?

27. Are there any other social or political factors that could affect the long-term survival of the clinic?

Questionnaire for semi-structured interviews with partners – *numbered questions to be asked, bullet points are for probing further depth or detail.*

Introduction

1. What kind of interaction do you have with Rahnuma?

- Please describe the work of your organisation
- Please describe the nature of the partnership if there is one.
- Do you implement projects together? Receive funding from Rahnuma? Participate in advocacy networks together? Coordinate work?
- How would you describe Rahnuma?

Partnership and networks

2. How effective is your partnership with Rahnuma?

- What is the benefit to your organisation of partnership with Rahnuma?
- How does your partnership contribute to the overall SRHR agenda in Pakistan?
- How would your work be affected if you were not working with Rahnuma?

3. Do Rahnuma and your organization share lessons, best practice and methodology?

- How does this happen?
- Give some examples

4. Does your organization participate with Rahnuma in networks?

- Does Rahnuma coordinate well with other organizations?
- Has Rahnuma initiated any networks?
- What role do they play?

5. What systems are in place for learning between SRHR organisations, women's groups and other CSOs in Pakistan?

6. How does Rahnuma interact with government?

- Do they have direct contacts with departments of health and parliamentarians for advocacy? Are they consulted for SRH public sector strategies?
- Do they implement services with government?
- Do they have a particular role in terms of the interaction with Government? How would Government be affected if Rahnuma were not there?

Service delivery

7. What is the main problem that for poor and vulnerable women and men face when trying to access sexual and reproductive health services?

- What are the problems specifically for: family planning; maternal health services (ante natal care, post natal care, delivery); and HIV and AIDS services

8. Are there any social or political barriers to the provision of good SRHR services for poor and vulnerable women and men? What about young women and men?

9. To what extent does Rahnuma address the needs of poor and vulnerable women and girls with their SRHR services and advocacy?

- Can you tell me about the approach that Rahnuma uses to target and reach poor and

- vulnerable people with services?
 - How effective are they at addressing the gender related barriers to SRHR? Would you say that Rahnuma is aware of how gender inequality impacts on SRHR?
10. Are you aware of how Rahnuma may have increased utilisation of SRH services over the last two years either through their own services or through other providers (public and non-state)?
11. What do you think has been the impact of Rahnuma's work?
- Please describe or give a specific example.

Advocacy

12. What advocacy objectives have been achieved over the last 2 years?
- Can you provide examples of Rahnuma national/international advocacy messages being taken up and repeated by others?
13. Is Rahnuma known for their advocacy?
- Are they thought to be effective and successful?
 - If yes, what is it about their work that makes them successful?

Management

14. Has Rahnuma undertaken any improvements in organisation recently that may have improve their work? Can you give an example?
15. To what extent has Rahnuma learned from its work and incorporated the lessons into improved performance
- Do you think that Rahnuma is innovative and promotes learning? Have you any examples?

Sustainability

16. How does Rahnuma contribute to or support the development of the SRHR sector overall?
- Do they provide technical assistance or funds to other organisations and public sector?
 - How do they support networks and partnerships and build capacity and inter-organisational learning?
17. How sustainable and resilient are Rahnuma's clinics and outreach services?
- Are there any other social or political factors that could affect the long-term survival of the clinics?

Overall quality

18. How would you rate the quality of Rahnuma's service delivery and advocacy work?
- How would you rate the quality of the service delivery? 1=excellent, 2=good, 3=average, 4=poor, 5=very poor
 - How would you rate the quality of the advocacy work. 1=excellent, 2=good, 3=average, 4=poor, 5=very poor
19. Do you have any suggestions for Rahnuma to improve performance or partnership?

Questionnaire for government staff – *numbered questions to be asked, bullet points are for probing further depth or detail.*

Name	Position	Organisation/department	Date

1. What is the main problem for poor and vulnerable women and men trying to access sexual and reproductive health services?

- Family planning?
- Maternal health services (ante natal care, post natal care, delivery)
- HIV and AIDS services

2. Are there any social or political barriers to the provision of good SRHR services for poor and vulnerable women and men? What about young women and men?

3. Do you have a strategy or plan for sexual and reproductive health services?

4. What role does the private sector or non-state providers have providing services and improving access?

5. Name and describe the main non-state organisations that provide SRHR services in this district/province?

- (hopefully one will be Rahnuma) – What kind of services does Rahnuma provide?
- Have Rahnuma been successful at reaching poor and vulnerable populations?
- What essential service is Rahnuma not able to deliver?
- Is it necessary for Rahnuma to be working in this district/province?
- Would you consider that Rahnuma is important for the delivery of your SRHR strategy or plan?

6. What kind of relationship do you have with Rahnuma?

- Do you discuss SRHR, HIV and AIDS or MNH policy with Rahnuma?
- Do you value their technical expertise and input into discussions?
- Does Rahnuma participate in networks with other CSOs to campaign for better SRHR for poor and vulnerable people?
- Do you find this useful?

7. Does Rahnuma provide any services or training within the public sector?

- How do you value their contribution to public sector delivery?
- What is the quality of their technical input? (1 – 5 score)
- Does Rahnuma input directly into the management of government clinics or to the delivery of health services in the public sector?
- What difference has their involvement made?
- Do Rahnuma and government clinics or community health workers refer clients to each other?

8. Do you think Rahnuma is an innovative organisation with new ways of improving the populations SRHR?

- Has the government adopted any of Rahnuma’s methods for providing services, or learnt from their approach?
- Is Rahnuma thought of as a technical leader in the area of SRHR?

9. Do you think that Rahnuma will still be providing SRHR services to the population in 20 years time?

- Would you like to see their services expand or reduce? Why?
- Are there any social or political factors that could affect the long-term survival of Rahnuma run clinics or outreach services?

10. What more could Rahnuma be doing to improve the health of poor and vulnerable people in Pakistan/KPK/this district?

- Do you have any specific recommendations for Rahnuma?

IPPF Evaluation Questions Focus Group Discussions

OBJECTIVES

- Identifying the factors that impede or facilitate poor and vulnerable women and girls' access to and receipt of quality SRH services – at the individual, household, community, facility and society level.
- Understanding perceptions of quality of SRH care and related services.

TARGET GROUPS

- Women Service Users aged 25-49
- Women Service Users aged 15-24
- Women Non-service users aged 25-49
- Men non-service users aged 25-49

The primary aim of the focus groups will be to map the process of accessing and receiving SRH services. We would like to explore the various barriers and facilitating factors – from the point of the need for SRH services arising to the point of having received the treatment – that affect poor people's access to healthcare. These barriers and facilitating factors can exist at the household, community, facility and society levels. We have adapted our methodology to make it more appropriate to the Pakistan context, and have decided to opt for the story telling method for the discussion. This will involve introducing the project, and outlining clearly the questions we hope to get answered, and asking one woman to volunteer to tell her story – or that of someone she knows - about accessing family planning services. The volunteer will be encouraged to tell the story from the point of her perceiving need, to the point of receiving the services. Other participants will be encouraged to not intervene until after the story is completed – this may take up to 10 minutes. Once the story is completed, the other participants will be encouraged to share their perspectives on the volunteers' experiences, and to discuss agreement and differences.

The story telling will be used to focus discussion, and the facilitator will ask specific questions throughout the discussion. The focus group will be limited to between 6-8 participants.

The questions for each of the four groups have been given below and organised by level.

1. Married Women Users aged 25-49

At the **individual/ general** level:

1. Where do you get your information about SRH?
2. How did you first find out about the Rahnuma clinic/ services?
3. Do you go the Rahnuma clinic/ services for all your SRH needs? Or do you go to different providers for different services?

At the **household** level:

1. Do you ever discuss family planning with your husband or other family members or friends?
2. Who in the household decides if you can go to a healthcare provider?
3. How was the decision to access Rahnuma's services made? What are the issues that were important, i.e. cost, distance, reputation for quality?

At the **community** level:

1. Does a LHW or CMW visit you? If so, what kind of support does she provide? If not, do you see a dai? What kind of support does the dai provide?
2. Does the community support women's access to SRH services?
3. Are there any community mechanisms to support women's ability to access services, i.e. Health education, community funds for healthcare or transport, support groups for pregnant women? Is there anything else the community could do to help?
4. What is the communities view about marriage before the age of 16 years? What is your view?
5. At what age do you think a woman should have her first child? Do you think that young women under 16 years are old enough to have children?
6. What kind of support does the Rahnuma volunteer provide?

At the **healthcare provider** level:

1. Do you go the Rahnuma clinic for all your SRH needs? Or do you go to different providers for different services?
2. Do you have to pay for the service? Is the cost reasonable?
3. How are you received at the facility? How long are you expected to wait?
4. How are you treated by the nurse/ doctor? Do you feel safe? What information/ advice do you receive? Is this helpful? Do you feel comfortable asking questions related to SRH?
5. Do you think the FP service receive is of good quality? Was it safe and effective?
6. What is it about the Rahnuma clinic/services that makes you choose them above the other providers?
7. Have you ever been referred to the DHQ by the clinic? What kind of service did you get at the hospital?

2. Married Women Users aged 15-24

At the **individual/ general** level:

1. Where do you get your information about SRH?
2. How did you first find out about the Rahnuma clinic/ services?
3. Do you go the Rahnuma clinic/ services for all your SRH needs? Or do you go to different providers for different services?

At the **household** level:

1. Do you ever discuss health services with your husband, mother or other family members?
2. Who in the household decides if you can go to a healthcare provider?
3. How was the decision to access Rahnuma's services made? What are the issues that were important, i.e. cost, distance, reputation for quality?

At the **community** level:

1. Has a LHW or CMW ever visited you? If so, what kind of support does she provide? If not, do you see a dai? What kind of support does the dai provide?
2. Does the community support young women's access to SRH services?
3. Are there any community mechanisms to support young women's ability to access services, i.e. health education, community funds for healthcare or transport? Is there anything else the community could do to help?
4. Is there a place in your community where young people like you are able to visit to talk and find out about SRH issues? What is the communities view about marriage before the age of 16 years? What is your view?
5. At what age do you think a woman should have her first child? Do you think that young women under 16 years are old enough to have children?
6. How do you reach/ travel to the service provider?
7. What kind of support does the Rahnuma volunteer provide?

At the **healthcare provider** level:

1. Do you go the Rahnuma clinic for all your SRH needs? Or do you go to different providers for different services?
2. Do you have to pay for the service? Is the cost reasonable?
3. How are you received at the facility? How long are you expected to wait?
4. How are you treated by the nurse/ doctor? Are you given privacy and is confidentiality ensured? Are you provided with proper information and advice to help you make decisions? Do you feel comfortable asking questions related to SRH?
5. Do you think the medical care you receive is of good quality? Does the treatment work?
6. Have you ever been referred to the DHQ by the clinic? What kind of service did you get at the hospital?

3. Married Women Non-Users aged 25-49

At the **individual/ general** level:

1. Where do you get your information about SRH? If you have a question about SRH, what do you do? Did you talk to someone about it? Who? If not, why not?
2. If you had a SRH problem, what would you do? Would you go to see someone? If yes, who would it be? If no, why not?
3. Where would you go to get contraceptives if you needed them? Is it difficult or easy to get contraceptives?
4. Sometimes women get pregnant when they don't want to. What do women do when they are pregnant but do not want to be?

At the **household** level:

1. Do you ever discuss family planning with your husband?
2. Who in the household decides if you can go to a healthcare provider? How is the decision to access healthcare made? What are the issues that come up in the discussion, i.e. cost, distance, reputation for quality?

3. Are different care providers chosen for different services?

At the **community** level:

1. Has a LHW or CMW ever visited you? If so, what kind of support does she provide? If not, do you see a dai? What kind of support does the dai provide?
2. Does the community support women's access to SRH services?
3. What is the communities view about marriage before the age of 16 years. What is your view?
4. At what age do you think a woman should have her first child? Do you think that young women under 16 years are old enough to have children?
5. Are there any community mechanisms to support women's ability to access services, i.e Health education, community funds for healthcare of transport, support groups for pregnant women? Is there anything else the community could do to help?
6. How do you reach the service provider?

At the **healthcare** provider level:

1. Who do you go to for your SRH needs?
2. Do you have to pay for the service? Is the cost reasonable?
3. How are you received at the facility? How long are you expected to wait?
4. How are you treated by the nurse/ doctor? Are you given privacy and is confidentiality ensured? What information/ advice do you receive? Is this helpful?? Do you feel comfortable asking questions related to SRH?
5. Do you think the medical care you receive is of good quality? Does the treatment work?
6. Have you ever been referred to the DHQ? What kind of service did you receive at the hospital?
7. Have you heard of the Rahnuma clinic or services? Why do you not use these services?

4. Married Men Non-Users aged 25-49

At the **individual/ general** level:

1. Where do you get your information about SRH? If you have a question about SRH, what do you do? Did you talk to someone about it? Who? If not, why not?
2. If you had a SRH problem, what would you do? Would you go to see someone? If yes, who would it be? If no, why not?
3. Where would you go to get contraceptives if you needed them? Is it difficult or easy to get contraceptives?
4. What other services do you need? HIV and AIDS, STI, advice?

At the **household** level:

1. Do you ever discuss family planning with your wife? Do you think you, your wife or other family members should use family planning services?
2. Why?
3. How do you decide which service provider to go to for you SRH needs? What are the issues, i.e. cost, distance, reputation for quality?
4. Do you choose different care providers for different services?

At the **community** level:

1. Do you think the community is supportive of men and women's SRH needs?
2. What is the communities view about marriage before the age of 16 years. What is

your view?

3. At what age do you think a woman should have her first child? Do you think that young women under 16 years are old enough to have children?
4. Are there any community mechanisms to support women's ability to access services, i.e health education, community support groups?

At the **healthcare provider** level:

1. Have you heard of the Rahnuma clinic and outreach services? Would you consider going there? Why have you not used it so far?
2. What kind of provider do you go to for your SRH needs?
3. Do you have to pay for the service? Is the cost reasonable?
4. How are you received at the facility? How long are you expected to wait?
5. How are you treated by the nurse/ doctor? Are you given privacy and is confidentiality ensured? Are you provided with proper information and advice to help you make decisions? Do you feel comfortable asking questions related to SRH?
6. Do you think the medical care you receive is of good quality? Does the treatment work?
7. Have you ever been referred to the DHQ? What kind of service did you receive at the hospital?

Annex 4. List of people consulted

Theory of Change Workshop 23rd May, 2012, IPPF Central Office

List of participants

Name	Title
Fleur Pollard	Evaluation Officer
Heidi Marriott	Head, Organisational Learning and Evaluation
Mahua Sen	Evaluation Officer
Jane Niewczasinski	Resource Mobilization Officer
Ilka Rondinelli	Senior Advisor, Access
Seri Wendoh	Senior Technical Officer, Rights and Gender
Katie Chau	Project Officer, Youth
Elizabeth Marks	Resource Mobilization Officer
Jenny Williamson	Lead Accountant, Donor Reporting
Liam Blake	Head, Finance
Celal Semad	Monitoring and Technical Officer, Abortion
Lynsey McElhinney	Lead Accountant – Secretariat, Finance and Grants
Doortje Braeken	Senior Advisor, Adolescents/Young People
John Good	Finance Director
Erica Berlanger	Resource Mobilization Officer
Jon Hopkins	HIV Officer: Youth
Matthew Lindley	Senior Advisor, Resource Mobilization
Jennifer Woodside	Head, Advocacy and Communications

Central Office interviews and group discussions

John Good, Finance Director

Liam Blake, Head Finance

Tewodros Melesse, Director General

Doortje Braeken, Senior Advisor Adolescents/Youth

Vicky Claeys, Acting Director of External Affairs

Kevin Osbourne, Acting Director of Programmes

Heidi Marriott, Head of Organisational Learning and Evaluation

Manuelle Hurwitz, Acting Senior Advisor Abortion

Matthew Lindley, Senior Advisor, Resource Mobilization

Elizabeth Marks, Resource Mobilisation Officer

Garry Dearden, Director of Organisational Effectiveness and Governance

Lucy Stackpool-Moore, Acting Senior Advisor HIV

Advocacy Team

Jennifer Woodside, Head, Advocacy and Communications

Stuart Halford, Advocacy Officer

Sarah Shaw, Advocacy Officer

Access Team

Ilka Rondinelli, Senior Advisor, Access

Seri Wendoh, Senior Technical Officer, Rights and Gender

Marcela Rueda Gomez, Programme Officer, Access - Health Systems Strengthening / Quality Improvement

Sarah Fox, Senior Technical Officer, Health Systems, Economics and Finance

General staff focus group

Achille Togbeto, Head Governance & Accreditation

Ros Miller, Head of Human Resources

Erica Berlanger, Resource Mobilisation Officer

Jon Hopkins, HIV Officer: Youth

Upeka de Silva, Programme Officer GCACI

Celal Semad, Monitoring and Technical Officer, Abortion

Jenny Williamson, Lead Accountant, Donor Reporting

Regional Office Interviews

Giselle Carino	Deputy Director of Programs	IPPF WHR
Lena Luyckfasseel	Director of Programmes	IPPF European Network
Fatma Douiri	Deputy Regional Director	IPPF AWRO
Sun Paranjothi	Director of governance and accreditation, acting regional director	IPPF ESEAOR, Malaysia
Anjali Sen Susmita Das	Regional Director Director Programmes	IPPF SAR
Elly Mugumya	Team Leader	Eastern and Southern Africa Sub Region
Yilma Melkamu	GCACI Manager and Acting Team Leader	WCASR
Lucien Kouakou	Regional Director	ARO

Annex 5. List of data sources – In annexes

Annex 6. Bibliography

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Annex 7. Sub-reports of country visits and case studies – attached separately

G1. Bolivia

G2. Ethiopia

G3. Pakistan

Annex 8. Details of the evaluation team

Team member	title	Responsibility
Georgia Taylor	Team Leader	Design of methodology and tools Theory of change workshop IPPF Central Office interviews and focus groups Bolivia case study
Seema Khan	Social development expert	Contribution to design methodology and tools Theory of change workshop Pakistan case study
Claire Hughes	Social development expert	Ethiopia case study Analysis of regional interview data
Erika Fraser	Researcher	Data analysis Document review Survey design, execution and analysis
Achim Engelhardt	Evaluation expert	Design of methodology and tools Theory of change workshop Regional Office interviews

Annex 9. PPA organisation's management response to report findings (post submission)

International Planned Parenthood Federation (IPPF), DFID PPA Mid Term Independent Progress Review, Management Response to Recommendations

Introduction:

The PPA Mid Term Independent Progress Review has provided an opportunity for IPPF to explore and reflect on the Federation's ability to deliver on its principal mandate: to provide effective sexual and reproductive health services, and to create an enabling environment for sexual and reproductive health and rights (SRHR), especially for poor and vulnerable people.

We welcome the key findings in the report: that IPPF's work – the provision of SRH information, education and services, SRHR advocacy, and supporting people to mobilize and claim their SRHR - is making a tangible and positive difference to young, poor and vulnerable people's lives. Further, that in delivering this mandate IPPF is performing well showing strong evidence that our work is appropriate, effective and relevant; that we are cost effective; and that we represent good value for money.

We are also pleased to see IPPF's Innovation Fund – an initiative which provides funds to IPPF Member Associations (MAs) to test new ideas and approaches to solving some of today's greatest sexual and reproductive health and rights challenges – receive acknowledgement and praise in the Review. The Innovation Fund in many ways epitomizes the spirit of our movement – a willingness to push boundaries, and a commitment to tackling what can seem like intractable challenges by engaging with the communities we serve.

We appreciate the recommendations that come from the Review which address, for the most part, the systems and processes that underpin our core programmatic work. Whilst we feel that the evaluation criteria have to some extent defined the parameters of the review to focus on such processes, and less on the programmatic aspects of IPPF's work, it has been an extremely useful exercise. In the coming period, IPPF will begin to develop a new Strategic Framework. The Review and its recommendations will inform the planning and strategic development, providing valuable insight for reflection and for ways to move forward.

Recommendation One

The IPR team has assessed that the collection and use of data for making programme decisions is not always rigorous enough. The methodology and processes for monitoring, situational analysis, needs assessment, evaluation or impact assessment have sometimes lacked rigor or have been absent. Specific issues identified include (i) Monitoring and verification of results is difficult due to the variety of data collection methods and service categories used by the MAs. This causes inefficiencies as a significant amount of time is spent cleaning and verifying data. (ii) There is a general feeling by staff in the secretariat and the MAs that investment in rigorous research needs to be balanced with investment in service delivery. The return on investment of data collection and rigorous methodology has not been fully explored and accepted by MAs. (iii) Some areas of work have had no impact assessment, such as the work to strengthen health systems, or the work to enable individuals and communities to hold governments to account.

Though there have been increases in investment over the last few years, there is progress to be made. As a result there remains a level of uncertainty around the targeting and effectiveness of the programmes. There are also missed opportunities to communicate interesting methodology and results that the Federation has achieved. Investment in better needs assessment and M&E has the potential to pay off significantly with increases in efficiencies and effectiveness and increased donor funding.

Recommendation 1: IPPF to invest more time and money into needs assessment and monitoring and evaluation in order to better target programmes and to gain efficiencies and effectiveness.

This should be directed from the Central Office and with increased technical assistance from the Regional offices to the Member Associations (MAs)s. Low cost methodologies such as the PEER methodology is already being rolled out for showing stories of change. This methodology could also be used for situational and needs assessment. There should also be an emphasis on MAs learning from each other to better use different methodologies and for research capability to be developed. In some cases resources could be pooled to undertake assessments or impact evaluations in the same region.

Management Response to Recommendation 1:

IPPF is continually improving how we assess client needs, to ensure that services remain relevant and appropriate. Investing time and money in needs assessment, monitoring and evaluation needs to be balanced against our investment in the delivery of SRH services and advocacy. IPPF's focus is on collecting enough quality data to provide us with the information we need for decision making and accountability purposes. We aim to make better use of the data we have and to prioritize the monitoring and evaluation initiatives that will support us to be more effective. On a broader level, we will continue to build and strengthen partnerships with relevant institutions (academic or otherwise) to maximise our contribution to sector-wide knowledge on SRHR.

In particular the following areas need some attention:

- (i) Investigate how to further standardise service reporting categories so that it is easier for MAs to report and to verify the figures.*

We are currently undertaking a revision of its service statistics categories to ease the burden of reporting for MAs, and to improve data quality. The revised model will be completed by the end of 2012. In early 2013, training and support will be provided for MAs, including a manual on service statistics (definitions etc). Data collected using the revised model will be available from 2013 onwards. We are also currently working with MEASURE Evaluation to develop a 'Data Quality Assessment Manual' to support Member Associations in data verification and identifying areas in the data flow where threats to data quality occur (to be completed in 2013).

- (ii) Baselines and needs assessments need to be better designed to understand the range of social, gender and stigma issues that act as barriers to health services. This type of investigation would also give important market research information that could support marketing and pricing strategy development through a better understanding of both clients who can pay and clients who can't pay.*

Member Associations are local organizations with in depth understanding and knowledge of the local context in which they work and the barriers related to health services. We do recognize, however, that information collected through needs assessments and baseline surveys provides evidence needed to build well-designed programmes that can be evaluated. IPPF's Monitoring and Evaluation Handbook is in the process of being revised to reflect this. The new version will include a stronger section on how to conduct situational analyses, needs assessments, baseline and endline surveys, drawing on lessons learned from the range of methodologies used by different Regional Offices and MAs.

(iii) Consider developing a longitudinal survey in a sample of countries in order to measure impact, changing lives and changes in the social and cultural enabling environment over the medium to long term.

IPPF will seek to collaborate where appropriate to gain a greater understanding of the long term impact of our work, and to address gaps in sector wide SRHR knowledge. In 2013, IPPF will become a member of the International Initiative for Impact Evaluation (3ie) with a view to implementing impact evaluations and supporting partnerships, for example, with academic institutions.

(iv) Evaluate and communicate areas of work that show wider impact – For example: work with government on health systems, demand side finance, social franchising, social accountability and community monitoring initiatives that are impacting on public sector service delivery.

IPPF is carrying out a number of initiatives to demonstrate the wider impact of its work. For example, in South Asia, IPPF has developed a Social Audit tool for MAs to explore the social and political impact of their work. Similar initiatives, where appropriate, could be introduced across the Federation.

IPPF is also carrying out a mapping exercise of the range of health financing and service delivery mechanisms that are employed throughout the Federation (social franchising, social marketing, public private partnership). The exercise will facilitate a learning exchange of the variety of initiatives that have the most impact for improving SRH services, particularly for poor and vulnerable people. It would also support a more systematic assessment of MA engagement with national health systems, and the range of forms this engagement takes.

