Sida Evaluation 06/55:1

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

Volume 2: Country Reports from Bangladesh, Uganda and Ethiopia

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Department for Democracy and Social Development

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Bangladesh

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The opinions expressed in the report are our own, and while we hope that there is no doubt concerning the empirical basis of the report, the conclusions that are drawn reflect our assessment. We hope our discussion will be useful in the future development of the organisation as we know it is presently undergoing significant changes.

Stockholm, Oslo, London and Dhaka
November 2006

Guide to the Reader

This evaluation of the International Planned Parenthood Federation, IPPF, commissioned by Sida and Norad 2006, consists of two volumes.

Volume I presents the synthesis report. This Volume II entails the three country studies from Bangladesh, Uganda and Ethiopia. The country studies can be read separately and the authors are presented in each country study.

In the end of this volume, the Terms of References and the data collection instruments are attached.

Contents:

Executive Summary

Background

This study is part of an evaluation to assess the effectiveness and relevance of the International Planned Parenthood Federation (IPPF), and in particular to study to what extent poor people are reached by the organisation's activities. The evaluation has been commissioned by Norad and Sida and has been undertaken by an external team of evaluators working in cooperation with the funding agencies and IPPF itself. This study of the IPPF Member Association in Bangladesh is one of three country studies, the other two are focused on IPPF's Member Associations in Uganda and Ethiopia.

Evaluation Methods

The evaluation started with an Inception Report which was completed in June 2006, which outlines the methodological choices and the instruments for data collection that are to be used in the three countries. The evaluation of the Family Planning Association of Bangladesh (FPAB) took place between August 19th and September the 1st. The evaluation team visited the FPAB, met with government ministries and other stakeholders that are working in the field of reproductive health in Dhaka, and then visited three areas; Chittagong, Sylhet and Barisal.

In these three locations the evaluation met clinical and non-clinical staff, conducted exit interviews with people who had come to clinics, and met a number of other user groups. The evaluation has a quasi-experimental approach in that non-users were also identified and interviewed.

Reaching Poor People

The evaluation concluded that the FPAB reaches poor people to a very large extent. A large majority of people who come to its clinics are poor; not only do they have low incomes but they are often disempowered and far from realising basic sexual and reproductive health rights. An even larger majority of those who are reached by the field workers are poor. The evaluation data show that field workers are more effective in reaching poor people than are the clinical services. Certain specific project activities are even more effective at reaching poor people, as they strategically focus on working with particularly marginalised groups, such as women who have been subjected to gender based violence.

In total FPAB reaches some 1.8 million people each year and classifies 75% of service users as poor, according to its own estimates. The evaluation's sample of respondents from different categories of users indicates that an even higher percentage might be considered poor, though it is difficult to say exactly how many – but probably in the range of 80–85%.

Reaching the Most Vulnerable

FPAB charges service fees for clinical services. At registration, people leave information about their income status, and the organisation is committed to providing free treatment to 10% of service users. This 10% is supposed to be the poorest of the poor. Approximately 80% of all users are poor people, and within this group some 10% are the poorest and most vulnerable. The people with lowest incomes, or who are most deprived/powerless make up more than 10% of the population in Bangladesh, and there are reasons to believe that FPAB does not reach them as effectively as it reaches poor people generally.

There are three reasons why FPAB does not reach the most vulnerable groups; (1) there are no clear strategies that effectively identify and target these groups, (2) there is a middle management layer that does not recognise and understand the needs of these particular groups; and (3) the overall location of clinics and other services puts some limit on the extent to which the most marginalised are able to access services.

Effectiveness

FPAB is a large organisation with 20 branches and 12 special working units; there are projects and there is a more permanent structure of clinics, satellite clinics and domiciliary services. Effectiveness is a question of whether the organisation reaches its goals, whether it attains its major relevant objectives. The FPAB is complex, and while some objectives are reached, some make progress in that direction, but yet others can hardly be reached during the present strategic planning framework (2005–2009). There is no doubt that effectiveness could be improved, but by and large the evaluation concludes that the FPAB is reasonably effective in respect of the ambitions and goals expressed in its mission and in its strategic framework. It reaches a large number of people and for many; the assistance they receive plays a role in their lives and has an impact on their well-being.

Relevance

In the 1960's the government of Bangladesh developed policies that were focused on family planning as a result of the advocacy efforts of FPAB and other NGOs (non-governmental organisations) working the field of sexual and reproductive health, SRH. FPAB's work has been relevant and has contributed to major national policy changes, but today the advocacy work is restricted to district levels with the exception of a few sporadic initiatives at national level.

However, the relevance must also be assessed in relation to the expressed needs of communities. The clinical and non-clinical services are based in areas that are allocated by the government, and in these areas there are few other SRH and wider health services – and in many there are none at all. Hence FPAB staff come to represent the first contact point with modern health services for many people, and the FPAB staff thus handle general primary health care issues. These general medical needs need to be met by FPAB and if the doctors and paramedics of FPAB did not deal with these needs, they would loose credibility in the communities.

The Organisation of FPAB

Many of the staff working at FPAB appear well motivated and dedicated, and this is particularly apparent among the field workers, paramedics and doctors. There are several problems related to structure and processes in the organisation; (1) the governance system with volunteer boards may lead to duplicating efforts and low accountability from management, (2) the system of strategic planning lacks coherence and focus on overriding targets and is much too project focused, and (3) there is a need to change the demographic structure of middle management – to include more women and younger people in these positions.

Organisational Change

The FPAB is going through a process of substantial change at present. There is a new management that is intent on developing the competencies and capacities and to change the structures and processes of the organisation. The change process started a year ago and is far from complete. It takes time to change an organisation that is as old and has so many entrenched values and attitudes, but change is necessary, and one of the reasons the FPAB has not made more progress around a broader SRHR

agenda is the result of its huge middle management cadre. Many in that category do not appear to understand the evolving needs of their clients, and particularly not the threats and challenges set by the HIV/AIDS pandemic, or the conditions of often migrant, transient and floating marginalised groups. Fortunately, at the field level, where the direct interface between the FPAB and its clients occur, many of the doctors, paramedics, counsellors and volunteer field workers appear dedicated and committed. The majority of them are women, and they have served the organisation for a long time. The community-outreach workers provide continuity and local knowledge about a range of health issues, and they are appreciated by the communities, particularly by poor people.

Conclusions and Recommendations

While the services provided to people should be considered relevant, there are still many areas that need to be addressed to ensure and improve the effectiveness of FPAB. The overall governance and strategic decision-making, the branch management, and the supervision need to be further developed. The efficiency of the organisation, as well as its effectiveness, has been hampered by structural as well as process problems. In the course of the evaluation, seven areas in particular were singled out for further attention:

1. FPAB should collect better quality data about people who access services, in particular data that relates to the poverty status of the clients. When collecting this data FPAB should focus on a broad definition of poverty, as utilised within this evaluation and should not simply focus on the income/assets of a service user. Such data would help the organisation focus on poor and marginalised people and enable FPAB to develop better strategies on how to reach them.
2. At present the FPAB has difficulties assessing its own effectiveness as the necessary systems of monitoring and evaluation are not in place. This evaluation has been able to make conclusions about effectiveness, but these conclusions are general and organisation wide assessments. The FPAB should collect more detailed information about the effectiveness of its own activities in order to set priorities and also in order to be held accountable on effectiveness by members as well as by external stakeholders.
3. In respect of governance, the roles and responsibilities of the volunteer boards need to be clarified and changed. The boards should be made smaller and their work more focused. They should provide strategic direction and advice to the organisation, but not be involved in implementation and decisions on programme and project level.
4. The Chief Executive Officer should be accountable to the National Council and through it to members, as the Constitution of FBAB states. But the practical delimitations of the board member's decision-making and the nature of their relation to management need to be developed. The Constitution is not sufficiently clear on how this should be worked out in practice.
5. The organisation must have a consistent and clear mission statement. There should not be a variety of such statements. The mission statement should be relevant and realistic to reflect what the organisation wants to do and can do.
6. Strategic planning needs to be developed; a programmatic approach should link projects to overarching objectives. A strategic plan is not the same as a list of projects and a summary of their objectives.
7. Human resource development needs to be continued and developed; the first priority should be further training for field volunteers, many of whom have very little professional development. The second priority should be large scale change at middle management levels – bringing women, younger professionals, and people that are well-attuned to the changing needs of poor people into executive positions. Staff and volunteers should also be sensitive to the needs of marginalized and vulnerable people whose SRH rights are threatened.

The FPAB is working closely with the government of Bangladesh but has not taken upon itself to be a progressive force to advocate for SRHR at the national level. Other actors in the community regret this situation, and there are certainly many issues that could be addressed and pioneered by FPAB including early marriages, gender-based violence and the inclusion of SRHR in the curriculum. The evaluation sees this as a missed opportunity, and concludes that past generations of managers have not used the heritage of the FPAB.

There is potential for FPAB to engage in pioneering advocacy initiatives, but it will not be easily accomplished. To influence public awareness at national level, to shape a policy environment, to see new policies in government and to see these effectively implemented is a huge challenge. The question is 'does the present organisation has the necessary competence in identifying target groups, shaping strategies, monitoring and evaluating progress towards policy changes that ultimately benefit poor people, for example concerning early marriage?' The answer is probably 'no', but on the other hand the FPAB probably did not have these skills when it started in 1952 either – the experience shows that competence can be developed in the course of doing the work. We would strongly recommend that the FPAB addresses advocacy at national levels and undertakes the necessary capacity building to do so.

1. Introduction

Background to the Evaluation

The International Planned Parenthood Federation (IPPF) and the development cooperation agencies of Norway and Sweden (Norad and Sida) have been partners in promoting family planning and sexual and reproductive health and rights for many decades. IPPF is the largest non-governmental organisation in this field, and it has 151 member associations in 182 countries around the world. IPPF was founded in 1952. In recent years many changes have occurred within the Federation. New systems of strategic planning have been introduced. There is a new focus on monitoring and evaluation to increase the accountability within IPPF. The organisation is shifting from traditional family planning activities to a more comprehensive approach to sexual and reproductive health and rights.

Norway and Sweden fund the core budget of IPPF, and together provide over 25% of the core income of the organisation. The governments of Great Britain, Japan, Denmark and the Netherlands, as well as many others, also contribute funds to the organisation. Both Norway and Sweden have been considering how to best cooperate with IPPF in the future, at which levels of funding and whether this should be through shorter or longer framework agreements. In order to better inform these decisions, they jointly commissioned this evaluation. It follows upon an earlier management audit, which was completed in 2005. The terms of reference for the evaluation are enclosed in annex 1. It is a global evaluation, but it will build on case studies of the IPPF Member Associations (MA) in three countries; Bangladesh, Uganda and Ethiopia. This study is the evaluation of activities in Bangladesh, and it is meant to be an annex, together with the two other country studies, to the main synthesis report of the evaluation.

Purpose and Key Questions

The main purpose of the evaluation is to assess relevance and effectiveness of the IPPF's activities. Both relevance and effectiveness can be studies at an abstract and theoretical level. Relevance is, for example, often assessed by analysing whether visions, strategies and plans of an organisation are synchronised with the government s policies and programmes. The approach in this evaluation is to assess relevance in the light of real life situations of the clients of the organisation, in this case, the

people who come to, or are reached by, the Family Planning Agency of Bangladesh (FPAB). Relevance is assessed in relation to the real and expressed needs of people, and the international consensus on sexual and reproductive health and rights.

Effectiveness and impact are related terms; an assessment of effectiveness could be based both on data that shows whether planned outcomes of projects are actually produced or not, and whether that has an impact. In practice, it may be difficult to draw the distinction between outcomes and impact, and at times project plans are not of much help either. We have assumed that many of the older activities, programs that FPAB have had for years, have not been subject to the same rigorous planning techniques as projects approved in later years are, and thus our discussion of effectiveness will be based on data concerning both outcomes and impact, where possible.

The key question in this evaluation is whether the FPAB reaches poor people with their services. Both Norad and Sida have sharpened their focus on contributing to poverty reduction in their development cooperation goal and policies, and hence the terms of reference for our evaluation place an emphasis on poverty. The question posed by the terms of reference is not whether SRHR projects and programs alleviate poverty. The question is whether FPAB does reach poor people in Bangladesh, and then how the projects and programs affect their lives. Poverty is a condition of life; characterised by a lack of power, lack of choice and lack of opportunities to exercise basic human rights, particularly in the field of sexual and reproductive health. Poverty is also a lack of assets, money in particular, but within the evaluation it is defined within a broader than low income levels.

Methods

Against this background, the most important sources of information would be the people who come into contact with FPAB's services: Who are they? What problems do they have? Have they been helped through the contact with FPAB? What are their opinions of the services? In the course of the evaluation we have carried out individual exit interviews with 34 persons, most of them women. We have also had group interviews with people who have come into contact with the community based activities, and through these we met another 200 persons. But we were concerned that we should not only speak with those who had access to services, but also those who lack access or choose to go to some other service provider. We met with a total of 52 such 'non-users' of the FPAB services.

The interviews were supplemented by observation data, including; visits to the clinics, satellite clinics, meetings at youth friendly centres, accompanying reproductive health promoters on their tours to communities and sitting in at a drama performance in a slum area of Chittagong. The staff at FPAB clinics were interviewed, as were non-clinical service providers, such as peer group educators, community based reproductive health promoters, the producers of drama, as well as actors, and volunteer members of the boards of FPAB – at district and national levels. The emphasis throughout the evaluation has been on the field level of operations, and where the FPAB meets the people whom their services are targeting[1]. The evaluation has also gathered data at national level. There were several interviews with the management and various staff members. There were meetings with other actors at national level; government agencies, NGOs, funding organisations and research centres working with sexual and reproductive health.

The data collection instruments are found in a separate annex, in volume 2 of the evaluation report, and they are of three different kinds, exit interviews that are a standardized format, agendas for focus group interviews, that are structured formats, and individual interviews that have an open structure. Table 1 summarises the data collection. In total the evaluation conducted around 80 interviews with

[1] For a full review of the methodological choices, design of the study, selection of samples, choice and design of data collection instruments, the reader should refer to the inception report of the evaluation team, and the chapter on evaluation methods in the synthesis report.

some 300 persons. The evaluation team spent 2 weeks in Bangladesh; the first three days with interviews in Dhaka, and the last three days also in Dhaka for additional interviews, report writing, and debriefing. In between there were field visits to three different districts. These were chosen out of the 20 districts available to visit, and the selection was made to reflect the diversity of environments in Bangladesh. One team went to Chittagong, which is a commercial area, port city, and with a reputedly conservative population in respect of sexual and reproductive health. Another team went to Sylhet, in the northeast, an area with large migration, a poor and largely rural area, which is also considered to be a socially conservative area, and has the poorest indicators regarding health and social development. The team going to Barisal, on the other hand, went to an area which is supposed to be less conservative but still rural, and impoverished. In each place, the local branch of FPAB helped set up a programme, organised visits and interviews.

Table 1. Numbers of people met and data collection according to place and method

	Dhaka	Barisal	Chittagong	Sylhet	Total
Interviews					
District level					
Exit interviews at clinics		17	17		34
Interviews/focus groups non-clinical service users		27	93	80	200
Interviews/focus groups non-users			25	27	52
Interviews/focus groups clinical service providers		4	6	25	35
Interviews/focus groups non-clinical service providers		20	39	26	85
Interviews community leaders		13	25	23	61
National level					
Interviews with FPAB	18				18
Interviews with other SRHR stakeholders	12				12
Sum of people met					497
Observations					
Member Association clinic		1	2	2	5
NGO/Government clinic			2	3	5
Non-clinical activities			1		1

Source: Completed interview formats from the evaluation process.

Limitations

Although the evaluation team members have travelled extensively and met many persons, what we have done is no more than scratching on the surface of the FPAB's activities. We have only visited three districts, and even there, we have only seen some parts of the services. The Reproductive Health Promoters reach out to on average some 600 couples, In a place like Chittagong we spoke to 12 of them (out of 94), and interviewed around 50 of those who use their services (which would be a total of around 50.000). Each clinic may have some 10.000 visitors in a year, and we spoke to no more than 10 – 20 of them. It is necessary to be careful when we draw conclusions, particularly as there could be a selection bias that we are not aware of.

Nevertheless, our focus has been on the people served by FPAB, and we have not undertaken a comprehensive analysis of the organisation as such. There is a chapter in the report which presents the organisation and brings up some features for discussion. But we are not analysing the process of programme and project implementation as such, nor other aspects of management, organisational structures and processes. Our terms of reference focus on relevance and effectiveness in order to conclude on how the organisation reaches the poor – no more, no less.

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

This presumes that we have some notion of impact and how impact has been created. Understanding attribution/causality is essential in any evaluation process. The classical notion of causality says that for something to have caused something else, the former should be both necessary and sufficient for the latter to appear. We discuss change and see evidence of change, but would never conclude that FPAB activities have been necessary and sufficient to cause that change. They have contributed, to an extent, to the changes that occur, and they are always part of larger and more comprehensive processes of change. When we discuss impact, we always do so with this notion of causality in mind. Nothing else would be credible.

At a more operational level, there was also a problem with the language during the interview situations. The majority of interviews with user groups were carried out by the Youth Consultants who spoke the language of the interviewees. But it was difficult to conduct interviews in English with community leaders and many of the service providers, and several of these were conducted by the non-Bangladeshi team members. Even though we employed interpreters and sometimes interviewed together with people employed by the FPAB, the quality of the information is lower than it ought to be. The more abstract the question, the more dubious the answers are because of the language barrier.

A Guide to the Reader

The main purpose of this text is to serve as an input to the synthesis report, where it will form an annex, but where it will also be used for a comparative assessment between the three countries. Still, it should be possible to read this country study as a stand-alone assessment of the activities in Bangladesh. Hence this report is a full analysis of what we have seen, discussed against the questions and issues raised in the terms of reference.

The key chapters are at the end; chapter 5 that discusses relevance and effectiveness, chapter 6 that analyses to what extent FPAB reach the poor. Those who are primarily interested in a quick response to these questions could go straight to these chapters and read from there. Before that, chapter 4 is devoted to advocacy work, as this is a particularly important subject, a strategic priority of IPPF and needs to be highlighted. Chapter 3 describes the organisation and analyses some of the key organisational processes; strategic direction, governance, human resources, monitoring and evaluation, as well as FPAB's image and reputation. Before setting out on the analysis, there is a short introduction to the issues and challenges in respect of sexual and reproductive health in Bangladesh. At the very end, the report presents conclusions and observations.

2. Sexual and Reproductive Health in Bangladesh

Background

Bangladesh is ranked 72nd out of 94 countries in the 2005 Human Development Index (HDI) with a HDI value of 0.519. With this HDI value, the country belongs to the category of medium human development countries, but it is the lowest ranked country in the South Asia region. Bangladesh is the most densely populated country in the world. The country has a population of about 140 million, with a corresponding population density of more than 900 per square kilometre.

As a result of continuing high fertility rates, especially in poor rural areas, the country's population is young. According to the 2001 census, 39% of the population is under 15 years of age, 57% are between 15 and 64 years, and 4% are age 65 or over (BBS, 2003:51). This young age structure creates a built-in 'population momentum' which will continue to generate population increases well into the future, even in the face of rapid fertility decline. The population projections indicate that the population will increase rapidly even after attaining replacement-level fertility because of the 'echo effect' of the high fertility experienced in the past. At the present time 30% of all births are to teenage mothers. The adolescent fertility rate is 133 births per 1,000 women. By comparison, more than half the countries in Asia have adolescent fertility rates below 50 per 1,000 women.

In 2004 the government adopted the Bangladesh Population Policy with the objectives of improving access to family planning, and improving maternal and child health, including reproductive health services. The policy strives to improve the standard of living for people in Bangladesh through striking a desired balance between population and development in the context of the Millennium Development Goals and a Poverty Reduction Strategy Paper. In the following text we provide a brief introduction to some of the major issues and challenges in sexual and reproductive health and rights.

Family Planning

In 1971–1975, women in Bangladesh were having on average 6.3 children. The total fertility rate declined to 5.1 fifteen years later, and to 4.3 in 1989-1991. For most of the 1990's the total fertility rate has plateaued at around 3.3 children per woman. Data from the 2004 Bangladesh Demographic and Health Survey, BDHS, indicates that after almost a decade long stagnation, the Bangladesh fertility rate has declined slightly to 3.0 children per woman. Differentials in fertility by background characteristics are substantial. Women in rural areas have more children than their urban counterparts (3.2 and 2.5 children per woman, respectively). The total fertility rate is highest in Sylhet division (4.2) and lowest in Rajshahi (2.6) (NIPORT 2005).

The 2004 BDHS survey shows that despite a steady rise in the level of contraceptive use over the past years, unplanned pregnancies are common in Bangladesh. Overall, 3 out of 10 births in Bangladesh are either unwanted (14%) or mistimed and wanted later (16%). While the proportion of unplanned births declined from 33% in 1999–2000 to 30% in 2004 the proportion of unwanted births did not change (NIPORT 2005).

Knowledge of family planning is universal in Bangladesh. Among ever-married women, the most widely known methods of family planning are the pill (100%), injectable (99%), female sterilization (96%), and condom (92%); these are followed by the IUD (85%), Norplant (76%), male sterilization (73%), periodic abstinence (70%), and withdrawal (58%). Knowledge of Norplant has increased from 56 to 77% among currently married women (NIPORT 2005).

The contraceptive prevalence rate (any method) among currently married women is 58%. The most commonly used modern method is the pill (26%), followed by injectables (10%). Female sterilization and male condoms are used by 5% and 4% of married women respectively, while Norplant, the IUD, and male sterilization are each used by only 1%. Periodic abstinence, used by 7% of married women, is the most commonly used traditional method (NIPORT 2005).

Over the past three decades, use of any method of contraception by married women has increased sevenfold, from 8 to 58%, while use of modern methods has increased almost tenfold, from 5 to 47%. Trends in the contraceptive method mix show that short-term methods, especially the pill, are gaining in popularity against long-term methods, such as the IUD, Norplant, and sterilization. The pill now accounts for 45% of all contraceptive use, compared with 35% in 1991. On the other hand, long-term methods now account for only 12% of all contraceptive use, compared with 30% in 1991.

Women in urban areas are slightly more likely to use contraceptive methods (63%) than their rural counterparts (57%); however, the condom is the only method that shows differentials in use by urban-rural residence, 8% in urban areas compared with only 3% in rural areas. Differentials are more marked by division: use of any method of contraception varies from 32% in Sylhet and 47% in Chittagong to 64% in Khulna and 68% in Rajshahi. Contraceptive prevalence is 54% in Barisal and 59% in Dhaka.

One in two contraceptive users in Bangladesh stops using their method within 12 months of starting. The most common reason for discontinuation is side effects or health problems. Both the public and private sectors are important sources of supply for modern methods of contraception. The public sector provides 57% of all modern methods and the private sector provides 36%. The most common public sector source remains government fieldworkers (23%), although their contribution to the supply of contraceptives has declined substantially between 1993 and 1994. Upazila health complexes are the second most important public source of modern methods of contraception and these health complexes currently supply 10% of all contraceptives. Pharmacies provide most (approximately 29%) of the methods in the private sector. This shows an increase from 21% in 1999. Only 6% of users obtain their contraceptives from an NGO source.

In 2004, 42% of pill users and 64% of condom users received their supplies from pharmacies. Another one-third of the pill users accessed their contraceptives from government fieldworkers. Approxiamtely four out of five people who were using injectable contraceptives received this injection from government health facilities, while one in nine people who were using this method of contraception received these injections from NGO facilities. Most IUD users obtain their method of contraception from government facilities. Both female and male sterilization procedures are mainly performed in government facilities.

Data from the Bangladesh Demographic Health Survey shows that 11% of married women have an unmet need for family planning. Unmet need in Bangladesh declined from 15% in 1999–2000 to 11% in 2004. It has remained high in Sylhet division (21%), while dropping substantially in Rajshahi (7%) and Khulna (8%). Overall, 84% of the demand for family planning is currently being met (NIPORT 2005).

According to Government of Bangladesh policy, menstrual regulation is permitted to be performed within eight weeks from the first day of the last menstrual period by a paramedic (a trained family welfare visitor) or within ten weeks from the first day of the last menstrual period by a trained medical doctor (People's Republic of Bangladesh 2005).

The Bangladesh Demographic Health Survey also reports that eight in ten ever-married and currently married women know about menstrual regulation. Although numbers of women who have undergone menstrual regulation have been rising since 1996. At the present time rates remain low, with 6% of

women reporting they had ever used menstrual regulation services. Rates of use of mnstrual rgulation services are highest among women in their thirties. In 2004 9% of currently married women and 8% of ever-married women had used menstrual regulation services.

FPAB's strategic plan and national situation analysis shows that unskilled and untrained providers are primarily responsible for terminating pregnancies Access to safe abortion services is very limited and religious and socio-cultural opposition to abortion is strong. Procuring funds for menstrual regulation services are also difficult. Internally menstrual regulation facilities are not adequately trained and post abortion care facilities are insufficient (FPAB 2006).

Exposure to family planning messages through media has increased – while exposure to messages on posters and billboards increased by 6 to 8%. During this period, exposure to family planning messages through radio and newspaper/magazines has remained largely unchanged. Efforts to disseminate family planning messages through community events appear to have declined, as reported by BDHS 2004, with only 3% of women reporting that they heard a message at a community event in 2004 compared with 6% in 1999–2000.

Maternal Health

The mean height of a Bangladeshi woman is 151 centimetres, which is above the critical height of 145 centimetres. A high proportion of women (16%) are below 145 centimetres. Thirty-four percent of women were found to be chronically malnourished, their body mass index (BMI) being less than 18.5. Among divisions, Sylhet has the highest proportion of women who are thin (48%) and Khulna the least (29%).

Although Bangladeshi women with children under five years are not getting taller, there is a substantial improvement in mothers' nutritional status as measured by BMI. Since 1996–97, the proportion of mothers below the cut-off point of BMI of 18.5 continued to drop, from 52% in 1996–97 to 38% in 2004 – a decline of 27% in less than ten years (NIPORT 2005).

According to BDHS antenatal care coverage has increased sharply between the 1999–2000 BDHS and the 2004. One-third of women received an antenatal check-up from a medically trained provider in 1999–2000 compared with approximately one half in 2004. Thirty-one percent of women received antenatal care from a doctor and 17% received care from a nurse, midwife, or paramedic. A relatively high proportion of women received no antenatal care (44%), especially in Sylhet (52%) and Barisal (53%). Two in three women received at least two doses of tetanus toxoid for their most recent birth in the five years preceding the survey, 21% received only one tetanus toxoid injection, and 15% received none (NIPORT 2005).

More than 90% deliveries occur at home. Three quarters of births in Bangladesh are assisted by traditional birth attendants with 14% assisted by trained and 63% by untrained traditional birth attendants. About 13% of births are assisted by medically trained persons. Two thirds of women (64.3%) did not discuss who would assist their delivery during their pregnancy. Among the one third who did discuss, the majority (21.7%) planned to call upon an untrained traditional birth attendant, with small numbers planning to call a trained traditional birth attendant (4.9%), a doctor (4.4%), a relative (3.1%), and a few would call a nurse/midwife (1.6%).

Bangladeshi culture remains oriented to home births and only 20% women have the decision-making authority about who will deliver their baby. 40% of the pregnancies were free of complications and 60% reported one or more problems. Overall, 45% of all pregnancies with complications were perceived as dangerous or potentially life threatening.

Awareness of the danger signs of obstetric complications is extremely low, particularly among the decision makers (mother-in-law and husband). Only 40% of women who perceived to have had life threatening complications during their pregnancy sought immediate care. Only 15% of women received postnatal care within two days of delivery; more than 80% received no postnatal care at all (People's Republic of Bangladesh 2005).

HIV/AIDS and STIs Issues

Bangladesh continues to have low HIV prevalence (less then 1%), but has high levels of documented risk behaviours: Low levels of condom use, very high turn over of clients of commercial sex workers, low knowledge regarding HIV/AIDS, and extensive needle and syringe sharing by drug users suggest a potential for growth in HIV infection rates. Adolescents, in particular, are increasingly getting involved in the sex trade, taking drugs, and migrating to other countries where they are exposed to risky situations.

According to a 2004 United Nations study the number of HIV infections in Bangladesh has tripled over the last six years, with increasing prevalence among most at risk populations: commercial sex workers, men who have sex with men, migrant workers and injecting drug users (IDUs). National survey data indicate that HIV infection among IDUs jumped from 1.8% in 2001 to more than 4% by 2004.

Factors contributing to Bangladesh's HIV/AIDS vulnerability include cross border interaction with the high prevalence areas in Burma and North East India, low condom use and a general lack of knowledge about HIV/AIDS, sexual disease transmission and risky behaviours. Heterosexual contact among commercial sex workers is a major mode of HIV transmission and the level of unprotected sex is high (40%). HIV/AIDS awareness among migrant workers is low, based on their limited access to information (USAID 2005).

Knowledge of HIV/AIDS among married women increased from 19% in 1996–1997 to 31% in 1999–2000, and then it almost doubled to 60% in 2004 as reported by BDHS. For currently married men, the corresponding proportions are 34, 51, and 78%. Eighty percent of women and 93% of men in urban areas have heard of AIDS, only 54% of women and 78% of men in rural areas have heard of the disease. Thirty-seven percent of married women, 57% of never-married men, and 45% of currently married men know that condom use is a way to avoid contracting HIV/AIDS. About one in three married women and one in eight of all men or currently married men know that limiting the number of sexual partners can prevent HIV/AIDS. Overall, six in ten women and 42% of men do not know any way to avoid the disease. Knowledge of HIV is high among sex workers and their clients but extremely low among the general population. A recent study showed also that only 20% of married women and 33% of married men had heard of HIV/AIDS.

Knowledge of STIs, sexually transmitted infections, is generally lower than that of HIV/AIDS. Ninety-four percent of women and 78% of married men still do not have any knowledge of STIs. Knowledge of STIs is highest among women and men who have completed secondary education, 19 and 38%, respectively. In Bangladesh the legal age of marriage is 18 years for women and for men is 21 years; however a large proportion of marriages still take place before the legal age. The 2004 BDHS, data shows that 68% of women age 20–24 were married before age 18. Data indicate that over the last two decades, the proportion of women marrying before the legal age had been gradually declining; but in recent years, it has increased again. Still, more than half of all women age 20–49 enter marriage before their 15th birthday.

In Bangladesh an estimated 47% of women are reported to suffer from gender-based violence, where the practice of men attacking women with acid is also widespread. The nature of the violence is varied and includes food deprivation, physical isolation and refusal of access to SRH services and other health services, physical beatings, rape and dowry-related deaths. Violence against women, in all its forms, has

undermined the impact of safe motherhood programme in that maternal mortality rates have remained high despite their implementation over decades.

Women from lower socio-economic groups are more likely to be at risk of gender-based violence and less likely to be able to access services or the justice system. gender-based violence also contributes to the cycle of poverty for many women, children and families by disempowering women, diminishing self esteem, restricting their ability to participate and contribute to their community and degrading the health status and economic capacity of the family as a whole (USAID 2005).

Adolescents in Bangladesh live in a community that hold traditional beliefs and practices that still restrict the discussion and flow of accurate sexual and reproductive health information in the household, the community and schools. Pre-marital sex is taboo for social, religious and cultural reasons, and access to accurate information on key sexual and reproductive health issues, including reproductive physiology, sexuality, family planning, and sexually transmitted infections, is severely restricted at all levels. Reproductive health services that do exist are often unresponsive to the broader needs of adolescents, especially those who are unmarried (EU/UNFPA 2006).

A 1999-2000 survey which addressed obstacles to accessing care found that 80% of women felt that there was no adequate healthcare facility nearby; 50% mentioned a lack of confidence in the services and problems accessing the health centre; 70% couldn't meet the financial requirements for treatment and about two thirds said that not knowing where to find health centres was the major obstacle to accessing care (NIPORT 2005).

Concluding Remarks

This brief review indicates the SRHR issues and challenges. In the course of the evaluation, we have also asked a number of community leaders, government officials and others about their view of the most critical challenges in the field. The most common answer focuses on religious conservatism, which is an underlying factor affecting many of the conditions described above. Early marriage and gender based violence were the other two most commonly cited issues. When we discuss the relevance of FPAB's activities in chapter 5 below, we will return to the information recounted here.

3. The Family Planning Association of Bangladesh

Origins and Evolution

The Family Planning Association of Bangladesh is the oldest NGO in the country and was formed in 1953 to pioneer a family planning movement. In 1954, it became a member of the International Planned Parenthood Federation (IPPF), and started its activities with the following objectives; (1) to popularise the concept of family planning (2) to motivate the government to frame a national policy, (3) to provide services to those who voluntarily want to adopt family planning. The activities of the association focused on what would today be called advocacy, plus limited services through a model clinic in Dhaka.

The Government recognised family planning activities by an act of Parliament in 1958. This was followed by an experimental project that started in 1960, then followed up and brought to scale through a fully-fledged programme in 1965. The FPAB then redefined its role to supplement and complement the national programme with emphasis on popularising the concept of family planning with the

support of modern methods of communication, filling up gaps in the provision of services, mobilising community support, and demonstrating new and innovative approaches[2].

In the late sixties, the association expanded its coverage and moved from the urban to rural areas. During this period FPAB received funds from other donors as well as grants from the national government. The scope of services and activities continued to evolve and broaden in scope. In 1980, FPAB initiated its youth programme aimed to educate and raise awareness about sexual and reproductive health and rights among young people through peer organisers. Initially FPAB provided education about family planning and in 1992 the organisation widened its focus to educate people about sexual and reproductive health issues. The organisation's first strategic plan (1994–2002) included a strategic objective about young people – 'education to prepare youth for their future parenthood life'.

The organisation is still the largest NGO in Bangladesh in the field of sexual and reproductive health. It is a member-based organisation, and now has a total of 6.003 members. The national organisation has 20 branches, and each branch has a board of volunteers who are accountable to an annual meeting of members in the branch. The Governing Council at national level is elected by the boards of the branches.

Table 2. Summary of programme activities and finances 2006.

Project	Description	Budget 2006 (in USD)
Adolescents (5% of program budget)		
Sexual and Reproductive Health Education for Adolescents and Young People	Strengthen commitment to SRHR education, increase access to comprehensive, youth friendly services, training through peer educators.	76.000
AIDS (11% of program budget)		
Education and Awareness Raising through Training	Reduce social, religious, cultural, economic, legal and political barriers that make people vulnerable to HIV/AIDS.	135.000
Capacity building in the 5 As	Strengthen programmatic and policy linkages between SRH and HIV/AIDS	-164.000
Access (13% of program budget)		
Comprehensive Family Planning and Reproductive Health Clinic	Improve access to SRH information and sexuality education for poor marginalised and underserved people using a rights based approach.	177.000
Quality of Care (no cost extension of a completed project)	Improve access to high quality SRH services	12.000
Safe Motherhood Project		354.000
Abortion (25% of program budget)		
Flourishing lights on Women Empowerment and Rights to Services	Information and education on SRH and FP among million population through 400 field volunteers, 1010 community volunteers, 400 community birth assistant,	352.000
Advocacy (3% of program budget)		
Advocacy for Breaking the Silence	To achieve greater public support for government commitment and accountability for SRHR, strengthen recognition of SRHR, including policy and legislation.	47.000
Working Towards Safe Motherhood in South Asia: Combating Gender-based violence	Protect the rights of women at risk for gender-based violence with special focus on pregnant women. Raise awareness of entitlement to medical care and related support.	74.000
Other (44% of program budget)		
Centre of Excellence on Organisational Development		536.000
National Headquarters	Indirect costs of FPAB	134.000

Sources: 'Bangladesh 2006 Assets. PDF (provided by IPPF on September 7th 2006)

[2] Information on the background of the FPAB comes from past evaluation reports, such as the Bangladesh Country Evaluation Report (2003) '*Addressing the Reproductive Health Needs and Rights of Young People since ICPD: The contribution of UNFPA and IPPF*', the FPAB's report on Global Indicators, as well as from the presentation by the management of FPAB.

The activities of the FPAB can be split in two major categories. First there is the core of SRHR services provided through the clinics operated by each branch, as well as by the satellite clinics and outreach programs around each clinic. The range of services may differ between the district branches, but essentially they are made up of clinical SRHR services as well non-clinical services; testing, supplies of contraceptives, counselling and referring to clinics, done by field volunteers in designated areas. Apart from this core structure of services that are regionally based, there are programme activities; projects for which FPAB has earmarked funding from IPPF. Table 2 presents an overview of the projects being implemented in 2006. FPAB claims to reach a total of 1.8 million clients. It has a total staff of 1.028 persons, some of which work part-time or on temporary assignments. There are also a large number of volunteers working for the organisation, estimated at some 6.000 persons. The organisation therefore has almost 7.000 paid and volunteer staff that are working in accordance with FPAB's mission and strategic plan.

Overall funding to the organisation has declined over the last few years, as the core funding from the IPPF has decreased, while at the same time the direct project financing from other partners have been unchanged or decreased. The charges on services play a minor role in the overall budget of the organisation, nor do the government or the private sector contribute much.

The overview in Table 2 shows where the strategic priorities lie during this year. All projects except two are identified under one of the five A's that guide IPPF's strategic planning. There are 11 projects in total and they have a total project budget for 2006 of USD 1.9 million. The single largest allocation of funds is in the sector 'others' and the largest project there, which is also the largest in the total budget, concerns organisational development – in line with the IPPF vision to create centres of excellence in the regions. This project accounts for one third of total budget, and the FPAB overhead costs constitute another 11%. The projects that fall under the 5 A's add up to 57% of the total programme budget These figures gives a sense of the strategic priorities of the organisation, and in the next section we turn to the policies and strategies of the organisation.

Policies and Strategies

The FPAB is in a process of change; not only was a new Director appointed last year, but several others in executive positions are also newly appointed. There is a clear break between the old leadership and a new group and naturally that affects the operations. A large number of changes have been introduced in the organisation, but it is yet too early for an evaluation to establish the effects. At the same time, it is of limited interest to pick up problems that relate to the old management. Hence this review of the FPAB as an organisation is rather short and focused on a number of specific issues.

Organisational strategies are usually made explicit in a small number of documents. The key document that we make use of in this analysis is the 'Mission Statement/Strategic Plan 2006', which sets goals and objectives for the period 2005 to 2009. It is a document of 13 pages, which is an appropriate volume of text; not too long and not too short. Within 13 pages it should be possible to set and motivate targets, provide a sense of direction and purpose against a background of needs, risks and opportunities.

The first item in the 'Mission Statement/Strategic Plan' is the mission statement itself. It is commonly said that mission statement should be short and concise, and that they should communicate well. They should be easily understandable. The substance should be relevant and should respond to needs, in this case to the SRHR situation in Bangladesh. The mission of FPAB (FPAB 2006) is:

> 'To accelerate human development through quality Reproductive Health including Family Planning Services, FPAB will improve sexual and reproductive health through effective advocacy and service delivery primarily to women, children, adolescents/youth emphasizing on underserved and disadvantaged areas through community ownership. '

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

The mission statement as such has its strengths and weaknesses. The strengths are that it is indeed short. It is clear and easily understood that there will be two main lines of action; advocacy and service delivery. Target groups are clearly identified. The concept of sexual and reproductive health is broadly understood. There are some weaknesses too. Even though the statement as such is short, it is a long sentence and it is difficult to perceive what it actually says. It would communicate better if split into a series of shorter sentences. There is no specific mention of HIV/AIDS, which would have been relevant as this is major issue in the country. Part of the sentence is a tautology – 'through quality reproductive health (…) will improve sexual and reproductive health'. The components of this argument need to be reconsidered.

It is important that the message of the organisation's mission is clear and consistent. The evaluation encountered several different mission statements; on the walls, on posters, in the above document, and in the Bangla version of the mission statement. It is obvious that all mission statements that are spread from the organisation should be the same. The Bangla version could serve as a model for the English mission statement, as it is better structured, clearer and even more comprehensive.

The remaining parts of the document are structured around the 5 A's, and then there are also subsections on accreditation and governance, and on capacity development. Under each of these come a number of boxes, wherein each box has a statement of strategic goal, situation analysis, and strategic objective. This is in itself a good and useful structure. However, some of these sections correlate to projects, but others do not. There is no sense of how these projects, or different strategic objectives and goals together address a common purpose in respect of advocacy, adolescents, or any of the other 5 A's, or in the other areas for that matter. There is a lack of purpose at the programmatic level, where one would want to see how the projects combine to achieve certain objectives, or contribute to a common purpose. As it is, the strategic plan gives the impression of a list of loosely assembled project activities that are somewhat arbitrarily sorted under the 5 As.

It is not easy for the FPAB to present its activities under the 5 A's. When one looks at the projects, it seems that they normally contain activities, outputs and outcomes that relate to several of the A's. A youth project may contain a large number of advocacy activities, the projects in access contain activities that relate to abortion and advocacy. The advocacy projects could also be seen as AIDS-related activities. Under the overall title of abortion, there are several components that relate to safe motherhood, even projects on safe motherhood. Safe motherhood is obviously a much broader concept and will certainly include many activities that are not abortion related.

This is a problem with the 5 A's in general as a management tool, and the weaknesses in how they are conceptualised becomes apparent in the strategic plan of FPAB. This also implies that the data on

financial expenditures organised under the 5 A's do not accurately reflect the activities of the organisation. So for example, the obvious conclusion from Table 2 that Abortion is the largest programme sector at 25% of the total budget would not be true, as only a minor share of the funds spent under that title would be related to abortion as such. This also suggests that it would not be possible to present results in respect of the 5 A's either. The problem goes beyond the FPAB, which appears to have tried its best to apply the strategic key words of IPPF, and the synthesis report of the evaluation will return to this issue.

