Working together for better health

Evaluation report of the Basic Health and HIV and AIDS programme of the ICCO Cooperation

Final Report

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Contents

Abbreviations

AIDS	Acquired Immune-Deficiency Syndrome
ANC	Antenatal Care
ART	Anti-Retroviral Therapy
BH & HA	Basic Health & HIV / AIDS
BCC	Behavioural Change Communication
BLiSS	Birth Life-Saving Skills
CBO	Community Based Organisation
CC	Country Coalition
CCMP	Church & Community Mobilisation Process
CHW	Community Health Worker
CSD	Civil Society Development
CSW	Commercial Sex Worker
CWD	Children with Disabilities
DCDD	Dutch Coalition on Disability and Development
DPA	Direct Poverty Alleviation
EHAIA	Ecumenical HIV and AIDS Initiative in Africa
F2F	Face-to-Face
FBO	Faith Based Organisation
FP	Family Planning
GAVI	Global Vaccine Initiative
GBA	Gender-Based Approach
GFATM	Global Fund for AIDS, TB and Malaria
HBC	Home Based Care
HEW	Health Extension Worker
HiAP	Health in All Policies
HIV	Human Immuno-deficiency Virus
HRH	Human Resources for Health
HSA	Health Surveillance Assistant
HSS	Health System Strengthening
IA	ICCO Alliance
IC	ICCO Cooperation
IGA	Income Generating Activity
ISAL	Internal Savings and Lending
KiA	Kerk in Actie
LAP	Leprosy Affected People
L&A	Lobby & Advocacy
LGBT	Lesbian, Gay, Bisexual and Transgender
MASP	Multi Annual Strategic Plan
MDG	Millennium Development Goal
MFS	Mede-Financierings Systeem (Dutch Ministry of Foreign Affairs' Co-Financing System)
MoH	Ministry of Health
NGO	Non-Governmental Organisation
OVC	Orphans and Vulnerable Children
PA	Programmatic Approach
PI	Policy Influencing
PLWHA	People Living With HIV & AIDS
PME(L)	Planning, Monitoring, Evaluation (and Learning)
PMTCT	Prevention of Mother to Child Transmission
PNFP	Private-not-for-Profit

PO	Programme Officer
PPM	Pregnancy Prevention Methods
ProCoDe	Programmatic Approach, Co-responsibility, Decentralisation
PWD	People with Disabilities
RBA	Rights-Based Approach
RFW	Results Framework
SAN!	Stop AIDS Now!
SAVE	Safer Practices, Access to Treatment, Voluntary Testing and Counselling, Empowerment
SHG	Self-Help Group
SILC	Savings and Internal Lending Communities
SLA	Service Level Agreement
SRH(R)	Sexual & Reproductive Health (and Rights)
TBA	Traditional Birth Attendant
ToC	Theory of Change
UHC	Universal Health Coverage
VHC / T	Village Health Committee / Team
VSLA	Village Savings & Loans Association
YFHS	Youth Friendly Health Services

Executive Summary

This evaluation of the MFS II funded Basic Health and HIV / AIDS programme implemented by the ICCO Cooperation in twelve countries was undertaken to provide an in-depth overview of the results of the programme.

The overall question of this evaluation was formulated as: *To what extent has the work of the ICCO Cooperation and their partner organisations during the period 2011 – 2014 contributed to the sustainable realisation of equal accessible and resilient health systems in rural areas, especially for poor people, vulnerable to and living with HIV and/or other diseases?*

The specific evaluation questions were:
Relevance: *To what extent is the Basic Health & HIV / AIDS programme designed to contribute to equally accessible and resilient health systems in rural areas, especially for poor people, vulnerable to and living with HIV and/or other diseases?*

Effectiveness: *To what extent have the objectives of the Basic Health & HIV / AIDS programme been achieved, or are expected to be achieved during the MFSII period?*

Efficiency: *To what extent has the ICCO Cooperation carried out the Basic Health & HIV / AIDS programme in a cost efficient way?*

Sustainability: *To what extent are the benefits of the Basic Health & HIV / AIDS programme likely to last after completion of the MFSII programme?*

Findings and analysis
The Basic Health & HIV / AIDS programme portfolio consisted of 102 projects: 82 projects implemented by partner organisations of the ICCO Cooperation (coPrisma members – 67 projects; ICCO – 15 projects), seven (7) Stop AIDS Now! projects (implemented by ICCO sometimes in collaboration with coPrisma members) and thirteen (13) regional and support projects. The findings and analysis of this meta-evaluation are largely based on the available country coalition evaluations (11), project evaluations (62) and regional project evaluations (3).

The roles of the ICCO Cooperation in the Basic Health & HIV / AIDS programme are described as: i) Funding; ii) Development of capacity and expertise; iii) Brokering; and iv) Lobby & Advocacy. The ICCO approach is often referred to as 'focusing on the big picture' rather than project implementation, which was the focus of most coPrisma partners.

Relevance
The ICCO Cooperation support provided to Country Coalitions and partner organisations was done utilising various approaches, i.e. policy / strategy guidance, including support in the development of the tailored results framework, induction of / guidance to partners in the Programmatic Approach and documentation produced by regional policy initiatives. Global and Regional Face-to-Face meetings were sometimes combined with training on the development of contextualised Theories of Change, Planning, Monitoring, Evaluation and Learning, Lobby & Advocacy and other general topics. The ICCO Cooperation support has been rated positive and can be considered appropriate, but uptake of results from regional initiatives was limited and the frameworks and approaches have been received and applied with mixed success. The Programmatic Approach met with much initial resistance because it was perceived as top-down; however, after 4 years of MFS II implementation appreciation for the programmatic approach and, to a lesser extent, the Theory of Change and the results framework has increased.

Working with a Theory of Change was considered relevant, but Theory of Change thinking proved difficult and the Theory of Change concept was not necessarily 'recognised' or 'understood': rather than focusing on the change to be achieved by the end of the basic health & HIV / AIDS programme, many partner organisations started from and maintained a strong focus on activities. Some Country Coalitions just pulled the partner organisations' log frames into a Theory of Change, while other Country Coalitions did not proceed to develop specific Theories of Change. Certain Theory of Change elements resonated well, i.e. use of Change Agents, while other elements were not easily recognised, e.g. how to achieve improved access to quality health services without supporting health service delivery (not all aspects of service delivery are mentioned yet service delivery formed part of activities in 73 projects with a recorded total of 348 separate interventions, of which 42% (145 interventions) referred to curative and rehabilitative services, which are not reflected in the Theory of Change.

Most project intervention strategies were based on international best practice with acknowledged effectiveness, were relevant and appropriate in the given contexts and were in line with nationally defined Basic Packages of Health Services / Essential Health Packages. The 'global' understanding of beneficiary needs has generally guided the programme interventions. A fair number of projects already existed before MFS II and were continued, largely because of the extent of unmet health care needs. This has however affected the updating and undertaking of joint multi-stakeholder analyses at the start of the MFS II implementation phase. Unfortunately, the unit costs of interventions were generally not available, which is a missed opportunity, because systematically updated unit costs of specific interventions allow comparison that may improve cost awareness and cost efficiency in the selection of priority interventions.

'Training' of Change Agents has been important in projects that focused on prevention and health promotion. Change Agents were 'recruited' from diverse groups, i.e. youth, women, people living with HIV / AIDS, health care providers including Community Health Workers / Traditional Birth Attendants, NGO staff, teachers, Church Leaders (most common) and Church Groups. Change Agents have largely been effective in promoting health, raising awareness and mobilising people to utilise available basic health & HIV / AIDS services. Change agents' involvement in reducing stigma and the uptake of health services has resulted in positive change, although there is little and slightly mixed information with regard to the extent that stigma has been reduced.

Almost all projects included interventions targeting the health workforce. These interventions mostly referred to training of health professionals and, more often, of non-professional individuals and groups. The effectiveness of training of people traditionally considered 'non-health' has generally been good; however, the effectiveness of 'health professionals' training has been difficult to establish as evaluation reports make little to no mention of the monitoring and relatively few projects mention supervision / mentoring to follow up on the application of new skills / knowledge. No evidence was found that governments have increased their budget allocation for the health workforce. Training workshops in lobby & advocacy have not been very effective: only few effective lobby & advocacy activities at national and local level were mentioned in evaluation reports.

Only few innovative approaches were identified, e.g. the Birth & Life Saving Skills project, the Disability projects, the establishment of grain banks to generate community support for vulnerable households and the Church & Community Mobilisation Process. These approaches offer opportunities for roll out in other countries.

The project and country coalition evaluations hardly provide indications that beneficiaries were consulted. It is unclear whether more extensive consultations with beneficiaries would have resulted in changes in project interventions because of community defined priorities.

In the application of the Gender-Based Approach reference is mostly made to women: a number of projects focused on increased involvement of men in Sexual & Reproductive Health (SRH), i.e. on sharing responsibilities for pregnancy / obstetric care. Few if any examples were found that showed a focus on addressing gender inequality in decision making and participation in community structures.

The Rights-Based Approach was not very explicitly applied and mainly focused on the right to health care access by supporting direct service provision, addressing stigma and discrimination of People Living with HIV and AIDS and of people living with disabilities and leprosy. Initiatives undertaken at regional level to use a theological foundation for acceptance of / respect for people who make different life choices were not applied in projects and partner organisations 'agreed to disagree' when referring to more contentious issues (e.g. homosexuality, abortion and condom use by adolescents).

Project interventions generally contributed to Securing Sustainable Livelihoods, i.e. disease control, eye care and disability projects contribute to increasing productivity of people otherwise involved in care giving or ill. Many direct linkages to livelihoods options and saving groups were forged, although the results have been mixed. The contribution of the Basic Health & HIV / AIDS programme to achieving 'Justice and Dignity for All' is clear given that the programme focused on ensuring access to health care.

Effectiveness
The establishment and capacity development of community structures received extensive support, which also aimed at community participation in the health sector to ensure accountability. However, limited attention was given to lobby & advocacy for accountability at different levels. Capacity development of interest groups mostly focused on livelihoods and not on strengthening the role of interest groups in lobby & advocacy, which may explain why lobby & advocacy for inclusion of 'marginalised groups' was only found in very few instances.

At the start of the programme the capacity of partners was measured using the O-scan, but these results have hardly been used. The project and Country Coalitions' evaluation reports provide inadequate information to state that projects generally corresponded with the strengths of the many partner organisations. This may be related to the fact that many partner organisations' projects had been initiated well before the MFS II funding cycle and were continuations of the same projects; hence the capacity / strength of the partner organisations may have been taken as a given, especially for projects of specialised organisations which built on established strengths.

The establishment of Country Coalitions was a requirement of the programme and many had a difficult start. Despite this, their value is increasingly recognised in most countries. The Country Coalitions were generally made up of partner organisations with very diverse experience and capacity and were often too scattered geographically or thematically to be effective.

Effective 'learning' is one of the most commonly reported positive results of Country Coalitions especially in combination with support provided by ICCO / coPrisma through the F2F meetings. However, learning remains inadequately institutionalised and experiences are rarely shared pro-actively. Participation in learning events has mostly only benefited one to two technical staff within organisations. Cross-thematic learning has not been a very strong focus of organisational development interventions: the focus has been on general organisational development, i.e. programme / financial management, networking as well as thematic learning.

Several Country Coalitions intend to continue collaboration after MFS II closure: some are more likely to continue, largely because of the already existing collaboration prior to and outside of MFS II or may continue at a smaller scale for specific interventions. However, most Country Coalitions are still in the

process of developing viable future 'business' plans and efforts to acquire funds through jointly developed project proposals have not yet been successful. Few partner organisations developed formal exit strategies, which is related to the likelihood that in many cases the coPrisma members will continue funding.

The collaboration of Country Coalitions and partner organisations with non-health stakeholders has generally been good. However, collaboration with government institutions could have been more prominent given that Ministries of Health have the general mandate to ensure harmonisation of approaches, the coordination of partners in health and ensuring that unmet health needs of specific target groups now covered through projects are covered by government service provision. In many cases parallel systems have been established or maintained because of capacity issues of the Ministries of Health.

The implementation of real multi-stakeholder approaches has been rare. In most countries, the initial multi-stakeholder analyses at the start of the MFS II programme were not revised and partner organisations have hardly focused on systemic approaches, but on the implementation of their own projects as well as ensuring collaboration and joint learning.

Although a level of synergy between the three key strategies has been achieved, Direct Poverty Alleviation and Civil Society Development received more attention than Policy Influencing. Overall, Civil Society Development interventions received most attention in projects and were largely effective and have in some cases led to Direct Poverty Alleviation. Civil Society Development has contributed to strengthened lobby & advocacy in some cases, but overall Policy Influencing has been weak and the interventions – mostly training – have not really been effective in improving accountability and ensuring inclusion of marginalised people through lobby & advocacy.

Almost all evaluations indicate that access improved and utilisation of health services increased as a result of project interventions. However, the reviewed evaluation reports show that projects have largely been output oriented and provide inadequate information to state that improved access and increased utilisation has effectively resulted in health gains: data on the effects of improved access and increased utilisation of services on for instance pregnancy outcomes, morbidity and mortality are missing. Many "contextualised indicators" are hidden outputs: *"… concrete evidence of change agents who have been able to positively influence factors that play a role in* silence and stigma…" has been reported as "*the number of change agents that are active*" and in practice all change agents who were trained have been counted as active.

Efficiency

Country Coalitions have not been effective in utilising a single PME system and PME capacity remains poor, despite learning events targeting PME capacity development. Harmonisation of PME has not been achieved: in the few countries that developed a single PME system, most coPrisma members still required separate reporting and monitoring data, which is inefficient.

There are many layers between the principal recipient of MFS II funding and the local partner organisations that are closest to the beneficiaries. Evaluation reports provided almost no information on transaction costs. An overview based on the analysis of budgets of fifteen randomly selected projects does not give the impression that overhead and coordination costs in the Netherlands are very high (17.2% of the overall budget), but benchmarks from similar Dutch alliances are not available for comparison.

Very few evaluations mention the monitoring of cost efficiency: most information has been provided by key informants, who indicated that partner organisations show some level of cost awareness by

sharing available resources between projects. There is no indication that the efficiency of training workshops, a much used capacity development format, has been questioned, so it is unclear whether other effective capacity development methods e.g. using internet, reading groups, etc. have been explored to ensure and / or increase the cost efficiency of an important intervention strategy of the Basic health & HIV / AIDS programme.

Sustainability

Changes that have occurred as a result of implemented interventions are largely expected to continue after project closure. This is especially true for health promotion including Behaviour Change Communication and social mobilisation activities undertaken by recruited and trained Change Agents that have led to increased utilisation of available health services.

However, support to service delivery and activities undertaken by community structures and interest groups for accountability and other interactions with government structures are unlikely to be sustained without external support. In general, partner organisations have made little effort to ensure that activities are included in government annual plans and will continue to require external funding.

Conclusions

1. The overall objective – *contribute to more equally accessible quality basic health care* - has largely been met, but there is inadequate evidence that this has resulted in more equal health outcomes. Most of the changes that the programme contributed to are felt by beneficiaries.

The first objective - *increased accountability* - has been met at health facility level, because of strengthened committees, but not at the level of governments. Participatory structures have been strengthened and there is evidence of increased influence in decision making. There has hardly been any lobby and advocacy for increased accountability and transparency and consultation of beneficiaries in planning has been limited.

The second objective - *contribute to breaking silence and stigma and to prevention* – shows anecdotal evidence of positive effects. Working through change agents has largely had positive effects on general health seeking behaviour, on reducing silence and stigma, although there are only few objective measurements that show the actual health gains made. Capacity development of interest groups was done in many projects, especially focusing on interest groups of people living with HIV / AIDS and people with disabilities, which show that lobby & advocacy for inclusion and equality has reaped positive effects, but effective advocacy by interest groups has been rare. The results of capacity development of interest groups in income generation have been mixed.

The third objective - increasing and improving human resources for health - has not been met as interventions have had a very limited effect on the size and distribution of the available 'professional' health workforce. The programme has included many training interventions, but the focus has hardly been on improved health workforce policies. The effects of training have not really been measured, although there are indications of improved performance in several projects. Partners often cooperate with governments, but only in a few cases has this led to increased government allocations for the health workforce.

2. Projects have implemented interventions based on international best practice which are recognised for their effectiveness and were largely relevant, because they have taken into account overall country contexts and evidence of globally as well as nationally established beneficiary needs (HIV, Sexual & Reproductive Health, basic health care, specific disease control). Interventions were also relevant because of the focus on the need for capacity development of community groups / structures to strengthen their engagement in demanding accountability and changing the balance of power, the need for a multi-sectoral approach in addressing social determinants of health and drivers of ill-health and the need to address socio-cultural practices and values that contribute to stigma and

discrimination using change agents. The many training / knowledge & skills transfer interventions are thought to have contributed to improved performance of the health workforce. However, the findings inadequately show that acquired knowledge and skills were consistently applied, possibly because of poor follow up, and other effective methods of knowledge and skills transfer have not been used.

3. ICCO Cooperation's policies, position and guidance papers and the Theory of Change and results framework have been helpful in providing guidance and assuring the financing for the programme. However, the training provided in lobby & advocacy, Planning, Monitoring, Evaluation and Learning and the Theory of Change has hardly been effective.

4. The introduction of the Programmatic Approach, although initially met with reluctance because of the top-down nature of introduction, has been important in ensuring cohesion in the projects. Despite the lack of systems' harmonisation, the Country Coalitions have largely been successful as platforms for sharing and networking, but much less as embodiment of multi-stakeholder approaches that work on systemic changes.

5. The Theory of Change of the programme was too specific to encompass the diversity of interventions and does not make clear how the various results should contribute to the objective of the programme.

6. Efficiency has not been at the top of partner organisations' agenda. However, most interventions are known for their cost effectiveness.

7. Clear benchmarks to compare programme, overhead and project overhead costs are not readily available, which makes it difficult to judge whether transaction costs of the ICCO Cooperation are acceptable. The duplication of reporting and monitoring (to Country Coalitions and the coPrisma member) is inefficient and may have increased the transaction costs.

8. It is unclear whether and where cost savings could have been made, because unit costs of commonly implemented interventions are not available. This lack of information is especially important for training interventions and support of change agents in health promotion, because it does not allow a comparison of formal training with other knowledge and skills transfer methods and of using already available community workers rather than newly recruited and trained change agents.

9. The effectiveness of the applied Planning, Monitoring, Evaluation and Learning system is doubtful: the monitoring of project implementation has largely focused on measuring outputs, even when they were framed as outcomes. Measurements of health gains at outcome level have not been undertaken. Insufficient attention was given to ensuring the quality of project evaluations.

10. Achieved changes in access to and utilisation of health services as well as in behaviour are likely to be sustained, but most partner organisations will be challenged in continuing their project activities without external funding after MFS II.

11. A number of Country Coalitions are committed to continue, although ultimately this commitment will need to be supported by viable business plans and funding, which is less straightforward.

12. The lack of partner organisations' capacity and willingness to innovate has not been given adequate attention in the selection of partners of ICCO and coPrisma members.

The table below summarises the judgements that were formulated for each of the criteria and evaluation questions. Annex 11 provides a more elaborate version of this table and includes further explanations.

Table 1. Complete list of judgement criteria and final assessments (scale 1-4), short version

Questions and Criteria	IC[1]	PO	CC / partners	Average
Relevance				
To what extent was the programme relevant?	2.8	1.8	2.6	2.7
1. Contribution to MASP principles	3.5			3.5
2. Appropriate guidance, support and policy	2.5	2.0		2.3
3. Alignment with beneficiaries' needs			3.5	3.5
4. Appropriate interventions	3.0	2.0	2.0	2.3
5. Relevant theory of change	2.0			2.0
6. Interventions aligned with partner capacities			2.5	2.5
7. Good collaborations	3.5	?	3.5	3.5
8. Gender and Rights based approaches used	2.5	1.5	1.5	1.8
Effectiveness				
To what extent was the programme effective?	2.3	2.5	2.7	2.5
1. 6 outputs of the alliance achieved		2.0		2.0
2. 9 outputs of the partners achieved			2.5	2.5
3. 8 outcomes of the target groups achieved			?	
4. More equally accessible quality basic health care			3.5	3.5
4. More equal health outcomes			?	
5. Changes at beneficiary level			4.0	4.0
6. Correct theory of change	2.0			2.0
7. Capacity development, brokering and L&A of IC helped effectiveness	2.5	2.5		2.5
8. Country Coalitions contributed to effectiveness			3.0	3.0
9. Multi-stakeholder approaches used			1.5	1.5
10. Synergy between intervention strategies			2.5	2.5
11. PME used for learning and adaptation	1.5		1.5	1.5
12. Learning takes place at all levels	3.0	3.0	3.0	3.0
Efficiency				
To what extent was the programme efficient?	2.0	2.3	2.8	2.3
1. Transaction costs minimised	2.5	2.5	2.5	2.5
2. Cost awareness in programme management	1.5	2.0		1.8
3. Cost effective interventions			3.0	3.0
Sustainability				
To what extent was the programme sustainable?	2.0		2.0	2.0
1. Changes continue			3.5	3.5
2. Relevant activities continue			1.0	1.0
3. Exit strategies and preparation for after 2015			2.0	2.0
4. Innovative programme	2.0		1.5	1.8

Recommendations

1. Health is a Global Public Good. Improving health was one of the intended and achieved results of the Basic Health & HIV / AIDS programme, in line with the core principles of the ICCO Cooperation's Strategic Plan 2020 as well as the MDG agenda. The ICCO Cooperation should continue its involvement in health to ensure that progress made in addressing drivers of ill-health and social determinants of health, and meeting health needs of disadvantaged people is built on in the post-MDG era. Health should be given appropriate attention, also when the organisation's focus moves towards supporting economic development.

[1] IC = ICCO Cooperation, mainly referring to the global office; PO = Programme Officer, from the coPrisma members as well as the ICCO regional offices; CC = country coalitions. Blank cells indicate that the judgement criterion is not considered relevant at that level. Questions marks indicate a lack of information to make a judgement.

2. Explore partner organisations' capacity to innovate, adapt to new approaches and concepts as well as their ability and willingness to institutionalise changes and attach consequences to these in programming. This should include further emphasis on the change from direct implementation to facilitation, including the facilitation of health prevention and health promotion interventions through existing structures.

3. Conduct research to determine whether programmes would be as or more effective if they target already available community workers linked to the health and other sectors and community structures instead of recruiting 'new' change agents to realise change.

4. Increase the focus on working on systemic change. In establishing Country Coalitions, consider already existing coalitions and alliances. Invest further in Theory of Change thinking to ensure that activities, interventions and collaboration are chosen to optimally serve the intended systemic change. Also ensure that Theories of Change continue to be fed by established international good practices.

5. Future programme financing opportunities are changing which requires that the ICCO Cooperation takes a firm decision with regard to its core role vis-à-vis partner organisations, i.e. decide between playing a prominent role in ensuring financing for partners' programmes or take on a more pro-active role by becoming a promotor of new programme approaches.

6. The development of Planning, Monitoring, Evaluation and Learning protocols should match the Theory of Change pathways. The reliable measurement of project interventions' health status and health sector performance outcomes should be given more attention. More attention should also be given to ensuring that the project evaluations meet quality standards.

7. In close collaboration with other Alliances, establish benchmarks for acceptable transaction costs' levels.

8. Establish the unit costs of key interventions and determine the acceptable deviation levels of established unit costs in specific contexts.

9. Prior to programme implementation in consortium with other organisations, it is imperative that administrative systems of all programme partners are harmonised to ensure that collaborative efforts are optimally effective and efficient.

10. In addition to promoting more exchange visits and peer reviews for learning, explore effective and cost efficient alternatives to training workshops for the transfer of knowledge and skills as well as for other capacity development interventions.

1 Introduction

The ICCO Cooperation[2] commissioned the evaluation of its MFS II funded Basic Health & HIV / AIDS 2011 - 2014 programme to Resultante and two independent consultants. The evaluation aimed to provide the ICCO Cooperation with in-depth insights in the results achieved in the twelve (12) countries where the programme has been implemented and to establish the benefits at beneficiary level. In addition, the evaluation should provide an objective assessment of the cooperation between ICCO and coPrisma and the added value of this cooperation in achieving the intended results. The results of the evaluation are meant to provide lessons learned and other input for on-going policy development in health. The report will be communicated to ICCO Cooperation partners, who in turn are expected to share the findings with their target groups, principal stakeholders, other donor(s) and the general public. The report of the meta-evaluation should ultimately function as a track record of the Basic Health & HIV / AIDS (BH & HA) programme implementation.

This evaluation report presents the findings and analysis of the 82 projects implemented in the twelve (12) programme countries as well as twenty (20) additional projects that include regional and support projects and seven (7) Stop AIDS Now! projects. The report comprises, in addition to the Executive Summary, nine chapters including this introduction:

- Chapter 2 provides a description of the methodology used for this evaluation.
- Chapter 3 provides an overview of the different organisations involved in the BH & HA programme, the policy environment and support provided to the eleven (11) Country Coalitions and approximately 100 partner organisations involved in programme implementation as well as the overall project portfolio. One section in Chapter 3 is dedicated to a description of the country coalition and project evaluations that provided the most important source of information and includes a reflection on the quality of these evaluations.
- Chapters 4 to 7 provide the findings and analysis of these findings related to the relevance (Chapter 4), effectiveness (Chapter 5), efficiency (chapter 6) and sustainability (Chapter 7) of the programme. At the end of each chapter a concluding paragraph containing a synopsis of the evaluators' judgements in relation to the evaluation questions is presented in tabular format.
- Chapters 8 and 9 present the conclusions and recommendations.

[2] At the start of the MFS II funded BA & HA programme referred to as the ICCO Alliance. The name ICCO Cooperation will be used, although it is acknowledged that the name change took place in the course of the implementation of the BA & HA programme.

2 Methodology

The evaluation has been designed around the following set of key evaluation questions:

Key Evaluation Questions
Overall evaluation question: To what extent has the work of the ICCO Cooperation and their partner organisations during the period 2011 – 2014 contributed to the sustainable realisation of equal accessible and resilient health systems in rural areas, especially for poor people, vulnerable to and living with HIV and/or other diseases?
Relevance: To what extent is the BH & HA programme designed to contribute to equally accessible and resilient health systems in rural areas, especially for poor people, vulnerable to and living with HIV and/or other diseases?
Effectiveness: To what extent have the objectives of the BH & HA programme been achieved, or are expected to be achieved during the MFSII period?
Efficiency: To what extent has the ICCO Cooperation carried out the BH & HA programme in a cost efficient way?
Sustainability: To what extent are the benefits of the BH & HA programme likely to last after completion of the MFSII programme?

For each of these questions specific judgement criteria that operationalise the different aspects of the questions have been defined. The findings and analyses for each of these judgement criteria are presented in chapters 4 to 7. Based on these analyses, each of the criteria receives a final score on a four point scale[3].

Some of the evaluation questions and associated judgement criteria apply to different levels or actors. These are the ICCO global and the coPrisma office, the ICCO regional offices and coPrisma members, and the Country Coalitions and member partner organisations that implement projects. Paragraph 3.1 describes these levels further.

The evaluation was designed as a meta-evaluation. The main sources of information were the available evaluation reports of Country Coalitions and projects. The quality of these evaluations was assessed (see Annex 2 for the format used) and the contents summarised. Additionally, relevant international literature was utilised and interviews were held with ICCO and coPrisma staff as well as all project officers for the countries involved (see Annex 4). The interviews were held to seek additional information and to validate the analysis of findings. Other project documentation that was analysed included key documents for all projects (including those that were not evaluated), policy documents (see Annex 3), information about networking, support activities and studies, overviews and monitoring data of ICCO and coPrisma.

The developed matrices included the judgement criteria (see Annex 5). Information contained in project documentation and other relevant information was structured using these matrices. Per country (and also for the regional projects) a synthesis was made of all projects and the synthesis of all countries formed a major basis for this final report. All findings and analyses presented in chapters 4 to 7 can be traced back to country and project documentation.

The two senior evaluators (Wilma and Wouter) divided the countries for in-depth assessments. The assessments for each judgement criteria were discussed by the two evaluators. To ensure that assessments of individual projects and coalitions undertaken by the two evaluators were consistent,

[3] Hardly or not at all (1), Occasionally or Somewhat (2), To a considerable degree (3), (Almost) completely or Very much (4)

a double blind analysis was done: four evaluations were assessed by both evaluators to assess the quality of the evaluation while seven evaluations were assessed by both evaluators on the contents of the evaluations in relation to the judgement criteria. The results are included in Annex 6 and show that the differences were small.

