KALEIDOS RESEARCH

ACCESS, SERVICES, KNOWLEDGE (ASK) – YOUTH EMPOWERMENT ALLIANCE (YEA)

END-OF-PROGRAMME EVALUATION, SYNTHESIS REPORT

Kaleidos Research and International Centre for Reproductive Health, Ghent University
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DISCLAIMER

The research team of ICRH and Kaleidos Research wishes to emphasize that it cannot guarantee the accuracy of data from documents on the ASK programme which were compiled by the Youth Empowerment Alliance and used as an input to the desk research part of this research. Responsibility for the interpretation of data and the information provided based on the field research and the online surveys lies entirely with the research team.

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This report is part of the end-of-programme evaluation for Access, Knowledge, Services (ASK), a programme focusing on sexual and reproductive health and rights (SRHR). The evaluation was initiated by the Youth Empowerment Alliance (YEA) alliance and its partner organizations based in the Netherlands and the United Kingdom. The evaluation has been undertaken by the International Centre for Reproductive Health (ICRH), part of Ghent University, Belgium, and Kaleidos Research, a research group and part of NCDO foundation and based in the Netherlands. The overall ASK evaluation comprises an assessment of seven countries involved in the programme.

The report is based on desk research, mainly using project documentation provided by the YEA, which was carried out between October 2015 and February 2016. Field research was performed between November 2015 and January 2016 in three countries - Kenya, Uganda and Indonesia - by researchers attached to ICRH and Kaleidos Research in close cooperation with local researchers.
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ACRONYMS AND ABBREVIATIONS

5C	5 capabilities (approach)
AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
ASK	Access, Knowledge, Services
CHI	Child Helpline International
CORPs	Community-Owned Resource Persons
CSE	Comprehensive sexuality education
CSO	Civil society organization
e&m health	Electronic and mobile health (technologies)
FGD	Focus group discussion
FGM	Female genital mutilation
HIV	Human Immunodeficiency Virus
ICRH	International Centre for Reproductive Health
IPPF	International Planned Parenthood Federation
LGBT	Lesbian, gay, bisexual and transgender
LGBTQI	Lesbian, gay, bisexual, transgender, questioning and intersex
M&E	Monitoring and evaluation
MSC	Most significant change
MYP	Meaningful youth participation
NGO	Non-governmental organization
NPC	National Programme Coordinator
OMR	Outcome measurement report
OR	Operational research
PME	Planning, monitoring and evaluation
SGBV	Sexual and gender-based violence
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
ToC	Theory of change
UFBR	Unite For Body Rights
VCT	Voluntary counselling and testing
YEA	Youth Empowerment Alliance
YPLHIV	Young people living with HIV

1. INTRODUCTION AND OBJECTIVES

1.1. The Access, Services and Knowledge programme

The Youth Empowerment Alliance (YEA) works through its 'Access, Services and Knowledge' (ASK) (2013–2015) programme to improve the sexual and reproductive health and rights (SRHR) of young people (aged 10–24 years) in seven countries. The programme's central objective is to improve young people's SRHR by increasing their uptake of SRHR services. The programme applies a similar theory of change (ToC) to that of the SRHR Alliance's Unite for Body Rights (UFBR) programme, but with a stronger focus on young people, meaningful youth participation (MYP) and direct delivery of SRHR information to young people. Young people are at the centre of the programme. Through their meaningful participation, the programme can be better customized to young people's individual needs, rights and realities.

The alliance

The YEA was established in 2013 and is based on the SRHR Alliance, which implemented the UFBR programme from 2011 to 2015. The YEA consists of Rutgers (lead agency), Amref Flying Doctors the Netherlands, CHOICE for Youth and Sexuality, dance4life, Simavi, STOP AIDS NOW! and the International Planned Parenthood Federation (IPPF). The alliances work with approximately 60 partner organizations, which all form local SRHR alliances in their country.

Result areas

The programme consists of four result areas:

- Result Area 1 on SRHR information for young people:
    - Young people (including lesbian, gay, bisexual, transgender, questioning and intersex (LGBTQI), young people living with HIV (YPLHIV), young adolescents (aged 10–16), young people in remote areas and young people with disabilities) are better informed and thus able to make healthier choices regarding their sexuality
- Result Areas 2 and 3 on SRH services for young people:
    - Increased access to SRH commodities, including antiretrovirals (ARVs) and contraceptives for young people (including LGBTQI, YPLHIV, young adolescents, young people in remote areas and young people with disabilities)
    - Public and private clinics provide better SRH services, which more young people are using (including LGBTQI, YPLHIV, young adolescents, young people in remote areas and young people with disabilities)
- Result Area 4 on an enabling environment for young people's SRHR:
    - Greater respect for the sexual and reproductive rights of young people, especially those from marginalized groups

In 2013, a baseline study was carried out in all the programme countries, and in 2015 the endline measurements took place, measuring progress on the outcome indicators. Partners reported every six months with a narrative report, including reports on the output indicators. Operational research was also an important component of the ASK programme.

Budget

The total budget for ASK over the three years of the programme was nearly €30 million. As Table 1.1 shows, the budget was more or less equally distributed over the three years, while some countries received a substantially larger share than others. Namely from a larger to smaller budget: Uganda, Kenya, Indonesia, Pakistan, Ethiopia, Ghana and Senegal.

Table 1.1: Overview of the total budget by country and year (€ millions).

	2013 budget	2014 budget	2015 budget	Total budget
Uganda	1.919	2.313	2.162	**6.394**
Kenya	2.005	1.984	1.939	**5.928**
Indonesia	1.447	1.558	1.527	**4.532**
Pakistan	1.239	1.412	1.357	**4.007**
Ethiopia	1.189	1.455	1.270	**3.914**
Ghana	0.930	0.972	0.972	**2.874**
Senegal	0.564	0.782	0.665	**2.011**
Total	**9.293**	**10.476**	**9.892**	**29.661**

1.2. Objectives and research questions

The SRHR Alliance commissioned an assessment of its achievements and the lessons that need to be learned. This end-of-programme evaluation was done by Kaleidos Research (the Netherlands) and the International Centre for Reproductive Health (ICRH) (Ghent University, Belgium). The objectives of this evaluation are to:

- assess what results have been achieved in the ASK programme;
- understand what processes have led to these results, including the enabling and hampering factors; and
- propose feasible recommendations to inform future programme design.

The evaluation assesses the programme's relevance, sustainability, impact, effectiveness and efficiency in specific dimensions. It aims to foster learning within the alliance and is expected to add to the current knowledge base on relevant planning, monitoring and evaluation (PME) approaches. The research questions and sub-questions this evaluation answers can be seen in Table 1.2.

Table 1.2: The evaluation matrix.

Dimension and leading question	Sub-questions
Dimension 1: Results and changes What are the results of the programme, and are these relevant and sustainable?	1. Did the programme achieve the expected results? In terms of outputs and outcomes? What were enabling and constraining factors?
	Add 1: In the areas of: CSS/CSE&SRHR information/SRH services/SRHR enabling environment/
	2. Did the programme achieve the overall goal/ results according to the main stakeholders?
	3. What are the unexpected results (positive and negative)?
	4. What can be concluded about the sustainability of the results?
Dimension 2: Implementation processes What have been effective, efficient and sustainable strategies under the ASK programme?	1. What strategies have been implemented to reach vulnerable groups in the programmes?
	2. What strategies have been implemented to*…. And which have been effective? With reference to the result chain - * Quality of (YF) SRH services - * Access to (YF) SRH services - * Quality of SRHR information/education - * Access to SRHR information and education - * Change values and norms at the beneficiary level, personal relationship level, community level, and policy level
	3. Has the multi-component approach been implemented? How/ Why/why not.
	4. Is the country affected by a change in the values and norms of the enabling environment? If yes, how has the increase in conservative forces influenced the program and how have partners dealt with these?
	5. What have been effective strategies for meaningful youth participation, and how has this contributed to results?
	6. Have strategies led to sustainable results? If yes, what strategies?
	7. What can be concluded concerning the efficiency of the (implementation of) strategies.
Dimension 3: Country Alliance & partners Has working in the ASK programme been relevant, effective, and efficient for partner organisations, in terms of their capacity?	1. How do partners perceive the collaboration with the Northern Alliance and their members? How do partners value the in-country collaboration (with each other and NPCs)? To what extent do partners feel they are part of an international / regional alliance or movement?
	2. Has the partnership led to changes in the capacity of NGOs and NGO staff, specifically in SRHR technical expertise, collaboration and advocacy?
	3. Has the partnership led to changes in values and norms around SRHR (incl. gender, SD and SGBV) and MYP, and (how) has this been incorporated in programming and organisational policies?
	4. Are gains/outputs of being part of the country alliances, in line with the required input of the individual partners?
Dimension 4: Northern Alliance & members To what extent has the partnership been relevant, effective, and efficient for the individual members and the programme?	1. Has the partnership been effective in increasing the professionalization of the individual members in SRHR and collaboration?
	2. Has the partnership (incl. Alliance Office) limited or restrained the members compared to working alone, or has it provided more opportunities? In what areas (PME, OR, advocacy etc.)?
	3. Has the partnership led to any changes in the programming of the members and partners? (what and how?)
	4. Are gains/outputs of the partnership in line with the input of the individual partners?
	5. How has working in the alliances affected the programmatic processes and results in the South? To what extent has the alliance stimulated or hampered equal partnerships in their North-South collaboration?

2. METHODOLOGY

In this chapter, we will present the overall evaluation framework, which is based on a realist approach, as well as the different methods that were used to answer the research questions.

2.1. Evaluation framework

2.1.1. Simplified realist evaluation

While the official definition of health is straightforward, the promotion of positive health behaviours, including SRHR, is a challenging domain. Alongside individual and interpersonal factors, health behaviour largely depends on social and structural factors. Determinants on these different levels interact to form a complex - often context-specific - web that influences individuals' health behaviour and society's health status. Such complex problems are characterized by the existence of non-linear causal relationships, multiple causal pathways and feedback loops, and embeddedness in multi-layered contexts and systems.

Accepting the complexity of health has an impact on the design, implementation and evaluation of health promotion interventions and programmes. The ASK programme is clearly aware of this complexity, as it not only focuses on one aspect but aims to address SRHR problems from a number of angles that are situated on the different levels of the socio-ecological spectrum (education, services, enabling environment). Furthermore, it includes a multitude of different strategies and activities implemented by a variety of partner organizations.

An appropriate evaluation framework should take this complexity into account. Therefore, we use a realist evaluation approach. Where traditional evaluations focus on the question 'does the programme work?', realist evaluation studies try to answer 'what works for whom, in what contexts, and how?'. Hence, a realist evaluation approach not only looks at outputs and outcomes but equally studies the processes through which these outcomes are being influenced. Basically, a realist evaluation approach is an iterative process that follows three main steps:

- describing and understanding the programme. This includes devising the programme's theory. In this step, the evaluators make explicit the processes through which the programme aims to achieve the desired outcomes, and uncover the assumptions that come with these processes (see Chapter 3);
- collecting data on mechanisms, context and outcomes to test the theory and its assumptions (country reports); and
- analysing (patterns in) the data, taking into account that both context and mechanism lead to certain outcomes (synthesis report).

2.1.2. Five capabilities approach

For the capacity-building analysis we intended to use the five core capabilities (5C) approach, developed by the European Centre for Development Policy Management (Keijzer et al., 2011). The five core capabilities are the capability to: 1) act and commit; 2) deliver on development objectives; 3) adapt and self-renew; 4) relate to external stakeholders; and 5) achieve coherence. This framework is mainly used to report on the strengthening of capabilities within the UFBR programme, thus it was proposed to use the end evaluation for both UFBR and ASK. Although we integrated the 5C model into the questions in the online survey and used the model in document analysis, we felt that the 5C approach was only partly useful to assess the actual capabilities strengthened within ASK, as the five capabilities are too general to gain good insights into the actual capabilities strengthened. The 5C model was, therefore, only partly used as a framework to answer questions in research dimensions 3 and 4, and more specific information was added on strengthening of capabilities.

2.1.3. Assessing partnerships

The academic management literature on cross-sectoral partnerships mentions several factors contributing to the success of partnerships: commitment (investment of time and resources, involvement of managers etc.), coordination, trust and communication (frequency, quality, sources etc.). Conflict resolution strategies within the partnership are also sometimes mentioned. In the evaluation we used these factors as a framework to assess how the alliances are functioning.

2.2. Desk study

The realist approach aims to provide an answer to the question 'what works for whom, in what contexts, and how?'. This has implications for our evaluation, as we do not limit ourselves to describing results but aim to link these to context and mechanisms. This requires the use of different research methods. An overview of research methods and how they are linked to the evaluation questions can be found in Table 2.1.

2.2.1. Document analysis

A number of research questions can be answered using existing documents compiled by the SRHR Alliance. We focused on a selection of documents: overall proposals, country work plans, synthesis report of all countries for each year, annual reports and operational research (OR) reports. In agreement with the PME team from the alliance office, only documents at country level and the overall ASK level were included in the analyses.[1] The desk review of available documents serves three purposes:

- answering several research questions: monitoring and evaluation and additional research has been carefully planned from the start of the ASK programme. This means a large amount of both quantitative and qualitative data is available to answer (part of) the research questions;
- preparation for the field research: the desk study was also used to identify remaining questions for the online survey and field research. We assessed gaps and identified remaining questions; and
- based on the documents, we analysed whether the ToC which is central to ASK is being put into practice. Furthermore, the evaluation aims to elaborate on the ToC model. A more explicit ToC is a good tool to use to identify programmatic strengths and weaknesses during the field research (research dimensions 1, 2 and 3).

Approximately 135 programme documents were reviewed. The following types of documents were taken into account:

- Generic programme documents, including annual programme reports and work plans
- Annual reports for each country
- Baseline measurement reports for each country
- Outcome measurement reports for each country
- Joint activities work plans for each country
- Operational research reports
- So called 'Pearl documents' with best practices of the programme

The analytical software tool ATLAS.ti was used to systematically code, assess and analyse all sources of information that were made available by Rutgers, the coordinating agency of the alliance. The evaluators jointly developed a closed coding tree based on the research questions (and allowing them to develop additional grounded codes) that was used by all evaluators to code the documents.

[1] The outcome measurement reports, which present the results of the effectiveness study, including the results from the baseline and endline studies, were only available at the end of the evaluation project.

Table 2.1: Overview of the research methods crossed with the research dimensions and questions it will address.

Dimensions and questions	Sub-questions/points of attention	Desk study					Field study			
		Desk Study - all countries	Matrix input/output	Online survey - all countries	Online survey Northern parnters	Interviews Northern partners	Field-research: interviews	Site visits & observation	Field-research: focus groups	Field research: most significant change
Dimension 1: results and changes: What are the results of the programme, are they relevant and sustainable?	Did the programme achieve the expected output- and outcome results for all result areas, and did the programme achieve the overall results according to the main stakeholders, such as young people?	X					X	X	X	X
	How did the programmes contribute to these changes?	X				X	X	X	X	X
	What were the enabling and constraining factors when implementing the programme?	X				X	X		X	
	Are there unexpected results? If so, what are unexpected results?					X	X		X	X
	What can be concluded about the sustainability of the results?	X				X	X		X	
	Analysis on a sub-set of activities vs. costs vs. results.	X	X				X			
Dimension 2: implementation process: What have been effective, efficient and sustainable strategies under the UFBR and ASK programmes?	What strategies were implemented in each of the result areas, and in meaningful youth participation? (this includes a review of the multi-component approach and an assessment of processes that led to change in values and norms at different levels (beneficiary to policy level).	X				X	X	X	X	
	What strategies have been effective, led to sustainable results and what can be concluded about the efficiency of the processes and strategies implemented?	X				X	X	X	X	
Dimension 3: country alliances and partners: Has working in the ASK/UFBR programme been relevant, effective, and efficient for partner organisations, in terms of their capacity?	How do partners value the in-country collaboration and to what extent do partners feel they are part of an international / regional alliance or movement?			X			X			
	What is the added value of the Alliance in the country and / or region?			X			X	X	X	X
	Did the partnership lead to changes in the capacity of NGOs and NGO staff and in what area?s (e.g. SRHR technical expertise, joint programming, advocacy, values and norms around SRHR and MYP)			X			X	X		
	Are gains/outputs of being part of the alliance in line with the required time and efforts / input of the individual partners?			X			X			
	The Alliance wishes to map current plans on continuation of the alliances, even without future support of the current programmes.				X		X			
Dimension 4: northern alliance and members: To what extent has the partnership been relevant, effective, and efficient for the individual members and the programme?	Has the partnership in the North led to any changes for the individual members (e.g.in their professionalization, capacities, expertise) and in what areas (e.g. advocacy, PME, research)?				X	X				
	How has working through this partnership affected the programmatic processes and results in the South?				X	X				
	In what way has the partnership restrained or provided more opportunities compared to working individually? Are gains/outputs of being part of the alliance in line with the required time and efforts/input of the individual partners?				X	X				
	In addition: to what extent and how have the ASK and UFBR programme influenced each other?				X	X	X			

2.2.2. Efficiency study

In addition to the analysis of existing documents, we included a proposal for an internal comparison of selected strategies, with the objective of gaining insights into the efficiency of a number of activities. Two additional analysis were foreseen for UFBR and ASK: 1) a cross-country comparison of one of the key activities of the ASK programme to complement the information from the available documents; and 2) an analysis of the comparison of efficiency of different strategies with the same

objective: comprehensive sexuality education (CSE) in/out of school in the three selected countries where fieldwork was carried out (see Annex 2).

The objective was to use this input together with other research findings to analyse the efficiency of the UFBR and ASK programmes. The study was designed in close cooperation with the alliance office. Obtaining the required data was, however, more difficult and took more time and effort than anticipated, which was mainly related to the financial set-up along the lines of the programme's result areas, the tight research period of the evaluation as well as the closing of the UFBR and ASK programmes and the start of a new programme. The end of 2015 and beginning of 2016 was a challenging time for all alliance partners. Obtaining the data not only required input from the alliance office and the finance department of Rutgers but also from partner organizations in the five partner countries. Because of these constraints, it was decided, together with the alliance office, to only focus on the ASK programme, with the set-up and use of websites as an important communication tool selected as a strategy, and a comparison between five countries where the ASK programme was operational was foreseen. It also proved to be difficult to access these data, and only a few partner organizations responded to the questions. Looking back, the efficiency study needed a quicker start and more time. A general lesson is to build in measurement of efficiency right from the start of the programme and to ensure that the financial administration is connected to it.

2.2.3. Web-based survey

An online survey was used to assess whether local partners in all countries feel that their organization has benefitted and has developed through the programme, and to gain insights into and consensus on the core strengths and weaknesses of the programme design, implementation and evaluation, and on the main results. A link to the online survey was sent to all partners (the Northern alliance members and their local partners). The survey consisted of the following topics:

- background information on the respondent;
- open and closed questions on the programme design, implementation and main results;
- functioning of the international partnership;
- functioning of the national partnership;
- perceived value of in-country collaboration;
- costs and benefits of being part of the alliance;
- capacity-building; and
- sustainability.

For part of the survey (open-ended questions on programme design, implementation and results) we used a Delphi approach. After the first survey round, the open-ended questions were analysed, and answers were grouped into categories and subsequently into questions with closed answer categories. These questions were sent to the same respondents. The online surveys can be found in Annex 3.

The survey was sent to 139 contacts (both for UFBR and ASK). In the first round, 91 respondents completed the survey; in the second round, 76. Their characteristics are shown in Tables 2.2 and 2.3. The data was subsequently further analysed with the statistical software package SPSS.

Table 2.2: Characteristics of respondents to survey 1.

		Programme			
		UFBR count	ASK count	UFBR and ASK count	Total
North vs South	North		7	18	26
	South	22	32	10	64
Gender	Male	10	21	8	39
	Female	13	18	20	51
	Other	0	0	0	0
Organization	Amref	1	3	1	5
	CHI	0	3	0	3
	Choice for Youth and Sexuality	0	0	2	2
	Dance4Life	2	0	8	10
	IPPF	0	4	0	4
	Rutgers	5	6	9	20
	Simavi	7	10	2	19
	Stop AIDS Now	0	8	0	8
	Other/NPC	2	1	3	6
	Multiple organizations	6	4	3	13
Country	Bangladesh	6	0	0	6
	Ethiopia	0	1	1	2
	Ghana	0	6	0	6
	India	4	0	1	5
	Indonesia	2	5	3	10
	Kenya	3	7	4	14
	Malawi	1	0	0	1
	Pakistan	0	7	1	8
	Senegal	0	3	0	3
	Tanzania	6	0	0	6
	Uganda	0	7	3	10
	Other: multiple countries	1	3	15	19

Table 2.3: Characteristics of respondents to survey 2

		Programme			
		UFBR count	ASK count	UFBR and ASK count	Total
North vs South	North	3	6	19	28
	South	14	32	2	48
Gender	Male				
	Female				
	Other				
Organization*	Amreff	2	2	2	4
	CHI	0	2	1	3
	Choice for Youth and Sexuality	0	2	3	5
	Dance4Life	2	2	10	12
	IPPF	0	5	1	6
	Rutgers	5	6	13	24
	Simavi	8	9	3	20
	Stop AIDS Now	0	15	1	16
	Other/NPC	2	0	5	7
Country*	Bangladesh	3	0	2	5
	Ethiopia	0	2	6	8
	Ghana	0	8	5	13
	India	3	0	5	8
	Indonesia	0	3	8	11
	Kenya	2	17	14	33
	Malawi	1	0	5	6
	Pakistan	0	4	6	10
	Senegal	0	6	4	10
	Tanzania	8	0	7	15
	Uganda	0	10	10	20

2.2.4. Face-to-face and telephone interviews followed by a workshop (Northern alliance partners)

To gain more in-depth knowledge about the added value of the SRHR Alliance, we did a series of interviews with Northern alliance partners. Complementary to the online survey, the interviews focused on the management level of the organizations included in the SRHR Alliance. We included one person per organization. In total, 11 persons were interviewed using a semi-structured interview guide: six interviews were done face to face, and two by telephone/skype. Following the analysis of the online survey and the interviews, we organized a three-hour workshop with representatives of each Northern alliance partner to discuss in depth the added value of the alliance based on the results. Three topics were discussed during the workshop:

- the preliminary results from the online survey and interview were presented, discussed and interpreted;
- the preliminary stakeholder map - based on document analysis and field studies - was presented and discussed; and
- the explicit ToC (see Chapter3) was presented and discussed.

The methodological aspects of the analysis are explained in a separate report on the partnership (*Partnership Assessment: The SRHR Alliance and the Youth Empowerment Alliance*).

2.3. Field study

As set out in the Terms of Reference for the evaluation, four countries were selected by the commissioner to do in-depth field research: Indonesia, Uganda, Kenya and Ethiopia. At the beginning of November 2015 it was decided in consultation with the M&E coordinators of Rutgers and the project team in Ethiopia to leave Ethiopia out of the field study. This allowed for more time for the evaluation in Kenya, Uganda and Indonesia. In collaboration with the respective country team, we selected two to three settings per country to allow us to gain an in-depth understanding of the mechanisms through which the ASK programme was implemented in each country.

The selection criteria for the study sites were the following:

- perceived success and/or perceived quality of the implementation of the programme (e.g. including a setting that is known to be successful and one that is known to be less successful);
- feasibility of the setting: ability to access the study sites (location, transport); existence of structures to enable coordination of focus group discussions and interviews; available partners and human resources attached to the ASK programme, to provide required support and information during the field study; and
- relevance to country team/programme: study settings that will provide opportunities to address the research questions outlined, and are also relevant for country teams in terms of learning.

A number of different methods were used to collect data at these sites. These are described in detail in the field study reports, so we will only provide a short overview here.

2.3.1. Semi-structured interviews

The semi-structured interviews provided information to answer a large number of research questions in all dimensions of the evaluation (see Table 2.1). We interviewed various stakeholders and programme staff: approximately 10 per country. The exact composition was discussed with the country lead and/or National Program Coordinator (NPC) and differed by country. Generally we aimed to include programme staff, people involved in the implementation (community leaders, health care providers, teachers, peer educators) and external stakeholders (ministries/administrations, policymakers, local health authorities, employees at embassies, members of councils, knowledge institutions). In the country reports where fieldwork was executed (Uganda, Kenya and Indonesia) detailed information can be found which respondents were interviewed in each country.

Topics covered in the semi-structured interviews with those involved in the programmes included: verification of the stakeholder map; outputs and outcomes; strategies (processes); partnerships; capacity-building; enabling and constraining factors; relevance; and sustainability. The interview guide can be found in Annex 4.

2.3.2. Focus group discussions

The focus group discussions (FGDs) provided information to answer a large number of research questions in all dimensions of the evaluation. We organized FGDs with a variety of stakeholders (policymakers, community leaders and youth-led organizations), service providers (health care providers/educators) and programme beneficiaries. The groups involved were related to specific regions and focus areas of the ASK programme. As it was not possible to cover all groups in each location, we aimed to work with heterogeneous groups consisting of various kind of actors. In total we organized six focus groups, each with 6–10 participants, in two different locations per country. Respondents were mostly selected on base of their involvement in the programme; for external stakeholders like policymakers and community leaders, some involvement was necessary to be able to reflect on the programme and therefore random sampling was not appropriate. All service providers included in the FGD were directly involved in the programme. With regards to beneficiaries

we aimed to select respondents randomly; in some cases it was not possibly to do this consistently due to practical constraints of time, geographical spread or access to respondents.

The main topics addressed in the FGDs were the same as those in the semi-structured interviews, though the emphasis may differ depending on the type of respondents. However, the FGDs provide opportunities to understand the context and perspectives of different stakeholders on the research dimensions. They were also used to verify other data obtained; based on data from different kinds of sources, it was possible to triangulate data. The FGD guide can be found in Annex 5.

2.3.3. Most significant change method

We used most significant change (MSC) methods to assess whether and how the programmes achieved change, to identify the most significant changes according to young people as key stakeholders and target groups, and to identify unexpected changes. By engaging the target group in the data analysis, the researchers receive additional data on the norms and values of the target groups.

For both programmes, young people (aged 15–24 years) themselves, coached by the research team, collected data among their peers, and another group of young people contributed to the analysis. We tried to involve young people who had already been involved in the OR in the field research countries or who had been working as peer educators. For the ASK programme 33 stories were collected in Indonesia and Uganda[2]. In Indonesia stories were mainly collected from LGBT youth, as the research assistants involved (peer educators) felt targeting this groups - as one of the marginalised groups - was key to the ASK programme. In North Uganda young people were interviewed via a health facility and via Mama's Club, one of the ASK partners that focused on HIV services for young people. Both in Indonesia and Uganda, young people who were present at health service sites and clubs during the time of the field work were interviewed randomly, decreasing a risk of selection bias.

2.3.4. Site visits and observations

For each study setting in each country we selected two to four sites that correspond with different strategies implemented (e.g. increasing knowledge, improving SRH services, enabling environment). These sites included health centres, youth clubs, schools or other relevant implementation settings. The sites were selected in consultation with the NPC and other relevant partners. During the site visits, a relevant staff member from the implementing partner was asked to provide information, and a young person (usually a peer educator) was included in the tour. The checklist used during the site visits can be found in Annex 6.

2.4. Feedback

Throughout the evaluation, the evaluation team was in continuous contact with the ASK programme's M&E coordinator. All the methods proposed were discussed and agreed. There were also several other opportunities for stakeholders to provide feedback:

- NPCs and country leads revised the country reports. This revision included fact checking and providing information on inconsistencies in the documents; and
- in the countries where field research was done, the local consultant organized a feedback workshop. This workshop was jointly prepared by the evaluation team member responsible for the country and the local consultant.

[2] In East Uganda and Kenya, stories of change were collected from young people who were reached by the UFBR programme. In those districts, alongside UFBR, the ASK programme was also implemented. These stories are analysed in the UFBR synthesis report.

3. THEORY OF CHANGE

3.1. What is a Theory of Change?

A first step in this evaluation is to make explicit the ToC of the ASK programme. A ToC can be described as *"the process through which it is expected that inputs will be converted to expected outputs, outcome and impact"*[3] or, in other words, a *"set of assumptions that explain both the steps that lead to the long-term goal and the connections between programme activities and outcomes that occur at each step of the way".*[4]

A ToC needs to include an explanation of how the programme's activities will contribute to the results, instead of just having a list of activities followed by the outputs and outcomes, without an explanation of how these are linked. Hence, a ToC articulates the theories and assumptions which underpin the anticipated change process and provides the supporting evidence.

A ToC often combines a 'simple' visual presentation which quickly communicates the theory to all audiences and a more detailed narrative that does justice to the complexity of the programme and explores the assumptions and evidence that underpins it. The ToC should also be consistent with the logical framework of the programme.

3.2. The theory of change of the YEA

In the available information, there is little reference to a specific ToC in the ASK programme. The general proposal for the ASK programme specifies that the alliance will continue the conceptual thinking (or ToC) that formed the basis of the SRHR Alliance's UFBR programme: to realize SRHR, a programme needs to address the capacity of the individual (through gender-sensitive SRHR education, information and skills-building), create an enabling environment (by working with communities and advocacy) and improve the availability, accessibility and quality of SRH services for young women and young men.

Hence, as in UFBR, the multi-component approach of ASK consists of three elements: **demand**, **supply** and **support**, which each have their own strategy but also influence each other:

- Through the provision of SRHR information, the ASK programme empowers young people to make healthy and well-informed decisions (improving knowledge, skills and self-efficacy of young people). By providing SRHR education, **young people's demand for services will grow**, and as such the demand for youth-friendly SRH services will increase.
- The ASK programme strengthens the provision of quality public and private SRH services (the availability, affordability and quality of SRH services and commodities) to meet the increased demand. **By strengthening the provision of services, the supply increases.**
- Community sensitization, participation and mobilization activities are implemented to create an environment that accepts adolescent SRHR and **increases broad community support for sexuality education and youth-friendly SRH services**. Furthermore, lobbying and advocacy activities are undertaken to facilitate the creation of policies and laws that are supportive of young people's rights and needs.

[3] DFID, Further Business Case Guidance "Theory of Change".
[4] Carol Weiss, M&E Specialist, 1995.

3.3. Review of the existing theory of change

The ToC leads the programmatic choices and defines the three areas the alliance works in: provision of SRHR information, access to and provision of SRH services, and influencing an enabling environment for young people's SRHR. The ToC has helped the different partners in countries to develop a better understanding of the ASK programme and their specific role.

In 2012, as part of the UFBR learning agenda, research was conducted to review the evidence base of the effectiveness of a multi-component approach. The literature review concluded that multi-component approaches are more effective than single-component approaches for improving the sexual health and behaviour of adolescents, particularly when they address structural factors and barriers, such as demand, supply and support. Nevertheless, the documents also identified challenges for such an approach in terms of structural barriers (such as poverty, gender inequality), organizational challenges (scattering of programmes, interventions and stakeholders) and a lack of rigorous evidence that supports the ToC. The ASK programme is designed to build on the work and the ToC of the SRHR Alliance, with a stronger focus on youth participation, SRH services and including innovative ways of disseminating SRHR information.

As the ASK ToC is similar to the UFBR ToC, the same flaws can be identified from the theoretical and practical point of view. The 'monitoring framework' explains how outputs lead to outcomes; however, it lacks an explanation as to how the programme activities will generate the outputs and short-term changes that in turn will allow for the improved provision of SRHR education, SRH services and a supportive environment. Furthermore, the linkages between different activities, outputs and outcomes are not made explicit. The annual reports and outcome measurements have gathered experiences and information on how different components interlink and reinforce each other. However, there is still a lack of 'evidence' that demonstrates how these linkages and changes lead to concrete outputs, outcomes and impact.

In the remainder of this chapter, we will try to develop a more detailed version of the ToC. It will spell out the assumptions at all levels of the programme. This more detailed ToC was tested by the evaluation team during the field visits and was used to gather further evidence. Northern alliance members also provided their feedback on it. The ultimate goal of this exercise is to help the SRHR Alliance gain a complete understanding of how each participant/stakeholder will facilitate change in the short, medium and long term. Furthermore, by spelling out all the assumptions and seeking evidence for these assumptions during the evaluation, the YEA will have a stronger evidence base for its ToC and the wider ASK programme.

3.4. More detailed theory of change and evidence base

Figure 3.1 presents a more detailed version of the ToC, linking it to the existing logical framework.

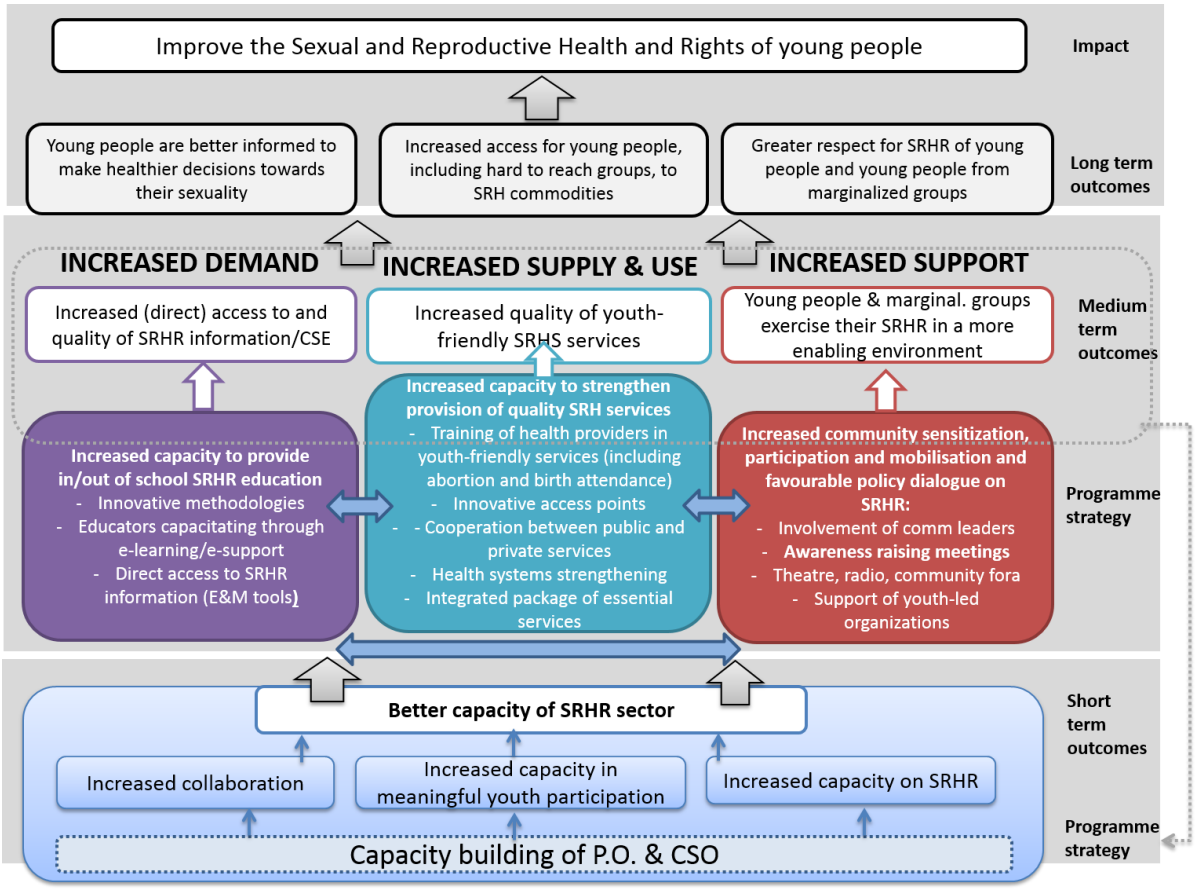

Figure 3.1: Explicit theory of change of the ASK programme

As part of the process of developing the ToC, it is important to identify evidence that confirms the assumptions and theory. A review of the literature in 2012, conducted within the UFBR programme, demonstrated that some academic research exists to support a multi-component approach. However, there is no rigorous evidence available yet to support each of the assumptions of the ToC. Hence, the evaluation will be useful to also verify and collect evidence for these assumptions, which are spelled out below:

Capacity-building

- Linking and learning between organizations leads to better programming.
- Individual capacity-building on SRHR increases the SRHR knowledge and skills of staff in partner organizations and civil society organizations (CSOs).
- Organizational capacity-building on project management, research and PME leads to improved implementation and monitoring of the programme.
- Increased capacity on MYP leads to the better involvement of young people throughout the programme.
- Better-connected and strengthened organizations contribute to a stronger national SRHR sector.
- OR leads to better-informed intervention strategies and, therefore, contributes to the quality of the programme.

Increased SRHR education (demand side)

- Training educators to deliver quality CSE through e-learning and e-support leads to improved capacities of educators to deliver CSE.
- Promotion of innovative CSE activities leads to increased access to SRHR information.
- Providing direct access to SRHR information will lead to large groups of young people, including marginalized groups, accessing this information.

- Increased access to quality SRHR information and CSE leads to better knowledge among young people, including marginalized groups, to make informed decisions about their SRHR.
- Increased access to quality SRHR information will lead to increased confidence and attitudes of young people, including marginalized groups.
- Increased knowledge, better attitudes and improved skills lead to increased capacity to make informed decisions about their SRHR.
- Increased capacity (knowledge, confidence and attitudes) of young people, including marginalized groups, leads to greater demand for quality SRHR services.