Governance and the Volunteer Boards

The question of governance is very important. FPAB is a member based organisation; the members are organised at district level. In each district there is a board, and the board elects the National Council. The National Council appoints a National Executive Committee, and on that there is also a subcommittee for management. The governance system is described in detail in the Constitution of the FPAB (FPAB 2005).

During the course of the evaluation there was a meeting with some National Council members and in each of the three districts the evaluation team met with the Boards – more or less fully present at the meetings. The volunteers on the Boards and National Council could be a valuable asset to the organisation, but whether they are an asset or not depends on how their skills are put to use. Several issues can be raised:

– In its overall composition, the board is dominated by people who are approaching the end of their careers or have already retired. There is a need to rejuvenate the boards at all levels to make sure that the insights, understandings and dynamism of young people are brought to the governance of the organisation. The mission of the FPAB emphasises the need to reach young people, but those who formulate key policies and strategies at the boards may not have the required backgrounds to take the right decisions for this purpose to be reached. This means that the board should also try to get members who understand the needs of a wide range of people in the community, that is, one should strive for a broad representation from the community.

– The boards aim to have an equal representation of men and women, and that is almost achieved, though some boards at district level still seem to have a predominantly male leadership. But it is not only the number of women that count, but also their voice in the decision-making process. The FPAB needs to ascertain that the women who serve as volunteers on the boards also have an equal say in decisions.

- The boards are generally large, the National Council has 21 members, and the district boards we visited had around 15 members. It is generally said that a board should not consist of more than 7 members if it is to work effectively.

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

– The boards appear to be quite active in the management of the organisation (though there is a difference between branches); while at the same time there is a professional management structure. This leads to a duplication of effort and confusion over roles and responsibilities. Management cannot be held accountable as the board members are present in the daily operations of the organisation, and might get involved in decision on use of funds, access to services,

appointment of personnel, etc. The board cannot be held accountable either, because there are still a number of operational decisions taken by management.

– A board could in theory take one of several roles. It could exercise power over the organisation, it could be advisory, or it could be representative (that is, contributing with networks to other people, assist in lobbying, inform other stakeholders of the organisation's activities). The present Constitution of FPAB makes the boards responsible for the management of the organisation, and hence board members are actively engaged. Many NGOs find it useful to have advisory boards and to leave managerial responsibility to professional management.

In short, there are many issues around the governance structure that require a closer analysis than we offer here. We have not been able to analyse closely how management at different levels work together with board members. There is a risk that the unclear responsibilities could create conflicts if worse comes to worst. In any case, the duplication of responsibilities makes the organisation less efficient than it could otherwise be.

Human Resources

Personnel at all levels is the most important asset of an organisation. During the evaluation we met with many different categories of personnel and had the opportunity to watch people at work, interacting with clients and performing other duties.

There is no doubt that the large majority are strongly motivated by a sense of duty to serve their clients and by their strong belief in the mission of the organisation. In a large organisation there are always those who perform below average and those who perform above average. We have met with some 60 reproductive health promoters, most of them knowledgeable and committed. They had worked for organisation as field level volunteers for an average of 6 years, many as long as 14 years and some were more newly recruited. But they had received very little training, on the average not more than 14 days during six years. That is far too little, particularly as these are the people who are most likely to reach the poor and who will provide essential services to them.

People in the clinics; medical doctors, paramedics, counsellors, have fared better and have received more training, on the average at least one major training every year. At this level too, many of those we met appeared to have the skills and the attitudes appropriate for their jobs, and they were motivated.

There is, however, a problem at middle management levels, and also among the coordinators of field volunteers. The demographic picture is that these groups are almost exclusively male and most of them are middle aged or older. Their attitudes pose a problem; many have an arrogant approach to the clients they are supposed to serve, and a number also have an intimidating and threatening approach to both clients and to employees at lower levels in the organisation. Their understanding of SRHR needs is often very limited. As an example, in one city visited a senior manager claimed that were no brothels in the city, which there obviously was – in large numbers. It is of course impossible to manage a dynamic and innovative programme in SRHR if one is ignorant of basic social structures and issues in the district.

The coordinators of the field workers pose a particularly serious threat. Most of the field workers are women, and they gain the confidence of women's problems. However, when they seek to solve them they need the backstopping of the organisation, and they need someone to turn to who can appreciate the problems and constructively help to solve them. As it is, the effectiveness of the field workers is severely hampered by the demographics of the supervisory level on top of them.

The evaluation discussed personnel issues with the Director of the FPAB, and it would seem that the analysis of strengths and weaknesses is shared. There also appears to be a strong commitment to

address these issues. A programme to address sexual harassment on the workplace has been initiated, and we think this is a very necessary and brave step to take. Many of the staff members at lower and voluntary levels are female, while their supervisors and managers have been characterised above. The risk for sexual harassment and exploitation is large and obvious. The organisational change programme is necessary and through it some may be motivated and trained to perform better. However, it would be prudent to assume that many in the latter category, middle management and coordinators may have advanced to far in their careers to change much, and that other solutions than training and motivation must be sought.

Image and Reputation

What kind of a reputation does the FPAB have? The evaluation team met with community leaders, national and district government agencies, representatives from other NGOs; in total around 60 persons. It is rather unanimous picture they paint; some quotes from interviews are:

> 'They were the first organisation to speak about family planning'
>
> 'They have shaped government policy in family planning'
>
> It has stability and continuity, other NGOs come and go, or are too small to provide real services. FPAB is large and can deliver to the poor'
>
> 'It is reliable and it works in many difficult areas'
>
> '20 years ago FBAB was a strong organisation, but then it became weaker'
>
> 'The people there are very motivated and do a good job'
>
> 'It is mostly working in family planning that is their strong part. They have not been able to change to a broader SRHR agenda. They do what they have always been doing'

The organisation appears to have a good reputation, but that depends on how one defines a good reputation. Many said the organisation stands for continuity and stability, which are positive attributes. But if change is necessary, it may not be so positive. Perhaps the most striking thing about the comments is how many associate FPAB with rather old-fashioned approaches to family planning. Still, the history of the organisation shows that it started working with broader SRHR issues already in the 1980s, and it had programmes for adolescents etc. already in the first five year plan. Nevertheless, in people's minds it is associated with basic family planning activities.

The organisation's networks among NGOs are strong, and while FPAB has found pragmatic and fruitful ways of cooperation with some other stakeholders at district level, it seems to remain a little bit aloof at national level. A characteristic comment was 'why should we join them, we had already been in existence for decades when they were created'. Bangladesh has many and strong NGOs and the country is a competitive scene; it is a challenge for FPAB to find the right balance of cooperation and competition with others – both are necessary.

Concluding Remarks

This is not an evaluation of management issues, structures and processes in the organisation. Nevertheless it is an evaluation of the FPAB; the focus is on relevance, effectiveness and reaching poor people, but the organisational structures and processes do explain some of its performance in these respects. In the text above we have pointed at some shortcomings in respect of the planning process, governance structures and human resources. We are aware that there is a new management team and that the problems we speak of are due to the history of the organisation.

FPAB is working together with SARO, the IPPF South Asian Regional Office, to address many of the issues. To mention a few examples; SARO is developing a 'deprivation ranking' tool, which will be pre-tested in October 2006, and the finalized tools will be shared with all member associations at a Vision Building Workshop scheduled for January 2007. This should help the FPAB focus on poor and marginalised groups (an issue we will return to in chaper 6).

Furthermore, the idea of 'Centres of Excellence' will also be a tool to strengthen the organisation. All the member associations in the region have adopted the Centre of Excellence approach, through which over the next three years, FPAB will be developed as a Centre of Excellence on Universal Access. Other steps include moving the perception of the organisation from being a family planning service provider to a Centre of Excellence on Universal access.

Yet another important aspect of change management relates to organisational networks. During the past year a number of technical committees have been formed that will advise FPAB on areas such as HIV/AIDS research. The FPAB has also completed a mapping of significant actors working in the SRHR field, with the intent of forming strategic coalitions with these organisations, where possible.

The management is starting these (and other) change programs, but it is of course much too early to say anything about the results yet.

4. The Advocacy of FPAB

Introduction

It is widely accepted that between 1953 and 1965, FPAB played a major role in creating a climate of opinion where family planning was widely accepted in Bangladesh. Through focused advocacy initiatives at the national and local levels, the organisation made a major contribution to ensuring that the government developed relevant policies and a national service-based programme that responded to the needs of the population for family planning programmes in 1965. Since this date, FPAB has increasingly directed its resources and strategic focus towards service provision rather than advocacy. However, IPPF's global indicators data shows that FPAB continues to engage in a range of advocacy programmes and at the present time is involved in a variety of local advocacy initiatives and dialogues with local and national decision makers.

When discussing the outcome of FPAB's advocacy initiatives, it is important to recognise that it is difficult to isolate the specific impact or outcome of one agency, as the overwhelming majority of organisations that work in an advocacy-based capacity do not work alone. This is because advocacy initiatives that have a very broad base of support from a range of organisations, communities and decision-makers are most successful in achieving their objectives. It is less complex to make an assessment about the outcome of a specific advocacy campaign.

This chapter uses data gained through interviews and focus groups with key local and national government decision makers, community and religious leaders, and major NGOs working in the field of SRHR to make an assessment about the outcome of FPAB's advocacy work that has targeted the local level, the policy environment and SRHR policies. In particular, it will focus on FPAB's work to raise awareness and acceptance of a variety of SRHR issues with key decision-makers, policy-makers, gatekeepers of information, and figures with authority at both the national and local level.

Defining Advocacy

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

i. Advocacy initiatives that are focused at the local level and target the general population and key community level decision-makers such as religious leaders

ii. The extent to which FPAB contributes towards the development of 'an enabling environment' where support for SRHR is acceptable and addressed by key Government agencies and NGOs

iii. Whether and how FPAB engages in policy dialogues with the government to contribute to and inform national policies that focus on a range of SRHR issues

It would thus be possible to 'map out' the advocacy activities of the FPAB along the two dimensions of, first, whether the work occurs at national level or at district or lower administrative levels, and second whether the target is government policy as such (expressed in legislation, actions plans, organisational structures and systems of implementation), or whether it is directed at the policy environment (journalists, other NGOs, community leaders), or whether the advocacy efforts are directed at the community at large through awareness raising activities. These different approaches are illustrated in Figure 1.

Figure 1. Dimensions of advocacy activities.

	Government policy	Policy environment	Public awareness
National level			
District/community level			

The 2003 UNFPA/IPPF evaluation of FPAB identified a lack of focus and work in the field of advocacy as a weakness and a missed opportunity for the organisation and the wider SRHR community in Bangladesh. In comparison to this report, the 2003 evaluation looked at a more narrow definition of advocacy with a focus on policy makers rather than key decision makers and community leaders at the local/district level.

Perception Versus Reality

It was quite common that people in the FPAB were not quite aware of what kinds of advovacy work the organisation was doing. For some, advocacy mainly meant to influence government policy. The activities at community level were sometimes, but not always, included in the understanding of advocacy. Despite this view, the analysis of interviews with NGOs and government agencies working in the field of SRHR highlighted that FPAB is implementing a variety of important local advocacy initiatives, particularly with religious leaders and that FPAB has also established relationships with key government agencies and consequently plays a role in shaping the national SRHR programme and policy environment. The interviews revealed that the organisation works with advocacy at primarily the district and community level.

Impact at the District/Community Level

FPAB currently implements a range of initiatives that aim to raise community and local level support for sexual and reproductive health and rights. Through this evaluation two major local advocacy initiatives were identified: FPAB's work to sensitize religious leaders about SRHR and street-based drama performances and programmes focused on raising awareness and broad community-based support for SRHR.

i) The Islamic Research Cell – Programmes to sensitize religious leaders

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

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

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

> 'FPAB has done some very impressive work with religious leaders – any organisation that wants to work with these leaders about SRH should contact FPAB. This work is very well recognised in Bangladesh'

> 'The quality of FPAB's work with religious leaders is a strength of the organisation'

> 'FPAB is implementing important work with Imams in conservative areas of the country'

Through its work with religious leaders the Cell has also been successful in reaching out to men, and raising awareness and support for sexual and reproductive health and rights among men, a group that has largely been neglected in SRHR programmes. In a focus group discussion with thirteen religious leaders in Barisal, four had attended training sessions implemented by the Islamic Research Cell and all requested further information and training from the Cell. The Imams provided positive feedback about the work of the Cell and commented that they thought the work of the Cell had had the outcome of encouraging people to 'open up' and discuss family planning and wider health issues. The leaders stated that they were supportive of a range of SRHR issues including family planning and FPAB's initiatives to address gender-based violence. They confirmed that as a result of the sessions they had spoken about these issues during the Friday sermons in mosques. The Imams also revealed that prior to their involvement with FPAB, they and other religious leaders in the area were very sceptical about the work of the NGO sector in Bangladesh. As a result of involvement with FPAB, religious leaders in the community are now more supportive of and committed to working with a range of NGOs in Barisal.

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

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

ii) Street drama performance and other local community activities

Street drama has been implemented by FPAB to increase community awareness and acceptance for SRHR. Drama performances are generally implemented by young volunteers and focus on a range of SRHR. They target the general public and community decision-makers.

In Chittagong the team observed a drama performance that was focused on creating greater understanding of gender-based violence and HIV/AIDS. A crowd of approximately 800 people from poorer backgrounds watched the performances (it was staged on a Saturday evening in a slum area close to the port in Chittagong). The drama portrayed a range of easily understandable messages about these issues. Interviews with representatives from NGOs revealed that this form of communication is particularly relevant to meeting the need for information among poor communities

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

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

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

The Chittagong branch has set up the drama at a cost of Th 8.000, which is just slightly more than USD 100. The drama has been performed twice a month over a period of six months, and at each performance there has been an audience of around 1.000 people. This suggests that the drama by peer educators is a highly cost-effective way of working. A total of 12.000 persons have been reached with basic messages around how HIV/AIDS is spread at a very low cost. Even though it would probably be necessary to supplement the drama with other activities to reinforce the messages and to move onwards to behavioural change, it is a very good start.

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

Impact on the Policy Environment: Creating an Enabling Environment

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

Interviews with representatives from the Bangladeshi Ministries of Health and Family Planning revealed some reluctance about the role that it is felt NGOs should play in informing the national SRHR agenda. For example, one interviewee commented that 'NGOs should not be involved in determining national policies, but should focus their attention to community-based advocacy and awareness raising initiatives'. Despite this difficult environment, the evaluation team found that FPAB is engaged in a certain number of initiatives with key stakeholders to shape the SRHR environment. In particular, the following initiatives were highlighted:

a) Work with media professionals to raise awareness about SRHR issues

In Dhaka the FPAB has implemented a range of seminars including a roundtable to sensitize and raise awareness about SRHR among journalists. The media training seminars are organized at a national level and are targeting key gatekeepers of information, decision and policy makers. As approximately one third of the population is illiterate, this initiative is not focusing on informing poorer populations directly, but those who make policies and decisions about the policy environment and programmes to meet their needs.

b) Networking and Co-ordination with key government ministries and NGOs that work in the field of SRH

The interviews with 20 representatives of NGOs and government agencies revealed that FPAB currently co-ordinates and co-operates with a broad range of NGOs and government agencies that work in the field of SRHR. In particular, shared working and programmatic collaboration with Marie Stopes International and the Ministries of Health and Family Planning were highlighted within the interviews. In general FPAB has informal working relationships with NGOs and government agencies,

but it also has formal Memorandums of Understanding and referral relationships with NGOs such as BLAST (Bangladesh Legal Aid and Services Trust) in Barisal.

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

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

Informing National Policy

As highlighted at the beginning of this chapter, FPAB played a significant role in creating a societal climate of opinion in Bangladesh that is largely accepting of family planning during the 1950s and 1960s. However, feedback from NGOs and key government ministries illustrates that in recent years, the organisation's involvement in national and local policy debates has declined and is currently relatively limited.

Representatives of Government agencies stated that while FPAB has strong relationships and works closely with the Ministries of Family Planning and Health, this work is primarily implemented to share working, knowledge and to co-ordinate service delivery rather than inform policy legislation and ensure the appropriate interpretation and implementation of legislation.

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

'FPAB is well established and respected in Bangladesh'

'They were the first organisation to speak about family planning'

They have shaped government policy in family planning'

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

Although FPAB is well placed to be a key player in policy development, the organisation is not currently taking the lead in this area. Interviews with UNFPA, USAID and Save the Children show that while a number of SRHR policy initiatives have recently been developed, including the HIV/AIDS curriculum agenda for schools and an adolescent reproductive health policy they have been developed largely without consultation and input from FPAB. The adolescent reproductive health policy dialogues with the government were led by Marie Stopes International, with the support of a consortium of NGOs, including FPAB. FPAB is not represented on the NGOs forum of the national health sector SWAP and

FPAB is also not currently working with Save the Children, the managing agent of the Global Fund for AIDS, Tuberculosis and Malaria in Bangladesh. The notable exception to this pattern is FPAB's involvement in the development of the 2004 national population policy. FPAB was consulted by the Ministry of Family Planning and attended a number of meetings to inform the development of this policy.

Systems to Monitor and Evaluate Advocacy Initiatives.

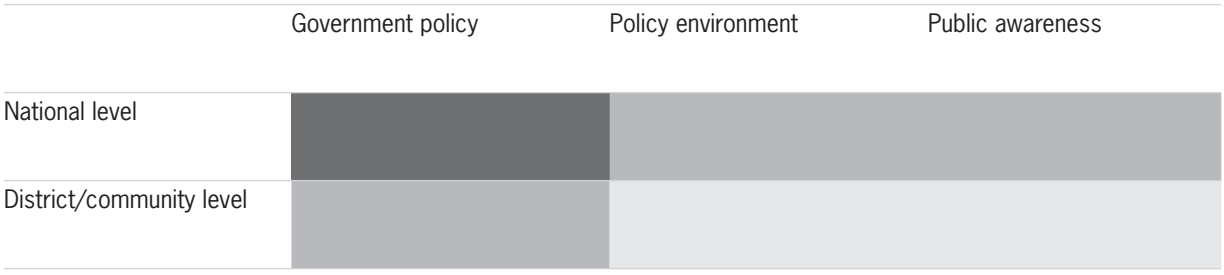
At the present time FPAB has very limited systems and capacity to monitor and evaluate the outcome or impact of advocacy initiatives at the local and national level. Outputs of advocacy initiatives such as newspaper clippings of articles about SRHR and number of religious leaders attending Islamic Research Cell initiatives are collected.

FPAB's management team acknowledged that the organisation currently has a limited capacity to assess the outcome and impact of its advocacy initiatives. If FPAB decides to become strategically focused on advocacy and decides to invest financial resources in this area it is important that the organisation is able to make an assessment about effectiveness of different advocacy initiatives. Methods and systems of assessing the impact of policy and advocacy campaigns have been developed and well documented by key NGOs, research and academic institutions in Europe and America. These systems could be adapted for FPAB with focused technical support from IPPF.

Concluding Remarks

This chapter has provided an overview of the advocacy initiatives of the FPAB. If we compare these activities described here to the overview of programme activities presented in Table 2, page 16, it is clear that FPAB does a lot more, and that advocacy activities make up far more than 3% of the annual budget of the organisation. However, if we now return to the analysis of advocacy at the beginning of this chapter, it is also clear that the activities are concentrated in some areas of the 'map', while others are almost empty. In Figure 2 below, we use the same map to illustrate where activities are focused (green), and where there is a loss of opportunities (red), with areas in between where there are some activities, but less than in the focus areas (yellow).

Table 2. Focus and lost opportunities of FPAB advocacy activities.



There is no doubt that FPAB is implementing a variety of local advocacy initiatives that are relevant to the needs of poor people in Bangladesh. The organisation is addressing major barriers to SRHR within the community, particularly through the work of the Islamic Research Cell FPAB has a high level of collaboration with key NGOs and government agencies that are working within the field of SRHR and through dialogues and relationships with key government agencies and NGOs, the organisation is influencing the policy environment

In a challenging environment, FPAB has the potential to play a significant role in informing national policies, but the organisation is playing a relatively minor role in this area at the present time. With its high level of brand recognition and relationships with major agencies working in the field of SRHR,

FPAB could make a major contribution to the SRHR field if it becomes more involved in informing national policies. At the present time FPAB has very limited capacity to assess the impact and effectiveness of the advocacy initiatives, and the question is if the organisation at present has the knowledge and competence to undertake major and sustained advocacy campaigns at the national level.

5. Effectiveness and Relevance

Assessing Effectiveness

In this chapter the evaluation analyses effectiveness and relevance and these are two of the five criteria that are usually mentioned in evaluation – the other three being efficiency, impact and sustainability. But as the terms of reference make clear, this evaluation focuses on effectiveness and relevance.

Effectiveness is particularly difficult to analyse in an old and established organisation such as FPAB. Many activities have been running for a long time and they are not always subject to strict formulation of goals and objectives, but are important to continue as long as they are in line with the mission and mandate of the organisation. The projects on the other hand, could be analysed in terms of effectiveness; that is, the extent to which objectives are achieved, or are expected to be achieved. As we have seen above, the strategic planning framework is from 2005 to 2009, so we are now only a year and a half into the five year framework. It is a bit early to form a definite opinion on effectiveness.

However, as Sida's Evaluation Manual (Molund & Schill 2004) make clear, effectiveness can be more loosely defined as 'an aggregate measure of (or judgement about) the merit or worth of an activity, i.e. the extent to which an intervention has attained, or is expected to attain, its major relevant objectives efficiently in a sustainable fashion and with a positive institutional development impact'. We will approach the issue by looking carefully at what the organisation does and how people are affected.

One of the strategic goals is 'recognition of the universal right of women to choose and have safe abortion'. So what happens on the ground? One of the field workers told the interviewer that in the past month she had – on request – administered 15 pregnancy tests for women in her area (10 of whom were married and 5 unmarried). Two of the tests that belonged to unmarried women proved to be pregnant. She referred them onwards to the clinic, where they choose to undertake menstrual regulation. Is this event an indication that the objective is reached? Obviously not, but it is a worthwhile activity – in line with the long range goal – which will of course not be reached within this five year period anyway.

This is the nature of our assessment, and we think it is possible to conclude about the effectiveness of what the FPAB does on the basis of similar evidence. Some field workers will counsel more women, some fewer. Some will have different stories to tell. But they do paint a picture of the services, and they indicate that large numbers of women (it is mostly women) get access to services in line with the overriding objectives of the organisation. But there are also geographical areas that are not reached. The following section provides a narrative description of this some of this situation is and provides an analysis of the effectiveness.

Clinical Services

From the exit interviews conducted at the static and satellite clinics, it appears that the majority of people who attend clinics live close to the clinics, come for general medical care as well as for SRH

services and are generally so satisfied with the level of service that they receive that they expect to attend again in the future and would recommend the clinic to a friend with a similar problem.

Thirty-five people (7 males; 28 females) were interviewed at the branch static clinics in Barisal, Chittagong, and Sylhet[3]. They ranged in age from 1 to 60 years. Sixty-six percent stated that they lived close to the clinic with 77% taking 20 minutes or less to travel to the clinic by foot or rickshaw. Fifty-four percent were attending for general medical concerns; 31% for contraceptive services; and 15% for other SRH concerns. A secondary reason for coming to the clinic for 4 attendees was to obtain information or receive counselling.

Forty percent were first time attendees. Eighty – three percent said that there were alternative providers they could have attended but chose to come to the FPAB static clinic. Among the reasons for attending was the awareness that medicines could be purchased for 10– 5% under the market price.

All but one person was able to get the service they came for and nearly all were satisfied with the service they received. The notable exception was a woman attending for a tubectomy who experienced considerable delays at the clinic. As her family did not know that she was seeking sterilization, this posed considerable problems for her. Other than this one patient, all people interviewed said they would return to the clinic in the future and would recommend the clinic to a friend with a similar problem.

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

Eighteen people, (1 male and 17 females) ranging in age from 18–65, at a satellite clinic in each district were interviewed. Sixty-one percent of those interviewed lived close to the mobile clinic having travelled twenty minutes or less to get to the service. Only 28% were new attendees, the others having been to the clinic before.

Half of the attendees were visiting the clinic for contraceptive services and the other half were seeking non – SRH medical care. All but one attendee was able to get the service (s) he came for and would recommend the clinic to a friend and return. Fourteen said that they were satisfied with the attention they received; two were not satisfied; and two were partially satisfied. All but one said that there were alternative places they could have gone to get the same service but chose to come to the FPAB mobile clinic.

While the exit interviews indicated high levels of satisfaction on the part of clinic users, we found, when talking to groups of young people and women that many were suffering from a range of discomforts and concerns which had not been adequately addressed despite repeated visits to the clinics. We were repeatedly asked questions such as: 'Is it important that I haven't seen my period for 3 months?' 'I have

[3] All the interviewees were asked if they agreed to be interviewed and it was made clear they could say no. In Chittagong, 13 declined, saying they were in a hurry, and 14 agreed to be interviewed.

had a pain in my left side for more than 6 months. Is it due to the Norplant?' 'I have become thin and wonder whether this is due to the pill I am taking.'

Domiciliary Services

The participation of domiciliary field workers is an important component of FPAB's work. They perform valuable work for little pay, and they appear to be in greater contact with poor people than staff at the static and satellite clinics. A field worker has a designated area of some 500 to a 1.000 'eligible couples'. She visits these couples and provides information about methods of contraception. Some field workers counsel people (usually women) about different sexual and reproductive health issues. Common services that the field workers provide are administering different tests; blood pressure, urine, sugar, and pregnancy test. There is a cost for each test. As these field workers get known in the area, they are also consulted and trusted by the people living in the geographical area – so this may mean, for example, that even unmarried people approach them to receive contraceptives or consult them for tests.

Whilst the evaluation team concluded that the field workers provide an important service, and one that is very much appreciated in the communities (the evaluation meet some 100 persons who are in regular contact with these field workers) the team identified a number of shortcomings with the way this service is carried out:

- Field workers themselves feel unprepared for the many questions that arise during their work. The request for comprehensive and systematic training was vocally raised by local level volunteers we met.
- Field workers receive little training for the job they do. Some of those we spoke to had been working for up to 14 years, but had no more than a few weeks training.
- All of the field coordinators we met were men while the field workers themselves are women. This gender divide creates barriers for the field workers when discussing women's concerns.
- Supervision of the field workers' work appeared to be lacking. The field coordinators appeared to be mainly concerned with ensuring smooth and uninterrupted availability of oral contraceptives and condoms. As the provision of simple diagnostic tests is often done on the initiative of individual field workers, it is uncertain whether quality assurance of the test results is carried out.
- The lack of supervision also became apparent when surprisingly low levels of knowledge were revealed by some of the people the field workers were directly working with. In one community, we found that no one knew that FPAB offered menstrual regulation for the low fee of Tk 260. People in the community thought that their only menstrual regulation service provider was another NGO where the fee was more than twice that of FPAB's.
- As the community based volunteers are often the first point of contact for many people, there is a need for systematic information about what information local level volunteers and field workers impart to their clients and how much of it is understood and acted upon by people receiving their services.
- If field workers were able to offer vitamin and iron tablets, this would add to their repertoire of benefits they can offer people in the community

Traditional Birth Attendants' Training

It is clear that a number of the field workers are also traditional birth attendants who have received training through FPAB. The training period described by the traditional birth attendants varied from 3

– 12 days. In Sylhet, over 60 attended a 12 day training course but there appeared to be different views about the purpose of the training.

Staff at FPAB national headquarters and safe motherhood staff are clear that the purpose of the training is to train traditional birth attendants to be a support to qualified providers by informing the traditional birth attendants of the complications of pregnancy and delivery so they can refer women to health facilities in a timely manner. *Nevertheless, it is clear that the trainers, the traditional birth attendants, and the public viewed the training as enabling traditional birth attendants to carry out deliveries in a safer manner.*

Research has shown that training of traditional birth attendants does not lead to a reduction of maternal mortality. The joint WHO (World Health Organization), ICM (International Confederation of Midwives) and FIGO (the International Federation of Gynecology and Obstetrics) statement on the skilled attendant gives a clear definition of the core skills and abilities required by skilled attendants.
The current training appears to give further legitimacy to traditional birth attendants. The provision of kits to traditional birth attendants, with apparently expendable supplies such as more than one pair of scissors further strengthened the notion that they were expected to use the kit during deliveries and that supplies would be replenished.

The WHO concludes that there is no evidence showing that training traditional birth attendants reduces maternal mortality. Thus, it is difficult to accept that training traditional birth attendants or encouraging them and the public to view those with additional training to be skilled in safe delivery has a place in safe motherhood efforts.

Traditional birth attendants are well established in their communities. Recognition of the danger signs signalling complications of pregnancy and delivery is disturbingly low among the general public and probably among the traditional birth attendants themselves. As the safe motherhood project is about to start in 3 districts, this presents the opportunity to actively and systematically reach out to traditional birth attendants and bring them into the formal FPAB services. Given the limited mobility of many women, the traditional birth attendant becomes even more important as a link to medical services.

Non-clinical Community Based Activities

We observed only a few of the groups gathered at the Family Development Centres. From the little we saw, it appeared that the activities were effective in empowering women to have more control over their lives. The micro-credit programmes appeared to be successful. One woman told us of how with a small loan of Tk 1000, she was able to build a home with concrete walls and floor. Her husband who had earlier treated her badly began to treat her better. But, the real turning point occurred last year when her husband, a drug user, was able to go through a drug rehabilitation programme which cost Tk10 000 paid for by his wife. 'Now, he tells everyone that earlier *'I was a bad man' – my wife is a good woman. I was down in the gutter and she believed in me and saved me.'*

Vulnerable Groups

FPAB does not seem to work extensively, systematically, or particularly successfully with especially vulnerable groups. Weaknesses in identifying local vulnerable groups were seen among FPAB staff in Chittagong and Sylhet. Knowledge of networks for specific vulnerable groups (e.g. men who have sex with men, injecting drug users, commercial sex workers, the 'floating people') was limited in Sylhet In Barisal, the project for women who were survivors of gender – based violence did not appear to have thought through the stigmatizing effect of identifying women as 'survivors' to all the members of their community through the specific name and association with the project.

Assessing Relevance

Relevance is defined as 'the extent to which the objectives of a development intervention are consistent with beneficiaries' requirements, country needs, global priorities and partners' and donors' policies' (Molund & Schill 2004). When we assess relevance here, we will primarily do so based on what FPAB does rather than on the objectives. This is a direct assessment, and it seems to us more relevant – particularly in an old organisation which is not totally run on a project basis, to look directly at what happens in the meeting with clients.

Let us start with the needs of people. The background section of this report indicated a number of the SRH needs among men and women in Bangladesh. Among the most significant are:

- The government's health facilities are not available in all areas
- There is an unmet family planning need, estimated to be 11%
- 50% of couples discontinue use of their contraceptive method within 12 months of starting it
- The maternal mortality ratio is estimated to be 320 per 100,000 live births
- 90% of deliveries occur at home
- 63% of births are delivered by untrained traditional birth attendants; only 13% are delivered by trained health workers
- 45.7 million young people (32% of the total population) are between 10–24 years of age
- HIV prevalence is concentrated in high risk groups where it has reached nearly 5% among injecting drug users
- Among the large migrant worker population, one finds low awareness of HIV/AIDS, low condom use, and substantial contacts with male and female commercial sex workers

A significant cross cutting issue inter-linked to all the issues above is the low status of women. Bangladesh was ranked 105 among 177 countries on the gender-related index (UNDP 2005). Among the women in the top quintile of households, 33% are malnourished; while among women in the poorest quintile, 65% are malnourished. Literacy rates among females aged 15–24 is 41%; among same aged males, 58% (Population Reference Bureau 2006).

When examining the intentions, activities, way of providing services, and intended beneficiaries, many aspects of FPAB's work are highly relevant to the SRH needs of the population.

Partner to the Government Services

FPAB is an important service partner to the government. FPAB is allocated specific geographical areas for coverage – primarily rural areas where there are no government services. It was reported that FPAB was often allocated areas which are among the most remote and difficult to reach.

FPAB's clinical and community services resemble the structure of the government's medical services with domiciliary services, paramedics, mobile, and static clinics. FPAB clinics offer the Essential Service Package as defined by the national authorities at its clinical sites. Altogether, NGOs provide 6–7% of contraceptive supplies and SRH services in the country. FPAB appears to be the leading NGO in this field.

The Provision of Primary Health Care

A number of informants both within the government administration and among other stakeholders noted that government health care provision is inadequate to meet the needs of the population. There is clearly a need for comprehensive primary health care services in addition to further SRH services, which are currently being provided by FPAB. The monthly statistics of the static clinic at the FPAB Branch in Sylhet showed that nearly half of the service users are accessing FPAB services for non – SRH conditions. In Barisal, an estimated 20% of attendances are for general treatment. In total, among the people we interviewed at the static clinics, 54% were attending for non – SRH general medical reasons. Thus, through its static and out-reach mobile clinics, FPAB may be the only provider bringing formal health care services in remote communities.

The paradigm shift marked by the ICPD, the International Conference on Population and Development, places family planning within a wider range of SRHR concerns, many of which can be dealt with at the primary health care level. Specifically, the static clinics provide ante-natal, post-natal, and neonatal care, menstrual regulation and post – abortion care in addition to care for reproductive tract infections and sexually transmitted infections. FPAB is poised to begin delivery of these services in three selected branch clinics.

Given the high rate of contraceptive discontinuation due to 'side effects or health problems', the provision of Primary Health Care services is especially important to ensure that women do not discontinue using contraceptives for reasons that they attribute to contraceptive side effects but which are really indications of general medical conditions that can be addressed through good primary health care.

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

Domiciliary Services

Domiciliary workers visit households at the community level. Reproductive health promoters are allocated an area and are given targets for the number of couples to reach for family planning. In addition to providing information about reproductive health and certain methods of contraception, they raise awareness about general health, and refer women to clinics when health problems arise. Reproductive health promoters provide oral contraceptives and condoms and can perform simple tests for pregnancy, high blood pressure, albumin in urine, diabetes, and can monitor weight gain.

Visiting a static clinic is not easy for poor women who live in a rural location in Bangladesh. Time and again, when asked why people did not attend clinics for different problems, the issue of transport was identified. Even though many of the reproductive health promoters visit women who live reasonably close to static clinics, it was apparent that transport to clinics was perceived as an obstacle to clinic attendance. Domiciliary services in women's homes are an appropriate mode of service delivery where

transport can be arduous and where it is socially unacceptable for women to travel unaccompanied. It appears that without the domiciliary service, many women from poor households would not have access to oral contraceptives and basic health information.

Working with Vulnerable Groups

In Barisal, FPAB is implementing a project working with 'survivors of gender – based violence'. The project gives women and their children shelter and seeks to develop skills and provide micro – credit opportunities in sewing, tailoring, and poultry raising. This is fine in itself, but is it relevant? We have argued in this report that relevance is something that must be assessed at the level of individual human beings who come into contact with the project activities.

One of the interviewees in Barisal had been beaten and tortured by her husband and his family for many years. She was at a loss on what to do, and had at times sought refuge at her parent's home. She had no means to support herself, she was a burden to her parents who wished her to get out, and she could not return to her husband as she feared for her life. She got in contact with the project personnel in Barisal, and received access to a temporary shelter and learnt to support herself. She has also become engaged in the project and has gained confidence and organisational skills that she now also works on the Board of the project – helping to address the needs of others in the same situation.

Is that a relevant project activity? This is an illustration of what empowerment and reaching poor people means in practice. We cannot but conclude that it is relevant. Even though relevance can be understood and addressed against the background of government and donor policies and objectives, it must also be understood in relation to the needs of people. Gender-based violence is very common and project activities such as these are relevant responses. It is another question, and another challenge, to assess their efficiency, effectiveness, impact and sustainability. But the project is certainly relevant.

Concluding Remarks

In summary, yes, FPAB services and activities are relevant: They are relevant because; (1) the domiciliary service reaches women and their families who find it difficult to travel from their homes, (2) their community based programme is designed for local conditions and to meet local health needs in areas with little media coverage and low levels of literacy, (3) the FPAB activities as a whole provide badly needed primary health care services, and they are in most instances a partner to the government of Bangladesh, providing health services within its local and national framework of coordination.

However, the effectiveness is hampered by the continuing inadequacy of primary health care, by the gender imbalance of the local teams (coordinators and middle management), the lack of supervision of the field workers, inappropriate training of traditional birth attendants and by a poor understanding of the needs of especially vulnerable groups.

There is hardly any doubt that the FPAB is working in line with its mission statement and with activities that contribute to the strategic goals and objectives of the organisation. But as the goals are long term and as goal attainment is the work of many other actors too, an assessment of effectiveness must build on a holistic understanding of the organisation. At times the difference between efficiency and effectiveness is explained as 'doing the right things' (effectiveness) and 'doing things right' (efficiency). Our assessment is that the most of what we have seen FPAB doing is 'doing the right things', but there are also many instances where 'things can be done better'.

6. Reaching the Poor

Poverty in Bangladesh

Bangladesh is still struggling to emerge from the realm of poverty and the country is ranked 72 among 94 developing countries in terms of the Human Poverty Index (HPI). The HPI is a multidimensional measure of poverty; it takes into account social exclusion, lack of economic opportunities, and life expectancy. The 2004 national DHS showed that Bangladesh has the highest incidence of poverty in South Asia and the third highest number of poor people living in a single country after India and China. Eighty-three percent of the population lives on less that USD 2 per day.

Over the past twenty years Bangladesh has achieved increasing equity in the use of certain health and family planning services. At the present time the poorest 20% (quintile) of the population has levels of health and family planning service use at around three quarters of the level of the wealthiest quintile. Health and family planning services with the greatest levels of equity tend to be services such as the expanded programme of immunisation and family planning, which have traditionally relied on the delivery of services by fieldworkers. In contrast, the provision of other vital reproductive and wider health services, such as safe motherhood services, remain disturbingly inequitable. For example, the poorest quintile of the population shows levels of delivery by a medically trained attendant, at around 10% of the levels of delivery by the wealthiest quintile (NIPORT 2005).

Data shows that gender inequities in Bangladesh have been decreasing, over the past twenty years, particularly in the area of child survival, where girls historically had high rates of mortality in the postnatal and childhood years in comparison to boys. At the present time significant geographic disparities persist within Bangladesh. Sylhet division and Chittagong division, to a lesser degree, lag behind other divisions in many of the health and family planning indicators. There are some paradoxes within these broad inequities. For example, Sylhet has a higher later age at marriage and age at first birth than Khulna and Rajshahi, but it has much higher lifetime fertility. Consequently, special and focused efforts are required in these parts of the country if the overall performance of the health, nutrition, and population sector is to reach the targets set by the country in the national Poverty Reduction Strategy Paper and the second and third Millennium Development Goals.

Are FPAB Services Reaching Poor People?

This evaluation adopts a definition of poverty that includes more than household assets by looking at whether FPAB reaches people whose life capabilities are constrained. Constraints may arise from lack of education, lack of choice in making contraceptive decisions, lack of mobility, and/or lack of decision-making in the use of household resources.

FPAB provides a range of clinical and non-clinical services through its twenty district level branch offices to specific target groups. The organisation is currently reaching a large number of poor people through the branch clinics, satellite clinics, community-based out-reach programme and a small number of specific projects that target the SRHR needs of very vulnerable or marginalized groups of people, such as survivors of gender-based violence. This is primarily because clinical services are provided in locations that are easy for people to reach, charge fees that poor people can afford, and are perceived by users to meet their needs. However, FPAB has not established specific strategies or mechanisms to systematically identify the specific needs of ultra-poor people and provide tailored and appropriate services to meet these needs. FPAB does not currently have mechanisms to monitor or evaluate the extent to which the organisation is able to effectively meet the needs of the most marginalised groups in society.

The Branch Clinics

While we were unable to ascertain the household wealth status of people attending the Branch clinics, we did find evidence from the exit interviews that clinic users were poor. Among those we spoke to during the exit interviews, 43% had had no schooling and an additional 34% had had 5 years of primary school or less.

Furthermore, we noted that in Chittagong, among new clients attending from January to June 2006, 36% chose injectable contraceptives. In Sylhet the rate of injectable acceptors was 23% of the total acceptors. This contrasts with national data which indicates that injectables are chosen by 10% of women i.e. 17% of those using a method of contraception. In our meetings with more than 80 informants at the community level, women repeated identified injectables as the contraceptive of choice because women can conceal its use from their husbands and in-laws.

FPAB clinics charge small fees for their services. The registration fee is in the range of Tk 5–10; the reattendance fee is Tk10 and the different services have separate and different prices. FPAB clinics sell medicine for 10–15% less than the market price. An exemption system and policy for those who are not able to pay is implemented but the way it is carried out varies from clinic to clinic. In Barisal and Chittagong, we found that the clinics aim to provide services free of charge to 10% of attendees – those who are the poorest and are unable to pay for services. But, the clinic in Sylhet did not have a transparent and systematic way of identifying those who are in need of free services.

The organisation is committed to providing free medicine as required to meet the needs of poor service users. A range of free and subsidized contraceptive commodities are also provided from the static and out-reach satellite clinics. The low cost of commodities and medication provides an entry point for poor people to visit FPAB's clinics. For example, service users are able to choose whether to buy free contraceptive pills (supplied by the government) or a branded pill (usually Famicon) for which FPAB charges a subsidized price of TK 5.