2.1 Additional analyses

The following additional analyses were done:

- A categorisation of all projects, using three analytical frameworks: the Health Systems Framework of the WHO was used for all projects; the behaviour change communication (BCC) framework of SAN! and Brinkerhoff's capacity development framework were used when the projects included relevant activities. These categorisations form the basis of the presentation of the project portfolio in paragraph 3.2 and Annex 9. The frameworks are presented in Annex 7.
- An analysis was made of transaction costs, i.e. of the costs incurred by every involved actor and, within the project, the costs for overhead, investments and the implementation of project activities. This analysis was done for fifteen projects: one regional project, two ICCO projects and one coPrisma member project from each of the twelve countries, all randomly selected.
- A brief analysis of unit costs was attempted for selected activities. However, because it was often difficult to find activities that were sufficiently comparable as well as activity-specific budgets, this only led to some results for home based care activities.
- A brief analysis was done of all monitoring data of the ICCO Cooperation. These have been used to compare the findings from this evaluation with the reported monitoring data. This analysis was done on the basis of ICCO's analyses of annual reports per partner and per country. In this way it has been possible to exclude countries and projects from the analysis that were not part of this evaluation.

2.2 Limitations of the evaluation

Evaluation reports were a major source of information as well as project documentation and interviews: the latter were used to access additional information and to triangulate preliminary findings. The findings and analyses chapters have a slight bias toward the projects with better quality evaluations, while projects without evaluations are underrepresented: information from the better evaluation reports was used more extensively, particularly when credible data about outcome level changes were presented. Information from weaker reports has also been used as well as information from projects that have not been evaluated, but to a lesser extent, especially if such project documentation was of poor quality or mainly comprised of proposals.

Assessment of the effectiveness of interventions was hampered by a lack of data on health outcomes: the measurement of the effects of improved access and increased utilisation, but also of training on the performance of the health workforce was not explicitly monitored. Evaluations reviewed by the evaluation team did not contain relevant information on this issue.

Assessing the efficiency question has been difficult, because of the relative absence of information. Not all project evaluations reported on this topic and those that contained information on efficiency often referred to process efficiency only (e.g. issues of timeliness).

Assessing the sustainability question is difficult because at this stage the projects and coalitions put a relatively large focus on intentions to continue: at the time of report writing it was not possible to assess if these intentions will indeed be realised after 2015.

3 The programme

This chapter presents the Basic Health and HIV / AIDS programme, i.e. the organisations involved, the policies and other support and guidance documents, an overview of the project portfolio and findings with regard to the quality of evaluation reports reviewed.

3.1 Players and their roles

The MFS II funded BH & HA programme has been implemented by the ICCO Cooperation: its members ICCO and coPrisma (a sister organisation of the association Prisma consisting of its members involved in the ICCO Cooperation), the established Country Coalitions and local partner organisations of ICCO and coPrisma members. The table below provides an overview of the various organisations involved in the MFS II BH & HA programme, their roles and the structure.

Table 2: Key players, their roles and structure

Key players	Who are they?	Role	Structure
ICCO	Principal Recipient MFS II funds for consortium	• Policy guidance including result framework and programmatic approach • Support, training and facilitation of learning • Review of annual plans and reports including progress against targets • Advice Regional Offices and Country Offices • Disbursement of funds and accountability to the Ministry of Foreign Affairs	• HQ • Regional Offices • (Some) Country Offices
coPrisma	Umbrella organisation of Dutch NGOs involved in MFS II	Same as ICCO and broad collaboration, but with more focus on coPrisma-members' partners and excluding accountability to the Ministry. Review done at country level. Coordinating agency of the BH & HA programme within the ICCO Cooperation	coPrisma office, members have final authority
Programme Officers of coPrisma members and ICCO regional and country offices	12 Dutch Christian NGOs involved in BH & HA programme	• Obtaining co-financing • Partnership relation / overall support partners • All necessary systems (financial, reporting, learning, etc.)	Some members have country offices / representatives; One lead per country
Country Coalitions	Alliance of partner organisations of ICCO and / *or* coPrisma members (only UG mixed)	• Joint ToC and PME framework • Coordination of partner organisations • Joint monitoring and reporting • Development annual plans • Networking and L & A • Learning	11 CCs (Haiti only 2 organisations, Malawi only ICCO, other CCs comprise only coPrisma partners); Some external facilitation; most have one staff member who is partly available for CC
Partner organisations	Close to 100 local partner organisations involved in implementation	• Development operational plans • Implementation, monitoring and reporting • Networking, exchange and learning	In most cases small or medium sized NGOs and FBOs with broad agenda. Some networks or specialised organisations

NB: Starting in 2012, ICCO and coPrisma also undertook the pilot ProCoDe (Programmatic Approach, Co-responsibility, Decentralisation) in the Central and East Africa Region. The aim of this pilot was to explore opportunities for coPrisma members to jointly participate in the ProCoDe process that ICCO / Kerk in Actie (KiA) initiated in 2007. The pilot covered three countries (Kenya, Ethiopia and Uganda)

and was managed by the Kampala Regional Office. Despite the recommendation by the 2013 evaluation team to turn the pilot into a definite *modus operandi* in Central and East Africa Region, the pilot was discontinued in 2014, largely because of challenges in harmonising the systems and processes of the individual coPrisma members.

Overall, the ICCO Cooperation aims to contribute to equally accessible and quality basic health care by:

1. Enabling Civil Society to demand accountability from (national, district and local) governments and other relevant stakeholders;
2. Supporting change agents to challenge exclusion mechanisms and contribute to prevention;
3. Reinforcing health systems by expanding and improving available human resources for health.

The corporate business plan of the ICCO Cooperation (2011-2015) distinguishes the following roles for itself: strategic funding, brokering, capacity development and lobby and advocacy. The MASP 2020 puts the emphasis slightly different by listing the roles as broker, facilitator, co-implementer, strategic financer and lobbyist (p.15).

In practice, the following main roles and activities of ICCO and coPrisma were seen in the programme:

- Policy development and facilitating programme management: both ICCO and coPrisma were involved in the development of relevant policies, instruments and tools[4]. Regular programme meetings attended by ICCO and the coPrisma members were facilitated in the Netherlands to discuss progress in implementation and programme management and policy development issues. The meetings – on average four meetings per year – addressed relevant and critical issues in relation to programming and content of the MFS II projects, annual plans as well as Planning, Monitoring, Evaluation and Learning (PMEL) and progress or lack thereof in meeting set objectives.
- Facilitating capacity development: coPrisma has a specific fund for capacity development of the Country Coalitions, which has also been utilised for the facilitation of training and exchange visits. ICCO has organised various training workshops for Country Coalitions and their members, mainly focusing on issues related to the PA - including coalition management and facilitation -, Theory of Change (ToC) development and planning, monitoring and evaluation. Specific training sessions were organised for Country Coalitions (CCs) and partner organisations with support of Stop AIDS Now! (SAN!) on Behaviour Change Communication (BCC) and Youth Friendly Services (YFHS) between 2012 and 2014.
- Linking and learning and the sharing of operational research findings was ensured through Global and Regional Face-to-Face (F2F) meetings: during the lifespan of the BH & HA programme four Global meetings and two Regional meetings for each of the three regions took place. The following table provides a summary of the various meetings as well as training / capacity development activities, including the targeted participants and facilitators.

Table 3: Overview of global and regional BH & HA linking and learning activities during MFS II

Year	Activity	For whom	By whom	Follow-up
2011	Programmatic Approach (PA) training	coPrisma staff and Programme Officers (POs) of coPrisma members	Capacity Development / Learning Programme manager and Centre for Development Innovation (Wageningen)	Applied while introducing PA at country level and establishing the Country Coalitions
2011	Global F2F BH & HA	BH & HA POs of coPrisma members and Regional Offices,	Specialists BH & HA with input from external experts	• Reports on the wiki

[4] Please refer to Annex 3. List of policy documents and literature consulted

Year	Activity	For whom	By whom	Follow-up
		and several coordinators of Country Coalitions		• Action plans formulated per country coalition and integrated in annual country plans • D group conversations • Individual contacts with PO's on specific issues
2011	Regional F2F BH & HA, South Africa	Relevant POs of coPrisma members and Regional Offices and relevant partners from Zimbabwe, Malawi, Angola and South Africa	Specialists BH & HA with input from external experts	• Reports on the wiki • Action plans formulated per country coalition and integrated in annual country plans • Dgroup conversations • Individual contacts with PO's on specific issues
2012	Regional F2F BH & HA, Uganda	Relevant POs of coPrisma members and Regional Offices and relevant partners from the DRC, Ethiopia, Kenya, South Sudan and Uganda	Specialists BH & HA with input from external experts	• Reports on the wiki • Action plans formulated per country coalition and integrated in annual country plans • Dgroup conversations • Individual contacts with PO's on specific issues
2012	Regional F2F BH & HA, Bangladesh	Relevant POs of coPrisma members and Regional Offices and relevant partners from Bangladesh, India, Nepal and Afghanistan	Specialists BH & HA with input from external experts	• Reports on the wiki • Action plans formulated per country coalition and integrated in annual country plans • Dgroup conversations • Individual contacts with PO's on specific issues
2013	Global F2F BH & HA	Relevant BH & HA PO's of coPrisma members and Regional Offices and coalition coordinators	Specialists BH & HA with input from external experts	• Reports on the wiki • Action plans formulated per country coalition and integrated in annual country plans • Dgroup conversations • Individual contacts with PO's on specific issues
2014	Three (3) Regional F2Fs in: • Uganda • South Africa • Bangladesh	Relevant POs of coPrisma member organisations and ROs and relevant partners from: • Ethiopia, South Sudan, Kenya, Uganda, the DRC and Haiti; • Zimbabwe, Malawi and South Africa; • Bangladesh, India, Nepal and Afghanistan	Specialists BH & HA	• Reports sent to all people present • Action plans formulated per country coalition and integrated in annual country plans
2011-2014	Three-monthly programme working group meetings at GO level	POs of coPrisma members	Specialists	• Minutes of the meetings sent to all coPrisma members
2012	Special training sessions were organised on e.g. measuring BCC		Together with Stop AIDS Now! (SAN!)	
2014	Youth friendly health Services – value clarification		Together with KIT	

- Lobby and Advocacy (L & A) and membership of Alliances and networks:
  - ICCO and coPrisma are members of several networks including the Dutch Coalition on Disability and Development (DCDD) and ShareNet, a knowledge platform on Sexual & Reproductive Health and Rights (SRHR). The ICCO and coPrisma representatives play active roles in these networks and are recognised for their expertise, especially because they represent a broad array of Dutch organisations, their Southern partners and experience gained in a large volume of projects.
  - L & A in relation to HIV / AIDS is mostly done through Stop AIDS Now! (SAN!). SAN! is an organisation established in 2000 by five Dutch organisations - the AIDS Fund, Cordaid Memisa, Hivos, ICCO and Oxfam Novib, aimed at harnessing Dutch expertise in strengthening the global fight against HIV / AIDS. SAN! represents ICCO (and coPrisma) in its lobby and advocacy interventions.
  - ICCO Cooperation furthermore has been active in L & A in the Netherlands on issues like HIV and AIDS, SRHR and the role of religious leaders.

3.2 Project portfolio

The programme consisted of 102 projects. Most of these projects have been implemented in the following twelve countries: Afghanistan, Bangladesh, India, Haiti, Malawi, South Africa, Zimbabwe, DR Congo, Ethiopia, Kenya, South Sudan and Uganda (82 projects). Most of the coPrisma related partners implementing these projects are collaborating in Country Coalitions, with the exception of Malawi, where partner organisations of ICCO and coPrisma have not established a country coalition. The project portfolio also comprises seven (7) specific HIV / AIDS projects funded by SAN![5] which are implemented by ICCO in collaboration with other non-ICCO Cooperation partners in East Africa and thirteen (13) support projects which include consultancies, research and contributions for memberships. The table below presents the financial volumes of these projects.

Table 4. Numbers and amounts of different types of projects

	No. Projects	Amount
Projects in 12 countries	82	€ 27,418,280
Specific SAN! projects	7	€ 407,788
Support projects	13	€ 985,291
Total	**102**	**€ 28,811,359**

Annex 8 presents an overview of projects and amounts per country, per organisation (coPrisma members and ICCO) and per intervention strategy as well as an overview of funding sources other than MFS: 57% of the funding of these projects is MFS funding.

The main interventions of the 82 projects have been categorised using the three frameworks (see paragraph 2.1) based on project plans and reports. Partners have not used these frameworks explicitly and therefore this categorisation is a post-hoc analysis. A detailed description of the interventions categorised in each of the three analytical frameworks is presented in Annex 9.

[5] These SAN! projects refer to a specific set of projects. Apart from this, there is also SAN! co-funding for several other projects. This is specified below. The support projects mainly include ICCO projects and coPrisma support projects for East Africa. coPrisma support for the other country coalitions is an additional amount of €120-140,000 (being 1% of the MFS amount and 2% of the coPrisma member financing from other sources).

The summary overview of all categorised interventions in the twelve countries and the totals of intervention sets are presented in Table 5 on the next page.

The overview shows that the total number of categorised interventions is 1,565. Of this broad set of interventions:

- 35.8% refers to the 'broad' *health workforce*[6]. These interventions include training of health professionals (including auxiliary health workers such as CHWs[7], TBAs and similar cadres – 108 interventions), training of other – mostly non-health professional – health workforce members including change agents and community committee members (294 interventions) and training of partner organisations' staff (recorded as organisational development – 61 interventions). 58 interventions referred to material development for training or other forms of knowledge transfer, while supervision and / or mentoring / coaching was recorded 39 times.
- 22.2% refers to *service delivery*: 42% of service delivery interventions referred to health promotion including BCC interventions, 36% to curative service provision including referral services, 16% to prevention and 6% to rehabilitation services.
- 17.3% refers to *Leadership & Governance*. The 83 L & A / inclusiveness interventions accounted for 31%, while the 127 interventions that had a bearing on 'the balance of politics and power' and accountability accounted for 47%. Interventions that included strengthening civic dialogue and other 'incentives' accounted for 23% of Leadership & Governance interventions.
- Interventions related to the provision of '*drugs, vaccines, new technology (equipment), transport and infrastructure*' and '*health information*' both accounted for 10.5% of the total interventions.
- 3.6% of all interventions related to *health financing* and comprises interventions related to livelihoods and establishing Village Savings & Loans Associations (VSLAs), other income generating activities (IGAs) and community-based health insurance schemes (50 interventions / 86% of health financing interventions); 14% of health financing interventions refers to cost recovery.

3.3 Evaluations

Eleven of the twelve Country Coalition programmes have been evaluated: Afghanistan was not evaluated because of the security situation and limited staff capacity. In Malawi the Country Coalition includes only ICCO partners (and not the two coPrisma partners), and in Haiti the 'coalition' is just two partners of the same coPrisma member (Woord en Daad).

Evaluation coverage of projects and evaluation quality are shown in the table below. In several countries[8], the evaluation of the coalition was combined with the evaluation of (some of) the projects, resulting in a combined report with annexes for each project. The coverage is the percentage of the financial volume that is covered by evaluations, which is 89%[9].

[6] The health workforce is understood as all people who contribute to health, hence is not limited to the professional health workforce and includes community volunteers, change agents, etc. who play a role in promoting health, social mobilisation and awareness raising.

[7] Community Health Workers have different job titles in many countries, e.g. Health Extension Workers in Ethiopia, Health Surveillance Assistants in Malawi.

[8] Haiti, Uganda, Kenya, Ethiopia, Zimbabwe, South Africa.

[9] And 76% of the projects. This implies that the projects that are not being evaluated are relatively smaller.

Table 5. Overview and total of BH & HA interventions per country categorised using the HSS framework[10]

	Leadership & Governance			Health Financing		Health Workforce					Drugs, equipment, transport and infrastructure				Health Information		Service Delivery				Total
Country	L & A	P&P	New incent-ives	Fees	Other	Knowledge & skills / training		Other		Org. Cap.	Infras	Supplies	Transport	Equipment	PME, exchange	Research / surveys	Prev.	Prom.	Rehab	Cura.	
						H. Prof.	Others	Mat. dev.	Superv.												
Afghanistan	8	0	2	2	0	4	7	2	0	3	0	?	0	?	1	1	1		2	4	37
Bangladesh	8	5	4	2	2	15	11	3	0	5	1	1	1	3	5	4	7	5	2	11	95
DRC	4	6	5	1	5	10	19	2	1	5	3	14	4	6	12	8	7	14	2	10	138
Ethiopia	5	16	5	0	13	7	33	2	3	4	5	24	0	3	9	2	5	20	3	18	177
Haiti	2	0	2	2	0	8	2	0	0	2	2	0	0	0	2	2	2	?	0	2	28
India	12	7	8	0	6	12	31	2	3	5	0	6	1	0	13	5	12	24	1	13	161
Kenya	10	12	3	0	6	9	42	2	0	7	3	12	0	0	6	0	1	15	4	15	147
Malawi	6	15	7	0	2	18	36	11	6	3	3	8	8	4	16	6	3	12	0	5	169
South Africa	11	20	8	0	7	2	35	6	4	12	3	7	0	1	7	6	6	19	5	12	171
South Sudan	2	7	1	1	1	12	16	1	4	4	2	7	0	2	2	2	5	5	0	13	87
Uganda	4	18	1	0	3	2	19	5	5	2	0	5	2	0	10	7	1	16	0	5	105
Zimbabwe	5	2	8	0	2	7	35	3	7	5	8	8	1	4	14	7	4	14	2	13	149
Regional	6	19	7		3	2	8	19	6	4	0	1	0	1	9	8	2	3	0	3	101
Total	**83**	**127**	**61**	**8**	**50**	**108**	**294**	**58**	**39**	**61**	**30**	**93**	**17**	**24**	**106**	**58**	**56**	**147**	**21**	**124**	**1565**
% per function	**31%**	**47%**	**23%**	**14%**	**86%**	**22%**	**59%**	**12%**	**8%**	**100%**	**18%**	**57%**	**10%**	**15%**	**65%**	**35%**	**16%**	**42%**	**6%**	**36%**	
Totals per function and % of total # interventions	**271 17.3%**			**58 3.6%**		**499 / 31.9%**				**3.9%**	**164 10.5%**				**164 10.5%**		**348 22.2%**				
						560 / 35.8%															

Legend:
L & A includes interventions aiming to increase inclusiveness
P&P: Interventions targeting politics & power which include accountability
H. Prof: health professionals
Mat. Dev.: Materials development
Superv.: supervision & mentoring
Org. Cap: Organisational capacity
Infra: infrastructure (construction and maintenance)
Prev.: Preventive
Prom: Health promotion
Rehab: Rehabilitative services
Cura: Curative services

[10] The BCC and capacity development matrices have been merged into the HSS matrix

The quality of the evaluations was assessed using eight criteria. Each evaluation was scored using a scale from 1 (red - poor) to 4 (green - excellent) for each of the criteria. The criteria most important for validity and reliability include those about data, analysis and findings. The evaluations score an average of 2.4 for these criteria, which is about 50% of the maximum score (between 1 and 4). Table 6 on the next page shows wide differences both in coverage and in quality of evaluations. The performance of the organisation in evaluations is calculated by multiplying the percentage coverage and the average evaluation quality and the organisations are given a rank from highest (1) to lowest (13) performing.

ICCO's evaluation coverage is lower than that of coPrisma members. One of the reasons is probably that ICCO's contribution to partners is often a small percentage of the partner's budget, which means they can make less demands. Another reason is that coPrisma combined evaluations in several countries covering all projects at once, which led to a high coverage but negatively affected the evaluation quality. Coverage is generally less among the organisations that have more projects in the programme.

Table 6. Evaluation coverage and quality

	No. projects	No. Eval.	Evaluation quality	Financial coverage	Performance rank[11]
coPrisma	**67**	**55**	**2.4**	93%	
Bijzondere Noden	2	2	2.3	100%	6
Dorcas	9	8	2.0	99%	9
De Verre Naasten	3	3	2.3	100%	5
Gereformeerde Zendingsbond	4	4	2.1	100%	8
Leger des Heils	1	1	1.9	100%	10
Light for the World	5	5	2.7	100%	2
Leprazending	5	5	2.6	100%	3
Operatie Mobilisatie	1	1	2.3	100%	6
Red een Kind	9	7	2.7	92%	4
Tear	12	8	1.9	76%	13
Trans World Radio	5	4	1.9	87%	11
Woord en Daad	11	7	3.0	88%	1
ICCO	**15**	**7**	**2.4**	67%	
ICCO	15	7	2.4	67%	12
Total	82	62	2.4	89%	

There is a relation between coverage and quality. Several countries have asked one single evaluator to evaluate all partners' projects. While this worked well in South Africa and Zimbabwe, it did not work well in DRC, Ethiopia, Uganda and Kenya. On average the quality of project evaluations that were done by one evaluator scored a 2.0 and those that were done by different evaluators scored higher at 2.9. The actual reason might not be the fact that they were done by the same evaluator, but the quality of the selected evaluator and the very few days assigned per project: some evaluations were really not more than a brief field visit with a few discussions with some groups of people; much content was

[11] To obtain this rank, the percentage coverage was multiplied with the average quality. The highest resulting number received rank 1, etc.

copied and pasted between projects and in some countries (notably DRC) the conclusions and recommendations for all projects were almost identical.

Annex 10 presents a further analysis of evaluation quality for each of the eight criteria per country, as well as differences between evaluations of coalitions and those of projects. Overall, the coverage of evaluations is very good and the quality of evaluations is modest, with several very poor evaluations (especially the combined evaluations) and few very good exceptions.

4 Findings and analysis related to Relevance

This chapter presents the findings and analysis related to the relevance of the programme.

4.1 Alignment

4.1.1 Alignment to beneficiaries' needs

The reviewed evaluations provide little to no indication that beneficiaries of project interventions were consulted or involved in the planning of the projects. However, there is no doubt that the chosen interventions were relevant in the given contexts: most interventions supported and / or implemented were in line with internationally identified needs defined in the Millennium Development Goals (MDGs) – especially the direct 'health' related MDGs 4, 5 and 6[12] and major Global Health Initiatives (Global Fund against HIV, TB and Malaria – GFATM, the Global Alliance Vaccine Initiative – GAVI, Worldwide Elimination of Leprosy and Vision 2020, the Global Initiative for the elimination of avoidable Blindness).

At country level the projects were generally aligned to national policies. However, beneficiary needs were not really assessed; rather, implementing partners continued project activities they were involved in prior to the MFS II funding cycle or involved project target groups in the implementation and monitoring of project activities.

What is clear and relevant is that many implementing partners have moved away from direct service provision to supporting and facilitating health service delivery through capacity development interventions targeting the 'implementers' and a focus on strengthening the capacity of community structures and interest groups enabling them to demand accountability and promote inclusion of marginalised groups. In a number of countries, new and relevant approaches were introduced to involve a larger and broader constituency in health promotion and prevention, i.e. the Safer Practices, Access to Treatment, Voluntary Counselling & Testing, Empowerment (SAVE) approach to address HIV and the Church & Community Mobilisation Process (CCMP) approach that aims at harnessing church leaders and groups as well as other community structures in addressing determinants of health and drivers of ill-health and promoting healthy lifestyles as well as addressing stigma and discrimination of marginalised groups.

4.1.2 Gender and rights based approach

The ICCO Cooperation has presented a clear position paper on the Rights Based Approach (RBA)[13] and provides Country Coalitions and local partner organisations with an overview of issues with regard to the application of the RBA in the BH & HA programme with special attention to the promotion of basic health and SRHR. In its RBA paper, the ICCO Cooperation emphasises its focus on:

- *"Those marginalised and/or excluded and therefore on addressing structural and root causes of marginalisation/exclusion*
- *Equality and non-discrimination*
- *Empowerment*
- *Participation*
- *Accountability of governments, health care providers and other stakeholders, upwards and downwards*

[12] MDG 4: Reduce Child Mortality; MDG 5: Improve Maternal Health; MDG 6: Combat HIV, Malaria and other diseases

[13] ICCO (2012)'The Rights Based Approach (RBA) in the Basic Health & HIV Programme of the ICCO Alliance', Utrecht

- *Community and the inter-relatedness of human-beings."*

Specifically with regard to SRHR, the ICCO Cooperation's position is as follows:

"The ICCO Cooperation prefers an approach towards family planning and contraception which is based on responsible and informed choices. We advocate a balanced approach, reflecting both on general Christian principles (like protection of life of mother and child, responsibility for family and its environment) as well as at the role of couples in being responsible for the size of their own family and what planning method is most appropriate. Also unmarried people need guidance in this area."

The position paper also addresses the dilemmas in applying the RBA for its partners and specifically gives nuances to issues presented in coPrisma's 2009 position paper 'Procreation'[14]. Pro-Creation is a clear document outlining the key principles of coPrisma with regard to SRHR which are founded in Christian norms and values: "*coPrisma advocates for responsible and informed choices, choices that originate from biblical norms and values*" (p. 9). The document emphasises the 'family' as key and coPrisma's support of an "*approach of public righteousness that also stresses the responsibility of vulnerable persons and of social actors for vulnerable persons and groups, not least the churches in addition to governments. … An approach based on* [only] *individual rights of a person does not do justice to cultural reality within which people live".* While the ICCO Cooperation policy paper is a joint document intended to be sufficiently broad to incorporate the differences in norms and values, the differences between the organisations are still evident. These differences could have led to conflicting family planning and other SRHR interventions within Country Coalitions, although the evaluation reports do not mention such conflicts: this is likely related to the fact that coPrisma members and their partner organisations were prominent in the BH & HA programme implementation and most Country Coalitions comprised of coPrisma members' partners only. Of importance is that the joint discussions have led to a gradual convergence on specific issues and has resulted in a shift of opinions and practices of many partner organisations, for instance on comprehensive sexuality education.

Some of the policies have been developed utilising findings of studies conducted to clarify different perspectives, e.g. the study on perspectives and practices with regard to Family Planning (FP) in DRC, Ethiopia and Malawi[15]. The study findings present a distinction between FP - for married couples - and Pregnancy Prevention Methods (PPM) - for unmarried people. The suggestion that women should preferably be accompanied by their partner / husband is obviously important to promote openness about FP. Yet, this requirement affects women's possibility to make their own well-informed and voluntary decisions.

Most key informants represented coPrisma members and generally indicated that the RBA and to a lesser extent the Gender-Based Approach (GBA) has been given limited to no attention in project implementation. This lack of attention may explain why regional initiatives such as EHAIA's work with theological institutions on inclusion of people with different sexual life styles and the 'Called to Care' booklet series developed by Strategies of Hope were not mentioned in evaluation reports. The Called to Care evaluation report provides excellent guidance to various religious groups in discussing issues on HIV / AIDS and contributing to talking openly about HIV / AIDS, sex and reducing related stigma. However, and despite the fact that the reports / booklets developed by the regional initiatives have

[14] coPrisma (2009) Pro-Creation. coPrisma Vision Paper on Sexual and Reproductive Health and Rights (SRHR). Hands up for Health. Utrecht

[15] Cornielje M, Dingemanse-de Wit G, Smilde W, Velema J (2014) Family Planning choices within marriage and before. Practices, perspectives and potentials in faith-based Family Planning programs in DR Congo, Ethiopia and Malawi. Alphen aan de Rijn

been presented in all the F2F meetings (key informants) no reference was found in any of the evaluation reports.

Country Coalitions and partner organisations have largely ignored the more contentious issues of the RBA and were quoted as saying that they 'agreed to disagree', for instance on issues related to the Lesbian, Gay, Bi-sexual and Transgender (LGBT) community and condom use by youth (key informants). This lack of attention likely resonates the thinking of project countries' populations, which may exhibit a lack of tolerance for people who make different choices than is common in communities.

That said, a number of countries (e.g. Afghanistan, Bangladesh, India, Uganda, Malawi and Zimbabwe) have successfully focused on the inclusion of marginalised groups, such as people with disabilities, people with leprosy and people living with HIV / AIDS. Hence, although the RBA has not been applied explicitly, many projects have undertaken interventions that fulfil the broad 'right to health care' objective of the BH & HA programme.

If applied, the GBA has been given a very local translation in Country Coalitions and by local partners and mainly focused on women's access to health rather than addressing unequal gender relations in decision making and unequal representation in public fora. In a number of countries (e.g. Malawi, South Africa, Zimbabwe and Afghanistan), activities have focused on involving men in Antenatal Care (ANC) visits as well as on issues related to gender relations such as masculinity (South Africa). Of interest is that women have a very limited voice in some of the Country Coalitions (Bangladesh and Afghanistan), while in other countries the representation of men in Village Health Committees (VHC), established with support of partner organisations, is dominant: women are largely absent in such committees (Uganda, Malawi and South Sudan).