Strengthening SRH services (supply side)

- Training of service providers on delivering youth-friendly SRH services leads to improved capacity of service providers to deliver quality youth-friendly SRH services.
- Establishing youth-friendly access points will lead to increased access of young people, including marginalized groups, to SRHR commodities.
- Cooperation between public and private services will lead to increased availability of youth-friendly services.
- A better supply of commodities and drugs leads to a better quality of SRH services.
- Offering integrated packages of essential services will lead to increased quality and availability of youth-friendly services.
- Improved quality of SRH services leads to greater client satisfaction.
- Improved access to formal and information SRH services leads to better uptake of health services.

Enabling environment for SRHR

- Advocacy at the local, regional or national level leads to increased involvement of authorities in the programmes.
- Advocacy at the local, regional or national level leads to improved SRHR policies and legislation.
- Support for youth-led organizations leads to increased involvement of young people, including marginalized groups, in youth-led community SRHR and advocacy activities.
- Youth-led SRHR awareness-raising activities at community level, including theatre, radio and community forums, lead to a more supportive environment for SRHR.
- SRHR awareness-raising activities at national level using (new) media lead to a more supportive environment for SRHR.
- Improved SRHR policies and legislation lead to a more supportive environment for SRHR.
- A more supportive environment for SRHR provides more support to young people, including marginalized groups, to exercise their sexual and reproductive rights.

Long-term changes

- More demand, supply and support for quality and equitable SRHR leads to young people, including marginalized groups, making healthier decisions regarding their sexuality.
- More demand, supply and support for quality and equitable SRHR leads to improved use of quality SRH commodities by young people, including marginalized groups.
- More demand, supply and support for quality and equitable SRHR leads to greater respect for SRHR for young people, including marginalized groups.
- Improved capacity of young people to make informed choices, improved utilization of quality SRH services and increased acceptance of SRHR leads to improved SRHR of young people, including marginalized groups.
- Combining different result areas leads to more effective programmes.

4. DIMENSION 4: NORTHERN ALLIANCE AND MEMBERS

Key messages

- Partners assess the collaboration as positive, perceiving many benefits of working together that outweigh the challenges they also experienced.
- The partnership has been effective in increasing the professionalization of the alliance members, on both the individual and the organizational level.

To what extent has the partnership been relevant, effective and efficient for the individual members and the programme?

Five alliance organizations in the Netherlands, working together in the SRHR Alliance, implemented the UFBR programme in nine countries from 2011 to 2015. In 2013, a second programme, ASK, was initiated, and an additional alliance, the YEA, was established to implement it. Two additional partners, one from the Netherlands and one from the UK, joined the initial five members. The ASK programme was implemented in seven countries from 2013 to 2015. This report focuses on the added value and the enabling and constraining factors within these two alliances. In general, we can conclude that the partnership was a good way to implement both programmes. For more information on these conclusions, see the separate evaluation report on the partnership that is part of this end-of-programme evaluation (Partnership Assessment: SRHR Alliance and Youth Empowerment Alliance).

Overall positive assessment of the partnership

We can conclude that the prerequisites are in place for the alliances to function well. The goals of the partnership fitted well with the mission and objectives of each individual organization. The ToC was a common framework as well as a 'bonding agent' for the collaboration. Members feel that the alliances possessed all the relevant expertise required to implement the programmes.

Partners assess the collaboration as positive, perceiving many benefits of working together. Partnering created synergy, which improved the quality of the work and resulted in better outcomes. Together the alliances are more visible, making it easier to lobby and advocate for SRHR. The collaboration also facilitated and stimulated learning.

Challenges

Collaboration was, however, not an entirely positive experience. Especially at the top level of the alliances, alliance members struggled with tensions between organizational and alliance interests, sometimes leading to mistrust and negative energy. Collaboration was also found to be bureaucratic and time-consuming. In addition, it was found that the alliances established a consensus-seeking culture, where most decisions were made democratically. This made the alliance less agile. All in all, however, the members feel that the benefits outweigh the disadvantages. This is also proven by the continuation of the partnership in a new programme, in which all but one organization are participating.

Increased professionalization

We can also conclude that the partnership has been effective in increasing the professionalization of the alliance members. This is most notable at the level of individual staff. Knowledge and skills obtained on PME and research, MYP and CSE were mentioned as being particularly valuable. Organizational learning has also been acknowledged and appreciated, but to a lesser extent than individual capacity-building. Three of the seven alliance members feel that their organization has been changed in a positive way by the programme, and two of these have adapted their programming with more attention to SRHR, especially with regards to rights.

Top-down approach

Both alliance members and partner organizations assess the international cooperation as positive, with Southern partners being more positive than Northern partners. In general, however, the programme was found to suffer from a top-down approach - although to a lesser extent than UFBR - which hindered ownership and sustainability of the programme in the South.

5. DIMENSION 3: COUNTRY ALLIANCES AND PARTNERS

Key messages

- While partners clearly have to invest time and effort to participate in the country alliance, the benefits of working together, learning from each other and jointly improving the quality of the SRHR sector in the country seem to compensate for these inputs.
- The focus on capacity-building was much appreciated by the partner organizations and led to an important improvement in both individual and organizational capacity. According to partners, capacities were mostly strengthened in MYP, CSE and the enabling environment.
- Partners felt that the short time frame of the ASK programme and a focus too much on quantity and not on quality were key weaknesses of the programme. It is likely that this had a negative influence on the in-country collaboration.

Has working in the ASK/UFBR programme been relevant, effective and efficient for partner organizations, in terms of their capacity?

5.1. In-country and international collaboration

5.1.1. National alliance

How do partners value the in-country collaboration (with each other and NPCs)?

The ASK programme brought together organizations with complementary strengths. Through collaboration, they increased their networking capacity and shared knowledge and expertise with each other. This aspect of the programme was highly valued in all seven countries that participated in the programme.

In the countries where UFBR was implemented, the ASK programme was launched in an existing alliance, although additional partners were attracted to join forces. On the one hand, using an existing partnership facilitated a smooth start to the programme; on the other hand, the addition of new partners also meant that a new balance needed to be found. In Uganda, for example, the alliance was expanded by eight different partners. While some partners integrated easily, it was also mentioned that other partner organizations continued to function in more isolation “due to the specific location of operations, approaches or magnitude of their own programme” (ASK annual report 2014). In Ghana and Senegal, countries with no UFBR history, new alliances were set up which took time and effort. At the same time, those partner organizations had to prepare activities to achieve the ambitious targets in a short time frame, making it challenging to build strong partnerships.[5] In line with this, 27% of the Southern ASK partners felt that the key organizational weakness of the programme was its short duration. Since the ASK programme lasted for only three years, the collaboration is likely to be less deep than for the UFBR programme. Another key weakness in terms of the principles of the programme was that the focus was too much on quantity and not on quality, which was mentioned by 16% of the respondents. When we look at the online survey, Southern ASK partners are somewhat less positive than the UFBR partners about the national partnership.[6]

[5] Ghana and Senegal were new countries to work in. After the closure of the programme, only Ghana will be included in the new Get Up, Speak Out programme. From a perspective of sustainability, a timeline of effectively only 2.5 years is a very short time to establish lasting effects in Senegal.

[6] Twelve national partnership statements on a scale of 0 (‘absolutely disagree’) to 10 (‘absolutely agree’) were combined in a scale. ASK partners gave the national partnership a score of 8.1, and the UFBR partners a score of 8.6, although the difference was not significant.

Not all country alliances were as effective in their collaboration from the start or even at the end of the programme. Various factors hindered collaboration; in Pakistan mechanisms for interaction were weak, and in Indonesia and Senegal the geographical spread complicated cooperation. Table 5.1 shows that partner organizations in these countries also awarded somewhat lower scores to the national partnership, compared to the other countries.

Table 5.1: Assessment of the national partnership by Southern ASK partners by country (mean of scale 0–10).

Mean	Ethiopia	Kenya	Indonesia	Pakistan	Ghana	Senegal	Uganda
National partnership	9.2	8.7	7.0	8.2	8.2	7.8	8.4
N	3	13	9	8	4	2	9

Three factors have contributed to relevant and effective in-country collaboration. First, a good mix of partners in the national alliances was important to encourage mutual learning. Regular progress meetings, experience-sharing visits and joint capacity-building have helped to identify opportunities for programmatic collaboration and complementarity. Partners felt that these exchanges ensured good working relationships and increased understanding of SRHR-related issues. A second important tool to strengthen the partnership was collaboration in joint activities. In each country, 10% of the annual country budgets was reserved for joint activities by partners in the so-called Country Alliance Fund (CAF). Joint activities included meetings/workshops, joint training of staff members (for example, on M&E or HIV prevention in Ghana), review and planning meetings with all partners, steering committee meetings, joint advocacy activities, campaigns and development of communication tools. For example, in Uganda the Alliance Week was mentioned as being very successful. Partners jointly organized mobilization and information activities, and provided health services. This both strengthened ties between alliance partners and improved their visibility to outside stakeholders. A third factor that helped to improve collaboration was the presence of the NPC. Northern alliance members also mentioned in the interviews that NPCs were crucial in the coordination and planning of joint activities and aligning the wide range of partner organizations.

When asked in the online survey about the main weaknesses of the partnership, Southern ASK respondents pointed to a lack of clarity on how to build the partnership (30%). This might seem straightforward for Northern partners; however, many partner organizations were not experienced in working in an alliance. Guidelines on how to build an alliance were found to be lacking. Having too many partners with small roles was another key weakness identified by the Southern ASK partners. In some countries, with the start of ASK, many additional partners were included in the programme (Kenya, Uganda). This might have led to fragmentation of tasks. Southern ASK partners also award a lower score to the national partnership statement ‘There are strategies in place to resolve conflict between national partners’ than to other statements and compared to UFBR partners, indicating that some issues might have arisen between partner organizations.

5.2. Value of being part of the alliance

Are there gains/outputs of being part of the country alliances, in line with the required input of the individual partners?

The programme documentation and online survey confirm that being part of the alliance was relevant to most Southern partners. First, the online survey confirmed that the mission and objectives of the partnership were aligned with their organizational objectives. Second, the country reports highlight that working together with other partners led to an increase in the quality of their programming, improved leverage in terms of advocacy and created greater visibility and professional credibility. Despite these gains, it was not always easy to reconcile their organizational interests and priorities with those of other partners. This required time and effort to build up mutual trust and a joint strategy.

Benefits

In our field research and the programme documents, country alliances mention different benefits of partnering. The joint activities increased collaboration, capacity-building and sharing and learning, making it easier for country alliances to incorporate the ToC. For example, in Ethiopia one partner organized a health connection tour in schools, while the other partner provided voluntary counselling and testing services at the same time.

Joint capacity-building and connection to national and international networks were other benefits. As an alliance, partner organizations gained greater visibility, which enhanced their lobbying and advocacy possibilities. Also, the country alliances gained more interaction and engagement with important stakeholders, which was not the case before. For example, the ASK partners in Senegal jointly advocated for and contributed to the inclusion of reproductive health education in school curricula. In Uganda several SRHR advocacy activities were undertaken, using young people as advocates: two young people from the alliance were chosen to present a communiqué on youth-friendly services to the President of Uganda and the Executive Director of UNFPA.

Also, collaboration was seen as cost-effective, due to the sharing of resources. By joining forces, partners were able to reduce duplication of services and deliver their activities more effectively. Working together also inspired more discipline, a greater focus on results and more accountability in terms of resources. The capacity-building activities strengthened the staff's ability to implement programmes and also improved their confidence. In terms of resource mobilization, some country alliances felt that they now have more bargaining power to mobilize resources jointly, and some have concrete plans for submitting joint funding proposals. However, quite a few partners also mentioned in the online survey that competition among alliance members has increased.

Challenges

Alliance-building took a considerable amount of time, budget and attention. The short duration of the ASK programme and pressures to implement many activities in such a short period of time hindered thorough collaboration. According to the ASK 2014 annual report, in some countries the number of joint meetings was reduced to give priority to implementing activities. One of the main challenges in alliance-building has been the competing schedules between partner organizations' activities and alliance joint activities, which at times hampered effective participation of partners in alliance activities. Another challenge mentioned in the country documents was delays in joint decision-making due to internal organizational dynamics. Also, a wide geographical spread between partners (Indonesia, Senegal) meant that collaboration - and especially organizing joint meetings - was time-consuming and costly and hindered truly effective implementation of the multi-component strategy. In Senegal collaboration was for that reason primarily limited to the national level in advocacy and other joint activities. In Ghana and Ethiopia the lack of coordination and communication between partners was found to hinder good collaboration.

Despite the challenges, partner organizations are generally positive about working in an alliance. It can, therefore, be concluded that the benefits of being part of the country alliances outweigh the required inputs and challenges of working as an alliance in most countries. While partners clearly have to invest time and effort to participate in the country alliance, the benefits of working together, learning from each other and jointly improving the quality of the SRHR sector in the country seem to compensate for these inputs.

5.3. International alliance

How do partners perceive the collaboration with the Northern alliance and its members? To what extent do partners feel they are part of an international/regional alliance or movement?

The Southern partners appreciate the collaboration with the Northern partners, particularly in terms of the technical assistance provided. When asked about the international alliance in the online survey

(see Table 5.2), Southern ASK respondents were most confident about the capacity of the international alliance to cater for the three components of the ToC and the fact that it is clear what the international partnership stands for. Most Southern partners also feel that national programmes are built on the basis of local needs and that Northern and Southern partners have a mutual understanding of the mission and objectives of the international alliance. The ASK partners awarded this statement a somewhat lower score (mean of 7.8) than the Southern UFBR respondents (mean of 8.5).

Table 5.2: Functioning of the international partnership by Southern and Northern ASK partners.

Statement	Northern partners		Southern partners	
	Mean	Variance	Mean	Variance
3.1. The Dutch/UK organizations, on the one hand, and the national alliances in the countries in the global South, on the other hand, have a mutual understanding of the mission and objectives of the international partnership	7.0	2.9	7.5	4.5
3.2. I know what the international partnership stands for	8.4	1.6	8.1	4.1
3.3. There is transparent communication between the Northern and Southern partners*	6.4	2.8	7.5	6.7
3.4. The appropriate governance systems and procedures are in place for the international partnership to function properly	6.3	3.8	6.9	6.4
3.5. There are enough monitoring and evaluation moments in place to manage the international partnership properly	7.7	2.8	6.8	5.7
3.6. There is mutual trust between the partners of the international partnership*	6.2	4.5	7.6	6.0
3.7. The programmes are built on the basis of local needs*	6.5	5.1	7.8	3.8
3.8. The international members of the partnership combined have the necessary competencies and knowledge to cover the three components	8.1	2.1	8.1	2.7

The Southern partners are less confident that sufficient monitoring and evaluation (M&E) moments are in place to monitor the *quality of the international partnership* appropriately. Also, concerns were expressed with regards to the governance systems and procedures that are in place for the international alliance to function properly. For example, in Senegal governance issues arose from the multi-layered structure of the ASK programme at national and international level. Both Northern and Southern partners feel that the ASK programme was driven too much from the top down and that decision-making powers were more skewed towards the North than the South. From the survey it became clear that Northern and Southern partners perceived the top-down approach as a key weakness of the management of the alliance. Although statements 3.3 to 3.6 receive lower scores, it should be noted that there was also disagreement between respondents on these statements; respondents' opinions differed quite a lot, as indicated by the high variance for these statements.

Interestingly, there are some differences in opinion between the Northern and Southern partners. Overall, the Northern partners awarded the statements lower scores, indicating a more critical stance and possibly different scoring preferences compared to the Southern partners. In particular, Northern partners were more negative about the transparency of communication and mutual trust between the North and South. There is also disagreement about whether the programme is built on local needs.

According to the respondents of the online survey, the main strength of the international ASK partnership was the mutual learning between partners (see Figure 5.1). The establishment of country alliances (17%) and technical assistance from the Northern partners (15%) were other strengths. In contrast, two key barriers to the overall partnerships were, according the Southern ASK respondents in the online survey, 'Organizational versus alliance interest' and 'Youth-led organizations are not always seen as equal partners'. The first barrier can be explained - as mentioned earlier - by partner organizations struggling with the competing schedules between their own activities and alliance joint activities. The second barrier points to the difficulties that youth-led organizations experienced in positioning themselves within country alliances. A staff member from CHOICE confirmed that many

of its youth-led partner organizations had to work hard to be seen as equal to the other organizations, especially in conservative societies. This shows that barriers still exist to integrating MYP in programmes.

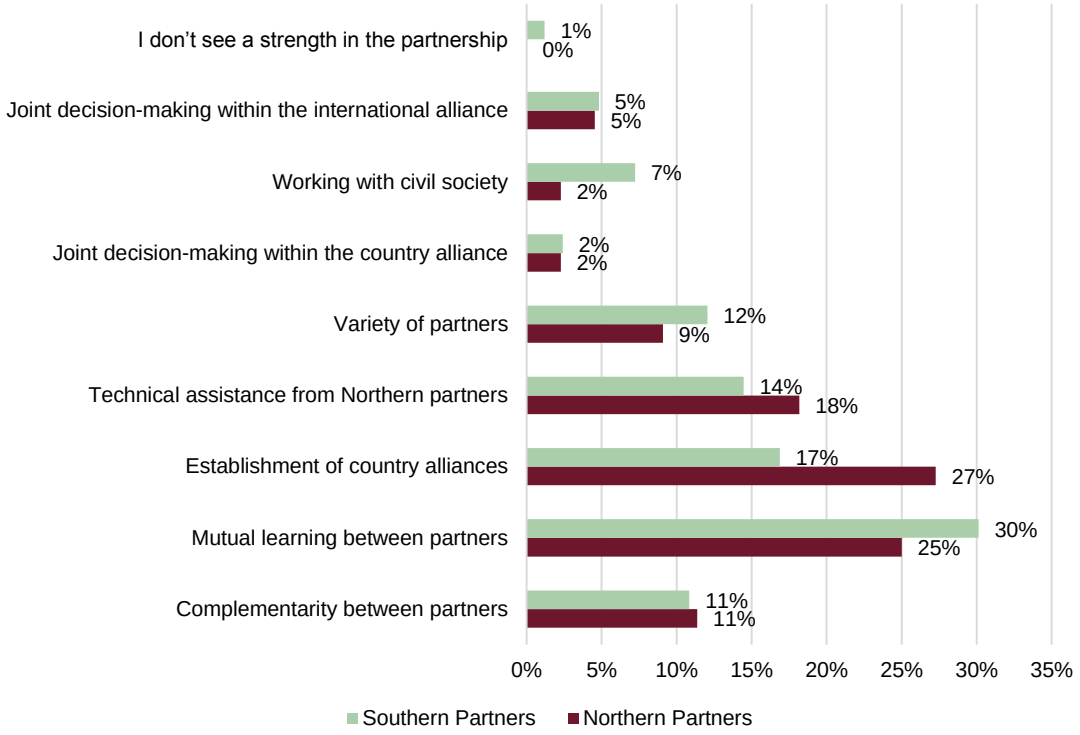

Figure 5.1: Main strengths of partnership (UFBR, all partners, second online survey).

In the ASK programme, lessons learned were also shared between different ASK country alliances. The annual NPC meeting in the Netherlands was an important opportunity to share knowledge, best practices and strategies between countries. Also, various documents were shared with the country alliances - for example, a magazine with best practices from different countries on electronic and mobile health (e&m health) tools. The alliance office, together with the country alliances, collected several ASK 'pearls' that presented best practices of the programme. In 2014, an OR symposium was organized for partner organizations in Kenya to share the results of the OR. However, not much can be concluded on the usefulness of this particular exchange, and it is not clear to what extent country alliances actually used all these different data sources for their own strategic planning. In the annual reports not much was mentioned about inter-country learning.

5.4. Changed capacity of partners

Has the partnership led to changes in the capacity of NGOs and NGO staff, specifically in SRHR technical expertise, collaboration and advocacy?

Southern partners attach great importance to the capacity-building component of the ASK programme. Particularly at the individual level, NGO staff were confident that they obtained technical expertise and experience on SRHR issues, and that they were able to integrate this knowledge and transfer it to other people. ASK respondents to the online survey gave an overall lower score for improvement of organizational capacity (mean of 8.6 out of 10) than for improvement of individual capacity (mean of 9.1 out of 10). Nevertheless, Southern partners are generally satisfied with the level of organizational capacity-building (see Table 5.3).

Partners are most positive about the statement that the organization has improved its capacity to carry out activities and achieve the desired results. This statement is connected to the capacity to act

and commit from the 5 capacities framework (5Cs).[7] Partners are also very positive about their organization being able to achieve its aims in a better way because of the partnership (related to the capacity to achieve coherence) and that they can better build and maintain networks with external stakeholders (related to the capacity to relate to external stakeholders). Slightly lower, but still very positive, are partners' scores for the internal structure to share knowledge and learn internally and the organization's adaptability in light of new challenges or external changes (both related to the capacity to adapt and self-renew). Southern partners gave their lowest scores to the statement 'Gender concerns are now part of my organization's policy and practice', with a mean of 8.3. Partners' opinions differ quite a lot on this statement, as can be gathered from the high variance, showing that some partners probably adjusted their policies, while others did not. This could, however, also be because some organizations already had gender policies and practices in place. These positive findings are backed up by information from the project documents and interviews in the field study. Staff of partner organizations felt that they themselves and their organization learned and benefitted a lot from being an implementing partner of the programme.

Table 5.3: Assessment of organization-level capacity-building by Southern ASK partners.

Statement	Southern partners	
	Mean	Variance
7.6. My organization has improved its capacity (knowledge, experience, expertise) to carry out actions and achieve results aimed for	9.0	1.0
7.7. My organization has better structures in place to share knowledge and learn internally	8.5	1.5
7.8. My organization is better able to adapt its strategies if there are new challenges or external changes (e.g. shift in government policies)	8.7	1.3
7.9. My organization can now better build and maintain networks with external stakeholders	8.8	1.3
7.10. Due to the programmes, gender concerns are now part of my organization's policy and practice	8.3	3.5
7.11. My organization is able to achieve its aims in a better way because of the partnership	8.8	1.3

The online survey showed that the Southern ASK staff's SRHR capacities were mostly strengthened in MYP (20%), CSE (13%) and the enabling environment (12%). Although the ASK programme also focused on access to and delivery of services, only 11% felt that their capacities had been improved on this topic. Conversely, staff felt least satisfied about their improved capacities in PME and research, and lobbying and advocacy (see Figure 5.2). It is quite surprising that PME and research is mentioned as a capacity that was least strengthened, given that OR had such an important place in the ASK programme.

[7] The 5 capabilities framework (5Cs) was developed by the European Centre for Development Policy Management (ECDPM) and used by the Ministry for Foreign Affairs as a monitoring framework for capacity development of Southern partner organizations in MFS2.

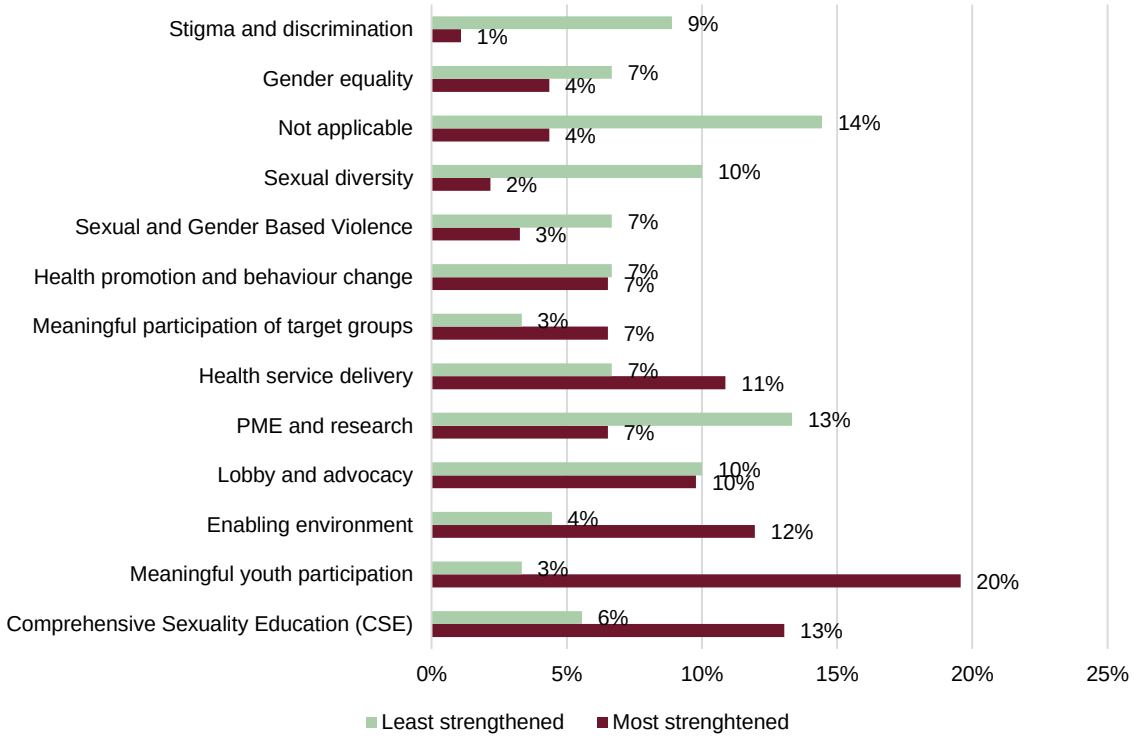

Figure 5.2: Capacities most and least strengthened (ASK, Southern partners).

Various mechanisms were used to strengthen organizational capacity, ranging from tailored joint workshops and training courses, symposiums, learning visits, regular progress meetings, joint activities and annual harmonization meetings. Partners were able to strengthen each other's capacity by training or advising each other on specific topics, such as e&m health or MYP, and jointly contract external trainers, which helped to reduce costs and increase efficiency. Northern alliance members also gave Southern partner organizations assistance in the form of documents - for example, the manual on Essential Packages, and best practices on e&m health. Also a set of tools was offered to the partners (self-assessment questions, roadmaps and an overview of resources).

Each country alliance addressed different topics for joint capacity-building that were tailored to the specific needs of the partner organizations. Topics that were mentioned included, among others: PME and research (Ghana, Ethiopia, Pakistan), CSE (Senegal, Uganda, Ghana), joint advocacy (Ethiopia, Uganda, Pakistan), fundraising (Ghana), commodity supply management (Senegal), sexual and reproductive rights (Senegal, Kenya), e&m health (Senegal) and finance (Indonesia, Uganda). The ASK programme had a specific focus on the use of direct communication, MYP and the use of OR. We will briefly discuss whether capacities were strengthened in each of these topics or not.

E&m health tools

According to the ASK 2014 annual report, the use of e&m health tools was often supported by capacity-building activities. However, e&m health is not mentioned much as a topic for capacity-building in country documents. In Uganda and Senegal some partners participated in training on e&m health to gain a better understanding of opportunities and its potential use. The Ugandan OR report on e&m health shows that some of the RAHU staff - an organization with expertise in mass communication - already had an educational background in IT-related courses, while the rest of the staff learned these skills on the job. However, some specialized IT skills were lacking, which is why they outsourced certain tasks. This example shows that the use of e&m health requires the partner organizations to have specific expertise which is sometimes easier to find through an additional partnership. In many countries (Ghana, Uganda, Kenya, Pakistan) we noted additional partnerships

with organizations with e&m health expertise or with youth organizations. By piloting and using e&m health tools, it is, however, likely - as the Ugandan OR shows - that partner organizations increased their capacity on this topic by learning by doing. In Indonesia partner organizations that specialized in services indicated that they lacked certain expertise, such as skills to moderate online discussions, knowledge about privacy issues and the use of framing/wording for websites.

Meaningful youth participation
To strengthen the capacity of partner organizations in MYP, many adult staff of partner organizations were trained how to meaningfully involve youth in programme design, planning, implementation, M&E, research and advocacy. Also, youth-led organizations joined the country alliances as partner organizations, as this was an integral part of the programme design of ASK. Within the country alliances these organizations advised or trained other alliance partners on how to integrate the voices of young people into their activities. It is difficult to assess whether partner organizations also improved their capacities on this topic due to the ASK programme, but Southern ASK partners themselves indicate that their capacity was strengthened more on MYP than on any other topics (see Figure 5.2).

In some cases, organizations changed their organizational policies on MYP. The Pakistan OR concludes that organizations that were already experienced in involving young people benefitted from the focus on MYP in the ASK programme. However, organizations that did not have active youth structures in their governance before the ASK programme made little progress in de-bureaucratizing their organizations to adjust to and accommodate young members. MYP was found to be a programmatic requirement and hardly framed within a rights-based discourse within partner organizations and the programme. This did not encourage a culture of acceptance of young people as strategic stakeholders in their development. Section 5.5 will elaborate more on changes in norms and values as a result of MYP and on how MYP was incorporated in organizations.

Operational research
Thirty different OR tracks were implemented in the seven ASK countries. Partner organizations and young people were closely involved in these research projects. Young people were trained in conducting research, and subsequently involved as research assistants. Partner organizations and other stakeholders took part in dissemination meetings to validate and discuss (preliminary) findings and what these meant for the programme. Through these research tracks, partner organizations learned more about OR but, more importantly, gained better insight into how their activities worked and how they could be improved. Through participation in these tracks, it is likely that the capacity of partner organizations was improved on various topics. According to the online survey, the Northern organizations valued OR as a useful strategy much more than Southern partner organizations did.

5.5. Changed values and norms on SRHR
Has the partnership led to changes in values and norms around SRHR (including gender, sexual discrimination and sexual and gender-based violence - SGBV) and MYP, and (how) has this been incorporated in programming and organizational policies?

Value clarification
As part of the ASK programme an Essential Packages Manual was delivered that clarified the underlying values of the ASK programme on six topics such as human rights, diversity, gender transformation, MYP, child protection and partnerships. For each of the result areas, the manual described how these values could influence the strategy of the programme. The document also provided information on the minimum and maximum standards that should be delivered. The provision of essential packages of services was mentioned as the most valued activity within the service component of the programme, indicating that the partners valued (part of) this manual highly.

Value clarification activities are mentioned in two countries. In Senegal it was found important to clarify values with staff and volunteers involved in the project to enable them to familiarize

themselves with the concepts and take ownership of project activities. In Indonesia partners conducted specific activities to address gender and sexual diversity issues such as the inclusion of sexual orientation and gender identity modules in training courses and the organization of internships in an LGBTQI organization. It is, however, difficult to assess the impact of these activities, as the results of these activities were not described. We also noted that value clarification was found to be one of the weaknesses of the UFBR programme. This is not mentioned for the ASK programme, and might be due to activities such as these and the Essential Packages Manual.

Views on abortion
In the programme 1,155 service providers where trained on abortion. Whether staff of partner organizations themselves changed their viewpoint on abortion is unclear. In general, in most ASK countries, abortion is still a very sensitive issue for health care providers. This is also because abortion is only legal under very strict circumstances in many ASK countries - for example, Ghana, Senegal, Uganda and Indonesia. Because interpretations of the laws are often ambiguous, medical providers may be reluctant to perform an abortion for fear of legal consequences. From an example from the programme documents from Ghana, we can conclude that partner organizations were not keen to implement training on abortion. The fact that there are medico-legal barriers to abortion in Ghana might also restrict partner organizations. This might indicate that partners may need a value clarification training to ensure that everyone is working towards the same goals, and possibly also juridical support to allay concerns about the legal context.

Meaningful youth participation
In general, field studies and ASK documents show that most staff are very positive about youth involvement. Young people are appreciated for their energy and commitment. However, the online survey also shows that youth-led organizations sometimes struggled to gain equal recognition in the country alliances. Apparently, not all partner organizations embraced MYP when it comes to more formal participation by young people. The OR tracks give some insight into whether values and norms were changed in partner organizations. The OR report on MYP in Ethiopia mentioned that several staff of partner organizations perceived young people as problematic, as opposed to being agents of change. There was also a lack of belief that young people would be able to contribute meaningfully, which led to excluding them from final decision-making.

This was also found in the OR in Pakistan, where young people in more *conservative partner organizations* were not trusted to participate in decision-making processes due to a perceived lack of skills. Partner organizations found it challenging to find young people with skills that matched bureaucratic settings. They often lose capable young people when they find other opportunities. The working environment at the top of conservative organizations is also difficult for youngsters to fit into; the report mentions “demoralizing environments like a traditional set-up of bureaucratic board members”. According to one of the Chief Executive Officers interviewed, this organizational culture mirrored Pakistani culture, where a “huge trust deficit exists between the two generations”. In Pakistani organizations with more young people as staff, it was easier to involve young people in various ways in the organization. This was also found in the Ethiopian OR, which concluded that younger or youth-friendly staff were an important factor that enabled trust in young(er) people’s abilities and reduced the divide between youth and adults. Similarly, in Senegal respondents noted that adult staff were initially reticent about the young people’s ability to manage the project, but, through experience with youth involvement (youth focal points) in the ASK programme, their attitudes about youth participation improved.

From the OR reports we can conclude that an initial lack of trust in the capacities of youngsters existed in partner organizations with no experience of youth involvement. However, by experiencing the positive gains that young people bring with them - positive energy, improved access to the target group, better results - adult staff slowly changed their attitudes; however, not in all cases. Having young people involved at lower stages of involvement - in implementation or research - and having

young staff are enabling factors to move partner organizations toward more MYP. However, this does not happen overnight and may even be something that might happen automatically. The OR reports from both Ethiopia and Senegal recommend developing mechanisms for decentralized power-sharing and decision-making in partner organizations to structurally embed youth involvement in the organization. The OR from Pakistan advises framing MYP in a rights-based approach to encourage a culture of acceptance of young people as strategic stakeholders.

All country alliances have made efforts to integrate interventions on MYP in their programmes, and some have developed specific polices on youth involvement. However, based on the field studies and the programme documentation, at the end of the programme, young people still seem to be more involved at the level of programme design and implementation than in decision-making. The OR report on MYP concludes that in Ethiopia the level of involvement of young people is at level 5 (consulted and informed) on a scale of 1 ('manipulated') to 8 ('initiated by young people, shared decisions with adults').[8] Positive examples of young people's involvement in decision-making were mentioned in Ghana, Senegal, Ethiopia, Indonesia and Uganda. In Ghana and Ethiopia a partner organization had a youth participation policy that requires roughly 30% of its governing board to be made up of young people, while in Senegal one partner organization had a policy to ensure that at least 25% of its governing body consists of young people (below the age of 25 years). In Pakistan young people were also involved in government bodies and were represented on the National Governing Board (NGB), while in Indonesia the alliance has a policy that 20% of the management team should be made up of young people. In Uganda several organizations developed a child protection policy, which ideally also determines how youth participation is integrated into their work. More examples can be found of young people involved in decision-making processes in the ASK programme than in the UFBR programme, although this could be further improved.

[8] This flower of participation scale was developed by CHOICE, the youth-led alliance partner, to give a better understanding of youth participation. See also http://www.choiceforyouth.org/information/meaningful-youth-participation/flower-of-participation. The classification in this OR report seems to have been done based on qualitative data.

6. EFFECTS AND RESULTS (DIMENSION 1)

Key messages

- The outputs of the programme are impressive - especially in combination with the short programme duration - and far exceed the target set.
- The programme is acceptable to and appreciated by the target groups.
- While the evidence of the individual studies is not strong enough to draw causal conclusions, the combination of quantitative and qualitative data allows us to build a plausible case for the effectiveness of ASK, although this is less conclusive than for the UFBR programme.
- It is likely that the short duration of the programme influenced its effectiveness.
- PME: Do not try to measure everything everywhere, but focus on a few well-designed effectiveness studies and process evaluation.

What are the results of the programme? Are they relevant and sustainable?

The main goal of the ASK programme was to improve the SRHR of young people (aged 10–24 years). This section of the report reviews the results of the multi-component strategy of the ASK programme, which consists of three core strategies for improving the SRHR of young people and women:

- improving access to and quality of SRHR education (Result Area 1);
- improving access to and quality of SRH services (Result Areas 2 and 3); and
- increasing the enabling environment (Result Area 4).

Although not formulated in a result area, the ASK programme also aimed to strengthen the capacity of partner organizations as well as learning and networking with other CSOs, thereby strengthening civil society. ASK targeted young people but had a specific focus on marginalized groups, including LGBTQI, YPLHIV, young adolescents (aged 10–16), young people in remote areas and young people with disabilities.

6.1. Did the programme achieve the expected results in terms of outputs and outcomes?

6.1.1. General results

Before delving into specific results of the programme, some findings from the online survey give an idea of how partners feel about the overall effectiveness of the programme. Items are scored on a scale from 0 (‘absolutely disagree’) to 10 (‘absolutely agree’). As seen in Table 6.1, both Northern and Southern partners rated the overall effectiveness of the ASK programme quite highly: the Northern partners with a mean score of 7.6, and the Southern partners slightly higher with 7.8. Both Northern and Southern partners also agree on the comparative effectiveness of the programme: Southern partners give this a score of 8.4, while Northern partners give it a somewhat lower 6.7. It should be noted that there was also disagreement between respondents on the statement of comparative effectiveness, especially in the North; respondents’ opinions differed quite a lot, as indicated by the high variance for this statement.

Table 6.1: Assessment of the effectiveness of the programme by Northern and Southern partners.

Statements	Northern Partners		Southern Partners	
	Mean	Variance	Mean	Variance
Overall score for effectiveness	7.3	0.9	7.8	1.7
Overall comparative effectiveness of ASK	6.7	3.6	8.4	2.5
N				

This chapter presents both outputs and outcomes of the ASK programme. The document analysis, field research and online survey show that partners felt that the ASK programme was very much

output-driven, due to unrealistically high targets which were set out at the start of the programme.[9] In 2013 a process was initiated with the country alliances to redefine the targets to a more realistic level. These adjusted targets are used in the output tables in this chapter.