In Sylhet we asked different groups of community informants (women served by field workers, political leaders at union level, and a group of non – users) whether the fee structure prevented people from attending the clinics. The spontaneous and unanimous response was that the fees did not pose an obstacle to access to care.

Similarly, it was evident from the interviews in Barisal that poor clients did not object to FPAB's registration fees or see this as a barrier to accessing FPAB's services. However, the majority of poor women said that they would like FPAB to provide more medicines free of charge as their husbands were reluctant to or do not give them money to buy medicines.

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

Some FPAB clinics gather information about the socioeconomic background of the clients attending the clinics. The data is used by FPAB's counsellor who is responsible for registering the clients and provides the basis for decisions that are made to categorise clients and ultimately provide free services. Information about the poverty status of a client is gained through information about income, appearance and area of residence. However, information about the number of poor people the clinics have reached is not fed back to the Central Office to be incorporated into the central MIS. Consequently, it is difficult for FPAB to provide precise information about the number and proportion of poor clients that they reach.

Exit interviews with service users showed that there may be other service providers who are located in close proximity to FPAB's clinics, but the FPAB clinic was selected because services and treatment cost less than these other service providers and there is a high level of client satisfaction with services provided. This causes a high number of clients to return to the clinics. Interviews with service users and discussions with users at the community level showed that the geographical location of the clinic, length of time it takes to reach a clinic and the cost of this journey are also important determinants of choice of health service provider.

Satellite Clinics

The out – reach satellite clinics are generally situated approximately 5–25 km from the branch office and static clinic. These clinics are usually held in a public building or a home that belongs to a senior member of the community. Approximately fifteen to twenty satellite clinics are organised by a branch each month. A medical doctor and clinical assistant are present at the majority of satellite clinics

Sixty-one percent of the clients interviewed stated that they 'lived close to' the satellite clinic. The majority of the clients who were interviewed and had visited a satellite clinic had travelled between a few minutes and half an hour to reach the clinic. An analysis of the clients who were interviewed showed that 50% were visiting the clinics to obtain contraceptives and the remaining 50% had visited the clinic to receive general medical services. Thirty-three percent of the clients attending the satellite clinic were illiterate and 50% had left school during their primary education. The data collected about the profile of satellite clinic beneficiaries shows that these clinics are meeting the SRH and wider health needs of poor women and women with low levels of literacy and education.

Again, in Sylhet, we find that during the first half of 2006, large numbers of women attend for injectable contraceptive – 218% above the target to be achieved.

Non-clinical Services

FPAB field volunteers are allocated 500–750 of households to provide SRH information and services to. The geographical areas that are allocated to these volunteers are not strategically selected based upon the levels or numbers of people living in poverty. Despite this method of allocation, almost all areas allocated contain large numbers of poor people. Field volunteers visit households twice in month with the main purpose of distributing oral contraceptive pills and condoms, providing information and advice about contraceptives and providing certain diagnostic tests (including pregnancy tests, blood pressure, and urine albumin) and information about these tests.

The field volunteers identify, refer and in some cases bring poor patients who need clinical services and further information to static clinics. The interviews suggest that the field workers find it easier to work with poor people than with the well-to-do. Field workers provided the following statements about their work with poor communities:

'With the poor we are like in the family, but many of the rich close the door on us'

'Poor people treat us with respect, the rich don't always do that'

The results of interviews with beneficiaries of non-clinical services, field workers and staff at FPAB's clinics all show that FPAB's non-clinical services are reaching and meeting the needs of poor populations for a range of SRH and wider medical services. While we also heard that some of the clients did not have their problems solved and had been living with them for years, it is important to remember that field workers in particular have little education to deal with many of the situations they have to cope with. Many of the poor people reached by FPAB's Local Level Volunteers are living in urban slums and remote rural areas with very limited access to static medical clinics.

Does FPAB reach extremely poor people and particularly vulnerable groups

Through interviews with community leaders, district officers, and other NGOs, certain groups were identified as particularly vulnerable groups. They were a) the 'floating migrant population' which included internally migrant workers and commercial sex workers. b) day labourers including rickshaw pullers, c) most at risk groups for HIV/AIDS i.e. injecting drug users (IDUs), male and female commercial sex workers, and men who have sex with men. These groups of people are highly marginalised and are difficult to reach. FPAB staff at the branch clinics did not seem to be concerned with reaching these groups and often seemed to be unaware of organisations that are specifically working with the group.

The SRHR needs of adolescents are often ignored and overlooked. When looking at the list of projects carried out by FPAB for adolescents, it appears that it is only engaged in a limited number of activities related to SRH education. But this is somewhat misleading because the majority of adolescent women are married by age 18 and are thus among those who have a need for family planning or safe motherhood services as well as for the wider range of SRH services.

When talking about 'adolescents' or 'youth', the implication is that one is referring to unmarried young people. It does not appear that FPAB has a coherent and comprehensive strategy for how to meet the SRHR needs of these young people who are under-served and marginalised in Bangladeshi society. The one youth friendly service facility visited by the Evaluation team did not appear to be appropriately designed or used.

Through focus group discussions with peer educators and beneficiaries, in Barisal and Sylhet, it appeared that the peer educators were trained and knowledgeable about a range of SRHR issues and were open and capable of talking about a variety of adolescent SRHR issues. Young people who interacted with peer educators were also aware of a variety of SRH issues including HIV/AIDS, body changes and gender-based violence. A gap in the area of knowledge among the young women was methods of contraception – when asked about their knowledge in this area, the girls said 'this will be relevant to us when we are married'. In Barisal, the male group asked for more information on contraceptives. The female groups wanted a medical doctor to have occasional sessions with them.
Many young people revealed that they are unable to share their SRH concerns and problems with their parents as one of them said 'I don't like to consult my problems with my parents at all but sometimes I talk with my grand mother'.

Consequently, it appears appropriate to consider youth as a particularly marginalised group although their numbers are large. They have a range of needs reflecting their different circumstances e.g. married/unmarried; in school/out of school; information/FP services. We did not find that FPAB demonstrated an understanding of the breadth of activities needed to meet the needs of young people.

FPAB has a few projects which try to reach particularly marginalised groups of people. For example, in Barisal a programme is being implemented to address the reproductive health and wider needs of

survivors of gender-based violence. The women in the beneficiary group have survived domestic violence, physical and emotional torture. Many have survived acid attacks, rape and the majority are no longer living with their husbands. Utilising a wide definition of poverty, that includes deprivation of rights and choices as well as a lack of income, these women can be defined as the ultra-poor and a particularly marginalized group. Through the Family Development Centre project FPAB volunteers are providing micro credit services[4] and providing assistance to encourage savings among women at community level in order to empower these women. One of these women stated that

> 'Even though my husband left me I didn't give up my hopes. I want to live and be strong for my child. The loan and training that I have received from FPAB has helped me to start a new life as now I have started to earn by sewing cloths for others and I'm paying back the interest on time. But the amount of loan is very little. I would appreciate a higher amount because now I have the confidence that I'll be able to return the interest'.

In addition to providing referrals to general health services, FPAB is providing legal support services to these women though a Memorandum of Understanding with a local NGO called Bangladesh Legal Aid and Services Trust (BLAST). One of the female survivors of an acid attack stated:

> 'Before meeting FPAB I was very much afraid to come out of my house. I thought my life has ended and I was a burden to the family. I'm grateful to FPAB because they helped to regain my self-esteem back and I am no longer afraid to come out. FPAB has enrolled me into a training programme which has a given me a direction and my independence.'

This programme is also engaging the wider community, including religious leaders in debates about gender-based violence and is trying to challenge the widespread silence and acceptance of the many forms of this practice. However, as noted in Chapter 5, the ramifications of identifying individuals as survivors of gender – based violence appear not to have been well thought out. The Evaluation Team heard that there had been a stigmatising effect resulting from the way the programme activities were conducted.

Concluding Remarks

The English version of FPAB's 2006 mission statement shows a commitment to improving SRH through effective advocacy and service delivery primarily to women, children, adolescents/youths emphasizing on underserved and disadvantaged areas through community owner ship. The Bengali version of the mission statement also expresses an intention to serve poor and vulnerable groups and meet the needs of adolescents.

From the three sites visited it was evident that FPAB is providing services to underserved and disadvantaged areas where government services and out – reach community programmes are not operating. Through its clinical and community-based out – reach programmes, FPAB is meeting the SRHR needs of many poor people. If the exit interviews are representative of FPAB clinical users, it appears that in addition to being materially poor, women attending FPAB's clinics have little or no education, often choose a contraceptive method which they can keep hidden from their husbands, do not travel long distances from their homes, and often do not have money to pay for medicines. The fee structure does not appear to be a hindrance to access to FPAB services.

FPAB does not appear to be able to reach exceptionally poor and marginalised groups in a systematic and appropriate manner. However, because poverty in Bangladesh is deep and widespread, perhaps FPAB's lack of efforts and results with these groups is not so important. FPAB's current activities are reaching poor people. Groups that are especially marginalised and vulnerable should perhaps be left to

[4] There is considerable evidence that micro credit opportunities do not benefit those who are extremely poor but provide opportunities for the 'moderately' poor.

organisations dedicated to their interests and which are agile enough to be able to make flexible and quick decisions.

7. Conclusions and Observations

The FPAB has a long history and has played an important role in the development of family planning and sexual and reproductive health policies and service delivery programmes in Bangladesh. Initially, its main role was to advocate for changes in government policies to address the need for family planning services. It did so very successfully and its pioneering role is widely recognised in the country.
Once these important changes were accomplished, the organisation moved onwards in two directions;

- First, it established a structure of clinics at district levels to provide a wide range of family planning, SRHR, as well as primary health care services, mostly in urban areas, and with these as a base it reached out to larger populations through satellite clinics and volunteer reproductive health promoters.
- Second, The FPAB broadened its interests to address a wider SRHR agenda, in accordance with the ICPD, for example by working with youth friendly programs or projects to reach out to religious leaders and other community leaders to raise awareness around health and family planning. These initiatives take the form of projects that are often implemented in one or more districts.

Whereas the first development is widely known in Bangladesh and is what the organisation is known for, the latter is not widely recognised. The image and reputation of the organisations rests on its early achievements and its continued work in family planning. This image exists despite the fact that the organisation has worked with the broader scope of SRHR for the past 10 years.

One of the reasons that the image of FPAB is closely tied to family planning is that the work it does in this field is both relevant and effective and it has been sustained over half a century. Through its branches and the clinical as well as non-clinical services, the FPAB reaches some 1.8 million people. These are people who often have no other access to health care, let alone family planning. The government coordinates the work of NGOs and government services, and as health services are geographically determined, the FPAB is mostly in areas where there are no other –or very few providers.
The name of FPAB also greatly contributes to the image of the organisation just focusing on family planning!

The static clinics are generally located in urban areas where the distance to either government hospitals or to private health providers is not sufficiently great to be a major barrier to FPAB's service users accessing the same services at these organisations. One reason why many clients still prefer to go to the FPAB clinic is that they provide cheaper services and medicines than many private alternatives, they 'don't ask as many questions' about issues such as unmarried women's pregnancies and other isses that the client wants to be kept confidential. FPAB focuses on the rights of the client, including the rights to privacy and confidentiality than many other service providers Consequently, the quality of care and respect for clients appears to be better at FPAB clinics in comparison to many other service providers. Still there are other NGOs who offer services, and some of them appear to offer a higher quality of services than FPAB – Marie Stope's clinics in particular. The target group of these clinics is different to FPAB – there is more of a focus on income generation – although there are some specific programmes/ outreach services to meet the needs of the poor, for example, services in garment factories.

The vast majority of people who come to the clinics and who access the services provided by the

Reproductive Health Promoters are poor. The statistics generated by FPAB show that around 75% of the people that the reproductive health promoters reach are poor. Interviews with staff at clinics and field workers confirm this figure. The data from the evaluation's interviews and focus groups with some 300 clients actually suggest that a higher percentage of people that benefit from FPAB's clinics and community-outreach programmes are poor. Almost 90% of the exit interviewees were classified as poor and approximately the same proportion of people who were interviewed following use of a non-clinical service were also classified as poor.

The data collected at clinics focus on the incomes and assets of service users to define and measure who the poor are and to what extent they are poor. However, it is important to recognise that many of the clients are impoverished in other ways too, for example young girls who have experienced and survived sexual harassment and rape in schools, within their families and at work, or others suffering from violence, such as acid attacks and other forms of violence. Whereas young women who have sought refuge from violent husbands with their families may have some material assets, they are stigmatised, distressed and have little power or choice in their life and must be considered amongst the poorest in society. At the field level, this seems to be widely recognised amongst the staff of FPAB.

It is not surprising that this extensive service provision dominates the public's perception of what the organisation does, nor is it surprising that many board members at district and national levels value this as their most important mission to preserve and maintain. But in the process, the organisation appears to have lost its origins and competences in national level advocacy work, and, has also failed to carve out a niche for itself in new areas of advocacy on a national scale. Even though one can justifiably speak of advocacy at district and sub-district level, or public awareness as a form of advocacy, this is limited and none of the projects have had the national impact of the organisation's advocacy activities in the 1950's and 1960's.

While there is no doubt that FPAB does reach poor people with its services, and has a considerable impact on the lives of people, it is more important that the organisation reaches those who are the most poor; disempowered and exploited people, with particular emphasis to adolescents. Though the mission of the organisation contains a commitment to reach marginalized groups, there are no focused and concerted programme efforts to meet the needs of this group of people. It is important for FPAB to have very clear targeted beneficiary groups, and clear strategies of how these groups can be reached. The projects encountered during the evaluation were too scattered, too small, and lacked a programmatic framework. While useful in themselves and having an impact on the people they served, they remained limited in geographical coverage and the achievements appear not to be effectively sustained by the organisation.

The FPAB is going through a process of substantial change at the present time. There is a new management that is intent on developing the competencies and capacities and to change the structures and processes of the organisation. The change process started a year ago and it is, far from complete. It takes time to change an organisation that is as old and has so many entrenched values and attitudes, but change is necessary, and one of the reasons the FPAB has not made more progress around a broader SRHR agenda is the result of its huge middle management cadre. Many in that category do not appear to understand the evolving needs of their clients, and particularly not the threats and challenges set by the HIV/AIDS pandemic, or the conditions of often migrant, transient and floating marginalised groups. Often this category of management do not even acknowledge who these people are, or what their needs are. Fortunately, at the field level, where the direct interface between the FPAB and its clients occur, many of the doctors, paramedics, counsellors and volunteer field workers appear dedicated and committed. The majority of them are women, and they have served the organisation for a long time. The community-outreach workers provide continuity and local knowledge about a range of health issues, and they are appreciated by the communities, particularly by poor people.

While the services provided to people should be considered relevant, there are still many areas that need to be addressed to ensure and improve the effectiveness of FPAB. The overall governance and strategic decision-making, the branch management, and the supervision have not made the best use of the organisation's resources. The efficiency of the organisation, as well as its effectiveness, has been hampered by structural as well as process problems. In the course of the evaluation, seven areas in particular were singled out for further attention:

1. FPAB should collect better quality data about people who access services, in particular data that relates to the poverty status of the clients. When collecting this data FPAB should focus on a broad definition of poverty, as utilised within this evaluation and should not simply focus on the income/assets of a service user. Such data would help the organisation focus on poor and marginalised people and enable FPAB to develop better strategies on how to reach them.

2. At present the FPAB has difficulties assessing its own effectiveness as the necessary systems of monitoring and evaluation are not in place. This evaluation has been able to make conclusions about effectiveness, but these conclusions are a general and organisation wide assessment. The FPAB should collect more detailed information about the effectiveness of its own activities in order to set priorities and also in order to be held accountable on effectiveness by members as well as by external stakeholders.

3. In respect of governance, the roles and responsibilities of the volunteer boards need to be clarified and changed. The boards should be made smaller and their work more focused. They should provide strategic direction and advice to the organisation, but not be involved in implementation and decisions on programme and project level.

4. The Chief Executive Officer should be accountable to the National Council and through it to members, as the Constitution of FBAB states. But the practical delimitations of the board members decision-making and the nature of their relation to management need to be developed. The Constitution is not sufficiently clear on how this should be worked out in practice.

5. The organisation must have a consistent and clear mission statement. There should not be a variety of such statements. The mission statement should be relevant and realistical to reflect what the organisation wants to do and can do.

6. Strategic planning needs to be developed; a programmatic approach should link projects to overarching objectives. A strategic plan is not the same as a list of projects and a summary of their objectives.

7. Human resource development needs to be continued and developed; the first priority should be further training for field volunteers, many of whom have very little professional development. The second priority should be large scale change at middle management levels – bringing women, younger professionals, and people that are well-attuned to the changing needs of poor people into executive positions. Staff and volunteers should also be sensitive to the needs of marginalized and vulnerable people whose SRH rights are threatened.

The FPAB is working closely with the government of Bangladesh but has not taken upon itself to be a progressive force to advocate for SRHR at the national level. Other actors in the community regret this situation, and there are certainly many issues that could be addressed and pioneered by FPAB including early marriages, gender-based violence and the inclusion of SRHR in the curriculum. The evaluation sees this as a missed opportunity, and concludes that past generations of managers have squandered the heritage of the FPAB. There is potential for FPAB to engage in pioneering advocacy initiatives, but it will not be easily accomplished. To influence public awareness at national level, to shape a policy environment, to see new policies in government and to see these effectively implemented is a huge

challenge. The question is 'does the present organisation has the necessary competence in identifying target groups, shaping strategies, monitoring and evaluating progress towards policy changes that ultimately benefit poor people, for example concerning early marriage'? The answer is probably 'no', but on the other hand the FPAB probably did not have these skills when it started in 1952 either – the experience shows that competence can be developed in the course of doing the work. We would strongly recommend that the FPAB addresses advocacy at national levels and undertakes the necessary capacity building to do so.

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Appendix 1. List of Persons Met During the Evaluation

Dhaka

Meetings at FPAB/Dhaka

Halida Hanum Akhter, Director General

Md Shamsul Ahlam Chowdhury, Honorary Secretary General

Md. Salahuddin Khan, Honorary Secretary

Dr. Jahir Uddin Ahmed, Additional Director General

Md. Abul Quasem, President

M. Abbas Uddin, Deputy Director

The evaluation team had an introductory meeting where the Director General had invited all sections heads from the office. The evaluation subsequently meet with several of these, and had a debriefing presentation/discussion with some 20 participants.

Meetings with other SRHR stakeholders in Dhaka:

Managing Director, Marie Stopes, Bangladesh

LynnGorton, PHN Director, USAID

AJ Faisal, Engender Health

Abdul Mannan, Director General, Family Planning at the Directorate General of Family Planning
Dr Jafar Ahmad Hakim, Director, Family Planning at the Directorate General of Family Planning

Hasibul Haque, Chief, Integrated Prevention and Health Unit, FHI

Rasheduzzaman Shah, Save the Childrenm USA, Dhaka

Shahana Nazneed Sayeed, Save the Children USA, Dhaka

Mohammed Shahjahan, Director, BCCP

Ms. Lynn Gorten, USAID

Dr. Sukumar Sarker, Project Management Specialist, USAID

Dr. Abu Jamil Faisel, Country Representative, Engender Health

Hasibul Hague, Chief, Integrated Prevention and Health Unit, Family Health International

Pornchai Suchitta, Deputy Representative, UNFPA

Tahera Ahmed, Assistant Representative, UNFPA

Touhid Ul Alam, National Programme Officer, Strategic Development, UNFPA

Hans P. Melby, Counsellor-Deputy Head of Mission, Royal Norwegian Embassy

Arne Haug, First Secretary, Royal Norwegian Embassy

Reazul Islam, Sida

Chittagong

Meetings with FPAB staff:
Md. Aktaruzzaman, Branch Director

Meeting with 7 members of volunteer board

Nirup Begum, Paramedic

Shafir Jannat, Paramedic

Rintu Kantabatheraju, Dr.

Youth Coordinator

Further meetings in group interviews with staff at the clinic and outreach clinic, and Community Health Promoters.

Meetings with other SRHR stakeholders:
Mostafa Kamal Uddin, Chief Executive Officer, Chittagong City Corporation

M.A. Mannan, Medicine Specialist,, Chittagong City Corporation

Sabiha Mussa,, Chittagong City Corporation

Nurul Alam, Commissioner,

Jasmeen Sultana Paru, Chief Executive, ELLMA

Deputy Director, Family Planning, Directorate Ministry of Family Welfare (3 persons)

Director, Womens Affairs Office,

Youth Directorate (3 persons)

Director, Marie Stopes Clinic,

Director and Chief medical Officer, Nishkriti

Sylhet

Interviews FPAB Sylhet (does not include FGDs with field workers and beneficiaries)
Meeting with entire FPAB Sylhet Branch but separate interviews (group and individual) with:

Md. Tahazzat Hossain, District Project Officer, FPAB

Dr. A.K.M. Abdun Noor, Safe Motherhood Project Unit Manager, FPAB

Dr. Taslima Sultana, Medical Officer, FPAB

Dr. Fahmida Chawdhury, Medical Officer, FPAB

Sabitri Data, Clinical Assistant, FPAB

FPAB Sylhet Branch Board

Deba B Rozer, President

Masudo Akhter Chawdhury, Vice-President

Dr. Azizur Rahman, Medical Secretary

Bahauddin Zakaria

Nazbeen Zakaria

M. Shamsul Alam Chowdhury

Supaiyo Chakravoty

M.A. Karim Chowdhury

Non-FPAB informants

Md Zahahgir Hossain, Deputy Director, Family Planning, Sylhet District

Dr. A.Z. Mahbub Ahmed, Civil Surgeon, Sylhet District

G.M. Anefin, Principal, FWVTI

Mrs. R. Akhter, Field Trainer, FWVTI

Shishin Kumar Roy, Deputy Director, Dept. of Youth Development, Sylhet District

Dr. Md. Shahedul Islam, Project Director, NSDP Project, SSKS

Md. Moshiur Rahman, Project Manager, NSDP Project, SSKS

Shima Chowdhury, Programme manager, VARD

Sk.A.G.M. Latifur Rahman, Programme Officer, Marie Stopes

Shah Muhammad Nazrul Islam, Astt. Director, Imam Training Academy, Sylhet

Chairman and Members of MoglaBazar Union, Sylhet

Barisal

DPO and ADPO including other branch office and clinic staff

Board members

Community and religious leaders

Volunteers and supervisors

Deputy Director FP, Barisal

Civil surgeon, Barisal

Medical officer, MCWC, Barisal

Director NSDP clinic and representative from a local NGO providing HIV/AIDS services, Barisal

Representatives from BLAST, Barisal

DD youth, Barisal

Marie Stopes, Barisal

Uganda

Acknowledgements

We would like to express our gratitude to the people who took the time to share their views and insights during the course of this evaluation. In particular, we would like to thank the Family Planning Association of Uganda (FPAU) for all its assistance in facilitating the Evaluation Team's visits to the branch clinics in Kampala, Mbarara and Tororo. Visits to the districts provided valuable insight in understanding the workings of FPAU. We further appreciate FPAU's assistance in arranging for us to meet sexual reproductive health and rights (SRHR) stakeholders at the national level. In preparation for the country visit, we also received background information from IPPF's Central Office in London and from the regional office in Nairobi.

The views and conclusions expressed in this report are our own and the recommendations reflect our assessment. We hope this report will assist FPAU in its future work with the sexual reproductive heath and rights of the men, women, and young people of Uganda.

Oslo, Stockholm, Kampala, November 2006

List of Acronyms

AIC	Aids Information Centre
AIDS	Acquired Immune Deficiency Syndrome
APB	Annual Programme Budget
CBRHA	Community Based Reproductive Health Agent
Danida	Danish International Development Agency
DDHS	District Directors of Health Services
DFID	Development for international Development
DSW	German Institute for Population and Reproductive Health
FGD	Focus Group Discussion
FP	Family Planning
FPAU	Family Planning Association of Uganda
HC	Health Centre
HIV	Human Immuno Deficiency Virus
IDP	Internally Displaced People
IEC	Information Education Communication
IPPF	International Planned Parenthood Federation
MA	Member Association
MMR	Maternal Mortality Ratio
MoH	Ministry of Health
NEC	National Executive Committee
NGO	Non Governmental Organisation
Norad	Norwegian Agency for Development
NPHC	National Housing and Population Census
PAC	Post Abortion Care
PE	Peer Educator
PLAN	Plan International
RH	Reproductive Health
Sida	Swedish International Development Cooperation Agency
SRHR	Sexual Reproductive Health and Rights

STI	Sexually Transmitted Disease
TASO	The AIDS Support Organisation
TFR	Total Fertility Rate
TT	Transient Traders
UDHS	Ugandan Demographic Health Survey
UNFPA	United Nations Population Fund
URHAN	Ugandan Reproductive Health Advocacy Network
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
YAIHD	Youth Action Initiative for Health and Development
YAM	Youth Action Movement

Executive Summary

Background

This study is part of an evaluation to assess the relevance and effectiveness of the work of the International Planned Parenthood Federation (IPPF), and in particular, to study the extent to which poor people are reached by its efforts. The evaluation has been commissioned by Sida and Norad and has been undertaken by an external team of evaluators working in cooperation with the funding agencies and IPPF. This study of the IPPF Member Association in Uganda, the Family Planning Association of Uganda (FPAU), is one of three country studies; the other two being carried out in Bangladesh and Ethiopia.

Methodology

The evaluation of FPAU took place from September 11th to 22nd, 2006. Four-day site visits to the branch clinics in Mbarara, Tororo, and Kampala were valuable components of the evaluation providing the team members with the opportunity to see FPAU activities on the ground. The 7-person evaluation team which included 3 youth consultants, gathered considerable information using a range of qualitative methods supplemented by some quantitative data.

A wide range of people were interviewed for the evaluation: FPAU staff and board members at national and branch levels, service users, participants in community based activities, national and district level government officers, partner organisations, representatives of donor agencies, and service non-users. More than 300 people were met. Data collection techniques included semi-structured interviews with key informants, exit interviews, focus group discussions with stakeholders, observations of activities and clinic settings, and document review.

Uganda's SRHR Context

The important SRHR issues in Uganda's relate to its persistently high total fertility rate of nearly 7 children per woman, unmet contraceptive need, lack of access to health care services, high levels of maternal deaths, HIV/AIDS/STIs, teenage pregnancies, unsafe abortion, and gender-based violence. The landscape of SRHR interventions faces social and political challenges. Community socialisation in Uganda encourages male dominance and promotes large families. Early marriages are socially sanctioned and lead to larger family size and school drop-out with attendant poverty. Polygyny is common throughout the country. Negative male attitudes towards family planning and sexual coercion pose challenges to the success of interventions. Men are dominant in household decision-making and this is critical when applied to health seeking behaviour.

The Family Planning Association of Uganda (FPAU)

The Family Planning Association of Uganda (FPAU) was started in 1957 by a group of volunteers. It was affiliated to the International Planned Parenthood Federation in 1964 and became a fully accredited member in 2004. FPAU is seen by all SRHR stakeholders we interviewed to be the leading NGO providing quality SRH services. With its 16 static clinics, outreach activities, and community-based efforts, it is recognised for its wide networks of service delivery points that reach deep into rural communities. The confidence partners have in FPAU's work is demonstrated by the large portion (over half) of its budget that is supported outside IFFP's core funding. Partners span a large range including, bilateral development agencies, other NGOs, UNFPA, the Ministry of Health, and IPPF member associations in European countries.

The Approved Programme Budget (APB) for 2006 amounts to nearly Ush 4 billion and is expected to fund 14 projects grouped under IPPF's Five A's and 3 supporting strategies. *It is difficult to gain a clear picture of FPAU's activities from the APB.* Projects are listed under each of the Five A's but each project may include activities relating to the other programmatic areas. A project listed under HIV/AIDS is designed for young people and is thus also relevant to the 'adolescent' programmatic area. The advocacy section lists only 3 projects but advocacy activities such as awareness raising or sensitisation to SRHR issues through radio shows may be included in other projects under other programmatic areas.

Recommendation: Together with IPPF Central Office and the Africa Regional Office, devise a reporting mechanism which gives a more accurate picture of the activities relating to the five programmatic areas, the Five A's

The evaluation found that young people are highly involved in decision-making and programme implementation of FPAU's activities. Youth are represented in a gender-balanced manner on the National Executive Committee (NEC) as required by the Constitution of FPAU. Young people have a governance structure from the Branch through the National Council to the NEC level. This is called the Youth Action Movement (YAM). The YAM aims at formalising the structures of young peoples' participation within member associations. Youth volunteers elect representatives at the branch, regional and national levels. At branch level, young people participate in the making of programmes and work plans.

One of the strengths of FPAU is the engagement of highly skilled staff. All staff are employed on 3 – year renewable contracts. Salaried staff members have received significant training. At the national office, we noted that most of the staff had not been in post for more than 5 years. It appears that FPAU's highly competent staff are recognised widely and are often recruited to other organisations. At the Branch level earlier this year, 5 in-charge staff departed for other jobs. There has recently been a review of the salary scale to make salaries more competitive with other organisations. FPAU's staff is gender-balanced with 55 males and 58 females. The gender balance is also reflected at management level. The numbers of women are shown in the organisation's organogram thus always illustrating the degree of gender-balance at different levels. Women are well represented on FPAU's Board.

Relevance and Effectiveness of FPAU's Services

The evaluation found FPAU's services to be relevant to country needs, expressed needs of beneficiaries, national policies, and international consensus on SRHR issues.

The current scope of FPAU's clinical activities include the provision of non-permanent contraceptive methods; primary health care for SRH conditions, minor ailments, and immunisation; limited post-abortion care; diagnosis and treatment of STIs; and voluntary counselling and testing for HIV. FPAU networks with other providers and refers clients to other organisations for permanent contraceptive methods, complications arising from unsafe abortions, counselling and treatment for HIV, and a wider range of maternal health services.

FPAU is widely recognised as a 'solid and good provider of family planning services'. Other than government services, FPAU is the service provider with the greatest network of facilities at community level where its outreach also extends to village level. There does not appear to duplication with government services. SRHR stakeholders, including government informants, underline that many government health units are non-functional due to inadequate infrastructure, under-staffing, and shortages of drugs, supplies, and equipment. Visits to 2 government facilities confirmed this picture.

A significant portion of FPAU's clinical work is the provision of primary health care (PHC) for both SRHR conditions e.g. pregnancy tests, ante-natal care and non-SRHR care e.g. malaria testing and treatment, deworming, immuniisation. The range and level of services offered are relevant to the SRHR and general health needs of men, women, and young in the country and are consistent with the many

government policies for the sector. Although available in the clinics, there appeared to be little demand for emergency contraception. Beneficiaries identified gaps in the service to be comprehensive post-abortion care and deliveries.

Recommendation: FPAU should strengthen its post-abortion care and make it known to potential users.

FPAU uses a number of effective approaches. These include the active engagement of its volunteers, peer educators, community-based agents for public awareness raising and motivation towards positive SRHR attitudes and behaviours. The priority placed on reaching young people is translated into action by the placement of clinics in close proximity to youth centres run by FPAU. These are important places for youth to gather, often providing the only social space for young people in an area. This allows young people aged 10–24 to gather at the centres where they are exposed to appropriate and accurate IEC in an atmosphere that fosters positive attitudes to SRHR, and allows easy access to clinical services where they can attend for advice, supplies, and testing without attracting attention.

Youth consultants met with peer educators who were able to point to weaknesses hampering their work. These included: a) *Insufficient training.* Some volunteers feel they have inadequate knowledge about important health issues like HIV/AIDS due to lack of comprehensive training around this topic, b) *Limited funding.* Peer educators find that this constrains the effective implementation of activities like community mobilisation, information dissemination, presenting drama shows etc. due to inadequate facilitation in terms of transport, furniture and the necessary equipment or materials, c) I*nsufficient support for the youth volunteers* particularly regarding remuneration and transportation.

Recommendation: FPAU should review its in-service and refresher training programme to ensure that peer educators and community-based volunteers are sufficiently trained to meet new SRHR challenges as they develop and are kept updated about the provision of HIV/AIDS prevention, treatment, care, and support efforts at their local levels.

FPAU's Advocacy Efforts

It is clear that the policy environment for improved SRHR in Uganda faces many challenges. Nearly all the SRHR stakeholders we spoke to noted the lack of agreed commitment to family planning among the country's leadership. Only 1% of the funds available under the health sector SWAp is allocated to reproductive health. USAID is significant actor in the field and the Mexico City Policy limits the number of organisations with which FPAU can collaborate. The legal status of prostitution, abortion, and men-who-have-sex-with-men creates an environment of stigma and discrimination which discourages opportunity to advocate in ways which would improve SRHR in these areas.

FPAU's APB categories 3 projects under the advocacy programmatic area. Together these have been allocated 9% of the 2006 annual budget. However, as indicated in the discussion above about the APB, it is difficult to get a clear and complete picture of FPAU's overall advocacy efforts. It appears that much of FPAU's advocacy activities are focused on sensitisation and debating. At the community level particularly, one finds 4 approaches that can be considered public awareness raising with the potential for behaviour change. They are the: a) commitment of the volunteer members often arising from their own personal histories, b) activities of the community-based volunteers i.e. the community-based reproductive health agents and the peer educators, c) information, education, and communication materials (IEC), and d) radio broadcasts.

Because IEC materials are important in advocacy efforts around sensitisation and mobilisation we examined the written materials produced by FPAU. We were informed that the IEC materials carried messages that went through a careful process of development, had targeted audiences, and addressed adolescent issues. These are pre-tested and carefully post-tested to ensure that the intended message is conveyed. When the youth consultants assessed the written materials they found that the messages cover

a wide range of SRHR issues. They are aimed at increasing awareness against the socio-cultural practices that impede improved reproductive health for adolescents and increased awareness for positive change in attitudes, behaviours, beliefs, values, and practices. The messages cover abortion, early and/or forced marriages, unwanted pregnancy, STIs, cross generational sex, HIV/AIDS, condom use, male involvement, immunisation, idleness, post abortion care, positive living, and family planning. They promote the rights of adolescents to information and services. The have catchy messages that use the language of the targeted audiences. They appeal to different groups in the population including those who cannot read.

Two limitations to the IEC materials were found: a) There is lack of a communication distribution policy. Donors strongly influence distribution of the IEC materials whose development they have supported. b) There is need for good monitoring system to test the effectiveness of the materials.

Recommendation: FPAU should establish an IEC materials distribution policy.

Recommendation: FPAU should develop a evaluation mechanism to test the effectiveness of its IEC materials.

With regard to advocacy efforts at the national level, we found that the Strategic Plan 2004 – 2008 highlights critical issues as a) resistance to some aspects of the integrated FP/RH agenda, b) negative cultural practices such as female genital cutting, widow inheritance, forced marriages, dowry, and c) limited resources for SRHR. We saw and were informed of few activities directed towards these issues (other than the IEC materials discussed above) and we did not see clear links between b) and c) above with the efforts of the volunteer members and the community-based volunteers.

There are 3 focal areas in Uganda's National Advocacy Strategy in support of reproductive health, population and development programmes that are directly related to FPAU's mission e.g. unmet contraceptive need, adolescents SRH services, and maternal health. *It is therefore surprising that FPAU does not appear to have a clear advocacy strategy related to these focal areas.* We did not hear of any FPAU advocacy efforts aimed at resource mobilisation for better maternal health. Nor did we hear of any efforts at social mobilisation to hold government authorities accountable for the services they offer.

With such a strong reputation in the field of SRHR, FPAU is well positioned to advocate for sensitive issues. Because of its well established credibility, people will listen to it if it disseminates research and information about taboo topics such as abortion or vulnerable groups. A number of stakeholders, including partners, expressed a desire to see FPAU take a more aggressive stand on a number of issues such as abortion, pushing the government to provide adequate services, and coordinating the non-governmental stakeholders. Despite being a well respected service provider, FPAU is not perceived to be a major actor in the field of advocacy. We found that efforts to influence the policy environment, especially at national level appear to be weak. FPAU does not appear to be using its established credibility as a service provider to leverage for policy change.

Recommendation: Develop a clear advocacy action plan with an identified topic, clear target audience, techniques that will be used, evidence that will be presented to support arguments, and identified partners for alliance.

Reaching Vulnerable Groups

One of the central questions of this evaluation is how well FPAU serves poor and vulnerable people. There appears to be little specific targeting of the poorest people, but that is probably a reasonable strategy given the structure of poverty in the country. We conclude that FPAU reaches poor and vulnerable groups and they are probably better than many other providers in this respect, particularly due to their effective network in rural areas. There are a number of methods for poverty targeting each with its advantages, disadvantages, and costs. It might be useful to consider all the pros and cons in using targeting strategies in the planning process.

Each Branch clinic is expected to carry out 4 'outreaches' each week. These are to hard-to-reach villages, workplaces, and community spaces such as churches. From our limited data of 75 exit interviews carried out at static clinics and outreach clinics in rural areas and urban slums, it appears that people attending the outreaches are poorer in terms of educational level and assets. We conclude that the outreach activities are more effective in reaching vulnerable groups than are the Branch static clinics.

Recommendation: FPAU should consider expanding its outreach services to cover a wider geographical range rather than adding services which expand the level of care.

FPAU operates a fee system with the fee structure posted clearly on the entrances to its clinics. Fees are sometimes cited as a reason why some people e.g. youth, women with limited access to cash do not attend for family planning. Exemption practices exist and people are often not turned away if they need care. But, we heard conflicting stories about how the exemption practice is carried out Exemption practices were observed but these do not appear to be consistently applied or well known.

Recommendation: A review of the fee structure and exemption practices is recommended. The policy should be clarified and made known to staff, volunteer members, and community volunteers.

In addition to reaching vulnerable groups, FPAU also serves the less poor. It was noted that some service users at the urban clinics, most notably in Kampala, most likely would be able to bear a higher fee for the FPAU services.

Recommendation: The possibility of cross-subsidisation from better off users to poor and vulnerable groups should be considered.

FPAU works with a number of vulnerable groups but the picture is incomplete. The evaluation talked to beneficiaries of FPAU's work with petty traders including commercial sex workers and street children. We were informed that FPAU also works with internally displaced people and victims of female genital cutting but we did not have the opportunity to observe these activities. We did not hear of any other work directed toward reducing gender-based violence.

In summary, the recommendations of this Uganda country report are:

1. Together with IPPF Central Office and the Africa Regional Office, devise a reporting mechanism which gives a more accurate picture of the activities relating to the five programmatic areas, the Five A's.
2. FPAU should strengthen its post-abortion care and make it known to potential users.
3. FPAU should review its in-service and refresher training programme to ensure that peer educators and community-based volunteers are sufficiently trained to meet new SRHR challenges as they develop and are kept updated about the provision of HIV/AIDS prevention, treatment, care, and support efforts at their local levels.
4. FPAU should establish an IEC materials distribution policy.
5. FPAU should develop an evaluation mechanism to test the effectiveness of its IEC materials.
6. Develop a clear advocacy action plan with an identified topic, clear target audience, techniques that will be used, evidence that will be presented to support arguments, identified partners for alliance, and a timeframe.
7. FPAU should consider expanding its outreach services to cover a wider geographical range rather than adding services which expand the level of care.

8. A review of the fee structure and exemption practices is recommended. The policy should be clarified and made known to staff, volunteer members, and community volunteers.

9. The possibility of cross-subsidisation from better off users to poor and vulnerable groups should be considered.

1. Introduction

Background to the evaluation

The International Planned Parenthood (IPPF) and the development cooperation agencies of Sweden (Sida) and Norway (Norad) have been partners in promoting family planning and sexual reproductive health and rights (SRHR) for many years. IPPF is the largest non-governmental organisation (NGO) in this field with 151 member organisations in 182 countries around the world.

A pioneer in the advocacy of family planning, IPPF has, since the early 1990s, broadened the scope of its activities to include a wider range of SRHR services and advocacy of sexual reproductive rights. Its current Strategic Framework 2005–2015 prioritises five programmatic areas: adolescents, HIV/AIDS, abortion, advocacy, and access. The governments of Sweden and Norway are strong supporters of the 1994 ICPD Cairo framework for population activities and have long supported IPPF. Currently their contributions make up more than 25% of IPPF's core budget or 'unrestricted funds.'

Purpose of the evaluation

The purpose of the evaluation is to examine the relevance and effectiveness of FPAU's work – its services, advocacy efforts, and information sharing – in promoting the SRHR of poor and vulnerable people and marginalised groups. The approach has been to assess the FPAU's work in the light of the life circumstances of the people they serve. The focus in this evaluation has been to ask what happens at the grassroots level. How do people react to, relate to, and use the services provided? How does FPAU reach poor and marginalised groups in their country?

Additionally, concerns in the area of development cooperation have changed over the years as both Sweden and Norway have increased their commitment to poverty reduction. The question here is whether FPAU reaches poor people. Poverty is treated as a condition of life: a lack of power, lack of choice, and a lack of opportunities to exercise basic human rights, particularly in the field of SRHR. Poverty is also a broader concept than low income levels, although it is often easiest to measure income levels or wealth. Even in these cases, one needs to bear in mind that poverty can be seen in both an absolute sense and a relative sense.

Methodology

The country study was carried out from September 11–22nd, 2006 by a 7 – person evaluation team. The evaluators brought different areas of competencies to the task. All together, there were specialists in evaluation and SRHR, an economist, a medical doctor with HIV/AIDS expertise, a journalist, and a SRHR researcher experienced in large population based surveys. The team included 4 national consultants of which 3 were youth consultants.