4.1.3 Alignment to the core principles of the MASP 2020

The MASP 2020 was developed and presented in 2012. Hence, alignment to the MASP could only be evaluated from its introduction in 2012. That said, the results achieved by the BH & HA programme have contributed to Securing Sustainable Livelihoods and Justice for All: 'health'[16] is considered a global public good and individual good health is imperative to achieving a productive life while public health interventions focus on the promotion of healthy lifestyles and effective public health interventions aimed at the prevention of disease and ill-health.

The BH & HA programme has had a bearing on livelihoods by ensuring that disease and ill-health of individuals and caregivers of people affected by ill-health, HIV / AIDS or disabilities were addressed allowing them to participate in productive / income-generating activities. For instance, the eye care projects have given caregivers of people with poor eye sight the opportunity to (re-)engage in the productive workforce; preventive activities related to the utilisation of pregnancy care / improving health seeking behaviour contribute to improved pregnancy outcomes and a reduction in the occurrence of adverse effects due to obstructed labour such as obstetric fistula, which affect women's potential in engaging in productive activities because of stigma; projects targeting the reduction in

[16] The World Health Organisation defines health as follows: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." WHO (1948) Preamble to the Constitution of the World Health Organisation as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organisation, no. 2, p. 100) and entered into force on 7 April 1948. Geneva

stigma and discrimination of people living with HIV / AIDS (PLWHA) and people / children with disabilities (PWD / CWD) allow these marginalised groups to lead productive lives.

The BH & HA programme activities have also contributed to ensuring that people have access to good quality health care, a recognised human right embedded in ICCO Cooperation's Justice for All principle. Examples of such interventions refer to activities focusing on strengthening accountability mechanisms through the establishment of effective community structures, the inclusion of marginalised groups by reducing stigma and marginalisation and the support rendered to health facilities in remote rural areas.

In essence, the health programme has promoted interventions that are in line with the post-MDG agenda that focuses on Universal Health Coverage (UHC), Health in All Policies (HiAP) and achieving the Sustainable Development Goals (SDGs): health will remain prominent in the post MDG agenda. Some examples of relevant project activities implemented in MFS II that have a clear link with the post-MDG agenda as well as the core principles of the MASP 2020 include various interventions that support interest groups in establishing livelihoods projects (e.g. Zimbabwe, DRC, Ethiopia and South Africa), the CCMP approach that addresses health in the broad sense and focuses on the role of different groups in society on health in general, not only on the health sector (Zimbabwe and Uganda) and the right to inclusion of marginalised groups (Bangladesh, Afghanistan and India).

4.2 Appropriateness

4.2.1 Appropriate support offered

The ICCO Cooperation has made substantial efforts to provide support to the implementation of the BH & HA programme. The various policy and guidance documents, where relevant developed separately by coPrisma, and the organisation of regular F2F meetings is evidence of this support as well as the regular programme meetings bringing together representatives of the coPrisma members and the ICCO Cooperation health advisors.

The PA guidance paper, the Indicator Reference Sheets and various data collection tools have been mentioned by key informants as support documents that have contributed to partner organisations' general and PMEL capacity. However, the PA has not been fully understood by all Country Coalitions that would have benefited from further guidance after the initial orientation on PA (e.g. Bangladesh and Malawi).

Annual plans have been discussed with coPrisma members and the F2F meetings have generally been rated as useful in exchanging experiences and learning. In general, ICCO has been perceived as working at a different level and being more distant from actual implementation.

The coPrisma members have supported a substantial number of training workshops for partner organisations – in total, 61 organisational capacity development interventions have been identified (also Rf. section 3.4 Project portfolio). Topics that have been addressed in the training sessions, on occasion facilitated by external experts, included networking, fundraising, PMEL, the PA, the ToC and L & A. Despite the many efforts to develop partner organisations' capacity, a disconnect between developed instruments and support provided is visible as the outcomes of support meetings did not lead to the revision of policies or the development of tools and left Programme Officers (POs) and partner organisations free to apply policies and tools as they felt appropriate. It is also unclear to what extent health related policies developed by individual coPrisma members (which were not shared) differ from the ICCO Cooperation policies.

4.2.2 Appropriate choices in context

The overview of the overall project portfolio (comprising 1,565 separate interventions) shows that interventions related to the health workforce, service delivery and leadership & governance functions were most prominent (see paragraph 3.2 for details).

Given the profiles of project countries (five profile 1 / low-income countries, five profile 2 / fragile states and two profile 3 / emerging economies), the available capacity to address social determinants of health and drivers of ill-health and the prevalence of diseases, this choice of interventions can be considered appropriate.

The interventions were also in line with the Primary Health Care (PHC) approach and nationally defined Basic Packages of Health Services / Essential Health Packages. Almost half of the 'service delivery' interventions referred to interventions targeting health promotion (42%). To facilitate health promotion interventions, the ICCO Cooperation has targeted many people to be 'trained' to act as Change Agents, including people living with specific conditions (e.g. PLWHA, PWD / CWD, Leprosy Affected People - LAP), women, adolescents, teachers and health care providers. Although people from various groups were trained as change agents, the ICCO Cooperation has emphasised working with religious leaders as Change Agents as these are often 'natural' partners of ICCO Cooperation and have a wide reach in communities where ICCO Cooperation partner organisations implement projects.

In general, the evaluation findings demonstrate that religious leaders have made important contributions in reducing stigma and silence around critical issues such as gender inequality, openness on sexuality, family planning and acceptance of PLWHA. However, religious leaders have generally paid little to no attention to changing attitudes and increased acceptance of members of the LGBT community, which remains a contentious issue in various churches as well as in a number of project countries (e.g. Uganda, DRC and Malawi).

In general, Regional Offices and coPrisma members have played a positive role in learning and exchange of experiences to ensure that project interventions are 'fit for purpose' in the implementation context. The twelve Country Coalitions have each received support from the selected 'lead' coPrisma member. In general this support revolved around programme management issues including reporting and other PMEL activities: this division of labour can be considered appropriate.

The pilot Programmatic Approach, Co-responsibility, Decentralisation (ProCoDe) in Central and East Africa aimed at exploring opportunities for coPrisma members (and Edukans) to jointly participate in the ProCoDe process started by ICCO / KiA in 2007. The partner organisations in Kenya, Ethiopia and Uganda are generally positive about the effects of the increased collaboration between ICCO and coPrisma, especially because of the emphasis on learning and sharing and the opportunities for joint fundraising. However, the decision was taken to stop the pilot because of lack of efforts to harmonise systems and approaches. This was said to be related to the coPrisma members' lack of a systemic approach – "*the coPrisma members remain too focused on projects and maintaining relations with the churches*" (key informant) – and the lack of interest in 'politics' and strategic thinking with regard to collaboration with non-Church related actors, which is one of the reasons that there was little attention for L & A among coPrisma members and their partners.

Many partner organisations continued already existing project interventions with new (MFS II) funding as well as funding from other donors. This has meant that intervention strategies were not always reviewed / revised before the start of the MFS II funding cycle based on updated context analyses. An important change was realised in the implementation of activities: a substantial number of partner

organisations moved away from health service delivery and provided support to and facilitated civil society structures in the implementation of activities. This change allowed local civil society to determine the most appropriate interventions in their context, but has in certain situations also resulted in inadequate attention to addressing cultural sensitivities. For instance:

- The restrictive legal limits with regard to condom use in DRC – 18 years – were not addressed in L & A interventions despite the high incidence of teenage pregnancies;
- In Kenya, the lack of Youth Friendly Health Services was not addressed;
- The exclusive focus on condom use by HIV discordant married couples in Uganda negates the existence of a need for adolescents and unmarried couples to access condoms, especially in light of the high HIV prevalence;
- In India, the exclusive focus on members of the religious community as change agents and the continued use of words like 'sinful acts' and 'wrong' in relation to PLWHA shows a lack in cultural sensitivity.

4.2.3 Relevant Theory of Change

For many partners it has been difficult to find the match between their projects and the ToC of the programme. The BH & HA programme's theory of change was not appropriate with regard to the following issues:

- Health service provision is not included in the ToC with the exception of the provision of preventive services. In reality access is not only increased by improving health seeking behaviour, but also requires that people have improved access to curative, preventive and rehabilitative services for health promotion to be effective. The fact that five of the twelve project countries are ranked as fragile states and have serious challenges in meeting the most basic health needs has obviously not been considered in the development of the ToC.
- L & A for accountability has hardly taken place, except at very local levels in a few projects. Although cooperation with government was largely forged and strengthened, the focus of L & A interventions lacked a focus on improving access to and the quality of service provision by the government. In projects with L & A / Policy Influencing interventions, the focus was mostly on inclusion of 'marginalised' groups.
- Change agents have not exclusively focused on breaking silence and reducing stigma, but also on health promotion including encouraging appropriate health seeking behaviour, raising health awareness, social mobilisation for increased utilisation of available preventive services, behaviour change, adherence to Anti-Retroviral Therapy (ART) and positive living.
- Capacity development of interest groups has largely focused on empowering the members in livelihood and income generation rather than providing support to interest group members in becoming effective advocates.
- Investments in human resources for health have not focused on supporting the development of appropriate health workforce policies, but a much broader set of issues with a clear emphasis on health and professional knowledge and skills' transfer through training workshops.

The perceived 'awkwardness' of the ToC has resulted in mixed experiences with the ToC. A number of Country Coalitions did not really develop a contextualised ToC, but pulled together the already developed logical frameworks in an adapted ToC format (DRC, Kenya, Malawi, Bangladesh and Haiti), while other Country Coalitions have had positive experiences in improving their understanding of and in developing / regularly revising their own ToC (India, Uganda and South Sudan). The introduction of change agents has been the most commonly used ToC pathway in partner organisations' projects,

while community participation and capacity development for inclusion also feature prominently in projects.

That said, almost all country coalition leads indicated that the Country Coalitions and partner organisations increasingly appreciate the value of and consider the ToC concept appropriate (key informants).

4.3 Capacities

All Country Coalitions were established at the start of the MFS II funded BH & HA programme and have encountered challenges in coordinating partner organisations and collaborating in the development and management of a joint country programme. The PA and the ToC concepts were new for most Country Coalitions (and Dutch coPrisma members). The Country Coalitions' capacity to manage country programmes has been the subject of many support activities undertaken by the Regional Offices and country leads as well as the F2F meetings. Capacity challenges related to PME and L & A activities have been especially important and have been addressed in many regional and F2F meetings.

The reviewed evaluation reports provide very limited insight in strengths and capacity challenges of Country Coalitions and partner organisations. Organisational scans (O-scans) undertaken in 2011 to establish the 'capacity' baseline of every partner and repeated in 2013 were not referred to in evaluation reports and seem not to have been used for specific capacity development initiatives. Hence it is difficult to state that projects generally corresponded with the strengths of the many partner organisations. This may also be related to the fact that many partner organisations' projects had been initiated well before the MFS II funding cycle and were continuations of the same projects; because of this, the capacity / strength of the partner organisations may have been taken as a given. This is especially true for projects of specialised organisations which built on experience gained in project interventions that commenced prior to the start of the MFS II funding cycle and their established strengths, e.g. the Leprosy, Disability Care, Eye Care and HIV projects in countries with a high prevalence or a substantial caseload of leprosy, disabilities, eye problems and HIV.

Key informants indicated that ICCO partners are generally stronger and have more capacity in programme management processes including PME. Country Coalitions that comprise at least one member active at national level have generally performed better than those Country Coalitions comprising organisations that work at community / local level (Key informants).

Many of the organisational capacity development interventions targeted L & A, PME and general project management capacity of partner organisations because of evidence that partner organisations' capacity in conducting interventions related to L & A and livelihoods / IGAs and in general project management (administrative and financial management, reporting and other PME activities) were found to be inadequate. However, although L & A is an important pathway of the ToC and much attention was given to strengthening partner organisations' capacity, L & A capacity remains mediocre. The capacity of partner organisations to look beyond their direct project horizon (health, which in many cases is understood to refer to health care provision only) and focus on multi-stakeholder approaches in health has also remained inadequate: evidence can be found in project attempts to undertake livelihood interventions / IGAs, which were often based on very naïve concepts, were set up in isolation and showed a lack of business insight.

Of interest is that in a number of countries, partner organisations still include a 'charitable' approach and continue to provide hand-outs to targeted beneficiaries as part of their project activities. In one

country, Ethiopia, this may be explained by the fact that the government requires that 70% of project funds is spent on implementation.

4.4 Collaboration

The ICCO Cooperation has been active in networking and sharing experiences gained in MFS II funded projects at different levels in the Netherlands. The membership of the ICCO Cooperation health advisors in various platforms on SRHR including HIV / AIDS, the health workforce and health financing are testimony to this. ICCO Cooperation staff members have also played an important role in general discussions around the management of MFS II funded projects. ICCO and coPrisma members' regional offices have been involved in networking with other MFS II consortia / alliances to share experiences and for learning.

The collaboration of Country Coalition coordinators and partner organisations with non-health stakeholders has generally been good. Collaboration with local and central health authorities have generally been forged, although the collaboration with government institutions could have been more prominent, especially the relationship between Country Coalitions and the MoH, given that the MoH has the general mandate to ensure harmonisation of approaches and the coordination of partners in health.

Little to no mention is made of Service Level Agreements (SLA)[17], which are often available and enable Church-owned health facilities to provide free health care to specific target groups, such as pregnant women, children, people living with HIV, etc.

In many cases parallel or complementary systems were established or maintained, largely because the capacity to apply existing systems were considered inadequate or because projects were embedded in local networks and encountered challenges in their collaboration with local authorities. Instead of developing a systemic approach to strengthening of the prevailing systems, the approach rather focused on gap-filling. For instance, few partner organisations strengthened the capacity of already available community workers involved in health promotion; instead, organisations opted for the training of 'new' change agents. In Bangladesh and India partner organisations continued project interventions despite the fact that the MoH had taken specific disease control programmes out of the basic health care package because of low incidence / prevalence (e.g. Leprosy interventions).

The supportive F2F meetings have brought partner organisations from different Country Coalitions together at regional level which has offered opportunities to discuss pertinent issues with regard to programme approaches and management issues as well as sharing and learning.

In certain countries, the level of collaboration between government institutions and the partner organisations has been limited, largely because the government has inadequate capacity or willingness to provide health services, e.g. DRC, Haiti and South Sudan. In other countries, collaboration between partner organisations and health authorities has been excellent, while Country Coalitions did not make in-roads in strengthening collaboration at national level, e.g. Kenya and DRC.

Collaboration with other NGOs, church leaders and groups, schools and teachers, community and traditional leaders, community structures and self-help / interest groups, etc. on (health) education

[17] Or comparable contracts between MoH and Private-Not-For-Profit (PNFP) organisations aimed at harnessing available health provision capacity for achieving Universal Health Coverage) and ensure that the PNFP facilities can provide free health services to priority population groups (especially under-fives, pregnant women, people with TB, HIV / AIDS and malaria)

and social welfare initiatives has generally been good. Unfortunately, collaborative efforts to harness experience in livelihoods initiatives has been less successful. Of note is also that collaboration between partner organisations and other NGOs may have been influenced by competition in acquiring project funding to sustain the partner organisation (e.g. in DRC, Bangladesh, Zimbabwe and Malawi).

4.5 Conclusions about relevance

The table below shows the final assessments (on a scale of 1 to 4) for the judgement criteria related to relevance. These judgement criteria were defined in the evaluation framework. A complete overview of judgement criteria and their assessments is found in Annex 11.

Table 7. Assessments on judgement criteria for relevance

Questions and Criteria	IC	PO	CC / partners	Average
Relevance				
To what extent is the BH & HA programme designed to contribute to equally accessible and resilient health systems in rural areas, especially for poor people, vulnerable to and living with HIV and/or other diseases.	2.8	1.8	2.6	2.7
Judgement criteria				
1. The intended changes contribute to the two core principles Securing Sustainable Livelihoods and Justice for all of the ICCO Cooperation MASP2020 (programme is relevant in the light of this new policy).	3.5			3.5
Health is a precondition for Securing Sustainable Livelihoods; access to health care is a basic human right and is within remit of 'Justice for All' core principle. However, on occasion the very poor are excluded.				
2. Appropriate guidance, support, policy instruments, tools, expertise and reflections were offered to facilitate the relevance of interventions.	2.5	2.0		2.3
Findings show a disconnect between instruments developed by IC and the support provided by POs to partners; F2F meetings good, but often too general and outcomes not translated into policies and tools, so POs and partners are free to apply or not to apply policies and tools. Specific health-related policies of coPrisma members not shared, so unclear whether these are different from IC policies.				
3. Programmes are designed in alignment with identified beneficiaries' needs.			3.5	3.5
Health needs have often not been ascertained prior to start of interventions, but are generally coherent with globally defined priorities. Hardly involvement of beneficiaries in identification of needs.				
4. The choices of programme interventions, approaches, and the values behind the interventions are appropriate in the specific context, based on an analysis of this context and show an optimal balance between cultural sensitivities and meeting programme objectives.	3.0	2.0	2.0	2.3
The IC has developed well-balanced policies, but often considered too 'Western'. Partners are better rooted in specific contexts, but critical reflection on drivers of ill-health and socio-cultural factors that contribute to poor health often lacking. Interventions often continuation of projects implemented prior to MFS II. At partner organisation level, support processes aimed at matching of partners' work to IC policies.				
5. The theory of change of the programme is relevant in the contexts where the programme is implemented.	2.0			2.0
Suitability of ToC limited in fragile states where (curative) service provision is relevant. Health workforce very relevant in most contexts but given little attention. ToC outcome pathways too specific and narrow. Results Framework does not really reflect ToC thinking.				
6. The choices of programme interventions corresponded with the specific strengths of partners and stakeholders.			2.5	2.5
Relatively many specialised organisations with extensive experience and capacity: leprosy, disabilities, eye care, some HIV / AIDS. Several health providers already involved for long time, while other partners weaker. Capacity for livelihoods interventions often low. ICCO partners are often large and respected organisations with adequate capacity. Capacity for lobby and advocacy has generally remained low. Country Coalitions have grown stronger and function better if a member partner organisation works at national level. Evaluations contain little information about partner organisations' capacities.				

Questions and Criteria	IC	PO	CC / partners	Average
7. Collaborations with health and non-health stakeholders have made the programme more relevant. This includes collaborations at various levels as well as linkages between those levels.	3.5	?	3.5	3.5
At IC level extensive efforts at networking with many linkages forged with (health) education and social welfare initiatives; less closely linked to interventions to improve food security in general. Evaluations provide inadequate information on efforts to really forge cooperation with other players. Most partners have established relevant collaboration at many levels with various stakeholders and no longer work in isolation.				
8. The gender and rights based approach principles are embedded in BH & HA programme policies, plans and implementation.	2.5	1.5	1.5	1.8
At IC level, the GRBA well integrated in policies, but inadequate attention given to weaknesses in partners' understanding of GRBA. At Dutch coPrisma members' and partner level there has been resistance to RBA, partially related to use of the term, but also disagreement on a number of contentious issues. GRBA largely focused on service delivery and / or self-empowerment, in certain cases more charity based and / or patronising ('we empower you') rather than focused on claiming rights. GBA: focused on women, only few in-depth analyses mentioned, but often superficial application (e.g. husbands accompanying wives to ANC or counting women involved / reached).				

5 Findings and analysis related to Effectiveness

This chapter presents the findings and analysis related to the effectiveness of the programme.

5.1 Achieving objectives

The three paragraphs below present the three main objectives of the programme and their realisation. For every objective the pathways of change as elaborated in the result frameworks are shown in a figure. The first level of results (output of the ICCO Cooperation) has not been monitored adequately and is therefore not included in this report. Only the other two levels are included: output of the partner and outcomes at the level of target groups.

5.1.1 Accountability mechanisms

The first main objective of the programme speaks about demanding accountability from government and relevant stakeholders. In practice, the result framework assumes three very different pathways of change, as shown in the figure at the left.

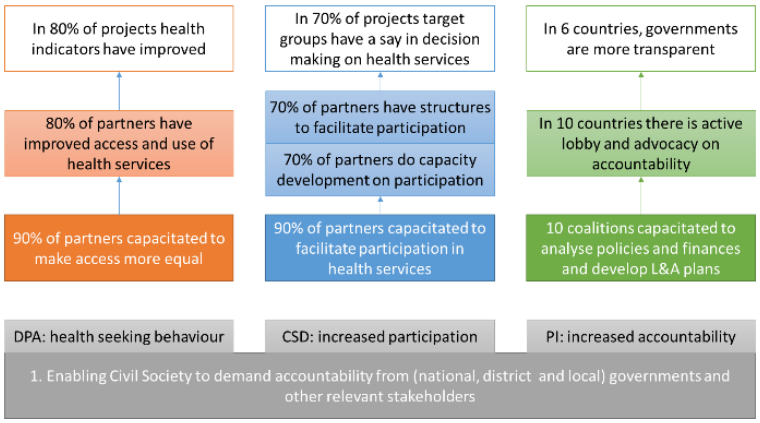


Figure 1 Result framework for objective 1

The table below presents the assumed pathways of change for this first objective as well as a summary of ICCO's own monitoring data from 2011 to 2014, compared with the findings from this evaluation.

Table 8. Theory and practice related to the first main objective

Objective 1 "Enabling Civil Society to demand accountability from governments and other relevant stakeholders"		
Direct Poverty Alleviation: "Health seeking behaviour"		
Logic: Partners capacitated to make access more equal -> partners have contributed to improved access and use of health services -> health indicators have improved		
Output partners	*Reported by ICCO Cooperation* Partners have improved access and use of health services *Target "80% of partners". Reported 53 of 76 partners = 76%*	*Found in the evaluation* Categorisation[18]: 66 projects mention offering preventive, 30 curative, 18 referral and 8 rehabilitation services. 46 projects mention health promotion. Evaluation reports: - Many projects have improved access and / or utilisation (health seeking behaviour). Sometimes, figures are presented that show increase in antenatal consultations (e.g. in DRC and Ethiopia), but in other cases no such data are shown (e.g. Uganda and India). - There are also many ongoing projects of health provision (e.g. in Bangladesh, DRC, South Africa[19], Kenya, Malawi and Haiti) where most resources are used to maintain access rather than increase it. - There are also several barriers to access, such as poorly performing health workers (1 health centre in DRC) or cost

[18] See paragraph 3.2. All project numbers refer to the 82 projects included in the project portfolio.

[19] Some projects in South Africa reported on this result with the contextualised indicator "Number of volunteers active". This is an example where it is unclear how this is related to "improved access and use of health care".

		barriers (noted in DRC, but also likely in projects in e.g. Bangladesh, India, Uganda and Afghanistan). In Ethiopia, health seeking behaviour improved, but referral and / or availability of health care is insufficient to meet this increased demand. - Increase of access through L & A is rare. Only in Zimbabwe, a nurse was seconded as a result of local level lobby. Improving access is almost always done by offering health services. The results framework and policy documents hardly mention this option, which in terms of resources makes up a large part of the programme.
Outcome target groups	*Reported by ICCO Cooperation* Health indicators have improved *Target "80% of projects". Reported 42 of 74 projects = 57%*	*Found in the evaluation* - Generally, accurate information on health outcomes is missing. Some only report the % HIV+ tested of the total number tested in their own VCT programme or other unreliable measures. - One large survey in Bangladesh (3,456 households) suggests decreased mortality. Some report provincial level HIV prevalence rates or the number of AIDS related deaths (e.g. Zimbabwe) that are declining. Some clinics (e.g. Kenya) report lower occurrence of some diseases among their patients (malaria, typhoid). - In many projects, improved health can be assumed, e.g. with increased use of health care or home based care for PLWHA. - In some cases, partners contextualised this indicator as "*people have access to external resources*" or "*people have access to information about SRH*" or "*communities indicated that there are changes in vulnerable groups*" (notably South Africa).
Conclusion: Access and use of health services has increased. There is little to no evidence that health outcomes have improved.		

Civil Society Development "increased participation"		
Logic: Partners capacitated to facilitate participation -> partners support capacity development on participation or have structure for participation -> target groups have a say in decision making on health services		
Output partners	*Reported by ICCO Cooperation* Partners do capacity development on participation or have structure for participation. *Target "70% of partners". Reported 34 of 48 partners support capacity development (71%) and 20 of 33 partners have structures for participation (61%)*	*Found in the evaluation* Categorisation: 21 projects mention working on organising or strengthening various health committees and 13 work with administrative committees. Evaluation reports: - Most partners that provide health care have some sort of structure already. Not all projects actively develop capacity of these structures. - Capacity development of such groups is done by many partners. This includes provider and community based groups. This was seen in DRC, Bangladesh, Malawi, Afghanistan, Uganda and India. In South Africa only one ICCO partner includes this (PACSA). - In some cases, capacity development for participation in health is done through multi-purpose groups, such as self-help groups (SHG), e.g. in Bangladesh. One large project in Bangladesh aims to hand over fourteen health centres to community committees. - In some cases, specific opportunities for participation are missed, e.g. in Ethiopia projects work on youth corners in health centres and with youth groups in communities, but do not link the two to increase youth participation in these health centres.
Outcome target groups	*Reported by ICCO Cooperation*	*Found in the evaluation* - Very few had instruments to measure this (only in Malawi with scorecards), but some evaluations give examples that show that people had more voice in decision making: in DRC committees are

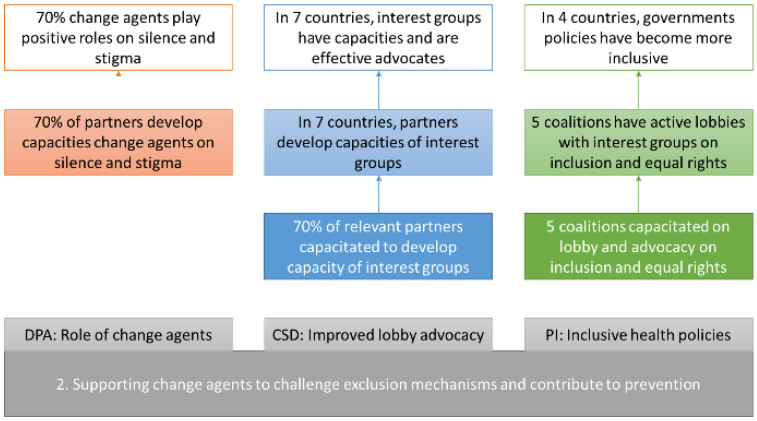
	Target groups have a say in decision making on health services. *Target "70% of projects". Reported 34 of 60 projects = 57%*	involved in staff recruitment (but were unable to force the removal of a non-performing nurse), in Bangladesh, committees will take over fourteen health centres, in Kenya, CHWs were given more voice in health services. - In many other projects that work with community or facility committees, increased influence in decision making can be assumed. Reporting is mainly based on assumptions.
Conclusion: Participatory structures have been strengthened and in some cases there are examples of increased influence in decision making.		

Policy Influencing: "increased accountability"		
Logic: Coalitions capacitated on lobby and advocacy -> active lobby and advocacy on accountability -> governments are more transparent		
Output partners	*Reported by ICCO Cooperation* Coalitions have active lobby and advocacy on accountability. *Target "10 coalitions". Reported 8 (!)*	*Found in the evaluation* Categorisation: 7 projects mention activities of monitoring or supervision of government health provision. Evaluation reports: Several coalitions made joint lobby plans, but most of these were rather naïve, too broad, not sufficiently harmonised between partners and often a mismatch between the scale of interventions and the ambitions for lobby (often causing a lack of viable connections and linkages). In some cases (e.g. Kenya and DRC) the L & A plans were not implemented. Exceptions are Bangladesh, India and Uganda where some joint lobby efforts have taken place. In other countries L & A has largely taken place at very local level, making joint effort with the country coalition less obvious. Specifically on lobby for accountability: in Bangladesh, there is cooperation with the BOOM platform which addresses this issue; in Uganda consumer groups and other committees are likely to demand greater accountability; in India this is done at local level; in South Africa the CBOs trained by PACSA and the members of AFSA could be involved in such lobby but this is not reported on. For other countries we did not find this.
Outcome target groups	*Reported by ICCO Cooperation* Governments are more transparent *Target "10 coalitions", Reported 0*[20]	*Found in the evaluation* No information provided. It is very unlikely that governments have become more transparent as a result of this programme.
Conclusion. There has hardly been any lobby and advocacy for increased accountability and transparency at national level.		

[20] Three country coalitions reported positive results, but ICCO has rightly rejected these

5.1.2 Change agents

The second main objective of the programme speaks about change agents and challenging exclusion. In practice, the result framework assumes three very different pathways of change, as shown in the figure at the left.



The table below presents the assumed pathways of change for this second objective, as well as a summary of ICCO's own monitoring data from 2011 to 2014, compared with the findings from this evaluation.