Overall, the ASK programme achieved a lot in a very short period of time. Taking all countries together, the outputs achieved exceeded the targets set (see Table 6.2). Some indicators were surpassed by a factor of 3.5 or even more - with an extremely high result for indicators 4.c (number of participants in SRHR groups for young people or internet-based SRHR forums for young people). Only one target was not entirely - though almost - reached: 4.f (number of policymakers who actively take young people's SRHR to the forefront of the political debate). While these results are impressive, it does raise some questions about whether the targets set were realistic, whether they were interpreted the same way by all partners, and whether the data collected were reliable.

Table 6.2: Overview of outputs achieved by the ASK programme.

No.	Output indicator	Number of times indicator was reached
1.a	No. of young people that have received information on SRH and SRH services (through e.g. dance4life trajectory, e&M channels)	3.7
1.b	No. of information channels that refer to services	1.7
1.c	No. of educators capacitated through e-learning/e-support	2.5
2.a	No. of contraceptives commodities by type provided to young people under the age of 25 years	1.8
2.b	No. Of clients that receive ARV in targeted clinics and through outreach (direct and indirect)	3.3
3.a	No. of service providers trained in YFS (Youth friendly services)	1.5
3.b	No. of service providers trained in safe abortion guidelines and procedures	3.2
3.c	No. of SRH services provided to young people under 25 years, including PMTCT, safe abortion, helplines and VCT	1.3
3.d	No. of births attended by skilled health personal in the targeted health clinics for women under 25 years (direct and indirect)	1.7
3.e	No. of women (under 25) receiving antenatal care (at least one visit and at least four visits) in targeted health services	2.8
4.a	No. of staff of youth led organisations trained in SRH service programming and advocacy	3.8
4.b	No. Of staff of partner organisations trained in meaningful youth participation in programme design, planning, implementation, M&E, research and advocacy	1.8
4.c	No.. of participants in SRHR groups for young people or internet- based SRHR forums for young people	10.4
4.d	No. of people reached by campaigns on Adolescents SRH and access to services	4.5
4.e	No. of youth led community activities to gain SRHR support	2.3
4.f	No. of policy makers that actively take young people's SRHR to the forefront of the political debate	0.8
4.g	No. of times consortium, including youth led organisations, is invited by policy makers to participate in meetings relevant for SRHR and at regional, national or international advocacy	1.4

With regards to the outcomes, although the PME approach was very comprehensive, we also noticed some methodological flaws in the outcome measurement of the programme. For that reason, Box 6.1

[9] Rough estimates for targets were formulated for applications for funds based on earlier experiences and in consultation with the partners. However, the budget was lower than expected, and, with a late start to the programme mid-way through 2013, some indicators were found to be too high and some too low. Interestingly, according to the PME coordinators of the alliance, one of the PME lessons learned after closure of the programme was that outputs were quite easily reached through collaboration. This factor was not taken into account when developing the targets by adding all individual partners' targets together. This could be an indication that collaboration increased effectiveness.

contains a more in-depth assessment of the PME approach. The results provided in this chapter should be interpreted with this in mind.

Box 6.1. Preface on the ASK programme monitoring and evaluation strategy

The end-of-programme evaluation focused on answering the research question: what works for who, and how? This question also entails reflection on the planning, monitoring and evaluation (PME) strategy of the programmes: what is measured by the programmes (and what not?), and how is it measured? Here we briefly highlight the strengths of the PME strategy and formulate a number of recommendations.

Compared to similar programmes, the ASK PME strategy has been thorough, elaborate and well conceived. Many aspects could be taken directly over by future programmes. Its comprehensiveness differentiates it from many other PME frameworks that often solely focus on quantitative outputs and outcomes using experimental study designs. The PME strategy of UFBR and ASK has a number of clear **strengths**:

- Design: The programme used a plausibility design, combining different data sources to build a plausible case for the effectiveness of the programmes. This is different from a probability design that aims to draw conclusions on the direct causal relationship between a programme and an outcome (often done through randomized controlled trials). Given the complexity of the topic (SRHR) and the many other factors influencing SRH, this is an appropriate evaluation design.
- Data: The evaluation combines different data collection methods, including quasi-experimental designs, in-depth interviews and focus group discussions, and the methods are adapted to the evaluation questions, using several original methods (such as mystery client and MSC). It uses existing data sources and monitoring systems — for example, clinical data from health services or the Demographic and Health Survey. Furthermore, the results are triangulated.
- Expertise: Local consultants are used for contextualized interpretation of the data obtained. The level of expertise of the PME officers at the alliance office is high.
- Learning approach: The different evaluation studies have been valuable throughout the course of the programme as a basis for joint reflection and sharing, stimulating mutual accountability and transparency, and for capacity-building.
- Operational research: As part of the ASK programme, 30 OR trajectories on specific ASK strategies were implemented, gaining better insight into how activities worked and how they could be improved. The OR served as an in-built mechanism to directly learn from the programme and improve future strategies.

Nevertheless, we also identified room for improvement. Several **recommendations** can be made to strengthen the PME in future programmes:

- In general, a good evaluation framework for a complex programme such as UFBR that includes a number of activities and multiple stakeholders: i) includes three types of evaluation (programme, process, output/outcome evaluation); ii) uses different data sources (depending on the evaluation question); and iii) triangulates the findings to answer the evaluation questions.
- While the output and outcomes of ASK are monitored, there is no real programme or process evaluation.
    - A programme evaluation assesses the quality of the (country) programme against the overall programme (or international standards), and could have provided evidence on whether, for instance, gender equality and sexual diversity are sufficiently addressed in the programme documents, and why (not).
    - A process evaluation studies whether the intervention was implemented as planned, and what contributed to or hindered this. For example, several MSC stories that were collected during the field studies contained references to abstinence-only messages. This was not the objective of the CSE included in UFBR, and is even proven to be ineffective by a number of studies. Capacity-building among teachers and service providers could be assessed to identify what they have learned and implemented, and what the main challenges are.
- There is a clear focus on outputs and outcomes linked to public health. While these are crucial, it remains important not to overlook other aspects of SRHR — for example sexual well-being, equitable relationships and self-esteem. Furthermore, it is important to formulate specific indicators for all aspects, target groups and objectives of the programme, including sexual diversity and marginalized groups.
- Results from different data sources (e.g. outcome measurements, focus group discussions) are often jointly presented; often they contradict each other. This is not problematic as such, but often no real reflection is made on this discrepancy, nor is a definitive conclusion possible.
- Five outcome indicators in the ASK PME framework used secondary national data. For many countries, these data could not be differentiated to district level, making it difficult to attribute changes found to the programme.
- There are important differences between countries in the quality of the outcome measurements, ranging from good (Uganda, Kenya) to relatively poor (Senegal, Indonesia). In a number of countries, the outcome measurement has been a missed opportunity. While much time and resources were invested to recruit health centres and respondents to participate in the baseline and endline measurements, there are significant problems in the selection of health centres/respondents, comparability between baseline and endline groups, lack of a control group, and the analyses (limited use of multivariate analyses and/or disaggregation). Furthermore, no sample size or power calculations have been done; subsequently, it is possible that changes took place but could not be observed with

the available sample. Post-hoc power calculations demonstrate that several (sub-)samples have small power (<50%). This means that, even if a change occurred, this could not be measured in the sample. These issues are related to doing research in a real-life setting, and M&E of many programmes is confronted with similar problems. Nevertheless, there are a number of other tools that can be used to make the quantitative outcome measurement data more reliable, such as using multivariate analysis or propensity scores to control for baseline differences, or working with an internal control group (only doing an endline survey in a random sample of the population and differentiating the respondents based on their level of exposure to the programme).

- It was the strategy of ASK to work with local partners for the programme M&E. This had two purposes: building their research capacity, and using their contextual knowledge to organize the studies and interpret the results. They were supported by PME advisors but may not all have had the same sound methodological background (demonstrated by large differences in the quality of the outcome measurement reports - OMRs).

In presenting the results on the different outcomes, we make a distinction in the strength of evidence. Unreliable data are left out of the tables, partly reliable data are put in italics, and reliable data are presented in normal font.

Before deciding on the PME strategy for future programmes, it is important to make a thorough analysis of the objectives of the evaluation and to weigh the costs against benefits. We recommend: 1) focusing on monitoring the quality of activities (process evaluation) in all sites; and 2) choosing a limited number of sites to do a comprehensive effectiveness study in a qualitative manner. Including research institutions in the alliance may help to maintain this strategy.

6.1.2. Comprehensive sexual education and SRHR information

Result area 1		Indicator
Expected outputs	Young people receiving information on SRH and SRH services	No. of young people that have received information on SRH and SRH services (through e.g. dance4life trajectory, e&M channels)
	The use of information channels that refer to services	No. of information channels that refer to services
	Capacitating educators through e-learning/ e-support	No. of educators capacitated through e-learning/e-support
Expected outcome	Increased capacity of young people to make safe and informed decisions on SRHR issues	% of young people with comprehensive/correct knowledge on SRHR/HIV
		% of young people with increased capacity in health seeking behaviour

The ASK programme experimented with the development and implementation of innovative approaches of direct communication with young people. This enables young people to directly receive or seek access to SRHR information without the need for intermediaries. Different so-called e&m health interventions were used such as mobile phone applications, web-based information platforms, social media and chat, but also more traditional interventions such as radio and helplines. These new tools were often used alongside more traditional CSE methods such as school programmes and peer educators and reinforced each other.

E&m health tools were useful for increasing delivery of information and knowledge, although references were made that these new tools complemented more traditional means of education and helped young people who were already connected to the programme to find additional and specific information on certain topics. Also, constraints were mentioned on the use of e&m health tools. Although it is an innovative means of reaching out to young people who have access to smart phones and internet facilities, most of the young people targeted live in rural areas and still have difficulty accessing web-based materials and content, as well as information passed on by mobile phones (Uganda, Ethiopia). Some tools, however, were particularly helpful for youth with no internet access - for example, SMS (text) messages and toll-free helplines. In addition, the existence of e&m health tools in itself is not sufficient. The tools need to be promoted to increase the number of young people accessing the information. In some countries this went well (Pakistan). Other countries needed to invest more in promoting certain social media platforms (Indonesia, Uganda). According to the ASK 2014 annual report, however, e&m health tools were actually the strategies that contributed to high outputs for SRHR awareness-raising campaigns.

In many ASK programme countries, school-based CSE interventions were also implemented. Teachers and peer educators were trained to deliver CSE programmes. Pakistan used the Life Skills Based Education methodology, whereas Kenya and Uganda piloted the whole-school approach using the digital World Starts With Me CSE programme. Qualitative data show that teachers felt better qualified to inform young people about SRHR issues, although it was also mentioned that teachers could be selective in the topics they taught. Several MSC stories, in particular for Uganda, demonstrate that the CSE activities still had a strong focus on abstinence, hence largely denying adolescent sexuality.

Based on the programme documentation, the OR and our field studies, we can conclude that the use of peer educators was a good way to reach young people; they played an important role in more informal settings and were for many young people the first choice when seeking information on SRHR. Through capacity-building, young people were empowered and acted as agents of change in their community. They also contributed to increasing access to direct channels of SRHR information (e.g. Senegal) and reaching hard-to-reach groups such as LGBT (e.g. Pakistan). The information peer educators share is mostly not comprehensive due to personal values or insufficient knowledge (most of them only receive training for a few days). During our field visits we encountered peer educators who, for example, emphasized the abstinence message more than messages on contraception. Therefore, it is important for peer educators to be linked to other, more reliable sources, such as partner organizations, health facilities, teachers and e&m health tools. Also, outreach and edutainment strategies, such as music, dance or football matches, were useful for reaching many young people. In Kenya some concerns were expressed on the effectiveness of these methods; it was mentioned that it was difficult to retain young people's attention when the entertainment stopped and education took over.

Based on document analyses, we can conclude that the ASK programme did very well in achieving the output targets for CSE and SRHR information; many countries overachieved, delivering more outputs than promised. Only one country, Kenya, failed to achieve the target number of educators trained. At the end of the programme a total of more than 15 million young people had received information on SRH and SRH services, more than three times the overall target of 4.2 million. Also, the target number of educators trained through e-learning was doubled, with almost 31,000 educators reached, against a multi-annual target of 12,260. Although these numbers are impressive, the quality of the information that teachers provide remains unclear.

According to the results chain and ToC, the comprehensive combination of activities is supposed to increase the capacity of target groups to make safe and informed decisions on SRHR. Table 6.3 presents an overview of achievements in the seven countries with regard to the outcomes that were set at the start of the programme.

Table 6.3: Progress against SRHR education indicator, overview of the countries.

Outcome indicators	Positive change	No improvement	Negative change
Young people have increased knowledge on SRHR/HIV	Kenya, *Indonesia, Pakistan, Ghana*	Uganda	
Young people have improved rights based sexual attitudes	*Indonesia, Ghana*	Uganda, *Pakistan*	Kenya
Young people have increased SRHR confidence and/or skills	*Indonesia*	Uganda, *Ghana*	Kenya
Young people have increased capacity in health-seeking behaviour	*Pakistan, Ghana*	Uganda	Kenya

Note: No baseline information was available for Ethiopia, and for Senegal the information was assessed as unreliable. In Pakistan no information was available on changes in confidence, and in Indonesia no information was available on increased capacity.

As confirmed by the OMRs that were performed in all seven countries, either the knowledge, confidence or attitudes of young people or women significantly improved in four of the seven ASK programme countries. According to the OMRs, knowledge increased more than attitudes or skills (which is confirmed by much literature in this field). In Uganda and Kenya - with relatively more reliable information than the other countries - less impressive results were found; in Uganda no improvement was noted on any of the indicators, and in Kenya negative changes were found on attitudes, skills and capacity. The fact that knowledge improved more than the other indicators might be connected to the fact that most CSE activities seem to be skewed towards knowledge than, for example, changing attitudes or behaviour. Also, research has demonstrated that changing attitudes and behaviours requires more time than the duration of this programme.

Several differences can be found between countries. They can be explained because each country focused on different knowledge areas in CSE, but also because different questions were asked in each country. In Kenya increased knowledge of sexually transmitted infections (STIs) and contraceptives was found, but no improvement on HIV knowledge. In Indonesia, knowledge of HIV and SRHR (including contraceptives) increased, while in Pakistan knowledge of STIs and HIV, SRHR services and physical changes in puberty increased. In Ghana knowledge of HIV and other STIs and sexual rights increased.

Looking at changing rights-based sexual attitudes, we see an improvement in Indonesia and Ghana and no change in Pakistan and Uganda, while in Kenya a negative change was found.[10] In Indonesia significant changes were reported on attitudes towards sexual orientation and towards people living with HIV. In Ghana attitudes on the use of contraceptives were positively influenced. Hardly any changes were found with regards to increased confidence. Only in Indonesia was an improvement found on confidence or skills, according to the OMR. Young Indonesians were more confident to use condoms or to refuse to have sex when they do not want to.

The different scales for SRHR knowledge, attitudes to rights-based sexuality and SRHR confidence were combined into a capacity index. In some countries, a multivariate logistic regression was performed to control for sample differences. In Pakistan and Ghana we see an improvement in the capacity of young people in SRHR-related health-seeking behaviour. In Senegal and Uganda no change was found between baseline and endline measurement, while in Kenya a negative change was found. In Indonesia this index was not created, while the data from Ethiopia were considered unreliable.

In addition to the quantitative data, qualitative data were also collected as part of the outcome measurement and as part of this evaluation. FGDs were held, and stories of change were collected to assess how young people themselves perceived the impact of the programme. From the available qualitative data we can conclude that in all countries - including those where no improvement was

[10] We do note that the operationalization of rights-based attitudes in the surveys is not fully comprehensive, focusing on acceptance of adolescent sexuality, gender equality, HIV stigma, sexual violence and refusing unwanted sex, and hardly including topics such as sexual diversity (exceptions are one item in the surveys in Uganda and Bangladesh), abortion, pleasure or sex work.

found in the quantitative study - they felt they benefitted from the programme. Young people reported how the programme enhanced their SRH knowledge. They learned about different contraceptive methods, HIV and AIDS prevention, body changes etc. (Kenya, Uganda, Ethiopia, Pakistan). They found it easier to discuss sexuality with their peers or with professionals such as teachers or service providers (Indonesia, Kenya, Uganda). In Pakistan girls and LGBT reported being empowered with respect to their rights. The stories of change that were collected for both the OMRs and this end-of-programme evaluation show that the ASK programme had a clear impact on the daily life of young people, particularly on increased knowledge and empowerment. The stories also reveal that the effects of the ASK programme are much broader than the standard Knowledge – Attitude – Practices (KAP) indicators can measure. Box 6.2 provides a more elaborate overview of the analysis of stories of change.

In a few countries, however, despite progress, misconceptions or unchanged attitudes were also found when looking at the qualitative data. In Ghana it was found that many young people did not test their HIV status due to fear of learning their status, the lack of test kits and the fear of being stigmatized in their communities. In Ethiopia misconceptions about menstruation, teenage pregnancy and negative attitudes to body changes (particularly girls) and masturbation were found. Respondents felt that many young people lacked skills to negotiate or discuss the use of contraceptives. Similarly, in Kenya misconceptions were found about, for example, menstruation and family planning. Also fear of HIV testing, peer pressure and lack of confidentiality of teachers and health facilities were mentioned. These examples show that, although progress has been made, continuous attention to CSE is needed, and receiving information is only the beginning of a process to change norms, values and behaviours.

Box 6.2: Impact of ASK according to youngsters

As part of this end-of-programme evaluation, 33 stories of change were collected from young people in the target group in Indonesia and North Uganda.[11] In Indonesia stories were mainly collected from LGBT youth, as the research assistants involved (peer educators) felt targeting this groups - as one of the marginalised groups - was key to the ASK programme. In North Uganda young people were interviewed via a health facility and via Mama's Club, one of the ASK partners that focused on HIV services for young people.

Many of these stories reveal the powerful impact the ASK programme had on young people's lives. What changes do young people mention when they are asked for the most significant change in their life due to the programme? A relatively large number of the 19 respondents obtained new SRHR-related knowledge, and an equally large number felt empowered by the programme. The ASK programmes aims to capacitate young people so that they can make *informed* decisions, so the fact that young people particularly refer to increased knowledge is not surprising. They refer to generic SRH knowledge, or specifically to HIV, STIs and contraceptives. Knowledge of rights was only mentioned three times, illustrating the approach to SRHR in many countries.

Apart from knowledge, a lot of respondents also felt empowered through the programme: more confident and assertive to make their own decisions. When analysing their responses, we can link the information to empowerment: knowledge helped young people to deal with SRHR challenges. Or, according to one young person, *"Many things have changed in my life after all the information I received."* Empowerment is mentioned much more in responses about ASK than in those collected for UFBR. This might be because ASK targeted marginalized groups that were in greater need of support and empowerment.

In addition, one third (10) of the young people changed their attitudes on SRHR. The respondents felt that the programme created more openness in themselves or in

[11] In East Uganda and Kenya, stories of change were collected from young people who were reached by the UFBR programme. In those districts, alongside UFBR, the ASK programme was also implemented. These stories are analysed in the UFBR synthesis report.

the people around them to discuss sexuality. Only in Indonesia — where young people in or around the LGBT scene were interviewed — were changed attitudes towards sexual diversity noted. In addition, nine people, who are all very different from each other, mentioned a behaviour change. For some, these were life-changing behaviour changes — for example, quitting drug addiction, going back to school, using family planning etc. Others refer to smaller behaviour changes such as using condoms, HIV testing or paying more attention to personal hygiene.

In line with the character of the ASK programme, a relatively large number of statements are explicitly related to services — unlike those for UFBR, where education is mentioned more. The topic that young people talked about most was HIV (11). This is probably influenced by the selection of youngsters (LGBT scene in Indonesia and YPLHIV in Uganda, among others). Contraception and family planning were also important to young people. Additionally, some respondents mentioned coming out (LGBT), gender equality and suicide. Below, a quote illustrates what kind of changes the young people referred to for each topic.

Obtaining knowledge (19x)	*"If I have to compare my knowledge before and after ASK, I would say the difference in terms of percentage is 20% before and 80% after I have known about SobatASK. With SobatASK, we can get more knowledge and be active again in learning about new things. Not just listening, we can read and access it anytime. I often access SobatASK, as it often updates the latest information. And I think the information is good. The social media and the internet are limitless. Anybody can access or upload just about anything. But many still have wrong information about sexuality issues. With the ASK programme, my friends can access the right information about sexuality issues."* (23-year-old male, Indonesia)
Empowerment (19x)	*"Before then, I was very fearful; I never loved myself because I felt like I was useless to myself and family members because I was HIV-positive. All hope was lost, and I had given up on life and attempted to commit suicide. The ASK project changed my attitude and personal perception about me and the family I am in with great significance. The fear I used to have has completely gone out of me; I now openly speak out about my status and advise my fellow youth who are infected to come and get treated so that they can have a better future."* (22-year-old female, Uganda)
Attitudinal change (10x)	*"Before I got the training and knowledge about sexual and reproductive health and rights, as well as gender, gender identity, etc., I hated gays, lesbians and transgenders. I thought they were misguided and sinful. I would avoid them, feel scared even and show disgusted expressions towards them. After these trainings from the ASK programme I know that every person has the right to choose their own gender and whom they love. I now am a better person and more tolerant. I even have several gay friends, and I respect their choice."* (22-year-old male, Indonesia)
Behaviour change	*"As a child mother I was given information on how to stay safe [for another unwanted pregnancy] using family planning methods. […] The fact that I gave birth at a younger age, I was asked if it was possible for me to go back to school. Through the information provided I was able to go back to school."* (17-year-old female, Uganda)
HIV testing (9x)	*"The HIV test I took has changed the way I see and think. I think that many people are afraid of taking an HIV test because they are afraid of what the outcome will be. But I think this way of thinking is not a smart thing. Not knowing our status means we still live in uncertainty about ourselves and what is happening in our body."* (23-year-old male, Indonesia)
Contraception and family planning (7x)	*"I am now using the family planning injection up to three months before I plan for the next child. My benefit is family planning, not to have another child soon."* (23-year-old female, Uganda)

6.1.3. Services

The ASK programme aims to improve the availability, accessibility and quality of SRH services for young people. Services were provided through partner organizations' health facilities but also indirectly via government or private health services. Services included prevention, diagnosis and management of SRH problems, both physical and mental, and distribution of contraceptives. Antenatal care and births attended by skilled health personnel were also promoted in health facilities. In addition to clinical services, value clarification and capacity-building on youth-friendly services received attention.

Accessibility of services

Result Area 2	Accessibility	Indicator
Expected output	Increased access to SRH commodities as ARVs and contraceptives for young people	No. of contraceptives commodities by type provided to young people under the age of 25 years
		No. Of clients that receive ARV in targeted clinics and through outreach (direct and indirect)
Expected outcome	Young people are increasingly using SRH services	Contraceptive prevalence rate -modern methods- to women under 25
		Proportion of population with HIV with access to ARVs

Several strategies were used to increase the uptake of services. Awareness-raising strategies were used in many countries and were successful in increasing service uptake (Ghana, Uganda). According to programme documents and qualitative data from our field studies, outreach activities and mobile service delivery in communities outside static clinics were very important and successful in bringing SRH services to young people and increasing their awareness of the range of services offered at static ASK partner clinics. In Uganda this strategy was particularly helpful to reach out-of-school youth. Also, the use of volunteers and peer educators as well as the establishment of non-traditional condom distribution outlets in project communities was seen to have increased the uptake of commodities such as condoms. The OR in Indonesia found that the availability of peer educators and other companions and of youth-friendly services were the most influential factors in increasing young people's uptake of SRH services.

Both multi-annual output targets on accessibility of services were successfully achieved. The number of contraceptives distributed was double the target indicator, and three times as many ARVs were provided than planned. Indonesia and Ethiopia did not manage to achieve either output indicator, and Ghana did not deliver the target number of ARVs. However, other countries (in particular Kenya, Uganda and Pakistan for contraceptives) overperformed and compensated for these gaps. In general, a delay in the implementation of the ASK programme is likely to have influenced whether some of the targets were achieved. In Indonesia unmarried couples are not allowed access to contraceptives by law, which poses a serious limitation to providing services to these young people. Also, their reluctance to buy and ask for condoms was noted; this might also have influenced the underperformance on the amount of contraceptives distributed in Indonesia.

Are young people increasingly using SRH services? For all countries this question is answered by using existing secondary data, mainly available at the national level. On the one hand, the fact that ASK M&E teams make use of national monitoring frameworks deserves praise; however, it makes it difficult to attribute any differences observed to the programme.[12] In Ghana an increase in contraceptive prevalence at the district level was shown, but access to ARVs decreased. In Ethiopia, Kenya and Uganda contraceptive prevalence and access to ARVs improved nationally. Because no district-level data were available, it is difficult to link this progress to the programme. In Indonesia the proportion of people living with HIV with access to ARVs remained relatively stable in the districts where ASK was implemented. In general, due to a lack of reliable quantitative data, it is difficult to assess whether contraceptive prevalence or access to ARVs improved due to the programme.

[12] The ASK programme did not have national coverage but was implemented in selected districts. Because data at the district level are lacking, it is difficult to assess whether progress has been made due to the programme.

Table 6.4: Progress against accessibility of SRHR services indicator, overview of the countries (RA2).

Outcome indicators	Positive change	No improvement	Negative change
Contraceptive prevalence rate -modern methods- to women under 25	Ghana, *Uganda, Kenya, Ethiopia*		
Proportion of population with HIV with access to ARVs	*Ethiopia, Kenya, Uganda*	Indonesia	Ghana

Note:
No data available for Senegal, no reliable data available for Indonesia on contraceptive prevalence, and Pakistan did not target access to ARVs.

However, qualitative data collected for the OMRs and the end-of-programme evaluation indicate that the programme contributed to the accessibility of services. The multi-pronged approach of providing several strategies at the same time, such as establishing referral networks, linking schools to facilities, community dialogues and outreach services, contributed to an increase in uptake of SRHR services (Kenya, Uganda, Ethiopia, Indonesia). Easy access to contraceptives - also free of charge in some countries - via mobile outreach strategies and distribution points in the communities particularly increased the uptake of contraceptives. The improved quality of services due to trained health care providers and youth corners in health facilities also led to a better uptake of services according to an OR on services in Indonesia.

In Indonesia and Pakistan it was particularly important to address the accessibility of services. In both countries young people were found to be reluctant to actually use services, even if they were aware of their availability. In Indonesia young people only access services when they are ill, and not for preventative reasons. In Pakistan young people hardly ever visit clinics, due to persisting norms: young people are not supposed to need youth-friendly services, and specifically girls (and women) are not supposed to visit a clinic without a responsible adult. In those countries the uptake of services was a challenge, but the stakeholders involved, such as health service providers and partner organizations, felt that progress was being made and that more young people had been visiting health facilities. In Senegal, at the end of the ASK programme, OR showed that, although youth-friendly services were available, young people with disabilities did not make use of them. Main barriers to access were financial barriers, provider attitudes, parents' attitudes and accessibility (physical and communication barriers). Although the ASK programme addressed the issue of accessibility, in many countries continuous efforts to improve accessibility of services will be needed.

6.1.4. Quality of services

Result Area 3	Quality	Indicators
Expected output	Improved capacity of service providers to deliver SRH services	No. of service providers trained in YFS (Youth friendly services)
		No. of service providers trained in safe abortion guidelines and procedures
		No. of SRH services provided to young people under 25 years, including PMTCT, safe abortion, helplines and VCT
		No. of births attended by skilled health personal in the targeted health clinics for women under 25 years (direct and indirect)
		No. of women (under 25) receiving antenatal care (at least one visit and at least four visits) in targeted health services
Expected outcome	Public and private clinics provide better SRH services, which more young people use	% of HIV-positive pregnant women receiving treatment to mother to child transmission
		Proportion of births attended by skilled health personal
		Antenatal coverage (at least one visit and at least four visits) in targeted area of implementation
		Young people express satisfaction with the quality and youth friendliness of health services
		No. of government health facilities that adopt and implement youth friendly SRH services
		No. of private/for profit facilities that adopt and implement youth friendly SRH services
		No. of partner organisations' health facilities that adopt and implement youth-friendly SRH-services
		No. of health facilities that comply with the most recent safe abortion guidelines

Youth-friendly services are quite often mentioned in official health policies but, in many countries, not put into practice. The efforts of the ASK programme to improve the quality of services for young people was, therefore, very relevant. Several strategies were used: health care providers and community health workers receiving training which changed their attitudes towards young people (Uganda, Pakistan, Indonesia); the capacity of health care providers was also strengthened indirectly through improved referral mechanisms (Kenya) and improved stock management (Uganda); in addition, health facilities were upgraded, and youth-friendly corners were established within public health facilities - sometimes with the help of young people themselves; and advocacy was carried out towards local government to improve health facilities and staffing levels (Uganda).

In countries where the UFBR programme was already being implemented, the ASK programme was seen as a welcome addition. For example, in Uganda - mid-way through the UFBR programme - young people were quite dissatisfied with the services provided by government health facilities. With the advent of the ASK programmes, more attention was paid to actual service delivery, improving stock and improving connections with young people through appropriate information and youth-friendly services and by targeting youth-led organizations. For other countries, however, in general a basic level of services was sufficient. In Kenya, for example, free maternal health care services were already provided by public health facilities. In Indonesia, many services were available at government and private health facilities, although SRHR services such as contraceptives were generally not easily available to unmarried couples due to legislation. In countries where SRHR services were generally available, the programme focused more on improving the accessibility and youth-friendliness of the services.

Box 6.3: MSC story Kenya

I am 19 years old, and I stay with my grandmother in Manga village. I dropped out of school when I was 18 years old. That is when I came to realize that my social life was much more important than school life, which was full of restrictions.

I became pregnant, and the sad thing is that the father of the pregnancy rejected me, saying that the child was not his. I refrained from telling people and even never informed my grandmother of anything. When I had experienced enough of a solitary life with no hope of a future, I decided to take my life. My friend who came to know of your programme earlier came to my aid and informed me about it, for it had changed her life greatly. She introduced me to the Youth-Friendly Nurse who then sat me down and asked me to share my story with her. It was the friendly atmosphere that she created for me which enabled me to open up. Before, the health attendants were always rude, and that is why most of us never felt comfortable sharing our stories with them.

The most significant change that I am so much proud of is how the Youth-Friendly Nurse managed to enrol me into therapeutic feeding after they took my anthropometric measurements and found out that I was malnourished and wasted. I was also given folic acid supplements and encouraged to attend the antenatal care clinic, which I promptly did. In conjunction, the services that were offered to us by the programme, such as the formation of a group of expectant mothers, really helped a lot in terms of delivery and after delivery.

The IEC materials that are pinned everywhere have also helped me a lot, since I get more information that I need. Also, the Youth-Friendly Centres have been placed closer to us, and I do not find any difficulty using transport. I am also able to talk to my fellow youths during health talks and to tell them about the available services that they should use.

Because of the entrepreneurship training I underwent, I am able to have a farm next to my home where I plant kale, tomatoes, watermelon and even trees, which has really benefitted me a lot. In the coming future, I am planning to go for training with the money I shall have accumulated so that I may develop myself in a very positive way.

Again, all multi-annual output indicators on the quality of services were achieved for the entire programme, although some gaps remained in individual countries. In Uganda two indicators were not achieved (SRHR services and number of births attended by a skilled provider), and in two countries one indicator was not achieved (in Ghana the amount of service providers trained on abortion, and in Senegal the number of births attended by a skilled provider). The programme provided more than 10 million SRHR services to young people against a set target of approximately 8.5 million. Also, 655,003 women under 25 received antenatal care - almost three times the target of 234,372 women. A total of 122,679 young women delivered their baby while being attended by skilled health personnel. The target of 362 service providers trained on abortion guidelines was also almost tripled, with 1,155 service providers trained through the programme.

To assess whether the programme led to an increased quality of health services, information from the OMRs was used. Table 6.3 presents an overview on all outcomes with regards to quality of services. As the table shows, in quite a few countries reliable data were lacking. For example, Senegal did not present any information on outcomes in this area. Again, for the first three indicators in many countries national secondary data were used, with no specific data for districts covered by ASK, making it difficult to attribute any changes found to the programme.

Two indicators are particularly interesting in the assessment of whether the quality of services improved in the ASK programme: the compliance with IPPF youth-friendly standards and young people's level of satisfaction with services. With regard to compliance with IPPF youth-friendly standards, we see an improvement in all six countries in health facilities (whether government, private or run by partner organizations) that adopt and implement youth-friendly SRH services. Although the data are not particularly reliable, due to low numbers of health facilities assessed and, in some cases, limited comparability with the baseline assessment, the fact that we see an improvement in all countries makes it plausible to conclude that services were improved by the ASK programme.

With regard to young people's level of satisfaction with services, an improvement was noted in four countries: Pakistan, Ghana, Kenya and Uganda. It is interesting to note that, although the health facilities are increasingly complying with quality standards for youth-friendliness and maternal health care, young people's satisfaction has not increased to the same extent. Generally, high staff turnover, long waiting times, lack of supplies and equipment and increased awareness of what might be expected contribute to lower levels of satisfaction.[13] In Ethiopia scorecard methods were successfully used, not as an accountability measurement but as a means to collect feedback from clients to improve services.

The indicator 'Abortion guidelines comply with the most recent safe abortion guidelines' was only achieved in Ghana.[14] Addressing abortion remained a sensitive issue in most countries. In some countries the legal framework allows abortion to be performed in certain conditions (e.g. to save the mother's life, in situations of incest or rape); however, a lack of clear guidelines and proper dissemination of the law makes it difficult for health care practitioners, especially in public health facilities, to provide abortion services on demand. During our field study in Kenya we found that some partner organizations provided safe abortion, which was not available in other centres, and allowed for increased uptake of this service and associated counselling.

Table 6.5: Progress against indicators of quality of SRHR services, overview of the countries.

Outcome indicators	Positive change	No improvement	Negative change
3.1 % of HIV-positive pregnant women receiving treatment to mother to child transmission	*Uganda, Ethiopia*		
3.2 Proportion of births attended by skilled health personal	Ghana, *Kenya, Ethiopia*	Indonesia	
3.3 Antenatal coverage (at least one visit and at least four visits) in targeted area of implementation	Ghana, *Kenya, Ethiopia*	Indonesia	
3.4 Young people express satisfaction with the quality and youth- friendliness of health services*	*Kenya. Pakistan, Ghana, Uganda*	*Indonesia, Ethiopia, Senegal*	
3.5–3.7. No. of government/private/partner health facilities that adopt and implement youth friendly SRH services	*Ethiopia, Kenya, Indonesia, Pakistan, Ghana, Uganda*		
No. of health facilities that comply with the most recent safe abortion guidelines	*Ghana*	*Ethiopia, Pakistan*	*Senegal*

Notes:
The data in this section are considered 'weaker', as no or very little information is given on the characteristics of the respondents in the baseline and endline (indicator 3.4) or because a self-assessment method was used (indicator 3.8).
Senegal did not provide any information on four of the six service outcome indicators. Information on Uganda and Pakistan (for three indicators), Kenya and Indonesia (for two indicators) was not included because information was missing or inconclusive.

Qualitative data - although not very elaborate on this topic - show that the ASK programme contributed to the adoption of a youth-friendly attitude among health care providers. In Indonesia, service providers mentioned that their attitudes towards, for example, LGTB or YPLHIV changed when they learned more about these groups, as well as SRHR. They stated that they would now treat everyone,

[13] An additional comment can be made about the definition of 'quality of services', which is mainly limited to aspects of provider–patient interaction, rather than the quality of the clinical services.
[14] Standards for abortion care refer to the underlying principles and essential requirements for providing equitable access to, and adequate quality of, lawful abortion services. Guidelines for abortion care are evidence-based recommendations for the delivery of safe abortion care (World Health Organization).

irrespective of their background. However, in the 2014 annual report for Indonesia it was also mentioned that even though service providers have been trained on youth-friendliness, they need to be coached and monitored to successfully ensure these services; otherwise, they are not sustained. It was also found that most trained service providers do not transfer skills and knowledge to their colleagues.

In Uganda and Kenya changes among service providers were also found. Young people felt that nurses were friendlier when providing services, and service providers felt that they had learned how to address sensitive topics with young people and believed that they would now help anyone irrespective of their age. In some of the stories of change that were collected for this end evaluation young people referred to the supportive attitude of health staff, which helped them. However, in both countries the regular transfers of trained service providers to other health facilities was a challenge.

According to qualitative data, the target group very much appreciated the establishment of youth corners in health facilities. Many young people are hesitant to share a waiting room with women from their community out of fear of being asked questions. Youth centres were provided with facilities such as internet services and games which attracted more young people and enhanced the use of SRHR services. We also encountered youth corners in government health facilities that were very basic and less attractive, but young people still appreciated the fact that they had their own place in the health facility. The OR from Indonesia showed that the availability of youth-friendly health services was an enabling factor for young people's use of services.