The first 2 days of the evaluation were spent in Kampala meeting FPAU staff and interviewing national level SRHR stakeholders. The team then divided into 2 smaller groups to travel to Mbarara and

Tororo. They spent 3 to 4 days at the branch clinics observing FPAU efforts and meeting FPAU service users, providers, and partners. Community leaders, district officers, service non-users, and alternative service providers were also interviewed. Visits were made to government and other NGO SRHR service providers. The team then regrouped in Kampala where some team members looked at the activities of the Kampala clinics. The others continued to meet with national stakeholders. The programme of meetings and visits to Branch clinics is given in Annex 1

Members of the evaluation team met with a wide range of stakeholders: FPAU staff and board members at national and branch levels, service users, participants in community based activities, national and district level government officers, partner organisations, and representatives of donor agencies. Data collecting techniques included semi-structured interviews with key informants, exit interviews, focus group discussions with stakeholders, observations of activities and clinic settings, and document review. A list of people interviewed is provided in Annex 1. Details about the informants and data collection methods used can be found in Annex 2.

Feedback on the main observations made during the evaluation was given to FPAU on the final day of the country visit. During this time, there was an open exchange of views which contributed to the preliminary report. Comments from FPAU on the preliminary report have been incorporated into this Draft Report.

Limitations

Although the evaluation team travelled extensively and met many people, it is aware that the information gathered can only give an impression of FPAU's work. None of the activities for internally displaced people (IDP) were observed. Nor were branch associations without clinics visited.

The evaluation does not examine the organisation and management of FPAU which clearly have a bearing on how its work is carried out. We comment on pertinent issues only to the extent that they relate to the purpose of the evaluation.

Guide to the Report

The purpose this report is three fold: a) to report to the donors and FPAU, the key findings of our visit, b) to provide sufficient information for the Evaluation Team so that it is able to write the Synthesis Report based on experiences in all three countries visited, and c) to provide in-depth detail for those who are concerned with specific topics. For this reason, this Uganda Country report is supplemented by a number of annexes for readers who wish to learn more details than are given in the main body of the report.

Chapter 2 gives the national context in which FPAU works. This is a key chapter as it points to the main issues discussed in the subsequent chapters on relevance and effectiveness and on advocacy. Chapter 3 highlights organisational features of FPAU and is supplemented by Annex 3 for those who want more details about FPAU's constitution and governance. Chapter 4 discusses FPAU's advocacy efforts. Because information, education, and communication (IEC) are essential components of advocacy efforts, we have included an Annex 4 which assesses FPAU's IEC materials from the perspective of the youth consultants. Chapter 5 discusses the relevance and effectiveness of FPAU's clinical and community-based efforts. Because adolescents comprise a prioritised target group for the IPPF, the Ministry of Health (MOH), and FPAU, the report includes a short chapter (Chapter 6) highlighting issues and observations as assessed by the Evaluation Team's youth consultants. Chapter 7 looks closely at how well FPAU reaches vulnerable groups. This chapter is also supplemented by Annex 5 which discusses in greater detail issues around poverty targeting and FPAU's approach to reaching vulnerable groups. Main observations and recommendations to FPAU conclude the report.

2. Sexual and Reproductive Health in Uganda

Background

Uganda had a large population estimated at 24.4 million people according to the 2002 population census. With a population growth rate of 3.3% per annum, the country is ranked as the third fastest growing country in the world. At the current growth rate, the country's population is estimated to reach 54 million people by 2025. The rapid growth rate is seen in part to be responsible for the escalating poverty with 84% of the population living on less than USD 1 per day.

The country's population is largely rural and young. Only 12% of the population live in urban areas. Thirty-three percent of the population is 10 -24 years of age while 3.8% of the population is 60 years and above (UBOS 2002 I). With one third of the population being young people, the population momentum is expected to have a tremendous impact in the future.

Limited coverage in family planning, high levels of maternal death, HIV/AIDS/STI, early marriages, unsafe abortion, gender – based violence and negative male attitudes were repeatedly identified to be significant SRHR issues by the majority of the respondents interviewed. We take a brief look at these issues.

Family Planning

Uganda's total fertility rate (TFR) has not changed from 7.0 for more than three decades despite nearly universal knowledge of at least one contraceptive method (98% for males and 96% for females). The level of knowledge contraceptive methods among females increased from 82% in 1988/89 to 96% in 2000/01. Pills, injectables, and male condoms are known by at least 80% of all women and men who are sexually active. Despite being relatively new on the market in Uganda, implants are known by 41% of the currently married women compared to 26% of the men (UBOS 2001). The contraceptive prevalence rate increased from 15% in 1995 to the current 23% (UDHS 2000/01). The family planning services are far from reaching most of the population with unmet need estimated at 35%. The unmet need for emergency contraception is even higher at 86% (UBOS 2001).

Maternal Health

Reproductive health indicators remain inadequate and have not changed for the past 30 years. Access to reproductive health services constitutes a major problem. Only 49% of the population lives within a 5 km radius of a health facility (MoH 2000).

Teenage pregnancy is still high at 31.4% (UBOS 2001) having dropped from 43% in 1995 (UDHS 1995). Among the females aged 15-24 years, 43% have children and among the 15–18 years, 17% have had an abortion UBOS 2001.

Figures of maternal mortality remain high. Uganda's maternal mortality ratio is reported to be 505 per 100,000 live births (UBOS 2001). The figure is estimated by others to be even higher at 880 (UNFPA 2005). There is general lack of information about SRHR. One woman MP recounted, 'Women are ignorant and delay at home thinking it is not yet time and end up with severe complications. I carried a woman from a roadside to hospital, she was stranded.' The proportion of mothers having assisted deliveries by skilled attendants has remained at 38% while deliveries in a health facility remain a humble 25%.

Unsafe abortion is regarded the third commonest cause of maternal death in Uganda. It has been estimated that about 300,000 induced abortions occurred in 2003 and that 86,000 women suffered from complications of a provoked abortion. (Singh et al, 2005).

HIV/AIDS and STIs

HIV/AIDS and STI constitute a big portion of the burden of disease in Uganda. National data measured at ANC sentinel sites indicate a sharp decline in HIV prevalence from 18.5% in the early 1990s to the current 6.5% (MoH, 2006). It is important to note that since 2001 ANC HIV prevalence has levelled off to between 6.1% and 6.5%. In some high risk groups and at some ANC sentinel sites, peaks of increasing incidence and hence prevalence has been observed (MoH, 2006). Results of the 2004/05 Uganda HIV/AIDS sero-behavioural survey indicate a population HIV prevalence rate of 6.4%. HIV rate among commercial sex workers is reported to be high at 47% (MoH KABS 2005).

The HIV/AIDS epidemic depicts differentials in age, sex, and residence. The peak age of HIV infection seems to have shifted from the young age group to the 30–39 age segment. Females (7.5%) are disproportionately more infected than males (5.0%). HIV infection is higher among the urban population (12.8%) compared to rural population (6.5%). Awareness of HIV/AIDS is universal at 98.8% but comprehensive knowledge remains low at 35%.

STI remains high on the burden of disease list. Three percent of Ugandan adults in the age 15–49 years have syphilis but sex and rural/urban differentials are demonstrated. (MoH & ORC Macro 2006).

Social attitudes

The landscape of SRHR intervention in Uganda faces social and political challenges. Community socialisation in Uganda encourages male dominance and promotes large families. Stakeholders indicated that many people would still like to have large families as a source of labor on farms.
Early marriages are socially sanctioned and lead to larger family size and school drop – out with attendant poverty. Polygyny is common throughout the country. Negative male attitudes towards family planning and sexual coercion pose challenges to the success of interventions. Men are dominant in household decision – making and this is critical when applied to health seeking behaviour.

Policy environment

Uganda has a policy environment which is supportive to good SRHR. The National Population Policy (currently under revision) and National Adolescent Health Policy (2004) are in place. In addition to these policies, a Strategy to Improve Reproductive Health in Uganda, the National Family Planning Advocacy Strategy 2005/10, and National Advocacy Strategy to improve Reproductive Health in Uganda have been developed. However, implementation of these policies and strategies has yet to be seen. Only 1% of funds available under the health SWAp are available to reproductive health (RH) services. Under-funding, under-staffing, poor health infrastructure, and poor management of available resources were identified by Ministry of Health (MOH) officers to limit the delivery of adequate RH health services.

Additionally, political leadership in Uganda has not been uniformly and consistently supportive of family planning and this is seen to affect the take up of family planning services particularly in rural areas. These challenges have been recognised by a cross party group of women parliamentarians who have recently joined together to advocate for implementation of the excellent array of policies which should guide the improvement of SRHR services in the country.

3. The Family Planning Association of Uganda (FPAU)

The Family Planning Association of Uganda (FPAU) was started in 1957 by a group of volunteers. It was affiliated to the International Planned Parenthood Federation in 1964 and was recognised as a fully re-accredited member in 2004. Membership in the IPPF accords FPAU an annual unrestricted grant, technical assistance, and backstopping.

The association has a membership of 3,090 volunteers including prominent political figures and a large number of professionals. It has 29 branches and 16 static clinics in the country with representation in all regions. At national and branch levels, the organisation is governed by an elected council and executive committee. Each branch elects its representatives to the national council. More details on the Constitutional provision and governance are provided in Annex 3.

Vision, Mission, and Strategic Plan

The Vision of FPAU is concise: 'A society which enjoys full sexual and reproductive health and rights.'

The mission statement is also short and conveys three messages:

a) addressing unmet need,

b) gender sensitivity, and

c) youth focus

The Strategic Plan 2004–2008 is the third such strategic plan for FPAU and according to the Executive Director, it was developed in a participatory manner by relevant stakeholders in 2003. The Strategic Plan is approved by the association's National Council.

The Plan reflects international developments and agreements such as the 1994 ICPD Cairo Programme of Action, the Beijing + 5 Platform for Action, the IPPF Strategic Plan (Vision 2000) and national policies and represented a paradigm shift with the following features:

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

The Strategic Plan is precise and includes sufficient text under each section. It presents the programme grouped under IPPF 5 A's in a logframe format listing a goal, strategic objective and its strategies, output and impact indicators and a budget to implement each objective. The strategic plan summarises key issues after each theme.

FPAU Activities

FPAU was the sole provider of family planning (FP) services in Uganda until 1986 when the Government of Uganda began to provide FP. Many informants told the Evaluation Team that FPAU is known to be a good and solid service delivery provider. The Association discharges its activities through static clinics, outreaches, and community – based activities. The current scope of activities include FP, safe motherhood, post abortion care (PAC), emergency contraception, treatment of STI and common illness, and Voluntary HIV counselling and testing (VCT).

The FPAU networks with other stakeholders in reproductive health and has clearly defined the role it plays in SRH. Its FP services are limited to non – permanent contraception and for permanent methods, FPAU refers its clients to other institutions. Similarly, while FPAU provides VCT, it refers people with positive results to The AIDS Support Organisation (TASO) and AIDS Information Centre (AIC) for confirmatory tests and support.

FPAU works closely with government and receives funding from MOH. Though small, this is in recognition of their role in SHRH in the country. The FPAU is a member of the Uganda Reproductive Health Advocacy Network and attends MoH meetings of SRHR stakeholders. It was part of the review team for National Population Policy for Uganda.

Each year the National Council approves an Annual Programme Budget which is presented by the National Executive Committee's (NEC) Programme and Finance Committee after its development by members of the NEC and senior management.

The Approved Programme Budget (APB) for 2006 amounts to close to Ush four billion shillings (3.9 billion) and the expenditures Ush 3,4 billion. The expenditure budget is expected to fund 14 projects under the Five A's and 3 supporting strategies. Projected expenditure per project and theme areas is presented as a portion of the total projected expenditure for the year 2006 details of which are highlighted in Table 1. [5]

Human Resources

Services with a human face are likely to be of quality and valued by the beneficiaries. One of the strengths of FPAU is the engagement of highly skilled staff. It is gender balanced with 55 males and 58 females. The gender balance is also reflected at management level. All staff are employed on 3 – year renewable contracts.

The salaried staff members have received significant training. This has been a double edged sword as there appears to be considerable staff turnover. At the national office, we noted that most staff had not been in post for more than 5 years. It is said that the salary is not competitive. Earlier in the year, 5 in-charge staff of Branch clinics were recruited to other jobs. There has been a review of the salary scale but the fact remains that it appears that the FPAU's highly competent staff are recognised widely and people are recruited to other jobs.

[5] The APB does not accurately reflect the activities of the organisation as a number of activities fall into more than one programmatic area.

Table 1. 2006 Projected annual expenditures

	Project	Donor/unrestricted funding	% total
Access			
1	Access Right Based	IPPF	20
2	Right based approach to SRHR in 4 districts	UNFPA	4
3	Childrens'Millenium Programme	PLAN	10
4	Backstopping SRH services in FPAU	MoH	1
	Subtotal		**35**
Adolescents			
5	Youth to Youth Project	DSW	<1
6	Gender & Youth Empowerment	IPPF	1
7	Young Men as equal partners	Sida	22
	Subtotal		**23**
Aids			
8	Balancing the scale, reaching out to young people	JFT	4
9	Expanding VCT services Provision	IPPF	1
10	HIV prevention among Vulnerable and Hard to reach Youth in Mbarara	DANIDA	7
	Subtotal		**12**
Advocacy			
11	Family Planning Policy and Monitoring and Action	IPPF	<1
12	Institutional Participatory Planning	IPPF	4
13	Raising Awareness, Knowledge and Understanding of SRHR in Uganda	DFID	5
	Subtotal		**9**
Abortion			
14	Integrated Post abortion care	IPPF	1
	Subtotal		1
Supporting Strategies			
15	Strengthening Governance & Human Resource Capacity	IPPF	3
16	Administrative and General Services	IPPF	13
17	Mitigating Exchange Loss on Governance, Programmes and Administration	IPPF	4
	Subtotal		**20**
	Grand total		**100**

In the branches we visited we met with several categories of staff motivated by high degree of commitment and a sense of humour and hospitality. The community volunteers we met included both peer educators and community based reproductive health agents. They were of varying educational background ranging from primary to university education. They were knowledgeable and committed to work, competing to answer our questions. Their duration of stay was variable ranging from six months to eight years and some even longer. The volunteers received a training course in counselling. They are also exposed to several workshops and some have participated in exchange study visits abroad.
The organisation appear to facilitate their work and provide a supportive environment.

We also met with members of the Branch executive committee in Tororo. The in-charge there has been especially effective in mobilising BEC members to take responsibility for special efforts in the villages in which they live. Thus, when a member of the Evaluation Team visit the sub-county level to look at a government facility, she was also able to meet participants of various income-generating groups which had started earlier in the year. The groups' activities were hair dressing, sewing/tailoring, handicrafts, and agriculture. In addition, there was a youth group which welcomed the evaluator with dance and song. All these groups appeared to have been organised by one volunteer!

Institutional Image

FPAU is recognised as the NGO with the largest network of service sites across the country and the only one with a systematic reach into local communities. It was described by one of its partners as the 'obvious choice' for carrying out the partner's reproductive health programme.

The Network of African Woman Ministers and Parliamentarians (Uganda Branch) which was mentioned at the end of Chapter 2 also noted that they had selected FPAU to provide technical capacity building for their advocacy work with other MPs and in their constituencies.

FPAU's information, education, and communication materials are recognised for their high quality. The Ministry of Finance's Population Secretariat spoke of a collaborative arrangement whereby FPAU provides technical assistance for their IEC materials.

It should be noted from Table 1, that 60% of the APB is provided through ear-marked funds i.e. not through core funding from IPPF. This is also an indication that FPAU's prominence and capacity is recognised by donors and others funders.

The systematic programme of outreaches appears to have broadened FPAU's image so that SRHR stakeholders now see FPAU as having an effective way of reaching low income and poor people. The youth clinics seem to further strengthen the positive image of FPAU.

FPAU derives its strengths from its pioneer status as a flag bearer for FP and in many people's minds, it is synonymous with family planning. Many people feel this gives the organisation a comparative advantage. But others see this as posing limitations because 'family planning' may not speak to the SRHR needs of young people. Staff at the national headquarters spoke of the need to 're-brand' and move to a more conscious use of the acronym 'FPAU.' We were told that many people did not know of the other services offered. This was confirmed in our evaluation when we carried out a focus group discussion (FGD) with a group of young people at a location where the youth centre had been standing for over 8 years. Only half of the people in that FGD of 12 members knew the full scope of services at the youth friendly clinic despite the billboards detailing the range of services which was placed at the entrance to the Youth Centre grounds.

4. Advocacy of FPAU

Introduction

As highlighted in Chapter 2 on the Background of sexual and reproductive health and rights in Uganda, there are serious SRHR issues that need to be addressed in Uganda. Advocacy efforts at national and community levels are needed to improve the SRHR of women and men in Uganda and may be aimed at policy change, enabling the policy environment, and/or raising public awareness. The National Advocacy Strategy identifies 8 techniques that can be used for different advocacy strategies: sensitisation, mobilisation, dialoguing, debating, negotiating, lobbying, petitioning, and pressuring.

This chapter uses a broad definition of advocacy and includes efforts at the national, sub-national, and village levels. It begins with a brief description of FPAU's projects within the advocacy programmatic area and then identifies key issues for advocacy at national and community levels.

We then look at:

a) awareness raising initiatives at the community level,

b) advocacy efforts at the national level, and

c) how other SRHR stakeholders, especially at national level, perceive FPAU's advocacy contributions.

Especially, when looking at activities at community levels, we also include awareness raising which may include information, education, and communication and behaviour change communication, and community mobilisation although we are aware that these are sometimes not included in definitions of advocacy. This is in part because FPAU, as a member-based organisation, expects a commitment from its volunteers to the undertake advocacy of SRHR. Included in this are efforts to address barriers to change, raise awareness, and change behaviour.

FPAU's Strategy and Programme Efforts

While FPAU has identified its advocacy goal and set of objectives and strategies to achieve its goal, it is difficult to gain a clear picture of what FPAU is doing in the field of advocacy. The Annual Programme Budget categorises 3 projects under the IPPF advocacy programmatic area. Together these have been allocated 9% of the 2006 annual budget. The projects with their allocated funding for 2006 are shown in Table 2.

Table 2. FPAU Advocacy projects 2006

Project	2006 Budget Ushs	IPPF Core funding/Donor
Family Planning Policy Monitoring and Action	14 145 680	IPPF
Strengthening FPAU communication component	79 841 283	IPPF
Raising Awareness, Knowledge and Understanding of Sexual and Reproductive Rights in Uganda	187 371 600	DFID
Total Advocacy	**281 358 563**	

From the 2006 Annual Programme Budget, it appears that there are three projects. The Family Planning Policy Monitoring and Action project is limited to activities in Mbale. The Strengthening FPAU communication component is focused on website development and public relations. The third project is a substantial 3 year DFID – supported project that has recently started. We did not observe any activities or outputs from this project but we comment more upon this later in this chapter.

Advocacy Issues

The Cairo ICPD marked a paradigm shift to a wider range of sexual and reproductive health and rights issues which placed the individual woman at the centre of autonomous sexual reproductive health decision – making. Underpinning this is a rights – based approach which highlights human rights established in a number of human rights conventions. Before looking at the relevance and effectiveness of advocacy efforts at the national and district levels, we first discuss what we judge to be the most important advocacy issues in Uganda.

Family Planning

Given the SRH issues identified in Ch. 2 and the GoU's reproductive health policy, it is clear that access to quality family planning services is a critical area for advocacy in Uganda, with its persistently high total fertility rate (7) and high level of unmet contraceptive need.

SRHR of Young People

Despite the legal prohibition against sex with and between young people under the age of 18, the high rates of teenage pregnancy, early age of sexual debut, and median age of marriage are clear indications that access to information and services by young people must be addressed. An additional concern relevant to young people, especially girls, is the early age of marriage.

Reducing the Underlying Factors that Contribute to Maternal Mortality

In addition to the prevention of unplanned and unwanted pregnancies, other factors that contribute to maternal mortality are unsafe abortion, lack of awareness of the need for skilled attendance at deliveries, lack of access to health facilities that are adequately staffed and provisioned to provide skilled attendance. Reducing unsafe abortion, providing widespread, accessible post-abortion care, and greater resource mobilisation to improve maternity services are keys to reducing maternal mortality.

Stigma and Discrimination

Stigma and discrimination pose significant barriers for some groups when attempting to access the information, services, and care they need. People who are HIV positive are among those vulnerable to stigma. The illegal status of prostitution in Uganda which makes it difficult to provide services to commercial sex workers. This is a group that has a clear need for HIV/AIDS prevention, care and support, and would benefit from empowerment activities enhancing their ability to exercise control over their lives. Another group that is discriminated against are pregnant teenagers who have difficulties returning to school. And, finally, providing stigma free information about men – who – have – sex – with – men would help to ease the harsh public views that now exist.

Advocacy Efforts at the District/Community Level.

- We noted four types of activities taking place at community level which could be considered public awareness raising with the potential for behaviour change.
- The first relates to the role of the volunteers members. People we spoke to at the Branch organisation in Tororo and CBRHAs gave highly personal accounts of why they had 'joined family planning.' The men on a Branch Executive Committee spoke of their awareness of the difficulties of providing for a large family, especially among farmers with limited tracts of land. A woman spoke of how, at age 13, she realised that her life would have been different had her father not had multiple wives and many children. Another woman said that she 'saw the light' after having six children. All of these people seemed quite committed to persuading others to limit their family size by using contraceptives. We were told that efforts are made to recruit volunteers who are influential in their communities as they are seen as effective change agents.
- The second relates to the role of volunteer members and community based volunteers in combating strongly held myths and misconceptions concerning SRHR. We heard about this so often from such a range of informants that we understood how strongly held many of these beliefs are; for example that family planning encourages women to go for extra-marital sex and consequently get infections like HIV/AIDS or that condoms can be washed and re-used. Peer educators in Tororo told the Evaluation Team that when they first came to a village, people hesitated to attend their information session because it was said that those going there would be infected with HIV/AIDS.
- A third type of effort relates to the printed information, education, and communication (IEC) materials. FPAU's IEC materials appear to be very much sought after by other organisations and institutions in Uganda. The materials go through a thorough pre-and post-test process to ensure that

the intended message is conveyed. Adjustments are continually made after post-testing, especially when posters are introduced in different areas where small details, such as the type of clothes a figure is wearing or colours used, have unexpected local significance. Because FPAU has focused much of its attention on young people, we asked the youth consultants on the Uganda Evaluation Team to assess the IEC materials. In summary, they found that the written messages are aimed at behaviour change covering a wide range of SRH issues including unsafe abortion, early or forced marriage, cross-generational sex, male involvement, and idleness as well as other issues. The materials are found to use catchy messages and language appropriate to the target group, youth. Importantly, they thought that the graphics and pictures are easily understood by people who cannot read. Moreover, they found the messages to be relevant to the life situation of poor people e.g. people in familiar village settings. More details of the assessment of FPAU's IEC materials can be found in Annex 4.

- Radio broadcasts both on national and local radios appear to be very popular, raising highly topical issues. In addition to the local radio programmes discussed in Chapter 6, we were also informed of a recent radio phone-in programme arranged by FPAU where the Minister of Youth discussed issues around the decriminalising of prostitution.

While the activities discussed above can be grouped as 'sensitisation' or 'awareness raising' around SRHR issues, we did not find any advocacy efforts around issues related to reducing maternal mortality which is a priority in the government's Strategy to Improve Reproductive Health. Transport in remote areas represents a considerable cost to a woman and her family; we were told that when emergency transport is needed the price of that transport is doubled. Developing community emergency transport schemes could assist in reducing this delay in getting to health facilities. Such a scheme would be in keeping with the government's reproductive health policy. Moreover, the involvement of FPAU volunteers in such a scheme would demonstrate an active understanding that the SRH agenda has moved to issues beyond family planning.

Advocacy Efforts at the National Level

The policy environment

It is clear that the policy environment for improved SRH in Uganda faces many challenges. Nearly all SRHR stakeholders we spoke to noted the lack of commitment to family planning at the highest levels of leadership in country. Some leaders have maintained that a large population makes for a strong country by attracting investment and stimulating economic growth. This lack of commitment is apparent when noting that reproductive health receives only 1% of the budget under the SWAp for health.

USAID is a significant actor in the field of SRHR. The Mexico City Policy prohibits any international NGOs in the field of SRH that receives funding from USAID from providing abortion-related services, information or referrals to abortion services providers (with the exception of post-abortion care). The policy also prevents any organisation that is a recipient of USAID sexual reproductive health funding from working in an advocacy or service provision basis with NGOs that provide abortion services, information about abortion or referrals for abortion services. As USAID funds many projects in Uganda, this poses a barrier for FPAU to working with certain organisations.

The legal status relating to 3 groups of people constrain the ability of everyone who wishes to work them. As noted earlier in this chapter, the illegal status of prostitution hinders work with commercial sex workers. Similarly, the highly restrictive grounds on which abortion can be carried out cast a shadow over post-abortion care and open debate about the public health consequences of unsafe abortion. Finally, the harsh laws relating to men-who-have-sex-with-men reinforce existing stigma and discrimination and thus make it more difficult to reach this group, vulnerable to HIV.

FPAU activities

As noted at the beginning of this chapter, it is difficult to get a good understanding of FPAU's advocacy focus and strategy. The APB gives only an incomplete picture of the range of activities. The Strategic Plan 2004 – 2008 highlights critical issues as a) resistance to some aspects of the integrated FP/RH agenda, b) negative cultural practices such as female genital cutting, widow inheritance, forced marriages, dowry, and c) limited resources for SRH/R. We saw and were informed of few activities directed towards these issues and we were unable to see how these link with with the awareness raising efforts we saw at the community level.

In the National Advocacy Strategy in support of reproductive health, population and development programmes there are 3 focal areas which are directly related to FPAU's mission e.g. unmet contraceptive need, adolescents SRH services, and maternal health. It is therefore surprising that FPAU's does not appear to have a clear advocacy strategy related to these focal areas. We did not hear of any FPAU advocacy efforts aimed at resource mobilisation for better maternal health Nor did we hear of any efforts at social mobilisation to hold government authorities accountable for the services they offer.

Networks

FPAU is part of the Uganda Reproductive Health Advocacy Network (URHAN) which has been identified as the lead agency for a number of initiatives in the National Advocacy Strategy in support of reproductive health, population and development programmes. However, it is not clear whether FPAU has a lead or central part within URHAN in relation to these activities.

Perceptions of other stakeholders

We were repeatedly told that FPAU is recognised as a 'good and solid service provider,' 'an organisation with a long history of service provision,' and 'the only organisation that reaches deep' into the community'. This is the reason that it was the only obvious partner for one of the funding agencies for its work in reproductive health.

Recognition in FPAU's technical competence is demonstrated by:

1. The level of earmarked funds and projects which comprise 60% of FPAU's total budget. Funding agencies include Sida, PLAN, DFID, UNFPA, DANIDA, MOH and other donors. The third project listed in under the advocacy programmatic area, 'Raising awareness, knowledge and understanding of sexual and reproductive rights in Uganda,' is a 3 years grant from DFID which had conducted a SWOT analysis on FPAU before awarding them the grant. This is an indication of their confidence in FPAU's ability to carry out advocacy initiatives.

2. The selection of FPAU by the Network of African Women Ministers and Parliamentarians to provide technical capacity building in the field of SRHR so that they can sensitise other MPs and opinion leaders in their constituencies to SRHR issues

3. Its technical support to IEC materials developed by the Population Secretariat

4. The selection of FPAU to provide capacity building in contraceptive methods for the Catholic Secretariat.

With such a strong reputation in the field of SRHR, FPAU is well positioned to advocate for sensitive issues. Because of their well established credibility, people will listen to them if they disseminate research and information about taboo topics such as abortion or vulnerable groups although occasionally when interviewing national stakeholders, we encountered people in the health sector who had never heard of FPAU. Public opinion against men-who-have-sex-with-men is quite harsh. This creates an environment of stigma and discrimination which discourages the opportunity to offer organised and directed services. The net result will be continued transmission of HIV infection.

A number of stakeholders, including partners, expressed a desire to see FPAU take a more aggressive stand on a number of issues such as abortion, pushing the government to provide adequate services, coordinating the non-governmental stakeholders. However, FPAU is not perceived to be a major actor in the field of advocacy.

Concluding Observations

If we apply the 8 advocacy techniques identified at the beginning of this chapter, it appears that FPAU's advocacy activities at the national and local levels are limited to sensitisation and debating.. There have been missed opportunities because FPAU is really able to be effective in this area. Partners are calling for a stronger voice. A well thought out, focused advocacy strategy is needed.

5. Relevance and Effectiveness of Service Delivery

This chapter will assess the relevance of FPAU's present services and then move to the effectiveness of the clinical services and the non-clinical services.

Relevance is 'the extent to which the objectives of a development intervention are consistent with beneficiaries' requirements, country needs, global priorities and partners' and donors' policies' (Sida 2004). In this evaluation, when assessing relevance, we do so based on what FPAU does rather than on its objectives. To look directly at the actual services provided seems to us to be more relevant.

The definition of effectiveness used here is 'an aggregate measure of (or judgement about) the merit or worth of an activity, i.e. the extent to which an intervention has attained, or is expected to attain, its major relevant objectives efficiently in a sustainable fashion and with a positive institutional development impact' (Sida 2004). We will approach the issue by looking carefully at what the organisation does and how people are affected.

When assessing relevance of health interventions in a low-income country with significant health needs, one could ask as a first question: What could possibly make these interventions irrelevant? Isn't every intervention helpful? There are at least three scenarios that would severely reduce the relevance of an intervention.

- *The interventions do not address country needs and beneficiaries' needs*
- *The interventions are not consistent with national strategies and policies.*
- *The interventions are not consistent with global priorities and donors' policies.*

Relevance – Country Needs and Beneficiaries' Needs

As described in Chapter 2, Uganda faces several serious SRHR problems. These include a persistently high TFR, limited access to general health services, a low number of deliveries assisted by skilled attendants, high teenage pregnancy rates, high numbers of unsafe abortions, and high numbers of maternal deaths as well as the HIV/AIDS and STI-related problems.

The general picture of the SRH problems in the country is confirmed in the interviews with SRHR stakeholders and beneficiaries in the communities we visited. This is especially the case in the very poor urban outreach sites. The need for FP services is urgent and the unmet need is large.

'Sometimes those [women] with 7 or 8 [children] come to me and cry. They say they wish they had known about family planning before, so they could have spaced their children. Women who work a lot don't want to be pregnant the whole time.'

Female Community Based Reproductive Health Agent, Owina market

FPAU is consistently viewed by SRHR stakeholders as the country's leading family planning organisation and was referred to as a 'good and solid family planning provider'.

While a systematic examination of FPAU's clinic visits was not undertaken as part of this evaluation, a 'snapshot' look at one month's service statistics from one of the branch associations visited revealed that nearly three times as many people attend for non-contraceptive services as for contraceptive services. One-third of the non-contraceptive visits were for primary health care (i.e. treatment for minor health conditions, immunisation, or growth monitoring). Exit interviews we conducted confirmed this picture.

During a focus group interview with a youth organisation in Kwampe, an urban slum outreach site in Kampala, the adolescents described the major problems in the area. The list was long, and among other things included poverty and unemployment, which forced most young teenage girls into prostitution, unwanted pregnancies resulting in a large number of teenage mothers, street children, and unsafe abortions. The interview ended with one girl posing the following question indicating the need for safe abortion services and post-abortion care:

'So you mean that people don't die from abortion in your country?'

The estimated numbers of induced abortions and complications arising from them are discussed in Chapter 2. We note that in FPAU's Strategic Plan 2004–2008, FPAU's post-abortion care was limited to post-abortion family planning and assessment of other SRH conditions. Strengthening of FPAU's capacity to a wider range of post-abortion care was planned.

When analysing the expressed needs of service users, people are generally very content with the services provided. However, two issues were brought up where FPAU might expand and strengthen its work. The first is that FPAU could start working with deliveries. The second one is that FPAU could strengthen its post-abortion care. The problem of unsafe abortions was brought up by a number of people during our meetings in the local communities. We further noted that although available, emergency contraception does not appear to be in great demand. We wonder about how widely it is known.

Relevance – the National Policy Environment

Guiding documents for the SRHR work in Uganda are, among others, the National Population Policy, the Reproductive Health Policy and Adolescent Reproductive Policy. In interviews with the district directors of health services (DDHS) and the Ministry of Health (MOH), we were informed that FPAU is considered an important partner working within the government's framework. FPAU is also a selected partner of several key organisations, two of which are planning to enhance their strategic partnerships with the organisation. The picture given in some of our meetings is that there is considerable interaction and networking among key stakeholders, and that FPAU is frequently part of that networking.

Relevance – Global Priorities and Donor Policies

The Millennium Development Goals provide objectives aiming for a substantial reduction of global poverty by the year 2015. That improved SRHR reduces poverty in the sense of increased power, choice, and opportunities is well established.[6] This global priority is also reflected in the development

[6] *For example, Investing in Development: A Practical Plan to Achieve the MDGs, full report, chapter 3 and 5. and Population, Reproductive Health and the Millennium Development Goals: Messages from the UN Millennium Project Reports, UNDP 2005*

goals of the donors funding this evaluation, i.e. Sida and Norad (Sida 2002, Norwegian MFA 2002). We therefore conclude that FPAU's services are highly relevant concerning the aspects of relevance selected above with some potential areas for improvement.

Effectiveness

To be effective, interventions need to be available, affordable, and accessible to users, offered in a manner that is acceptable to them, and result in the intended objective. We first describe FPAU's clinical services, then their non-clinical activities, and finally the possibility of duplication with other service providers.

Clinical Services

FPAU's clinical services are provided in their static and satellite clinics, and at their outreach sites. Branch clinics plan 4 'outreaches' each week. These may be mobile clinics to a village, work place, or community space such as a church. The package of services includes FP, VCT, STI-screening, post-abortion care, ante-and post-natal care as well as basic primary health care such as immunisation, de-worming, and malaria treatment.

In all clinics and outreaches we visited, we saw a steady number of beneficiaries coming for the services. This was especially the case at the outreach sites. During our visit to the Kyebando outreach clinic in Kampala, we did not have the chance to speak to any of the staff members or volunteers for even five minutes, although our visit lasted over two hours. In most outreaches where we were, beneficiaries expressed the desire for more frequent services. It was clear that the challenge was not to attract people, but to assist as many as possible of those wanting services.

Do people get the help they need? One indicator, although not perfect, is whether clients are satisfied. In our exit interviews, the almost universal picture was that the clients were very satisfied, got help with the problems they came for, would return to the clinic for future services, and would recommend the clinic to family and friends. Usual comments were that the staff was friendly, that it was easy to use the services, and that good and quick services had been provided. Sixty percent of attenders travelled by foot to the clinic and most clients used 30 minutes or less to get there. Most of the visitors we interviewed came for contraceptive or other medical services, but this differed according to the day and the clinic where the exit interviews were carried out on. Approximate 30% of clients were men. The age range was wide, from 11 to 80 years of age.

What then about changes of long-term behaviour? What does it mean for the communities to have access to these services? Does health improve in the areas served by FPAU? With the qualitative focus of this evaluation, we can only give a narrative picture of results and trust the opinions of those closely affected by the services. In our meetings with beneficiaries and community leaders, several stories about long-term effects were presented to us.

For example, a group of 12 community leaders in Kwampe, an urban slum in Kampala, maintained that the number of unwanted pregnancies and unsafe abortions had been reduced since FPAU opened its outreach clinic. A female Community Based Reproductive Health Agent (CBRHA) at the Owina market in Kampala told the evaluation team that most women working in the market now used FP methods. 'Women working a lot don't want to be pregnant the whole time', she said. In Kakoba Ward in Mbarara, a male community leader said that there are almost no women in his community (about 1000 persons) who do not use family planning through FPAU. He agreed to mobilise a group of women who were not using FPAU services, but failed to find more than one woman for us.

'We have a council meeting every month. We always advise women to go to FPAU to carry out family planning. The whole village is invited, sometimes 100 come, sometimes 400. Everyone can come. Every time we talk about family planning. You must have the children you can support. The mother gets tired when giving birth to many children.'

The evaluation team noted the high level of flexibility of the Branch clinic staff who rotated among the static clinics and different outreach sites on a daily basis. One potential problem with this is the limited access to follow-up care for people in the outreach communities when problems arise and FPAU services are not available. Many women experience or believe they experience side effects resulting from their use of contraceptives. If this cannot be addressed quickly and satisfactorily, there is a risk of discontinuing the use of the contraceptive. Similarly, we see potential problems with side-effects of malaria treatment.

Another potential problem is the limited number of lab technicians. In both Mbarara and Kampala, the lab technician mostly spends the afternoons at outreach sites. This means that clients coming to the branch clinic would leave a blood sample and return the next day for results. However, as pointed out in some interviews, this disturbs the delicate VCT process, where clients have been professionally prepared for results – negative or positive. When they have to wait for the result, some of them never return to pick up their results, due to fear and anxiety. The access to lab technicians seems to be a crucial component of the outreach programmes, and an factor that is hindering further expansion of the amount of outreach visits.

Non-clinical Activities

FPAU has a wide range of non-clinical services. These include youth centres and school programmes, skills training programmes and an extensive programme of Peer Educators (PE) and community based reproductive health agents (CBRHA).

The PE are young persons who receive an initial SRHR training and after that work with outreaches (for example drama or puppetry mixed with information sessions about SRHR and sometimes combined with mobile VCT), one-to-one sensitisation, workplace talks, door-to-door campaigns, condom distribution, information, education, and communication (IEC) materials distribution and so on. CBRHAs are generally older and aim to reach adults, rather than adolescents. They also distribute pills and condoms.

The evaluation team met with a substantial number of PE and CBRHAs and found the level of commitment among these volunteers to be impressively high. All PE and CBRHAs whom we met take their tasks very seriously. They become known in their communities, people come to them for advice, and the volunteers help their peers to address important health problems. One male PE from Mbarara told the team that he had worked so much with his volunteer tasks for FPAU, that he lost his job as a primary school teacher. However, for him this did not matter, as he wanted to serve his community.

The evaluation team also noted that the groups of volunteers were fairly gender-balanced. For example, in the FPAU outreach clinic in Mulago, we were informed that the 30 Peer Educators in the region are composed of 15 men and 15 women. The gender balance is likely to be important, keeping in mind the sensitive nature of SRHR issues.

Some challenges were also raised by the Peer Educators and Community Reproductive Health Agents. Among these were:

- *Need for more training.* When asked about their level of knowledge, some PEs and CBRHAs expressed the need for more SHRH training. After the initial training, some refresher courses are given, but according to volunteers, these was insufficient as some PEs feel they are unable to answer the many complicated questions people raise.

- *Lack of means of transportation*. Some PE felt the need for more and better bicycles. In Tororo, PE reported sharing 2 bicycles among 29 PEs.
- *The issue of remuneration*. Many of volunteers spend considerable time assisting staff and doing outreach work. To compensate for lost income and expenses, they receive a small amount of money, however only for the actual outreach day. The remuneration does not make up for the foregone income, especially for the transient traders who immediately lose income when they are away during a working day.

After having looked at the crucial role the volunteers have in the performance of non-clinical activities, the next questions are: Are people interested in their services? Do they listen? Do they seek help and do they change their behaviour?

In our meetings with volunteers, our universal picture is that most of them do a considerable amount of work every month for FPAU. One male PE from Mbarara said that he spent at least 2 hours every day answering SRHR questions from peers, and that since becoming a PE, he never had the chance to be alone anymore. One female PE said that she wears her FPAU T-shirt and FPAU cap every day at her work as a hair-dresser, and as a result she gets many questions about SRH from her customers. It is common that they invite her to their homes for further information. Two CBRHAs told the evaluation team that on average they were approached by 6 and 20 people respectively each day. The evaluation team was particularly impressed by the Transient Traders project in Mbarara, where PE have been recruited among low-income youth working with temporary jobs such as car-washing, hair-dressing, driving boda-boda (motorcycle taxi), vending etc. These are hard-to-reach groups, that due to their income poverty, age, and mobility, are very vulnerable to SRH problems such as HIV/AIDS and unwanted pregnancies.

The evaluation team has observed a number of outreach activities, for example a drama outreach in Mbarara with VCT tents and a puppetry show in Bwaise. The volunteers play a crucial role in these activities, carrying out the performances, mobilising people, distributing information and so on. During all activities the interest from the community was very large. During the drama outreach in Mbarara, approximately 300 persons watched the drama, while over 30 persons tested for HIV/AIDS in the tents next to the drama. Seventeen of them tested HIV positive.

A focus group interview with young females living in the community where drama outreach is performed on a regular basis, revealed that they like the services and dramas. According to the women, as a result of the recurring FPAU outreach, people have improved their SHRH knowledge in the community. Young people have learnt how to use a condom properly, those sick now seek prompt treatment, people have reduced their number of sex partners and more people practice safe sex due to the distribution of free condoms. However, the women also emphasised the need for increased services during the outreaches, such as testing for other diseases (like malaria) and provision of contraceptives (women are now referred to the FPAU clinic for that).

When the puppetry show in Bwaise started, the Peer Educators managed to mobilise over 50 children of age 1-12 already within minutes. The show was mixed with SRHR messages communicated through a megaphone and received considerable interest and attention from the children as well as from adolescents and adults.