Figure 2. Result framework for objective 2

Table 9. Theory and practice related to the second main objective

Objective 2 "Supporting change agents to challenge exclusion mechanisms and contribute to prevention"		
Direct Poverty Alleviation: "Role of change agents"		
Logic: partners develop capacities of change agents -> change agents play positive roles in reducing silence and stigma		
Output partners	*Reported by ICCO Cooperation* Partners develop capacities of change agents *Target "70% of partners"* *Reported 51 of 68 partners = 75%*	*Found in the evaluation* Categorisation: 57 projects include training of community members and leaders, most of which can be considered change agents. Change agents were active in activities such as health promotion (66) and training of TBAs (18). Evaluation reports: - All countries report on working with change agents, sometimes in large numbers (e.g. DRC 829). The concept 'change agent' is very wide and includes church leaders (largest group), community leaders, caregivers (e.g. in home-based care - HBC), peer educators and other youth. - To a lesser extent change agents also include target groups like PLWHA, PWD and even orphans and other vulnerable children (OVCs) or listeners of radio messages. In one case even partner's staff members are counted as change agents. - Some projects focus more on community level discussions than on individual change agents (e.g. coffee ceremonies and religious forums in Ethiopia), or on a combination of church leaders and communities as a whole (e.g. CCMP in Zimbabwe). - Change agents are often trained to address issues of stigma and silence, but also very often on general health promotion, healthy living, adherence to ART, early diagnosis of leprosy.
Outcome target groups	*Reported by ICCO Cooperation* Change agents play positive roles on reducing silence and stigma ("…concrete evidence of change agents who have been able to positively influence factors that play a role in silence and stigma…")	*Found in the evaluation* - A large number of change agents works on general health promotion rather than on silence and stigma. However, most do (also) address stigma and silence. - Silence: several indications that churches have become more open to discuss issues of sexuality and/or HIV / AIDS (e.g. "*church as talking space*", South Africa). The religious forums to discuss issues in Ethiopia are also successful. In Haiti, family planning was broadly accepted by church leaders. - Stigma: several examples show reductions in stigma, a survey in Bangladesh confirmed this. However, stigma is still significant

	Target "70% of projects" *Reported 42 of 66 projects = 64%*	(e.g. in Zimbabwe, the disclosure rate after testing still very low). A positive example is a Zimbabwean HIV positive pastor who was reinstated after being removed from office. The "Called to Care" booklet series and work by KZNCC (South Africa) also provide theological underpinnings for the church as a caring community. Several evaluations report improvements in churches that care for PLWHA or PWD (e.g. DRC, South Africa, Zimbabwe and Ethiopia). In one case (India) stigmatising language was being used even by the partner's change agents. - Most indications come from anecdotal evidence in the evaluations. Reporting by partners was weak and were mostly outputs in disguise, e.g. "*change agents perform behaviour changing activities*", "*educators were identified and trained*", "*they reported that their behaviour was changed*" (all South Africa).
Conclusion: A large majority of projects has included work through change agents. By and large this is reported to have had effects on general health behaviour and also on silence, stigma and supporting attitudes, although there are few objective measurements to provide evidence.		

Civil Society Development "Improved lobby and advocacy"		
Logic: Partners capacitated to develop capacities of interest groups -> partners develop capacities of interest groups -> interest groups are effective advocates		
Output partners	*Reported by ICCO Cooperation* Partners develop capacities of interest groups *Target "7 countries"* *Reported 26 of 42 partners = 62% in 8 countries*	*Found in the evaluation* Categorisation: this is included in part of the 57 projects that mention training of stakeholders. 10 projects specifically mention training of PLWHA or PWD. Evaluation reports: - All countries include these interventions. Mostly groups of PLWHA or PWD or LAP. Sometimes also families of OVCs - Most support to these groups focuses on income and livelihoods, e.g. through saving groups (VSLA, SILC, ISAL, SHG) or income generating activities. - Some projects (e.g. in Ethiopia, South Africa and Zimbabwe) give direct handouts or cash to people. Other projects (also Ethiopia) develop solidarity systems in the community (e.g. grain banks of Idirs used to support PLWHA). - Support to interest groups for L & A was reported in Uganda, Afghanistan, India and Bangladesh (and indirectly in Zimbabwe with the CCMP approach).
Outcome target groups	*Reported by ICCO Cooperation* Interest groups are effective advocates *Target "7 countries"* *Reported 22 of 22 partners = 100% in 6 countries*	*Found in the evaluation* - Most activities did not focus on strengthening interest groups' capacity to become effective advocates, but on income and livelihoods with very mixed results. Saving groups are often successful, pass-on schemes (e.g. of goats) not always. Where livelihood support is mainly providing direct handouts, little capacity strengthening can be expected. - Examples of interest groups becoming effective advocates are noted Bangladesh (with CDD at national level, CSF at community level), India and Zimbabwe (CCMP approach, with successful lobbies by pastors' fraternities (not really interest groups)). - In some cases this outcome indicator was contextualised as "capacities are strengthened", just counting the same groups as at output level.

Conclusion: Capacity development of interest groups is done in many projects, particularly focusing on PLWHA and PWD. The main focus has been on capacities for income generation and results of this have been mixed. Effective advocacy by interest groups is rare.

Policy Influencing: "Inclusive health policies"		
Logic: Coalitions capacitated on lobby for inclusion and equality -> coalitions lobby with interest groups for inclusion and equal access to health -> government policies have become more inclusive		
Output partners	*Reported by ICCO Cooperation* Coalitions lobby with interest groups for inclusion and equal access to health *Target "5 coalitions"* *Reported 7*	*Found in the evaluation* Categorisation: 20 projects mention lobby for the rights of marginalised groups. Evaluation reports: - Clear examples of such lobbies were seen in Bangladesh (inclusion of leprosy and PWD and access to social funds), South Africa (by ICCO partners only), Zimbabwe (local level, by pastors' fraternities), Afghanistan, India and Uganda (mostly one project in each country). - In some cases support in organising celebrations of special days (e.g. World AIDS day) is reported as lobby. But if no advocacy issues are formulated and no follow up is given, this is questionable (e.g. DRC)
Outcome target groups	*Reported by ICCO Cooperation* Government policies have become more inclusive *Target "4 countries"* *Reported 8 of 19 partners (42%) in 6 countries*	*Found in the evaluation* - In Bangladesh, two discriminating government policies were repealed, the 1898 'Leper's act' and the 'pollution law' which stated that CWD would pollute other children. In India, similar efforts to repeal a discriminatory Act related to LAPs were undertaken. In Afghanistan some policies have become more favourable for PWD and for inclusion of eye care. - Also in Bangladesh there is an increase in early detection of leprosy in the public health system and in Zimbabwe attention for PWDs was successfully integrated in health centres. - Two ICCO partners in South Africa report that the government has become more proactive in responding to health and HIV issues. But the contribution of their work is unclear and there are also indications that the government has become less open to cooperation with CSOs and FBOs.
Conclusion: Lobby for inclusion and equality is done in six countries. In 3 or 4 countries there is evidence (or indications) of positive effects on governments or on health providers.		

5.1.3 Health staffing

The third main objective of the programme speaks about human resources for health. In practice, the result framework assumes two different pathways of change, as shown in the figure at the left. No outputs and outcomes in relation to Direct Poverty Alleviation were defined.

The table below presents the assumed pathways of change for this third objective, as well as a summary of ICCO's own monitoring data from 2011-2014 compared with the findings from this evaluation.

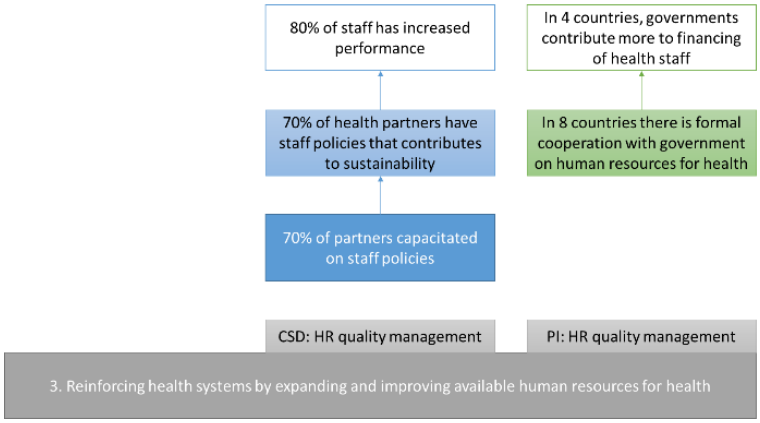


Figure 3. Result framework for objective 3

Table 10. Theory and practice related to the third main objective

Objective 3 "Reinforcing health systems by expanding and improving available human resources for health"		
Civil Society Development: "Human resources quality management"		
Logic: partners capacitated on staff policies -> health partners have improved staff policies -> staff has increased performance		
Output partners	*Reported by ICCO Cooperation* Health partners have improved staff policies *Target "70% of health partners"* *Reported 7 of 10 partners = 70%*	*Found in the evaluation* Categorisation: 45 projects mention training of medical and health staff. No specific mention of health workforce policies. Evaluation reports: - Training of health professionals is included in many projects. Very few training interventions focus on policies, but rather on skills (e.g. 365 health staff in DRC, in South Sudan main focus on training nurses, and many countries include training of CHW / HEW / HSA or other community agents), not on policies that focus on sustainability. - Some partner organisations (mostly not health partners) report working on their health workforce policies and several (notable two in Bangladesh) report problems on staff retention.
Outcome target groups	*Reported by ICCO Cooperation* Staff has increased performance *Target "80% of staff"* *Reported 7 of 13 partners = 54%*	*Found in the evaluation* - Several evaluations (or outcome studies) mention improved performance of staff: two projects in DRC, India and South Sudan's nurse training project; some projects report poor performance (unknown if deteriorated or stable at poor level): in DRC and in Haiti poor performance of staff was cited as main reason for underutilisation of health services. - In almost all cases partners did not measure the effects of training of the health workforce, although some conduct satisfaction surveys or measure quality of service regularly, but even then the findings were not used to analyse performance changes achieved by training.
Conclusion: The programme has included much training of health professionals, but the focus has hardly been on improved policies. The effects of training have not really been measured and follow-up was hardly done; there are only few examples of improved staff performance.		

Policy Influencing: "Human resources quality management"
Logic: formal cooperation with governments on human resources for health -> governments contribute more to financing of health staff

Output partners	*Reported by ICCO Cooperation* Formal cooperation with governments on human resources for health *Target "8 countries"* *Reported 3*	*Found in the evaluation* Categorisation: Lobby for increasing of health workers pay is mentioned in 1 project. Evaluation reports: - Several partners already had formal cooperation for human resources before the project, e.g. MMH in Zimbabwe, RCEA in Kenya and Mfesane in South Africa. - Several partners focus on cost recovery rather than government inputs, e.g. in Bangladesh, but also DRC and Afghanistan. - In many countries there is good cooperation with government institutions, but not for providing human resources. In DRC two of six health partners have formal cooperation, but only for inspection visits, for which partners even have to pay. In Haiti, health staff is included in training organised / provided by the government. - In South Sudan, the good cooperation with State level Ministries of Health allows partners to train community health workers, which is outside official national policies.
Outcome target groups	*Reported by ICCO Cooperation* "Governments contribute more to financing of health staff" *Target "4 countries"* *Reported 2*	*Found in the evaluation* - Apart from the health partners who already had their health professionals paid by the government, one nurse was seconded in Kenya, and one in Zimbabwe (replacement, as a result of lobby by pastors' fraternity).
Conclusion: Partners often cooperate with governments, but this has hardly ever led to increased contributions of governments to financing of health staff.		

In the presentation of the results of ICCO Cooperation's monitoring system, there seem to be some serious flaws that render the reported measures of little value.

- Almost all indicator values are percentages. Outputs are calculated on the basis of numbers of partners that report on the indicator. Thus the target "70% of our health partners" is met if only 10 partners report on the indicator and 7 of them meet their target.
- In practice, partners can choose to report on an output indicator without reporting on the associated outcome indicator. Thus, 42 partners can report strengthening capacities of interest groups (with 26 meeting targets), while only 22 report on the associated outcomes.

5.1.4 Main objective: Equal accessibility and equal health outcomes

According to the programme's ToC, the three main objectives discussed in the paragraphs above should contribute to the overall objective of the programme, i.e. to greater equality in accessibility of basic health care and thereby also more equal health outcomes. This is represented in the figure below. To some extent, the same objective is also included in the first objective, discussed in paragraph 5.1.1.

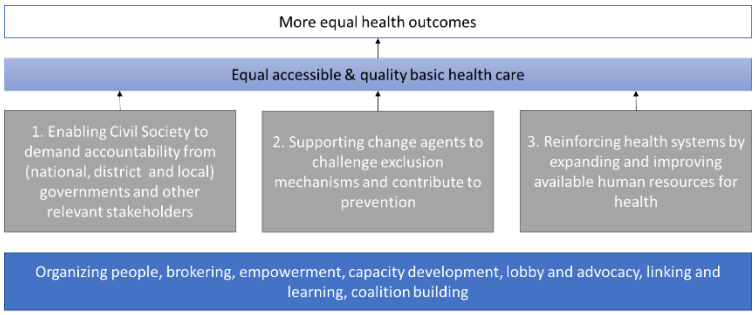


Figure 4. Simplified visualisation of the overall theory of change,

The question is whether there are indications that these overall objectives are being achieved.

Overall, there is an increase in access to and (to a lesser extent) quality of basic health care because of the programme. It is likely that there are also positive effects on health outcomes, but this is uncertain as this has hardly been measured in the projects. Projects that do offer figures on morbidity, mortality or prevalence often use secondary data that are either old or that refer to a much larger level of scale than the interventions, or they offer figures that are unreliable[21]. Further comments:

- Access to basic health care is mostly offered directly through the projects. In many cases, these are on-going interventions (e.g. HBC and OVC care in South Africa, support to running of health centres in DRC, South Sudan and Haiti), which means that existing access is maintained rather than increased. Additional access is offered by scaling up former project activities and including new health centres (Bangladesh, DRC and Uganda). New interventions more often refer to the provision of preventive and promotive services (including peer education) than to the provision of curative services.
- Several projects report increased numbers of consultations (e.g. of antenatal care or deliveries), but there are also several projects where facilities are underutilised (notably in DRC) because people cannot afford payments or prefer to make use of other facilities that are cheaper or better.
- A number of projects use cost recovery strategies for sustainability purposes. This can have a negative impact on equity (the very poorest cannot pay). In some cases attempts at cross-subsidy (e.g. using poor funds) are made or the establishment of small-scale community based insurance schemes (DRC) or institution based insurance (Bangladesh) was supported.
- There is relatively little increase in access as a result of lobby efforts, but there are some examples of improved performance because of local level lobby (e.g. availability of health staff because of lobby by pastors' fraternity in Zimbabwe).
- In some cases there is additional access to care and support for groups of people because communities have started to support people (e.g. grain banks by Idirs in Ethiopia).

5.1.5 Is the Theory of Change correct?

Paragraph 4.2.3 has shown to what extent the ToC has been relevant. The question here is whether or not the ToC is correct. Paragraphs 5.1.1 to 5.1.3 have assessed to what extent the various objectives (and related outcome pathways) as building blocks of the ToC have worked or where outcome level results were disconnected from outputs.

The question is also to what extent the eight[22] different pathways of change did lead to the overall objective: more equal access to health services and more equal health outcomes. The table below briefly discusses these contributions. This is mainly based on logical reasoning which has not been found in the programme documents[23], not even in the ToC description. The question answered in the

[21] An example is the use of HIV prevalence data based on the percentage positive testing during VCT.
[22] This refers to the different pathways shown in Figure 1, Figure 2 and Figure 3
[23] Quote from the Ethiopia country coalition evaluation: "...*it is hard to easily comprehend the internal logical connections of the programme*".

table below is how each pathway contributes to more equally accessible quality health care and more equal health outcomes.

Table 11. Relation between pathways of change and the overall intended change

Pathway of change	Contribution to overall intended change
1. Increasing access to and use of health services leading to better health outcomes	This pathway overlaps completely with the overall intended change. This is confusing, implies that the contribution is very direct and reinforces the misconception that health sector interventions are the main contributors to health outcomes (health outcomes are achieved by progress made in many sectors, such as security, communication, roads, water & sanitation, etc.). *Note: in practice providing health services has been a major component*
2. Increasing participation leading to more say in decision making	A bigger say of communities / clients in health care increases its quality. Whether it increases equity in accessibility is not immediately clear and will depend on the representativeness of the (s)elected committee members.
3. Lobby for accountability leading to more transparent governments	Bigger transparency of governments will make more funding available for actual health service delivery and will contribute to better performance of health staff (including supervision etc.), thus increasing access and quality of health care. *Note: in practice this pathway was hardly present*
4. Capacity development of change agents leading to breaking of silence and stigma	When silence and stigma are reduced, people will more easily come forward to use (or even demand) health services they may need, thus increasing utilisation of health services. *Note: in practice change agents also focused on other issues, most of which also contribute to improved utilisation*
5. Capacity development of interest groups leading to them being effective advocates	Interest groups that are effective advocates can demand more and better services, thus increasing access for their groups. *Note: in practice almost all efforts focused on improving livelihoods. If successful this does not contribute to more access and use of health care, but to better health for these vulnerable groups resulting in a reduction of health care needs.*
6. Lobby for inclusion leading to more inclusive health policies	The implementation of more inclusive health policies contributes to improved access to health services for marginalized groups. However, translation from policies to implementation cannot be assumed. Alternatively, policies could become less stigmatising (see also pathway 4).
7. Better staff policies leading to better staff performance	Policies in themselves do not lead to better performance, but are one of a broader set of health workforce issues. If health staff perform better, the quality of health services is improved, which could also increase the utilisation of the services. *Note: in practice most attention was given to training with little supervision and follow up.*
8. Formal cooperation with government leading to more government finances for health	Increased mobilisation of funds for health contributes to more services (or more sustainable services), increasing access and thus health outcomes. *Note: in practice, cooperation with government only had this effect in a few cases.*

5.1.6 Changes at beneficiary level

The short answer to the evaluation question "*Can changes that are related to the programme be observed at beneficiary level?*" is 'yes'. However, this is mostly based on assumptions (most of which are rather obvious) but real measurement at this level is rare. Some examples are provided in the table below.

Table 12. Examples of changes at beneficiary level

Type of interventions	Changes at beneficiary level
Support to groups	All interventions that include support to specific (interest) groups[24] lead to changes that are felt by the beneficiaries. The various focus group discussions confirm this. The many livelihood-focused interventions show more mixed results: not all of them are income-generating.
Services and utilisation	Many interventions include provision of health services, i.e. preventive, promotive, rehabilitative and / or curative services. To the extent that people make more use of health services (because of improved access or improved health seeking behaviour), they are likely to be aware of such changes. However, there is hardly reliable information about reductions in morbidity or mortality. The few projects that conducted client satisfaction surveys generally show positive appreciation.
Awareness raising and behaviour change	Any changes in terms of increased awareness (of health risks, service options) or changed behaviour (in taking risks, openness to discuss issues, stigmatising behaviour) are likely to be felt by those having changed, or by those affected by them. In several focus group discussions, participants testified to experiencing such changes.
Inclusion, participation, accountability	Interventions focusing on promoting inclusion, participation or accountability do not show changes that are directly felt by beneficiaries. Only in those cases where e.g. capacity development for inclusion supports organisations in addressing additional groups of people changes are felt at beneficiary level.

5.1.7 Synergy between intervention strategies

Direct poverty alleviation (DPA), civil society development (CSD) and policy influencing (PI, also including lobby and advocacy) are the three main strategies of the programme. Appropriate interventions for each of these strategies should also contribute to achieving progress in meeting objectives of other strategies. In brief, CSD is the strongest part of the programme, PI the weakest and DPA the biggest in terms of utilised budget[25]. In the programme ToC, it is easy to reason how each strategy interacts with others toward the common goal. See Table 11 where pathways 1 and 4 are related to DPA, 2, 5 and 7 are related to CSD and 3, 6 and 8 are linked to PI.

At a more concrete level, interaction effects could be observed in many projects. The most common of these are summarised below.

- DPA contributes to CSD: change agents form groups of people, who continue to take initiatives and develop social capital, e.g. peer and interest groups.
- CSD contributes to DPA: health committees help to improve the quality of health services in many countries; community groups are strengthened and start projects together for specific groups (e.g. grain banks for PLWHA by Idirs in Ethiopia) or for the community as a whole (e.g. CCMP projects where churches organise communities and develop small scale projects); Community Based Organisations (CBOs) are strengthened and start (or improve) HBC activities.
- CSD contributes to PI (or rather lobby and advocacy): community groups are strengthened and become involved in local level lobbies (e.g. in the CCMP approach in Zimbabwe), or they join a network with the partner that lobbies together (e.g. PACSA and the CBOs they support in South Africa).

[24] For example PLWHA, PWD / CWD, LAP, OVCs but also groups such as commercial sex workers (CSW).

[25] In theory 49%, but this is based on a theoretical estimate of projects included in the project database (MSD). In practice, the DPA component is much bigger, also because the PI component has been much smaller than the estimated 15%, but also because CSD components such as capacity development of interest groups consisted largely of livelihood interventions and sometimes direct cash or food handouts (which is clearly DPA).

Apart from these examples of positive synergy, there are also examples of tension between the strategies, notably between DPA and PI, when lobby is done with government to start, increase or take over health services, while the partner is currently offering these. This may serve as a disincentive for the government to act, while there may be a conflict of interest for the partner as handing over would make the partner organisation's project (and possibly the partner organisation itself) redundant.

Even though the above interactions were frequently observed, there are also missed opportunities, where community groups and committees could be used much more for advocacy. Particularly the link between CSD and lobby and advocacy could be stronger in many projects.

5.2 Country Coalitions and multi-stakeholder approaches

ICCO Cooperation has introduced the programmatic approach (PA) in 2007. From the beginning of the current policy period, this approach was introduced. For most partners it was still new. ICCO Cooperation defines the PA as follows:

"A multi stakeholder process that leads to organisations working together, based on a joint analysis, shared vision and objectives and clear perspective on the results of the cooperation. In such a process all actors can do different things, work at various levels and use their specific strengths for the common purpose and objectives, as well as share activities, and in particular participate in the mutual linking and learning processes. The programmatic approach aims at change in systems rather than addressing single problems" (Walters, 2011).

While the name PA could suggest that the approach is meant to implement a programme (in this case the BH & HA programme), a more recent development is to refer to multi-stakeholder approaches rather than PA and to delink PA from the ICCO Cooperation (as suggested in evaluation of PA).

Given the nature, location and strategies of the partner organisations, one could consider multi-stakeholder approaches at two levels, preferably interlinked: the joint level of all partners and the level at which each partner operates. In practice, the PA has been operationalised in the established Country Coalitions in which all ICCO Cooperation partners collaborate, but much less at the level at which each partner implements its own projects. The following conclusions can be drawn:

Difficult start. Most Country Coalitions had a difficult start. This was not only because the approach was new, but also because there was resistance as the approach was experienced as compulsory and top-down by coPrisma members as well as the partner organisations. coPrisma members often did not really believe in the approach and, even though there is a country lead person for each country, it is difficult for coPrisma members to discuss issues from the joint perspective of a coalition: very often, the bilateral interests of each member's own partners prevail.

Despite the difficult start all countries established a Country Coalition except Malawi, because the ICCO-funded network in Malawi did not want to dilute the already restricted funding by adding the two partner organisations of coPrisma.

Delivery mechanisms. The Country Coalitions have proven to be relevant delivery mechanisms for interventions and management systems related to the BH & HA programme: donor requirements, joint formats, protocols, instruments, but also joint training as discussed above. This has been more effective and efficient than presenting and discussing these with each partner individually.

Learning and trust. There has been much learning in the Country Coalitions. Almost all evaluation reports are positive about this aspect. Partners have learned from each other, they trained each other and increasingly they organised exchange visits to learn how specific approaches are applied. This learning has been actively stimulated by the definition of learning questions, but also through the F2F meetings. The quality and activity of the coordinator (sometimes external and sometimes a staff member of a partner organisation) also influenced and stimulated learning. The togetherness and trust that was built through the meetings is the main determinant of most coalitions' ambition to continue after MFS II, even without funding (and even though some coalitions do not seem viable).

However, learning has been too little institutionalised, e.g. position papers / guiding documents developed by partner organisations at regional level were scantily used by the coalitions; within each partner organisation only one or two technical staff members benefitted from / had the opportunity to attend learning events. Also, some of the learning sessions were largely 'show and tell' events, with each partner eagerly showing / demonstrating the results of projects with limited discussions and few organisations showing serious interests in really learning new ways of working and adapting. Learning also seems to have taken place from an "all is good" attitude, which may have been necessary to build and maintain trust. However, it also led to limited or no attempts by coalitions composed of partners with very opposite approaches to reconcile or determine whether or not the differing approaches can be considered 'good practice' (e.g. in Ethiopia some partners simply provide direct handouts to PLWHA while others facilitate sustainable community structures to support such groups). Finally, learning seems to have centred more on specific topics (as formulated in the learning questions, e.g. around the change agents, or around participation) than on encouraging reflections on analysed monitoring data. In this sense, learning on the basis of PME has been weak in most cases.

The *effects of learning* have been diverse. In some countries there is convergence towards joint approaches, such as SAVE and CCMP in Zimbabwe, and family and group approaches ('salt pots') in South Africa. There has also been a real exchange of relations, linkages and networks among members. However, in most cases the effects of learning on implementation practices have been limited: each partner continued doing its own 'things', focusing more on 'selling' their ideas to others than on 'buying' new ideas. In this sense, joint country plans can often be considered as a simple compilation of the individual project plans. In individual reports, the effects of the country coalition are hardly mentioned, even when reports speak about learning and adaptation.

Few real multi-stakeholder initiatives. In most countries, joint implementation of activities of coalition members hardly took place. Sometimes, these joint activities were rather stand-alone activities such as the joint celebration of a special day, or joint implementation did not move beyond the developed plans because of a lack of commitment or a lack of clarity and focus (e.g. the lobby plans in DRC and Kenya).

One reason that there were relatively few real joint activities is that coalition members were often very diverse, geographically scattered and small. Being diverse is a strength, but not if each member does different things at a relatively small scale in different areas.

In general collaboration with other actors has been good (see par 4.4) with a focus of collaboration on harmonisation, reaching agreement / receiving approval and avoiding duplication. Rather than targeting other actors and encouraging these to join in a multi-stakeholder initiative, many collaborative efforts targeted the stakeholders of partners.

The essence of the programmatic approach, i.e. conducting a joint analysis as the basis for joint planning and aimed at achieving systemic changes through various strategies and with various actors

has hardly been broached. Rather, the approach has focused on finding common ground in the activities each partner was implementing anyway and then learn from each other. A clear symptom of this is the fact that almost none of the Country Coalitions has non-ICCO Cooperation partners as members: the coalitions often feared that (relatively) scarce resources would have to be shared[26], did not manage to convince prospective members of the benefits, or there were multiple competing coalitions working on the same theme (e.g. in Kenya where there are several coalitions related to HIV and AIDS). Nevertheless, some individual projects can be considered as multi-stakeholder initiatives. The CCMP approach focuses on collaboration of church and community leaders and can be regarded as a multi-stakeholder initiative, especially when the partner supports linkages to (government or other) actors and broadens the scale of effects to raise these to a higher level. The establishment of religious forums brings together a wide range of actors who move toward broad change. Again, the linkages forged at higher levels with an increase in the scale of progress / change would make these efforts at collaboration more exemplary and stronger. Unfortunately, opportunities in achieving wider change have been missed, e.g. AFSA in South Africa with its eighty members forms a broad network, but the focus is mainly on capacity development and obtaining funding.

5.3 Roles of ICCO Cooperation and coPrisma members

Policies, approaches and instruments have been developed by ICCO and coPrisma (see paragraph 3.1). In the first place, they developed the MFS II project proposal that was the basis to obtain the biggest part of the funding for the programme. They also introduced the BH & HA programme's theory of change (and also stimulated a change toward theory of change thinking), a results framework and monitoring protocol that assured the accountability relation toward the Dutch Ministry of Foreign Affairs, the programmatic approach (which was mainly translated in working with Country Coalitions), and gender and rights based approaches. Most of these approaches were compulsory, although there has always been emphasis on the need to contextualise projects' interventions. The relatively high level of freedom for partner organisations to contextualise project plans has resulted in a blurring of the clarity of the introduced approaches.

Apart from the more or less compulsory approaches, ICCO and coPrisma have facilitated action research on the application of client satisfaction instruments, which was piloted with several partners of the programme and led to an interesting set of tools that has been used by several partners of this programme and beyond[27].