Enabling environment

Result area 4		Indicators
Expected outputs	Empowering young people to give them a voice in the programme	No. of staff of youth led organisations trained in SRH service programming and advocacy
		No. Of staff of partner organisations trained in meaningful youth participation in programme design, planning, implementation, M&E, research and advocacy
	Involvement of youth in implementation of the programme	No.. of participants in SRHR groups for young people or internet-based SRHR forums for young people
		No. of people reached by campaigns on Adolescents SRH and access to services No. of youth led community activities to gain SRHR support
	Advocacy conducted on SRHR by partner organizations or country alliances, together with youth-led organizations	No. of policy makers that actively take young people's SRHR to the forefront of the political debate
		No. of times consortium, including youth led organisations, is invited by policy makers to participate in meetings relevant for SRHR and at regional, national or international advocacy
Expected outcome	Greater respect for the sexual and reproductive rights of young people, including those from marginalized groups	Acceptance/ support of young people's right to access SRH services at community/ local level
		Parents/care takers give support to young people in SRHR
		No. of youth-led organisations with organisational capacity in SRH service-programming and advocacy
		No. of partner organisations with functional structures for the involvement of young people in program design, planning, implementation, monitoring, evaluation, research and advocacy
		Development and enforcement of implementation of SRHR policies promoting access to youth SRHR and access to YFS, including hard to reach

Key to the alliance approach are partner organizations' lobbying and advocacy activities to make the political and social environment at the community, district and national level more enabling. This was done by engaging key stakeholders in the communities and at the district and national levels with the programmes, either through advocacy meetings or thorough collaborative networks. It allowed partner organizations to be involved in strategic policy meetings and networks. Also, the involvement of young people themselves was very important for the ASK programme as a means to change communities from the inside out (see also Section 7.4.5 on MYP). At the community level this also enhanced uptake of services, because community volunteers and peer educators already had an established presence in most communities.

The programme managed to achieve all output indicators for the enabling environment, apart from one indicator, the number of policymakers who take young people's SRHR to the forefront of the political debate. For five of the seven indicators the countries delivered far more than was promised. For example, 2,426,033 young people participated in SRHR groups or internet-based SRHR forums, which was 10 times more than the target. Also, more than 45 million (young) people were reached by campaigns on adolescent SRHR - five times more than expected. The number of staff members (11,306) of youth-led organizations trained in SRHR service programming and advocacy was four times more than the target. Ethiopia did least well on this component, underperforming on four of the seven enabling environment output indicators.[15] Five countries underperformed on one of the seven indicators; however, this was outweighed by the achievements of other countries.

There were five outcome indicators for measuring changes with regards to the enabling environment. Information for these indicators in the OMRs was obtained through desk reviews, FGDs and interpretation workshops; no quantitative data were available. As can be seen in Table 6.6, a few gaps can be identified, especially for indicators 4.3, 4.4 and 4.5. If data are available, however, they indicate positive changes in the environment, with greater respect for young people's sexual rights.

Table 6.6: Progress against indicators of an enabling environment, overview of the countries.

Outcome indicators	Positive change	No improvement	Negative change
4.1. Acceptance of/support for young people's right to access SRH services at community/local level	*Ethiopia, Kenya, Pakistan, Ghana, Uganda, Indonesia,*		
4.2. Parents/caregivers give support to young people on SRHR	*Ethiopia, Kenya, Pakistan, Ghana, Uganda, Indonesia,*		
4.3. No. of youth-led organizations with organizational capacity in SRH service programming and advocacy	*Kenya, Indonesia, Pakistan*		
4.4. No. of partner organizations with functional structures for the involvement of young people in programme design, planning, implementation, monitoring, evaluation, research and advocacy	*Kenya, Pakistan*	*Senegal*	
4.5. Development and enforcement of implementation of SRHR policies promoting access to youth SRHR and access to youth-friendly services, including for hard-to-reach populations	*Pakistan, Indonesia*	*Senegal*	

Notes:
Information on the enabling environment outcome indicators was quite often missing or inconclusive. Senegal, Ghana and Ethiopia did not provide information on three targets, Indonesia and Uganda on two targets, and Kenya on one target.

[15] There are two possible explanations why Ethiopia did less well than other countries on the enabling environment. In Ethiopia the ASK programme was delayed by almost a year due to due to restrictions in the government's policies on how CSOs should operate. This late start hindered the achievement of outputs in all result areas. A second possible reason is that the Ethiopian partner organization actually paid the enabling environment a lot of attention and that sometimes delayed the implementation of some of the activities because it waited for buy-in from the different stakeholders.

All countries that reported on indicators 4.1 and 4.2 noted an increased acceptance of SRHR issues by communities. Topics that are mentioned in the OMRs are: an increased openness in the communities to talk about SRHR (Kenya, Uganda, Pakistan); increased knowledge on SRHR (Kenya, Pakistan); more youth-friendly attitudes among service providers, which improved the accessibility of services (Kenya, Indonesia); improved attitudes on family planning and contraceptives (Kenya, Ethiopia); increased acceptance of and support for young people's right to access SRH services at the community level (Pakistan, Ghana, Uganda); and acceptance of CSE in communities (Kenya, Uganda). In Ethiopia and Pakistan, community changes were also mentioned on topics such as SGBV and female genital mutilation (FGM). However, although, in general, improvements are mentioned, in many of the ASK documents it is also noted that persistent negative cultural beliefs still hinder young people's access to services. It is important to note, however, that most of the community outreach programmes were targeted at promoting SRHR education, and very few were focused on addressing value systems.

It is difficult to assess whether MYP was really achieved in the seven countries, due to the lack of data in the OMRs. Only two countries reported that youth-led organizations improved their capacity and that functional structures were improved for the involvement of young people within partner organizations. However, when looking at other qualitative data, we see that many country alliances made progress on involving young people in the programme. Through the attention to MYP in the ASK programme, more openness and awareness was created on how to involve young people. Partner organizations acknowledged that young people can speak for themselves, organize activities and come up with good ideas. However, young people were still more involved at the level of design and implementation than in decision-making (see also Sections 5.4, 5.5 and 7.5 of this report).

Four OMRs reported on the development or enforcement of the implementation of SRHR policies - namely, Pakistan, Indonesia, Uganda and Senegal. In Pakistan and Indonesia the alliance influenced provincial/local policies on SRHR topics. In Indonesia, for example, a decree was issued for female students with unintended pregnancy to be able to continue their education after giving birth. In Uganda - although these results were alliance results and not specifically for ASK - district authorities made CSE mandatory, and from 2017 it will be included in the national secondary school curriculum. In Senegal no improvements were found.

6.1.5. What are the unexpected results (positive and negative)?

Just a few unexpected results were mentioned in documents or in the fieldwork - none of them negative. The ToC of the ASK programme is very comprehensive, so most of the results fit in this broad framework. In general, an important result is that members of several alliances will continue to work jointly. They were brought together by an external 'force' but are now continuing to collaborate voluntarily. In Uganda partnering in an alliance accelerated more collaboration, and new initiatives were set up beyond and outside the alliance. In Ethiopia the alliance secured additional funding.

In Ghana a District Consumer Health Association was set up, which was unexpectedly very successful and became the main advocacy agent in the district, leading campaigns for equitable, transparent and accountable youth-friendly SRHR services. In Kenya it was mentioned that volunteers profited from career development opportunities and that due to their involvement in the programme they decided to take up a career path in health care.

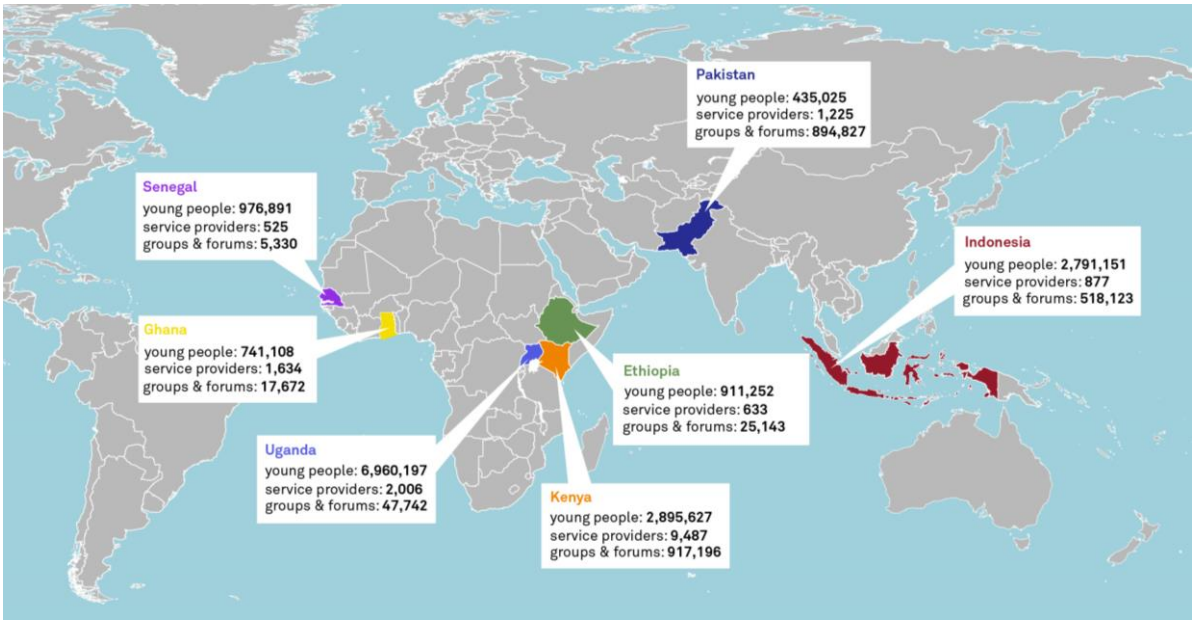

Figure 6.1: Key output numbers for the ASK programme. (Young people = Number of young people which received SRHR information & services. Service providers = Number of service providers trained in Youth Friendly Services. Groups & Forums = Number of young people in SRHR groups & internet based SRHR forums.)

6.1.6. What were enabling and constraining factors?

The ASK programme was implemented in seven different countries in Africa and Asia, each with a unique context. It is, therefore, hard to determine a generic subset of enabling and constraining factors that influenced the programme. There are, however, some commonalities between countries. Enabling factors that were mentioned frequently are the following:

In countries with a **supportive national policy environment** it was obviously easier to implement the programme. It was easier to work on certain issues because these were already prioritized at a national level. These policies could also provide opportunities for strategic collaborations with the national government in promoting specific policy documents and strategies. For example, in Ethiopia an already established family law which addressed domestic violence, polygamy and inheritance issues was used as a starting point for programme activities. Amref Ethiopia organized policy review and sensitization meetings with other stakeholders to develop advocacy strategies to promote the implementation of the family law in the Afar region, thereby also addressing SGBV and gender equity.

Related to this, **cooperation with authorities** is imperative for the success of every programme, but when this alignment is secured, the implementation of the programme is made much easier. In some cases, the alignment was built through a focused advocacy effort, while in other cases cooperation with local governments evolved very naturally. For example, in Ghana local governments seemed very keen to welcome SRH interventions into local schools. Their support was crucial in convincing schools to participate.

Both of these factors may seem to state the obvious. Of course it is easier to implement an SRHR programme when the national policy environment is supportive and local governments acknowledge the importance of the programme. Moreover, the fact that these services do not exist are actual reasons to want to implement the programme in the first place. It does show, however, that in less favourable circumstances, lobbying to change national policies and advocacy for local government cooperation are crucial to make a programme successful.

Another success factor was **the complementarity of partners**. Partner organizations were brought together into an alliance mainly due to former linkages with Northern alliance members. Alliances were not thoughtfully composed beforehand to match organizations' expertise and strengths in such a way that they would form a winning team. The fact that in some countries the complementarity of partners was found an enabling factor shows that in some cases this somewhat 'random' composition really worked out well. This might be because the Dutch alliance members all have different profiles, so it is likely that their partner organizations differ and match equally well. The fact that most of these partners already had an established presence in the communities they were working in enhanced their effectiveness. Most communities already trusted the partner organizations due to their earlier engagements with them.

In all reports, constraining factors are more frequently mentioned than enabling factors. The main barrier to the success of the programme, which has been mentioned in every country, has been **deep-rooted socio-cultural and religious values and norms in the target communities**. The actual content of these norms might differ between countries, but in all countries we see a consensus that particular values and norms hindered programme acceptance and implementation. This has limited the scope of programme implementation activities and has also affected the attitudes and perceptions of programme staff members. A shift in socio-cultural and religious values and norms, especially surrounding sexuality and SRHR, usually takes a long time and may negatively impact programme objectives in the short term.

For some countries, national policies were also mentioned as a limiting factor, when they are not that favourable for SRHR issues. For example, in Indonesia the programme was hindered by legislation that prohibited SRHR services for unmarried couples. In Uganda the criminalization of consensual same-sex activities created a barrier to addressing sexual diversity. In Ethiopia and Kenya certain positive SRHR laws were present, but a lack of domestication of these laws within communities or providers created barriers for implementation.

High mobility of trained staff in partner organizations, schools, health services and within communities created a practical barrier of losing valuable SRHR knowledge. These people needed to be replaced and trained again, to ensure the continuity of activities.

For ASK, some very specific **barriers were mentioned about e&m health tools** being less effective for marginalized groups. Although the tools are innovative means of reaching out to young people who have access to smart phones and internet facilities, most of the young people targeted live in rural areas and still have difficulties accessing web-based materials and content, as well as information accessible by mobile phone (Kenya and Uganda). There are also concerns that tools are not gender-specific, and that young men are more inclined to be active on social media or to be interested in these tools. Another concern is that illiteracy is higher in rural areas, so illiterate young people are unable to access information on SRH via social media (Ghana).

For ASK, the very **short programme duration** and **focus on outputs** have also been mentioned as constraining factors to achieving results. The implementation of the ASK programme had a slow start in many countries, as partner organizations had to prepare the programmes and also look for complementarities to other programmes. It is possible that one of the main goals of ASK, reaching marginalized groups, did not receive much attention, due to the output-driven focus and the short programme duration, as reaching these groups requires more time and effort, and obtaining results will always be more challenging than among young people who are easier to reach.

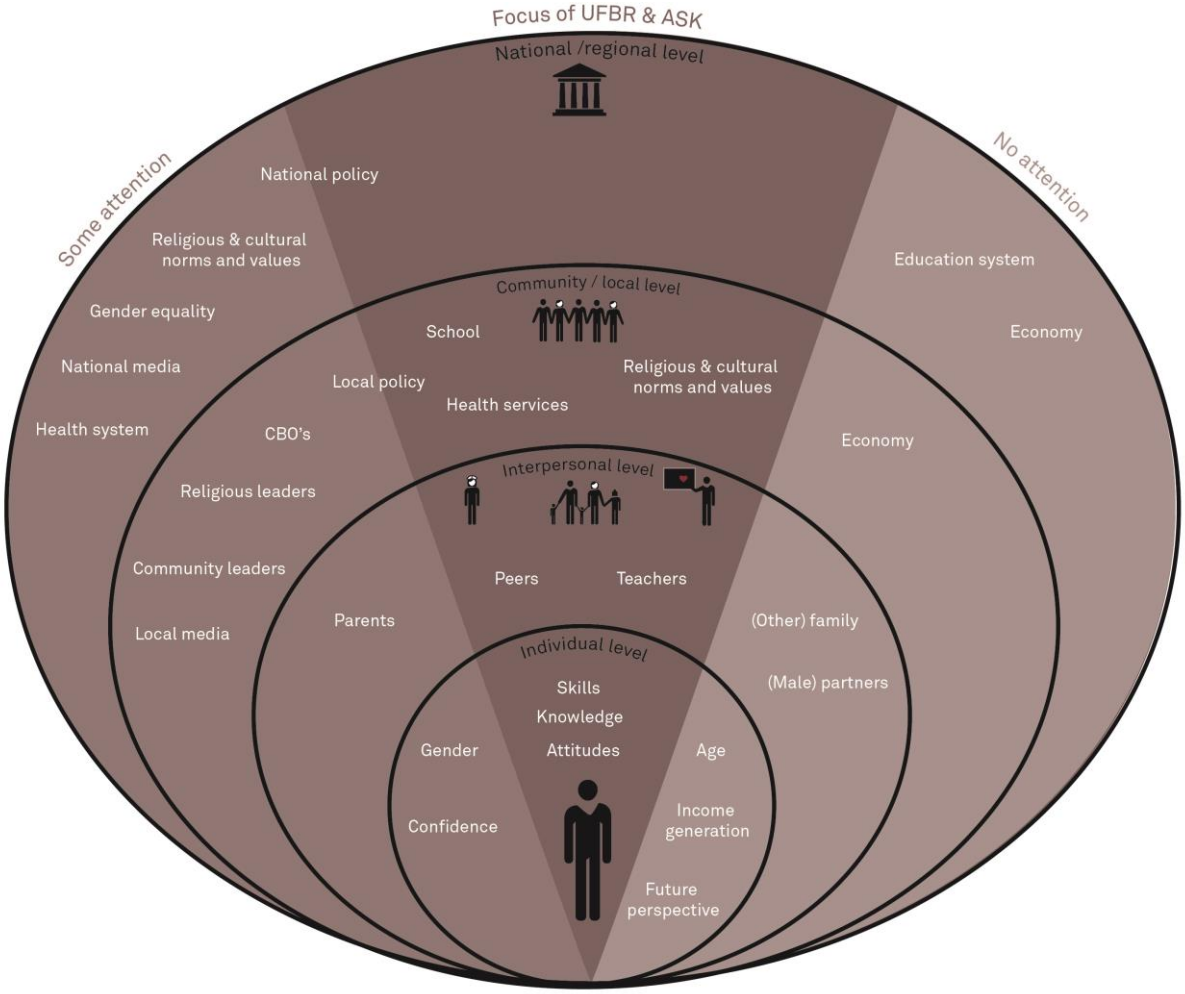

Figure 6.2: Socio-ecological model of UFBR and ASK: different levels of influence of the UFBR and ASK programmes divided by focus of the programme, some attention and no attention.

6.1.7. What can be concluded about the sustainability of the results?

With regards to the *sustainability of the partnerships*, results are quite positive. Joint collaboration and networking is an important result from the ASK programme. According to the survey, almost all partners are confident that they will continue to share knowledge and experiences even if the programme comes to an end (see Table 6.7). This is an important indicator that the collaboration that was built through the programme - in one way or another - will be sustained.

With regards to the *sustainability of activities*, results are more mixed. Partners are quite positive that they will continue to implement activities in this field, even if financial support from Dutch partners comes to an end. For all other sustainability statements in the survey the assessment is less positive. Partners disagree with statements about the local government financially supporting certain activities, and they neither agree nor disagree with sustainability statements such as '*My organization will continue implementing projects, as we already have funding from other sources' (e.g. another donor*) and '*My organization will only continue within a new multi-annual funded programme'*.

Table 6.7: Assessment of sustainability by Southern ASK partners (mean on a scale of 0–10).

Question	Southern Partners	
	Mean	Variance
9.1. My organization will certainly continue to implement activities in this field, even if financial support from Dutch partners/the Ministry of Foreign Affairs comes to an end	7.31	6.06
9.2. My organization will continue implementing projects, as we already have funding from other sources (e.g. another donor)	5.19	9.27
9.3. My organization will only continue within a new multi-annual funded programme	4.77	11.59
9.4. The local government/Ministry of Foreign Affairs or communities are (financially) supporting certain activities	4.29	9.27
9.5. My organization has taken steps (hiring staff, blocking budgets, looking for new partners) to be able to continue working on the activities even if the programmes come to an end	5.15	9.38
9.6. My organization will continue to share knowledge and experiences with other SRHR organizations in my country even if the programmes come to an end	8.68	3.12

Table 6.8 presents an overview of how Southern respondents assess the sustainability of the ASK programme by country.[16] Although these results need to be interpreted cautiously due to low numbers for each country, it gives an impression of how confident partners feel about the continuation of the programme. The alliance in Ethiopia is the most positive about the future, while the alliances in Ghana and Uganda are the least positive of all countries. The fact that the Ethiopia alliance is quite positive might be because it was successful in securing new funding from the UK Department for International Development.

Table 6.8: Mean sustainability scale for ASK by country (on a scale of 0–10).

Mean	Ethiopia	Kenya	Indonesia	Pakistan	Ghana	Senegal	Uganda
Sustainability scale	8.0	6.9	7.3	7.1	5.8	7.5	6.4
N	3	13	9	8	4	2	9

With regards to the results achieved for CSE/SRHR information, it is difficult to assess whether the specific elements of the ASK programme around e&m health tools will be sustained after the programme. In general, partner organizations are quite positive about the use of these tools, although some challenges were also found. It is unclear whether partners are able to continue with these tools without funding from the ASK programme. Only in Senegal was it mentioned that some associations have decided to continue scaling up activities around the platform without the financial support of the project. With regards to the more traditional CSE tools such as school programmes and peer educators, more information is available. In quite a few countries (Uganda, Pakistan, Indonesia, Ghana) the alliances are confident that these results will be sustained, specifically by securing government support. In Uganda, for example, CSE will been included in the new lower secondary school curriculum. In Ghana strong linkages were formed with the Ghana Education Service to implement school-based interventions that build on existing school health programmes.

At the level of health services, new policies on youth-friendly services were developed (Senegal, Indonesia and Pakistan) and are likely to have a positive impact on the quality of services beyond the

[16] A sustainability scale was created that included all six statements in the survey.

time frame of the programme. In Ghana project activities were integrated into government district health plans, and trained birth attendants and community-based health volunteers have been integrated into the mainstream health system. In most countries a pool of local expertise of health care providers and Community-Owned Resource Persons (CORPs) has been established that will continue to provide youth-friendly SRH services and commodities. Although government support has been established in certain areas of the programme, in all countries a lack of integration of programme needs into government budgets is noticed; governments are not able to take over financial support of ASK activities. That means that certain resource-intensive aspects of the programme, such as establishing youth-friendly centres, mobile outreach and certain supplies, will not be continued or will only be continued less intensively.

The progress that is being made in terms of the enabling environment will most likely continue in most countries because sustainable strategies were used to ensure the involvement and ownership of communities (Ghana, Uganda) and to foster collaboration between the communities and the local government. In Kenya and Ethiopia for example, key opinion leaders, such as district heads, local leaders and school heads, were closely involved, ensuring that they maintained a stake in the sustainability of programme impacts. This area, however, needs continuous work and effort, since cultural norms do not change overnight.

Thus, results were achieved for all three components, and different strategies were used to ensure these results after the end of the programme (see also Section 7.5 on sustainability strategies). However, a lack of continued funding will be a major barrier to ensuring that some results or activities are maintained. Specifically, when it comes to services, we notice a specific struggle for partner organizations concerning the balance between affordability for clients and the financial independence of (private) health services. A large number of young people are still reluctant to pay a fee for services, due to financial constraints. When it comes to services and service outreach, partner organizations, therefore, remain dependent on external donor funding. The ASK programme is, more than UFBR, focused on services. Especially with regards to this component, we can conclude that the likelihood of sustainability without future external support remains fragile.

7. DIMENSION 2: WHICH HAVE BEEN EFFECTIVE, EFFICIENT AND SUSTAINABLE STRATEGIES AND IMPLEMENTATION PROCESSES UNDER THE ASK PROGRAMME?

Key messages

- ASK was found to correspond to a real and urgent need for SRHR information and services for young people and marginalized groups, and can be considered very relevant.
- The combination of working on three different components (education, services and enabling environment) has the potential to achieve real and substantial change.
- Working with direct information on SRHR was an important addition to indirect information (through teachers, peer educators). To reach all young people, including marginalized groups, more traditional methods were also necessary.
- Meaningful youth participation was well integrated into the programme, especially at the programme design and implementation level, but less in decision-making processes.
- The different strategies are well adapted to the context. Important determinants for choosing appropriate strategies in the various countries were the presence of UFBR, the level of decentralization and the strength of the health system.

This chapter reviews the relevance, effectiveness, efficiency and sustainability of the strategies used by the ASK programme.

Relevance of the strategies implemented

The relevance of the strategies implemented is assessed on three levels: (1) was the underlying ToC implemented, and did it help to achieve the programme's objectives?; (2) were the programme strategies appropriate for the target groups?; and (3) to what extent is the programme objective still valid in the context of the ASK countries, in particular with regards to the changed norms and values of the enabling environment?

7.1. Implementation of the Theory of Change (TOC)

Has the multi-component approach been implemented? How, and why or why not?

Generally, partners had a good understanding of the ToC, and partner organizations focusing on a specific component have been linking to each other during the course of the programme. Both partners in the North and South felt that the use of the multi-component approach was one of the key strengths of the programme. Looking at the appreciation of the different components: increasing access to SRHR information was seen as one of the key strengths, while other components of the ToC were mentioned less as a key strength. Partners in the South also felt that the creation of an enabling environment was an important strength, while this was hardly mentioned by partners in the North. The objective of increasing access to services was not highly ranked by all the partner organizations, which seems remarkable, as the ASK programme had a specific focus on services. However, more partner organizations were focusing on the education component, which is likely to have influenced the research findings: 34% of the respondents to the online survey mentioned that they worked mostly on SRHR education, while 26% worked mostly on services, and 22% on enabling environment.

Although the ToC as a whole was seen as a key strength, not all partner organizations had a specific strategy to link the three main components. They particularly mentioned the importance of the

programme in establishing referral mechanisms between government and private health services and between schools and health services. According to the online survey results, implementing referral systems was one of the most highly valued activities, alongside essential packages of services (see Figure 7.1). In countries where the health services were relatively well organized, a focus on education was said to be especially important. In Indonesia health providers involved in the end-of-programme evaluation mentioned, for example, the need for support and the importance of awareness-raising activities through schools and communities, as they themselves had limited capacity to invest in these activities. In countries where the health services were less adequate, such as Uganda, investments to improve the quality and availability of services were particularly appreciated. In Ethiopia all three components were brought together through an interesting catalyst: football matches. These were described as an effective way to engage with young people, as they provided a means to combine CSE with sports, while at the same time linkages were also made with service providers before or after the football match. In Uganda joint activities were said to have increased collaboration, capacity-building and sharing and learning, making it easier for the Ugandan alliance partners to incorporate the ToC.

However, the adoption and implementation of the multi-component strategy was less successful in a few countries for different reasons. While the Indonesian alliance had a good understanding of the ToC, it was not often used or integrated in programming, and not all partners had strategies in place to link the various components. While health services were generally well equipped, unmarried couples faced constraints in assessing SRH services due to legislation. In Pakistan it was hard to implement the multi-component strategy due to political restrictions on working on service delivery, so most of the efforts concentrated on civil society strengthening and SRHR education. Similarly, in Kenya most partners were working on the demand side, with only a few having the capacity to provide services. Also in terms of creating an enabling environment, the focus was on creating demand to increase uptake of SRHR services and education.

Box 7.1. Mutual influence between UFBR and ASK

An open question in the online survey probed for the influence of UFBR on ASK, and vice versa. The influence of UFBR on ASK is quite clear: it served as a solid basis for the start of the new programme. Several topics were particularly mentioned as strengths. First, the fact that the organizational structure was already in place facilitated the start of ASK. Second, the YEA was able to incorporate lessons learned from UFBR. UFBR provided insights into good practices and areas of weakness that could inform ASK. One respondent said that UFBR was like a pilot for ASK.

ASK also had an influence on UFBR. Several topics are mentioned, including the OR and innovative strategies done for ASK, as helping improve the UFBR programme. Positive experiences with MYP for ASK boosted the involvement of young people in UFBR. Strengthening health services and outreach activities that were initiated under ASK also helped improve access to services for UFBR target groups.

7.2. Relevance of the programme for vulnerable groups

Which strategies have been implemented to reach vulnerable groups in the programmes?

Reaching marginalized groups was assessed as one of the strengths of the ASK programme by stakeholders, although they also acknowledged that there was still too much focus on young people who were easier to reach. This is probably related to the high targets which were set at the outset of the programme. For instance, in East Java, Indonesia, partner organizations focused mainly on ‘skateboard youth’ which concentrated in a particular area. Strategies to reach vulnerable groups varied between countries, and there were no strict guidelines included in the programme as to which

marginalized groups should be targeted. Strategies included the training of partner organizations, health providers and peer educators to reach marginalized groups, as well as cooperation with specialist organizations and the use of e&m health tools such as SMS services and hotlines alongside social media. The ASK programme was said to be especially helpful for training service providers in reaching marginalized groups such as LGBT. Service providers mentioned that their attitudes towards, for example, LGBT or YPLHIV changed when they learned more about these groups and about SRHR. Several service providers stated that they would now treat everyone, irrespective of their background (see also Box 7.1, the MSC story selected as the most significant one for the ASK programme).[17]

Box 7.2. MSC story Indonesia

I am a 22-year-old gay. I don't share much of my private life with my family. My story took place when I was 20 years old. My first boyfriend at the time was HIV-positive. We dated for a month. The reason I gave him when I said I wanted to end the relationship was because of the distance. I lived in Jakarta, while he was in Jogjakarta. But my real reason was because I was worried about being infected with HIV from him. Fear was the first thing that I had in my mind. I did not want to be infected with HIV and depend on ARV therapy for the rest of my life. Everyday I measured my body temperature, and I became paranoid. On the other hand, my performance at the university went downhill. I failed in one of my faculty's obligatory subjects.

I went to a big hospital in South Jakarta to take a voluntary HIV test. Throughout the counselling process, the number of sessions was more than one, doctors would lecture me about my sexual orientation. He even asked me to atone for my sins and change my behaviour. The result of the HIV test I took was negative. But the doctor told me that the result was not guaranteed as accurate. I was asked to come back after three months.

During the wait, I was mentally unstable. My mind went to places it should not have. I thought about dying young, about the useless life without optimal health status. I felt fever every day, forcing me to check every five minutes. In this sorry mental state I went to a psychiatrist, accompanied by my mother. In a depressed mental state, I came out to my mother. After processing and digesting what she had just learned, she took me to the psychiatrist, who told me I had psychosomatic syndrome. I was given anti-depressants to alleviate my anxiety.

Taking VCT at ProCare Clinic made my mental state far better. The doctor and counsellor I met never once comment on my sexuality, even though I told them clearly I was gay. They focused on how sexually active young people should be responsible for their bodies, whatever their sexual orientation is — i.e. by practising sexual behaviours that are safe with condoms and routine checks.

I got my HIV test result, and it was negative. The doctor explained that I should not worry too much, as what I did with my HIV-positive boyfriend was a low-risk behaviour. Indeed, dating him for a month, the only sexual activity that I did was kissing.

From that day on, I am no longer worried about getting HIV. So long as I refrain from doing risky sexual activities, and take periodic VCT once every three to six months, I should be fine. Now mentally I am far better. Not only because I am well accepted by my mother, I now also practise safe sexual behaviours with my partner. One thing that I still feel guilty for is the fact that I broke up with my boyfriend on the grounds of ignorance.

The use of e&m health tools was generally seen as a useful tool for increasing delivery of information and knowledge, especially to marginalized young people. Each of the seven country alliances had a different approach to achieving the overall programme goal depending on what worked in the specific context of the country and what was already in place before the ASK programme was introduced. In Kenya one of the ASK implementing partners, ADS Nyanza, developed an SMS platform to provide information to young people about SRHR education. This approach worked well in countries or regions within countries marked by low incomes. The programme took into account marginalized young people

[17] Partner organization YPI in Jakarta, Indonesia, also had a special approach of recruiting members of the young underserved community as their workers to improve the programme penetration among the target group.

who did not have regular access to the internet or mobile phones. For these groups, access to SMS platforms increased through community mobilization efforts whereby parents (or other family members or friends) allowed the young people to use their mobiles to check SRHR messages with special SIM cards at specific times. Also ‘call-in’ services (Kenya) or hotlines (Indonesia and Pakistan) were mentioned as a useful way to reach marginalized young people, who in turn were able to share their concerns or ask questions on SRHR-related issues. Young people, including marginalized groups, were able to access these services without cost and loss of privacy. Partner organizations responding to the calls could help these young people directly or could refer them to other organizations. For instance, the partner organization Nairobits in Kenya mentioned that it would refer young LGBTQI with specific concerns to organizations focusing on LGBTQI issues.

Another approach to reach marginalized groups was to closely cooperate with these specialist organizations. This approach worked particularly in those regions where specialist organizations were active and where partner organizations did not have the necessary expertise themselves. For instance, in northern Uganda the programme worked with a local NGO, Mama’s Club, to reach out to young mothers living with HIV/AIDS. Through peer education and Mama’s Club mentor mother activities, young mothers were encouraged and supported to live positively with HV/AIDS (see also the MSC story in Box 7.2). In some case more ‘technical partners’ were included, such as an association of female lawyers which provided legal support for victims of abuse. Another method was to provide services on site, where needed. In Ethiopia FGAE, one of the ASK programme partners, targeted broker houses, to reach young migrants looking for low-skilled jobs, some of whom end up as sex workers. They provided SRHR counselling, referrals and services (e.g. contraceptives) at these broker houses.

Box 7.3: MSC story Uganda

I am an 18-year-old girl, a peasant farmer and a beneficiary of the ASK programme at Patiko health centre III. My father died, and I have no idea where my mother is; however, there are rumours that she has remarried. I am currently doing a course in tailoring while living with my relatives. Before joining the ASK programme, I had no idea about the existing medication for HIV; however, when I discovered I was pregnant I went to the health centre for antenatal care, I took a blood test and discovered I was HIV-positive. With this horrid news I was devastated; however, the health worker counselled me and informed me about the available treatment. I was calm, and even the idea of abortion did not slip my mind. I was introduced to the Mama’s Club, but being new to the club I was very shy and sceptical at first, with the notion that I would be laughed at. When I got used to the club I started to live freely with the people in the community, and I was stress-free. When I gave birth I was happy that my baby was HIV-negative, and now I am happy that I am always healthy, and I do not have fever that comes and goes like in the past years. However, my husband is in denial with the notion that I infected him with the disease; that does not sting as it was before. I am grateful that my baby celebrated a year. The ASK programme and the Mama’s Club has really made my life easy, and I now know when to have my next child and with whom, and that will be when I am settled. I feel prouder of myself now than those days when I was still pregnant and not aware that I was HIV-positive. The ASK programme has now made me test my blood whenever I feel like. I am really grateful for the programme and the activities they offer us.

In general, young people in remote areas are well targeted, as most countries focused on rural districts, while each country had a specific emphasis on certain groups depending on the main marginalized groups present in these areas. Ethiopia adapted its activities so that young people with disabilities could also access their computer training programmes. In Indonesia reaching groups in remote areas and specific minority groups such as LGBTQI was central. In Uganda young people (10–14 years) were targeted at primary schools. In Pakistan marginalized groups such as young mothers, out-of-school youth and LGBT groups were reached via mobile camps, which proved very effective at increasing demand and providing services on the doorstep of these groups. Specific target groups in

Senegal included sex workers and young people living with HIV, who were reached through community meals.

However, some vulnerable groups have received less attention than others. Challenges mentioned in reaching marginalized groups include:

- In Pakistan reaching out to young gay men was difficult, as it was hard for them to 'come out' about their sexual orientation. It was also challenging to overcome myths and misconceptions around abortion and to reach young women who needed abortion services.
- In Kenya and Indonesia it was mentioned that services did not yet fully reach transgenders, as partner organizations were struggling to find the most appropriate approach to reach this closed group (Linking outputs to outcomes, March 2014).
- In some cases programme staff did not feel at ease working on LGBTQI issues. For instance, in Kenya a general public health approach was central and did not create many opportunities for more transformative or rights-based approaches or focusing on sexuality or sexual rights. Most programme staff members felt uncomfortable being identified with organizations promoting LGBTQI.
- E&m health tools were also said to be less effective for marginalized groups. The tools are used to reach out to young people who have access to smart phones and internet facilities. However, most of the young people targeted in rural areas still have difficulty accessing web-based materials and content, as well as information accessible by mobile phone (Kenya and Uganda). There are also concerns that these tools are not gender-specific, and that young men are more inclined to be active on social media or to be interested in these tools. Another concern is that illiteracy is higher in rural areas, so illiterate young people are unable to access information on SRH via social media (Ghana).

These specific challenges and constraints illustrate that specific approaches were needed for specific countries or regions.

7.3. Relevance of the programme within a changed enabling environment

Is the country affected by a change in the values and norms of the enabling environment? If yes, how has the increase in conservative forces influenced the programme, and how have partners dealt with them?

Changing the norms and values of the enabling environment is a complex and long-term process. All countries refer to entrenched cultural and religious norms as serious barriers for improving access to and use of SRHR. Furthermore, several countries (e.g. Indonesia and Uganda) have seen an increase in conservative forces that had a negative impact on the programme. In Indonesia a general tendency towards more conservative norms and values was mentioned as an obstacle for the implementation of the programmes. Having sex before marriage is a taboo, and LGBT movements face a challenging time, as gay and lesbian couples are generally not well accepted in Indonesia. In Uganda the 2014 Anti-Homosexuality Act had a strong impact on homosexuals and the work of LGBT movements. In these challenging contexts, some issues were not addressed, or partner organizations had to find ways to address them. LGBT issues were hardly addressed in the ASK programmes in Uganda, while in Indonesia several service providers attached to government health clinics indicated that they did still find ways to provide services to unmarried couples, saying that their clients' health was central to their activities.

Challenging environments also implied that lobbying and advocacy were crucial to try to make these environments more enabling. In Uganda a CSE programme for primary schools was not accepted by the Ugandan Ministry of Education. Also, conservative leaders in both Kenya and Pakistan questioned

the introduction of CSE materials in schools in UFBR programmes, which is likely to also have had an impact on ASK programmes. The country alliances in these countries tried to mitigate the negative impact of this political and public backlash by working more closely with the local media.

Generally, through continued awareness-raising using local media and lobbying of key stakeholders, the partners are addressing norms and values that negatively affect the SRHR of target groups. However, not all countries were successful in addressing the enabling environment effectively, as was already discussed for Indonesia in Dimension 3.

7.4. Effectiveness of strategies

Which strategies have been implemented, and which have been effective? With reference to the result chain.

As was mentioned in the previous chapter, both Northern and Southern partners rated the overall effectiveness of the ASK programme quite highly: the Northern partners with a mean score of 7.6 out of 10, and the Southern partners slightly higher, with 7.8. ASK has built on UFBR, and most of the ASK partners already had an established presence in the communities they were working in, which enhanced their effectiveness.