While it is hard for the evaluation team to estimate long-term effects of activities like these, it seems clear that they are effective in disseminating information and attracting some people to services. It also seems like these activities are particularly useful in attracting people who would otherwise not be reached by information or SRH services. The profound interest and the high number of participants the evaluation team observed, indicates a large unmet need for SRH services in the targeted communities.

Another effective non-clinical activity is the life planning skills training observed in Mbarara and Kampala. Many PE highlighted the issue of poverty as an obstacle in the dissemination of SRHR knowledge and using information gained.

This problem has led to initiatives to integrate SRHR information with life planning skills training. In Mbarara, three such training efforts have been held during 2006. The trainings continued for more than a month and some hours of training were offered on a daily basis. Main components of the trainings have been SRHR information integrate with life-building skills such as assertiveness, decision-making, time-planning, financial planning etc. Most participants have become members of a community based organisation called Youth Action Initiative for Health and Development (YAIHD), that was formed after the training was completed. The evaluation team interviewed a group of YAIHD members to hear about their experiences.

A 19-year old female hair-dresser and YAIHD member told about how the skills training changed her ways of thinking. She had dropped out of upper secondary school when her parents died when she could not afford to pay the school fees.

> 'Before we had many partners, now we have changed. Now we have friends, but not boyfriends. We use what we learnt every day. We learnt how to live our lives. How to make small business. How to manage work and manage time, to plan my day. If I get 500 ush every day, how will I use it? I didn't know about saving before. Before when I made 500 Ush I used the money immediately. Now I make 1000 Ush every day and I save 300 Ush. In the end of the month I have enough money to buy something, maybe a skirt or a goat. I have 2 goats now. After that I will buy a cow, so I have milk. I will start selling the milk.'[7]

When the girl has managed to save enough money, her dream is to finish secondary school and then to study medicine.

YAIHD has also started carrying out projects of their own. Two other members told the evaluation team about their work with street children. Then have worked with a group of about 30 street children on a volunteer basis. We were told that many of these children now have been rehabilitated, some are relocated back to their homes whereas others are in drama and sports training. The YAIHD volunteers also report noticeable behaviour changes among the former street children.

> 'At first, their behaviour was almost unbearable but we were patient, now they have good manners, they can interact and socialise with age mates without fighting.'

YAIHD is working closely with FPAU, which provides them with transport, venues for their activities, training, IEC materials, and free health care for the street kids.

The Life Planning Skills training obviously has an important potential both for individual change and for community mobilisation. However, it is important that it really reaches the most needy and not persons who could access similar trainings in other ways. At the Katego clinic in Kampala, we learnt that some of the adolescents taking parts of training sessions could actually pay for it themselves.

FPAU – added Value or Duplicating Other's Work?

A final and third aspect in the analysis of relevance and effectiveness is the question about the added value a certain activity or service brings into a community. The issues of relevance and effectiveness are less significant if the services are provided in an setting where another provider is offering the same services. The core questions here are what alternatives are there to FPAU services and why do people choose or choose not to come for FPAU services.

[7] 1840 Ush = $1

The alternatives in the areas we have visited are the government health units, private-for-profits and NGO's, including faith-based organisations. The government health units in theory offer free services including VCT. However, in all our interviews the picture is clear and uniform. A number of obstacles prevent people's access to the government health services they need.

- *Time and costs.* There are few government health units and the number does not in any way meet the demands arising from the present health situation. Because many people live a far distance from a government health unit, it is very expensive for people – in time and money – to go there. Also, while the services are for supposed to be free, informal fees are often charged. These are in addition to the costs incurred by having to buy drugs privately if the health unit has run short.

- *Staff shortages.* Health units are badly understaffed. In Tororo we were informed that while there is a staffing establishment of 3 midwives per HC3, there was, in fact, only 1 midwife per health unit.

- *Interpersonal patient care.* According to our informants, government health units have a number of quality problems. The staff is often perceived to be rude and unfriendly. There are normally no youth-friendly services. Anonymity is often compromised which makes people reluctant to go to a government health centre for VCT.

- *Shortage of drugs and supplies.* A problem cited in virtually all interviews is the scarcity of drugs and supplies. The services are theoretically free, but after having waited for hours the client is often met by the message that no drugs are available, and have to be bought somewhere else.
  We were also told that many government health units, especially in the rural areas, do not have the equipment for rapid HIV/AIDS testing.

- *Overload of clients.* When attending a government health facility, one can expect to wait for many hours. This adds to the time costs which may be at the expense of time that could otherwise be spent working. In one of the focus group discussion we had, we were told that some people even faint in the lines, because of the long waiting time.

The reasons stated for choosing FPAU during the exit interviews confirm the picture of the government health system gained from focus group discussions and SRHR stakeholder interviews.

People who go to other places get serious complications.

> (...) but those [other providers] charge money for condoms & there are better services [in the FPAU clinics], like TV screen, youth centre where people can interact & learn.

> (...) but other places charges highly, give wrong results to find a way of charging money which doesn't happen here.

The picture given by our informants is therefore that poor people might go to the government health providers, if they live in areas where they are available, but that they either end up not getting the help they need, or end up paying more for the transportation and drugs than they would have done had they gone to FPAU.

Other NGOs in some places are a real option, but in the communities where such service providers exist, the unmet demand is still great and FPAU is considered to be cheapest by most people we interviewed.

When citing the reasons for choosing FPAU, 48% of the people interviewed at the outreach sites said that close distance was a reason for their choice, while only 17% of those interviewed at the static clinics pointed out that close distance was important for their choice. This is an indication that the outreach sites serve people with more limited access to SRH care than the static clinics, and/or that the outreach sites serve people with less time and money for long transportation for health care.

We were able to observe and talk to alternative providers at some of the outreach sites. For example, in the large Owina market in central Kampala, where FPAU has a small satellite clinic, we were able to quickly visit another NGO which also offered family planning services. From observation during that visit, we noticed that there were no people waiting at that clinic and that the prices were substantially higher than at FPAU where a number of people were waiting in line.

How are the activities coordinated on the ground? In no single interview did we hear about overlapping services. Rather, the overall picture was that the need is enormous and the providers too few. The level of coordination seems to differ from place to place. In Mbarara, we were told that there are quarterly coordination meetings at the district level where all the health providers meet and share information to avoid duplication. However, in Tororo, there is no such planning mechanism according to our informants.

Concluding Remarks

To summarise this chapter on relevance and effectiveness, our observations are that FPAU is offering services that are very relevant from all perspectives. Some beneficiaries would additionally like to see FPAU doing deliveries and do more work in the field of post-abortion care.

- The FPAU services are effective in providing quality health care and community needs go far beyond the present levels of FPAU services.
- FPAU target communities with very limited or many times, no access to alternative services.
- The network of committed volunteers has a crucial role in increasing effectiveness, spreading information and mobilising people.
- Effectiveness in reaching under-served communities could potentially be increased if even more outreach activities were scheduled. This would of course, have human resource implications as static clinics might be left uncovered.

6. A Focus on Young People

Introduction

Young people in Uganda make up 33 per cent of the country's population. Many of these are at a risk or are already struggling with poor reproductive health. In Uganda, SRHR is a concern for health development which has led to intervention from stakeholders including Family Planning Association of Uganda (FPAU).

This report is highlighting issues relevant to young people in a separate chapter because of the priority placed on youth by FPAU, IPPF and the evaluation. FPAU's mission is to address the unmet needs and demand for quality sexual and reproductive health services, and promote sexual and reproductive rights in a gender sensitive manner, with primary focus on the youth. IPPF has the youth as one of its programmatic areas in the strategic framework 2005–2015.

This chapter will highlight the SRHR issues, youth involvement, approaches used in reaching the youth, list the activities and examine there appropriateness to the youth and mention challenges faced by the young volunteers.

SRHR Issues

- People interviewed identified the following as the major adolescent SRHR problems;
- High maternal deaths and infant mortality rates
- High rates of STIs and HIV infection
- Prostitution (in some areas respondents felt that the majority of girls in their areas between the age of 13 and 17 are involved in commercial sex)
- Unwanted pregnancies, abortions and complications that arise from attempts to abort
- Teenage mothers (most of these drop out of school)
- Early marriages especially in Tororo district were due to poverty, girls marry at an early age

Youth Involvement

The evaluation found that youth are highly involved in decision making and programme implementation of FPAU's activities.

Youth are represented in a gender-balanced manner on the National Executive Committee as required by the Constitution of FPAU. Young people have a governance structure from the Branch through the National Council to the NEC level. This is called the Youth Action Movement (YAM). The YAM aims at formalising the structures of young peoples' participation within member associations (MA). Youth volunteers elect representatives at the branch, regional and national levels.

Young people participate in the making of programmes and work plans. A young person on the Branch Executive Committee in Tororo said, '*we come up with a mini workplan every month which we share with the branch in-charge to be included in the programmes for that month.*'

The youth coordinator at the Katego clinic which is located at the FPAU headquarters is a young person and heads the youth corner where they plan their activities.

Approaches to Reaching Young People

There are five major approaches to reaching the youth:

- Youth Friendly Services in close proximity to Youth Centres
- Radio broadcasts
- Transient Traders (TT)
- Youth Cascade Model
- Peer educators

Youth Friendly Services/Youth Centres

The youth centre is a focal point for the young people in the area. It has sports facilities for basketball, netball, volleyball and indoor sports like pool, table tennis, darts etc. It also has IEC material, computer facilities and is an avenue for performances including variety shows. The Youth Centre provides a supportive environment for the youth to build their confidence and self esteem, increase their knowledge of SRH by sharing information, develop vocational skills, and computer literacy.

It was evident in the Tororo youth centre that the MA is strong in youth mobilisation. A fairly big number of young people, about 100 gather in the youth centre to watch SRH movies, music, dance and drama. They are poems on SRHR, HIV/AIDS that are recited during the shows.

The young people have a schedule of activities which nclude variety shows, club metting, and MDD for the week which they make with assistance from the branch in – charge. These are aimed at hard to reach young people e.g. street kids, school dropouts, teenage mothers and in Mbarara CSWs and Transient Traders. Additionally radio youth programmes are arranged from the Youth Centres.

A static FPAU clinic is located close to the Youth Centre which allows young people to use its services without attracting special attention. Referrals for sexual reproductive health can be easily made from the counsellors Youth Centres. The static clinic offers the range of clinical services for contraception, VCT, STI diagnosis and treatment, and treatment for minor health complaints. Age appropriate written IEC materials are available and videos are continually playing.

Radio Broadcasts

A local radio broadcast, Youth Crossroads Talk Show on Rock Radio Tororo was also observed. Discussions with PE and youth clubs indicate that many young people listened to the weekly programme and said that it increased their knowledge of SRHR issues. The programme was started in 2003 as a forum to discuss youth activities by the youth. Topics for discussions included a youth's living, politically, economically and socially. Sexual reproductive health as a frequent theme was introduced after FPAU started sponsoring the programme. SRH was from then discussed as a stand alone topic or in any topic in subjects of politics, economy, socialisation, culture etc. It is a one hour talk show with a radio presenter and two youth discussants. Youth club members indicated that they wished there was broader participation in the radio talk show i.e. not all clubs had provided discussants and said there was a need to broadcast in local languages.

Transient Traders

Transient Traders are people who are engaged in mobile and low income generating jobs like commercial cyclists (boda boda), hair dressing, car washing, food vendors, hawkers and tailors.

A 3-year HIV prevention project among vulnerable and hard-to-reach youth in Mbarara focuses on reaching transient traders who are young people. This is a peer education programme that has recorded success stories in reaching the youth who are hard to reach and vulnerable.

> 'I see positive changes. People used to doubt about condoms. I give condoms, I demonstrate. Now people come for testing. And they want other treatments. People have changed a lot. Drama works very well. But some are still shy.'
> 24 year old male vendor, peer educator

Youth Cascade Model

The youth cascade model was developed in Luwero and Bushenyi but the concept is also used in Mbarara and Tororo. The model is where young people form a club which undertakes SRHR activities aimed at graduating into a community based organisation (CBO), business entity, or cooperative movement. In some cases, the participants engage in some income generating activities like bee keeping, goat rearing, tailoring, and other forms of vocational work, these are later allowed to become independent organisations.

Peer Educators

The use of peer educators as an approach to reach out to the youth is a cross cutting model. Young people are trained in SRHR issues and equipped with knowledge and skills to enable to communicate effectively on the subject with their peers. They learn how to deliver lessons on contraceptives like using condoms and encouraging their peers to go for Voluntary Counselling and Testing (VCT).

The use of young people as peer educators is an effective means of disseminating RH messages as adolescents identify much with their peers. Messages passed on by members of the same age group are more likely to influence attitudes and behaviours. The use of peers is sustainable as it reaches the grass roots especially adolescents who are not in school and it provides the most effective channel of service delivery to adolescents.

In the Transient Trade project in Mbarara some of the TTs are trained in peer education.

In some cases peer educators are also community based reproductive health agents who form youth clubs, did income generating activities, organised community health talks and school health debates and make home visits to sick people to them with day to day work. The income-generating activities are especially important in areas where there are many orphans. These aim to address issues of poverty and unemployment which is wide spread among youth in Uganda.

Challenges Faced by the Peer Educators

The peer educators the Evaluation Team's youth consultants met, were able to point to ways their work could be improved. We repeat their comments here, not just as comments on their programme but also because they serve to remind us of the needs of other community-based volunteers.

- Insufficient training. Some volunteers lack adequate knowledge about important health issues like the basic facts about HIV/AIDS due to lack of comprehensive training in the area of SRH
- Limited funding. This constrains the effective implementation of activities like community mobilisation, information dissemination, presenting drama shows etc. due to inadequate facilitation in terms of transport, furniture and the necessary equipment or materials
- Insufficient support for the youth volunteers. Regarding this issue, one of the volunteers had this to say; 'Volunteering requires dedication and commitment and its very hard for one to commit time and energy on an empty stomach'.
- Unmet expectations of poor people 'who ask for things we can't afford to provide e.g. roofing, school fees, money etc.'
- Cultural practices such as attitudes towards to contraception, early marriage
- Feeling of hopelessness among the vulnerable groups of people. Because of this, they show no interest in seeking health services.
- Religious influence (resistance from Catholics)

7. Reaching Vulnerable Groups

In this chapter we look at how well FPAU reaches various vulnerable groups and what the obstacles are in doing so. These vulnerable groups include those with low income, low levels of schooling, women in particularly vulnerable situations, people living in geographically isolated areas (particularly rural areas) and some other groups.[8] This is important to consider since in many developing countries people with low income usually use health services less than those with higher incomes. This is often also the case for supposedly free public services. In Uganda, according to Kapell et al (2005), better off individuals have a higher utilisation of public hospital care, while this is not the case for public *primary care.* There is a more elaborate discussion of these issues in the Annex insert but the main conclusions from the evaluation are:

Poverty Targeting

To better focus their work on people with low incomes some aid programmes around the world apply various elaborate targeting strategies. These strategies might include identifying poor individuals or identifying poor groups or areas or using so-called self-targeting designs. Some of these techniques have been found to improve the coverage of programme benefits among the poorer part of the population, even in relatively low-income countries. However, since targeting also entails various costs, and the effectiveness might be low in some settings, the suitability depends on circumstances.

There is little specific targeting of the poorest people but that is probably a reasonable strategy. FPAU does not have any such explicit targeting of low income groups in Tororo, while there was evidence that some targeting strategies are used in Kampala, i.e. the selection of outreach areas was based on the poverty level of the area. This probably makes sense given the structure of poverty in the two districts in question, i.e. high general levels of absolute poverty in Tororo and more concentrated areas of poverty in Kampala. Eighty five percent of Uganda's population lives on less than USD 1 per day (UNFPA 2005). Thus, some of the practices of FPAU, such as the outreach activities, could be considered de-facto targeting, even though they are not targeting 'by design'.

It might nevertheless be useful to consider all the pros and cons in using some targeting strategies, even though it might very well be that the present strategies indeed are the most suitable ones given the local circumstances.

FPAU Reaches Vulnerable Groups, But it Also Serves the Less Poor

There is no clear over-or under – representation, of people with 'assets of the well-off' among those interviewed in our exit interview when compared with the Ugandan average in the DHS. The same goes for the level of schooling. Thus, what can only be concluded is that while the visited clinics do serve some of the poorer segments of the population, they do not only serve them.[9]

A look at the Uganda poverty mapping and health facility data shows that the geographical distribution of FPAU branches are not solely located in the richer districts of the country or in districts that are already oversupplied with public services, nor are they concentrated solely in the poorest districts or in districts with the lowest number of government health units.

[8] We have tried to avoid the term poor and poverty as much as possible in this section since it causes so much confusion. Many people probably think of poverty as those with low income, e.g. less than 1$ per day. Many others take a much broader perspective in the spirit of the capability framework of Amartya Sen. Poverty in that sense could include a whole range of vulnerable groups.

[9] The exception is that piped water, ownership of a radio and a higher level of schooling seem to be somewhat more common as compared to the DHS. However, this probably mainly reflects the fact that a high share of the exit interviews were made in urban locations, where poverty is lower, and that the fact that the DHS was produced five years before the exit interviews.

If a pro-poor provider is found to have a clientele that is, on average, less poor than is desired, this could be due to: (a) things specific to how the provider in question works, e.g. having fees that are too high, or (b) general obstacles in reaching the poor e.g. poor people lack the time to use the services. The latter obstacles are ones that all providers have to deal with if they want to reach more poor people. Ways to overcome these general obstacles are usually not readily available, even though they sometimes can be found. Some of these might be very costly which creates a conflict between reaching as many people as possible and having a high proportion of very poor clients. For the former type of obstacles, on the other hand, it might be easier to perceive possible recommendations.

The general constraints on reaching poor people are likely to be substantial in Uganda (we will discuss some of them below), which is reflected in a generally lower use of health services by poorer groups. And, there are clear disparities between poorer people and those who are better off in use of contraceptives. The 2000 Uganda Demographic and Health Survey found that 11.3% of women in the poorest household quintile use a modern contraceptive method compared to 40.6% in the highest quintile. The poorest of the poor are always difficult to reach. But, Victoria (2004) notes, in an international overview of targeting, that the coverage in the second poorest quintile is often better even when the programme is primarily targeting the poorest quintile.

Hence, we do not imply that FPAU is worse than other providers in reaching poor people. Also, this does not mean that any provider, including the FPAU, could reasonably reach more poor people with the resources available. A high share of those we interviewed could be considered poor in an absolute sense, and many could be considered poor even in a relative sense. Indeed, we have other evidence indicating that FPAU is better in reaching vulnerable groups than other SRHR providers in the country.

'Outreaches' are Better at Reaching Vulnerable Groups Than the Branch Clinics

Both the exit interviews and the qualitative interviews indicated that the outreaches had a more pro-poor profile than the branch clinics and are better in reaching other vulnerable groups as well. The branch clinic in Kampala in particular seems to partly serve a somewhat better-off clientele, which raises the possibility of using it to offer more expensive services for cross-subsidisation.

FPAU Works With a Number of Vulnerable Groups but the Picture is Incomplete

FPAU works with petty traders, including commercial sex workers, and street children whom the Evaluation Team talked to. In addition, we were informed of that FPAU also works with internally displaced people and with female genital cutting in selected areas. However, we did not hear of any other activities directed towards gender-based violence. Another group, identified as having SRHR needs are HIV positive women who wish to become pregnant. These women need information about how to protect their health during and after pregnancy, potential effects of anti-retroviral treatment on their pregnancy, and prevention of mother-to-child-transmission. An HIV/AIDS stakeholder organisation pointed out that there is no organisation supporting women in this situation. We did not hear of any work directed towards reducing stigma and discrimination against men-who-have-sex-with-men.

General Constraints in Reaching Vulnerable Groups in Uganda

Low levels of schooling, poor access to transportation, inadequate information on the availability and quality of SRHR services, and lack of women's power to make decisions within the household are general constraints for using SRHR services. These are external constraints that all providers have to take into consideration.

FPAU's fee Policy and the Lack of Knowledge of Their Exemption Practice

One FPAU specific constraint is their fee policy and lack of knowledge of their exemption pactice. FPAU requires fees for several, but not all, of its services. Their rationale for this is: (a) a service with a fee is perceived as having a higher quality; (b) it provides evidence for voluntary acceptance of contraception; (c) it contributes to building a culture of saving and investing in health care rather than spending on consumables only; and (d) it is a preparation for a likely future without donor hand-outs. Funding is not one of the arguments: fees only make up a small share of FPAU's funding.

To assure that the fees do not hinder poor people from accessing services, the fees are low and even lower in the outreaches. There is a practice of exempting people who cannot afford the fees. Still, the user fees were reported to make it more difficult for some people with low incomes to use FPAUs services. The reason is that the fee exemption practice is not known by the potential low-income users, and they will thus never seek the services. Accordingly, they will never realise that they do not have to pay, nor discover any other potential advantages, such as higher availability of drugs and no informal fees.

Even though the fees are lower than for many other providers, including the public sector (if one includes all extra costs of 'informal fees' etc), they are still perceived to be an obstacle for people, particularly women, who have little say over the use of household resources or little access to cash. There was also a lack of awareness of the exemption practice among many of the community leaders, peer educators, and community based agents, as well as other providers that sometimes refer clients to FPAU.

However, we cannot be sure that it is the (perceived) fee that is actually causing non-use. There could very well be other factors that are more important for seeking health care even though the fee is given as the reason. The fee policies affect various groups differently so it is hard to know the exact extent of the problem. Nevertheless, maintain a problem exists.

We do not recommend abolishing the fees or to make the exemption practice publicly known. However, we consider it useful for FPAU to be aware of existing problems. Better information to the volunteers is one improvement to consider.

8. Observations and Recommendations

Relevance and Effectiveness of FPAU's Activities

FPAU has a long history in the field of family planning in Uganda and is recognised as the leading NGO providing quality SRH services. With its 16 clinics, outreach activities, and community based efforts, it is recognised for its wide networks of service points that reach deep into rural communities. The confidence partners have in its work is demonstrated by the large portion of its budget which is provided outside IPPF's core funding. Partners span a large range including bilateral donors, other NGOs, UNFPA, MOH, and IPPF member associations in other countries.

FPAU's services are relevant to country needs, expressed needs of beneficiaries, national policies, and international consensus around SRHS issues. FPAU's services do not appear to duplicate those of other providers. There appears to be little demand for emergency contraception. Some users identified gaps in the services to be post – abortion care and deliveries.

- *Recommendation:* FPAU should strengthen its post-abortion care provision and make it known to potential users.

Widespread use is made of community – based volunteers e.g. community-based reproductive health agents and peer educators who are a major asset to the organisation. The need to address well entrenched negative attitudes towards family planning was identified by nearly all informants.
Peer educators (PE) carry much of the responsibility for the work on changing entrenched negative attitudes in the community and among men. In Kampala, Mbarara, and Tororo, PE asked for more training, transport (bicycles), and higher remuneration,

- *Recommendation:* FPAU should review its in-service and refresher training programme to ensure that community based volunteers are sufficiently trained to meet new SRHR challenges as they develop

Youth centres provide social space for young people to meet in their communities where positive attitudes to SRHR can be fostered. The close proximity of Youth Centres to Youth Friendly Clinics makes it easy for young people to attend for contraceptive advice or testing.

FPAU's advocacy efforts seem to focus largely on awareness raising using volunteer member, community-based volunteers, information, education, and communication (IEC) materials, and radio broadcasts. FPAU's IEC materials were assessed by the evaluation youth consultants to be relevant and appropriately designed. They are sought after by other SRHR providers and their distribution is strongly influenced by the donors who support their development.

- *Recommendation:* There is a need to develop an IEC materials distribution policy.

Radio broadcasting is another frequently used means of awareness raising but as with the written IEC materials, the effectiveness of these two methods is not systematically monitored.

- *Recommendation:* There is a need to develop a monitoring system or evaluation mechanism for the effectiveness of the IEC materials and radio broadcasts.

However, efforts to influence the policy environment, especially at the national level appears to be weak. Other SRHR stakeholders do not see FPAU as an advocacy organisation. A number of them indicated that they would like to see hear FPAU having a stronger advocacy voice.

- *Recommendation* Develop a clear advocacy action plan with an identified topic, clear target audience, techniques that will be used, evidence that will be presented to support arguments, identified partners for alliance, and a time frame.

Reaching Vulnerable Groups

FPAU is recognised as having well-developed networks in rural areas. The outreaches are viewed as an effective way to reach poor and vulnerable groups. We note that when outreaches are carried out, services at the static clinic may be left uncovered. This might disrupt services for attenders at the static clinic, especially for VCT. From our limited data of 75 exit interviews carried out at static clinics and outreach clinics in rural and urban slums, it appears that people attending the outreaches are poorer in terms of educational level and assets. In addition to the information gained through the exit interviews, we met in the homes with women who are not using family planning near one of the villages of the clinic outreach. These women were poor by other measures as well. They had little cash available which would have enabled them to attend a clinic; they were in polygynous marriages where they had little influence within their wider family; they married early and had large families; they were young and had minimal, if any schooling.

- *Recommendation:* FPAU should consider expanding its outreach services to cover a wider geographical range rather than adding services which expand the level of care.

Poverty targeting does not appear to have been carried out in Tororo. This might reflect an understanding of the structure of poverty in the district. There are a number of methods such as self targeting, group targeting, and means testing – each with its advantages, disadvantages, and costs. These should be considered when deciding whether to include poverty targeting in the planning process. FPAU might consider the pros and cons of including poverty targeting in their planning processes.

FPAU operates a fee system with the fee structure posted clearly on the entrances to its clinics. This was cited by some respondents as a reason why people do not use services. In fact, exemption practices exist and people are often not turned away if they need care. But, we heard conflicting stories about how the exemption practice is carried out.

- *Recommendation* A review of the fee structure and exemption practices. The policy should be clarified and made known to staff, volunteer members, and community volunteers.

At the same time, it was noted that some service users at the urban clinics, most notably in Kampala, could well afford the services and perhaps could have borne an even higher fee.

- *Recommendation:* The possibility of cross-subsidisation from better off users to poor and vulnerable groups should be considered.

Appendix 1. People Interviewed

FPAU in Kampala

Elly Mugumya, Executive Director, FPAU
Dr. Ismail Ndifuna, Programme Coordinator, FPAU
Annet Kyalimpa, Medical Coordinator, FPAU
David Naigeni, Head, Monitoring and Evaluation, FPAU
Diana Opolot, Gender and Youth Coordinator, FPAU
Chekweko Jackson, Project Coordinator, Earmarked Funds, FPAU
Sanyu Nkinzi Kagwa, Communication & PR/Advocacy Coordinator, FPAU
Group interview with FPAU Board Patron, Vice-Chairman, and Treasurer
Demeter Kamuyobo, Service Provider In-Charge Katego Clinic

SRHR Stakeholders at National Level

Charles Zirarema, Head, Policy and Planning Dept., Population Secretariat, MOFPED
Anthony K. Mbonye, Reproductive Health Commissioner, Ministry of Health
Nestor Owamuhangi, Programme Officer, UNFPA
Klas Rasmussen, First Secretary, Swedish Embassy
Olive Bwanika, Programme Officer, Royal Norwegian Embassy
Arthur van Diesen, Social Development Adviser, DFID
Dr. Anwar Kakeeto and Dr. Karama Said Ali, Islamic Medical Association of Uganda
Dithan Kiragga, Country Health Advisor, PLAN Uganda
Monica Barenzi and Praxida Nakitia, FLEP Uganda Catholic Secretariat
Daniele Giusti, Executive Secretary, Uganda Catholic Medical Bureau
Sereen Thaddeus, Sr. Technical Advisor, USAID
Prossy Namakula Magoba, Coordinator, National Forum for PLHA Networks inUganda
Carina Hickling, Country Director, DSW

FPAU in Mbarara

Sylvia Namulema, FPAU Mbarara Branch clinic In-charge
John Thembo, Youth Counsellor, FPAU Mbarara Branch clinic
Jude Collins Busingye, Lab Technician, FPAU Mbarara Branch clinic
Mr Sam Mwandara, Programme Officer, Mbarara Branch clinic

Non-FPAU in Mbarara

Dr. Amooti Bwera Kaguna, District Director of Health Services
Eriya Murana, Branch Manager, AIDS Information Centre
Hatibu Jimbe, Lugazi, Kakoba Ward
Ms Eva Matsiko, Branch Field Coordinator, Red Cross
Mr Richard Semiju, Project Coordinator and Mr Franklin Asiimwe, Finance & Administrative Manager, Mariestopes International.
Ms Harriet Katusabe; Administrative and Human resource Manager, Mr Sunday Goddard; Counselling Coordinator, Dr Amanyire Godden; Medical Coordinator, TASO

FPAU in Tororo

Kennedy Otundo, FPAU Tororo Branch Manager
Regina Katumba, Robina Abalo, James Opepa, Stella Awedo, FPAU Tororo Branch clinic staff
FPAU Tororo Branch Executive

Non-FPAU in Tororo

Sylvester Oboth, Chief Administration Officer, Tororo District
Dr. David Okumu, District Director of Health Services, Tororo District
Doya Gamusi Yona, District Education Officer, Tororo District
Emmanuel Joe Ongiertho, Programme Area Manager, PLAN Uganda
Emmanuel Osillo, Social Support Officer, TASO Tororo
Simon Owino, and Daniel Emoot, Radio Tororo

The list does not include interviews with TBAs, traditional healer, local community leaders.

Appendix 2. Methodology

The Uganda Country study was carried out from 11th to 22nd September, 2006. Beside interviews with various national key-informants in the capital, activities in three locations were studied: Tororo in the east, Mbarara in the west, and Kampala. In each location both the clinical and non-clinical activities were observed, both at the branch clinic and in some of the outreach clinics. The outreaches were in either rural villages or slum areas, or, in the case of Owino, a market area.

In all locations several types of respondents were interviewed:

1. FPAU staff and volunteer members. These included people in management positions, clinical staff, and Board members.

2. Other providers. These included government health workers, management of other NGOs, TBAs, a traditional healer, and private-for-profit providers. These could provide general background information on the SRHR situation in their local context and a view of FPAU's efforts. When interviewing other providers at their work place, for example a health facility, we were able to take the opportunity to walk through the health unit and observe the physical standard and availability of drugs, supplies, and equipment. These informants, especially the private-for-profit providers were valuable sources as they do not have a stake in FPAU.

3. Users and other beneficiaries of FPAU. These were mainly interviewed through the exit interviews and focus group discussions. Some of the beneficiaries of FPAU clinical services are also community-based volunteers such as community-based reproductive health agents and peer educators so the division between beneficiaries and providers is not always clear

4. Non-users and other local informants. A wide range of other local informants was also interviewed (generally in more informal ways). Examples of these were women in their homes. Again, these people were important as they could be assumed to have little stake in FPAU.

5. SRHR stakeholders at the national and local levels. This included government officers, political leaders, community leaders, and representatives of international agencies, bilateral donors, and other NGOs.

A variety of data gathering techniques were used including observations of the facilities and the various activities; semi-structured interviews; focus group discussions; and exit interviews

Sometimes informants were approached and interviewed in a more informal way, implying that they were not prepared to be interviewed as was the case with the arranged interviews. This was important since they could confirm the information we got more formally, e.g. that the clinic attendance on the day the Evaluation Team visited was not exceptional

Table 2.1 Numbers of people met and according to place.

	Kampala	**Mbarara**	**Tororo**	**Total**
Interviews district level				
FPAU Exit interviews	29	23	23	75
FPAU Non-clinical service users	5	23		28
Non-users		18	12	30
FPAU Clinical service provider	1	12	13	26
FPAU Non-clinical service providers				
	28	37	82	147

Community leaders/other SRHR stakeholders				
Total	**14**	**10**	**16**	**40**
Interviews national level				
FPAU staff	22			22
Other SRHR stakeholders	15			15
Total	**114**	**123**	**146**	**383**
Observations	*7*	*5*	*3*	*15*

A total of 383 people were met and shared their views with us as users, providers, members of the general public, SRHR stakeholders, and community leaders. Forty eight percent of the people met were women.

Exit interviews of clients were conducted at three static and three outreach clinics, using a structured questionnaire with largely closed questions. The Katego clinic is situated in the same building as the FPAU head office. Gwaragwara is a village in the Tororo district (where the outreach clinical services are provided under a tree). Owino is a market area in Kampala and Mulago II is a Kampala slum area. FPAU has fixed facilities in both of the Kampala outreaches.

The first person exiting the service was approached and asked if (s)he would like to participate, and was informed that participation was voluntary. After the interview was finished the next person exiting was approached. Thus, only people exiting around the time of the ending of a previous interview were approached (no one was kept waiting for any longer time). The interviews were carried out by one or two of the youth consultants.

All exit interviews were conducted during one day only for each clinic, except for the Mbarara clinic, where interviews were carried out on two consecutive days. The number of people interviewed and the number of refusals are indicated in the table below. A total of 75 individuals were interviewed (if counting a couple that came together as two) and a total 5 people refused (i.e. a total of 80 people were approached). This gives a refusal rate of 6%, which should not cause any major concerns.[10]

Table 2.2 Number of exit interviews at the static and outreach clinics

Name	Type	Interv. females	Interv. male	Interv. total	Refu-sals	Refusal rate %
Katego clinic	Kampala branch	9	5	14	0	0
Tororo clinic	Tororo branch	9	6	15	3	17
Mbarara clinic	Mbarara branch	20	3	23	0	0
Gwara-gwara	Tororo outreach	6	2	8	0	0
Mulago II clinic	Kampala outreach	4	2	6	1	14
Owino clinic	Kampala outreach	5	4	9	1	10
Grand Total		**53**	**22**	**75**	**5**	**6**

Refusal rates calculated as refusals/total number approached. Total number approached equals total number of interviewed plus refusals.

There are of course many limitations with a small, non-random, sample like this one. We cannot be sure that the days we visited were typical (even though the clinic staff said they were), or that the clinics are representative of FPAU in general. The various exit interviews were conducted at service points in very different settings, with only a few observations at each point. Only extremely clear patterns can be taken as an indication of anything, and then only as a supplement to other sources of information.

[10] The stated reason for refusal was normally that the person was in a hurry. The refusal rate is what could be expected in a low-income country, where refusal rates normally are lower than in high income countries (see Deaton 1997).

Appendix 3. Constitutional Provisions and Governance

Constitutional Provisions

Key documents guiding the operations of the organisations include the Constitution, Constitution regulations, Policy Hand book, Volunteer members code of conduct, Strategic Plan 2004–2008, Staff competency profiles/job descriptions for all jobs, Financial management regulations manual, Logistics & stores manual, Human resources manual.

The organisations constitution and the constitutional regulations were revised in May 2004. The FPAU strategic Plan had been revised and amended at a mid term review in September of the previous year.

Governance

FPAU an NGO made up of volunteers and governance issues require involvement and transparency. The organisation has two administrative levels, the district and national.

At the national level, National Executive Council enacts constitution & bye-laws. It appoints auditors/ lawyers and approves audited accounts, approves strategic plan. The National Executive Council (NEC) considers & approves Annual Programme Budget & donor reports, meets quarterly to monitor programme & policy implementation.

NEC appoints and appraises Executive Director. The institution has been having stable leadership since 1999 when the current Executive Director was brought on board. His predecessors having been shown exit in 1994 and 1998 respectively because the board/council was not satisfied with the management performance. Sincethen things have been very smooth, and they never had to intervene substantially. The current executive Director has had a cordial working relationship with the board. IPPF has been very satisfied with accounts and reporting, and so have other donors. They guide but do not participate in the day-to-day affairs. They can intervene but have not had any reason to do so in recent years. Treasurer has almost daily contact with accounts staff to sign financial documents.

The representation on the board is gender balanced. The board member may serve up to a maximum of three consecutive terms of two-year duration each. After spending six years in office, a board member is allowed to stand for another term of office only if he had a break of two years. The Patron and the treasurer were the longest serving members close 12 years each. Though this is good for institutional memory, it limits creativity and dynamism. It was however good that both the executive and the board members themselves indicated these members will not re-run and that they are prohibited by the constitution

At district level, all branches have branch councils & branch executive committees. The district branches have a board that is responsible for elections and conducting the annual general meeting. The Youth are organised in Youth Action Movement (YAM).

On all the councils youth are included, a phenomenon that has increased youth confidence in the management of the association because their issues are articulated. The inclusion of the youth on the governing councils has strengthened their involvement and commitment in FPAU activities. One of the youth in Youth Action Initiative for Health and Development (YAIHD) said we are committed to this work. I am a teacher but was chased away from my work because I spent much time as a volunteer. My motivation is improved heath for my people'. Their main achievement is life skills what they referred to as life building skills. During the evaluation we found members of the council/board knowledgeable about AFPU activities.

Appendix 4. Information Education and Communication Materials

Because Information Communication and Communication materials are important in advocacy efforts around sensitisation and mobilisation we are looking at the written materials produced by FPAU separately.

A large number of posters, information cards, magazines and newsletters were made available so that the Ugandan evaluation team members could assess them. Information about the materials was also provided by the communications coordinator.

The evaluation team found that the IEC materials carried messages that went through a careful process of development, had targeted audiences, addressed adolescent issues and were appropriate to SRHR issues.

Process for Development

The message development process depends on the target audience and the funders. PLAN International which is a major funder is a child-centred organisation and all the IEC materials supported by PLAN must involve young people in the message development. While developing the IEC materials FPAU uses children from the community. The children's knowledge about SRH issues is explored. They are then asked about what they want to know more about SRHR and what they want the community to know particularly about their rights. They are encouraged to come up with slogans which are later adopted as IEC key messages.

These are pre-tested and carefully post tested to ensure that the intended message is conveyed. Post testing has revealed the need to be sensitive to unintended messages being conveyed such as the use of colours in a figures clothing indicating political affiliation. Different cultures have been shown to require modification to a basic template. For example the 'Gomesi' is used in Buganda while Banyankole cannot identify with it.

Target Audience

FPAU targets all the categories of people in IEC development. These include young people, parents, females and males, the community and policy makers.

Messages

The messages developed cover a wide range of SRH issues including abortion, early and or forced marriages, unwanted pregnancy, STIs, cross generation sex, HIV/AIDS, condom use, male involvement, immunisation, idleness, post abortion care, positive living and family planning. Most of these messages are aimed at behavior change.

Appropriateness

– Considering the SRH situation of the youth in the country, the IEC materials attempt to address a majority of the SRH needs. The materials are aimed at increasing awareness against the socio cultural practices that impede RH for adolescents and increased awareness for positive change on attitudes, behaviours, beliefs, values and practices on SRH.

- IEC materials have a wide coverage in terms of scope and content.
- The IEC materials have catching messages that use the language of targeted audience for example 'its cool, its fun, its yours' for young people.
- They appeal to all categories of people including those who cannot read and get the message across. The graphics and pictures are easily understood by people who can not read. Many of the messages are also relevant to the life situation of poor people. for example people in familiar village settings.
- Adolescents need accurate information about issues that affect them and IEC materials provide such messages with intention of enabling them to make informed decisions relating to SRH.
- They promote the rights of adolescents to information and protection of the adolescent SRH rights by sensitising the community members about the rights of adolescents.
- They give directions about the services available and where to get them.

Dissemination/Distribution

All the FPAU branches get IEC materials in English and the local language. The branches visited by the evaluation team had materials posted around the health centres and other areas that are commonly visited like youth centres. The Community Based Reproductive Health Agents and Peer educators have the responsibility of distributing IEC materials to their communities.

Limitations

There two limitations to the IEC materials;

- There is lack of a communication distribution policy. Donors strongly influence distribution of the IEC materials whose development they have supported. PLAN supports most of the development of the IEC materials but their dissemination is limited to only PLAN area of operation which results in these areas receiving large amounts of the materials while other areas may receive few. The PLAN area of operation includes districts of Kampala, Tororo, Luwero and Kamuli.

There is need for good monitoring system to test the effectiveness of the materials.

Appendix 5. Reaching Vulnerable Groups

In many developing countries people with low income usually use health services less than those with higher incomes. That this is the case for private for profit providers is not so surprising, but it is often also the case for supposedly free public services, especially hospital services. Pro-rich utilisation could be due to lower access to information by poor people, informal fees, and other costs incurred when using the service, e.g. opportunity costs, transportation costs and complementary expenditures on medicines and the like. Kapell et al (2005) indicates that this pattern to some extent can be found also in Uganda. According to their study, better off individuals have higher utilisation of all private-for – profit and not – for-profit health services. This is also the case for public hospital care, but not so for public primary care.

It should be noted that in cases where the utilisation of public services are lower for the poor, and where these services are funded by not so progressive taxes, these services might actually imply a subsidy to the rich by the poor. Given this it is interesting to see whether FPAU is good at reaching those with low income.

There are, as we will see, indeed indications that FPAU does serve those with low incomes and that they might be better in this than many other providers. This is true not only in relation to the private-for-profit providers but also, at least to some extent, vis-à-vis other NGO-providers and the public sector. At the same time, it is also clear that they do not only serve the poorest in society, and in a country with so many unmet needs one could always say that more could be done. However, any perceived shortfalls from the ideal case are not necessarily due to the FPAU, but rather due to external constraints of a more general character. We will discuss both FPAU-specific and general constraints in more detail further on.

Here we will mostly discuss the income aspect of poverty, but to the extent that low income goes hand in hand with other aspects of vulnerability, such as low formal education, lack of women's power within the household, geographical isolation etc, these bring their own constraints, something that we will discuss later. However, the first thing we look at is whether FPAU is using any targeting strategies vis-à-vis those with low incomes.