Other forms of support from ICCO and coPrisma are their memberships of Dutch or international networks, such as ShareNet and the Dutch Coalition on Disability and Development (DCDD) and participation in or facilitation of research / studies. The participation in networks and platforms has contributed to Dutch and international lobby and to general awareness about basic health, SRHR and HIV / AIDS, and links international and local best practices. However, in practice we have hardly seen such links and use of information.

Capacity development. Training has been offered around four main themes: lobby and advocacy, programmatic approach, planning monitoring evaluation and learning (PMEL) and the theory of change. This included training for coPrisma members, but mostly for partner organisations. Most of these were integrated in the coalition meetings or F2F meetings. The latter also included more informal information sessions with training elements, e.g. on the rights based approach and linkages

[26] Interestingly, many coalitions have become more open to new members for the period beyond 2015.
[27] See www.clientsatisfactioninstruments.org where these instruments and the pilot experiences are presented.

with livelihood interventions. In some cases, the training was specific and covered general concepts as well as the practical development of instruments and (joint) plans, but most training was rather general. While training was generally needed, the number of training workshops was insufficient and given insufficient follow up with coaching or mentoring to be translated into practical action.

Typically, the four main topics addressed in training remain challenging for many Country Coalitions and partners: most project evaluations identified the lack of a consistent PMEL system or lack of outcome measurement; L & A is admittedly the weakest part of the programme, although a number of organisations are slowly recognising the possibilities and the value of L & A; 'ToC thinking', i.e. starting at the change the project wants to achieve and then determining which interventions and actors are most appropriate to achieve the change, is in many cases still overtaken by 'activity thinking', i.e. how current activities can achieve changes; the PA has not led to many real multi-stakeholder initiatives and even though the necessary collaboration is established and there is much linking and learning, the focus is still mainly on each organisation's own interventions rather than on achieving systemic change by addressing multiple factors at multiple levels with multiple actors.

This does not imply that the training was poor or redundant, but rather that more follow up would have been needed in the form of hands-on coaching, mentoring and joint action, rather than ever more training or workshops. Some criticism on capacity development interventions / formal training indicated that it was often "too little, too late". It also shows that paradigm shifts (PA and ToC thinking) take much time and that more investment is needed in some cases, e.g. when partner organisations do not have dedicated PMEL staff or other resources required for PMEL.

Programme management. A major challenge for ICCO and coPrisma in coordinating the programme is that ICCO and coPrisma have the responsibility for the overall programme, but they do not have the authority to take actions, so they can only use conviction and persuasion: the programme officers (both coPrisma and ICCO) hold the position of donor of the Country Coalitions as well as partner organisations and have the deciding voice.

CoPrisma members and ICCO regional offices have played a more direct role in relation to partners. The programme officers (POs) assigned to the different countries had direct relations with the partners, in most cases already before this policy period, while ICCO and coPrisma were not directly involved in programme implementation. It has been difficult to get a comprehensive view about the added value of POs (or broader: coPrisma members and the regional offices), since very few evaluation reports or other documentation commented on this. Where evaluations referred to POs their input was largely viewed positively. This is related to the fact that most coPrisma members have long term relations with their partners with a large shared basis. POs were perceived as 'being together with the partners' and helping them to fulfil the requirements of the programme.

Sometimes coPrisma member staff played a role in facilitating the Country Coalitions. They also facilitated additional capacity development (e.g. in South Africa for three weaker CBOs in the coalition). The relation between ICCO and their partners seems somewhat more distant: most partners are much bigger than coPrisma partner organisations, ICCO's share in funding is often much smaller (in one case below 1%) and the partner organisations often do not need ICCO's input in capacity development efforts. The assessment documents of partner proposals often mention many ideas about linking and learning. In practice, only few of these suggestions seem to have been realised.

Support in conducting evaluations, i.e. ensuring that ToRs are clear, commissioning of evaluations is done in a transparent manner, the methodological aspects are appropriate, and applying quality

criteria and assessment of evaluation reports, would have contributed to improving the (external) evaluations of partners' projects.

One interesting case to mention is the reciprocal capacity development between CDD in Bangladesh and Light for the World. Light for the World changed its main strategy as a result of discussions with CDD and moved towards supporting lobby and capacity development for inclusion of people with eye problems rather than service delivery interventions.

Monitoring. The programme's monitoring system was mainly based on the results framework. Formats were made available, partners had to choose which results they could report on and for each of these they had to develop contextualised indicators. Joint country plans were made, mostly consisting of a compilation of the project plans. Reporting was mostly done by the individual projects. A number of issues were observed in the evaluations:

- The results framework, especially the results and indicators, was difficult to understand. Many results included in the framework were too specific for the projects and large parts of the projects could not be fit in the results framework[28] or were artificially linked to some results.
- There were numerous critical comments[29] about the guidance on PMEL: formats were often late, training on the use of formats or guidelines came late which led to misunderstandings about the application of formats and reporting requirements were often unclear.
- The results framework influenced the choice of project interventions: more attention has been given to working with change agents, strengthening relations with governments, capacity development of groups and lobby and advocacy (even if it was not always very successful).
- There has been little measurement at outcome level, e.g. measurement of health outcomes or effects of training. When outcomes were reported, they were often assumptions[30] or outputs. In some cases joint outcome studies were done, but these were often not well linked to jointly conducted baseline studies making it difficult to compare indicator values. In some countries such outcome studies apparently had hardly any link with the results framework. And in general, in countries where (sometimes good) baseline studies were seen, they were never regarded as the first measurement of the country programme to be followed up by subsequent and similar measurements in order to establish whether change occurred.
- Since the projects in the countries were not really harmonised, but rather grouped together, it has also been difficult to harmonise monitoring and reporting. In most cases partners reported to the Country Coalitions on the results framework and to their coPrisma members on all issues the partners required to be reporting on. In some cases, it has been the coPrisma partner who reported to the Country Coalitions on the basis of the partners' reports. Harmonising reporting requirements as members of Country Coalitions and challenging the coPrisma members to accept this harmonised reporting has never been considered as an option, because each coPrisma member has its own requirements that are difficult to change.

[28] An example can be seen in Zimbabwe, where the coalition developed four objectives. But these had to be (and were indeed) replaced by the outcomes of the programme's results framework.

[29] Including the following "*New formats and requirements kept coming in*" and "*Thematic and limited results framework precluded real programmatic approach and systemic approach*" (Bangladesh), "*The PME was very donor driven, with a focus on reporting and not learning*"(South Africa)

[30] One interesting example (Bangladesh): a partner reported an outcome at 10%. The coPrisma member asked how this was measured and the response was "*we thought it could be 10% by now*". Quote from country coalition evaluation South Africa "*Due to the fact that the contextualised indicators do not specify the desired outcomes explicitly, the partners mostly submitted evidence that was proof of their activity (outputs), rather than the results of their work (outcomes)*".

- The available database systems have not been appreciated by all who worked with these. It also did not provide a single coherent system to define projects and their properties. Also in the course of this evaluation various lists of projects (database, Excel) were provided which always required much manual labour to reconcile.

5.4 Conclusions about Effectiveness

The table below shows the final assessments (on a scale of 1 to 4) for the judgement criteria related to effectiveness. These judgement criteria were defined in the evaluation framework. A complete overview of judgement criteria and their assessments is found in Annex 11.

Table 13. Assessments on judgement criteria for effectiveness

Questions and Criteria	IC	PO	CC / partners	Average
Effectiveness				
To what extent have the objectives of the BH & HA programme been achieved, or are expected to be achieved during the MFSII period?	2.3	2.5	2.7	2.5
Judgement criteria				
1. The 6 "outputs of the alliance" have been achieved or are on track for the three objectives and the three strategies.		2.0		2.0
In reality, the "outputs of the Alliance" have hardly been measured. Capacity development for partners at very general level focusing mainly on skills and knowledge; limited follow up on correct application of newly acquired knowledge and skills.				
2. The 9 "outputs of the partner" have been achieved or are on track for the three objectives and the three strategies.			2.5	2.5
Reporting on partner outputs unclear (indicator values / percentages calculated using different denominators). DPA and CSD outputs mostly achieved, PI outputs mostly not.				
3. The 8 "outcomes at the level of the target groups" have been achieved or are on track for the three objectives and the three strategies.			?	
Outcomes are hardly or inappropriately measured and mostly assumed. Evaluations provide some anecdotal evidence that outcomes have been achieved but this is not supported by accurate measurements. L & A outcomes hardly achieved. Assessments are mainly based on assumptions, i.e. that increased access and use leads to improved health status, that increased participation leads to more accountability and that change agents really contribute to reducing stigma and silence.				
4. There are indications that the objectives of more equally accessible, quality basic health care are being achieved.			3.5	3.5
Increased and more equal access and utilisation has been achieved: more equal and improved health outcomes are assumed.				
There are indications that the objectives of more equal health outcomes are being achieved.			?	
Achieved increase and more equal access and utilisation is assumed to have resulted in improved health outcomes.				
5. Changes related to the programme can be observed at beneficiary level.			4.0	4.0
Most interventions were very concrete and directly felt by beneficiaries.				
6. Is the theory of change correct? Are there indications that the causal relations between the result levels operate in practice?	2.0			2.0
ToC was too narrowly defined with almost linear relations between outputs and outcomes, neglecting other outcome pathways and other contributing / attributing factors from other sectors.				
7. The roles of funding, capacity and expertise development, brokering, and lobby and advocacy of ICCO Cooperation have led to positive effects.	2.5	2.5		2.5
Funding has certainly supported the achievement of results as well as capacity development interventions, although the latter often too blinkered, too general and too focused on skills and knowledge only; brokering has been attempted with limited success; lobby and advocacy has been done through wider networks at Dutch level, with few linkages to partners' work.				
8. The activities of the Country Coalitions have contributed to higher effectiveness of the BH & HA programme.			3.0	3.0
Effective as delivery mechanisms of donor requirements, for mutual learning and reflection, for better collaboration and moving toward facilitating roles. Less effects on programme improvement - change takes time - and hardly real joint planning.				

Questions and Criteria	IC	PO	CC / partners	Average
9. The BH & HA programmes in the countries are based on multi-stakeholder approaches, Country Coalitions (so-called programmatic cooperation).			1.5	1.5
Multi-stakeholder approaches not really systemic, mostly still based on implementation of own activities, which were largely restricted to health care interventions.				
10. Synergy is realised between the three intervention strategies (direct poverty alleviation, civil society strengthening, policy influencing); all three were helpful in reaching results and combining them added value.			2.5	2.5
Examples of synergy between interventions targeting DPA and CSD, less between CSD and PI.				
11. Country Coalitions and partners use their PME system for measuring results, learning lessons and improving the quality of the programme and the monitoring protocol as part of this PME system supported the programme proceedings.	1.5		1.5	1.5
The results framework did influence partners' choices of interventions, but monitoring was poorly done and hardly used for programme improvement. Harmonisation of systems has proven difficult and was important reason for discontinuation of ProCoDe pilot in Central & East Africa.				
12. Learning (thematic and cross-thematic) took place at all levels and increased the programme effectiveness.	3.0	3.0	3.0	3.0
Many programme working group meetings, F2F meetings and annual reflections contributed to learning. In the Country Coalitions many external inputs, exchange visits and sharing of experiences. Institutionalisation of learning and the linkage of learning with practice weaker.				

6 Findings and analysis related to Efficiency

This chapter presents the findings and analyses related to the efficiency of the programme.

6.1 Transaction costs

Paragraph 3.1 introduced the various actors in the programme. The table below presents an estimate of the transaction costs related to each of these players. This is based on agreed-upon standard percentages for coPrisma partners with the assumption that for ICCO projects the situation is comparable. As paragraph 2.1 explains, the percentages of total funds 'available for partners' are based on an analysis of the budgets of fifteen random projects.

Table 14. Overview of transaction costs of the programme

Cost item	% of total amount	
Programme costs	6.0%	
Programme coordination costs coPrisma		1.0%
Programme coordination costs coPrisma member		1.0%
PME-costs Alliance		4.0%[31]
Overhead costs	11.2%	
Programme management costs ICCO		1.0%
Programme management and administration costs coPrisma		5.1%
Programme management and administration costs coPrisma member		5.1%
Available for partners	82.8%	
Overhead (general costs of the organisation)	(12.2%)[32]	10.1%
Implementation costs (salaries, transport, related to the programme)	(40.0%)	33.1%
Investments (vehicles, building)	(2.6%)	2.2%
Activity costs (direct costs for activities)	(45.3%)	37.5%

Analysis of the table with transaction costs shows that:

- Costs for the Country Coalitions are mainly included in the upper section of the table: programme coordination costs. However, in most countries the partners also contributed to the costs of the coalition from their own budget, but no systematic information about this could be found. This means that a small part of the partner's overhead costs (or possibly implementation costs) has also been spent on the upkeep of the coalition.
- It is difficult to give an assessment on the total overhead and implementation costs of the Dutch organisations (17.2%, part of which has been spent on capacity development of the Country Coalitions). We do not have the impression that this is very high, but it would be useful to obtain benchmarks from similar Dutch alliances.
- Overhead costs of the partner organisation vary (between the fifteen projects) from 6 to 23%. An average of 10% can be considered as reasonable.
- Assessment of the implementation costs versus the activity (and investment) costs is also difficult. Projects that include much direct service provision (which is expensive) tend to have relatively lower implementation costs (because higher activity costs) and projects that include cost recovery or mostly focus on L & A have very low activity costs and hence higher implementation costs. It is

[31] Later changed to 3%

[32] The percentages in brackets are the percentages of the total amounts that are available to partners. From the partners' perspective these are more relevant. The right hand column provides the percentages of the total amount available at IC.

interesting to note that Ethiopia has a law requiring NGOs to have at least 70% direct activity costs[33].

Analysis of data from evaluations, documentation and interviews highlights the following:

- The fact that there are many layers in the programme increased the transaction costs. However, an advantage is that programmatic issues (formats, training) can be handled jointly rather than separately for each partner organisation. Also, using exchange visits and peer reviews are relatively cheap forms of capacity development.
- In most cases coPrisma partners have been confronted with double reporting lines: through the Country Coalition on the IC results framework and to their own coPrisma member on issues determined by that organisation. In none of the Country Coalitions has there been an attempt to combine all reporting through the coalition. The reason is that each coPrisma member has its own (donor) requirements and is not willing (or able) to change and harmonise this: this is demonstrated by CBAP (Zimbabwe) which is funded by two coPrisma members and writes different reports for both. In some cases, the coPrisma member takes care of the reporting on the IC results framework, thus reducing the workload for partners. Reporting requirements of ICCO partners are limited: in many cases partner organisations do not write specific reports to ICCO, but submit their general annual reports, particularly in those cases where the ICCO contribution is very low.

Unit costs

In addition to the judgement criteria for efficiency, an attempt was done to calculate unit costs for some specific activities. However, it turned out difficult to relate budgets specifically to certain activities, as many projects are broad and include many activities. We were only successful for home based care (HBC) interventions. For five projects, the costs for these interventions were calculated, with and without costs for overhead and programme management. Because of incomplete information, some calculations are based on multi-annual budgets and estimates of clients (HBC receivers) and others on reports (mostly for 2013). Amounts were corrected for purchasing power parity to ensure comparability of costs between countries. Factors that may have influenced the differences shown below include intensity of HBC, level of incentives / payments for volunteers, client density, distance of the organisation from the intervention area and combinations with other support systems in communities (or families).

Organisation	Direct annual costs per client	Total annual costs per client
Malawi, WAM	€ 31	€ 66
South Africa, Nakalele	€ 40	€ 43
South Africa, Mfesane	€ 29	€ 30
Ethiopia, BBBC		€ 83
Kenya, Wikivuvwa	€ 16	€ 29

[33] In some of the Ethiopian projects this is realised by including direct handouts.

6.2 Monitoring of cost efficiency

The efficiency of different intervention strategies has not been strictly monitored. The reviewed evaluations provided limited information with regard to Country Coalitions' / partner organisations' cost awareness, i.e. the evaluation reports do not show that efforts were made to minimise and share resources between BH & HA and non-BH & HA activities of the projects or the country programmes. Monitoring of efficiency was also hardly mentioned in evaluations. This may be considered a missed opportunity, especially with regard to the efficiency of the many formal training workshops organised: the overview of project interventions shows that 463 (30%) interventions referred to training that targeted health professionals, non-(health) professional workers / volunteers and staff of partner organisations, while supervision and / or mentoring interventions were only mentioned 39 times. This difference raises questions with regard to the monitoring of the effects of the training workshops, i.e. has the transfer of knowledge and skills had the desired effect and can therefore be considered an efficient use of available resources?

Specific project examples refer to the use of motorbikes rather than (4x4) vehicles to reduce expenditure on transport and referral services, targeting existing health care providers and the combining of different target groups in outreach activities, such as outreach services for leprosy patients combined with the provision of preventive services for under-fives, women (family planning and pregnancy care) and PLWHA.

Key informants indicated that some coPrisma members compare efficiency of their partner organisations, for instance comparisons of salary costs and costs for similar projects by different partner organisations are made. Sharing of information derived from these comparisons is not a common practice. Attempts to incorporate technical support to partner organisations by the ICCO country office in countries where the Dutch members do not have a representation has been considered, but has not really materialised and was questioned / considered irrelevant by other key informants.

Two coPrisma members have calculated unit costs for specific interventions on which the budget allocations have been based (Light for the World and Leprazending). This example has not been followed by other coPrisma members, although some key informants indicated that having a better idea of unit costs in different contexts could be very useful.

At country and partner organisations' level cost awareness does not really feature as an important aspect of the programmes / projects: in only one country coalition evaluation the high operating costs, especially costs for transport and accommodation, were mentioned, but this mention did not specifically refer to cost awareness. That said, indications that projects are unnecessarily expensive have not been found.

6.3 Selection of interventions

There is little to no evidence that cost effectiveness has been explicitly considered in the selection of interventions. The above example of training as the most commonly included project intervention may be evidence of this. However, in general most if not all interventions have been based on international best practice and are included in national essential health packages because of the proven cost effectiveness.

As already stated, a substantial number of existing projects continued their interventions with MFS II funding. The selection of interventions was generally guided by the results framework, such as the training of change agents, community structures and interest groups in relevant topics. Livelihood

interventions were often included to improve chances of sustainability and / or generate income for the most marginalised members of the communities. It has not been possible to determine whether these interventions were the most cost effective or cost efficient in the given contexts, because the evaluations provide inadequate information / data.

While the introduction and training of change agents selected from community, interest and church groups has been part of most projects, there is inadequate information to determine whether this has been the most cost effective manner to realise change. The main question in this regard which is not answered in the reviewed evaluations: could projects have been as or more effective if they had targeted already available community workers - either linked to the health sector or to other sectors and community structures, such as Health Extension Workers (HEWs – Ethiopia), Health Surveillance Assistants (HSAs – Malawi) and similar cadres deployed at community level in the different project countries - instead of the large number of selected change agents from different groups in communities?

6.4 Conclusions about Efficiency

The table below shows the final assessments (on a scale of 1 to 4) for the judgement criteria related to effectiveness. These judgement criteria were defined in the evaluation framework. A complete overview of judgement criteria and their assessments is found in Annex 11.

Table 15. Assessments on judgement criteria for efficiency

Questions and Criteria	IC	PO	CC / partners	Average
Efficiency				
To what extent has the ICCO Cooperation carried out the BH & HA programme in a cost efficient way?	2.0	2.3	2.8	2.3
Judgement criteria				
1. Transaction costs of all actors relating to programmes and projects are minimised.	2.5	2.5	2.5	2.5
Clear benchmarks or standards to assess whether minimising of transaction costs occurred are lacking. Impression that attempts to minimise costs were made and excessive programme costs not found.				
2. Assessments and monitoring of the programme include cost awareness.	1.5	2.0		1.8
Very few reports mention cost awareness or attempts to share or minimise resources. Cost efficiency / effectiveness of commonly used intervention strategies such as formal training inadequately questioned and other methods to strengthen capacity not found.				
3. Interventions are selected and designed with explicit considerations on cost effectiveness.			3.0	3.0
Cost effectiveness is not really considered explicitly. However, interventions are generally based on international standards of good practice which include notions of cost effectiveness.				

7 Findings and analysis related to Sustainability

This chapter presents the findings and analyses related to the sustainability of the programme.

7.1 Sustainability of results and continuation of activities

The BH & HA programme implementation has resulted in changes in health seeking behaviour and consequent uptake of health services which are likely to be sustained in all project countries. Other changes brought about as a result of the BH & HA project interventions relate to the increased engagement of communities – either in self-help groups, interest groups, peer groups, church groups or village / health facility committees – in reducing stigma and discrimination, improving inclusion and, to a lesser extent, seeking accountability, are also likely to be sustained in most countries if the village / community structures remain active. However, village health committees may become less active without some support for the organisation of meetings in a number of countries: since 1987, the year the Bamako Initiative was launched, many efforts have been made to increase the engagement of community structures in health throughout the 'developing' world. Unfortunately, evidence[34] shows that community structures often become inactive without external support. The evaluation reports are generally positive about the likelihood that general health promotion including behaviour change messages communicated by change agents, especially the religious leaders and church groups, will continue.

Changes brought about by livelihood interventions / income generating activities which were often aimed at ensuring that poorer households can make use of paid health services are unlikely to continue without external support (e.g. in DRC, Zimbabwe and Kenya), although established community-based health insurance schemes have more chance to be sustained (DRC).

Health care support activities, especially directed towards the provision of home-based care and general curative service delivery are unlikely to continue without external support. However, a substantial number of partner organisations involved in service delivery have guaranteed funding from other than MFS II sources and will be able to continue their interventions (e.g. India, Afghanistan, Malawi and South Africa). In some countries, government authorities have agreed to take over clinics established by projects (Haiti) or have contracts with faith-based health care providers (Malawi): in these cases, activities will largely continue. In other countries, efforts have been made by partner organisations to continue with or introduce cost recovery aimed at sustaining their activities (DRC, India, Afghanistan and Bangladesh) which may lead to continuation of activities although it is unclear whether enough funds can be generated through costs recovery alone to sustain the functioning of health facilities. One partner organisation in Bangladesh is currently developing the capacity of community groups attached to 14 health facilities to enable these groups to manage the clinics after the departure of the partner organisation.

7.2 Financial sustainability and exit strategies

Several Country Coalitions indicate that they will continue to exist beyond 2015. However, in many cases, the development of a financial plan after the MFSII funding has only recently started. Some (at least three) coalitions have already written joint proposals, but so far none has been successful. In some cases the survival prospects are low, because partner organisations are too diverse, have a too wide geographical spread or lack a real joint vision (e.g. DRC). Other coalitions have better prospects

[34] McCoy D, Hall J, Ridge M (2011) A systematic review of the literature for evidence on health facility committees in low- and middle-income countries. Health Policy and Planning 2011;1–18 doi:10.1093/heapol/czr077

for continuation, for example when they focus on joint strategies (e.g. family approaches in South Africa, the CCMP approach in Zimbabwe) or when they have developed strong connections with major players (e.g. Zimbabwe). Only in one case have members already committed to membership fees to keep the coalition going beyond 2015 (South Africa) and in at least one case a coPrisma member has committed to contribute some money towards the continuation of the coalition (DRC). Several coalitions are willing to accept more members in order to become a stronger network, but in most countries, potential member organisations have insufficient interest in the coalition to invest in it and sometimes several competing coalitions already exist (notably Kenya). Notable exceptions are South Africa and India. None of the coalitions has explicitly decided to stop collaboration after 2015, even if this bold decision could provide clarity and avoid keeping a coalition alive only in theory. ICCO and coPrisma are involved in these discussions to the extent that the topic is raised in the country plans.

Exit strategies were not often seen or only at a very general level. Almost all partners are trying to continue their interventions. In many cases, coPrisma members will also continue funding, albeit often at a lower level. In some cases coPrisma members are phasing out (Woord en Daad will phase out its health projects completely and Tear ends cooperation with two partners in Zimbabwe), but even then the partners focus on getting funds for continuation of projects from other sources. For some partners who are highly dependent on the coPrisma partner as the sole donor (or more than 80%) this will likely be difficult. Many interventions have also been on-going before the current programme period and the partners intend to continue the interventions without planning exit or phase out strategies. In some cases partners simply discuss with their target groups that funding will end or reduce, hoping that the existing coping mechanisms of target groups will maintain the changes. A number of partners have introduced cost recovery to enable continuation of (health provision) interventions. One large project in Bangladesh (CSS, main funding from EU through Woord en Daad) built sustainability in the project as a core objective and monitors this specifically. In this project, six health centres were closed because the scope for sustainability was insufficient. And yet some other projects attempt to have their activities taken over by the government (e.g. a health centre in Haiti, decentralised distribution of ART in Zimbabwe). Examples of involvement of beneficiaries in planning for the period beyond 2015 are hardly seen, but in most cases beneficiaries are likely to endorse the strategy of continuation of the interventions.

7.3 Innovation

The development of innovative approaches to the delivery of BH & HA interventions has not been prominent. In a number of countries, new approaches that had been successful in achieving better results were introduced, such as the Birth & Life-Saving Skills (BLiSS) and the SAVE approaches which had been piloted in other countries and were adopted in projects in Afghanistan (BLiSS), Zimbabwe and Uganda (SAVE). Also the interventions targeting the inclusion of people with disabilities in Afghanistan and Bangladesh were successful: children with disabilities can participate in schooling in / close to their communities and no longer have to be placed in special schools. The use of religious leaders as 'change agents' has broadened the base for health promotion, social mobilisation and behavioural change communication in health and is in line with the Health in All Policies approach for the post-MDG era: the proximity of church leaders to communities and their willingness to work with people from different denominations offers opportunities to expand the utilisation of the CCMP approach in health and for other development activities.

While the change from direct implementation to facilitation cannot be considered innovative as such, this change is important in achieving sustainable development: the exploration of change

management approaches and addressing determinants of health through broad-based community structures is encouraging. The regional projects (EHAIA and Strategies for Hope) that were implemented in support of HIV / AIDS projects and aimed to increase openness in discussions around HIV and sexuality, including homosexuality using theological interpretations and respect for all people as an important Christian value, were innovative and broadening the utilisation of these approaches is worth promoting extensively.

7.4 Conclusion about Sustainability

The table below shows the final assessments (on a scale of 1 to 4) for the judgement criteria related to effectiveness. These judgement criteria were defined in the evaluation framework. A complete overview of judgement criteria and their assessments is found in Annex 11.

Table 16. Assessments on judgement criteria for sustainability

Questions and Criteria	IC	PO	CC / partners	Average
Sustainability				
To what extent are the benefits of the BH & HA programme likely to last after completion of the MFSII programme?	2.0		2.0	2.0
Judgement criteria				
1. Changes that the programme contributed to are likely to continue after completion of the programme.			3.5	3.5
In general, many changes have been rooted firmly and will be maintained.				
2. Relevant activities of the project of the implementing partner organisations are likely to continue after completion of the programme.			1.0	1.0
Almost all activities will require continued external support or need to be embedded in existing (government) institutions.				
3. Partner organisations and Country Coalitions are preparing themselves for the post-MFSII period (by means of e.g. exit strategies, strategies for financial sustainability). They involve beneficiaries as well as the IC in relevant ways.			2.0	2.0
Most Country Coalitions are working on strategies to guarantee future funding, but with little success as of yet. Few partners have exit strategies. Many coPrisma members will continue funding.				
4. IC programmes/projects can be considered innovative and innovation is stimulated in the programme.	2.0		1.5	1.8
Most interventions are very standard, with only few exceptions. At programme level, the use of change agents as approach to change management at community level can be considered 'novel' as was the move towards facilitating rather than implementation roles. The establishment of coalitions and alliances has become a general trend in development cooperation.				

8 Main conclusions

1. The overall objective – contribute to more equally accessible quality basic health care - has largely been met, but there is inadequate evidence that this has resulted in more equal health outcomes. Most of the changes that the programme contributed to are felt by beneficiaries.

The first objective - *increased accountability* - has been met at health facility level, because of strengthened committees, but not at the level of governments. Participatory structures have been strengthened and there is evidence of increased influence in decision making. There has hardly been any lobby and advocacy for increased accountability and transparency and consultation of beneficiaries in planning has been limited.

The second objective - *contribute to breaking silence and stigma and to prevention* – shows anecdotal evidence of positive effects. Working through change agents has largely had positive effects on general health seeking behaviour, on reducing silence and stigma, although there are only few objective measurements that show the actual health gains made. Capacity development of interest groups was done in many projects, especially focusing on interest groups of people living with HIV / AIDS and people with disabilities, which show that lobby & advocacy for inclusion and equality has reaped positive effects, but effective advocacy by interest groups has been rare. The results of capacity development of interest groups in income generation have been mixed.