Recommendation Two

The IPR found that most MAs are not routinely using cost data for management decisions and they are also not calculating cost effectiveness. The Central Office does calculate cost/CYP and cost/unintended pregnancy averted, but is hampered by a financial reporting system that does not give enough line information about MA expenditure. Obviously many countries do not have the resources or know how to invest in extensive IT systems for financial and project management. However the IPR found significant efficiency gains in MAs that do have these kinds of IT systems.

Recommendation 2: Increase RO and MA capacity to measure and improve value for money. *Overall the Secretariat should have higher expectations of MAs in terms of financial and organisational management and ensure effective leaders are rewarded. As this involves greater investment in organisational development overall it may be advisable to schedule the*

support over a number of years by prioritisation – much as ARO have done with their support to the MAs. Investment in better systems, processes and especially financial management should accelerate improvements in efficiency and effectiveness.

Management Response to recommendation 2:

Improvements in the efficiency and effectiveness of the Federation require a strong understanding of how we use our resources, at all levels. In the coming period, the IPPF Secretariat will undertake a number of initiatives to raise the standard of MAs' financial and organisational management, providing the necessary support and technical advice.

The following areas of work need particular attention:

(i) Develop methodology for calculations of unit costs and cost benefit – target a subset of MAs in the low income countries to pilot both of the approaches to unit cost calculation. Particularly where there is no electronic MIS system. Include training and mentoring for managers at MA and clinic level so that they can use the information and market research together to make decisions and improve efficiency. This should help MAs to understand their market and their costs better to improve pricing strategies. The Secretariat should also assess the best way to calculate DALYs, agree methodology with donors and train MAs to use it.

The IPR tested and used a unit costing methodology at clinic level which could be utilized more widely within the Federation. IPPF is also discussing with another PPA holder in the sector – Marie Stopes International – the possibility of using a costing tool they have developed. From this work, IPPF will then test the applicability of different approaches, and find the most suitable solution for implementation in 2013 /2014 recognising that different methodologies may be appropriate for different MAs.

Working with management consultancy, Redstone, we have developed a management tool that enables MAs to understand clinic efficiency, including cost data and performance. Using this tool, MAs develop an activity plan to improve effectiveness and efficiency. An initial group of 12 MAs is working with the tool in 2012. These initiatives will be an important step towards greater understanding and analysis of unit costs and cost benefit, and with the necessary support from the Secretariat, will lead to stronger systems for measuring and improving value for money.

IPPF is currently using the internationally recommended values for DALYS (International Health Metrics and Evaluation - IHME) following work with the Guttmacher Institute. Values for DALYS are currently being revised by IHME and will be published in the Lancet in 2012. IPPF will continue to use the internationally recognized measures of impact when available. Note: not all donors agree on which methodologies to use, however, IPPF is committed to harmonizing its impact reporting with other organizations wherever possible, for example, we are planning to use MSI's Impact 2 model in 2013 where possible (contraception and abortion-related services only). All Member Associations will be encouraged and supported to use the model for their own country estimations of impact.

(ii) Analyse and change the process and categories of financial reporting from the MAs. Functional reporting lines would be more useful than reporting against the 5As. Ideally there should be enough data to be able to extract expenditure data for a number of different categories. If possible there should be a move towards standardisation of

financial management approaches. This could include supporting the phased introduction of SAP-type financial and project management IT based systems. There is a Latin American lower cost version of the SAP that could be accessed to enable wider rollout.

IPPF conducted a review of systems and processes that was completed in May 2012. This review concluded that the organization of budgets and financial reports by 'A', as required by IPPF, was problematic. A working group will be convened in early 2013 to review and revise planning, budgeting and reporting formats for the Federation. This will include considering a move to functional budget reporting lines. The changes made will be applied in 2014.

Recommendation Three

The South-South learning initiative in the Western Hemisphere Region has been successful and is well valued. There are also several other learning links in different regions. However these have not been so systematically coordinated and there is a lack of coordinated inter-regional exchange. Technical assistance is also an important and effective mechanism for learning within IPPF. The Regional Offices provide most of the TA to MAs. This is mostly focused on the SRHR technical areas and MAs are asking for more assistance to improve their organisational development and systems. Linked to the previous recommendation to improve financial reporting and management this recommendation encourages processes for supporting MAs to address some of their challenges.

Recommendation 3: Further develop organisational learning in the following two areas:

The South-South learning initiative in the Western Hemisphere region has been successful and is well valued. There are also several other learning links in different regions. However these have not been so systematically coordinated and there is a lack of coordinated inter-regional exchange. Regional offices play an important role in learning through the provision of technical assistance. This is mostly focused on the SRHR technical areas and MAs are asking for more assistance to improve their organisational development and systems. Linked to the previous recommendation to improve financial reporting and management this recommendation encourages processes for supporting MAs to address some of their challenges.

Management Response to recommendation 3:

- **South-South or Exchange learning, which may include technical hubs.** *Include a more strategic approach to inter-region learning. This would increase motivation to share information and expertise more widely in the federation. It would also ensure a more south-south based system of experts.*

As this IPR has pointed out, there is a wealth of expertise, knowledge and experience among IPPF's Member Associations. We have good examples of exchange learning to draw from: IPPF's Western Hemisphere and Africa Regional Offices both support MAs to share learning, expertise and provide technical support to each other. Both programmes have yielded impressive results, identifying and addressing gaps in both programmatic and management knowledge and skills.

We are exploring the possibility of a learning programme to allow for greater inter-regional exchange. This would capture the enormous potential that lies in the rich and varied experience of the MAs and facilitate sharing and learning on a global scale. Learning is also supported in the Federation by our extranet, *IPPF Exchange*, which is currently being redesigned to ensure that the 'People Search' function effectively supports sharing of expertise. The website is open to all IPPF volunteers and staff, and also encourages sharing of resources and provides a Federation-wide communications platform. As well, MA staff presence at global events (UN Commission on the Status of Women, UN Commission on Population and Development etc) regularly presents opportunities to learn from each other.

Establishing and strengthening technical hubs – centres of excellence where a particular MA has developed a specialism in an area of SRHR – will also provide expertise to support learning within and outside of the Federation.

- **Technical assistance to MAs to improve financial management, support IT systems introduction, improve resource mobilisation and strengthen other components of organizational effectiveness**

The provision of technical support to Member Associations has increasingly focused on these areas following the Mid-term Review of the Strategic Framework (2005-2015) undertaken in 2010 which made the same recommendation. We agree that these areas are critical for the Federation and we are increasingly focusing investment in them. For example, following the review Resource Mobilization positions were established in the Regional Offices in 2011 with a view to providing more support to MAs. The Federation already provides support for financial management and, as outlined in the management response, will look to strengthen these over the next two years. We also feel that additional expertise is needed at the MA level in human resources, IT and clinical management information systems. The 'non-programmatic' teams at IPPF CO and ROs are therefore increasingly exploring ways to make provision for technical assistance on these areas.

Recommendation Four

This review has been struck by how effective the 5As framework has been in mainstreaming previously under attended health areas and target groups throughout the federation. There is still more work to do, but the focus on the 5As has been extremely effective. However there has been some inefficiency with the way the 5As overlap and address different categories of work. The IPR also found that the structure of the organisation around the 5As is not necessarily the best way of organising as the institution develops further. The IPR also found that, rather than focusing on core areas, the 5As strategic areas tended to expand into numerous activities that run the risk of becoming unmanageable.

Recommendation 4: When developing the new strategy and structure of the organisation over the next two years ensure that lessons from the previous experience is fully analysed and used to develop a more functional and efficient organisation, with the kind of skills needed for the next 10 years of progress.

IPPF should consider the challenges of the implementation of the 5 As and question whether the whole organisation has to be structured around the strategic priorities or whether there are other ways of ensuring delivery – such as clear indicators and targets for success.

Management Response to recommendation 4:

A multi-stakeholder meeting will take place in November 2012, which will reflect on the past, and on the best way to move forward, paying particular attention to efficiency and effectiveness.

In a survey conducted for this Mid Term Independent Progress Review, almost all MAs who responded (99 per cent) either strongly agreed or agreed that the IPPF Strategic Framework had provided them with a common goal/clarified vision of IPPF (72.2 per cent strongly agreed). In addition, 91.8 per cent either strongly agreed or agreed that the Framework had united the Federation into a global movement. These are positive findings that should be taken into account when reviewing what has worked well, for example, the need for a unified vision that reinvigorates the movement. Already, IPPF has begun to group its work according to three 'Change Goals'³⁷: Unite, Deliver, Perform, that build on the current Strategic Framework 2005–2015. The Change Goals provide us with renewed focus and priority, whilst also being a workable programmatic framework.

There are three areas to consider when planning for future strategy:

(i) Focus: Build on the experience of prioritisation and focus from the HIV team and the ARO country prioritisation. IPPF needs to consider how best to focus on and prioritise (a) activity areas and (b) support to MAs. This should aim to maximise results for IPPF's core business: SRHR for poor and vulnerable people. Effective work on SRHR requires addressing multiple issues, such as the 5As and beyond. IPPF should make sure that the strategic focus and its core SRHR commitment does not expand to too many initiatives, as this can become unmanageable. There should also be further prioritisation and phasing of support to the MAs in order to maximise impact over the medium to long term. This is especially important in an environment of potentially shrinking and restricted donor funding.

IPPF has demonstrated that we can accelerate progress by targeting specific MAs for additional technical assistance and in some cases increased resources, or by addressing specific thematic areas. IPPF's Secretariat abortion and youth teams' strategies both reflect the need to direct resources to key areas of work and focus countries, drawing on both unrestricted and restricted funding sources. Also, ROs carry out a review of MA technical assistance needs on an annual basis to ensure that support provided to MAs meets their needs and maximizes results for the Federation.

Identifying MAs for support continues to be complex, however, and requires a (delicate) balance between country/beneficiary need, MA capacity, and donor priorities (where applicable).

IPPF is a movement whose goal is to ensure SRHR for poor and vulnerable people, through service provision and advocacy. As a Federation of 150+ MAs, each will be working on a variety of different SRHR issues at any one time and in response to their different national contexts.

³⁷ The Change Goals are: Unite – a global movement fighting for sexual rights and reproductive rights for all; Deliver - access for all: to reduce unmet need by doubling IPPF services; Perform – a relevant and accountable Federation.

(ii) Review the expertise needed by the organisation. The IPR would recommend that IPPF should especially increase the professional capacity of communications and advocacy experts throughout the organisation.

IPPF's Advocacy team is currently restructuring at the CO level to develop separate Communications and Advocacy functions. As part of this process, the professional capacity of communications and advocacy experts at all levels of the Federation are being assessed, and further detailed recommendations will be made on how to take this forward.

(iii) Target groups: The new strategic goals should address the issue of target groups, which may differ by country. For example, in some countries the MAs have not yet fully developed work with men through service delivery and norm change, though the youth work does target both boys and girls. Consider how to develop work with men (as change agents, service users, supporters of women and girls SRHR), particularly where MA clinics are primarily serving women (e.g. Bolivia, Ethiopia, Pakistan).

One of the main strengths of IPPF's strategic Framework is the flexibility it allows MAs to respond and adapt to their respective country situations, and work with men where this is a priority. For example, in the South Asia Region, most of the MAs have developed policies on Men and SRH, and currently have a number of initiatives that reach out to men both as clients and in terms of supporting women's SRHR. IPPF's South Asia Regional Office is a member of the Steering Committee of the Men Engage Alliance South Asia, and their MAs have conducted several community based programmes on issues of men and masculinities, GBV, sexuality, and outreach services for men and boys. IPPF SARO has also partnered with SANAM (South Asian Network to Address Masculinities) on curriculum development, integrating SRHR into their fellowship programme. This work offers learning opportunities that will feed into the strategic planning process, as well as strengthening MAs' work with men and boys in other regions.

Recommendation for DFID

Some overlap in clinic location and outreach services was found with MSI, who is also a PPA holder. It appears that MSI have a strategy of locating service delivery where there is already demonstrated demand. This has not been verified with MSI in London. However there is definitely a need to address this issue at central office level with both organisations.

Recommendation: Discuss overlap and competition between PPA holders in the same sector. Make sure that the grantees take action and eradicate negative competition by prioritising their social and development objectives. Facilitate agreement between SRHR organisations to grow the whole market not just the CYPs of each organisation.

Annex 10. Evaluation Manager's response to report findings (post submission)

Annex 11. Evaluation Questions detail

Relevance

1. Representativeness: Do the interventions and outcomes (as expressed in the Logframe) reflect the needs and wishes of the target population?
2. Targeting. To what degree do the interventions and outcomes reach the poorest and most marginalised?

Sub-questions:

- a) What analysis have IPPF country offices undertaken of the SRHR needs of underserved, poor and vulnerable people, and those in crisis, particularly young women, and is this of sufficient depth and quality?
- b) Is there a gender and/ or social exclusion policy and/ or strategy that clearly analyses poor women's barriers to SRHR and guides staff?
- d) How have the community, and particularly underserved, poor and vulnerable groups (such as adolescents, ethnic/religious minorities, indigenous communities, disabled persons, etc) been included in the projects?
- e) Are targeting strategies used to direct benefits towards the poorest and vulnerable groups?
- f) What specific initiatives were used to address gender issues in relation to access and acceptability at community level?
- g) How does IPPF monitor the reach of services among poor and excluded groups and in remote areas?

Efficiency and value for money

To what extent is IPPF able to evidence its cost effectiveness and value for money?

Sub-questions:

- a) How has IPPF performed against the value for money indicators in the logframe?
- b) What is IPPF's methodology for measuring cost effectiveness?
- c) What are the unit costs of specific services?
- d) Is the PPA funding of IPPF good value for money?
- e) Are value for money concepts well embedded in the management of the organisation at country level?
- f) Does the organizational culture promote efficiency and good management?

In addition efficiency will be evaluated by assessing institutional efficiency through the following areas:

- Leadership and management
- Human resource management
- Financial management
- Systems and processes
- Communications
- Procurement, logistics and inventory control.

Effectiveness, results and impact

What is the distinctive offering of IPPF and how does it complement or add value to DFID's portfolio?

Sub-questions:

- Performance against the Log Frame: to what extent is IPPF achieving (or progressing towards) the intended outcomes?
- Changes in lives. Assess the information about what changes these outcomes are making in people's lives and how many people are affected.
- To what extent is civil society enabled to hold government to account?
- To what extent does DFID funding achieve additionality, i.e. enable IPPF to achieve things they would have otherwise not been able to achieve?

The following evaluation questions will also be addressed as part of this evaluation:

- a) How do PPA results benefit the creation of an enabling sexual and reproductive health (SRH) policy environment
- b) To what extent does IPPF and its PPA achievements align to DFID's theory of change for the PPA?
- c) What are the additional benefits realised as a result of DFID's PPA funding? To what extent are those results contributing to IPPF's organisational effectiveness?
- d) To what extent has IPPF the ability to measure results through its monitoring and evaluation system?
- e) What specific activities and results are new and linked directly to the PPA funding – what could not have been achieved without the PPA funding?

Learning and Innovation

- To what extent does the culture of the organisation promote and encourage learning and innovation – especially with respect to governance structures, leaders and management?
- To what extent has IPPF learned from its work and has incorporated the lessons into improved performance?
- To what extent has IPPF produced generalisable learning that has been incorporated into its own practice and shared with others?
- Assess the extent to which IPPF innovates in terms of developing, testing and achieving the adoptions by others of new knowledge.
- Assess IPPF's monitoring and evaluation capacity and in particular its ability to measure results (focusing on the quality of reported results and lessons learned rather than an assessment of M&E systems themselves).

Sustainability

How sustainable are the results? Sub-questions:

- a) To what extent are the benefits of the programme activities likely to continue after PPA funding ceases? Will components of the project be taken over by other partners or the government?
- b) What were the major factors influencing the expected achievement or non-achievement of sustainability of the programme activities?

c) Has a process been identified to systematically phase out the support to partners, e.g. an exit strategy? What mechanisms have been put in place to avoid the jolt of termination of funding? How were partners / government facilitated to own the project before termination or scaling down of funding?

d) What have been the extent/depth and achievements of local capacity building (both at government and civil society levels) for sustained results around enhancing SRSH services demand and supply and engaging with and influencing policy mechanisms for SRHR?

Annex 12. Results against the logframe as presented in the IPPF Annual Review

Table 1: Output 1, Indicator 1.1 SRH Services in 2011

		Baseline (2009) ³⁸	2011 actuals	2011 milestones in logframe	Performance (above/below target)
All clients	All SRH services	45,776,418	62,955,932	44,200,000	+42%
	CYP	4,039,683	4,438,856	4,100,000	+8%
Young people	All SRH services	20,547,708	26,355,377	22,000,000	+20%
All clients	HIV/STI/RTI services	4,446,916	9,244,207	4,200,000	+120%
	Abortion-related services	610,393	571,976 ³⁹	640,000	-11%
	Long term reversible methods	2,711,018	4,106,820	3,100,000	+32%
	Poor, marginalised etc	75%	80.4%	72.5%	+11%

Output 1, Indicator 1.2: MAs providing Integrated Package of Essential Services (IPES)

Table 2: MAs providing IPES

Package of Essential Services (PES)	75% of services provided		Performance (above/below target)	100% of services provided		Performance (above/below target)
	2011 Actual	2011 milestone		2011 Actual	2011 milestone	
Baseline (2009)						
60%	67%	61%	10%	31%	27%	15%

Table 3: IPPF's influence on national funding mechanisms, 2009-2011

Type of funding mechanism	% of Member Associations in GSWACH+ countries	
	2009	2011
National Development Planning	55.6	60.5
Poverty Reduction Strategy Papers (PRSP)	48.9	67.4
MTEF	20.0	30.2
Sector wide approaches (SWAPs)	62.2	65.1
CCMs	64.4	65.1
Donor national level programmes	62.2	62.8
National contraceptive security committee	68.9	n/a

³⁸ Due to improved data assessment and collection, some changes have been made to baseline data. Details are given in notes to the logframe.

³⁹ In real terms this is not a decrease, due to reclassification of services – a full explanation is provided below.

Annex 13. Regional Office Interview Findings – attached separately

Main findings from IPPF Regional Office Interviews

Overall Findings

- IPPF is achieving large scale SRH service expansion globally, largely driven by expansion in the Africa Region. One MA, Nigeria, accounts for a large proportion of the service expansion in Africa.
- Work to promote efficiency is at an early stage of development within IPPF. This needs concentrated attention in the coming years to take the seeds currently being planted to fruition.
- IPPF programmes are generally closely aligned to national SRH priorities; some divergence may be noted, specifically in countries where the legal or policy space for SRH is restrictive. In these cases, IPPF activity seeks to expand the space for SRH.
- A standardized approach for determining the poverty profile of IPPF clients is not evident, although a tool to estimate the poverty likelihood of clients has been piloted in some countries. Current data reported to DFID on the percentage of clients who are poor, marginalized, socially excluded or underserved are estimates based on assumptions such as all clients accessed through outreach are considered underserved, all clients reached through special projects are either marginalized or socially excluded.
- There is evidence of fruitful experience sharing between MAs and ROs, allowing models developing in one country to be adapted and implemented in others. Annual focal point meetings and MA exchanges appear to be central to this success.
- Virtually none of IPPF's clinics are self-sustaining, although a small proportion of them are within striking distance of sustainability and many are conscious of the need to gradually increase internally generated revenue. The ability to achieve financial sustainability is constrained by poverty levels and a commitment to make services accessible to the poor. Making progress in this area is a long term process which will require innovative approaches and gradual diversification of income streams.
- Work to measure and promote efficiency remains at an early stage of development across IPPF ROs and little evidence is currently available in this area. There are though important steps being taken, including the costing of services in several countries and the introduction of performance based financing in others. Important steps forward are likely in this area in the coming years.
- Although difficult to quantify, outcome data suggests that IPPF is making an important, and growing, contribution to MDGs 5 and 6 on maternal mortality and HIV/AIDS. In 2011 alone, in GSWACH+MA countries, IPPF was able to avert over 1 million unintended pregnancies and nearly 400,000 unsafe abortions. The combination of direct service, with advocacy and partnerships with government, civil society and private sector agencies appear to be central to IPPF's success.
- As DFID provides core funding, it is difficult to quantify the specific outcomes from this support. There is though evidence to suggest that it ensures the continuity of SRH services, provides flexibility to respond to emerging needs, to take risks and to innovate and enables institutional capacity building.

Results

Over the last 3 years, IPPF has achieved large scale service expansion. Moderate growth has been recorded in most regions, but the most significant expansion has taken place in the Africa Region. Here, between 2009-2011, the total number of SRH services provided, the number of SRH services provided to young people, the number of HIV/RTI services provided, the number of services that reduce recourse to unsafe abortion all more than doubled. In 2011, the Africa

Region provided a total of 26.36 million SRH services, far exceeding the 15.05 million recorded by the South Asia Region, which previously had recorded the highest figures for service provision in the IPPF network. The Africa Region does, of course, include many more GSWACH+MA countries than the South Asia Region (26 compared to 5) but this is not the main source of the Africa Region's incredible growth. It is largely due to a small number of countries, the most significant of which is Nigeria. In 2011, Nigeria alone provided 12.24 million SRH services.

The great strides in service provision are also translating into increases at the outcome level. All regions, except the Western Hemisphere, recorded increases in the number of unintended pregnancies averted, the DALYS averted and the number of unsafe abortions averted. In terms of pure numbers, the South Asia Region contributes the most to the first and last of these indicators, whilst the Africa Region is now contributing most to the DALYS averted. As one would expect, it is the Africa Region, and Nigeria specifically, which is driving the improvements at this level. In 2011, Nigeria made up 38% of the number of unintended pregnancies averted in the Africa Region, and 41% of the number of unsafe abortions averted. The Arab World Region is also making significant progress, doubling figures for each of these 3 indicators in the 2009-2011 period. However, figures in this region remain small and therefore do not contribute a large proportion to the overall totals.

Based on the GSWACH+MA data, the Western Hemisphere is the poorest performing region. This is in large part due to figures reported by Brazil and, to some extent, by Peru. In the 2009-2011 period, Brazil's figures for the number of SRH services provided and the number of SRH services provided to young people fell significantly, although important increases were made in the provision of comprehensive abortion services. The reductions in SRH service provision affected the CYP, which fell from 714,883 in 2009 to 355,968 in 2011. This, of course, has a knock-on effect at outcome level.

The Western Hemisphere Region is the only region where results based financing has been initiated. Introduced in 2011, it is too early to say whether it can make a contribution in improving MA performance, but this is certainly something that needs to be monitored in the coming years.

Most regions are managing to increase the percentage of poor, marginalized, socially excluded and underserved people amongst their clients. Africa is the exception, with the percentage of clients falling into these categories dropping from 72% in 2009 to 69% in 2011. Overall, figures suggest that about 75% of IPPF's clients globally can be considered poor, marginalized, socially excluded and underserved populations, up from 65% in 2009. A robust approach to measuring the number of PMSEU clients is however lacking in most regions and so this data must be treated with caution.

There are a few isolated indicators where progress is not being recorded. In South Asia and in East and South East Asia and Oceania Regions the number of services provided that reduce recourse to unsafe abortion has fallen by 36% and 10% respectively between 2009 and 2011. In South Asia reductions in the number of safe abortion services provided were recorded in 3 countries: Bangladesh, India and Nepal. In ESEAOR, Myanmar was the main source of the decrease in safe abortion services provided.

ESEAOR has also seen a fall in the number of SRH services provided to young people, falling from 3.74 million in 2009 to 2.96 million in 2011. Again, Myanmar was the main source of this

decrease. In contrast, rapid growth in the number of services provided to young people was recorded in Cambodia and in Vietnam, and the Regional Office reports youth services as being in greatest demand.

Work to promote efficiency is clearly at an early stage of development within IPPF. Currently, none of the Regional Offices reported MAs producing standardized activity cost data, a key indicator for performance measurement at the clinic level and a basis for service planning decisions. Only the Western Hemisphere Region is using results driven financing. This is an area that IPPF is building up and it is encouraged to place significant emphasis on this across the regions in the next 1-2 years.