Does FPAU Have Any Strategies to Target Those With Low Incomes?

Some aid programmes around the world apply various elaborate targeting strategies to better focus their work on people with low incomes. The idea is to encourage those who can afford to pay for non-subsidised services to do so and thereby allowing more resources to be directed to those with greatest need. The various targeting techniques are in the literature normally divided into:

1. Only give the service to *individuals* identified as poor. These could be identified with a variety of methods, e.g. means testing.

2. Only give the service to *groups* with a high share of poor people. This could, for example, be people living in a certain area.

3. *Self targeting* by designing the intervention in such a way so that non-poor is discouraged from utilising it, even though it might be formally available to everyone, e.g. by offering a service with high quality in its essential aspects, but give the service some less attractive attributes in a few non-essential aspects (such as the location of the facility or by not prioritising outward appearances).

Targeting also entails many costs, such as administrative costs, negative incentives, risks of excluding the wrong people, risks of corruption etc. Hence, when all things are taken into account, it is not self

evident that poverty targeting always leads to improved impact for the poor. It has been argued that it is less suitable to use poverty targeting in environments where: a) the majority can be considered poor in an absolute sense, even if not in a relative sense; b) where the poor is not concentrated in some easily identifiable way; and/or c) where the general administrative capacity is low. Still, studies of poverty targeting have in some cases reached positive conclusions even in countries where absolute poverty is high (see Grosh, 1995 for a discussion).

Is FPAU using any of these poverty targeting techniques? A first step could be to look at the geographical location of its branches, to see if they are located in districts with low incomes. However, given that the extent of income poverty might vary a lot within the districts and since transport costs mean that the take up area might be quite small when it comes to poor people, this would not be a particularly effective method of targeting. One would perhaps raise an eyebrow if it were found that the FPAU branches was clearly concentrated only in the richer districts of the country or in districts who is already oversupplied with public services. A look at the Uganda poverty mapping and health facility data reveals that this is not the case.

On the next page all the districts in Uganda are plotted against the (rural) poverty level in 1999, as indicated by the Ugandan poverty mapping, and the density of hospital beds in 2002. The official poverty line adopted by the government of Uganda is used. It is are estimated taking both food and non-food requirements of households into account (see Emwanu et al, 2003 I, for further details).

As for targeting within the districts we looked at the urban district of Kampala, and the rural district of Tororo. In Tororo there did not seem to be any explicit consideration of income levels when selecting which areas to work with, or any other targeting mechanism. Still, they do gather data, for example through so called ELCO-mapping, that are used to identify which households to revisit, but the concern is then the needs in the households for specific SRHR services. The fact that the user statistics gathered by the FPAU contain no socio-economic information seems to mirror this lack of explicit targeting. Much of the above also applies to other aspects of vulnerability. For example, the lack of income as an selection criteria in Tororo is mirrored by the lack of other criteria directly linked to vulnerability, e.g. schooling, women living in particularly vulnerable household settings etc. Even though there are some exceptions to this, which will be discussed below, the main selection criteria concern the SRHR needs more rather than poverty in itself.

Since rural areas are generally poorer than urban ones, in Tororo as in most other districts, and since transport is a major constraint for most poor, the focus on rural outreaches is likely to be a good way of targeting, even though the lower incomes in rural areas was hardly mentioned as a reason for this focus.

This lack of an explicit pro-poor targeting strategy is probably quite reasonable given the distribution of poverty in the district. According to district administrators and others (in accordance with the poverty mapping) the distribution of poverty could be described as:

- The rural areas are generally poorer than Tororo town.
- There is a small number of people in the town who can be considered 'well-off', and quite a large share that could be considered non-poor. There are also clearly poor areas within the city. However, since the city is not large, the geographical location of the Branch Clinic does not appear to make it inaccessible to poor people.
- There are clearly some income differences within the rural communities as well. However, the number of 'rich' households is negligible and families are normally not resident. The majority of people are more or less poor, and a substantial number could be considered really poor.
- Poor people are not clearly concentrated in any particular areas of the district, and the villages are obviously so small that any geographical concentration within the villages has no meaning for the access to any particular service point.

Figure 5.1 Population per hospital beds.

X-axis: estimated district poverty rate in 1999. Source: Emwanu, Thomas et al (2003 I & II). Purely urban districts seem to have been excluded in that data set. Hence poverty rate for Kampala was taken from Duclos et al (2006), table 4 'Central Urban'.

Y-axis: population per hospital beds in 2002. Source: Government of Uganda (2003 I).

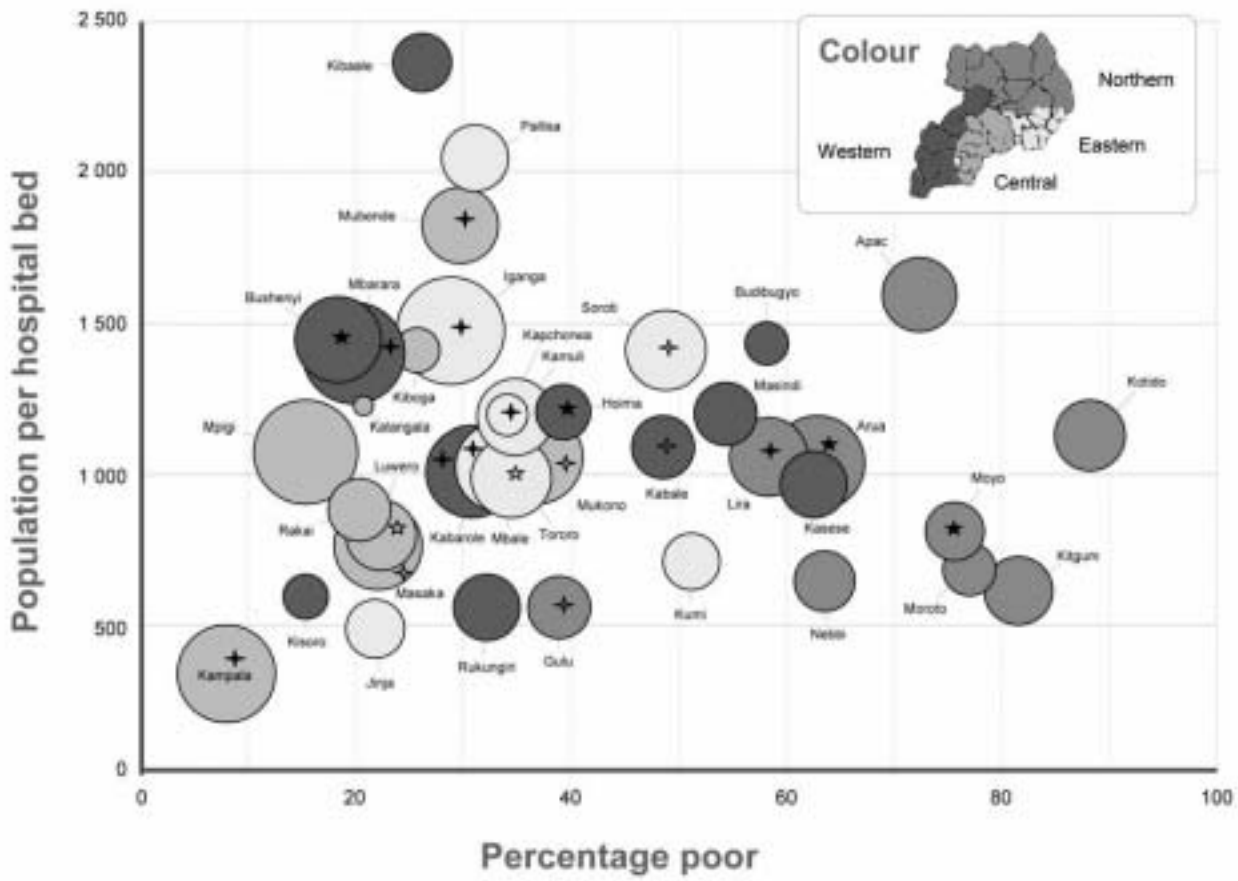
Hence, low and to the left indicates low poverty and high availability of health care. Size of bubbles indicates district population (taken from Ministry of health above). FPAU presence in a district is indicated as follows (taken from FPAU 2006 II):

✚ IPPF supported

✛ Volunteers only

★ UNFPA supported

☆ PLAN supported



Thus, the costs of an elaborate targeting strategy, such as the administrative costs, would probably exceed any gain in Tororo. Although it appears that the lack of targeting is reasonable, there might nevertheless be useful for FPAU to consider all the pros and cons in using some targeting strategies, for example to reach out more to the uneducated (see below), before rejecting all use of explicit targeting in a district such as Tororo.

In Kampala, on the other hand, there are clearly both rich and poor neighbourhoods. The FPAU has clinics throughout Kampala. According to FPAU staff, the selection criteria for locating services have been that the area should be poor and that there should be no competing government service nearby. The high poverty of the areas was apparent during visits to several of these clinics. Thus, an explicit

consideration of poverty appears to be used in Kampala, which, again, makes sense given the structure of poverty within the city.

It should also be added that the appearance and location of most of the outreaches implies a self targeting, if not by design, so at least in practice, i.e. those who can afford the unsubsidised fees by the private-for-profit providers would in all likelihood prefer to use these rather than the cheaper FPAU services located in the slums. This cannot be said with the same certainty for many of the branch clinics, something that will be dealt with when we now turn to the issue of the profile of the clientele of the FPAU.

The Clientele of the FPAU

If a provider is found to have a clientele that is, on average, less poor than in the perceived ideal case, this could be due to:

- First, things *specific* to how the provider in question works, e.g. mainly offering services relevant to the rich, working in richer areas or having high fees. In such a case there might be obvious things that the provider could change if it wanted to reach a poorer clientele, and there are potentially other providers that do a better job in reaching the poor. Of course, the solution of the provider might still be the best response to circumstances so that it is not possible to do any better than they are already doing.
- Second, it might also be due to more *general* obstacles in reaching the poor, such as lack of resources among the poor for accessing the services.[11] These are obstacles that any provider has to deal with if they want to reach more poor. We cannot be sure that there are reasonable methods to overcome these obstacles, even though that is sometimes the case. Even if there are ways to reach poor people these might be very costly and then it becomes a conflict between reaching as many as possible and having a high share poor clients.

So what can we say about the profile of FPAU's clientele? The questions on education and assets in the exit interviews were chosen from the DHS so that the profile of the clientele could be compared with the pattern of the total population of Uganda. Comparisons between the DHS and the exit interviews have other limitations in addition to the small sample size.

The Ugandan DHS is from 2000–2001, i.e. there is a 5 year time gap between the DHS and the exit interviews. During these years the Ugandan economy has grown quite substantially, which means that the ownership of assets at the time of the exit interviews are likely to exhibit a higher wealth profile than the DHS data indicates.

Furthermore, given the Universal Primary Education initiative, the primary enrolment has increased quite a lot, which means that the educational data should be adjusted up for the younger age cohorts, at least when it comes to primary education.

Another important point is that wealth and education vary a lot between various parts of Uganda. The clientele of a clinic might look poorer than the Ugandan average, but might still be among the 'best – off' in the area of the clinic in question. Accordingly, the observed profile in the exit interviews reflects the combined effect of two things: the location of the clinic, and whether the clinic serves richer or poorer segments of the population in the uptake area of the clinic.

When we look at education we must take the age of the individuals into account since the educational attainment differs between age cohorts, with younger age cohorts having substantially more education. Hence, a well educated clientele of a clinic might reflect that the clinic attracts the more educated

[11] In Uganda, as many other countries, the richer segments of the population have a higher use of health service, as well as better health status. The DHS has many indications of this; some examples are given in the annexes.

within each age group, or it might simply reflect that they attract a younger clientele than the population average.

Similarly, we must consider gender since men have somewhat higher educational attainment than women. Finally, the differences between rural and urban areas are substantial.

Let us begin with schooling. One question in the exit interviews concerns the last year of completed studies. The distribution, by service point, is shown in Table 5-1 below (we will return to the comparison between service points later on). The Ugandan school system is based on 7 years of primary education, 4 years of lower secondary and 2 years of upper secondary, giving a total of 13 years of study. This is followed by the higher education.

Table 5.1 Last year of completed schooling

Name	Type	None/ preschool	7 yr primary	4 yr lower secondary	2 yr upper secondary	Higher education	Number of observations
Katego clinic	Kampala branch	0ä	14ä	36ä	14ä	36ä	14
Tororo clinic	Tororo branch	0ä	33ä	40ä	0ä	27ä	15
Mbarara clinic	Mbarara branch	0ä	43ä	22ä	9ä	26ä	23
Gwara-gwara	Tororo outreach	13ä	13ä	38ä	13ä	25ä	8
Mulago II clinic	Kampala outreach	33ä	67ä	0ä	0ä	0ä	6
Owino clinic	Kampala outreach	11ä	56ä	33ä	0ä	0ä	9
Total		**5%**	**36%**	**29%**	**7%**	**23%**	**75**

Note: Sum of rows equals 100%.

To put this in perspective we show the educational attainment of the DHS in Table 5–2 below. The majority in the exit interviews have more than primary education, which, at face value, would make them somewhat better educated than the Ugandan average. This seem to be so even if we consider the age and gender of the respondents. The fact that the DHS is five years older than the exit interviews would only affect the younger age groups.[12]

Table 5.2 Educational attainment separated by residence

	No schooling	Some primary	Complete primary	Some secondary	Complete secondary	More than secondary
Rural	26ä	47ä	10ä	13ä	1ä	3ä
Urban	7ä	24ä	13ä	34ä	4ä	16ä
Total	**23%**	**44%**	**11%**	**16%**	**1%**	**5%**

Sum of rows equals somewhat less than 100% due to missing observations.

Source: Uganda Bureau of Statistics & ORC Macro (2002 II), Table 2.1.3

However, this might only reflect the fact that most of the exit interviews were made in urban locations (62% of urban men had more than primary education, a number that is likely to be significantly higher for the younger age groups). The only thing that could probably be said, given the data, is that the visited clinics are not only serving the least educated parts of the population.

[12] The breakdown by age and gender is not shown here, but the both the exit interviews and the DHS included information to do this. However, the DHS summary tables did not include attainment separated by age, gender and location.

The exit interviews also included questions on the ownership of various household assets. These assets were taken from the Uganda DHS, and are part of the set of assets that are used to calculate the wealth status of the household. These are shown in Table 5-3 below together with the data from the exit interviews (the comparison between the outreaches and branches will be discussed in the next section).[13]

The assets used are of course not unproblematic, e.g. some have a different significance in an urban setting compared to rural ones. Also, things such as a bicycle might be more common in rural areas and piped water is a factor that is dependent on public investment in infrastructure, which might be at variance with other factors than household wealth.

There seems to be an overrepresentation of people with piped water and with a radio. There is no other apparent pattern of over-or under representation on the other indicators of household wealth. Thus, we can again only make the very weak conclusion that the visited clinics are *not only* serving the least well endowed households.

Table 5.3 Household ownership of assets

Asset	Alternative	Outreach (exit inerv.)	Branch (exit interv.)	DHS rural	DHS urban
Drinking water	Water from open well	9ä	8ä		
	Water from covered well	4ä	4ä		
	Water from borehole	26ä	4ä		
	Surface water	4ä	0ä		
	Other source	0ä	4ä		
	Piped water	57ä	81ä	0ä	12ä
Toilet facility	No/bush/field	4ä	0ä	19ä	3ä
	Pit toilet/latrine	91ä	73ä	79ä	88ä
	Septic tank/modern	4ä	27ä	1ä	9ä
Bicycle	No bicycle	78ä	65ä		
	Have bicycle	22ä	35ä	42ä	20ä
Radio	No radio	30ä	6ä		
	Have radio	65ä	94ä	47ä	78ä
	NA	4ä	0ä		
Roof	Thatched	13ä	2ä		
	Iron sheets	87ä	92ä		
	Tiles	0ä	6ä		
Floor	Natural floor	39ä	25ä		
	Finished floor	61ä	75ä	10ä	74ä
Walls	Mud and pole	17ä	15ä		
	Unburnt bricks	0ä	10ä		
	Burnt bricks with mud	22ä	38ä		
	Cement	61ä	12ä		
	Burnt bricks with mud & cement	0ä	25ä		
Housing	Rent	61ä	54ä		
	Own	39ä	46ä		

Notes: The answers indicating a higher wealth status has generally been put at the end of the list for each type of asset. Sum of percentage for exit interviews equals 100% for each assets, for each type of service point (i.e. branch or outreach). "Finished floor" from the DHS is defined as either wood, vinyl, tiles or cement.
Source for the DHS: Uganda Bureau of Statistics & ORC Macro (2001) table 2.6 and 2.7

[13] Not all assets were included in the summary tables of the DHS available to us.

Before assuming that this shows that FPAU could or should have a more pro-poor profile we should remember that the general constraints on reaching the poor are likely to be substantial in Uganda (we will discuss some of them below). This is reflected in a generally lower use of health services by poorer groups, as indicated in the DHS, among other sources. It is also important to remember that the poorest of the poor is always difficult to reach. Victoria (2004) notes, in an international overview of targeting, that the coverage in the second poorest quintile is often better even when a programme is primarily targeting the poorest quintile.

Hence, we do not imply that FPAU is worse than any other provider in reaching the poor. Also, this does not say that any provider, including the FPAU, could reasonably reach more poor people with the resources available. In any case, a high share of those interviewed could be considered poor in an absolute sense, and many could be considered poor even in a relative sense. Indeed, there was some qualitative evidence that FPAU is better in reaching many vulnerable groups than many other SRHR providers in the country. Many factors are likely to make FPAU more attractive to the poor than many of the other providers: the outreaches in poor and isolated areas, their work with some specific vulnerable groups (to be discussed later) and the fact that they seem to be cheaper than many other providers, especially when put in relation to the quality of their services.

The Exit Interviews: Comparing the Branches with the Outreaches

Both the interviews, as well as direct observations, indicated that the outreaches might reach out to poor people to a larger extent than the branch clinics. Since lack of transportation is a major constraint for poor people, even in the cities, and since the outreaches visited were located in clearly poor areas, and since many of the clients apparently came from the area, this would indeed support the notion that FPAU outreaches are effective in serving poor people. This cannot be said with the same certainty for the branch clinics since these seemed to be located in somewhat less poor areas.

To be sure, there are poorer areas close to the branch clinics and some clients travel long distances to access the services. However, it was pointed out by FPAU staff that at least the Kampala branch clinic had a quite different clientele as compared to the outreaches, with a higher share of middle class, or at least people that could be considered non-poor. It was also said that there occasionally were some affluent clients.

Turning to the exit interviews we can begin with the schooling level of the clients, as was shown in Table 5.1 above. Keeping all the mentioned shortcomings of the data in mind it is still interesting to see that the only clients without any formal education were found in the outreaches. Furthermore, in the Kampala outreaches, there was no one with schooling beyond lower secondary, while the branch clinics (as well as the outreach in Gwaragwara) had some very well educated individuals among their clients. Hence, it seems as if the perceived differences between the outreaches and branch clinics are consistent with the educational data in the exit interviews.

It is possible that the differences between the service points could be due to a different age profile since younger age cohorts have much more education. This does not seem to be the case though, if we look at the data by age groups (not shown).

However, 4 of the 6 individuals at the Mulago II clinic were still in school, which means that we do know whether they will eventually end up with a much higher level of education, something that would make the pattern less clear. Nevertheless, 2 of these 4 were older people that had just started adult training (e.g. one was a 30 years old that was enrolled in pre-primary schooling), so these could still be considered as people with a poor educational background.

Let us now turn to the ownership of assets among the clientele of the branches and the outreaches, as was shown in Table 5.3 above. The pattern is not very clear, at least when one considers the limitations of the data. However, the pattern is quite consistent across the various asset types: the assets of the 'best – off' are somewhat more common among the clientele of the branches, something that is also consistent with our other sources of information. Piped water is somewhat more common among the clients of the branches, as are a modern toilet, ownership of a bicycle, ownership of a radio, a roof of tiles, or at least of iron sheets, a finished floor and home ownership. The only asset where there is no pattern is the material of the walls of the house.

All this implies that the outreaches indeed are more effective in reaching out to the poor. Furthermore, for the Kampala branch clinic many of the clients might be considered belonging to a group that perhaps could pay higher fees for their services. This could, in such a case, point at the possibility of either shifting resources from the Kampala branch clinic to outreach activities, or to offer services with even higher fees at this clinic to fund outreach activities.

As we have pointed out, the fact that FPAU is not only serving the poor might be due to general obstacles that make poor people harder to reach as well as some obstacles specific to the FPAU. In the latter category only one major constraint was found, a constraint we now turn to.

FPAU Specific Constraints: Fees and the Exemption Practices

One potential constraint for some poor people without access to cash, especially young people and rural women with little power within the households, is FPAU's fee policy. FPAU requires fees for several, but not all, of its services. Their rationale for this is:

- A service with a fee is perceived as having a higher quality
- It provides evidence for voluntary acceptance of contraception
- It contributes to building a culture of saving and investing in health care rather than spending on consumables only.
- It helps prepare the users, communities, and FPAU for a likely future scenario when donor handouts will not be available.

Furthermore, the fees help them to validate their own data on client load (since managers can cook the data if they do not have to show the money they got from the clients). Some examples given by community based agents and others gave some indications that these arguments indeed have some merits. It should also be noted that funding is not one of the arguments: fees only make up a small share of FPAU's funding.

To ensure that the fees do not hinder poor people from accessing services, the fees are set low, and even lower in the outreaches. In addition, there is a practice of exempting people who cannot pay the fees. There are no clear criteria as to who should be exempted, but the decision is made at the face-to-face meeting with the service provider. The practice is that no one who came for a service should leave without it, due to lack of money.

The fees, when applied, seem not only to be lower than those charged by the formal private-for profit providers, who cater to the more well-to-do, but also lower than several other NGO providers.[14] This, combined with the high quality of services, was mentioned a reason for choosing FPAU in a high share of the exit interviews.

[14] The health facility survey from 2000 indicate that fees were generally higher among the private-for-profit providers than among the NGO-providers. (Lindelöw et al, 2003, table 17).

In theory the FPAU fees are higher than the fees in the government health facilities, since, supposedly, government health care is free of charge. However, the public services are often connected with various 'informal' fees (some users could immediately tell interviewers what the 'going informal fee' was). In addition, there are often drug shortages in government facilities. This means the patient ends up paying for drugs from private providers. This, in combination with the exemption policies, and the fact that there are clear indications that the FPAU offers better quality services than government providers, makes FPAU an attractive alternative, whenever available, especially for poor people.

Indeed, many users in the exit interviews, as well as other informants, attested to the attractiveness of FPAU and its ability to reach poor people, something that is not contradicted by the profiles of the clients. Many in the exit interviews had also been exempted or had their fees reduced. However, these advantages only work to the extent that the poor are aware of them. Those who do not know will never attend for services and will thus never discover any of the advantages, including the exemption practices.

The fees, if they have to be paid in full, are not affordable to people with very low incomes or with no access to cash[15], even though the fees are low compared to many other providers. Focus group discussions with users, non-users, community leaders, and other providers all indicated that clients and potential clients generally are unaware of the exemption practice. The Katego branch clinic (i.e. the clinic at the national headquarters), was the only place where the price list included information on the possibility of exemption. As we saw this clinic is the one where the need for exemptions is likely to be lowest, given the profile of the clientele. At the exit interviews at this clinic respondents were explicitly asked whether they were aware of the possibility of exemption. About half of them were not, in spite of the sign.

The potential clients are not the only ones who lack information. This also goes for many of the community leaders, peer educators, community based agents, as well as other providers that sometimes refer clients to FPAU. Furthermore, many informants did not even know about the services that are free of charge, such as condoms.

Several informants had examples of people who wanted to attend the clinic, but did not, because they did not think that they could afford it. Some said that they occasionally helped these potential clients with money from their own pockets, or tried to convince them to save some money to go later. Sometimes the peer educators know about the exemption policy, but do not feel they can tell potential clients about it. As one peer educator in Mbarara expressed it:

> 'Fees limit the youth very much. People say they are ready to come for a test, but don't have the money. This is a challenge in our outreach work. Their first question is always if it is for free, everyone is asking that. We cannot tell them about the exemption rule when we are out, because then everyone would come and want it for free.'

Many of those who are aware of the exemption practice still feel that the lack of clear guidelines poses a problem. The decision to exempt seems arbitrary to many and there seems to be some confusion as to what the actual fees and fee policies are.

Thus, we found that the fees, or at least the lack of clarity and information of the exemption practices, indeed do constrain some people with low incomes from accessing the services. A wide range of informants claimed that vulnerable people did indeed choose not to use the FPAU services because of the fees, even though they wanted to. Instead they were said to be trying to use the public services, often with disappointing results, or not using services at all.

This being said, some caveats are important to point out. Even if an obviously poor person claims that (s)he cannot afford the fee and is indeed not using the service, we cannot be sure that it is the fee that is

[15] The 2000 DHS (UDHS 2001) indicates that among the women working in agriculture (75% of the women), almost half are paid in-kind or not at all.

actually causing the non-use. There could very well be other factors that are much more important for the health seeking behaviour of the individual.

In some cases there might be relatively poor people with some room for paying the fees, even though that room might be small. For example, one informant agreed that the low incomes of some transient traders indeed make the fee for VCT a very large burden, something that the transient trader themselves used as an explanation for not testing. However, as the same informant pointed out, they still manage to save enough to take girls out drinking, which clearly indicates that at least for some poor it is a matter of priorities, and that the high fee only functions as a rationalisation for the non-use.

In cases where other factors than fees are the real cause of the non-use, a lower fee may not enable an increased use of the service. There are likely to be cases when the individual really does not have the money, e.g. women who are dependent on their husbands for cash. Thus it is clear that the fee policies affect various groups very differently. It is difficult to know the exact extent of this problem, but we would still say that it is there.

The discussion on the potential problems with the fees should accordingly not be taken as a recommendation to stop using fees, or to make the exemption practice publicly known: there are reasonable arguments for the present strategy and we do not know if any changes in these respects would mean an improvement. It is still useful for the FPAU to be aware of the complication. Furthermore, better information on the matter to the volunteers could be one improvement to consider. The Evaluation Team was informed that FPAU is planning to conduct a willingness to pay study – something that indicates that it takes the issue of fees seriously and acknowledges the complexity of the problem. Having thus dealt with a FPAU specific constraint we now turn to more general obstacles that makes it more difficult to reach poor people.

General Constraints for Reaching Poor People

Many of the general constraints are connected to some aspect of vulnerability, e.g. low levels of schooling, which could be part of the definition of poverty, as well as being correlated with the income aspect of poverty. The problems with the fee exemption practices also affect other vulnerable groups, such as women with no say over the use of household resources. On the other hand, the strengths of the outreach programme in reaching those with low income also apply to many other aspects of vulnerability. For example, all of the visited outreach sites were situated in areas that exhibited other aspects of vulnerability than low income, e.g. poor infrastructure and sanitation systems.[16]

Before we go on we should also point out that those who are very poor might consider all other problems secondary to the most immediate need of food and survival and can hence also be hard to reach, as several peer educators pointed out. We now discuss the other constraints.

Low Schooling as a Constraint

Schooling and income often go hand in hand. The relationship is not perfect, of course, with many exceptions of educated poor and uneducated rich. Under some special circumstances the relationship might even be the reversed.[17]

Focus groups of peer educators and community based agents made it clear that low schooling can pose a constraint on service usage in its own right. This might be so for two reasons:

[16] FPAU volunteers also described many other aspects of vulnerability in the outreach areas, such as low schooling, high unemployment, highly disempowered women, high rates of crime, and high rates of single mothers.

[17] For example, in a context where education has less value for the family business than the trust of family ties it has been observed that those with more assets in form of cattle, land or family businesses prefer to employ their children rather than to send them to school. Incidentally, one focus group of peer educators pointed out that children from families with a lot of cattle were harder to reach since they were often away rearing the animals.

- It is more common that people with little schooling had various misconceptions about family planning and it is harder to change their views. Even some primary education was said to make a noticeable difference compared to no education at all.
- One major method to reach young people was the school visits, but out – of – school youth obviously cannot be reached in this way.

The exit interviews seem to indicate that the outreaches are better in reaching those with low education.

Transport and Living in Isolated Areas

The costs of transport can often be much higher than any fees charged. The availability of a bicycle can make the whole difference for someone in need of care, if the health care is only available in the town some 10 km away, as it was in the outreach village in Tororo. This is an especially severe constraint in rural areas. Many rural areas are also totally underserved with health services, and the health is generally much poorer in rural areas than in urban (see, for example, Duclos et al, 2006).

The fact that the FPAU carries out outreaches is thus important for their ability to reach isolated communities. The outreaches could be considered an explicit targeting of geographically isolated populations. The government health service has in theory quite an extensive network of facilities, but many of these are severely understaffed and regularly experience drug shortages thus making them unable to deliver any real services in the rural communities.

Women With LittleSay in the Household

Women can also be considered a vulnerable group in Uganda.[18] However, some women might be living in situations that make them more vulnerable than others. Some live in households where

a) little information regarding SRHR is available,

b) their ability to make decisions regarding health matters is limited,

c) they have little access to household resources, and

d) there is considerable age disparity between husbands and wives.

This also has implications for the family planning. At one outreach site there were women who had agreed with their husbands to limit their family size. However, it was still the women who were expected to find the money for contraceptives and clinic attendance.

The outreach activities and low costs of FPAU are especially important for this group of women since transportation and money is a particularly severe constraint for them. The problems with the present fee exemption policies apply also here.

Some Other Vulnerable or Important Groups

Commercial sex workers and transient traders are more exposed to SRHR related risks. FPAU has projects directed at these two particular groups. Street children comprise another vulnerable group for whom FPAU has also designed projects. FPAU's own assessment of these programmes is that they are reaching out.

Other vulnerable groups include internally displaced people and drug users. For these groups we have too little information to be able to assess how well FPAU is working with them. The Evaluation Team

[18] The exit interviews indicated about 2/3 women among the clients. There were no clear differences between outreaches and branch clinics in this respect.

was informed of FPAU's work with internally displaced people but it was not possible to visit and see these project activities.

Another vulnerable group is women living with HIV/AIDS. Due to the stigma they face, access to family planning services is often difficult especially for those who wish to have children. A stakeholder organisation indicated that there was no organisation addressing this need, including FPAU.

Survivors of gender based violence, finally, is another group of great relevance for many SRHR issues but the Evaluation Team did not find evidence that FPAU project activities addressing this issue. Young people, finally, are an important group too, but they have already been dealt with in chapter 6.

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The views and conclusions expressed in this report are our own and the recommendations reflect our assessment. We hope this report will assist FGAE in its future work with the sexual reproductive health and rights of the men, women, and young people of Ethiopia.

Addis Abeba, Oslo, Stockholm

November 2006

List of Acronyms

CBRHA	Community Based Reproductive Health Agent
FGAE	Family Guidance Association of Ethiopia
IEC/BCC	Information Education Communication/Behaviour Change Communication
IPPF	International Planned Parenthood Federation
NGO	Non-Governmental Organisation
Norad	Norwegian Agency for Development
Sida	Swedish International Development Cooperation Agency
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
VCT	Voluntary Counseling and Testing

Executive Summary

Introduction

This study is part of an evaluation to assess the effectiveness and relevance of the International Planned Parenthood Federation (IPPF), and in particular to study to what extent poor and vulnerable people are reached by its activities. The evaluation has been commissioned by Norad and Sida and it is undertaken by an external team of evaluators working in cooperation with the funding agencies and IPPF. This study of the member association in Ethiopia is one of three country studies, the other two being in Uganda and Bangladesh.

The purpose of the evaluation is to examine the relevance and effectiveness of FGAE's work – its services, advocacy efforts, and information sharing. A core question is how well FGAE reaches poor, vulnerable, and marginalised people.

The evaluation started with an Inception Report which was completed in June 2006 and which outlines the methodological choices and the instruments for data collection for the three country studies. The evaluation of FGAE took place between 25th of September and 7th of October 2006. The evaluation team met with a wide range of SRHR stakeholders, including exit interviews with clients and focus group discussions with potential clients not using the services. Interviews, observations and meetings were carried out in Addis Abeba, Bahir Dar, Dire Dawa, Harar, Awasa, Chiro and Nazareth.

Image and staff

FGAE is recognised as the pioneer organisation for family planning in Ethiopia and is generally seen as an influential, credible organisation. It is acknowledged for reaching further out into rural areas and for providing services to adolescents to a greater extent than other providers. Its credibility is proven by its good relations and many partnerships with other non-governmental organisations (NGOs), and with the government.

There seems to be a gender imbalance in the organisation, with top management staff positions largely filled by men, while many of the clinical staff and volunteers are women.

Advocacy

Advocacy is one of the five programmatic areas in FGAE's Strategic Plan 2005–2009. The strategic goal is an enhanced enabling environment for the commitment, acceptance and attainment of SRHR at all levels.

FGAE works with advocacy in different ways. Apart from advocacy at the national level, local awareness work is carried out through the youth centres, peer service providers and community based reproductive health agents.

The evaluation team found that FGAE is viewed as a leading provider of family planning services in Ethiopia. It is credited with introducing new contraceptive technology; its technical expertise is sought when training for permanent contraceptive methods and designing youth friendly services; its training and IEC/BCC (Information Education Communication/Behaviour Change Communication) materials are used by other organisations. However, beneficiaries expressed some negative opinions about the materials and considered them to be poorly designed for certain groups of people.

Networking and building alliances are important parts of establishing a positive policy environment. FGAE works closely together with other SRHR organisations and with governmental bodies at all

levels. Ethiopia's Criminal Code was changed in 2005 and is seen as allowing a more open practice regarding legal abortion. FGAE is credited by many as having been a significant actor in effecting this change of legislation. However, some partner organisations would like FGAE to speak with a stronger voice, especially on controversial issues.

Relevance

FGAE's strategies and work are consistent with the national policy environment and the country's SRHR needs. This is confirmed by interviews with SRHR stakeholders and beneficiaries, who are generally very satisfied with the services offered by FGAE. We did not see any examples of FGAE providing services that should not be provided, nor services that people did not ask for. In most places, stakeholders and beneficiaries haved asked for expansion of services. Hence, the unmet need is large.

FGAE has a full range of permanent, long term, and short term contraceptive services, and has a wider range of such methods than any other provider in the country. The FGAE clinics are pioneers in reaching out to adolescents in urban areas, and the network of peer service providers provide them with access to contraceptives and information that they would not get otherwise.

Some partner organisations pointed out that they would like FGAE to strengthen its training programmes substantially, as there is an unmet training need in the SRHR community.

Other areas of possible strengthening/expansion are: abortion services, safe motherhood services in the rural areas, long-term contraceptive methods in the rural areas, information about and demand for emergency contraception, expansion of income-generating activities, strengthening of the programmes on gender-based violence and harmful traditional practices, and introduction of mobile VCT (Voluntary Counseling and Testing).

Effectiveness

Client satisfaction with services is very high, and the quality of FGAE services is often cited by partner organisations and other key SRHR stakeholders.

FGAE's network of volunteers, i.e. the community based reproductive health agents and the peer service providers, is instrumental in reaching out to the urban and rural communities in an effective way.

The evaluation team observed some challenges concerning the programmes of peer service providers, that if better addressed might increase effectiveness. These are a lack of youth involvement, lack of transport, training and sufficient re-imbursement of the volunteers. According to our informants, updated and improved IEC/BCC materials would also enable the volunteers to better reach out in their awareness raising activities.

Coordination with other NGOs and government services generally seems to work very well.

Reaching Poor and Vulnerable People

FGAE reaches poor and vulnerable people to a large extent and they do so better than many other providers of SRHR services. Their network of community based reproductive health agents reach poor and vulnerable people in the rural areas, including women with little control over their sexual and reproductive health, who are vulnerable to harmful traditional practices. The network of peer service providers reaches adolescents in the urban areas and provides them with access to contraceptives and information, that they would not get otherwise. In some locations, the network of peer service providers also targets street children and commercial sex workers, through volunteers recruited from these groups.

The rural outreach sites reach poorer people than the branch clinics, which also attract some better-off persons. However, many of the clients coming to FGAE in the urban areas would not be able to afford alternative quality SRHR services. It is also in the urban branch clinics that certain groups of vulnerable people are targeted, such as the street children and the commercial sex workers. While the majority of people met and interviewed are poor in an absolute sense, they mostly do not seem to belong to the very poorest groups in their communities.

FGAE operates a modest fee structure which is considered fair by most beneficiaries and one that even most poor people can afford. People who cannot pay are not denied services. Whether a person can pay is determined during the face-to-face encounter with the service provider. This practice generally seems to work well; we heard few complains about fees limiting access for the poorest.

Recommendations

The recommendations to FGAE listed in the final chapter on conclusions and recommendations are:

Image and staff

- FGAE should consider affirmative action initiatives to get more women into the organisation at all levels.

Advocacy

- FGAE should review its IEC/BCC materials to make sure that they are attractive and effective in reaching out to different target groups, such as adolescents and those who do not read.

Relevance

- FGAE should consider adding a wider range of clinical services in all the outreach sites, unless this conflicts with the government's Health Service Extension Package.
- FGAE should make emergency contraception better known by providers, clinic attenders, and the public, so that demand is increased.
- FGAE should be careful when expanding its HIV/AIDS activities, to ensure that they are well coordinated with the national and local responses. FGAE may want to consider what its niche is in the country's fight against HIV/AIDS.
- FGAE should consider expanding its training programmes to other service providers, as a means of further cross-financing services for poor people.

Effectiveness

- FGAE should improve youth participation in the running of the youth centres and in the design of the programmes of peer service providers, as well as in the organisation as a whole. A review of the programmes for peer service providers should be carried out, so that problems with transport, reimbursements, and training are addressed.
- FGAE should review the youth centres to ensure that activities are designed for the wide range of youth who could attend. Special efforts should be made to attract more young teenage girls to the centres.
- When expanding the provision of maternal health care to include deliveries, FGAE should make sure that their activities are well coordinated in a continuum of care at the local level. It is especially important that the ante-natal activities are linked to the provider who will be with the mother at delivery.

Reaching poor and vulnerable groups

- In order to increase effectiveness in reaching poor and vulnerable groups, FGAE should consider collecting data on poverty indicators from their clients, to facilitate more systematic analysis and comparision between different service delivery points.

1. Introduction

Background to the Evaluation

IPPF, Sida and Norad have been partners in promoting family planning and SRHR for many years. IPPF is the world's largest NGO in this field with 151 member organisations in 182 countries around the world.

A pioneer in the advocacy of family planning, IPPF has, since the early 1990s, broadened the scope of its activities to include a wider range of SRHR services and advocacy of sexual and reproductive rights. Its current Strategic Framework 2005–2015 prioritises five programmatic areas: adolescents, HIV/AIDS, abortion, advocacy, and access.

Sida and Norad are strong supporters of the 1994 International Conference on Population and Development framework for population activities. Currently their contributions make up more than 25% of IPPF's core budget or 'unrestricted funds'.

Purpose of the Evaluation

The purpose of the evaluation is to examine the relevance and effectiveness of FGAE's work – its services, advocacy efforts, and information sharing. The approach has been to assess FGAE's work in the light of the life circumstances of the people they serve. How do people react to, relate to, and use the services provided? The core question is how well FGAE reaches poor, vulnerable, and marginalised people. Poverty is treated as a condition of life: a lack of power, lack of choice, and a lack of opportunities to exercise basic human rights, particularly in the field of SRHR. While poverty is also the lack of assets including money, it is a broader concept than low income levels.

Relevance is assessed in relation to the real and expressed needs of people, national policies, and international consensus on SRHR. Effectiveness has been loosely defined as an aggregate judgement about the merit or worth of an activity.

Methodology

Against this background, the most important sources of information are the people who come into contact with FGAE's services. Who are they? What problems do they have? Have they been helped through the contact with FGAE and are they satisfied with the range of services provided by the organisations? In the course of this evaluation we met with a wide range of stakeholders. Users of FGAE services were interviewed in exit interviews and in-depth personal interviews, as well as in focus group discussions. Groups of 'non-users' were interviewed about their access to SRHR and their knowledge and views of FGAE. We met with FGAE staff and board members at national and branch levels, groups of community based reproductive health agents and peer service providers, national and sub-national government officers, community leaders, traditional birth attendants, alternative SRHR providers, stakeholder and partner organisations, research institutions, and representatives of donor agencies.

The interviews have been supplemented by observation data, for example, by visits to branch clinics, outreach clinics, FGAE youth centres and government youth centres, as well as visits to homes covered by programmes of home-based HIV/AIDS care.

As Table 1 shows below, we met with 323 persons and carried out 18 observations of clinics or activities.

Table 1. Observations and people interviewed in Ethiopia.

	Addis Abeba & Nazreth	**Awasa**	**Bahir Dar**	**Dire Dawa**	**Harar**	**No**
Interviews district level						
Exit interviews at clinics		33	22	3	15	73
Interviews/focus groups non-clinical service users	4	12	7	1	19	43
Interviews/focus groups non-users			48	5		53
Interviews/focus groups clinical service providers	11	1		3	2	17
Interviews/focus groups non-clinical service providers	4	11	25	9	11	60
Interviews community leaders and local NGOs	1	11	13	10		35
Interviews national level						
Interviews with FGAE	22					22
Interviews with other SRHR stakeholders	20					20
Total number of people met:	**62**	**68**	**115**	**31**	**47**	**323**
Observations						
Observations of FGAE clinics and youth centres	3	1	3	2	1	10
Observations of government/NGO clinics	1			4		5
Observations of FGAE non-clinical activities	2		1			3
Total number of observations:	**6**	**1**	**4**	**6**	**1**	**18**

The country study was carried out between the 25th of September and the 6th of October 2006 by a 10-person evaluation team. The team included 6 nationals, of which 5 were youth consultants. The first 2 days of the evaluation were spent in Addis Abeba. The team then divided into 3 smaller groups to travel to Dire Dawa and Harar, Bahir Dar, and Awasa. The groups spent 4 days in the field. The team then regrouped in Addis Abeba where some team members looked at the activities of clinics in Addis Abeba and Nazareth. The others continued to meet with national stakeholders.