The third objective - increasing and improving human resources for health - has not been met as interventions have had a very limited effect on the size and distribution of the available 'professional' health workforce. The programme has included many training interventions, but the focus has hardly been on improved health workforce policies. The effects of training have not really been measured, although there are indications of improved performance in several projects. Partners often cooperate with governments, but only in a few cases has this led to increased government allocations for the health workforce.

2. Projects have implemented interventions based on international best practice which are recognised for their effectiveness and were largely relevant, because they have taken into account overall country contexts and evidence of globally as well as nationally established beneficiary needs (HIV, Sexual & Reproductive Health, basic health care, specific disease control). Interventions were also relevant because of the focus on the need for capacity development of community groups / structures to strengthen their engagement in demanding accountability and changing the balance of power, the need for a multi-sectoral approach in addressing social determinants of health and drivers of ill-health and the need to address socio-cultural practices and values that contribute to stigma and discrimination using change agents. The many training / knowledge & skills transfer interventions are thought to have contributed to improved performance of the health workforce. However, the findings inadequately show that acquired knowledge and skills were consistently applied, possibly because of poor follow up, and other effective methods of knowledge and skills transfer have not been used.

3. ICCO Cooperation's policies, position and guidance papers and the Theory of Change and results framework have been helpful in providing guidance and assuring the financing for the programme. However, the training provided in lobby & advocacy, Planning, Monitoring, Evaluation and Learning and the Theory of Change has hardly been effective.

4. The introduction of the Programmatic Approach, although initially met with reluctance because of the top-down nature of introduction, has been important in ensuring cohesion in the projects. Despite the lack of systems' harmonisation, the Country Coalitions have largely been successful as platforms for sharing and networking, but much less as embodiment of multi-stakeholder approaches that work on systemic changes.

5. The Theory of Change of the programme was too specific to encompass the diversity of interventions and does not make clear how the various results should contribute to the objective of the programme.

6. Efficiency has not been at the top of partner organisations' agenda. However, most interventions are known for their cost effectiveness.

7. Clear benchmarks to compare programme, overhead and project overhead costs are not readily available, which makes it difficult to judge whether transaction costs of the ICCO Cooperation are acceptable. The duplication of reporting and monitoring (to Country Coalitions and the coPrisma member) is inefficient and may have increased the transaction costs.

8. It is unclear whether and where cost savings could have been made, because unit costs of commonly implemented interventions are not available. This lack of information is especially important for training interventions and support of change agents in health promotion, because it does not allow a comparison of formal training with other knowledge and skills transfer methods and of using already available community workers rather than newly recruited and trained change agents.

9. The effectiveness of the applied Planning, Monitoring, Evaluation and Learning system is doubtful: the monitoring of project implementation has largely focused on measuring outputs, even when they were framed as outcomes. Measurements of health gains at outcome level have not been undertaken. Insufficient attention was given to ensuring the quality of project evaluations.

10. Achieved changes in access to and utilisation of health services as well as in behaviour are likely to be sustained, but most partner organisations will be challenged in continuing their project activities without external funding after MFS II.

11. A number of Country Coalitions are committed to continue, although ultimately this commitment will need to be supported by viable business plans and funding, which is less straightforward.

12. The lack of partner organisations' capacity and willingness to innovate has not been given adequate attention in the selection of partners of ICCO and coPrisma members.

9 Strategic recommendations

1. Health is a Global Public Good. Improving health was one of the intended and achieved results of the Basic Health & HIV / AIDS programme, in line with the core principles of the ICCO Cooperation's Strategic Plan 2020 as well as the MDG agenda. The ICCO Cooperation should continue its involvement in health to ensure that progress made in addressing drivers of ill-health and social determinants of health, and meeting health needs of disadvantaged people is built on in the post-MDG era. Health should be given appropriate attention, also when the organisation's focus moves towards supporting economic development.

2. Explore partner organisations' capacity to innovate, adapt to new approaches and concepts as well as their ability and willingness to institutionalise changes and attach consequences to these in programming. This should include further emphasis on the change from direct implementation to facilitation, including the facilitation of health prevention and health promotion interventions through existing structures.

3. Conduct research to determine whether programmes would be as or more effective if they target already available community workers linked to the health and other sectors and community structures instead of recruiting 'new' change agents to realise change.

4. Increase the focus on working on systemic change. In establishing Country Coalitions, consider already existing coalitions and alliances. Invest further in Theory of Change thinking to ensure that activities, interventions and collaboration are chosen to optimally serve the intended systemic change. Also ensure that Theories of Change continue to be fed by established international good practices.

5. Future programme financing opportunities are changing which requires that the ICCO Cooperation takes a firm decision with regard to its core role vis-à-vis partner organisations, i.e. decide between playing a prominent role in ensuring financing for partners' programmes or take on a more pro-active role by becoming a promotor of new programme approaches.

6. The development of Planning, Monitoring, Evaluation and Learning protocols should match the Theory of Change pathways. The reliable measurement of project interventions' health status and health sector performance outcomes should be given more attention. More attention should also be given to ensuring that the project evaluations meet quality standards.

7. In close collaboration with other Alliances, establish benchmarks for acceptable transaction costs' levels.

8. Establish the unit costs of key interventions and determine the acceptable deviation levels of established unit costs in specific contexts.

9. Prior to programme implementation in consortium with other organisations, it is imperative that administrative systems of all programme partners are harmonised to ensure that collaborative efforts are optimally effective and efficient.

10. In addition to promoting more exchange visits and peer reviews for learning, explore effective and cost efficient alternatives to training workshops for the transfer of knowledge and skills as well as for other capacity development interventions.

Annex 1. Terms of Reference for the evaluation

Terms of Reference for the Program Evaluation on the Basic Health & HIV and Aids program of the ICCO-Cooperation 2011 – 2014

1. Introduction

This Terms of Reference is written for the evaluation of the thematic program Basic Health & HIV and Aids (BH&HA) of the ICCO Cooperation (2011 – 2014). ICCO Cooperation (IC) wants to have a more in-depth look into the BH&HA program. Focus will be on revisiting its program logic as laid down in its business plan (and further developed in its Theory of Change for the BH&HA programme), determining the results in the countries where the program has been implemented, to see what are intermediate tangible results on beneficiary level and to evaluate the cooperation within the ICCO Alliance /ICCO Cooperation and its added value in relation to this program. The results of the evaluation are meant to feed into the Post 2015 strategies as laid down in the MASP 2020.

Special feature of this evaluation is its partial meta-evaluation character, since it will include the country coalition evaluations as well as the project evaluations all done in the period 2013-2014.

2. Background

IC and especially cooperation member coPrisma, has a long history in supporting basic health and HIV oriented activities. In 2007, ICCO, Prisma, Edukans and others formed the ICCO Alliance (IA). This Alliance implemented the MFS I funded subprogram Health and subprogram HIV & Aids (2007-2010). The MFS II funded BH&HA program, 2011-2015, subject of this evaluation, is in fact a combination and continuation of these 2 subprograms. Main difference between the two is the strong accent on accountability and civil society strengthening in the actual program.

The program started in 14 countries1 and is actually being continued in 12 countries2. The following Dutch organizations are implementing the actual BH&HA program: Kerk in Actie, ICCO and coPrisma members Operation Mobilisation, Help a Child, Salvation Army NL, Trans World Radio, De Verre Naasten, Leprosy Mission Netherlands, Light for the World, GZB, DORCAS, TEAR, Woord en Daad, Bijzondere Noden. These organizations mainly work with local partners, ICCO works with regional and international partners as well.

Part of the IA, ICCO and Kerk in Actie, started decentralizing their organizations in the period 2007-2010. Apart from the Global Office (GO), in 2014 7 Regional Offices (RO) are in function. Through these offices regional strategic planning is taking place as well as maintaining relations with partners and fundraising. In 2013 the ICCO-cooperation was established. Kerk in Actie coPrisma and Edukans are principal members of the Cooperation.

In 2012 and 2013 a pilot has been implemented in the region Central and East Africa to explore in which way ICCO Cooperation members coPrisma and Edukans can collaborate with ICCO and Kerk in Actie in their decentralized structure. Main objective of the collaboration is supporting the programs and country coalitions in Kenya, Uganda and Ethiopia and the increase of impact. coPrisma members and Edukans handed over the responsibility for implementation of the health, education and food security programs to the RO in Kampala. A network sturcutre has been developed in which the RO Kampala collaborates with country offices/representatives of coPrisma members and Edukans in Kenya, Uganda and Ethiopia

1 Afghanistan, Bangladesh, DR Congo, Ethiopia, Haiti, India, Kenya, Malawi, Malawi, Uganda, South Sudan, Zimbabwe, South Africa
2 Due to policy choices made in the ROs, the BH&HA program was phased out in Angola and Latin America.

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(the Regional Working Organisation, RWO). Main conclusion of the evaluation of the pilot was that within the IC we need to continue working on models of southern collaboration that fit better with the vision and ways of working of the coPrisma members (and Edukans).
The MFSII BH&HA will close in December 2015. Parts of the program will continue in different settings: guided by members of coPrisma, by ICCO and Kerk in Actie, or the ICCO Cooperation. Each of these organisations has formulated, or are currently formulating their strategies and thematic focus for the Post 2015 period.

There are a two other programs within ICCO Cooperation that have a focus on health in general and/or sexual and reproductive health and rights (SRHR), including HIV and AIDS. The first one is Educaids, a program of ICCO Cooperation (Edukans, ICCO, Kerk in Actie and Prisma) focusing on young people and the promotion of their SRHR through education. The second one is Impulsis, a combined program of ICCO, Kerk in Aktie and Edukans supporting small scale development programs (the so-called private initiative); health and HIV are two of its themes. Both programs will not be included in this evaluation. The Educaids program will be partly evaluated within the Basic Education program, e.g. integration of SRHR within (extra) curricular activities, and will be partly evaluated separately, e.g. the Shareframe component of the program. Impulsis is working in quite a different manner then the BH&HA program.

One of our strategic partnerships and funder is Stop Aids Now (SAN), an expertise organization focusing specifically on a comprehensive approach to address the HIV and AIDS pandemic effectively. Their initiatives and interventions, including lobby and advocacy, do contribute to the quality of our BH&HA program, their funds to the size of our program. As their funds are being used together with MFS II funds within the 12 countries where our overall BH&HA program is being implemented, we will not make a distinction between partners funded with SAN or with MFS II funds, both will be included in the evaluation.

3. BH&HA program logic

At the start of the MFSII period a concise program logic for the BH&HA program was formulated in the original MFSII proposal (see annex 1A). Based on this Thematic Country Plans were formulated for all countries, which were updated annually. In these plans the program logic and more specific country objectives and the process of country coalition building were further defined.
ICCO countries do not develop thematic country plans. In *Malawi* the Uchembere network develops its own annual planning on the basis of a 3 year program plan as it differs from most country coalitions within the BH&HA program (not consisting of mainly ICCO Cooperation partners but involving a variety of different sector actors). The ICCO program in *South Africa* consists of 3 strategic partners that are all operating as coalitions. They develop annual work plans which are in line with their multi annual strategic plan.
Apart from the programs at country level, ICCO supports a number of strategic organisations working regionally, for example EHAIA covering Sub Sahara Africa, or internationally, for example Ecumenical Advocacy Alliance. These partners develop their annual working plans which are in line with their multi annual strategic plan.

Summary of the ToC

The Theory of Change (ToC), developed on the initial program logic can be summarized as follows.

the problematic

The last decade showed important improvements in the general health status of people worldwide. However, not everybody has profited equally. Due to weak and non-available or non-accessible health systems inequalities in health outcomes, in access to care and in what people have to pay for care have grown despite worldwide commitments such as MDG's 4, 5 and 6[3]. The ICCO alliance believes that a strong and organized civil society is needed to ensure the fulfillment of the right to health. This is based on lessons learnt in previous years like the lesson that community involvement, including the involvement of religious leaders, is crucial for positive change towards better accessible and improved quality basic health care. Scientific evidence supports these lessons; it shows that organizing and empowering communities and people's organizations is important to effectively pressure the state into action towards addressing persistent health inequities[4].

ICCO Alliance's vision of change
To realize more equal health outcomes the ICCO alliance in its Basic Health & HIV program focuses on equal accessible and quality basic health care. Investing in basic health care at community level has shown to reach those most vulnerable to ill health best. The ICCO alliance puts specific emphasis on preventative interventions as these are being perceived as contributing to sustainability of the health system. The ICCO alliance acknowledges that besides health related interventions, other social determinants have an impact on the health outcomes of (vulnerable) people. The ICCO alliance works on other determinants of health too. Within the health care program we explicitly focus on health care but we try to connect these interventions to other areas of our work there were relevant, e.g. connecting maternal health to food security or connecting our SRHR programs for young people to education.

the program
Assuring the access of people to basic and quality healthcare services is the primary responsibility of the national, district and local government of a country. In many countries pro poor health policies do exist but implementation is rather weak. Governments do not prioritize delivery of health care and do not give special priority to services for vulnerable groups. Therefore the ICCO alliance works towards equal accessible and quality basic health care by:

1. Enabling Civil Society to demand accountability from (national, district and local) governments and other relevant stakeholders
2. Supporting change agents to challenge exclusion mechanisms and contribute to prevention
3. Reinforcing health systems by expanding and improving available human resources for health

ad 1. As stated earlier civil society has a role to play to ensure the fulfillment of the right to health, It can only do so if it is organized: voices of individual people are much better heard when they speak out together. These organizations of people, so called civil society organizations (CSOs), must also have the capacity be able to monitor performance of the health system, particularly in areas of access and perceived quality. CSOs also play a role in feeding the health system with information about the health needs of its members, e.g. potential users of the system, and with ideas how to improve on access and quality to health services for all. If CSOs are able to ask governments and other service providers to account for their performances, it is being expected and proven that governments and providers will put the implementation of (existing) pro poor (government) policies higher on their agenda.

The health system is a crucial actor in realizing access to quality health care; however there are other mechanisms that play an important role in access as well (both within communities and in the health sector itself) like position in society, gender, stigma and discrimination. These mechanisms make access to health care unequal for people or even exclude them from access to care. CSOs do have a key role to play in making these mechanisms explicit and to challenge these.

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3 WHO, World Health Report 2008, http://www.who.int/whr/2008/en/index.html
4 Political will for better health, a bottom-up process, Wim De Ceukelaire, Pol De Vos and Bart Criel, 2011

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ad 2. On community level the ICCO Alliance sees an important role for religious leaders and other change agents, e.g. peers, teachers, to address these mechanisms that contribute to discrimination and exclusion. Religious leaders and other change agents have strong influence in their communities; they are therefore well placed to challenge these (social) mechanisms that marginalize and exclude people that life for example with HIV, people with a disability and other vulnerable groups. By challenging these exclusion mechanisms by breaking the silence surrounding them, challenging taboos and informing people properly, it is envisaged that excluded groups will become accepted and considered as 'normal' citizens within their communities. This will enable them to participate within and contribute to their community and will improve their equal access to quality health care services.

Another aspect indirectly related to improving the access to quality care for all has to do with enlightening the burden on the health care sector, Many communicable and non-communicable diseases can be prevented if people are well informed and are able to adopt a healthy life style. Because of their position in society, religious leaders and other relevant change agents are key actors in promoting health under the condition that they are well informed, able to change negative attitudes and perceptions, build necessary skills and co-construct a supportive environment.

ad 3. In rural communities basic health care services are scarce. One of the reasons for this scarcity is the lack of adequate and good quality health care personnel. Communities, CSOs and Faith Based Organizations are important actors/stakeholders/providers within the health system. Focusing on developing the capacities of community, lay and professional, and health care personnel in general ánd working on their complementarities will not only increase the number of staff but also their capacities contributing to better quality and greater access to, community, health care for all.

strategies
Strategies related to the objectives are:

- Multi-actor coalition building (civil society needs to collaborate with other stakeholders like governments, beneficiaries and the for profit private sector)
- Lobby and Advocacy (e.g. accountability, input)
- Linking and Learning (e.g. improving own effectiveness, sharing of good practices)
- Capacity Development
- Empowerment (of civil society and its members)
- Brokering and Organizing people (e.g. by combining voices of people they become better heard, better visible and less vulnerable than when acting alone)

More about the program logic can be found in annex 1B: Theory of Change Basic Health & HIV/AIDS program.

The budget spent for BH&HA during the evaluation period is about 30 million Euros (figures till end of 2014).

BH&HA learning, knowledge development and capacity development
Over the years a variety of support has been given to various bodies in the organization to draw the BH&HA program to a higher level. In this support the lessons drawn from working in a programmatic way in practice are being taken along. The table below gives an overview of the various learning and capacity development activities around the BH&HA Program

Table 1. Overview of BH&HA activities during MFSII period

Year	Activity	For whom	by whom	Follow-up
2011	Programmatic Approach (PA) training	coPrisma staff and Programme Officers (POs) of coPrisma members	Capacity Development and Learning Program manager and Center for	-Applied while introducing PA at country level and building up country coalitions

			Development Innovation (Wageningen)	
2011	Global F2F BH&HA	BH&HA POs of coPrisma members and Regional Offices, and several coordinators of country coalitions	Specialists BH&HA with input from external experts	-Reports on the wiki -Action plans formulated per country coalition and integrated in annual country plans -D group conversations- Individual contacts with PO's on specific issues
2011	Regional F2F BH&HA, South Africa	Relevant POs of coPrisma members and Regional Offices and relevant partners from Zimbabwe, Malawi, Angola and South Africa	Specialists BH&HA with input from external experts	-Reports on the wiki -Action plans formulated per country coalition and integrated in annual country plans -Dgroup conversations -Individual contacts with PO's on specific issues
2012	Regional F2F BH&HA, Uganda	Relevant POs of coPrisma members and Regional Offices and relevant partners from Ethiopia, South Sudan, Kenya, Uganda and the DRC	Specialists BH&HA with input from external experts	-Reports on the wiki -Action plans formulated per country coalition and integrated in annual country plans -Dgroup conversations -Individual contacts with PO's on specific issues
2012	Regional F2F BH&HA, Bangladesh	Relevant POs of coPrisma member organisations and Regional Offices and relevant partners from Bangladesh, India, Nepal and Afghanistan	Specialists BH&HA with input from external experts	-Reports on the wiki -Action plans formulated per country coalition and integrated in annual country plans -Dgroup conversations -Individual contacts with PO's on specific issues
2013	Global F2F BH&HA	Relevant BH&HA PO's of coPrisma members and Regional Offices and coalition coordinators	Specialists BH&HA with input from external experts	-Reports on the wiki -Action plans formulated per country coalition and integrated in annual country plans -Dgroup conversations -Individual contacts with PO's on specific issues
2014	Regional F2Fs in Uganda South Africa, Uganda and Bangladesh	Relevant POs of coPrisma member organisations and ROs and relevant partners from: Ethiopia, South Sudan, Kenya, Uganda, the DRC and Haiti; Zimbabwe, Malawi and South Africa; Bangladesh, India, Nepal and Afghanistan	Specialists BH&HA	-Reports sent to all people present -Action plans formulated per country coalition and integrated in annual country plans
2011-2014	Three monthly program working group meetings in at GO level	POs of coPrisma members	Specialists	-Minutes of the meetings sent to all coPrisma members

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	Special training sessions were organised on e.g. basics of Behaviour change (2012) and Youth friendly health services-value clarification (2014)		Together with Stop Aids Now (SAN) Together with KIT	

BH&HA Learning and Knowledge Development

Besides the activities already mentioned above, the BH&HA program initiated and/or participated in the following learning and knowledge development activities:

1. Policy paper Prisma on SRHR, 'Pro-Creation; Prisma vision paper on sexual and reproductive health and rights' (2009)
2. Active participation in Educaids, a network of IC members and its partners focussing on the connection between education and SRHR (2004-continuing)
3. Dgroup conversations on different topics (2011-2012)
4. Position paper Rights Based Approach in Health (2013)
5. Led by SAN: Training of Trainers on SRHR for young people, including ICCO POs and partner organisations (2012-contunuing)
6. Together with SAN: learning group in Ethiopia on HIV & livelihoods (2013-continuing)
7. Research related to informed choices about Family Planning & access to contraceptives, 'Family Planning choices within marriage and before; Practices, perspectives and potentials in faith-based Family Planning programs in DR Congo, Ethiopia and Malawi' (2014)
8. IOB evaluation on contribution of MinBuZa partners to realisation of its SRHR policy (2013)[5]
9. Project and country coalition evaluations (2013-continuing)
10. Expert meeting 'Managing Ideals and Realities; the work of faith based organisations in reproduction and sexuality'(2012)
11. Expert meetings of Share-Net on SRHR related issues (2001-continuing) and of DCDD on inclusion of people with disabilities (2006-continuing).

4. Purpose and evaluation objectives

4.1 Purpose

This program evaluation will be used to communicate on results reached in the field of BH&HA. The results will be communicated to our partners, they will be asked to share it with their target groups, with principal stakeholders, donor(s) and the general public (building an evidence based narrative). The evaluation will function as a track record on BH&HA. The evaluation is meant to provide input (learnings) for (ongoing) policy development.

4.2 Overall objectives

The objective of the evaluation of the Basic Health & HIV/AIDS Program is to get insights in the results of the implementation of the program and the ways of implementation until now.

5 Balancing Ideals with Practice. Policy study of Dutch Involvement in Sexual and Reproductive Health and Rights 2007 – 2011. IOB evaluation 381

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The outcomes of the evaluation help to give pointers for a future Health program as will be implemented post 2015 by co-Prima or Prisma member organizations or ICCO Cooperation (for the latter this will be part of the two core principles of ICCO Cooperation's MASP 2020.

The overall evaluation question is:
To assess to what extent the work of the ICCO Cooperation and their partner organizations during the period 2011 – 2014 has contributed to the sustainable realization of equal accessible and resilient health systems in rural areas, especially for poor people, vulnerable to and living with HIV and/or other diseases.

4.3 Focus
The overall focus of the evaluation is to analyse the relevance, effectiveness, efficiency, sustainability and approach of the BH&HA programmes in the 12 countries it is actually being implemented.

For *relevance* the aim is to establish the extent to which the BH&HA country programs and the projects of the implementing partner organisations meet the development priorities and needs on local and national level.
For *effectiveness*, the objective is to establish the extent to which the BH&HA overall program reaches its objectives, and to which extend this is visible on outcome level: what has changed for the target group?
For *efficiency* the aim is to establish the extent to which the BH&HA program is operating in a cost efficient way.
For *sustainability* the aim is to establish the extent to which the benefits of the BH&HA program are likely to continue after completion of the program, to which extent activities of the program are likely to continue after completion of the program and the extent to which exit strategies are (being) developed.
For *approach* the aim is to establish the extent to which the BH&HA program worked according to ICCO-cooperation approaches like country coalition building and programmatic cooperation, the RBA and gender approach and the extent of the added value of the cross thematic linkage laid particularly between SRHR and education.

5. Evaluation questions

For *relevance*

- To what extent are the interventions contributing to equally accessible and resilient health systems in rural areas, especially for poor people, vulnerable to and living with HIV and/or other diseases

subquestions:

1. To what extent are the changes realised by the BH&HA country coalition programs in line with the (identified) beneficiaries' needs?
2. To what extent are the changes realised by the BH&HA projects of the partner organisations in line with the (identified) beneficiaries' needs?
3. To what extent are the changes contributing to the 2 core principles Securing Sustainable Livelihoods and Justice for all of the ICCO Cooperation MASP2020?
4. To what extent has collaboration with relevant stakeholders (different levels, health and non-health) increased the program relevance?

For *effectiveness*

- To what extent have the objectives of the BH&HA program been achieved, or are expected to be achieved during the MFS2 period?
- To what extent has the IA contributed to changes observed at the beneficiary level?

subquestions:

1. To what extent does the Thematic Country Planning of the country coalitions contributed to higher effectiveness of the BH&HA program? (see also remark on p. 2 about different way of working ICCO partners).
2. To what extent is synergy realized between the three intervention strategies? Were the three intervention strategies helpful in reaching results?
3. To what extent does (use of) the Monitoring Protocol support the proceedings of the program?
4. To what extend did partners / country coalitions use their PME system for measuring results, learning lessons and improving the quality if the program?
5. How did learning take place in the BH&HA Program?

For *efficiency*

- To what extent has the IA carried out the BH&HA program in a cost efficient way?

subquestions:

1. To what extent has program efficiency increased by working in program coalitions and/or other alignment and collaboration with relevant stakeholders (different levels, health and non-health)?

For *sustainability*

- To what extent are the benefits of the BH&HA program likely to last after completion of the MFSII program?

subquestions:

1. To what extent are relevant activities of the project of the implementing partner organisations likely to continue after completion of the program?
2. To what extent and in what ways are partner organizations preparing themselves for the post-MFSII period (by means of e.g. exit strategies, strategies for financial sustainability)? Is there involvement? To what extent is IC involved in this? To what extent do partners involve their beneficiaries in their search for sustainability?
3. To what extent and in what ways are country coalitions preparing themselves for the post-MFSII period (by means of e.g. exit strategies, strategies for financial sustainability)? To what extent is IC involved in this?
4. To what extent can ICCO programs/projects be considered as innovative?

For *approach*

- To what extent are IC's principles integrated in the BH&HA program?

subquestions:

1. To what extent are gender and rights based approach principles embedded in BH&HA programs?

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2. To what extent are the BH&HA programs in the countries based on multiple stakeholder cooperation, country coalitions (so-called programmatic cooperation)? Please do give a valuation of these, based on the findings of the coalition evaluations
3. To what extent does cross-learning and cross-thematic learning at country and global level, e.g. between partners, partners and strategic partners, and IC and its partners and strategic partners, take place?

6. Approach

In order to answer the evaluation questions listed above the evaluation will make use of the following approach.

In 2014 external evaluations of the projects and of most of the program coalitions of the BH&HA have been carried out or are under execution (see annex 2 and 3 for the general ToR for both evaluations). Given this fact, and for the sake of cost- and time management (the ending of the MFSII subsidy framework is December 31, 2015), this program evaluation will partly have the character of a meta-study (as far as results on the beneficiary level is concerned and the implementation and results of the programmatic coalition). The evaluation will rely on a desk study of the different evaluation and program documents in the first place. The desk study aims to be comprehensive. If there are sufficient good-quality evaluations, the study will be representative. If not field visits to complement the findings will be considered.
The more elaborate valuation methodology is to be presented by the evaluators in the inception report (as elaboration of the initial proposal).

In the whole evaluation process the evaluators should be open to 'surprises'' and unintended effects (both positive and negative) of the BH&HA program.

The table summarizes the various stages of the evaluation:

Inception	Initial interviews program coordinator and education specialists coPrisma & ICCO
	Inception report
Desk study	Project documents (portfolio)
	Assessment project and program coalition evaluations
	Financial data
	Literature on Basic Health, SRHR and HIV & aids
Interviews	POs coPrisma
	POs ICCO and KerkinActie
	External experts

Inception report

The evaluation study starts with a further elaboration of the ToR by the evaluation team to get overview of the theme and to phrase the approach of the study more precisely. The inception report contains a detailed mode of operation (including detailed research questions, corresponding indicators and data collection overview) and overview of methodologies used, a detailed time schedule and budget. The

inception report is to be discussed with the evaluations specialist of the PMEL unit and – if necessary – adjusted accordingly.

Desk study
The evaluation team makes a portfolio analysis of the BH&HA projects, that are in the data system of coPrisma and ICCO and KerkinActie (an inventory of the activities, objectives and indicators – and if possible the results – of the Education programme). This will provide a comprehensive overview of the theme and of the division of programmes and projects over the countries and regions and a basis to situate the project and programmatic coalition evaluations. Furthermore, a few explorative interviews with relevant coPrisma and IC staff in the ROs and GO have to be made exploring the subject from their perspective. The next step of the desk study is review of the Theory of Change. The main input for this is the portfolio analysis of the BH&HA projects, its Theory of Change and other policy documents. For answering the evaluation questions on the relevance, effectiveness, sustainability and approach, the desk study will rely on the available project and program coalition evaluations. The desk study therefore includes a quality assessment of the available project and program coalition evaluations (using the quality assessment grid in annex 5). Those evaluations of satisfactory quality will be summarized and be input for the evaluation. More interviews with IC staff and other relevant informants in the Netherlands could be organized.
Based on all the information gathered, the researchers will be able to make an assessment to what extent the evaluation questions from the ToR can be answered and give an indication of what information is still missing and/or has to be verified and how this has to be done, to be able to make an accurate judgement of the results of the programme.