At the same time, the key challenge for the ASK programme was the short project duration of three years, 2013–2015. In practice, in most countries partner organizations involved in the programme started during the course of or even at the end of 2013, which had a significant impact on effectiveness. Various partner organizations held the view that the programme duration was too short; it was identified as the main weakness in the programme (see Table 7.1). Qualitative research (interviews with partner organizations) also indicated that implementing all programme activities has generally put a lot of pressure on the partner organizations. Partner organizations in Indonesia mentioned that the focus on outputs was even perceived as so demanding that it prevented them from thinking about more effective or strategic approaches. It should also be mentioned that some partners already involved in UFBR indicated that they found it difficult to clearly distinguish between the two programmes. In practice the implementation of UFBR and ASK programmes was intertwined in some countries or regions within countries.

Table 7.1: Assessment of the main weaknesses of the ASK programme by partner organizations in the North and South (ASK all respondents, online survey 2).

	North	South
Lack of strategic planning	20%	8%
Lack of sustainability strategies	20%	18%
Weak accountability structure	2%	4%
The programme included too many countries; it is better to focus	0%	0%
The programme was too short	27%	30%
There was a lack of a centralized monitoring and evaluation system within the international alliance	2%	5%
There was no economic empowerment of partners	4%	8%
The funding was too limited	4%	13%
The funding was too much for such a short programme duration	6%	1%
Lack of scaling-up strategy	12%	8%
I don't see a weakness in the organization and planning	2%	5%

As Table 7.2 shows, partners in both the North and South valued the use of the multi-component approach. One of the three components of the ToC: increasing access to SRH information - was most highly valued. Partners in the South also felt that the creation of an enabling environment was an important strength, while this was hardly mentioned by partners in the North. The objective of increasing access to services was not highly ranked by all the partner organizations.

As the previous chapter showed, not all targets were met, and there were also some constraints in data on the outcome measurements of the programme. Especially for the service component, as well as for the enabling environment component, outcome data were lacking, making it difficult to draw firm conclusions on the effectiveness of the programme for all three components. Countries also used various methods for CSE, and because of the range of activities it was hard to identify which activities were particularly effective or contributing to changes. Activities mentioned as being effective also varied between countries. For instance, outreach and edutainment strategies, such as music, dance or football matches, were generally perceived as positive ways to reach young people, while in Kenya the effectiveness of these methods was also discussed, as it was difficult to keep their attention when the entertainment stopped and education took over. Key components of ASK were the use of e&m health tools, and there are general limitations to drawing conclusions on the effectiveness of these methods (see Box 7.4). Although not all targets were met on health services, qualitative data showed that the programme has been effective in building the capacity of service providers, which proved to be crucial in reaching marginalized groups, while the use of peer educators was also said to be an effective strategy to offer young people easy access to SRHR knowledge. As the previous chapter discussed, there were, however, limitations in the comprehensiveness of the information they provided.

Table 7.2: Assessment of key strategic strengths of the ASK programme by partner organizations in the North and South (ASK all respondents, online survey 2).

Strategy	North	South
The use of a theory of change/the multi-component approach	22%	18%
Increasing access to sexual and reproductive health information	14%	24%
The creation of an enabling environment	6%	15%
Increasing access to services	8%	8%
Focusing on advocacy/awareness-raising	4%	10%
The support to improve the youth-friendliness of services	2%	0%
The use of operational research	26%	6%
The use of social media	10%	13%
Civil society strengthening	8%	6%
I don't see a strength in the strategies	0%	0%

Box 7.4: Effectiveness of e&m health tools

After three years of the ASK programme, it is still difficult to assess whether e&m health tools, a key strategy of CSE in ASK, are effective or not. In a desk study at the beginning of the ASK programme it was already noted that, in general, there is still little evidence on the outcomes of such interventions. The ambition at the start of the ASK programme was, therefore, that each intervention should be accompanied by collecting evidence.

Country documents mainly reported output data and anecdotal stories about results. The ASK programme ensured that best practices were shared among all partners, and OR was carried out in Indonesia, Uganda and Senegal. In general, partners are positive about using those tools in addition to other strategies. Several lessons were learned through OR - for example, that provision of digital information does not (necessarily) promote use of services, and that e&m health tools are sometimes weak in referring young people to available health facilities or services. Gaps between the information provided and the information needed, were noted. Also, peer educators

networks were found to be important for the success and the promotion of e&m channels.

Although efforts were made to assess the actual impact of the programme, existing data do not present convincing evidence on how many young people were actually reached and what kind of knowledge they obtained, let alone if this had led to changes in their behaviour. Although the OMRs showed some progress in young people's knowledge, it is hard to tell which strategy contributed to this. In most countries e&m health tools were piloted (not really scaled up) and used alongside traditional CSE methods. It is also impossible to assess whether these tools are more effective than, for example, school programmes. However, at the same time it can be argued that in the short time frame of the programme a lot has been achieved, as partners have set up or enriched existing tools, and they are now operational. It should also be noted that the SRHR information provided by websites might also have a larger reach than envisioned, as young people outside the project area - and even outside the country - can also access this information.

7.4.1. Quality of (YF) SRH services

The alliance has been implementing the following major strategies to improve the quality of services:

1. Training of health staff and community health workers
2. Advocacy towards (local) government by local CSOs and community groups to improve health facilities and staffing levels
3. Upgrading of health facilities and construction of new facilities
4. Establishment of youth-friendly corners/youth desks in health facilities
5. Prevention of stock-outs through (improvement of) supply (management) of essential drugs.

Training of health staff and peer educators was a central approach used in all countries to improve the quality of services for young people and, especially, marginalized groups. Particularly in countries with a low acceptance of or even hostile environment for specific groups such as LGTBQI, this was an important aspect of the programme, as service providers themselves did not always fully accept these groups or even used to reject them. In Indonesia the MSC stories illustrated that through training health facilitators became more receptive towards LGBT. For instance, one gay boy indicated that, after a long period of worries and bad experiences with a doctor in a general hospital wanting to convert him, the open approach of an ASK partner organization was very important to him (see Box 7.1).

Peer educators were highly valued in all countries, as they provided easy access to young people. In Ghana, for instance, peer educators provide information on the use of contraceptives, and symptoms of STIs. In Uganda a partner organization developed an approach for the ASK programme to train peer educators and Village Health Trainers (VHTs) to give information and deliver contraceptives for (young) people in the communities. According to the project documentation, this increased utilization considerably.

In many countries youth corners were set up, or existing health services were made more youth-friendly, as it was not always feasible to create a separate corner due to space constraints. In some countries the focus of the programme was mainly on setting up youth corners. This was the case in Senegal, a country with no UFBR history. These youth corners were set up by rearranging work schedules, facilitating the availability of communication tools and ensuring confidentiality. Also, services were provided at reduced rates, and clinics included an information centre, which reduced stigma attached to visiting the clinic. In Ethiopia youth centres were set up in cooperation with educational institutions and universities, which was found to be a useful way of providing SRH services to a large number of young people. In several countries young people were involved in making health services more youth-friendly. The PKBI private health facility in Jakarta (Indonesia) involved young people in the whole new design and set-up of its services (see photos 7.1 and 7.2).

Mention was also made of increasing the quality of services, particularly in those countries where the general quality of services was low, by ensuring that SRH commodities were available through good stock management. This was the case in Uganda, where stock management was improved by linking all the service providers to ASK partner organization CHAI. CHAI worked on improved national quantification and supply planning and improved collaboration between the public and private warehouses to work on stock transfer when stocks were low in certain warehouses. This not only improved the general quality but also supported access to services for the target group.

Photo 7.1 & 7.2: Youth-friendly services in Indonesia.

Photo 7.3: Youth-friendly centre in Kenya.

7.4.2. Access to (YF) SRH services

Related to improving the quality of the services, several strategies were used to increase access to services and make them more youth-friendly. According to partner organizations participating in the online survey, the activity most valued was the integration of an integrated package of essential services, followed by reaching marginalized groups and setting up referral systems between public and private health facilities (see Figure 7.1).

As Box 7.5 shows, the integrated package of essential services is not a fixed set of services which is similar for each country, but the services can be adapted to the specific country. The ASK programme developed a manual to explain this concept, as it also did for other concepts and values.

Box 7.5: Integrated package of essential services

The Northern alliance developed an integrated package of essential services for ASK, to ensure that SRH services are of high quality, integrated and rights-based and include services such as counselling, contraception, emergency contraception, abortion care, STI care and HIV care. An Essential Packages Manual was developed and shared with all country alliances, but each country had the flexibility to adapt it to the local context. According to the manual, “an essential package of youth-friendly services implies not only a set of services and supplies that are available, but also a minimum standard of quality of care. The minimum standards are specific to the type of service outlet: a static service outlet, outreach service, including mobile clinics, and community-based, or peer distribution. For some partners, it may not be effective to provide particular services because government clinics or other partners already have coverage. In all cases, partners who cannot provide a particular type of service included in the minimum package should be trained and able to provide referrals to an appropriate service provider who can” (Essential Packages Manual for the ASK programme, 2014 edition p. 18).

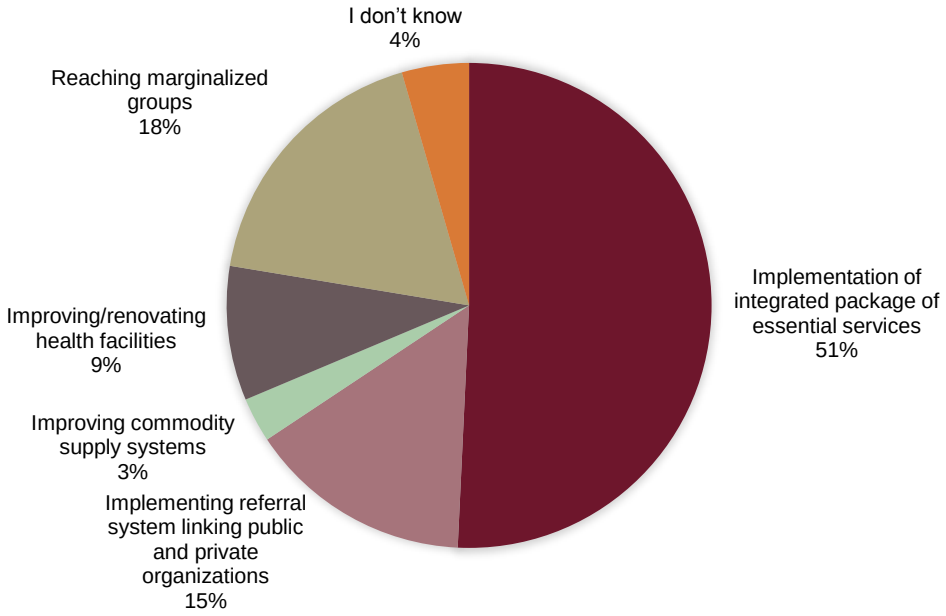

Figure 7.1: Most valued activities on services (ASK all respondents, online survey 1).

The ASK programme has set up a strong system of referrals between public and private health services, as well as between partners and ‘technical partners’ with specific expertise, such as an association of female lawyers in Senegal providing legal support for victims of abuse. Referral between public and private health services was especially important in countries where public health services did not provide all services - for instance, due to budget constraints or legislation (e.g. not providing contraceptives in Indonesia or not providing safe abortion). Generally, private health services had more funds and more freedom to offer these services.

ASK also focused on commodity provision through mobile clinics or other distributors, thereby increasing access to contraceptives in particular. Mobile health facilities in Pakistan and Indonesia, for instance, facilitated young people’s access to these services. In Pakistan partner organizations FPAP and PIDS also identified private practitioners and community-based distributors to distribute free contraceptives, while mobile camps proved very effective at increasing demand and providing services on the doorstep of marginalized groups such as young mothers, out-of-school youth and LGBT groups.

Providing access to safe abortion proved difficult in various countries, as abortion is taboo in many countries involved in the ASK programme. For instance, in Indonesia health services would focus on counselling and referral to abortion clinics outside the scope of the alliance partners. In Uganda service providers where trained on youth-friendly services and on abortion guidelines, however, in practice, service providers mainly provided 'post-abortion care'.

Despite various efforts to increase access to SRH services, this did not imply that young people would actually attend the services. Although OMRs generally showed there was a significant increase in service utilization, according to project documentation, young people in general do not readily visit health services. In some countries, young people would mainly visit the services when they had a health problem. For instance, during field visits in Indonesia few young people were encountered at the health facilities, which was also confirmed by project documentation. Especially in countries where young people do not readily visit health services, strategies to bring services closer to them, such as mobile health facilities close to schools, were important. Also, the strategy to combine health services with other activities, such as leisure activities, was important to lower the threshold to visit these services.

7.4.3. Quality of and access to SRHR information/education

The ASK programme made use of various methodologies to provide quality SRHR information - both 'direct information' as well as indirect information whereby information was transferred via teachers, peer educators or other people. Activities included awareness creation, peer-to-peer learning and e&m health strategies. The specific focus on direct or indirect approaches also related to practices already in place. In those countries where both UFBR and ASK were carried out, CSE activities were already being undertaken, and the ASK programme provided additional strategies. It should also be mentioned that in some countries, such as Uganda, there was no clear-cut difference in the CSE approach between UFBR and ASK, and the two programmes were in practice intertwined.

The CSE activities which partner organizations valued most included awareness creation and peer-to-peer learning. E&m health and formal education were also mentioned frequently in the online survey which was part of the end-of-programme evaluation (see Figure 7.2).

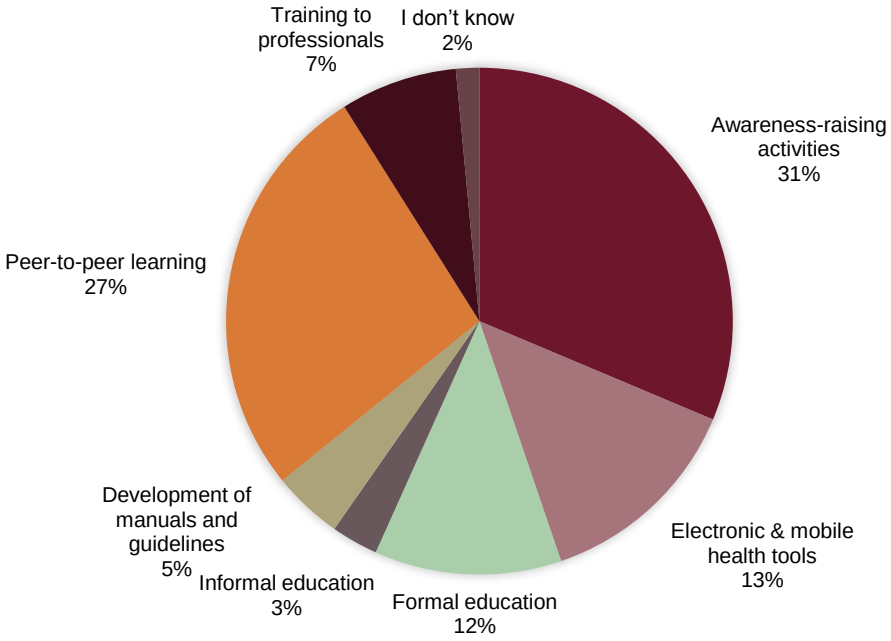

Figure 7.2: ASK Most valued activities on SRHR education (ASK all respondents, online survey 1).

Direct information

One of the central approaches of ASK, which was also complementary to UFBR, was the development and implementation of so-called 'direct information'. Through direct information young people can access SRHR information without the need for intermediaries (such as teachers, parents or peers). This information is delivered via different so-called e&m health interventions, including mobile phone applications, web-based information platforms, social media and chat services. Information is also delivered through more 'traditional' interventions such as radio and helplines. At the outset of the programme, desk review and OR were used to identify best practices, as e&m health tools are relatively new. Based on these insights, it was decided to choose to strengthen existing e&m health tools, rather than creating new tools, and where possible, to link different initiatives to each other. In each country SRHR information/CSE was adapted to fit the local context. New websites were set up in those countries with no relevant websites in place, or existing websites were adapted in countries which already had websites. Websites were set up by the alliance in Pakistan and Indonesia, and by partner organizations in Uganda and Kenya. Senegal chose to work with an existing platform, with different components added as part of the ASK programme. OR was used (in Kenya, Indonesia, Uganda, Senegal) to strengthen new or existing platforms.

Several countries also introduced telephone helplines (or hotlines) offering young people low-level access to information on SRHR issues. In Ethiopia, for instance, Amref developed a telephone hotline for young people that allowed them call in and discuss SRHR issues '24/7'. In Pakistan nine existing helplines were joined, and CSE was made assessable via a new central line. As mentioned above, the tools needed to be promoted to increase the number of young people accessing the information. In some countries this went well (Pakistan). Other countries needed to invest more in promoting certain social media platforms (Indonesia, Uganda).

More 'traditional awareness-raising activities' varied between countries. In Indonesia these included the use of mainstream radio, printed materials (leaflets) and billboards. Most people were said to be reached by broadcast media, especially radio and television. In Ghana a radio programme run by dance4life partner Curious Minds was mentioned as a good example. It is a bi-monthly one-hour live radio show that is broadcast in northern Ghana (a relatively poor area compared to southern Ghana) and facilitated by peer educators trained in SRHR issues. The target group was mainly young people, although at the same time policymakers, teachers and adults were also targeted. This meant that the programme also had an impact on the enabling environment. In Kenya using music and dance was mentioned as a useful approach for increasing the uptake of SRHR information by young people, especially out-of-school youth. However, one of the drawbacks of this method was to keep young people 'on board' after the entertainment session to discuss SRHR issues.

Indirect information

In addition to these direct information methods, CSE in and outside schools was also used as an approach to stimulate learning on SRHR. It should be noted that this was also a main activity of UFBR, and in those countries (or regions of countries) where both UFBR and ASK were implemented, it was often already addressed through UFBR. This was the case in Indonesia, for instance, where ASK mainly focused on direct communication. In other countries it was part of ASK, such as Senegal (where only ASK was carried out) and Kenya (where both UFBR and ASK were carried out). In Senegal partnerships with schools and youth organizations were established to train teachers and student leaders in CSE. CSE programmes in schools were also linked to ASK's multi-component approach. They were connected to youth-friendly services provided by partner organization ASBEF and public health centres, to establish a smooth referral system. Educational strategies included the training of educators in the use of e&m health tools, with the aim of encouraging information-sharing.

Photo 7.4: Peer educator at work in Uganda.

Furthermore, a critical note needs to be made relating to the comprehensiveness of CSE. While the original manuals and most CSE activities at the outset of the programme can be considered comprehensive, the activities that were actually implemented were less comprehensive. Often, the more controversial topics - such as sexual diversity, rights and abortion - were taken out, and sometimes activities were reduced to abstinence promotion (see also Figure 7.3).

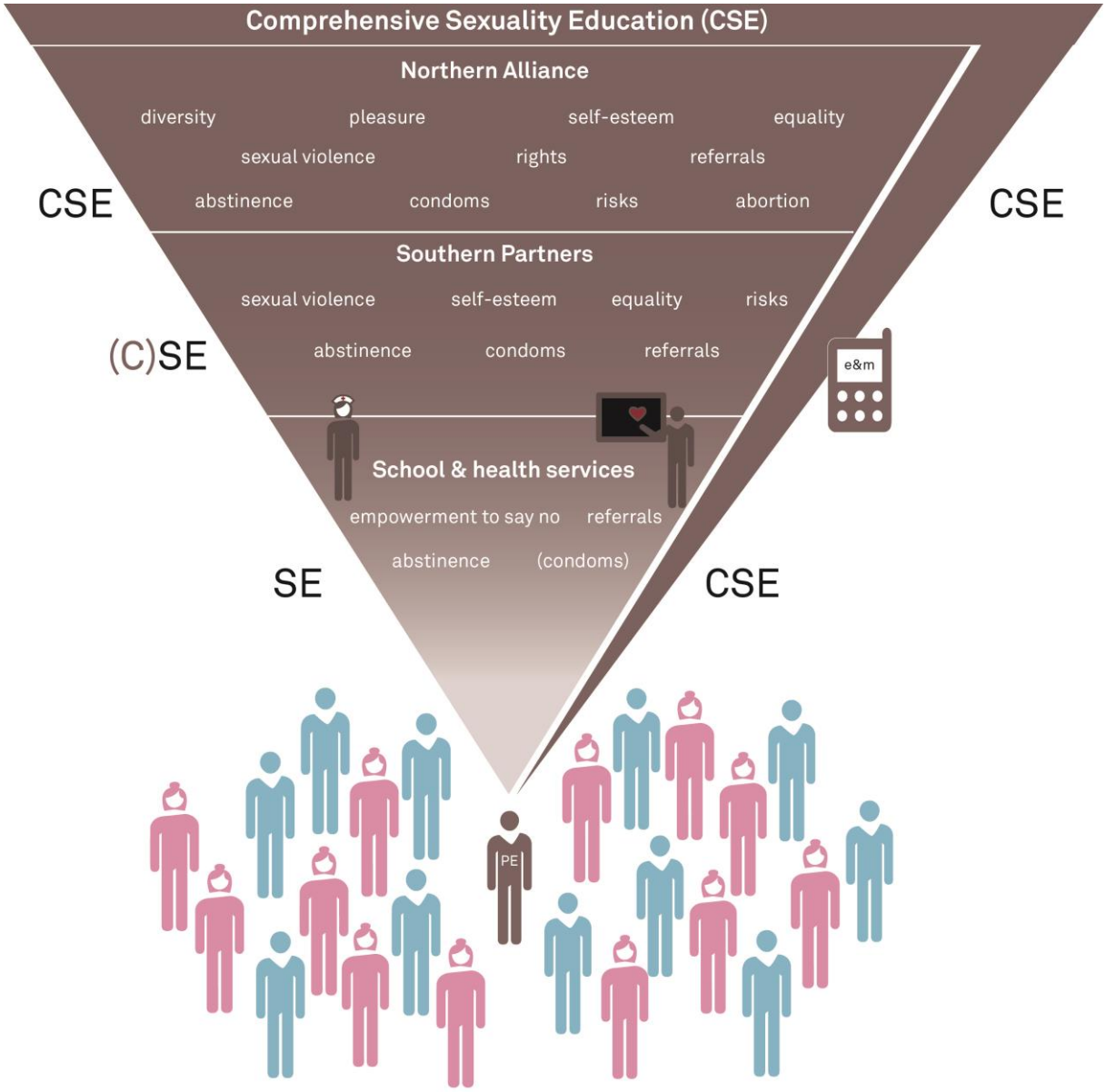

Figure 7.3: The extent of comprehensiveness of comprehensive sexuality education (CSE).
(SE = Sexuality education, PE = Peer educator, e&m = electronic and mobile health technologies)

7.4.4. Change values and norms at the beneficiary level, personal relationship level, community level and policy level

Strategies used in all countries to try to make the environment more enabling can largely be divided into three main categories: 1) awareness-raising activities, including community meetings and theatre pieces; 2) lobbying and advocacy activities, such as one-on-one engagement with national policymakers, local leaders and external stakeholders; and 3) community stakeholder support. The online survey showed that, according to the Southern ASK staff, SRHR capacities on the enabling environment were among the three most strengthened (alongside MYP and CSE). While in most countries widespread support exists for family planning, in nearly all countries persistent norms and values on more sensitive issues, such as the position of LGTBQI, played an important role in SRHR activities and, therefore, required continuous attention.

Although awareness-raising activities were extensively discussed in the project documentation, and many examples are provided, it was not mentioned as the most valued activity for working towards an

enabling environment (see Figure 7.4). This could possibly be explained by awareness creation also being seen as a way to increase access to SRHR knowledge for the target groups. Another explanation might be that there are no clear dividing lines between the categories ‘awareness-raising activities’ and ‘community stakeholder support’. Project documents made no clear distinction either.

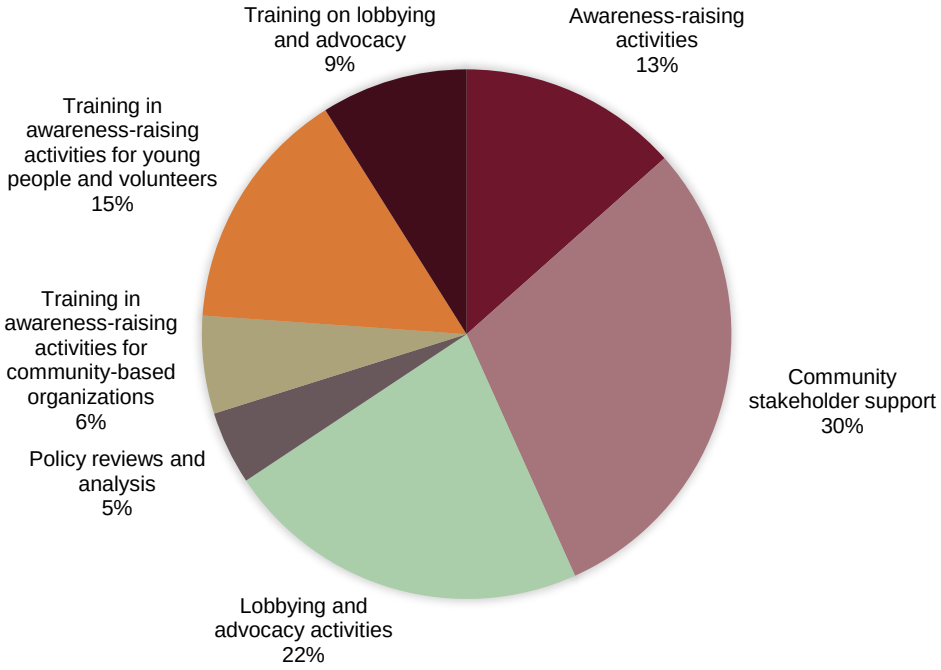

Figure 7.4: Most valued ASK activities for ensuring an enabling environment (ASK all respondents, online survey 1).

A wide range of awareness-raising activities and activities to create community stakeholder support were used in the ASK programme. Community meetings and theatre pieces are just some of the ways partners engage with various stakeholders to gain support for programme work. In Ethiopia ‘engagement meetings’ were organized in which different kinds of actors participated. According to the project documents, they created visibility for the programme and the organizations. In Ghana especially, community engagement was cited as a critical factor for success. The ASK team in Pakistan also organized and trained a local team to perform sketches in communities to raise awareness on SRHR. By involving young people and securing the support of parents and teachers, these mini theatres were said to be successful. Two partner organizations of the Senegalese alliance organized an ‘awareness-raising caravan’ on SRHR, as well as a competition at the close of the school year in 2014. In Uganda a Y+ (Young Positives) Beauty pageant was organized, with the main objective of addressing the stigma surrounding YPLHIV and creating ambassadors for addressing this issue.

Lobbying and advocacy was used as an important approach to create a more enabling environment, and although several positive examples were documented and mentioned in the fieldwork (which was part of this end-of-programme evaluation), it was also referred to as a challenging activity. In Indonesia joint lobbying and advocacy did not work well, which limited the impact of the alliance. In Kenya alliance partners focused mainly on lobbying political leaders and local administrators, as well as budget advocacy to increase funding for SRHR services. This approach relied on the goodwill of those leaders and has brought mixed results, including negative ones due to corruption.

Qualitative data showed that involving communities and, especially, community leaders led to a more enabling environment for young people. The ASK 2014 annual report concluded that it was possible to develop an enabling environment, which was illustrated by 'a best practice': an alliance member in Ghana managed to engage an imam in SRHR issues. This imam was previously opposed to the ASK project, and family planning activities in general. After involvement with the ASK programme he embraced the ASK project, accepted family planning within his community and even became a distributor of condoms. Not much mention is made of engaging parents and caregivers in the programme activities, although progress was documented on the indicator 'parents/caregivers support young people's SRHR'. This raises some questions on the role of parents/caregivers in the programmes.

7.4.5. Meaningful youth participation

Which have been effective strategies for meaningful youth participation, and how has this contributed to results?

The involvement of young people was very important within the ASK programme as a means to reach them, to ensure that activities are aligned to their needs and to change communities from the inside out. All country alliances made efforts to integrate interventions on MYP in their programmes, and some have developed specific polices on youth involvement. As described in Chapter 5, Southern ASK partners themselves indicated that their capacity on MYP was strengthened more than on other topics (see Figure 5.2). ASK used different strategies to ensure youth involvement. Generally, based on the field studies and the programme documentation, at the end of the programme, young people still seem to be more involved at the level of programme design and implementation than in decision-making. It should be mentioned that output and outcome indicators for UFBR and ASK do not measure the process of MYP explicitly; rather, MYP is seen as a strategy to achieve programme goals.

The main MYP strategies implemented were:

1. Youth organizations have been involved in most of the country alliances, which was generally perceived as a useful strategy. In five countries (Ethiopia, Ghana, Indonesia, Kenya and Uganda) seven youth-led organizations were members of local YEAs. These included four YPLHIV networks. Through these organizations, young people were involved in various programme activities such as programme planning (e.g. designing SRHR content), implementation (e.g. as advocates and peer educators) and M&E (e.g. as researchers in OR). A participatory approach - 'photo voice' - was used in six countries as a way to encourage young people to share their thoughts and perspectives on SRHR by taking photographs. This method proved successful as a way to use visual materials to discuss SRHR issues.

2. The ASK programme also prompted the establishment of youth centres or youth corners, with young people involved in setting them up. In most countries this was seen as a useful way of providing SRH services to a large number of young people (see also Section 7.4.1).

3. Young people were key implementers of the ASK programme. The following examples illustrate their involvement in programme activities: in Senegal the use of young people as Youth Focal Points was thought to be one of the most effective strategies for making contributions to all three components of the ToC; young people also wrote and created the quarterly ASK magazines; in Pakistan peer educators contributed to reaching out to LGBT groups; and in Kenya young people created an online platform (www.youth4life.co.ke).

4. In some countries young people were also involved on boards or in management positions of organizations. However, although the involvement of young people within organizations was well established, they were not involved at the management level of all organizations. Positive examples were mentioned in Ghana, Senegal, Ethiopia and Indonesia. In both Ghana and Ethiopia a partner organization had a youth participation policy that required that roughly 30% of its governing board be made up of young people, while in Senegal one partner organization had a policy to ensure that at least 25% of its governing body consists of young people (below the age of 25 years). In Pakistan young people were also involved in government bodies and were represented in the National Governing Board (NGB), while in Uganda several organizations developed a child protection policy, which ideally also determines how youth participation is integrated into their work.

OR on MYP conducted in Ethiopia, Pakistan, Indonesia, Senegal and Kenya showed that there were major differences between the countries which already involved young people and those which did not. The countries which already involved young people (such as Pakistan) benefitted from the focus on MYP in the ASK programme, while organizations that did not have active youth structures in their governance before the ASK programme made little progress in accommodating young members. In these countries MYP was found to be merely a programme requirement and hardly framed within a rights-based discourse within partner organizations and the programme.

Although the importance of MYP was recognized in various documents, not much reference was made to how these strategies actually work or what the actual impact was. Also, clear evidence of changes occurring as a result of the programme is lacking. Generally, reference is made to more openness and creativity in processes as a result of MYP.

In some cases, reference was made to the concept of MYP not being clear to partners, even though the ASK programme incorporated value clarification on MYP. In Indonesia, for instance, it was found that there was a need to develop a common understanding on MYP for the programme, with clear standards and criteria.

7.5. Sustainability of strategies

Have strategies led to sustainable results? If yes, which strategies?

The previous chapter showed that almost all partners are confident that they will continue to share knowledge and experiences even if the programme comes to an end. Overall results were quite positive. Different sustainability efforts have been undertaken by alliances in the various countries, such as alliance-building, fostering networks and partnerships, civil society strengthening, capacity-building, lobbying and advocacy, and long-term strategic planning and financing.

Linking with local and national government bodies was identified as a key strategy to improve sustainability. When programme activities can be integrated into or linked to existing government systems or procedures, this increases the likelihood of these activities continuing. In most countries this happened in one way or the other. On the other hand, in some countries, such as Indonesia, a lack of linking to government services was perceived as a key obstacle for sustainability. That said, positive examples were also documented in Indonesia.

A second strategy that was used to improve the sustainability of programme activities was to integrate elements of the ASK programme into the core activities of the partner organizations, which makes it more likely that activities can be continued after the end of the ASK programme. As each partner

organization has strengthened organizational and individual staff capacities through the ASK programme, partners felt that they would use this knowledge for the strategic development of new activities in the future. Whether this will indeed be the case is, however, hard to assess, just after the closure of the programme. This depends a great deal on organizational capabilities and whether or not the partners can mobilize separate resources to continue implementing programme activities. Most partners tried, as much as possible, to integrate programme activities within their wider organizational work plans so that, with or without continued funding through these programmes, activities could still go on (through external funding) and impacts would be sustained.

It should also be noted that partner organizations also chose to build on existing strategies, rather than creating new ones. This was also set out as a central programme strategy of the ASK programme. At the start of the programme, a literature review on the use of e&m health tools was undertaken to learn more about previous experiences of the most efficient and sustainable approaches. Based on that review, several activities were set up, such as an online platform that provides youth-friendly SRH information in an interactive way in Senegal, which was led by OneWorld UK and focused on updating and scaling up the existing Click-info ado platform.

Also, efforts have been made in the area of capacity-building at the local level by CORPs, community leaders, peer educators, community-based organizations etc., local participation in programme activities, local ownership and beneficiary-led implementation of project activities. The knowledge and skills acquired through training courses for teachers, health workers and peer educators are likely to be used in the future. However, they are also prone to changes, and several project documents mentioned the struggle with the staff turnover of volunteers, teachers and health providers and the high degree of mobility of young people. A recommendation is to integrate income-generating schemes for young volunteers and community health volunteers within the programmes as incentives for them to stay with the programmes.

A fourth strategy, mentioned least, is to mobilize separate resources to continue implementing programme activities. In general, alliances or partner organizations do not seem to have been very successful in this regard, which might also be the reason why it was not mentioned very often. That said, in some countries, such as Indonesia, partner organizations did not depend on one source of funding and were attached to other networks and engaged in other donor programmes.

The documents also listed some challenges when it came to sustainability. Although government support has been established in certain areas of the programme, in all countries a lack of integration of programme needs into government budgets was reported. Alignment with national policies and changes in government legislation, monitoring of programme activities at the district level etc. quite often took place, but governments have not been able to take over financial support for ASK activities. This means that certain resource-intensive aspects of the programmes, such as establishing youth-friendly centres, engaging CORPs or peer educators and mobile outreach, will probably not be continued or will only be continued less intensively.

7.6. Efficiency of strategies

What can be concluded concerning the efficiency of the (implementation of) strategies?

The total budget for ASK over the programme duration of three years was nearly €30 million. As Table 1.1 in Chapter 1 showed, the budget was more or less equally distributed over the three years, which implies an average of €1.4 million per year per country. However, some countries received a substantially larger share than others: Uganda received the most, followed by Kenya, Indonesia,

Pakistan, Ethiopia, Ghana and, finally, Senegal, which received the least. It is hard to draw general conclusions on the overall efficiency of the strategies, as project documents did not generally include much information on this subject. For some countries hardly any information could be gathered, which indicates that partners were not required to report on the cost-effectiveness of their programmes. Overall, the Southern participants in the online survey rated the efficiency of the ASK programme with a mean score of 7.5 out of 10, which is relatively high. The comparative efficiency (the efficiency of ASK related to other programmes) received a lower score: 6.5. There were differences between Northern and Southern alliance members: Southern partner organizations were more positive: on average they awarded a score of 7.9, while Northern partner organizations awarded this question a score of 6.9. Several components or activities of the ASK programme can be considered efficient, while there were also less efficient strategies.

First, efficiency was at the heart of the ASK programme, as the programme chose an approach of building on existing policies, instruments and guidelines, rather than creating new ones. At the outset of the programme, desk research was executed, and it was decided that, when appropriate, the programme would build on existing initiatives. In countries with existing helplines (such as Pakistan) or a website (e.g. Senegal), these were taken as a starting point and adapted as part of ASK. The programme also strengthened established partner organizations and other CSOs. It also engaged with existing community health workers who had good access to the target groups, making it easier for them to carry out outreach activities more effectively. Also, in most cases, programmes were linked to governance structures and policies. However, in some cases, alignment with national government was limited or absent. In Indonesia it was concluded that the efficiency of the programme could be increased by engaging relevant external stakeholders, including government bodies.

Second, several of the methods central to the programme, such as e&m health and cooperating with more traditional media such as newspapers and radio, were generally not very expensive and allowed a large number of young people to be targeted. Radio was said to be especially cost-effective because of its wide reach. However, these methods are less intense than going through a whole CSE curriculum, and it is difficult to assess which young people are reached and what kind of knowledge they have picked up. Also, making use of peer educators was perceived as a successful and efficient way to reach young people, including marginalized youth, as most of them worked as volunteers. One disadvantage was the high staff turnover, as was the need to keep them motivated to remain engaged with the programme. The combination of youth-friendly SRHR centres with other kind of services was also mentioned as a positive part of the ASK programme for increasing efficiency.

Third, the partner organizations of the alliance shared resources and performed joint training courses, which was also considered to increase efficiency. Although the exchanges between partner organizations were appreciated, the number and timing of joint meetings could be more efficient. This applied especially to large countries such as Indonesia. Arranging training courses for service providers and teachers was also, in some cases, time- and cost-intensive, especially when a large group of trainees travelled from different regions to one central location. Meetings could sometimes have been set up more strategically — for instance, regionally instead of centrally. This approach also implied a more scattered approach, with a limited number of individuals being trained. As the research findings from Indonesia indicate, this was challenging for these trained individuals, as their direct environment was not always receptive to the programme. It is likely to also be less efficient. In contrast, a ‘whole-school approach’ was perceived as efficient (see also UFBR synthesis report).