Feedback on the main observations made during the evaluation was given to FGAE on the final day of the country visit. During this meeting, there was an open exchange of views which were incorporated into the draft report. FGAE has also commented in written on the draft report, and their comments were considered and incorporated into this final report.

Limitations

Although the evaluation team travelled extensively and met many people, the information gathered can only give an impression of FGAE's work. We have not visited all districts, and even in those districts visited, we have seen only some parts of the services.

The evaluation does not examine the organisation and management of FGAE which clearly have a bearing on how its work is carried out. We comment on pertinent issues only to the extent that they seem to relate to the purpose of the evaluation.

Guide to the Reader

- Chapter 2: *Ethiopia* – A Background. A brief picture of the SRHR situation in the country.
- Chapter 3: *The Family Guidance Association of Ethiopia*. A background to the organisation, the budget, and the planning process.
- Chapter 4: *Advocacy.* An analysis of the advocacy work.
- Chapter 5: *Relevance and Effectiveness of Service Delivery.* An analysis of the services provided.
- Chapter 6: *Reaching Poor and Vulnerable Groups.* An analysis of how well FGAE reaches different groups.
- Chapter 7: *Observations and Recommendations.*

2. Ethiopia – a Background

Ethiopia, a least developed country, ranks near the bottom – as number 170 of 177 countries – in UNDP's Human Development Index 2005 (UNDP 2005). Seventy eight percent of its 77 million inhabitants have an income of less than US$2 a day and 44% live under the national poverty line (Population Reference Bureau 2005, UNFPA 2005).

There are many SHRH problems, including a large unmet need for family planning, unwanted pregnancies and unsafe abortions, HIV/AIDS and other STIs (Sexually Transmitted Infections), and high maternal and infant mortality. Gender based violence, female genital cutting and other harmful traditional practices like early marriage and abduction are also serious reproductive health issues in Ethiopia.

Family Planning

The total fertility rate is estimated to be 5.4, with 6.0 in rural areas and 2.4 in urban areas. Nearly 84% of the population has knowledge of at least one family planning method but utilisation of contraceptive service is very low. Recent data indicates that use of modern contraceptives ranges from 11% in rural areas to 42% in urban areas with considerable differences among regions (3% in Somali to 45% in Addis Ababa) (EDHS 2005). The past two years have seen a notable increase of contraceptive use. But the country's unmet need for contraceptive services still remains at around 36% (UNFPA 2005 & PRB 2005).

HIV/AIDS

It is estimated that 4.4% or 1.5 million Ethiopian adults are currently infected with HIV. While the epidemic appears to have a steady prevalence of 12.6% in urban areas it is projected to raise from the current 2.6% to 3.4% by 2008 in rural areas. Women are more vulnerable to the infection (5% prevalence rate) than are the men (3.8%) due to physiological, social, economical, legal and cultural factors. The country has the seventh highest number of AIDS orphans in the world. In 2003 there were half a million children who had lost at least one of their parents due to HIV/AIDS and this figure is expected to increase to 1.8 million by 2007 and 2.5 million by 2014 (MoH 2006).

Maternal Health

Ethiopia has a high maternal mortality ratio (871 per 100 000 live births). It is estimated that 25 000 maternal deaths occur every year in the country. Abortion is the leading cause, accounting for a third of maternal mortality.

Ante-natal coverage is low. According to the Ethiopia Demographic and Health Survey 2005 only 30% of women who gave birth within the last five years attended for ante-natal care by a health professional at least once. Only 6% of deliveries are assisted by health professionals and 5% take place at health facilities.

The high neonatal mortality (58 of 1000 live births) is directly related to the high maternal mortality in the country. Sixty percent of the deaths occur within the first 24 hours of birth and are associated with the low availability and quality of obstetric services (MoH 2006).

Gender – Based Violence and Other Harmful Traditional Practices

Gender-based violence is common in Ethiopia. According to a WHO study in 2005, half of the women have experienced sexual violence at least once in their life, and 8 of 10 women had faced either sexual or physical violence. The majority of the women said they were violated by a person they trusted, such as a husband, a boyfriend, or another family member.

Female genital cutting is one of the frequently practiced harmful traditions in Ethiopia. However there has been a decline in the practice in more recent years, demonstrated by the lower percentage of women circumcised in the younger age group compared with older age groups. Sixty two percent of women aged 15 to 19 have been circumcised compared to more than 80% for age 35 and above (EDHS 2005).

Early marriage is another common problem. Women marry at an average age of 16, while the average age of first marriage for men is age 23. The age gap between husband and wife commonly contributes to a power disparity between spouses.

Other practices like polygamy, wife inheritance, marriage by abduction, exchange and other forms of forced marriage also have a negative impact on women's status and reproductive health.

Adolescents

A large part of Ethiopia's population is very young; those aged 10 to 29 comprise 60% of the population and of those, 80% live in a rural area. Unemployment and lack of entertainment facilities such as sport, theatre, and culture, are common problems for the young population. These problems are believed to increase exposure to HIV/AIDS and substance use, and increase migration to urban areas (MoH 2006).

Government Health Provision

Primary responsibility for the delivery of health care services has traditionally rested with the public sector, and it has been estimated that nearly two-thirds of all health care services are provided through government owned facilities. In the last five years the number of public sector health facilities has risen dramatically from 110 to 131 hospitals; from 382 to 600 health centres; and from 1,023 to 4,211 health posts (MoH 2006).

However, there are still large disparities between rural and urban communities. In rural areas, only one third of the population has a health facility within 5 km, while nearly all of the urban population has a

health facility within that distance. A positive sign however, is that the proportion of people living more than 20 km away from a health facility has fallen from 20% in 1996 to 13% in 2000. The Ministry of Health has now launched an initiative called the Health Service Extension Package. The aim is to train a large number of Health Extension Workers, to provide 2 Extension Workers to each kebele, including the rural kebeles. The Health Extension Workers are expected to provide the community with preventive health information and care, such as environmental hygiene and family planning, including the injectable contraceptives (MoFED 2005). The programme has just been initiated and it remains to be seen how well it will work in reality.

Policy Environment

Recently developed policies aim to strengthen a positive SRHR development. In the past 2–3 years, the government appears to have embraced the notion that population growth is detrimental to the country's development. The government's commitment to family planning has been demonstrated by the explosive increase in oral and injectable contraceptives distributed through government facilities between 2002 and 2005. The government distribution of oral contraceptives in 2005 was 14 times higher than in 2002, and the number of injectables provided was 8 times higher as compared to 2002.

A revision in 2005 to the Criminal Code has eased the restrictions on abortion for those women whose continuation of pregnancy might endanger their wellbeing and lives, and safe abortion guidelines have been developed. Over the past decade, a number of other strategies have also been developed e.g. the National Reproductive Health Strategy 2006–2015 (2006), the Policy and Strategy for Prevention and Control of HIV/AIDS (2005), a National Youth Policy (2004), a National Population Policy (1993), and the National Policy on Women (1993). All these strategies could potentially improve the country's SRHR situation.

3. The Family Guidance Association of Ethiopia

One of the breakthroughs in the history of family planning in Ethiopia was the foundation of FGAE in 1966. Direct services were first provided in the capital city but FGAE currently provides services in 8 of the country's 11 regions through it's 8 branches, 18 clinics, 26 youth centres, 740 community based outlets and 242 outreach sites. The organisation has 513 staff, 1740 voluntary service providers, and over 7000 members.

Vision and mission

The FGAE vision is: 'An Ethiopian society where all people, particularly young people have the right to and enjoy quality sexual and reproductive health.'

FGAE's mission statement identifies the role the organisation wishes to play in Ethiopia, highlights the services and thematic areas it intends to work in, stresses the importance of collaborating with volunteers, local communities, and government, and states its future ambition to become a centre of excellence in information, service provision, and capacity building.

Strategic Plan 2005–2009 and 2006 Approved Programme Budget

The Strategic Plan 2005– 009 charts the strategic direction for the next 5 years. It begins with the major areas of organisational change and then presents the strategic goals, objectives, expected outcomes, and stakeholders organised according to the IPPF Five A's: Adolescents, HIV/AIDS, Access, Advocacy, and Abortion together with supporting strategies for organisational strengthening.

The Approved Programme Budget (APB) 2006 provides information on projects and activities and forms the basis for the anticipated expenditures for 2006 that are provided in Table 2. It is difficult to form an accurate picture of FGAE's work in each of the Five A's because projects listed under one programme area in both the Strategic Plan and in the Approved Programme Budget may be directly relevant to another programme area. Similarly, some activities may fall within more than one programme area e.g. activities related to HIV/AIDS among adolescents. This is especially apparent with the cross cutting programme areas: advocacy and access. We find for instance, under Abortion/Safe Motherhood, Objective One: 'to increase community understanding of the existing abortion laws and advocate for the liberalisation of this law.' Here advocacy is clearly identified as an objective under another programme area and shows that FGAE's advocacy efforts are more than just the one listed project, 'Advocacy for better policy and program support in SRH', currently listed in the Approved Programme Budget under the advocacy programme area.

Table 2. Projected annual expenditures 2006.

	Projects	**Donor/Unrestricted Funding**	**% Total**
Advocacy			
1	Advocacy for better policy and program support in SRH	RNE, DCI	2
	Sub Total		**2**
Adolescent			
2	Young people empowerment to exercise their SRHR	EED, DCI	12
3	Expanding Youth access to ARH e-info & Service in interactive centres	D & L Packard F, PPFA, RNE	8
4	Meeting SRHR of rural youth through participatory mo in 878 Pas	RNE	3
	Sub Total		**23**
HIV/AIDS			
5	Integrating VCT services in 5 SRH Clinics 5 semi urban Towns	UNICEF, UNFPA,Eth Gov WB, Global Fund	2
6	Major Urban youth only attached to YCs, Integration of HIV/AIDS Service	UNICEF, Eth Gov WB, Global Fund	3
7	Combating STIs/HIV/AIDS Expansion; Integrated VCT Services in 4 Regions	UNICEF, UNFPA, Eth Gov WB	4
8	Integrating of comprehensive HIV/AIDS/STIs prevention Care and support	UNICEF, UNFPA, Global Fund	4
9	Model Clinic attached HBC&S for AIDS victim families in 3 towns	FHI	5
10	Home and Community Based Care project Ziway	FHI	1
11	Home and Community Based Care project in Shashemene & Asela	FHI	3
	Sub Total		**22**
Access			
12	Learning our way out (LOWO)	DCI	4
13	Demonstrating Model SRH Services through SRH centre in 8 major towns	EED, Packard F, IPPF, Engender H	13
14	Increase Access to SRHS through SRH Clinics in 10 semi-urban towns	Packard F, RNE	7

15	Reducing resistance and increasing FP use among rural communities	Engender H, PPFA, Packard F	3
16	Strengthened Provision of FP services among rural communities	Packard F, RNE, EED	5
	Sub Total		**32**
Abortion			
	Elimination of Unsafe Abortion	BUFFET/IPPF	5
	Strengthen and Expansion of Safe Motherhood services	RNE	2
	Sub Total		7
Supportive Programs			
	R & E Services	DCI	5
	Mobilisation & PR Services	RNE	6
	Enhancing Visibility	DCI, RNE	3
	Sub Total		**14**
	Grand Total		**100%**

When compared with figures provided in the 2005 Annual Report, it appears that the supporting strategies and all programme areas with the exception of 'access' have been allocated a greater proportion of funds in 2006 than were spent in 2005.

Major Activities

FGAE's strategic plan states that its core services are:

a) family planning,

b) STIs/HIV/AIDS prevention services,

c) abortion related services and safe motherhood, and d) sexual violence. It also provides a range of non-core services at some of its clinics but these do not appear to be uniformly available at all branch clinics.

Within the core services are a number of non-clinical activities and services including youth centres; community – based distribution of oral contraceptives, injectable contraceptives, and condoms; and home-based HIV/AIDS care and support.

Training of government and NGO staff in new and different contraceptive methods such as permanent surgical methods, are an important part of FGAE's work.

Funding

The 2005 Annual Report noted that FGAE had a 94% utilisation of the more than 50 million birr planned budget. Donors include IPPF, bilateral donors, UN agencies, the government of Ethiopia, and local NGOs. Substantial multi – year contributions have been pledged from the Royal Netherlands Embassy, Irish Aid, and the Packard Foundation. Together with contributions from IPPF, these contributions are seen as 'unrestricted' funds. Figures given in the 2005 Annual Report provide a picture of the 'restricted' and 'restricted funds' as shown in Table 1.2 below. Thus, we can see that 55% of FGAE's funding for 2005 was unrestricted funding from non – IPPF sources; 18% was unrestricted funding from IPPF, and 27% was restricted funding directed towards specific activities. This large portion of unrestricted funding gives FGAE considerable flexibility in planning its activities.

Table 3. 2005 Financial contributions from partners

Donor	Unrestricted/ Restricted	% of total Budget
IPPF	U	18.3
Royal Netherlands Embassy	U	37.8
Packard	U	6.4
Irish Aid (DCI)	U	10.5
Government	R	5.2
UN agencies	R	4.8
NGOs	R	16.3
Others	R	0,8
Total		**100.0**

Staff

FGAE has 513 paid staff and a large number of volunteers working as peer service providers and community based reproductive health agents. The top management staff positions appear to be filled largely by men. Only 1 of the branch managers is a woman while many of the clinical staff are women as are the peer service providers. This gender imbalance is recognised by top management at FGAE which pointed to difficulties in attracting qualified women with the salary scale FGAE offers. The high turnover of physicians, accountants, and gender specialists was reported to present a problem for the organisation.

Image and Branding

FGAE is recognised as the leading family planning organisation by major stakeholders and the public. It is also recognised as the initiator and leading organisation for youth friendly services. Many know that FGAE also provides HIV/AIDS prevention, care, and support services. Because of FGAE's close collaboration with the government, it is sometimes seen by members of the public to be part of the government. The Amharic acronym for FGAE is well known. Some informatns have questioned whether the emphasis on 'family' and the logo showing a man, woman, and 2 children speaks to the needs of young people.

The FGAE logotype.

4. Advocacy

This chapter uses a broad definition of advocacy and looks at efforts at the national, sub-national, and local levels in awareness raising, enabling the policy environment, and/or policy change. We look at the networks and alliances of which FGAE is a part and how other stakeholders, especially at national level perceive FGAE's advocacy contributions.

Advocacy is one of the five programmatic areas in FGAE's Strategic Plan 2005–2009. The strategic goal is an enhanced enabling environment for the commitment, acceptance and attainment of SRH and rights at all levels. The objectives identified are: a) political commitment of high level policymakers, b) increased resource commitment, and c) reduction of socio-cultural barriers that negatively impact the acceptance of SRHR by the community. The Strategic Plan further identifies different stakeholders for specific advocacy topics.

The limitations of looking to the Approved Programme Budget to provide an accurate picture of FGAE's advocacy efforts have been described in Chapter 3. Here we report on observations and information provided by informants relating to FGAE's efforts in awareness raising, enabling the policy environment, and policy change.

Awareness Raising

One general method of awareness raising is the use of posters and other printed IEC/BCC materials. In all clinics visited, waiting rooms, examination rooms, and laboratories had SRHR and patients rights posters as well as other types of IEC/BCC materials on the walls. The posters were also seen at out – reach sites on walls and trees when people were gathered outside. The evaluation team was told that materials are also provided to organisations such as night schools running classes for housemaids and other partner organisations. However, we also met with some organisations that co-operated with FGAE in different ways, but which lacked materials of their own and would like to receive more materials from FGAE. We also heard some negative opinions about the materials from beneficiaries, who said that some of the posters and brochures were old, boring, and very clinical.

Three types of volunteers are used to promote SRHR on a more personal level. Community based reproductive health agents are supposed to engage in various awareness raising activities in the community. In some villages we observed the volunteers conducting coffee ceremonies or community conversations around a range of SRHR topics. In other villages it appeared that they mainly focused their attention on the distribution of contraceptives, keeping a record of the users, reminding them of when to get their contraceptives and encouraging them to attend the static clinic when problems arose that were beyond their mandate.

In towns, *peer service providers* are supposed to raise awareness of contraception and HIV/AIDS in the community where they live. At one site, it was reported that they are expected to have five new clients both for condoms and for pills every month.

At youth centres, volunteers are in charge of various activities such as music and drama performances, specially designed games, training, and the formation of youth clubs are designed to raise awareness around a range of SRHR issues. Local and religious leaders, as well as parents, may be invited to attend the performances so that the advocacy efforts reach beyond the young people themselves. Some youth centres also run school programmes.

We found however, that in the area of gender – based violence and harmful traditional practices, FGAE's efforts were less focused. While the 2005 Annual Report cites an example of work against

female genital cutting among peasant associations in the Eastern Branch, the evaluation team did not find this work to have been prominent and widespread at the sites it visited. Moreover, when talking to stakeholders and partners, FGAE is not identified as an organisation doing significant work in this area.

To the left, a group of community based reproductive health agents and villagers in a remote village outside Dire Dawa. To the right, a community conversation about the problems of having to many children, in a village outside Harar. IEC/BCC posters were placed in the trees during the meeting.

Enabling the Policy Environment

One of the most important conclusions of the Evaluation is that FGAE is universally viewed as a leading provider of family planning services. It is credited with introducing new contraceptive technology; its technical expertise is sought when training for permanent conceptive methods and designing youth friendly services; its training and IEC/BCC materials are used by other organisations. FGAE's experience and technical competence give it advocacy credibility. The activities, techniques, and practices used in its services, in themselves, influence the wider national policy environment.

FGAE has relatively recently started to provide services related to HIV/AIDS e.g. VCT and home – based care for people living with AIDS and is seen to be doing a good job with these initiatives. FGAE's VCT efforts have been to provide the service in an integrated manner with other SRH services. This is, of course, important in the face of strong pressures to provide HIV/AIDS services in a vertical manner. As with the earlier sensitive area of family planning, integrated VCT may contribute to the reduction of stigma surrounding HIV/AIDS.

Networking and building alliances is another important part of establishing a positive policy environment. FGAE was one of seven founding members of the Consortium of Reproductive Health Agents (CORHA), a SRH network working in capacity building, resource mobilisation, advocacy, and co-ordinating, networking and representation. The network, with FGAE as an active contributor, acted as 'a catalyst that spear-headed the development of a national curriculum' for in-service training of facility and community based family planning services, according to one partner organisation.

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

A close working relationship with government has advantages and disadvantages. The advantage is that FGAE can influence government activities and policies. However, some people perceive the relationship as being so close that it makes it difficult for FGAE to speak out on sensitive issues or that it at least,

mutes its voice. A number of stakeholders expressed the view that they would like to see FGAE take on a stronger advocacy role in lobbying and pressuring for change i.e. have a stronger voice on some controversial issues. One informant felt providing good services was not enough and that FGAE should be more vocal. But, another informant indicated that perhaps the 'soft' voice was a strategic choice made by FGAE.

Contributing to Policy Change?

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

- There has been a significant shift in the government's view on population growth. While the earlier government view was that a large population was important for a strong country, the current poverty reduction strategy recognises that reducing population growth is essential for the country's development. As noted in Chapter 2, this policy shift is demonstrated by the explosive increase in the distribution ofcontraceptives in government facilities between 2002 and 2005. FGAE has long been recognised as the leading advocate for family planning.
- The Criminal Code regarding abortion was changed in 2005 and is seen as allowing a more open practice regarding legal abortions. FGAE is credited by many as having been a significant actor in effecting this change of legislation. Equally important, FGAE was a member of a Working Group together with Ipas, professional associations, Addis Ababa University and WHO, established under the Ministry of Health that developed the recently launched 'Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia.' This is a clear example of how FGAE's technical competence is translated into advocacy.

5. Relevance and Effectiveness of Service Delivery

This chapter will assess the relevance of FGAE's present services, and thereafter look into effectiveness and coordination of its SRHR work.

Relevance is *'the extent to which the objectives of a development intervention are consistent with beneficiaries' requirements, country needs, global priorities and partners' and donors' policies'* (Molund and Schill 2004). In this evaluation, when assessing relevance, we will do so based on what FGAE does rather than on the stated objectives in its Strategic Plan.

The definition of effectiveness here is *'an aggregate measure of (or judgement about) the merit or worth of an activity, i.e. the extent to which an intervention has attained, or is expected to attain, its major relevant objectives efficiently in a sustainable fashion and with a positive institutional development impact'* (Molund and Schill 2004). We will approach the issue by looking carefully at what the organisation does and how people are affected.

Assessing Relevance

Relevance – the national policy environment

As described in Chapter 2, a number of new SRHR policy documents have been developed by the government the past years. We find that the strategies and work carried out by FGAE are consistent with the national policy environment, both the government's work and the work carried out by other NGOs. An indication of this is the very good relation with the government, as described in Chapter 4.

However, we found one area of policy discrepancy. According to the government's guidelines, children below 18 years of age are not to be accepted for VCT without their guardian's permission. The concern is that someone needs to be in charge of the after care, in cases of children testing positive. This restriction can impact negatively on an adolescent's access to SRHR services. This, however, does not apply to FGAE services, as exceptions are made for providers offering youth-friendly services. We were informed that FGAE has been working with the government to change the guidelines, and that a new and revised policy is now being drafted.

Relevance – country needs and beneficiaries' needs

As described in chapter 2, Ethiopia is a very poor country with several serious SRHR challenges, such as low contraceptive uptake, high prevalence of HIV/AIDS and STI's, many unwanted pregnancies and unsafe abortions, poor maternal health and problems with gender-based violence as well as with other harmful traditional practices.

Stakeholders and beneficiaries are generally very satisfied with the services offered by FGAE. We didn't see any examples of FGAE providing services that should not be provided, nor services that people did not ask for. In most places, people haved asked for expansion of services. Hence, the unmet need is large. Some observations from the interviews are highlighted below.

Family planning

- FGAE offers a full range of permanent, long term, and short term contraceptive services, and has a wider range of such methods than any other provider in the country.
- Stakeholders and beneficiaries highlighted the need for more long-term contraceptive solutions (especially Norplant), especially in the rural areas. There, limited access to health services and negative attitudes towards family planning among men create a demand for long-term solutions. The advantage with long-term solutions is that women can use them without the permission or knowledge of their husbands. However, we have understood that a problem for expansion of these methods is the limited supply of Norplant in Ethiopia. The evaluation team also noted that no beneficiaries expressed a demand for, or even mentioned emergency contraception, maybe due to a lack of information.

HIV/AIDS and other STIs

- FGAE offers awareness raising and VCT in all their branches, and treatment for opportunistic infections and home-based care in some locations. At present, they do not offer anti-retroviral drugs.
- The fragmentation of services, i.e. that different HIV/AIDS related services are offered in different places, could create some confusion concerning the role communicated to the public and to other organisations. FGAE however sees their role as gap-filling, and maintains that services are being offered depending on local needs and the presence of other providers in each location.

- In some interviews, the need for mobile VCT was emphasised, for example in outreache sites and in urban slum areas. We have understood that FGAE now has plans to initiate mobile VCT in some areas.

Maternal health

- FGAE offers abortion, post-abortion, ante-natal care, post-natal care and immunisation. Different services are offered at different locations. Deliveries are not offered although in Harar preparations are being made to start to provide delivery services.
- Stakeholders and beneficiaries pointed out that FGAE could be stronger in abortion. Strengthening the maternal health care in their rural outreach sites, where they now mainly provide pills and injections, could potentially also serve as an entry point to their contraceptive services. According to FGAE's strategic plan 2005–2009, abortion is one of the areas to be strengthened the coming years.

Adolescents

- FGAE offers youth-friendly services in the clinics and youth centres. Its pioneering work in reaching adolescents is something that many informants highlighted in interviews. Many SRHR stakeholders also point out that FGAE is the only organisation that has worked extensively with SRHR for adolescents in the country.

Gender-based violence (GBV) and harmful traditional practices

- FGAE has some projects in different locations, but its work in this area does not appear to be systematic or comprehensive. Nor do the efforts appear to be equal to the great needs of the country.
- It is not clear to the evaluation team the extent to which the community based reproductive health agents have the capacity to create long-lasting attitude and behavioural change in the areas where harmful traditional practices are well entrenched.

Income-generating activities and SRHR

- FGAE has a number of projects where income-generating activities are integrated with SRHR activities, for example the community conversation projects. However, the need for more projects like these was highlighted in interviews with commercial sex workers and others. As pointed out by these women, SRHR information is not enough to address their problems; they also need assistance to change their whole life situation.

Training

- Quite a few partner organisations pointed out that although FGAE is very strong in service provision, its role is not as unique now as it used to be, and that its competence could be even better used if they also strengthened their training programmes for other stakeholders.

Assessing Effectiveness

After having looked at the relevance of services, we will look into three different aspects of effectiveness. These are:

- Client satisfaction and profile of clients
- The network of community based reproductive health agents
- The network of peer service providers and the youth centres.

Client satisfaction and profile of clients

FGAE's clinical services are provided in their static urban clinics, and to a limited extent, in their rural outreach sites. The static clinics offer a wider range of services, whereas the monthly outreach visits mainly focus on the supervision of community based reproductive health agents and provision of injectable contraceptives and pills.

In the clinics we visited, there was a steady flow of clients coming for services. In our exit interviews, all clients were very satisfied with the quality of services citing specifically staff friendliness, short waiting times, and high technical quality. Almost all would return for future services and recommend it to friends. The only exception to the general satisfaction among the clients came from a focus group discussion with a group of street children in Bahir Dar. They felt that for general medical care, diagnosis and treatment could be indifferent. They reported that their complaints were not taken seriously, that they were not examined and tested thoroughly, and thus not treated appropriately. Some said that they later went to private-for-profit providers, who diagnosed and treated them effectively.

The majority of users used 30 minutes or less to travel to the clinic and came by foot. Most came for contraceptive services. On average, 10% were men, and the age range varied from age 12 to 80, however including only 3 persons under the age of 18.

The network of community based reproductive health agents

Community based reproductive health agents are persons in the rural areas, who are selected by their communities and trained and supervised by FGAE. Their role is to distribute pills and condoms, educate and sensitise people in their communities to SRHR, and refer clients to the clinics.

Many stakeholders highlighted the importance of going from door to door in the countryside, and compared this with the government's health posts, where the health agents 'just sit and wait'. In areas where health seeking behaviour is limited and trust with public institutions is low, the FGAE approach generally results in more clients using contraceptive services.

In one interview with a local government officer, discussing the approach of FGAE and the quality of the government services, it was said that:

> 'The government health post is not always open, all of a sudden it will close down for 4 months. I am sure that FGAE reaches more people in that single day every month than we do during the whole month in the same place'.

The network of peer service providers and the youth centres

Peer service providers are generally younger than community based reproductive health agents, based in urban areas and attached to the youth centres.

The youth centres run by FGAE have a good reputation among key stakeholders, and offer a range of recreational activities such as libraries, movie shows, music and drama activities. We observed two government youth centres in Dire Dawa, and noted that equipment and attendance was substantially better at the FGAE Youth Centre. The peer service providers attached to the youth centres generally seem to carry out impressible amounts of volunteer work. In one group interviewed, the young volunteers worked 2-3 hours a day, 4-5 days a week. However, we observed some areas for potential improvement:

1) *The link between the youth centres and the clinical services* seems to be strong in most of the places we have visited. It was however not completely clear if this was also the case in Dire Dawa.
   There we were told by several persons that it was very hard to convince the youth at the Youth Centre to also take part of IEC/BCC information or SRHR clinical services. Statistics from the attached Youth Clinic in Dire Dawa also show that most of their clients are married, whereas most

people coming to the Youth Centre are unmarried. This confirms the impression that links between the two might not be as strong as they could be. One potential reason for this could be that the Youth Clinic in Dire Dawa also attracts and accepts a large number of non-youth.

2) There seems to be a general *lack of youth ownership*, in relation to both the youth centres and the programmes run by the peer service providers. Groups of peer service providers at most sites visited expressed dissatisfaction that the planning and decision processes were not transparent, that they did not have a substantive role in planning activities, and that staff did not recognise and appreciate their hard work. The peer service providers did not appear to reflect the diversity to be found among young people in terms of age, educational status, or occupation. Users of the youth centres appeared to be predominantly older males. At one youth centre, the main room was locked and in disrepair – thus of little functional use to users. Street children who were users of the adjacent youth-friendly clinic were unaware of the existence of the youth centre. Libraries are a common feature of most of the youth centres, but naturally only appeal to certain groups of youth.

3) There seems to be no 'voluntary career path' within the organisation, where the volunteers would gain more influence over time and be able to develop themselves within the organisation. This is likely to decrease sustainability of the volunteer work, as the volunteers will probably stay a shorter time in the organisation. This was in fact confirmed in an interview with one of the branch managers, who said that the normal volunteer time in the organisations was only 2 years, and that this was preferred by the staff as the volunteers 'turned to demanding' after that time.

4) Peer service providers also complained about *lack of transpor*t (too few bicycles and bicycles of poor quality), *inadequate monthly re-imbursements* for public transport and *insufficient ongoing training* after the first introduction.

To the left, boys watching a movie at the Youth Centre in Dire Dawa. To the right, boys reading in the library at the same youth centre.

FGAE – added Value or Duplicating Other's Work?

The questions of effectiveness and relevance are not very interesting if services are provided in an environment where another provider is offering the same services. The core questions here are therefore what alternatives are there to FGAE services and why do people choose or choose not to come for FGAE services.

The alternatives in the areas we have visited are the government health posts and centres. In the urban areas, there are also other NGO's and private-for-profit providers. All clients interviewed at the exit interviews knew about alternative providers, but said that they prefered the FGAE services for various reasons.

The family planning services offered by the government are free, but clients pointed out the following limitations of the government services:

- Poor and irregular supplies; limited range of contraceptives.
- Shortage of staff; irregular schedule (sometimes absent for extended periods).
- Unfriendly approach to clients
- Overload of clients and long waiting hours
- Anonymity compromised

When asked about the importance of distance for their decision, all clients interviewed at the outreach site said that distance was important for their decision, whereas only 13% of those interviewed at the static clinics said the same. This is an indication that the outreach sites serve people with more limited access to SRH care than the static clinics, and/or that the outreach sites serve people with less time and money for long transportation for health care.

How are the activities coordinated on the ground? Generally, there seemed to be very good coordination between the NGOs and the government. The only case of duplication we heard of was due to the recently launched government initiative with Health Extension Workers in the rural areas. The government has in a short time trained and hired 10 000 Health Extension Workers in the rural communities, without sufficient coordination with the operating NGOs. The lack of coordination has caused problems and confusion for FGAE volunteers in some areas. There are also questions concerning the quality and training of the Health Extension Workers. The lack of coordination is now being addressed by the government and FGAE, who hopes that the new government initiative will prove sustainaible within some years, so that FGAE can shift its focus to other areas of work in the rural areas. This is anticipated in the Strategic Plan for 2005–2009, where FGAE intends to withdraw from many rural sites to re-focus its community-based presence in an alternative manner. However, as the governmen's initiative is still in the initial phase, it is not clear how it will develop and whether it will be implemented as intended.

6. Reaching Poor and Vulnerable Groups

In this chapter we look at how well FGAE reaches poor and vulnerable groups with its services and advocacy efforts.[19]

People With Low Income and Low Education

The general conclusion when analysing the data from Ethiopia is that FGAE reaches out to many people with low incomes, and that this is especially the case in the rural areas. A complete assessment of the socio-economic status of the clients is not possible for us to make. From what we have understood, there is no collection of socio-economic information from the clients.

Below we present some of the data from our exit interviews. The data has to be interpreted with great care. Our sample of interviews is small, and in Ethiopia our outreach sample comes from only one outreach site. A non-representative sample of certain age groups might affect the outcomes in important ways. There are differences in poverty levels between the districts, that affect the national statistics derived from the Ethiopia Demographic and Health Survey, EDHS. The data only indicates potential interesting areas to investigate further.

[19] All comparisions with national statistics in this chapter comes from the Ethiopia Demographic and Health Survey 2005.

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

	None/ preschool	4 year primary	2 year lower secondary	2 year upper secondary	2 year post secondary	Higher education	No of observations
Static clinics	15ä	13ä	15ä	15ä	33ä	9ä	45
Outreach site	67ä	22ä	7ä	4ä	0ä	0ä	27

As Table 4 shows above, nearly 70% of the users at the outreach site had no formal education, whereas only 15% of the clients at the static clinics fell into the same category. At the other end, no one at the outreach clinic had a post-secondary education or a higher education, whereas at the static clinics more than 30% had post-secondary education and nearly 10% had higher education.

If we compare this data with 2005 EDHS, we find the following:

- Of the population in the lowest wealth quintile, 84% of the women and 73% of the men lack formal education, whereas 38% of the women and 24% of the men in the highest quintile of the population fall into the same category. Of the clients we interviewed in the static, urban clinics, 15% lack formal education. In the countryside it is 67%. Hence, the urban clients we have met have far better education levels than the highest wealth quintile in the country. If we look at the rural clients we interviewed, they had substantially higher levels of education than the poorest groups in society.
- Of the population in the lowest quintile of the population, 0% have more than secondary education, whereas 3% of the women and 6% of the men in the highest quintile fall into the same category. Of the interviewed urban clients, 33% have a post secondary education and 9% have a higher education. Hence, also here they show far higher levels of education levels than the top wealth quintile of the country. Turning our eyes to the rural clients, they show the same figures as the lowest wealth quintile.
- If one looks at the DHS data divided into the rural and urban population, 31% of the urban women and 16% of the urban men lack formal education, whereas 73% of the rural women and 57% of the rural men fall into the same category. Repeating our data from above, 15% of the urban clients we have interviewed lack education, whereas 67% of the rural clients fall into the same category. These data also show that when separating the urban and rural population, especially the urban clients seem to be very much better off than the average urban population. (Especially when taking into consideration that only 12% of our urban respondants were male.)
- The picture is confirmed when looking at higher education. 4% of the urban women have more than secondary education and 8% of the urban men. Of the rural population it is 0%. In our sample, 33% of the clients at the urban, static clinics have a post secondary education and 9% of them higher education. At the outreach clinic, it is 0%.

So, we see that the urban services reach some people who are very poor in an absolute sense, looking at the education dimension. 3 of 10 have no education at all, or only 4 years of primary school education. But the services also seem to reach some people who are quite well off in an absolute sense. 4 of 10 persons have a post-secondary education. We also see that the urban clients reached do not belong to the poorest urban groups; in fact they are relatively seen far better off than most urban people. Hence, the picture of the urban clients is mixed.

Turning our eyes to the rural services, we see that they reach a lot of people who are very poor in an absolute sense, looking at the education dimension. 7 of 10 have no education at all. This is clearly a very poor and vulnerable group of people, especially exposed to SRHR problems.

Apart from education levels, we have other indicators of socio-economic status. Below you find Table 5, showing the reported occupations of the clients in Ethiopia. The picture confirms the education data. In the urban static clinics, there is a wide range of occupations. At least 40% seem to be quite well off when judging by their occupations. Opticians, book store owners or pharmacists can hardly be among the income poorest in a society. In the rural areas, no one has employment outside the home.

Table 5. Occupations of clients in Ethiopia, from exit interviews.

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

We also have data on a number of assets. Table 8 below presents the data from Ethiopia. Again we see large differences between the outreach site and the static clincs. There are also many indicators of absolute poverty, for example none of the people from the outreach site has piped water and no one has a radio. Everyone at the outreach site has grass roofs, natural floor, and walls made of mud and poles. Even in the static clinics, half of the clients have natural floors and walls made of mud and poles.

Turning to the picture of relative poverty, comparing with the DHS data, we find the following:

- Ninety percent of the urban population have some sort of piped water and 13% of the rural population. Of our informants, 96% of the urban clients have piped water compared to none of the rural clients.
- Twelve percent of the urban population and 70% of the rural population have no toilet, i.e. use the bush/field,. In our sample, 2% of the urban clients and none of the rural fell into the same category.
- Forty six percent of the urban population have earth, sand or dung as flooring material, compared to 98% of the rural population. In our sample, 50% of the urban clients has a natural floor, and 100% of the rural clients.
- 76% of the urban population owns a radio, as compared to 27% of the rural population. Of our interviewees, the urban figure is 89% and the rural figure is 0%.

The relative picture here is a bit mixed, but generally the urban clients are better off than the average urban population, and the rural population is worse off (with the exception of the toilet).

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

Asset	Alternative	Outreach	Static
Number of observations		**27**	**46**
Drinking water	Water from open well	26ä	0ä
	Water from well	0ä	0ä
	Water from borehole	15ä	0ä
	Surface water	0ä	0ä
	Rainwater	59ä	0ä
	Other source	0ä	2ä
	Piped water	0ä	96ä
	NA	0ä	2ä
Toilet facility	No/bush/field	0ä	2ä
	Pit toilet/latrine	100ä	85ä
	Septic tank/modern	0ä	11ä
	NA	0ä	2ä
Radio	No radio	100ä	2ä
	Have radio	0ä	89ä
	NA	0ä	9ä
Roof	Grass	100ä	0ä
	Plastic sheet	0ä	0ä
	Iron sheets	0ä	89ä
	Tiles	0ä	2ä
	NA	0ä	9ä
Floor	Natural floor	100ä	50ä
	Finished floor	0ä	43ä
	NA	0ä	7ä
Walls	Grass	0ä	0ä
	Mud and pole	100ä	52ä
	Unburnt bricks	0ä	9ä
	Burnt bricks with mud	0ä	0ä
	Cement	0ä	20ä
	Other	0ä	7ä
	NA	0ä	13ä
Housing	Rent	0ä	61ä
	Own	100ä	30ä
	Dont know	0ä	4ä
	NA	0ä	4ä

So, our limited sample of exit interviewes indicates that:

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

This picture is confirmed in interviews with staff at the member associations. Many point out that it is in the outreaches that the most poor and the really poor people are reached. In some branch clinics we heard stories about some better-off clients attending because of the higher quality of services. A logical question then is whether some or a few of the clients coming to the branch clinics would actually be able to afford non-subsidised private services. The picture is not clear and is not possible for us to analyse fully. We were told in Ethiopia that also the relative 'middle class' earns so little that they would not be able to afford alternative quality services. When discussing possible cross-financing with senior management staff in Ethiopia, we also heard insightful arguments about the danger of losing the NGO image of the organisation, which might lead to a loss of poorer clients. Practically, it might also be difficult to administer different fees for various groups of clients. Hence, we understand that this is a delicate balance to walk where there are many different considerations.

Additionally, it was clear that many government officers and SRHR stakeholders, acknowledged FGAE for its outreach services to poor, rural areas. FGAE is seen as a pioneer in this approach. The community based reproductive health agents have served as a model for other government initiatives and NGOs.

Fees

FGAE operates a modest fee structure which is considered fair by most beneficiaries and one that even the poor people can afford. A list of fees is not posted at the clinics; small amounts are charged for each procedure e.g. each test or examination. The lack of a publicly available list was not cited to be problematic by users. We were informed that the level of service fees is reviewed every two years and is based on information gained from feasibility and affordability studies commissioned by FGAE and carried out by external consultants.

People who cannot pay for care are not denied services. Whether a person can pay is determined during the face-to-face encounter with the service provider. Community based reproductive health agents and peer service providers are instructed to tell people wishing to attend clinics that no one who needs services and cannot afford them will be turned away. However, it is up to the service provider to decide whether to extend an exemption to a user. There do not appear to be explicit exemption criteria and it is recognised that users' ability to pay is seasonal; at times, many people will not have funds. It was reported that service providers do not have difficulties in determining who qualifies for exemptions.

The exemption criteria that community based reproductive health agents and peer service providers can use with regard to the provision of pills and condoms are not clear. Peer service providers in one youth centre reported that they were not allowed to exempt poor people from paying for condoms and pills. The evaluation team was told by a staff member that exemption always meant problems with accounting and reporting to their supervisor, and that there was no way in practice to know whether these clients existed in real life or not. Hence, the peer service providers had to either account for money paid or be able to show the clients. In practice, they interpreted this as not being allowed to exempt poor people.

Young People

As with community based distribution, FGAE was identified by key informants in government, NGOs, and international agencies as having first established and set the standards for how youth friendly services should be designed and run. Other organisations and institutions turn to FGAE to provide technical assistance, guidelines, and training when developing their own youth friendly services.

A systematic review of FGAE's service statistics was not undertaken and we have not been able to ascertain how many young people FGAE has served in its clinics. We note that VCT services provided in a manner that is accessible to young people are an important part FGAE's service package.

Service statistics at Bahir Dar show an increasing number of young people attending for VCT since the youth-friendly services started. Young people account for approximately one-third of the VCT attendances. A 'snapshot' look at one month's statistics found that over a quarter of these were in the age group 15–19.

It is clear that FGAE reaches out to many young persons who have no other youth-friendly services available.