Regional Offices highlighted two important factors, which they felt had contributed to increasing service provision: i) outreach and taking services into communities (SAR); ii) partnerships (SAR, ARO). The South Asia Regional Office reported how, in Sri Lanka, a partnership between the MA and the Plantation Board had increased reach of services to plantation workers in their workplace. In India, establishment of small rural based satellite clinics connected to a larger Reproductive Health and Family Planning Centre not only increased access to services, but also facilitated task shifting between clinics, particularly in the areas of family planning and medical abortion and promoted a better continuum of care and client follow up. ARO also reported that the formation of partnerships between the MA and public and private sector organizations had been key in increasing the MA's service utilization rates in Burkina Faso (ARO). ARO also felt that partnerships helped increase influence at a policy level.

In terms of demand for services, ARO, AWRO and ESEAOR reported that family planning services were the most in demand, particularly diversifying the range of family planning methods available (ARO). Youth services were also reported to be in demand (ARO, EN, SAR), as are safe abortion related services (ARO, EN, SAR). Other popular services mentioned included safe motherhood services (ESEAOR), services in response to gender based violence (SAR) and HIV related services (ARO, SAR). The SAR Office noted that many of its clinics had spare capacity and that more investment in demand creation was needed.

Whilst the MAs drive service delivery, the Regional Offices make an important contribution to improving service quality and facilitating service expansion. They do this in a number of ways, including

- Provision of technical assistance to MAs, including through country visits (ESEAOR, EN, ARO). For example, the shift in approach in the Burkina Faso programme described above resulted from recommendations made during an Regional Office visit to the country.
- Training service providers (ARO, EN, ESEAOR). For example, ARO reported training service providers on abortion in Uganda, Mozambique, Swaziland and Ethiopia), whilst the EN Office had trained youth volunteers.
- Provision of self-assessment systems to quality assure the MAs' performance, with Regional Offices overseeing these systems (ESEAOR)
- Bridging funding gaps in service provision where necessary (ESEAOR).
- Supporting MA fundraising efforts (AWRO)
- Supporting experience sharing and networking events (EN). For example, the European Network has hosted networking meetings on youth work.

2. Relevance

2.1 Representativeness

At the national level, relevance of services to target audiences is promoted through:

- Conducting needs assessments often at the start of interventions, or broader situation analyses;
- Working closely with government to ensure that SRH services are in line with government policy and complement available government services.

To tailor services to the needs of client groups, MAs often conduct needs assessments prior to the start of interventions (ESEAOR, MA Ethiopia). These might be supported by the RO, for example by conducting data analysis (EN), highlighting relevant reports, providing technical inputs to the needs assessment tools and methodologies, or even providing small amounts of funding for the assessments (SAR). In the case of AWRO, situation analyses, including document review and stakeholder analysis, are conducted annually. These are led by the RO and done in partnership with MA staff. With current levels of political change in the region, it was reported that this level of frequency was inadequate to remain in touch with the emerging threats and opportunities. None of the ROs referred to client exit interviews, or routine community needs assessment as a means for improving the tailoring of services.

Many MAs appear to have close working relationships with national governments and use this as a means to align their programmes to government policy and ensure their services are complementary to those provided by government. For example,

- In Bangladesh, the government has requested the MA to provide family planning services in specific regions of the country (SAR).
- In Afghanistan, the MA complements government clinic based services through mobile clinics (SAR).
- In India, the MA has worked closely with government to reposition family planning in rural areas (SAR).

There are though cases where MA priorities may diverge from those of the government. This tends to be where the legal or policy space for the provision of certain services is limited e.g. for abortion. In these contexts, the MA may focus efforts on extending this space. This has been the case in the Western Hemisphere Region on abortion and in the European region on SRH more broadly.

Co-ordinated strategic planning enables RO activities to be aligned to national SRH priorities. Each Regional Office has a 5 year strategic plan, which is complemented by annual programme budgets. The Africa RO reported that the needs of MAs, as expressed in their own strategic plans and annual programme budgets, determined their own focus. ARO supports 44 MAs and so further prioritization is necessary. It uses a set of criteria, including unmet need for contraceptives, potential of MA, scale of donor interest, to determine priority countries for ARO's financial and technical support (See table 1 below). Current priority countries are Nigeria, Ethiopia, Uganda, Tanzania, Kenya and Burkina Faso.

Table 1: ARO criteria to determine priority countries for technical and financial assistance

THEMATIC AREA	CRITERIA FOR MA CATEGORISATION	MA CATEGORISATION		
		High Priority	Medium Priority	Low Priority
Family Planning	Unmet need, population size, regional contribution to SS, potential for expansion (clinic, CBD etc), current capacity and market share, donor preference/priority country, potential for becoming technical hub or learning centre, competitive advantage over competitors/partners.	<ol style="list-style-type: none"> 1. Nigeria 2. Mozambique 3. Ethiopia 4. Uganda 5. Ghana 6. Mali 7. DRC 8. Togo 9. Benin 10. Côte d'Ivoire 11. Burkina Faso 12. Madagascar 13. Guinea-Conakry 14. Kenya 15. Tanzania 	<ol style="list-style-type: none"> 1. Guinea-Bissau 2. Burundi 3. Zambia 4. CAR 5. Rwanda 6. Lesotho 7. Angola 8. Senegal 9. Congo 10. Liberia 11. Sierra Leone 12. Niger 13. Cape Verde 14. Mauritius 15. South Sudan 16. Namibia 17. Malawi 18. Chad 	<ol style="list-style-type: none"> 1. Botswana 2. Swaziland 3. Comoros 4. Gabon 5. Seychelles 6. Zimbabwe 7. Sao Tome
HIV	Prevalence, level of national response (ART, PMTCT), regional contribution to SS, potential for expansion (clinic, CBD), current capacity and market share, potential for becoming technical hub/learning centre, comparative advantage over partners/competitors, donor preference/priority country.	<ol style="list-style-type: none"> 1. Nigeria 2. Ethiopia 3. Kenya 4. Uganda 5. Ghana 6. Burundi 7. Rwanda 8. Mozambique 9. Burkina Faso 10. Comoros 11. Benin 12. Tanzania 13. Swaziland 14. Senegal 15. DRC 16. Cameroun 17. Malawi 	<ol style="list-style-type: none"> 1. Togo 2. CAR 3. Côte d'Ivoire 4. Angola 5. Zambia 6. Sierra Leone 7. Mauritius 8. Niger 9. Guinea-Conakry 10. Botswana 11. Madagascar 12. Lesotho 13. Namibia 14. South Sudan 15. Mali 	<ol style="list-style-type: none"> 1. Gabon 2. Congo 3. Guinea-Bissau 4. Chad 5. Cape Verde 6. Liberia 7. Sao Tome 8. Seychelles 9. Zimbabwe
Abortion	National Laws, magnitude of unsafe abortion, regional contribution to SS, potential for expansion (clinic, CBD etc), current capacity and market share, donor preference/priority country, potential for becoming technical hub or learning centre, competitive advantage over competitors/partners.	<ol style="list-style-type: none"> 1. Ethiopia 2. Mozambique 3. Nigeria 4. Ghana 5. Zambia 6. Swaziland 7. Tanzania 8. Burkina Faso 9. Benin 10. Uganda 11. Guinea 12. Cote d'Ivoire 13. Mali 14. Senegal 15. DRC 	<ol style="list-style-type: none"> 1. Comoros 2. Lesotho 3. Central African Republic 4. Guinea-Bissau 5. Niger 6. Malawi 7. Sierra Leone 8. Mauritius 9. Cape Verde 10. Togo 	<ol style="list-style-type: none"> 1. Chad 2. Congo 3. Botswana 4. Namibia 5. Gabon 6. Seychelles 7. South Sudan 8. Zimbabwe 9. Sao Tome

		16. Burundi 17. Rwanda		
THEMATIC AREA	CRITERIA FOR MA CATEGORISATION	MA CATEGORISATION		
		High Priority	Medium Priority	Low Priority
CYP	Unmet need, fertility rates, population growth rate, population size, regional contribution to SS, potential for expansion (clinic, CBD etc), current capacity and market share, donor preference/priority country, potential for becoming technical hub or learning centre, competitive advantage over competitors/partners.	<ol style="list-style-type: none"> 1. Nigeria 2. Ethiopia 3. Ghana Uganda 4. Cote d'Ivoire 5. Mali Kenya 6. DRC 	<ol style="list-style-type: none"> 1. Benin 2. Zambia 3. Madagascar 4. Burundi 5. Lesotho 6. Burkina Faso 7. Togo 8. Namibia 9. Senegal 10. Guinea 11. Mozambique 12. Liberia 13. South Sudan 	<ol style="list-style-type: none"> 1. Rwanda 2. Central A Republic 3. Swaziland 4. Congo 5. Tanzania 6. Chad 7. Comoros 8. Cape Verde 9. Cameroon 10. Niger 11. Botswana 12. Sierra Leone 13. Malawi 14. Mauritius 15. Angola 16. Gabon 17. Guinea Bissau 18. Sao Tome and P 19. Seychelles 20. Zimbabwe
Other SRH Services	Contribution to regional non-contraceptive SS, potential for expansion (clinic, CBD etc) of services such as cervical cancer screening and management, gynaecology, breast cancer screening and management, obstetric fistula diagnosis and treatment, maternal health, male DRH clinics for prostate, erectile dysfunction, SGBV, specialised services etc., current capacity and market share, competitive advantage over competitors and or partners.	<ol style="list-style-type: none"> 1. Nigeria 2. Tanzania 3. Ethiopia 4. Kenya 5. Uganda 6. Mozambique 7. Burundi 8. Botswana 9. Senegal 10. Benin 11. Ghana 12. Niger 13. Togo 14. Burkina Faso 15. CAR 16. Mauritius 	<ol style="list-style-type: none"> 1. Sierra Leone 2. Rwanda 3. Zambia 4. Cote d'Ivoire 5. Guinea-Conakry 6. Swaziland Comoros 7. Madagascar 8. Chad 9. Cameroun 10. Angola 11. Malawi 12. Lesotho 13. DRC 14. Gabon 15. Congo 16. Mali 17. Cape 18. Verde 19. Guinea-Bissau 	<ol style="list-style-type: none"> 1. Namibia 2. Liberia 3. Seychelles 4. Zimbabwe 5. Sao Tome 6. South Sudan

2.2 Targeting

A standardized approach for determining the poverty profile of IPPF clients is not evident in the RO interviews¹. The SAR Office appears to be making a considered attempt at understanding the poverty profile of clients, with the introduction of a tool to estimate the number of poor, marginalized, socially excluded and underserved people amongst its clients. This tool uses a

¹ Although a specific question to elicit this was not included in the questionnaire.

small number of questions about the client's social status and household assets. The resulting score is then compared to a poverty line index to determine the client's "poverty likelihood". During the pilots in SAR MAs, 3-5 clients were assessed per day per clinic to generate a representative picture of client poverty profiles. A first full data set is expected to be available for the 2012 service statistics. In the meantime, the percentage of clients who are poor, marginalized, socially excluded or underserved² is estimated, using the following assumptions: all clients entering through outreach services are considered underserved; all clients of special projects such as are considered marginalized or socially excluded. AWRO reports the poverty profile of clients and therefore their ability to pay for services being decided by clinic staff, based on where the client lives, the number of children they have, who their neighbours are etc. A similar approach was reported by the MA in Ethiopia and in Pakistan.

Effectiveness

Learning and Innovation

Promoting learning and innovation is one of the responsibilities of the IPPF Central Office and Regional Offices. A number of different approaches are used, including:

- Annual focal point meetings, where MAs meet and share good practices;
- Exchanges between MAs: this is an opportunity for one MA to gain in-depth knowledge of a particular practice initiated by another MA, for example the MA in Togo visited Cameroon to look at services for lesbians, gays and transsexuals. In addition, the Africa Region Office has initiated a buddy system, which pairs a strong MA with a weaker MA for organizational strengthening.
- Technical assistance visits by Regional Office staff and/or Central Office staff to MAs
- Organisational learning sessions, held quarterly in the ARO, where, with the assistance of internal and external speakers staff are able to learn about thinking and approaches in relevant areas, new IPPF programmes in the region and outcomes from on-going programmes.
- IPPF intranet providing updates on global, regional and national activities and achievements
- Regional Office task force meetings, held monthly for each IPPF task force to think about strategies and innovation to strengthen performance.

This review has identified numerous examples of lesson learning between MAs and ROs (see Box), evidence that internal knowledge sharing approaches are having some impact. Encouragingly, it was also reported that formal strategic planning processes included the opportunity to reflect on lesson learnt, thereby making some link between learning and planning (ARO).

Box X: Examples of experience sharing within IPPF network

- WHR experience in clinical management systems and performance management systems has been drawn upon by both the EN and ESEAOR
- WHR has hosted an exchange with the Philippines MA to learn about the provision of safe abortion services
- social marketing model developed in Sri Lanka has attracted interest in ECR and Africa Region (SAR);
- Training for visually challenged people in Tunisia has replicated in other countries outside the region (AWR);

² This is one of the PPA logframe indicators.

The approach adopted by the Central Office to pilot new initiatives, promote lesson learning and facilitate scale up seems particularly well thought through. For initiatives led by Central Office, an initial pilot in a small number of countries is supported. At the end of the pilot, outcomes and lessons learnt are packaged in attractive and focused presentations and supporting documentation, and are discussed at technical meetings with MAs. MAs are then able to express an interest in piloting the methodology in their own country. A series of discussions with the MA then follows to determine their readiness to implement the initiative, including fit with national needs and the availability of necessary financial and human resources.

Whilst internal lesson learning appears to work well, links into international networks are less obvious. At the country level, there is a sense that MAs depend on their own national contacts and the IPPF network for new thinking. There was little evidence of MAs being directly connected to international networks.

Organisational effectiveness

Regional Offices and MAs reported a strong sense of belonging to the IPPF Federation (EN, ESEAOR, SAR, AWRO, ARO). Affiliation to the federation was seen as a mark of credibility by members with certain standards assured through the accreditation process (ARO, ESEARO, SAR). The wide ranging technical and organizational management support available through the network was also particularly valued (ARO, EN, SAR), as was the fundraising assistance available.

The IPPF Central Office and Regional Offices are responsible for strategic leadership of the network, provision of technical support to MAs, introducing and maintaining effective management systems, including communication systems. During the review, Regional Office staff were invited to score the performance of the Central Office in each area on a scale of 1-5, with 1 being very good, and 5 being very poor. A total score of 10 or under can be considered good. The results are surprisingly varied. The Central Office appears to perform best in strategic leadership and the provision of technical support although there are significant variations in the scores by region. Some Offices did however feel that the line of action for the new agenda of Deliver, Unite, Perform needed further clarification (EN, WHR). ARO also suggested that there was duplication in available expertise in the RO and the CO and, as a result, technical support from the CO was not generally needed. Management and support systems is the area where performance is rated lowest. Compared to other organizations, one Regional Office felt that IPPF's systems were well behind (WHR). Another recommended more extensive use of technology to improve information sharing, especially for the benefit of the MAs (ARO).

Table X: Performance Assessment of Central Office in core areas, by Regional Office Staff³

Type of Support	ARO	AWR	EN	SAR	WHR	Total (optimal score = 10 or under)
Strategic Leadership	1	1	3	2-3	4	11-12
Technical Support	3 (not really sought)	2	2	2-3	2	11-12

³ ESEAOR did not score performance.

Management and systems support	2	2	3	2	5	14
Communications	4	2	2	2	2	12
Total (optimal score = 10 or under)	10	7	10	8-10	13	

Lines of communication between the ROs and the CO were generally felt to be improving. The EN and WHR reported having focal points in the Central Office, whilst the ARO indicated this was lacking but needed. The level of support provided by different thematic areas was reported to vary, perhaps due to the internal resourcing of particular areas. For example, CO support on abortion was considered good, whilst available support on youth was less forthcoming. Guidance on clinical issues was flagged as a particular gap in the support the CO provides.

Sustainability

Achieving financial sustainability is a long term process, which requires gradual diversification of funding sources (ARO). Currently, virtually none of IPPF's clinics are self-sustaining, although a small proportion of them are within striking distance of sustainability and many are conscious of the need to gradually increase internally generated revenue. Bolivia, Morocco, Egypt and Sudan⁴ are achieving high levels of internally generated resources and could potentially achieve financial sustainability in years to come. In Brazil, Cambodia, India, Pakistan and Zimbabwe government funding delivered through different modalities⁵ is an important factor in moving towards sustainability. In the Africa Region, about 10 MAs were reported to be improving levels of internally generated revenue, including Cote d'Ivoire, Gabon, Kenya and Nigeria but none had exceeded 30% of their annual costs (ARO). The establishment of training hubs, which would sell training courses, was highlighted as a key strategy for diversifying local income streams in the Africa region (ARO).

In South Asia, efforts have been made to reduce the financial dependence on IPPF. In 2003, SAR MAs received approximately 53% of their annual budget direct from IPPF. By 2010, this figure had been reduced to 35%. International donor funding had largely replaced that of IPPF with the proportion of funding from international sources increasing from 14% in 2003 to 38% in 2010. This is, of course, positive, since it would seem to indicate a growing confidence amongst international donors in the MAs. However, it has been accompanied by a fall in the amount of locally generated resources, from 32% of annual budgets in 2003 to 27% in 2010, and concerns about the self sufficiency of SAR clinics still remain.

⁴ Morocco, Egypt and Sudan were reported to generate approximately 50-60% of their costs through internally generated revenue.

⁵ In Brazil, a partnership with local authorities provides government funding for 5 clinics; in Cambodia, clinics benefit from a government voucher scheme to cover some costs for the poor accessing SRH services; in India and Pakistan, MAs run some clinics on behalf of government, with government providing funding; in Zimbabwe, health the MA's services are supported financially by national government.

Table X: Donor diversification in South Asia

Income	Percentage from local sources	Percentage from international sources	Percentage from IPPF	Total
2003	32.09	14.17	53.74	100.00
2004	34.15	22.54	43.31	100.00
2005	28.76	22.09	49.15	100.00
2006	33.41	15.99	50.59	100.00
2007	41.97	14.55	43.48	100.00
2008	42.56	12.03	45.41	100.00
2009	28.57	36.51	34.92	100.00
2010	26.95	38.22	34.83	100.00

Poverty levels were identified as a critical obstacle to achieving financial sustainability in most regions. IPPF is committed to ensuring access to SRH services by poor and marginalized groups and opportunities for increase internally generated revenue must be carefully balanced with what target groups are able to pay.

Several other social, political and institutional factors were felt to affect the sustainability of IPPF clinics across the network (see Box). Of the 8 mentioned, 5 of them are beyond the influence of IPPF and therefore could pose significant risks to operations. In some contexts, the highly sensitive nature of some of the issues IPPF engages in can pose real threats to the life and well-being of staff. This highlights the need for strong relationships with communities and governments to be in touch with community sentiments and as far as possible provide some kind of safeguards.

Box X: Factors affecting clinic sustainability

- Political instability particularly in countries where government is an important funder of health services (EN, ESEAOR, SAR)
- Conflict
- Corruption (EN)
- Relations between national governments and international development partners: MAs in some countries such as Kenya, Mali, Niger and Uganda receive commodity supplies from national governments. The latter are depending on international development partners for funding, and in some cases, procurement. Cases of stock outs have been known, affecting the ability of MAs to provide basic SRH services.
- Laws, which prevent CSOs from charging service fees e.g. in Tunisia
- Religious restrictions and general opposition to sensitive issues, which constrain certain activities and can pose threats to the well-being of clinic staff (ESEAOR, SAR)
- Limited supply of skilled staff and competition amongst health service providers: many MAs lose staff to international agencies able to offer higher salaries
- Incentives provided to encourage uptake of certain services, for example in Bangladesh, India, Nepal, and Pakistan government is offering financial incentives for sterilization.

Efficiency

Work to measure and promote efficiency remains at an early stage of development across IPPF ROs and at the moment, there is little available evidence in this area. Several MAs are in the process of costing services (ARO, AWRO, ESEAOR, SAR), an important step in determining the efficiency of services and where improvements may be made. In the SAR region, a branch performance tool has been developed and piloted in India. Performance based financing is also currently being piloted in the Africa Region (Ghana and Uganda). A key lesson emerging from this experience is that strong M&E systems need to be in place to make PBF a workable system.

The Western Hemisphere Region is slightly more advanced in understanding organizational efficiency. It has just finalized a peer assessment of its MAs to establish the relationship between IPPF investment and service outputs. It has concluded that the Bolivia MA is a highly efficient MA due to high SRH needs, a large implementation budget and strong leadership at Board and Executive Director level. Nicaragua appeared to be less efficient, with weaker leadership at the Board and Executive Director levels being key differences.

Despite the lack of evidence, IPPF ROs point to some factors, which they believe contribute to organizational efficiencies. These include:

- Clear leadership by the Board and senior management, with the roles of each clearly defined (ESEAOR);
- Strong management systems (ESEAOR)
- Stable funding streams, which allows investment to be made in MA systems and procedures (ESEAOR)
- RO quality assurance to ensure minimum standards, for example in strategic plans, strategies for resource mobilization, implementation of M&E systems etc. The accreditation process was highlighted as a critical means of quality assurance (AWRO), as well as desk-based support, and TA/monitoring visits to MAs by the Regional Offices (ARO, AWRO)
- Size of MA, with larger MAs e.g. India, Nepal, Pakistan, Bangladesh, able to achieve economies of scale (SAR)

High staff turnover has been highlighted as a key factor, which undermines MA efficiency (AWRO, MA in Ethiopia, Pakistan, Bolivia?). As local NGOs, MAs cannot compete with salaries offered by International NGOs and donors and they frequently lose staff to them.

Impact and value for money of PPA funding

With such a large number of stakeholders involved in the field of SRH, it is difficult to quantify with any certainty the contribution IPPF is making towards reducing maternal mortality (MDG 5) and combating HIV/AIDS (MDG 6). The outcome data presented above does however suggest that IPPF is making an important, and growing, contribution to these two MDGs, especially to reducing maternal mortality. In 2011 alone, in GSWACH+MA countries, IPPF was able to avert over 1 million unintended pregnancies and 388,000 unsafe abortions (one of three leading causes of maternal mortality (WHO 2008)).

Direct service provision is, of course, a critical factor in this important contribution. However, Regional Offices have also highlighted the importance of IPPF's advocacy work, as well as partnerships with other organizations. Advocacy conducted at the national, regional and global levels is reported to be improving the enabling environment for reproductive health services

(ESEAOR), which in turn allows the expansion of services, and, one assumes translates into reduced maternal mortality and prevalence of HIV/AIDS. Alliances with other organizations help to increase influence and enable governments to be held more accountable for the promises they have made (AWRO, EN).

In addition to partnerships, Regional Offices identified other factors, which, they feel, have contributed to their achievements. Dynamic MA leadership and active and connected Board members were considered to be two important success factors (WHR). A strong relationship with active government partners was also felt to be important (WHR). In many cases, Board members help to facilitate this kind of relationship, which enables the MA to have considerable political influence (ESEAOR).

As DFID provides core funding, it is difficult to quantify the specific outcomes from this support. Feedback from Regional Offices suggests that its impact depends on the context in a particular country. In countries where few donors support SRH and where poverty levels make the ability to pay for services low, the impact of DFID's funding is significant. For example, AWRO reported that in the absence of DFID support, about 50% of their clinics would be forced to close⁶. Vietnam, similarly, would be forced to close some clinics if DFID funding were not forthcoming (ESEAOR). In contrast, countries such as Myanmar, Indonesia and Cambodia are reported to have a range of funding sources for SRH services, including income from services and could therefore survive without DFID support. Large MAs in South Asia such as Bangladesh, India, Nepal, Pakistan and Sri Lanka were also felt to be relatively stable, having strengthened their institutional base and diversified funding sources through previous core funding (SAR).

DFID core funding clearly enables IPPF to do certain things, which, if dependent on restricted funding, would be more challenging. Key benefits reported by the Regional Offices include:

- Provides **flexibility to respond to emerging needs**, whether at government, MA, clinic or community level (SAR);
- Gives the opportunity to **take risks and innovate** (SAR). For example, in Bangladesh the IPPF Innovations Fund supported a pilot project to promote SRHR in 10 Islamic religious schools, or madrasahs. The context was extremely challenging. Initially, broad health needs were addressed and, as trust grew, SRHR issues were gradually introduced. These were tackled from a perspective of Islamic values and references to Islamic texts were made to help communicate messages. This work within madrasahs was complemented by the development of partnerships with the Islamic Foundation, Imam Association and the Madrasah Education Board to demonstrate the compatibility of the initiative with Islamic values. After 2 years, results were so significant that the MA was able to leverage new resources from Ausaid, the Government of Netherlands and IPPF to scale up the initiative to a further 42 madrasahs. The experience has also been studied by the MA in Pakistan, which has adapted strategies to work with religious leaders, institutions and communities and established an Islamic Resource Centre in Lahore.
- Enables **institutional capacity building**, an area where funding is normally inadequate (SAR). As a result of strengthened institutional capacity, MAs in Nepal and India are now accredited to train government doctors in their respective countries. They are the only NGOs in their countries who have achieved this.