Efficiency study

In addition to the analysis of existing documents, we aimed to include an analysis of a cross-country comparison of one of the key activities of the ASK programme to complement the information from the available documents (an analytical model is presented in Annex 2). The set-up and use of websites as an important communication tool was selected as a key strategy, and a comparison between five ASK programme countries was foreseen. As explained in Chapter 2, obtaining the data collected was, however, more difficult and required more time and effort than anticipated. The financial set-up of ASK is arranged along the lines of the programme's result areas, which meant that information on budgets for specific strategies or programme activities was not easily available at the alliance office or offices of partner organizations in the North, and obtaining the information also required input from partner organizations in the three partner countries.

A detailed format was set up with the costs and outputs of the websites in these countries, in close collocation with the alliance office, and this format was sent to the five partner organizations in the five respective countries. Three partner organizations responded, but the information they provided varied, making it hard to make an accurate comparison between countries. However, the study did provide some lessons, such as the differences in costs of hiring Northern and Southern experts and the fact that websites need continuous maintenance and new content and thus require continuous investment. This makes it even more relevant, where possible, to build on existing structures. A general lesson is to build in mechanisms to measure efficiency right from the start of the programme and to ensure that financial administration is connected to them.

To conclude, the use of existing and available resources (such as community volunteers and peer educators), structures (such as existing CSOs, health facilities and community structures) and certain programme activities was an efficient component of the programme. However, several parts of the ASK programme could have been set up more strategically and efficiently — for example, the alignment with governance bodies and arrangements for joint meetings and training. No details on efficiency are available, and it is difficult to determine the overall efficiency of the programme.

8. CONCLUSIONS

To conclude, this synthesis report reviews to what extent the ASK programme achieved its overall goal, by assessing the assumptions of the ToC and the progress made on each of the components. Furthermore, it summarizes the programme's relevance, effectiveness, efficiency and sustainability.

8.1. Achievement of the overall goal

The central objective of the ASK programme was to improve the SRHR of young people (10–24 years) by increasing their uptake of SRH services. The programme ran from 2013 to 2015 in Ethiopia, Ghana, Indonesia, Kenya, Pakistan, Senegal and Uganda.

To achieve this ultimate goal, the ASK programme acted on three different components which were set out in the ToC:

1. Through the provision of SRHR information, the ASK programme empowers young people to make healthy and well-informed decisions (improving their knowledge, skills and self-efficacy). By providing SRHR education, young people's demand for services will grow, and the demand for youth-friendly SRH services will increase.
2. The ASK programme strengthens the provision of quality public and private SRH services (the availability, affordability and quality of SRH services and commodities) to meet the increased demand. By strengthening the provision of services, the supply increases.
3. Community sensitization, participation and mobilization activities are implemented to create an environment that accepts adolescent SRHR and increases broad community support for sexuality education and youth-friendly SRH services. Furthermore, lobbying and advocacy is undertaken to facilitate the creation of policies and laws that support young people's rights and needs.

Did the achievements at output level contribute to the outcomes and final goal as set out in the programme? In this chapter we assess the assumptions of the ToC and the progress made in each of its components.

8.2. General reflections

The ASK programme was implemented in societies with significant SRHR issues for the target populations. This applies especially to young people and marginalized groups — the main target groups for the programme. While SRH issues prevail in many settings (teenage pregnancies, FGM, early marriages, lack of antenatal care etc.), in many cases, SRH is not seen as a priority, and in particular the concept of sexual and reproductive rights is not accepted. ASK took up the challenge of addressing these topics in a comprehensive manner, often going against dominant socio-cultural beliefs and deep-rooted traditions. When not only many national contexts are becoming more conservative, but also in the international context less attention is being paid to SRHR (see the limited attention to SRHR in the newly developed Sustainable Development Goals), this deserves particular praise.

Compared to other programmes in the same field, we can clearly identify a number of key **strengths** of the ASK programme. These strengths are partly similar to the UFBR programme, on which the ASK programme has built in five of the seven countries where it was implemented alongside UFBR.

The use of the **ToC and the multi-component approach**: ASK addresses SRHR in a comprehensive way, following the UFBR programme. SRHR is influenced by a large number of factors operating on individual, interpersonal, environmental and social-structural levels. While many programmes focus on

only one aspect, ASK has chosen to tackle a significant number of key SRHR issues and, therefore, has the basic set-up to make real changes. Furthermore, the programme uses a range of different strategies and engages key stakeholders. This gives ASK a clear advantage over other programmes. Therefore, we find it remarkable that the new programme - Get Up, Speak Out - chose to reduce the emphasis on one of the components, providing quality services. Especially in countries with weak services, it will remain important to address this issue, and governments may not have the resources and capacities to guarantee sustainability.

The ASK programme received a **large budget** from the Dutch government, really standing out against other programmes that can only include a small number of partners, countries and activities. Therefore, it can really make a difference at the population level.

In most countries ASK was introduced alongside UFBR and was, therefore, able to **build on UFBR**, making use of structures and alliances of different partner organizations which were already in place. The strategy of bringing together different (types of) organizations is not only relevant for improving learning between organizations but also serves as a guarantee of comprehensiveness, stimulates adaptation to the local context and is a strategy for sustainability. Furthermore, ASK invested significantly in both **individual and organizational capacity-building**.

ASK focused specifically on reaching **young people and marginalized groups**. In most ASK countries young people make up a large share of the total population, and there is a lack of awareness of SRHR and a lack of (access) to services. The decision to work with marginalized youth, such as young people with disabilities and transgender youth, was relevant, as many of these groups are not well served. It is also in line with the Sustainable Development Goals' focus on 'leaving no one behind'. The programme had a strong focus on **meaningful youth participation**, and efforts were made to involve young people in all stages of the projects.

Linking up with local and national **governments** and involving key **stakeholders** such as community leaders and teachers is crucial for any innovative intervention. Nevertheless, it is often overlooked or reduced to a minimal level. ASK developed a comprehensive strategy to lobby governments and involve key stakeholders, as a basis for sustainable change.

Compared to similar programmes, the **monitoring and evaluation** of ASK has been thorough, elaborate and well conceived. Many aspects could be taken over directly by future programmes. Its comprehensiveness differentiates it from many other PME frameworks that often solely focus on quantitative outputs and outcomes using experimental study designs. ASK also made use of operational research on topics such as e&m health tools and MYP, which served as an in-built mechanism to directly learn from the programme and improve future strategies.

Overall, we could also identify a few **weaker points**. Some of these issues are also found in a number of SRHR programmes and are, therefore, not specific to ASK.

The ASK programme had a **short programme duration** of three years (2013–2015), and in practice this time frame was even shorter, as partner organizations had to prepare themselves before being able to implement project activities. Also, targets were set high. It proved hard to achieve all the targets, and the pressure of meeting targets in a relatively short period of time prevented some partners from operating more strategically.

The rather complicated **structure** of the alliance, with different communication lines, may have led to a bureaucratic burden for the participating organizations. Especially at the top level of the alliance, members struggled with tensions between organizational and alliance interests, sometimes leading to mistrust and negative energy. Collaboration was also found to be bureaucratic and time-consuming. This is partly related to the consensus-seeking culture, with most decisions being made democratically.

ASK set out to approach SRHR using a rights-based approach, including addressing sexual diversity, and implementing comprehensive sexuality education. Direct information was used together with more traditional forms of awareness creation. At the same time the programme emphasized service delivery. In practice an approach was used in which **public health** was central. This is probably related to feasibility: it is easier to focus on health in more conservative settings, than on rights.

There were some tensions between these approaches. While the Northern partners had an ambitious, progressive agenda, this conflicted with the more conservative norms and values of the Southern partner organizations. ASK included a process of **value clarification**, which also addressed more progressive parts of the programme (e.g. gender diversity, real CSE); nevertheless, addressing these sensitive issues was still a major challenge for partner organizations.

While the **PME strategy** was very comprehensive, a stronger focus on programme and process evaluation could have helped address and provide solutions to some of these weaknesses. Studying the programme itself and the way it is implemented is also crucial for the interpretation of the results (see also Box 6.1).

8.3. Results by area

Providing SRHR information and education
Through the provision of SRHR information, the ASK programme empowers young people to make healthy and well-informed decisions (improving their knowledge, skills and self-efficacy). By providing SRHR education, young people's demand for services will grow, and the demand for youth-friendly SRH services will increase.

All country alliances aimed to improve access to (quality) CSE and SRHR information by delivering direct information, awareness-raising activities, and CSE in and out of schools. ASK was implemented in five countries where the UFBR programme was already being implemented (Ethiopia, Indonesia, Kenya, Pakistan and Uganda) by the Dutch SRHR Alliance. In these countries partners were already working on CSE in and outside schools. The ASK programme was also implemented in two other countries in West Africa (Ghana and Senegal).

The added value of the ASK programme compared to the UFBR programme was particularly in the **use of direct communication and targeting marginalized groups** such as young people living in remote rural areas, young people with disabilities and LGBT youth. The promotion of formal and informal CSE activities in the programme led to an improvement in target populations' (direct) access to SRHR information.

In countries where the local or national governments were supportive of CSE, communities were overall also more receptive to CSE; therefore, educators could work in a more enabling environment than in countries where this was not the case. Direct communication tools such as e&m health were useful to improve access to SRHR information for young people, including marginalized groups. At the

same time it was noted that an important group of marginalized youth had no access to internet or mobile phones; therefore, public awareness-raising activities, printed materials, radio programmes and working with peer educators were also important ways to reach them. While partner organizations were positive overall about the approaches used to provide CSE through teachers and peer educators, there were problems keeping trained educators engaged. This applied in particular to peer educators. Furthermore, a critical note needs to be made relating to the comprehensiveness of CSE. While the original manuals and most CSE activities at the outset can be considered comprehensive, the activities that were actually implemented were less comprehensive. Often, the more controversial topics - for example, sexual diversity, rights and abortion - were taken out, and sometimes activities were reduced to abstinence promotion (see Figure 7.2). For direct information on SRHR messages this was less of a problem, as these methods do not make use of intermediary channels. However, this method excludes interaction with the target groups; therefore, it is impossible to get feedback on the kind of information the target groups pick up and how they receive and perceive messages.

Nearly all output targets were reached in all countries, and some indicators were even surpassed by a factor of 3.5 or more. At the end of the programme a total of 15,711,251 young people had received information on SRH and SRH services, more than three times the overall target of 4,217,498. Also, the target number of educators trained through e-learning was doubled: a total of 30,923 educators were trained, against a multi-annual target of 12,260. These findings do raise some questions about whether the targets set were realistic, whether they were interpreted the same way by all partners and whether the data collected were reliable.

As confirmed by the OMRs that were performed in all seven countries, either the knowledge, confidence or attitudes of young people or women significantly i**mproved in four of the seven ASK countries**. It should be noted that there was no reliable information for Ethiopia, as there was no baseline information available, while for Senegal the information was assessed as unreliable and not incorporated in the analysis.

There were some differences between countries. In Indonesia progress was made on three of the four indicators, whereas in Uganda no clear evidence could be found on either of the outcome indicators in this area, and in Kenya a negative change was noted for three of the four indicators. Generally, knowledge increased more than confidence and attitudes (which is confirmed by much literature in this field). The targets on confidence and attitudes which were not met are likely to also be related to the short programme duration.

From the qualitative data in both the OMRs and in our field study, we gathered many stories of change from young people who had accessed CSE. Both quantitative and qualitative data make it possible to link improved quality of and access to SRHR education to an increased capacity of target populations to make informed SRHR decisions. However, we cannot really say that e&m health tools have contributed to this improved knowledge or change of attitudes. As the results show, receiving quality CSE alone is not enough to improve young people’s knowledge, skills and attitudes, in particular when the environment does not support SRHR. Based on the quantitative and qualitative data, however, it is plausible to conclude that the changes found can be attributed to the ASK programme.

Strengthening the provision of quality public and private SRH services
The ASK programme strengthens the provision of quality public and private SRH services (the availability, affordability and quality of SRH services and commodities) to meet the increased demand. By strengthening the provision of services, the supply increases.

By linking schools with SRH facilities, making use of direct communication tools such as e&m health, radio, television, helplines and theatre, as well as service outreach strategies, the ASK programme has contributed to increasing young people's demand for SRH services.

The programme provided 10,870,985 SRHR services to young people against a target of 8,497,530. Also, 655,003 women under 25 years of age received antenatal care, almost three times the target of 234,372 women. In total 122,679 young women delivered their baby while being attended by skilled health personnel. The target of 362 service providers trained on abortion guidelines was also almost tripled, with 1,155 service providers trained through the programme.

To increase access to services, community volunteers were equipped with the necessary means to conduct outreach activities, e&m health tools facilitated access, and SRHR providers were subcontracted. To improve the quality of SRH services, the programme trained health service providers, upgraded health services and made them more youth-friendly. This was done by training staff, but also by introducing youth corners, combining health facilities with leisure activities and extending opening hours. These activities and, in particular, the youth-friendly services were effective in increasing access to formal and informal SRH services for young people, including marginalized groups. The document analysis and field research indicated that training led to improved attitudes of health care providers towards the provision of SRH and towards young people, including marginalized groups. Especially in countries with a low acceptance of or even a hostile environment towards specific groups such as LGBT, this was an important aspect of the programme, as service providers themselves did not always fully accept these groups or even used to reject them. In all six countries with reliable data an improvement was achieved on the implementation of youth-friendly services. Nevertheless, young people's level of satisfaction with the services did not increase to the same degree, which could be explained by high staff turnover, long waiting times and a lack of supplies and equipment, but possibly also by higher expectations because of their increased knowledge.

The ASK programme also worked on improving the availability of essential commodities and especially the essential package of health services, which was much appreciated by partner organizations. Most other output indicators on the quality of services were also achieved, although some gaps remained, and for each target there were one or two countries that did not achieve the targets. Mention was also made of increasing the quality of services by ensuring that SRH services and commodities were available through good stock management. This was particularly important in those countries where the general quality of services was low, such as Uganda. Referral between public and private health services was especially important in countries where public health services did not provide all services - for instance, due to budget constraints or legislation (e.g. not providing contraceptives in Indonesia or not providing safe abortion). Private health services generally had more funds and more freedom to offer these services.

The ToC assumes that the increased capacity of young people, including marginalized groups, to make informed decisions about SRHR will lead to increased demand for quality SRH services. Based on the available data from the OMRs, it is hard to draw strong conclusions, as no conclusive data were available in most cases. In most of the countries outcomes were measured with secondary data at a national level, which makes it hard to directly link these findings to the ASK programme. UFBR or other programmes or policies may also have contributed to the national increase that was found in those countries.

In conclusion, although progress was made in strengthening the provision of quality public and private SRH services, it is hard to confirm the ToC on this component for the ASK programme, due to a lack

of conclusive data. It should be noted that the duration of the ASK programme was also very short especially when taking into account that the set-up of the programme needed time. Many activities started during the course of 2013, and most outcome measurements had already started in mid-2015. Also, the targets set at the outset of the programme were considered high by all partner organizations. This made it difficult to meet the targets.

Creating an enabling environment

Community sensitization, participation and mobilization activities are implemented to create an environment that accepts adolescent SRHR and increases broad community support for sexuality education and youth-friendly SRH services. Furthermore, lobbying and advocacy is undertaken to facilitate the creation of policies and laws that support young people's rights and needs.

The efforts to contribute to a more supportive environment were to a large extent similar for ASK and UFBR (in five of the seven countries where both programmes were implemented). As mentioned before, improving CSE and SRHR information alone was not enough to change perceptions on SRHR; cultural and religious norms were often mentioned as barriers. To address these issues and contribute to a more enabling normative and policy environment, ASK aimed to improve SRHR policies and legislation and to raise awareness within communities and among community leaders. Joint advocacy was successful in most countries and contributed to changing local or national SRHR policies. The ASK output targets on the enabling environment were achieved in most of the countries, although for each target there were one or two countries that underachieved. The target of the number of policymakers taking young people's SRHR to the forefront of the political debate was the only indicator not achieved. On five of the seven indicators the countries delivered far more than was promised.

To change the environment at local level, communities and community leaders were trained in SRHR and encouraged to participate in SRHR awareness-raising activities. By using various types of activities ranging from peer-to-peer learning, dance, drama, music, discussions, films and social media at community and national level, the programme was able to reach a large number of people. For example, 2,426,033 young people participated in SRHR groups or internet-based SRHR forums - ten times more than the target. Also, 45,435,152 (young) people were reached by campaigns on adolescent SRHR - five times more than expected. The number of staff members (11,306) of youth-led organizations trained in SRHR service programming and advocacy was four times the target.

Although in all countries that provided information, improvements were mentioned with respect to increased acceptance of SRHR issues within communities, persistent negative cultural beliefs still hinder young people's access to services. In particular, topics such as sexual diversity, sexual rights and gender equality remain contentious issues in most countries. An example of a framework for gender responsiveness can be found in Annex 7. This component of the programme is unlikely to change dramatically in a short-term programme; for norms and values to change, a long-term vision and investment are required. It should also be mentioned that, in some countries (e.g. Indonesia), conservative forces in society became stronger over the course of the programme, leading to a more hostile environment towards transgenders and homosexuals. The involvement of community leaders has been particularly important to address specific cultural and religious barriers. Not much mention is made of engaging parents and caregivers in the programme activities, although progress was documented on the indicator 'parents/caregivers support young people's SRHR'. This raises some questions on the role of parents/caregivers in the programmes.

8.4. Relevance, effectiveness, efficiency and sustainability of the ASK programme

ASK was relevant to young people, including marginalized groups, as it addressed their real and urgent needs. These were different in each country but included issues such as access to contraceptives, HIV/AIDS counselling, STI screening, addressing early forced marriages and FGM, as well as assessing essential medicines. The most significant change stories that were collected for this end evaluation are powerful illustrations of these urgent needs. According to the ASK partner organizations, the programme was adapted to the local contexts and generally well received by the people reached. MYP was well addressed in all countries; youth organizations were involved, and young people successfully participated in the design and implementation of activities; however, they were less involved in decision-making processes. Young people were also involved as peer educators. MYP did lead to more openness and creativity in programme activities, but not much reference is made to how strategies actually worked or what the actual impact of MYP was.

The multi-component approach was appropriate to the extent that it enabled the partners to address all three closely interrelated components at the same time. That said, partner organizations both in the North and the South clearly valued the education component most. This seems a remarkable finding, as the ASK programme emphasized the service component; however, more partner organizations with a focus on the education component participated in the online survey, and they were likely to favour education over the other components. It was hard to draw clear conclusions on whether the multi-component approach has really worked in practice, as several targets were still not reached, while in some cases use was made of secondary data, which made it hard to attribute changes to the programme. Especially for the service component, as well as for the enabling environment component, outcome data were lacking, making it difficult to draw firm conclusions on the effectiveness of the programme for all three components. Furthermore, there are issues with the data collected for the outcome measurements, in particular the comparison between baseline and endline populations. For instance, in several countries, studies did not control for differences in age groups between the base- and endline.

However, based on the combination of quantitative data, qualitative data, field studies and observations, we can build a plausible case for the programme having met some of its objectives. We can conclude that some of the objectives were not met because the programme was too ambitious given its short duration, especially as new methods were introduced, requiring specific expertise from the partners implementing these methods. Questions can also be raised about how targets were set. Generally, partners felt the ASK programme was very output-driven, with high targets set for a short time frame at the start of the programme.

Strategies that were said to be particularly useful included aligning the programme with the local and national government and obtaining their buy-in where possible. Using direct information tools, including e&m health, was valued due to their broad reach. Generally they were also considered useful to reach marginalized groups. That said, it was found they should be accompanied by more traditional forms of communication such as radio and theatre, as some marginalized groups, such as young people living in remote rural areas, have no or limited access to the internet and/or mobile phones. Also, combining direct information with more traditional ways of communicating is important, as it is impossible to identify whether the information reached the target groups in an appropriate way. There are also signs that using teachers, peer educators and community leaders as agents of change was effective, especially when they embraced the comprehensiveness of sexuality education and the programme was able to get them fully on board. However, more thought should be given to how the impact of training can be sustained. For example, the training of service providers could be more effective if it is integrated into the national curriculum. Also, although young people's involvement in

the implementation and design of the programmes was essential, more could be done to ensure their meaningful engagement in advocacy and at organizational decision-making level.

While the effectiveness of some programme activities can be assessed, insufficient information is available to make conclusive statements about the efficiency of the programme. Partners were not required to report on the cost-effectiveness of their programmes, so more effort should be made to measure programme efficiency. It was observed that there have been cost-savings by working in a partnership and sharing resources. At the same time joint sessions and training for partners could be organized more strategically - for example, by planning various programme activities better and considering which activity could be best to organize at which level.

The ASK programme has contributed to sustainable results in certain areas. It used existing community structures and also made use of existing websites and helplines where applicable. In most countries the alliance also engaged local and national governments where possible. This has contributed to increased ownership by key stakeholders. Support to continue providing SRHR services is more fragile, especially when cost-intensive investments need to be made. The enabling environment will continuously need attention, as norms and values change slowly, and even negative changes can occur. Finally, the country partnerships are likely to continue after the programme, in particular for sharing lessons, learning and joint advocacy.

9. ASSESSMENT OF THE STRENGTH OF EVIDENCE FOR THE TOC ASSUMPTIONS

This chapter presents an assessment of the strength of evidence for the assumptions for the ASK programme. As was explained in Chapter 3, as part of the process of developing the ToC, it is important to identify 'evidence' that confirms the assumptions and the ToC. As there is no rigorous evidence available to support each of the assumptions of the ToC yet, the evaluation will be useful to verify and collect evidence for these assumptions. The explicit ToC and the assumptions connected to it are covered in Chapter 3. Table 9.1 aims to provide an estimation of the strength of the evidence of the ToC. It is based on available evidence from the UFBR documentation and the end-of-programme evaluation. The colour codes refer to the strength of evidence for the causal link defined in the assumption, not to the effect of the ASK programme itself.

To assess the evidence of the ToC assumptions, the following criteria are used:[18]

Very strong	High quality, large in size, consistent, closely matched to programme context
Strong	High quality, large or medium in size, generally consistent, matched to programme context
Medium	Moderate quality, medium size, generally consistent, matched to programme context
Limited	Moderate or low quality, small or medium size, inconsistent, not matched to programme context
No evidence	No evidence identified

Table 9.1. Assessment of the strength of evidence for the ToC assumptions

CAPACITY-BUILDING ASSUMPTIONS	
Linking and learning between organizations leads to better programming	The evaluation has found strong indications that due to the country partnerships, partners are better connected and were able to learn from each other. In many countries this contributed to better-quality programming.
Individual capacity-building on SRHR increased knowledge and skills on SRHR among staff of partner organizations and CSOs	A large number of staff were trained, and respondents in the online survey as well as in field research indicated that their individual capacity on SRHR has strengthened.
Organizational capacity-building on project management, research and PME leads to improved implementation and monitoring of the programme	According to the partners themselves, the organizations' capacity changed because of working in the alliance, which led to improved implementation. Scores on the online survey for organizational capacity-building were high, although somewhat lower than individual capacity-building. PME and research is, however, one of the capacities built least according to the ASK partners.
Increased capacity on meaningful youth participation leads to better involvement of young people throughout the programme	We can conclude that partner organizations increased their capacity on MYP and involved young people more in the programming. MYP was mainly found at the strategic and implementation level as well as in research activities, but less on the level of decision-making. Some staff of partner organizations did not fully embrace MYP. This applies especially to staff with less experience in MYP, who sometimes had negative perceptions about MYP. In addition, youth-led organizations sometimes struggled to gain equal recognition in the country alliances.

[18] DFID (2013). *How To Note on Assessing the Strength of Evidence*. London: DFID: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/158000/HtN_-_Strength_of_Evidence.pdf.

DEMAND-SIDE ASSUMPTIONS	
Training educators to deliver quality CSE through e-learning and e-support leads to improved capacities of educators to deliver CSE	There is little evidence that e-learning or e-support led to improved capacities of educators to deliver CSE; hardly any data were available on this topic. Some educators were trained via more traditional methods through the ASK programme on how to use e&m health tools.
Promotion of innovative CSE activities leads to increased access to SRHR information	There is qualitative evidence available that promotion of tools is necessary to increase young people's access to information. In some countries this went well, while others needed to invest more in promotion. In general it was found that e&m health tools led to high outputs on the number of people reached in SRHR awareness-raising campaigns.
Providing direct access to SRHR information will lead to large numbers of young people, including marginalized groups, accessing this information	The output indicators show that providing direct access to SRHR information via e&m health tools reached high numbers of young people. However, no conclusions can be drawn on what kind of information they accessed. Concerns were raised that not all e&m health tool were accessible for marginalized groups - for example, those who are illiterate, girls and young people in rural areas who face barriers in accessing web-based materials and content, as well as information accessible by mobile phone.
Increased access to quality SRHR information and CSE leads to better knowledge of young people, including marginalized groups, to make informed decisions about their SRHR	Based on both quantitative and qualitative data, we can conclude that young people who accessed SRHR information and CSE improved their SRH knowledge levels. It is unclear, however, whether direct information via e&m health tools has a similar effect to more traditional face-to-face CSE methods.
Increased access to quality SRHR information will lead to increased confidence and attitudes among young people, including marginalized groups	The OMRs show inconclusive results of improved attitudes and confidence through CSE information. Young people might change their attitudes on certain topics, such as the acceptability of condoms, but not on more sensitive topics, such as sexual diversity or gender equality. Also, attitudes that were quantitatively researched were not conclusive; on some SRHR topics no data are available. Qualitative data from FGDs with young people yielded mixed findings; apart from positive changes, misconceptions or unchanged attitudes were also found. In the stories of change marginalized youth referred to empowerment and increased confidence, but this was not backed up by quantitative results. We conclude that there is limited evidence that (only) access to SRHR information will increase young people's confidence to make informed decision. In general, not much scientific research has been done yet on the effects of e&m health tools on young people in resource-poor settings.
Increased knowledge, better attitudes and improved skills lead to increased capacity to make informed decisions about SRHR	The quantitative data show inconclusive results that increased knowledge, better attitudes and improved skills lead to reported better capacity to make informed decisions. Qualitative data show, however, that young people feel better qualified to make more informed decisions, which is positive considering the short programme duration. However, an enabling environment is a prerequisite for feeling empowered to make and implement decisions. Currently, persistent norms and values limit young people's space to make and implement these decisions.
Increased capacity (knowledge, confidence and attitudes) of young people, including marginalized groups, leads to greater demand for quality SRHR services	Output data and secondary data give an indication that uptake of services increased. MSC stories and qualitative data show that young people felt it was easier to access services. This also applies to marginalized groups when they are targeted well.

SUPPLY-SIDE ASSUMPTIONS	
Training of service providers on delivering youth-friendly SRH services leads to improved capacity of service providers to deliver quality youth-friendly SRH services	Qualitative data - although not very elaborate on this topic - show that training contributed to youth-friendly attitudes among health care providers. Research findings show that there is limited support to sharing this capacity within a health facility.
Establishing youth-friendly access points will lead to increased access of young people, including marginalized groups, to SRHR commodities	Easy access - in some countries also free of charge - to contraceptives via mobile outreach strategies and distribution points in the communities increased uptake of contraceptives.
Cooperation between public and private services will lead to increased availability of youth-friendly services	A strong system of referrals between public and private health services was set up and, according to the online survey, valued by partners as a means to increase the availability of youth-friendly services.
Better supply of commodities and drugs leads to better quality of SRH services	Improvement of supply (management) of essential commodities and drugs was found, leading to service providers being better able to service clients. Compared to UFBR, where sometimes the supply of commodities and drugs received less attention, these gaps were successfully addressed in the ASK programme.
Offering integrated packages of essential services will lead to increased quality and availability of youth-friendly services	The online survey shows that partners valued the integrated package of essential services very highly, compared to other service components. However, little evidence was found of whether this strategy also increased the quality and availability of youth-friendly services.
Improved quality of SRH services leads to greater client satisfaction	This assumption can be partly confirmed. Based on the OMRs, we can conclude that improved quality of SRH services was linked to increased client satisfaction, although this was not a linear relation. Although the health facilities are increasingly complying with quality standards for youth-friendliness and maternal health care, young people's level of satisfaction did not increase to the same degree.
Improved access to formal and informal SRH services leads to better uptake of health services	There are limited data available to support this assumption. Outcome data on uptake are based on secondary data which cannot be linked directly to the programme. The qualitative evidence from the field study and country reports indicated an increased uptake of antenatal and youth-friendly services.

ENABLING ENVIRONMENT ASSUMPTIONS:	
Advocacy at local, regional or national level leads to increased involvement of authorities with the programmes	Project documents and field research findings indicate that in all countries advocacy was crucial for increased involvement of district or local authorities. This supported the implementation of the programme and contributed to more sustainable results. In countries where governments were less involved, implementation was frustrated, and results became more fragile.
Advocacy at local, regional or national level leads to improved SRHR policies and legislation	Advocacy led to increased involvement of partner organizations in policy development. There is, however, limited evidence of the outcomes of this involvement, although outcome measurements and qualitative data show that, in some cases, lobbying and advocacy did lead to improved policies and legislation
Support for youth-led organizations leads to increased involvement of young people, including marginalized groups, in youth-led community SRHR and advocacy activities	Research findings confirm that the ASK programme has stimulated and supported the involvement of youth-led organizations, which was relevant to linking young people to the programme. Youth-led organizations were also important to link young people to advocacy activities. In turn, young people involved in the programme implementation were key to increasing access in the communities.
Youth-led SRHR awareness-raising activities at community level, including theatre, radio and community forums, lead to a more supportive environment for SRHR	Qualitative data showed that specific youth-led activities were used to engage community members, parents and leaders. This increased the involvement of communities in programme activities. Qualitative data also showed improved support of communities and parents for youth SRHR, although negative attitudes were also still found. It is, however, not clear whether this increased support is directly linked to

ENABLING ENVIRONMENT ASSUMPTIONS:	
	awareness-raising activities or to other strategies, such as improved services etc.
SRHR awareness-raising activities at national level using (new) media lead to a more supportive environment for SRHR	SRHR awareness-raising activities were found to be an effective way to communicate messages and reach many people, but there is little evidence that this specific strategy results in a more supportive environment
Improved SRHR policies and legislation lead to a more supportive environment for SRHR	Qualitative data showed consistently in all countries that SRHR policies or legislation can be a key enabling factor, when they are geared towards positive SRHR for young people, but also a very constraining factor when no attention is paid to SRHR.
A more supportive environment for SRHR provides more support to young people, including marginalized groups, to exercise their sexual and reproductive rights	There is strong evidence that a lack of an enabling environment hinders the exercise of sexual and reproductive rights. Community opposition was often seen as a major barrier to target groups' exercise of their rights. Policies and legislation made it more difficult for people to exercise their SRHR (e.g. unmarried couple cannot access contraceptives in Indonesia; LGBTQI rights are violated in Uganda).

LONG-TERM CHANGES	
More demand, supply and support for quality and equitable SRHR leads to young people, including marginalized groups, making healthier decisions towards their sexuality	Theoretically these statements seem valid. Looking at the socio-ecological model (see infographic 6.1), individuals' SRH is influenced by a large set of factors at the individual, interpersonal, community and socio-structural level. With the ASK programme, the YEA implemented a comprehensive programme, addressing several factors at these different levels. It can, therefore, be expected that its impact is greater than when only one or a few factors are addressed. Furthermore, there is strong evidence for the individual factors (from improved preventive behaviour, utilization of quality SRH services or improved enabling environment to improved SRHR). Therefore, we can assume that the combination of factors will only generate a greater effect.
More demand, supply and support for quality and equitable SRHR leads to improved use of quality SRH commodities by young people, including marginalized groups	
More demand, supply and support for quality and equitable SRHR leads to greater respect for young people's SRHR, including marginalized groups	
Improved capacity of young people to make informed choices, improved utilization of quality SRH services and increased acceptance of SRHR leads to improved SRHR of young people, including marginalized groups	
Combining different result areas leads to more effective programmes	

10. RECOMMENDATIONS

Based on the research findings, the following recommendations can be made:

At the level of the partnership and the overall programme

- Set realistic targets for a short programme duration together with the partner organizations involved. It should be recognized that changes related to SRHR take time. Setting unrealistically high targets is possibly discouraging and likely to limit more strategic thinking and to negatively impact ownership of the programmes.
- Design the M&E framework in cooperation with the partner organizations, to increase ownership and enhance understanding of all indicators.
- To further strengthen the SRHR sector, consider the participation of other actors such as knowledge institutions, journalists with experience of online content, young doctors, clinical counsellors and professional associations.
- Analyse the use of OR, as this is an important component of the programme which is highly valued by partners in the North, while it seems to be less appreciated by partners in the South.
- To improve efficiency, country alliances should critically assess when joint activities are useful and at what level they should be organized.
- Review the current governance structure in the international alliance to ensure that country alliances have sufficient ownership (see also *Partnership Assessment: The SRHR Alliance and the Youth Empowerment Alliance,* which is part of this end-of-programme evaluation).
- In some countries the number of partner organizations is considered too many, since it leads to fragmentation of tasks. Assess in cooperation with the NPCs what the optimal size of an alliance is, and adjust accordingly.
- Continue to set programme requirements on MYP. At the same time continue to use value clarification methods to discuss MYP by using a rights-based approach.
- Give additional support to youth-led organizations on what is needed for them to find their position within the alliance.
- Find ways in each alliance organization to institutionalize knowledge to make more use of the individual capacity-building that is achieved. Organize informal 'bring-a-colleague' meetings in each working group every once in a while. Share lessons learned or new approaches from the field for working groups to reflect together, but with new input from staff outside the programme. In this way staff not involved in the programme also participate in knowledge exchanges.

On PME and programme management

- Review the PME structure and explore other ways of measuring the impact of SRHR programmes. More use could be made of linking qualitative and quantitative methods. A stronger focus on processes and learning by partner organizations might be helpful to gain more insight into the results of the programme. Also, learning and implementation of lessons learned by main agents of change, such as teachers, service providers and peer educators, is important to assess the changes in line with the ToC.
- Connect PME more to the ToC, including the assumptions. Focus more on assessing the capacity-building of agents of change, such as service providers and teachers (assessing the knowledge acquired, learning and utilization of knowledge).
- Instead of trying to cover all sites with quantitative assessments or outcome measurements, focus on a selection of sites and do these really well (including large numbers of respondents, corrections and tests). An implementation science approach could be helpful, which would mean that significant planning would be involved in choosing target sites, sampling for endline and baseline measurements and also in the decision-making on which interventions to implement. The focus of the programmes would also be on generating evidence on what works best, where, for

uptake and the sustainability of interventions. This would also require consideration of the type of staff employed at the different country/partner organizations and collaboration with research institutes within the country as partners.

For improving SRHR education

- Develop mechanisms to set up M&E systems to measure the impact of direct information strategies, such as analysing the number of visitors to websites, carrying out research among website users or analysing questions asked through hotlines/SMS. This is not only important to determine the impact of the programme but can also be used to improve e&m health activities.
- Increase the capacity of partner organizations to work with direct information such as e&m health, as this requires specific expertise, including using specific 'language' and wording for websites (accessible for a wide audience), moderating discussions, and issues such as open access in relation to privacy.
- Use a combination of easy-access tools such as websites, hotlines and SMS, on the one hand, and a one-to-one approach, on the other, in case young people need more support.
- Continue using value clarification and make more effort to achieve participatory value clarification with regards to CSE with all stakeholders throughout the entire programme, including parents.
- Continue to strengthen links between schools and SRHR services.
- Link (or keep on linking) strategies such as CSE programmes, peer educator networks and health facilities to the e&m health tools available.
- Stimulate whole-school approaches.

For improving SRH services

- Lobby for changes in educational institutes for health care providers, to create more awareness of youth-friendly services in the curriculum.
- Continue to sensitize health care providers on providing youth-friendly SRHR services.
- Involve community leaders and parents in programme activities for youth-friendly services, especially with regards to their role in promoting information dissemination and use of youth-friendly SRH services.
- Create more opportunities for linkages and referral between public and private institutions, as this might provide opportunities for sustainable funding mechanisms.
- More attention could be given to the management of services, including the supply chain, to prevent stock-outs.
- In some countries, value clarification is needed for partner organizations and health care providers, particularly on topics that are sensitive due to religious and cultural norms, such as safe abortion and access to contraception.
- Continue with service outreach strategies, since these are successful in reaching marginalized groups. Outreach activities are useful as a first entry point for access and referral to services. Furthermore, outreach activities are highly valued by the target groups. However, the sustainability of these activities over the long term is questionable, and a cost-effectiveness analysis could be beneficial to assess their real value.
- Employ a 'health systems approach' to improving service delivery: develop interventions that aim not only to improve specific components of the health institutions but to improve the structure of service delivery and the health system as a whole, since this provides more opportunities for sustainable changes in SRHR service delivery in the target health facilities. This is already being done in some countries, but not systematically. This also provides greater opportunities for co-funding with government institutions and local authorities, which is likely to increase sustainability, as they will see the interventions as being holistic and not specifically directed at components of health care which might not be a priority for them.