The team writes either an evaluation report (based on the desk study)t in which they either are able to explicitly answer the evaluation questions (including a limited number of recommendations) or answer them partly combined with an elaborate proposal on how proceed with collecting relevant information that is still missing.
In the first case the desk study is the final report, which will be presented by the team to the Reference Group (RG). Following the presentation the RG will give their comments. Based on their comments the evaluation team is supposed to finalize the report within ten working days.
A presentation of the final results of the evaluation to the Executive Board of IC and directors of the coPrisma member organizations belongs to the possibilities.
In the second scenario a motivation and approach for a limited field study is clearly worked out: which information is lacking and needs to be gathered locally to answer the left over research questions. This proposal furthermore elaborates in which way the choice of the cases optimizes the representativeness of the research (as the selection should be representative for the total of ICCO Cooperation's interventions on BH&HA). In case representativeness is a challenge, the proposal identifies ways to tackle this issue in a justified way. This elaborated proposal is to be discussed with the Reference Group (RG).

Final analysis and reporting
There will only be a final analysis phase in case there is a need for additional, limited field work. In this phase the information of the previous phases is merged in a final report; the research questions are explicitly answered and where deemed necessary a limited number of recommendations is given. This final report is presented to the RG by (the leader of) the evaluation team. Following the presentation, the RG give their comments. The evaluation team is supposed to finalize the report within ten working

days. A presentation of the final results of the evaluation to the Executive Board of IC and directors of coPrisma organisations belongs to the possibilities.

The evaluation needs to meet the standards set out by the Policy and Operations Evaluation Department (IOB), an independent body of the Netherlands Ministry of Foreign Affairs (see annex 6).

7. Deliverables

The following final products have to be presented in English:

1. A detailed plan of approach (including a detailed budget)
2. A desk study report, including , if relevant an elaborate proposal how to assure answering all questions, which might include the necessity of a field study
3. The next deliverable is only expected in case the option to carry out a field study is positively answered
4. County reports, that are considered to be internal working documents
5. A draft synthesis report; to be submitted June 15 2015 latest.
6. A final synthesis report (max 40 pages), excluding annexes. The report is delivered in electronic version and in hard copy (5 copies). The final report should be submitted within 10 days after receiving ICCO Cooperation's comments on the draft report.
7. Presentation of the final report to the Executive Board of IC, directors of coPrisma organizations and relevant people within IC.

8. Process

The responsibility for the evaluation lies with Dieneke de Groot (the PMEL unit of the SSC, which is a joint department of ICCO Cooperation and the Protestant Church). She works in close cooperation with Anke Plange, BH&HA Program Coordinator and Willeke Kempkes, Policy advisor SRHR IC.
Within the ICCO Cooperation the evaluation is supported by a small reference group (RG) which gives advice on strategic moments (desk study report, draft synthesis report). The RG is supported with methodological advice by one or two external experts.

9. Planning

The evaluation is carried out from January 2015 - June 2015

The following planning for the evaluation is foreseen:

Part of the evaluation	when
Selection consultant	15th of January – February 21 2015
inception report	
Inception report	March 8th, 2015
Desk study	
Portfolio analysis	March 8 – 29, 2015
Study documentation, interviews and evaluations	March 29 - April, 2015
Analysis and draft desk study report	May 30, 2015

Final evaluation report	June 15, 2015
Final report presented to ICCO Cooperation	End of June, 2015

When field work will be included, the evaluation will be finalized by the end of July 2015.

Synthesis report	
Field work	June 15 – July 15, 2015
Analysis & synthesis report writing	15th of July – 15th of August 2015
Submission draft synthesis report	15th of August 2015
Finalisation synthesis report	Till end of August, 2015
Final report presented to ICCO Cooperation	August 31 2015

10. Profile evaluators

The team of 2 evaluators should have the following qualifications:

- background in a relevant field like Social Sciences (including Social Research methods), Public Health, Development Studies
- knowledge of different approaches of civil society strengthening, including working in a programmatic approach
- knowledge of RB and gender based Approaches
- experience with innovative evaluation methods and social survey methods (data collection, entry, analysis), semi-structured interviews and focus group discussions
- analytical skills
- proven skills in conduction evaluations in the field of Basic Health and/or Hiv & aids
- well aware of issues related to working in rural setting
- well aware of issues related to working with faith based organizations
- at least 5-10 years' experience working in the South
- able to quickly compose a team that has English and French language skills in case field work will be carried out

The team leader should have proven skills to lead the more complex type of (program) evaluations

11. Budget

The program evaluation Basic Health & HIV is part of the budget set aside for PMEL.
The budget proposal should give a breakdown of the expected number of days per team member and their fees. Prices need to be calculated in Euros, and cannot be changed during the contract.

The **maximum** budget available for the evaluation without field studies is €55.000 (**VAT included**).

Payments:
The payment procedure is the following:
30% at the start
30% at presentation draft report
40% after receipt of approved final report and financial justification

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Annex 2. Assessment tool for evaluations

Each of the criteria in the table below was assessed for each evaluation using a four point scale: 1 - Unacceptable, 2 - Weak, 3 – Good and 4 - Excellent.

1. Meeting needs
The report adequately meets the information needs expressed in the terms of reference in a way that reflects the stated priorities. The demands which were made during the evaluation process are mentioned and satisfied when possible.
2. Appropriate design
Key concepts and criteria are precisely defined. The method is described clearly and is adequate for addressing the questions. Methodological limitations are explained as well as their consequences on the strength of conclusions and on the substance of recommendations.
3. Reliable data
Data are sufficiently reliable with respect to the conclusions that are derived from them. Data collection tools have been applied in accordance to standards. Sources are quoted and their reliability is assessed. Potential biases are discussed.
4. Sound analysis
Data are cross-checked, interpreted and analysed systematically and appropriately. Underlying assumptions are clarified. The main external factors are identified and their influence taken into account.
5. Valid findings
The findings are based on evidence through a clear chain of reasoning. The limitations to validity are clearly stated.
6. Impartial conclusions
The conclusions are based on explicit criteria and benchmarks and are free of personal and partisan considerations. Points of disagreement are reported truthfully. Lessons of wider interest are identified.
7. Useful recommendations
Recommendations stem from conclusions. They are applicable and detailed enough to be implemented. The level of recommendations (political, strategic, managerial, others) reflects that of the evaluation questions.
8. Clear report
The style of the report is interesting for and accessible to the intended users. A short summary stresses the main findings, conclusions, lessons and recommendations in a balanced and impartial way.
Overall assessment
Taking into account the contextual constraints on the evaluation, the report satisfies the above criteria.

Annex 3. List of policy documents and literature consulted

Brinkerhoff D (2007) Capacity Development in Fragile States. Discussion paper No 58D, ECDPM. Maastricht

Cornielje M, Dingemanse-de Wit G, Smilde W, Velema J (2014) Family Planning choices within marriage and before. Practices, perspectives and potentials in faith-based Family Planning programs in DR Congo, Ethiopia and Malawi. Alphen aan de Rijn

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ICCO – Kerk in Actie (2012) Client Satisfaction Instruments. A learning guide to give voice to clients in improving service delivery. Utrecht

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ICCO Alliance (2013) Facts & Factors related to effective behaviour change. Utrecht

ICCO Project Group Health in MASP (2014) Health in the ICCO Cooperation MASP; a paper on 3 perspectives from expertise on Health & SRHR (incl. HIV) in the ICCO Cooperation. Utrecht

McCoy D, Hall J, Ridge M (2011) A systematic review of the literature for evidence on health facility committees in low- and middle-income countries. Health Policy and Planning 2011;1–18 doi:10.1093/heapol/czr077

Prisma (2009) Pro-Creation. Prisma Vision paper on Sexual and Reproductive Health and Rights (SRHR). Hands up for health. Utrecht

Walters H (2011) Guidance Note for the Programmatic Approach of the ICCO Alliance. Utrecht

WHO (2007) Everybody's business. Strengthening health systems to improve health outcomes. A framework for action. Geneva

Annex 4. People interviewed

Name	Organisation	Position
Anke Plange – van Well	coPrisma	Thematic specialist and Coordinator BH & HA programme
Brenda Kacheche	ICCO Malawi	PO Malawi
Jacob Jan Vreugdenhil	Woord en Daad	PO Haiti
Jakolien Meas	De Verre Naaste	PO South Africa
Jan Harmen Drost	ICCO RO Kampala / ProCoDe CEA	PO Ethiopia, Kenya and Uganda
Jan Janssen	Leger des Heils	PO DRC
Klaas Aikes	Light for the World	PO Afghanistan
Nico Zwemstra	Leprazending	PO Bangladesh
Pieter-Jan Bouw	Red een Kind	PO India
Willeke Kempkes	ICCO	Policy Advisor SRHR
Willem Klaassen	TEAR	PO Zimbabwe

Annex 5. Matrix used to analyse coalitions and projects

The following matrix was used to structure all information. Each project was given its own column. Per country (and separately for the regional projects), one column was included for the country coalition evaluation and one column that synthesised the information of the project evaluations. These two columns for each country were the basis for the four findings and analyses chapters (4 to 7).

KEQ	Judgement Criteria
General	Name alliance
	Members
	Quality of the evaluation, average
	coPrisma members
	Lead
	website
	Comments
	Structure
	Joint activities
Relevance	1. The intended changes contribute to the two core principles Securing Sustainable Livelihoods and Justice for all of the ICCO Cooperation MASP2020 (programme is relevant in the light of this new policy).
	2. Appropriate guidance, support, policy instruments, tools, expertise and reflections were offered to facilitate the relevance of interventions.
	3. Programmes are designed in alignment with identified beneficiaries' needs
	4. The choices of programme interventions, approaches, and the values behind the interventions are appropriate in the specific context, based on an analysis of this context and show an optimal balance between cultural sensitivities and meeting programme objectives.
	5. The theory of change of the programme is relevant in the contexts where the programme is implemented
	6. The choices of programme interventions corresponded with the specific strengths of partners and stakeholders
	7. Collaborations with health and non-health stakeholders have made the programme more relevant. This includes collaborations at various levels as well as linkages between those levels.
	8. The gender and rights based approach principles are embedded in BH & HA programme policies, plans and implementation
Effective-ness	1. The 6 "outputs of the alliance" have been achieved or are on track for the three objectives and the three strategies
	1-DPA. 90% of partners capacitated to make access more equal
	1-CSS. 90% of partners capacitated to facilitate participation in health services
	1-PI. 10 coalitions capacitated to analyse policies and finances and develop L & A plans
	2-CSS. 70% of relevant partners capacitated to develop capacity of interest groups
	2-PI. 5 coalitions capacitated on lobby and advocacy on inclusion and equal rights
	3-CSS. 70% of partners capacitated on staff policies
outputs partner	2. The 9 "outputs of the partner" have been achieved or are on track for the three objectives and the three strategies
	1-DPA. 80% of partners have improved access and use of health services
	1-CSS. 70% of partners do capacity development on participation
	1-CSS. 70% of partners have structures to facilitate participation
	1-PI. In 10 countries there is active lobby and advocacy on accountability
	2-DPA. 70% of partners develop capacities change agents on silence and stigma
	2-CSS. In 7 countries, partners develop capacities of interest groups
	2-PI. 5 coalitions have active lobbies with interest groups on inclusion and equal rights
	3-CSS. 70% of health partners have staff policies that contributes to sustainability
	3-PI. In 8 countries there is formal cooperation with government on human resources for health

KEQ	Judgement Criteria
outcomes	3. The 8 "outcomes at the level of the target groups" have been achieved or are on track for the three objectives and the three strategies
	1-DPA. In 80% of projects health indicators have improved
	1-CSS. In 70% of projects target groups have a say in decision making on health services
	1-PI. In 6 countries, governments are more transparent
	2-DPA. 70% change agents play positive roles on silence and stigma
	2-CSS. In 7 countries, interest groups have capacities and are effective advocates
	2-PI. In 4 countries, governments policies have become more inclusive
	3-CSS. 80% of staff has increased performance
	3-PI. In 4 countries, governments contribute more to financing of health staff
Effective-ness further	4. There are indications that the objectives of more equally accessible, quality basic health care and more equal health outcomes are being achieved.
	5. Changes related to the programme can be observed at beneficiary level
	6. Is the theory of change correct? Are there indications that the causal relations between the result levels operate in practice?
	7. The roles of funding, capacity and expertise development, brokering, and lobby and advocacy of ICCO Cooperation have led to positive effects.
	8. The activities of the Country Coalitions have contributed to higher effectiveness of the BH & HA programme.
	9. The BH & HA programmes in the countries are based on multi-stakeholder approaches, Country Coalitions (so-called programmatic cooperation).
	10. Synergy is realised between the three intervention strategies (direct poverty alleviation, civil society strengthening, policy influencing); all three were helpful in reaching results and combining them added value.
	11. Country Coalitions and partners use their PME system for measuring results, learning lessons and improving the quality of the programme and the monitoring protocol as part of this PME system supported the programme proceedings.
	12. Learning (thematic and cross-thematic) took place at all levels and increased the programme effectiveness.
Efficiency	1. Transaction costs of all actors relating to programmes and projects are minimised.
	2. Assessments and monitoring of the programme include cost awareness.
	3. Interventions are selected and designed with explicit considerations on cost effectiveness.
Sustaina-bility	1. Positive changes that the programme contributed to are likely to continue after completion of the programme.
	2. Relevant activities of the project of the implementing partner organisations are likely to continue after completion of the programme.
	3. Partner organisations and Country Coalitions are preparing themselves for the post-MFSII period (by means of e.g. exit strategies, strategies for financial sustainability). They involve beneficiaries as well as the IC in relevant ways.
	4. IC programmes/projects can be considered innovative and innovation is stimulated in the programme.

Annex 6. Double blind analysis

The following table presents the double blind analysis for 4 evaluation reports that both evaluators assessed independently from each other.

	11 wilma	11 wouter	12 wilma	12 wouter	13 wilma	13 wouter	14 wilma	14 wouter
Meeting needs	2	2	2	2	2	2	1	2
Appropriate design	2	2	3	2	2	2	2	2
Reliable data	2	2	2	2	1	2	1	2
Sound analysis	2	1	1	1	1	1	1	1
Valid findings	2	2	2	2	1	2	1	2
Impartial conclusions	1	2	1	2	2	2	2	2
Useful recommendations	1	2	2	2	2	2	2	2
Clear report	1	2	2	2	2	2	2	2
Overall assessment	<2	1.875	<2	1.875	<2	1.875	<2	1.875
	1.625		1.875		1.625		1.5	

The table shows the following:

- The difference between assessments is never bigger than 1 (on the 4 point scale)
- The difference between the overall averages between the two evaluators is 0.2 (Wouter higher than Wilma) on a scale of 1 to 4
- Wilma has 2 scores higher (indicated in green) and Wouter has 9 scores higher.

At the end of all assessments, the average score for both evaluators (each for the own set of evaluations was 2.4, thus showing no difference).

Overall, the conclusion is that differences in assessments between evaluators were small.

Annex 7. Summary of three frameworks

As indicated in the methodology paragraph, three analytical frameworks were used for the categorisation of programme interventions.

The health system framework

The health system framework separates six functions that are interconnected. The framework applies to all interventions that contribute to achieving the intended outcomes of a well-performing health system (improved health, responsiveness, social and financial risk protection and improved efficiency) and includes actions and interventions undertaken outside of the health sector, i.e. the framework offers opportunities to organise / categorise interventions that are undertaken at community level as well as health sector specific interventions.

The BH & HA programme interventions will be categorised using the six pillars as shown in the diagram below:

Figure 5: Health system framework - WHO (2007)

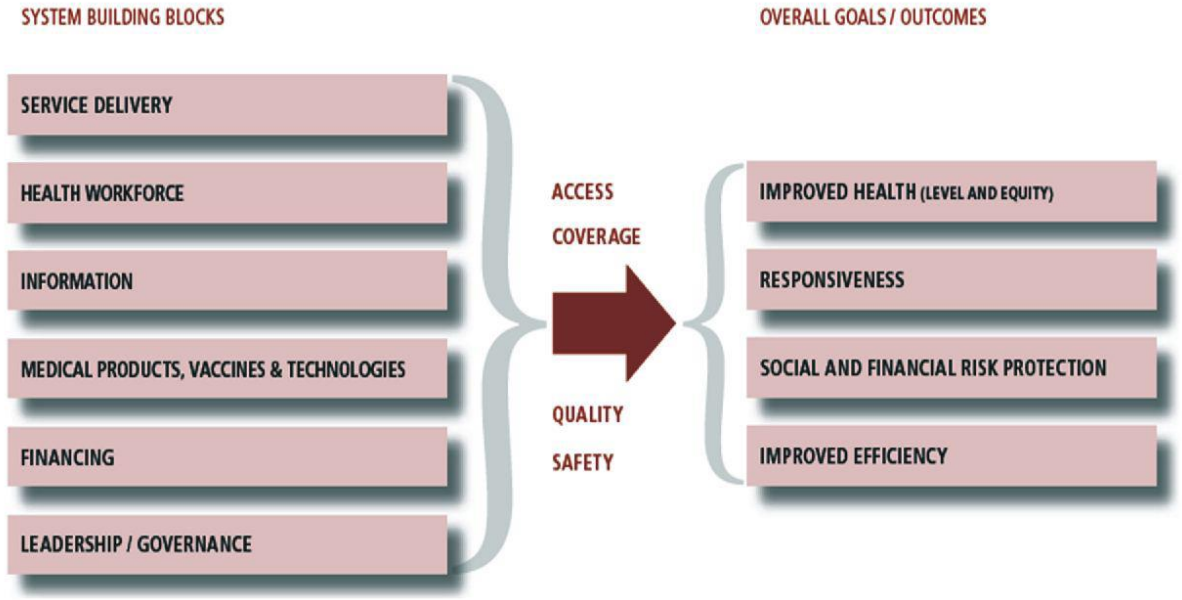


Table 17: Examples of interventions related to HSS

If HSS targets…..	Then interventions may focus on….
Service delivery	Provision of promotive, preventative, curative and rehabilitative services; these include health promotion, BCC, but also eye care, leprosy care, etc.
Medical products, vaccines, technologies & infrastructure	Provision of drugs, medical and non-medical supplies and equipment, construction (health facilities, women's shelters, toilets, etc.), vehicles including bicycles
Health workforce	In-service training, training of CHWs, training of change agents, supervision, material development, training of partner organisations' staff
Health financing	Mobilisation of additional financial resources including insurance, user charges, paying services, Service Level Agreements, etc.
Health information	Data collection, including research / studies, surveys, and analysis of data sets, reviews for monitoring
Leadership & governance	Lobby & Advocacy; establishment Health Facility Committees (HFC); Meetings HFCs; participation in national bodies; development of policies & guidelines, manuals, etc.

The SAN BCC Framework

To categorise behavioural change interventions, the framework below that provides a model of determinants that influence behaviour has been used. This framework offers the opportunity to identify the specific behaviour that programme interventions aim to change.

Figure 6: Model of determinants that influence behaviour

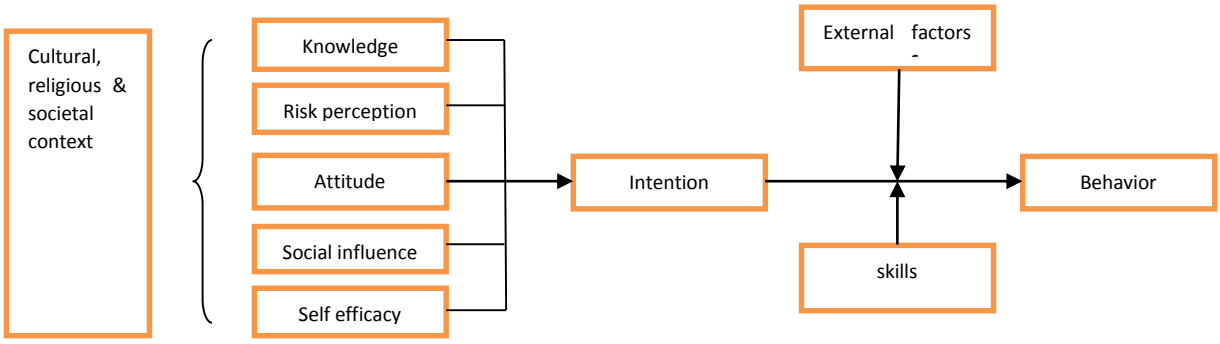


Table 18: Examples of interventions related to BCC

If BCC targets …	Then interventions may focus on ….
Cultural societal, including specific religious context	Health promotion (HP) activities to address harmful cultural / religious practices, e.g. Holy needle, marginalisation of PLHIV, PWDs, other groups
Knowledge	Training and other forms of transfer of knowledge (access to libraries, KM platforms, networking, etc.)
Risk perception	HP targeting increased understanding of exposure to potential risks, e.g. unprotected sex increases chance of ST infections, unwanted (teenage) pregnancy
Attitude	HP that deals with attitudes that have harmful effects, discriminate (women, gays, youth, etc.)
Social influence	HP related to peer pressure; HP related to adult - adolescent relations in society
Self-efficacy	HP dealing with people's beliefs in their ability to achieve goals, i.e. to persist and succeed
Skills	HP, for instance sexuality education that imparts life skills for informed choices

At the start of the classification of interventions this BCC framework was utilised. The information gleaned from project documentation was subsequently incorporated in the HSS framework, especially in service delivery and / or governance interventions.

Capacity development framework

We understand that the capabilities of partner organisations involved in the implementation of the BH & HA programme have been assessed using the 5Cs scan at the start of the programme. In the evaluation Country Coalitions and Partners capacity development interventions are assessed using the Brinkerhoff model for capacity development, as shown in the table below.

Table 19: Capacity Development model Brinkerhoff

If CD targets are defined in terms of…	Then interventions focus on…
Resources	• Material & equipment • Micro-credit or (social) business approaches • Budget support

If CD targets are defined in terms of…	Then interventions focus on…
	• Dedicated funding (e.g., trust funds, social funds)
Skills and knowledge	• Training • Study tours • Technical assistance • Technology transfer
Organisation	• Management systems development • Organization twinning • Restructuring • Civil service reform • Decentralization
Politics and power	• Capacities for community empowerment • Civil society advocacy development • Legislative strengthening • Discouraging ethnic-based politics
Incentives	• Capacities for sectorial policy reforms (e.g. trade and investment, pro-poor social safety nets, monetary and fiscal policy, private sector friendly regulation, Health, Education, etc.) • Working on staff retention, motivation and incentives • Encouraging civic dialogue, social compacts, and consensus building • Strengthened accountability structures and procedures • Improved rule of law

The Capacity Development framework will only include those interventions that have been implemented in the projects.

The choice to use the Brinkerhoff framework rather than the 5 core capabilities framework was based on the fact that the 5C framework focuses on the status of organisations, while the Brinkerhoff framework focuses on capacity development **interventions** rather than capacities or capabilities. We acknowledge that both frameworks have arisen from the same basic concepts (both ECDPM, both using complex adaptive systems as general view on organisations). But rather than categorising capacity development interventions on the 5Cs (and debating to which of the Cs an intervention contributes), it is easier to use the Brinkerhoff framework which directly categorises interventions.

Annex 8. Further overviews of the programme portfolio

Table 20. Overview of numbers and amounts of projects per organisation

	No.	Amount
Bijzondere Noden (BN)	2	€ 742,739
Dorcas	9	€ 3,013,943
De Verre Naaste (DVN)	3	€ 717,936
Gereformeerde Zendingsbond (GZB)	4	€ 1,720,510
Leger des Heils (LdH)	1	€ 405,993
Light for the World (LftW)	5	€ 2,791,269
Leprazending (LZ)	5	€ 1,607,138
Operatie Mobilisatie (OM)	1	€ 570,484
Red een Kind (REK)	9	€ 2,565,091
Tear	13	€ 2,796,642
Trans World Radio (TWR)	5	€ 661,743
Woord en Daad (W&D)	11	€ 5,773,858
ICCO	34	€ 5,444,013
Total	**102**	**€ 28,811,359**

Table 21. Overview of numbers and amounts of projects per country

	coPrisma		ICCO	
	No.	Amount	No.	Amount
Afghanistan	3	€ 1,644,799		
Bangladesh	8	€ 2,909,865		
DRC	6	€ 1,935,535		
Ethiopia	12	€ 2,045,908	3	€ 253,788
Haiti	2	€ 1,514,958		
India	7	€ 1,783,625		
Kenya	6	€ 2,016,418	2	€ 79,000
Malawi	2	€ 760,974	6	€ 2,029,261
Regional			14	€ 2,160,035
South Africa	6	€ 2,404,242	4	€ 730,000
South Sudan	4	€ 2,773,280		
Uganda	7	€ 1,773,885	3	€ 135,934
Zimbabwe	7	€ 1,859,852		
Total	**70**	**€ 23,423,341**	**32**	**€ 5,388,018**

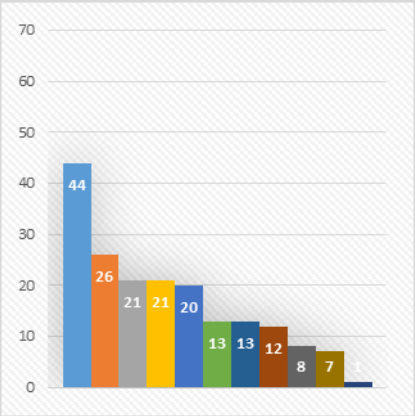
Table 22. Amounts per intervention strategy (estimated in project database)

Intervention strategy	coPrisma		ICCO	
Direct Poverty Alleviation	€ 12,872,804	55%	€ 1,255,512	23%
Civil Society Strengthening	€ 8,143,951	35%	€ 2,339,631	43%
Policy Influencing	€ 2,406,585	10%	€ 1,792,875	33%

Annex 9. Overviews of programme interventions

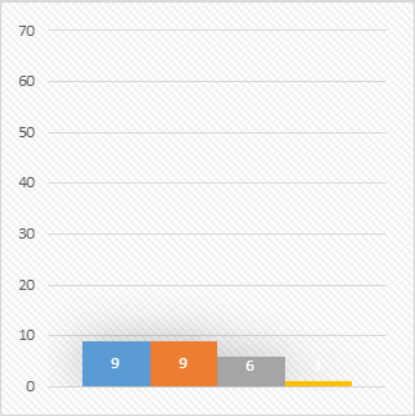
Activities categorised in the Health Systems Framework

The first framework used for categorisation is the health systems framework. This framework distinguishes six functions, also referred to as 'building blocks' which are inter-linked and ensure functional health systems. Interventions aimed at strengthening health systems can focus on one or more functions.



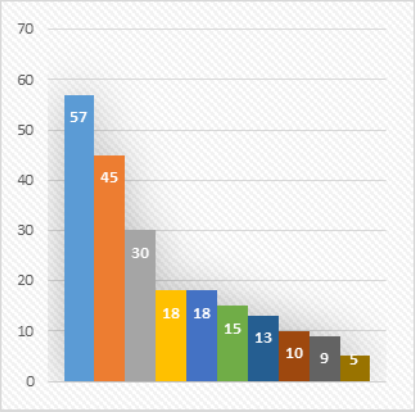
Leadership and governance

A total of 73 of 82 projects (90%) have activities that deal with leadership and governance. In 44 projects partners are active in networking or formation of networks, linkages or partnerships. In 26 projects formation of groups is supported. In 21 projects activities organise community members and other stakeholders. Also 21 projects lobby for capacity of health workers and health facilities to increase performance. At least 20 projects include lobby activities for the position of vulnerable groups, rights of vulnerable and marginalised groups. In 13 projects partners work on formation of committees or strengthening of committees at different levels. Also 13 projects work on improved (inclusive) policies. Other activities in this category are establishment or participation in fora (12), lobby against harmful practices or pro-positive behaviour (8), monitoring and supervision to increase accountability (7) and lobby for health workers pay (1).



Health financing

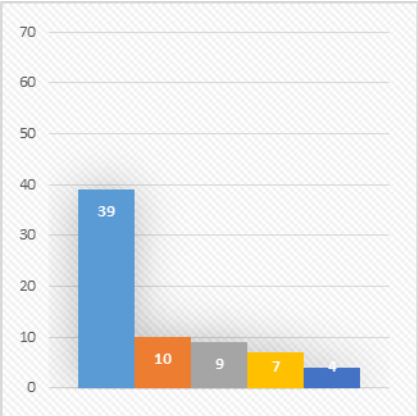
A total of 25 out of 82 projects (31%) have activities in the area of health financing. In 9 projects the implementing organisations seek contributions from clients. Also in 9 projects other sources of income are sought without asking for clients contributions. In 6 projects the income is sought from the government by linking to health financing schemes. In one project pooled procurement is practised.