⁶ MAs would choose to maintain a wide range of services in fewer clinics, rather than reducing the range of services in clinics.

- Ensures the **continuity of SRH services**, particularly at times when other large donors withdraw e.g. under the Bush administration.

References

World Health Organisation, (2008), Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008, http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241501118/en/, accessed 15 August 2012.

Annex 14. Desk Review Report - attached separately

IPPF PPA: DESK REVIEW

Overall findings:

(1) IPPF's 'Strategic Framework 2005-2015' focuses on five priority areas – the Five 'A's. A survey of Member Associations (MAs), conducted as part of the mid-term review in 2009, found that the IPPF Strategic Framework has had the **strongest influence on MAs' agendas in the area of adolescents, followed by access, HIV, and advocacy**. The area perceived to have been influenced the least by the Framework is abortion, with legal and cultural barriers existing in many countries.

(2) Almost all MAs agreed that the IPPF Strategic Framework had provided them with a **common goal/clarified vision of IPPF** (72.2 per cent strongly agreed). In addition, 91.8 per cent either strongly agreed or agreed that the Framework had **united the Federation into a global movement**.

(3) Key **barriers** to implementing the Framework identified in the mid-term review include: socio-cultural issues; restrictive legal frameworks and attitudes towards abortion of decision-makers; lack of adequate financial resources to implement the Five 'A' objectives; staffing challenges; national context; and limiting structure and content of the Framework.

(4) While the Framework is still in place, IPPF's 5As are now framed within **three new change goals - Unite, Deliver and Perform**.¹

Policies and strategies

(5) The **quality of strategies to support the 5As is mixed. Where they exist, indicators are not always clear or SMART**. While the advocacy strategic framework has clear objectives and SMART indicators targeted to different contexts and based on a sound analysis of the situation, the adolescent strategy indicators do not appear to be time-bound, with no targets, milestones or means of measurement presented. **The advocacy and access strategic frameworks do not contain indicators**. IPPF does not yet have a comprehensive and standardized system to monitor the outcome and impact of advocacy activities. **HIV?**

(6) **All strategic frameworks place emphasis on access on gender and social exclusion. HIV?**

- The abortion strategic framework includes indicators focused on access for poor and vulnerable women and girls, for example: “% of clients for Comprehensive Abortion Care (CAC) and Family Planning (FP) services in Intensive Focus MAs who are poor, marginalized, socially excluded and/or under-served”.
- The advocacy strategy has a clear social/gender lens, with each of the three programme outputs related through a shared emphasis on marginalized groups, with a particular emphasis on young women and girls – ‘Girls Decide’.
- The adolescent strategic framework identifies as one of the four priority areas for 2012-2015: “Expand commitment to work with the most underserved including the youngest, young women and girls and young people living with HIV, disabilities”.
- The access strategy aims to provide SRHR information and services that are gender- and rights-based and meet the needs of PMSUs [the poor, marginalized, the social excluded and under-served], especially youth.

(7) Given the wide range of contexts that MAs work in, there appears to be a **move towards different strategic approaches within several of the 5As and targeting of resources**. This trend is particularly evident for the advocacy strategic framework with its differing approaches for the three types of focus countries: Intensive Focus MAs, Emergent MAs, and Countries to Watch. The adolescent strategic direction will also be implemented through a mix of core funded activities and project /restricted funded activities for different countries, such as the Choices programme (14 countries) and the A+ initiative (15 countries). **Also appears to be the case for HIV**

The 5A's results

(8) IPPF's Member Associations generate an enormous amount of results on the 5As in a range of different formats and reporting styles, making it challenging to summarise the key lessons learned, what works well and what impact the MAs are having globally.

(9) While all 5As increased their services in 2011, the most progress occurred in HIV-related services and adolescents. Of the 5As, the least progress has been made on abortion, which is seen to be 'uneven and overall behind the progress seen in other areas'². Results from 2011 for each of the 5As are:³

- **HIV-related services:** increased by 120 per cent compared to the 2011 milestone and more than 100 per cent compared to the 2009 baseline figure.
- **Advocacy:** 94 per cent of all MAs conducted advocacy activities to advance national policy and legislation on SRHR in 2011 (up from 92.5 per cent in 2009), with a record 116 policy or legislative changes achieved and/or defended against by MAs in 67 countries.
- **Abortion-related services:** increased globally by 13 per cent between 2009-2011, especially in Africa. However, IPPF was not able to meet the 2011 milestone for abortion-related services (it was 11 per cent lower than the milestone set in the logframe and quite significantly lower in the South Asia Region), although it is believed that the difference can be explained by a reclassification of abortion categories.
- **Access:** 80.4 per cent of IPPF's clients in 2011 were classified as poor, marginalized, stigmatized, socially excluded or under-served (11 per cent higher than the 2011 milestone). Service-delivery points with a community-based presence increased by 64 per cent during 2011, helping IPPF to access some of the hardest-to-reach populations.
- **Adolescents:** Over 40 per cent of IPPF's total services provided in 2011 reached young people. SRH services provided to young people increased nearly by 30 per cent between 2009-2011 in the GSWACH + countries.

Innovation Fund

(10) Since 2005, the Innovation Fund (IF) has funded **a total of 41 projects**. The IF has **funded a broad range of projects by "A" and geographical spread**, including for example, addressing coerced marriage (Pakistan); empowering men who have sex with men (China); piloting medical abortion (North Korea); and advocacy for combating female genital mutilation (Cote d'Ivoire).

(11) In a preliminary review of the portfolio of IF projects, all 41 projects were viewed to have been **innovative** for the implementing MA and have **advanced IPPF's strategic priorities**. All projects include a **capacity building** component. 35 projects have worked to **empower vulnerable groups**, 30 projects have **addressed sensitive and taboo issues**, and several IF projects have been **scaled-up** by the government or by the MA with external donor funding, which has **ensured the sustainability** of project activities.

(12) Innovation Fund projects are **showcased on the IPPF website**, with a recognition that some projects will fail and it is important to learn from the pitfalls and take up good practice. **Lessons learned have also been communicated to other MAs** in a series of three 'Learning from Innovation' publications.

Peer Reviews

(13) The rapid PEER approach supplements other IPPF evaluation methodologies and provides an immediate and authentic 'insider view' account of the impact at local level of projects, based on narrative data generated by the beneficiaries of the project themselves.

(14) The 'Changing lives' series on IPPF's website summarizes the PEER results from all reviews and helps communicate the work of IPPF to external audiences, share lessons learned and good practice across the Federation. PEER review data are also used by MAs to inform decisions about projects / programmes, and as part of final evaluations.

(15) In terms of the relevance, effectiveness and impact, the following observations are made in the IPPF literature on PEER reviews:

- Relevance: PEER reviews look at how the programme has made a difference, to whom and how. The PEER review methodology actively involves project beneficiaries who have regular involvement with the programme (for example, peer educators, volunteers, activists, etc.). The PEER approach can help overcome barriers to accessing high quality data such as culture, language and mistrust and can be particularly useful in working with hard-to-reach and vulnerable groups.
- Effectiveness: PEER reviews examine the challenges that IPPF projects have faced and how they have been overcome.
- Impact: PEER reviews look at what worked, what did not work and why.

To follow up:

- Any progress on three-year IPPF abortion stigma initiative?
- What is the 'Choices' adolescence programme?
- Do timeframes or targets for the adolescence indicators exist? Are there any access indicators?
- Has any progress been made in securing funding for better advocacy reporting systems?
- Do we have the latest HIV strategy?

1. Policies and strategies

Overall mission

IPPF's 'Strategic Framework 2005-2015' focuses on five priority areas – the Five 'A's: **adolescents/young people; HIV and AIDS; abortion; access** to services and information; and **advocacy**.

A survey of MAs,⁴ conducted as part of the mid-term review in 2009, found that the IPPF Strategic Framework has had the strongest influence on MAs' agendas in the area of adolescents, followed by access, HIV, and advocacy. **The area perceived to have been influenced the least by the 2005-2015 Strategic Framework is abortion**, with many Member Associations saying that their abortion work was limited due to the legal and cultural contexts in their countries. As will be seen later, the updated abortion strategy tackles these different circumstances by moving towards different strategic approaches and targeting of resources for different Member Associations. The survey also found that the Strategic Framework had a considerable influence on Member Association agendas post-2005 in terms of the Five 'A' objectives. The least influence was on the access agenda, which can be largely explained by a high percentage of Associations already working on the access objectives before 2005.

Almost all Member Associations (99 per cent) either strongly agreed or agreed that the IPPF **Strategic Framework had provided them with a common goal/clarified vision of IPPF** (72.2 per cent strongly agreed). In addition, **91.8 per cent either strongly agreed or agreed that the Framework had united the Federation into a global movement**.

Key barriers to implementing the Strategic Framework identified in the mid-term review include:

- **socio-cultural issues:** intolerance and opposition among religious leaders, right-wing politicians and other groups, as well as cultural norms, traditions and customs, particularly in the area of abortion;
- **working on increasing access to safe abortion remains a challenge**, due to restrictive legal frameworks and attitudes of decision-makers in several countries;
- **lack of adequate financial resources to implement the Five 'A' objectives;**
- **staffing challenges**, including recruiting and maintaining trained and skilled office and clinical staff
- **national context**, including legal barriers to advocacy initiatives and working with adolescents (as well as for abortion, mentioned above)
- **structure and content of the Strategic Framework** has been limiting for some Member Associations' programme design and implementation, resource allocation and reporting. Specific problems mentioned include the way that the Five 'A's are structured, how they overlap, and what work they include or do not include.

Following the mid-term review, updated strategies were developed for each of the Five 'A's. The following section looks at the quality of policies and strategies that support these 5A's and particularly the area of access for poor and vulnerable women and girls.

It should also be noted that from 2012, IPPF's existing strategic framework will be framed within **three new goals - Unite, Deliver and Perform:**

- Goal 1: Unite – a global movement fighting for sexual rights and reproductive rights for all;
- Goal 2: Deliver - access for all to reduce unmet need by doubling IPPF services; and
- Goal 3: Perform - a relevant and accountable Federation.

Abortion

The IPPF strategic goal on abortion is based on the Federation’s belief that access to safe abortion services is a basic right of any woman faced with an unwanted pregnancy. However, abortion remains a sensitive issue in several countries, making it hard to address abortion within all of the IPPF Member Associations. In the first five years of implementation of the 2005-2015 Strategic Framework, “progress on work on abortion across the Federation has been **uneven and overall behind the progress seen in other areas**”.⁵

IPPF’s updated abortion strategy⁶ therefore highlights the need to **focus resources on key areas of work and focus countries**. Table 1 below shows some of the key characteristics of the three focus groups: (1) Intensive Focus MAs; (2) Emergent MAs; and (3) Countries to Watch. With the emergent MAs, minimum levels of investment are needed to move them to the level of Intensive Focus, such as provision of Values Clarification Training or seed money for equipment and renovation. Countries to Watch have the minimum goal of ensuring the provision of the essential abortion services that are part of IPPF’s Integrated Package of Essential Services (induced surgical/medical abortion and/or treatment of incomplete abortion AND pre-/post- abortion counselling). The updated IPPF abortion strategy notes that some MAs within the Countries to Watch category may receive technical assistance to move forward their work on abortion, if resources permit.

Table 1: IPPF Abortion Strategy by Focus Countries⁷

Focus Countries	Description	Western Hemisphere Region	European Network	Arab World Region	Africa Region	South Asia Region	East-Southeast Asia and Oceania Region
Intensive Focus MAs - Total: 33	Shown the willingness and capacity to move forward work on abortion and can be expected to produce results in a short timeframe with some additional investment and/or support.	Argentina Barbados Belize Bolivia Brazil Colombia Costa Rica Guatemala Mexico Peru Puerto Rico St. Lucia Venezuela	Kazakhstan Kyrgyzstan	Palestine Sudan Tunisia	Burkina Faso Cameroun Ethiopia Ghana Kenya Zambia	Bangladesh India Nepal Pakistan	Cambodia Indonesia Mongolia Thailand Vietnam
Emergent MAs - Total: 19	Have potential to start or scale up work on abortion but which, thus far, lack the initial training or infrastructure to do so. Some smaller amounts of investment will be required to move the Emergent MAs to the level of Intensive Focus	Dominican Republic Ecuador Suriname	Albania Macedonia Tajikistan	Egypt Mauritania Morocco Syria	Benin Guinea Conakry Mozambique Nigeria Swaziland	Afghanistan Sri Lanka	DPR Korea Philippines

Countries to watch - Total: 21	Exhibited some interest in working on abortion in the recent past but which may not justify a large degree of involvement from the Regional or Central Office Abortion Teams at this time.	Chile Haiti Nicaragua Panama Paraguay	Armenia Bosnia & Herzegovina Georgia		Burundi Cote d'Ivoire DR Congo Mali Rwanda Senegal Tanzania Uganda	Bhutan Iran Maldives	Malaysia Laos
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IPPF's updated abortion strategy includes a logframe at the back, with **clear objectives and SMART indicators**, including means of verification. As previously mentioned, the circumstances in IPPF countries vary greatly with regard to abortion, and the **logframe reflects this variation in context**, with different indicators for Intensive Focus MAs, Emergent MAs, or Countries to Watch.

IPPF's abortion strategy also highlights the need to address barriers that keep women from being able to access safe abortion services (Objective 2.3) with the intended outcomes of "Improved access of poor, young and marginalized clients to safe and affordable contraceptive and abortion services" and "Increased awareness of abortion and contraception among communities served by the MAs". **Indicators which focus on gender and social exclusion** are only collected for Intensive Focus MAs and include, for example: % of clients for Comprehensive Abortion Care (CAC) and Family Planning (FP) services in Intensive Focus MAs who are poor, marginalized, socially excluded and/or under-served.

IPPF is also seeking to address the problem of abortion stigma, which it believes "keeps the issue of unsafe abortion hidden and poses a significant barrier to women being able to exercise their rights to safe abortion and post-abortion care"⁸. To this end, IPPF held an expert meeting in July 2011 as the first step in the larger **three-year IPPF abortion stigma initiative** (funded by the David and Lucile Packard Foundation) to include the following activities: (a) increase global awareness of the impact of abortion stigma; (b) adapt and pilot an abortion stigma assessment tool or interventions; and (c) develop an advocacy funding mechanism to support organizations working on abortion stigma.

Georgia – has there been any progress on these activities?

Access

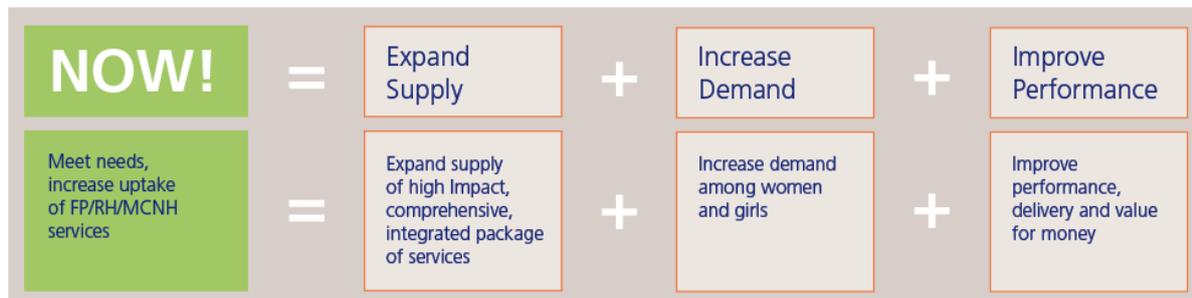
IPPF's Access Global Strategy (2011-2014) has the following goal: "IPPF's sexual and reproductive health and rights information and services are stigma-free, high quality, integrated, youth-friendly, gender- and rights-based, and meet the needs of PMSUs [the poor, marginalized, the social excluded and under-served], especially youth."⁹ The access strategy aims to address the findings of the 2009-2010 Mid-Term Review (MTR), which identified gaps in: SRHR for vulnerable populations especially youth; commitment to IPPF's vision, mission and core value; performance culture; and capacity building.

The Access Global Strategy has four key strategic priorities: (1) Scaling-up and lesson learning; (2) capacity development of IPPF managers and staff; (3) Strengthening sexual rights and integrating gender based violence (GBV) initiatives within services delivery programmes; and (4) publicize, communicate and advocate for IPPF's Access/HSS successful stories. Although the access strategy outlines activities for each of these priorities, **no access indicators have been provided making it difficult to measure progress**. **Cannot find any indicators in the strategy or in any of the access documents in the dropbox – Georgia: are there any?**

In addition to the Access Global Strategy, IPPF has developed a **No Opportunity Wasted! (NOW!) approach (2011-2014)**,¹⁰ which extends family planning and reproductive health choices, increases

uptake and improves value-for money. The Now Model (see Figure 1 below) includes innovative approaches to improve service delivery, such as social franchising, results driven financing, demand side mechanisms such as voucher schemes, the integration of new technologies within the supply chain and IPPF's innovative Clinical Management Information System (CMIS). **Georgia – it isn't clear from the documents provided how the NOW approach fits in with the Global Access strategy.**

Figure 1: IPPF's Access NOW! Model¹¹



Adolescents

IPPF's adolescent strategy¹² notes that the first five years of the implementation of the Adolescent Strategic Framework have been **"quite successful"**, with an increase of more than 50% of youth services. The Adolescent 'A' teams across IPPF see their work as overlapping with and complementing IPPF's other programmatic areas of work.

A key element of the 2012-2015 strategy on adolescents is the need for **focussed implementation**, with strategies and activities related to directions will be implemented through **core funded activities as well as project /restricted funded activities** including:

- Choices Programme (**Georgia – do we have any info on what this is?**): Dominican Republic, Guatemala, Bosnia, Albania, Egypt, Zambia, Kenya, Ethiopia, Senegal, Vietnam, the Philippines, Indonesia, India, Pakistan
- A+ initiative until 2012 (also known as the 'Adolescents and Advocacy for Sexual and Reproductive Health and Rights project', funded by Danida): Afghanistan, Nepal, Bangladesh, Benin, Zambia, Uganda, Burkina Faso, Tanzania, Rwanda, Kenya, Togo, Ghana, Malawi, Namibia, Bolivia

IPPF (2011) notes that the Choices Programme led to a **change in the way youth budgets were allocated**: "CO Core Youth costs were re-allocated to restricted funding, along with staff and other elements of RO Youth costs, and represent a new way of funding of Secretariat costs, compared to the traditional IPPF model. This new way of budget allocation may have an impact on roles and responsibilities of CO and RO".¹³

The strategic plan includes activities, results and indicators for each of the four key strategy areas for 2012-2015:

- Increase **internal and external commitment to IPPF's core values** on adolescent sexual reproductive health and rights (ASRRH)
- Increase the **sustainability and cost effectiveness** of youth programmes
- Expand commitment to high quality, cost effective, **innovative approaches** to implement youth programmes
- Expand commitment to **work with the most underserved** including the youngest, young women and girls and young people living with HIV, disabilities

The adolescent strategy **indicators do not appear to be time-bound, with no targets, milestones or means of measurement** presented in the strategic framework for 2012-2015 (**Georgia, do**

timeframes for indicators exist elsewhere, and are just not presented in the strategic framework document?).

HIV/AIDS

It is not clear what IPPF's current HIV/AIDS strategy is from the documents shared. The indicators outlined in the 2012 powerpoint presentation from the HIV team's budget planning are different from those in the 2005-2010 'Community Links' five year implementation plan on mainstreaming HIV/AIDS into IPPF.

Advocacy

IPPF's global advocacy strategy¹⁴ for 2011-2015 contains advocacy priorities, as well as outlining roles and responsibilities, how to measure results, and where there are funding/activity gaps. There are three intended outputs of the Global Advocacy Programme:

1. Holding governments and intergovernmental bodies accountable for existing political and financial commitments to reproductive health in current development framework at global and regional level including but not limited to ICPD; G8, MDG5b and GSWACH
2. For norm setting institutions and key national governments to refer to and include RH indicators in the post-2015 development framework.
3. Mainstreaming sexual rights issues in existing legal and political mechanisms.

The advocacy strategy has a clear social/gender lens, with each of the three programme outputs above related through a shared emphasis on marginalized groups, with a **particular emphasis on young women and girls – 'Girls Decide'**.¹⁵

At present, **IPPF does not have a comprehensive and standardized system to monitor the outcome and impact of advocacy activities**. The 2011 Global Advocacy Programme notes that although the current Global Indicators provide a practical measure of national inputs and outcomes, it does not capture important information on impacts and effectiveness such as:

- the details of these advocacy successes for scale up;
- the necessary follow up to ensure implementation of advocacy gains; and
- details about the longer term impact on improving people's lives.

In the 2011 advocacy report, IPPF recognises the need to develop better reporting systems to document and assess advocacy work at the country, regional, and global level. **Check progress – there was a possibility of Packard funding for M&E of advocacy and a Concept note was being prepared in late 2011 for submission to the Packard Foundation.**

2. The 5A's results

Adolescents

During 2011, IPPF's delivery of a SRH services to young people increased significantly, with a **20 per cent higher number of SRH services provided to young people than the expected milestone for 2011** (SRH services provided to young people increased nearly by 30 per cent between 2009-2011 in the GSWACH + countries included in the Logframe). Over 40 per cent of IPPF's total services provided in 2011 reached young people.¹⁶

A key element of DFID funding has also been support to youth advocacy networks, which is enabling IPPF to nurture a new generation of young leaders, advocating for SRHR.¹⁷ For example, Tanzania's UMATI hosted a 'Change our World' event in August 2011 in celebration of the Youth International Day, bringing representatives the Youth Action Movement (YAM) from other African IPPF MAs.¹⁸ Zambia's PPAZ also has a wide network of volunteers, which enables young people to be active participants in programmes, administration and governance of the Association. Young people constitute more than 30% of the committees. The YAM was also instrumental in accelerating SRH information and service provision in the communities through community theatre and peer education. Some YAM members participated in trainings such as peer educators' trainings, while others were facilitators at various trainings. At PPAZ health centres, tasks such as counselling and receptionist roles were executed by young people.¹⁹

The A+ initiative (funded by DANIDA) is building the capacity of 16 IPPF Member Associations to deliver sustainable, rights-based and client-centred youth programmes. Analysis of the 2011 narrative reports highlights ways in which adolescent and youth programmes are having an impact (for example, see Box 1). For example, Youth Friendly Corners in Zambia are expanding services offered for young people, especially the most underserved and vulnerable.²⁰ The reports also contain a range of youth activities aimed at promoting and/or expanding gender equality. Several MAs have strategies in place to sustain youth-friendly services beyond the life of the project and are integrating project activities within the core work of their Association.

Box 1: Impact of A+ Initiative: Case Study from Afghanistan

"I am Habiba working as a teacher in tailoring center for women in the community - I am also a health promoter for AFGA. One of our students was married at the age of 13 to an older man. Now 17 years old she has four children and lives in a difficult economic situation. She has been experience family based violence as well, which did not permit her to visit the clinic for FP services. I visited her family and provided information regarding child marriage, possible consequences of multiple pregnancies and benefits of family planning. After four visits her family agreed to bring her to the mobile clinic for FP service. She is now regular client of the clinic and she has also started working as a tailor at home."²¹

Access

The Access team is relatively new (less than two years old), and perhaps as a result there is more of a lack of focus in terms of results compared to the other four A's. For example, the Dropbox contained only three files on 'Access' and these were all strategy documents.

The 2011 PPA Annual Review highlights the following access achievements:

- In 2011, 80.4 per cent of IPPF's clients were classified as poor, marginalized, stigmatized, socially excluded or under-served, this is 11 per cent higher than the 2011 milestone. Almost all regions saw an increase in the proportion of poor and vulnerable clients.
- Service-delivery points with a community-based presence increased during 2011, helping IPPF to access some of the hardest-to-reach populations. Particularly in the Africa Region, IPPF's service delivery points increased by 64 per cent compared to 2010.