For a more supportive enabling environment

- Advocate nationally for youth-friendly services in health facilities, not only at policy but also at budgeting level.
- Continue to work with religious and cultural leaders to define and uphold positive SRH practices among young people and communities.
- Ensure continuous community dialogue to find the best way to deal with conservative cultural and religious norms.
- Continue to use several kinds of (new) media to raise awareness about SRHR for young people and women.
- Involve community leaders and parents in programme activities for youth-friendly services, especially with regards to their role in promoting information dissemination and the use of youth-friendly SRH services. Encourage mothers and fathers to take responsibility for sharing SRHR messages with their children.
- Move from community mobilization to community engagement. Proper community engagement provides opportunities for sustainability and to ensure that interventions are relevant and context-specific. It requires a well-thought-out process to help identify and engage different stakeholders that influence the programme and its impact on beneficiaries at the personal, interpersonal, community, national and global level. During this end-of-programme evaluation, stakeholder mapping exercises were used in the different fieldwork exercises in the different countries, and they were useful for assessing stakeholders that were strategically placed to either enable or constrain the impact of the programme.
- Develop effective and relevant communication tools. There is a need to incorporate a clear communication strategy within the implementation plan of the programmes, to increase their visibility and improve uptake of interventions.
- Create more opportunities for linkages and referral between public and private institutions, as this might provide opportunities for sustainable funding mechanisms.

On efficiency

- Build in mechanisms to measure efficiency right from the start of the programme, and ensure that the financial administration is connected to them.
- Report on efficiency — for instance, by incorporating information on budgets at the level of programme interventions in annual reports.
- In future SRHR programmes, make better use of comparing programme strategies and interventions between the countries involved in previous programmes.
- Increase transparency of budgets and costs of programme activities, to increase partner organizations' awareness of efficiency - for instance, by including information on programme budgets in general project documents.

EPILOGUE

The YEA Alliance commissioned this external evaluation, with an accountability and learning objective. After three years of implementation of the ASK programme, the YEA Alliance generally felt positively about the ASK programme and it's progress, but was keen on having a validation of this assumption. Furthermore, the Alliance desired an external eye to critically assess the programme and fill in the blind spots that might occur after being closely involved in the ASK programming for three years.

In reaching these objectives, the Alliance has not been let down by the evaluation of ICRH and Kaleidos research. Our positive understanding of the results of the programme has been confirmed. We are proud that the evaluation team has identified a number of key strengths of the ASK programme compared to other programmes in the same field, like 1) the comprehensiveness of the programme because of our multi-component approach, 2) strengthening of SRHR country alliance for learning, comprehensive programming, context specificity and sustainability, 3) the collaboration with governments and key stakeholders, 4) the strong focus to involve young people meaningfully in all stages of the projects, 5) the focus on marginalised group, such a disabled and transgender, groups hardly ever well targeted for, and 6) the comprehensiveness of the monitoring and evaluation.

As important as these positive and endorsing findings are the recommendations of the evaluation team for our future programmes. From 2016-2020, the Get Up Speak Out (GUSO) programme funded by the Dutch Ministry of Foreign Affairs, will build upon the results and lessons learned from the ASK programme. The assessment of the strength and evidence for the ASK Theory of Change by the evaluators, is an important tool to (re-)check our assumptions and strengthen our GUSO Theory of Change. GUSO will use the practical recommendations on partnership development as well as on the programmatic level to improve both governance structures at the alliances, and the quality, efficiency and sustainability of the programme. A number of the recommendations are part and parcel of the new programme, like increasing the ownership of country alliances over the programme, a stronger focus on gender and gender transformative approaches, and the continuation setting programme requirements on meaningful youth participation, including the use of value clarification methods to discuss MYP by using a rights based approach. In addition, recommendations for assessing efficiency, and a stronger focus on quality and process monitoring will be seriously explored to strengthen the PMEL system, and to timely adjust the programmes strategies where relevant. The implementation of a scientifically-based implementation approach will enable a stronger focus on what works best, where, on for whom, for uptake and sustainability of interventions.

Youth Empowerment Alliance

ANNEX 1: OUTPUTS AND OUTCOMES TABLE

This annex provides an overview of all achievements of the output and outcome targets for ASK, based on the project documentation provided by the YEA alliance office.

The following criteria are used for the outcomes and outputs:

Effect/ outcome	significant positive change - strong evidence (adjusted)	Significant positive change - weak evidence (not adjusted)
	no significant change - strong evidence (adjusted)	No significant change - weak evidence (not adjusted)
	significant negative change - strong evidence (adjusted)	Significant negative change - weak evidence (not adjusted)
	No information	

Outputs	Targets achieved	
	Targets not achieved	
	No information	

Table 1: Overview of achievement of multi-annual CSE output targets.

	Ethiopia	Kenya	Indonesia	Pakistan	Ghana	Senegal	Uganda
1.a No. of young people that have received information on SRH and SRH services							
1.b No. of information channels that refer to services							
1.c No. of educators capacitated through e-learning/e-support							

Table 2: Overview of achievement of multi-annual CSE outcomes.

	Ethiopia	Kenya	Indonesia	Pakistan	Ghana	Senegal	Uganda
Young people have increased knowledge on SRHR/HIV							
Young people have improved rights-based sexual attitudes							
Young people have increased SRHR confidence and/or skills							
Young people have increased capacity in health-seeking behaviour							

Table 3: Overview of achievement of multi-annual service output targets (RA2).

Result Area 2	Ethiopia	Kenya	Indonesia	Pakistan	Ghana	Senegal	Uganda
2.a No. of contraceptive commodities by type provided to young people under the age of 25 years							
2.b No. of clients who receive ARV in targeted clinics and through outreach (direct and indirect)							

Table 4: Overview of achievement of multi-annual service outcomes (RA2).

Result area 2	Ethiopia	Kenya	Indonesia	Pakistan	Ghana	Senegal	Uganda
2.1 Contraceptive prevalence rate -modern methods- to women under 25							
2.2 Proportion of population living with HIV with access to ARVs							

Table 5: Overview of achievement of multi-annual quality service output targets (RA3).

Result Area 3	Ethiopia	Kenya	Indonesia	Pakistan	Ghana	Senegal	Uganda
3.a No. of service providers trained in youth-friendly services							
3.b No. of service providers trained in safe abortion guidelines and procedures							
3.c No. of SRH services provided to young people under 25 years, including PMTCT, safe abortion, helplines and VCT							
3.d No. of births attended by skilled health personal in the targeted health clinics for women under 25 years (direct and indirect)							
3.e No. of women (under 25) receiving antenatal care (at least one visit and up to four visits) in targeted health services							
3.f X% of the project areas have a referral system linking public and private-for-profit SRH services[19]							

Table 6: Overview of achievement of quality of service outcomes (RA3).

Result area 3	Ethiopia	Kenya	Indonesia	Pakistan	Ghana	Senegal	Uganda
3.1 % of HIV-positive pregnant women receiving treatment for mother-to-child transmission							
3.2 Proportion of births attended by skilled health personal							
3.3 Antenatal coverage (at least one visit and up to four visits) in targeted area of implementation							
3.4 Young people express satisfaction with the quality and youth-friendliness of health services							
3.5–3.7 No. of government, private and partner health facilities that adopt and implement youth-friendly SRH services							
3.8 No. of health facilities that comply with the most recent safe abortion guidelines							

Table 7: Overview of achievement of multi-annual enabling environment output targets (RA4).

	Ethiopia	Kenya	Indonesia	Pakistan	Ghana	Senegal	Uganda
4.1 No. of staff of youth-led organizations trained in SRH service programming and advocacy							
4.2 No. of staff of partner organizations trained in meaningful youth participation in programme design, planning, implementation, M&E, research and advocacy							
4.3 No. of participants in SRHR groups for young people or internet-based SRHR forums for young people							
4..4 No. of people reached by campaigns on adolescent SRH and access to services							
4.5 No. of youth-led community activities to gain SRHR support							

[19] Indicator 3f was difficult to measure in regular output measurement. Therefore, in agreement with the donor, it was decided to only reflect on this in a narrative way.

	Ethiopia	Kenya	Indonesia	Pakistan	Ghana	Senegal	Uganda
4.6 No. of policymakers that actively take young people's SRHR to the forefront of the political debate							
4.7 No. of times consortium, including youth-led organizations, is invited by policymakers to participate in meetings relevant to SRHR and at regional, national or international advocacy							

Table 8: Overview of achievement of enabling environment outcomes (RA4).

	Ethiopia	Kenya	Indonesia	Pakistan	Ghana	Senegal	Uganda
4.1 Acceptance of and support for young people's right to access SRH services at community/local level							
4.2 Parents/caregivers support young people's SRHR							
4.3 No. of youth-led organizations with organizational capacity in SRH service programming and advocacy							
4.4 No. of partner organizations with functional structures for the involvement of young people in programme design, planning, implementation, monitoring, evaluation, research and advocacy							
4.5 Development and enforcement of implementation of SRHR policies promoting access to youth SRHR and access to youth-friendly services, including hard-to-reach populations							

ANNEX 2: ASK EVALUATION EFFICIENCY STUDY INFORMATION SHEET

Proposal: A cross-country comparison of one of the key activities of the ASK programme to complement the information from the available documents

Selected strategy: Using e&m health strategies to increase knowledge in five of the seven ASK programme countries

Focus: Websites containing SRHR information for young people. Current projects identified:

- Pakistan (website set up by the alliance from joint activities budget; website under revision), led by Rutgers WPF Pakistan, joint activities budget (among others, with alliance office): http://www.youask.pk/
- Senegal (existing platform, thanks to ASK add-on of different SRHR components), led by IPPF, combined with operational research budget (among others, with alliance office): http://www.clickinfoado.org/
- Indonesia (by the alliance from joint activities budget): http://guetau.com/
- Kenya (ASK partner dance4life, with other partners outside ASK): http://www.youth4life.co.ke/
- Uganda: (by Reach a Hand - Uganda, partner of Rutgers): http://sautiplus.org/

Summary of intervention:

- Objective
- Strategies used
- Situation at the start
- Situation now
- Outputs achieved
- Partners involved

Research method: In close collaboration with the alliance office/Rutgers office, an information sheet was set up and sent to the five partner organizations in the five partner countries. The information sheets are presented below.

ASK evaluation efficiency study information sheet – focus: websites containing SRHR information for young people

Name of website:

Implementing organization:

Implemented together with (name of other partners, if applicable):

Costs					**Source of information**
Direct information (specified for websites)	**2013**	**2014**	**2015**	**Total**	
Human resources – to set up website					
Technical assistance/training of local experts					
Technical assistance/training of experts from Northern YEA					
Design and set up website					
Subtotal human resources I					
Human resources – to manage website					
Content of website					
Technical support					
Promotion of website					
Subtotal human resources II					
Travel and accommodation costs for experts					
Investment costs (e.g. computer, network)					
Communication costs					
Subtotal investment costs					
Other costs					
Operational research					
Joint activities					
..					
Subtotal other costs					
Contingencies					
Total project costs					
Funded by:					
ASK					
…which budget line(s):					
Other sources					
Total project income					

Info sheet websites – additional information

TIMELINE	Main questions	Sub questions	Answers
SET-UP	When did you start with the set-up of the website?		
	When was the website launched?		
	If the website has built on an existing platform: when was CSE/SRHR information added to an existing website?		
	How many FTE worked on updating the website and keeping it operational during that period? (+ salary cost)		
	Did you make use of consultants and/ or external stakeholders in the set-up of the website?	Did you make use of consultants in the set-up of the website? If so: what was the fee?	
		Did you include stakeholders (adolescents, parents etc.) in the set-up of the website? If so: what was the fee?	
TIMELINE	**Main questions**	**Sub questions**	**Answers**
IMPLEMENTATION	How many FTE worked on updating the website and keeping it operational during that period? (+ salary cost)		
	Did you make use of consultants and/ or external stakeholders (adolescents, parents etc.) in the implementation phase of the website?	Did you make use of consultants to provide the content of the website? If so: what was the fee?	
		Did you make use of consultants for maintenance of the website? If so: what was the fee?	
		Did you make use of stakeholders to provide the content of the website? If so: what was the fee?	
		Did you make use of stakeholders for maintenance of the website (e.g. advisory board)? If so: what was the fee?	

TIMELINE	Main questions	Sub questions	Answers
PROMOTION	Did you publicize the website? If so: How many FTE worked on promotion of the website? (+ salary cost)		
	Did you make use of consultants and/or external stakeholders in the promotion of the website?	Did you make use of consultants in the promotion of the website? If so: what was the fee?	
		Did you include stakeholders (adolescents, parents etc.) in the promotion of the website? If so: what was the fee?	
TIMELINE	**Main questions**	**Sub questions**	**Answers**
OUTPUT	Output indicator 1.a: Number of young people who have received information on SRHR and SRHR services (through e.g. the dance4life trajectory, e&m channels etc.)		
	Output indicator 4.d: Number of (young) people reached by campaigns on adolescent SRHR and access to services (through (community) stakeholder support of SRHR programmes and youth-friendly services)		
	Do you keep track of the number of unique visitors and/or unique page views?	If so: could you indicate these numbers for 2014 and 2015?	
	Do you use Facebook? If so: do you keep track of Facebook likes?	What were these numbers for 2014 and 2015?	
	Do you use online platforms where young people can pose questions? If so: do you keep track of the questions posed?	What was the number of questions you have received for 2014 and 2015? What was the number of answers to the questions you have provided for 2014 and 2015?	

ANNEX 3A: ONLINE SURVEY I - UFBR AND ASK

Objectives

- To get a complete view of whether local partners in all countries feel that their organization has benefitted and has developed through one or both programmes
- To gain insights into and consensus on the core strengths and weaknesses of the programmes' design, implementation and PME, and on their main results.

Methods

We will develop a short online survey that will be sent to all partners: the Northern alliance partners of both programmes and their local partners. This survey will consist of two parts: one general section that is applicable to all partners, and one section that is specifically for Southern or Northern partners. For each Northern partner organization we aim to have one respondent per organization fill in the questionnaire: the person most experienced in working in the alliance (in most cases the country leads) and the implementation of the programme. Due to the already heavy PME workload of Southern partners we also aim for only one person per organization to fill in the survey. To increase response, the invitation email will be personalized, and we will ask each country lead to emphasize to these people the importance of cooperation. In cases where two people work on the coordination of activities due to the high number of activities (e.g. Kenya and Indonesia), both can be involved in this survey.

The survey will consist of two parts:

- The first part consists of questions on the programme design, implementation, evaluation and main results. This part will use a Delphi method in which multiple rounds of online surveys will be run. This will allow us to extract insights into and consensus on the three core strengths and weaknesses of the programme design, implementation and evaluation (Dimensions 1, 2, 3 and 4). The survey will include open-ended questions on the following topics:
  - Strengths and weaknesses of the design
  - Strengths and weaknesses of implementation
  - Outcomes of the programmes
- The second part will explore capacity-building and partnership collaboration at the international and national level. It will include the following topics:
  - Perceived value of in-country collaboration
  - Value of the alliance (added value/benefits/costs/disadvantage)
  - Changes in capacity (in line with the 5C approach)
  - Mutual influence between UFBR and ASK
  - Sustainability at the project level and of the partnership/alliance (plans to continue the alliance and activities, even without future support from the current programmes)
  - Willingness to use other donor funding to continue ASK/UFBR interventions
  - Statements on critical success factors on working in partnerships
  - Development of the partnership after the recommendations of the mid-term partnership review.

START: INTRODUCTION

Dear Madam, dear Sir,

Over the past years you have been a member of the Sexual and Reproductive Health and Rights Alliance (SRHR Alliance) and/or the Youth Empowerment Alliance (YEA). Both partnerships have been implementing programmes for the promotion of sexual and reproductive health and rights: the Unite for Body Rights (UFBR) and/or the Access, Services and Knowledge (ASK) programmes. Researchers from Kaleidos Research (NCDO foundation) and the International Centre for Reproductive Health (ICRH, Ghent University) are currently conducting an evaluation of both programmes.

As you are a key partner in one or both programmes, we would like to include your expert opinion in this evaluation. Therefore, we would like to invite you to participate in an **online survey** on several important aspects of the programme(s). While part of the survey will be classic *closed questions* focusing on capacity-building and partnerships, a second part will use a *Delphi approach* with questions on strengths and weaknesses of the programme(s). This approach is typically used to build consensus among experts in the field. After a first survey round of open questions, the answers in this part will be analysed and fed back to the participants for a second and possibly third round of questioning, to arrive at a common set of key conclusions. The answers you give will be treated anonymously and confidentially.

We would highly appreciate your cooperation. Participation in this survey will take approximately 20 minutes. Thank you very much for participating in the research.

Please contact us at Emilomo.Ogbe@ugent.be if you have any further questions about the survey.

Click here to start the survey.

[p. 1 FILTER QUESTION:]

1.1. For which programme do you work?

- UFBR → SURVEY 1: only show answer options for UFBR
- ASK → SURVEY 2: only show answer options for ASK
- Both → SURVEY 3: show answer option for both

[p. 2]
1.2. In which country do you work?

- The Netherlands
- United Kingdom
- A country where the programme is implemented

1.3. In which country programmes are you involved? *[more than one option is possible]*

- Bangladesh
- Ethiopia
- Ghana
- India
- Indonesia
- Kenya
- Malawi
- Pakistan
- Senegal
- Tanzania
- Uganda
- Other: …

1.4. Which Dutch/UK counterpart organization are you working for or are you affiliated with? (This information and any personal identifiers will be anonymized and kept confidential) *[more than one option is possible]*

- Amref Flying Doctors
- Child Helpline International (CHI)
- Choice for Youth and Sexuality
- dance4life
- International Planned Parenthood Federation (IPPF)
- Rutgers
- Simavi
- STOP AIDS NOW!
- Other/I am a National Programme Coordinator

1.5. Please specify which component of the programme(s) you work on most.
- SRHR education
- SRH services
- Enabling environment
- Other/I am a National Programme Coordinator

1.6a. When did you start working for the UFBR programme?

- 2010
- 2011
- 2012
- 2013
- 2014
- 2015

1.6b. When did you start working for the ASK programme?

- 2013
- 2014
- 2015

1.7. What is your position in the SRHR Alliance?

- Project Officer
- Country Lead
- Program Officer
- PME Officer
- Advocacy Officer
- NPC
- Director
- Other: ……

1.8. What is your gender?

- Male
- Female
- Other: …….

1.9. How old are you? … years

[p. 3]
2. We will start with a number of open questions on the programme design, implementation and main results. This part will use a Delphi method in which two rounds of online surveys will be run. This will allow us to extract insights into and consensus on the core strengths and weaknesses of the programme design, implementation and results.

You will be asked to provide between one and three answers to the questions.

[AT LEAST ONE ANSWER, before they can move to the next page]

2.1. As a partner in the UFBR/ASK programme(s) what are, according to you, the **three greatest strengths** of the general set-up and core principles of the programme(s)?

	2.1.a UFBR	2.1.b ASK
1		
2		
3		

2.2. What are, according to you, the **three weakest points** in the general set-up of the programme(s)?

	2.2.a UFBR	2.2.b ASK
1		
2		
3		

[p.4]

2.3. You and your organization have been implementing several activities within the UFBR/ASK programme(s). What are, according to you, the **three strongest activities;** if only three activities could be continued, which ones would you choose?

	2.3.a UFBR	2.3.b ASK
1		
2		
3		

2.4. What are, according to you, the **three weakest activities;** if three activities were to be stopped immediately, which ones would you choose?

	2.4.a UFBR	2.4.b ASK
1		
2		
3		

[p.5]

2.5. What was according to you the **most useful** activity in each of the domains?

2.5.1. Education
- Awareness-raising activities
- Electronic & mobile health tools
- Formal education
- Informal education
- Development of manuals and guidelines
- Peer-to-peer learning
- Training of professionals
- Training of volunteers
- I don't know

2.5.2. Services
- Implementation of integrated package of essential services
- Implementation of referral systems linking public and private-for-profit SRH services
- Improving commodity supply systems
- Improving/renovating health services
- Reaching marginalized groups
- I don't know

2.5.3. Enabling environment
- Awareness-raising activities
- Community stakeholder support
- Lobbying and advocacy activities
- Policy reviews and analysis

- Training on awareness-raising activities for community-based and civil society organizations
- Training on awareness-raising activities for young people and volunteers
- Training on lobbying and advocacy
- I don’t know

[p.6]

2.6. What was according to you the **least useful** activity in each of the domains?

2.6.1. Education
- Awareness-raising activities
- Electronic & mobile health tools
- Formal education
- Informal education
- Development of manuals and guidelines
- Peer-to-peer learning
- Training of professionals
- Training of volunteers
- I don’t know

2.6.2. Services
- Implementation of integrated package of essential services
- Implementation of referral systems linking public and private-for-profit SRH services
- Improving commodity supply systems
- Improving/renovating health services
- Reaching marginalized groups
- I don’t know

2.6.3. Enabling environment
- Awareness-raising activities
- Community stakeholder support
- Lobbying and advocacy activities
- Policy reviews and analysis

- Training on awareness-raising activities for community-based and civil society organizations
- Training on awareness-raising activities for young people and volunteers
- Training on lobbying and advocacy
- I don't know

[p.7]

2.7. You and your organization have been implementing several activities within the UFBR/ASK programme(s). What are, according to you, the **three main barriers** to the implementation of activities? What hindered the implementation of the activities the most?

	2.7.a UFBR	2.7.b ASK
1		
2		
3		

2.8. Could you name **three facilitating factors** that made it easier to implement activities? What facilitated the implementation of the activities the most?

	2.8.a UFBR	2.8.b ASK
1		
2		
3		

2.9. As the UFBR/ASK programme(s) will be rounded off: What are, according to you, the **three main achievements/results** of the programme(s)?

	2.9.a UFBR	2.9.b ASK
1		
2		
3		

[p.8]

2.10. Within the different outcome domains, which are the most and least achieved outcomes? Increased SRHR education

	2.10a UFBR		2.10.b ASK	
	Most positively changed (1 option)	Least changed or worsened (1 option)	Most positively changed (1 option)	Least changed or worsened (1 option)
Quality of SRHR education programme and comprehensive sexuality education				
Capacities of educators to deliver comprehensive sexuality education				
Access to formal SRHR education				
Access to informal SRHR education				
Access to quality SRHR education and CSE				
Capacity (knowledge) of young people, women and men to make informed decisions about their SRHR				
Demand for quality SRH services				

2.11. Within the different outcome domains, which are the most and least achieved outcomes? Strengthening SRH services

	2.11.a UFBR		2.11.b ASK	
	Most positively changed (1 option)	Least changed or worsened (1 option)	Most positively changed (1 option)	Least changed or worsened (1 option)
Capacity of service providers to deliver SRH services				
Access to SRH services in health centres				
Access to SRH services outside health centres				
Quality of SRH services				
Client satisfaction				
Uptake of health services				
Access to services for marginalized groups				

2.12. Within the different outcome domains, which are the most and least achieved outcomes? Supportive environment for SRHR

	2.12.a UFBR		2.12.b ASK	
	Most positively changed (1 option)	Least changed or worsened (1 option)	Most positively changed (1 option)	Least changed or worsened (1 option)
Advocacy campaigns				
SRHR policies and legislation				
Involvement of communities and community leaders in SRHR awareness-raising activities				
Acceptance of sexual diversity and gender equality				
Equal sexual and reproductive rights for young people, women, men and marginalized groups				

[p.9]

	UFBR	ASK
2.13. How would you score the overall effectiveness of the programme, meaning how well the objectives of the programme are reached?	0–10	0–10
2.14. How would you score the overall efficiency of the programme? (are results proportionate to investments?)	0–10	0–10
2.15. I feel that the programmes of UFBR and ASK are more effective then programmes we implement(ed) for other donors	0–10	0–10

2.16. UFBR and ASK are two distinct programmes, yet several organizations are involved in both partnerships. According to you, what is the main influence of UFBR on ASK?

2.17. And of ASK on UFBR?

[p.10]
3. The UFBR and ASK alliances have an international component and a national component. For the following set of items will ask for your perspective on **the international partnership** between all organizations involved in the entire programme (in The Netherlands, UK, countries in the South). Can you indicate, on a scale from 0 to 10, how much you agree with the statement, with 0 meaning completely disagree and 10 meaning completely agree, or you can answer 'I don't know', if you feel a statement is not applicable to you.

FUNCTIONING OF THE INTERNATIONAL PARTNERSHIPS	**UFBR**	**ASK**
3.1. The Dutch/UK organizations, on the one hand, and the national alliances in the countries in the global South, on the other hand, have a mutual understanding of the mission and objectives of the international partnership	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know
3.2. I know what the international partnership stands for	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know
3.3. There is transparent communication between the Northern and Southern partners	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know
3.4. The appropriate governance systems and procedures are in place for the international partnership to function properly	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know
3.5. There are enough monitoring and evaluation moments in place to manage the international partnership properly	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know
3.6. There is mutual trust between the partners of the international partnership	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know
3.7. The programmes are built on the basis of local needs	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know
3.8. The international members of the partnership combined have the necessary competencies and knowledge to cover the three components	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know

[p.11]
4. The UFBR and ASK alliances have an international component and a national component. For the following set of items will ask for your perspective on **the national partnership between all organizations involved in your country**. Can you indicate, on a scale from 0 to 10, how much you agree with the statement, with 0 meaning completely disagree and 10 meaning completely agree, or you can answer 'I don't know', if you feel a statement is not applicable to you.

Note: Dutch/UK respondents are asked to consider the partnership in the Netherlands when completing the following items.

FUNCTIONING OF THE NATIONAL PARTNERSHIPS	**UFBR**	**ASK**
4.1. In my country, every partner has clear roles and responsibilities	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know
4.2. The organizational structure of the partnership is clear in my country	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know
4.3. Each partner in my country has a strong sense of ownership of the programme	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know
4.4. The organization I work for understands the importance of the partnership and aligns with this	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know
4.5. I feel the partners in my country work in a transparent and accountable manner	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know

4.6. All partners in my country invest enough time and resource in the partnership	0-1-2-3-4-5-6-7-8-9-10-I don’t know	0-1-2-3-4-5-6-7-8-9-10-I don’t know
4.7. The Theory of Change of the alliance (and its three components) is known to me	0-1-2-3-4-5-6-7-8-9-10-I don’t know	0-1-2-3-4-5-6-7-8-9-10-I don’t know
4.8. The national members of the partnership combined have the necessary competencies and knowledge to cover the three components of the Theory of Change	0-1-2-3-4-5-6-7-8-9-10-I don’t know	0-1-2-3-4-5-6-7-8-9-10-I don’t know
4.9. In the national partnership, we share and agree with the joint objectives of the programme(s)	0-1-2-3-4-5-6-7-8-9-10-I don’t know	0-1-2-3-4-5-6-7-8-9-10-I don’t know
4.10. There are strategies in place to resolve conflict between national partners	0-1-2-3-4-5-6-7-8-9-10-I don’t know	0-1-2-3-4-5-6-7-8-9-10-I don’t know
4.11. In the international partnership, we celebrate our successes with each other.	0-1-2-3-4-5-6-7-8-9-10-I don’t know	0-1-2-3-4-5-6-7-8-9-10-I don’t know
4.12. I think the national partnership is a strong brand; in our sector everybody knows who we are	0-1-2-3-4-5-6-7-8-9-10-I don’t know	0-1-2-3-4-5-6-7-8-9-10-I don’t know

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5. The following set of statements will ask your perception on and experiences with working in such a partnership. Can you indicate, on a scale from 0 to 10, how much you agree with the statement, with 0 meaning completely disagree and 10 meaning completely agree, or you can answer 'I don't know', if you feel a statement is not applicable to you.

***[PERCEIVED VALUE OF]* IN-COUNTRY COLLABORATION**	**UFBR**	**ASK**
5.1. Working with partners in my country has generated a new positive dynamic in the SRHR sector in my country	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know
5.2. Working with partners in my country has increased competition in the SRHR sector in my country	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know
5.3. It is easier to produce changes in relevant policies through individual advocacy by different organizations than by advocating in partnership	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know

[p.13]
6. This set of statements will ask your perception on the costs and benefits of working in a partnership. Can you indicate, on a scale from 0 to 10, how much you agree with the statement, with 0 meaning completely disagree and 10 meaning completely agree, or you can answer 'I don't know', if you feel a statement is not applicable to you.

COST-BENEFIT OF BEING PART OF THE ALLIANCE	**UFBR**	**ASK**
6.1. The complementarity of the partners in the partnership ensures that SRHR problems are dealt with in a comprehensive way	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know
6.2. Aligning different views on SRHR within the partnership takes little time and effort	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know
6.3. The mission and objectives of the partnership are in line with the mission and objectives of my organization	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know
6.4. The results of the programme would have been less if the activities were implemented by individual partners rather than by a partnership	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know
6.5. Resources, such as knowledge, know-how and ideas are shared within the partnership, and partners can learn from each other	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know
6.6. I feel my contributions within the partnership are acknowledged and valued by other partners	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know
6.7. As a result of the alliance our organization is collaborating with other organizations outside the partnership which we did not know before	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know

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7. The following set of items will ask for your perspective on the changes in your personal capacity and that of your organization since the start of the programme(s). Can you indicate, on a scale from 0 to 10, how much you agree with the statement, with 0 meaning completely disagree and 10 meaning completely agree, or you can answer 'I don't know', if you feel a statement is not applicable to you.

CAPACITY-BUILDING	UFBR	ASK
Please think about your own functioning before and at the end of the UFBR/ASK programmes. Could you indicate to what extent you agree or disagree with the following statements: 7.1. I have obtained new knowledge, experience and expertise on SRHR issues 7.2. I was able to also integrate this new knowledge, experience and expertise in my own work 7.3. I am able to transfer what I learned to other people (e.g. staff at schools or service providers). 7.4. I have improved my project management capacity as a result of the UFBR/ASK programmes 7.5. I can now better build and maintain networks with external stakeholders	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know
Please think about the functioning of your organization before and at the end of the UFBR/ASK programmes. Could you indicate to what extent you agree or disagree with the following statements. 7.6. My organization has improved its capacity (knowledge, experience, expertise) to carry out actions and achieve results aimed for 7.7. My organization has better structures in place to share knowledge and learn internally 7.8. My organization is better able to adapt its strategies if there are new challenges or external changes (e.g. shift in government policies) 7.9. My organization can now better build and maintain networks with external stakeholders 7.10. Due to the programmes, gender concerns are now part of my organization's policy and practice 7.11. My organization is able to achieve its aims in a better way because of the partnership	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know

STRENGTHENING OF THE SRHR SECTOR		
Please think about the functioning of the SRHR sector (including health services, schools, governments, NGOs etc.) before and during the implementation of UFBR/ASK programs. Could you indicate to what extent you agree or disagree with the following statements? 7.12. The SRHR sector in my country has been substantially strengthened through working in this alliance. 7.13. There is a strong in-country network of partners that will continue to collaborate and learn from each other, even if the programme comes to an end	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know

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8.1. On which topics of SRHR was your organization's capacity most strengthened? Please rank the three most strengthened capacities.

- PME and research
- Lobbying and advocacy
- Meaningful participation of target groups
- Meaningful youth participation
- Gender equality
- Health promotion and behaviour change
- Sexual diversity
- Sexual and gender-based violence
- Stigma and discrimination
- Health service delivery
- Comprehensive sexuality education (CSE)
- Enabling environment
- Other: ...

8.2. On which topics of SRHR was your organization's capacity least strengthened? Please rank the three least strengthened capacities.

- PME and research
- Lobbying and advocacy
- Meaningful participation of target groups
- Meaningful youth participation
- Gender equality
- Health promotion and behaviour change
- Sexual diversity
- Sexual and gender-based violence
- Stigma and discrimination
- Health service delivery
- Comprehensive sexuality education (CSE)
- Enabling environment
- Other: ...

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9. The following set of items will ask for your perspective on the sustainability of the programmes. Can you indicate, on a scale from 0 to 10, how much you agree with the statement, with 0 meaning completely disagree and 10 meaning completely agree.

SUSTAINABILITY	**UFBR**	**ASK**
9.1. My organization will certainly continue to implement activities in this field, even if financial support from Dutch partners comes to an end 9.2. My organization will continue implementing projects, as we already have funding from other sources (e.g. another donor) 9.3. My organization will only continue within a new multi-annual funded programme	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know
9.4. The local government or communities are (financially) supporting certain activities	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know
9.5. My organization has taken steps (hiring staff, blocking budgets, looking for new partners) to be able to continue working on the activities even if the programmes come to an end.	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know
9.6. My organization will continue to share knowledge and experiences with other SRHR organizations in my country even if the programmes come to an end	0-1-2-3-4-5-6-7-8-9-10-I don't know	0-1-2-3-4-5-6-7-8-9-10-I don't know

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10. Anything you would like to share with the evaluation team?

ANNEX 3B: ONLINE SURVEY II - UFBR AND ASK

Dear,

First of all, we would like to thank you for your participation in the online survey. The information you have provided will be very helpful in the evaluation of the UFBR and ASK programmes and in future programming.

As we announced at the start of the online survey, a part of the survey uses a Delphi method. This means that answers to the open questions from the first round will be used to develop a second round of questions. The advantage of this method is that you can reflect on answers from other respondents that you may not have thought of yourself.

This second round of questions is very short, contains only 20 questions and will only take you about 10 minutes to complete. We would highly appreciate your collaboration in this second online survey.

To start the survey, please click on this link:

1. For which programme do you work?

- UFBR programme
- ASK programme
- UFBR and ASK programmes

Because of the anonymity of the previous survey, we will need to ask three questions on your affiliation with the programme again.

2.1. In which country do you work?

- The Netherlands
- United Kingdom
- A country where the programme is implemented

2.2. In which country programmes are you involved? *[more than one option is possible]*

- Bangladesh
- Ethiopia
- Ghana
- India
- Indonesia
- Kenya
- Malawi
- Pakistan
- Senegal
- Tanzania
- Uganda
- Other: …

2.3. Which Dutch/UK counterpart organization are you working for or are you affiliated with? (This information and any personal identifiers will be anonymized and kept confidential) *[more than one option is possible]*

- Amref Flying Doctors
- Child Helpline International (CHI)
- Choice for Youth and Sexuality
- dance4life
- International Planned Parenthood Federation (IPPF)
- Rutgers
- Simavi
- STOP AIDS NOW!
- Other/I am a National Programme Coordinator

3. In the previous survey we asked you to note down <u>the strengths of the general set-up</u> of the UFBR/ASK programme. We have analysed and regrouped the answers of all respondents and now aim to get a better insight into the consensus among these answers. We would like to know, for each of the groups, which are <u>the two greatest strengths</u> of the UFBR/ASK programme: what makes up the essence of UFBR/ASK?

3.1. General set-up: When looking at the overall ***principles*** of UBFR/ASK, what are according to you the two greatest strengths?

- Sex-positive approach
- Rights-based approach
- Evidence-based approach
- Attention to diversity
- Working on sensitive topics (LGBT, SGBV, abortion)
- Focus on hard-to-reach target groups
- Adapted to local context
- Local ownership
- *ASK: Participation of young people*
- I don't see a strength in the overall principles

3.2. General set-up: When looking at the overall ***partnership*** of UBFR/ASK, what are according to you the two greatest strengths?

- Variety of partners
- Complementarity between partners
- Mutual learning between partners
- Establishment of country alliances
- Technical assistance from Northern partners
- Joint decision-making of the partners
- Working with civil society
- *ASK: Building on UFBR*
- I don't see a strength in the partnership

3.3. General set-up: When looking at the overall ***strategies*** of UBFR/ASK, what are according to you the two greatest strengths?

- The use of a Theory of Change/the multi-component approach
- The multi-component approach
- Increasing access to sexual and reproductive health information
- Increasing access to services
- Focusing on advocacy/awareness-raising
- The creation of an enabling environment
- UFBR: Civil society strengthening
- The use of operational research
- The support to improve youth-friendliness of services
- The use of social media
- I don't see a strength in the strategies

4. **In the previous survey we asked you to note down <u>the weaknesses of the general set-up</u> of the UFBR/ASK programme. We have analysed and regrouped the answers of all respondents and now aim to get a better insight into the consensus among these answers. We would like to know, for each of the groups, which are the <u>two greatest weaknesses</u> of the UFBR/ASK programme? What should be avoided in future programmes?** ***Note: as there was a great variety of answers on this question, there are more answer categories for this question than in the question on strengths, where there was much more coherence in answers.***

4.1. General set-up: When looking at the ***overall principles*** of UBFR/ASK, what are according to you the two greatest weaknesses?

- The Theory of Change and the logframe are weak (not context-specific; too much created in the North)
- The values of the different partners were not sufficiently made explicit (lack of value clarification)
- Not enough focus on gender
- Not enough involvement of high-level government representatives
- Not enough involvement of local authorities
- Not enough male involvement
- Not enough focus on youth leadership
- Lack of mainstreaming of sensitive issues (such as SGBV and LGBT)
- Not enough meaningful youth participation
- The focus was too much on quantity and not on quality
- There were no strong strategies to reach target groups
- I don’t see a weakness in the overall principles

4.2. General set-up: When looking at the ***organization and planning*** of UBFR/ASK, what are according to you the two greatest weaknesses?

- Lack of strategic planning
- Lack of sustainability strategies
- Weak accountability structure
- The programme included too many countries; it is better to focus
- The programme was too short
- There was a lack of a centralized monitoring and evaluation system within the international alliance
- There was no economic empowerment of partners
- The funding was too limited
- *ASK: The funding was too much in relation to the programme period*
- *ASK: Lack of scale-up strategy*
- I don’t see a weakness in the organization and planning

4.3. General set-up: When looking at the ***partnership*** of UBFR/ASK, what are according to you the two greatest weaknesses?