Health workforce

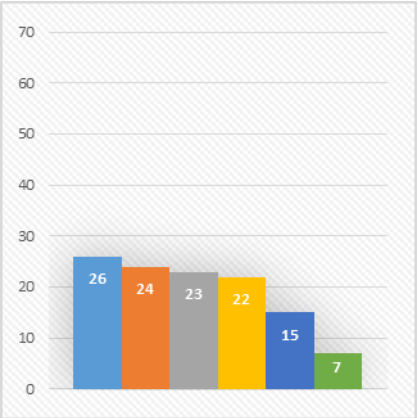
Activities dealing with health workforce are part of 78 out 82 projects (96%). In 57 projects partners train community members and stakeholders (such as police officers, community and religious leaders, CBOs, SHGs, interest groups). 45 projects include training of medical and health staff (doctors, nurses, CHW, caregivers). In 30 projects training of other staff, often on cross cutting issues, takes place. Training on mainstreaming disability and or HIV/AIDS is part of 18 projects. The same counts for training of TBA and other activities related to live saving skills at birth, family planning or midwife training. Other activities in this category are: production of educational materials on health related topics; Teacher training; Training of

PLWHA / PWD; Training of family members (and guardians) of PWD / PLHWA / OVC and training of community development and / or executive committees. These activities are included in 15, 13, 10, 9 and 5 projects respectively.



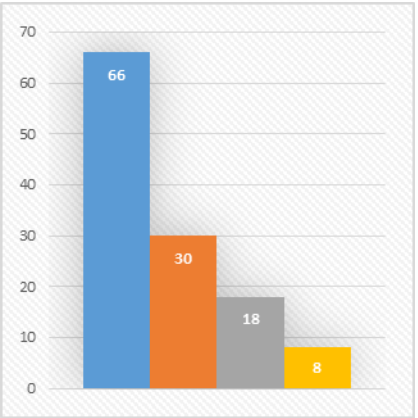
Provision of medical products, vaccines, technologies & infrastructure

In 45 out of 82 projects (56%) drugs, medical and non-medical supplies, equipment and / or means of transport (incl. bicycles) are provided and / or construction of infrastructure takes place. In 39 projects medical and non-medical supplies and equipment are provided. Construction activities are part of 10 projects. In 9 projects vehicles are provided. In 7 projects supply of drugs is part of the activities and in 4 projects provision of assistive devices took place.



Information

58 out of 82 projects (72%) mention activities that can be placed in the category 'information'. In 26 projects data collection in general is mentioned as an activity. In 24 projects research and studies were done. Surveys and the analysis of data sets also took place in 23 projects. 22 projects provided a platform for exchange of lessons learned and in 15 projects reviews carried out for monitoring. 7 projects provided expertise in M&E.

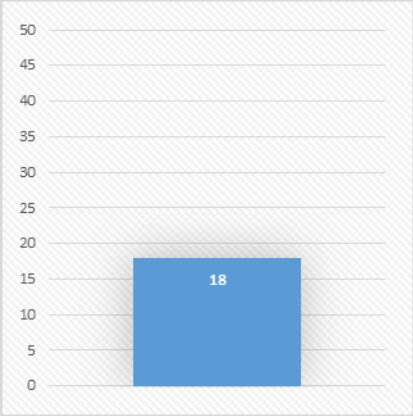


Service delivery

73 out of 82 projects (90%) have activities that can be categorised as 'service delivery'. In 66 projects preventative services (Health promotion, BCC, testing) are provided. Curative services (incl. eye care, leprosy care etc.) are part of 30 projects. Referral services and rehabilitative services are provided by respectively 18 and 8 projects.
Besides, 42 projects offer other services that are not health related.

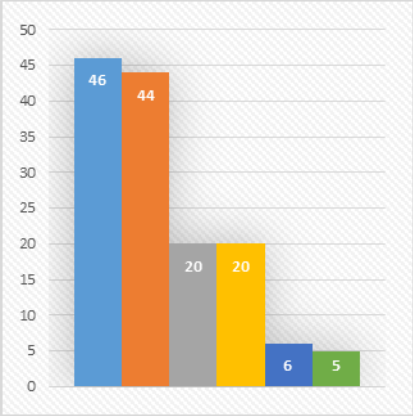
Activities categorised in the Behaviour Change Communication Framework

The second framework used is a framework to distinguish various activities and factors that contribute to behaviour change.



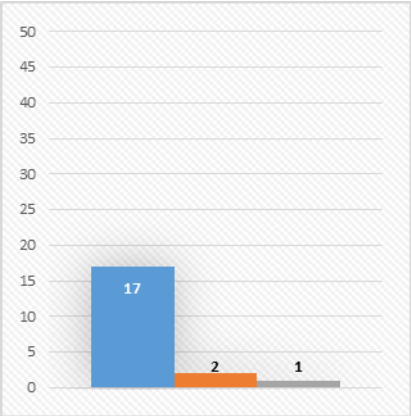
Cultural societal, incl. specific religious context

18 out of 80 projects (23%) have activities that address the cultural societal context, including specific religious context. Activities in this category are health promotion (HP) activities that explicitly address harmful cultural / religious practices (e.g. 'Holy needle', cultural factors for marginalisation of PLHIV, PWDs and other groups).



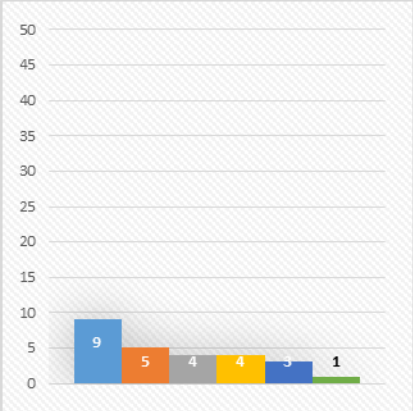
Knowledge transfer

65 out of 82 projects (80%) have activities related to knowledge or knowledge transfer. The most common activities in this category are raising awareness, motivational activities (motivating people to get tested) and dissemination of (radio) messages regarding HIV / AIDS and disabilities. These activities are implemented in 46 projects. Training is an activity that forms a part of 44 projects. In 20 projects knowledge transfer is promoted through support of resource centres, the production of or provision of access to IEC materials on health and healthy lifestyle. 20 projects include the provision of sexual health education and / or life skills education. Other activities in this category are PMTCT training and other health education, respectively offered in 6 and 5 projects.



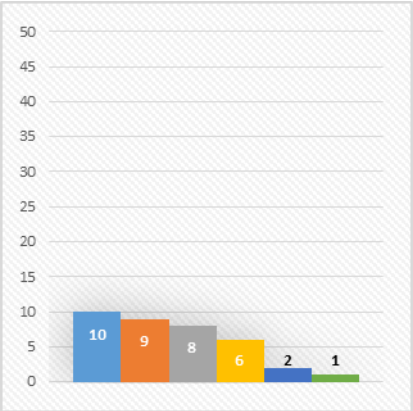
Risk perception

In 19 out of 82 projects (23%) activities are included that clearly address the issue of risk perception. In 17 projects this means that training or education takes place with focus on health risks. In 2 projects condom promotion and demonstration is provided and in 1 project health risks are explicitly part of the health message disseminated during home visits.



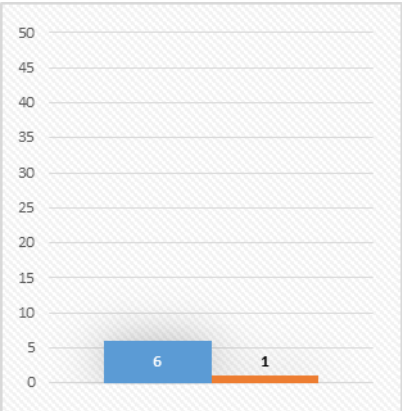
Attitude

In 19 out of 82 projects (23%) activities are included that address attitude. In 9 projects these are health promotion activities that deal with attitudes that have harmful effects on PLWHA, discriminate PLWHA and / or OVCs. In 5 projects health promotion activities are carried out that deals with attitudes that have harmful effects on peoples' health (in general). Health promotion that deals with attitudes that have harmful effects (on the position of) women or discrimination of women is part of 4 projects. The same counts for health promotion activities that deal with attitudes that have harmful effects on people or discriminate people with disabilities. In 3 projects activities target attitudes that have harmful effects on children / youth, discrimination or violation of rights of children and youth. In one project health promotion is focusing on attitudes that have harmful effects on or discriminate people with leprosy.



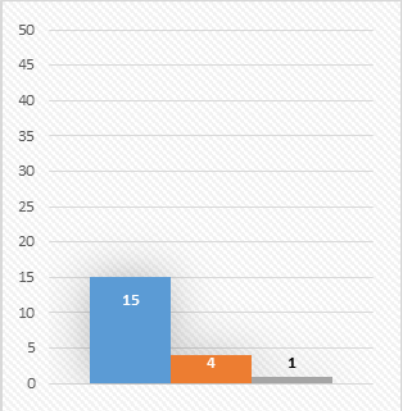
Social influence

18 out of 82 projects (22%) have activities that can be categorised in the category of 'Social Influence'. In 10 projects these are health promotion activities particularly targeting youth and teens. Peer education is part of 9 projects. In 8 projects formation of or support of peer groups (adolescents, youth) takes place. In 6 projects implementing organisations are actively involved providing training in peer learning. In 2 projects discussion platforms for peers have been formed. In one project male caregivers are supported.



Self-efficacy

In 6 out of 82 projects (7%) activities are included that address self-efficacy. 6 projects teach youth and women in SHGs on importance of setting goals, in some cases in combination with stressing the importance of safe sexual practices. In one project development of health plans is part of the activities, which contributes to self-efficacy.

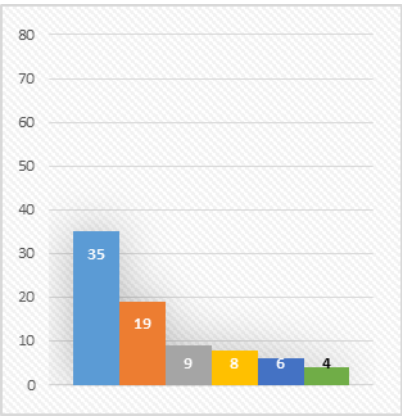


Skills

18 out of 82 projects (22%) have activities that address skills development. Most of these projects (15) include life skills education. Also training in sex negotiation skills takes place (in 4 projects). In one project group / club competitions are organised contributing to development of skills.

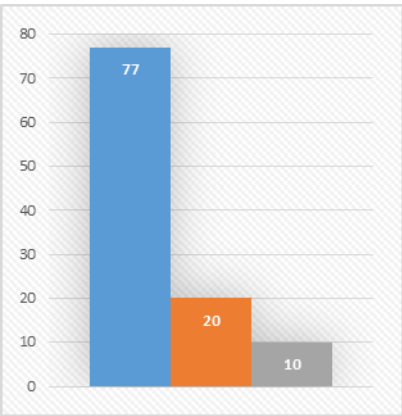
Activities categorised in the Capacity Development Framework

The third framework used categorises activities related to capacity development of the partner organisations. Capacity development activities done by ICCO, coPrisma and coPrisma members is not included, since this is often not reflected in project documentation. The objects of capacity development are the partners themselves and their staff, but also various other civil society, community or government related target groups.



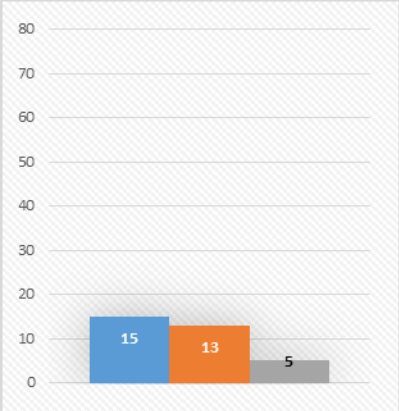
Resources

In 52 out of 82 projects (64%) activities are included that deal with capacity development at the level of resources. In most cases (35 projects) this concerns provision of material and / or equipment. In 19 projects implementing organisations are involved in support of Income Generating Activities and support or training on (new) ways to generate income, including business training. In 9 project implementing organisations support construction of infrastructure. 8 projects include micro credit, micro finance and / or support village savings. 6 projects include subsidised health care, insurance and/ or support with acquiring social grants and training on decentralised funds. Education and vocational training / sponsoring for studies (scholarships) is provided in 4 projects.



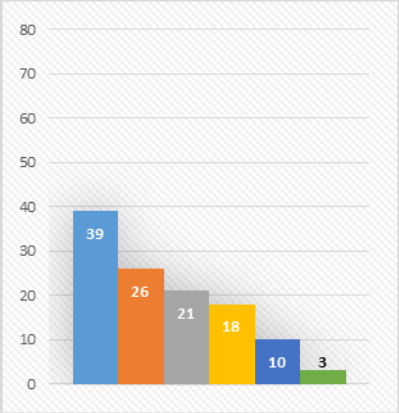
Skills and knowledge

78 out 82 projects (96%) have activities that support skills and / or knowledge development. 77 projects include training. In 20 projects supported organisations are working on capacity building of their partner network and / or facilitate exchange of knowledge and information. Technical support of the government is included in 10 projects.



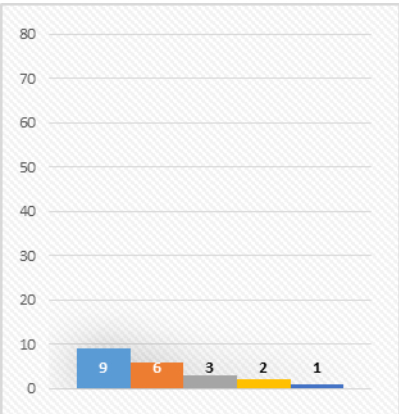
Organisation

31 out of 82 projects (38%) have activities related to organisational development. In 15 projects capacity development of staff regarding information, project cycle and financial management roles takes place. In 13 projects implementing organisations work on systems development (MIS, PME, Financial accounting systems). Development of SOPs and policies is part of the activities in 5 projects.



Politics and power

In 61 out of 82 projects (75%) activities are implemented that concern politics and power. In 39 project implementing organisations support formation of various types of groups or group structures like SHGs, CBOs, peer groups, interest groups, federations and health advisory committees. Lobby training or training of influential individuals or groups are activities which are implemented in 26 projects. In 21 projects implementing organisations are active in networking or in formation of networks, partnerships and referral linkages. In 18 projects lobby is carried out towards the government. Other activities in this category are: organising stakeholder meetings, participating in stakeholder meetings and fora, encouraging stakeholders to take their roles and responsibility (in 10 projects) and facilitating community participation in clinic management (in 3 projects).



New incentives

In 19 out of 82 projects (23%) activities are implemented dealing with new incentives. In 9 projects one can find activities encouraging civic dialogue, social compacts, and consensus building, while in 6 projects activities are carried out that contribute to strengthening of accountability structures and procedures. In 3 projects implementing organisations are working staff retention, motivation and incentives. Activities enhancing capacities for sectorial policy reforms are found in 2 projects. One project has activities contributing to improved rule of law.

Annex 10. Further overviews of evaluation coverage and quality

Table 23. Numbers of projects and evaluation, and coverage of (financial) portfolio with evaluations.

	No. projects	No. evaluations	Coverage
coPrisma members	67	55	93%
ICCO	15	7	67%
Total	82	62	89%

The quality of the evaluation was assessed on eight criteria. These are summarised in the tables below.

	Coalition	Project
Meeting needs	2.5	2.5
Appropriate design	2.3	2.4
Reliable data	2.4	2.3
Sound analysis	2.7	2.3
Valid findings	2.6	2.4
Impartial conclusions	2.3	2.2
Useful recommendations	2.5	2.3
Clear report	2.6	2.7
Average	**2.5**	**2.4**

	Coalition	Project
Afghanistan		2.8
Bangladesh	2.5	2.6
India	2.6	2.6
DRC	2.8	1.9
Ethiopia	2.0	1.9
Kenya	2.0	2.0
Malawi	1.0	3.1
South Africa	3.4	2.3
South Sudan	2.3	1.8
Uganda	2.3	1.7
Zimbabwe	3.4	2.5
Haiti	3.3	3.3
Regional		3.1
Average	**2.5**	**2.4**

This includes both project and coalition evaluations for all partners and countries.

	AFG	BD	IN	DRC	ETH	KE	MA	SA	SSU	UG	ZIM	HA	REG
Meeting needs	2.8	2.9	2.4	2.1	1.5	2.0	2.8	2.1	2.0	2.5	3.0	3.0	3.0
Appropriate design	3.0	2.4	2.9	2.1	1.5	1.0	2.3	2.7	2.0	2.0	2.2	3.0	3.0
Reliable data	2.2	2.6	2.6	2.0	1.5	2.0	2.5	2.4	1.8	2.0	2.2	3.0	3.3
Sound analysis	2.8	2.9	2.6	1.3	2.0	2.0	2.8	3.0	2.2	1.5	2.6	3.0	3.0
Valid findings	3.0	2.4	2.9	2.1	2.0	2.0	2.5	2.7	1.8	1.5	3.0	4.0	3.0
Impartial conclusions	2.4	2.3	2.3	2.1	2.0	2.0	2.8	2.1	1.2	1.3	2.4	4.0	3.0
Useful recommendations	3.0	2.3	2.6	2.0	3.0	2.0	2.5	1.7	2.0	1.7	3.0	3.0	3.3
Clear report	3.0	3.0	2.6	2.1	2.0	3.0	2.8	3.0	2.0	2.0	3.2	3.0	3.0
Average	**2.8**	**2.6**	**2.6**	**2.0**	**1.9**	**2.0**	**2.6**	**2.5**	**1.9**	**1.8**	**2.7**	**3.3**	**3.1**

There is no systematic difference between the quality of evaluations of coPrisma partner projects and ICCO partner projects (both 2.4 on average).

The 5 best evaluations.

Organisation	country	Name	Partner	Quality
REK	MALAWI	Health HIV Mzimba 2011-2015	WAM	4.0
ICCO	REGIONAL	Call to Care phase 5,Call 2 Care 2012-2013,Called to Care Phase 7	SFH	4.0
REK	MALAWI	Health HIV Nkhata Bay 2011-2015	LISAP	3.9
LftW	AFGHANISTAN	IAM NETC 2011-2015	IAM PK	3.8
W&D	INDIA	HIV/AIDS prevention project, Andra Pradesh, 2011-2015	Count	3.5

Annex 11. Judgement criteria and assessments

The table below offers the complete list of judgement criteria with their final assessments on a scale of 1 (weak) to 4 (strong), colour coded from red to green. The first table is a short version for quick reference, while the second table offers more elaborate definitions and justifications. The assessments for the key evaluation questions are simple averages of the assessments for the related judgement criteria. IC refers to ICCO Cooperation, mainly the global office; PO refers to programme officers, either of coPrisma members or of ICCO regional offices, and CC refers to Country Coalitions.

Table 24. Complete list of judgement criteria with their final assessments (scale 1-4), extended version

Questions and Criteria	IC	PO	CC / partners	Average
To what extent has the work of the ICCO Cooperation and their partner organisations during the period 2011 – 2014 contributed to the sustainable realisation of equal accessible and resilient health systems in rural areas, especially for poor people, vulnerable to and living with HIV and/or other diseases.	2.3	2.2	2.5	2.4
Relevance				
To what extent is the BH & HA programme designed to contribute to equally accessible and resilient health systems in rural areas, especially for poor people, vulnerable to and living with HIV and/or other diseases.	2.8	1.8	2.6	2.7
Judgement criteria				
1. The intended changes contribute to the two core principles Securing Sustainable Livelihoods and Justice for all of the ICCO Cooperation MASP2020 (programme is relevant in the light of this new policy).	3.5			3.5
Health is a precondition for Securing Sustainable Livelihoods; access to health care is a basic human right and is within remit of 'Justice for All' core principle. However, on occasion the very poor are excluded.				
2. Appropriate guidance, support, policy instruments, tools, expertise and reflections were offered to facilitate the relevance of interventions.	2.5	2.0		2.3
Findings show a disconnect between instruments developed by IC and the support provided by POs to partners; F2F good, but often too general and outcomes not translated into policies and tools, so POs and partners are free to apply and may decide not to apply policies and tools. Specific health-related policies of coPrisma members not shared, so unclear whether these are different from IC policies.				
3. Programmes are designed in alignment with identified beneficiaries' needs			3.5	3.5
Health needs have often not been ascertained prior to start of interventions, but are generally coherent with globally defined priorities. Hardly real involvement of beneficiaries in identification of needs to be addressed with priority.				
4. The choices of programme interventions, approaches, and the values behind the interventions are appropriate in the specific context, based on an analysis of this context and show an optimal balance between cultural sensitivities and meeting programme objectives.	3.0	2.0	2.0	2.3
The IC has developed well-balanced policies, but often considered too 'Western'. Partners are better rooted in specific contexts, but critical reflection on drivers of ill-health and socio-cultural factors that contribute to poor health often lacking. Interventions often continuation of projects implemented prior to MFS II. At partner organisation, support processes aimed at matching of partners' work to IC policies.				
5. The theory of change of the programme is relevant in the contexts where the programme is implemented.	2.0			2.0
Suitability of ToC limited in fragile states where (curative) service provision is relevant. Health workforce very relevant in most contexts but given little attention. ToC outcome pathways too specific and narrow. Results Framework does not really reflect ToC thinking.				
6. The choices of programme interventions corresponded with the specific strengths of partners and stakeholders.			2.5	2.5
Relatively many specialised organisations with extensive experience and capacity: leprosy, disabilities, eye care, some HIV / AIDS. Several health providers already involved for long time, while others partners weaker (e.g. DRC). Capacity for livelihoods interventions often low. ICCO partners are often large and respected organisations with adequate capacity. Capacity for lobby and advocacy has generally remained low. Country Coalitions have grown stronger and function better if a member partner organisation works at national. Evaluations contain little information about partner organisations' capacities.				

Questions and Criteria	IC	PO	CC / partners	Average
7. Collaborations with health and non-health stakeholders have made the programme more relevant. This includes collaborations at various levels as well as linkages between those levels.	3.5	?	3.5	3.5
At IC level extensive efforts at networking with many linkages forged with (health) education and social welfare initiatives; less closely linked to interventions to improve food security in general. Evaluations provide inadequate information on efforts to really forge cooperation with other players. Most partners have established relevant collaboration at many levels with various stakeholders and no longer work in isolation.				
8. The gender and rights based approach principles are embedded in BH & HA programme policies, plans and implementation.	2.5	1.5	1.5	1.8
At IC level, the GRBA well integrated in policies, but inadequate attention given to weaknesses in understanding of GRBA by partners. At Dutch coPrisma members' and partner level there has been resistance to RBA, partially related to use of the term, but also disagreement on a number of contentious issues. GRBA largely focused on service delivery and / or self-empowerment, in certain cases more charity based and / or patronising ('we empower you') rather than focused on claiming rights. GBA: focused on women, only few in-depth analyses mentioned, but often superficial application (e.g. men accompanying wives to ANC or counting women involved / reached).				
Effectiveness				
To what extent have the objectives of the BH & HA programme been achieved, or are expected to be achieved during the MFSII period?	2.3	2.5	2.7	2.5
Judgement criteria				
1. The 6 "outputs of the alliance" have been achieved or are on track for the three objectives and the three strategies.		2.0		2.0
In reality, the "outputs of the Alliance" have hardly been measured. Capacity development for partners at very general level focusing mainly on skills and knowledge; limited follow up on correct application of newly acquired knowledge and skills.				
2. The 9 "outputs of the partner" have been achieved or are on track for the three objectives and the three strategies.			2.5	2.5
Reporting on partner outputs unclear (indicator values / percentages calculated using different denominators). DPA and CSD outputs mostly achieved, PI outputs mostly not.				
3. The 8 "outcomes at the level of the target groups" have been achieved or are on track for the three objectives and the three strategies.			?	
Outcomes are hardly or inappropriately measured and mostly assumed. Evaluations provide some anecdotal evidence that outcomes have been achieved but not supported by accurate measurements. L & A outcomes hardly achieved. Assessments are mainly based on assumptions, i.e. that increased access and use leads to improved health status, that increased participation leads to more accountability and that change agents really contribute to reducing stigma and silence.				
4. There are indications that the objectives of more equally accessible, quality basic health care are being achieved.			3.5	3.5
Increased and more equal access and utilisation has been achieved: more equal and improved health outcomes are assumed.				
There are indications that the objectives of more equal health outcomes are being achieved.			?	
Achieved increase and more equal access and utilisation is assumed to have resulted in improved health outcomes.				
5. Changes related to the programme can be observed at beneficiary level.			4.0	4.0
Most interventions were very concrete and directly felt by beneficiaries.				
6. Is the theory of change correct? Are there indications that the causal relations between the result levels operate in practice?	2.0			2.0
ToC was too narrowly defined with almost linear relations between outputs and outcomes, neglecting other outcome pathways and other contributing / attributing factors from other sectors.				
7. The roles of funding, capacity and expertise development, brokering, and lobby and advocacy of ICCO Cooperation have led to positive effects.	2.5	2.5		2.5
Funding has certainly supported the achievement of results as well as capacity development interventions, although the latter often too blinkered, too general and too focused on skills and knowledge only; brokering has been attempted with limited success; L & A has been done through wider networks at Dutch level, with few linkages to partners' work.				
8. The activities of the Country Coalitions have contributed to higher effectiveness of the BH & HA programme.			3.0	3.0
Effective as delivery mechanisms of donor requirements, mutual learning and reflection, better collaboration and moving toward facilitating roles. Less effects on programme improvement - change takes time - and hardly real joint planning.				

Questions and Criteria	IC	PO	CC / partners	Average
9. The BH & HA programmes in the countries are based on multi-stakeholder approaches, Country Coalitions (so-called programmatic cooperation).			1.5	1.5
Multi-stakeholder approaches not really systemic, mostly still based on implementation of own activities, which were largely restricted to health care interventions.				
10. Synergy is realised between the three intervention strategies (direct poverty alleviation, civil society strengthening, policy influencing); all three were helpful in reaching results and combining them added value.			2.5	2.5
Examples of synergy between interventions targeting DPA and CSD, less between CSD and PI.				
11. Country Coalitions and partners use their PME system for measuring results, learning lessons and improving the quality of the programme and the monitoring protocol as part of this PME system supported the programme proceedings.	1.5		1.5	1.5
The results framework did influence partners' choices of interventions, but monitoring was poorly done and hardly used for programme improvement. Harmonisation of systems has proven difficult and was important reason for discontinuation of ProCoDe pilot in Central & East Africa.				
12. Learning (thematic and cross-thematic) took place at all levels and increased the programme effectiveness.	3.0	3.0	3.0	3.0
Many programme working group meetings, face to face meetings and annual reflections contributed to learning. In the Country Coalitions many external inputs, exchange visits and sharing of experiences. Institutionalisation of learning and the linkage of learning with practice weaker.				
Efficiency				
To what extent has the ICCO Cooperation carried out the BH & HA programme in a cost efficient way?	2.0	2.3	2.8	2.3
Judgement criteria				
1. Transaction costs of all actors relating to programmes and projects are minimised.	2.5	2.5	2.5	2.5
Clear benchmarks or standards to assess whether minimising of transaction costs occurred are lacking. Impression that attempts to minimise costs were made and excessive programme costs not found				
2. Assessments and monitoring of the programme include cost awareness.	1.5	2.0		1.8
Very few reports mention cost awareness or attempts to share or minimise resources. Cost efficiency / effectiveness of commonly used intervention strategies such as formal training inadequately questioned and other methods to strengthen capacity not found				
3. Interventions are selected and designed with explicit considerations on cost effectiveness.			3.0	3.0
Cost effectiveness not really considered explicitly. However, interventions are generally based on international standards of good practice which include notions of cost effectiveness.				
Sustainability				
To what extent are the benefits of the BH & HA programme likely to last after completion of the MFSII programme?	2.0		2.0	2.0
Judgement criteria				
1. Changes that the programme contributed to are likely to continue after completion of the programme.			3.5	3.5
In general, many changes have been rooted firmly and will be maintained.				
2. Relevant activities of the project of the implementing partner organisations are likely to continue after completion of the programme.			1.0	1.0
Almost all activities will require continued external support or need to be embedded in existing (government) institutions.				
3. Partner organisations and Country Coalitions are preparing themselves for the post-MFSII period (by means of e.g. exit strategies, strategies for financial sustainability). They involve beneficiaries as well as the IC in relevant ways.			2.0	2.0
Most Country Coalitions are working on strategies to guarantee future funding, but with little success as of yet. Few partners have exit strategies. Many coPrisma members will continue funding.				
4. IC programmes/projects can be considered innovative and innovation is stimulated in the programme.	2.0		1.5	1.8
Most interventions are very standard, with only few exceptions. At programme level, the use of change agents as approach to change management at community level can be considered 'novel' as was the move towards facilitating rather than implementation roles. The establishment of coalitions and alliances has become a general trend in development cooperation.				