HIV/AIDS

There are indications that the HIV/AIDS team’s strategy of focusing on particular countries and technical areas is helping the IPPF **to achieve its HIV-related global indicators, particularly reaching key populations (indicator 10), conducting BCC to reduce stigma (indicator 11) and HIV workplace policy (indicator 7).**²²

However, as Figure 2 below shows, there is **still considerable work to be done to provide services along the prevention to care continuum (indicator 8), particularly in emergent focus countries.** Figure 3 shows that almost half of MAs now provide at least six services on the prevention to care continuum, but more Global Focus Countries provide the ‘harder’ to provide services (on the left).

The 2011/2012 PPA Annual Review notes that in 2011, **the number of HIV-related services increased by 120 per cent compared to the 2011 milestone** and more than 100 per cent compared to the 2009 baseline figure. Although there has been a significant and sustained increase in HIV-related services in all the regions, **the Africa Region is the main driver for the increase.**

The increase in HIV-related services can be partly explained by the **integration of HIV services into existing SRH services**, which have helped to target outreach efforts. For example, the Family Planning Association of Malawi (FPAM) is reaching out to young people in under-served and hard-to-reach areas in Malawi with integrated youth-friendly SRH and HIV services. The project has enabled FPAM to expand its services to young people and according to PEER reviews: “Not only has it allowed FPAM to provide more services, but the quality and accessibility of the services has improved”.²³

There are also indications that **IPPF’s work on reducing stigma has also helped expand the outreach of HIV services.** For example, through its ‘Equally Different’ project, INPPARES in Peru is providing essential services to a highly stigmatized sector of the population - lesbian, gay, bisexual, transgender and questioning (LGBTQ) people, especially youth. PEER reviews of the Equally Different project found that it has led to increased access of LGBTQ people to appropriate and sensitive SRH services, in turn leading to improvements in their physical and emotional health.²⁴

Figure 2: HIV-related global indicators by focus country type²⁵

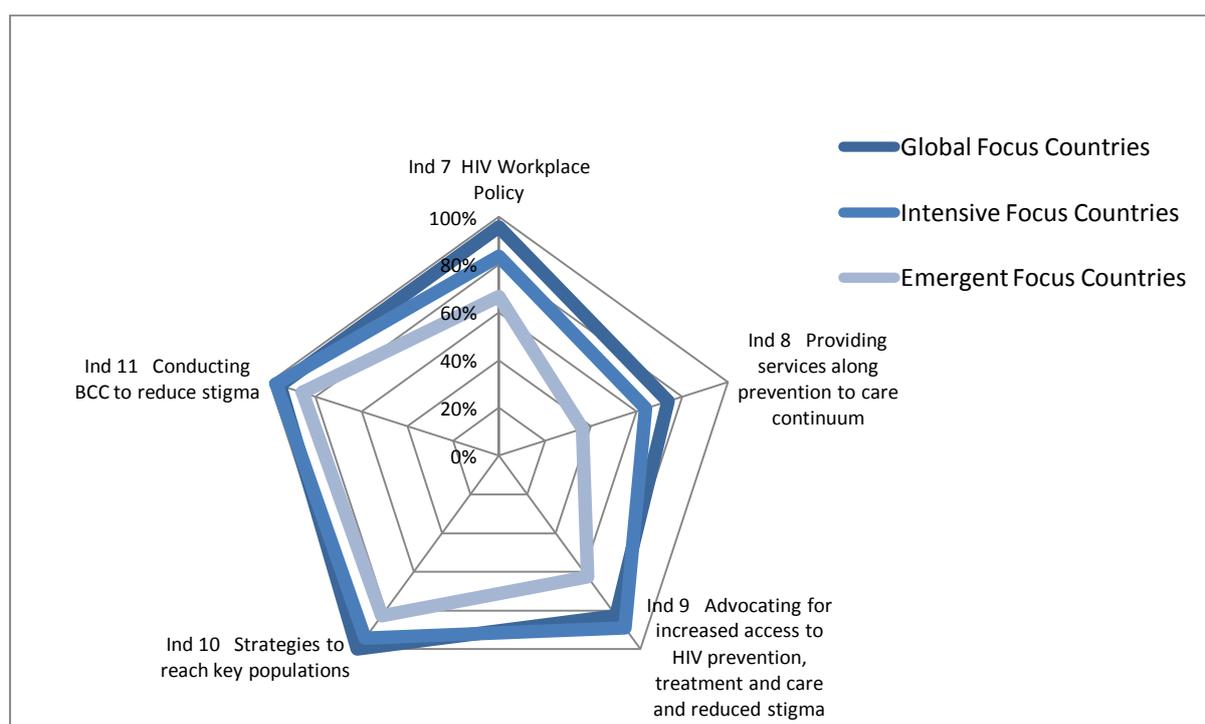
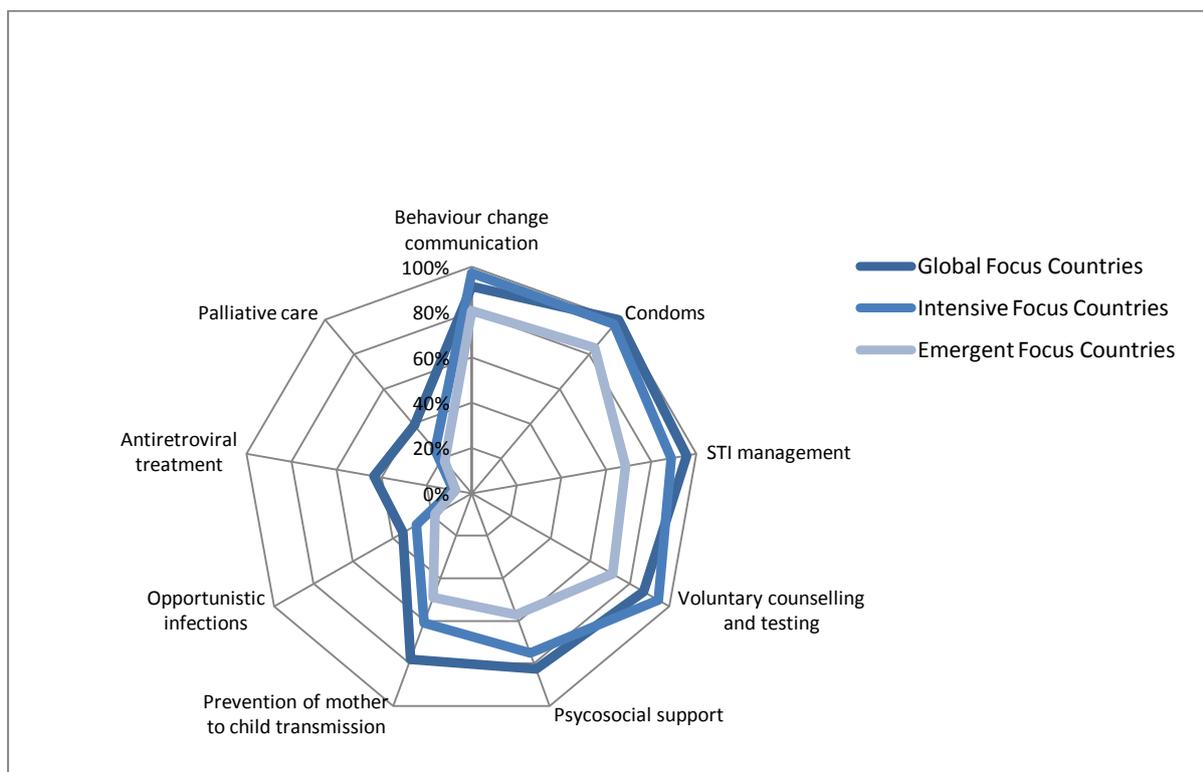


Figure 3: Prevention to care continuum by focus country type²⁶



Over the last few years, PPA funding has also enabled IPPF to develop the **People Living with HIV (PLHIV) Stigma Index²⁷** – the first large-scale international comparison of standardised HIV-related stigma indicators. The PLHIV Stigma Index will help increase the evidence base for policies and programs to reduce HIV-related stigma and discrimination, and help ensure the GIPA (Greater Involvement of People Living with HIV and AIDS) Principle is enshrined in local, regional and national responses to HIV. As of end-2011, the PLHIV Stigma Index survey has been undertaken in 27 countries, with work progressing in 13 others and plans underway in a further 20. (Georgia – latest progress?)

In addition, more than half of eligible Member Associations receive funding from the **Global Fund** to Fight AIDS, Tuberculosis and Malaria, helping them to increase their HIV-related services and push for greater linkages between HIV and SRH health services.

Advocacy

In 2011, 94 per cent of all Member Associations conducted advocacy activities to advance national policy and legislation on SRHR (up from 92.5 per cent in 2009), with a record **116 policy or legislative changes achieved and/or defended against by Member Associations in 67 countries**. 86 per cent of the MAs have also implemented initiatives to influence public opinion on SRHR to support favourable policies and legislation, primarily by radio (used by 90.7 per cent of MAs), followed by newspaper and magazine articles and community outreach activities (86.8 per cent).²⁸

IPPF does not yet have a comprehensive and standardized system to monitor the outcome and impact of advocacy activities, making it more difficult to pull out advocacy results compared to other of the 5 'A's such as abortion or HIV/AIDS. However, there are some examples of successful advocacy campaigns:

- **FPAB in Bangladesh’s advocacy for Breaking the Silence (ABS)** aims to increase public and financial commitment to and support for sexual and reproductive health and rights at the national and community levels. The campaign developed good working relationship with partners, media, and parliamentarians.²⁹
- **Sierra Leone’s SRH and Rights 2011 advocacy programme** has achieved several gains, including influencing State actors and traditional leaders to develop bye-laws abolishing FGM for children under 16 years. In collaboration with other CSOs, they were also able to influence Government to increase financial and resource allocation to health. Working with networks and coalitions of SRHR partners has given strengths and opportunities to the Association in engaging and influencing policy makers on right issues. However, a major constraint encountered in the implementation of planned activities was the **delay in the receipt of the Core Grant**.³⁰

Abortion

Abortion-related services provided by Member Associations have **increased globally by 13 per cent between 2009-2011**, especially in Africa. However, IPPF was not able to meet the 2011 milestone for abortion-related services (it was 11 per cent lower than the milestone set in the logframe and quite significantly lower in the South Asia Region), although it is believed that the difference can be explained by a reclassification of abortion categories.³¹ Abortion remains a contentious issue and it is hoped that by targeting resources on particular countries, as outlined in the revised Abortion Global Strategy, IPPF will be able to accelerate progress for abortion-related services in the next three years (2012-2014).

Examples of recent IPPF achievements in improving abortion-related services include:

- **Implementation of the electronic clinic management information system (eCMIS) has increased MAs’ capacity to monitor performance**, including the rapid expansion of the system beyond the clinics currently funded by the Initiative, for example in Bangladesh, India, Indonesia and Nepal.³²
- **Targeted marketing strategies** for publicising abortion services and ensuring that women seek services as early as possible and within the legal gestational limit, for example in Ethiopia, the MA produced national radio programmes which contributed to a 148 per cent increase in the number of clients provided with an abortion service at the FGAE clinics. In Cameroon, the MA intensified their community level sensitization and referral activities, leading to a seven fold increase in the number served at the CAMNAFAW clinics.³³ In Kyrgyzstan, the MA has worked with local youth groups in order to increase referrals for their services. In Bangladesh, over 90 per cent of referrals to the MA clinics for MR services have been provided by reproductive health promoters.³⁴
- **Practical training workshops for clinic staff and opportunities to participate in regional learning events** are helping to share knowledge and ensure compliance with IPPF quality of care standards, as well as being helpful incentives for motivating staff, particularly in the Africa region where high staff turnover is a challenge.³⁵
- **Innovative ways of reducing barriers and stigma have helped increase demand for comprehensive abortion care**, such as: reducing personal information to that which is legally required, which reassures clients that their privacy is being respected; reducing user fees in conjunction with a ‘no refusal policy’; ensuring that clinics provide a range of integrated services so that clients, particularly those travelling great distances from rural areas, need only make one visit to the clinic; increasing opening hours to include evening periods; and strategically placing signboards that can direct clients to the clinic location, details of the clinic opening times and the services provided.³⁶

3. Assessment of the Innovation Fund

The Innovation Fund supports Member Associations to develop pioneering initiatives in support of IPPF’s strategic priorities. Established in 2005, the Fund has the goal *“to foster, pilot and promote ground-breaking initiatives in support of IPPF’s strategic priorities, which enhance learning and contribute to the increased relevance and effectiveness of SRH programmes throughout the Federation and beyond.”*³⁷

The Fund has two main aims: (1) to serve as a mechanism to encourage MAs to experiment and take risks in developing new approaches, tackling sensitive issues and working with previously under-served, marginalized and vulnerable groups; and (2) for IPPF to learn from these experiments and incorporate the lessons learned from Innovation Fund projects to improve programming and replicate or scale up the more successful projects.

Since 2005, the IF has funded a **total of 41 projects** including 12 in 2005, 8 in 2006, 4 in 2007, 9 in 2008 and 8 in 2009, with a **broad range of projects by “A” and geographical spread (by “Region”)** (see Table 2).

Table 2: Number of projects funded by the Innovation Fund by ‘A’ and by Region³⁸

Region	Abortion	Access	Adolescents	HIV/AIDS	Advocacy	Total
AR	-	2	-	4	1	7
AWR	-	1	1	1	1	4
EN	2	2	3	-	3	10
ESEAOR	1	2	1	1	1	6
SAR	-	2	2	2	-	6
WHR	-	4	2	-	2	8
Total	3	13	9	8	8	41

Some of the **achievements** highlighted in a preliminary review³⁹ of the portfolio of Innovation Fund projects include:

- All 41 projects have been **innovative** for the implementing MA and have **advanced IPPF’s strategic priorities**;
- All projects include a **capacity building** component and have developed tools, guidelines and training modules as well as building staff and volunteer’s skills in the new programme areas.
- 35 projects have worked to **empower vulnerable groups** including survivors of gender based violence and sexual abuse, people affected by child marriage, disabled young people, sex workers, sexually diverse groups, prison inmates and refugees; and
- 30 projects have **addressed sensitive and taboo issues**, such as the criminalization of HIV, initiated public debate and brought change to government policy and public attitudes.
- Several IF projects have been **scaled-up** by the government or by the Member Association with external donor funding, which has **ensured the sustainability** of project activities. For example, the success of the Tunisian project on empowering visually challenged youth has been recognised by the Government of Tunisia, who will develop similar activities for other disabled young people, using this project as a model.

Examples of projects funded by the Innovation Fund include:

- **Abortion:** piloting medical abortion (North Korea); reproductive rights for women (Northern Ireland); safe, legal abortion (Portugal); and providing safe abortion (Armenia)

- **AIDS and HIV:** integrating HIV services (Kenya, India, Swaziland and Sudan); empowering men who have sex with men (China); preventing mother-to-child transmission (Burkina Faso); and empowering people living with HIV (Iran)
- **Advocacy:** knowing your reality (Paraguay); knowing your rights (Canada); advocating for choice (Ireland); and combating female genital mutilation (Cote d'Ivoire)
- **Adolescents:** empowering madrasah students (Bangladesh); addressing trafficking (Bulgaria); empowering chronically ill and disabled people (Netherlands); promoting positive sexuality (Haiti); new communication technology (Sri Lanka); empowering visually challenged youth (Tunisia); and sexual diversity (Venezuela)
- **Access:** refugee reproductive rights (Palestine); addressing trafficking (Bosnia and Herzegovina); masculinity and sexuality (Peru); empowering sex workers (Trinidad and Tobago); fertility promotion (Hong Kong); addressing coerced marriage (Pakistan); empowering displaced persons (Poland); sexual diversity (Cameroon); addressing child marriage (Ethiopia); empowering young Maoris (New Zealand); and empowering overseas domestic workers (Philippines).

Box 2: Example of Innovation Fund project – addressing coerced marriage in Pakistan⁴⁰

The practice of 'Swara' or 'blood price', whereby women and girls are given in marriage as compensation for crimes committed by male family members, is still practiced in parts of Pakistan. Although illegal, Swara is an accepted dispute resolution mechanism and prevalent form of child marriage, with girls as young as 5 years old given in Swara. In 2009, the Pakistani Member Association, Rahnuma-FPAP, launched an innovative project in the North-West Frontier Province (funded by the IF) to change community perceptions of Swara and reduce gender-based violence. Project activities included youth theatre groups, sensitization sessions with mother-in-laws and female teachers, Jirga meetings and poetry sessions.

In total, the project served more than 30,000 community members, including youth, women and men. It won the support of several religious scholars/leaders, with 18 fatwas received from different Madrassa against Swara practice, as well as positive coverage in local and national media. The project developed an active and motivated group of partners and seven MOUs have been signed with NGO and Government officials to strengthen partnership around Swara. Lessons learned include the need to develop support systems for Swara survivors (a particularly hard-to-reach group) and to conduct national research on the issue.

Innovation Fund projects are showcased on the IPPF website, with a reminder that: "Because they are risky, some of these projects will 'fail' when they are judged against their original plans and objectives. But the role of the Innovation Fund is to promote organizational learning from both positive and negative experiences, inspiring all of our Member Associations to take up good practice and guiding them to avoid pitfalls".⁴¹

Lessons learned have been communicated to other Member Associations in a series of 'Learning from Innovation' publications. So far, three documents have been produced to provide inspiration and practical ideas on Innovation Fund projects that have: (1) empowered and improved the health of vulnerable young people;⁴² (2) addressed the marginalization of sexual minorities;⁴³ and (3) challenged accepted norms through rights-based frameworks.⁴⁴

Some of the key **lessons learned across the Innovation Funds** (see Annex 1) include the need to:

- Understand what makes particular groups vulnerable (for example, through needs assessments and situational analyses) and develop appropriate strategies to address them
- Build in time to allow for meaningful participation of project beneficiaries and to build trust and respect

- Conduct research to identify opportunities for change and develop communications strategies based on research, facts and evidence
- Use existing resources and engage with local champions to build organizational capacity and maximize project impact
- Design activities to target the interactions between sexual and reproductive health and other factors
- Partner with complementary organizations and share good practice / information
- Involve project beneficiaries, particularly young people, in project implementation. A peer education approach is particularly effective when working with marginalized groups to educate individuals on their sexual rights, and leads to empowerment.

4. Peer reviews

The rapid PEER (Participatory Ethnographic Evaluation and Research)⁴⁵ approach is a qualitative methodology that trains project beneficiaries to interview people in their social network to understand how IPPF programmes are making a difference.

The reviews provide an immediate and authentic ‘insider view’ account of the impact at local level of projects, based on narrative data generated by the beneficiaries of the project themselves. PEER reviews do not replace an evaluation, but rather supplement other IPPF evaluation methodologies. Although PEER reviews are not representative of the achievements of project objectives, the reviews often capture unexpected outcomes and achievements of IPPF’s projects.⁴⁶

The ‘Changing lives’ series on IPPF’s website⁴⁷ summarizes the PEER results from all reviews. This series helps communicate the work of IPPF to external audiences, and it shares lessons learned and good practice across the Federation. PEER review data are also used by Member Associations to inform decisions about projects / programmes, and as part of final evaluations. Some examples of ‘voices’ from PEER reviews of IPPF projects are shown in Box 3.

Box 3: PEER Reviews: Voices from IPPF beneficiaries and clients

“In the past, during menstruation she and the other women in her family had to stay out of the house, but once she had been educated about this from the centre, she persuaded her family to change their views on this and now she is allowed to sleep in the house rather than the cow shed” (Nepal – peer educator discussing project beneficiary of a youth-friendly SRH project)⁴⁸

“It isn’t just a health service, but a place, a space, with opportunities to improve quality of life – especially of young people who are vulnerable, and on the street” (Peru – beneficiary of INPPARES clinics)⁴⁹

“When I started coming here (FPAM), I started playing volleyball, but in the past, I would be doing other things with my friends like taking beer. I have learned new skills. When I come here, I’m kept busy, learning many new things and getting information” (Malawi – 21 year old male)⁵⁰

“When I get married, I will not have the same problems as my parents and grandparents. My grandfather had three wives and 15 children. Two wives died due to pregnancy-related problems. When I came here, I understood why those wives died” (Morocco – young project beneficiary)⁵¹

Key findings from the PEER reviews for the evaluation include:

Relevance

- PEER reviews look at how the programme has made a difference, to whom and how.
- The PEER review methodology actively involves project beneficiaries who have regular involvement with the programme, as peer educators, volunteers, activists and so on. For example, the 'Girls at Risk' Peer study was carried out by young women in poor urban communities of Sierra Leone (Freetown) and Liberia (Monrovia) to assess the context, experiences and impact of teenage pregnancy and early motherhood. Young women were trained as peer researchers, interviewing their peers – other girls at risk - within their communities using conversational prompts that they themselves had helped to develop during a three day participatory training course.⁵²
- The PEER approach can help overcome barriers to accessing high quality data such as culture, language and mistrust and can be particularly useful in working with hard-to-reach and vulnerable groups.

Effectiveness

- PEER reviews examine the challenges that IPPF projects have faced and how they have been overcome. For example, PEER reviews of the Models of Care project,⁵³ implemented by Family Health Options Kenya (FHOK) which integrated HIV and AIDS services within a SRH care setting for residents in Mitumba slum in Nairobi, identified challenges including: perceptions of the services being for married, rather than unmarried, youth; high staff turnover; and problems implementing the service integration of HIV and SRH services without substantial financial and human resources. Project achievements identified in the PEER review included increased access to services, reduced stigma, and an enhanced sense of hope amongst beneficiaries. However, questions were raised in the PEER review as to whether the project was effective in reaching the most under-served and most vulnerable within Mitumba, as well as whether activities were sustainable when the project ends.

Impact

- PEER reviews look at what worked, what did not work and why. For example, PEER reviews of a two-year comprehensive sexuality education (CSE) project implemented by the Family Planning Association of Nepal (FPAN)⁵⁴ found that by clarifying myths relating to menstruation, the CSE project has helped reduce the exclusion of girls. The CSE project has brought about positive changes in girls' lives, so that they can now attend school, participate in family life and attend family events during menstruation. The PEER review found that there is a need for ongoing training and awareness-raising at all levels to challenge menstruation taboos and myths. It also highlighted positive lessons, for example how FPAN engaged multiple stakeholders (government representatives, other NGOs, medical professionals, academics and school teachers) to develop the new CSE curriculum. Coordination around the curriculum improves accuracy, builds a shared sense of ownership and hopefully will ensure the sustainability of the project.

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Annex 1: Key Findings from Learning from Innovation series

Sexual diversity, from the margins to the mainstream

Lessons	Putting learning into practice
The needs of sexual minorities can only be met if the factors that lead to their marginalization are understood, and an appropriate strategy developed to address them	<ul style="list-style-type: none"> • Conduct a situational analysis of the legal and social environments for sexual minorities. • Consider the realities of the environment in which you are working, develop a range of appropriate strategies and be prepared to adapt them if necessary.
It is vital to address internal organizational attitudes and practices at the outset, to create a strong basis to work with people of diverse sexual orientations and gender identities.	<ul style="list-style-type: none"> • Invest time at the beginning of project implementation for discussion and sensitization with volunteers and staff. • Train staff on a frequent and ongoing basis to ensure the highest quality of care.
The meaningful participation of sexual minorities in project planning and implementation has multiple benefits and is essential for establishing trust and respect.	<ul style="list-style-type: none"> • Consult with the target population from the outset and use their ideas to shape project activities. • Take time to interact with project beneficiaries on a personal and social level to build trust and respect.
Engaging with community-based organizations and local partners is essential to create an enabling environment for people of diverse sexual orientations and gender identities.	<ul style="list-style-type: none"> • Use existing resources and engage with local champions to build organizational capacity and maximize project impact. • Establish effective partnerships with organizations and develop robust referral systems to maximise access to all available services.
It is essential to develop an approach that addresses emotional well-being as well as physical health using a rights-based and holistic model of care.	<ul style="list-style-type: none"> • Use 'Sexual Rights: an IPPF Declaration' to inform people about sexual rights and to empower beneficiaries. • Provide access to emotional support networks, for example through peer groups and/or professional counsellors.