- There was no strategic partner selection: partners were selected based on existing relationships, not on best fit and complementarities
- There was no clear roadmap for creating a strong partnership
- Partners don't know each other well enough
- The partnership in the North is unbalanced
- There was no room for new partners to join

- There was a lack of regular meetings
- Too large geographical spread of implementation regions, limiting opportunities for collaboration and complementarity
- *ASK: There were too many partners with small roles*
- *ASK: There was a lack of collaboration resulting in fragmented work*
- *ASK: The programme did not always build well on UFBR (no learning from UFBR, thus no change in general set-up)*
- I don't see a weakness in the partnership

4.4. General set-up: When looking at the ***alliance management*** of UBFR/ASK, what are according to you the two greatest weaknesses?

- The use of a top-down approach (uneven decision-making power)
- Poor governance structure of the alliance (bureaucracy; lack of flexibility; delays in decision-making)
- The roles and responsibilities were unclear
- The link between the country alliances and the Northern alliance was weak
- There were politics dominating the relations between the Northern partners
- There was too much emphasis on measuring results instead of implementation
- The country alliances were not sufficiently independent
- I don't see a weakness in the alliance management

4.5. General set-up: When looking at the ***capacity of partners*** in the UBFR/ASK programme, what are according to you the two greatest weaknesses?

- The available technical expertise was not sufficiently used
- The capacity of partners was not built enough
- There was a lack of dissemination of lessons learned to stakeholders outside the alliance
- The capacity of the National Programme Coordinators was limited
- There was not enough sharing and exchange within the country
- There was not enough sharing and exchange within the international alliance
- I don't see a weakness in the capacity of partners

5. In the previous survey we asked you to note down <u>the main barriers to the effective implementation</u> of the UFBR/ASK programme. We have analysed and regrouped the answers of all respondents. We would like to know, for each of the groups, which are the <u>two main barriers</u> for the implementation of the UFBR/ASK programme.

5.1. Implementation barriers: When looking at the ***environment*** in which UBFR/ASK was implemented, what are according to you the two main barriers?

- Cultural-religious barriers (e.g. gender inequality)
- Unfavorable national policies (e.g. condoms not allowed in schools or in health services)
- Infrastructural problems (e.g. roads, electricity)
- Resistance by important stakeholders (e.g. parents, service providers)
- Poor functioning of health and education systems
- I don't see a barrier in the environment

5.2. Implementation barriers: When looking at the ***organization*** of the UBFR/ASK programme, what are according to you the two main barriers?

- High staff turnover

- High bureaucracy
- Donor-target-driven approach
- Budget limitations
- Too much funding for secretariat in the North
- In-country variety in implementation areas was too large
- Too much emphasis on results
- No clear definition of results areas
- *ASK: Combination with UFBR*
- I don't see a barrier in the organization

5.3. Implementation barriers: When looking at the ***partnership*** within the UBFR/ASK programme, what are according to you the two main barriers?

- Some partners/implementers were too conservative (values of implementers)
- Lack of agreement among partners on some sensitive issues
- Not knowing the other partners well
- Poor collaboration between Northern partners
- Little in-country ownership, because Northern partners took the lead
- Organizational versus alliance interest
- Youth-led organizations are not always seen as equal partners
- *ASK: Too many small partners*
- *ASK: Too many partners in the Netherlands*
- I don't see a barrier in the partnership

5.4. Implementation barriers: When looking at the ***capacity of partners*** in the UFBR/ASK programme, what are according to you the two main barriers?

- Lack of didactic skills of implementers
- Little capacity in operational research
- Lack of monitoring and evaluation capacity
- Lack of clear understanding of meaningful youth participation
- Lack of capacity in innovative strategies
- Limited capacity of youth-led organizations
- Lack of understanding of the programme among partners
- I don't see a barrier in the capacity of partners

6. In the previous survey we asked you to note down <u>the main facilitators to the effective implementation</u> of the UFBR/ASK programmee. We have analysed and regrouped the answers of all respondents. We would like to know, for each of the groups, which are the <u>two main facilitators</u> of the UFBR/ASK programme.

6.1. Implementation facilitating factors: When looking at the ***environment*** in which UBFR/ASK was implemented, what are according to you the two main facilitating factors?

- The community support and engagement
- The cooperation from government facilities
- The support from the Ministry of Health
- The existing infrastructure
- The existing community-based structures
- I don't see any facilitating factors in the environment

6.2. Implementation facilitating factors: When looking at the ***capacity of the partnership*** through which UBFR/ASK was implemented, what are according to you the two main facilitating factors?

- The sexual and reproductive health expertise of the donor
- The sharing between and learning from partners (team work)
- The capacity-building workshops
- Important role of individual agents of change/inspirational staff members
- The good alliance offices in the North and South
- The equality between partners
- The partners were given freedom to focus on their interest
- The partners were committed
- I don't see any facilitating factors in the capacity of the partnership

6.3. Implementation facilitating factors: When looking at the ***general organization*** of the UBFR/ASK programme, what are according to you the two main facilitating factors?

- The proper planning of the entire programme
- The good governance structure of the alliance
- The existence of the joint activities budget
- The National Programme Coordinator week
- The mid-term review
- The Memorandum of Understanding at the start of the programme
- The available funds for piloting and experimenting
- The integrated approach
- The learning agenda
- The close collaboration with on-the-ground staff
- I don't see any facilitating factors in the general organization

7. In the previous survey we asked you to note down <u>the main results</u> of the UFBR/ASK programme. We have analysed and regrouped the answers of all respondents. We would like to know, for each of the groups, which are the <u>two main results related to the partnership/alliance</u> of the UFBR/ASK programme.

- Almost every country alliance has become a national player
- There are strong advocacy movements in the countries
- The creation of strong working relationships with the local governments
- A clear insight that countries need more ownership in programme planning, design and evaluation.
- The Theory of Change is embraced at all levels (partners and stakeholders)
- Sensitive issues such as sexual diversity are put on the agenda of the organizations
- Partners are better trained on sexual and reproductive health and rights
- Staff members and relevant stakeholders are sensitized to create a more open and progressive attitude
- Programmatic learning through participatory operational research
- The partners are more open to work with young people (and not only for young people)
- I don't see any main results on the level of the partnership and alliance

8. Do you have any further comments?

ANNEX 4: SEMI-STRUCTURED INTERVIEWS NORTHERN PARTNERS

United for Body Rights (UFBR) and Access, Services and Knowledge (ASK)

Set-up of the document

This document consists of three main parts. It first outlines the objectives of the interviews and the target respondents and provides instructions. The second part provides introductory information that should be shared with the respondent. The third part is the interview guide. The guidelines are general for both programmes, but during the interviews it will be checked regularly if there are differences for UFBR and ASK. The interview guide consists of six main topics:

- Involvement in the UFBR/ASK programmes
- Partnerships/alliance collaboration in the North (effectiveness and efficiency)
- Partnerships/alliance collaboration with and in the South (effectiveness and efficiency)
- Capacity-building (relevance)
- Assessment of programmes
- Sustainability

Objective

The semi-structured interviews with the Northern alliance members will provide information to answer research question 4: To what extent has the partnership been relevant, effective and efficient for the individual members and the programme?

Participants

We will interview representatives of the seven alliance partners of both programmes at management/director level. Members of the programme team are managers within their organizations, and members of the steering committee are directors of organizations, with the exception of IPPF, where the member of the steering committee is Doortje Braeken, Senior Advisor at IPPF. We aim at seven in-depth face-to-face and (telephone) interviews. If one of them is available, that is fine, but the evaluators are also open to making this a duo-interview.

Northern alliance partners	Country Lead in
Amref	Ethiopia, Tanzania
D4L	Indonesia
IPPF (UK)	Senegal
Rutgers	Malawi, Uganda (Bangladesh in past)
Simavi	Ghana, Kenya, India, Bangladesh
Choice	-
Stop Aids Now	-

SEMI-STRUCTURED INTERVIEW GUIDES

United for Body Rights (UFBR) and Access, Services and Knowledge (ASK)

INTRODUCTION
Explanation of the goal of the interview, focus on the partnership
Anonymity of the information

1. Knowledge of and involvement in the UFBR/ASK project

Interview questions and prompts	
1.1.	Is your organization involved in the UFBR programme, the ASK programme or both? Ask for confirmation in which countries they are you active in
1.2.	When did your organization get involved with the ASK/UFBR project? Prompt to find out specific programme areas/interventions they are involved in and duration Prompt which focus this Dutch organization has (CSE, services, enabling environment, other) in ASK/UFBR and in their organization as such
1.3.	What is your role within the programme? When did you personally get involved with the ASK/ UFBR project? Is involvement in UFBR/ASK the only role/responsibility, or does the respondent have other roles/responsibilities?
1.4.	What are, according to you, the main objectives of the ASK/UFBR programme?
1.5.	[In case you are involved in both UFBR and ASK] We're evaluating two programmes, UFBR and ASK. Do you experience this as two specific programmes? What, in your view, are important differences?

2. Partnerships/alliance collaboration in the North

Interview questions and prompts	
2.1	UFBR/ASK includes many different organizations and actors in the programmes and is implemented in several countries. What are, according to your experience, the strengths of this comprehensive approach? Prompt for the added value of working in such partnership/alliance (fruitful connections, ease of implementation, capacity-building, increased knowledge of context, stronger advocacy and lobbying, does the alliance help to achieve the organization's goals etc.)
2.2	What are, according to your experience, the weaknesses of this comprehensive approach? Do you experience any disadvantages in working in a partnership? (less efficiency, additional time in consultation) And at what level? (in countries, at management level, at exchange level etc.)
2.3	How do you assess the cost–benefit ratio of working in the alliance? Do you feel the costs of working in an alliance (refer to weaknesses the respondent mentioned) outweigh the benefits (refer to the strengths)? Why did your organization decide to join this alliance? What benefits did you expect from it? What does your organization bring, and what do you get out of it? Please note that IPPF and Stop AIDS Now! are only involved in ASK and might only have a general first

Interview questions and prompts	
	impression of UFBR. It could be interesting though to ask specifically whether they knew UFBR, why they were interested in becoming a member of a similar alliance (which turned into the YEA) and how they experienced that process (possibly already in your questions below). Same for how UFBR members experienced it when Stop AIDS Now! and IPPF joined in.
2.4	Do you feel there is a good balance between the partners here in the Netherlands? Probe for commitment of own organization versus commitment of other alliance partners (investment in time and resources, involvement of managers etc.) and for an equal say in decision-making
2.5	How do you describe the relationship between the alliance partners? Probe for trust and conflict strategies
2.6	What is, in your opinion, the role of the alliance office within both alliances? What is your assessment about how the alliance office functions within both alliances?
2.7	Is there a difference between the SRHR Alliance and the YEA? In what way? Probe for: decision-making process, cooperation between partners, different expertise of partners etc.
2.8	Only for UFBR partners: a mid-term partnership review was carried out two years ago. Are you familiar with the findings? If so, do you feel the outcomes have led to changes within the partnership? For example, did it influence how the partners collaborate? Probe for examples and for the themes that were addressed
2.9	In general, how do you feel both alliances have developed through the years? What are important milestones for the SRHR Alliance? And what are important milestones for UFBR? (Focus on the period after 2013, as the mid-term review already provides an overview of milestones for UFBR)
2.10	Do you feel that cooperation with other actors (outside the alliance) in the Netherlands would help achieve the goals of the programmes? With which kind of actors would you like to cooperate?
2.11	Which lessons from the collaboration do you take with you from the last three to five years? Do you think these lessons will be incorporated into the new programme? (or in the case of Amref: will be incorporated into your activities in the future)

3. Partnerships/alliance collaboration with and in the South

Interview questions and prompts	
3.1	How would you describe the relationship between the Northern and Southern partners? How do you see the involvement of Southern partners in the international alliance? It could be useful to also probe for the one-on-one-relationship they have with their partners, and the role they see for their partners in the international and local alliance. Probe for balance, trust, equality, power relations etc.
3.2	Do you think the governance structure for the international alliance — both North and South — is effective?

Interview questions and prompts	
3.3	How do you assess the alliances in the Southern countries you are involved in? Do you feel it has added value that partners in the South are also (forced to) collaborating together in the South? Are the programmes more effective because of collaboration from Southern partners? Probe for difference between countries Probe whether the Southern alliance consists of the most relevant partners in that country, or whether important players are missing
3.4	Since the Southern partners are collaborating in the programme, does this influence their efficiency? Do you feel they are more or maybe less efficient then before?
3.5	Do you feel between-country and in-country learning has been achieved in the alliance? Probe for added value of an international alliance from the perspective of the Southern partner

4. Capacity-building

Interview questions and prompts	
4.1.	Has collaborating in the alliances and participating in these programmes had any effects on you personally? Probe for new knowledge, skills, attitudes, level of responsibilities and tasks What have been the most important lessons, changes of skills or attitudes that you have obtained? Can you give examples of these lessons? Could you also implement these lessons in your own work? In case the programme has had an effect: did you share what you learned and obtained with other people within your organization?
4.2.	Has collaborating in the alliances and participating in these programmes had any effect on your organization? Probe for sustainable changes within the organization. Try to be as specific as possible (was the organizational strategy changed, are new guidelines being developed?)

5. Sustainability

Interview questions and prompts	
Why does your organization want to continue with this programme (or in the case of Amref: Why doesn't it?)	
5.1.	Do you feel that there are mechanisms in place in the countries you are involved in to continue with activities, even when funding is stopped or reduced?
5.2.	Some programmes might come to an end or the funding might be reduced: Does your organization have plans to continue to work on the interventions, even without the current financial support from the Ministry of Foreign Affairs? What would be the conditions to do so?

6. Assessment of programmes (only if there is time left)

Interview questions and prompts
6.1. Please describe the most important impacts and results of the interventions in the countries you are involved in for both UFBR and ASK programmes. Probe for changes in knowledge, attitudes, behaviours and health outcomes Probe for specific impact/outcome domains. Could you think of specific results in: o SRHR education? o the delivery of services? o the creation of an enabling environment? Probe for changes in gender roles (position of girls in the household, access to schools for girls etc.) Probe for results for specific target groups, such as youth in general or marginalized groups What were the most important results for the interviewee (look at services, policies etc.) From the results that you mention, which ones were easy to achieve, which ones difficult? Probe for unexpected results Probe for results that were expected to be achieved that were not achieved Probe for negative results
6.2 What makes you most proud, looking at both programmes?
6.3. Which lessons, when it comes to improving SRHR in Southern countries, do you take with you from your experience of ASK/UFBR?

ANNEX 5A: FOCUS GROUP DISCUSSION GUIDES FOR BENEFICIARIES

United for Body Rights (UFBR) and Access, Services and Knowledge (ASK)

Set-up of the document

This document consists of three main parts. It first outlines the objectives of the interviews and the target respondents and provides instructions. The second part provides introductory information that should be shared with the participants in the focus group discussion. The third part is the focus group discussion guide. The guide consists of six main topics:

- Knowledge of and involvement in the UFBR/ASK programmes
- Programme implementation: strategies and methods used for implementation
- Impact and outcomes of the programmes
- Stakeholder involvement and partnerships
- Capacity-building
- Sustainability

Objective

The focus group discussions will provide information to answer a large number of research questions in all dimensions of the evaluation (see Table 1 of inception report field study).

Participants

We will organize focus group discussions with a variety of stakeholders (policymakers, community leaders and youth-led organizations), service providers (health care providers/educators) and beneficiaries. The groups to be involved will depend on the specific region and focus of the UFBR/ASK programmes. As it is not possible to cover all groups in each location, we aim to work with heterogeneous groups consisting of various kind of actors involved in both UFBR and ASK. Each focus group will include 6 to 10 participants.

In total we are aiming for three focus groups per country (covering both UFBR and ASK):

- beneficiaries (women, community members): one focus group (both UFBR and ASK). As the most significant change methods (see below) will focus on young people, we aim to include other beneficiaries from the programmes as much as possible. As the beneficiaries for ASK are exclusively young people, we will pay specific attention to community perceptions of activities for and changes in young people, and on the community as an enabling environment;
- services providers (health care providers — including village health workers — teachers, representatives of community-based organizations): one focus group (both UFBR and ASK); and
- local policymakers, district health authorities and community leaders: one focus group (both UFBR and ASK).

The selection of respondents will be different for each country and setting. Local partner organizations are expected to help in the selection of participants.

Instructions

Before the interview starts, it should be clear to the interviewer which topics are most important to focus on in depth. This decision needs to be made in agreement with the evaluation team.

Material

- Recorder
- Papers
- Pens
- Post-its
- Flip-charts
- Photo camera

KALEIDOS
RESEARCH

FOCUS GROUP DISCUSSION GUIDES for BENEFICIARIES
United for Body Rights (UFBR) and Access, Services and Knowledge (ASK)

INTRODUCTION
Good morning. My name is …….. (and my assistants' names are)
…….

We are very pleased you have agreed to join us today. We are researchers working with *ICRH/Kaleidos Research/local researcher's organization* working on reviewing two programmes on sexual health and rights of the SRHR Alliance in your country. One is called Unite for Body Rights (UFBR), and the second programme is called Access, Services and Knowledge (ASK). The goal of this evaluation is to determine what the results are of the programmes, but also to recommend ways to improve the programmes' performance.

We are here to discuss your knowledge and experiences of working with these programmes. You have been involved in these programmes because you implement activities as a … *[recipient, health service provider, community health worker, teacher, peer educator etc.]*.

The discussion we are going to have is a focus group discussion. For those of you who have never participated in one of these sessions, I would like to explain a little bit about this type of research.

Focus groups are used to gather information informally from a small group of individuals who either share common features/qualities or have a common interest in a particular subject. In focus group discussions there are no right or wrong answers. We want to hear from everyone in the room. We are pleased you can be part of this group because we think your knowledge about the ASK and/or UFBR programmes and interventions will help improve our understanding of the projects. Don't hesitate to speak up when you have a point you would like to make.

I will be moderating the session and moving us along so that we touch on all of the key subjects on our agenda. I would like to avoid spending too much time on issues that don't pertain to everyone in the group. If I think that we are spending too much time on one subject, I will step in to keep the discussion moving.

We will record this discussion so that I don't have to take notes. I like to follow what is being said and then go back later to review what you said again so that I can accurately convey your ideas and opinions. My assistants will transcribe our conversations, but your identity and other personal identifiers will be anonymized. My role today is to see that we have a productive discussion and to summarize the group's feelings. I will not refer to any participant by name in the reports I prepare. The information will be kept confidential and used only by our team to develop recommendations to help improve the performance of the ASK and/or UFBR programmes. Was all the information I provided you with clear? Do you have any further questions?

Name of interviewer	
Date of interview	
Duration of the interview	
Composition of group	Male: Female: Age range: Other characteristics?
Involvement in the programme (to be completed after the interview, based on responses to question 2.1)	**Which activities?** **Intensity of participation**

Throughout the interview: pay attention to gender attitudes. How do they talk about men/woman, boys/girls, masculinities/femininities? Probe for changes in this thinking when relevant.

Start with round of introduction: name

1. Knowledge of and involvement in the UFBR/ASK project (estimated time: 15 minutes)

Questions and prompts	Comments
1.1. When did you first hear about UFBR/ASK?	Find out how the respondents refer to UFBR/ASK, and use these terms throughout the FGD. Always make sure the differences between UFBR and ASK are clearly specified.
1.2. What are, according to you, the main objectives of the ASK/UFBR programme? What does it try to achieve? Prompt to understand familiarity with the programme	
1.3. We're evaluating two programmes: UFBR and ASK. Do you experience this as two specific approaches? What, in your view, are important differences?	
1.4. Are you aware of any other programmes in this domain (SRHR activities)?	

2. UFBR/ASK programme implementation: strategies and methods used for implementation (estimated time: 40 minutes)

Questions and prompts	Comments
2.1. What were the specific activities you participated in? Probe for participation in the different domains: ○ SRHR education ○ the delivery of services (e.g. training health providers, outreach health services) ○ the creation of an enabling environment Probe for the level of involvement/participation: how often/how actively did you participate? Probe for participation barriers/enablers in specific domains	Always make sure the differences between UFBR and ASK are clearly specified. Question 2.2. This question asks about changes the implementers made to the activities. This can be sensitive. Assure the participants that it was not a problem if they made changes, and that you are only trying to understand why they did so. For questions 2.3 and 2.6: check beforehand whether respondents are able to read/write. If not, don't use the post-it method but write their different answers on the flip-chart. In both cases: use an H-diagram to organize the ideas. See last pages for instructions and example.
2.2. Could you please write on a post-it/piece of paper: Which of the activities did you feel was most useful/most relevant for yourself? Which one was least useful? If you were to choose one activity that could be continued, what would it be? Why? If you were to choose one activity that should be definitely ended, what would it be? Why?	
2.3. Do you have any suggestions of other approaches that could be used?	
2.4. Do you know any activities that were organized for the young people in your communities? Was it easy/difficult to get them involved? Why? Probe for participation barriers/enablers in specific domains	
2.5. Could you please write on a post-it/piece of paper: Which of the activities did you feel was most exciting (you remembered best, made you happy etc.) for the	

young people in your community? Which activities did you feel were least exciting for the young people in your community? If you were to choose one method that could be continued, what would it be? Why? If you were to choose one method that should be definitely ended, what would it be? Why?	
2.6. Do you have any suggestions of other approaches that could be used to reach young people	
2.7. In general, do you think the messages you received in the activities you participated in were coherent? Or did they contradict each other sometimes? Probe for examples	

3. Results and outcomes (estimated time: 20 minutes)

Interview questions and prompts	Comments
3.1. Could you please write on a post-it/piece of paper the most important impacts and results of the activities in your communities/country in general, and for young people in particular. Discuss results Probe for changes in knowledge, attitudes, behaviours and health outcomes Probe for specific impact/outcome domains. Could you think of specific results in: o SRHR education? o the delivery of service? o the creation of an enabling environment? Probe for changes in gender roles (position of girls in the household, access to schools for girls etc.)	Always make sure the differences between UFBR and ASK are clearly specified. Focus on the outcomes in the particular field of the respondents: • Beneficiaries: changes in themselves and young people For question 3.1: check beforehand whether respondents are able to read/write. If not, don't use the post-it method but write their different answers on the flip-chart. In both cases: use an H-diagram to organize the ideas. See last pages for instructions and example.
3.2. Except for these positive changes, did you also observe negative results?	

4. Stakeholder involvement and partnerships

No questions for beneficiaries

5. Capacity-building (estimated time: 10 minutes)

Interview questions and prompts	Comments
5.1. Have you noted any difference in the capacity of service providers (health services — formal and informal providers, educational services)?	Always make sure the differences between UFBR and ASK are clearly specified. Indonesia (for service providers) and Ethiopia have indicated that this part is very important.

6. Sustainability

No questions for beneficiaries

Which activities were NOT useful/relevant?	Overall score of activities: 0 - 1 - 2 - 3 - 4 - 5 - 6 -7 -8 -9 -10	Which activities were useful/relevant?
	What could be done to improve the activities?	

In ‘overall score of the activities’, respondents are asked to put a cross below the value of their score.

Example:


could we have
one better?
1 2 3 4 5 6 7 8 9
What did we
What would make it
better?

ANNEX 5B: FOCUS GROUP DISCUSSION GUIDES FOR SERVICE PROVIDERS AND EXTERNAL STAKEHOLDERS

United for Body Rights (UFBR) and Access, Services and Knowledge (ASK)

Set-up of the document

This document consists of three main parts. It first outlines the objectives of the interviews and the target respondents and provides instructions. The second part provides introductory information that should be shared with the participants in the focus group discussion. The third part is the focus group discussion guide. The guide consists of six main topics:

- Knowledge of and involvement in the UFBR/ASK programmes
- Program implementation: strategies and methods used for implementation
- Impact and outcomes of the programmes
- Stakeholder involvement and partnerships
- Capacity-building
- Sustainability
- Objective

The focus group discussions will provide information to answer a large number of research questions in all dimensions of the evaluation (see Table 1 of inception report field study).

Participants

We will organize focus group discussions with a variety of stakeholders (policymakers, community leaders and youth-led organizations), service providers (health care providers/educators) and beneficiaries. The groups to be involved will depend on the specific region and focus of the UFBR/ASK programmes. As it is not possible to cover all groups in each location, we are aiming to work with heterogeneous groups consisting of various kind of actors involved in both UFBR and ASK. Each focus group will include 6 to 10 participants.

In total we are aiming for three focus groups per country covering both UFBR and ASK:

- beneficiaries (women, community members): one focus group (both UFBR and ASK). As the most significant change methods (see below) will focus on young people, we aim to include other beneficiaries from the programmes as much as possible. As the beneficiaries for ASK are exclusively young people, we will pay specific attention to community perceptions of activities for and changes in young people, and on the community as an enabling environment;
- service providers (health care providers — including village health workers — teachers, representatives of community-based organizations): one focus group (both UFBR and ASK); and
- local policymakers, district health authorities and community leaders: one focus group (both UFBR and ASK).

The selection of respondents will be different for each country and setting. Local partner organizations are expected to help in the selection of participants.

Instructions

Before the interview starts, it should be clear to the interviewer which topics are most important to focus on in depth. This decision needs to be made in agreement with the evaluation team.

Material

- Recorder
- Papers
- Pens
- Post-its
- Flip-charts
- Photo camera

KALEIDOS
RESEARCH

FOCUS GROUP DISCUSSION GUIDES for SERVICE PROVIDERS and EXTERNAL STAKEHOLDERS

United for Body Rights (UFBR) and Access, Services and Knowledge (ASK)

INTRODUCTION

Good morning. My name is …….. (and my assistants' names are)
…….

We are very pleased you have agreed to join us today. We are researchers working with *ICRH/Kaleidos Research/local researcher's organization* working on reviewing two programmes on sexual health and rights of the SRHR Alliance. One is called Unite for Body Rights (UFBR), and the second programme is called Access, Services and Knowledge (ASK). The goal of this evaluation is to determine what the results are of the programmes, but also to recommend ways to improve the programmes' performance.

We are here to discuss your knowledge and experiences of working with these programmes. You have been involved in these programmes because you implement activities as a … *[recipient, health service provider, community health worker, teacher, peer educator etc.]*.

The discussion we are going to have is a focus group discussion. For those of you who have never participated in one of these sessions, I would like to explain a little bit about this type of research.

Focus groups are used to gather information informally from a small group of individuals who either share common features/qualities or have a common interest in a particular subject. In focus group discussions there are no right or wrong answers. We want to hear from everyone in the room. We are pleased you can be part of this group because we think your knowledge about the ASK and/or UFBR programmes and interventions will help improve our understanding of the projects. Don't hesitate to speak up when you have a point you would like to make.

I will be moderating the session and moving us along so that we touch on all of the key subjects on our agenda. I would like to avoid spending too much time on issues that don't pertain to everyone in the group. If I think that we are spending too much time on one subject, I will step in to keep the discussion moving.

We will record this discussion so that I don't have to take notes. I like to follow what is being said and then go back later to review what you said again so that I can accurately convey your ideas and opinions. My assistants will transcribe our conversations, but your identity and other personal identifiers will be anonymized. My role today is to see that we have a productive discussion and to summarize the group's feelings. I will not refer to any participant by name in the reports I prepare. The information will be kept confidential and used only by our team to develop recommendations to help improve the performance of the ASK and/or UFBR programmes. Was all the information I provided you with clear? Do you have any further questions?

Name of interviewer	
Date of interview	
Duration of the interview	
Role of respondents *(teacher, external stakeholders)*	
Composition of group	Male: Female: Age range: Other characteristics?

Throughout the interview: pay attention to gender attitudes. How do they talk about men/woman, boys/girls, masculinities/femininities? Probe for changes in this thinking when relevant.

Start with round of introduction: name and organization and role in the programmes

1. Knowledge of and involvement in the UFBR/ASK project (estimated time: 10 minutes)

Questions and prompts	Comments
1.1. What are, according to you, the main objectives of the ASK/UFBR programme? Prompt to understand familiarity with the programme	Find out how the respondents refer to UFBR/ASK, and use these terms throughout the FGD. Always make sure the differences between UFBR and ASK are clearly specified.
1.2. We're evaluating two programmes: UFBR and ASK. Do you experience this as two specific approaches? What, in your view, are important differences? Probe to find out if they are aware of the difference between UFBR and ASK, if they mention UFBR/ASK and if they're involved in both programmes or just one (or they don't know)	
1.3. Are you aware of any other programmes in the field of SRHR? How are they aligned?	

2. UFBR/ASK programme implementation: strategies and methods used for implementation (estimated time: 25 minutes)

Questions and prompts	Comments
2.1 What were the specific activities you worked on within the ASK/UFBR programme? Which target groups did these activities focus on? Probe for methods/strategies to reach specific target groups, such as youth in general or marginalized groups	Always make sure the differences between UFBR and ASK are clearly specified. For health care providers, teachers and peer educators: focus on their specific activities.
2.2 In your experience, were these activities easy or difficult to implement in your communities/countries? What went well, and what was challenging? Could you describe what made it easy/good or difficult/challenging? Was it easy/difficult to reach the target groups? Why? Probe for implementation barriers/enablers in specific domains (that have not yet been mentioned before). What are, according to you, particular barriers/enablers in the field of implementing: ○ SRHR education? ○ the delivery of SRHR services?	If the respondent indicates s/he has not implemented activities (e.g. external stakeholders), these questions will need to be asked in a more generalized way (e.g. in your opinion, what would be factors that would hinder/facilitate implementation of activities). The focus should then be on ○ the last prompt of question 2.2. ○ the multi-component approach (2.8.)

Questions and prompts	Comments
○ the creation of an enabling environment?	○ Probe to verify mandate and financial resources, extent of decentralization/ dependency on higher levels of government for the policymakers and local leaders Question 2.3. This question asks about changes the implementers made to the activities. This can be sensitive. Assure the participants that it was not a problem if they made changes, and that you are only trying to understand why they did so.
2.3 During your participation in this programme, you received training and were asked to implement several activities. Did you implement all activities that were asked? What changes did you make to which activities? Why? Which parts do they find hard to implement? Why? Probe for changes on the level of the content (e.g. discussions on sexual intercourse were left out of the sexuality education curriculum) and on the level of the method (e.g. participatory methods are more difficult to implement)	
2.4 Which of the activities or strategies (changes in the organization of your work) did you feel was most useful in the community or among the target groups? Note: a strategy can also mean changes in the organization of your activities — for example, making health centres accessible by making sure they are open after school hours; involving school nurses etc. If you were to choose one method/strategy that could be continued, what would it be? Why?	
2.5 Which activities did you feel were least useful? If you were to choose one method that should be definitely ended, what would it be? Why?	
2.6 Do you have any suggestions of other approaches that could be used?	
2.7 UFBR/ASK opts for a 'multi-component approach' — that is, focusing on knowledge, services and the enabling environment. What are, according to you, the strengths and weaknesses of this approach? Probe: according to you, were the messages and services spread in the programmes always coherent? Or did they contradict each other sometimes?	

3. Results and outcomes (estimated time: 25 minutes)

Interview questions and prompts	Comments
3.1 Could you please write on a post-it/piece of paper the most important impacts and results of the activities in your communities/country in general, and for young people in particular. Discuss results and ask for relevance	Always make sure the differences between UFBR and ASK are clearly specified. Focus on the outcomes in the particular field of the respondents:

Interview questions and prompts	Comments
Probe for changes in knowledge, attitudes, behaviours and health outcomes Probe for specific impact/outcome domains. Could you think of specific results in: o SRHR education? o the delivery of service? o the creation of an enabling environment? From the results that you mention, which ones were easy to achieve, and which ones difficult? Probe for changes in gender roles (position of girls in the household, access to schools for girls etc.)	• Service providers: education and health services • External stakeholders: policies For question 3.1: check beforehand whether respondents are able to read/write. If not, don't use the post-it method but write their different answers on the flip-chart. In both cases: use an H-diagram to organize the ideas. See last pages for instructions and example.
3.2 Efficiency: do you think the results achieved were proportionate to the efforts (staff, money) invested? How could resources have been better spent?	
3.3 Were there any results that you did not expect? What were these unexpected results?	
3.4 Were there results you expected to achieve that were not achieved? Can you think of any particular reason why these results were not achieved?	
3.5 Except for these positive changes, did you also observe negative results?	
3.6 Are there circumstances, people, policies or other factors that assisted or made it easier to achieve some of the results/impacts we discussed above?	
3.7 Are there circumstances, people, policies or other factors that made it difficult to achieve some of the results/impacts we discussed above?	
3.8 How do you assess the extent to which young people play an active role in shaping the programmes? Can you give some examples in your own work of how youngs people are involved in the activities? To what extent do you think it important for the programmes to succeed that they are involved?	

4. Stakeholder involvement and partnerships (estimated time: 25 minutes)

Interview questions and prompts	Comments
4.1 UFBR/ASK includes many different organizations and actors in its programme. What are, according to your experience, the strengths and weaknesses of this approach?	Always make sure the differences between UFBR and ASK are clearly specified.

Interview questions and prompts	Comments
What is the added value of working in such partnership/alliance Probe for added value/negative value of partnership/alliance (fruitful connections, ease of implementation, capacity-building, increased knowledge of context etc.)	
4.2 With which stakeholders do you interact? How? **(Let the respondents draw a map)** What are the results of these interactions? Probe for enablers (those that want change), blockers (those that don't want change), floaters (those that want change, but under certain conditions). Do you feel that cooperation with other actors would help achieve the goals of the programmes? With which kind of actors would you like to cooperate? Probe for involvement of youth (meaningful)	

5 Capacity-building (estimated time: 20 minutes)

Interview questions and prompts	Comments
5.1 Has participating in these programmes had any effects on your professional work? Probe for new knowledge, skills, attitudes, level of responsibilities and tasks What have been the most important lessons, changes of skills or attitudes that you have obtained? In case the programme has had an effect: did you share what you learned and obtained with other people within your organization?	Always make sure the differences between UFBR and ASK are clearly specified. Indonesia (for service providers) and Ethiopia have indicated that this part is very important.
5.2 Do you experience any tension between your professional actions and your personal opinions/attitudes? (e.g. the respondent can understand the health risks of unprotected sexual intercourse and sensitize young people to use a condom but personally think that young people need to abstain until marriage) How do you deal with these tensions?	
5.3 Have these programmes had any effect on your organization?	

Interview questions and prompts	Comments
Probe for sustainable changes within the organization Try to be as specific as possible (was the organizational strategy changed, are new guidelines being developed?)	
5.4 Are there specific capacity-building needs that you think the programme should have addressed?	

6 Sustainability (estimated time: 10 minutes)

Interview questions and prompts	Comments
6.1. Would you like to continue to work with the ASK/UFBR programmes? In case you do: are there specific parts of the programmes you would like to continue? What are main reasons to continue (part of the) programmes? Prompt for perceived benefits and challenges of continuing to work on the programmes	Always make sure the differences between UFBR and ASK are clearly specified. Probe to see whether sustainability mechanisms have been put in place (refer to appendix or guide on sustainability factors)
6.2. Do you or your organization have plans to continue to work on the interventions, even without these programmes? What would be the conditions to do so?	
6.3. Did you undertake any actions, or did changes occur in your organization (staff hiring, strategic plan formation, grant applications or funding etc.) to allow for these programmes to continue?	

Which activities were NOT useful/relevant?	Overall score of activities: 0 - 1 - 2 - 3 - 4 - 5 - 6 -7 -8 -9 - 10	Which activities were useful/relevant?
	What could be done to improve the activities?	

In ‘overall score of the activities’, respondents are asked to put a cross below the value of their score.

Example:


could we have
one better?
1 2 3 4 5 6 7 8 9
What did we
What would make it
better?

ANNEX 6: SITE VISITS CHECK LIST

Note: Try to be guided around the site by a project partner and a young person.
Note: Try not to attend activities that are specifically prepared for your visit, but rather see the reality.
Note: Bring a photo camera to take pictures of activities.

Topic	Assessment			Comments
	Yes	Partly	No	
VISIBILITY				
Is it clear from/at the sites that UFBR/ASK is implementing the activity *[beforehand: check with the local partner what the programmes are called]*				
Are activities advertised *[are they announced, how, sufficiently visible?]*				
Is the material present?				
Is material relevant?				
Is material culturally appropriate?				
In what way are activities at this site supported by the ASK/UFBR programme (staff trained, materials provided etc.)?				

Topic	Assessment			Comments
	Yes	Partly	No	
PARTICIPATION TARGET GROUP				
Are young people present at the site?				
Are young people meaningfully involved?				
Is the activity youth-friendly (language, visuals, content)?				
Are other target groups (specify) present at the site?				
Are they meaningfully involved?				
Is the activity adapted to the needs of the target group (language, visuals, content)?				
Is the activity gender-equitable? Are gender stereotypes used? Is sufficient attention paid to the specific needs of girls and boys?				

Topic	Assessment			Comments
	Yes	Partly	No	
CONTEXT				
Are there signs of links to other activities (e.g. poster in school that informs about where to get health services)?				
Are there any factors present hindering implementation of the activity (e.g. the health centre is in the centre of the village, making it difficult for young people to attend anonymously)? Are there mitigation strategies present?				
Are there any factors present facilitating implementation of the activity (external factors, or factors developed by the programme)?				
OTHER RELEVANT OBSERVATIONS				

ANNEX 7: EXAMPLE OF A GENDER-RESPONSIVE FRAMEWORK

Gender-responsive framework

Gender analysis category	Gender-unequal	Gender-blind/neutral	Gender-sensitive	Gender-specific	Gender-transformative
Components	Does current context, project or policy reinforce unequal access to opportunities and resources?	Ignores differences in gender roles and access to resources	Acknowledges these differences, creates pathways to address them without changing the status quo	Targeted at a specific gender that is identified as being marginalized without addressing underlying causes	Engages with norms and underlying cause of inequalities, identity, power, hegemonic masculinities and gender roles

Increasing gender-responsiveness