Specific Vulnerable Groups

A positive picture

- FGAE has a working relationship with the Forum for Street Children in many of the sites visited. FGAE provides the SRH and general medical care for children referred to its clinics by the Forum. Users said the SRH and VCT services there were welcoming and friendly although complaints were heard about the general medical care received as discussed in Chapter 5.
- FGAE has started some home – based care activities for people living with AIDS which beneficiaries find very supportive. However, compared to family planning, FGAE's work in HIV/AIDS is recent and their specific role remains to be mapped out in the future.

An incomplete picture

- SRHR covers a wider range of issues than family planning and HIV/AIDS. In the Ethiopian context, this also includes gender-based violence, female genital cutting, early marriage, and women's autonomy in making decisions which affect their SRH. Young people, especially young girls, are vulnerable in these situations. Young married women are often unable to make decisions regarding their family size, contraceptive choice, and use of household resources for health services.
  The evaluation team saw and heard of individual project activities related to these issues, for example the services provided to rape survivors in Addis Abeba and also an advocacy project on early marriage in the Amhara region. However, we did not find FGAE to be working extensively with these issues at the sites visited. Moreover, when talking to local stakeholders, FGAE was not identified as an organisation working with these issues. Discussing this with FGAE, they agreed with our conclusion. They pointed out that the need for community-based services is still very large, and that their resources are not sufficient to cover all the different SRHR areas in the country. However, they also wanted to highlight that they work together with some partner organisations when it comes to some of these issues.
- We noted the absence of activities among groups that we would consider to have high SRHR needs e.g. the military, people living along trucking routes, refugees, and people living near refugee settlements. We also noted that FGAE does not work in all of the country's 11 regions; there are no services in Afar, Beni-Shangul, or Gambela. In Somali, there is only a youth centre. These are recognised as very remote areas that are under-served by government and NGOs.

Conclusion

FGAE reaches many poor and vulnerable groups, especially in the outreach sites. Of the vulnerable groups, they reach especially the young. Other groups, such as commercial sex workers and street children, are targeted in specific projects.

It is clear that the rural outreaches reach poor people to a much higher extent than the urban clinics. However, it is important to point out that the urban clinics do reach poor people too, and that also the relatively better-off urban citizens often cannot afford alternative quality services. Hence, also the urban clinics reach people who would otherwise have no access to SRHR services. However, it might be

useful to collect some sort of data on poverty indicators from the clients, for a more systematic picture of the clientele at different clinics.

When asked about the criteria for selecting outreach sites, the common answer was that the selection was made in cooperation with the local government administration, and that they selected under-served areas and a location which would be accessible for as many people as possible. Poverty was never mentioned specifically. However, taking the pattern of poverty of Ethiopia into account, targeting under-served, rural and remote areas is a way of explicitly targeting the poorest and most vulnerable groups in society.

When looking at how well FGAE targets different groups, it is important to point out that a specific organisation with limited financial resources cannot be expected to cover every group and every need there is. Noting the areas in which they do not work does not necessarily mean a recommendation to cover all those areas.

To the left, playing children close to an outreach site in a village outside Dire Dawa. To the right, community leaders telling about the problems of harmful traditional practices in their community outside Harar

7. Observations and Recommendations

Image and Staff

- FGAE is recognised as the pioneer organisation for family planning in Ethiopia and is generally seen as an influential, credible organisation. It is acknowledged for reaching further out in rural areas than other providers and for providing services to adolescents to a greater extent than other providers. Its credibility is proven by its good relations and many partnerships with other NGO's and with the government.
- There seems to be a gender imbalance in the organisation, with top management staff positions largely filled by men, while many of the clinical staff and volunteers are women.

Recommendation: FGAE should consider affirmative action initiatives to get more women into the organisation at all levels.

Advocacy

- FGAE is credited with having influenced the policy environment through advocacy initatives, for example in relation to the recent changes of the legislation on abortion.
- Some partner organisations would like FGAE to speak with a stronger voice, especially on controversial issues.
- Beneficiaries expressed some negative opinions about the IEC/BCC materials and considered them to be poorly designed for certain groups of people.

Recommendation: FGAE should review its IEC/BCC materials to make sure that they are attractive and effective in reaching out to different target groups, such as adolescents and those who do not read.

Relevance

- FGAE offers a full range of contraceptive services, and is the only SRHR provider in Ethiopia that does so. They have a wide range of clinical and other services, varying with the local need and situation. Ethiopia is a highly decentralised country and hence, FGAE's services appear to be less uniform than the other countries visited for this evaluation.
- Beneficiaries and stakeholders are generally very satisfied with the range of services provided by FGAE. When suggestions of changes are made, they generally refer to new and expanded services rather than changing the focus of the present services. Hence, we conclude that the FGAE activities are very relevant to the country needs.
- Among the areas of possible strengthening/expansion are: abortion services, safe motherhood services in the rural areas, long-term contraceptive methods in the rural areas, information about and demand for emergency contraception, expansion of training programmes for other stakeholders, expansion of income-generating activities, strengthening of the programmes on gender-based violence and harmful traditional practices, and introduction of mobile VCT.

Recommendation: FGAE should consider adding a wider range of clinical services in all the outreach sites, unless this conflicts with the government's Health Service Extension Package.

Recommendation: FGAE should make emergency contraception better known by providers, clinic attenders, and the public, so that demand is increased.

Recommendation: FGAE should be careful when expanding its HIV/AIDS activities, to ensure that they are well coordinated with the national and local responses. FGAE may want to consider what its niche is in the country's fight against HIV/AIDS.

Recommendation: FGAE should consider expanding its training programmes to other service providers, as a means of further cross-financing services for poor people.

Effectiveness

- From what we have seen, client satisfaction with quality of services is very high. The good quality of care is commonly cited as a reason to choose FGAE, both among beneficiaries and stakeholders.
- FGAE's network of volunteers, i.e. the community based reproductive health agents and the peer service providers, carry out the major part of their outreach work and increase the effectiveness of the organisation. However, there are some challenges to overcome in order to further improve

the effectiveness. Among the challenges pointed out in this evaluation are: lack of youth involvement, and lack of transport, training and sufficent re-imbursement.

Recommendation: FGAE should improve youth participation in the running of the youth centres and in the design of the programmes of peer service providers, as well as in the organisation as a whole. A review of the programmes for peer service providers should be carried out, so that problems with transports, re-imbursements and training are addressed.

Recommendation: FGAE should review the youth centres to ensure that activities are designed for the wide range of youth who could attend. Special efforts should be made to attract more young teenage girls to the centres.

Recommendation: When expanding the provision of maternal health care to include deliveries, FGAE should make sure that their activities are well coordinated in a continuum of care at the local level. It is especially important that the ante-natal activities are linked to the provider who will be with the mother at delivery.

Reaching Poor and Vulnerable Groups

- FGAE reaches out to many poor and vulnerable people, and they do so better than most other providers of SRHR services. Their network of community based reproductive health agents reach poor and vulnerable people in the rural areas, including women with little control over their SRH decisions and vulnerable to harmful traditional practices. The network of peer service providers reaches adolescents in the urban areas, and provides them with access to contraceptives and information, that they would not get otherwise. In some locations, the network of peer service providers also target street children and commercial sex workers, through volunteers recruited from these groups.
- The rural outreach clinics reach poorer people than the branch clinics, which also attract some better-off persons. However, many of the clients coming to FGAE in the urban areas would not be able to afford alternative quality SRHR services. The urban clinics also target certain vulnerable groups, such as street children and commercial sex workers.

In order to increase effectiveness in reaching poor and vulnerable groups, FGAE should consider collecting data on poverty indicators from their clients, to facilitate more systematic analysis and comparision between different service delivery points.

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Appendix 1. List of Interviews and Observations

SRHR national stakeholders, Addis Abeba

• Dr. Atnafu Setegn, Family Planning Team Leader	Ministry of Health
• Ms. Roman Tesfaye, Head Policy and Strategy Implementation	Ministry of Women's Affairs
• Ms. Genet Mengistu	National Office of Population
• Ms. Ato Tesfaye, Coordinator Youth Policy	Ministry of Youth and Sport
• Mr. Asrat Kelemework, Project Coordinator	HAPCO
• Dr Teo Pas	Royal Netherlands Embassy
• Mr. Seifu Admasu, Programme Coordinator	Tesfagod/Down of Hope
• Mr Aklilu Kidane	Miz-Hasab Research Foundation
• Yemeserach Belayneh, Programme Coordinator	Packard Foundation
• Getachew Bekele	Marie Stopes
• W/ro Tsegie	Family Health International
• Mr Seifu Tadesse, DME Advisor	CARE
• Dr Kidane Ghebrekidan	UNFPA
• W/ro Saba Kidanemariam, Country Director	IPAS
• Dr Solomon and Dr Beyeberu	ENGENDERHEALTH
• Mr Megistu Asnake, Dep. Country Representative	PATHFINDER
• Mr. Andrew Pillor, Director	DKT
• Mr. Mirgissa Kaba, Programme Officer HIV/AIDS	UNICEF
• Dr. Alemach Teklehaimanot, Project Officer, Health and Nutrition	UNICEF
• Ms Tigest Alemu, Executive Director and Ms Zewditu Kebede, Technical Support Manager	CORHA
• Dr Getinet Tadele, Department of Sociology	Addis Abeba University

National level FGAE staff and board members in Addis Abeba

- Mr Amare Bedada, Executive Director, 10 male and 5 female staff members also present.
- Meeting with the national board, 1 woman and 1 man
- Mr Fekadu Chala, Programme Director
- Molla, Youth Coordinator
- Ato Tesfaye, Coordinator of Youth Policy
- Dr Asefa, Head HIV/AIDS

Local FGAE staff and volunteers

• Mr Lebagha Sub-branch Manager	Dire Dawa
• Mr. Kaleb Getachew, Youth Counselor, Youth Clinic	Dire Dawa
• Ms Aster Tikehun, Nurse, Youth Clinic	Dire Dawa
• Menbere, Nurse, Youth Clinic	Dire Dawa
• Sr Tizida Aservesea, Midwife, Dechatu Clinic	Dire Dawa
• Fisseka Melaku, Negash Seifu, Yeshi Sebeko, BranchManagement Committee, Eastern Branch.	Harar
• Mr. Alemayehu Belachew, Branch manager	Harar
• Mr Mesfin Asefa, Head nurse, Model Clinic	Harar
• Chair of Executive Committee, Eastern Branch	Harar
• Sr. Hidaya Jami, Midwife, Model Clinic	Harar
• Mr Ababa Kirkos, Youth Centre Head, Kirkos Youth Centre	Addis Abeba
• Health Officer and Head, Ferensey Model Youth Centre	Addis Abeba

• Head, Sheger Youth Centre	Addis Ababa
• Worku Eshetu, Planning and Programme Coordinator, Bahir Dar Clinic	Bahir Dar
• Dr. Beleta Tafesse, Model Clinica Head	Bahir Dar
• Mekvvda Worknem, Lab Technician	Bahir Dar
• Yenework Amera, Druggist	Bahir Dar
• Bizunesh Tessema, Clinical Nurse,	Bahir Dar
• Yalemferie Asefa, Nurse Counsellor,	Bahir Dar
• Genet Zemenu, Senior Nurse, Bahir Dar Clinic	Bahir Dar
• Nurse, Youth Clinic Head, Bahir Dar Youth Clinic	Bahir Dar
• Mr Kassahun Shiferaw, branch manager	Nazareth
• Staff meeting, 10 persons present	Nazareth
• Nurse at outreach post, Safe Motherhood Programme	Awasa
• 4 board members and 6 volunteers	Awasa

Providers of non-clinical FGAE services

• Group of 5 female peer service providers	Harar
• Female CBRHA at outreach site.	Harar
• 2 Contact Women/Traditional Birth Attendants, 1 male CBRHA.	Dire Dawa
• Peer service providers, 3 girls and 1 boy	Dire Dawa
• 1 male home-based care volunteer	Nazareth
• 1 female CBRHA in the Kebele of Handa	Bahir Dar
• 3 CBRHAs at Tis Abay Health station	Bahir Dar
• 4 peer service providers	Bahir Dar
• 5 female and 3 male peer service providers	Bahir Dar
• 6 male CBRHAs	Bahir Dar
• 1 female CBRHA in Wetete Village	Bahir Dar
• 2 traditional birth attendants	Awasa
• Shashemane, Project Manager of Home-Based Care Programme	Awasa

Users of non-clinical FGAE services

• Participants in a Community Conversation session, 15 women & 4 men.	Harar
• 1 female user of CBRHA services	Dire Dawa
• 3 beneficiaries of home-based care	Nazareth
• 1 male beneficiary of home-based care	Nazareth
• Chairman and 2 members of Women's Association	Awasa
• Husband and wife who delivered twins	Awasa
• 3 beneficiaries of the home-based care programme	Awasa
• 3 beneficiaries of the home-based care programme	Awasa
• 1 female beneficiary of home-based care programme	Awasa
• 1 commercial sex worker	Bahir Dar
• 6 commercial sex workers	Bahir Dar

Users of clinical FGAE services

- 73 exit interviews with clients from clinics, in Awasa, Bahir Dar, Hara, Dire Dawa, Addis Abeba and Mamana.

Non-users of FGAE services

• 14 girls, age 15-18, at the Forum for Street Children	Bahir Dar
• 15 commercial sex workers	Bahir Dar
• 9 married young women	Bahir Dar
• 10 unmarried young women	Bahir Dar
• 5 children 12-18 at the government youth centre	Dire Dawa

Community leaders, local government, alternative providers

• Dr. Tsegerada, Head, Regional Health Bureau	Dire Dawa
• Mr. Solomon Aliyu, Ministry of Youth and Sport	Dire Dawa
• Sr. Tewabech Zewde, Head, Maristopes clinic	Dire Dawa
• Mr Abebe Mekonna, Manager, Yerusalem	Dire Dawa
• Ms Mekete Faris, Deputy Project Manager and Mr Selamamit Muleta, Health Officer, Forum for Street Children	Dire Dawa
• Getnet Mekonin, President, Tesfagod/Dawn of Hope	Dire Dawa
• Ms Lemlem Bezabih, HAPCO	Dire Dawa
• Sr. Selamawit, midwife, Sabian Government Health Centre	Dire Dawa
• Health assistant, Lege Birra Government Health Post	Dire Dawa
• Atio Desalegn, Marie Stopes	Bahir Dar
• Ato Getaneh, HAPCO	Bahir Dar
• Antenen Gelaye, Project Manager, CARE	Bahir Dar
• Eleni, Project Coordinator, Forum for Street Children	Bahir Dar
• Tesfahun Wondie, Project Coordinator, Adeet project	Bahir Dar
• Milkeyas Tabor, Bahir Dar City Health Bureau Head	Bahir Dar
• 6 male village elders in Mananna	Awasa
• Ministry of Health	Awasa
• Tizet Alam, Umbrella	Awasa
• Mrs. Pinna, OSSA	Awasa
• Dr Ayenlisu, Addis Abeba Fistula Hospital	Addis Abeba

Observations of FGAE clinics and youth centres

• Harar Model Clinic and Youth Centre	Harar
• Dire Dawa Youth Clinic	Dire Dawa
• Dechatu clinic	Dire Dawa
• Chiro clinic	Chiro
• Ferensey Model Youth Centre	Addis Abeba
• Sheger Youth Centre	Addis Abeba
• Bahir Dar Youth Centre	Bahir Dar
• Bahir Dar Youth Clinic	Bahir Dar
• Bahir Dar Model Clinic	Bahir Dar
• Tis Abay Health Post	Bahir Dar
• Awasa Clinic	Awasa

Observations of FGAE non-clinical activities

• 2 home visits under the home-based care programme	Nazareth
• Outreach activity for commercial sex workers	Bahir Dar

Observations of government and NGO clinics and youth centres

• Sabian Government Health Centre	Dire Dawa
• Lege Birra Government Health Centre	Dire Dawa
• 2 government Youth Centres	Dire Dawa
• Fistula Hospital	Addis Abeba

Annex 1. Data Collection Instruments (for the whole report)

Below you find the data collection instruments for the field work, however slightly modified for each country context.

MA national level

Date, time, place:
Interviewer/s:
Person/group interviewed:

Core information:

- To inform them about the evaluation and to introduce our team.
- Information about work of MA at country level: achievements, poverty targeting, areas and issues of specific importance, previous evaluations of interest, networks. Focus on achievements, rather than descriptions of their activities.

Introduction

- The interview begins with greetings, introductions, explanation of the project. How we are going to give feedback to the MA.
- What the work of the MA is about, general profile, brief introduction of the various programmes. Organisational setup – overview of clinics and staff, services and programmes.

SRHR context

- The SRHR context in the country – main challenges.

Achievements and role of the MA, training

- What is the role of the MA as you see it, in the national context? What do you contribute with now? How do you differ from other organisations?
- Among the five A:s, in which area do you think that you have achieved most results? Has there been any examples of failures?
    - Advocacy
    - Adolescents
    - HIV/AIDS
    - Access.
    - Abortion
- What are your strengths and weaknesses? How do you think you could make the MA even more effective?
- How do you decide what you do, how do you set your goals and priorities?
- (Senior management level). History of the present location of clinics and non-clinical services. Expansions of new services or closures of services the past years? Reasons and strategies behind?
- What measures do you have in place to assure specific attention to gender sensitiveness and youth sensitiveness?

- Training programmes for field offices, staff and volunteers? Is there specific training on gender and youth, would you say that the training makes a difference in the field?

Networks and cooperation

- Policy environment in the country, relations to the government.
- Which are your key partners in the country, national and field levels?
- How are your programmes coordinated with key partners?

Volunteers and outreach work

- Can you tell us more about the non-clinical outreach work attached to the clinics?

Poverty related questions

- Could you give us more information about your target groups?
- Do you have special strategies to reach the poorest and most vulnerable groups? How do you reach them?
    - What are the challenges and problems?
    - Do you have statistics concerning target groups?
- Can you tell us about the use of fees in the clinics? Has there been a discussion in the MA? Advantages and disadvantages with the present approach?
    - Strategies and criteria for exemption of the poorest and most vulnerable groups?
- How much information do you have from poor people locally concerning what their needs and wishes are when it comes to SRHR?
    - Do you think that your local clinics meet the demands of the poor locally?
    - Could anything be improved?

Some final questions

- Monitoring and evaluation systems. To what extent do you think you are meeting your goals and objectives. Previous evaluations.
- Is there anything you would like to add? Do you have any advice for the evaluation?

National level non-MA SRHR actors

Date, time, place:
Interviewer/s:
Person/group interviewed:

Core information:

- Overview of SRHR situation in the country
- Information about the role and work of the MA, slight focus on advocacy.

Introduction, SRHR context, their own organisation

- The interview begins with greetings, introductions, explanation of the project and why (s)he has been asked to talk to us, and assurance of anonymity. When introducing the evaluation, we are not mentioning poverty specifically. It might be worthwile to explicitly explain that we are not representatives from IPPF, to make them speak more freely.

- What are the most important SRHR issues in the country – main challenges and problems.
- Which are the key players in the SRHR field in the country?
- What is your own organisation mainly working with? (Discussion on their specific area of knowledge, for example HIV/AIDS).

The role of the MA

- What is the MA contributing with concerning the important SRHR issues mentioned earlier?
- How do they work with: (are there any particularly good and bad examples)
    - Advocacy
    - Abortion
    - Adolescents
    - HIV/AIDS
    - Access
    - Ask for specific examples.
- MA's strengths and weaknesses? Is there anything the MA could improve to be more effective?
- Has the organisation changed in the recent past? Do you see any positive or negative development?

Networking with the MA

- Do you cooperate with them? What is your experiences of cooperating with them? In what fora do you cooperate with them?

Poverty targeting

- Which issues do you think are most important to reach the poorest and most vulnerable groups in this country? How does your own organisation work with that?
- How well do you think that the MA is targeting the poorest and most vulnerable in the country?
- Is there anything they could do to reach out to the poorest in a better way?
- To what extent do you think that the activities of the MA is relevant to the needs of poor people and the socio-economic development of the country?
- Do you think that the location of MA clinics makes them accessible to the poorest and most vulnerable groups?

Final questions

- Is there anything you would like to add? Do you have any advice for the evaluation?

Focus group agenda with staff at a clinic

Date, time, place:
Interviewer/s:
Person/group interviewed:

Core information:

- Overview of services
- Work at service delivery points
- Target groups
- Fees
- Outreach

Introduction

- The interview begins with greetings and introductions.
- Brief presentation of the project noting that while the evaluation has been commissioned by funding agencies it is expected to be participatory with input from MA, IPPF.
- The staff may have prepared a presentation of the clinic. If not, the moderator can touch upon the following questions:
    - SRHR situation locally
    - History/size of clinic e.g. number of new patients, old patients each month/year
    - Range of activities
    - Intended target groups: male/female; in-school/out-of school, married/unmarried; aged groups of adolescents; vulnerable group
    - Who are the beneficiaries?
        - Male/female; married/unmarried; in-school/out of schools; age; vulnerable groups
    - Does the clinic collect information about its users? If so, what? How is this information used?
    - Alternative services available in this area?
    - How do you select where to schedule outreach activities?
    - What are the things that prevent people from using this clinic? What things do they like about the clinic? Which users go to that/those clinic/s instead of yours, and why?
    - Is there anything that would enable more people to come here?
    - Are there any obstacles you face in the providing the care you are expected to provide?
    - Do you take fees for your services? If so, describe including exemption mechanism(s)

Do you have any related comments, proposals, suggestions to improve service delivery?

Individual Interviews With Non-clinical Service Providers/ Community Based Volunteers

Date, time, place:
Interviewer/s:
Person/group interviewed:

Core information:

- Information about their target groups
- Overview of activities (what kind of, frequency etc.), level of knowledge

Introduction

- The interview begins with greetings, introductions, explanation of the project and why (s)he has been asked to talk to us, consent, and assurance of anonymity.

Overview of their work

- Could you tell us about the activities you do?
- How long have you been working with this?
- How much time do you spend on it?
- Have you received some training for this?
- Why are you working with this?
- What is your place of work?

Target groups: profile and numbers

- Who are the people you mostly work with?
- Are there any special groups that you try to reach? Who are they? Why?
- How many do you reach out to, interact with, during a week? (eg, to how many classes, how many students were there)
- Are there difficulties reaching certain groups in the community? Why?
- Have you any suggestions on what could be done to reach the groups that you want to reach?

Changes and impact

- What happens when you have done.. x…, what do people think of it?
- Are you able to notice changes? (which group)
- Could you tell us what kind of changes you noted?
- Are there also examples of when you have not been able to get the work done, or when you were disappointed?
- Is it more common that you get disappointed with some groups?

Support

- What kind of support do you get in your work?
- What supplies do you need?

- Are there any problems in getting supplies?
- How do you work together with the MA clinical staff? (Do you refer clients to the clinic.)
- Is there anything that could be done better by the clinic?

Final questions

- What are the key challenges/problems regarding SRHR in the community?
- Is there anything else you would like to tell us about?

Individual Interviews With Community Leaders and Other non-MA SRHR Actors at Branch Level

Date, time, place:
Interviewer/s:

Core information:

- Local SRHR context
- Poverty outreach – how is it, what could be improved
- Quality of services

Introduction

- The interview begins with greetings, introductions, explanation of the project and why (s)he has been asked to talk to us, consent, and assurance of anonymity. When introducing the evaluation, we are not mentioning poverty specifically.
- The first question is to help make the interviewee comfortable and could ask whether (s) he has been working in the field of SRHR for some time.

Local SRHR situation

- What are the most important SRHR issues in this area now? How is your organisation working with these issues?
- Who are the most important organisations in this field? What services are available in the area? What is your perceptions of these services?

Structure of poverty in the local area

- Can you tell us a bit about where poor people in this community live?

Perception of quality of MA

- Views of the MA activities
- How is the MA meeting the local SRHR needs?
- What are the MA strengths and weaknesses? What could they do different/better?
- Does/how does the MA work with other groups/organisations? Do they work with your organisation? If so, what is your view on that cooperation?
- Is the MA/branch reaching out to meet groups with special SRHR needs? If so,
    - Who
    - What

- How
- When
- Where

- Do poor people or vulnerable groups (specify group appropriate to the local area) use the MA/branch services or participate in their activities? If so,
  - Who
  - What
  - How
  - When
  - Where

Final question

- Anything else you would like to comment on? Thanks for taking their time.

Exit Interviews With Clinical Service Users

Date, time, place:
Interviewer/s:
Male/female:

Core information:

- Why clients use this clinic service
- Whether satisfied
- Poverty status

Introduction

- Before the interview, the interviewer should be presented to the person to be interviewed so as to establish that the interviewer is at the clinic with the clinic's permission.
- The interview begins with greetings, introductions, explanation of the project and why (s)he has been asked to talk to us, consent, and assurance of anonymity. *If consent is not given, end the discussion.* Make sure the interviewee is comfortable, i.e. (s)he is sitting comfortably and can be confident that s(he) will not be overheard by others.

Access

- The first question is to put the clinic user at ease and could ask whether (s) he lives close to the clinic. Followed by questions about how (s)he travelled to the clinic and how long it took.
- Do you live close to this clinic?
- How long did it take you to travel here?

Perception of services used

In a conversational manner, the interviewer should ask:

- Is this the first time you have come to the clinic?
- *Ask in a culturally sensitive manner:* Why did you come to the clinic? (the reason may be one of the following

    - Contraceptive service
    - VCT
    - Other STIs
    - Other SRH medical service
    - Immunisation
    - Minor non-SRH medical service
    - Information/counselling
    - Other (specify)
- Were you able to get the service/help/information you came for?
- Overall, would you say you were satisfied with your visit to the facility today or were you dissatisfied with your visit today?
    - Yes/no/Why? (comment)
    - Invite comments on:
        - Staff friendliness
        - Secure that what was told to the providers here will be kept confidential
        - Waiting time
        - Need to pay fees or "gifts" for contraceptives/drugs.
        - Other
- Do you think you will return to this clinic?
- Were there other places you could have gone to for this problem? If so, why did you decide to come here?
- Would you recommend this clinic to a friend who needed similar help?

Personal profile

- Can you tell me how old you are?
- Are you currently going to school?
- What is the last year of your completed studies?
    - None/preschool
    - 4 yr primary
    - 2 years lower secondary
    - 2 years upper secondary
    - 2 year post secondary
    - higher education

- Can you tell me what kind of work you do? Your household source of income?
- I would like to ask you some questions about your home/household.
    - What is the main source of drinking water for members of your household?
        - Piped water
        - Water from open well
        - Water from well
        - Water from borehole
        - Surface water
        - Rainwater
        - Other (Specify)
    - What kind of toilet facility does your household have?
        - Septic tank/modern toilet
        - Pit toilet/latrine
        - No facility/bush/field
        - Other (specify)
- Does your household (or any member of your household) have:
    - A radio that is working? Yes/no
- What is the main material used in the roof of your home ?
    - Grass
    - Plastic sheet
    - Iron sheets
    - Tiles
    - Other (specify)
- What is the main material used in the walls of your home?
    - Grass
    - Mud and pole
    - Unburnt bricks
    - Burnt bricks with mud
    - Cement
    - Other
- What is the main material used in the floor of your home?

- Natural floor
- Finished floor

- Do you own your home or rent?
  - Own/rent/don't know
- Thank the interviewee for taking the time to share her views with us.

Focus Group Interviews for Non-users

Date, time, place:
Facilitator(s):
Numbers, gender, approximate ages of the participants:
Brief description of the participants:

Core information:

- The most important SRHR needs of this participant group
- Participant overview of relevant services/service providers in this area
- If participants know of MA services which are relevant to their needs, their views of these services
- Why doesn't this group of potential users use the MA services?

Specific guidelines:

- 6–10 people, homogeneous by age, gender, marital status, ethnicity, educational background
- After each question, summary and reflect upon what we have heard to ensure that we have understood correctly and participants can modify etc.
- Encourage equal/even participation among group members

Welcome & Introduction

- Introductions of ourselves, project
- Introductions of group members
- Why we are here
- Ground rules: Confidentiality, respect, anonymity

Lead question appropriate to the group (get them into talking about the topic)

- Groups married/unmarried women and men
- Different age groups of adolescents
- Married women: (example) tell me about how many children you have? How many do you want? Who do you turn to for family planning?

Core questions:

- Can you tell me about what you think are your most important SRHR needs in relation to this issue?
- Who in this area are helping you meet this needs?
- Why, how/what, when,where?

- If MA is not mentioned,
    - Have you ever heard that the local MA offers: (insert activity e.g. VCT, CC provision, referral to other services, STIs etc.)
- Can you tell us something about what people like you think about the MA's (insert activity)
- Can you tell us about why some people do not use the MA's services?
- Can you tell us about why some people use the MA's services

Socio-demographic background

- Can you tell me how old you are?
- Are you currently going to school?
- What is the last year of your completed studies?
    - None/preschool
    - 4 yr primary
    - 2 years lower secondary
    - 2 years upper secondary
    - 2 year post secondary
    - higher education
- Can you tell me what kind of work you do? Your household source of income?
- I would like to ask you some questions about your home/household.
    - What is the main source of drinking water for members of your household?
        - Piped water
        - Water from open well
        - Water from well
        - Water from borehole
        - Surface water
        - Rainwater
        - Other (Specify)
    - What kind of toilet facility does your household have?
        - Septic tank/modern toilet
        - Pit toilet/latrine
        - No facility/bush/field
        - Other (specify)
- Does your household (or any member of your household) have:

    - A radio that is working? Yes/no
- What is the main material used in the roof of your home ?
    - Grass
    - Plastic sheet
    - Iron sheets
    - Tiles
    - Other (specify)
- What is the main material used in the walls of your home?
    - Grass
    - Mud and pole
    - Unburnt bricks
    - Burnt bricks with mud
    - Cement
    - Other
- What is the main material used in the floor of your home?
    - Natural floor
    - Finished floor
- Do you own your home or rent?
    - Own/rent/don't know
- Thank the interviewee for taking the time to share her views with us.

Summary of the session

- What SRHR needs did this group identify?
- Who are the service providers meeting these needs?
- If the MA is discussed as one of the relevant service providers, what did the group think about their services?
- What prevents people from using MA services?
- Why do some people in this area use the MA services?

Interview/FGD Guidelines for Participants in Community Based Acticities

Date, time, place:
Interviewer/s:
Person/group interviewed: male/female, number of persons

Core information:

- Quality of activities, perceived change/impact
- Why chose this activity and not other
- Poverty status

Introduction

- The interview begins with greetings, introductions, explanation of the project and why (s)he has been asked to talk to us, consent, and assurance of anonymity.

Access

- Where do you live (area, distance)
- How did you get in contact with the service?

Perception of service

- Could you describe what you got out of the service?
- How often do you use the service?
- Is there any alternative to the service?
- Why do use this service and not an alternative?
- What do you think of the service?

Impact/change/obstacles

- Do you think people change/do things differently after the …..xxxx?
- Have you any examples of how things have changed? Have you yourself changed behaviours or attitudes?
- What do think are the obstacles for people to change/act on the service?
- Why do some people never use the services/or interact?

Personal profile (if only group questions, try to pick some individuals before/after)

- Can you tell me how old you are?
- Are you currently going to school? Yes/No
- What is the last year of your completed studies?
    - None/preschool
    - 4 yr primary
    - 2 years lower secondary
    - 2 years upper secondary
    - 2 year post secondary
    - higher education

- Can you tell me what kind of work you do? Your household source of income?
- I would like to ask you some questions about your home/household.
    - What is the main source of drinking water for members of your household?
        - Piped water
        - Water from open well
        - Water from well
        - Water from borehole
        - Surface water
        - Rainwater
        - Other (Specify)
    - What kind of toilet facility does your household have?
        - Septic tank/modern toilet
        - Pit toilet/latrine
        - No facility/bush/field
        - Other (specify)
- Does your household (or any member of your household) have:
    - A radio that is working? Yes/no
- What is the main material used in the roof of your home ?
    - Grass
    - Plastic sheet
    - Iron sheets
    - Tiles
    - Other (specify)
- What is the main material used in the walls of your home?
    - Grass
    - Mud and pole
    - Unburnt bricks
    - Burnt bricks with mud
    - Cement
    - Other

- What is the main material used in the floor of your home?
    - Natural floor
    - Finished floor
- Do you own your home or rent?
    - Own/rent/don't know

Final question
- Anything else you would like to comment on? Thanks for taking their time.

Observation Guidelines, Community Based Activity

Date, time, place:
Observer:

Core information:
- Observe how the non-clinical services are performed: location, interaction, quality etc.

Access to the NCSP (if applicable)
- Suitability of location
- Signs/recognition
- Sense of well-being/comfort
- Discretion of access, queueing
- Youth friendliness

Clients
- Number of persons attending. Sex balance. Age composition.
- Interested and attentive?

Approach/attitude/communication when meeting clients?
- At ease?
- Formality?
- Language … speak the language of kids/etc.
- Greetings?
- Who are they speaking to, when/if we go out

Materials
- Availability
- Local language?
- Storage
- Youth friendliness?
- Best example

- Worst example
- What makes them good/bad?
- Controversial sign, posters?

Other observations…

Check with provider if this was a normal outcome, or if there was anything different compared to a normal day.

Observation Guidelines, clinic

Name
District
Date of observation
Checklist completed by (insert initials)

Core information:

- Observe aspects in the clinic which might be importance to explain why people come or don't come to this particular clinic as opposed to alternatives.
- Type of facility
  - Branch clinic
  - Mini-clinic
  - Special work unit
  - Satellite clinic
  - Stand alone youth clinic
  - Stand alone individual provider (e.g. drug dispensary)
- Facility run by
  - MA
  - Government
  - Other NGO (Specify)
  - Private
  - Private for profit
  - Private non-profit
  - Other (specify)
  - Location of facility
    - Urban
    - Rural
    - Peri-urban

Access

	Yes	No	Comments
Signs/poster to indicate that there is a family planning clinic			
Information about fees (if applicable)			
Separate facilities for youth			
opening hours and frequency of services			
Specific signs encouraging and informing the youth?			
Opening hours? Are they indicated clearly?			

Clients

- Number of women waiting
- Approximate age groups and numbers in each
- Number of men waiting
- Approximate groups and numbers in each

Comfort in waiting room and examination room

	Yes	No	Comments
Seating arrangements for everyone?			
Gender separate waiting rooms (if appropriate)			
Separate toilets for men and women			
Are they clearly signed?			
Are they open?			
Are they clean?			
Roof protection from rain and sunshine?			
Sufficient lighting			
Area clean			
Inviting environment			

Materials (posters, brochures, videos...)

	Yes	No	Comments
Available			
Local languages			

Other comments about materials:

Privacy

	Yes	No	Comments
Registration area			
Examination room			
Counselling area			

Other comments about privacy

Other observations...

Check with provider whether this was a normal clinic day, or if there was anything different compared to a normal day.

Media (radio) questionnaire for Uganda

Background Information.

The Family Planning Association of Uganda (FPAU) has been running a radio programme on _____ fm Radio. We would like to find out whether people know about the programme and what their views are. We know you may or may not be aware of the programme but there are other questions that we would like you to respond to in order to improve on the programme. The information you provide will be treated in confidence and will be used for purposes of this research only.

Whose radio do you listen to?

- Mine
- Spouse's
- Friend's
- Parents'
- Relative's
- Employer's
- Other specify_____

How often do you listen to radio?

- Daily
- 4–6 days per week
- 2–3 days per week
- Less than 2 days per week
- Don't know
- Other, Specify_____

Do you listen to _____ fm radio?

Have you ever tuned into the _____ Sexual Reproductive Health (SRH) programme on this radio?

How often have you listened to this programme?

Have you called in or written to contribute to the programme?

How did you learn about the SRH programme on this radio?

Has the programme improved your knowledge on SRH and Rights?

Has the programme changed your views about SRH and Rights?

Has the programme changed your behaviour as regards SRH and Rights?

What changes would you like to be made to improve the programme?

Personal profile

Sex

- Male
- Female

How old are you?

What is your highest level of education?

- None
- Lower Primary
- Upper Primary
- Lower Secondary
- Upper secondary

Annex 2. Terms of Reference (for the whole report)

Evaluation of the International Planned Parenthood Federation (IPPF)

1. Background

1.1 ICPD

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

1.2 IPPF

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

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

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

1.3 Sexual Reproductive Health and Rights and Poverty

The links between SRHR and poverty are many and complex. Poor SRH results from and contributes to poverty. Abridging sexual reproductive rights hampers poverty reduction. There is no doubt that improving SRH and guaranteeing sexual reproductive rights improves the lot of poor men and women. The ability to plan, space, and determine the number of children an individual and/or couple has is a critical factor impacting on later life opportunities for both the adults and the children involved. Pregnancy related conditions and sexually transmitted infections (STI) account for one-third of the global burden of disease among women aged 15–44. Women in poorer regions are disproportionately affected. In Sub-Saharan Africa, two-thirds of the disease burden for women of reproductive age is attributable to SRH problems. It is estimated that 250 million years of productive life are lost each year due to death or disability resulting from poor SRH.[20] Adolescents are particularly vulnerable to poor SRH outcomes.

The importance of SRHR is woven into many of the Millennium Development Project documents e.g. *Investing in Development: a Practical Plan to Achieve the Millennium Development Goals,* its summary Overview document, and the Task Force Reports. These reports underline that the key to achieving the MDGs in low-income counries is to ensure that each person has the essential means to a productive life. These means include adequate *human capital, access to essential infrastructure, and core political, social, and*

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

economic rights. SRH is one of the five key elements of adequate human capital. Equal rights, including reproductive rights for women and girls and equal access to public services are two of the five core rights.[21]

2. Knowledge gaps: Evaluation Purpose and Focus

2.1 Starting points for the evaluation

An underlying premise for this Evaluation is that improved SRHR contributes to improving the lives of poor men and women. IPPF's core business is '….to improve the quality of life of individuals by campaigning for sexual and reproductive health and rights through advocacy and services, especially for poor and vulnerable groups.'[22] This Evaluation will not reiterate work done elsewhere that establishes the links between SRHR and poverty reduction. The assumption is that if IPPF's work is relevant to the SRHR agenda and if it is effective in carrying out its core business, it is contributing to poverty reduction.

2.2 Sida's s perspective on poverty

Sweden's new Policy for Global Development requires a sharpening of Sida's poverty focus. [23]
The concept of poverty is not limited to economic and material aspects, but includes lack of power, lack of security, and lack of freedom and opportunity to decide over and shape one's own life.
The perspectives of poor people means that the needs, interests, capacities, experiences and conditions of poor people should be a point of departure in all efforts to achieve equitable and sustainable development.

Core notions in Sida's poverty concept are:

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

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

2.3 Earlier evaluations

Some donors have shown increasing concern over seeing 'results' of the support they provide. In 1997, Stenson and Brolin carried out a study of the IPPF Secretariat. This was followed in 1998, by a six country performance assessment conducted by Options Consultancy Services for the Norwegian Ministry of Foreign Affairs, Sida, and DFID. In 2003, a consortium of organisations evaluated UNFPA and IPPF work in addressing the needs of adolescents for GTZ, Danida, Norway's Ministry of Foreign Affairs, and DFID. Most recently a 'Management Audit of IPPF' was carried out by Professional Management AB for Sida. Much valuable information about IPPF can be found in reports of these efforts. Of particular note is the lack of monitoring and evaluation observed in both the 2003 Evaluation and the recent management audit

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

2.4 Purpose of the evaluation

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

3. Methodology

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

3.1 The Evaluation will be carried out in 3 phases.

Phase 1: Document Review; Inception Report

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

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

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

Phase 2 Field Studies

Given the wide diversity among MAs, field studies in 3 countries will be used to create the picture of how IPPF works at country level. It is recognised that different MAs are trying to achieve different outcomes because the national context for promoting SRHR varies considerably across countries. Countries will be selected among the most needy, poor countries. Together they should provide regional representation.

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

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

Phase 3 Synthesis Report; Reporting to donors and IPPF.

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

4. Key Evaluation Questions

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

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

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

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

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

5. Performance of the Evaluation

5.1 Evaluation management

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

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

5.2 The evaluation team

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

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

The Evaluation Team should fulfill the following requirements:

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

6. Timing

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

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

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

7. Reporting

The Evaluation Team shall produce the following outputs:

- Inception Report focussing on the conceptual framework for analysis, indicators, data, and data sources to be used during the field studies. This report shall be presented on 30 June, and the remainder of the assignment is subject to its approval by Sida, and NORAD
- Verbal reports to the Advisory Group outlining activities undertaken and results achieved, as well as possible bottlenecks or concerns and recommendations for improvement.
- A brief draft report from each of the field visits (ideally, some five to ten pages), analyzing the main findings in the local context in each country visited. This report shall be distributed to relevant stakeholders (including IPPF and the MA, NGOs, representatives of client groups, and other individual and/or groups who provide information to the Evaluation Team during the Field Visit) in each country within a week of departure. They shall be given the opportunity to comment on its contents.
- The Final Evaluation Report should ideally not exceed 60 pages, excluding annexes. The format and outline of the report shall follow the guidelines in Sida Evaluation Report – a Standardised Format. It will include recommendations to help the participating donor countries make informed decisions about its support to IPPF. In addition a Power Point presentation of 10–15 pages of main conclusions and findings.

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

8. Budget

Costs for the Team Leader will be covered by Sida

Costs for the SRHR consultants will be covered by NORAD

Costs for the youth consultants will be covered by Sida

Costs for the local SRHR consultants will be covered by Sida

To be discussed: Some local costs e.g. local transport, translators, convening the focus groups, and dissemination of the report will be covered by IPPF.

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