Young people, from vulnerability to resilience

Lessons	Putting learning into practice
To reduce vulnerability, the reasons why a particular group is vulnerable must be understood at individual and social levels.	<ul style="list-style-type: none"> • Use a needs assessment to identify the different factors that make young people vulnerable • Decide which factors you can address most effectively
An intersectoral approach, going beyond sexual and reproductive health to address the different dimensions of vulnerability, is necessary.	<ul style="list-style-type: none"> • Partner with organizations that provide complementary services and establish effective referral systems • Design activities to target the interactions between sexual and reproductive health and other factors
The rights-based approach increases the resilience of young people and challenges communities and authorities to recognize and act on young people's rights.	<ul style="list-style-type: none"> • Help young people to empower themselves by offering activities that strengthen decision-making and communication skills, assertiveness and critical thinking • Use Sexual Rights: An IPPF Declaration as a tool to advocate for young people's rights
Organize and train groups within the community who engage with vulnerable young people to provide support when it is needed.	<ul style="list-style-type: none"> • Form a support network of adults (e.g. teachers and other authority figures) who are accessible to and trusted by young people • Recognize the importance of parents in young people's lives by including them in activities
Even within a group of highly vulnerable young people, the extent and nature of vulnerability will be different for young men and young women.	<ul style="list-style-type: none"> • Apply a gender lens and adapt activities to the different vulnerabilities of young women and men • Strengthen women's rights and support for young women within all key strategies

Sexual rights, from rhetoric to reality

Lessons	Putting learning into practice
<p>Emphasizing the universality of sexual rights in addressing sensitive issues can create a new perspective that reduces value-laden reactions and challenges previously accepted norms.</p>	<ul style="list-style-type: none"> • Use 'Sexual Rights: an IPPF Declaration' to identify the sexual right (or rights) being compromised or at risk that will be addressed by the programme. • Use practical steps to apply sexual rights in programme implementation to address sensitive issues by emphasizing the universality of sexual rights.
<p>Sexual rights integrated with fact-based information can generate and shape an informed and constructive debate among professionals, stakeholders and with the wider public.</p>	<ul style="list-style-type: none"> • Develop a communications strategy based on research, facts and evidence, while integrating rights-based language. • Create opportunities for debate and bring the issues into the public arena to engage a range of stakeholders and normalize the dialogue on sexual rights.
<p>A multi-dimensional and flexible advocacy strategy targeting legal and policy instruments can be used to create a more favourable environment for sexual rights.</p>	<ul style="list-style-type: none"> • Conduct research to build a strong understanding of political and legal processes, at both national and international levels, to identify opportunities for change. • Use a number of different advocacy strategies and engage a variety of actors to leverage support for change in the political and legal arenas.
<p>Using a peer education approach to educate individuals on their sexual rights is particularly effective when working with marginalized groups, and leads to empowerment.</p>	<ul style="list-style-type: none"> • Adapt existing or develop new peer education tools and programmes to increase awareness and understanding of sexual rights to empower individuals. • Support marginalized people to become peer educators and build their skills to educate and communicate effectively on sexual rights.
<p>Health service provision can be strengthened by producing clear guidance and by sharing good practices to increase quality of care, through a rights-based approach.</p>	<ul style="list-style-type: none"> • Collaborate with partners to produce tools and guidelines for use in service provision to ensure that sexual rights are protected systematically. • Convene service providers and health professionals in training sessions, networks and forums to facilitate sharing of good practice and sexual rights information.

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Annex 15. Survey Findings - attached separately

METHODOLOGY

This report presents the findings of a survey of IPPF member association's experiences and views on being part of the IPPF federation, what support they receive, what is working well, what could be improved, their sense of belonging, what positive (or negative) impacts programmes are having, and how effective their programmes are at increasing access to SRHR services for poor and vulnerable groups. The survey also examines relevance, sustainability and donor funding, monitoring and value for money, and what impact core funds from IPPF Central Office are having.

The survey was developed in consultation with Fleur Pollard (Evaluation Officer at IPPF's Organisation Learning and Effectiveness department) and tested with a sample of IPPF staff and member associations. The survey was anonymous and administered by an independent consulting firm, Social Development Direct, using the online survey tool SurveyMonkey. IPPF's Director General, Tewodros Melesse, sent emails to member associations in the 45 DFID GSWACH+ focus countries, inviting two to three senior staff to complete the survey. In total, 34 surveys were completed (14 in English, 11 in French, 3 in Spanish and 6 in Portuguese).

22 of the 45 DFID GSWACH+ focus countries responded to the survey (see Table 1) - a response rate of just under 49%. A further two respondents did not complete the question: 'What is your country of operation?' All four data sets were compiled together before analysis began. Unless otherwise stated, the percentages are calculated using respondents (not member associations) as the denominator.

Table 1: Member associations who completed the survey

Africa Region	Arab World Region	European Network	South Asia Region	ESEAO Region	Western Hemisphere Region
Burundi Cote d'Ivoire Ghana Kenya Madagascar Mali Mozambique Niger Rwanda Togo	Sudan Yemen		Afghanistan Bangladesh India Nepal Pakistan	Myanmar	Bolivia Brazil Peru
Total = 10	Total = 2	Total = 1	Total = 5	Total = 1	Total = 3

Throughout the survey, respondents were invited to provide additional comments after several questions. As well as including analysis of these open-ended responses within this report, a selection of respondents' comments are presented as direct quotations in text boxes. While representative, these quotations do not necessarily reflect the views of all IPPF member associations.

SUPPORT FROM IPPF REGIONAL OFFICES

Table 2 shows the percentage of respondents who requested support from their Regional Offices in various areas, and the extent to which they received the support they asked for. Respondents required the **most support with adolescents** (93.8 per cent of respondents), **followed by the other 5As**: HIV and AIDS, access, abortion, advocacy (84.4 per cent for each of the other As), monitoring and evaluation (84.4 per cent), and governance (84.4 per cent). In contrast, only 40.6 per cent of respondents asked their Regional Offices for support in the areas of human resources, and 46.9 per cent in IT.

Although most MA respondents who requested support from their Regional Office received it either from their Regional Office or from Central Office, **at least 1 in 5 MA respondents have not yet received any support following requests in the areas of: human resources (23.1%); eIMS (22.7%); and resource mobilisation (20.8%)**.

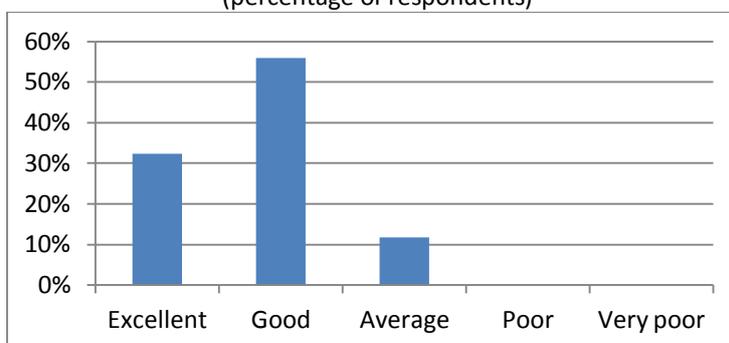
Other areas where support was requested included: dispute management; social franchising project; mobile health units; a sex workers prevention project; reproductive health in emergency situations; and for participation in international conferences and trainings.

Table 2. Support received from Regional Offices
(percentage of respondents)

	% who requested support from their Regional Office	% who received the support they requested from their Regional Offices	% who received support from Central Office	% who did not receive any support following a request
Adolescents	93.8	86.7	26.7	6.7
HIV and AIDS	84.4	88.9	25.9	0
Access	84.4	88.9	18.5	0
Gender	71.9	91.3	17.4	8.7
Sexual and reproductive rights	78.1	80.0	32.0	0
Abortion	84.4	92.6	37.0	7.4
Advocacy	84.4	81.5	22.2	14.8
Governance	84.4	77.8	18.5	3.7
Accreditation	75.0	95.8	16.7	8.3
Resource Mobilization	75.0	70.8	25.0	20.8
Capacity building	75.0	91.7	20.8	8.3
Monitoring and evaluation	84.4	88.9	22.2	3.7
eIMS	68.8	77.3	27.3	22.7
IT	46.9	80.0	20.0	13.3
Financial management	81.3	92.3	15.4	11.5
Human resources	40.6	84.6	15.4	23.1
Commodities	87.5	85.7	32.1	3.6

Member associations gave **high ratings to the overall quality of the technical assistance from Regional Office**, with 32.4 per cent of respondents rating it as excellent, 55.9 per cent as good and 11.8 per cent as average (see Figure 1). The four respondents who rated support as ‘average’ came from different countries and regions, as did the eleven respondents rating support as ‘excellent’, suggesting that there is not one particular Regional Office that is offering better or worse quality of technical assistance than the others.

Figure 1. How would you rate the overall quality of the technical assistance from the IPPF Regional Office?
(percentage of respondents)



In an open-ended question, member associations were asked to describe what more the IPPF Regional Office could do to support their work. Respondents who rated the support as ‘average’ gave the following comments:

- “Be more timely in offering technical advice”
- “They should have more experienced staff to provide support. They should also understand the ground realities of the MA”
- “To focus on capacity building, resource mobilization and governance”
- “The regularity of visits to the MA”

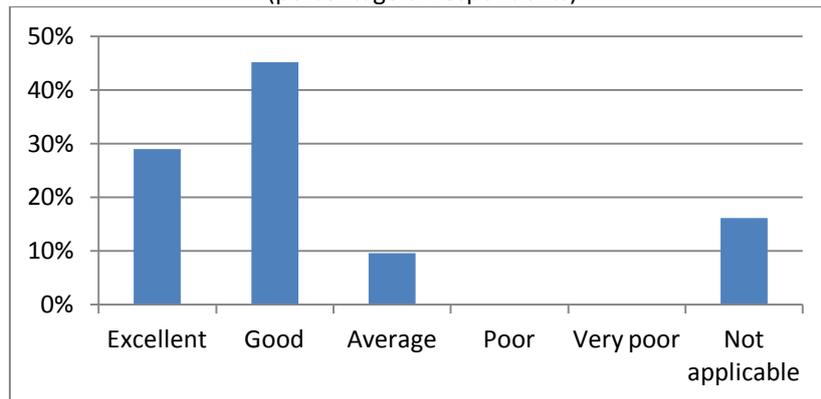
Other respondents (who rated quality of technical assistance as ‘excellent’ or ‘very good’) provided the following suggestions for what more IPPF Regional Office can do to support their work:

- More technical support for new initiatives like contraceptive tracking and forecasting, SGBV, eIMS, CMIS etc.
- More MA-to-MA buddy learning exchanges and regional seminars
- More training, including: institutional training on how to work in a Federation like IPPF; training on organization development; IT, eIMS and relevant trainings; and capacity building in emerging technical areas
- Increased resources to meet unmet needs and reduce delays in releasing funds
- Participation in development of strategic planning
- Technical support for resource mobilization, logistic and supply management, and costing specific clinical services
- Greater involvement in determining the areas and timing of the support
- Continuing to provide technical assistance in monitoring and evaluating quality assurance data
- Ensuring availability of the new presentation framework for half-yearly and annual reports.
- Consider whether there is a need to remedy any gaps in wage levels which exist between various MAs - “The same work is requested from staff who receive different levels of pay. There are major gaps here”.

SUPPORT FROM IPPF CENTRAL OFFICE

Member associations also gave **high ratings to the overall quality of the technical assistance from IPPF Central Office**, with 29 per cent of respondents rating it as excellent, 45.2 per cent as good, 9.7 per cent as average and 16.1 per cent as ‘not applicable’ (see Figure 2).

Figure 2. How would you rate the overall quality of the technical assistance from the IPPF Central Office?
(percentage of respondents)



The three respondents who rated IPPF Central Office support as 'average' gave the following comments on areas for improvement:

- Technical trainings to be conducted in member association for local technical and clinical staff
- Provide assistance in formulating applications for national and international calls for tender, particularly for USAID tenders
- Increase frequency of the visits to the member association

Overall, comments were very positive about Central Office, with several respondents noting a recent improvement in communications. For example: "Previously ... the central office was very distant from our member association. With the new director and current team, communications are much more proactive." Respondents provided the following suggestions for what more IPPF Central Office can do to support their work:

- More MA-to-MA learning exchanges, particularly cross-regional exchanges of knowledge and sharing experiences
- Organise virtual meetings on topics of group interest
- Develop impact assessment tools and continue to provide assistance in monitoring and evaluating quality assurance data
- Increase resources to meet unmet SRH/FP needs
- Provide support with resource mobilization and managing donor relationships
- Generalize the methodologies of technical assistance provided from HIV/AIDS, Adolescents and abortion teams to other teams
- Facilitate exchange experiences between managers of the six IPPF regions
- Provide technical support to establish IT system including electronic recording and reporting system from grass root level to national level
- Allocate more time to the period of technical assistance and ensure that language difficulties do not affect the quality of assistance.

NETWORKING & COMMUNICATING WITH OTHER MEMBER ASSOCIATIONS

A strong feature of the IPPF federation is the way it enables member associations with similar challenges to share their experiences and learn from innovation solutions. In the survey, respondents highlighted several examples of the valuable role that South-South networking and communication plays in enhancing member associations' capacity to respond to SRHR challenges and ensure the poorest and most vulnerable have access to services. **Most respondents (81.8 per cent) communicate with other member associations** to share their experiences, lessons learnt and best practice. Communication is "fluid" and includes networking at regional and international meetings, sharing documentation, capacity exchange, technical support with specific issues, and informal communication by phone/email. South-South sharing of knowledge tends to be between member associations in the same region, which speak the same language and are similar socio-culturally, as the examples in Table 3 show.

Table 3. Examples of South-South learning between IPPF member associations

Member association	Which member association did you learn the most from this year?	Why?
Yemen	Morocco, Tunis, Egypt	We are very new MA working in this field, it is crucial to see the other MAs who have long experiences and learn lessons
Kenya	Malawi	Very good relationship and same nature of services that both MAs provide at the clinic level
Nigeria	PPAG in Ghana	To assist us with HIV test Kits
Pakistan	India and Nepal	GCACI project dealing with safe abortion was first implemented in India and Nepal and Rahnuma FPAP learnt from their experiences
Nepal	FPA Sri Lanka on Logistic Management	The Logistic Management guideline will help to manage logistic in a systematic way
Rwanda	RHU in Uganda	I know a lot of its staff
Ghana	Last year we learnt on abortion issues from the Ethiopian MA	To enable the MA to improve on the Abortion program area.
Afghanistan	FPA Iran	Socio-cultural similarity
Togo	Madagascar	A volunteer from the Madagascar MA trained MA service providers in vasectomies.
Cote d'Ivoire	Cameroon Togo and Benin	We participated in a study at the training centre and saw how the LGBTI project was implemented. Joint leaderships alongside the Regional Office of training and logistics and community distribution of injectables
Bolivia	BEMFAM Brazil	It has institutional and technical management experience in common areas of interest, the staff are open and very communicative and transparent
Peru	Bolivia and Colombia	Practice and experience exchange in systems, services and reproductive health social programs
Brazil	Dominican Republic	Successful mobile units experience
Mozambique	Bemfam, Portuguese MA, and ANGUBEF Ghana's MA	I've learned a lot with BEMFAM because I have contact with this MA since 2000 when elaborating AMODEFA's strategic plan, and I've also kept contact with BEMFAM, both with Dr Ney Costa and with Francisco Mulher, Executive Secretary and Financial Director. It's well organised and has a strong team with regards to youth and adolescents

Over two-thirds (69 per cent) of respondents had heard of ideas or innovations from within IPPF this year that they might try and implement. When asked what these ideas/innovations were, member associations highlighted the three change goals of unite, deliver and perform, the impact of the London Family Planning Summit, and the need to double indicators by 2015. Other innovations mentioned included:

- Measuring PMSEU among the service receivers
- Computerized commodity tracking and forecasting system
- Implementation of Integrated Package on Essential Services (IPES) from all SDPs.
- Concept of social franchising as a mean to double the family planning performance
- Kenya model of HIV/AIDS prevention
- Subsidies focused on performances
- Social marketing process via partnership with major show-business personalities, sports stars and others
- Use of mobile health units
- To change the way of electing YAM members and guarantee their active participation in governance bodies

Just over a half (53.5 per cent) of respondents said their member association's ideas/innovations had been used within other member associations, at Regional Offices, or at Central Office. Some examples mentioned are shown in Box 1.

Box 1. Examples of member associations' ideas and innovations used elsewhere in the IPPF federation

"FPAB implemented a project on "Madrasa students initiative for adolescents health in Bangladesh". The Madrasa system is a religious form of education. The project improved the knowledge and understanding of sexual and reproductive health and rights to increase access to youth friendly SRH service to Madrasa students and teachers. Other member associations were interested in this idea and innovation. Member association (Pakistan) RAHNUMA and Afghanistan visited our country to learn how to implement the project. And Rutgers WPF Pakistan has been using this idea - they started similar project in their country." (Bangladesh)

"The way we developed statutory documents such as policies of resource mobilisation, of prevention and risk management, among several that have been used in Angola and Cape Verde." (Mozambique)

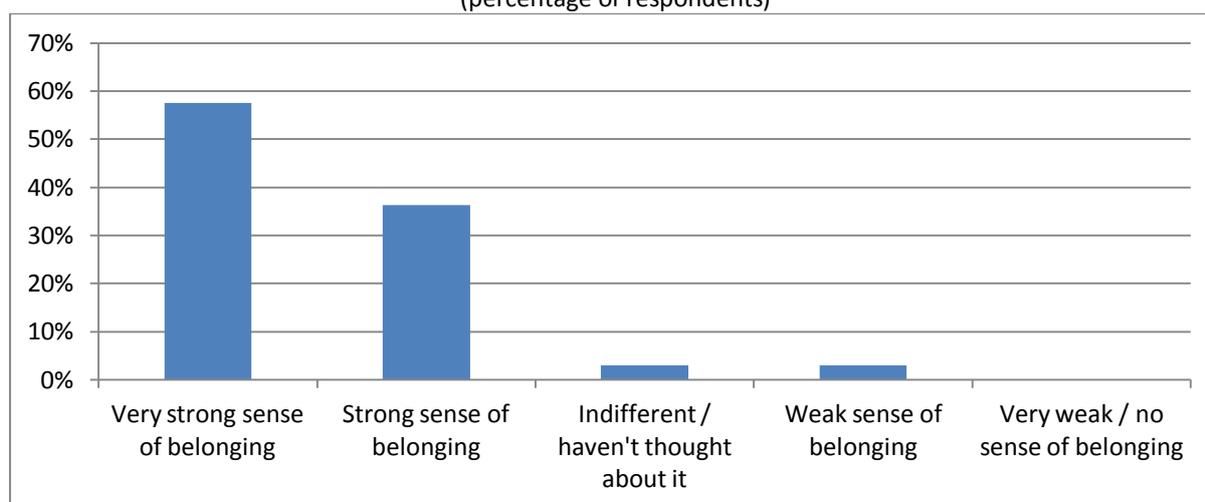
"Community Based Distribution (DBC) in rural areas where the majority of populations live so as to facilitate access to reproductive health/family planning services. This strategy, which has rapid gains, was considered as best practice in light of the results achieved." (Niger)

"The MA contacts stars, and undertakes large-scale advocacy so as they adhere to their cause and so as this advocacy work reaches an almost continental level. This innovation is beginning to be implemented by FHOK Kenya." (Madagascar)

SENSE OF BELONGING

The vast majority of respondents have a **very strong sense of belonging** (57.6 per cent) or strong sense of belonging (36.4 per cent) to a wider international federation (see Figure 3). Those respondents who said they were indifferent or had a weak sense of belonging had been with their member association for less than five years (0-4 years), so it is possible that their weak sense of belonging is due to them being relatively new to IPPF.

Figure 3. To what extent do you have a sense of belonging to a wider international federation?
(percentage of respondents)



When asked for additional comments, a key message coming from member associations was the **need for more cross-regional sharing of experiences**, including exchange visits, collaborative activities, participation of local members in international gatherings and promotion of a knowledge network to share best practice between regions would add to the wider sense of belonging. For example, one respondent said, "I have never had to deal with or communicate with any person outside of CO and ARO. I want to establish links with the Heads of Finance of MAs outside Africa. We can all learn from each other to improve ourselves, our MAs and IPPF in general."

Other suggestions for what could be done by the Central Office or Regional Offices to increase member associations' sense of belonging to a wider international federation include:

- More communication and sharing of resource materials
- Allocation of resources to training and dissemination of topics relevant to this theme
- Standardise logos, colours and standardised programmes (respondents from Mali and Niger also requested to change their names to Mali IPPF and Niger IPPF, rather than Mali MA and Niger MA)

- IPPF Central Office or Regional Office advocacy at government level in each country for full involvement in MA activities
- Promoting debates about the federation as many don't know what it is and think of it as a donor.
- Respect the work of the MA and understand the ground realities. Build on what they have.
- Continuing to place confidence in us as a member association

Almost all respondents (96.8 per cent) thought it was important to their member association to be part of the IPPF Federation. The IPPF logo is used on member associations' websites and promotional documents (letterheads, vouchers, statements, banners, tarpaulins, etc.) Being part of IPPF gives member associations a sense of **credibility** and is "a label of **quality**"; it offers a **strong platform and voice** for controversial SRHR issues (see box 2).

Box 2. Is it important to your member association to be part of the IPPF Federation?

"The IPPF name is a label of quality and the logo appears on all of our communication and advertising tools."

"IPPF is very well recognized in our community because of its very nice and inspiring publications, its strong advocacy movement and its services which reflect community needs."

"The IPPF systems, particularly the accreditation process ensures transparency, accountability and adherence to high standards of operations gives the MA credibility at all levels."

"The association with IPPF means a lot. I can't think of my MA without IPPF brand."

"The IPPF brand attracts respect from donors because the brand is credible. Donors believe that IPPF MAs are effective and major contributors to SRH in their country. Other agencies like UNFPA always work very closely with IPPF MAs."

"Because it allows global advocacy on the issue of SRR and knowing that others have the same objectives. Being part of the federation allows us to have support in our actions and multiple learning opportunities."

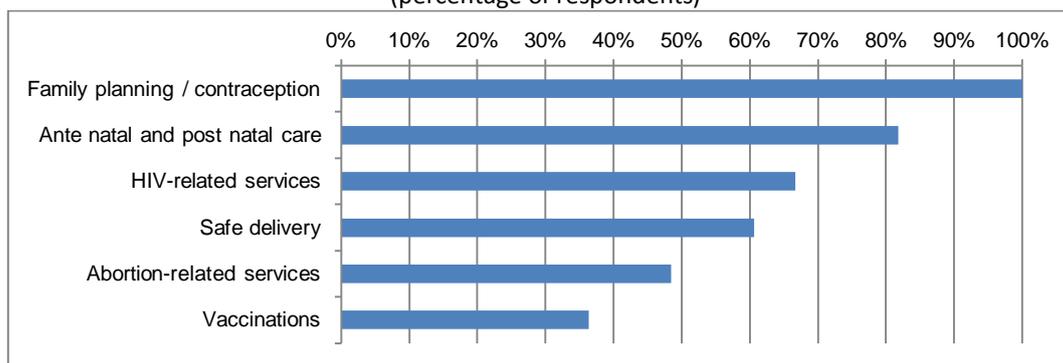
"For us, the IPPF represents respect of rights in terms of sexual health, as well as supporting destitute and marginalised populations."

ACCESS AND SERVICE DELIVERY

The survey highlighted a strong commitment by IPPF member associations to reaching clients who are poor and vulnerable. Respondents estimated the percentage of poor and vulnerable people as **between 70 and 95 per cent** of clients. Member associations use a **range of methods for estimating the poor** include: nationally accepted Demographic and Health Surveys; conducting baseline surveys before initiating project; using the 'poverty toolkit' (with added questions to estimate vulnerable groups); clinic records and profiles; and yearly vulnerability assessments. Some member associations have **well-developed systems** of ensuring that their services reach poor and vulnerable clients, for example a respondent from Bolivia said "We have an online electronic system which automatically monitors the access of users likely to be poor, those excluded and those with poor access, permitting the adoption of institutional strategies. This data is disaggregated by region, and at national level".

As shown in Figure 4, areas of service delivery most in demand by poor and vulnerable people include **family planning / contraception** (mentioned by 100 per cent of respondents), **ante natal and post natal care** (81.8 per cent), and **HIV-related services** (66.7 per cent), followed by safe delivery (60.6 per cent), abortion-related services (48.5 per cent), and vaccinations (36.4 per cent). Other areas of service delivery identified by member associations included adolescent and youth SRH services, counselling, and treatment for general health complaints (elderly, paediatrics, and malaria).

Figure 4. What areas of service delivery are in most demand by poor and vulnerable people in your country? Please tick up to three options.
(percentage of respondents)



Member associations have developed a **variety of innovative access strategies** to make sure that the poorest and most vulnerable have access to SRHR services, including:

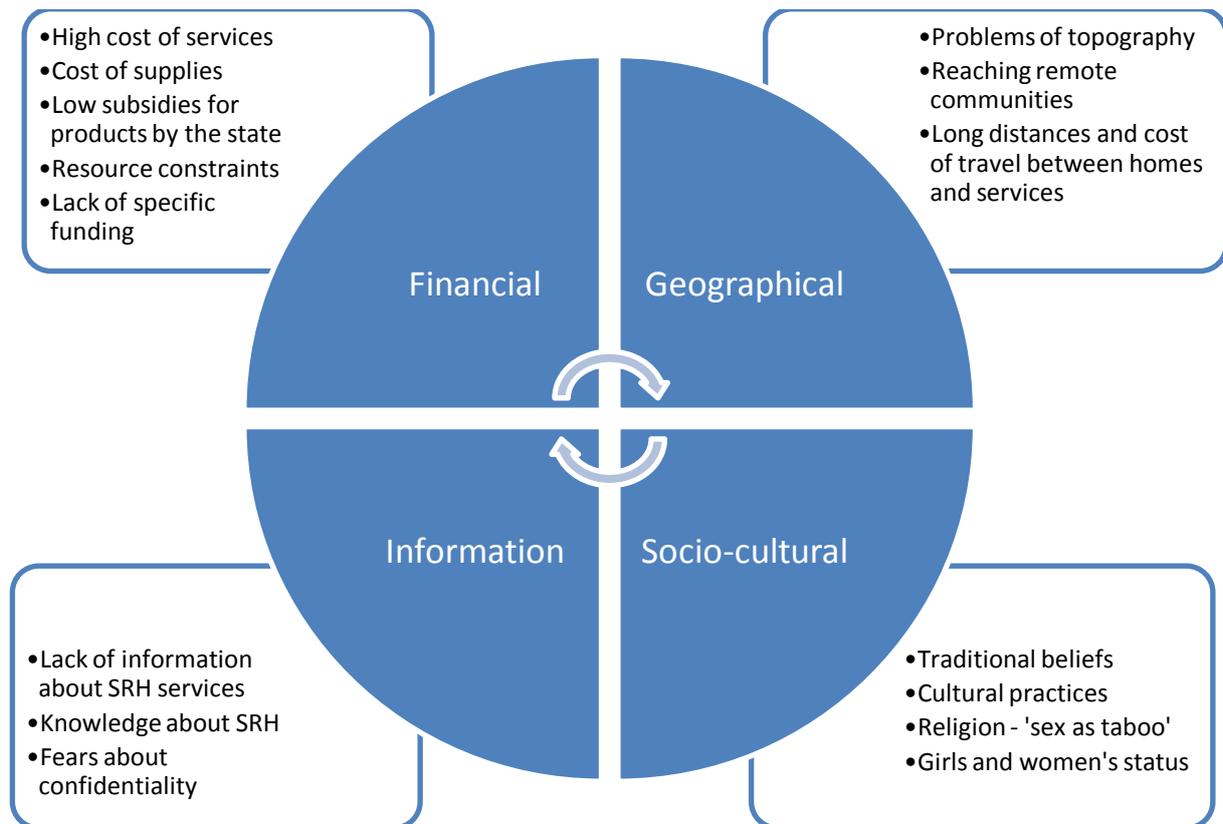
- Free and subsidised services for the poorest and most vulnerable services, including social pricing practices
- Locating projects in communities with poor and marginalised groups
- Mobile health units to reach remote areas
- Cross-subsidisation of services and coordination with partners (government, private sector and NGOs)
- Involving the poor and vulnerable in implementation
- Monitoring indicators that measure access and quality of services for poor and vulnerable people
- Investing in advocacy – “we talk about our activities in meetings with community leader, youth events, on radio and TV and we mention that we offer free services”
- Demand generation and ensuring that all groups of people are aware of their rights, as well as dialogue with decision makers/service providers as duty bearers to make them accountable to the constituents
- Improving quality of services
- Ensuring that the provision of services to poor and vulnerable groups is a key element of the member association’s policy

Box 3. Access strategies targeted at poor and vulnerable groups: example from Pakistan

“Rahnuma FPAP has no refusal policy that is visibly displayed at every SDP, which ensures that the poorest and the most vulnerable have access to SRHR services. FPAP has programs for key/ vulnerable population such as Youth Friendly Clinics, Youth Resource Centers, Youth Helplines, Projects for Sex Workers, Micro Credit and Capacity Development Initiatives for Women and Girl Children, SWARA project for socially excluded women and girl children. Rahnuma also extends its outreach through mobile clinics as well as establishment of static clinics in the marginalized and under-served areas such as Turbat, Badin, AJK etc. to ensure the access to the poorest and most vulnerable. Besides, Rahnuma FPAP has disaster management plan in place for responding to the immediate SRH needs of disaster hit population with special focus on women and children. Rahnuma FPAP also develops networks and alliances to enhance access of the poor and marginalized to SRH services including collaboration with public sector.”

When asked what were the biggest barriers to delivering sexual and reproductive health services to the poorest and most vulnerable groups, respondents identified four key types of barriers, which can be categorised as **financial, geographical, socio-cultural and information barriers** (see Figure 5). Other constraints mentioned less frequently include security issues, availability of trained service providers, lack of committed support and transparency from the state, difficulties identifying LGBTI people (as they try to hide their identity), lack of skills to use evidence, and lack of proper monitoring systems.

Figure 5. What are the biggest barriers to delivering sexual and reproductive health services to the poorest and most vulnerable groups? (Most frequently mentioned barriers)



RELEVANCE

All member associations who responded to the survey **use national health plans or wider strategies** (for example, youth, population and poverty strategies) to guide their programming. Member associations said they used national strategies as reference documents when deciding areas of intervention, as the basis of development partnerships with the government, to provide profit areas of intervention, and used them in advocacy. Examples are provided in Box 4 below.

Box 4. Examples of member associations using national health plans or strategy to guide programming

"We link our activities to Ministry of Health Reproductive Health strategy 2011-2015" (Yemen)

"The National Health Sector Strategic Plan and the Community strategy are extensively used to design programmes" (Kenya)

"We work closely with the line government bodies and we are requested to adapt our programs to national framework" (Rwanda)

"We work to compliment the efforts of the country and therefore [it is] practical to use it as a strategic guide" (Ghana)

"Our work has to be compatible with the country situation and also follow the mandate of the country hence we do consider the national plans and programmes while planning for the MA. We do supplement and compliment the national programme." (India)

"The MA has strong relationship with the federal and state Ministries of health and signed MOU with them, in each service delivery point of the MA you find the protocols and Guideline of the MOH, the teams of the supervision regularly visited our service delivery points, in addition the MA representative regularly attends the MOH meeting. Before we write our proposals we contact the MOH and have long discussions and sometimes technical assistance." (Sudan)

"AMODEFA has signed an agreement with the ministry of health and provides services following its policies" (Mozambique)

Several member associations also provide **substantial inputs into the development of national healthcare policies**. Only two of the 20 member associations are not involved in national or local planning processes, with most member associations involved in national forums or strategic partners in technical working groups related to reproductive health (see Box 5).

Box 5. Examples of member association involvement in national or local planning process

“We work closely with the line government bodies and we are requested to adapt our programs to national framework” (Rwanda)

“Rahnuma FPAP is at steering committees of all key relevant national and local planning process, for example: Department of Health, Department of Population Welfare, Women and Youth Development Departments, National & Provincial AIDS Control Programmes, etc.” (Pakistan)

“Sections of the FISA policies have been taken as a basis for elaborating national or local policies” (Madagascar)

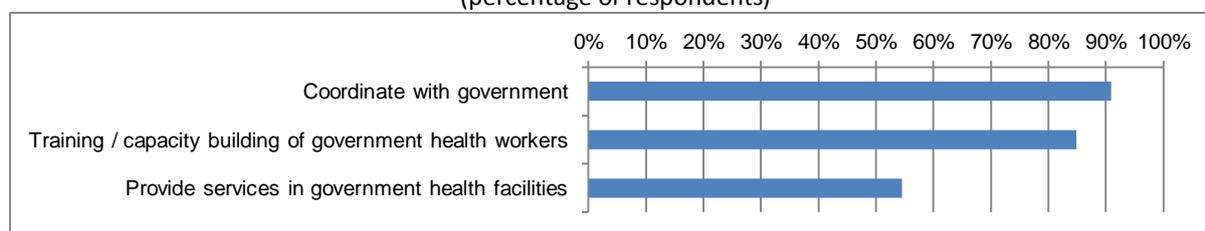
“The MA is heavily involved in the entire process through its various Ministerial Departments concerned through committees of which the MA is a member, and notably in elaboration, design, implementation, monitoring and evaluation.” (Niger)

“MA data is integrated into data from local areas where we provide our services – The MA is a member of national and local healthcare planning teams” (Mali)

“The MA is part of the planning forum of the MOH, Ministry of social welfare and population council.” (Sudan)

Member associations **work in partnership with government** in a variety of ways: 90.9 per cent of respondents coordinate with government, 94.8 per cent help with training / capacity building of government health workers, and 54.5 per cent provide services in government health facilities (see Figure 6). Other ways that member associations work in partnership with government include: co-financing in areas of interest; providing joint services in mobile units; provision of government employees using its budget; and supply of commodities and supplies (by government); capacity building and training; and allocation of land by the State for construction of infrastructure (clinics, Communal Child and Youth Centres (CCEJ)).

Figure 6. How does your member association work in partnership with government?
(percentage of respondents)



MONITORING AND VALUE FOR MONEY

12 out of 22 member associations (54.5 per cent) regularly calculate the cost of specific clinical services, allowing them to specify the cost of providing one family planning service. When asked how this information was used to minimise costs, respondents provided a range of examples of how monitoring the cost of clinical services was helpful for demonstrating value for money and keeping costs down (see Box 6). Considering the benefits of costing clinical services, but given that almost half of member associations do not yet do so, there is **further scope for IPPF member associations to improve value for money**.

Box 6. Examples of the value of costing clinical services

“Rahnuma FPAP compares its service unit / CYP cost with local, regional and international standards and continue to minimize it.” (Pakistan)

“It helps us to know which services to provide for free, which ones to waive and which ones to charge.” (Kenya)

“We do cost recovery rate of clinic and therefore do a comparative analysis to show clinics cost of service provision” (Nigeria)

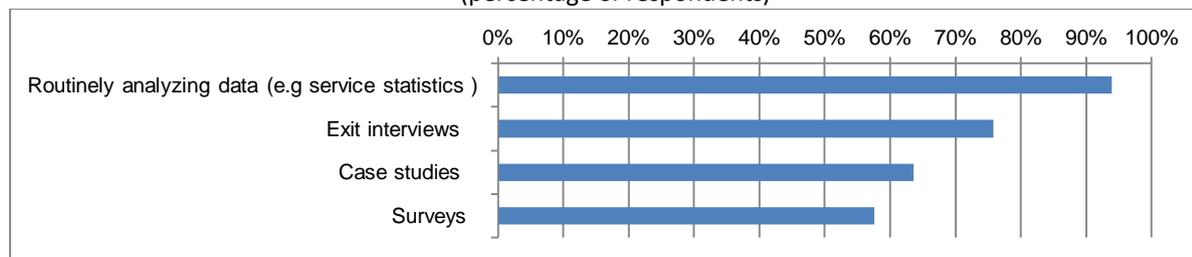
“We use this information to make our services cost effective. We use the data to train our staff managing the SDPs” (India)

“The MA used the CORE system [cost and revenue analysis] to calculate the actual cost of a single service” (Sudan)

“We’ve developed a cost worksheet which is essential in our contracts with the government (municipal)” (Brazil)

There is a strong **culture of monitoring and learning lessons** within the IPPF federation, with all respondents measuring results, albeit in different ways: 93.9 per cent of respondents routinely analyse data (e.g. service statistics); 75.8 per cent use exit interviews; 63.6 per cent use case studies; and 57.6 per cent use surveys (see Figure 7). Other ways of learning lessons or measuring results include group discussions, informal feedback from service providers and clients, yearly evaluations, student theses or dissertations, and baseline and endline evaluations for restricted projects.

Figure 7. How do you measure results and lessons learned? Please select all that apply.
(percentage of respondents)



Respondents listed a range of **initiatives/programmes that are making an impact** on people's health and other aspects of their lives, from encouraging pregnant women to attend routine antenatal check-ups (Nepal) to providing RH information to young people and preventing early marriage (Afghanistan), from projects targeted at prison inmates (Nigeria) to worked with minorities and hearing impaired patients (Mozambique) (see Box 7 for a selection of examples).

Box 7. Examples of how IPPF programmes are making an impact

"FPAB implemented a project 'Combat VAW during pregnancy time among the vulnerable women' in Khulna district one of FPAB's working area. The findings of the end-line evaluation shown that a significant number of women (98%) received pre-natal care from institution. And 80% delivery performed by skilled persons which was achievement of the project. (Bangladesh)

"Implementing a model of vaccination for girls from 9 to 13 against HPV, which causes cervical cancer which is now in the government's plan for mass implementation in the country." (Bolivia)

"Rolling out the stigma index for people living with HIV/AIDS, The MA carried out the survey all over Sudan (15 states) the data collector, supervisors, data entry officer and the resource persons all of them from PLHIVs, the sample size exceed 1000 persons and huge data gained, the results extracted from analysis appear that there large room for intervention, a lot of activist and UN agencies benefited from the result to change the life of people living with HIV/AIDS." (Sudan)

"A project (Adolescents Count Today) funded by ViiV Healthcare based in the UK is supporting young children with HIV treatment in one of our clinics. The guardians of the kids are supported with small loans to initiate income generating activities through a micro finance institution. The guardians save some of the money they make (a dollar a day) with the bank which accumulate and make interest. The interest is ploughed back for more people to borrow. The IGAs ensure that the kids who are on HIV treatment access good diet, school fees and are able to live quality lives with HIV." (Kenya)

"The MA implemented a community based services program between 1999 and 2003. This was suspended in 2004 due to lack of funds. This program impacted significantly on communities by increasing access to service provision and the supply of contraceptives. It increased the CYP of the country during the period, 1999 to 2003. Based on these results the MA saw the need to reintroduce this project in some communities in 2011. Similar results are being reported with increase of the distribution of non-clinical contraceptives. The project has resulted in empowering the communities to take charge of their lives." (Ghana)

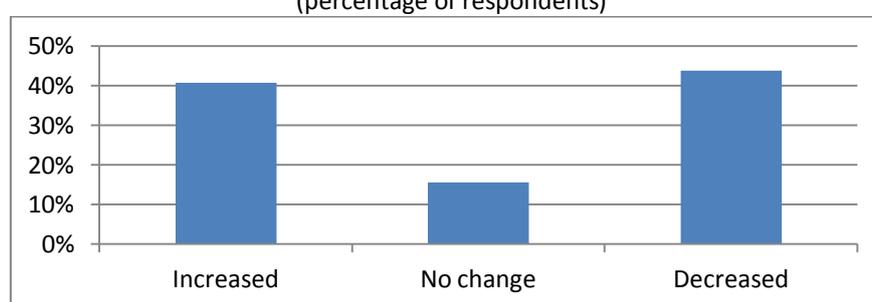
"Project on 'women as compensation' changed attitude and practices of catchment population towards traditional practice of giving women as compensation for resolving disputes" (Pakistan)

"MA service outlets are undertaken in addition to State initiatives with a view to improving the health condition of the population as a whole, and reproductive and sexual health in particular. The Community Based Distribution (DBC) programme allowed women in local villages to access contraceptives so as to space out the frequency of childbirth. Family Planning services contributed towards an overall reduction of unfulfilled requirements." (Niger)

DONOR FUNDING

Over the last five years, member associations have had **mixed experiences of trends in donor funding** (excluding IPPF core grant funds), with 40.6 per cent of respondents saying that funds had increased, 43.8 per cent noticing a decrease, and 15.6 per cent saying there was no change (see Figure 8). Interestingly, **member associations in the Western Hemisphere Region (Brazil, Peru and Bolivia) all said that donor funding had decreased**, commenting that “for Latin America and Peru, there is less funding” and donor funds “have fallen and have more and more restrictions”. Another said, “The tendency is a decline and many donors are withdrawing from the country because of the apparent improvement in economic income. The tyranny of averages.” Other members associations witnessing declines in donor funding over the last five years included Kenya, Ghana, Afghanistan, Cote d’Ivoire, Madagascar and Sudan. Those respondents who had noticed a decrease in donor funding for their member association observed that there were “hard economic times worldwide and increased competition for scarce resources” and that “this is affecting implementation of projects and also coverage”.

Figure 8. What trends have you noticed in donor funding (excluding IPPF core grant funds) over the last five years?
(percentage of respondents)



However, not all member associations had noticed a decrease in donor funding. For example, the Pakistan member association commented that “funds for Rahnuma FPAP have increased in last 5 years, however overall funds for SRH have declined globally”. While some respondents believed that donor restricted funds were still available and there are a range of donors keen to support SRHR service provision (for example, AUSAID, USAID, Packard Foundation, NORAD, Dutch embassies, anonymous donors), they also acknowledged that it was becoming **more challenging to access these funds**. For example, one respondent commented: “Donor restricted funding is increasing. However, accessing them is now more competitive as there are many NGOs looking for them and donors' demands are ever increasing”.

In response to earlier questions in the survey, several respondents requested support from IPPF Regional and Central Offices with resource mobilisation, managing donor relationships and assistance in formulating applications for national and international calls for tender. Out of the 22 member associations who responded to this survey, 19 member associations (86.4 per cent) have a **sustainability plan or resource mobilisation strategy**. Of these 19 member associations, 13 received technical support from IPPF Regional Offices developing this strategy, five from IPPF Central Office, and three received no support.

IMPACT OF CORE FUNDS FROM IPPF CENTRAL OFFICE

Member associations were asked ‘Out of your most successful projects over the last year, what have the core funds from IPPF Central Office enabled you to do, that you would not have been able to do without it?’. Respondents gave numerous examples of **projects that member associations were able to implement as a result of core funds from IPPF Central Office**, including, for example: capacity building of staff (e.g. Yemen); construction of new clinics and improvement of clinic infrastructure, employment of staff, and procurement of drugs and supplies (e.g. Kenya); mobile health clinic services in rural areas to poor including RH services, youth friendly services and GBV (e.g. Afghanistan); starting abortion-related services (e.g. Sudan); advocacy initiatives (e.g. Madagascar); and programs for young people (e.g. Peru and Mozambique). Box 8 highlights some of the respondents’ views about the importance of core funds from IPPF Central Office.

Box 8. Out of your most successful projects over the last year, what have the core funds from IPPF Central Office enabled you to do, that you would not have been able to do without it?

"The IPPF core funds are a stabilizing factor in PPFN; it is always there for us. It has helped us to do almost everything" (Nigeria)

"Youth Parliament: With an aim to address deprivation of youth participation in advocacy and decision making process, lacking of entitlement to access to information on SRH issues and youth friendly services, youth parliament was established through an exciting peaceful beginning at grass root level election. The youths recognize this initiative to constitute a youth parliament as a cornerstone of the process of creating a platform for the young people. Based upon the recognition of cultural diversity and principles of unity, democracy, this parliament shall pursue the well-being of young people. This parliament aims to ensure the SRHR, protect the rights of access to comprehensive sexuality education, youth friendly services, gender equity, participate in decision making process and ensure accountability. This is an innovative platform for the young people to raise their voices freely." (Bangladesh)

"IPPF central Office core funds contribute major share for implementing successful projects and if there're weakness in some project, financial and technical insufficient will be the main reason" (Myanmar)

"The 5As projects would not have been implemented but most importantly the Access Project through which the poorest and most vulnerable is served" (Nigeria)

"We would not be able to continue projects without support of IPPF core funds" (Nepal)

"Swara project was initiated with restricted fund. Due to outstanding achievement and innovative approaches adopted during the first phase of the project, Rahnuma FPAP has decided to continue with the project from IPPF core as more donors in country either have identified districts of area and/or avoid the most risky areas. Similarly, HIV/AIDS project in Quetta initially funded by JTF, which at the conclusion of agreement with JTF, was taken up from IPPF core funds due to its access to socially excluded and vulnerable population in one of the most conservative society. Without this support, the success achieved in both the projects would have been lost" (Pakistan)

"Most of the projects came by virtue of our partnership with IPPF" (Anon)

"IPPF played a very determinant role in moving our advocacy forward – IPPF has helped us apply the concept 'Comprehensive Sexuality Education' in our programs and advocate for it nationwide - IPPF helped us increase our Monitoring and Evaluation skills" (Rwanda)

"IPPF core funding supports all the five program areas and supporting strategies such as human resource, program coordination, indirect and governance. It is the main funding source for the MA. A lot of projects would not have been carried out without the core grants from IPPF CO" (Ghana)

"Even if our organization had all the donors under the restricted funding which run projects, without IPPF core grant we would not exist. We would close down" (Kenya)

"The core funding we receive from IPPF CO is the base for garnering other funding. Core helps us to exist and other funding helps us to expand and extend" (India)

Annex 16. Examples from MA annual reports - attached separately

DOCUMENT REVIEW OF MA REPORTS

OVERALL COMMENTS

- Difficult to compare across MA reports, due to IPPF's organisational structure as a federation and the associated variations in reporting styles. Many country reports are in the format of the Redbook system (particularly in the Western Hemisphere region), whereas others use the eIMS standard reporting system. Some are additional documents, such as mid-term reports (Cambodia's MSM programme) or six-monthly programmatic reports (Kyrgyzstan's GCACI report).
- Some of the reports are very lengthy (for example, FPA India's Annual Report is 273 pages).
- It was not possible to review those documents not in English (for example, Mauritania and Yemen)
- It is hard to attribute change to the PPA between IPPF and DFID, as many of the projects mentioned seem to be funded by other donors and it is not entirely clear what is due to the IPPF core funds.
- However, the reports do **demonstrate depth and breadth of achievements** and an **organisational culture of examining what works well, what hasn't worked well and what could be improved upon**. This report has focused on pulling out examples of good practice, learning and innovation.
- **Gaps** that aren't in the MA document reviews and should be covered by the survey include: perceptions of IPPF assistance and how this could be improved; what would have happened without the IPPF core funds; and sense of belonging to a wider federation.
- In addition, a key gap is the **difficulty of accurately saying the proportion of MAs** that do X, Y or Z due to variations in reporting. For example, although it is possible to find examples of where strategies for sustainability are in place, it isn't possible to say what proportion of MAs have strategies in place.

1. EFFICIENCY

Examples of support from regional office or IPPF HQ

PROFAMIL in Haiti – example of an MA which has received substantial technical support - PROFAMIL received at least 13 technical visits in 2010 from the IPPF/WHR Program Advisor and Financial Advisor, with subsequent visits by the MIS Manager and MIS Consultant to institute the finance system. The MA was also visited by Dr. Nguyen Toan-Tran, IPPF Global Advisor, to assess QOC needs in the context of the current crisis (see page 14 in Haiti's Redbook).

Many country reports note that **donor funding has declined** (see for example, Redbooks of Haiti, Guatemala, Brazil) and discuss the **importance of diversifying sources of financial support/income**, for example increased reliance on SRH and non-SHR services and sales.

Several MAs have developed resource mobilization strategies with TA from IPPF HQ or regional offices, for example FPAB in Bangladesh aims to increase resources from donors, foundations and individuals both globally and locally, in response to declining IPPF funds. FPAB used a consultant to help in identify funding opportunities, meet donors, and make a plan to access these opportunities. Technical support from IPPF/SARO helped to prepared concept notes and project proposals (see pages 95-97 in Bangladesh 2011 Annual Report).

RHAC in Cambodia received technical support from IPPF, enabling RHAC clinics to provide quality services to the **MSM community** and to work with other partners to create a more supportive environment for addressing SRHR of MSM in Phnom Penh – See Mid-Term Report for the project 'Increasing access to integrated sexual health and HIV services for MSM in Phnom Penh' (document titled 'Cambodia JTF SMTR1 Nov 2011').

FPAN in Nepal received technical support and core funding **to increase access of SRH information, education and services** to marginalised and underserved groups (see pages 1-59 in Nepal 2011 Annual Report).

2. RELEVANCE/SUSTAINABILITY

Advocacy

FPAB in Bangladesh's advocacy for Breaking the Silence (ABS) aims to increase public and financial commitment to and support for sexual and reproductive health and rights at the national and community levels. Developed good working relationship with partners, media, and parliamentarians (see pages 20-25 in Bangladesh 2011 Annual Report).

INPPARES in Peru is implementing the Voices and Accountability Project with DFID support. This project focuses on holding national governments accountable for their reproductive health and gender equality commitments. The project also aims to **improve the ability of IPPF regional offices to provide high-quality and timely technical assistance to MAs specific to advocacy** and governmental accountability related to SRHR issues (see page 11 of Peru's Redbook).

Capacity building

One of the achievements of **FPAB in Bangladesh's programme 'Increasing access to SRHR information & services for poor & marginalized people'** has been to ensure quality of care of services and professional trainings provided to new service providers. However, withdrawal of donor funding support (AusAID) meant it was not possible to organise capacity building training for all 72 Family Development Centre (FDC) organisers, as FPAB only had funds for 26 organisers (see pages 27-37 in Bangladesh 2011 Annual Report).

FPA India's Mother NGO (MNGO) scheme for Reproductive and Child Health (RCH) programme provides technical and managerial support to smaller Field NGOs (FNGOs) for implementing the RCH-Phase-2 programme at the grassroots level (see pages 101-104 of India 2011 Annual Report).

Relevance

Afghanistan's AFGA program is not aligned with national donor funding mechanism (BPHS/EPHS) and donors are not willing to fund only RH as it is part of integrated package. For the future, AFGA is aiming to streamline its program with national health system delivery, thereby enabling it to apply for BPHS/EPHS funding in future rounds of grants (see page 69 of Afghanistan 2011 Annual Report).

Sudan's SFFA project 'Provision of SRH services in collaboration with other sectors' aims to **align SFFA services with 69 MOH clinics and 72 associated clinics with other NGOs**. The purpose of the project is to provide services in rural areas through existing providers in governmental facilities and other institution centers. These providers are supplied with technical knowledge and skills required and contraceptives and small incentives. The midwife or the health visitor distributes FP methods, gives counselling, and educates clients (see pages 34-38 of Sudan 2011 Annual Report).

CIES in Bolivia – Mobile Health Unit (MHU) project is closely aligned with the MOH's approach to providing healthcare to rural populations (Modelo de Salud Familiar, Comunitaria e Intercultural). Plans for ensuring sustainability include establishing a well-defined and time-bound plan for transferring these high-quality MHU services to the public sector (See pages 11-12 of Bolivia's Redbook).

Examples of sustainability

PROFAMIL in Haiti highlights the **need to use online accounting systems** to reduce long term infrastructure costs, facilitate online support, and ensure business continuity in the event of a catastrophe. The 2010 earthquake in Haiti resulted in the loss of the ACCPAQ accounting system. PROFAMIL's only backup was lost due to theft following the earthquake. Since February the MA has

tracked its disbursements and income using Excel spreadsheets. PROFAMIL now uses the online accounting system - NAVISON (see page 10 of Haiti's Redbook).

INPPARES in Peru uses a wide range of sustainability strategies, and has a sustainability plan in place that focuses on marketing products and services (especially through its *Red Plan Salud* strategy which has 1,825 professionals, affiliated or sales) and in its subsidiaries in 10 cities, cross-subsidization, increasing efficiency, diversifying services and products, competitive pricing, and ensuring access to quality services and modern technology (see page 14 of Peru's Redbook).

3. ACCESS

Examples of improving access and targeting

CIES in Bolivia was chosen as the IPPF pilot site for a **client vulnerability assessment methodology** in 2010, to help improve access to SRH services for hard-to-reach and otherwise marginalized populations (see pages 8-9 of Bolivia's Redbook).

APROFAM in Guatemala began a 5-year project in 2010 funded through PSI in partnership with IPPF and other organisations aimed at reaching the most vulnerable and underserved groups, including ambulatory sex workers, difficult-to-access MSM, such as bisexuals, "closeted" or non-self-identified gay men (including young MSM and prisoners) - *Combination Prevention for Most at Risk Populations (MARPs)*, also known as **ComPrevention** (see pages 5-6 of Guatemala's Redbook).

Sudan's SFPA trained youth on counselling, SRHR, gender, and HIV/AIDS/STIs. These young people then worked on a voluntary basis in 11 '**youth corners**' of the IRHC to assist the service providers in **providing youth-friendly counselling and awareness raising sessions**. A total of 205 awareness raising sessions were conducted, with 4309 young people benefitting (see pages 15-18 of Sudan 2011 Annual Report).

Meeting the needs of vulnerable groups

FPA India's Outreach Services Project is being implemented with the core funding from IPPF in the rural, semi-urban and urban areas, through 39 Branches and four Projects covering a population of more than 2 million from the poorer socio-economic strata of the society. (Detailed statistics, achievements, what worked well, what didn't work well and lessons learned are interesting and found on pages 49-58 of India 2011 Annual Report).

Barriers to access

AFGA in Afghanistan's project 'Access of RH Information, Education and Services to Marginalized/Underserved' highlights the difficulties of socio-cultural barriers and need for well-designed BCC approaches (pages 23-31).

PROFAMIL in Haiti is an interesting example of an **MA reinventing itself and changing its modus operandi to be more responsive and improve access** (moving from one centralised clinic to multiple and strategic service delivery points) following the catastrophic 2010 earthquake (see page 6 in Haiti's Redbook).

4. SERVICE DELIVERY

Improving service delivery

FPA India's project 'Enhancing Male Involvement and increasing access to GBV screening and referral' is funded through IPPF special grants for improving the services related to male involvement and GBV (see pages 161-162 of India 2011 Annual Report).

Monitoring service delivery

APROFAM in Guatemala's established **Quality of Care (QOC) monitoring process** that includes supportive supervision, medical audits, client exit interviews, systematic surveys and situation analyses – these improvements appear to be a result of recommendations from USAID that they strengthen their QOC arrangement (see page 7 of Guatemala's Redbook).

Kyrgyzstan's Family Planning Association uses the **IPPF monitoring instrument** for its Global Comprehensive Abortion Care Initiative. The six-monthly programmatic report observes that this has been a good tool for self-assessment to improve quality of services.

Attribution

BEMFAM in Brazil - In 2010, IPPF's contribution to the MA's total budget was 5%, with the main source of income coming from SRH and non-SRH services and sales. IPPF provided TA in a number of areas (see pages 12-16 of Brazil's Redbook).

5. MONITORING AND VALUE FOR MONEY

FPA India's Knowledge Management and Evaluation programme is funded by IPPF. In 2011 Performance Based Funding (PBF) was introduced at FPA India and programme strategies were strengthened to increase performance (see pages 69-76 of India 2011 Annual Report).

AGHA in Afghanistan's M&E system has been reviewed and evidence-based decision-making area was found weak (Afghanistan 2011 Annual Report, page 65).

6. ORGANISATIONAL LEARNING

Examples of networking and communicating with other MAs:

CIES in Bolivia is an innovative and cutting-edge organisation, providing **TA on cost analysis / systems, HPV prevention and treatment, MHUs, and how to measure the socioeconomic profile of users to other MAs through IPPF's South-to-South Program**. It also provides important innovations - fully working enterprise resource planning system (SAP), a native add-on for their clinics to capture client data (See pages 4-5 of Bolivia's Redbook).

APROFAM in Guatemala participated in the South-to-South program on the harm reduction model, with visits to Bolivia and Argentina (See page 16 of Guatemala's Redbook).

Annex 17. Theory of change workshop report - attached separately

IPPF PPA review – Theory of Change workshop May 2012

1. Analysis of situation and barriers

Problem statement: Young, poor and vulnerable people, especially women and girls have poor levels of sexual and reproductive health and are denied sexual and reproductive rights in low-income countries; this is inhibiting achievement of MDGs.



Young, poor and vulnerable people do not have access to good quality services and support for their sexual and reproductive health and rights



1. SRH services are poor quality and scarce – health system is inadequate and does not support sexual and reproductive rights:

- **Human resources:** There are not enough well trained health workers and managers. There is a lack of support and understanding of gender equality and social inclusion. Poor understanding among health workers of sexual behaviour and health needs of their clients. Resistance to provision of SRH services at primary level.
- **Equipment and supplies:** Reproductive health supplies, logistics, procurement and inventory systems are poorly managed and so supply is inadequate and irregular. There are limited funds available for commodities.
- **Health finance:** There is inadequate finance from governments, private sector and donors for SRHR services. Finance policies can result in lack of supply and inflexibility on user fees. Donor financing and poor aid effectiveness can lead to vertical programmes and inefficiencies.
- **Health management information systems:** Poor information systems and referral systems that cannot measure health status and support service delivery access.
- **Health sector governance** and accountability (especially at service delivery points) is inadequate and leads to inefficiencies. Lack of good leadership and management and poor coordination within government, and between civil society and government.
- **Health infrastructure:** health facilities are scarce or distant and there is a lack of affordable transport for accessing services

2. An inadequate legal, political and regulatory enabling environment can create barriers to SRHR access.

- There is **poor political will** to prioritise women's and poor and vulnerable people's health – this is linked to gender and other inequalities.

- **Laws and constitutions** can inhibit people's sexual and reproductive rights – such as laws on early marriage, safe abortion, HIV transmission and MSM.
- **Lack of adequate regulations and guidelines** for SRHR services

3. The cultural and social context and lack of information can act as a barrier to accessing SRHR information, services and support

- **Gender inequality** in the home and in communities can inhibit women's decision making power and their ability to get to and to pay for services and care
- **Exclusion and vulnerability** can act as barriers for example, HIV related stigma, discrimination in terms of age, religion, ethnicity, race & gender, specific vulnerabilities/exclusion related to disabled, transgender, gender norms, MSM, early marriage,
- **Beliefs, attitudes and stigma** act as barriers to information and service access – stigma on abortion, HIV, early sexual activity
- Lack of **access to information** about health issues and rights; and information on SRH services, especially safe abortion.

2. IPPF initiatives and change keys

	Service delivery and access	Enabling environment	Organisational development
Initiatives – what we do	<p>Service delivery: Static and mobile/outreach service delivery, client focussed and comprehensive – integrated package of essential services (includes VIA)</p> <p>VIA approach: (i) training providers, (ii) establish referral system, (iii) monitoring, (iv) document, (v) Scale up.</p> <p>Community mobilisation (some overlaps with enabling environment) Volunteers and community involvement Promotion of services and awareness of SRHR Education services in and out of schools and peer education IEC and sensitisation activities, awareness raising and media</p> <p>Human resources: training (e.g. LAPM), management skills, professional development, supportive supervision Task shifting and task sharing. Training of government providers</p> <p>Finance: Adequate funds, realistic user fees and cross subsidisation, social franchising, voucher schemes</p> <p>Protocols and guidelines (internal and</p>	<p>Political and legal: International (ICPD, MDGs, CEDAW), regional and national level advocacy for policy, law and budget change. Collaboration with partners on key issues - e.g. girls at risk of child marriage. Build coalitions and networks. Capacity building and technical support to decision makers. Enhance accountability (watchdogs). Promote the registration of medical abortion drugs.</p> <p>Social and cultural: Economic empowerment and gender equality training. Partnerships with diverse groups (such as religious leaders, organisations working with street children etc.). Comprehensive Sexuality Education</p> <p>Technological innovations and research: new processes and technology (such as VIA). Research with young people to understand barriers. Use of the PLHIV Stigma Index to highlight HIV related stigma.</p> <p>Communications: Evidence and stories for donors and other providers. National and international campaigns raising awareness. Building capacity of media</p>	<p>Strategic framework – 5A’s and the three change goals – Unite, Deliver, Perform.</p> <p>Accountability – global indicators and accreditation process and system</p> <p>Systems – EIMS, CMIS, systems review</p> <p>Financial management – external audit, standards for financial procedures, branch performance tool, performance based funding, funding agreements</p> <p>Resource mobilisation.</p> <p>Governance structure – national, regional and international</p> <p>Human resource management</p> <p>Policy processes: The Governing Council (representing the MAs) is responsible for agreeing policy. Secretariat (RO and CO) leads on the technical input to develop policy documents and guidance to support the MAs. But the initiative, ideas and energy for these may come from the MAs</p>

	<p>for governments) Quality control and improvement.</p> <p>Infrastructure improvement and upkeep</p> <p>Secure commodity supplies Adequate funds and logistics systems in place</p>	<p>Advocacy for commodity and drug security (including timely distribution) and budgets for SRHR</p>	<p>themselves or from the ROs, or from donors.</p> <p>Learning and innovation – innovation fund (internal IPPF initiative), IPPF exchange website, learning days, informal learning sessions, technical assistance and capacity building, peer support</p> <p>IPPF structure – CO is in the process of re-structuring. Focal point groups for the A's and other technical areas.</p>
<p>Change keys - How we do it</p>	<p>Directing resources to supporting the poorest and underserved</p> <p>Client focused and rights based approach</p> <p>Health systems strengthening – providing services in combination with support to the public sector and expanded non-state service delivery</p> <p>Integrated approach – linking services together which are traditionally vertically provided to increase access. (Abortion, HIV, FP etc)</p> <p>Approach to new initiatives within the federation: Train, Pilot, Document, Scale up – e.g. such as Quality Improvement</p>	<p>If people can exercise their SRH rights they are less likely to resort to unsafe behaviour like unsafe abortion or unsafe sex. Less likely to get HIV or other STI. Leads to better health and lower morbidity / mortality.</p> <p>MAs are based in communities so they know who the stakeholders are, they include them effectively, young people get consistent messages from all people in their lives, young people access services.</p> <p>Building partnerships – women's movement and human rights.</p> <p>IPPF have seen that they are successful at influencing when they are useful by having technical expertise and supporting government. Providing</p>	<p>Integration of rights into IPPFs mission: The Charter (1994-5), Strategic framework (2005), The declaration (2008). involvement across the federation and institutional commitment.</p> <p>Youth: Youth support and participation at central, regional and local level. Youth manifesto developed by young people. Strong focus on young people has changed attitudes.</p> <p>It is the mixture of focusing on the services, but also including young people in governance and allowing their voices to be heard.</p> <p>Volunteers in the MAs have two functions: (i) Governing boards with 20% youth and 50% women, which has also</p>

	<p>Model - capacity building at regional and MA level, then pilot QI efforts, then document and scale up.</p>	<p>technical information, capacity for decision makers, briefing papers etc has made them useful and therefore they are listened to. Being active in service delivery gives them more legitimacy to provide technical support and information.</p> <p>Being locally owned organisations they have more legitimacy to be leading on advocacy and also know more about change processes and political realities.</p> <p>Linking international, regional and national advocacy for issues such as SRH supplies has been effective. Also the link between clinics and national information has supported this process</p>	<p>changed attitudes. (ii) Volunteers that are embedded in the communities providing information and services and representing communities. Volunteers are connected to and know the local context intimately. They can identify gaps and connect with relevant partners to reach under served groups.</p> <p>Partnership between the MAs and the Secretariat is a balance between ensuring accountability for the Funds distributed (budget approval, reporting, accreditation standards etc), and a facilitation and service role (technical and other support, advocacy partner etc).</p> <p>Better understanding of and analysis of cost will lead to better investment decisions.</p>
<p>Change keys across all areas – facilitating factors</p>	<p>Sharing good practice and lessons learned across the federation, between MAs – south to south, and beyond Integrating human rights with sexual and reproductive rights – embedding rights in structures and policies (e.g. HIV policy, gender equality). The rights based approach is integral to everything we do: the way services are provided, who we target, the enabling environment. It is both a principal and a more effective way of working.</p> <p>Fomenting partnerships – public and private partnerships – advocacy partnerships – social franchising – partnership with government</p> <p>Diversity – flexible in our approaches – initiatives may come from MAs ROs or CO. Because decision making processes are not rigid, there is the potential for ideas and innovation to come from the MAs the RO or the CO or from donors or governments. The federated structure allows for this flexibility as it is based on fairly democratic understanding of decision making processes. But this can also be a lengthy process and there is also a level of bureaucracy in the organisation.</p>		

Evidence : we know that:

- Sex education and service delivery together lead to increased impact
- Empowerment of women reduces fertility
- Reduced fertility and increased birth spacing improves maternal and child health outcomes
- Access to contraceptives lowers fertility and leads to lower MMR and IMR
- VIA is an effective way of reducing cervical cancer
- Integrating HIV prevention, treatment and care and support services into SRH services decreases mother to child transmission of HIV and improves the SRHR of PLHIV
- Access to safe abortion is an essential part of women's sexual and reproductive rights and contributes to reducing maternal morbidity and mortality.

Facilitating factors

Federation and locally owned

- Connected to communities
- Understanding of culture
- Advocacy connections
- Ownership and motivation

Rights based approach

- Respecting what clients want and need – service approach
- Targeting poor and vulnerable
- Potential for wider impact than just health

Integrated approach

- Integrating services so that they are more efficient and cost effective (e.g. HIV and AIDS and SRHR services)
- Providing client with more user friendly approach
- Integrating across advocacy and communications for more effective cultural and social change

Flexibility

- Organisation is able to respond to initiatives and innovation coming from any part of the federation
- Clear strategic framework, accreditation and mission makes flexibility possible

Partnerships

- To deliver services to hard to reach groups
- To have more clout in advocacy and policy influencing
- To develop new approaches and have a wider impact

Change keys

How we provide services and ensure access:

- Integrated, client focused and rights based approach
- Evidence based
- Health systems strengthening
- Working with partners
- Linking service delivery and advocacy efforts (e.g. SRH supplies)
- Train, pilot, systems, document, scale up

How we improve the political, legal, social and cultural enabling environment

- Building coalitions and networks
- Making ourselves useful – being a technical expert
- Partnerships with organisation and people who can do what we can't
- Linking international with national advocacy
- Knowing what is going on - local

How we improve the organisation to deliver results

- Support and encourage good leadership
- Inclusive policy processes
- Systems and efficiency maximising
- Internal communications
- Learning and improving
- Participation of volunteers and youth

Initiatives

Service delivery to poor and vulnerable people, especially women and girls.

- Clinics, mobile services and outreach
- ### Building capacity of others to deliver services
- Social franchising
 - Technical assistance to state and non-state providers
- ### Supporting health seeking behaviour
- SRHR Information to individuals

Influencing policies, practice and legal change

Influencing social and cultural attitudes to SRHR

- Working in communities
- Working with the media and ICT to communicate messages

Fomenting empowerment and resilience

Change goals: Unite, Deliver, Perform

Structure and staff improvements

Systems review and improvements

Improvements in financial control and cost management

Structure and systems for providing technical assistance and learning

Communications

3. Theory of change

Poor, young and vulnerable people, especially women and girls, have improved sexual and reproductive health status and this leads to accelerated MDGs progress.

Annex 18. ARO criteria to determine priority countries for technical and financial assistance

THEMATIC AREA	CRITERIA FOR MA CATEGORISATION	MA CATEGORISATION		
		High Priority	Medium Priority	Low Priority
Family Planning	Unmet need, population size, regional contribution to SS, potential for expansion (clinic, CBD etc), current capacity and market share, donor preference/priority country, potential for becoming technical hub or learning centre, competitive advantage over competitors/partners.	<ol style="list-style-type: none"> 1. Nigeria 2. Mozambique 3. Ethiopia 4. Uganda 5. Ghana 6. Mali 7. DRC 8. Togo 9. Benin 10. Côte d'Ivoire 11. Burkina Faso 12. Madagascar 13. Guinea-Conakry 14. Kenya 15. Tanzania 	<ol style="list-style-type: none"> 1. Guinea-Bissau 2. Burundi 3. Zambia 4. CAR 5. Rwanda 6. Lesotho 7. Angola 8. Senegal 9. Congo 10. Liberia 11. Sierra Leone 12. Niger 13. Cape Verde 14. Mauritius 15. South Sudan 16. Namibia 17. Malawi 18. Chad 	<ol style="list-style-type: none"> 1. Botswana 2. Swaziland 3. Comoros 4. Gabon 5. Seychelles 6. Zimbabwe 7. Sao Tome
HIV	Prevalence, level of national response (ART, PMTCT), regional contribution to SS, potential for expansion (clinic, CBD), current capacity and market share, potential for becoming technical hub/learning centre, comparative advantage over partners/competitors, donor preference/priority country.	<ol style="list-style-type: none"> 1. Nigeria 2. Ethiopia 3. Kenya 4. Uganda 5. Ghana 6. Burundi 7. Rwanda 8. Mozambique 9. Burkina Faso 10. Comoros 11. Benin 12. Tanzania 13. Swaziland 14. Senegal 15. DRC 16. Cameroun 17. Malawi 	<ol style="list-style-type: none"> 1. Togo 2. CAR 3. Côte d'Ivoire 4. Angola 5. Zambia 6. Sierra Leone 7. Mauritius 8. Niger 9. Guinea-Conakry 10. Botswana 11. Madagascar 12. Lesotho 13. Namibia 14. South Sudan 15. Mali 	<ol style="list-style-type: none"> 1. Gabon 2. Congo 3. Guinea-Bissau 4. Chad 5. Cape Verde 6. Liberia 7. Sao Tome 8. Seychelles 9. Zimbabwe
Abortion	National Laws, magnitude of unsafe abortion, regional contribution to SS, potential for expansion (clinic, CBD etc), current capacity and market share, donor preference/priority country, potential for becoming technical hub or learning centre, competitive advantage over competitors/partners.	<ol style="list-style-type: none"> 1. Ethiopia 2. Mozambique 3. Nigeria 4. Ghana 5. Zambia 6. Swaziland 7. Tanzania 8. Burkina Faso 9. Benin 10. Uganda 11. Guinea 12. Cote d'Ivoire 13. Mali 14. Senegal 15. DRC 16. Burundi 	<ol style="list-style-type: none"> 1. Comoros 2. Lesotho 3. Central African Republic 4. Guinea-Bissau 5. Niger 6. Malawi 7. Sierra Leone 8. Mauritius 9. Cape Verde 10. Togo 	<ol style="list-style-type: none"> 1. Chad 2. Congo 3. Botswana 4. Namibia 5. Gabon 6. Seychelles 7. South Sudan 8. Zimbabwe 9. Sao Tome

		17. Rwanda		
THEMATIC AREA	CRITERIA FOR MA CATEGORISATION	MA CATEGORISATION		
		High Priority	Medium Priority	Low Priority
CYP	Unmet need, fertility rates, population growth rate, population size, regional contribution to SS, potential for expansion (clinic, CBD etc), current capacity and market share, donor preference/priority country, potential for becoming technical hub or learning centre, competitive advantage over competitors/partners.	<ol style="list-style-type: none"> 1. Nigeria 2. Ethiopia 3. Ghana Uganda 4. Cote d'Ivoire 5. Mali Kenya 6. DRC 	<ol style="list-style-type: none"> 1. Benin 2. Zambia 3. Madagascar 4. Burundi 5. Lesotho 6. Burkina Faso 7. Togo 8. Namibia 9. Senegal 10. Guinea 11. Mozambique 12. Liberia 13. South Sudan 	<ol style="list-style-type: none"> 1. Rwanda 2. Central Republic A 3. Swaziland 4. Congo 5. Tanzania 6. Chad 7. Comoros 8. Cape Verde 9. Cameroon 10. Niger 11. Botswana 12. Sierra Leone 13. Malawi 14. Mauritius 15. Angola 16. Gabon 17. Guinea Bissau 18. Sao Tome and P 19. Seychelles 20. Zimbabwe
Other SRH Services	Contribution to regional non-contraceptive SS, potential for expansion (clinic, CBD etc) of services such as cervical cancer screening and management, gynaecology, breast cancer screening and management, obstetric fistula diagnosis and treatment, maternal health, male DRH clinics for prostate, erectile dysfunction, SGBV, specialised services etc., current capacity and market share, competitive advantage over competitors and or partners.	<ol style="list-style-type: none"> 1. Nigeria 2. Tanzania 3. Ethiopia 4. Kenya 5. Uganda 6. Mozambique 7. Burundi 8. Botswana 9. Senegal 10. Benin 11. Ghana 12. Niger 13. Togo 14. Burkina Faso 15. CAR 16. Mauritius 	<ol style="list-style-type: none"> 1. Sierra Leone 2. Rwanda 3. Zambia 4. Cote d'Ivoire 5. Guinea-Conakry 6. Swaziland Comoros 7. Madagascar 8. Chad 9. Cameroun 10. Angola 11. Malawi 12. Lesotho 13. DRC 14. Gabon 15. Congo 16. Mali 17. Cape Verde 19. Guinea-Bissau 	<ol style="list-style-type: none"> 1. Namibia 2. Liberia 3. Seychelles 4. Zimbabwe 5. Sao Tome 6. South Sudan